

# Baseline Survey *for* UPHSSP Social Accountability Intervention



*Submitted to :*

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## LIST OF ACRONYMS

AMS	-	Academy of Management Studies
ANC	-	Antenatal Care/ Check-up
ANM	-	Auxiliary Nurse Midwife
APL	-	Above Poverty Line
ASHA	-	Accredited Social Health Activist
AWC	-	Anganwadi Centre
AWH	-	Anganwadi Helper
AWW	-	Anganwadi Worker
BCC	-	Behavioural Change and Communication
BCG	-	Bacille Calmette Guerin
BP	-	Blood Pressure
BPHC	-	Block Primary Health Centre
BPL	-	Below Poverty Line
CAPI	-	Computer Assisted Personal Interviewing
CBR	-	Crude Birth Rate
CHC	-	Community Health Centre
cm	-	Centimeters
CMO	-	Chief Medical officer
DM	-	District Magistrate
DPT	-	Diphtheria, Pertussis, Tetanus
ENBC	-	Essential New-born Care
FGD	-	Focus Group Discussion
FLW	-	Front Line Worker
Hb	-	Haemoglobin
HH	-	Household
ICDS	-	Integrated Child Development Scheme
IDA	-	International Development Association
IDI	-	In-depth Interviews
IEC	-	Information Education and Communication
IFA	-	Iron Folic Acid
IMR	-	Infant Mortality Rate
JSY	-	Janani Suraksha Yojana

kg	-	Kilograms
LPG	-	Liquid Petroleum Gas
MCH	-	Maternal and Child Health
MMR	-	Maternal Mortality Rate
MUAC	-	Mid-Upper Arm Circumference
NGO	-	Non-Governmental Organisation
NRHM	-	National Rural Health Mission
OBC	-	Other Backward Classes
OPV3	-	Oral Polio Vaccine
PHC	-	Primary Health Centre
PNC	-	Post Natal Care
PRI	-	Panchayati Raj Institution
PSU	-	Primary Sampling Unit
RSBY	-	Rashtriya Swasthya Beema Yojana
RTI	-	Reproductive Tract Infections
SA	-	Social Accountability
SC	-	Sub-centre
SC	-	Scheduled Castes
SI	-	Sampling Interval
SRS	-	Sample registration System
ST	-	Scheduled Tribes
STI	-	Sexually Transmitted Infections
TAP	-	Technical Assistance Providers
TFR	-	Total Fertility Rate
TT	-	Tetanus Toxoid
ULW	-	Ultra Low Weight
UP	-	Uttar Pradesh
UPHSSP-		Uttar Pradesh Health Systems Strengthening Project
VHND	-	Village Health and Nutrition Day
VHSNC	-	Village Health Sanitation and Nutrition Committee
WDR	-	World Development Report

## EXECUTIVE SUMMARY

Social accountability refers to the broad range of actions and mechanisms beyond voting that citizens can use to hold the state to account. It also includes actions on the part of government, civil society, media and other societal actors that promote or facilitate such efforts. The Uttar Pradesh Health Systems Strengthening Project (UPHSSP) proposes to develop and implement mechanisms that will help increase the social accountability of service providers and that of the health system as a whole in the State. A baseline study was undertaken to generate key insights into the current status of identified intervention areas. This report elaborates upon the key findings and presents estimates for key indicators that would be useful for assessing the impact of intervention at a later stage.

Some of the major findings of the study that hold special importance in light of the social accountability intervention are enumerated hereunder –

➤ **Overall Status of Study Districts:**

Of the 12 districts covered under the study, Sultanpur & Fatehpur emerge as the weakest ones, being rightly selected for intensive social accountability interventions. Fatehpur was found to be the weaker one between the two. These two districts will surely pose greater challenges for the implementing agencies.

➤ **Status of Village Level Institutions & Forums:**

An inquiry into the status of villages with regard to availability of forums for exacting accountability from service providers, reflected extreme lack of awareness amongst villagers regarding such forums. Overall, merely 8% of the households were aware about the existence of Village Health Sanitation & Nutrition Committees (VHSNCs). Further, only 22% households affirmed that Village Health Nutrition Days (VHNDs) were celebrated in their village. When probing about VHNDs, villagers were asked about days when all three key frontline workers, including ASHAs, ANMs and AWWs together gathered to offer health & nutrition related services to mothers and children. However, when asked in terms of immunization days, many respondents appeared to be aware of such events. This was further corroborated by the fact that immunizations are taking place in the villages to an appreciable extent. Under such conditions, VHNDs cannot be considered being celebrated in their true spirit and at best be called 'immunization days'.

These findings surely raise concerns regarding the ability of such platforms to deliver the services that they ought to. The VHNSCs have not gained prominence in the community and the VHNDs are not being celebrated as per the design outlined for them. This reflects

that rejuvenating such platforms and enhancing their effectiveness will be an uphill task for the intervention.

➤ **Assessment of Social Integration in Communities:**

The study also investigated the extent to which people are willing to contribute towards activities that are beneficial for the community at large, though they may not bring any direct benefits for the individual household. The findings revealed that people are willing to contribute monetarily (56%) but are rarely willing to invest their time in such activities (30%).

Further, while conducting focus group discussions (FGDs), the researchers experienced great difficulties in gathering willing participants and making them talk about their experiences related to seeking of health services. The FGDs also reflected that the health issues do not form a major point of discussion amongst community members. In light of the lack of openness and the willingness to contribute to group activity, observed during FGDs, it may be inferred that bringing the community members together and making them stand for their rights and seek accountability from authorities will be a major challenge for the social accountability initiative.

➤ **Status of Maternal Health:**

Further, while exploring the status of maternal health in the district, the maternal mortality burden was found to be as high as 302 per lakh live births. Among the two categories of districts, category-A districts reflected a much higher maternal mortality ratio (386) as compared to category-B districts (226).

An insight into the status of uptake of key maternal health services reflected that over 92% mothers reported to have received 1 TT injection during their last pregnancy. Whereas, the proportion of those receiving the second dose or more dropped significantly to a mere 51% pointing to the lack of follow-up by the frontline functionaries, and lack of awareness & willingness among beneficiaries to get remaining doses. Further, less than one-fourth of the respondents reported to have undergone blood and urine tests, blood pressure & weight measurement, and abdominal examination during their last pregnancies.

The provision of such services is mandated under VHNDs being organized at the village level. Interviews with target respondents reflected that the ANMs, whether or not assisted & accompanied by ASHA & AWW, visited their village to offer immunization to pregnant women & children. More often they quoted that ANMs usually attended the beneficiaries on a shop, under a tree or at AWCs which usually lacked proper arrangements for privacy, which was a major hindrance for conduct of abdominal examination, urine test, blood test

etc. It must be mentioned here that these tests hold special importance for identification of high risk pregnancies, and the observable lack of it is a pointer to the fact that many of the high risk pregnancies are still going unidentified leading to higher mortality burden in these districts.

Moreover, the focus of all VHNDs being organized currently primarily remains on immunization of children and distribution IFA tablets and administering of TT injections to mothers. These trends reflect that the VHNDs, wherever celebrated, have failed to focus on these aspects and are not offering all the services they are mandated to offer to the community. Thus, it would be correct to say that VHNDs have merely become immunization days and the celebration of VHNDs in their true spirit is highly questionable.

➤ **Status of Child Health:**

Examination of child health scenario revealed that the infant (51.4 per thousand live births) and neonatal (33.4) mortality rates are very high in the study districts. Between the two categories of study districts, category-A was found to be poorer with IMR and NMR amounting to 60 & 40 per thousand live births respectively, as compared to 44 & 27 in category-B districts. With regard to immunization among children, while the immunization levels for certain preliminary vaccines was found to be considerably good across the districts, there was an observable drop when it came to administration of repeat or booster doses. Overall, 58% children were found to have received complete immunization.

Another pertinent observation with regard to child health was that in incidence of minor illnesses like diarrhoea and fever among children, a majority of people depended on private facilities and practitioners for treatment. Only a minor proportion approached Government health facilities for treatment. Further, it would be worth mentioning here that only 2% or lesser proportion of households reporting incidence of these illnesses in the two weeks preceding the survey, informed that they sought treatment from ANMs of their village. None of the respondents reported to have approached the ASHAs or AWWs for treatment. This is a cause of concern for the authorities as the frontline functionaries are mandated to dispense basic medicines like paracetamol, ORS, zinc, etc. The fact that people are not seeking treatment from these functionaries on one hand, points to the lack of awareness on part of the community. While on the other hand, it reflects the lack of willingness and efforts amongst our functionaries to reach out to community for offering essential medical care.

The aforementioned findings are a clear pointer to the need for social accountability initiatives in the study area. These findings need a special attention from authorities while designing the interventions under the proposed social accountability initiative. The report ahead presents

detailed findings with regard to existing maternal and child health status, and the current status of village communities with regard to willingness and ability to exact accountability for service providers. A brief quantitative summary presenting the estimates for key indicators is presented in the subsequent section of this document. It is hoped that the insights and findings offered by this study would be helpful for authorities to design an effective intervention for alleviating the overall health scenario amidst our rural communities.

On the basis of assessment of the situation at sampled villages, few **recommendations** have been proposed to strengthen the social accountability mechanisms in the intervention areas.

- ✓ **Utilize District Level Nutrition Committees under State Nutrition Mission as a forum to enable convergence effects to percolate down the block and village levels:** These committees can be utilized as a forum to enable convergence effects to percolate down the block level and village level. The intervention agencies may seek to facilitate meetings and support implementation of activities outlined at these forums within their intervention blocks and villages. Further, since the triple A (ANM, ASHA and AWWs) forum is also looked at an effective means of reaching out to grassroots level, therefore, a proper coordination with them under the ambit of already existing mechanisms would prove to be highly effective.
- ✓ **Utilize Matru Samitis along with VHSNC for delivery of Health and Nutrition Services:** Matru Samitis (Mothers' Groups) are especially formed for dealing with mother, child care and adolescent issues and their meetings are organised under the aegis of ICDS. Therefore these forums would be most suited to serve the objectives of social accountability interventions. It is recommended that the capacities of the members of Matru Samiti should be built in view of the role envisioned for them under the social accountability initiative.
- ✓ **Build Capacities of Panchayati Raj Institutions (PRIs) and Members of VHSNC and offer handholding support for effective functioning of VHSNCs:** It is recommended that capacity building programmes must be initiated for the VHSNC members with special emphasis and hand holding support for preparation of village health plans. It is also recommended that all ASHAs and AWWs of a particular Gram Panchayat should be members of VHSNC and must be involved in formulation of the Village Health Plan so that a holistic plan is designed keeping in loop all the functionaries operating in the GP. Capacity building efforts for VHSNC must also target the frontline functionaries so that they are able to offer proper inputs for carrying out the activities of VHSNC.

To summarize, it may be said that many interventions targeting the improvement in maternal and child health of rural communities are being implemented in different districts of Uttar Pradesh. Convergence and coordination between different implementation agencies and departments working at the village level would help in providing a synergistic effect to the interventions and the overall objective and target of a healthy & empowered community would be much easier to achieve.

\* \* \* \* \*

## Quantitative Summary

Indicators	Uttar Pradesh (AHS 2012-13)	Estimates of Social Accountability Baseline		
		Overall of SA Study	Category A Districts	Category B Districts
<b>KEY MATERNAL HEALTH INDICATORS</b>				
<b>Antenatal Care</b>				
Mothers who Received 2 or more TT Injections during Pregnancy (%)	-	51%	46%	55%
Mothers whose Abdomen Examination was Done (%)	-	26%	26%	27%
Mothers whose Blood Pressure taken (%)	31%	20%	20%	19%
Mothers whose Weight Measurements were taken (%)	-	18%	19%	18%
Mothers whose blood taken for Hb (%)	23%	29%	28%	30%
Mothers whose urine tested (%)	-	25%	25%	25%
Mothers who underwent ultrasound (%)	26%	34%	29%	38%
Mothers who went for at least 1 ANC Visit (%)	84%	55%	55%	55%
<b>Mothers who Received ANC at</b>				
Government Health Facility	75%	38%	44%	33%
Private Health Facility	-	26%	17%	34%
Anganwadi Centres	-	22%	18%	25%
Mothers who went for 3 or more ANC Visits (%)	34%	42%	43%	41%
<b>Delivery Care</b>				
Institutional Delivery (%)	55%	73%	71%	75%
Govt. Health Facility	41%	55%	60%	51%
Private Health Facility	14%	17%	11%	24%
Home Deliveries by Skilled Birth Attendant (%)	27%	4%	3%	5%
Safe Delivery (%)	62%	76%	74%	79%
Mothers who availed financial assistance for deliveries under JSY	36%	43%	43%	42%
<b>KEY CHILD HEALTH INDICATORS</b>				
<b>Mortality Indicators</b>				
Infant Mortality Rate	72	51	60	44
Neonatal Mortality Rate	52	33	40	27
<b>Immunization Status</b>				
Children aged 12-23 months having Immunization Card (%)	71%	70%	72%	69%
Children aged 12-23 months who have received BCG vaccine (%)	86%	80%	74%	86%
Children aged 12-23 months who have received 3 Doses of Polio vaccine (%)	63%	64%	57%	70%
Children aged 12-23 months who have received 3 Doses of DPT vaccine (%)	62%	69%	62%	76%
Children aged 12-23 months who have received Measles vaccine (%)	65%	71%	62%	79%

Indicators	Uttar Pradesh (AHS 2012-13)	Estimates of Social Accountability Baseline		
		Overall of SA Study	Category A Districts	Category B Districts
Children aged 12-23 months Fully Immunized (%)	52%	58%	51%	64%
<b>Incidence of Diseases</b>				
Children Suffering from Diarrhea (%)	11%	13%	13%	14%
Children Suffering from Diarrhea who sought Treatment (%)	85%	89%	87%	91%
Children suffering from Fever (%)	25%	22%	24%	20%
Children Suffering from Fever who sought Treatment (%)	96%	65%	66%	64%

***Some other Quantitative findings that are of special interest with regard to Social Accountability intervention are as follows –***

- As regards nutritional status of children, one-third (33%) of the weighed children were found to be moderately or severely underweight. In males, the underweight percentage was 35%, while in females it was 30%.
- 13% of children were found to be severely underweight. The severely underweight proportion in male children was 14% while in females was 11%.
- 87% of the households perceived routine immunization as the primary responsibility of ANMs. 55% also cited ANC services as one of the main tasks of the ANM. Services related to family planning, PNC care, home visits and counselling were recalled by only a limited number of respondents showing their lack of exposure to such services from ANMs.
- 68% households felt that conducting home visits and providing counseling on nutrition, hygiene, birth preparedness and safe delivery was the main responsibility of ASHAs. Counselling on contraception, prevention of common infections and escorting women and children to health facilities for treatment appeared as neglected areas with lesser number of respondents being able to recall the same.
- 76% households felt that preschool education for children was the main work of AWW. More than two-thirds also mentioned providing nutritional supplements to children aged 0-6 years as one of the primary tasks of AWW. Growth monitoring, counseling related to IYCF and providing IFA to pregnant women and adolescent girls were quoted by very few respondents indicating possible neglect of these functions.

- About 55 of 240 ANMs, 39 of 240 ASHAs, 23 of 240 AWWs reported that they had received incentives for their appreciable service. Most of them received incentives and certificates of appreciation from Government. AWW also given incentive from community.
- About 97% Village Pradhans reported the presence of VHSNC in their villages. About one-fourth of the Village Pradhans informed that 3 or more meetings of VHSNC had been held in the 3 reference months. In contrast to this only 55% ANMs confirmed the presence of VHSNCs in sampled villages.
- When asked about organization of VHNDs from households, only 22.6% households responded in affirmative, while in a stark contrast 97.1% Village Pradhans said that VHNDs were being organized. Households were aware of Immunization Days and Matru Samiti meetings, but a deeper probe reflected that VHNDs are not being organized in their true spirit offering all the mandated services.

Comprehensive details of the above findings have been presented in the relevant chapters of the report.

\* \* \* \* \*

# INTRODUCTION I

## 1.1 Background & Context

Health has always remained one of the focal areas of development across the globe. In particular, there has been mounting evidence showing relatively weak links between quantity of public sector health spending and health outcomes (World Bank 2004). In view of this, various interventions have been introduced time and again to improve the outcomes of public health programmes.

Health sector governance has been recognized as a significant intervening variable between inputs and outcomes. Numerous strategies including training capacity building initiatives, outsourcing of basic non-key services, decentralization of services, etc. have been implemented for improving the health sector governance. Community participation has been advocated to build links between primary services and their users, and to improve service quality (Manandhar D.S. et.al., Lancet 2004). Of late, community-based accountability initiatives, which promote greater community involvement in monitoring & oversight of health services being offered, have gained attention in various countries.

### 1.1.1. National Rural Health Mission in India:

In order to improve the provision of health services to the rural masses (especially women), in 2005, the Government of India launched the National Rural Health Mission (NRHM). NRHM aimed at providing “integrated primary care services” to the most marginalized segments of the rural population in India. NRHM sought to provide effective health care to the rural population, especially the disadvantaged groups including women and children, by improving access, enabling community ownership and demand for services, strengthening public health systems for efficient service delivery, enhancing equity and accountability, and promoting decentralization.



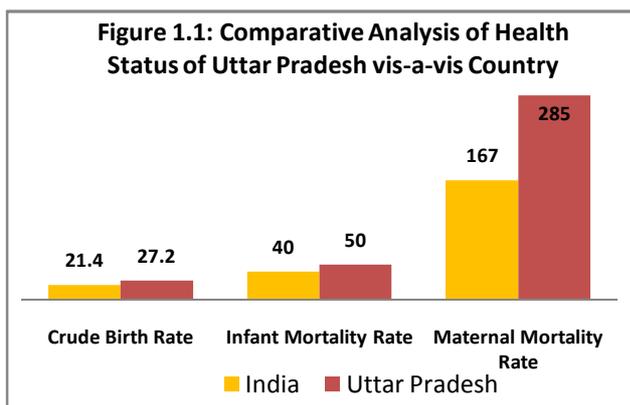
The thrust of the mission has been on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. The core

strategies of NRHM include community based Accredited Social Health Activist (ASHA), the establishment of Village Health and Sanitation Committees (VHSC), etc.

### 1.1.2. Health status in Uttar Pradesh:

With a population of 19.96 crore, Uttar Pradesh is the most populous state in the country. As per the Census 2011 estimates, over 77% of the population in UP resides in the rural areas. In terms of literacy, there exists a wide differential between males and females, with male literacy rate amounting to 79%, while female literacy rate stood at a mere 59%. Sex ratio was reported to be 912 as compared to the 946 females per thousand males across the country (Census, 2011). The state also fairs poorly in terms of developmental status. As per the National Human Development Report (2001), Uttar Pradesh ranked 23 out of 32 states in India in terms of population living below the poverty line.

The health statistics of the State has remained a cause of concern for authorities since a long time. A comparison with the country statistics for key maternal and child health indicators highlights the extent of backwardness of the state. As per SRS (2012-13), the Crude Birth Rate of the State stood at 27.2 as against the country average of 21.4. The maternal and child mortality rates of UP are amongst the highest in the country. The infant mortality rate was reported at 50 as against the country average of 40 (SRS, 2012-13)<sup>1</sup>. The State also bears a massive burden of maternal deaths, with maternal mortality being 285 deaths per lakh live births when compared to the country average of 167 (SRS 2011-13)<sup>2</sup>.



In terms of utilization of maternal and child health (MCH) services, the state is far behind many states. Even after the introduction of the Janani Suraksha Yojana (JSY)

<sup>1</sup> SRS Bulletin, Volume 49, No.1, September 2014, accessed from [http://www.censusindia.gov.in/vital\\_statistics/SRS\\_Bulletins/SRS%20Bulletin%20-September%202014.pdf](http://www.censusindia.gov.in/vital_statistics/SRS_Bulletins/SRS%20Bulletin%20-September%202014.pdf)

<sup>2</sup> MMR Bulletin, Sample Registration System, accessed from [http://www.censusindia.gov.in/vital\\_statistics/mmr\\_bulletin\\_2011-13.pdf](http://www.censusindia.gov.in/vital_statistics/mmr_bulletin_2011-13.pdf)

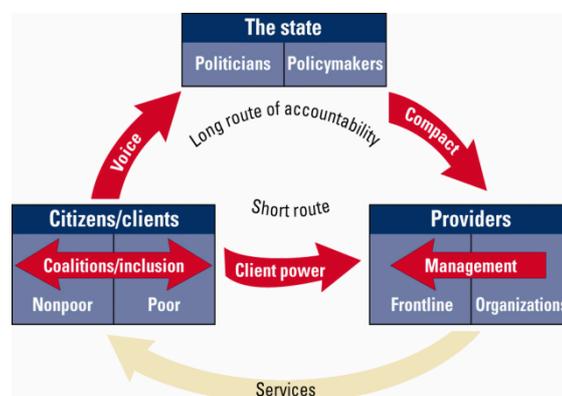
under the National Rural Health Mission (NRHM), the coverage of institutional delivery, immunization, and antenatal and postnatal care has been substantially low. Hence improving coverage of MCH services continues to be a major challenge for policy makers and program implementers. Weak institutional capacities and systems, have been recognized as the key challenges to improving access to quality of health care service delivery in UP. It called for radical rethinking and reorganizing of the health systems in order to make the health services more accessible and affordable to common masses. At such a point, the World Bank assisted Uttar Pradesh Health Systems Strengthening Project (UPHSSP) was introduced as a strategic initiative to complement NRHM in its effort to alleviate the existing status of health scenario in the State.

### 1.1.3. Uttar Pradesh Health Systems Strengthening Project:

The Uttar Pradesh Health System Strengthening Project (UPHSSP) supported by the International Development Association (IDA) is implementing various strategies to improve the quality of healthcare service in the state. The overall development objective of UPHSSP is to improve the efficiency, quality and accountability of health services delivery in Uttar Pradesh by strengthening the State health department’s management and systems capacity. It primarily focuses on institutional development, strengthening local systems and accountability, generating demand side accountability, introducing incentives for performance, and piloting alternative delivery models including outsourcing non-clinical services. One of the most vital sub-components of this project includes introducing and strengthening the social accountability action research with a view to institutionalizing community assessments of health & healthcare services aimed at demanding better health services from the public health institutions. Needless to say, such an exercise will go a long way in improving both the State’s responsiveness to the community needs & aspirations, and the vital indicators of health.

## 1.2 The Social Accountability Initiative:

Evidence from around the world suggests that Social Accountability mechanism can contribute to improved governance and increased development effectiveness through better service delivery and citizen



empowerment. As per the World Bank's Social Accountability Sourcebook, '**Social accountability**' is about affirming and operationalizing direct accountability relationships between citizens and the state. Social accountability refers to the broad range of actions and mechanisms beyond voting that citizens can use to hold the state to account, as well as actions on the part of government, civil society, media and other societal actors that promote or facilitate these efforts.

The 2004 World Development Report: *Making Services Work for Poor People* (World Bank 2003). The WDR defined a framework for analyzing accountability relationships among policy makers, providers, and citizens. Within this framework, accountability can be implemented through either a "long route," whereby citizens influence policy makers who in turn influence service delivery through providers, or a "short route," through which citizens— individually and collectively—can directly influence, participate in, and supervise service delivery by providers. The accountability framework of the 2004 WDR is a useful starting point for identifying the entry points for influencing the quality, efficiency, and responsiveness of service delivery. The main channels for strengthening accountability are the institutions and relationships between the three sets of actors: policy makers and politicians, service providers, and citizens.

A generic framework of social accountability proposed in a study commissioned by the Department of Administrative Reforms & Public Grievances, Government of India suggests that 'social accountability' is an approach towards ensuring accountability that relies on civic engagement, i.e. in which ordinary citizens and citizen groups participate directly or indirectly in exacting accountability. This involves deploying tools like participatory budgeting, public expenditure tracking, citizen report cards, community scorecards, social audits, citizen charters, and so forth. Two prominent characteristics stand out in these tools and mechanisms. First: social accountability efforts work to enhance and integrate citizen voice into the everyday workings and decision-making processes of the state. There has, in this sense, been a shift from 'vote' to 'voice' is the principal accountability tool in the hands of the citizens. Second: central to social accountability efforts is transparency in governance. The main channel through which citizens are being empowered to demand accountability is through creation of, and access to, more information. So the recurrent theme seems to be: more information means more empowerment, which in the context of greater participation means more voice, which means greater accountability.

The 1993 World Development Report (WDR), *Investing in Health*, described strengthening accountability as one of the core elements of health sector reforms.

Since then, both participation and accountability have become increasingly popular and part of strategic plans for developing and transitioning countries' health sectors. UPHSSP proposes to develop and implement mechanisms that will help increase the social accountability of service providers and that of the health system as a whole. The mechanism for Social Accountability would essentially focus on three key aspects–

- Information provision by the health system to its intended beneficiaries to let them know what they can expect from the health services delivery system,
- Institutionalization of a mechanism for receiving feedback from the citizens on what they end up receiving,
- Corrective actions on part of the health providers and facilities based on the feedback received

Besides these, citizens could also, as a result of 'behaviour change communication' (which is both informational and motivational) take responsibility for certain health actions and achieve positive outcomes. The consequence of such a promotion is reduction in morbidity which also reduces stress on the health delivery system. Eventually, the entire process helps in improving the quality of delivery of health services. The rationale for undertaking this set of activities is clear. In order to improve health services and outcomes, the health system needs to be more transparent and responsive to local needs and demands; citizens are part of the 'health system' and need to play an active role not only as informed clients but also in assisting and holding the system to account.

