Assessment of Maternal and Child Health Under the NRHM Framework
A Study of four Districts of UP: Bahraich, Balrampur Varanasi and Lucknow

(SUMMARY)

OF THE

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Prof. Rakesh Chandra

By
Pravesh Dwivedi

Institute Of Women’s studies
Faculty of Arts
University Of Lucknow
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Introduction

Women’s health status is very important to understand the condition of women in any society. It is not only medical conditions that cause poor health, but gender and patriarchy plays a very important role in women’s health. There are many issues related to women’s health like malnutrition and anemia, STI’s and RTIs, maternal health related problems and even work related health issues like aches and pains that women face in everyday life. All of these can be linked to gender and patriarchy in different ways. Women’s access to food, decision for treatment, access to proper care, hours spent on work and kind of work done are often not in her control. These have a lot of impact on their health. So it is important to study women’s health from this angle.

Although there are many issues related to women’s health, maternal health is very important in the context of India. India has very high maternal morality ratio. If we compare India with other countries, India’s performance is even worse that some of the neighboring countries like Sri Lanka. In 2008 India had maternal MMR of 253.8, whereas Sri Lanka had MMR of only 29.8. Nepal is also ahead of India in MMR. In most developed countries the MMR is as low as 4-10 deaths per 100,000 live births. India is one of the six countries that account for 50 per cent of the maternal deaths worldwide. However it has reduced the Maternal Mortality Ratio (MMR) by four per cent per year since 1990. According to a study published in the journal Lancet this is more than double the global average.

Maternal deaths are preventable if women have access to proper care at the right time. This is the reason that MMR is very low in developed countries where availability, accessibility and quality of maternal health services are very much better. There are many services that are required for maternal health. For proper maternal care and related to care of infants there has to be services available not only at the time of delivery but before and after that also. This is called continuum of care. The care should start during pregnancy. This is called Ante Natal Care (ANC) and continues till after the birth of the child (Post Natal Care or PNC). Care should be available during childbirth
also (Intrapartum care), especially emergency obstetric care (EmOC) so that the life of the woman can be saved in case there is an emergency. Other than these services the woman should have access to good and nutritious food at home and rest which is mostly not there for poor women.

**Infant mortality rate** define as Probability of dying between birth and exactly one year of age expressed per 1,000 live births. In 1990 IMR in Uttar Pradesh was measured at 99 and it was agreed that by 2015 it would be brought down to 33. If IMR continues to reduce at the same rate at which it has declined between 1990 and 2012, the MDG of 33 (IMR) will be achieved only in 2034. It will not be out of place to mention that around two and a half million children die every year in India. Out of them anything close to over 4,00,000 children must be dying every year in UP alone. This is an alarming situation. On the day of birth asphyxia and preterm birth emerge as the common most killers. On day one and during the first week of the life preterm birth and sepsis or pneumonia emerges as big killer. From second week to fourth week sepsis or pneumonia emerge as the main cause of child death. In the post-neonatal period diarrhea also emerges as a major determinant of child mortality. If we really want to reduce mortality rates then these big killers will have to be appropriately tackled.

In Uttar Pradesh according to the latest figures released by the Registrar General of India (based on births 2004 – 06) 440 women die out of every 1 lakh who give birth. In the period 2001 -03 this was 517 and earlier in 1995 this was 707. Even at this reduced MMR there are over 28 thousand maternal deaths in the state every year and over five and half lakh women face life threatening situations. Under the Child health Number of infant deaths per 1,000 live births counted as Infant Mortality Ratio (IMR). IMR for UP is also at 73 which is so critical at present level and efforts are needed to reduce this ratio for better future of nation.

Reduction in Infant, both neonatal and post neonatal components, and Child mortality has been an important objective of NRHM initiatives. A holistic policy intervention to promote child survival in NRHM comprises of new born care, both home and facility based, proper counseling and widespread messages on proper breast feeding practices,
and food supplementation at the right time and a complete package of immunization for children. Immunization programme being a key intervention for protection of children from life threatening and preventable diseases predominantly facilitates reduction in post neonatal component of infant mortality. Thus, proper breast feeding, nutritional supplementation and complete immunization package envisages reduction in infant and child mortality. Efforts are being made to strengthen routine immunization by usage & disposal of auto destructible syringes, community mobilization by volunteers, special IEC activities, alternate vaccine delivery system, strengthening of cold chain etc. In India, children are supposed to be vaccinated for six serious but preventable diseases – tuberculosis, diphtheria, Pertusis, tetanus, poliomyelitis and measles.

This research will therefore do a detailed study of the situation of maternal and child health services in Uttar Pradesh and try to understand how this impacts maternal and child health in an area. This research will focus on community level intervention running under NRHM.

1. Statement of the problem

In twenty first century, India is facing many challenges one of them is poverty and underdevelopment. A large part of India is living in villages and deprived of basic amenities of life. In the past sixty years, many schemes of development have been made for these areas but the picture has not changed as needed.

Children are not getting education, nutritional food despite the fact many prominent schemes are running for the purpose. Corruption is spreading like virus in the whole society. Marginalized sections of society, poor are unable to demand their rights because they don't know what their rights are. Old age people, widows don’t have proper information about their pension scheme. Awareness and information dissemination level among the rural people is at the bottom line and they are living their lives in bizarre condition.

Tall claims have been proved as total false and the divide between urban and rural parts of India has widened drastically. Rich people are becoming richer and poor is becoming poorer. Purchasing power of middle class has not changed as it was anticipated. Unemployment has increased by and large. Government jobs have decreased and private sector is not growing
enough to provide needed support to rural aspirants. Quality of health care facilities is dipping in rural areas due to negligence of government. Government institutions are not improving with changing time. NRHM has been launched some years back. Hospitals don’t have staff, infrastructure and medicines,. This is very grim situation because villagers don’t have any other alternative to go for their treatment.

In brief, one can say people don’t know clearly what scheme are operational for their benefit and they even don’t know what amount of money has been spent in the name of public welfare. PHCs, CHCs, district hospitals, shelters and many more facilities are functioning very casually and villagers are being forced to be exploited by private healthcare facilities. Providing better healthcare facilities and mobilizing the community have become need of hour and every effort should be centered on these two priorities.

2. Research Plan:-

2.1. Selection of the research problem

It is very loud and clear that rural areas are most backward areas in the country. Basic health care facilities are not available at satisfactory level and poor people are facing very tough conditions. Many governmental agencies agree on the fact that there should be more and more emphasis on development of medical facilities in these backward areas. Civil Society Organization has shown the naked picture of mismanagement of resources at ground level.

The research problem selection was very crucial for whole research work. If maternal healthcare schemes have been implemented well then no pregnant women would have faced any kind of trouble. Working with villagers will provide great opportunity to understand basic health needs, awareness pattern, tolerance level of rural people, and resource management capabilities of rural people also. Working on this problem will facilitate the good understanding of various health issues within the community and its impact on their overall well being.

