



## “CHANGING PARADIGM OF GENDER INEQUALITY AND HEALTH IN UTTAR PRADESH: A STUDY OF JAWAN BLOCK (DISTRICT ALIGARH)”

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### **ABSTRACT**

*Women are facing numerous sorts of gender inequalities; health inequality is one of them. The issues regarding gender inequality and health are reverberating since last two decades. Many health issues most importantly breast feeding, Ante Natal Check Ups, Ante Natal Mortality, Post Natal Mortality, Infant Mortality, Maternal Mortality, immunization are drawing the heed of scholars working in different disciplines. Good health is a prerequisite to human productivity and the development. A healthy community is considered as the infrastructure upon which we can build an economically viable society. Professional efficiency, good health and productivity are interrelated. Despite of all importance of health, women's health has largely been neglected. Still a large population of rural women has no access to quality health care at all and for many of the rest what they receive doesn't alleviate their problems. In a narrow way gender approach to health is based on an analysis of how socially and culturally constructed inequalities between men and women determine their unequal exposure to various sorts of diseases, their access to health care. There are many health policies and programmes launched by the Indian government to reduce and eliminate the various health problems of women. On some fronts these policies and programmes succeeded but on others failed in achieving their time bound objectives. Now there is significant improvement we are seeing in Women's health. Infant Mortality and Maternal Mortality rates have been reduced to an appreciable extent. In health sector National Rural Health Mission and various Programmes and policies played and playing very important role in shifting the paradigm of gender inequality in terms of health in the country.*

**Key Words:** Gender Inequality, National Health Policy, NRHM, NFHS, RCH, Ante-natal, Post-natal, Maternal Mortality, Breast Feeding, Immunization.

## **Introduction**

Across time and space, biological differences between ‘men’ and ‘women’ have been invariably used to construct social categories in order to put one in an advantageous situation over the other. In a patriarchal setting, such systems, which insinuates the social construction of biological sexes, often creates ‘power structures’ that relegates women to a lower pedestal in social hierarchies. Of course than the power structure so constructed tends to benefit particular class and sex, namely the rich and the males. Among different sub-sets under ‘empowerment’, health is one of the important determinants which probably have the greatest potential to influence the gender balance within a particular society and community. Therefore in order to understand the ‘shift’ in gender equality, it thus becomes important to deconstruct the situation in the area of health per se.

The present study has been conducted with the following objectives to achieve:

- To find out the reproductive health conditions of the respondents.
- To find out the factors responsible for gender inequality with special reference to health.
- To explore the changing paradigms of gender inequality with reference to health.
- To investigate the challenges faced by the women related to their health.

## **Study Design and Methodological Framework**

Descriptive method has been adopted to study the Paradigm shift is the change in variables of empowerment. The study is designed as a holistic assessment, comprising both the qualitative and quantitative components designed to capture the paradigm shift in ways of thinking of women on gender inequality in health.

As far as the present research is concerned, the KAP methodology has been primarily used. What does KAP actually means? Knowledge, attitude and practice constitute a triad of interactive factors characterized by dynamism and unique interdependence. Emphasis is laid, for each component of the triad, on the value of ethical conduct in raising the application of the component in real life to a peak. Special treatment is given to several important factors that can influence or control the course of practice in the medical profession.

Both Primary and secondary source of data is collected to check the hypothesis. Primary Source of data is collected through structured questionnaire and qualitative tools.

As the methodology for the study is exploratory and used both quantitative & qualitative tools, quantitative structured questionnaire was used with provision of some open ended

questions. Qualitative tools like PRA and FGD were being used for qualitative data collection.

As far as area of study concern, this is the study of Jawan Block which comes under District Aligarh of Uttar Pradesh. Administratively a block is an identified unit of Development which comes under one or more than one tehsil based on its size and population. As is evident from above, more than one block comes under a tehsil. For example, the Jawan Block comes under the tehsils of Koil and Gabhana.

### **Sample Size Estimation**

The sample is designed to get reliable estimate of the variable of interest of the study, which is Jawan Block of Aligarh district. Assumption is that there is no prior reliable estimate of the variable of interest in the area which can be used to determine the required sample size. Therefore, in order to get a sample size adequate to provide reliable estimate of the variable under consideration at a reasonable level of precision(c), P= 50 % is used in determining the sample size. Moreover, 95% confidence level(x) ( $Z_x=4.44$ ), design effect (1.5).