### **1.3 Rationale for the Baseline Study**

In order to facilitate implementation of the abovementioned *Social Accountability* intervention, and to subsequently be able to analyse its effectiveness, it is imperative to first collect baseline data of the existing key health care delivery parameters at the block level in the State. In this light, the UPHSSP aptly called for conducting a baseline survey of key health & household economic indicators and existing condition & capabilities of the health functionaries. AMS was commissioned by UPHSSP to undertake the said baseline study in the identified areas of the State. This report presents the findings obtained from the study, which would serve to inform the planning and formulation of intervention design.

# OBJECTIVES & METHODOLOGY **2**

## 2.1 Research Objectives:

The overarching goal of this study is to generate baseline estimates for various healthcare performance indicators to help the authorities understand the current status of the sampled villages. The findings generated out of this study will serve as a crucial input for designing social accountability strategies and interventions for bringing about quality improvements in the health service delivery. The estimates so developed will also help set benchmarks for planned improvements and serve as a base against which the effectiveness of interventions can be judged at a later stage. Under the purview of this overarching goal, this study will seek to achieve the following specific objectives –

- ✦ To evaluate the effectiveness of VHSNCs and PRIs for planning and implementing various interventions for improving the healthcare scenario of the village.
- ✦ To assess the functioning of VHSNCs in terms of regularity in carrying out the activities mandated for them.
- ✦ To generate various health indicators for the village residents to inform the authorities about the healthcare needs of the people in the selected locations.
- ✦ To take anthropometric measurements of the children under 5 years of age in order to assess their nutritional status and assess the level of malnourishment in the population.
- ✦ To bring to light various socio-economic and demographic characteristics of the sampled villages to help the authorities develop a better understanding of the overall status of these villages.
- ✦ To assess the level of awareness regarding social accountability mechanisms among the general population, PRI members, VHSNC members and healthcare staff.
- ✦ To evaluate the BPHCs for the availability of requisite healthcare infrastructure for offering quality healthcare services to the population in their catchment area.
- ✦ To appraise the utilization of key health services, especially services that would be made available to all recipients irrespective of health/illness conditions such as vaccinations and ANC services, etc.

- ✦ To study the obstetric history of ever married women between 15-49 years of age, including associated infant/child survival to develop a better understanding of the maternal and child health scenario.

## 2.2 Study Design:

The study adopted an **exploratory research design** in order to probe into the underlying conditions and health related issues prevailing in the sampled villages. The study adopted a **mixed-methods approach** using both, quantitative and qualitative techniques to collect requisite information. The research instruments were designed having both **open and closed ended questions** to elicit the responses of the functionaries as well as potential beneficiaries on the existing healthcare scenario in the district. It also involved some **village level assessment** to be able to evaluate the current functioning of health committees and health functionaries delivering the required services in the village.

The proposed baseline survey involved carrying out a comprehensive primary data collection from the household with respect to their key demographic and economic indicators. The focus of the survey remained on maternal and child health, and for eliciting related information the mothers of children less than 5 years of age formed our key respondents from the household survey. Further, it entailed capturing the households' perceptions of the implementation of all aspects of *Social Accountability* interventions under the healthcare delivery mechanisms. Besides, the survey involved collecting relevant village level information pertaining to the performance of healthcare delivery mechanism through both primary data collection from the PRI representatives & healthcare providers and conducting FGDs with the community.

A summary of all the research tools adopted for the assignment along with the respective key respondents/ sources of information is presented in the matrix given ahead—

SN	Data Collection Methods	Data Collection Instruments	Key Respondents / Sources of Information
1	Household Survey (CAPI based structured survey)	i. Women's Schedule	♦ Mothers of children less than 5 years of age.
		ii. Anthropometric Schedule	♦ Children (0-59 months)
2.	Focus Group Discussions (FGDs)	FGD Topic Guide	♦ Community members including mothers of children less than 5 years of age [ <i>other than those sampled for face-to-face interviews</i> ]
3.	Key Informants' Interview	Semi-structured Interview Schedule	♦ Stakeholders from the supply side of healthcare delivery— ✗ ANMs ✗ ASHAs ✗ Anganwadi Workers (AWWs)
4.	Village level data	Semi-structured village schedule	♦ Village Pradhan or any other knowledgeable member of Panchayat

### 2.3 Key Issues Probed:

In view of the research objectives and study design proposed above, the study probed various participant respondents along pertinent issues of interest. The matrix presented ahead provides a detailed insight into the key issues on which various stakeholders were probed. It also presents the expected outcome from each type of research instrument in terms of various indicators that were generated from the data thus collected.

S. No.	Survey Instrument/ Key Respondent	Issues to be probed	Results/ Indicators
1	Household Listing Sheet	<b>General Details of all Households of Villages-</b> <ul style="list-style-type: none"> <li>• Number of members in the family</li> <li>• Number of children in the family under 5 years</li> <li>• Deaths of children under five years in the family</li> <li>• Number of children in the family under 1 year</li> <li>• Death of children under 1 year in the family</li> </ul>	<ul style="list-style-type: none"> <li>• Crude Birth Rate</li> <li>• Under 5 mortality rate</li> <li>• Infant mortality rate</li> <li>• Neonatal mortality rate</li> </ul>

S. No.	Survey Instrument/ Key Respondent	Issues to be probed	Results/ Indicators
2	Household Schedule/ Women of Household	<p><b>General details of the family –</b></p> <ul style="list-style-type: none"> <li>• Age of the Head of household</li> <li>• Gender</li> <li>• Religion</li> <li>• Social Category</li> <li>• Economic Status</li> <li>• Number of members in the family</li> </ul> <p><b>Family members’ Details like –</b></p> <ul style="list-style-type: none"> <li>• Age</li> <li>• Gender</li> <li>• Educational Qualification</li> <li>• Marital status</li> <li>• Employment status</li> <li>• Nature of employment of woman</li> <li>• Migration of family members for work</li> <li>• Mobile numbers</li> </ul> <p><b>Household Characteristics-</b></p> <ul style="list-style-type: none"> <li>• Electricity connection</li> <li>• Source of water</li> <li>• Means of water purification</li> <li>• Availability of toilet</li> <li>• Household Assets, farming assets, livestock assets</li> </ul> <p><b>Birth related information -</b></p> <ul style="list-style-type: none"> <li>• Number of children born to the married woman</li> <li>• Gender of the child</li> <li>• Outcome of birth – Live/still birth</li> <li>• Present Survival Status of child- living/dead</li> </ul> <p><b>Health services availed during last two pregnancy/deliveries–</b></p> <ul style="list-style-type: none"> <li>• <b>Antenatal Care:</b> Whether registered for ANC, number of ANC check-ups</li> </ul>	<ul style="list-style-type: none"> <li>• Age profile</li> <li>• Sex ratio</li> <li>• Literacy rates</li> <li>• Religion profile</li> <li>• Social category profile</li> <li>• Proportion of APL/BPL families</li> <li>• Average family size</li> <li>• Occupational profile</li> <li>• Proportion of households having electricity connection</li> <li>• Proportion of households having access to safe drinking water</li> <li>• Proportion of households having toilets available</li> </ul> <ul style="list-style-type: none"> <li>• Total fertility rate</li> </ul> <ul style="list-style-type: none"> <li>• Percentage of pregnancies registered</li> </ul>

S. No.	Survey Instrument/ Key Respondent	Issues to be probed	Results/ Indicators
		<p>availed, number of IFA tablets consumed, whether TT injections taken, type of care received at the health facility in terms of taking weights, getting tests done, blood pressure monitoring, whether received supplementary food from AWC, etc.</p> <ul style="list-style-type: none"> <li>• <b>Delivery Care:</b> Place of Delivery, person who conducted the delivery</li> <li>• <b>Postnatal Care:</b>Duration of Postnatal stay at the facility, whether received supplementary food from AWC during lactation period.</li> </ul> <p><b>Child health related information for 2 most recent births of children under 5 years of age –</b></p> <ul style="list-style-type: none"> <li>• Date of Birth</li> <li>• Age</li> <li>• Immunization status</li> <li>• Receipt of nutrition from AWC</li> <li>• Amount and regularity of nutrition received</li> <li>• Incidence of illnesses like diarrhea, fever or cough in past 2 weeks</li> <li>• Nature of treatment sought</li> <li>• Place of treatment</li> </ul> <p><b>Performance of ASHA, ANM and AWW-</b></p> <ul style="list-style-type: none"> <li>• Awareness about responsibilities of the workers</li> <li>• Home Visits of the workers and centre visits of families</li> <li>• Satisfaction with workers in terms</li> </ul>	<ul style="list-style-type: none"> <li>• Women who received 3 or more ANC's</li> <li>• Women having received IFA tablets</li> <li>• Women having received 2 or more TT injections during pregnancy</li> <li>• Delivery assistance</li> <li>• Place of delivery/ institutional delivery rate</li> <li>• Women who stayed at health facility for at least 48 hours during pregnancy</li> </ul> <ul style="list-style-type: none"> <li>• Proportion of children received various vaccinations</li> <li>• Proportion of children receiving supplementary nutrition from AWC</li> <li>• Proportion of children having suffered with any illness in past 2 weeks</li> <li>• Most preferred source of treatment</li> </ul>

S. No.	Survey Instrument/ Key Respondent	Issues to be probed	Results/ Indicators
		<p>of her behaviour, explaining capabilities, concern for women etc.</p> <ul style="list-style-type: none"> <li>• Receipt of nutrition by pregnant women, lactating mother and children under 5 years from AWC</li> <li>• Regularity and amount of nutrition received</li> </ul> <p><b>Status of VHNDs and VHSNC:</b></p> <ul style="list-style-type: none"> <li>• Awareness about VHND, number of VHNDs organized in last year, number of VHNDs attended, awareness about types of services in VHND.</li> <li>• Awareness about VHSNC, number of meetings held in last year, number of meetings attended, whether VHSCN playing active role, whether effective in bringing positive changes in the health scenario</li> <li>• Grievances aired by the family</li> <li>• Place of registering grievances</li> <li>• Redressal of grievances</li> <li>• Community participation</li> <li>• Social integration in terms of friendship and mutual trust in the community</li> </ul> <p><b>Anthropometric measurements</b> of all children under 5 years including -</p> <ul style="list-style-type: none"> <li>• Height in inches/ cms</li> <li>• Weight in kgs</li> <li>• MUAC (mid-upper arm circumference)</li> </ul>	<p><b>Effectiveness</b> of -</p> <ul style="list-style-type: none"> <li>• VHNDs and VHSNCs SA mechanism</li> </ul> <ul style="list-style-type: none"> <li>• Proportion of children severely malnourished</li> <li>• Proportion of children moderately malnourished</li> </ul>
3	Village Schedule	<ul style="list-style-type: none"> <li>• <b>Availability of health infrastructure</b> – Distance from nearest health</li> </ul>	<ul style="list-style-type: none"> <li>• Accessibility of healthcare</li> </ul>

S. No.	Survey Instrument/ Key Respondent	Issues to be probed	Results/ Indicators
		<p>facility, availability of general, maternal and child health care facilities, anganwadi facility, presence of ANM, aww and ASHA in village</p> <ul style="list-style-type: none"> <li>• <b>Status of VHNDs</b> in the villages, nutrition and health education sessions organised in the last calendar month, types of services offered</li> <li>• <b>Effectiveness of VHSNC</b> – whether VHSNC playing active role, meetings of VHSNC, roles and responsibilities.</li> <li>• Other Govt/ NGOs endeavours in the village</li> </ul>	<p>services</p> <ul style="list-style-type: none"> <li>• Effectiveness of VHNDs and VHSNCs</li> </ul>
4	In-depth interview schedules for ANMs, ASHAs, AWWs	<ul style="list-style-type: none"> <li>• General details of workers- age, caste, educational status etc.</li> <li>• Types of services offered by the workers</li> <li>• Records of the services provided in the last 3 months</li> <li>• Help received from the village level authorities in providing healthcare services to the community</li> <li>• Number of VHNDs attended and Support provided during VHND</li> </ul> <p><b>Problems &amp; challenges faced</b> by healthcare staff in executing their roles &amp; responsibilities</p>	<ul style="list-style-type: none"> <li>• Status of services provided by healthcare workers</li> <li>• Barriers to effective service delivery</li> <li>• Type of support desired</li> </ul>
5	FGD Topic Guide / Knowledgeable persons within local community	<ul style="list-style-type: none"> <li>• Peoples' preference for healthcare facility and the reasons for such choice. Awareness about roles of ANM and AWW and suggestions for improvement in services of ASHA, ANM and AWW.</li> <li>• Nutritional supplement sanctioned</li> </ul>	<ul style="list-style-type: none"> <li>• Accessibility of healthcare services</li> <li>• Quality of healthcare services delivered</li> <li>• Operational leakages of nutritional supplements at AWC</li> </ul>

S. No.	Survey Instrument/ Key Respondent	Issues to be probed	Results/ Indicators
		<p>for AWC and received at AWC in the last month</p> <ul style="list-style-type: none"> <li>• Number of children received nutrition at AWC in last month</li> <li>• <b>Effectiveness of VHND and VHSNC</b> – whether VHND and VHSNC playing active role, whether effective in bringing positive changes in the health scenario</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Effectiveness</b> of VHND and VHSNC</li> </ul>

## 2.4 Sampling Approach:

As aforementioned, the proposed baseline study involves conducting interviews primarily with the households. The primary sampling units (PSUs) for the same would be the census villages within the identified districts in the State. The detailed methodology for selecting the coverage area as well as respondents for the study is as follows—

### 2.4.1. Sample Size:

As per the RFP, the study sample was proposed across 12 districts in the State. However, out of those 12 districts, 2 districts (category-A) were such where the survey had maximum focus. Thus, half of the PSUs were sampled from the 2 focus districts, while the other half was spread across the remaining 10 districts (category-B). Further, a total of 120 villages were selected from category-A districts and an equivalent number from category B districts. The sampling of districts, blocks and villages was undertaken by the World Bank’s Impact Assessment Team.

Within each of the identified 240 villages, exactly 20 households were to be selected for the face-to-face interviews. Thus, the entire study sample comprised of 4,800 households, with category-A (2 Nos.) and category-B (10 Nos.) districts having 2,400 households each. In addition, FGDs were conducted with the knowledgeable members of the local community. A total of 30 FGDs were conducted across the study districts, 15 from category A and 15 from category B districts. 3 semi-structured interviews were conducted per village with the key health functionaries including ANM, ASHA and AWW to assess the supply side of healthcare delivery mechanism. The overall quantum of fieldwork carried out under the said assignment is summarized in the matrix given ahead—

Particulars		Sample Size
<b>A. Physical Sample</b>		
I. Districts		12
II. Villages		240
<b>B. Functional Sample</b>		
I. Survey of mothers of children less than 5 years of age		4,800
II. Focus Group Discussions (FGDs) with local community members		30
III. In-depth Interviews (IDIs)	1. ANMs posted at Sub-centers	240 each
	2. ASHAs	
	3. AWWs	
IV. Village schedule		240

#### 2.4.2. Sampling Methodology:

The selection of coverage area of the study sample has been carried out by UPHSSP in consultation with TAP and World Bank team. This has led to the identification of the 12 study districts. The list of 12 study districts has been presented in the table ahead.

Category-A Districts	Category-B Districts	
Fatehpur	Moradabad	Chandauli
	J.P. Nagar	Mau
	Hapur	Kushinagar
Sultanpur	Banda	Basti
	Bhadohi	Ambedkarnagar

The list of selected districts was shared with AMS, after which AMS collected and compiled the block and village wise information along with population details to facilitate sampling of villages for the study. The complete data set was shared by AMS with the World Bank team, who would now undertake the sampling of villages. The names of sample districts, blocks, and villages selected by World Bank team will be shared with AMS team.

Following receipt of the names of sample districts, blocks, and villages, the field teams of AMS undertook the complete mapping & listing of all the households within the sample villages. This exercise was undertaken through the household listing schedule

in paper-pencil format. Thereafter, exactly 20 households per village were selected by AMS for undertaking the survey of mothers of children less than 5 years of age. The methodology used for selecting the sample households from the listing data has been described ahead.

- ✘ During the household listing, each household was be asked if they have a child less than 5 years of age in the family.
- ✘ Those households that confirmed the presence of a child less than 5 years of age were filtered to create a list of such households which formed the sample frame for this study.
- ✘ The sample households were then selected using '*circular systematic random sampling*'. This included the following steps –

- First, we computed a sampling interval using the formula given ahead :

$$\text{Sampling Interval (SI)} = \frac{\text{Total Number of households having Children less than five years of age (N)}}{\text{Number of Households to be sampled (n)}}$$

- Then a random number (r) was chosen, which fell anywhere between 1 and N. This acted as the random start point and the household of this serial number was selected as the first sample unit for the survey.
- The subsequent sample households were selected by adding sampling interval to the random start number, that is, r+SI; r +2SI; r+3SI.....r+19SI.

In this way a total of 20 households were selected from each village for administering the household survey instrument. The mothers of children under 5 years formed our key respondent from the survey.

In addition to the households, the village pradhans, ANMs, ASHAs and AWWs related to each sampled village were selected for eliciting desired information from them using pertinent research instruments. The chapters ahead outline the key findings obtained from the baseline survey in view of the research objectives outlined in the study.

# 3

## DESCRIPTION OF SURVEY SAMPLE

The preceding chapter brought to light the approach and methodology adopted to select the desired number and type of respondents for the study. Before presenting the findings of the survey, it would be pertinent to highlight the socio-demographic characteristics of the sampled villages, households and functionaries covered under the survey. This chapter presents an overview of the sample characteristics which must be borne in mind while analysing the respective study findings. The sections ahead describe the status of sampled villages, households, and key informants surveyed.

### 3.1 Coverage under the Study

The matrix hereunder demonstrates the actual coverage of the study in terms of number of number of villages, households and key functionaries covered across 12 sample districts.

Table 3.1: District wise details of sample covered during the Baseline							
Districts	Villages covered	Households Listed	Household interview	Village schedule	ANM interview	ASHA interview	AWW interview
<b>CATEGORY-A DISTRICTS</b>							
Sultanpur	60	19058	1161	60	60	60	60
Fatehpur	60	18407	1181	60	60	56	60
<b>TOTAL</b>	<b>120</b>	<b>37465</b>	<b>2342</b>	<b>120</b>	<b>120</b>	<b>116</b>	<b>120</b>
<b>CATEGORY-B DISTRICTS</b>							
Ambedkarnagar	12	3255	260	12	12	12	12
Banda	16	6187	331	16	16	16	16
Basti	4	923	83	4	4	4	4
Chandauli	16	3802	347	16	16	16	16
Hapur	12	5357	244	12	12	12	12
J.P. Nagar	12	3634	243	12	12	12	12
Kushinagar	28	10691	593	28	28	28	28
Mau	12	3274	251	12	12	12	12
Moradabad	4	1317	82	4	4	4	4
Sant Ravidas Nagar	4	941	80	4	4	4	4
<b>TOTAL</b>	<b>120</b>	<b>39381</b>	<b>2514</b>	<b>120</b>	<b>120</b>	<b>120</b>	<b>120</b>
<b>GRAND TOTAL</b>	<b>240</b>	<b>76846</b>	<b>4856</b>	<b>240</b>	<b>240</b>	<b>236</b>	<b>240</b>

Thus, in all, a total of 76,846 households were listed and 4856 were interviewed across 240 villages of 12 districts covered under the survey. Amongst the key functionaries only 236 ASHAs could be interviewed. There were four villages in Fatehpur (village Gokan, Dighwara, Baraichi, & Saidpur) where ASHAs were not sanctioned for the village at the time of survey.

### 3.2 Description of Sampled Villages:

As described in the preceding section of this document a total of 240 villages were covered across 12 sample districts. A complete listing of households was undertaken in the sample villages and a specific research instrument was designed to obtain village level information. For the village level schedules, the key respondents included village representatives like Pradhan, Panchayat secretaries, or other PRI officials to collect information about the village. The information pertaining to key characteristics derived from the village level information obtained has been presented hereunder –

#### 3.2.1 Population Characteristics:

A complete listing of the households was undertaken in the sampled villages for preparing the sampling frame for household selection. As per the listing data obtained, a total population of 2,27,639 persons was reported in the 2 category-A districts, while the total population of sampled villages from category B districts was found to be 2,55,998. District-wise details of the number of villages covered in each district and the total population listed in these villages is presented in the matrix that follows –

<b>Table 3.2: Village coverage and Population</b>				
<b>Districts</b>	<b>No of villages covered</b>	<b>Total Population</b>	<b>Average Village Size</b>	<b>Average Household Size</b>
<b>Category-A Districts</b>				
<b>Sultanpur</b>	60	118440	1974	6.4
<b>Fatehpur</b>	60	109199	1820	5.7
<b>CATEGORY-A</b>	<b>120</b>	<b>227639</b>	<b>1896</b>	<b>6.0</b>
<b>Category-B Districts</b>				
<b>Ambedkarnagar</b>	12	22891	1908	6.9
<b>Banda</b>	16	38180	2386	6.2
<b>Basti</b>	4	5699	1425	6.2
<b>Chandauli</b>	16	24916	1557	6.5
<b>Hapur</b>	12	32674	2723	6.4
<b>J.P.Nagar</b>	12	23549	1962	6.5
<b>Kushinagar</b>	28	69252	2473	6.4
<b>Mau</b>	12	23849	1987	7.1
<b>Moradabad</b>	4	8127	2032	6.1
<b>Sant Ravidas Nagar</b>	4	6861	1715	6.9
<b>CATEGORY-B</b>	<b>120</b>	<b>255998</b>	<b>2133</b>	<b>6.5</b>
<b>OVERALL</b>	<b>240</b>	<b>483637</b>	<b>2015</b>	<b>6.3</b>

The data thus obtained was analyzed to assess the average size of villages covered and average household size in these villages. The figures presented above are merely indicative in nature and in no way shall be treated as statistical estimate of the district characteristics, as the number of villages covered under a particular district varies widely from 4 to 60 villages per district. However, it may be surmised that on an average the sampled villages had an average population of 2000 people, and the average household size was found to be about 6.3. Though these estimates may be of value to evaluate the impact of interventions at a later stage, these may be useful for designing the interventions in order to meet the demand of the targeted communities.

### 3.2.2 Availability of Health Facilities within the Village

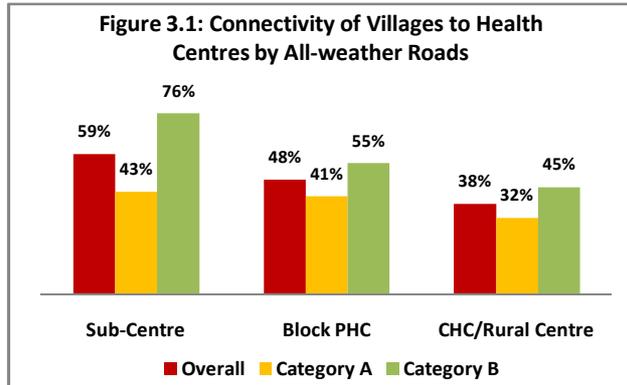
One pertinent field of inquiry while undertaking village profiling was to assess the availability of health facilities of various levels within the village. The villages were examined to assess the presence of Aanganwadi Centres, Sub-centres, and other private health facilities within the village. The overall findings obtained in this regard have been presented in the table ahead –

<b>Table 3.3: Availability of Health Facilities within the Village</b>		
<b>Type of Health Facilities</b>	<b>Villages reporting presence of facility (n=240)</b>	<b>Proportion of Villages reporting presence</b>
AWC	217	90%
SUB CENTRE	90	38%
PRIVATE CLINIC	60	25%
AYUSH FACILITY	31	13%

On the whole, out of 240 villages covered under the study, 90% reported to have an aanganwadi centre within the village. As the AWC forms the primary unit for dispensing maternal and child health related services, these become important component to be considered while designing the programme interventions. Presence of Sub-centres within the village was reported by a mere 38% of villages. This is understandable given the fact that each SC usually serves multiple villages. Therefore, it may not be expected to show its presence in all the sampled villages. Further, it was also noted that private clinics were available in 25% of the villages, which is good in the sense that it enhances the accessibility of villagers to health facilities. AYUSH facilities were also reported to be available in 13% of the villages. These figures are reflective of the availability of health facilities within the village, which becomes one of the major constraints while promoting health seeking behavior within the community.

### 3.2.3 Accessibility of Health Facilities:

One important aspect that was examined to assess the accessibility of health facilities was the connectivity of villages to health facilities by all weather roads. The respondents were asked if the various types of health facilities, that is, the sub centre, PHC, CHC, and district



hospital were connected by all weather roads. Figure 3.1 presents the overall status of 12 districts, and that of Category-A and Category-B districts in this regard. Overall, as expected, the connectivity to Sub-centres was highest while that with the CHC was the lowest across the two categories. Category-wise comparison reveals that Category-A districts fared poorly showing lesser connectivity as compared to the category-B districts.

District-wise details pertaining to connectivity of villages covered under the survey has been presented in table 3.4 ahead. Among the category-A districts, villages of Sultanpur exhibited better status in terms of connectivity with various types of health facilities as compared to Fatehpur. Comparing the category-B districts, it may be observed that the villages of Ambedkarnagar, Chandauli and Kushinagar showed better connectivity with health facilities by all-weather roads. While the villages of Hapur, J.P.Nagar, and Banda were largely deprived of road infrastructure connecting these villages to various types of health facilities.

