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Towards Equity in Health: A Study of Barriers in Accessing RCH Services in Uttar Pradesh

MAY 2010

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FOREWORD

Governments strive to provide equal access to all in need of services under their health programs, including those for reproductive health. In India, major health infrastructure has been constructed, impressive new health schemes have been launched, and increased financial allocations to the health sector provide ample testimony to good intentions. However, the proportion of advantaged people seeking free government health services is significantly higher than that of those who are disadvantaged and deprived. Reproductive health programs must be aware of this fact and should put mechanisms in place to address this situation. Absence of such mechanisms not only leads to inefficient use of scarce resources, but also accentuates inequities. Equity is both an economic and an ethical issue.

Inequities in social systems based on wealth, status and power act as major barriers to accessing reproductive health services. For that reason, all health programs should make a conscious effort to develop strategic approaches as well as operational mechanisms to overcome these barriers.

There have not been many studies conducted on equity issues in India, particularly in hard to reach rural parts of Uttar Pradesh. This study aims to fill part of this gap by exploring the causes of inequities in utilization of reproductive health services at individual, family, community and societal levels in the Eastern, Central, Western and Bundelkhand regions of Uttar Pradesh.

The Innovations in Family Planning Services Technical Assistance Project (ITAP) has done impressive work in delineating the complex set of factors that influence the utilization of reproductive health services in Uttar Pradesh. We hope that the findings will be useful in addressing the programmatic gaps and in reducing inequities.

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ABBREVIATIONS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BPL	Below Poverty Line
CBR	Crude Birth Rate
CHC	Community Health Center
DLHS	District Level Household & Facility Survey
FGD	Focus Group Discussion
FP	Family Planning
GOI	Government of India
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
INGO	International NGO
IUD	Intrauterine Device
JSY	Janani Suraksha Yojana
KI	Key Informant
KII	Key Informant Interview
MMR	Maternal Mortality Ratio
MOHFW	Ministry of Health and Family Welfare
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
OBC	Other Backward Class
ORS	Oral Rehydration Solution
PHC	Primary Health Center
RCH	Reproductive and Child Health
SC	Sub-Center
SC	Scheduled Caste
ST	Scheduled Tribe
TFR	Total Fertility Rate
UP	Uttar Pradesh

Chapter 1

INTRODUCTION, METHODOLOGY AND STUDY DESIGN

1.1 EQUITY AND HEALTH

Equity in health can be described as the absence of systematic disparities in health (or in the major social determinants of health) between social groups, who have different levels of underlying social advantages and disadvantages. Pursuing equity in health reflects a concern to reduce unequal opportunities to be healthy, associated with belonging to less privileged social groups. Inequities in health typically occur in socially disadvantaged groups of people (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic or religious group).

Health inequity, defined as 'inequalities in health status, risk factors or health services utilization between individuals or groups that are unnecessary, avoidable, and unfair', has emerged as a major policy and programmatic concern in the health field mainly over the last few decades (WHO 1998). Health inequities are the result of a complex system operating at global, national and local levels. Technical solutions within the health sector are important, but are not sufficient. Health equity, as a starting point, cannot be a central feature of the justice of social arrangements. In general, the reach of health equity is immense. But, there is a converse feature of this connection to which we must also pay attention. Health equity cannot be concerned with only health. Rather, it must come to grip with the larger issue of fairness and justice in social arrangements (Sen 2003).

There are different arguments put forth by various researchers. Some are of the view that health inequalities are socially produced whereas others are of the view that various socio-economic, cultural, environmental and individual lifestyle factors cumulatively contribute to health.

One way of describing the magnitude of inequalities is the gap between top and bottom socio-economic groups. In EL Salvador, for example, the babies of completely uneducated mothers have 100 percent chance of dying in the first year of life; and where mothers have at least secondary education, the infant death rate is a quarter of that (World Bank 2006). Such dramatic inequalities in health within countries are seen in rich and poor countries. In the Scottish city of Glasgow, life expectancy of men in one of the most deprived areas was 54 years, compared with 82 years in the most affluent (Halon *et al* 2006). This means that the poorest men in Glasgow have lower life expectancy than the Indian average. With few exceptions, the evidence shows that the lower an individual's socio-economic position, the worse their health. Infant and child mortality in developing countries is, primarily, a consequence of poverty and people who are financially poor, are also poor in health.

The differential status of men and women in almost every society across the globe is perhaps the single most pervasive and entrenched inequity. The relation between the genders represents a societal issue for health as pressing as the social gradient itself. This crisis situation is most clearly reflected in the wide disparities between the health status of indigenous people and non-indigenous people within the same country (Nettleton, Napolitano and Stephens 2007). Survival is essential, but so is the quality of children's development. Adult health needs and health inequity are sown in early childhood. Education and the associated high social standing in adult life may protect against health damaging early life exposures (Barker *et al* 2001).

The influence of education on health is seen only as a difference between those with some and those with none, but it is a gradient that runs to the highest level (Erikson 2001).

Equity in health means equal opportunity to be healthy for all population groups. Equity in health, thus, implies that resources are re-distributed and processes re-designed in ways most likely to move toward equalizing the health outcomes of disadvantaged social groups with the outcomes of their more advantaged counterparts. The rural-urban distribution of services is important from the point of view of both the supply and demand and similar treatment concepts of equity.

Promoting health equity requires better accessibility to health systems, appropriate intervention programs at the right time and integrated and coordinated social, economic, political and physical environment action to bring about health for all.

1.2 EQUITY AND REPRODUCTIVE HEALTH ISSUES

Reproductive health problems are the leading cause of women's ill health and death. When both men and women are taken into account, reproductive health conditions are the second highest cause of ill health globally (UNFPA, 2005).

1.2.1 Maternal Death

Every minute, one woman dies of pregnancy-related complication, which adds up to more than half a million mothers every year, of which 99 percent occur in developing countries, while India accounts for about a quarter of maternal deaths worldwide. Currently, the maternal mortality ratio (MMR) in India is 301 maternal deaths out of every 100 thousand live births, which vary across different states, with the highest being 517 maternal deaths per 100 thousand live births in the state of Uttar Pradesh (UP).

In UP, the lack of progress in reducing maternal mortality from 539 in 1999-2000 to 517 in 2002-03 highlights a low value placed on the lives of women in the public health domain. A study of maternal mortality in the state in 1990 shows that maternal death varies across the regions of the state and is more severe in the eastern districts than in the western part. The main causes of these deaths were direct obstetric causes with hemorrhage being the most prevalent. The study also concluded that most of these maternal deaths could have been prevented, if timely medical care were made available to the pregnant women.

Besides lack of proper healthcare facilities and health professionals, another important reason for high maternal death rates in the state is poverty. According to the National Family Health Survey Phase 2 (NFHS-2) (1998-99) in UP, 77 percent of the mothers belonging to lower economic group did not take any antenatal care during their pregnancy and only seven percent of births took place in a health facility. The disparity is enormous when we compare the low economic groups with the middle and high economic group. There is also a huge disparity in health utilization behavior among rural and urban women as well as educated and uneducated women in the state. The variation can also be observed among different ethical and religious groups.

1.2.2 Family Planning

Accessibility and affordability of contraceptive methods is key to achieving development. Family planning has proven benefits in terms of gender equality, maternal health, child survival, and HIV prevention. It can also reduce poverty and promote economic growth by improving family well-being, increasing female participation in workforce as well as by lowering fertility. Though the family planning program in India was initiated very early and there is a provision of free delivery of contraceptive methods, the use of contraceptives is still quite low, specifically in certain pockets of the country.

In UP, the current contraceptive prevalence rate is only 44 percent, which reduces to 29 percent while taking into consideration the modern methods (NFHS-3, 2005-06). Thus, we can say that less than 3 out of every 10 couples in the state are protected with one or the other effective method of family planning. The pattern of use varies across different groups with less than one-fifth of couples using any modern methods in the lower economic group (14 percent), couples residing in rural areas (18 percent), illiterate women (18 percent), Scheduled Caste (SC) and Scheduled Tribes (STs) and Other Backward Class (OBC) couples (less than 18 percent).

1.2.3 Barriers in RCH Utilization

Utilization of health services is affected by a complex inter-relationship of multiple factors that work synergistically at individual, community and societal levels. Factors that contribute to or act as a barrier to health utilization are:

- Economic factors: Poverty, income, access to food and shelter
- Social factors: Social status, gender discrimination, perceived power, self-esteem, social support, isolation
- Environmental factors
- Political factors
- Access to services
- Cultural factors: Cultural and language barriers
- Cost of services
- Individual factors

1.3 NEED OF THE STUDY

During the past two decades, some improvements have been made in the state healthcare delivery system in UP. The understanding that the system should attempt to reach out to people who are marginalized and reside in the remotest areas, has led to experimentation with many models and, in some cases, their replications. Various government-driven programs to enhance family planning use, prenatal and natal care, along with other public-private partnerships with massive and innovative intervention efforts had been launched in the state, but these did not bring a remarkable change in the reproductive and child health (RCH) situation, which still remains bleak. In this context, the present study aims to have a re-look at the factors that prevent or promote people from accessing RCH services in the state.

1.4 OBJECTIVES

The present research attempted to understand the factors contributing to the differentials in accessing RCH in UP.

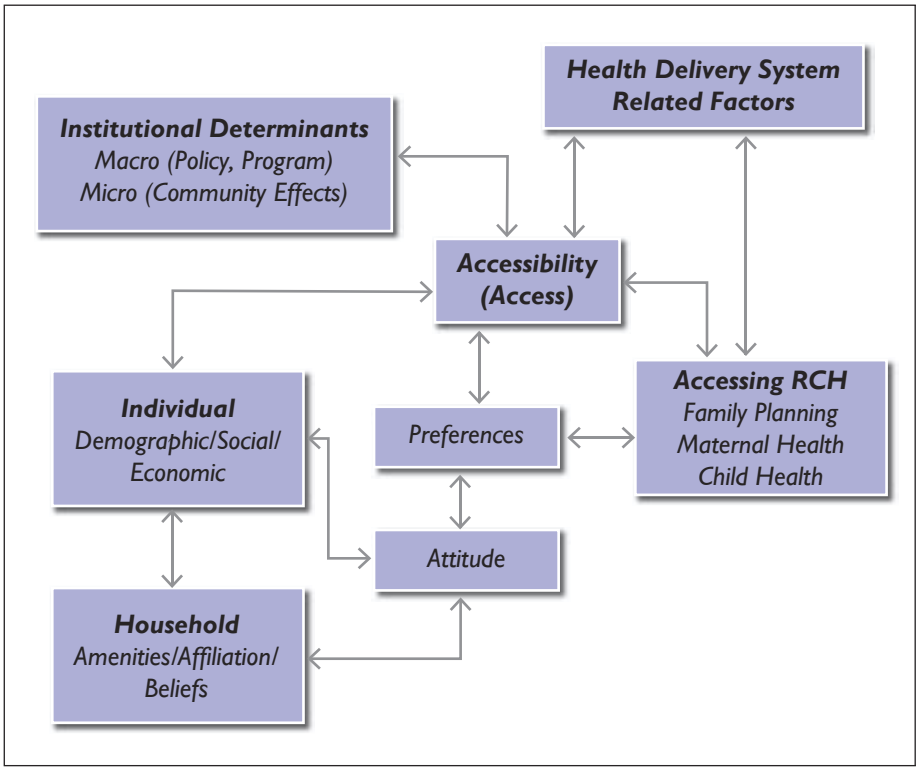
The specific objectives of this study were:

- To undertake a review of existing literature on barriers in accessing reproductive health in general, with special reference to India and UP and thus, to arrive at a tentative framework for the research.
- To examine the social, cultural and economic factors that limit the access to and utilization of RCH in UP. The study emphasized the role of institutional factors – both at macro level and community level – in deciding accessibility to RCH in the state. This also helped to understand the situations that determine people's attitude and behavior, which in turn influence the decisions and practice of accessing various types of health services.
- To suggest feasible and sustainable measures to significantly improve access to RCH in UP.

1.5 CONCEPTUAL FRAMEWORK

The following conceptual framework was used to begin the study. It is held that institutional factors (both at the broader level and at the community level) interact with household and individual level factors. These interactions along with the healthcare delivery system related variables shape people's perceptions, attitudes and behaviors related to RCH.

FIGURE 1: CONCEPTUAL FRAMEWORK



1.6 STUDY DESIGN AND METHODOLOGY

1.6.1 Study Design

The stakeholders considered in this research are mainly the service providers and beneficiaries, which include women and men. Apart from the two, another category considered for the study was 'key informants' (KI), who are not primarily from the health sector, but work in the area of health in some capacity, directly or indirectly.

In the service providers group, an attempt has been made to incorporate all the existing entities such as public sector providers, private practitioners, indigenous practitioners, and the non-governmental organizations (NGOs) working on health and health related issues. These targeted providers were selected from the state, district, block, primary health center (PHC) and village levels. The service providers have been included in the study as the KIs.

Among beneficiaries, the target groups were married women, married men, and relatives of married women (mothers-in-law or other relatives). These informants were selected from both urban and rural areas of each selected district, and were included as respondents for in-depth interviews.

1.6.2 Identification of the Study Areas

The selection of the district was done in consonance with the objectives of the study during a consultative meeting. Four districts from four different zones of the state were chosen on the basis of their RCH vulnerability rank.

The districts in the Bundelkhand region and central UP are the better performing districts, while Agra, in the western zone, is considered an average performing district on RCH status. Siddharth Nagar district in eastern UP is one of the worst performing districts in the state.

FIGURE 2: SELECTED DISTRICTS OF UTTAR PRADESH

TABLE 1: RCH VULNERABILITY RANK OF DISTRICTS

Region	Districts	Overall Score	Vulnerability Rank
Western UP	Agra	38.71	31
Bundelkhand	Lalitpur	44.50	43
Eastern UP	Siddharth Nagar	25.38	12
Central UP	Unnao	43.07	40

Source: *Baseline Facts – Uttar Pradesh, June 2005-Feb 2007.*

Note: Both the overall score and the vulnerability rank are positively related to the district RCH status/situation. That is, more of overall score and higher vulnerability rank signify better RCH situation of respective districts and vice versa.

Once the districts were finalized, two blocks from each district and two villages from each block were selected on the basis of the proportion of institutional and home delivery, contraceptive use, and mother-child immunization. These statistics were collected from the respective district hospitals as well as the block level community health centers (CHCs) and PHCs.

1.6.3 Survey Tools

The data collection procedures adopted for this research study, which is qualitative in nature, are as follows:

- Key Informant Interviews (KIIs)
- Focus Group Discussions (FGDs)
- In-Depth Interviews (IDIs)

1.6.4 Sample Size and Data Collection

As mentioned earlier, four districts were selected: Agra, Lalitpur, Siddharth Nagar and Unnao.