It is well known that early marriage; repeated pregnancies, short intervals between pregnancies, maternal anemia are some of the factors which contribute to maternal and child ill health. According to the National Family Health Survey of 2005 -06 women who received various maternal health services in UP compared to the all India figures is given below:
<table>
<thead>
<tr>
<th>Indicator</th>
<th>India</th>
<th>UP</th>
<th>Percentage diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC visit in first trimester</td>
<td>43.9</td>
<td>25.7</td>
<td>70.8</td>
</tr>
<tr>
<td>Weighed</td>
<td>63.2</td>
<td>20.9</td>
<td>202.4</td>
</tr>
<tr>
<td>BP measured</td>
<td>63.8</td>
<td>25.6</td>
<td>149.2</td>
</tr>
<tr>
<td>Urine sample taken</td>
<td>58.1</td>
<td>24.7</td>
<td>135.2</td>
</tr>
<tr>
<td>Blood sample taken</td>
<td>59.5</td>
<td>22.1</td>
<td>169.2</td>
</tr>
<tr>
<td>Abdomen examined</td>
<td>72</td>
<td>43.1</td>
<td>67.1</td>
</tr>
<tr>
<td>Told where to go for complications</td>
<td>41.1</td>
<td>18.9</td>
<td>117.5</td>
</tr>
</tbody>
</table>

Data shown clearly that woman in UP received much less services compared to the country as a whole. Five others direct complications account for more than 70% of maternal deaths: hemorrhage (25%), infection (15%), unsafe abortion (13%), eclampsia (very high blood pressure leading to seizures – 12%), and obstructed labor (8%). Some causes of maternal death, unavailable, inaccessible, unaffordable, or poor quality care is fundamentally responsible. They are detrimental to social development and wellbeing, as some one million children are left motherless each year.

Services necessary for reducing MMR and IMR

- Nutritional supplementation
- Contraceptive services
- Safe abortion services
- Full Ante natal care and early detection of complications
- Safe delivery with quick referral services
- Emergency obstetric care services available within 2 hours.
- These include services for control of convulsions, caesarian operation, blood transfusion and resuscitation of the new born.
- Children breastfed within one hour of birth.
- Children 12-23 months fully immunized (BCG, measles, and 3 doses each of polio/DPT).
• Children age 0-5 months exclusively breastfed.
• Children age 6-9 months receiving solid or semi-solid food and breast milk

We must give these information and required support to our women beneficiaries for improvement of their reproductive health, help her through a pregnancy, and care for her and her newborn well into childhood. The vast majority of maternal deaths could be prevented if women had access to quality family planning services, skilled care during pregnancy, childbirth and the first month after delivery, or post-abortion care services and where permissible, safe abortion services. A working health system with skilled personnel and generation of awareness about women’s health are keys towards saving pregnant women's lives.

Lack of awareness and low importance of women’s health is the prime reason in rural areas where mothers are excluded from life-saving care at childbirth. In Our country "numerous women and children are excluded from even the most basic health benefits: those that are important for mere survival”. Often the poorest, show a pattern of massive deprivation, with only a small minority, usually the urban rich, enjoying reasonable access to health care, while an overwhelming majority is excluded. Among those left out, women and their children suffer most. Being poor or being a woman is often a reason for being discriminated against, and may result in abuse, neglect and poor treatment, poorly explained reasons for procedures, compounded by views sometimes held by health workers that women are ignorant. The care that women are offered may be untimely, ineffective, unresponsive or discriminatory.

The right to health is a fundamental right and the poorer health indices of half the population is a cause for concern. Many researchers and activists are no longer convinced that we can succeed in improving women’s health or status unless society attempts to confront its gender bias openly. For too long we have been refusing to discuss women’s health issues openly with society. It would appear that nothing short of a social revolution would bring about an improvement in the health of Indian women. Many approaches have been suggested. They will all need to include approaches which examine, understand and confront gender discrimination in social, cultural and
religious spheres. There is an urgent need for a detailed re-examination of public health statistics for India, disaggregated by gender and region.

In this study we are going to undertake an assessment of service providers of grassroots level maternal health system for getting better results on Maternal and child health. Also, study attempts to investigate the maternal and child health problems, along with existing mother and child health care facilities at PHC and sub center level, and levels of utilization of MCH services by women’s and community members.

2.2. Hypothesis

The main hypothesis of the present study is that poor administration of health services at grass root level plays a great role in increasing the maternal and child mortality and morbidity rates. People in rural areas are not fully aware about the available health services and the various health care programs this makes the problems more complex. More precisely the hypothesis of the study is as follow:

1. Proper administration of health services in rural areas can affect the health status of the community
2. Absence of missionary sprit among the health facilities of community level adds to the problems.
3. Absence of cooperative attitude, in respect of participation of services providers, is a great barrier towards solving problems.
4. Ignorance about the available health facilities of community level adds to the health problem.

2.3. Objective of the study

1. To assess maternal and child health care delivery system of PHC /CHC and sub center level.
2. To assess the level of utilization of maternal and child health services by the community.
3. To assess the knowledge, attitudes and opinion of the men’s regarding the maternal and child health issues.
4. To assess the knowledge, attitudes and opinion of the women’s regarding their own health and child health issues.
5. To find out the care barriers in maternal and child health services.
6. To identify the gaps to be strengthen.
7. To provide feedback to health planners in terms of utilization pattern of the modern health care services.
8. To identify the actual need of health care facilities for pregnant and lactating women.

2.4. Scope of the study

The constitution of India provides many empowering provisions to provide better health care facilities to all marginalized sections and poor communities specifically women. But at present, no section of the society is in a condition that one can say that “they don’t have any health problems.” So, to assess all these situations one has to go through deep analysis and interpretation. For solid conclusion a unit area has to be selected for data collection and intervention also. By doing this, sentiments of the common people, administrative behavior, irregularities in health scheme’s implementation, corruption, lack of awareness, lack of information, prevailing status of maternal and child healthcare facilities and other relevant factors can be counted easily.

2.5. Primary preparation

For the study it is very important to select correct medium of information, to collect some specific details regarding rural development programs and to visit the whole area where intervention or research work has to start. Many civil society organizations have evaluated government health schemes NRHM and ICDS. Collecting these social audit reports or impact analysis brief findings provided much needed data base. Discussion with guide, CSOs, health experts, common people, and elective representatives of the villages provided sound guidelines for the effective handling of the study.

Common people are most important stakeholder of the total exercise. So tapping their sentiments, feelings experiences and difficulties would provide very sharp edge to the study. It will become a genuine exercise containing solutions and findings regarding health problems of rural people. School teacher living in the village area supported this whole study, whole heartedly and guided for the best. Primary preparation for the study also includes
understanding psychology of rural people and specifically women. This helped enormously during the data collection exercise. People do want to express their problems through answering question and body language. One has to be very calm, cool and patient while interacting with respondents.

Before starting the study the researcher went through relevant literature on maternal health, child health care policies and programmes, health care administration and management etc. In order to get a general idea about the problems to be studied, a questionnaire has been prepared for interviewing the relevant respondent.

3. Research Design

The term design means “drawing an outline” or planning or arranging details. It is a process of making decisions before the situation arises in which the decision has to be carried out. “Research design” is planning a strategy of conducting research. It plans as to: what is to be observed, how is to be observed, when/where it is to be observed, why it is to be observed, how to record observations, how to analyze/interpret observations, and how to generalize. Research design is, thus, a detailed plan of how the goals of research will be achieved.

According to eminent social scientists there are three types of research as descriptive, explanatory and exploratory. But black and champion have also painted out differences in designs of three other types of researches too, as survey research, case study research and experimental research. In this research, exploratory research design has been used in order to figure out the grey areas in whole institutional reproductive health delivery system.

3.1. Selection of District and the Block

Uttar Pradesh is counted as backward state in the rural health perspective. Many districts don’t have good health infrastructure even now. UP is lagging behind in all key indicators of health services. So the correct selection of the area for the study was very crucial.