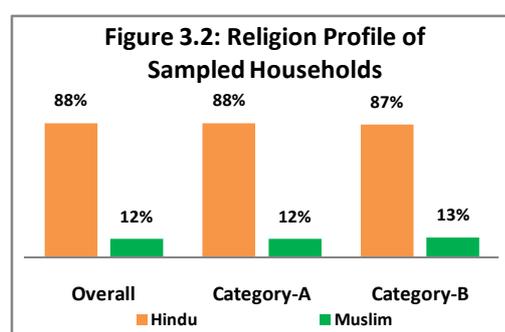
Districts	N	Sub Centre	Block PHC	Community Health Centre
<b>Category-A districts</b>				
Sultanpur	60	34	34	34
Fatehpur	60	17	15	4
<b>Category-B districts</b>				
Ambedkarnagar	12	11	10	10
Banda	16	9	6	2
Basti	4	3	1	1
Chandauli	16	13	11	12
Hapur	12	9	3	0
J.P.Nagar	12	9	4	1
Kushinagar	28	25	21	21
Mau	12	6	8	6
Moradabad	4	4	1	1
Sant Ravidas Nagar	4	2	1	0

### 3.3 Socio-demographic profile of Households

The selected households were examined for their socio-demographic characteristics in order to gain insight into the composition of population residing in the villages across 12 sampled districts. For the purpose of the study, the households having at least one child under five years of age were selected for a detailed survey. As depicted in the preceding section, a total of 4856 households were interviewed under the survey. The sections hereunder present the socio-demographic characteristics of sampled households.

#### 3.3.1 Religion Profile:

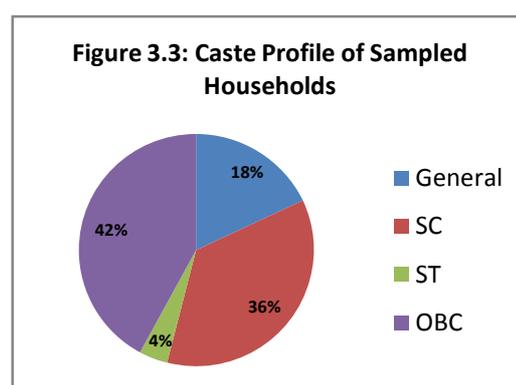
Two major religions, that is, Hindus & Muslims, were represented in the sampled households. Overall, a significant majority of 88% respondent families were found to be following Hindu Religion. While the remaining 12% were Muslims. A minuscule proportion of 0.3% households reported to be following religions other than the above two.



Though, all the villages covered were predominantly populated by Hindu families, it would be pertinent to highlight that in certain districts including Moradabad(29%), J.P Nagar (27%) and Basti (27%) the proportion of Muslims was reportedly higher than the overall average.

#### 3.3.2 Caste Profile:

The caste profile of the sampled households was assessed to identify the representation of socially disadvantaged groups across the rural communities studied in sampled districts. In terms of overall representation of households from various categories, it was found that about two-fifth of the households belonged to the OBC category, a little over one-third belonged to Scheduled castes, and roughly one-fifth were reported to be from the General category. Though small, roughly 5% of the households were found to belong to the scheduled tribes. Thus, it may be surmised that the rural communities covered under the survey were predominantly constituted of the backward or socially disadvantaged communities.



The table ahead presents district-wise caste-profile of the sampled households.

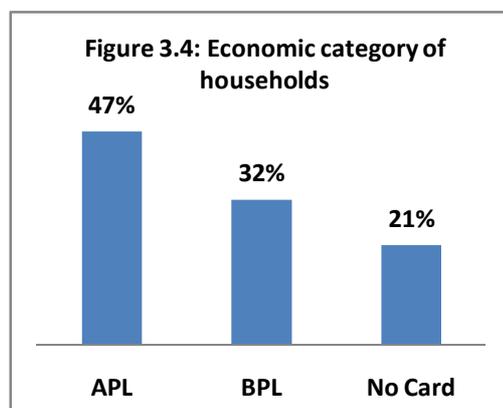
Table 3.5: Caste Profile of Sampled Households					
Districts	n	GENERAL	SC	OBC	ST
<b>Category A</b>					
Sultanpur	1181	26%	32%	41%	2%
Fatehpur	1161	16%	46%	29%	8%
<b>Category B</b>					
Ambedkarnagar	260	10%	42%	46%	2%
Banda	331	17%	34%	40%	9%
Basti	83	12%	8%	75%	5%
Chandauli	347	9%	52%	39%	0%
Hapur	244	29%	27%	35%	9%
J.P.Nagar	243	11%	30%	56%	4%
Kushinagar	593	18%	23%	59%	1%
Mau	251	14%	34%	48%	5%
Moradabad	82	32%	18%	49%	1%
Sant Ravidas Nagar	80	1%	38%	59%	3%
<b>Overall</b>	<b>4856</b>	<b>18%</b>	<b>36%</b>	<b>42%</b>	<b>4%</b>

Among the Category-A districts, Sultanpur exhibited higher proportion of OBC households, while in Fatehpur a considerable majority of households belonged to the scheduled caste. The representation of ST category of households was higher in Fatehpur. Overall, Fatehpur displayed higher proportion of disadvantaged category households among the rural communities covered under the survey.

Further, as regards category-B districts, Basti (75%), Kushinagar (59%) and Sant Ravidas Nagar (59%) had a significantly higher proportion of households belonging to OBC category. A considerable proportion of households in Moradabad (32%) and Hapur (29%) belonged to the General category. The population of Chandauli predominantly belonged to SC and General category. Banda & Hapur reported a comparatively higher representation of ST category households.

### 3.3.3 Economic category:

The respondents were probed about their economic category whether they were APL or BPL. The classification of families was done on the basis of type of ration cards available with them. It was found that around one third (32%) of the households were found to be below poverty line, while about 47% household were Above the Poverty Line. It would be



worth mentioning here that a considerable proportion of 22% households were reported to have no ration cards, hence their economic status could not be confirmed.

District-wise analysis presented in table 3.6 ahead, revealed that among Category-A districts, Fatehpur exhibited a better condition with 66% of households reporting to be above poverty line as compared to 27% of such households in Sultanpur. Further, a wide disparity in economic status was observed among the Category-B districts as well. On one hand, where about 51% of households in Basti reported to be below poverty line. While on the other hand, it was reported that 70% of households were above poverty line in JP Nagar. Additionally, it was noted that more than one-third of the households in Banda (34%) and around one-fourth of the households in Sultanpur(27%) and Sant Ravidas Nagar(28%) displayed lack of any ration card.

<b>Table 3.6: Economic Status of Sampled Households</b>			
<b>Districts</b>	<b>Proportion of APL</b>	<b>Proportion of BPL</b>	<b>Proportion having no Card</b>
<b>Category-A Districts</b>			
SULTANPUR	27%	46%	27%
FATEHPUR	66%	17%	18%
<b>Category-B Districts</b>			
AMBEDKARNAGAR	34%	43%	24%
BANDA	43%	23%	34%
BASTI	24%	51%	25%
CHANDAULI	35%	46%	19%
HAPUR	63%	18%	20%
J.P. NAGAR	70%	11%	19%
KUSHINAGAR	48%	34%	17%
MAU	45%	41%	14%
MORADABAD	65%	15%	21%
SANT RAVIDAS NAGAR	46%	26%	28%

### **3.3.4 Educational Qualification:**

As the head of the households act as major decision makers or influencers in the family, the study attempted to assess their educational status. The table ahead presents the details of the educational status of head of households covered under the survey.

Table 3.7: Educational Qualification of head of Households						
Districts	1 TO 5	6 TO 8	9 TO 10	11 TO 12	Grad & Above	Illiterate
<b>Category A</b>						
Sultanpur	18%	22%	16%	7%	5%	32%
Fatehpur	17%	17%	18%	6%	5%	36%
<b>Category B</b>						
Ambedkarnagar	14%	15%	17%	10%	6%	39%
Banda	19%	19%	19%	6%	3%	33%
Basti	19%	13%	12%	11%	2%	42%
Chandauli	10%	12%	22%	11%	5%	40%
Hapur	12%	17%	29%	11%	7%	24%
J.P.Nagar	12%	21%	18%	10%	7%	33%
Kushinagar	15%	18%	20%	7%	5%	35%
Mau	11%	16%	19%	10%	8%	36%
Moradabad	12%	20%	20%	5%	5%	37%
Sant Ravidas Nagar	16%	6%	14%	15%	9%	40%
<b>Overall</b>	<b>16%</b>	<b>18%</b>	<b>19%</b>	<b>8%</b>	<b>5%</b>	<b>35%</b>

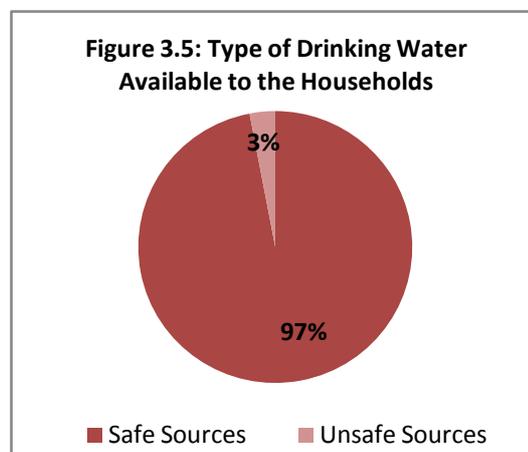
It would be pertinent to highlight that over one-third of head of households were found to be illiterate, and about 16% were educated between classes 1 & 5. This reflects that a wide proportion of heads of households were not educationally empowered enough. This is bound to have a considerable impact on the decision making and redressal seeking behaviour of people in the targeted communities.

### 3.4 Availability of Basic Infrastructure and Assets with the Sampled Households:

This segment attempts to describe the status of sampled households in terms of availability of basic infrastructural facilities with the households, including major source of drinking water, availability of toilet, electricity connection, etc. Further, the households have been described in terms of availability of key assets including both movable and immovable assets which are reflective of their economic status.

#### 3.4.1 Source of Drinking Water:

The availability of water is of prime importance for existence of human life and the quality of water has a direct bearing on the health status of the community. Thus it was pertinent to study the status of availability of safe drinking water to the community. In this context, the households were enquired about the main sources of drinking water. The graph alongside presents the



distribution of households in villages in terms of the type of drinking water source that they are currently using.

When probed about the major source of drinking water being utilized by the households, it was found that a majority of households were using safe sources like piped water supply, handpumps and tube well/ bore wells. While, a small proportion of the households also reported to be dependent on unsafe water sources like protected/ unprotected wells. The table hereunder presents the district-wise details about the major source of drinking water for the sampled households.

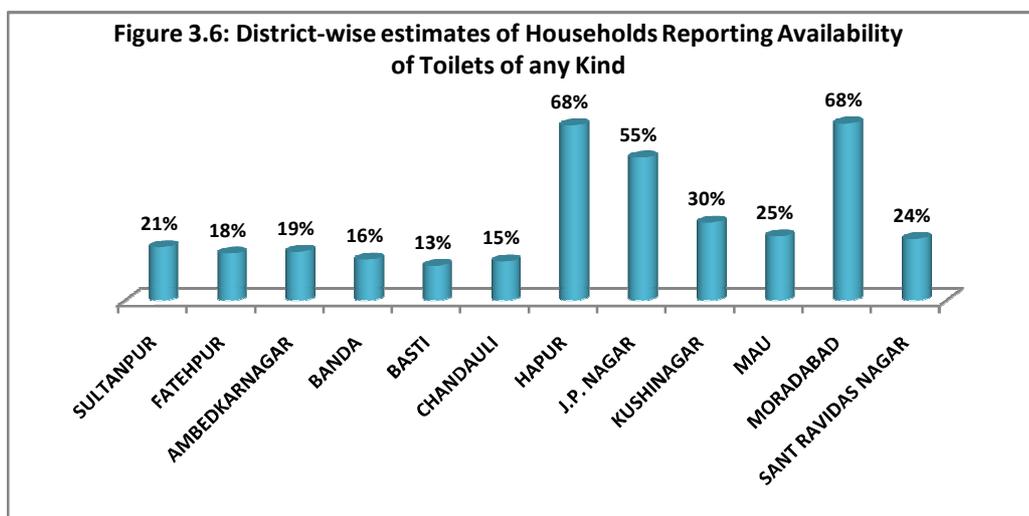
<b>Table 3.8: Major Sources of Drinking Water for the Sampled Households</b>					
<b>Districts</b>	<b>N</b>	<b>Piped Water Supply</b>	<b>Personal Handpump/ tube well</b>	<b>Community Handpump</b>	<b>Protected /Unprotected Wells</b>
<b>Category-A Districts</b>					
SULTANPUR	1181	2.4%	59.8%	35.1%	2.7%
FATEHPUR	1161	3.7%	13.0%	76.2%	7.1%
<b>Category-B Districts</b>					
AMBEDKARNAGAR	260	0.0%	85.0%	85.0%	0.8%
BANDA	331	3.6%	20.5%	20.2%	2.2%
BASTI	83	2.4%	94.0%	94.0%	0.0%
CHANDAULI	347	0.0%	44.7%	44.7%	6.9%
HAPUR	244	4.1%	76.7%	73.0%	0.3%
J.P. NAGAR	243	1.2%	85.1%	83.5%	0.1%
KUSHINAGAR	593	0.4%	90.2%	90.2%	0.8%
MAU	251	1.2%	82.9%	82.1%	0.0%
MORADABAD	82	1.2%	82.9%	82.9%	0.0%
SANT RAVIDAS NAGAR	80	0.0%	31.3%	28.8%	8.7%

Among the Category-A districts, it was noted that a significant proportion of households of Fatehpur were dependant on unsafe sources of drinking water, that is, protected/unprotected wells (7.1%). Usage of such unprotected sources was also noted to be significant in districts like Chandauli, Sant Ravidas Nagar and Banda.

### **3.4.2 Availability of toilets:**

Availability of toilets is also looked at as one of the key criteria that needs to be assessed as it has wide ramifications on the health of individual household members as well as community. The sampled respondents were enquired about the availability of toilets in their households. The responses obtained reflected that a vast majority of about three-fourth of households did not have any toilet, which is indicative of the

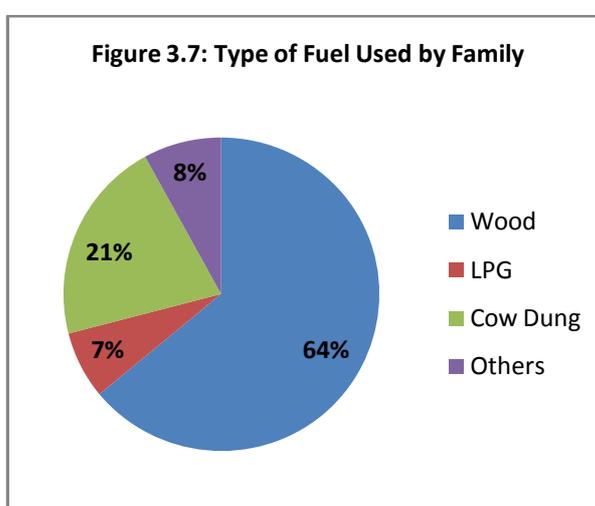
common prevalence of the practice of open defecation. Among the category-A districts, over 80% households reported absence of toilets and in the category-B districts, 69% reported unavailability of toilet within the household. The district-wise estimates of households reporting availability of any type of toilets is presented in the figure hereunder –



As shown in the figure above, among Category-A districts, only 18% of households in Fatehpur and 21% in Sultanpur reported to have any kind of toilet within the households. Among category-B districts, the western districts of Hapur, JP Nagar and Moradabad exhibited better status with more than half of the households reporting presence of toilets. The condition of districts like Basti, Banda, Chanduali and Amberdkarnagar was very poor in this regard with less than 20% households affirming availability of toilets.

### 3.4.3 Fuel used for cooking:

The respondents were asked about the type of fuel used for cooking in their households. The overall trend of type of fuel used by households has been depicted in the figure alongside. As evident, there is still a wide majority of 64% households that use wood as a fuel, while cow dung cakes emerged as the second prominent choice with



21% respondents reporting to be using for cooking purposes. LPG was being used by a mere 7% of the households, while remaining 8% used other material such as Crop residue, grass/shrub, biogas, coal, etc. This is a pertinent finding given the impact of fuel on the health status of households.

The district-wise findings pertaining to usage of different types of fuel has been tabulated in the following table:

<b>Table 3.9 : Type of Fuel used by the Households for cooking</b>					
<b>Districts</b>	<b>N</b>	<b>Wood</b>	<b>Animal Dung</b>	<b>LPG</b>	<b>Others</b>
<b>Category A</b>					
<b>Sultanpur</b>	1181	61%	25%	6%	8%
<b>Fatehpur</b>	1161	82%	7%	5%	7%
<b>Category B</b>					
<b>Ambedkarnagar</b>	260	59%	27%	5%	9%
<b>Banda</b>	331	71%	22%	2%	5%
<b>Basti</b>	83	48%	31%	12%	9%
<b>Chandauli</b>	347	54%	33%	8%	6%
<b>Hapur</b>	244	55%	22%	17%	6%
<b>J.P.Nagar</b>	243	44%	37%	10%	9%
<b>Kushinagar</b>	593	60%	15%	16%	9%
<b>Mau</b>	251	53%	28%	6%	13%
<b>Moradabad</b>	82	44%	40%	12%	4%
<b>Sant Ravidas Nagar</b>	80	60%	23%	0%	17%

It is quite evident from the table, 64% of the households were using wood for cooking, another 21% respondents were dependent on animal dung as the source for cooking food. Only 8% households were using LPG for cooking. Rest of the households were using electricity, natural gas, bio gas or grass for cooking.

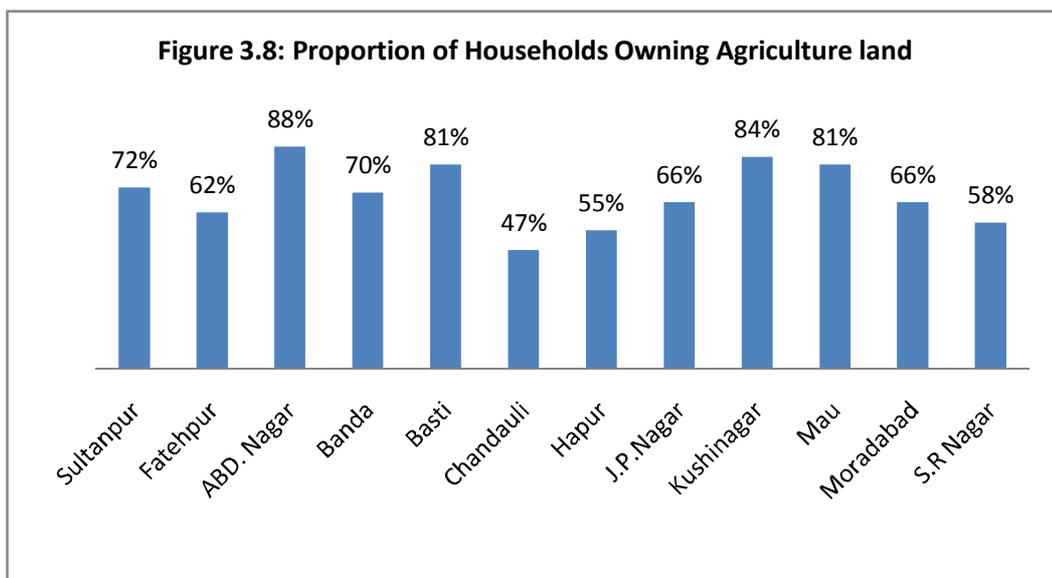
#### **3.4.4 Place of cooking:**

When probed about the place of cooking, about 86% of the households affirmed that cooking was usually done within their houses. About 8% of the respondents mentioned that they cook in a separate building. Rest of the 6% households stated that they cook food outdoors.

On further probing, it was brought to light that only one-fourth (25%) of the households had separate room which was used as kitchen. In Hapur, around 47% households had kitchen in their homes. On the contrary, in Chandauli only 16% households confirmed having kitchen in their households.

### 3.4.5 Agriculture land:

Assessment of economic status of the households also delved into the ownership of agricultural land by the household. Overall, over two-thirds of the households (69%) affirmed having their own agricultural land. The district-wise details are given in the table ahead:



As shown in the figure above, among category-A households lesser proportion of households owned agricultural land as compared to Sultanpur. Among category-B districts, more than 80% households in districts Ambedkarnagar, Basti, Kushinagar and Mau had agricultural land available with them. On the other extreme, merely 47% households in Chandauli district had agricultural land with them.

Furthermore, it was highlighted that 65% households across 12 districts owned livestock, poultry or any other farm animals. Majorly, 78% households in Sant Ravidas Nagar district had their own livestock or other farm animals.

### 3.4.6 Asset Ownership:

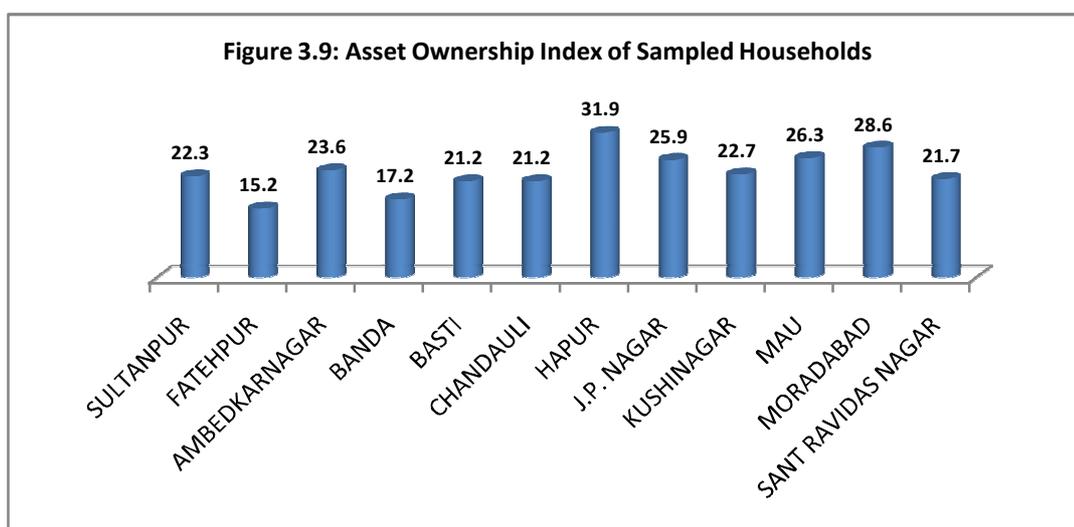
Examination of asset ownership formed another important area of investigation for the study. The households were asked about the availability of various types of household and agricultural assets in the family. An Asset Ownership Index was created using the formula given ahead for comparing the districts on this criteria. The asset ownership index (AOI), which is defined as the average of the proportions of households reporting ownership of individual items under a given asset category, enables the comparison of the asset bases among different groups of households.

$$AOI = \left( \frac{\sum_{i=1}^{i=n} P_i(I_i)}{n} \right)$$

Where—

- $P_i(I_i)$  : Proportion of households reporting ownership of  $i^{\text{th}}$  item under a given asset category
- $n$  : Number of items under a given asset category

Thus, in order to compare the relative asset bases among the households in different districts, the district-wise asset ownership indices pertaining to household assets including daily use assets (like pressure cooker, sewing machine, electric fan, television, mobile phone, fixed/other phone, fridge, radio, computer, bicycle and motor cycle) and agricultural assets (thresher, tractor, pump-set, etc) have been estimated. Table 3.9 ahead illustrates district-wise asset ownership indices for households sampled across 12 districts.



In terms of asset ownership, district Fatehpur lagged far behind the other districts with an asset index of 15.2. Districts Hapur and Moradabad appeared best among the lot with asset ownership index reaching 31.9 and 28.6 respectively.

### 3.5 Characteristics of Anganwadi Centre:

During the survey, a total of 240 Anganwadi workers were interviewed across 12 districts to gauge the status of human resource and infrastructural facilities at Anganwadi centres.

#### 3.5.1 Location of Anganwadi Centres:

Assessment of Anganwadi centres delved into the location characteristics, to be able gauge the accessibility of AWCs. About 70% of the Anganwadi centres were located at

the corner of the villages. About three-fourth (75%) of the Anganwadi workers in intervention villages confirmed to have Anganwadi centre located at the corner of the village as against 63% of those in regular villages. Almost all the Anganwadi centres in Hapur district were located at the corner of the village.