Although the target number of interviews in each sample was 90 in the three districts, the number of interviews and discussions completed were more than 90. The total number of interviews conducted in Agra, Lalitpur, Siddharth Nagar and Unnao was 91, 90, 93 and 99 respectively. Data collection of the study started with Unnao followed by Agra, Siddharth Nagar and finally Lalitpur. The names of the blocks and villages selected from each district for this study are given in Table 3.

1.6.5 Number of Interviews

As mentioned in the earlier section, from each district, more than 90 interviews/discussions were completed. The distribution of interviews/discussions conducted according to the residence and type of methods adopted are given in Table 4.

Seventy-six KIIs were conducted in the rural areas and 24 were conducted in the urban set-ups in four districts. IDIs with married men totalled 30 in rural and 16 in urban areas, while 108 IDIs were conducted with rural women and

TABLE 3: BLOCKS AND VILLAGES SELECTED FOR THE STUDY

District	Blocks	Villages
Unnao	Fatehpur Chaurasi	Dostpur Sivali Jamuriddin Pur
	Sumerpur	Sarai Manihar Bhatkherwa
Agra	Pinahat	Siktara Arjunpura
	Achhnera	Ardaya Kasauti
Siddharth Nagar	Jogia	Sonaura Harni Bujurg
	Khesraha	Bankegaon Vishnupur Musthakam
Lalitpur	Mahrauni	Sindwaha Bhadaura
	Talbehat	Thana Hasarkala

TABLE 2: PROPOSED SAMPLE SIZE

Provider/Beneficiary	KII		FGD		IDI	
	Rural	Urban	Rural	Urban	Rural	Urban
Public (MO, ANM, AWW, ASHA)	MO–-2 ANM-–2 AWW-2 ASHA-2	MO-2	-	-	-	-
Private	MBBS-2 RMP-2 *DAI*-2	MBBS-2	-	-	-	-
NGO	Activist-2		-	-	-	-
Others	4	2	-	-	-	-
Married Women	-	-	8	2	24	6
Married Men	-	-	-	-	8	4
Mother-in-law/Others	-	-	-	-	8	4
Total	**20**	**6**	**8**	**2**	**40**	**14**
	26		**10**		**54**	
TOTAL	**90**					

TABLE 4 : NUMBER OF INTERVIEWS BY TYPE AND DISTRICTS

Name of the Districts/Type of Interview	Rural	Urban	Total	Name of the Districts/Type of Interview	Rural	Urban	Total
Unnao				**Agra**			
KII	15	04		KII	20	07	
IDI (M)	07	04	99	IDI (M)	06	04	91
IDI (F)	33	13		IDI (F)	27	06	
IDI (RELATIVE)	09	04		IDI (RELATIVE)	06	04	
FGD	08	02		FGD	09	02	
Siddharth Nagar				**Lalitpur**			
KII	21	07		KII	20	06	
IDI (M)	08	04	93	IDI (M)	09	04	90
IDI (F)	24	06		IDI (F)	24	06	
IDI (RELATIVE)	09	04		IDI (RELATIVE)	07	04	
FGD	08	02		FGD	08	02	

31 with urban women. As many as 31 relatives, mostly mothers-in-law, in rural areas and 16 from urban areas were interviewed. Total number of group discussions accounted for 33 from rural areas, which included one male group discussion, and eight from the urban areas. In total, 373 interviews/discussions were conducted in four districts for this study. A detailed description of the interviews for each district is given in the Appendix.

1.6.6 Data Analysis

The information collected from the field was translated into English. Analysis of the collected data was carried out by using the ATLAS.ti software. The data was coded, following which, system analysis was carried out. In consonance with the objectives to unearth the barriers in accessing RCH by people, in rural and urban areas, and to achieve a comparative view, the analysis was done from both the provider's and the receiver's perspective.

Chapter II

RCH SITUATION IN UTTAR PRADESH: EXISTING SCENARIO

2.1 UTTAR PRADESH IN BRIEF

2.1.1 Population

According to the 2001 Census, UP has a population size of 166 million, with an annual growth rate of 2.6 percent and a relatively high population density of 689 persons per sq. km. (Table 5) Just above one-fifth of its population resides in urban areas; the extent of urbanization being less than the national average. UP has a young age structure, with 41 percent being children below 15 years. Sex ratio (898 females per 1000 males) in UP is lower than the national average (930 female per 1000 males); the level of child sex ratio indicates gender-based discrimination (916 girls per 1000 boys) and is also lower than the national average (927 girls per 1000 boys).

TABLE 5: BASIC INDICATORS OF UTTAR PRADESH

Indicator	Value
Population Size 2001 (million)	166.05
Annual Growth Rate (percent)	2.58
Population Density (per sq. km.)	689
Percent of Urban Population	20.78
Age Structure (percent; 2001)	
0-14 years	41.1
15-59 years	52.9
60 years and above	6.1
Sex Ratio (Female per 1000 Males; 2001)	898

Source: Census of India, 2001

TABLE 6: SOCIO-ECONOMIC INDICATORS OF UTTAR PRADESH

Indicator	Percent
Literacy Rate*	
Total	57.4
Male	70.2
Female	43.0
Work Participation Rate**	
Rural	
Male	49.6
Female	24.0
Urban	
Male	52.4
Female	11.7
Per Capita Income (INR; 2004-05)	11,477
Percent Living Below Poverty Line**	
Rural	33.4
Urban	30.6

* Census of India, 2001
** NSS 61st round, 2004-05

2.1.2 Socio-Economic Scenario

Literacy, an important indicator of social development, shows the dismal situation of the state. Only 57 percent of the state's population is literate; the gender gap is very high compared to many other states (27 percent). Work participation rate in the state is about 50 percent but female work participation rate is quite low both in rural and urban areas. Per capita income of UP is much lower than the national average, putting pressure on the people in availing quality services in the changing context. The extent of poverty is high in both urban and rural areas of the state; close to one-third of the state's population lives below poverty line (BPL).

TABLE 7: MAJOR DEMOGRAPHIC INDICATORS OF UTTAR PRADESH

Mean Age at Marriage*	
Male	20.1
Female	17.5
Crude Birth Rate$^{\alpha}$	29.1
Crude Death Rate$^{\sigma}$	8.6
Total Fertility Rate$^{\alpha}$	3.82
IMR	71
Total	75
Rural	
Urban	53

* Census of India, 2001
$^{\alpha}$ NFHS 3 2005-06
$^{\sigma}$ SRS, 2006

2.1.3 RCH Scenario

The state has shown a clear trend of declining fertility over a period

of seven years, from 4.06 during NFHS-2 (1998-99) to 3.82 in NFHS-3 (2005-06), and is set to reap the advantages of demographic windows, if planned carefully. At the current juncture, crude birth rate (CBR) and total fertility rate (TFR) show that fertility is still high in the state, and there is great scope for fertility decline if focused programmatic interventions are implemented. One of the factors contributing to high fertility in the state is the relatively low mean age at marriage, especially among females (17.5 years), indicating that close to half of the marriages in the state take place when the bride is less than 18 years old.

On the other hand, the dependency ratio in the state during 2001 was 89 per 1000 persons, and it is projected that the ratio will decrease to 69 per 1000 persons by 2016, and to 63 by 2026. Usually, such a trend of decline in the dependency ratio as a consequence of bulging of youth and middle age groups in the age pyramid, would last for about 40 years or so. UP has to now turn its attention to the growing young population, who, in fact, are in the reproductive age group. Therefore, reproductive health in the state will assume increased significance and emphasizing this significance over the period of time will make a huge difference in the health scenario of the state. At the same time, the state cannot divert investments from child health, since a sizeable proportion of the population is made up of children, and their health situation is still far from ideal.

Coming to some of the basic child health related indicators, the infant mortality level is still very high (71 percent) with considerable rural-urban difference.

TABLE 8: VACANT HEALTH STAFF POSITIONS AND SC FACILITIES IN RURAL UTTAR PRADESH: 2007

	Number
Vacant Positions	
ANM	1756
MPW	3348
LHV	407
HA (M)	1651
MO (PHC)	NA
Specialists	697
Availability of SCs	
No. of SCs	20521
SCs with ANM quarters	6494 (32%)
SCs with ANM Living in SC Quarters	5183 (80%)

Source: Bulletin of Rural Health Statistics, 2007, MOHFW, GOI

2.1.4 Availability of Health Personnel and Health System

The study of the state's social and economic indicators shows that improving the health condition across the population would not be so easy, given the existing differential among the groups. The situation is made more difficult as the state has not been able to provide adequate health facilities to its people (Tables 8 & 9). There is a shortfall of 5823 Sub-Centers (SCs), 730 PHCs and 711 CHCs in the state as of March 2007. This shortfall in health facilities leaves about 29 million of the state's population bereft of public health services. Not just the physical facilities, there is an acute shortage of health functionaries at all levels, as shown in Table 8. The state is thus, experiencing what may be referred to as a 'double trouble'.

Thus, the social and economic indicators of the state tell us that the capacity of the people (in terms of awareness as well as purchasing power) is dismally low, along with inadequate physical availability of the health services. Even if one expects high quality services from all the existing facilities, there is a significant proportion of population left out by the system, though unintentionally.

TABLE 9: HEALTH FACILITIES IN UTTAR PRADESH: 2007

Details	Required	In Position	Shortfall
SC	26334	20521	5823
PHC	4390	3660	730
CHC	1097	386	711
MPW (Female)/ANM at SC or PHC	24181	21900	2281
HW (M)/MPW (M)	20521	5732	14789
HA (F)/LHV at PHCs	3660	2128	1532
HA (M) at PHCs	3660	4061	-
Doctors at PHCs	3660	NA	NA

Source: Bulletin of Rural Health Statistics, 2007, MOHFW, GOI

2.2 CURRENT RCH SITUATION IN UTTAR PRADESH

The current RCH situation at the state level has been analyzed using the information collated from NFHS findings. The data in Table 10 reveals a clear differential in the fertility, contraception and maternal health situation between rural and urban areas of UP.

2.2.1 Fertility and Contraception

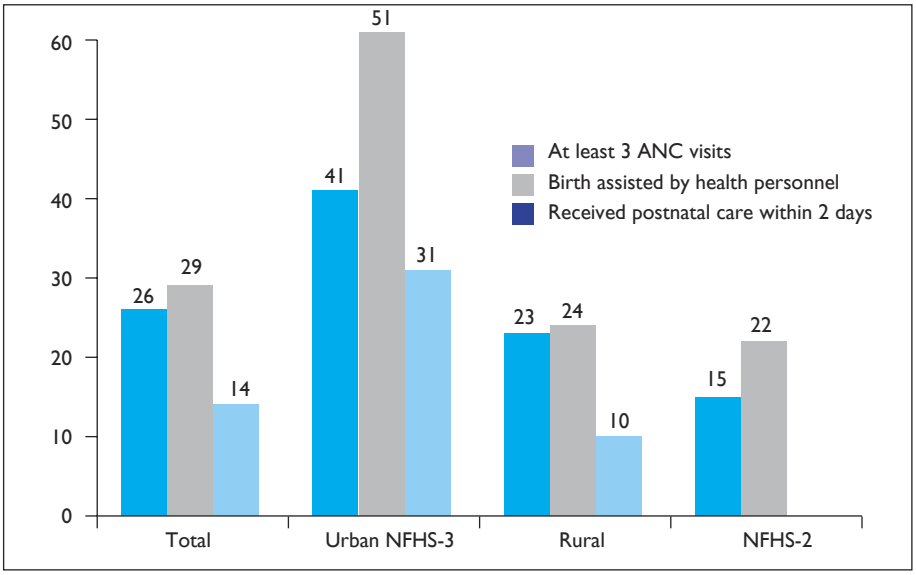
The TFR shows that the women in rural areas (comprising about 80 percent of the population) have almost one child more than their urban counterparts. Similarly, the extent of contraceptive use is low (40 percent), whereas the unmet need of contraception is as high as 24 percent. While the demand for contraception is low in the state, the state health delivery system is unable to meet 25 percent of the current demand itself.

2.2.2 Maternal Health

Only a little higher than a quarter of mothers in the state had three or more antenatal visits, with a vast rural-urban difference. Also, the extent of assisted delivery by trained health professionals is still very low in the state, particularly in the rural areas.

The most striking picture of the low level of maternal healthcare utilization can be seen in the postnatal check-up figures, which shows as low as 14 percent of mothers in the state, with only 10 percent of rural mothers receiving postnatal care. Although maternal healthcare indicators have shown signs of improvement over the seven years period between NFHS-2 and NFHS-3, the overall situation is still far from satisfactory.

FIGURE 3: MATERNAL HEALTHCARE SCENARIO IN UTTAR PRADESH



Source: NFHS-3, 2005-06

TABLE 10: MARRIAGE, FERTILITY AND CONTRACEPTION IN UTTAR PRADESH: 2005-06

	NFHS-3			NFHS-2
(1998-99)	Total	Urban	Rural	
1. Women aged 20-24 married by age 18	53.0	30.0	61.1	64.3
2. TFR (children per woman)	3.82	2.95	4.13	4.06
3. Women aged 15-19 who were already mothers or pregnant at the time of the survey	14.3	7.8	16.3	NA
4. Current use of any method	43.6	56.3	39.7	27.1
5. Total unmet need	21.9	15.5	23.8	25.4
5a. For spacing	9.3	6.0	10.3	11.8
5b. For limiting	12.6	9.5	13.5	13.6

Source: NFHS-3: 2005-06

2.2.3 Child Health

Closely associated with maternal health is the health status of children. Only 23 percent of the children between 12 and 23 months are fully immunized, registering a marginal improvement of 2.4 percentage points between NFHS-2 and NFHS-3. Only 12 percent of the children who had suffered from diarrhea were given oral rehydration solution (ORS) and 64 percent of children suffering from acute respiratory infections (ARIs) were taken to a health facility for treatment.

The breastfeeding pattern has considerable impact on the future survival status of children and

TABLE 11: CHILD HEALTH INDICATORS IN UTTAR PRADESH: 2005-06

	NFHS-3			NFHS-2
	Total	Urban	Rural	(1998-99)
1. Children 12-23 months fully immunized (BCG, measles and 3 doses each of polio/DPT)	22.9	32.6	20.5	20.2
2. Children with diarrhea in the last 2 weeks who received ORS	12.0	15.0	11.2	15.2
3. Children with ARI or fever in the last 2 weeks taken to a health facility	63.6	83.8	58.6	NA
4. Children under 3 years breastfed within one hour of birth	7.2	8.5	6.9	5.7
5. Children aged 0-5 months exclusively breastfed	51.3	31.8	55.8	50.8
6. Children under 3 years who are underweight	47.3	37.9	49.4	51.8

can affect their overall nutritional status. Only 7 percent of children are breastfed immediately after birth (within the first half an hour), while 51 percent of children are exclusively breastfed for the first five months.

