

CHAPTER 8

Summary of Findings and Conclusions

8.1 Introduction

The present study is an attempt in the direction of analytical research on the aspect of provisioning, accessibility and utilisation of various facets of maternal and child health care services, in West Bengal at the macro level and in Hugli and Murshidabad at the micro level. The main thrust of the present work is (i) to analyse the nature and spatial dimension of the associated variables of provisioning, accessibility and utilisation of maternal and child health care services, (ii) to evaluate and to analyse the nature of relationship between the three axes of provisioning, accessibility and utilisation of maternal and child health care services, highlighting their associative impact on each other and (iii) to explore the problem issues regarding provisioning, accessibility and utilisation of the maternal and child health care services. In the following section the main findings of the present study has been summarised.

8.2 Summary of Findings

The **first chapter** comprises of the introductory section stating the research problem and includes objectives of the study, brief description of the study area, review of literature related to different aspects of accessibility and utilisation of maternal and child health care services, the conceptual framework, objectives, research hypotheses, data sources, methodologies and relevance of the study followed by the organisation of the thesis.

The **second chapter** analyses the systematic and hierarchical method of the selection of study area through the spatial nature of utilisation of maternal and child health care services and the various regional development factors.

In the **third chapter**, the nature of provisioning of health care services in the light of the policy and programme perspectives and health financing has been dealt, with analysis of the achievements in the maternal and child health care services. From the study, it can be summarised that substantial thought process has gone in streamlining the health services delivery system in India over the years through the various plans and programme implementation in maternal and child health care. In West Bengal, the provisioning of health care services has been uniform in its distribution pattern of public health facilities as per the population size but there is a relative concentration of private health facilities in urban areas. However, there has been regional differences in the provisioning of various health facilities over the districts which proves the point that *provisioning of maternal and child health care services is not uniform over space and there is an urban bias for private health care services*. In West Bengal non-resident status of health functionaries in spite of available accommodation, under-utilisation of Subcentres, in-patient facilities in the PHCs, shortage of manpower have been identified as some of the problems in the health care system. However, the RCH programme provides for additional ANMs, staff nurses or public health nurses at difficult SCs and PHCs to improve access to maternal care services. In

many health facilities, quality of care is poor; many of the buildings, especially critical ones such as operation theatres and labour rooms, badly need repair and renovation. There is a concentration of specialists in medical colleges and large district hospitals with an acute shortage of staff in sub-district hospitals and FRUs. Though the public health sector has been performing moderately in West Bengal, much is needed to be done to strengthen the infrastructural facilities of health institutions for the rural areas to meet the needs of the people. Due to inadequate and nonperforming public health infrastructure, the poor are forced to approach private practitioners who charge exorbitant fees. Thus, it is vital to ensure access to functioning public sector health care facilities. There is an urgent need to transform the public health system into an accountable, accessible and affordable system of quality services. In case of financing of health care sector, there is a need for proper revival of the existing system. The screened assessment will result in effective utilisation of the funds allocated to the various sectors. The external assistance from donor agencies has been involved in actively influencing and building the capacity of governments to initiate health reform. There has been progressive achievements in maternal and child health indicators over the years in West Bengal. However, to strengthen the proper functioning of the health care services, it should be based on the community needs assessment and the specific provisions are to be actualised where they are mostly needed. The districts should be categorised according to their performance and additional support is to be provided to them for their progress. There should be regular monitoring and evaluation of services. This will enable optimal utilisation of resources, strengthening of infrastructure and experimentation of innovative approach.

The **fourth chapter** provides an evaluation of the nature of utilisation and quality of maternal and child health care services in India and West Bengal. The main findings of the study highlights the fact that West Bengal has performed moderately in utilisation of maternal and child health care services among the states of India but there is a stark inter-district variation. Hugli and Murshidabad feature among the high and low performing districts respectively in utilisation of maternal and child health care services. The effect of religion, education and regional (development) factors is more in influencing women to seek ANC checkups. This is also true for seeking full ANC. Majority of the women have sought ANC from public health institutions, with major proportion from Subcentres. It has been found that women of urban areas, non-Muslims, educated women and of higher standard of living are more likely to seek ANC from both private and public institutions. Regional effect has also shown significant results regarding place of seeking ANC. More than half the women of West Bengal have performed delivery at home. Among institutional delivery, majority have gone to public health institutions. Women of urban areas, non-Muslim, non-SC/ST, educated women, of higher standard of living, of higher age at marriage, having partial and full ANC, with delivery complications, who have been advised by health workers and of few districts are more likely to go for institutional delivery (in both public