The formulae adopted for determining the sample size is

$$n = P(1-P) \left( \frac{Z_x}{c} \right)^2 \left[ 1 + P(1-P) \left( \frac{Z_x}{c} \right)^2 / N \right]$$

Where:

n = the required sample size.

P = Population Proportion=50%.

$Z_x$  =Z value required for 95% confidence level(x) =4.44

c= Precision required =10%

N=Size of Population.

The formulae yielded an overall sample size of 456 households. Taking into account the non-response rate of 5%, the overall sample size is adjusted to 480 households for house hold survey.

### **Sampling Plan**

A multistage stratified sampling methodology is adopted for the sample selection of Villages. Purposive random sampling is used in selection of households.

### **Selection of Block**

Criteria for selection of one block from 12 block of Aligarh district was population of Scheduled Cast and distance from the district head quarter. Base on the criteria Jawan Block of Aligarh has been the sample for the study. Jawan Block has 24% of SC population and it is at the representative distance from the district head quarter.

## Selection of Villages

The universe of the study is Jawan Block of Aligarh District. Altogether 6 villages: Daopur, Khurd Khera, Bhim Garihi, Chaupur, Alampur, Hetampur, were sampled from proportion to population sample (PPS) method for the survey. The criteria for PPS were population of Scheduled caste and distance from the block head quarter. There might be possibilities of paucity of data on above mentioned indicators at village and block level. From each sampled villages 70-90 household were interviewed based on the population proportion.

## Selection of Households

At first stage, number of respondent for each village were calculated on the basis of proportion to population i.e. by formulae total population in the village divided by total population of all 6 villages multiplied by 480 sample size as shown in the table below.

**Table 6: Household Sample distribution across sampled villages**

Village	Total	Sample Size
Daopur	302	129
Khurd Khera	234	102
Bhim Garihi	210	90
Chaupur	183	78
Alampur	147	63
Hetampur	40	17
Total	1121	480

Based on the total number of households in the village, Investigators than randomly choose a direction, count all the HH in that direction, randomly selected a number in between one and total number of counted HH, go to that HH and select an individual from whom to collect data. If that random selected HH do not fulfill the eligibility criteria (women age 18 to 50) respondent than go to the next HH in the same direction and repeat the process until the completion of the required sample size in the village.

## Data collection

The survey process has involved primary data collection using quantitative methodology (administration of questionnaires) to provide general background information by looking at: A) The general characteristics of the sampled households (household head, gender, marital status, Occupation, Age, educational level, etc); B) The socio-economic characteristics of the sampled households with focus on land, livelihood etc ( sources and level of income, owner,

employment status, contributing to household income, dependence of types of industry etc) has also been collected.

### **Data Entry and Analysis**

Software for data entry (in SPSS) was reviewed before the survey starts. Data entry system was developed as soon as the tools were finalized, so that data entry takes place as the survey is in the progress. Consistency and redundancy checks were built into the data entry system to minimize entry error.

The tabulation of the data was done as per the analysis plan. The analysis of data included a descriptive analysis of all the variables, and a determination and analysis of associations among them by generating variables/index. Advance level analysis for some identified variables was also done. To analyze the quantitative data SPSS 18 statistical software was used, where as for Qualitative analysis Atlas-ti software was used. Main statistics use for analysis were cross tabulation, percentage, mean, standard deviation, correlation, regression and one way anova.