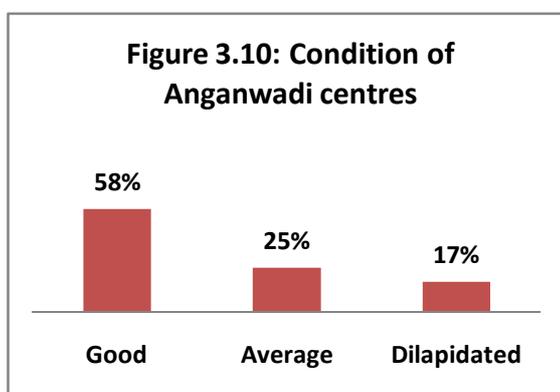
### 3.5.2 Type of AWC Building:

The AWCs were further assessed to examine the type of building in which they were housed. On-site observation revealed that on the whole, a vast majority of 2 in every three AWCs were located in the school building, 15% had own ICDS building, and 8% were located in panchayat building. Of the remaining, some were housed in AWWs house, in a private building, a religious or community building. The district-wise details of the type of AWC building are given ahead –

Table 3.10 : Building in which Anganwadi Centre was Housed (in Numbers)					
DISTRICTS	N	In a school	Own ICDS Building	In Panchayat Building	Others
<b>Category-A Districts</b>					
SULTANPUR	60	47	2	5	6
FATEHPUR	60	40	5	6	9
<b>Category-B Districts</b>					
AMBEDKARNAGAR	12	7	2	2	1
BANDA	16	14	0	0	2
BASTI	4	1	2	0	1
CHANDALI	16	11	2	1	2
HAPUR	12	6	5	1	0
J.P.NAGAR	12	7	5	0	0
KUSHINAGAR	28	16	9	1	2
MAU	12	5	1	1	5
MORADABAD	4	3	1	0	0
SANT RAVIDAS NAGAR	4	1	1	1	1

### 3.5.3 Condition of AWC Building:

The observation of AWC building was also done to assess the condition of AWC building to assess its suitability for use. Overall, 58% AWCs were found to be in good condition, 25% were assessed as average in condition, while a considerable proportion of 17% AWCs were found to be in dilapidated state, requiring



repairs. In Sultanpur, out of 60, the condition of 39 Anganwadi centres was good. However, in Sant Ravidas Nagar and Basti the situation was not good with just one of four Anganwadi centres were found in good condition.

### 3.6 Profile of Anganwadi Workers:

During the study, a total of 240 Anganwadi workers were interviewed for gathering relevant information and inputs in context of the services provided and their level of participation in the community. This portion gives a brief description of the general, educational profile of the Anganwadi workers interacted during the assessment as given ahead —

#### 3.6.1 Age profile:

The data pertaining to age of AWWs interviewed was analyzed to find that about half (49%) of AWWs belonged to belonged to 31 to 40 years age group. While about one in every five belonged to 41 to 50 years age group. In the younger lot, that is AWWs between 20 to 30 years age group, only 11% Anganwadi workers were found.

#### 3.6.2 Place of Residence:

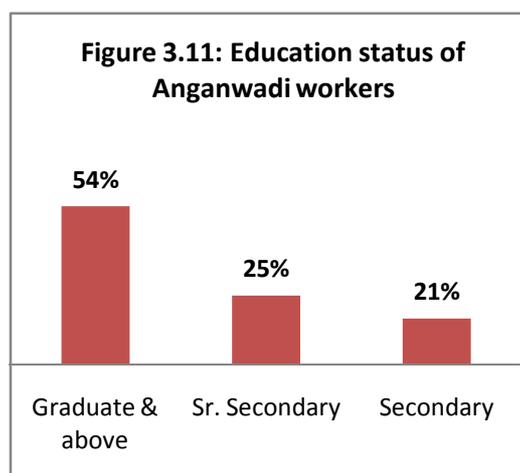
The AWWs were probed about the place where they resided, that is, whether they resided within the village or came from some other village. As the place of residence of AWW has some bearing on the regularity of AWWs, it was considered pertinent to assess this feature. Overall, around four-fifth of the Anganwadi workers (79%) lived in the same village in which the Anganwadi centre was situated. Table 3.10 ahead presents district-wise details in this regard.

<b>Table 3.11: Proportion of AWWs Residing in the Same Village where AWC is Located</b>	
<b>DISTRICTS</b>	<b>Value</b>
<b>Category-A Districts</b>	
<b>SULTANPUR</b>	53 of 60
<b>FATEHPUR</b>	45 of 60
<b>Category-B Districts</b>	
<b>AMBEDKARNAGAR</b>	9 of 12
<b>BANDA</b>	12 of 16
<b>BASTI</b>	2 of 4
<b>CHANDAULI</b>	14 of 16
<b>HAPUR</b>	8 of 12
<b>J.P.NAGAR</b>	10 of 12
<b>KUSHINAGAR</b>	27 of 28
<b>MAU</b>	5 of 12
<b>MORADABAD</b>	3 of 4
<b>SANT RAVIDAS NAGAR</b>	2 of 4

Among Category-A districts, only 75% of AWWs of Fatehpur resided in the same village, while 88% of them in Sultanpur were the residents of the same village where AWC was located. In Kushinagar, 96% AWWs informed to be residing in the same village, while on the other extreme, only 42% of AWWs of Mau reported to be doing so.

### 3.6.3 Educational Status:

Educational status is one of the key determinants of AWWs' awareness and knowledge about her work areas, and her performance in the same. The sampled AWWs were examined to assess their educational status. Overall, it was encouraging to note that 54% of the Anganwadi workers were at least Graduates. Another 25% of the Anganwadi workers had completed their senior secondary education and the remaining 21% of the Anganwadi workers had completed their secondary schooling.



The table ahead indicates the education level of workers across 12 districts. It is to be noted that the Anganwadi workers in Ambedkarnagar, Moradabad and Sant Ravidas Nagar districts were more educated and well versed in comparison to other Anganwadi workers.

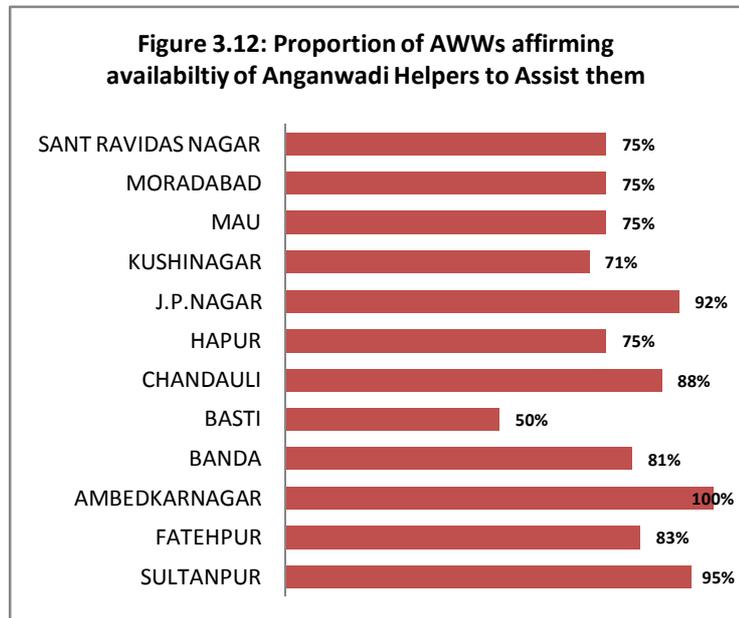
Table 3.12: Educational status of Anganwadi workers (in Numbers)				
Districts	N	Secondary	Senior Secondary	Graduate & above
<b>Category-A Districts</b>				
Sultanpur	60	10	14	36
Fatehpur	60	10	11	39
<b>Category-B Districts</b>				
Ambedkarnagar	12	0	4	8
Banda	16	6	4	6
Basti	4	1	1	2
Chandauli	16	3	5	8
Hapur	12	6	4	2
J.P.Nagar	12	4	0	8
Kushinagar	28	9	9	10
Mau	12	1	4	7
Moradabad	4	0	2	2
Sant Ravidas Nagar	4	0	3	1

### 3.6.4 Total Experience as AWWs:

In order to get a clear view about the years of association, Anganwadi workers were asked about the total years of work experience as AWW. It was highlighted that 52% of Anganwadi workers had been working for less than 10 years. Around 22% of the Anganwadi workers were reported to have 11 to 15 years of experience. Another 15% Anganwadi workers were into this service for past 16 to 20 years. There were instances where 4 Anganwadi workers reported to have had an experience of more than 30 years.

### 3.6.5 Availability of Anganwadi Helpers:

The Anganwadi helper is responsible for assisting Anganwadi worker in conducting various activities and providing services to the community. Overall, 85% of the Anganwadi workers interviewed, reflected that they had Anganwadi Helpers in place to assist them in performing all the routine activities efficiently and effectively. Figure 3.12 presents district-wise status in this regard. Ambedkarnagar district was the only district in which all the Anganwadi centres had Anganwadi helpers for assistance.



## 3.7 Profile of ASHA Workers:

As mentioned in the preceding section of this document, a total of 236 ASHAs were interviewed across 12 districts to gather relevant information pertaining to the services provided by them for the welfare of the community. This section elaborates the general profile of ASHAs including age, educational qualification and work experience.

### 3.7.1 Age Profile:

The information obtained regarding the age of ASHA workers interviewed reveals that more than half (53%) of the ASHAs belonged to 31 to 40 years age group, while 28%

were aged between 20 to 30 years. Another 14% ASHAs belonged to 41 to 45 years age group and rest 6% ASHAs more than 46 years of age. Around 92% of ASHAs in Ambedkarnagar district belonged to 31 to 40 years age group. Few instances were also found in Sultanpur and Moradabad districts where ASHAs reported to be above 50 years of age.

### 3.7.2 Educational Status:

The educational background has a strong impact on the understanding of ASHAs regarding her duties and responsibilities, and the extent to which she is able to perform her tasks effectively. While interacting with ASHAs, it was found that overall, around three-fifth (61%) of ASHAs had only completed their secondary schooling. About 28% of ASHAs had completed their senior secondary schooling and only 11% ASHAs were graduate and above. The district-wise details are given ahead –

<b>Table 3.13: Educational Status of ASHAs (in Numbers)</b>				
<b>Districts</b>	<b>N</b>	<b>Secondary</b>	<b>Senior Secondary</b>	<b>Graduate &amp; above</b>
<b>Category-A Districts</b>				
<b>Sultanpur</b>	60	35	22	3
<b>Fatehpur</b>	56	37	12	7
<b>Category-B Districts</b>				
<b>Ambedkarnagar</b>	12	2	3	7
<b>Banda</b>	16	13	3	0
<b>Basti</b>	4	2	1	1
<b>Chandauli</b>	16	9	5	2
<b>Hapur</b>	12	10	2	0
<b>J.P.Nagar</b>	12	9	2	1
<b>Kushinagar</b>	28	19	8	1
<b>Mau</b>	12	5	4	3
<b>Moradabad</b>	4	3	1	0
<b>Sant Ravidas Nagar</b>	4	1	2	1

The table above clearly reflects that overall, a majority of ASHAs were less educated, having received education only up to class 10. There were some exceptions also, where on one hand, where 81% ASHAs in Banda and 83% of them in Hapur were only qualified up to class 10<sup>th</sup>. While on the other extreme, 58% ASHAs of Ambedkarnagar were found to be at least graduates.

### 3.7.3 Total Experience as ASHAs:

On enquiring about the work experience as ASHA, around 36% of the respondents stated to have an experience of more than 8 years. A majority of 57% ASHAs had 6-8 years' experience, while a small proportion of 5% ASHAs had an experience of 5 years or lesser. The table below provides details of the experience of ASHAs across 12 districts covered during the survey –

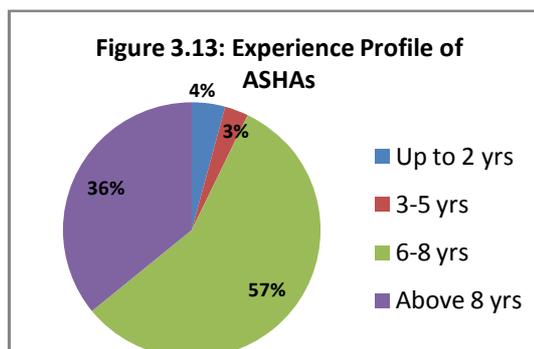


Table 3.14: Experience of ASHAs					
Districts	N	Up to 2 years	3-5 years	6-8 years	Above 8 years
<b>Category-A Districts</b>					
Sultanpur	60	0	2	33	25
Fatehpur	56	3	1	34	18
<b>Category-B Districts</b>					
Ambedkarnagar	12	0	0	9	3
Banda	16	0	0	10	6
Basti	4	0	0	1	3
Chandauli	16	0	3	10	3
Hapur	12	2	0	6	4
J.P.Nagar	12	2	1	5	4
Kushinagar	28	3	0	13	12
Mau	12	0	0	10	2
Moradabad	4	0	0	2	2
Sant Ravidas Nagar	4	0	0	2	2

### 3.8 Characteristics of Sub-Centres:

Assessment of basic characteristics of ANM Sub-centres also formed an important area of investigation under this study. Presented ahead are basic characteristics observed or recorded for Sub-centres related to sampled villages.

#### 3.8.1 Location of Sub-centre:

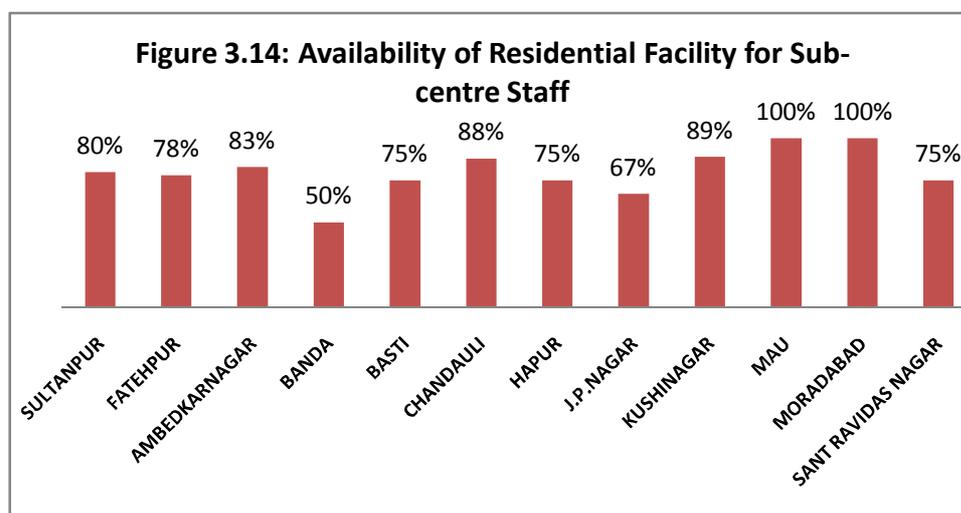
It was found that three-fourth of the sub-centres were functioning in the Government building provided for the centre. Around 15% of them were functioning in rented buildings and 3% of sub centres were operating in some other Government buildings.

Table 3.15 : Buildings where Sub-Centres were Housed (in Numbers)					
Districts	N	Own Govt. Building	Rented Building	Other Govt. Building	Others
<b>Category-A Districts</b>					
Sultanpur	60	43	10	3	4
Fatehpur	60	47	9	1	3
<b>Category-B Districts</b>					
Ambedkarnagar	12	7	3	0	2
Banda	16	11	4	1	0
Basti	4	3	0	0	1
Chandauli	16	15	1	0	0
Hapur	12	7	3	1	1
J.P.Nagar	12	10	2	0	0
Kushinagar	28	22	2	0	4
Mau	12	11	1	0	0
Moradabad	4	2	2	0	0
Sant Ravidas Nagar	4	3	0	0	1

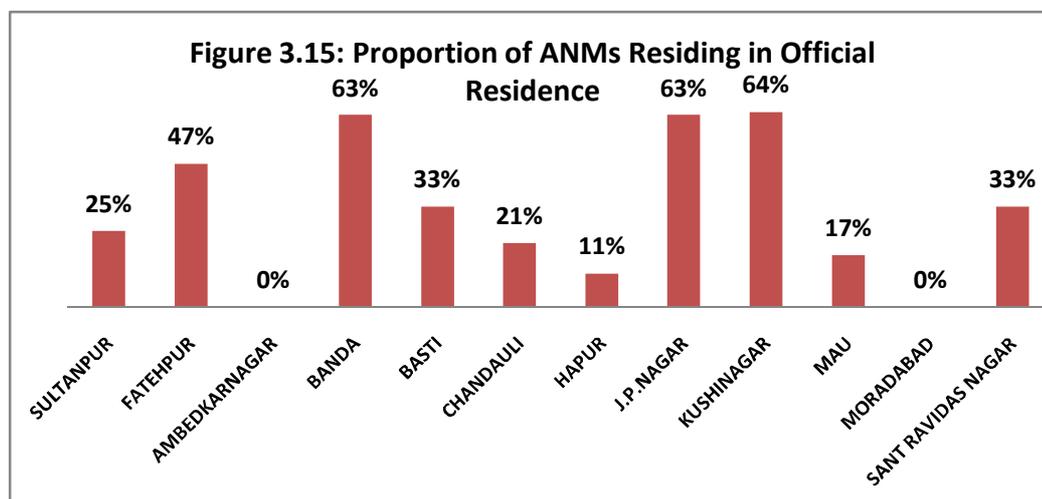
It is quite evident from the table above, 94% Sub-centres in Chandauli district, followed by 92% Sub-centres in Mau district were functioning in their own government building. On the contrary, 2 out of 4 Sub-centres in Moradabad were operating in rented building.

### 3.8.2 Availability of Residential Facility for Sub-Centre Staff:

When probed about the availability of residential facility for the sub-centre staff, 80% of ANMs affirmed that residential facility was available. 100% ANM in Mau and Moradabad districts confirmed that residential facility was provided to Sub-centre staff. The graph below shows the details of the residential facility across various districts:



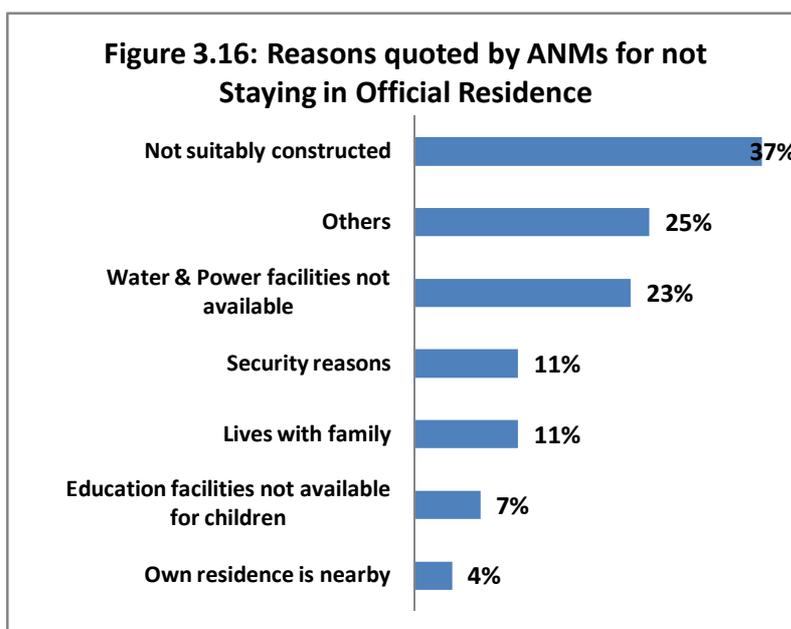
Furthermore, when probed if ANMs were residing in the facility provided for the Staff, it was brought to notice that out of 191 ANMs who agreed upon availability of residential facility, only 36% admitted that they were residing in the official residence allotted to them. The details are given ahead—



In order to clarify whether ANM's official residence lies in the same village in which Sub-centre is located, questions were asked from ANMs. It was informed by 30% ANMs who were residing in the official residence that they were residing in the Sub-centre village.

### 3.8.3 Reason for not Staying in Official Residence:

The ANMs who denied staying at the residence provided for staff were probed about the reasons why they were not using the residence provided. In response to this, the main reason quoted by 37% ANMs for not staying in the



official residence provided was that the residence was not suitably constructed.

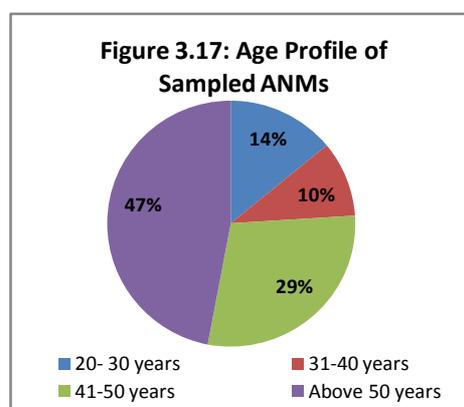
Another 23% ANMs stated that the water and power facilities were not available. Around 11% ANMs mentioned that they were living with their families and another 11% stated that due to security reasons they were not staying in the official residence provided to them.

### 3.9 Profile of ANMs:

During the study, a total of 240 ANMs were interviewed for gathering relevant information regarding human resources, infrastructural facilities and general profile of the ANMs.

#### 3.9.1 Age profile:

The data pertaining to age of ANMs was assessed under the study. Figure 3.17 shows the findings obtained in this regard. It would be worth highlighting here that a little less than half of the ANMs were above 50 years of age which is indicative of the level of expertise and experience that these functionaries would have gained in their lifetime. 29% of ANMs were aged between 41-50 years, 10% between 31-40 years and 14% between 20-30 years of age.



#### 3.9.2 Educational status:

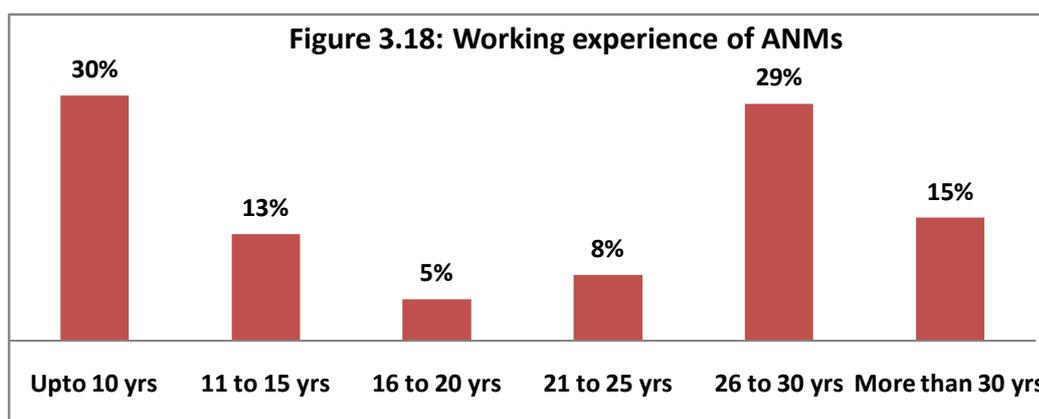
The educational background of an individual has a strong impact on the perception and level of understanding on various issues. While analyzing the profile of ANMs, it was observed that 45% of the ANMs interviewed had completed their senior secondary schooling, around 28% ANMs were at least graduates and rest of the 27% ANMs had completed their secondary schooling or were qualified below that standard. The details of the educational profile of ANMs is listed in the table ahead –

Table 3.16: Educational status of ANMs (in Numbers)				
Districts	N	Secondary	Senior Secondary	Graduate & above
<b>Category A</b>				
Sultanpur	60	14	26	10
Fatehpur	60	18	32	10
<b>Category B</b>				
Ambedkarnagar	12	3	5	4
Banda	16	7	5	4
Basti	4	1	3	0
Chandauli	16	4	10	2

Table 3.16: Educational status of ANMs (in Numbers)				
Districts	N	Secondary	Senior Secondary	Graduate & above
Hapur	12	4	5	3
J.P.Nagar	12	1	6	5
Kushinagar	28	10	9	9
Mau	12	2	6	4
Moradabad	4	1	0	3
Sant Ravidas Nagar	4	0	2	2

### 3.9.3 Work Experience as ANM:

On enquiring about the working experience, 30% ANMs informed that they were working as ANM for less than ten years and another 29% ANMs stated that they were associated with this role for 25 to 30 years. A considerable proportion of 15% ANMs reported to have been working for more than 30 years. The graph below shows the experience of ANMs working across 12 districts covered under survey –



The above chapter brought to light some important features of the sampled respondents, which would be pertinent to understand their behaviors being studied in the succeeding sections of this report.

# STATUS OF MATERNAL HEALTH **4**

As described in the preceding sections of this document, the mothers of children less than five years of age were the primary respondent for the Household Survey. The mothers in sampled households were interviewed using a structured CAPI based questionnaire on various maternal and child health care aspects to gain an insight into the health seeking behavior of the households and the extent of utilization of health services by the families. The mothers were asked about the services received during the last pregnancy and child birth. The data gathered from the field has been analyzed and presented in the following chapter.

## 4.1 Maternal Mortality Ratio:

In order to know about the occurrence of deaths due to pregnancy or its complications in the sampled villages, the Village Pradhans were asked about the number of maternal deaths that had taken place in their village in the last 2 years preceding the survey. The data obtained against this query was utilized to get an estimate of the maternal mortality ratio in the sample. Since the sample varied across different districts with number of villages ranging from 4 to 60 per district, therefore, district wise data was insufficient to calculate the MMR. The table presented ahead shows the MMR of the overall sample, Category-A and Category-B districts.

The overall MMR of 12 districts was estimated to be 302 as per the information provided by Village Pradhans. In Category-A districts (Fatehpur and Sultanpur), the MMR was high (386). It is important to mention here that the Category-A districts also fare poorer in other socio-economic and health

<b>Parameters</b>	<b>Maternal Mortality Ratio</b>
<b>Overall</b>	<b>302</b>
<b>Category-A Districts</b>	386
<b>Category-B Districts</b>	226

indicators as compared to Category-B districts. Furthermore, as would be explained later, Fatehpur demonstrated the highest percentage of home deliveries (one-third) and lowest percentage of safe deliveries (two-thirds). In Category-B districts there were many districts that had a better socio-economic and developmental profile.