and private sectors) than domicile delivery. In case of obstetric morbidity, religion, educational status, standard of living, age of women, history of pregnancy wastage, status of ANC checkups, having RTI/STI problems, pregnancy and delivery complications, type and place of delivery are the influencing factors in the incidence of pregnancy, delivery and post delivery complications. Regional development effect is also quite prominent as has been revealed during the analysis. These factors also play significant roles in treatment seeking behaviour as well as in deciding the type of health facilities (public and private health institutions) from which treatment have been sought. In West Bengal, child immunisation is almost universal. Almost all of them have either gone for partial or full immunisation. Immunisation is universally sought from public health institutions, mainly from the Subcentres. More than half of the children have also received Vitamin A (to prevent night blindness) while an insignificant proportion of children have received IFA tablets/liquid (to protect against nutritional anaemia). Diarrhoea and Pneumonia are the two childhood diseases representing childhood morbidity in this study. Regional effect is more prominent than demographic and socio-economic correlates in case of the incidence of both Diarrhoea and Pneumonia and treatment seeking behaviour. Regionalisation scheme shows that the districts of the central and eastern regions of West Bengal, in some cases have performed poorly in the maternal and child health care services. On the contrary, the southern districts have performed better than the other regions.

It has been found that majority of women who have availed the public health facilities for maternal and child health care are satisfied with the quality of services. However, those who have gone to private health facilities have complained about the quality of services at public health facilities. It has been revealed that the health workers have focussed their discussions towards immunisation, child care, antenatal care and family planning as part of their service delivery in generating awareness and have neglected other major issues regarding maternal and child health care like delivery and postpartum care, nutrition and feeding habits, sanitation and personal hygiene. Overall perception of women regarding various services of public health facilities is good.

All the above mentioned findings illustrates the fact that *the socio-economic and cultural correlates of accessibility vary across social groups and over space; and the level of utilisation of maternal and child health care services is determined by the accessibility and quality of care provided.*

The **fifth chapter** provides an analysis of the nature of utilisation and quality of maternal and child health care services in Hugli and Murshidabad. From the study it can be summarised that, in case of women who have sought ANC, the differences are marginal in all the categories of demographic and socio-economic variables in Hugli, which is not true in Murshidabad where differences are found, comparatively on a large scale in case of place of residence, religion,

education, standard of living, age of women and parity of women. Larger proportion of women have gone for full ANC checkups in Hugli, wherein in Murshidabad, women have gone more for partial ANC checkups. In Hugli, most of women have gone to the private medical sector for ANC checkups. On the contrary, the proportions are more for public sector in Murshidabad. A high proportion of women with no ANC checkups have been recorded in case of Murshidabad, which is quite alarming. While assessing the place of delivery of child, it has been found that in Hugli, most of women have gone to the public medical sector for delivery, followed by delivery at home and women who have gone to the private sector. Whereas in Murshidabad, there is predominance of delivery at home, followed by that of public medical sector and a low proportion for private medical sector. In both the districts of Hugli and Murshidabad, majority of the delivery at home have been conducted by unskilled assistance. The incidence of pregnancy and post delivery complications is more in Murshidabad than in Hugli while in both the districts similar proportion of women have suffered from complications during delivery. In Hugli, more women who have suffered from pregnancy and post delivery complications have gone for treatment whereas, a low proportion of women with complications have sought treatment in Murshidabad, wherein the health problem of women gets neglected. In Hugli, majority of women have gone to the private sector for treatment of pregnancy complications while in Murshidabad majority have gone for public medical sector. However, in both the districts majority of women have consulted the private medical sector for treatment of post delivery complications. While considering immunisation of children it has been revealed that in Hugli, most of the children have received complete immunisation whereas in Murshidabad, both the cases of partial and complete immunisation are found at same proportions. In Hugli, majority of children have received immunisation from any of the public sector institutions, mainly Subcentres, while others have sought immunisation from any of the private sector institutions; which in case of Murshidabad is almost universal for public sector institutions. More number of children of Hugli has received Vitamin A than in Murshidabad. In both the districts, only a fragment of children have received IFA tablets/liquid. The incidence of Diarrhoea among children is very little in Hugli which is comparatively a little high in case of Murshidabad. In Hugli, all of the children who have suffered from Diarrhoea have sought treatment while the proportion is comparatively low in Murshidabad, where negligence in case of Diarrhoea is more widespread. Among the two districts, the prevalence of Pneumonia is more in Hugli than in Murshidabad. In both the districts, the proportion of children who have sought treatment for Pneumonia is high. In both Hugli and Murshidabad, treatment has been mostly sought from private medical sector for Diarrhoea and Pneumonia.