### **Gender Inequality and Health**

The goals of improving women's health have been in place and recognized for some time from the first International Safe Motherhood Conference in 1987 to the International Conference for Population and Development (ICPD) in 1994, the Fourth World Conference on Women in 1995, and ICPD+5 in 1999.<sup>1</sup> The health status of women has improved over the last few decades; however it remains a major development task. Long standing challenges-like reducing unwanted fertility-still exist in some countries while other countries have moved on to new and different challenges. Among them, in developing world like India, the underlying social and cultural factors were found to have a cumulative effect on women's health.<sup>2</sup> For example, girls who are fed inadequately during childhood may have stunted growth, leading to higher risks of complications during childbirth and low birth weight babies. As such, complications of pregnancy and childbirth constitute a major cause of death and disability among women of reproductive age in the developing world.<sup>3</sup>

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<sup>1</sup> There have been a considerable concerns and initiatives on safe motherhood. See Marge Berer, T. K. Sundari Ravindran, and Reproductive Health Matters (Project), *Safe Motherhood Initiatives : Critical Issues* (Oxford London: Blackwell Science ; Reproductive Health Matters, 1999). Also see, Hilda Saeed and others, *Icpd+15 : Investigating Barriers to Achieving Safe Motherhood : A Study in Selected Sites in Rural Sindh and Punjab, 2009* (Lahore: Shirkat Gah, 2010).

<sup>2</sup> World Bank., World Health Organization., and United Nations Fund for Population Activities., *Safe Motherhood* (Nairobi?: s.n., 1987).

<sup>3</sup> Jyotsna Pattnaik, *Childhood in South Asia : A Critical Look at Issues, Policies, and Programs*, Research in Global Child Advocacy (Greenwich, Conn.: Information Age Pub., 2004); United Nations. Economic Commission for Africa., *The Impact of Maternal and Child Health and Family Planning (Mch/Fp) Programmes*

In India, despite having a growth rate of about 8% and significant progress in socio-economic spheres, the results in the area of maternal health have been relatively modest. The Maternal Mortality Ratio (MMR), defined as number of women aged 15-49 years dying due to maternal causes per 1,00,000 live births, is as high as 212 for the period 2007 -2009. This is probably owing to the fact that 50% of the eligible women are still not catered through 3 mandatory Ante Natal Check-ups (ANC), 60% deliveries are not institutional, and 56% of women in the reproductive age group are still anaemic.<sup>4</sup> Traditional ideologies of masculinity/femininity often push men and women to unsafe sexual behaviors. A 'culture of silence' about women's health problems still prevails which often restricts women's access to healthcare.

Men and women have dissimilar rates of different diseases, and seek medical care differently and in differing amounts, are well known. Do gender differentials in health indicators call for attention? Are these differentials determined by sexual differences only or are there other variables that mediate these differences? These are some of the questions that often perplex academicians and practitioners alike. In this context, understanding of existing gaps in health and health seeking behavior of men and women are important.

This study therefore, seeks to explore knowledge, attitude and practices of women towards health against the backdrop of recent National Health policies and programmes. Such analytical framework identifies and discerns changes and shift in the overall gender situation.

The following domains under the health are analyzed in the present study:

1. Maternal health (Ante Natal and Post Natal)
2. Immunization

### **National Policies and Programmes on Health: Historical perspectives**

As part of its commitment to overall development, Government of India since early 1950's formulated various policies and programmes to improve the health of its citizens, including women. A number of committees were formed to evaluate the existing health system and make recommendations for its more effective delivery. These committees from time to time apprised the government of the existing gaps in the health care systems and made recommendations that ultimately paved the way for formulation of National Health Policy in 1983.<sup>5</sup> The International Conference on Population and Development (ICPD) held at Cairo in

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on Fertility, Infant and Childhood Mortality, and Maternal Health (Addis Ababa: United Nations, Economic Commission for Africa, 1989).

<sup>4</sup> For Details see Ernst & Young India. and Federation of Indian Chambers of Commerce and Industry., Opportunities in Healthcare : "Destination India" (New Delhi: Ernst & Young, 2006).

<sup>5</sup> Rajiv Misra, Rachel Chatterjee, and Sujatha Rao, India Health Report (New Delhi ; New York: Oxford University Press, 2003).

1998 showed great concern for the deteriorating health of women and children, particularly in the developing country. There was a call for the adoption of a vertical plan and programme concentrating simultaneously on maternal and child health. The major impact of ICPDR in India has been the total elimination in method-specific targets.<sup>6</sup> As a result of Cairo, India is committed to several new initiatives. Consequently Reproductive and Child Health (RCH) project was launched in India in 1997 with a focus on reproductive health. RCH-II aimed at people to acquire to regulate their fertility, women able to go pregnancy and childbirth safely. The outcome of pregnancy is successful in terms of maternal and infant survival and well being with couples having sexual relationship without the fear of pregnancy and contracting diseases. It also aims at maneuvering the health care services in such a way that it may induce a desired change in specific community health indicators like IMR, TFR, MMR, CBR, effective CPR and immunization coverage and delivery through trained hands.