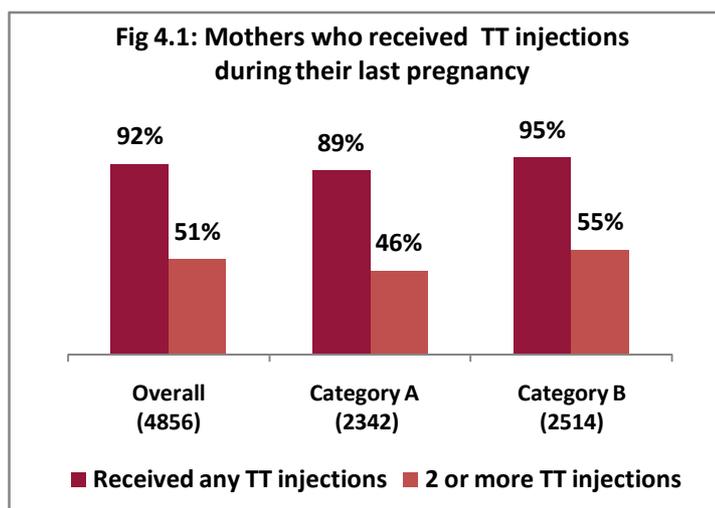
The sections henceforth portray the findings regarding the services sought and received by sampled mothers of children under 5 years of age during her last pregnancy and delivery.

## 4.2 Services Received during Pregnancy

In order to understand the health seeking behavior of the families in sampled districts and their preferences and consciousness about the various health services required during pregnancy, the mothers were probed in detail on the type of services availed by them during their last pregnancy. Since the survey entailed capturing pregnancy and delivery details of mothers and health details of children below 5 years of age, therefore, the time duration from 1<sup>st</sup> January 2010 to 31<sup>st</sup> December 2014 was set as reference period for these queries.

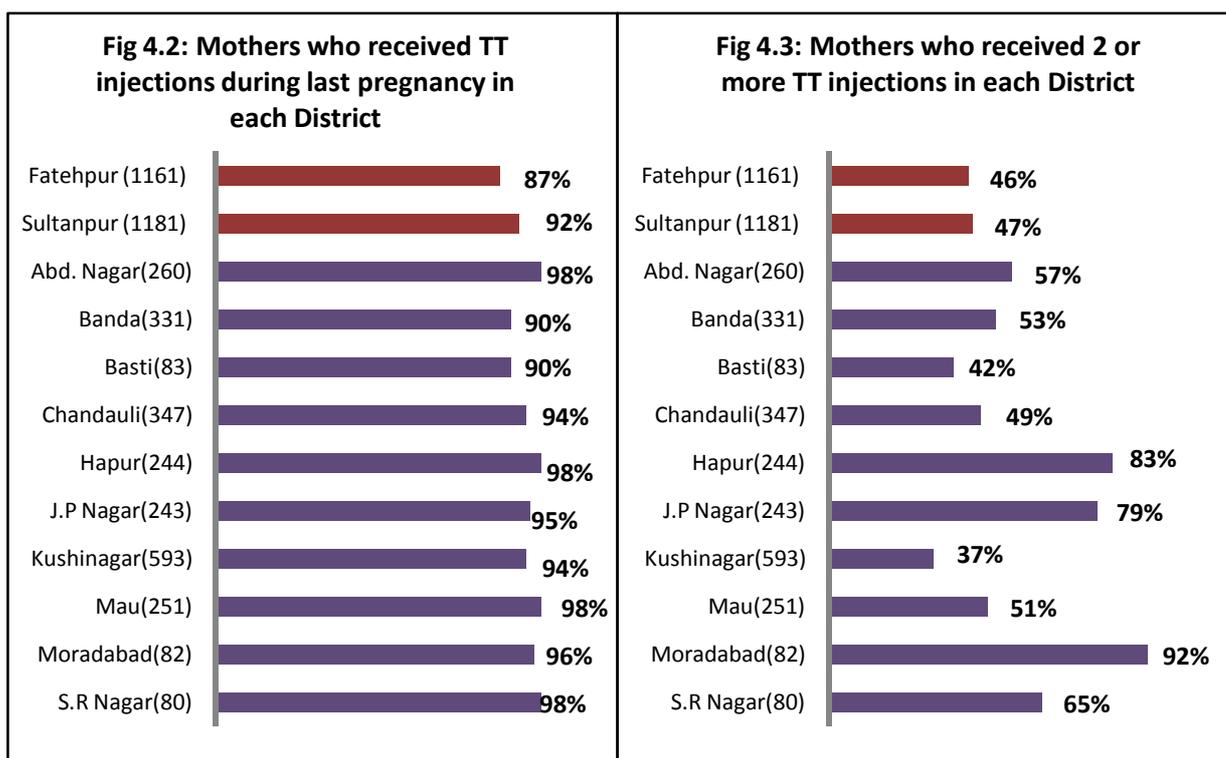
### 4.2.1 Tetanus Toxoid (TT) Injection:

The mothers of sampled households were probed to know whether they had received TT injections during their last pregnancy. TT injections act as a prevention to future possibilities of tetanus. The table alongside provides details of receipt of TT injection by



mothers in Category-A and B districts. Overall, more than 90% of the mothers affirmed that they had received TT injections during their last pregnancy. Category-A districts (Fatehpur & Sultanpur) reported a lower percentage of mothers receiving TT injection than Category-B districts. However, only about one-half of the sampled mothers reported to have received 2 or more TT injections.

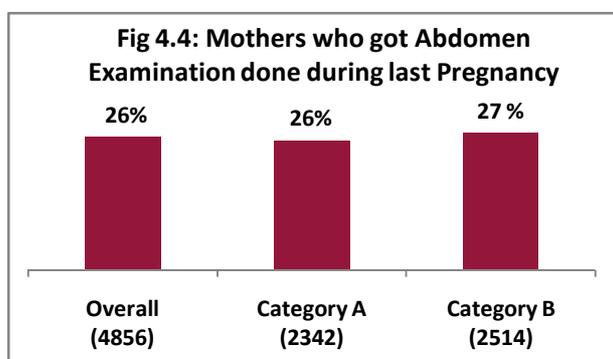
The district-wise proportion of mothers having received any TT injection and those having received 2 or more TT injections has been presented in the chart ahead:



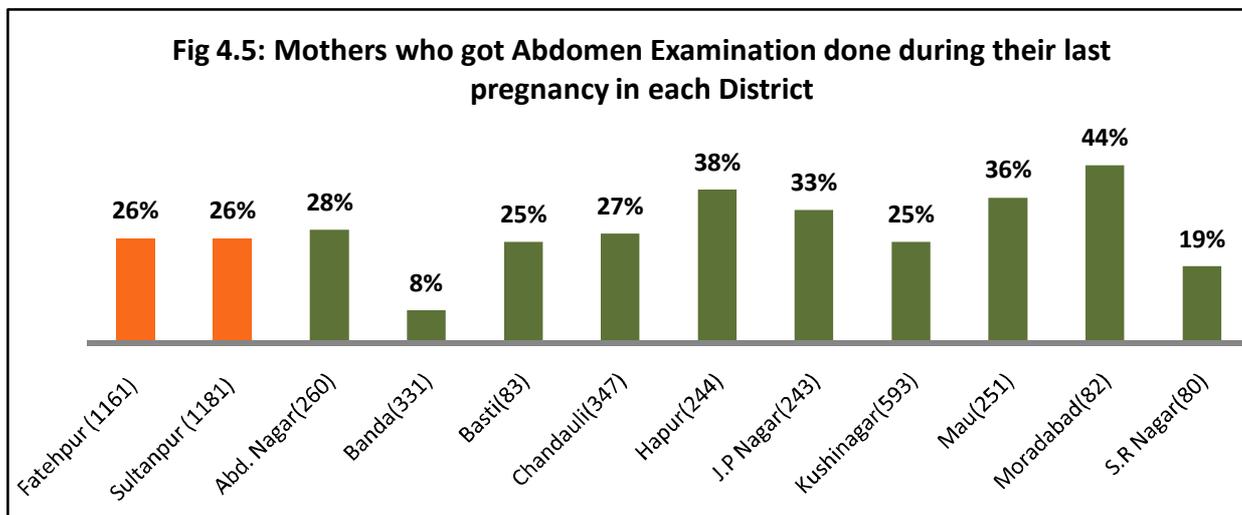
As evident from the chart above, among category-A districts, in Sultanpur more than 90% mothers reported to have received TT injection whereas in Fatehpur, the proportion was slightly less. Among the 10 Category-B districts, comparatively Banda and Basti (90%) reported a slightly lower percentage of TT injection than other 8 districts. When probed about the number of TT injections received, it was found that less than one-half of the mothers in Sultanpur and Fatehpur had received 2 or more injections according to the data reported from the field. Among category-B districts, the estimates were on the higher side in Moradabad, J.P.Nagar and Hapur.

#### 4.2.2 Abdomen Examination:

The sampled mothers were enquired if they had received abdomen examination during their last pregnancy. The chart presented alongside shows that overall, about one-fourth of the mothers in both Category-A and Category-B districts reported that they had undergone abdomen examination during last pregnancy.



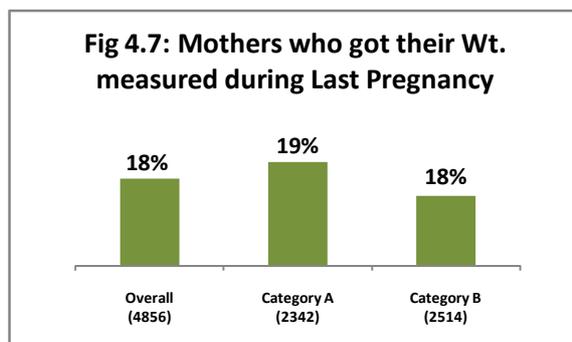
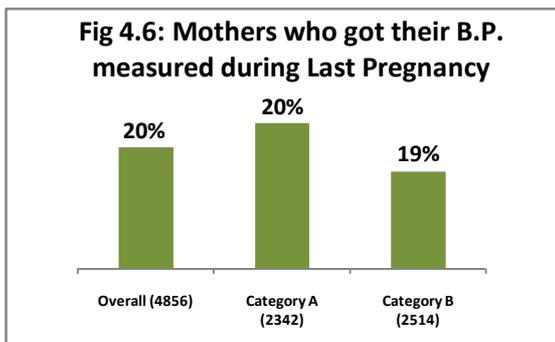
Above details have been expanded district-wise in the following chart to get a clear picture of the service uptake in each of the 12 surveyed districts.



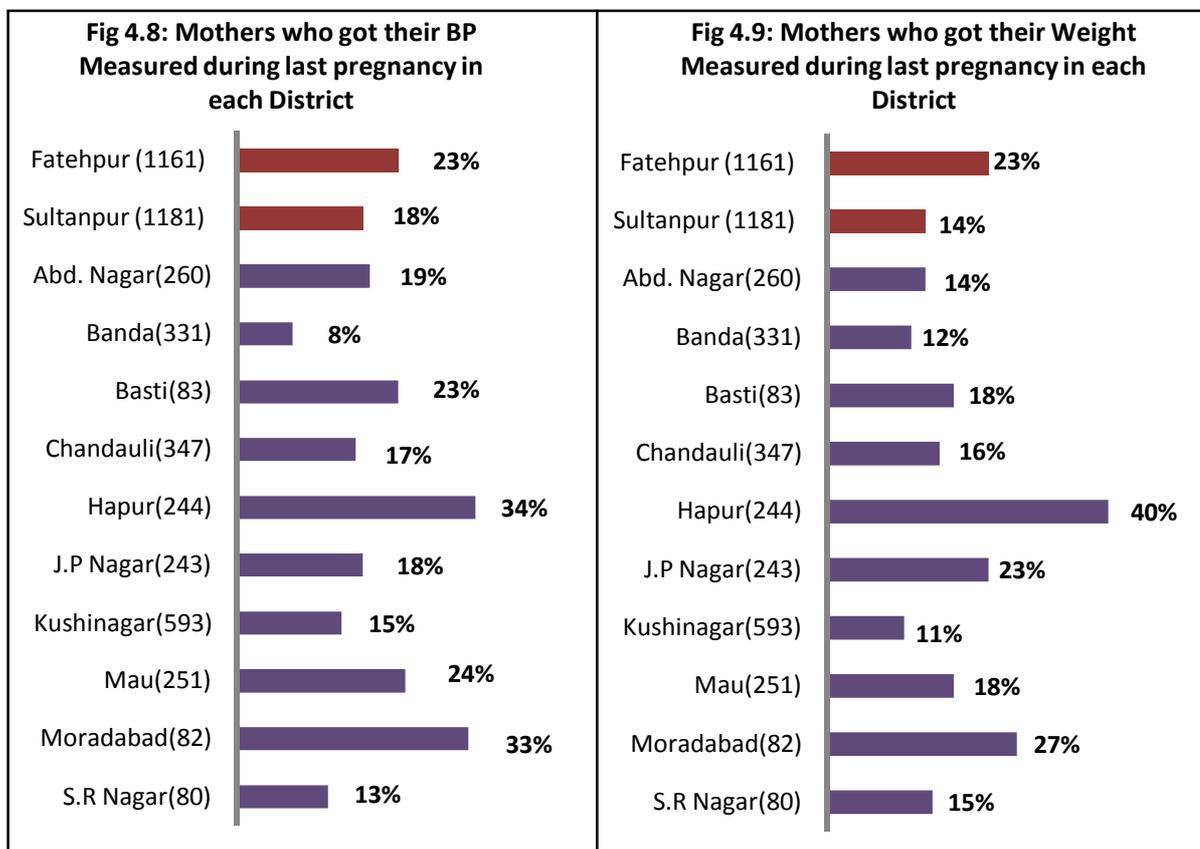
The above chart indicates that Banda recorded the lowest performance (8%) in terms of sampled mothers undergoing abdomen examination during their last pregnancy. In contrast, Moradabad reported the highest proportions (44%). The low proportions in Banda may be attributed to the fact that it lags behind the other districts in terms of general socio-economic characteristics which is bound to have an impact on the populations' health seeking behavior. In both the Category-A districts, Sultanpur and Fatehpur, 26% of the sampled mothers confirmed that they had undergone abdomen examination.

#### 4.2.3 Blood Pressure and Weight Measurements:

The interviews with the mothers also sought to know about the status of receipt of services like blood pressure measurement and weight monitoring under antenatal care during pregnancy. The mothers were asked if their blood pressure and weights were checked during their last pregnancy. The following chart presents the details of the above query:



About one-fifth of the mothers reported that their blood pressure and weights had been measured during pregnancy. The figures for Category-A and Category-B districts were similar for both blood pressure and weight measurements.



As evident from the above charts, Fatehpur demonstrated a better performance than Sultanpur on the parameters of blood pressure and weight measurement of mothers during last pregnancy. About one-fourth of the mothers sampled in Fatehpur affirmed that their blood pressure had been measured. Similar percentage of mothers also affirmed to have got their weights checked. As also seen in other ANC services, the least proportion of mothers receiving ANC services like BP and weight measurements were reported in Banda while some of the highest were reported in Hapur and Moradabad. The high performance of the latter districts may be attributed to the fact that they have better socio-economic and development statistics than districts like Banda and Basti.

#### 4.2.4 Blood and Other Tests Required during Pregnancy:

The following chart presents the details of other major ANC services like blood examination for haemoglobin testing, urine test for albumin & sugar, and ultrasound examination received by mothers during their last pregnancy.

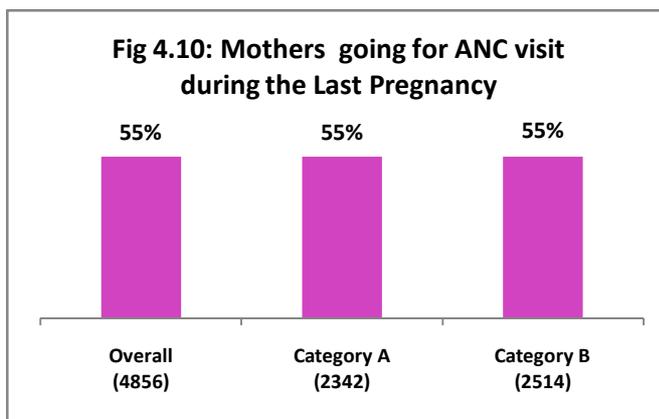
<b>Table 4.2: Mothers who had Received Other ANC services During Last Pregnancy</b>				
<b>PARTICULARS</b>	<b>n</b>	<b>Mothers who had undergone Blood test</b>	<b>Mothers who had undergone Urine test</b>	<b>Mothers who had got ultrasound done</b>
<b>Overall</b>	4856	29%	25%	34%
<b>Category-A Districts</b>	2342	28%	25%	29%
<b>Category-B Districts</b>	2514	30%	25%	38%
<b>DISTRICT-WISE STATUS</b>				
<b>Category-A districts</b>				
Sultanpur	1181	30%	24%	34%
Fatehpur	1161	26%	25%	24%
<b>Category-B districts</b>				
Ambedkarnagar	260	30%	25%	32%
Banda	331	14%	8%	9%
Basti	83	30%	24%	33%
Chandauli	347	23%	24%	29%
Hapur	244	48%	41%	65%
J.P. Nagar	243	38%	20%	62%
Kushinagar	593	27%	26%	37%
Mau	251	41%	35%	47%
Moradabad	82	49%	23%	71%
Sant Ravidas Nagar	80	18%	18%	10%

The above table shows the proportion of mothers in each district who reported to have got their blood tested for Hb, urine tested for sugar & albumin content, and ultrasound of the abdomen for fetal positions and development. Overall, the uptake of above services ranged from one-fourth in case of urine tests to one-third in case of ultrasound examination. The best performing districts were like before, Hapur and Moradabad while Banda recorded the lowest figures of all the 3 ANC services mentioned above. It is important to note that the proportion of mothers who had got their ultrasound done during last pregnancy is very high in Moradabad, Hapur and JP Nagar. The high figures probably point to prevalence of prenatal sex determination practices in these districts which need separate explorations.

The mothers were also enquired if their cases were referred to a district or any larger hospital for consultation to which about 10% mothers responded in affirmative. The referrals were made to CHC and District hospitals.

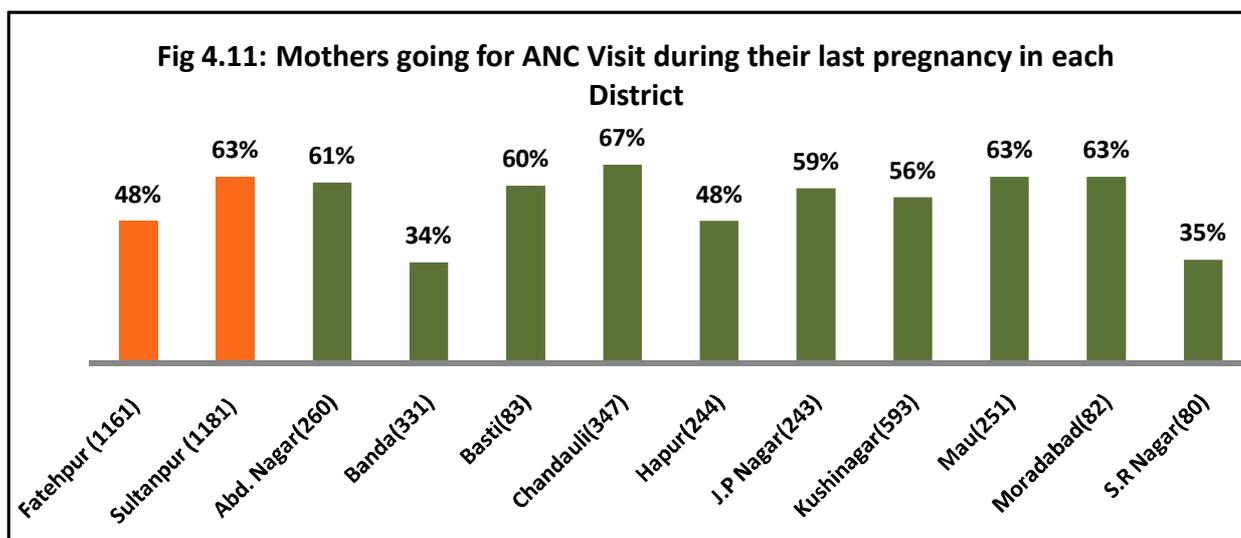
#### 4.2.5 Antenatal Care

The sampled mothers were asked whether they had gone for ANC during their last pregnancy. Overall, a little more than one-half of the mothers reported to have gone for ANC visits across both Category-A and Category-B districts. When this data was analyzed



according to social standing of the sampled families, it was found that only about two-fifth of the households of ST community reported to have gone for ANC visits to avail checkup services which is quite lower as compared to other communities.

The district wise details of mothers have been shown through the chart given ahead:



As seen in the chart above, the proportion of mothers going for ANC during last pregnancy was low across all districts. However, the proportion across the 12 sampled districts varied between one-third to two-thirds. In Fatehpur, about one-half of the sampled mothers reported that they had gone for ANC while in Sultanpur, more than two-thirds gave the above response. Banda and Sant Ravidas Nagar recorded the lowest percentages while Sultanpur and Chandauli recorded the highest. Banda was consistently found to be performing poorly among all districts on almost every health parameter studied.

More than 96% of the mothers who went for ANC reported that ANC checkups were done by skilled professionals. The following table shows the places where mothers had gone for getting their ANC done.

<b>Table 4.3: Place of Receiving ANC</b>						
Parameters	n	At Home	Government Health Facility		Private / Trust hospital/ Other Facilities	AWC
			Sub-centre/ PHC	CHC/District Hospital		
<b>Overall</b>	4856	15%	24%	14%	26%	22%
<b>Category-A Districts</b>	2342	21%	25%	19%	17%	18%
<b>Category-B Districts</b>	2514	9%	23%	10%	34%	25%

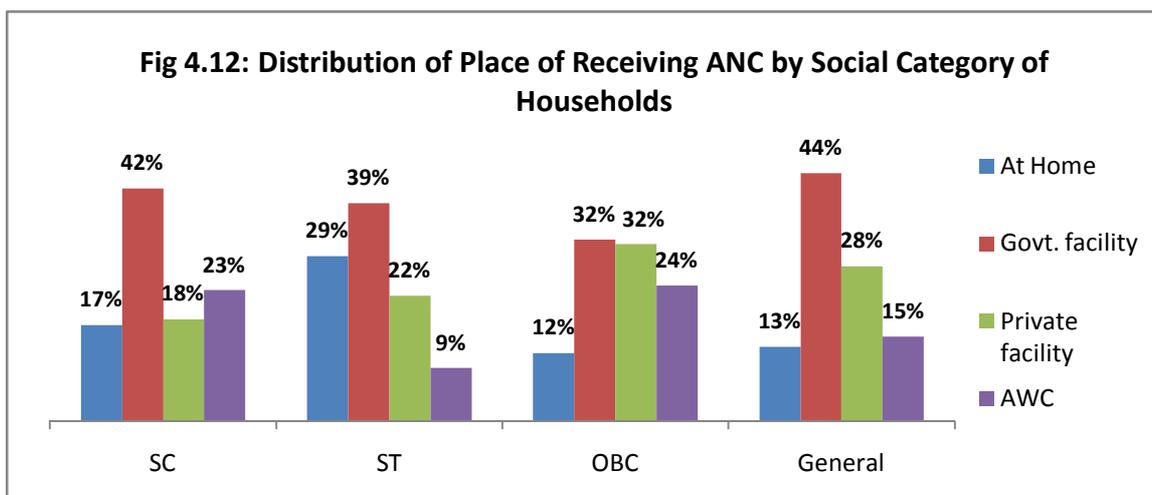
Among the mothers who had received ANC, overall, about one-sixth had taken ANC at home while the majority had taken ANC at Government health facility. In Government facilities, most of the mothers had received ANC checkups at Sub-centre or PHC. About one-fifth of the mothers affirmed that they had received checkup at AWCs. The proportions for ANC checkups at private facility were higher in Category-B districts than Category-A districts because of some Category-B districts which had a higher socio-economic profile.

<b>Table 4.4: Place of Receiving ANC in Each District</b>						
PARTICULARS	n	At Home	Government Health Facility		Private / Trust hospital/ Other Facilities	AWC
			Sub-centre/ PHC	CHC/District Hospital		
<b>Category-A Districts</b>						
Fatehpur	1161	34%	24%	26%	8%	25%
Sultanpur	1181	11%	26%	9%	24%	13%
<b>Category-B Districts</b>						
Ambedkarnagar	260	11%	20%	16%	49%	4%
Banda	331	5%	16%	5%	3%	71%
Basti	83	0%	28%	14%	44%	14%
Chandauli	347	21%	31%	7%	26%	16%
Hapur	244	1%	24%	3%	33%	39%
J.P. Nagar	243	2%	8%	1%	48%	41%
Kushinagar	593	7%	22%	15%	35%	21%
Mau	251	10%	30%	13%	36%	10%
Moradabad	82	4%	10%	8%	39%	40%
SantRavidas Nagar	80	7%	64%	11%	14%	4%

As evident from the table above, two places which were reported by maximum proportion of mothers when asked about the place of ANC were Sub-centre or PHC and Anganwadi centre. On further explorations about the ANC service delivery at AWC, it was found that the ANM while visiting the villages sat at AWCs. The mothers and pregnant women were then called at AWC where ANC services were given to them. Therefore, instead of going for home visits, the ANMs delivered services at AWCs.