The assessment of quality of care has divulged that majority of women of Hugli and Murshidabad who have been visited at home by public health personnel for maternal and child health care are satisfied with the quality of services. The health workers have focussed their

discussions towards immunisation, family planning and antenatal care as part of their service delivery in generating awareness. Overall perception of women regarding various quality indicators of public health facilities is good in both the districts. Although some women of Hugli have complained about the inconvenient location of public health facilities and the long waiting time to avail those services. In Murshidabad also, women have complained about the long waiting hours. However, those who have gone to private health facilities have complained about the inconvenience in location of public health facilities, in case of Hugli and poor quality of services at public health facilities in case of Murshidabad, as reasons for not visiting public health facilities.

Thus the analysis illustrates that the utilisation of maternal and child health care services varies regionally over space and is a reflection of the levels of development of that locale. As before, it also reveals that *the socio-economic and cultural correlates of accessibility vary across social groups and over space; and the level of utilisation of maternal and child health care services is determined by the accessibility and quality of care provided.*

The **sixth chapter** evaluates the nature of provisioning, accessibility and utilisation of maternal and child health care services in the selected villages and towns of the CD Blocks of Hugli and Murshidabad, based on the primary survey. The main objectives of this research – to gauge the extent of variation in physical, socio-cultural and economic accessibility; the nature and determinants of utilisation; and the interlinkages between provisioning, accessibility and utilisation of maternal and child health care services – have been dealt with in this chapter. While analysing physical accessibility, it has been found that the potential accessibility is low in the CD Blocks of Murshidabad than Hugli, in case of both the number of health units and health workers/personnel; thereby highlighting the fact that potential accessibility is very much related to the overall development of the region. In the analysis of population and distance factors as per health provisioning, it has been revealed that there is comparatively less population pressure on the public health units in Hugli than in Murshidabad where the population size is much higher relative to the available number of medical centres. The people of villages and towns of Hugli, on an average, have to travel moderate distances to reach a health facility. This also holds true in case of the more developed CD Block of Murshidabad (Beldanga I), whereas in less developed Samsorganj, the people on an average have to travel long distances to seek health care. From the analysis it has been found that the villages and towns of the CD Blocks of Hugli district have moderate to high physical accessibility to the basic services and facilities thereby connoting to have better connectivity. While in case of the CD Blocks of Murshidabad district, most of the villages fall within moderate to low category of physical accessibility implying poor connectivity facilities. However, the towns of the respective CD Blocks of Murshidabad fair well in connectivity aspect with high physical accessibility. In case of infrastructural facilities, most of the villages and towns of Hugli and Murshidabad have moderate to low level of dimension indices with very few

belonging to the higher level. The results illustrate that there is less number of allocated infrastructural facilities in comparison to the respective population size. From the analysis it has been observed that physical accessibility plays a very important determining role in the utilisation of maternal and child health care services and as the value of physical accessibility decreases, denoting more accessibility, the proportional value of utilisation increases. Thus it connotes that *distance, connectivity and infrastructural facilities play predominant roles in utilisation of maternal and child health care services.*

From the study it can be depicted that in case of utilisation of maternal and child health care services, the response of ANC checkups is moderate among pregnant women and drop out cases of ANC course is also prevalent among them; there is also good response of PNC checkups among women. It is the presence of SCs in villages and the performing outreach camps in distant villages which enable villagers to seek ANC, PNC and child immunisation. Awareness about child immunisation is high and the rate of immunisation is almost universal; continuity of booster doses is also found at high rates. However, delivery of children at home is high in villages of Murshidabad whereas in Hugli district it is that of institutional deliveries. This is because of low physical accessibility to health facilities in Murshidabad; as the areal extent of Murshidabad is more in comparison to that of Hugli and the health facilities are spread out at large distances. So the pregnant women have to travel more to reach the health facilities where poor transportation facilities are added obstacles. Women prefer to have delivery at home rather than travelling such long distances in poor transport facilities like cart, tractor, etc. People of distant villages find it difficult to commute to the institutions for delivery and so mainly undergo delivery at home with skilled assistance. Delivery at home is also conducted by unskilled dais, which is more common among the poor illiterate and unaware people. The level of urbanisation is also low in Murshidabad, thereby nullifying the diffusion effect of better infrastructural facilities and awareness for institutional delivery.