NHP-1983, in a spirit of optimistic empathy for the health needs of the people, particularly the poor and underprivileged, had hoped to provide 'Health for All by the year 2000 AD', through the universal provision of comprehensive primary health care services. In retrospect, it is observed that the financial resources and public health administrative capacity which it was possible to marshal, was far short of that necessary to achieve such an ambitious and holistic goal. Against this backdrop, it is felt that it would be appropriate to pitch NHP-2002 at a level consistent with our realistic expectations about financial resources, and about the likely increase in Public Health administrative capacity. The recommendations of NHP-2002 will, therefore, attempt to maximize the broad-based availability of health services to the citizenry of the country on the basis of realistic considerations of capacity. The changed circumstances relating to the health sector of the country since 1983 have generated a situation in which it is now necessary to review the field, and to formulate a new policy framework as the National Health Policy-2002. NHP- 2002 will attempt to set out a new policy framework for the accelerated achievement of Public health goals in the socio-economic circumstances currently prevailing in the country.

National Health Policy 2002 was formulated to achieve an acceptable standard of good health among the general population of the country, secondly to increase the total public health investment through a substantially increased contribution by the government of India, thirdly to ensure the increased access to tried and tested systems of traditional medicine.

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<sup>6</sup> Asian-Pacific Resource and Research Centre for Women., Monitoring Ten Years of Icpd Implementation : The Way Forward to 2015 : Asian Country Reports (Kuala Lumpur, Malaysia: Asian-Pacific Resource & Research Centre for Women, 2004); India. Ministry of Health and Family Welfare., Population and Development 10 Years after International Conference on Population and Development : India Country Report (New Delhi: Ministry of Health & Family Welfare, Govt. of India, 2004).

It is perhaps because of these evident and in-built shortcomings in the health policies that even after fifty years of independence, the health indicators, especially one concerning maternal health remains poor. The NFHS – II (1998-99) reported approximately 130,000 maternal deaths. Mothers of only 20 percent of live births received all the required components of antenatal care. Mothers received at least one antenatal check-up for 65 percent of births but received the recommended three or more check-ups for only 44 percent of births. For 67 percent of births, mothers received two or more doses of tetanus toxoid vaccine and for 58 percent they received iron and folic acid tablets or syrup. There has been no change since NFHS-1 (1992-93) in the proportion of mothers receiving antenatal check-ups. Three-quarters of the women who received antenatal check-ups had their abdomen examined, but two thirds or fewer received any of the other recommended checks or advice. Only 36 percent of women were told about signs and symptoms of a risky pregnancy. One-third of deliveries take place in health facilities, up from one-quarter at the time of NFHS-1. Among deliveries at home more than half are attended by a traditional birth attendant, and fewer than one in eight are attended by a health professional. There has, however, been an increase in the proportion of all births attended by a health professional from 33 percent in NFHS-1 to 42 percent in NFHS-2.

The low budgetary provision on health infrastructure, as highlighted above also had its share in poor health indicators of women. The healthcare in rural areas has been developed as a three tier structure based on predetermined population norms. The sub-centre is the most peripheral institution and the first contact point between the primary healthcare system and the community. Each sub-centre is manned by one Auxiliary Nurse Midwife (ANM) and one male Multi-purpose Worker [MPW (M)]. Primary Health Centers (PHCs) comprise the second tier in rural healthcare structure envisaged to provide integrated curative and preventive healthcare to the rural population with emphasis on preventive and promotive aspects. (Promotive activities include promotion of better health and hygiene practices, tetanus inoculation of pregnant women, intake of IFA tablets and institutional deliveries.) PHCs are established and maintained by State Governments under the Minimum Needs Programme (MNP)/Basic Minimum Services Programme (BMS). A medical officer is in charge of the PHC supported by fourteen paramedical and other staff. It acts as a referral unit for six sub-centers. It has four to six beds for inpatients. The activities of PHC involve curative, preventive, and Family Welfare Services. Though the numbers appear to be increasing there is still a shortfall of about 16 per cent when compared to the required norms for PHCs.