In Fatehpur, about one-third of the mothers informed that they had received ANC at home which was the highest proportion for home ANCs among all districts. In Sant Ravidas Nagar, about two-thirds of mothers reported to be going to Sub-centre/ PHC for ANC which was the maximum proportion among all districts whereas in J.P. Nagar, less than 10% mothers were going to Sub-centre/ PHC which was the lowest proportion. In this district, most of the mothers received ANC at AWC.

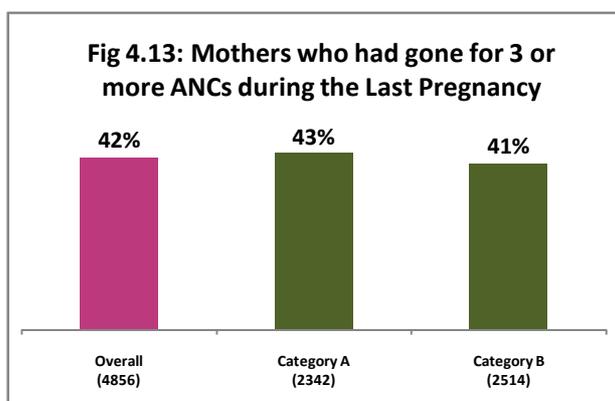
The same data when analyzed caste wise gave a picture as depicted in the chart ahead:



In all the communities, most of the mothers had gone for ANC at Govt. health facilities. However, as regards other places, some variations were observed among different communities. While in general community, more than two-thirds of the mothers had received ANC checkups at Govt. or private institutions, in OBC and SC communities AWCs were found to be an important place for these checkups. In ST households, about 30% reported that they had received the checkups at home. Thus, it may be inferred from the above emerging pattern that the households of General community were much more conscious and aware about the need for ANC and pursued it at health facilities. Whereas, the lack of awareness among other

communities prevented them to seek the services themselves and had to be given the ANC checkups either during VHND days at AWCs or home visits.

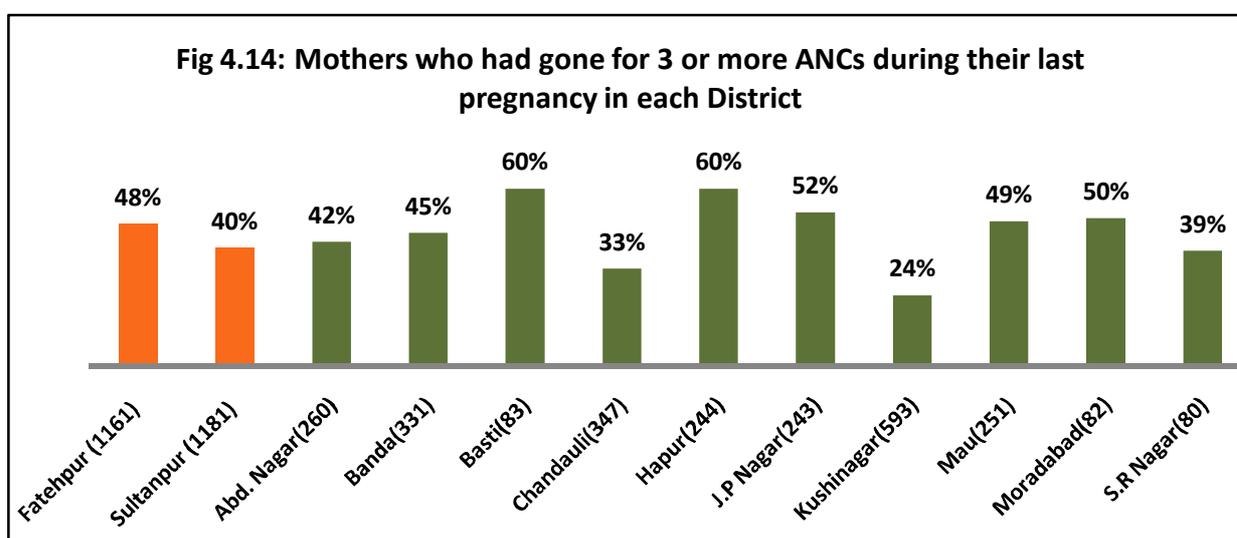
The mothers who had received antenatal care were further enquired about the number of such visits that they had undertaken during last pregnancy. A little more than two-fifths of the mothers who had reported receiving ANC informed that they had gone for ANC 3 or more times. The details have been



presented in the chart alongside. Among the 12 districts, Kushinagar had the lowest proportion of mothers (24%) who had taken 3 or more ANCs.

Thus, it may be inferred that about one-half of the sampled mothers had gone for ANC during last pregnancy and majority of them visited the health facility either once or twice. It must be mentioned here that ideally, minimum 3-4 visits are considered to be vital to monitor the health of pregnant woman and her foetus. If most of the complications are apprehended and timely intervened during antenatal period, there can be a substantial reduction in mortality and morbidity associated with child birth. Therefore, it becomes utmost necessary for the health care authorities to ensure that the pregnant women visit the health facility at least 3 times during pregnancy.

The following chart shows the district-wise details of mothers who had gone for 3 or more ANC visits during their last pregnancy.



More than two-fifths of mothers in Fatehpur and Sultanpur reported that they had gone for 3 or more ANC visits the last time they were pregnant. The highest proportions were seen in Basti and Hapur while the lowest were seen in Kushinagar and Chandauli. It must be mentioned here that Chandauli reported the highest percentage of mothers affirming that they had gone for ANC while the proportion for Kushinagar was also fairly high. Thus, in when the two parameters are seen in conjunction, it may be inferred that though in Kushinagar and Chandauli, a high percentage of mothers went for ANC but the visits were either 1 or 2 during their entire term of last pregnancy.

### 4.3 Services Availed during Delivery

The sampled mothers were probed about the place where they had delivered their last baby and the persons who had performed or assisted the delivery.

#### 4.3.1 Place of Delivery

The following table presents the details of place of birth of last baby of the sampled mothers in the two categories of districts.

Table 4.5: Place of Delivery of Last Child of Sampled Mothers				
Districts	Home Delivery	Institutional Delivery	Institutional	
			Govt. Health Facility	Private Health Facility
<b>Overall</b>	27%	73%	55%	17%
<b>Category-A Districts</b>	29%	71%	60%	11%
<b>Category-B Districts</b>	26%	75%	51%	24%

Overall, about three-fourth of the mothers reported that they had delivered their last child in health facility. Majority of the mothers preferred Govt. health facility over private hospital. More than one-half of the sampled mothers delivered their last baby in Government hospital.

Table 4.6: Place of Delivery of Last Child of Sampled Mothers					
PARTICULARS	n	Domiciliary Deliveries	Institutional Deliveries	Institutional	
				Government Health Facilities	Private Health Facilities
<b>Category-A Districts</b>					
Fatehpur	1161	39%	61%	54%	7%
Sultanpur	1181	20%	80%	66%	14%
<b>Category-B Districts</b>					

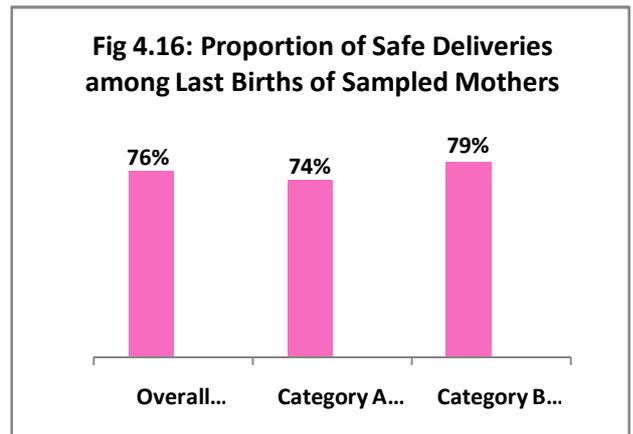
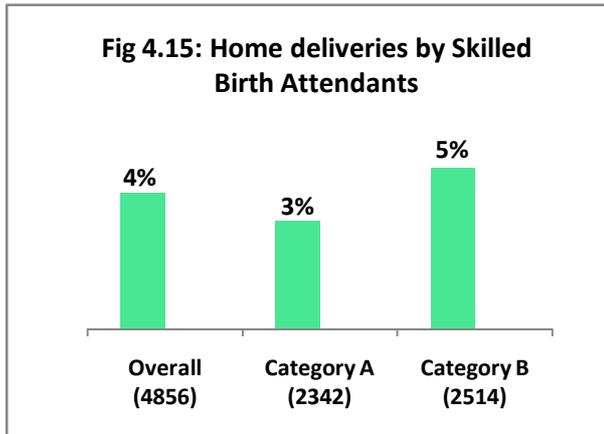
Table 4.6: Place of Delivery of Last Child of Sampled Mothers					
PARTICULARS	n	Domiciliary Deliveries	Institutional Deliveries	Institutional	
				Government Health Facilities	Private Health Facilities
Ambedkarnagar	260	17%	82%	55%	27%
Banda	331	26%	75%	73%	2%
Basti	83	16%	85%	80%	5%
Chandauli	347	26%	73%	59%	14%
Hapur	244	32%	68%	24%	44%
J.P. Nagar	243	33%	67%	27%	40%
Kushinagar	593	28%	72%	50%	22%
Mau	251	17%	84%	57%	27%
Moradabad	82	29%	71%	28%	43%
Sant Ravidas Nagar	80	20%	80%	50%	30%

All the districts demonstrated a high percentage of institutional deliveries. In most districts, Government facilities score high over private health facilities except in Hapur, Moradabad and J.P Nagar. The highest percentage of home deliveries was seen in Fatehpur and highest percentage of institutional deliveries was seen in Basti. The high home delivery percentage in Fatehpur can be attributed to the fact that the district lags behind other districts in socio-economic profile and general developmental status. Institutional delivery rate has been constantly on the rise for the past few years due to targeted interventions and dedicated schemes like Janani Suraksha Yojana and 102 ambulance services etc.

In comparison with other communities, households of general and APL categories had a higher rate of delivery in private institutions. However, majority preferred Government institutions only. In relatively affluent districts like Moradabad, J.P. Nagar and Hapur, considerably higher proportion of respondents got their deliveries conducted in private health facilities.

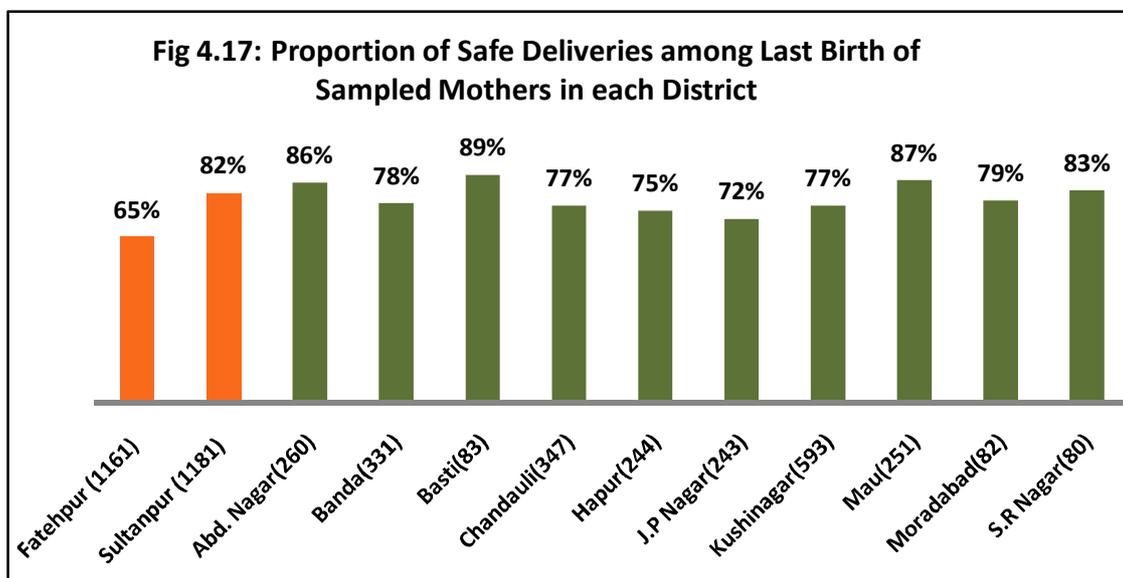
#### 4.3.2 Home Delivery Performed by Skilled Birth Attendants & Safe Deliveries:

The mothers who had delivered their last child at home were asked whether their deliveries were performed by skilled birth attendants. The responses gathered from the households on place of delivery and the person performing the home deliveries were analyzed to identify the proportion of safe deliveries in the sample. The details of the above have been presented in the charts hereunder:



Less than 5% of the home deliveries were reportedly performed by skilled birth attendants. According to the households, home deliveries were either conducted by family members or Dai/ traditional birth attendant. In many cases, ASHA was reported to be present during home deliveries.

About three-fourths of the deliveries reported by the sampled households can be called as safe deliveries because they were either performed in a health facility (Govt. or private) or performed at home under the supervision of skilled birth attendant. The district wise details of safe deliveries have been shown in the table presented ahead:



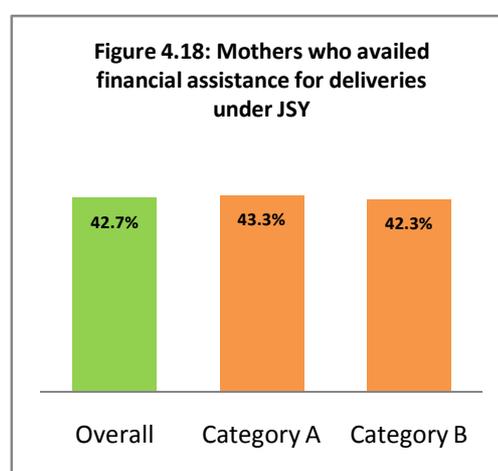
The districts with higher proportions of institutional delivery fared higher in this parameter (Basti, Mau etc.) while those with higher proportions of home deliveries fared lower (Fatehpur). As shown before, less than 5% of home deliveries were

conducted by skilled birth attendant. Therefore, majority of home deliveries were regarded as unsafe deliveries.

Thus, we find that the institutional delivery rate is high in all the surveyed districts and shows constant improvement. However, Fatehpur lags extremely far behind in this aspect with about one-third deliveries occurring at home. Fatehpur is also one of the backward districts of Uttar Pradesh and has fared poorly in many indicators discussed in the chapter. Among the Category-B districts, Banda, Sant Ravidas Nagar and Basti are weaker than other districts in the group like Hapur, Moradabad, J.P. Nagar etc.

#### 4.4 Janani Suraksha Yojna Benefits Availed

Janani Suraksha Yojana (JSY) is perhaps the largest conditional cash transfer program in the world which was launched by the MOH&FW, Government of India in 2005 with the goal to reduce maternal and infant mortality through accelerating institutional delivery and other continuum of services at government health services, particularly among the poor and marginalized groups. The study thus attempted to delve into the utilization of this benefit in the sampled districts. The village level assessment reflected that of all the women who delivered in the last two years preceding the survey, 43% had availed the JSY benefit. The utilization across category A and category B districts was roughly similar. The figure alongside presents the overall status with respect to utilization of JSY in study districts in the past two years.



The above chapter brought to light the aspects of maternal health in the surveyed households. As was mentioned, the uptake of ANC services was found to lag far behind the recommended norms. Though there has been an increase in the cases of institutional deliveries after the commencement of 108 and 102 ambulance services, much still needs to be done to ensure that home deliveries are supervised and performed by skilled birth attendants. It is hoped that the findings of the above chapter would serve as valuable inputs while planning the intervention in these areas.

# STATUS OF CHILD HEALTH **5**

The previous chapter dealt with the maternal health and maternal care aspects for the mothers of children under 5 years of age sampled for the survey. The mothers were also interviewed over the status of immunization of their children and the incidence of childhood diseases like diarrhea, cough and fever. Further, in a separate exercise, anthropometric measurements were taken for two youngest children of sampled mothers who were less than 5 years of age. The measurements included height, weight and mid upper arm circumference. The following chapter brings out the details of queries and exercise relating to health of children below 5 years.

## 5.1 Child Birth and Death Indicators in the Surveyed Districts:

For the selection of sample households, complete listing of all the households of the selected villages of 12 districts was done. The listing questionnaire also recorded data like the number of children born in the family in 2014, number of infant deaths in 2014 and number of neonatal deaths in 2014. Since the survey was initiated in the early months of 2015, therefore, the reference year for these calculations was set as 2014. From the above data, crude birth rate, infant mortality rate and neonatal mortality rate were calculated for the sample. Since the sample varied across 12 districts from 4 to 60 villages in a district, therefore, the district-wise CBR, IMR and NMR have not been given in the report. The table presented alongside shows the CBR, IMR and NMR of the overall sample, Category-A districts and Category-B districts.

Overall, the crude birth rate in the sample was 22.5 and it was similar across both category-A and B districts. Infant mortality rate was calculated to be 51.4 and neonatal mortality rate was computed to

<b>Table 5.1: Child Mortality Indicators in the Survey Sample</b>			
<b>Parameters</b>	<b>Crude Birth Rate</b>	<b>Infant Mortality Rate</b>	<b>Neonatal Mortality Rate</b>
<b>Overall</b>	<b>22.5</b>	<b>51.4</b>	<b>33.4</b>
<b>Category A Districts</b>	22.8	60.0	40.0
• <b>Sultanpur</b>	22.1	56.0	36.0
• <b>Fatehpur</b>	23.5	63.0	44.0
<b>Category B Districts</b>	22.5	44.0	27.0

be 33.4. The estimates of category-A districts were found to be higher than estimates of category-B, which is indicative of the poor status of Fatehpur & Sultanpur districts, when compared to other 10 study districts. This may be attributed to the fact that category-A districts are developmentally and socio-economically more backward than

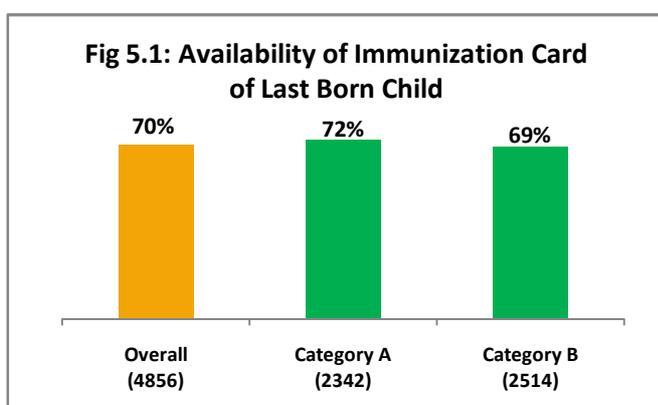
many category-B districts, hence were rightly selected for social accountability intervention. Further, between the category-A districts, Fatehpur exhibited higher CBR, IMR & NMR as compared to Sultanpur.

## 5.2 Immunization Status of Sampled Children:

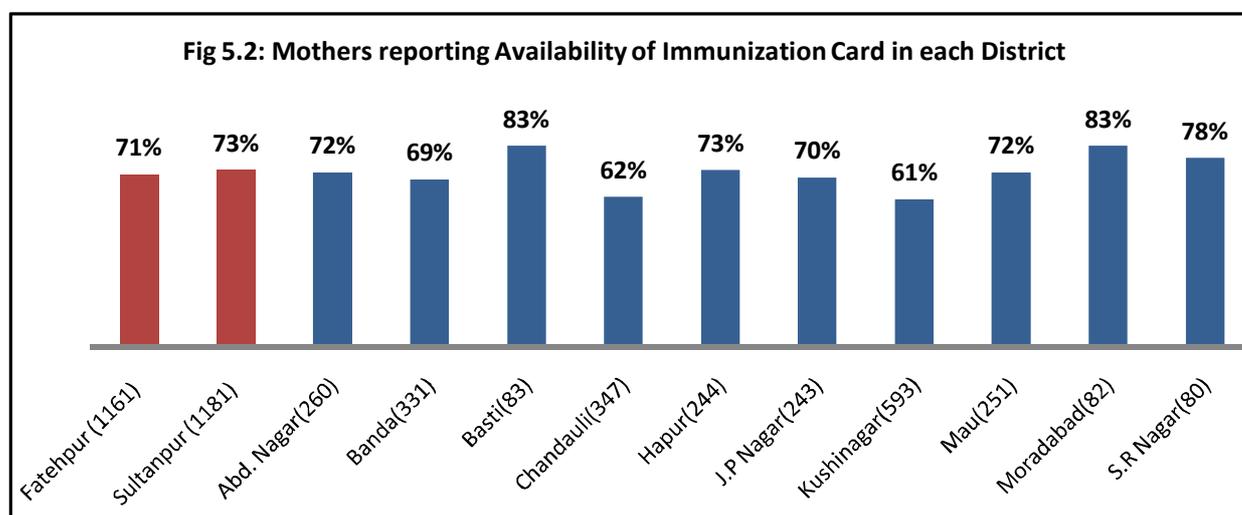
The mothers were enquired about the immunization status of their last child who was below 5 years of age. They were asked about the availability of immunization card. The following sections bring out the findings regarding the status of immunization in sampled districts.

### 5.2.1 Availability of Immunization Card:

The mothers in the sampled households were asked about the immunization received by their last born children who were less than 5 years of age. On enquiring if the mothers had immunization card for their children, more than two-thirds responded in



affirmative. The details have been presented in the chart alongside. In Category-A districts (comprising Fatehpur and Sultanpur), a little less than three-fourths reported to have immunization card. When the data was analyzed according to the social category of households, it was found that in ST community only 57% of the mothers had reported the availability of immunization card. The highest availability was reported in General community (72%).



Except Kushinagar and Chandauli, 70% or higher proportions of mothers reported the availability of immunization card in all other districts. However, it must be mentioned here that many of them could not produce it at the time of survey because they were reported to be submitted with the ANM or ASHA. Overall about 48% mothers could show the immunization card when asked for it.

The mothers were further enquired in detail about the different vaccines received by the last born children. Where the card was available, the details were sought from the card while in other cases the mothers answered the questions on their recall.

### 5.2.2 Status of BCG, Polio, DPT and Measles Immunization in Children:

The mothers of children under 5 years were asked if their last born child had received BCG, Polio, DPT and Measles vaccination. The following table gives the details of children who received BCG vaccine, 3 doses of Polio vaccine, 3 doses of DPT vaccine and Measles vaccine as reported by their mothers and verified from card wherever available.

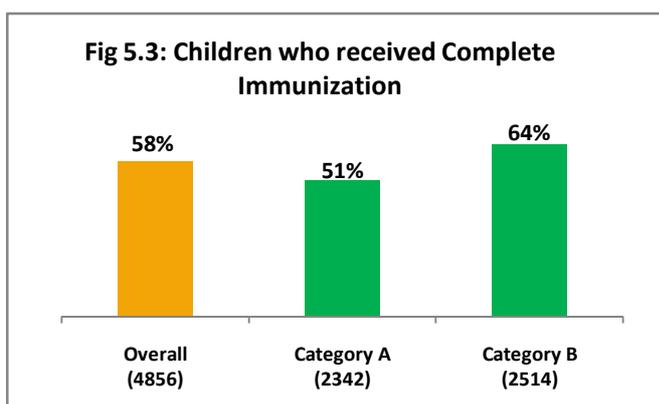
<b>Table 5.2: Immunization Status of Children</b>					
<b>PARTICULARS</b>	<b>n</b>	<b>Received BCG vaccine</b>	<b>Received 3 Doses of Polio vaccine</b>	<b>Received 3 doses of DPT vaccine</b>	<b>Received Measles vaccine</b>
<b>Overall</b>	<b>4856</b>	<b>80%</b>	<b>64%</b>	<b>69%</b>	<b>71%</b>
Category A Districts	2342	74%	57%	62%	62%
Category B Districts	2514	86%	70%	76%	79%
<b>DISTRICT-WISE STATUS</b>					
<b>Category- A Districts</b>					
Sultanpur	1181	78%	61%	64%	60%
Fatehpur	1161	70%	53%	61%	62%
<b>Category- B Districts</b>					
Ambedkarnagar	260	95%	75%	85%	88%
Banda	331	75%	59%	66%	69%
Basti	83	74%	65%	70%	65%
Chandauli	347	92%	84%	76%	84%
Hapur	244	89%	85%	85%	86%
J.P. Nagar	243	81%	76%	79%	76%
Kushinagar	593	88%	70%	77%	80%
Mau	251	87%	65%	66%	78%
Moradabad	82	78%	70%	78%	70%
SantRavidas Nagar	80	81%	69%	66%	69%

As evident from the table above, overall, about four-fifths of the mothers reported that their children had received BCG vaccine and two-thirds reported that children had received all the 3 doses of polio and DPT. A little less than three-fourths also confirmed the receipt of measles vaccines by their last born children. The category A

districts had a lower percentage of children reported to be immunized for the above vaccines than category B districts. Among the 12 districts, Hapur, JP Nagar and Chandauli demonstrated a higher status of immunization of BCG, polio, DPT and Measles vaccine while Fatehpur and Sultanpur lagged behind in this aspect.