The selected area in the study is spread in four district of UP Bahraich, Balrampur, Varanasi, Lucknow. These districts are selected on the basis of data of DLHS –3; 2007-08. There is main three indicators to assess the status of Maternal and Child health. First is, three or more ANC checkups of the pregnant woman, the second is efficiency of Institutional delivery and third is proper immunization (BCG, measles, and 3 doses each of polio/DPT) of Child within 12-23 months. On the basis of these three indicators Bahrich and Balrampur has
lowest institutional delivery with 7% and 8.6% and Lucknow and Varanasi are highest institutional delivery with 47.3% and 54.5%. Same condition for complete immunization status for children in these districts as Behraich and Balrampur has lowest with 15% and 18% complete immunization and Lucknow and Varanasi are highest with 51.1 and 47.2% of complete immunization. From all these districts, one block has been selected for the research through lottery method.

3.2. Sampling Plan

A sample is a portion of people drawn from a larger population. It will be representative of the population only if it has same basic characteristics of the population from it is drawn. Sampling is not about what types of units will be interviewed/ observed but with how many units of what particular description and by what method should be chosen.

In this research, 30 lactating women (having child nine to twenty four months) have been selected as respondents using convenience sampling from 5 villages each selected randomly from 4 blocks each in above mentioned 4 districts. It is clear now that total 600 respondents have been interviewed during data collection process. During the interaction male members (preferably husband of the respondent) have also been interviewed on some crucial issues for their perspective.

Further, AWW, ANM, ASHA workers and Medical Officer of CHC and PHC have also been consulted in order to clarify certain issues came up during the interaction with respondents. Views of other Stake holders related with the NRHM/RCH/ICDS programs have also been considered to analyze the grassroots level situation and figure out the grey areas in overall reproductive health service delivery mechanism. Some studies published in development magazines have also been used for analysis of data.

3.3. Collection of Data: Tools and techniques

Data collection is very important phase of the whole study because if collected data is useful and correct on the defined criteria then study will proceed in right direction otherwise total efforts would be wasted. There are different kinds of tool and techniques of data collection. Major tools and techniques are listed here-

- Questionnaire and Interview Schedule
- Interview Observation
• Content analysis
• Projective techniques
• Published study

The researcher interviewed the respondent by applying the formal and personal interview and unbiased observation techniques.

3.4. Interview Schedule-

The set of structured questions in which answers are recorded by the interview himself is called interview schedule or simply the schedule. It is distinguished from the questionnaire in the sense that in the questionnaire the answers are filled in by the respondent himself. Schedules are more important in securing information from the respondents. The wordings of the questions in the schedule should be simple and if there is some complex questions interviewer can explain that one easily. Questions in the schedule should cover all aspects of research subject/problem. Number of questions should be accordingly determined, not more and less.

3.5. Observation

Observation is a method that employs vision as its main means of data collection. It implies the use of eyes rather than of ears and the voice. It is accurate watching and noting of phenomena as they occur with regard to the cause and effect or mutual relations. It is watching other person’s behavior as it actually happens without controlling it. Observation is also defined as “a planned methodical watching that involves constraints to improve accuracy”.

The Interview schedules were used to collect primary data. The interview schedules were prepared after studying a lot of research literature, text books and consulting reproductive health experts and development workers.

3.6 Data Processing

Data processing mainly involves various manipulations necessary for preparing the data for analysis. This process could be manual or electronic. It involves editing, categorizing the open ended questions, coding, and computerization and preparation of tables and diagrams. Information gathered during the stage of data collection varies in nature and quantity from study to study. Checking also needs that data are relevant and appropriate and errors are modified. Editing is required for proper coding and entering in the computer in larger studies. Editing process begins in the field itself. Interviewers, soon after completing the interview,
should check the completed forms for errors and omissions. Editing also occurs simultaneously with forming categories and requires re-arranging answers to open-ended questions.

**3.7. Tabulation of Data**

After editing which ensures that the information on the schedule is accurate and categorized in a suitable form, the data are put together in some kinds of tables and may also undergo some other forms of statistical analysis. There is nothing like statistical sophistication in tabulation. It amounts to no more than counting the number of cases falling into each of several categories. Tabulation is not only total adding but counting frequencies in each category. Tables are useful to the researchers and the readers in three ways

- They present an overall view of the findings in a simpler way.
- They identify trends.
- They display relationship in a comparable way between parts of the findings.

Each table presents a specific description in its title, has columns and rows, and gives information either in numbers or in percentages. Data arranged in a table provides great help in analysis. Better analysis gives right direction in which study could proceed. Comparing various aspects of problems becomes very easy through tabulation.

**3.8. Sources of Data**

Respondent’s Answers collected through interview schedule and information collected through observation technique have been the main sources of primary data.

Reports on NFHS-3 & DLHS -3, News articles & Case studies Published in daily news papers, Books and magazines on reproductive health and other Literature available on MCH care problems have been the main sources of secondary data.

**3.9. Data Analysis and Interpretation**

The analysis is the ordering of data into constitutional parts in order to obtain answers to research questions. Analysis is the process from which hypotheses are checked, certain facts and figures take shape which help ultimately in conclusion. However, merely analysis does not provide answers to research questions. Interpretation of data is also necessary. Interpretation takes the results of analysis, makes inferences and draws the conclusions about the relationship. Thus, to interpret is to explain, to find meaning. In most cases, it is difficult to explain raw data. Analysis paves way for correct interpretation of data. Data are interpreted in two ways: one, the
relations within the study and its data are interpreted; and two, the results of the study and the inferences drawn within the data are compared to theory and to other research results.

The analysis of a research is done in four stages. These are: categorization, frequency distribution, measurement and interpretation.

3.10. **Categorization**: Categories are setup according to the research problem and purpose of study. These are mutually exclusive, independent and exhaustive.

3.11. **Frequency distribution**: Frequency distribution is the tabulation of quantitative data in classes. It indicates the number of cases or distribution of cases falling into different categories. Frequency distribution is of two types: primary and secondary. Primary analysis is descriptive and only gives the number of cases in each class. Secondary analysis is comparisons of frequencies and percentages. It is thus concerned with relations as comparing the frequency of men with women, or educated with illiterate.

3.12. **Measurement**: Measurement could be in the form of central tendencies or statistical averages. The mean is the arithmetic average of a set of measures. The medium is the midmost measure of any set of measures. The mode is the most frequently occurring measure of a set of measures.

3.13. **Interpretation**: Interpretation of data can be descriptive or analytical it can be from a theoretical standpoint. Negative results are much harder to interpret than positive results. Positive results are evidence of the fact that the methodology, the measurement and the analysis are satisfactory. The interpretation of data culminates in conditional probabilistic statements of “if a, then b type.”


Preparation of report is the final stage of the research and its purpose is “to convey to interested persons the whole results of the study in sufficient details and so arranged as to enable each reader to comprehend the data and to determine for himself the validity of conclusions”. The time required for preparation of a report always depends upon numerous factors. These factors can affect the “deadline” of the report sometimes but in this case compromise should never be done with quality of report. Nevertheless this carefully planned research work well analyzed findings and suggestions.
Key Findings

In the analysis has been done with the data collected from the respondents and some key findings have been derived out of that analysis. Here some core issues have been pointed out in reference of responses from the field. It was observed that many responses provide a clear the picture prevailing in high performing and low performing districts.