Community Health Centers (CHC) forming the uppermost tier are established and maintained by the State Government under the MNP/BMS programme. Four medical specialists including Surgeon, Physician, Gynecologist, and Pediatrician supported by twenty-one paramedical and other staff are supposed to staff each CHC. Norms require a typical CHC to have thirty in-door beds with OT, X-ray, Labor Room, and Laboratory facilities. A CHC is a referral centre for four PHCs within its jurisdiction, providing facilities for obstetric care and specialist expertise. There were 3346 CHCs in the country, almost a 50 per cent shortfall.

Data on facilities within these centers are not available. Most reports and evaluation studies point to the lack of equipment, poor or absence of repairs, improper functioning, or lack of complementary facilities such as 24-hour running water, electricity back-ups, and so on. But conditions being what they are, unreliable electricity and water supplies also take their toll on the performance of these centers. There exists shortfall across all cadres in the posts of MPW (F)/ANM, MPW (M), Health Assistant (Female)/LHV, and that of Health Assistant (Male). The large shortfall in Male Health Workers has resulted in poor male participation in Family Welfare and other health programmes and overburdening of the ANMs. This shortage is despite government efforts to train health workers through various training programmes throughout the country for more effective and systematic service delivery.<sup>7</sup>

The analysis of the above section reveal that despite having National Health Policy since 1983, the health of Indian women did not achieve international acceptable standards. This is precisely because of the fact that the focus of these policies has been on Family planning and population control rather than on health. The focus on women health, especially reproductive health was seldom explicit in the policies. With growing expenditure on defense, the expenditure outlay in health despite significant rise in GDP has never been more than 2%. These factors contributed a great deal towards poor health of women and high mortality. The policies, even with a focus on population control, failed to check even the growing population, and the less expenditure on health to improve infrastructure implied overburdened medical facilities with poor outreach and access. It was under these circumstances that India, like other developing countries, ratified the CEDAW and ICPD recommendations and finally launched a Reproductive and Child health programme in 1997

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<sup>7</sup> S. C. Gulati, Suresh Sharma, and Institute of Economic Growth (India), Fertility and RCH Status in Uttaranchal and Uttar Pradesh : A District Level Analysis, Working Paper Series (Delhi: Institute of Economic Growth, 2002).

## **National Rural Health Mission and RCH-II: Strengthening the Initiatives on Women's health**

The RCH-I ushered in a new era in the history of Reproductive health in India. Despite its failures in many areas, the project is widely acclaimed for bringing in a paradigm shift not only in policy making but also in making women's health focus of development. The lessons from RCH-I were carefully analyzed and adapted into a new programme, National Rural Health Mission. A revamped Reproductive and Child health programme was launched under an umbrella programme of National Rural health Mission in 2005.<sup>8</sup>

National Rural Health Mission was launched in 2005 in the country is a departure from the earlier policy and plan documents. It shifted the paradigm of health of rural people. The objective of national rural health mission is to provide health care facilities in the rural areas of the entire country with special focus on 18 states: Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh. The main objective of NRHM is to provide accessible, affordable, accountable, effective and reliable health care, especially to poor and vulnerable sections of population with the ultimate objective to achieve Population Stabilization in the high fertility states of the country. It addresses the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure. NRHM defines time-bound goals and it report publicly on their progress. It focuses on effective integration of health concerns with various determinants of health.

The major goals of NRHM are: 1. Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR), 2. Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition, 3. Prevention and control of communicable and non communicable diseases, including locally endemic diseases, 4. Access to integrated comprehensive primary healthcare, 5. Population stabilization, gender and demographic balance, 6. Revitalize local health traditions and mainstream AYUSH, 7. Promotion of healthy life styles.<sup>9</sup>

National Rural Health Mission is a shift in paradigm of health in rural India. It has brought out drastic changes in the health system of our country. National Rural Health Mission has improved and still continues to improve the health status of rural population. It has failed in

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<sup>8</sup> Ibid.