Tables 11 and 12 show that the nutritional status of children in UP is far from ideal; 47 percent of children below 3 years are underweight and 85 percent are anemic. The increase in the extent of anemia among children between NFHS-2 and NFHS-3 is alarming. The fact that anemia is high in children in all educational categories, points to system related factors that shape the belief and practices of people in the state regarding child care.

TABLE 12: NUTRITIONAL STATUS IN UTTAR PRADESH

	NFHS-3			NFHS-2
	Total	Urban	Rural	
BMI (% below normal)				
Women	34.1	23.3	37.2	36.5
Men	32.7	21.9	36.5	NA
Percent Anemic				
Children aged 6-35 months	85.1	82.5	85.7	73.8
Ever-married women (15-49)	50.8	50.7	50.8	49.0
Pregnant women (15-49)	51.6	51.3	51.7	45.8
Ever-married men (15-49)	24.7	15.7	27. 8	NA

Table 12 also provides information on the nutritional status of adult men and women in the state, which has implications for reproductive as well as child health. More than one-third of married women and men in the state have Body Mass Index (BMI) less than normal, whereas more than 10 percent are overweight. Prevalence of anemia is high among married women, though it is still better than that among children. More than half of the pregnant women are anemic. There is hardly any significant difference in anemia levels among the rural and urban population.

Chapter III

INTRODUCTION TO THE STUDY AREA AND RCH ISSUES

3.1 INTRODUCING THE DISTRICTS

3.1.1 Geographical Location

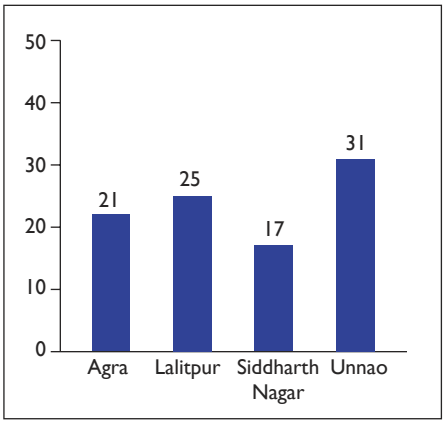
Lalitpur district is situated at the border of the state, touching Madhya Pradesh and is one of the southern districts of the state with a geographical area of 5,039 sq. km. Siddharth Nagar, which is situated in eastern UP, is one of the smallest districts in the state with an area of 2,752 sq. km.

3.1.2 Population

The four districts selected for this research represent the demographic as well as developmental heterogeneity in UP (Table 13). The population size in the districts ranges from 11.2 million in Lalitpur to 41.6 million in Agra.

The average annual population growth in two of the selected districts (Siddharth Nagar and Unnao) is lower than the state average. Lalitpur's growth rate is close to the state average and the growth rate in Agra is a little higher. In terms of urbanization, these districts present a wide range – while only 4 percent of Siddharth Nagar has urban population, in Agra it is 45 percent. Sex ratio in the selected districts is generally low, with the exception of Siddharth Nagar (948 females per 1000 males). Agra, the most urbanized, has the lowest sex ratio (846 females per 1000 males) followed by Lalitpur (882 females per 1000 males). Unnao has a sex ratio of 898 females per 1000 males, which is the same as the state average. The share of SC population in these districts ranges from 17 percent in Siddharth Nagar to 31 percent in Unnao.

FIGURE 4: PROPORTION OF SCHEDULED CASTE POPULATION



3.1.3 Literacy Level

In terms of literacy, Unnao is close to the state average, while Siddharth Nagar and Lalitpur have a lower literacy rate (Table 14). Female literacy rate in these two districts is particularly low – 27 and 33 percent respectively. Agra has a higher literacy rate of 48 percent. As the female literacy rates differ across the selected districts, the extent of gender gap in terms of literacy is also very striking.

The degree of gender gap in literacy varies from 24.7 percentage points in Unnao to 30.8 percentage points in Lalitpur. Also, gender gap in literacy is much more pronounced in rural areas (ranging from 27 to 35 percentage points) as compared to urban areas (ranging from 14 to 21 percentage points).

TABLE 13: BASIC DEMOGRAPHIC PROFILE OF THE SELECTED DISTRICTS, 2001

Districts	Area (sq. km.)	Population	Urban Population	Average Annual Growth Rate (%)	Sex Ratio
Agra	4,027	41,61,113	44.66	2.7	846
Lalitpur	5,039	11,16,737	14.77	2.6	882
Siddharth Nagar	2,752	23,01,515	3.87	2.4	948
Unnao	4,558	29,99,828	16.10	2.0	898

Source: Census of India, 2001

TABLE 14: LITERACY IN SELECTED DISTRICTS, 2001

Districts	Literacy Rate (percent)			Gender Gap in Literacy (percentage points)		
	Total	Male	Female	Urban	Rural	Total
Agra	62.6	74.6	48.3	15.2	35.4	26.3
Lalitpur	49.5	63.8	33.0	20.6	32.9	30.8
Siddharth Nagar	42.3	56.7	27.1	20.8	29.9	29.6
Unnao	54.6	66.3	41.6	14.4	26.6	24.7

Source: Census of India, 2001

3.1.4 Economic Scenario

Economic activities of the people also vary across districts, with significant variation between males and females. Overall work participation rates vary between 27 percent in Agra and 43 percent in Lalitpur. In rural areas, the variation ranges from 28 percent to 46 percent, while the difference in urban areas is marginal, between 26 percent and 29 percent.

Growth of employment has been marginal in all the districts. In rural areas, it ranges from 2.2 percent in Agra and Unnao to 2.9 percent in Lalitpur and Siddharth Nagar. The annual employment growth rate in the urban areas ranges from 1.9 percent in Siddharth Nagar to 3.3 percent in Lalitpur. Thus, among the four districts, Lalitpur has greater employment opportunities in both rural and urban areas.

According to the District Level Household and Facility Survey Phase 2 (DLHS-2) (2002-04), more than 65 percent of the population in Lalitpur (67%), Siddharth Nagar (70%) and Unnao (65%) fall in the low standard of living category.

3.2 HEALTH FACILITIES AND GENERAL HEALTH STATUS

Information on health facilities in the selected districts is presented in Table 16. The report indicates the availability of 7 CHCs in Siddharth Nagar and only 3 in Lalitpur. Agra and Unnao have equal number of CHCs (5 each). The number of PHCs in the districts range from 29 in Lalitpur to 81 in Siddharth Nagar and the number of SCs range from 191 in Lalitpur to 383 in Agra and 348 in Unnao.

TABLE 15: WORK PARTICIPATION IN THE SELECTED DISTRICTS, 2001

District	Work Participation Rate (percent)					Annual Growth in Employment: 1991-2001	
	Rural	Urban	Total	Male	Female	Rural	Urban
Agra	28.4	25.7	27.2	44.1	7.2	2.2	2.8
Lalitpur	45.5	29.4	43.2	50.4	35.0	2.9	3.3
Siddharth Nagar	38.5	26.0	38.1	47.6	28.0	2.8	1.9
Unnao	35.6	27.1	34.3	50.0	16.8	2.2	3.1

Source: Census of India, 2001

TABLE 16: HEALTH FACILITIES IN THE SELECTED DISTRICTS, 2007

District	No. of CHCs	No. of PHCs	No. of SCs
Agra	5	68	383
Lalitpur	3	29	191
Siddharth Nagar	7	81	274
Unnao	5	56	348

Source: Bulletin of Rural Health Statistics, 2007, MOHFW, GOI

More important is the population size covered by a PHC and Sub-Centers. In Siddharth Nagar, the population covered by a PHC is 28,414; it is as high as 53,568 in Unnao and 61,193 in Agra. This indicates that most PHCs in the selected districts actually cover a greater population than the actual norm. While on an average, the recommended population coverage by a SC is 5000, in all four districts, the population covered by a SC is also found to be exceeding the norm. In Unnao, the population covered by a SC is, on an average, 8,620 and in Agra it is exceptionally high at 10,865. These calculations were made based on the population figures for 2007; the population covered would be much higher at present.

The Department of Planning of the UP government has made an attempt to measure the relative portions of the districts in terms of their health status, by calculating composite health index. The districts selected for research by and large (three out of four) reflect the state average. Unnao

TABLE 17: POSITION OF SELECTED DISTRICTS ON COMPOSITE HEALTH INDEX, 2002-03

District	Composite Health Index	Rank
Agra	60.1	15
Lalitpur	48.6	49
Siddharth Nagar	44.9	61
Unnao	46.2	59
Uttar Pradesh	49.1	-

Source: Note on Health Sector in UP, Dept. of Planning, Govt. of UP, 2005: www.planning.up.nic.in/articles/note_on_health_sector

and Siddharth Nagar have an index value slightly lower than the average. Agra, however, has a much higher index of 60 percent. In terms of ranking among the 70 districts, Agra ranks 15, while Lalitpur ranks 49, Unnao rank 59 and Siddharth Nagar ranks 61. Thus, considering the index, the present study has covered districts with different performance levels.

3.3 RCH SITUATION IN THE SELECTED DISTRICTS

This section provides brief information on the RCH scenario of the studied districts. The recently concluded NFHS-3 recorded a TFR of 3.8 children per woman at the state level, which is the second highest TFR recorded at the state level after Bihar (four children per woman). The urban TFR is 2.95, the highest in the country, while the TFR is 4.13 among rural women.

The situation regarding the fertility level is found to be quite high in the selected districts. Unnao closely resembles the state average, while the other districts have a TFR higher than four children per woman; rural Agra has the highest TFR of 5.03.

TABLE 18: FERTILITY INDICATORS, 2007

Districts		Total Fertility Rate	Mean Children Ever Born	Women Married below Age 18 (%)	Women with 3 or More Children (%)
Agra	Rural	5.03	3.23	68.69	55.09
	Urban	3.53	2.91	35.41	54.81
Lalitpur		4.74	3.10	76.10	53.10
Siddharth Nagar		4.55	3.82	60.78	60.69
Unnao		3.83	3.05	51.25	52.03

* Women aged 15-49 years
Source: Baseline Facts – Uttar Pradesh, June 2005 – February 2007.

Table 18 also shows the other indicators of fertility in the selected districts. The percentage of women who got married below the legal age of marriage (18 years) is found to be very high in all the districts, and varies from 51 percent in Unnao to 76 percent in Lalitpur. Likewise, the percentage of women in the reproductive age group with three or more children is also high in all the districts, from 52 percent in Unnao to 61 percent in Siddharth Nagar.

Use of family planning methods among the couples in the study areas is quite low. Modern methods of contraceptive use are lowest in Siddharth Nagar (11 percent) and highest in Agra (31 percent). The unmet need for family planning is very high in all the districts, with couples in Siddharth Nagar district registering the highest unmet need for contraception.

Both antenatal care and delivery care indicators are presented in Table 20, which shows the heterogeneity across the selected districts. Any antenatal care coverage from a public sector shows below 10 percent utilization among the mothers in Siddharth Nagar and Unnao districts. Since we cannot assume the extent of antenatal visits to private health facilities in Siddharth Nagar and Unnao, their

TABLE 19: FAMILY PLANNING INDICATORS, 2007

Districts	Any Method	Women using Modern Method	Unmet Need	
			Spacing	Limiting
Agra	37.7	30.8	10.9	19.2
Lalitpur	39.9	29.7	10.5	21.3
Siddharth Nagar	23.4	10.9	20.2	20.4
Unnao	34.8	20.9	10.5	18.9

Source: Based on RCH II District Level Household Survey – 2002-04.

figures indicate the low level of utilization of health services during pregnancy. Even for complicated deliveries, a very low proportion of women access services from government facilities. Institutional deliveries is found to be low across all the districts.

Across the districts, less than a quarter of children aged 0-11 months received all the vaccinations recommended during the first year of birth. More than 40 percent of children aged 12-23 months did not receive any vaccination in Agra and Unnao districts, while it is about 23 percent in Siddharth Nagar and Lalitpur districts.

TABLE 20: ANTENATAL AND DELIVERY CARE IN THE SELECTED DISTRICTS, 2007

Districts		Any ANC Visits at Govt. Facility	Seeking Treatment at Govt. Facility for Complicated Pregnancy	Institutional Deliveries
Agra	Rural	33.33	12.00	27.14
	Urban	21.48	12.41	55.95
Lalitpur		48.70	33.60	29.70
Siddharth Nagar		5.97	9.84	10.53
Unnao		9.74	9.74	24.49

Source: Baseline Facts – Uttar Pradesh, June 2005 – February 2007.

Chapter IV

RCH DIFFERENTIALS AND ASSOCIATED FACTORS

Reproductive health exemplifies the multifaceted interactions between biological and gender differences, but in most cases, they are manifested as social discrimination and lack of power to decide on one's reproductive health status. Time and again, it has been found that the decision of reproductive health status of women depends on their partners, cultural orientation, and often on availability of health systems and providers. All these, along with individual and community factors, interplay greatly on the level of healthcare behavior, particularly for a woman during her reproductive span.

This section presents the salient findings from the qualitative research carried out in the four study districts. The previous section highlighted the current RCH situation in the study districts which differed across districts. The difference is also found across the rural-urban areas, while analyzing the national level as well as state level surveys undertaken by different agencies. The existence of such difference is also revealed by qualitative research. Moreover, it was found that accessing RCH services is, in general, limited to the well-educated, higher earning groups, whether it is from public or private sources. Yet, inter-district differences were found. For example, it was reported by some KIs as well as during FGDs that in recent years, accessing RCH services is not confined to the affluent families. Yet, overall, access to RCH services by the poor and marginalized groups remains limited, especially in rural areas.

While one would expect a certain extent of class and caste differences, it is imperative to note that the differences observed in this study do not exactly match with the developmental differences across the districts, as evident from broad indicators considered in the previous section. This implies that apart from the broad indicators, there are local level factors that shape the behavior of people in accessing RCH services in the state.

The study explores the individual and household factors that are responsible for unequal access and exist as barriers to the homogenous reach of the existing services. The study tried to record the reasons for the same, from providers as well as beneficiaries. While discussing the socio-cultural rites and rituals pertaining to reproductive and child health with the married women, their mothers-in-law and husbands, we came across various cultural traditions that have been in practice at the community and household levels. These traditional practices come into play once the woman conceives.

4.1 INDIVIDUAL AND HOUSEHOLD FACTORS

Inadequate Food Habits:
There are restrictions in the diet of a mother-to-be. Mothers-in-law believe that certain items are not recommended during pregnancy, and hence, they restrict their pregnant daughters-in-law from eating, so that the foetus doesn't get affected. For example, during an FGD, the women said that they were not taking jaggery, spices and tea in large quantities because they believe these food items generate heat in the body. During pregnancy, they consume normal home-made food, depending on the availability and affordability. There were no instances where a special arrangement of nutritious food for the pregnant women was mentioned by any woman during the study. As cited by a mother-in-law:

"There was no restriction on her food; whatever was available, she used to cook for every one in the family. From the very beginning of her pregnancy,

I told her not to eat papaya, because if a pregnant woman eats papaya, the foetus gets aborted at once." **Mother-in-law, 60 years, illiterate.**

Most of the women ate or were given less than adequate diet during their pregnancy. They also observed the ritual of keeping fast during the pregnancy, to bring good fortune for the child.