The analysis of the hypothesis, *socio-cultural and economic correlates of accessibility vary across social groups and over space*, reveals that the socio-cultural and economic factors have less influence in determining the utilisation of maternal and child health care services in better performing CD Block of Hugli (Chanditala II). However, the influences are far more higher in the less performing CD Block of Hugli (Pandua) than the better performing CD Block of Murshidabad (Beldanga I) in cases of institutional delivery and full immunisation of children. The differences in socio-cultural and economic correlates justify the effect of regional factor (development) in playing a determining role in utilisation of maternal and child health care services specially for institutional delivery and full immunisation of children. Another striking observation is that education, standard of living and awareness have more controlling effect in bringing about regional differences in the utilisation of maternal and child health care services as have been

depicted in the analysis. However, other factors like place of residence, religion, work status, parity and age of mother have lesser effect in bringing about regional differences in utilisation aspect. In overall analysis, ethnicity has shown very marginal differences in all the aspects of utilisation of maternal and child health care services over the regions.

The health status depicts that nutritional anaemia is quite prominent among both women and children. High risk pregnancy cases and post delivery complications are referred to the FRUs. RTI/STI cases are there and people are aware of the problems and often refer to the ANMs and go to private health facilities for treatment. Among childhood diseases, Diarrhoea, ARI, Pneumonia, Measles are the most rampant; TB cases among children are found in the villages of Samserganj.

From the foregoing analysis it can be highlighted that *the level of utilisation of maternal and child health care services is determined by the interplay of provisioning and accessibility of services*. Availability of infrastructural facilities and easy access to health services does necessitate utilisation. Other socio-cultural and economic factors also play their roles in utilisation and it varies regionally. That is why, even though there is low to moderate level of infrastructural facilities in Hugli, utilisation is more, but in Murshidabad, even though there is moderate to high level of infrastructural facilities available, the utilisation level is low. Thus it can be highlighted that apart from provisioning and accessibility, the level of overall development of a region has significant influence in determining the level of utilisation of health care services.

In the **seventh chapter** the problem issues pertaining to maternal and child health care services has been dealt in great details from the health providers as well as health seekers perspectives. It can be summarised from the main findings that the population pressure is high on the ANMs in most of the Subcentres with large jurisdiction; the work pressure is also high on part of the ANMs which often hampers the quality of services provided and the people suffer as a result of it. There is a need of assistance to the ANMs, apart from those of the CHGs, Anganwadi workers and the linkman, to carry out the administrative duties of record keeping and other such services. However, the Gram Panchayats and the NGOs help the ANMs in spreading awareness. The Gram Panchayats often compel people to have complete immunisation of their children in some of the less progressive villages of Murshidabad. The hard labour of years of awareness drive among the villagers are now bearing fruits and people now have become more conscious about immunisation and child health care, though health of mother still gets neglected.

The doctor-patient and nurse-patient ratio is very high in the public hospitals. There is also the problem of less number of beds in the public hospitals which causes over-crowding and the women and the newborns often have to lie down on the floors which is highly unhealthy and life threatening as they are much more prone to get infections during that point of time. The health infrastructure still does not match the requirements of the patients. In the absence of doctors and medical staff, the patients face severe hardships. Lack of female doctors and paramedical staff for

gynae-support has been reported to be impediment for achieving goal of institutional deliveries. The general opinion has indicated that the drugs, sometimes even lifesaving drugs are not available at these health facilities. There are no minimum mandatory service provision standards for every levels of health facility in place which can make full use of available human and physical resources and there is also absence of any road maps to show how the desirable levels can be achieved. People often prefer to go to private doctors or health institutions for better facilities, medicines and attention depending upon their affordability factor. However, the private health institutions are mostly urban-centric in their growth.