1. During antenatal period, it is essential to monitor complications that could arise during pregnancy or delivery, detect and treat the existing problems, provide advice on the diet and about various preventive measures that should be taken during pregnancy. As per norms, the expecting mothers should receive two doses of tetanus toxoid vaccine, adequate amount of iron and folic acid tablets or syrup to prevent anaemia. Pregnant women are expected to visit a health facility to have at least three antenatal check-ups for blood and urine test and other procedures to detect pregnancy related complications. To woman’ questionnaire had probed whether the pregnant women had sought any antenatal check-ups or not, and if availed then from where, whether from public or private health care facilities.

It was observed that 74% respondents form low performing and 59.33% respondents form high performing districts did not received advice by any of the health service providers for ANC checkups during delivery time. It very clear that ASHA, AWW and ANM (all three service providers) are village based and their job description includes counseling of Pregnant women for ANC but research data shown a large gap (nearly 15%) while comparing high performing and low performing districts. So actually in high performing districts situation is not good but in low performing districts situation is worst.

2. In the 9 month pregnancy period health expert suggest at least 3 times Antenatal checkups. Study showed 55.67% respondents from low performing and 42.67% respondents from high performing districts not had a single time Antenatal
checkups. About 12.67% respondents from low performing districts and 21% respondents from high performing districts had one time ANC checkups. 6% respondents from low performing districts and 11.33% respondents had two times ANC checkups. Early detection of complications is also a part of ANC checkups. If complications have been detected early, lives of mother and child can be saved. Here we can saw a significance difference between high and low performing districts in antenatal checkups. If our service provider will give more counseling to every respondent at the time of ANC then very easily one can convert one & two times ANC checkups to full ANC checkups. It was found that service provider’s efforts and alertness were not very satisfactory. Research recommends that, In high and Low Performing indicators districts full ANC checkups will increase, if counseling by service providers being done very efficiently with full efforts.

3. As a pregnant woman, one needs to go for regular prenatal care. Such medical checkups and the necessary screening tests assist in keeping both the mother and the child safe and healthy. Prenatal care would also include counseling and education regarding the manner in which the mother should handle several pregnancy aspects. During such visits, the care giver would put on board several issues such as physical activity, healthy eating, the kind of screening test the mother may need to undergo and what the mother should expect during labor and delivery. There has been evidence that pregnant women who regularly go for prenatal checkups end up with a healthier pregnancies and babies. Research showed counseling on health & nutrition by ANM, ASHA & AWW is very low. Only 45% respondents told they given counseling on health & nutrition. ASHA & AWW both are living in the same village with the respondents but it was very unfortunate that near to 55% respondents from both type of districts told they had not got any suggestions from them.

4. During pregnancy many times emergancy situation emerges. Sometimes Pregnant women are suffering from lower pain, bleeding, stomach ache, swelling in legs and other body part, stopped Movement of child etc. It is observed that In low performing district 33% respondents accepted that they face emergency situation during pregnancy. Compare to this in high performing district only 15.67% womens face the emergency situation. Many times emergency situation arise because lack of proper care
and awareness. It is very necessary to plan, whom you call in emergency situation. Here research explored that during emergency situations Nearly 37 Respondent’s from both district said that they will call ANM. Near to 24% respondents told they will call ASHA worker in any emergency. From Low performing district 6.67% respondents are also said they will go to quack nearby his village in any emergency situation. Nearly 30-33 % respondents from both types of the districts did not even think about whom they will call in emergency. This finding says from both district one third of respondents not even knows the danger sign of pregnancy. If they have knowledge of danger signs they must think about whom they will call in any emergency situation.

5. Reduction in maternal mortality and child mortality is an important aim of National Rural Health Mission and the Millennium Development Goals (MDGs). Many innovations have been done in the State with the support of GOI to strengthen Village Health and Nutrition Day which provides comprehensive outreach services for pregnant women and children at their doorstep. Data shown that near to 91% respondents are not aware of VHND day. During research respondents were asked about VHND term and their participation in it. Research found that very few respondents were aware about the day are called by service providers to participate in the proceedings.

6. NRHM has been working constantly on the issues of birth preparedness and institutional delivery; study explored the status of institutional delivery vis-à-vis home delivery. Place of delivery is my key indicator for selection of my districts. Research shown 68.33% institutional delivery happened in high performing districts and compare to this only 56.67% institutional delivery done in low performing districts. Situation in low performing districts is very alarming near to 35% respondents having home delivery. Under NRHM government provide all support in JSSK scheme and JSY scheme but percentage of institutional delivery in not increased as we think. Under DLHS survey institutional delivery is comparatively very low it comes only 7% in Behraich and 8.6% in Balrampur. Looking on these indicators both districts have been termed as low indicators districts. This research is also showing comparatively better results in these indicators because after DLHS survey GoI and GoUP put a lot of pressure on its functionaries for increasing institutional delivery.
7. The essential newborn care should be based mainly in the community that may prove life saving for newborn. First week is very significant for new born and his mother. Pneumonia, Sepsis, birth asphyxia and other several dieses causes of neo natal deaths. Through counseling of lactating mothers and other family member’s neonatal deaths reduced. Study shown only 19.33% Service providers done home visits in first week in low indicators districts compare to this 33.67% are doing home visits in first week from high indicators districts. Near to 80.67% Service providers are not doing home visits in first week. In other words we can say child and lactating mothers was not counseled when actually it’s needed.

8. The newborn is most sensitive to hypothermia during the stabilization period in the first 6 – 12 hours after birth. Because newborns have poor thermal insulation and small body mass to produce and conceive heat. Hypothermia is a major cause in neonatal death cases. During Hypothermia baby temperature getting down very quickly and before taking any action in rural area neonatal child died. To maintain the temperature of neo born baby, it’s suggested that in winters at least 7 days and in summers at least 5 days bathing of baby not done. Many studies shown by successfully implementing this intervention IMR is reduced by half. Low indicator districts study finds 37.33 % babies have been given bath in first hour of birth and its very dangerous practices happening across rural areas. During first hour after birth, body of child never adapts with the outer sphere and its temperature is also not balanced. High performing districts also showing 22.33% babies have been given bath in first hour which was also very alarming. Near to 15% babies from both type of districts have been given bath within one to two days of birth. If these 15% respondents are provided good counseling, lives of many neonates can be saved and IMR will be reduced drastically. During discussion respondents told that they were not suggested by any service providers about this. They followed their yearlong practices in lack of information and counseling.

9. It is also recommended that the first breast milk (colostrum) should be given to the child rather than squeezed from the breast and discarded, because it provides natural immunity to the child. As per DLHS-3 the proportion of women who initiated
breastfeeding within one hour, within 24 hours and later are 15.1, 33.6 and 66.4 percent respectively.

Research showed that only 28% respondents gave colostrums feeding to their children belongs to low performing districts where as 23.33% belongs to high performing districts. Colostrum feeding is very necessary to strengthen the immune system of baby. Vit A is being given to babies after completion of 9 months and before that only Colostrums will prevent baby from diseases as it boosts baby’s immune system. Study shows over to 70% mother respondents told they did not feed colostrums. Study shown in high performing districts percentage of colostrums is very low and it’s just because of they did not think it’s important. Comparing with other indicators awareness in high performing districts in this regard is very low. To reduce IMR, an important indicator emphasis should be on improving counseling practices more and more.

10. Further one of the key interventions to ensure good nutrition & health status is promotion of exclusive breastfeeding for up to six months as the World Health Organization (WHO) recommends exclusively breastfeeding is important and it saves child from many infections. In rural conditions children easily get sick from infected food and food poisoning. Exclusive breast feeding prevent child from these type of infection. Doctors recommend exclusive breast feeding because mother milk is complete nutritious diet for child. It is recommended that exclusive mother milk is enough up to six month child. Doctors suggested Even water is not needed till six month completion of child. 89% of respondents from high performing districts and 87.33% low performing districts respondents were not giving exclusive breastfeeding to their children. Research shows that more than 80% people are not aware about importance of exclusive breast feeding.