The food habits of women post-delivery are completely different as in all the study areas. It has been found that for up to 10 days after delivery, women were only given tea, milk, *dalia* (crushed wheat flakes) and a special sweet (*ladoo*) made of dry fruits, jaggery and ginger. The number of days vary from four to 10 days across the population. The reason behind this practice was cited as:

"My wife was given only tea, bread, and ladoo for four to five days after delivery to eat. Though I think she must be *given normal food, but this is our tradition and my mother told me that by eating the ladoos, the dirt which gets accumulated in a pregnant woman's stomach gets cleaned."* **Husband, 27 years, educated, Master's Degree holder, teacher**

Heavy Workload: Pregnant ladies in the villages continue to work till they feel the labor pain. They believe that if they keep on working till the last moment, then the delivery will be easy. They say, *"We do all the work for complete nine months, because if you work, the delivery will take place with ease."* But this was not universally applicable to all the pregnant women.

During an FGD with married women, aged 20-30 years, in rural areas, it was found that:

"During pregnancy, we women carry on with all the household work for the entire nine months period. We also go down to the field to help our husband and other family members. We work because of two reasons: (i) if one works during pregnancy, the delivery takes place quite easily; and (ii) if we don't help our husband in field in cultivation and other related activities, we will not get enough output from the field and what will we eat then? Thus, working during pregnancy is a compulsion for us. Apart from that, there is pressure from the other family members. There is a ritual that once the son gets married and brings his bride home, her mother and other elder women do not do household work and it is compulsory for the daughter-in-law to work, whatever may be her condition. They say, "If she does not work then who will do it?" We do all household work right from working in the field, fetching water from a long distance to preparing food and looking after our children."

Due to their heavy workload during pregnancy, there are instances of pregnant women having miscarriages. For instance, *"a pregnant lady shared that she lifted full bucket of water and because of this, she had intense pain in the stomach. When she went to the toilet, she was bleeding heavily."*

Restrictions on Movement: In certain cases, the prospective mother is not allowed to go out of the house. The relatives believe if she goes out, then the child may die. One woman shared that during her pregnancy, her mother-in-law did not let her go anywhere outside at any time. She was not sent to her mother's place even once. They believe if the pregnant lady moves out of home, then she will be affected by the 'evil eye' of others. Under such restrictions, the pregnant women are not able to go for their antenatal care (ANC) check-ups or for other services.

Decision-Making: In households across villages/communities, decisions of any kind pertaining to the health of the women is generally taken by the mother/mother-in-law of the household. The mother/mother-in-law decides whether the daughter-in-law should be allowed to go out, go for ANC check-ups, how many children should she bear, use of family planning, when and by whom.

"In most of the cases, family planning decisions are taken by the husband. Women do not allow their husbands to adopt sterilization, as they feel men will become weak and will not be able to perform heavy work." **Male health supervisor, 47 years**

While, in case of pregnancy related decisions, a father of three daughters stated, *"I can't take care of my wife during pregnancy, because I am afraid of my mother. My mother says pregnancy doesn't need my involvement or presence. Thus, every time my wife's delivery took place, I was either in the field or somewhere else."*

4.2 SOCIAL FACTORS

Gender Issue: Gender differentials exist both at the community as well as at the health system level. A male child is preferred and welcomed as

opposed to a girl child, across all educational and economic brackets.

"*If the newborn child is a girl, then both mother and child are given bath on the third day from the delivery, but if it is a male child, the bath is given on the fifth day." The reason behind this as stated by her is that "as you know, everyone likes a boy and when a male child is born, we all want him to be healthy and well, so if we give bath to the child and mother too early, there is a chance that they can catch a cold and develop fever. In such cases, we don't allow our daughter-in-law to work for 10 days after delivery, so that she can take rest and look after her son."* **Mother-in-law, 60 years, illiterate, rural area**

"Nobody wants daughters, as they are the property of some other family. Women who have only girl children are not considered auspicious." **Married woman, 28 years, literate, rural area**

Even the health service provider shows a bias toward the male child. A medical practitioner informed that at the PHC, the auxiliary nurse midwife (ANM) asks for money after she performs the delivery and the fee depends upon the sex of the newborn child. If it is a boy, she demands Rs. 500 and for a girl child, it is usually Rs. 200 per delivery.

In case of contraceptive use, as found in other societies too, it is mostly women who are oriented toward such methods, both in the accepters' group as well as in the health providers. Women confined themselves as the only source of accepters of any family planning methods. In addition, the women also believe that only they should use the methods, because they say, *"If their husbands undergo sterilization operation, village people consider them worthless or ineffective, as men need to do heavy work and once they are sterilized they become weak, cannot lift heavy things, and their masculinity reduces. Women also don't want their husband to undergo sterilization operation, because they think that if something happens to their husbands, then who will feed them and their children, because they are the sole earners for their households."*

The community regards sterilization as a female-oriented method, as they feel women can undergo the operation and it will not lead to any complication. If a woman dies at any point of time because of the operation, they believe that the man can re-marry and produce more children. However, if the man undergoes sterilization and his wife dies, then he is rendered unproductive and incapable of having children from his re-marriage.

Ignorance about health: People in the villages do not give importance to their health problems. Taking medical care or getting proper diagnosis is not very common in villages, but only the severity of their illness/complexities compels them to go to a hospital or see a doctor. For instance, as mentioned, "When the sickness can be cured easily at home, why do we go to hospital?"

"In general, if someone is sick at home, we do not rush to the doctor but usually take them to ojha (traditional doctors) for treatment. They have lots of power and in most cases, the sick person gets cured. Going to doctors is very costly as well as time-consuming, be it a private doctor or PHC doctors." **Young urban married man, 22 years, high school educated, businessman**

Ignorance about family planning: There are quite a few myths regarding contraceptive methods among the community members and health providers. In general, couples are reluctant to opt for permanent methods, especially if they do not have sons. There is a belief that once they undergo sterilization, in case of any casualty such as death of a child or death of a spouse, the other partner becomes incapable of having more children.

"Both of us don't want any more children, as we have a son and a daughter. But we don't want to go for sterilization, since we believe that if any couple undergoes this operation; their children will die one after another." **Sanjana (name changed), 30 years, married woman, educated up to higher secondary level (12th completed), housewife**

Ignorance about other temporary methods is also widespread. During the discussion, it was found that women mainly perceive intrauterine device (IUD) as a method which is dangerous for the uterus, as it leads to infection and other problems in and around the uterus. They also stated that *"Copper 'T' is not meant for them as it will not suit their health and they believe that it has a tendency to move upwards. This method is only meant for women who have two children, and it can't be implanted after the birth of the third child, as adviced*

by the ANM." **FGD, married women, rural, 25-35 years, illiterate**

There is also a belief among women that taking pills for too long is harmful as it may lead to stillbirth and weight gain.

The perceived failure of contraceptive methods also restricts many couples from accepting methods to space the two births or stop childbearing. As stated, *"I will definitely not go for sterilization operation, because women in my village had children even after the operation".* **Married woman, 23 years, primary educated**

Overall, it is mostly women (rather than men) who opt for sterilization after they achieve a complete family size. Sterilization is believed to be positioned in our family planning program solely for women. In many villages, men were unaware of male sterilization or had negative information about the method. Even the influential persons of the villages were found motivating women to accept the permanent method, rather than their husbands.

"Most family planning operations are conducted on women. Male sterilization results in physical weakness; it becomes difficult for men to work and lift heavy materials after the operation. Thus, I advice women to take this responsibility. If a woman has any reservation with the procedure, she can easily opt for abortion later. It costs INR 400-500 in a government set-up and around INR 800-900 in private clinic/hospitals." **Village *pradhan*, 32 years, middle school educated**

Ignorance about contraceptive methods is also prevalent among the health providers. As informed by ASHA, *"I encourage women to take the pill as this is a convenient and safe method for them. I don't have any idea about Copper 'T' or family planning operations and hence, never advice them to opt for these methods. I do not talk about condoms to any woman, as I feel shy and uncomfortable about this method."* **ASHA, 20 years, one year experience**

"Consuming pills to avoid pregnancy is not advisable, as it turns one's blood black. Taking pill also leads to cancer and HIV. Thus, I don't advice or distribute pills to any woman." ***Dai*, 40 years**

Traditional contraceptive methods are also practiced by the community members, but their use is not very widespread. These medicines are made of different herbs found locally.

Ignorance about maternal care (Pre-delivery, delivery, post-delivery): Maternal care is one of the neglected areas of women's health. Most people in the community believe that pregnancy is a natural process which every woman needs to experience, and therefore, it is not necessary to visit any health facility or health professional, unless there are complications. It was found that people still believe in supernatural power and black magic.

"Sanjana's eldest son was seven years old when she had another son. He died six days after birth due to an unknown reason. He used to bleed through his nose. He died immediately. After a few months, Sanjana again got pregnant and gave birth to twins – a son and a daughter. Five days later, the boy died and after 14 days it was the turn of the girl. After that, Sanjana once again became pregnant. She gave birth to a healthy daughter. She is now seven months old. All the deliveries took place at home. Because of the consecutive deaths of her children, she started believing in Jamogha (outside air which does not allow children from a family to survive).

At the time of birth of the youngest daughter in the house, lots of puja and recitation of religious verses was done. Babaji (local religious leader) also did magic (tantra mantra). Puja was also performed by Baba. The delivery room where the earlier deliveries took place was changed. After Sanjana conceived, we started taking care and did lots of puja in the house."

It was found that, despite getting iron and folic acid (IFA) tablets from ANM or PHCs, women do not take them because the tablets taste bad or smell foul or because they feel nauseated/ constipated on consuming the iron tablets. A married woman says that she did try the iron tablets, but she did not feel like taking them, and thus stopped. Another says, *"I got the iron tablets free of cost but have thrown them away. They taste bad and can also damage our and our child's health."*

A married man says about his wife, *"My wife took half the tablets and threw away the rest. She said taking iron tablets has no benefit, therefore, she did not take them."* He adds, *"My wife does not like to take medicine."*

Women do not use antenatal care facilities because they just don't

feel the need. They believe that since their parents and in-laws never went for any check-ups and their children were all born healthy without any difficulties, antenatal check-ups as well as delivery at health facilities are unnecessarily forced on all pregnant women.

One of the private medical officers/ practitioners whom we interviewed had shared his view that "women don't pay attention to ANC and they don't heed the doctor's advice. They only listen to their mothers-in-law and sisters-in-law."

Ignorance about breastfeeding and child immunization: Breastfeeding is universally practiced by all the community members, but initiation of breastfeeding is affected by traditional beliefs and myths. Breastfeeding was found to be initiated after some delay, specifically on the third or fourth day after birth. Feeding colostrums (the first milk) to the baby was rarely adhered to. The community as well as many health providers consider colostrum to be poisonous for the newborn. As stated, *"I tell all new mothers about the importance of breastfeeding. I always ask them to throw the first milk, because if that is given to the newborn child, he/she gets severe cough. I do inform them to continue exclusive breastfeeding for at least six months."* ***Dai*, 40 years**

The women also believe that the first milk remains in the breast for nine months, and is, thus, dirty and unhealthy for the child. Most of the elderly women believe that the first milk should be given to Mother Earth, so that the mother and child are blessed by her. The majority of newborn children were given goat's milk for the first few days. In general, it was found that most of the mothers reported that they did not have breast milk for the first few days.

As found in other studies on child health, polio drops are almost universally available and accepted by the community, but there is a mixed reaction regarding routine immunization. Many discussions brought up the fact that immunization in the form of vaccination leads to pus formation, pain and high fever in the child, and thus, creates more problems than benefits. As observed, acceptability of routine immunization depends on the availability of the ANM and her routine visits to the villages. Most of the women reported that although the ANM *didi* (sister) makes a weekly visit to the village, either on Wednesday or Saturday, due to the size of the village, they can't reach her with their small children in tow. Most community members also said that they do not have the time to take their child to the hospital/center or that the facility is at a distance and the availability of transport is limited. The completeness of routine immunization was found to be quite fuzzy, as women with children just over a year old were not sure about the number of vaccinations to be provided to their child.

"How do I know how many vaccinations were given to my child. It's the duty of the ANM didi. Whenever she came to my village for vaccination, I went with my child, but she is not regular." **Married woman, 22 years, illiterate**

It was also observed that most women reported episodes of pain and fever in their children, related to the DPT vaccine. In case of BCG, in most cases, it was confirmed with the presence of a mark on the hand by the investigating team.

4.3 HEALTH SYSTEM RELATED FACTORS

No/Minimal trust in government services: The people have developed a notion that any treatment or medicine dispensed in/from government hospitals will not work or help them recover from their illness. They say, *"When our child is sick, we go to a private clinic, because medicines from the government hospitals do not have any effect."* Moreover, most of the medicines prescribed by the PHC doctor are not available in the facility, and thus, need to be bought from the market.

Hence, instead of going to the government hospital, they prefer to visit unqualified practitioners in the village or at market places and get certain medicines and counseling at a cheaper rate/charge. For instance, some of the married women mentioned that *"buying medicines from the market is costly, therefore, we buy them from the village doctor. His medicine is cheap and will also benefit us. You do not have to go anywhere else."* Some of the relatives of married women stated that *"they take medicine from the doctor in the village because his medicines are cheap and people are cured by them."* A married man says, *"There is no doctor in my village. I show the child to the doctor in the nearby village.*

He takes 10-15 rupees and gives medicine. If necessary, he also comes home and examines the patient. His medicines have positive results and benefit people."