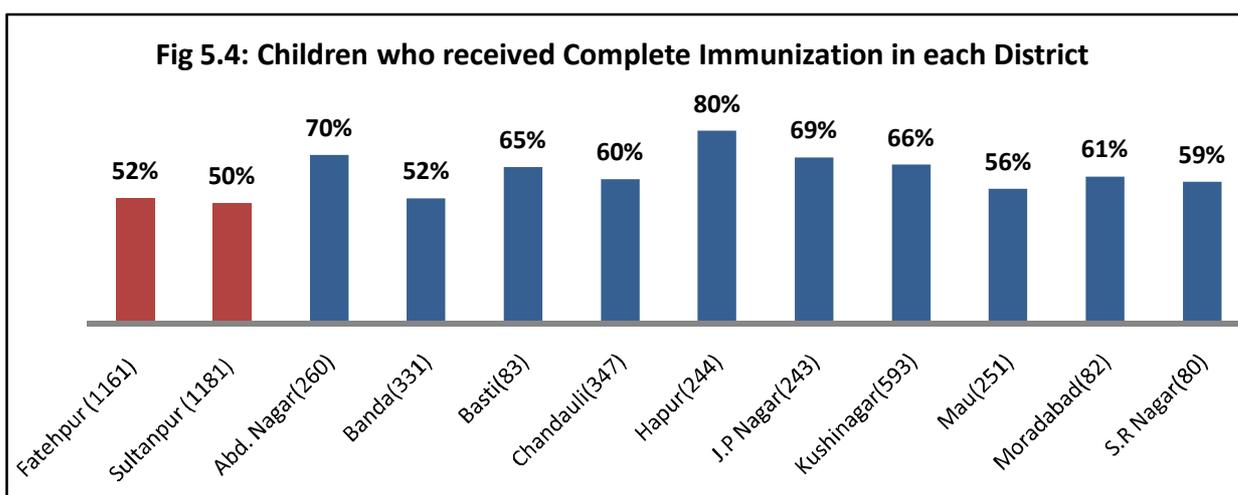
### 5.2.3 Full Immunization of Children:

The responses received from the mothers regarding immunization status of their children was analyzed to determine the proportion of children in the sample who had received complete immunization. The chart presented alongside depicts the proportions of children



completely immunized in the overall sample and category A and B districts. The proportions of completely immunized children in category A districts were significantly less than category B districts, a reflection of the above data that shows the receipt of individual vaccines by children in each district.

The following chart demonstrates the district wise details of completely immunized children as reported by their mothers.



In Fatehpur and Sultanpur, only about one-half of the children were reported to be fully immunized. Among the Category B districts, Banda demonstrated the lowest percentage of complete immunization followed by Mau and Sant Ravidas Nagar. The

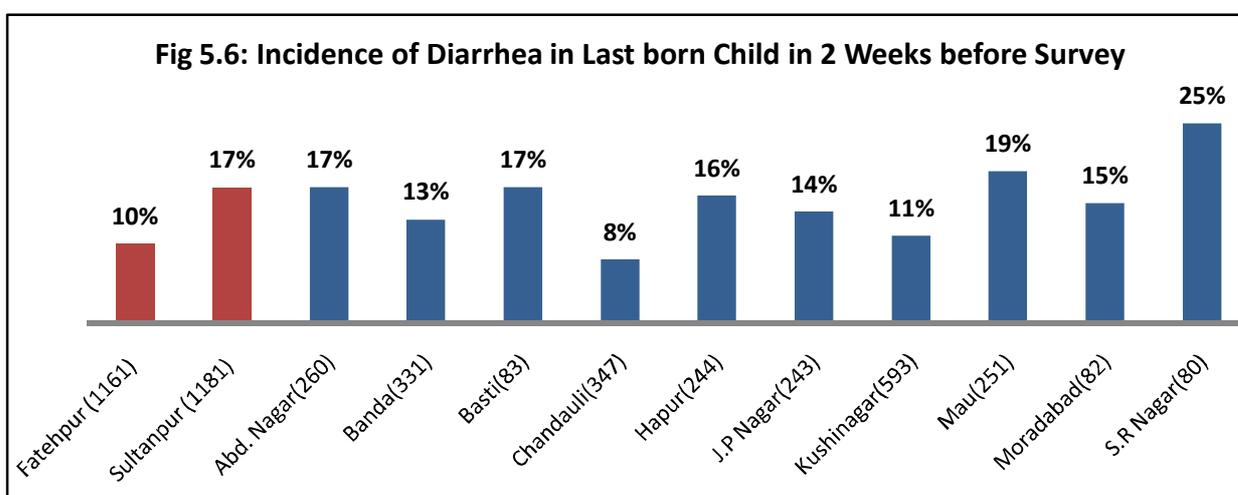
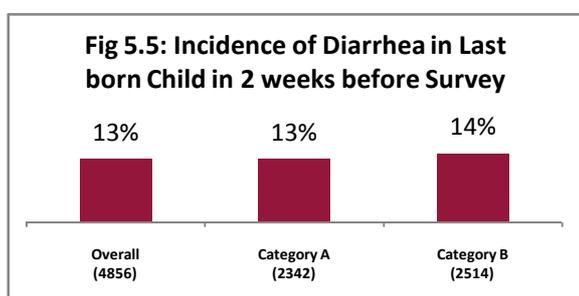
maximum immunization percentage was seen in Hapur which has also been seen to perform well in other maternal health care indicators, and Ambedkar Nagar.

### 5.3 Incidence of Diseases in Children:

The sampled mothers were probed about the health conditions of their children who were below 5 years of age. They were asked if their children had suffered from diarrhea or fever in the two weeks before the survey date and where had they got the children treated. These questions were asked so as to get an insight on the health seeking behavior of the households especially relating to the diseases of children.

#### 5.3.1 Incidence of Diarrhea within 2 Weeks Before Survey:

On asking about the incidence of diarrhea in their last born child who was less than 5 years of age, **overall about 13% (654 of 4856 households) mothers reported that the children had suffered from the disease within 2 weeks before survey.**



The lowest incidence of diarrhea was reported in Chandauli (8%) and Fatehpur (10%) while the maximum incidence was visible in Sant Ravidas Nagar (25%). The mothers whose children had suffered from diarrhea were further probed to know if they had sought treatment from any source (doctor or other service provider etc.). **Overall, about 90% of the mothers affirmed that they had sought treatment for the disease. Amongst the remaining, less than one-third had treated the child at home.**

The mothers were enquired about the place where treatment for the disease was sought. Overall, about 91% of children (594 of 654 households) who were reported to have suffered from diarrhea within 2 weeks before survey had sought treatment for the disease. The following table presents details in this regard:

Table 5.3: Place of Seeking Treatment for Diarrhea					
Parameters	N	Government Health facility	Private Health Facility	Quacks/ Traditional Healers	Others
Overall	594	8%	67%	6%	19%
Category A Districts	277	10%	58%	9%	22%
Category B Districts	317	4%	76%	3%	17%

As evident from the table above, more than two-thirds of the households who had sought treatment for diarrhea of their children had visited the private health facility. About one-fifth took treatment from places like pharmacy or drugstore or shopkeeper or friends and relatives etc. About 6% took treatment from less than fully qualified people like Vaidya, Hakim and other traditional healers. A small proportion of roughly 8% households visited Government facility for consultation and treatment of their children.

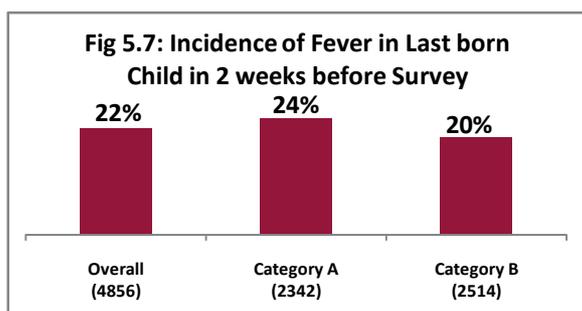
The proportion of people seeking treatment from Government facilities was higher in the category-A districts, which may be attributed to the poorer socio-economic status of households in these districts. Amongst those visiting the Government Health Facilities, ***a miniscule proportion of 1.3% respondents asserted that they sought treatment from the ANM at sub-centre. It will be worth pointing out here that none of the respondents approached ASHAs or AWWs for seeking treatment for diarrhoea.*** This goes on to indicate that the villagers do not rely on frontline functionaries for treatment of any illness, while these functionaries are supposed to offer advice and dispense ORS & Zinc to the diarrhoea patients.

Table 5.4: Place of Seeking Treatment for Diarrhea in each District					
Parameters	n	Government Health facility	Private Health Facility	Quacks/ Traditional Healers	Others
<b>Category-A Districts</b>					
Sultanpur	171	8% (13)	57% (98)	14% (24)	21% (36)
Fatehpur	106	16% (17)	58% (62)	2% (2)	24% (25)
<b>Category-B Districts</b>					
Ambedkarnagar	39	5% (2)	69% (27)	5% (2)	21% (8)
Banda	42	14% (6)	62% (26)	0% (0)	24% (10)
Basti	15	7% (1)	73% (11)	7% (1)	13% (2)
Chandauli	24	8% (2)	88% (21)	4% (1)	0% (0)
Hapur	39	8% (3)	72% (28)	0% (0)	21% (8)
J.P. Nagar	33	0% (0)	82% (27)	0% (0)	18% (6)
Kushinagar	56	0% (0)	80% (45)	4% (2)	16% (9)
Mau	40	3% (1)	68% (27)	10% (4)	20% (8)
Moradabad	12	0% (0)	92% (11)	0% (0)	8% (1)
Sant Ravidas Nagar	17	0% (0)	94% (16)	0% (0)	6% (1)

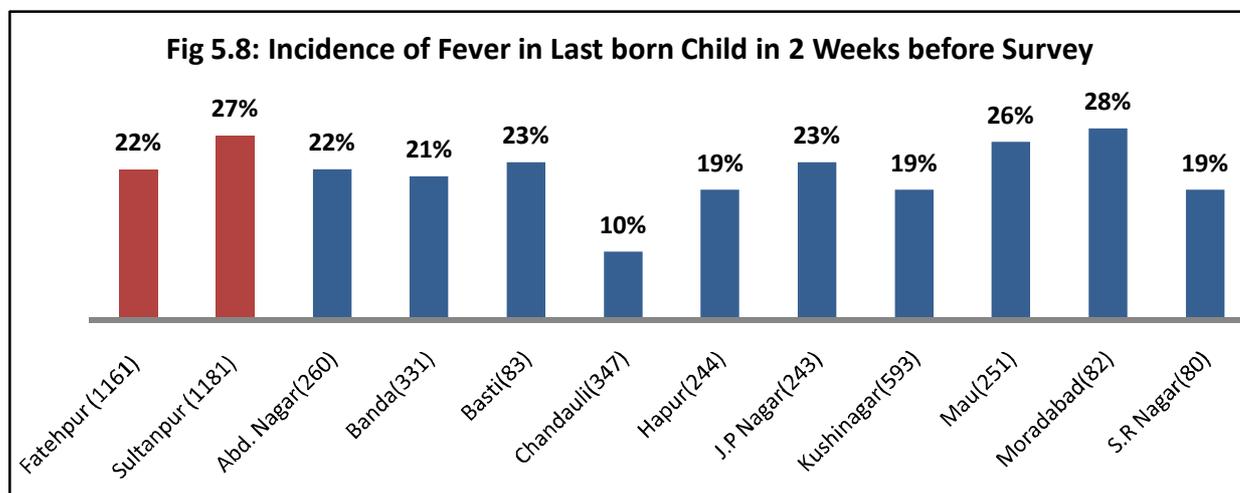
Most of the households sought treatment for diarrhea at private hospitals, nursing homes or clinics. The proportion of households seeking consultation and treatment at Government health facility is very less across all the districts. Preference of private facility over Govt. can be attributed to the lack of trust among communities regarding the quality of treatment of childhood diseases at Govt. hospitals. A significant amount of people were reported to have sought treatment from less than qualified people like traditional healers, Neem, Hakim or shopkeeper etc. which highlights the lingering trust towards faith and miracle healing among the rural communities in the surveyed districts.

### 5.3.2 Incidence of Fever within 2 Weeks Before Survey:

The sampled mothers were asked whether their last born child had suffered from fever in the two weeks before survey and the place where treatment was sought for fever condition. On analysis of the responses recorded in this query,



it was found that **overall about 22% (1071 of 4856 households) mothers told that their last born child had contracted fever in the 2 weeks before survey. Out of these, about 74% (796 of 1071 households) had sought treatment for their child's fever.**



As in the case of diarrhea, Chandauli was seen to have the lowest incidence of Fever in the two weeks before survey. All other districts were found to have about 20% children who had suffered from fever in the reference period of 2 weeks. The places where the treatment for fever was sought have been depicted through the following charts for overall proportions and district wise details.

**Table 5.5: Place of Seeking Treatment for Fever**

Parameters	n	Government Health facility	Private Health Facility	Quacks/ Traditional Healers	Others
<b>Overall</b>	796	9% (74)	63% (503)	6% (51)	21% (168)
<b>Category A Districts</b>	428	11% (48)	55% (234)	9% (37)	25% (109)
<b>Category B Districts</b>	368	7% (26)	76% (280)	4% (14)	16% (59)

Just as in the case of diarrhea, in fever too, private hospitals and clinics remained the choice of treatment facility for children. Overall, more than three-fifths of the household reported to have sought treatment from private facility whereas less than 10% went to Govt. centres. The preference towards private centres was more prominent in category B which consists of a few districts with a higher socio-economic profile than category A districts. In about one-fifth of the households the children were attended to by less than qualified people, Neem, hakim or traditional healers.

Amongst those seeking treatment from Government facilities ***a miniscule proportion of 2% respondents asserted that they sought treatment from the ANM at sub-centre. It will be worth pointing out here that like in case of diarrhoea, none of the respondents approached ASHAs or AWWs for seeking treatment for fever.*** This is despite the fact that the ANMs are supposed to dispense basic medicines like paracetamol for such illnesses.

The following table shows the proportions for each district in the sample.

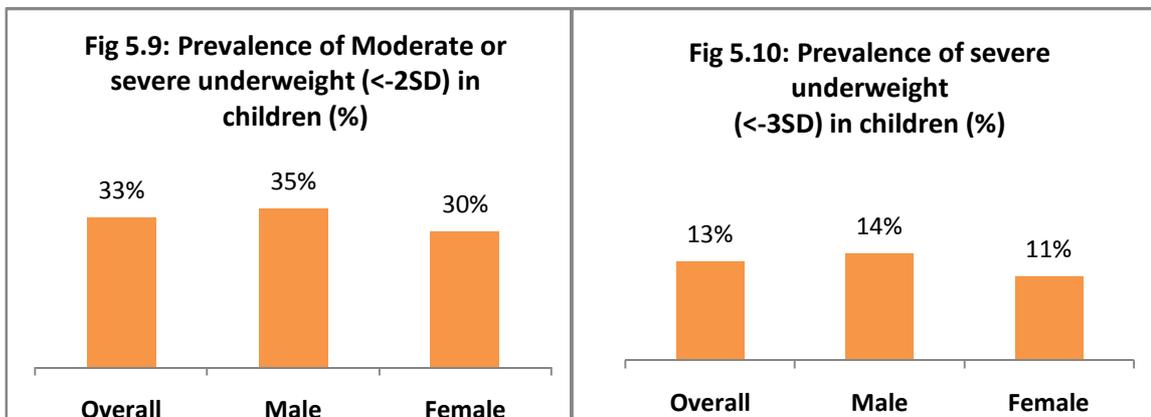
Table 5.6: Place of Seeking Treatment for Fever in each District					
Parameters	n	Government Health facility	Private Health Facility	Quacks/ Traditional Healers	Others
<b>Category-A Districts</b>					
Sultanpur	212	8% (17)	57% (121)	15% (31)	20% (43)
Fatehpur	216	14% (31)	52% (113)	3% (6)	31% (66)
<b>Category-B Districts</b>					
Ambedkarnagar	29	0% (0)	69% (20)	21% (6)	10% (3)
Banda	59	15% (9)	66% (39)	0% (0)	19% (11)
Basti	19	5% (1)	53% (10)	5% (1)	37% (7)
Chandauli	26	4% (1)	77% (20)	4% (1)	15% (4)
Hapur	38	5% (2)	68% (26)	0% (0)	26% (10)
J.P. Nagar	47	2% (1)	83% (39)	0% (0)	15% (7)
Kushinagar	62	5% (3)	79% (49)	3% (2)	13% (8)
Mau	61	13% (8)	70% (43)	7% (4)	10% (6)
Moradabad	14	0% (0)	93% (13)	0% (0)	7% (1)
SantRavidas Nagar	13	8% (1)	77% (10)	0% (0)	15% (2)

Most of the households in all districts sought consultation and treatment at private health facility. A significant proportion of households had faith in the treatment modality of traditional healers and Neem, Hakims and went to them when their children suffered from fever. It may be pointed out that the percentage of households seeking treatment at Government health facility was extremely less which shows the lack of willingness among people to go to health centres for treatment of childhood diseases.

#### 5.4 Nutritional Status of Children Below 5 years of Age:

One of the primary objectives of the study was to evaluate the nutritional status of children below 5 years of age in the selected districts. To achieve this objective, weight measurements of last 2 born children (less than 5 years of age) of sampled

mothers, were taken during the survey. In total, 5767 children were weighed during the survey to evaluate their nutritional status. The following charts depict the proportion of children who were moderately and severely underweight.



Overall, about one-third of children were found to be moderate or severely underweight. When the data was analyzed gender-wise, it was found that the proportion of male underweights in the sample was more than proportion of female underweights. In figure 5.6, the proportion of severely underweight has been shown which is less than one-sixth (13%) of the total number of children weighed. Here again it was seen that higher percentage of males were severely underweight than females.

The above chapter brought to light many important findings with respect to the immunization status of the children in the sampled households and incidence of diarrhea and fever in the 2 weeks before survey. Further, the children of the sampled households were weighed to determine the percentage of children who had lower weight for age (underweight). It is hoped that the above findings would help the healthcare planners to develop an insight of the healthcare scenario of sampled districts and villages which would be useful for planning further interventions in this area.

# SOCIAL INTEGRATION & STATUS OF VHSNCs



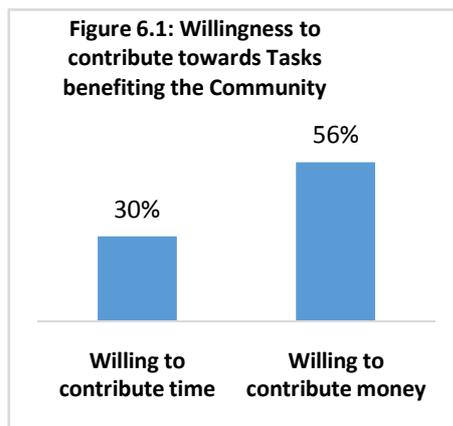
One of the key requirements for social accountability mechanisms to work is the social integration among villagers. The higher the extent of integration, the greater is the possibility that people would be willing to come together for exacting accountability from various service providers. The Village Health Sanitation and Nutrition Committees (VHSNCs) and Village Health & Nutrition Days (VHNDs) were conceptualized as forums for ensuring community engagement and participation in health and sanitation related issues. The committees constituted at the village level serve as a platform where the villagers can raise their grievances regarding the health and sanitation related issues and seek redressal for the same. Further, in VHNDs, the villagers get to interact with key health functionaries and avail a variety of maternal, child and adolescent health related services. As the project proposes to strengthen social accountability mechanisms at the village level, it would be pertinent to gain an insight into the extent of social integration in communities, and status of village level committees and VHNDs. The study thus delved into these aspects to cull out pertinent findings which have been presented in the sections hereunder.

## 6.1 Extent of Social Integration among Communities:

The study intended to understand the existing level of social integration among targeted communities. Findings with regard to some important accountability aspects are discussed in the sections that follow –

### 6.1.1 Willingness to Contribute towards Tasks Benefitting the Community:

The respondents were asked that if there came a situation when any task has to be undertaken for the larger benefit of the community and which may not have direct benefits for them, would they be willing to contribute towards the same. They were specifically asked if they would be willing to contribute time or money for the same. The responses obtained in this regard have been presented in the figure alongside. As is evident, while more than half of the respondents were willing to contribute monetarily to such tasks, less than one-third were willing to give their time for such activities.

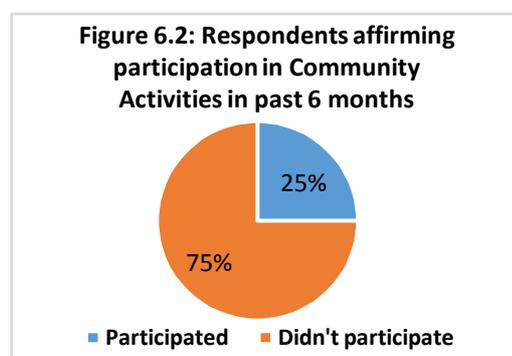


It is an interesting finding for 2 reasons. First, contrary to the belief of availability of disposable spare time in rural areas, fewer people were willing to contribute time. Secondly, and even more important, it hints towards the mindset of people of not caring to spare their valuable time for such activities. From the point of view of requirements for social accountability mechanisms contribution of time to these causes is far more important than money contribution. Thus, it can be deduced that government needs to increase its efforts in sensitizing people to partake in healthcare delivery processes and mobilizing the communities to exact accountability from the service providers. The table ahead outlines the district-wise findings obtained in this regard –

<b>Table 6.1: Willingness to Contribute Time and Money towards Tasks Benefiting the Community</b>		
<b>Districts</b>	<b>Will contribute Time</b>	<b>Will contribute Money</b>
<b>Category-A Districts</b>		
Fatehpur	27%	60%
Sultanpur	37%	42%
<b>Category-B Districts</b>		
Ambedkarnagar	35%	55%
Banda	25%	52%
Basti	4%	88%
Chandauli	37%	54%
Hapur	23%	62%
J.P.Nagar	14%	74%
Kushinagar	37%	59%
Mau	27%	59%
Moradabad	17%	83%
Sant Ravidas Nagar	20%	36%

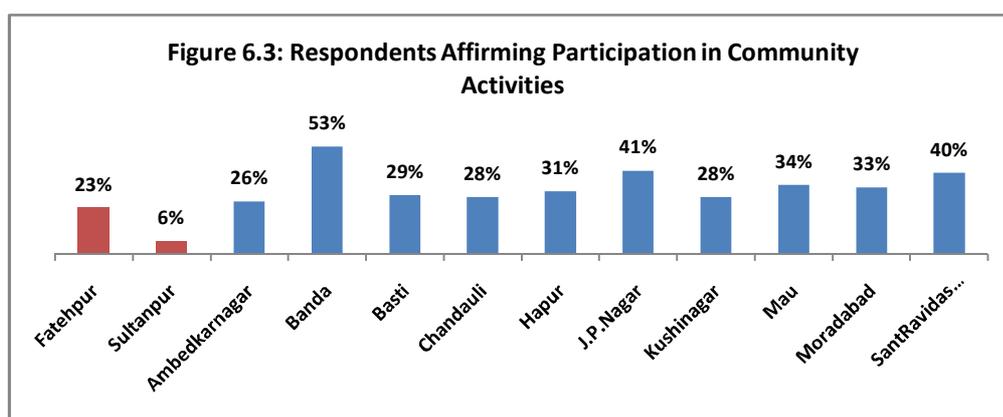
### 6.1.2 Extent of Participation in Community Activities:

The respondents were further probed that whether someone in their household had actually participated in any such community activity in last 12 months. The responses to this query corroborate with the finding about willingness to contribute time towards such activities. As depicted in the figure alongside, only one in every



four respondents agreed to have participated in any such activity in the past 12 months preceding the survey. This may also be attributed to the fact that there may not have been any such community activities organized in the village in the said time period.

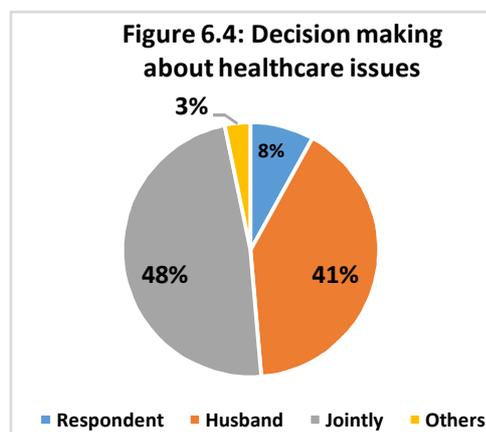
District-wise estimates in this regard have been presented in the figure that follows –



Among category-A districts, the participation reported in Sultanpur was lower than Fatehpur, in fact, it was lowest amongst all 12 districts. While in Category-B districts district Banda outperformed the others in this regard.