11. Nutritional status is a major determinant of the health and well-being of children. Inadequate or unbalanced diets and chronic illness are associated with poor nutrition among children. Research shows only 20% respondents from high performing district and 19.33% from low performing district starts giving semi solid food to their babies in fifth month. It also presents 2.33% respondents from high performing district
and 2.67% respondents from low performing district who starts semi solid food in sixth month. Research shows 10.33% respondents from low performing and 9.67% from high performing starts semi solid foods from seventh months. Research shows most respondents starts semi solid foods in eight months. 55% respondents from low performing districts and 58.67% from high performing districts starts semi solid foods in eight months. Near to 12.67% respondents from low performing district and 9.33% from high performing districts starts feeding semi solid food to their child in ninth month.

12. Immunization and Vitamin A - Universal immunization of children against common vaccine preventable diseases has long been a goal of the Universal Immunization Programme and the National Population Policy, 2000, has now reiterated this goal. India’s Immunization Program is one of the largest in the world in terms of quantities of vaccines used, numbers of beneficiaries, and the numbers of immunization sessions organized, the geographical spread and diversity of areas covered under the immunization program, seven vaccines are used to protect children and pregnant mothers against Tuberculosis, Diphtheria, Pertusis, Polio, Measles Tetanus and Hepatitis-B. Study made an attempt to explore the immunization status of children and in order to do so the status of immunization of children 0-12 months old for different vaccines was measured through recall method or vaccination card. Research shown Polio vaccination is very high and seems satisfactory. 92.33 % people from low indicators and 94.33% from the high performing districts completed zero dose polio vaccination. Hepatitis-B Zero Dose vaccination is very high and adequate. 91.33 % people from high indicators and 89.33% from the low performing districts completed zero dose HB vaccination. BCG vaccination is also very high and satisfactory. 90.33 % people from low indicators and 89.33% from the high performing districts completed BCG vaccination. Research showed that 66.67% respondents from high indicators having full does of DPT however only 57.33% from low indicator respondents receive the same. Research showed that 64.33% respondents from high indicators having full dose of HB however only 59% from low indicator respondents received all three doses. Research showed that 64.67% respondents from high indicators having full does of routine polio vaccine however only 68.67% from low indicator respondents received all
three doses. 56.33 % respondents from low indicators and 72% from high indicator districts having measles vaccination done. Research showed that 41.00% respondents from high performing districts received full vaccination however only 36.67% from low indicator respondents received the same.

The Government of India recommends that children under five years receive Vitamin A supplements every six months, starting at age 9 months. In last few years, GoMP conducts special mop up campaign called “shishu shanrakshan mah” for achieving the target along with development partner organization every six months. Research showed 67% of high performing districts respondents administered with vitamin A and 61.33% low performing districts persons having vitamin A Vaccination. 38.67% respondents not administered vitamin A belongs with low indicator districts and 33% respondents not having vitamin A vaccination belongs with high performing districts.

13. **Janani suraksha yojana** is cash assisted scheme for institutional delivery to women delivering in health facilities to reduce transportation and delivery costs. This study also found institutional delivery increase because of this scheme. About to 91.67% respondents from low performing districts and 94 % respondents from high performing districts had knowledge about this scheme. Research showed very few people are not aware about benefits of this scheme. Under Janni suraksha yojana pregnant women got money for expense’s occurred in institutional delivery. Research showed hospital staff takes money from family of pregnant women received under JSY scheme .GOI started this scheme because often villagers are not taking pregnant women to community health center because of money. Overall expenses often are higher than the JSY incentive amount. As per discussion with community member’s expenses of diagnostics, drugs and injections, which often have to be procured from outside the facility and the demand for informal payment by hospital staff, are two major reasons for high out-of-pocket expenses for women choosing institutional deliveries. Study found in most of the cases Hospital staff taking money from beneficiaries for various reasons. Research found 88.75% respondents from high performing districts and 91.55% respondents from low performing districts accept that they give money to hospital staff on the name of rituals and other expenses.
14. IN JUNE 2011, Ministry of Health and Family Welfare, Government of India launched the **Janani–Shishu Suraksha Karyakram (JSSK)**, a national initiative which entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section. The scheme emphasizes utmost importance on “Free Entitlements”. The idea is to eliminate out-of-pocket expenses for both pregnant women and sick neonates. Under this scheme, pregnant women are entitled for free drugs and consumables, free diagnostics, free blood wherever required, and free diet up to 3 days for normal delivery and 7 days for Caesarian section. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth. Study founds about to 83.8% low performing districts and 53.65% high performing districts respondents reports they born all medicine expenses by them self during institutional delivery.

This research focus light on referral point selected by the respondent while **baby illness in first month.** Study finds in low indicators districts 30.23% respondents went to nearby sub center as first referral point where as in high indicators districts 3% respondents went to same. 8.14% respondent from low indicator and 21.52% from high indicators not went for proper medical checkups. They were taking home based medicine only. 33.47% respondents from low indicators and 27.85% from high indicators went to government hospitals. It was observed that still 20.93% respondent from low indicator districts and 16.46% from high indicators districts went to quacks. 31.18% respondents from high performing districts shows confidence to private hospitals for treatment of their baby however Low indicator districts people not prefers going to private hospitals, only 7.23% people went to private hospitals.

Linking with the same question attention was paid on the facility preferred by the respondents for treatment of sick child. Research showed that 42.33% respondents from low performing districts & 38% respondents form high performing districts **preferred private hospitals** for treatment of their sick child. 21.67% from high performing and 25% low performing districts respondents showed their belief with quacks. 31.67%
respondents from high & 23% from low performing districts preferred government hospitals for treatment of sick child. 9% respondents from low performing districts and 7.67% respondents from high performing districts preferred home based treatments.

15. In continuation with the above findings whereas Research showed 31.67% respondents from high performing and 23% from low performing districts given faith in government hospitals. To get a clear picture, it was necessary to explore basic problems in government hospitals. For this, it was asked why people were not going to the Government CHC/PHC? About to 35% respondents from high performing districts 38.33% respondent from low performing districts told they were not going to govt. hospitals because they did not get free medicine from there. 13% respondents from high and low both type of districts told government hospital taking much waiting time, as many time doctor not coming on time and many time staff was also not present. 19.33% respondents from high performing districts and 14.33% respondents from low performing districts told they did not go to government hospitals because health staff (ANM/Nurse/Pharmacists) not available many time. Due to non availability of health staff they did not receive free medicines; other checkups recommended by doctors and others facilities. About to 15% respondents from high performing districts and 24% respondents from low performing districts told they did not go to government hospitals because doctors are not available. In this scenario they waste their time to go again to a private doctor who again take more money in transportation and mostly are daily laborer so delays affects many times their job also.

16. Research showed impact of BCC message and how much community remembers the messages. About to 58.33% respondents from high performing districts and 37.67% respondents from low performing districts listen or read reproductive and child health related BCC message. 41.67 % respondents from high and 62.33% respondent low from performing districts are not listening or read health related BCC messages. It’s actually very sad that government invest a lot on BCC but in low performing districts situation not changed enough.
17. A further classification was done which showed that 33.67% respondents from low performing districts and 58.33% respondents from high performing districts accept presence of ANM in the village every month. About 64.67% respondents belong to low performing districts told they saw ANM in the every second month however 39.67% respondents from high performing districts told have seen ANM in the every second month. Near to 2% respondents from high performing and 1.67% from low performing told they haven’t seen ANM single time in the village doing her Job. In other words, only 33.67% respondents from low & 58.33 high performing districts respondents expressed positively about ANM doing his regular Job.