<sup>9</sup> National Rural Health Mission (India), National Rural Health Mission : Meeting People's Health Needs in Rural Areas : Framework for Implementation, 2005-2012 (New Delhi: National Rural Health Mission, Ministry of Health & Family Welfare, Govt. of India, 2007).

achieving many time bound goals but surely has opened up new avenues through which Rural Health care can be upgraded.<sup>10</sup>

### **Maternal Health: Findings from the Survey**

Out of all 1119 women, at least 49.3% are in the reproductive age group, classified as 15 – 40 years under the present research. Out of such women, approximately 75% are/were married. This figure includes all currently married women, all widows, all divorced and all women who are separated from their husband.

**Table 22: Composition of Ever Married Women**

<b>Women in Reproductive Age Group</b>	<b>Frequency</b>	<b>%age</b>
Ever Married	409	74.1
Unmarried	143	25.9
Total	552	100.0

Out of all 409 ever married women no less than 91% have given birth to a child or children. This implies that 91% of women have gone through pregnancy and would have required medical/health attention at some stage during their course of pregnancy.

A further question was asked to probe the outcome of the last pregnancy. The results of this question are analyzed below at Table 21.

**Table 23: Result of Last Pregnancy**

<b>Result of Last Pregnancy</b>	<b>Frequency</b>	<b>%age</b>
Live Birth	382	93.40
Still Birth	14	3.42
Natural Abortion	8	1.96
Induced Abortion	5	1.22
Total	409	100

The table above reveals that majority of the last pregnancies of ever married women resulted in live births. Approximately 93% of pregnancies resulted in live births, while 3.4% resulted in still birth. About 1 % of pregnancies were terminated either naturally or were induced.

### **Reproductive Health**

While we leave aside the issue of abortion, we will concentrate for a while on the outreach of health services and providers during pregnancies of rural women. The survey reveals that the Auxiliary Nurse and Midwife (ANM) have just visited approximately 38% of the pregnant

<sup>10</sup> National Rural Health Mission (India), "Performance Audit of National Rural Health Mission (NRHM): Report of the Comptroller and Auditor General of India," (Shillong: Govt. of Assam); National Rural Health Mission (India) and Centre for Health and Social Justice New Delhi., Reviewing Two Years of Nrhm : Citizens Report, October, 2007 (New Delhi: Centre for Health and Social Justice, 2007).

women. This implies that the National Rural Health Mission, at least in rural Uttar Pradesh has failed to make their service outreach accessible to majority of pregnant women. Approximately 61% of past pregnancies were left unattended.

**Table 24: ANM Visit during Pregnancy**

<b>ANM Visit During Pregnancy</b>	<b>Frequency</b>	<b>%age</b>
Yes	157	38.39
No	252	61.61
Total	409	100

Government of India has paid rigorous and continued stress to reduce the Maternal Mortality Rate (MMR) and in this regard much emphasis has been laid on the ANC checkups, especially in the hinterlands of the country. Recently under National Rural Health Mission (NRHM), the government of India has again reiterated its commitment to reduce MMR through various activities that includes at least three compulsory ANC check-ups.

What is more revealing is the fact that the first contact of ANM with pregnant women was in second trimester. Approximately in 58% of the instances, the first point of contact or the first Ante Natal Check up by the ANM was conducted second trimester that is between 4 – 6 months.

**Table 25: Month of First Check by ANM during Pregnancy**

<b>Month of Pregnancy when ANM first Visited</b>	<b>Frequency</b>	<b>%age</b>
Ist Trimestes	35	22.29
IInd Trimester	91	57.96
IIIRD Trimester	31	19.75
Total	157	100

It is normally established that the danger signs of pregnancy becomes evident during the first trimester only and becomes life threatening during the last trimester, if danger signs are not adequately addressed as early as possible. This in turn becomes one of the major causes of Maternal Mortality. What is quite evident from our analysis is the fact that ANMs are not extending their services to impact maternal mortality as they are not able to make first contact with pregnant women in the first trimester. This is still lower in the third trimester when most of the maternal death occurs.