There is problem of untimely procurements of resources and choked fund flows which need to be streamlined and flexible. The dispatch of JSY funds often takes long time which causes much inconvenience for the beneficiaries of this incentive. Easy and timely execution of monetary incentives under JSY will prove to be effectual in encouraging institutional delivery. The allocated funds for the entire maternal and child health programme should go directly to the districts rather than states to avoid delay and transfer of funds to other sectors.

As part of infrastructural development, there is need to improve the mode of transportation and condition of the roads. Infrastructural facilities are poor in the public health institutions. Rural Hospitals and BPHCs need infrastructural development. The PHCs also need to be made functional to deliver in-patient facilities and other recommended services under the NRHM programme. Subcentres mostly are conducted in rented accommodations or in local clubs, pointing out to the dearth of adequate space. The Subcentres need to have government buildings for proper functioning.

Therefore, it can be highlighted that both the quality and coverage of maternal and child health care services can be improved subsequently within the existing health infrastructure during the antenatal, intranatal and postnatal periods using simple tools of interventions in the comprehensive maternal and child health care package. Infrastructural development, skill management, training and capacity building among the existing manpower resources, additional recruitments of health personnel to ease out the work overload, adequate supply of logistics, tertiary support to peripheral health institutions, supervision, monitoring and evaluation via the health management information system are some of the probable solutions to strengthen the public health system to have effective, affordable, accessible and quality health delivery services to sustain the need for efficient maternal and child health care.

8.3 Conclusions

The foregoing analysis depicts the fact that utilisation of maternal and child health care services is significantly influenced by the provisioning and accessibility aspects of the health delivery system, apart from the facet of overall regional development. Thereby, to promote effective utilisation of health care services, there is an imperative need to upgrade and strengthen

the health delivery system. This can be done through efficient and pragmatic provisioning and accessibility of services; by sustaining and enhancing the levels of the developed regions and by bringing about progressive improvement of less developed locales. The critical areas of concern where concerted efforts must be made are: satisfactory functioning of health facilities; quality and accountability in the delivery of health services; taking care of the needs of the poor and vulnerable sections of the society and their empowerment; preparation for health transition with appropriate health financing; pro-people public-private-partnership; convergence for effectiveness, efficiency and responsive health system.

Health Service Providers Perspective:

- **Strengthening of the existing health delivery system:** For **strengthening the existing health delivery system**, certain imperative measures must be initiated. **Subcentres** should be strengthened **infrastructurally** as well as with **manpower**. Subcentres must have adequate space so that health checkups of women can be done properly with due privacy. Also basic amenities like existence of a toilet or a tubewell at the Subcentre must be ensured. The manpower resources are over-pressurised with workloads and need additional recruitments. Some Subcentres are entitled to large jurisdictions wherein the excessive population pressure often hampers the quality of services. The skills of health functionaries have indicated that antenatal checkups are carried out by them solely with the purpose of distribution of IFA tablets and TT immunisation. None of these health functionaries correlated the findings of their examinations of the pregnant women with the possible detection of risk factors and subsequently for the purpose of referrals. Postnatal care is limited to breastfeeding, diet and family planning. Emphasis must be laid upon by the ANMs on discussion of other relevant health related issues and general awareness apart from their regular jobs. **Infrastructural facilities** in the **PHC/BPHC/RH** also need to be improved and upgraded with special emphasis on the condition of the wards, toilets, OT, labour rooms and OPDs. Provisions of beds for in-patient facilities in the PHCs need to be actualised which are now functioning only for out-door patients. There is also increasing demand of additional bed facilities at the BPHC/RH to suffice the population pressure.
- Rural health care is mostly marked by absenteeism of doctors/health providers, low levels of skills, shortage of medicines, inadequate supervision/monitoring and insensitive attitudes. There are neither rewards for service providers nor punishments for defaulters. As a result, health outcomes are adverse. The patient and health personnel ratio must be improved to curb the problem of work overload which hamper the **quality of services**. There is requirement of surgeons and resident doctors to provide emergency services whenever required. Doctors and health workers should be sensitised for providing proper maternal and child health care services. Lady doctors must be appointed in these health facilities so that women can freely talk to them and seek advice for gynaecological problems. The conditions are very poor in terms of physical space, storage

facilities, equipments, general drugs and ambulance facilities in these health institutions. Poor infrastructure is frequently the reason that hospitals cannot provide essential obstetric care. Inadequate power and water supplies as well as non-functional operating theatres can often be addressed by simple, local interventions. Ensuring supply side logistics has a very important role in generating demand for SC/PHC/BPHC/RH services. But unfortunately, many a time, either medicines or vaccines are in short supply. To make the system more effective and successful, this problem must be rectified immediately so that clients regain faith in the public health care mechanism and this can be utilised to the fullest extent.