18. **Behavior of service providers** having greater impact on services. Research wants to know the behavior of ANM with respondents. ANM is key people who has technical knowledge and have presence in the village also. ASHA worker are working like a bridge between community people and ANM. Here research focus on behavior and evaluate it on scale of good /not good/not good not bad. About to 65.33% respondents from low performing districts and 16% respondent from high performing districts told behavior of ANM is not good .11% respondents from low performing districts and 16.33% respondents from high performing districts told behavior of ANM is good. 23.67% respondents from low performing districts and 67.67% respondents from high performing told behavior of ANM is normal not good not bad. Simultaneously, research assesses the behavior of ASHA workers in same indicators. About to 67% respondents from low performing districts and 14.67% respondent from high performing districts told behavior of ASHA is not good with them. 34.67% respondents from high performing districts and 20.33% respondents from low performing districts told behavior of ASHA is good. 50.67% respondents from high performing and 12.67% respondents from low performing districts told behavior of ASHA is normal not good not bad. **AWWs are also responsible** for counseling of pregnant women on health and nutrition behaviors. Research wants to know the behavior of AWW with respondents. 57% respondents from low performing districts and 14.67% respondent from high performing districts told behavior of ASHA is not good with them. 44.67% respondents from high performing districts and 23% respondents from low performing districts told behavior of AWW is good. 40.67% respondents from high performing and
20% respondents from low performing districts told behavior of AWW is normal not good not bad

19. **Behavior of Government hospitals staff** members also responsible for increasing institutional delivery ratio and other key indicators in NRHM. Many studies and findings reflect that behavior of hospital staff link with RCH is not too good. This Research given focus on this matter. About 79.33% respondents from low performing districts and 42.33% respondent from high performing districts told behavior of Hospital staff is not good with them. 19.67% respondents from high performing districts and 8.67% respondents from low performing districts told behavior of Hospital staff is good. 38% respondents from high performing and 12% respondents from low performing districts told behavior of Hospital staff is normal not good not bad. Behavior of Government hospital’s Doctor also matters towards increasing institutional delivery ratio and other key indicators in NRHM. Data shows that 85.33% respondents from low performing districts and 61% respondent from high performing districts told behavior of Hospital Doctor is not good with them and 19.33% respondents from high performing districts and 8.67% respondents from low performing districts told behavior of Hospital Doctor is good. 19.67% respondents from high performing and 7% respondents from low performing districts told behavior of Hospital Doctor is normal not good not bad.

20. In our country family decision is always taken by head of the house hold and mostly male members of house are involve while taking any decision. **Place of delivery is also a very important decision in family.** Here research showed 35.67% respondents from low performing districts and 42.33% respondents from high performing districts accept that their husband is decided place of delivery. 32.33% respondents from low performing districts and 25.67% respondents from high performing districts accept that their mother in law having main role in making decision on place of delivery. About to 10% pregnant women from low performing districts and 14 % from high performing districts accepts they have asked their choice for place of delivery as many of them have been counseled by ASHA and AWW. 22% respondents from low performing districts and 18% from high performing districts told decision on place of delivery is taken by family members together. If we assess all above data, it is very clear that men think reproductive health is women’s domain and they do not
discuss this with service providers in most of the cases. At the time of decision on institutional delivery or any special care during pregnancy it depends upon male members of the family. Most of the time, women put their health problems in front of other family members at the last stage so it’s actually very critical time for taking decision and this late decision enhances the maternal morbidity and mortality rate.

21. In male dominating society male members always think, baby birth is very common thing and see nothing serious in it. Having this perception they did not asked their wives about their reproductive health. Mostly they leave this matter on her mothers and having old mentality, mother in laws always prefer home delivery as in her time mostly home delivery happens. This research also wants to focus the attention on gender related issue. Research tries to focus on role of Male members of the family during pregnancy. 88.33% from low and 72% of high performing districts male members preferably husbands of pregnant women’s did not enquire with health staff (ANM/ASHA/Doctors) about health of pregnant women during pregnancy period. 28% respondent (Husband of PW) from high performing and 11.67% respondents from low performing enquired about health of her wife with the health staff. Women’s voices have always been suppressed or neglected by male members of the family. Due to this they mostly never speak if it is related with their health also. Results of this they always report their problem with her husband in late stages. Here, women problem have been measured on a scale of Sevier /bad /normal stages. About to 67.67% respondents from low performing districts and 47.33% respondents from high performing districts reported that women told their health problems were at Sevier stage. 22% respondents from low performing districts and 41.67% respondents from high performing districts reported that women told their health problems were at bad stage. 10.33% respondents from low performing districts and 11% respondents from high performing districts reported that women told their health problems at normal stage. This shows that women of our villages are not giving importance of their health issues. Very few women are discussed their health problem with their husbands. This study also showed that male members were well aware about this, although they have not asked about health problem of their wife’s by themselves.
22. Research also focusing on Gender aspect as it is also having a vital role in decreasing MMR and IMR. Research focused on awareness among the male members especially opinion of pregnant women’s husbands. Pregnancy period is very critical in medical term and needs a special care of pregnant. Rural areas people take it very lightly and they don’t think, it takes any specials attention. Research showed the similar data where 82% respondents from low performing and 78% respondents from high performing districts thinks delivery is a normal phenomenon and doesn’t needs any special care. Only 18% respondents from low performing and 22% respondents from high performing districts thinks it very serious issue and needs special care. It’s very clear by review of results that awareness among male members is very low and they were not sensitized by any of agencies. As If we are on the way to reducing IMR and MMR, we should also try to sensitize male members on gender and health issues. We can see a large gap in the both type of district exists and also the male members of the villagers still perceive it as no big deal and a easily manageable situation.
Conclusion & Suggestion

State governments have designed and implemented many maternal health interventions in a very good way but due to lack of proper monitoring expected results have not been achieved. ASHA, AWW & ANM, the three field based facilitators, are working in the same geographical area but many times their mutual coordination is not good and that is why quality of services comes down sometimes. To improve IMR and MMR in UP, first step should be to establish better coordination among these field staffs and it is very sure, if they start working as a team many problem and barriers can be removed very easily. This research find the awareness is a major issue in low performing districts and efforts should be there to start a massive campaign through electronic media, print media, folk songs and debates in schools and panchayat meetings. It is clear from the study that Gender has played a lead role during specific situation such as decision making for place of delivery, behavior of patient, knowledge of husbands of pregnant women about health of her wife and others. It is recommended to focus more on husband and mother in laws of pregnant women during designing BCC campaigns. Government is providing all facilities free of cost and gender barriers should not come in way of availing these facilities. In South Africa, involving men as partners in maternity care and in couples counseling resulted in greater numbers of men assisting their partners in emergency situations. Communication between couples on topics such as sexually transmitted infections and sexual relations also improved.