Not only the beneficiaries, but some of the providers (mainly the ANMs, ASHAs and private medical practitioners) are also of the opinion that the community does not rely on or trust the existing government health services. Some of the ANMs whispered, *"Some people do not have trust in the government schemes. Medicines given by the government are not good. Good medicines are sold off. Whatever medicines are available are distributed and those which are not, are prescribed for purchasing from the market."* An ASHA says, *"Many people belonging to a higher caste still don't go to the hospital for delivery, because they think that the child should not be born there. The mothers will face lots of problems and the government hospital is very dirty."* Another private practitioner who handles multiple medicinal streams says, *"Most of the people from the village come to me for medicine. I give homeopathic, allopathic and ayurvedic medicines. Whatever medicine the people ask for, I give it immediately. Because of my medicine, people get cured. Therefore, they come to me for medicines and do not go to government hospitals."*

Poor infrastructure: Most of the existing government hospitals in the study areas lack proper infrastructure, machinery, and instruments. Most of the hospitals don't have proper labor rooms. Often, serious cases have to be referred to private hospitals or to the district level/tertiary hospitals. Poor people are not in a position to follow the referrals, and they prefer or, rather, the situation compels them to remain deprived of/without medical care. A medical officer from the public sector says *"In government hospitals, effective medicines are not available. There is no supply of medicines from the government, then how can we distribute them to patients? There are no laboratories, X-ray machines, and ultrasound machines in our hospital. Patients have to get these tests done from outside."*

Another public sector medical officer says *"Some PHCs are such that during an emergency, there is no facility to bring patients immediately to the district hospital. The ambulance is out of order almost always. If it is in working condition, there is no driver available at night. In such conditions, the family members of a pregnant woman cannot bring her to the district hospital in time for delivery, which thus leads to higher chances of maternal deaths."*

Hospital charges: Almost all the interviewees have complaints and dissatisfaction with the supply of services in hospitals, particularly the government hospitals. The extent of callousness on the part of hospitals is seen when extremely poor families are mercilessly compelled to pay without a thought spared for their pitiable living conditions. A young married man exclaims, *"Neither have I gone to hospitals nor any of my family members. We have no information regarding mother and child health. We are poor; whatever happens to my children, we deal with it at home. I have three daughters, all of whom were born at home without any professional help."*

The villagers generally try to stay away from health centers or doctors, until the situation goes beyond their control. Quite often, this is due to their workload or due to lack of transportation, which is why the villagers are reluctant to visit a health center in case of any illness. The most crucial reason for the villagers' reluctance to visit any such setup is the sheer unaffordability of the charges of the health workers' services.

Health centers at remote locations: Another factor stated by most of the respondents as a reason for not availing government health services is the location of health centers at a distance. *"Government facilities are so far away, that patients/ expecting mothers become more critical en route to these centers. Even if we do manage to reach there, with great difficulty, the doctors at the center ask for too much money, which we can't afford. So, we generally take care of health issues at home, even the deliveries."* **Married woman, 23 years, primary educated**

In general, the geographical area of the blocks which were chosen for the study were in a radius of almost 35 to 40 kilometers, comprising 6-13 villages, and almost all in an interior setup with minimal or no transportation facility, even to the block headquarters. If anything goes wrong with the villagers, there is only one PHC (in some places, it is CHC), and that too at the block level.

Inferior quality of service: Employees from the lower to the upper levels in the blocks and villages, responsible for uplifting

the health scenario under the decentralized health planning system, are usually seen as rather casual in their approach and spirit. The public sector medical officers often hold the ASHAs, AWWs and ANMs responsible for not being able to deliver the services to the villagers. As one of them says *"RCH services are not reaching all people even now. The main reason is illiteracy and lack of awareness. ASHA, ANM and AWWs are also not working properly. They are unable to explain RCH to the people correctly. Therefore, people do not come to government hospitals."* The respondent also added, *"If all facilities are provided in the correct way and all workers perform well, then RCH programs will do very well."*

Poor or no transport facilities: This is another issue which is often pointed out by both the providers and beneficiaries. As most of the villagers are stuck in the poverty trap, they suffer all the more when someone in their family becomes unwell. Most of them remain engaged in earning their daily bread and in agricultural practices. Due to lack of proper transportation, going to hospital to see a doctor or seeking service in hospital becomes a tedious endeavor.

"I don't go to the hospital. The hospital is very far away from here; it costs me around Rs. 100 for going there once. Moreover, there is no facility in the hospital." **Married woman**

"The PHC is at a distance from my village. There is no vehicle available to go there. Therefore, even if my wife wants to go to the PHC, she cannot travel alone to such a distance and I also do not get the time to take her there. The presence of a government health post/center in my village with essential health facilities would immensely benefit the villagers." **Married man**

Not only it is difficult for people from the community to visit ANC facilities, but the facilities themselves are often open at rather inconvenient times or are not staffed enough to treat the patients' problems. Their services are only available at specific times on specific days.

The villagers often say that it will benefit them if the health workers positioned themselves in two or three places in the village, and that too in different directions. The health workers usually sit in one place, like the *pradhan's* (community leader) house and do not announce their arrival. The *pradhan* only informs his close kin, friends and people from his religion/caste to avail the services.

Shortage of manpower: In most of the PHCs, CHCs, and even in the district hospitals, the medical officers and the chief medical officers expressed regret about the shortage of staff. Some of the PHCs have been seen running with a single medical officer. Poor patients who are already in a bad state are looked at casually by a non-medical person, helper or by a clerk (or quite often, even left unattended). Instead of qualified pharmacists, these personnel themselves dispense medicines that are only available in the hospital.

A careful interpretation of the interviews reveals that there are differences in personal understanding and thoughts among people of the same homogenous group. People who try to avail the health services are found to be relatively better educated than those who don't avail the services. It is found that at least one of the members of the family (in general the man/husband) who uses the existing services, is a bit more educated or aware of the available services and the importance of better health.

Health-related Programs/ Schemes: Awareness regarding health-related schemes like Janani Suraksha Yojana (JSY) was found to be prevalent among all the communities, while the level of awareness regarding the components of the schemes varies according to the different levels of educational attainment, social hierarchy and economic status.

"People are mostly aware about the scheme wherein if the delivery is conducted at the government hospital, they will get Rs. 1400. Initially, most of the people in my village took their wife/daughter/daughter-in-law to the nearby PHC for the delivery, spending around Rs. 500-600, thinking that they will get the JSY money from the doctor. It's been more than a year and no one has got a single penny. Whenever they ask the doctor or ANM, the answer is to wait for some more time or that they have not received the money from the government. Even the ASHA, who took them for the delivery did not receive anything. People have now lost faith in these schemes and all the deliveries are taking place at home." **Married woman, 25 years, illiterate**

A village head stated that *"in the advertisement, it is always mentioned that Rs. 1400 will be given to the beneficiary after a delivery is conducted in the government hospital, but I have seen people getting only Rs. 500-600 and that too, not everyone. It was a very good scheme, especially for people in the villages who don't go to hospitals for delivery, fearing the costs incurred in the process. Due to improper implementation and other hindrances, the scheme is dying rapidly."* ***Pradhan*, female, 32 years, middle school educated**

4.4 CULTURAL ISSUES RELATED TO RCH

We have tried to explore the cultural factors that create difficulties for the people in availing the health services, particularly in rural areas.

- During pregnancy, superstitions regarding eclipse are most common. Women refuse to do any household work on that day, believing that, if they use a knife to cut things, then parts of the baby's body will also be cut and deformed. Women spread cow dung on their bellies to ward off evil during eclipse.
- There are a number of cultural beliefs related to breastfeeding, specifically colostrum feeding. As mentioned earlier, elderly women believe that the first milk is dirty and harmful, as it remains for nine long months in the breast of the pregnant women. There is also a ritual of squeezing out the first milk on the ground as an offer to Mother Earth, who in turn will bless the mother and child.
- In most of the study areas, it was found that after the delivery is done, if the newborn is male, the umbilical cord is put inside soil within the residence premises. In case of a girl child, the cord is thrown away from the residence. The explanation for this practice was that, "*in our culture, the girl goes away from her parent's house. Girls don't belong to us, they belong to some other family, and thus, we can't keep her part (umbilical cord) in our house.*"
- There is a belief, among certain communities, that a woman who uses any form of contraception will become infertile in her next life. It is also generally believed that, it is a sin for a woman to use any form of contraception to protect herself from becoming pregnant, as children are God's gift and obstructing this natural process can lead to the deaths of children that are already born.

4.5 ECONOMIC AND POLITICAL FACTORS

Some of the economic and political factors affecting RCH are:

- Women from low-income households have mentioned that antenatal care is not affordable. The care and treatment should, in fact, be free of cost, but the health staff often charge their clients for services, medicines, as well as vaccinations.
- Low-income households are unwilling to go for antenatal care, since the facilities are often not available in their areas. This is especially true in rural areas, where PHCs and SCs are not properly equipped to handle their needs, and patients have to travel to urban areas for proper facilities. This means that the husband or male head of the household has to seek time off from work (which, in case of daily wage and low income workers, means a large cut in their pay) to escort their family members to the centers. Women and their families often do not find the quality of service good enough to make such financial sacrifices.
- The influence of local level politicians has been highlighted in many interviews. Those who are close to them, by caste or class affiliation, have a better chance to utilize the services and can get help in emergencies. It is believed that the poor are not acknowledged at the government hospitals/SCs, while rich people and those from higher castes are given preferential treatment. The economic capacity of the upper caste and the rich automatically marginalizes the poorer sections.
- There is a perception that in many instances, ASHA will do only what the *Pradhan* says, as he/she was instrumental in getting her this appointment. A common, related complaint is that the nexus between local politicians and the health system is the main reason for women not getting the promised financial assistance under JSY.

The key factors which act as a barrier to utilization of RCH services have been demonstrated in Figure 5 below, so as to understand

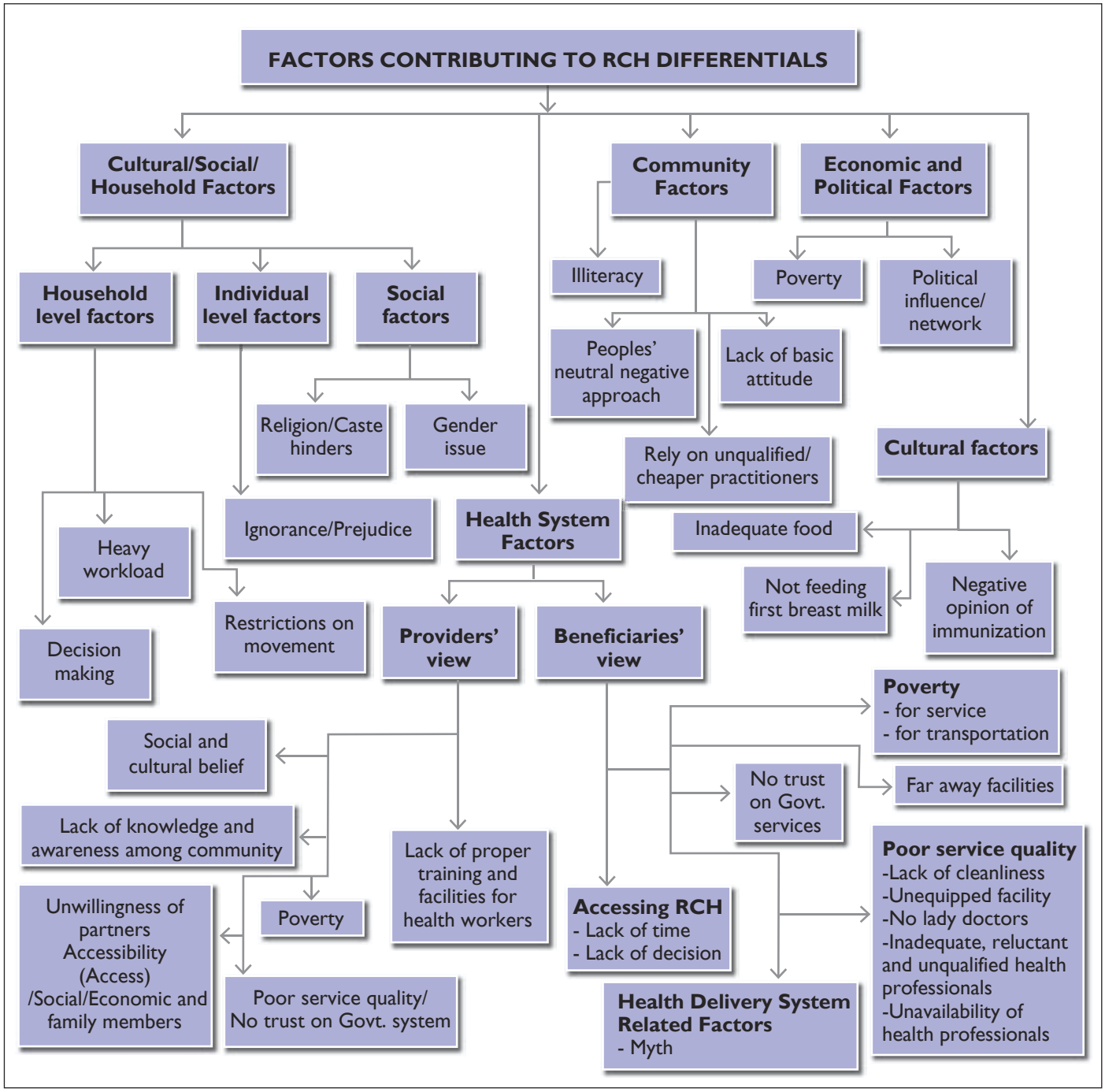
the direct and indirect relationship between different components which hinder healthcare utilization.

4.6 SALIENT ISSUES RELATED TO EQUITY IN RCH

"I did not go to the doctor for check-up even once. I did not even get vaccinated, because hospitals were far away from house. I did not take any iron tablets. When we go to the government hospital, we need to pay Rs. 5/- for making a card. And you do not get medicine from there. When you ask for medicine from the pharmacists, they say that medicine has finished. If somebody gets sick suddenly, we have to take medicine from the nearest unqualified doctor." **IDI of married woman, rural area, 35 years, illiterate, housewife, Unnao**

As against this example of ignorance and general apathy

FIGURE 5: FACTORS CONTRIBUTING TO RCH DIFFERENTIALS IN UTTAR PRADESH



towards the government health system, the following quotation amply demonstrates that ignorance is not always associated with lack of education.

"The respondent says that she has two children. Her first son is four years old and second is two years old. During the last pregnancy, she had gone to the doctor for check-up. The ANM came to the Anganwadi Center and gave the injections. The ANM had given her a strip of iron tablets in which, there were approximately 100 tablets, but she ate only one or two tablets. She didn't like the tablets, so she didn't eat the rest of them. Her delivery took place in the government hospital. She had gone to the hospital with her mother-in-law and husband. The delivery took place smoothly in the hospital and was normal delivery. Rs. 2000/- was spent in the hospital. Her children have been given vaccinations at the Anganwadi Center." **IDI, married woman, 21 years, illiterate, age at marriage - 12 years**

The differences in the association between education, awareness and behavior are evident from the FGDs, where most of the participants were illiterate:

"*They (group members) said that during pregnancy, two vaccinations were given. We did not go to the hospital. Those who have got the vaccinations, got them when there was a vaccination drive at the primary school. Some of them said that they had gone to Kediya hospital for check-up. Out of 10, nine members had deliveries at home and only one delivered at the hospital. They said that at home, the delivery is conducted by other females in the family or neighborhood, and the Dai cuts the umbilical cord."* **FGD of 11 married women, rural, illiterate, 20-30 years**

"All respondents said that when they conceived, they went to Tilauli for check-up. There, the doctor tested their urine. He charged Rs. 50/- for the test. But now, the doctor is charging Rs. 70/- for it. All respondents said that, they received two tetanus vaccinations during pregnancy. Every month, on Wednesday and Saturday, the ANM comes to the village. The ANM does not go from house to house for vaccinations. The ANM comes to the village and sits in the school or the Pradhan's house. You have to go there for vaccination. Those who are busy at work or are alone at home or live at a distance, are not able to go for the vaccination. Except for two respondents, whose deliveries took place at the PHC, others said that their children were born at home. They said that in their village, nearly all children are born at home; it is only when there is some complication that they go to the hospital. Otherwise, why should we take the pain and get the delivery done in the hospital?" **FGD, married women, rural, illiterate, SC and OBC, 20-30 years, Siddharth Nagar**

What is evident is the near universal phenomenon of deliveries at home, irrespective of educational level, and the equally popular pulse polio campaign in rural areas of the selected district. The data suggests the obvious higher extent of utilization of RCH services in urban areas and also a very high extent of institutional deliveries, especially among the better educated and economically advantaged group.