Referral system and proper feedback is still lacking in majority of areas. Furthermore, the physical distances about the availability of referral services is equally important, since the referrals to the District Hospitals/Apex Institutions are less utilised by the pregnant women due to the longer physical distance involved in reaching them. A functional referral system, including reliable means for communication and transport are needed to ensure that women with complications are taken promptly to health facilities capable of providing appropriate care.

Accessibility: Accessibility remains a major issue especially in areas where habitations are distant and scattered and women and children are unable to make use of the available health services. **Public transport system** in rural areas must be improved by introducing proper modes of transport with regular frequency. The **road infrastructure** also needs to be laid down with due emphasis on the quality and effectiveness of the facility.

Training and capacity building: The revival of the existing health delivery system involves mainstreaming within the system through increasing and **improving human resources** in rural areas, **training** of health personnel, development of **multi-skill** of existing staff, systematic and continuous **skill upgradation**, strengthening by **capacity building**, application of knowledge and appraisal with incentives or disincentives for good or poor performance and governance related problems. In order to make the peripheral health institutions to be functional there is need to have compulsory rural posting added with contractual appointment for filling short term gaps and support for capacity development; fair transfer policy; incentives for difficult areas and terrain, where the health personnel are reluctant to serve; training and development of local residents for remote areas with appropriate cadre structure and incentives; need-based pooling of medical officers and experienced and skilled health personnel from CHCs to PHCs during day care and its optimal utilisation; and emergency management. Expanding the ANM workforce especially in remote areas and in larger villages and semi-urban areas is required. There should also be planned synergy of ANMs, AWWs and ASHAs workforce and where available, with local SHGs and women's committees and there must be a linkage of all the above to the Panchayat Committee on health. At all levels of the system – community, health centre, district and regional hospitals – quality services require the availability of adequate supplies and resources on an ongoing basis.

Greater autonomy and management, combined with motivated bureaucracy accountable to the people can form the basis of improvement of public sector hospitals.

- **Health financing:** The health financing system also needs to be reviewed. The **flow of funds** must be made more **flexible** so that they can be utilised efficiently and on time. The pro-poor monetary incentives must serve the deliverable purpose. There must be transparency within the whole system so as to avoid discrepancies.
- **Involvement of Gram Panchayats:** The failure of the government in extending access to essential public services such as clean drinking water and sanitation has resulted in culmination of various diseases making the rural women and children to suffer. Unhealthy living environment with water stagnation has added to the woes of the people. This emphasises the fact that the **Panchayat representatives** must take effective initiatives and be fully **involved with the health delivery system**. Due to their proximity to the people, involving them in the programme and giving them a mandate to work in this area is very important. However, very little effort has been made in this direction. In view of the fact that there is very little community mobilisation, Panchayats could play a crucial role in influencing the health seeking behaviour of the people.
- **Convergence and Integration:** Success in the health sector involves focussing on genuine **convergence and integration** of multiple efforts in many sectors other than health and family welfare. Convergence involves the **inter-sectoral coordination** and integration corresponds to the **intra-sectoral synchronisation** to improve delivery of health services to achieve the targets of various social determinants of health. Convergence measures can be initiated to ensure better coordination between various departments in bringing about improvement in the health delivery mechanism. The special challenges to integration are development of human resources for health care and a workable health monitoring and management information system apart from those of financial integration, integrated procurement, infrastructural integration, integrated service delivery, quality assurance, training, supervision and counselling and behavioural change through dissemination of information, education and communication (IEC) – which are the essential dimensions that need to be addressed for operationalising the concept of an **integrated health service system**. While there have been certain improvements in programmatic integration across the national programmes under the NRHM, still there is huge information overload and there is need to rationalise **information collection**. The ability to provide supportive supervision to ensure data quality, reliability, prompt analysis and feedback is very scarce at district level and limited at state level. The intra-sectoral integration of information system must be supported by inter-sectoral integration for evaluation, planning and implementation of policy and programmes. The contextual region specific problems of local areas must be tackled rather than concentrating at national level. These issues need to be addressed with due importance and immediate action. Consideration of the issues and activities from the systems perspective can bring about the much needed alignment