Under NRHM it is mandated that association of PRI members through Village health Sanitation and nutrition committee will participate in health intervention at grassroots level but due to lack of monitoring by authorities this committee is also not working properly. Vision of NRHM is to empower the PRIs at each level i.e. Gram Panchayat, Panchayat Samiti (Block) and Zilla Parishad (District) to take leadership to control and manage the public health infrastructure at district and sub district levels. This is actually not happening in UP currently still provisions are there but only formalities are being completed at every level. To build awareness among men regarding women’s health issues effective PRI support is very much needed. Research showed High performing districts have performed better mainly because of good awareness campaigns so UP
government should think about ways and means to increase awareness in remote districts for decreasing the IMR and MMR ratio to achieve the 4&5 MDGs in given time period. Some below mentioned aspects also have major importance and have been discussed with reference of study conducted in field.

1. Increasing Awareness age of marriage

Age at marriage in low performing districts and high performing districts is almost in similar trend. Pregnancy in low age is itself a danger sign. Under age pregnancy causes maternal death and infant death. It’s suggested that in revised strategy NRHM should also focus on this issue and under BCC activity they should plan different type of spots on spreading this message. This issue is very serious and critical because though we have all facility for safe delivery in institutions but if mother happens to be weak and under age, risk of maternal death is always there.

2. Advice of ANC & PNC

ASHA workers are working in efficient way in taking pregnant women to institutional delivery only. Community linkage and Care during pregnancy and after delivery is not done properly. We cannot achieve our aim to reduce IMR and MMR without this and it is suggested that ASHA should more emphasis on antenatal and post natal care. ASHA worker if focus on first ANC and give all messages, full ANC done scenario can be achieved. When a pregnant women comes at session site for first ANC service providers should convince her for coming twice and thrice visits. After delivery ASHA worker have to visit again to new born in first week for PNC and suggest for new born care. It has been found that very few health workers are going to respondents home after delivery of babies. ASHA worker should be sensitized on this aspect and asked to visit respondent’s home for providing suggestions on PNC and new born care.

3. Awareness on TT Vaccination & IFA consumption in low performing Districts

TT vaccination and IFA consumption are very low in low performing districts. This shows that awareness among people living in high performing districts is good enough
and respondents know the importance of TT vaccination. Research suggests that we must do some special efforts in low performing districts for spreading awareness on this issue. If people are aware about importance of vaccination they will come forward and load of ASHA workers and other service providers will be reduced.

4. **Effective logistic support**
There are enormous logistic problem like perennial shortage of medicine, non-availability of proper equipments, storage facilities at sub Centre. At the time of emergency in pregnancy people rush to nearby facilities. It observed in low performing districts they taken pregnant women to quack in emergency situation. They increase problems and charge too much from rural people. Respondents rush to quack in emergency situation because they don’t have faith in government health services and also due to non-availability of services in sub centers. Effective logistic support will enable the building of community confidence in health services.

5. **Effective Monitoring system**
Supervision of MPW/LHV needs to be strengthened as supervision is considered the connection between PHC and the grass-root workers. Actually current supervision system has many loopholes. At VHND day Supervision done in two way, first relates with vaccine carrier drop and pickup work done one person at session site who ensure delivery of vaccine carrier to ANM and LHV/MPW and second health staff visits village during VHND day. Due to distance and having more official work, senior officers have not done supervisory visit on that day. They only have completed the formalities by visiting road side and nearby sub centers from the hospitals. Mostly vaccine carrier received by ASHA worker will be deposited with report at the end of day. Monitoring system should be revised and a software system will include who also showed the option for field visits plan for senior supervisors and MPW/LHV should monitor by village head and VHSC member’s .MPW/LHV will submit their report signed by at least two beneficiaries along with village head and VHSC members.

6. **Transport Facilities for beneficiary:**
Most of the time villagers rush to PHC/CHC at the last stage of pregnancy in emergency situation. When lower pain started only then villagers rush to the hospitals. Most of the time villages not having public transport system and in this case arranging a transport facility takes a lot time which is very crucial for pregnant women. If some Transport facilities remain available at the nearby hospitals to be used in this situation, it will save the life of mother and will increase institutional delivery also. State of Madhya Pradesh have introduced the facility of Janani express under which private vehicles remain available within hospitals and on beneficiary request hospital sent vehicles in the particular village and all expenditure is borne under provision of JSY. This is such a good scheme and by this scheme safe delivery percentage has increased in MP. This type of scheme should be introduced in UP also.

7. Linkage between Community and PHC:
There are very poor linkages between the PHC and the Community. Research has proved that hospital staff including Doctor's behavior is not good towards the beneficiary. The staff rarely fined any time to visit the community and diagnose its problems to ascertain their needs. To build linkage between communities to PHC, it is suggested that the PHC staff must visit community once a week to provide health education through well-arranged lectures in school building / panchayat ghars or exhibitions. If Hospital staff starts visiting villages they will understand problems and also can solve this as per need of villagers. This is a need of courteous behaviors with the patients who are already troubled with their sufferings. Village Health and sanitation committee is also non-functional and actually many of villagers don't know this committee. Only village head and ASHA completes formality of this meeting or in other words it runs on paper. If used properly, it can be a platform between community and PHC.

8. Building Confidence and Motivation of AHSA, ANM & Field workers:
The direct causes of maternal mortality like hemorrhage, pre-eclampsia / eclampsia, sepsis, obstructed labour –can be taken care of by skilled birth attendance and quality
maternal health services. Building Confidence of these workers gives respect of work and gives positive energy of work. It is a self-stimulating incentive within the minds and hearts of the multipurpose workers. A whole some morale stimulates loyalty generates co-operation and encourage team work. All these are essential for the achievement of the goals of sub Centre and primary health care system. A beginning can be made by developing a system of rewarding on good performance. ASHA bahu sammelan gives a pride to ASHA workers and others. It will be more beneficial if it is covered by media houses and work recognized by district authorities.

9. Coordination with Development Agencies:
There are a large number of development agencies working at block level and villages under jurisdiction of PHC, but there is no coordination among these agencies. State of Bihar and Madhya Pradesh and several other states are running health reforms projects and they linked with development partner for technical assistance and monitoring of community worker by two way gives better results. It is suggested that all the development agencies in a particular area must promote the problems of developments simultaneously to produce sustained impact on population inhabiting these areas.

10. Community Participation and BCC:
For improvement in delivery of health services, and its application to the community, it is necessary to involve community members. Community participation has been a successful method for delivery of health care. For effective community participation it is very necessary to motivate people for a positive change in behavior, this can be done through Behavior change communication strategy (BCC), education communication (IEC). Here numerous modes such persons to persons contact use of print and electronic media, sensitization workshops, nukkad natak, haat shows etc. are used for awareness building among the community regarding health issues which facilitates community participation.

11. Strengthening of Village health and sanitation Committee:
The active involvement of PRI in VHSC is making people aware about their rights to health services through panchayat meetings, demanding for quality of services and getting a role in local management and delivery of health services. So the active participation of PRI must be encouraged through VHSC. Strengthening of Village health and sanitation committee can prevent village from many diseases. VHSC have funds for cleaning village nalli (drainage facility) and make arrangement of many other things for safety of village in health regards. Root causes can be addressed through community-level interventions as well as making maternal health a political issue, which is of concern for society at large.

12. Strengthening of Village health and Nutrition Day

Under Strategic Communication Plan for VHND a logo can be developed for branding VHND. Micro Planning template, monitoring formats, reporting formats should be there for facilitating better implementation. District level capacity building workshops should be conducted in all the districts and capacity building of frontline workers (ASHA, ANM and AWW) and VHNSC members should be focused a lot. To make VHND a successful programme, a common platform for convergence - be it inter-sectoral or inter-departmental - is required. At the village level, it calls for convergence amongst service providers of health; Integrated Child Development Services (ICDS); Panchayati Raj Institutions (PRIs), and the community. For instance, Accredited Social Health Activists (ASHAs) along with Anganwadi Workers (AWWs) are responsible for mobilizing the community for VHNDs (and holding health education sessions), with support from PRIs. Auxiliary Nurse Midwives (ANMs) provide maternal, new-born and child health services such as antenatal care (ANC) and routine immunizations.