The extent of rural-urban differences within a district can be seen from the contrasting picture from Unnao, where the differences between the educated and uneducated groups are also illustrated:

"My last delivery took place in 2005. All my children were born at home. I never went to the doctor or took iron tablets, because I did not know about it. The ASHA and ANM never came. No one told me about the care to be taken during pregnancy. During pregnancy, my husband was looking after me. Whatever I wished to eat, I used to eat. For five days after delivery, nobody touched me, I could not meet my other children, nor did I do any household work. I was not allowed to even cook food. I was considered as untouchable for these five days. I did not feed my first milk to my child, because it is dirty. It is also very thick. The child will not be able to drink it." **IDI, married woman, rural, 34 years, illiterate**

"My last delivery took place in a private hospital. During my first pregnancy, I used to go to the government hospital for check-ups. I also went for my first delivery to the government hospital, but when I reached the hospital, no doctor was available. The nurse admitted me and gave me some medicine to delay the delivery, as the doctor was supposed to reach the facility only by 9 am. Due to the delay and wrong medicine being administered, my son was stillborn. But the nurse and doctor were not prepared to accept their mistake." **IDI, married woman, urban, 28 years, BA, teacher**

In general, most of the women do not use contraception. Those who have tried oral pills did not continue

for long. A small proportion of men use condoms. IUD has received a negative response in all the study districts. The women generally resort to postpartum amenorrhea for contraception. Abstinence for a long period after childbirth also acts as a contraceptive. The general opinion is that, women get their menstrual cycle only one or more years after childbirth; hence, there is no need for any contraception. Those who have completed their childbearing, which is signified by the number of sons they have (preferably two or more), are willing to accept tubectomy. Still, a section of the population does not prefer this procedure, due to a possible history of failures or because of cultural beliefs. Further, women (as well as men) have reservations with male sterilization, as vasectomy is believed to weaken men. Thus, in instances, where the man himself was willing to try vasectomy, he could not, because both his wife and mother were opposed to it.

The influence of the mother-in-law and elders in the family and neighborhood is often a deciding factor in prenatal care, where and how the childbirth should take place along with the practices to be adopted during the postnatal period. In some cases, the mother-in-law's influence also prevents the husband (regardless of the level of education) from providing appropriate care to the pregnant woman or the newborn; many men have expressed their helplessness.

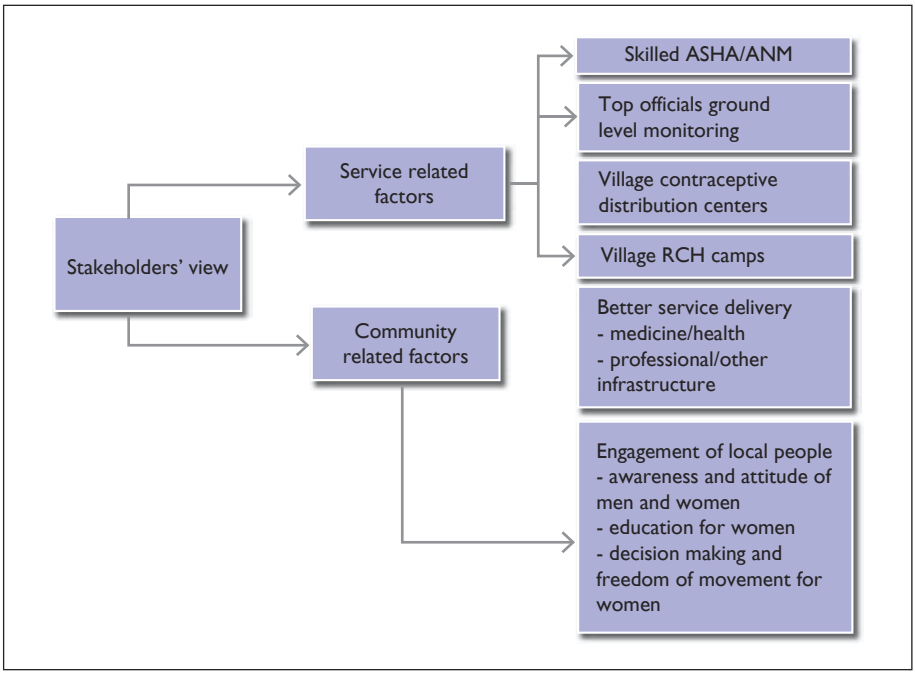
Thus, there are two main household level stakeholders that need special attention, if the RCH situation has to improve: men and older relatives, especially the mother-in-law. Without their support and understanding, it would be difficult to get through the existing cultural barriers. A cause for concern which surfaced in this study repeatedly was the influence of the men's awareness and attitude toward RCH. To further complicate matters, most illiterate women do not understand the significance of care during pregnancy and childbirth.

4.7 IMPORTANT STAKEHOLDERS

Apart from the women and the health system, which are hitherto considered as the most important stakeholders in ensuring better RCH, recent initiatives have highlighted local politics and ASHA as the other key players who can contribute significantly to the improvement of healthcare. This study has underlined the weaknesses of ASHA and the problem in relying largely on local politics without any control factor. However, one also has to appreciate the fact that the local administration and ASHA have wielded considerable influence in areas, where the RCH is kept away from politics and caste affiliations. For the success of the endeavour, thorough monitoring of the activities of ASHA and involvement of local administration is required. While it is believed that the involvement of local administration in health delivery would act as a monitoring mechanism, its success is questionable as evident from this study.

Two other stakeholders in the RCH scenario have been identified through our study: the men and the family elders. While the role of men has been sporadically examined by other studies, except on paper, there does not seem to have been much progress on that front. Also, recent interventions and their evaluations have revealed the significance of the role of relatives.

FIGURE 6: STAKEHOLDERS' VIEW



Judging from the interviews we conducted in the study districts, we strongly believe that empowering men through knowledge would go a long way in improving the RCH situation in the state. The fact that empowerment of women is intertwined with that of men in the families, has somehow escaped attention. The role of relatives, especially the mother-in-law, as a stakeholder requires greater attention from interventionists. While it is easy to ignore them by labelling them as old or as belonging to an older generation of false beliefs and practices, we must recognize the considerable influence they have on daily household matters. Imparting awareness within this category is vital to progress in the RCH scene.

A key category which seems to have escaped the attention of interventionists consists of faith-based organizations and prominent individuals in the immediate society. These figures still have a substantial say in prenatal and postnatal practices. The role of the *pundit* in deciding the time for the newborn's bath, the mother's bath and other postnatal practices is quite significant and cannot be ignored. Making them a target group and educating them is crucial to achieving the RCH objectives. The suggestions that came up during the interviews with the various stakeholders are summarized in Figure 6.

Chapter V

EQUITY ISSUES

Although decision making in the reproductive health of a women is her individual attribute, it is governed by the interplay of many socio-cultural, economic, and environmental attributes in which she lives. The overall prospectus from the point of view of beneficiaries related to the barriers to RCH services and related indicators of equity issues are mostly dominated by overall factors of existing poverty and inadequate services, which can be summarized as:

- Affordable or free services which includes services for the poor with nominal and subsidized fees, if necessary
- Accessibility of better health facilities and availability of health professionals at the facility
- Better coverage of immunization campaign (routine immunization)
- Proper family planning (FP) counseling, information and education to all regardless of age, parity, economic status
- Proper and adequate supply of medicines
- Accurate information about JSY and proper and timely disbursement of the incentives
- Other monetary benefits to the poor and needy
- Improved prenatal, delivery and postnatal services
- Accessibility to health facilities: Proper transport facilities.

Indicators proposed by women across all the districts were largely reflective of the constraints imposed upon them. The study revealed that women's issues centered on the following heads:

- Not having enough money to consult
- Not having enough money to pay for transportation to go to the facility
- Not having enough time to go to the clinic because of workload
- Not allowed to go out during pregnancy due to myths and beliefs
- No decision-making power
- Poor, unhygienic and unequipped facilities
- Distance to health facilities too far
- Not enough, reluctant, and unqualified health professionals
- Unavailability of health professionals in far away and remote areas
- Caste-based healthcare services.

The key indicators mentioned by the women were affordability of services, accessibility of the health facilities, and free health services which were more of community level problems. A large number of personal issues that substantially influence women's healthcare behavior must be considered while developing indicators for a better reproductive healthcare system.

The proportion of women expressing satisfaction with the service delivery system remains low, despite the fact that, a large number of areas covered in this study were reported to have at least one public health facility along with private providers. We need to look at and address the reasons for this dissatisfaction, while tackling the structural problems as well as the problems associated with healthcare providers' attitude and services.

Family planning services are rather scanty as reported by most of the women, though the awareness among the couples themselves is satisfactory.

Perceived indicators for equity issues among service providers are:

- Lack of knowledge in the community
- Poverty
- Social, religious, and cultural beliefs in the community
- Unwilling partners and other family members
- Lack of proper training and facilities among health professionals

- Level of service quality including service delivery system, shortage of manpower, availability of infrastructure, and services.

The primary barriers to family planning and maternal health-related services identified by the healthcare providers are lack of knowledge and willingness among the community members, specifically among women. As has been stated by the health professional of a PHC in Unnao:

"The women are unable to utilize the services provided by the government due to ignorance, since most of them are uneducated. Also, they do not want to avail these services. They say that whatever will happen, will happen. Taking medicines will not change anything."

These findings support the fact that there is an urgent need for information dissemination, from the providers as well as policy makers, as an enabler for family planning, maternal healthcare services along with prevention and management of other reproductive health services.

These Information, Education and Communication (IEC) activities cannot improve the level of knowledge and utilization of the services among the community, without measures to improve the supporting structures, manpower and other essential services in the facilities and other health functionaries.

Social and cultural beliefs refer to the social stigma, myths, and traditional practices attached to family planning and maternal and child care. These beliefs tend to victimize women and lead to women being blamed for low utilization of the services.

As far as acceptance of family planning services is concerned, religious and cultural factors clubbed with the unwillingness of partners and family elders continue to create barriers.

"Pills are very convenient, but my husband doesn't want me take the pill because of its side effects. He told me that once you start taking the pill, you will never become pregnant again. We have decided that once the family size is completed, I will go for an operation." **Married woman, 32 years, 3 living children, illiterate**

"Family planning is a crime; we are not allowed to adopt any methods. We believe that if a woman uses any method, she will be born infertile in her next life." **Mother-in-law, 45 years, illiterate**

There is a definite lack in providing knowledge and creating awareness about family planning on the health provider's part. Even the availability of pills and condoms is scanty at the village level health centers.

"Condom use is very important to space births and should be encouraged by health providers by distributing free condoms. The health workers should make visits to the villages and distribute them, since going to the market is difficult for people like us who work in the field throughout the day. I have also tried getting condoms from the PHC, but there they sell them. We do not have enough money to sustain the family, how can we then spend money on buying condoms and other family planning methods?" **Married man, 34 years, illiterate**

"We hear about condoms and pills from people in our community, but do not know where they are available." **Women, 20-30 years, FGD**

There is also a lack of faith in providers who distribute/implant family planning aids.

"Going for sterilization is not at all recommended, as after getting the operation done, women still become pregnant, which becomes very embarrassing for us. Women are also reluctant to go for surgery in the government hospital because there is no privacy during the operation, and in most cases, the operation is conducted by male doctors. On the other hand, men can't go and opt for surgery as it reduces their masculinity and they become weak." **Married woman, 23 years, literate, 2 children**

Interestingly, none of the healthcare providers mentioned inadequate family planning services or absence of proper communication from their part as a need or indicator for equity. Most of them did mention unwillingness of the community to accept family planning as an important barrier.

It is an accepted fact that economic, socio-cultural, and political aspects interact and affect people, including women, positively and negatively. The barrier cited by the health providers reflects the negative effects of these aspects in women's utilization of reproductive health services.

Besides the ignorance of women and socio-cultural barriers, the sheer cost of services, as mentioned by community members (specifically women), remains a formidable obstacle in a poverty-stricken area, where economic disparity remains large. Poverty not only restricts women's access to the health services, but also increases the risk of premature deaths in women.

It is important to understand the entire context in which the services are delivered, be it the level of knowledge/awareness, social barriers, religious beliefs and economic capacity of the people, factors which affect the entire reproductive health services scenario. It is simply not enough to provide services or overcome obstacles at the community level; we also need to address the various personal, socio-cultural and economic factors that create hindrances so as to ensure better, affordable, accessible, and friendly services from the health system.

Chapter VI

PROGRAM RECOMMENDATIONS

Successful community-wide or state-wide RCH programs can be made possible by a collaborative process involving all community stakeholders. It is impossible for any one healthcare provider to cover the needs of an entire community. It is important then, to set up a coalition of stakeholders, including public and private healthcare service providers, private clinics, alternative health system providers, NGOs and international NGOs (INGOs), pharmaceutical companies which provide vaccines, medicines, and RCH-related medical and surgical equipment, community leaders, etc.

A coalition of such nature will be able to decipher what the needs of a community are, and of those, which needs are being met, and which are still unmet. Also, each stakeholder in the coalition may be able to cover certain needs or cater to certain target groups within the population. So, a network of referrals may be achieved where, working together, the stakeholders can cover the largest possible area of the community.

Another benefit of such a coalition is that unqualified health providers (such as registered medical practitioners who run private clinics) in the community can be separated out. Instead of antagonizing them, these people can also be targeted as part of a community-wide RCH program. They can be trained and certified in certain aspects of primary healthcare and used to alert the community about RCH programs and events. These people can essentially be used on the frontlines of a referral network, in case of RCH-related and other general healthcare emergencies.

6.1 IDENTIFYING STAKEHOLDERS

Stakeholders will include representatives from every type of healthcare provider from both public and private sector. They should include representatives from district hospitals, community health centers, urban health centers, primary health posts and sub-centers in every community of each district. Private healthcare providers should also receive representation and so should registered medical practitioners, mid-wives, etc.

NGOs and international organizations with experience and expertise in developing RCH programs should also be a part of the group, along with others such as pharmaceutical and medical companies which provide vaccines, medical and surgical equipment.