The Health Department guidelines makes it compulsory at least 3 Ante Natal Check-ups during pregnancy, one each in three trimesters. However, the findings from the survey undertaken for this research reveal that only 12% of pregnancies receive all 3 ANC. The majority of pregnancies at 68% receive only 1 check up out of mandatory

**Table 26: Number of Ante Natal Check Ups**

No. of ANCs	Frequency	%age
3	19	12.10
2	32	20.38
1	106	67.52
Total	157	100

During the ANC, the guidelines of the health department makes it mandatory to have the blood pressure and weight measured, hemoglobin count taken and 100 tablets of Iron and Folic Acid given.

**Table 27: Services Rendered Ante Natal Check Ups**

Service Offered during ANC	Frequency	%age
Weight measured	19	9.00
Hemoglobin measured	32	15.17
Blood Pressure	21	9.95
Iron Folic Acid Tablets	17	8.06
General Check Up with no services	122	57.82
Total	211	100.00

Table 25 above highlights that majority of the ANC were just general check up (or just visits) with no critical services offered. Only 9% of the pregnant women had their weight taken and the blood pressure of the same number was measured. 15% of the pregnant women had their hemoglobin count taken.

An ANM has on average 10 – 15 villages to cover. Since most of them reside at district and/or Block headquarters, they find it problematic to carry weighing machine and BP instrument along with them to villages. This appears to be a major reason behind critical services not offered during ANCs.

Approximately 48% of the pregnant women had some problem during their pregnancy for which they sought medical attention as shown in the table below.

**Table 28: Problems during Pregnancy**

Problems during pregnancy	Frequency	%age
Yes	76	48.41
No	81	51.59
Total	157	100.00

It was surprising to note that a vast majority of the problems faced during pregnancy were attended to by the private doctors. Approximately 46% of the pregnant women who faced some problem during their pregnancy consulted private doctors. This was followed by Traditional Healers with whom approximately 25% of the pregnant women consulted. The

combined figure of government owned health institutions catered to the medical need of just about 6% of the pregnant women.

**Table 29: Place where Medical Assistance was sought**

Place where medical assistance was sought	Frequency	%age
District Hospital	2	2.63
Community Health Centre	3	3.95
Primary Health Centre	0	0.00
Private Doctors	35	46.05
Traditional Healers	19	25.00
Private Nurse	4	5.26
Friends/Relatives	13	17.11
Total	76	100.00

This is indeed surprising given that NRHM, which had aimed to improve medical and health facilities across rural areas have been implemented since 2005. It appears that the rural women still do not have confidence in the government health facilities. The other plausible reason is the non-availability of gynecologist or even services during odd hours at CHC/PHCs.

Deliveries attended and/or assisted by unprofessional outside medical facility was cited as a major reason for high maternal mortality ratio. In its effort to have more deliveries attended by professionals at a medical facility, the Government of India under National Rural Health Mission introduced conditional cash transfer scheme called Janani Suraksha Yojna (JSY). The scheme offered instant cash transfer to women who had their deliveries at medical institutes, and also offered cash assistance to women / mobiliser who took the pregnant women to such medical facility.

The findings from our survey suggest that there has been a success in reducing the number of deliveries taking place at home and attended by unprofessional.

**Table 30: Place of Delivery**

Place of Delivery	Frequency	%age
District Hospital	83	42.35
CHC/PHC	27	13.78
Private Hospital	76	38.78
Sub Centre	7	3.57
Home	3	1.53
Total	196	100.00

Majority of deliveries are now taking place at medical facilities. Altogether nearly 60% of all deliveries were taking place at government hospitals, while nearly 38% of the deliveries were

taking place at private hospitals. Only 1% of deliveries have taken place at home. This appears to be a major success of NRHM/RCH-II.

The government guidelines also equally emphasize on Post Natal Check Ups and require ANM to visit the new mothers after delivery. This is because that some maternal deaths also occur within 48 days after the delivery due to various reasons. However, we find that PNC services are not reaching to everyone. While the ANC was low, PNC are still lower. Only 34% of the women who had delivery had a PNC by an ANM

**Table 31: ANM Visit after Delivery**

<b>ANM Visit After Delivery</b>	<b>Frequency</b>	<b>%age</b>
Yes	67	34.18
No	129	65.82
Total	196	100

### **Immunization**

India has a high Infant Mortality Rate. Since the neo natal and infants are taken care by mothers, the poor health of child adversely affects the empowerment of women. If a neo natal or an infant is in poor health it affects the mobility and health of a woman. Unfortunately if the neo natal or an infant dies, the pressure of again bearing a child from males is more. Frequent pregnancies, for sure adversely affects the health of the women. It in this context that the health of child is equally important to the health and empowerment of woman.