District and Block Level Coordination Committees can be established for Inter-sectoral convergence and better implementation. Representatives of Panchayati Raj Institutions are also been included as members of these committees. VHND Micro planning and Session Monitoring template and data entry tool can be developed by the state with technical assistance from development partners and Micro planning exercise should be jointly carried out by ANM, AWW and ASHA.
13. Sensitization of service providers on Gender Issue

Strategy to limit Gender bias is also necessary to reduce MMR and IMR. Many times, service providers are not behaving well with pregnant women. They treat them badly and this behaviour creates distance between patient and health service providers. ANM & ASHA worker are also not behaving well with female clients they were not given appropriate information if any pregnant women asked, if same information asked by husbands they provide the information. Doctors and MPW are also not well behaving especially with women as in her mentality women is inferior in comparison to Men. Comprehensive interventions including gender sensitization initiatives are required to bring down maternal mortality ratios. Gender-accommodating approaches typically do not seek to change norms and inequities, but endeavor within existing normative structure to improve outcomes for women. This approach is strategically necessary as a first step in women’s health related programs in our conservative society.

14. Behave respectfully towards patients

All staff should be oriented to behave respectfully towards patients. Every one working in the facility should behave respectfully with patients since their arrival and until their departure. Aspects of respectful care include timely response to patients in labor, fully answering to patient questions, not scolding women for yelling or seeking more comfortable positions when they are in pain, allowing a trusted person to comfort them in the delivery, encouraging cooperation with clinical procedures in a caring and calm manner, not seeking “gifts” or illegal payment for standard delivery practices or postpartum care. Facility managers should consult with community health workers to determine if abuse of patients is being reported in the community and take appropriate action to investigate and respond to any such reports. Staff should be encouraged to participate in Village Health and Nutrition Days to answer questions about the ANC & institutional deliveries.

15. Biometric attendance be made compulsory

It is a common problem to see that doctors are missing or come only for a few hours or few days in a month. It is suggested that the entire NRHM attendance moves paperless
(biometric attendance be made compulsory). With this, the problem of absenteeism will certainly come to an end and service delivery will be smooth.

16. **Paper less reporting for productive time of the health workers**

Preparing reports and paper work takes most of the productive time of the health workers. With the advent of low cost tablet PC’s & low price 3G enabled phones; it might be worth considering giving these devices to health workers like ASHA’s. Also, if these mobiles / tablets have a GPRS connection, it can mean live data updates, thereby, reducing the three month gap between the village data entry and the central review points at Delhi. Digitizing the records through mobile phones would be great as the data will be updated live and the impact will also be significant with no chances of multiple entry and errors. Real time actions can happen through SMS based follow up and care.

17. **Community Radio**

Community radio is a very new concept and it will create significant awareness among villagers. Through this villagers may know provision of VHSC and other public interest scheme running under NRHM. Similar services can be started in villages to drive healthy behaviors. Simple awareness campaign (pictorial & through songs in local dialect) can reduced the maternal mortality effectively. The expenses in this project will not be more than Rs.5000.00 per village. Such models need to be adopted as soon as possible in as many areas.

18. **Mobile Sub centers**

Sub centers are built at a cost of Rs.8.5 – 13.5+ Lacs. It might be worth considering to set-up mobile sub centers (Mobile Vans ) that can go across to the remotest areas and conduct outreach programmes. So the cost of operating the sub center ( rental , electricity etc ) gets consumed in the form of fuel expenses for the mobile health center and also, these sub centers can be used as an ambulance in case of medical emergencies. Thus it would save Rs.300 that is given for transferring patients to the referral center. The cost of mobile center is expected to be much lower than the cost of a physical center.
Location of PHC’s & Sub Health Centers is mostly around a few Km’s from the residential areas and this fault line needs to be corrected through provision of such mobile health center.

19. Incentive to health workers:

It is expected that since ASHA’s and ANM’s are incentivized for institutional deliveries, referral etc. The incentive might also make them turn to private practitioners over a period of time, as the lure of money will drive them to recommend private gynecologists & give less focus to home visits and counseling, and this might be happening even today as well. It is suggested that the ASHA’s & ANM’s must be incentivized for counseling, home visits, immunization & preventive checks as a routine part of their job and the incentive must be paid for each home visit (even Rs. 2 to Rs.3 per visit is good enough). This will lead to a fixed remuneration to ASHA’S & ANM’s. Certain Evaluation parameters for the success of an ASHA must be established like how many households are aware of sanitation, hygiene, preventive health and healthy lifestyle. ASHA is not paid a salary but is paid incentive for institutional deliveries (Rs.100), DOT treatment (Rs.250), meetings for once a month (Rs.150, out of which Rs. 100 is for travel and Rs.50 for refreshments).

20. Role model & Case study publication:

People believe in facts, and the case studies & success stories of ASHA & ANM’s must be shared state wide to make the acceptance more impactful for behavioral change. Cases of good pregnancy can be shared with print media and electronic media. Case study should be covering ANC & PNC visits by ASHA and their experiences, new born care issues and danger signs during pregnancy.

21. Learning’s from other State Experience:

Many states are doing some innovative approaches which can be replicated in Uttar Pradesh NRHM. Tamil Nadu, for example, has operationalized strategically located primary health centers for basic emergency obstetric care and referral services, developed sub district hospitals for emergency obstetric and neonatal care, and instituted an audit of maternal deaths. The delivery rate in institutions is now 98%. Importantly, maternal care facilities have been shifted from district level hospitals to
PHC hospitals and also from the private to the public sector hospitals. Gujarat has shown that public-private partnerships can strengthen system towards increasing access to delivery in institutions and emergency obstetric care. The Government of Gujarat by recognizing the shortage of obstetricians in the public system in rural areas, and at the same time their presence in the private sector in nearby towns developed an innovative partnership. The Chiranjeevi scheme provides childbirth and services for emergency obstetric care in private hospitals under the care of qualified private obstetricians, free of cost to families (fully sponsored by the government). More than 800 obstetricians have joined the scheme and have undertaken more than 300 000 deliveries for clients who are poor, with acceptable rates of caesarean section. At about $46 per delivery, the government has negotiated a low average rate of payment per delivery, including caesarean sections. The model can be replicated in our state.

22. Encouraging ongoing research projects with Universities

A major problem in formulation of effective policy and devising intervention methodologies at the local level is prevailing due to lack of credible, timely and regular data on various health indicators. The survey based data is either too infrequent or in most of the cases the desegregation level at which the data is available leaves much to be desired. The MMR data for the state was available only for 1997 (NFHS 1998). Now the same is available for 2005 (NFHS3) and DLHS (2007). For the intervening period even the state level data was not available. As far as desegregation is concerned the district level data is just not available, seriously compromising the bench-marking or monitoring of the efforts towards maternal mortality reduction. The IMR data is now available for the district level (RCH data). However, both the frequency of the data and its reliability in terms of throwing up credible district level IMR information leaves many unanswered questions. Similarly, disaggregated data for neonatal mortality, which is one of the biggest contributors to IMR are also not available. The problem of the availability of such disaggregated data on a regular basis which can throw up policy directions and enable areas specific interventions has to be addressed urgently.