Local media (radio, television and newspapers) can be useful in spreading awareness and information on immunization drives, and RCH-related schemes (such as the public-private partnership, voucher systems, JSY, etc.).

Local businesses, community leaders, politicians, and celebrities can also help in spreading awareness on local RCH programs. Community leaders and politicians are useful in lobbying for RCH-friendly legislation and increased funding. Local businesses, too, can help bring in financial aid towards RCH activities in the community.

6.2 NEEDS ASSESSMENT

In order to fully understand and affect behavioral change, the theoretical model of Political Economic Medical Anthropology can be recommended, which states that people's actions are a result of a complex mix of local and national forces, shaped by past histories and current conditions. The core components of this model include:

- Agency: People's actions and individual will
- Complex macro/micro intersection: Mix of local and

national/global (political economy focuses on this intersection)
- Social construction: Things people do are the result of some other forces/result of things that came before/result of identities, relationships and expectations
- Historical data
- Current and local details
- Ethnographic data: Rooted in local conditions.

Accessibility and availability of RCH services:
The following factors need to be kept in mind:
- There needs to be greater awareness in the community about services being offered by public and private health sectors.
- The community must be assured that free services are advertised as such, and healthcare providers do not charge patients for services which are supposed to be rendered free of charge.
- Build a referral system, so that people living in remote rural areas do not have difficulty accessing basic services, and can be transported to health posts with better facilities for efficient care and treatment, should the need arise.
- Immunization programs should be available all days a week.
- Services should be streamlined.

Behavioral Change: Health providers often come from the same community as the clients and share a socio-cultural background. Therefore, they should be responsible for working with clients to ensure that proper antenatal and postnatal care is not shunned due to erroneous beliefs that could endanger the life and health of mother and child.

Also, in case clients prefer delivery at home, it should be ensured that a trained health professional conducts the delivery, and in case of complications, immediate referral is planned well in advance. There should be a system in place to register the births immediately with local authorities, so that local, district and state governments can keep accurate records of births, live births, etc., and administer healthcare more efficiently to the mother and child.

Behavior change is necessary not only to dispel myths and misinformation, but also to change the community's attitude towards availing health services. The attitude of "We have never done it before, so why start now?" is extremely prevalent.

Female empowerment: In male-dominated cultures, women must be encouraged to seek medical advice regarding RCH services. Making RCH services readily available, easily accessible and affordable will go a long way towards empowering women to seek these services. This is especially true in situations where transportation is not readily available and male members of the household, who may be earning daily wages, do not feel obliged to take time off from work to escort the patient to the health facility.

Male empowerment: As important as it is for women to be empowered to seek healthcare advice, it is equally important to empower male members of the family and male heads of the household to participate in and support the healthcare plans of the female members of their household. They should be encouraged to play an active role in family planning, fertility and contraception, ante/postnatal care and child delivery. Health providers should be responsible for busting myths such as "Vasectomies make males weak and prevent them from doing heavy work."

Other goals: There is a need to increase the number of family health programs. An RCH program would be incomplete without holistically targeting the entire family unit. This includes looking at other factors in RCH, such as child development, immunization, nutrition, education, etc. FP programs must be targeted concurrently.

Holistic family health and FP can help reduce MMR, IMR, and eventually, TFR. Education (particularly women's education along with women's empowerment to make decisions regarding contraception and family planning) and male empowerment (to play a supportive role to the female in making healthcare decisions) will help in raising the average age of the female at the time of delivery of the first child.

6.3 WHITE PAPER AND STRATEGIC PLAN DEVELOPMENT

A work group can provide opinions and informed viewpoints; a needs assessment can provide facts; but at some point of time, jurisdictions may wish to weave these into a unified public health strategy.
A white paper presents a strategy on how to address an issue at

hand. It provides a framework from which one can begin adapting and/or building infrastructure. Similarly, a strategic plan is a method that can be used to convey a public health strategy as well as to help foster consensus on the most pressing needs within a jurisdiction. Strategic planning can provide a clear vision which will prevent the various stakeholders from working at cross purposes.

It is necessary that this strategic plan encapsulates all the RCH needs of the community. Only then, can the stakeholders reinforce services already being offered, and also provide services that target the unmet needs of the community. This must be done at the state level as well as the district level, focusing equally on urban and rural areas.

6.4 SECURING LEGISLATION AND/OR FUNDING

These programs obviously cannot function very well, or for very long, without the necessary public health authority and sufficient funding needed to implement them. The preceding steps of identifying stakeholders, convening a group, conducting a needs assessment and publishing a strategy document can demonstrate the need for new legislation and/or funding. However, in some jurisdictions, there may also be impetus from legislators themselves and/or from community advocates for legislation and funding. Therefore, some programs may find themselves conducting their integration programs as a result of legislation, rather than as a precursor to it. Nonetheless, the preceding steps may also be of use to jurisdictions in this situation.

Along with fund raising and legislation, policy changes can be lobbied for, and the strategic plan which is now in place may be implemented.
A committee needs to be constituted to oversee the implementation of the strategic plan, and to regularly take up monitoring activities to ensure a successful RCH program.

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Appendices

Appendix I

CONSENT FORMS

TOWARDS EQUITY IN HEALTH: A STUDY OF BARRIERS IN ACCESSING REPRODUCTIVE AND CHILD HEALTHCARE IN UTTAR PRADESH

Informed Consent Form for Key Informants Interviews (KII): Service Providers

Purpose of the Study
Namaste. My name is……, I am a member of the research team from the Tata Institute of Social Sciences, (Deemed University) Mumbai. We, in collaboration with Futures Group International, New Delhi are conducting a study in Uttar Pradesh to understand the factors that limit accessibility to RCH. This study would examine the social, cultural and economic factors that promote limit the access to, and utilization of reproductive and child health in the state of Uttar Pradesh. Through this research, we would be able to understand the situations that determine people's attitude and behavior. This, in turn, would influence the decisions and practice of accessing various types of health services available in the state.

Nature of Participation
We would like to request your consent to participate in the study. If you agree to participate, you will be asked questions about different RCH issues and the major reasons which influence the decision and practice of various types of reproductive and child health services by the local communities and couples of Uttar Pradesh in general.

Risks and Discomforts
The following are possible problems that may result from your participation in the study. Some of the questions may make you feel uncomfortable. To protect you from this sense of discomfort, you can answer only those questions you feel like responding to. The study will ensure complete confidentiality of your information.

Benefits
Although you will not receive an immediate benefit from this study, you and others from your community may benefit from this in the future, if this research succeeds in finding ways to improve the RCH situation in Uttar Pradesh.

Duration of the procedures
The interview process may take about 60-75 minutes and your responses will be recorded on paper and if you agree on tape as well.

Compensation
There will be no monetary compensation for your participation in the study.

Confidentiality
To make sure that no one learns about any information discussed by you in this project, your name will not appear on any document or other materials associated with the project. Your name will also not appear on any interview records used for computers, or on any recording of conversations. Interview notes will be kept in a safe place under lock and key and only authorized persons designated by us and/or Constella Futures-ITAP will have access to them. The identity of the interviewee will remain confidential. The tapes will be destroyed after the information has been noted down on the paper. Your name will be removed from all records and your record will be given a unique code.

Right to refuse or withdraw
Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at anytime without penalty and without loss of benefits to which you are otherwise entitled.

Your refusal to participate in the study will not negatively influence the services that you are currently receiving. If you agree to participate, a representative of the sponsor may contact you to ensure that you have actually consented to do so. At that time too, you will have the option of accepting/declining the interview. It is also possible that you will be invited to participate in an additional interview in future, as part of the same research.

If you have questions about the research
The project staff is willing to answer any questions you may have concerning the procedures described. If you have any questions about the research, you may contact _____(Telephone no. office) or_____ _____ (Mobile no._____).

Participants' consent
I have read/been explained about the consent form and any questions I have, have been answered to my satisfaction. I agree to participate in the study and to respond to the questions. I understand the purpose, nature and length of my involvement in the study. I understand that I may choose not to participate at the beginning of the project or at anytime during the project without penalty.

_____ Date

_____ Signature of Respondent

OR

If interviewee is illiterate and/or unable to read and write,

Verbal consent
Yes
No

I, the undersigned, have explained to the volunteer in the language he understands, the procedure to be followed in the study, and the risks and benefits involved.

_____ Date

_____ Signature of Investigator

_____ Name of the Investigator

TOWARDS EQUITY IN HEALTH: A STUDY OF BARRIERS IN ACCESSING REPRODUCTIVE AND CHILD HEALTHCARE IN UTTAR PRADESH

Informed Consent Form for In-depth Interviews: Married Women

Purpose of the Study

Namaste. My name is……, I am a member of the research team from the Tata Institute of Social Sciences, (Deemed University) Mumbai. We, in collaboration with the Futures Group International, New Delhi are conducting a study in Uttar Pradesh to understand the factors that limit accessibility to RCH. This study would examine the social, cultural and economic factors that limit the access to, and utilization of reproductive and child health in the state of Uttar Pradesh. Through this research, we would be able to understand the situations that determine people's attitude and behavior. This, in turn, would influence the decisions and practice of accessing various types of health services available in the state.

Nature of Participation

We would like to request your consent to participate in the study. If you agree to participate, you will be asked questions about different RCH issues and the major reasons which influence the decision and practice of various types of reproductive and child health services by you and the local communities.

Risks and Discomforts

The following are possible problems that may result from your participation in the study: Some of the questions may embarrass you or make you feel uncomfortable. To protect you from this sense of discomfort, you can answer only those questions you feel like responding to. The study will ensure complete confidentiality of your information.

Benefits

Although you will not receive an immediate benefit from this study, you and others from your community may benefit from this in the future, if this research succeeds in finding ways to improve the RCH situation in Uttar Pradesh.

Duration of the procedures

The interview process may take about 60-75 minutes and your responses will be recorded on paper and if you agree on tape as well.

Compensation

There will be no monetary compensation for your participation in the study.

Confidentiality

To make sure that no one learns about any information discussed by you in this project, your name will not appear on any document or other materials associated with the project. Your name will also not appear on any interview records used for computers, or on any recording of conversations. Interview notes will be kept in a safe place under lock and key and only authorized persons designated by us and/or Constella Futures - ITAP will have access to them. The identity of the interviewee will remain confidential. The tapes will be destroyed after the information has been noted down on the paper. Your name will be removed from all records and your record will be given a unique code.

Right to refuse or withdraw

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at anytime without penalty and without loss of benefits to which you are otherwise entitled.

Your refusal to participate in the study will not negatively influence the services that you are currently receiving. If you agree to participate, a representative of the sponsor may contact you to ensure that you have actually consented to do so. At that time too, you will have the option of accepting/declining the interview. It is also possible that you will be invited to participate in an additional interview in future, as part of the same research.

If you have questions about the research

The project staff is willing to answer any questions you may have concerning the procedures described. If you have any questions about the research, you may contact _____(Telephone no. office) or_____ _____ (Mobile no._____).

Participants' consent

I have read/been explained about the consent form and any questions I have, have been answered to my satisfaction. I agree to participate in the study and to respond to the questions. I understand the purpose, nature and length of my involvement in the study. I understand that I may choose not to participate at the beginning of the project or at anytime during the project without penalty.

_____ Date

_____ Signature of Respondent

OR

If interviewee is illiterate and/or unable to read and write,

Verbal consent
Yes
No

I, the undersigned, have explained to the volunteer in the language he understands, the procedure to be followed in the study, and the risks and benefits involved.

_____ Date

_____ Signature of Investigator

_____ Name of the Investigator

TOWARDS EQUITY IN HEALTH: A STUDY OF BARRIERS IN ACCESSING REPRODUCTIVE AND CHILD HEALTHCARE IN UTTAR PRADESH

Informed Consent Form for Focus Group Discussion: Married Men

Purpose of the Study

Namaste. My name is……, I am a member of the research team from the Tata Institute of Social Sciences, (Deemed University) Mumbai. We, in collaboration with futures Group International, New Delhi are conducting a study in Uttar Pradesh to understand the factors that limit accessibility to RCH. This study would examine the social, cultural and economic factors that limit the access to, and utilization of reproductive and child health in the state of Uttar Pradesh. Through this research, we would be able to understand the situations that determine people's attitude and behavior. This, in turn, would influence the decisions and practice of accessing various types of health services available in the state.

Nature of Participation

We would like to request your consent to participate in the study. If you agree to participate, you will be asked questions about different RCH issues and the major reasons which influence the decision and practice of various types of reproductive and child health services by you and the local communities. We would also discuss with you the role of men regarding women's reproductive health and child health utilization.

Risks and Discomforts

The following are possible problems that may result from your participation in the study: Some of the questions may embarrass you or make you feel uncomfortable. To protect you from this sense of discomfort, you can answer only those questions you feel like responding to. The study will ensure complete confidentiality of your information, as described below in detail.

Benefits

Although you will not receive an immediate benefit from this study, you and others from your community may benefit from this in the future, if this research succeeds in finding ways to improve the RCH situation in Uttar Pradesh.

Duration of the procedures

The discussion would last for about 60-75 minutes and your responses will be recorded on paper and if you agree on tape as well.

Compensation

There will be no monetary compensation for your participation in the study.

Confidentiality

To make sure that no one learns about any information discussed by you in this project, your name will not appear on any document or other materials associated with the project. Your name will also not appear on any interview records used for computers, or on any recording of conversations. Interview notes will be kept in a safe place under lock and key and only authorized persons designated by us and/or Constella Futures -ITAP will have access to them. The identity of the interviewee will remain confidential. The tapes will be destroyed after the information has been noted down on the paper. Your name will be removed from all records and your record will be given a unique code.

Right to refuse or withdraw

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at anytime without penalty and without loss of benefits to which you are otherwise entitled.

Your refusal to participate in the study will not negatively influence the services that you are currently receiving. If you agree to participate, a representative of the sponsor may contact you to ensure that you have actually consented to do so. At that time too, you will have the option of accepting/declining the interview. It is also possible that you will be invited to participate in an additional interview in future, as part of the same research.

If you have questions about the research

The project staff is willing to answer any questions you may have concerning the procedures described. If you have any questions about the research, you may contact _____(Telephone no. office) or_____ _____ (Mobile no._____).

Participants' consent

I have read/been explained about the consent form and any questions I have, have been answered to my satisfaction. I agree to participate in the study and to respond to the questions. I understand the purpose, nature and length of my involvement in the study. I understand that I may choose not to participate at the beginning of the project or at anytime during the project without penalty.

_____ Date

_____ Signature of Respondent

OR

If interviewee is illiterate and/or unable to read and write,

Verbal consent
Yes

I, the undersigned, have explained to the volunteer in the language he understands, the procedure to be followed in the study, and the risks and benefits involved.