which holds the key to integration in service delivery as well as consistency and hence quality. Integrated planning must begin with epidemiological profile, a health services situational analysis and the health seeking behaviour of the community. The parameters to be addressed for horizontal integration at each level of the services as well as for vertical integration between the different levels also need to be worked out. There is a need for **community involvement and participation** and state support and intervention in social policy and programme implementation for any positive outcome of the efforts made in this regard wherein the central government has already started executing the plan outlay. Achieving a good quality of integration and convergence will require such processes to unfold over a period of time. Therefore, this approach must be initiated on an urgent basis for it to achieve a reasonable degree of progress within the stipulated time frame and be sustainable in nature.

- **Promotion of public-private-partnership:** There is also a growing consensus on increasing public health expenditure and investment in strengthening public health service delivery and promoting **public-private-partnership** through private provisioning, involvement and support and public financing targeted to the poor while guaranteeing hospitalisation at functional facilities. Innovations for **risk pooling mechanisms** should be made addressing the poor section of the population so as to reduce their economic burden of disease. Possible mechanisms include health insurance schemes, sliding-scale fees and collaboration with the private sector (including private providers and non-governmental organisations). Hospital-level health services can be improved and expanded through partnerships with NGOs, private not-for-profit hospitals and a better regulated private sector. Safe motherhood and health of mothers and children must be a priority for governments, policy makers, health care providers and for civil society at large. Alliances need to be formed, not only among advocates for human and women's rights, but also with men's groups and religious groups, with non-governmental organisations, donors and other sectors of government as well.

Health Service Seekers/Beneficiaries Perspective:

- From the health seekers/beneficiaries point of view, it can be highlighted that the **general awareness** of the people has improved over time as a result of the **motivational work** of the health personnel. This gets reflected on the nature of utilisation of health care services. Women in rural areas often rely upon **home visits of the ANMs** for utilisation of maternal and child health care services. But excessive work pressure on the part of the ANMs often compels them to reduce the number of home visits. These home visits are very essential for **communication and awareness generation** which often gets neglected. Concerted effort must be made to give a solution to this problem by reducing the work pressure of the ANMs.
- Many women lack **access to quality services** before, during and after pregnancy that are critical for ensuring their survival and wellbeing. The obstacles that prevent women from using available

care are physical barriers of **poor roads and long distances**; financial barriers; or other problems with the **quality of services**, including poor provider attitudes. Health services should be located as close as possible to where women live and must offer affordable, high quality services. The lack of easy transportation facilities deters women to seek maternal and child health care services. This is also a reason for low utilisation of **ANC and PNC services**, wherein the lack of privacy and proper toilet facilities in the Subcentres are added factors. Due to improper transportation facilities, poor infrastructure of public health institutions and unavailability of beds, the proportion of **institutional deliveries** are less and women prefer to have delivery at home with skilled assistance. Although the ANMs spread awareness about institutional delivery, they are conscious of the problem issues involved in it.

- As the number of **home deliveries** are more, **TBAs** continue to be the primary care-givers. **Training** them and improving their ability to identify complications and referring them in time to the nearest Subcentre, PHC/BPHC/RH/FRUs or district hospital is important. Sufficient number of skilled attendants – primarily midwives – need to be trained and deployed especially in rural areas. They need to be supported within adequate supplies and equipment, regulations that permit them to carry out necessary procedures and supportive supervision and monitoring.
- Women in rural areas who suffer from **RTI/STI problems** often find it difficult to consult services at the SC/PHC where the ANMs refer them to BPHC/RH/FRUs. ANMs are being educated about RTI/STI, but there is still no mechanism to provide medical care to women (and men) suffering from these ailments. People still go to private doctors/RMPs/quacks for this kind of diseases. But women suffering from RTI/STI still suffer in silence. Provisions must be made at each level of the health facilities to identify and offer treatment to these reproductive morbidities.

It can be concluded that improved infrastructure and health services will enable women to have access to health services and its utilisation will thereby improve their quality of life and their children as well. Services should be respectful of and responsive to women's needs, preferences and cultural beliefs. Proper provisioning, easy accessibility and good quality of care are viewed as being key factors in ensuring success of the maternal and child health programme enabling good response in the utilisation facet. These efforts should be complemented with enhancement of IEC so as to increase awareness and felt-need of the beneficiaries.