The findings from our survey confirms that majority of the mothers do not receive any advise on exclusive breast feeding to the new born. Approximately 68% of women did not receive any advice on giving exclusive breast feeding to the new born child. This fact is quite surprising given the fact that most of the deliveries are now institutionalized.

**Table 32: Advise on Exclusive Breast Feeding**

<b>Advise on Exclusive Breast Feeding</b>	<b>Frequency</b>	<b>%age</b>
Yes	121	31.68
No	261	68.32
Total	382	100.00

It means that the care giver/service provider, in this case a doctor or a nurse is not counseling the mothers properly on how to keep their young ones healthy. Bottle milk or water is normally given to children in rural areas as a part of their traditional belief. This is a major reason for causing diarrhea, a major killer of neo natal and infants.

The National Immunization plan recommends 6 immunization namely, BCG at birth, DPT 1, 2 and 3 at 1.5 months, 2.5 months and 3.5 months respectively, measles and a dose of vitamin

A at 6 months. The findings of our survey confirm that majority of the young ones get immunized with BCG. 1005 of the new born get a dose of BCG. This is probably because of the fact that most of the deliveries are now taking place at health/ medical facility. In order to be eligible for JSY, a mother has to remain at hospital for 3 days. This probably is the reason for boosting us BCG doses to new born children, as shown in table below.

**Table 33: Immunization**

<b>Immunization</b>	<b>Frequency</b>	<b>%age</b>
BCG	382	100.00
DPT 1	264	69.11
DPT 2	184	48.17
DPT 3	73	19.11
Measles	123	32.20
Vitamin A	238	62.30

However when it comes to immunization doses at a later stage, such as in the case of DPT, the immunization level drastically falls out. From 100% at BCG the immunization drops to 69% at DPT 1 level, and further drops down to 48% at DPT 2 level. The drop rates in DPT are consistent with only 19% getting the DPT 3 dose.

**Table 34: Reasons for not Immunizing Children**

<b>Reasons for not immunizing</b>	<b>Frequency</b>	<b>%age</b>
Baby Too Young	48	18.18
Not Aware	183	69.32
Baby Healthy	124	46.97
Fever	201	76.14

The major reason for not giving immunization doses to children appears to be fever. Normally there is a fever after the DPT dose, which medically is a symbol of showing that the medicine has worked. However with the awareness level low, the rural parents think it as a bad sign and therefore deters from giving the doses of DPT to children. The low awareness level is also confirmed by the findings of the survey. Approximately 69% of the mothers were not even aware of the immunization schedule, while 46% thought that there is no need for immunization since their baby is healthy.

### **Summary of the Findings**

The analysis of the survey on health highlights that there has been significant improvement in terms of institutional deliveries and also in terms of immunizing children with BCG. This has been primarily the result of the innovative scheme Janani Suraksha Yojna under NRHM. However, the outreach of basic services envisaged under NRHM/RCH-II is far from satisfactory. The role of Accredited Social Health Activist (ASHA) and ANM has to be



further strengthened so that they can reach out to women in a timely manner. The skills of ASHA have still to be further capacitated in order for her to counsel the mother and communities in an effective manner. The amount of funds allocated in NRHM for strengthening ASHAs is not corroborating with the physical achievements in rural areas.

#### **For Further Readings**

1. New Delhi. Reviewing Two Years of NrhM : Citizens Report, October, 2007. New Delhi: Centre for Health and Social Justice, 2007.
2. National Rural Health Mission (India). "Performance Audit of National Rural Health Mission (NrhM) : Report of the Comptroller and Auditor General of India." v. Shillong: Govt. of Assam.
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4. J. Kishore, J. National Health Programs of India: National Policies and Legislations Related to Health, Century Publications, 2011