_____ Date

_____ Signature of Investigator

_____ Name of the Investigator

TOWARDS EQUITY IN HEALTH: A STUDY OF BARRIERS IN ACCESSING REPRODUCTIVE AND CHILD HEALTHCARE IN UTTAR PRADESH

Informed Consent Form for Focus Group Discussion: Relatives of Married Women

Purpose of the Study

Namaste. My name is……, I am a member of the research team from the Tata Institute of Social Sciences, (Deemed University) Mumbai. We, in collaboration with futures Group International, New Delhi are conducting a study in Uttar Pradesh to understand the factors that limit accessibility to RCH. This study would examine the social, cultural and economic factors that limit the access to, and utilization of reproductive and child health in the state of Uttar Pradesh. Through this research, we would be able to understand the situations that determine people's attitude and behavior. This, in turn, would influence the decisions and practice of accessing various types of health services available in the state.

Nature of Participation

We would like to request your consent to participate in the study. If you agree to participate, you will be asked questions about different RCH issues and the major reasons which influence the decision and practice of various types of reproductive and child health services by your family members and the local communities. We would also discuss with you the role of men regarding women's reproductive health and child health utilization.

Risks and Discomforts

The following are possible problems that may results from your participation in the study: Some of the questions may embarrass you or make you feel uncomfortable. To protect you from this sense of discomfort, you can answer only those questions you feel like responding to. The study will ensure complete confidentiality of your information, as described below in detail.

Benefits

Although you will not receive an immediate benefit from this study, you and others from your community may benefit from this in the future, if this research succeeds in finding ways to improve the RCH situation in Uttar Pradesh.

Duration of the procedures

The discussion would take about 60-75 minutes and your responses will be recorded on paper and if you agree on tape as well.

Compensation

There will be no monetary compensation for your participation in the study.

Confidentiality

To make sure that no one learns about any information discussed by you in this project, your name will not appear on any document or other materials associated with the project. Your name will also not appear on any interview records used for computers, or on any recording of conversations. Interview notes will be kept in a safe place under lock and key and only authorized persons designated by us and/or Constella Futures -ITAP will have access to them. The identity of the interviewee will remain confidential. The tapes will be destroyed after the information has been noted down on the paper. Your name will be removed from all records and your record will be given a unique code.

Right to refuse or withdraw

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at anytime without penalty and without loss of benefits to which you are otherwise entitled.

Your refusal to participate in the study will not negatively influence the services that you are currently receiving. If you agree to participate, a representative of the sponsor may contact you to ensure that you have actually consented to do so. At that time too, you will have the option of accepting/declining the interview. It is also possible that you will be invited to participate in an additional interview in future, as part of the same research.

If you have questions about the research

The project staff is willing to answer any questions you may have concerning the procedures described. If you have any questions about the research, you may contact _____(Telephone no. office) or_____ _____ (Mobile no._____).

Participants' consent

I have read/been explained about the consent form and any questions I have, have been answered to my satisfaction. I agree to participate in the study and to respond to the questions. I understand the purpose, nature and length of my involvement in the study. I understand that I may choose not to participate at the beginning of the project or at anytime during the project without penalty.

_____ _____

Date Signature of Respondent

OR

If interviewee is illiterate and/or unable to read and write,

Verbal consent
Yes

I, the undersigned, have explained to the volunteer in the language he understands, the procedure to be followed in the study, and the risks and benefits involved.

_____ _____

Date Signature of Investigator

_____

Name of the Investigator

Appendix II

QUALITATIVE GUIDELINES

KEY INFORMANT INTERVIEW GUIDELINES

(A) Service Providers – Public sector

A. *Background Details of Key Informants*
Age; gender; education; occupation; number of years in health sector; major job responsibilities (current/ recent past)

B. *Experiences of Key Informants at the time of providing services*
- Aspects of RCH
- Coverage area
- Profile of clientele
- RCH services mostly sought
- Which groups (use/do not use)?
- Which are the services least available/sought after?
- What could be the reasons for use or non-use?

C. *Reproductive Health Situation in the State/District/Block/PHC*
- General RCH situation (past, present)
- RCH situation in comparison with other state/districts/block/PHC
- Situation regarding various dimensions of RCH
  - Antenatal care
  - Care during delivery
  - Postnatal care
  - Fertility and contraception
  - Breastfeeding and other feeding practices
  - Immunization

D. *Status of RCH differentials*
- Which group accesses RCH services?
- Which groups do not access?
- Which geographical areas?
- What is the rural/urban difference?
- What are the religious differences?
- What are the caste differences?
- What are the class differences?
- Any age difference (i.e. younger versus older women)?

Probe for various dimensions of RCH

E. Factors contributing to differentials in accessing RCH

Social factors
Cultural influences
Economic factors
Political factors
Health system factors

→

Individual level factors
Household level factors
Community level factors

- Antenatal care
- Care during delivery
- Postnatal care
- Fertility and contraception
- Breastfeeding and other feeding practices
- Immunization

Probe for getting perceptions on

- Availability of services
- Geographical access
- Decision making
- Cost
- Mobility and access
- Clients' attitude

F. Role of various factors in changing RCH situation in the state/district/block/PHC area (past/current)

- Social
- Cultural
- Economic
- Political

How have changes at individual and household levels contributed to the overall scenario?

G. Past/Current roles of various stakeholders in improving RCH situation at various levels

- Government Health System
- NGOs
- Community
- Alternative Health Systems

H. Have the recent initiatives been successful in improving RCH? If so, how?

- What are these initiatives?
- Observations

I. What are the ways to further improve RCH situation in the state/district/block/PHC?

J. What would be the contribution on each stakeholder group in future RCH interventions? How to achieve this?

- Which stakeholder groups are most important?
- How to ensure stakeholder involvement?

K. *Observations on voucher system (Specific to few districts)*
- Objectives
- Strategies
- Coverage
- Aspects of implementation
- Effectiveness
- Associated factors

L. *Other special government schemes to improve RCH*
- What are the other government schemes?
- The aspects of RCH addressed
- Effectiveness and contributing factors

(B) Service Providers – Private sector/NGOs/Alternative Health Systems

A. *Background Details of Key Informant*

Age; gender; education; occupation; number of years in health sector; system of medicine; type of services provided; geographical areas covered

B. *Experiences of Key Informant at the time of during Providing Services*
- Aspects of RCH
- Coverage Area
- Profile of Clientele
- RCH Services mostly sought
- Which Groups (use/do not use)?
- Which are the services least available/sought after?
- What could be the reasons for use or non-use?

C. *Reproductive Health Situation in the State/District/Block/PHC*
- General RCH situation (past/present)
- RCH situation in comparison with other state/district/block/PHC
- Situation regarding various dimensions of RCH
  - Antenatal care
  - Care during delivery
  - Postnatal care
  - Fertility and contraception
  - Breastfeeding and other feeding practices
  - Immunization

D. *Status of RCH differentials*
- Who tend to access RCH services?
- Which population groups do not access?
- Which geographical areas?
- What is the rural/urban difference?
- What are the religious differences?
- What are the cast differences?
- What are the class differences?

Probe for various dimensions of RCH

E. Factors contributing to differentials in accessing RCH

Social factors
Cultural influences
Economic factors
Political factors

→

Individual level factors
Household level factors
Community level factors

- Antenatal care
- Care during delivery
- Postnatal care
- Fertility and contraception
- Breastfeeding and other feeding practices
- Immunization

F. Role of various factors in changing RCH situation in the state/district/ block/PHC area (past/current)

- Social
- Cultural
- Economic
- Political

How changes at individual & household level situations contributed to the change?

G. The contributions of private sector in improving RCH services

H. What are the differences in RCH/Provision between the Government and Private Sectors?

- Types of services
- Geographical accessibility
- Waiting time
- Economic aspects
- Quality of service
- Follow up services

I. Past/current roles of private sector/NGOs/Alternatives Health System in improving RCH situation at various levels

- Government Health System
- NGOs
- Community
- Alternative Health Systems

J. Have the recent government initiatives been successful improving RCH? If so, how?

- What are these initiatives?
- Observations

K. What are the ways to further improve RCH situation in the state/district/block/PHC?

L. *Are there any initiatives from your sector (Pvt, NGO, AHS) aimed at RCH services? If yes, what are they?*

M. *What would be the contribution on each stakeholder group in future RCH interventions – How to achieve this?*
- Which stakeholder groups would be the most important?
- How to ensure stakeholder involvement?

N. *Observations on voucher system (specific to districts)*
- Objectives
- Strategies
- Coverage
- Aspects of implementation
- Effectiveness
- Associated factors

(C) Other Key Informants

A. *Background Details of KI*

Age; gender; education; occupation; leadership position in the community

B. *Details of association with the health sector*
- Duration
- Context(s) of association
- Nature of association with various services
- Types of activities involved in
- RCH aspects in the activities
- Geographical coverage

C. *Reproductive Health Situation in the Area*
- General RCH situation (past/present)
- RCH situation in comparison with other areas
- Situation regarding various dimensions of RCH
  - Antenatal care
  - Care during delivery
  - Postnatal care
  - Fertility and contraception
  - Breastfeeding and other feeding practices
  - Immunization

D. *Status of RCH differentials*
- Who tend to access RCH services?
- Which population groups do not access?
- Which geographical areas?
- What is the rural/urban difference?
- What are the religious differences?
- What are the cast differences?
- What are the class differences?

Probe for various dimensions of RCH

E. *Factors Contributing to Differentials in Accessing RCH*

Social factors Cultural influences Economic factors	→	Individual level factors Household level factors Community level factors

- Antenatal care
- Care during delivery
- Postnatal care
- Fertility and contraception
- Breastfeeding and other feeding practices
- Immunization

F. *Role of Various Factors in Changing RCH Situation in the area: (past/current)*
- Social
- Cultural
- Economic
- Political

How changes at the individual and household levels contributed to the change?

G. *The role of Government Health Sector in RCH*
What are your observations on Government Health Sector in bringing about RCH in the area?

H. *Have the recent government initiatives been successful improving RCH? If so, how?*
- What are these initiatives?
- Observations on each initiative?

I. *Role of private sector/NGOs/Alternatives Health Systems in improving RCH situation at various levels*
- Private Sector
- NGOs
- Community
- Alternative Health Systems
- How have the roles been changing over the years?

J. *What are the ways to further improve RCH situation in your area?*

K. *Any specific problem existing in this area?*
- From Community perspective
- From health providers

GUIDELINES FOR IN-DEPTH INTERVIEWS

(A) Married Women (15-49 years) [include both users and non-users]

A. Background of the woman
- ***Demographic***
  - Age
  - Age at marriage

    - Number of children born
    - Number of children living

- ***Social***
    - Education
    - Religious/caste
    - Staying with natal family or not place
    - Childhood place of residence (rural/urban)

- ***Economic***
    - Occupation
    - Number of people in the household
    - Income per month (self/household)
    - Number of economically active household members

Now, I would like to ask you few details about the reproductive and child health situation in your household.

B. Birth history of the woman

C. Antenatal care during the last pregnancy

- Year of last delivery
- Extent and nature of antenatal care sought/received
- Type of facility
- Frequency
- Type of care received
- Perceived quality of services
- Difficulties experienced
- Husband's involvement (includes interpersonal communication)
- Cultural practices during pregnancy
    - Food
    - Care taken /restrictions
    - Work
    - Rituals performed
    - Others

D. Care during delivery

- Place of delivery
- Cultural beliefs about delivery place, care during delivery
- Skilled attention at delivery/type of delivery
- Opinion about delivery care services
- Difficulties experienced
- Birth weight taken
- Husband's role during delivery and after delivery (Specifically related to new born child)

E. Postnatal care

- Advices on postnatal care received or not
- Extent of care, type of facility
- Type of care, frequency of follow up visits

- Rituals and ceremonies after birth and month after

F. *Breastfeeding practices*
- Initiations (Includes cultural practices/religious ceremonies)
- Continuation of breastfeeding

G. *Infant feeding practices*
- General practices
- Practices during illness

H. *Childhood immunization details and social-cultural norms and practices*

I. *Contraception*
- Beliefs
- Practice
- Services available
- Services sought and received
- Observations
- Reasons for non-use of contraception, if applicable

J. *Reproductive Health Situation in the Community*
- General RCH situation (past/present)
- RCH situation in comparison with other areas
- Situation regarding various dimensions of RCH
  - Antenatal care
  - Care during delivery
  - Postnatal care
  - Fertility and contraception
  - Breastfeeding & other feeding practices
  - Immunization

K. *Status of RCH differentials*
- Who tend to access RCH services?
- Which population groups do not access?
- Which geographical areas?
- What is the rural/urban difference?
- What are the religious differences?
- What are the cast differences?
- What are the class differences?

Probe for various dimensions of RCH

L. *Factors contributing to differentials in accessing RCH*

Social factors
Cultural influences
Economic factors
Political factors

→

Individual level factors
Household level factors
Community level factors

- Antenatal care
- Care during delivery
- Postnatal care
- Fertility and contraception
- Breastfeeding and other feeding practices
- Immunization

M. *Role of government health system in providing RCH services*

N. *Are you aware of any special schemes or programs of the government in providing RCH? Give details.*

O. *Role of private health sector in RCH services*

P. *Do you think there have been attempts to bring the private and government sectors together to improve RCH services?*

(B) Married Men

A. *Background Characteristics of woman*

- ***Demographic***
  - Age
  - Number of children living

- ***Social***
  - Education
  - Religious/caste
  - Family Type

- ***Economic***
  - Occupation
  - Number of people in the household
  - Income per month (self/household)

B. *Factors contributing to differentials in accessing RCH*

Social factors
Cultural influences
Economic factors
Political factors
} → Individual level factors
Household level factors
Community level factors

- Antenatal care
- Care during delivery
- Postnatal care
- Fertility and contraception
- Breastfeeding and other feeding practices
- Immunization

C. *Role of Men during (their own perception)*

- Antenatal care
- Care during delivery

- Postnatal care
- Fertility and contraception
- Breastfeeding and other feeding practices
- Immunization

D. *Perception of community about involvement of men during*
- Wife's pregnancy
- Delivery
- Child rearing (specifically initial days after birth)
- Family Planning
  - Who should use
  - Who decides
  - Choice of method
  - Discussion

E. *Opinion regarding changes in the situation of RCH over time*
- Role of Media
- Role of Government
- Role of Private sector
- Any other

GUIDELINES FOR FOCUS GROUP DISCUSSIONS

A. Background Characteristics of Group Members

In the Focus Group Discussions, give special attention to the following issues:

i. Social and Cultural Beliefs and Practices about RCH
ii. Societal Perceptions about RCH Services
iii. Availability and Accessibility of RCH Services
iv. Reasons for Differential Accessibility
v. Observations about Different Types of RCH Facilities (regarding services provided)
vi. Awareness and Opinion about Recent Initiatives to Improve RCH
vii. Observations on How to Improve RCH in the Area

All the above issues should be focused at individual, household and community levels.

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