### 6.1.3 Decision Making

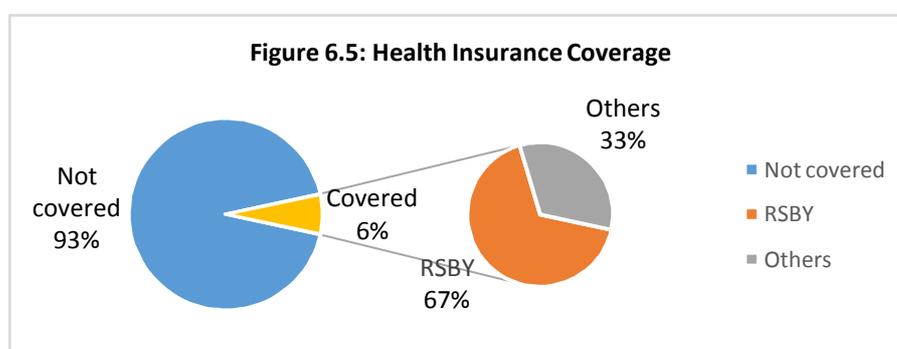
In another question attempt was made to understand gender dynamics in decision making and the extent to which the family made decisions jointly. The respondent women were asked that when it was a matter of their health, who usually took the decisions. It was encouraging to note that a substantive 48% women responded that both she and her husband jointly made decisions about such issues. While a



considerable majority of 41% respondents expressed that the decisions were taken solely by the male partners. Though few, about 8% of them also expressed that they themselves made the decisions. However, such findings may be viewed in light of the type of healthcare issues, and the status of household pertaining to permanent presence of male members in the family. For example, there may be instances when husbands are not available to consultation in times of emergencies as they work outside the village. In such cases the decision making dynamics would change.

## 6.2 Coverage of Family under Health Insurance

The study intended to probe into the households' behavior pertaining to seeking coverage under health insurance schemes. Thus the household were probed about healthcare insurance cover availed by the family in order to assess the penetration of healthcare insurance schemes in rural communities. It would be worth highlighting here that merely 6.8% households affirmed that at least any one member in the family is covered by any health insurance scheme. Those who agreed to have such cover, were further probed about the type of insurance cover they are availing. In response to this it was found that the Rashtriya Swasthya Beema Yojana (RSBY) had the highest coverage with around 67% share of total insurances being under RSBY. It should also be kept in mind that among others, the proportion of life insurances is quite high as respondents weren't quite able to distinguish a life insurance from a health insurance.



District-wise findings in this regard have been presented in the table that follows –

<b>Table 6.2: Households confirming Availability of Health Insurance Cover</b>	
<b>District</b>	<b>Have Health Insurance</b>
<b>Category-A Districts</b>	
Fatehpur	7%
Sultanpur	9%
<b>Category-B Districts</b>	
Ambedkarnagar	6%
Banda	2%
Basti	7%
Chandauli	13%
Hapur	%
J.P.Nagar	1%
Kushinagar	9%
Mau	4%
Moradabad	%
Sant Ravidas Nagar	4%

### 6.3 Village Health, Sanitation and Nutrition Committee (VHSNC)

VHSNCs are village level committees which are expected to take collective action on issues related to health and its social determinants in a village. As per new NRHM guidelines each village is required to constitute at least one VHSNC which will function under the ambit of Gram Panchayat. The Committee shall constitute of at least 15 members, whereas no upper limit has been set for the maximum number of members the committee can have. The principles and guidelines of VHSNC state that participation of women and SC, ST communities should be ensured in VHSNC composition. ASHA, ANM and AWW are ex-officio members of the Committee, which effectively makes the VHSNC a healthcare interface for village community.

In order to get an idea about the functioning of VHSNCs, Interviews/ surveys were conducted with 3 types of stakeholders, that is, the service providers (ANM, ASHA and AWWs), Village Pradhans and Households in each village. We have tried to assess various aspects of VHSNCs' functioning from the point of view of all the 3 key stakeholders to be able to see the issue from different vantage points and internally verify the consistency of the responses.

#### 6.3.1 Presence of VHSNC in village

Different stakeholders were probed about the existence of VHSNC in the village. They were asked if they knew that such a committee has been constituted for their village. There were considerable differences among the responses by different stakeholders as depicted in the table below-

S. No	Stakeholder	Proportion affirming Existence
1	Village Pradhans	96.6%
2	Households	8.4%

A drastic variation was observed in the responses obtained from Gram Pradhans and Households. A vast majority of 97% Pradhans affirmed that such a committee has been constituted for the sampled village. Roughly 3% of Pradhans who denied presence of VHSNC during interviews were contacted again to confirm absence of VHSNCs in their villages. 2 of the Pradhans said that they weren't aware of the committee, though they had received some untied funds in the account. One of the Pradhans said that there was a problem in opening bank account which has led to VHSNC not being in existence in his village. A complaint has been filed with SDM regarding sorting out the issue. 3 Pradhans admitted that there was no VHSNC and they weren't also aware about any such committee.

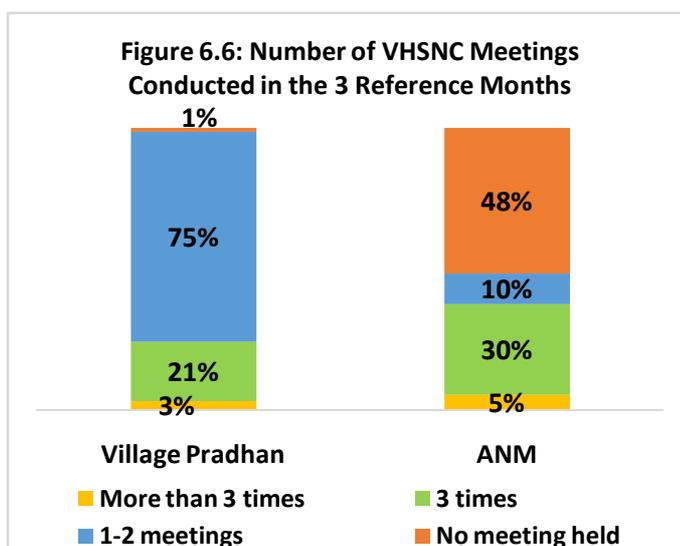
On the other extreme, only 8% of sampled households affirmed that such a committee existed. This is a clear pointer to the absolute lack of awareness regarding presence of any such committee among the community members, who are supposed to be the ultimate beneficiaries for the same. It may be inferred that though constituted, these committees have played no active role that was earmarked for them in the community, because of which none of the villagers are aware of the constitution of such committees. This makes a case for ensuring that these committees actually start functioning in the way that was envisioned for them and in addition some awareness generation initiative needs to be undertaken in the communities so that they can avail the benefits of such village-based institutions.

Further, a wide discrepancy was observed among the responses obtained regarding the presence of VHSNCs in the village by respective Gram Pradhans and ANMs. . Overall, where 94.6% Pradhans affirmed the presence of VHSNCs, only 55% ANMs confirmed the same. This is purely reflective of the lack of awareness and coordinated action among key VHSNC functionaries. The table ahead highlights district-wise findings in this regard –

<b>Table 6.4 : No. of ANMs and Gram Pradhans Affirming Presence of VHSNCs in the Village</b>			
<b>District</b>	<b>Number of villages (N)</b>	<b>ANMs Affirming Presence</b>	<b>Pradhans Affirming Presence</b>
<b>Category-A Districts</b>			
Fatehpur	60	49	60
Sultanpur	60	21	60
<b>Category-B Districts</b>			
Ambedkarnagar	12	6	10
Banda	16	6	9
Basti	4	2	4
Chandauli	16	6	16
Hapur	12	9	11
J.P.Nagar	12	8	12
Kushinagar	28	13	27
Mau	12	7	11
Moradabad	4	3	4
Sant Ravidas Nagar	4	1	3

### 6.3.2 Number of VHSNC Meetings held in 3 reference months

The stakeholders were then probed about the number of VHSNC meetings held in the 3 reference months, that is, November 2014 to January 2015. The responses obtained for the number of meetings also reflected a considerable difference among the stakeholders. As Village Pradhans and ANMs are the key



functionaries responsible for the working of these committees, their responses have been displayed in the figure ahead.

The data for Village Pradhan was available for last 6 months, suitable changes have been made to make it comparable with others. On one hand, where a significant majority of the Village pradhans expressed that 2 or more such meetings had been conducted in the last 3 months. While on the other hand, a majority of about half of the ANMs denied that any such meeting had been conducted in the last 3 months.

<b>Table 6.5: Number of ANMs and Gram Pradhans Confirming Conduct of 3 or more VHSNC Meetings in the 3 reference months</b>			
<b>District</b>	<b>Number of villages (N)</b>	<b>ANMs</b>	<b>Pradhans</b>
<b>Category-A Districts</b>			
Fatehpur	60	26	4
Sultanpur	60	15	9
<b>Category-B Districts</b>			
Ambedkarnagar	12	4	4
Banda	16	6	5
Basti	4	6	0
Chandauli	16	6	8
Hapur	12	7	7
J.P.Nagar	12	6	6
Kushinagar	28	6	5
Mau	12	6	2
Moradabad	4	1	4
Sant Ravidas Nagar	4	1	1

In view of such wide discrepancies in the responses, no remarks can be made regarding the conduct of VHSNC meetings for sure. This needs further probing and on-site verification for making any assessment of the actual number of meetings conducted and the regularity with which they are conducted in the communities

### 6.3.3 Awareness regarding Functions of VHSNCs among Village Pradhans-

Village Pradhans are ex-officio members of the VHSNC. Therefore, in a logical flow, an attempt was made to also understand the awareness about the functions of VHSNC among these village Pradhans. It was found that a fairly decent number of village Pradhans (70%) were aware about most of the activities done in VHSNCs. An important finding, inter alia, was that less than 30% Pradhans were aware about the management of village health untied funds through VHSNCs. Interviews with some of the Pradhans revealed that though they know that some untied fund is released for the Panchayat, but were unaware of the heads under which they receive such grants.

<b>S. No.</b>	<b>Functions of VHSNC</b>	<b>Awareness percentage among Village Pradhans</b>
1	Awareness about health programmes	78%
2	Get death registered at Panchayat	74%
3	Maintenance of Village health register and health information board/ calendar	74%
4	Discuss maternal and neonatal deaths occurred in the village	73%
5	Oversees the work of health and nutrition functionaries	70%
6	Take the problems of the community in consideration and suggest mechanisms to solve it	70%
7	Suggest necessary action to prevent such deaths	68%
8	Village level nutritional awareness activities	67%
9	Develop Village health plan	61%
10	Estimation of annual expenditure in diseases management	36%
11	Managing the village health untied fund <sup>6</sup>	30%

## 6.4 Village Health and Nutrition Day (VHND)

A Village Health and Nutrition Day is a monthly event. On this day, health services are provided in the morning and Behavioral Change and Communication (BCC) activities are conducted in the 2<sup>nd</sup> half of the day. It is usually organized at Anganwadi Centre and all Village Frontline Workers are supposed to attend the activities. PRIs are also supposed to ensure participation from VHSNC members, school teachers etc. to make the day more successful in improving village health scenario.

As per the VHND guidelines counseling is an extremely important component of VHND. Expecting mothers and lactating women are counseled on better nutrition practices. Essential New-born Care (ENBC) is also explained to women who have recently given birth. Apart from these tasks, on this day identification of special attention cases such as children with disabilities, and severe malnutrition cases is done and compilation of data for the same is completed.

### 6.4.1 Number of VHNDs organized in 3 months

All the stakeholders, that is, Households, Village Pradhans, Frontline workers (ANM, ASHA and AWWs) were asked questions regarding organizing the VHND regularly. When asked if any VHND was organized in their village, only 22.6% households confirmed the conduct of VHNDs. A majority of the community members were found to be aware of so called 'immunization days'. The status of immunization coverage presented in the preceding section of this document further reaffirms that 'immunization days' are being conducted in the villages on a regular basis. Some of the community members also confused it with 'Matru Samiti' (Mothers' Committee) meetings, and expressed that they such meetings were a regular affair in the village.

However, when asked if there was any day when all three functionaries including ASHAs, ANMs and AWWs gathered to offer maternal & child care services and counseling regarding health & nutrition in the presence of PRIs, less than one-fourth of them confirmed that such an event was being organized. While in a stark contrast 97.1% Village Pradhans said that VHNDs were being organized. This goes on to indicate that a vast section of the community has still not been exposed to a VHND being organized in its true spirit following the guidelines provided for the same.

All the frontline workers, who are supposed to be present in the VHNDs were asked about number of VHNDs organized in 3 reference months. The responses obtained exhibited discrepancies in the responses obtained from different stakeholders. While, over 60% of ANMs, AWWs and ASHAs confirmed that 3 or more meetings were

organized in the reference months, less than one fourth of households could recall conduct of any VHND in that period. Under such a condition, the conduct of VHND in its true spirit is highly questionable.

<b>Table 6.7 : VHNDs organized in 3 Reference Months (November, December and January, 2015)</b>					
<b>S. No</b>	<b>Front-Line Worker</b>	<b>Number of VHNDs Organized</b>			
		<b>No VHND organised</b>	<b>1 to 2</b>	<b>3</b>	<b>More than 3 VHNDs</b>
<b>1</b>	ANM	11%	8%	57%	16%
<b>2</b>	ASHA	17%	19%	60%	4%
<b>3</b>	AWW	11%	20%	62%	5%

#### **6.4.2 Activities Conducted in VHNDs -**

In order to assess the type of services being offered during the VHNDs, the households affirming the conduct of such days were probed. As per the guidelines, 10 salient functions to be performed during VHNDs are given in the table ahead. The respondents were asked about the type of services that are usually conducted during VHNDs without giving them any hint about the actual activities to be undertaken. The responses obtained have been presented in the table hereunder-

<b>Table 6.8: Type of Activities Conducted under VHNDs As per Households Affirming Conduct of VHNDs in their Village</b>		
<b>SN</b>	<b>Activities undertaken in VHNDs</b>	<b>Responses</b>
1	Registration of birth	53%
2	Complete routine immunization, Vitamin A and measles administration	40%
3	Registration of pregnancy, ANC services, referral for safe abortion and pregnancy complications	38%
4	Counselling about contraception	32%
5	Counselling on ANC, institutional delivery, JSY, PNC services	29%
6	Counselling about care of new-born, breastfeeding and complementary nutrition	24%
7	Weighing of children and preparation of growth charts	18%
8	Providing supplementary nutrition and referral of cases of malnutrition	9%
9	Communication about sanitation, TB, outbreaks, common ailments	8%
10	Information about family planning, contraceptives and RTI/STI	2%

Registration of birth was recalled by approximately half of the households as an activity undertake during VHNDs. Routine Immunization, administration of Vitamin A

and Measles Vaccine, Pregnancy registration and antenatal care services were recalled by a considerable proportion of about two-fifth of the respondents. Apart from this, recall for other activities was rather low which is a clear pointer to the lack of focus of functionaries on these important activities to be undertaken during VHNDs. It calls for better IEC activities to convey the importance and necessity of VHND activities among households, and the need for better monitoring mechanisms to ensure that all the required functions are undertaken during the said days to ensure that VHNDs meet their envisioned purpose.

This chapter brought to light some important findings with regard to existing behaviors and mechanisms which need to be borne in mind while designing social accountability interventions.

# PERFORMANCE OF FRONTLINE FUNCTIONARIES



There are more than 6 lakh villages in India and with the current status of skilled manpower available in the country it is almost impossible to have a qualified health practitioner in each village. The government has been trying to increase healthcare infrastructure by continuously expanding its number of Primary Health Centres (PHC) and Sub-Centres (SC). A sub-centre is the smallest unit of government healthcare ecosystem and around 5 SCs fall under one PHC. Auxiliary Nurse Midwives (ANM) provide their services at sub-centre which caters to 5-6 villages (A population of approximately 5000).

Accredited Social health Activist (ASHA) is identified from each village by Gram Panchayat and they are provided remuneration by government as per the work done. Most of their work goes in conjunction with *Janani Suraksha Yojana* (JSY) and involves maternal health. An ASHA generally caters to a population of 1000, therefore, it is possible that one village have more than 1 ASHAs. Anganwadi Worker (AWW) comes under ambit of Integrated Child Development Scheme (ICDS). They have important task of providing nutrition and pre-school education to children under 6 years of age. Apart from this, nutrition supplements to young girls and lactating mothers are also given via Anganwadi Centres.

All these 3 functionaries (ANM, ASHA and AWW) make 3 most important pillars of healthcare, nutrition and sanitation in a village. They are also called Front-Line workers because they outreach to the remotest parts and deliver government healthcare services to the beneficiaries as per government schemes. Assessing the performance of these health functionaries formed another pertinent are of investigation under this study. The chapter ahead outlines the findings reflecting the status of performance of health functionaries in the

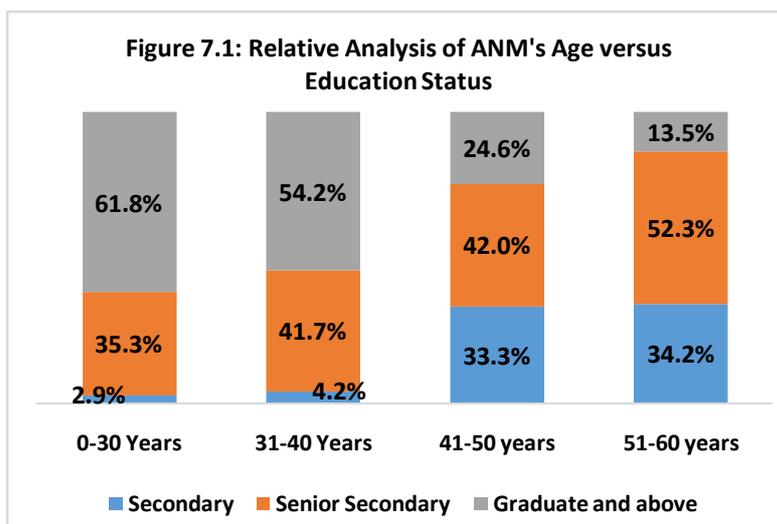
## 7.1 Auxiliary Nurse Midwives (ANMs)

At smaller villages where sub-centres are the healthcare delivery point, ANMs spearhead various tasks related to last mile outreach of services. Routine immunization during VHNDs, identification of special attention cases (such as disability, ULW babies etc.) and imparting healthcare awareness are some of the tasks performed by ANMs. The study involved undertaking in depth interviews with ANMs related to sampled villages to elicit pertinent information about services that they are delivering to the villagers, the type of incentives they receive and their expectations.

Further, the respondent mothers were also probed about their awareness regarding the services that ANMs are supposed to offer and their experience with ANMs. The pertinent findings in this regard have been presented in the sections hereunder-

### 7.1.1 Age versus Education Status of ANMs:

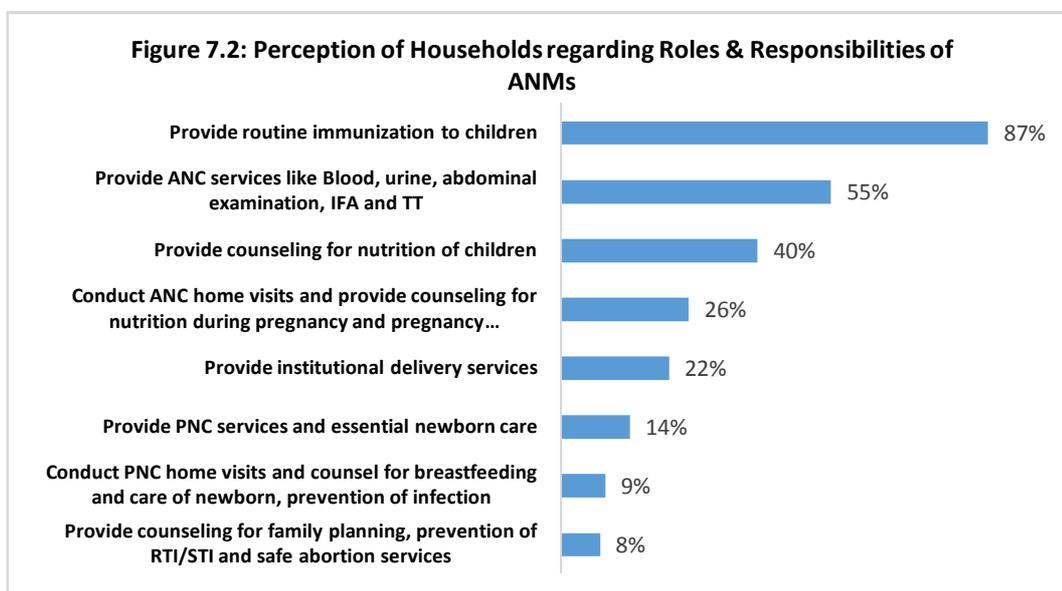
The chapter describing the survey sample has already delved into the age and education status of ANMs. A quick relative analysis of the same that brought to light an interesting finding which may of interest to the authorities has been presented in figure 7.1 alongside. As



indicated in the figure, the ANMs of the younger age-groups were found to be better qualified than the older lot. This brings hope that in the near future this equation will reverse and we will have more and more ANMs who are better qualified and experienced.

### 7.1.2 ANMs' Roles & Responsibilities as Perceived by Households

In the households selected for interview, women respondents were probed about their awareness of expected roles and responsibilities of ANMs. Responses obtained to this query have been presented in the figure hereunder –



The responses presented above were completely based on recall by respondents, they were not offered any hint regarding the same. It can be seen from the responses that most known activity of ANMs is routine immunization, with 87% respondents having awareness of the same. ANC services and nutrition counseling are other better known activities with 55% and 40% respondents showing awareness of the same. This is reflective of the actual work being undertaken by the ANMs in the targeted communities.

### **7.1.3 Incentives received by ANMs**

The ANMs were probed about the incentives they received from any source as a recognition for their good services to the community. A considerable proportion of ANMs (55 out of 240) affirmed to have received any incentives in various forms for their appreciable service. When asked about the source from which they received such incentive it was found that the Government has by far been the most rewarding stakeholder. Most of the ANMs informed to have received incentives for their work in family planning and maternal care. But there have also been examples when NRHM and WHO teams have given certificate to ANMs for their work in Pulse Polio drive etc. In addition, from the Government side, CMOs delivered the Certificate of Appreciation to well performing ANMs. Many a times (in around 25% cases) beneficiaries and communities have also given incentives for the ANMs which mostly comprised of rewards in kind.

### **7.1.4 Support Received by ANMs from Different Stakeholders**

When asked about the support received from Gram Panchayats, 25% ANMs said they received complete assistance from Panchayats. Around two-third (67.1%) ANMs said they didn't receive any cooperation whatsoever from Gram Panchayats. This is a clear pointer to the fact that health systems and PRIs are working in silos. This is despite the fact that both these stakeholders along with those from the ICDS department are required to work in coordination for ensuring better health and sanitation environment in the village.

The ANMs were further probed about the barriers they face while discharging their duty, more than half of the ANMs said they didn't feel any barrier that was hampering them from providing healthcare services. On the other hand, around one-fourth ANMs admitted that local people were not cooperative enough and this acted as a barrier for them. A rather smaller number of ANMs (15.4%) said that health department was not cooperative and didn't fully support them.

### 7.1.5 Expectations of ANMs for Support from Different Stakeholders

ANMs are one of the most important healthcare emissaries in a village. But, in a complex social and economic environment in a village their work is highly dependent on the support of other stakeholders. When asked to express their expectations of support and cooperation from different stakeholders, the ANMs offered following expectations –

<b>Stakeholders</b>	<b>Expectations</b>
From the Community	Villagers should help more in carrying out activities, such as- organization of VHND
From Gram Panchayat	Panchayat should actively support in logistics related issues
	Panchayat members should encourage villagers to adopt better healthcare behaviour.
From Functionaries of Health Department	Employees should get regular promotions
	Complete support needed in training and capacity building, and for logistics support to carry out activities
	Appreciation for good work
From ICDS Department	Nutritional supplements' distribution should be done on the immunization day
From NGOs	NGOs could be helpful by creating awareness among the masses for healthcare seeking behavior
	NGOs should provide human resource and other supports
	They should help mobilize children from their houses at the time of VHND

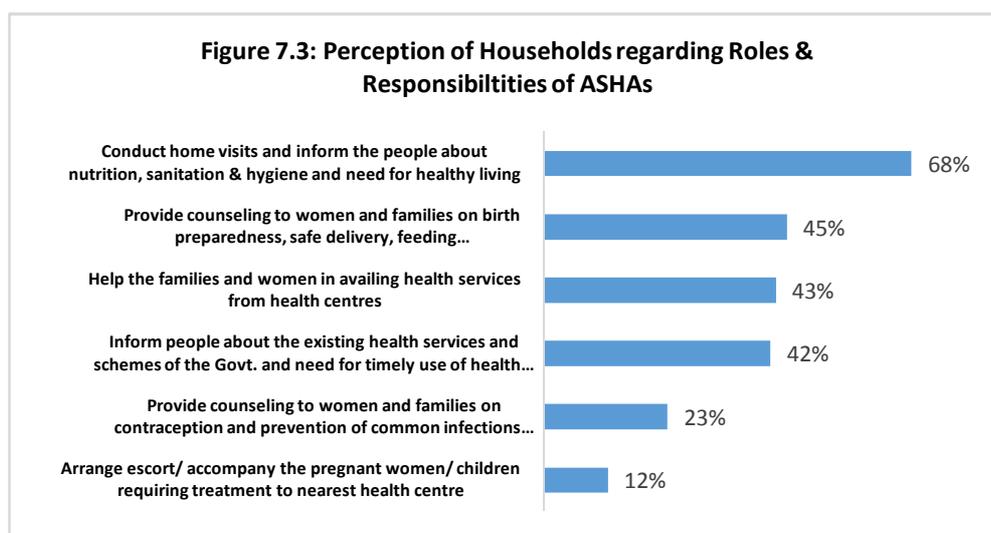
## 7.2 Accredited Social Health Activist (ASHA)

As the ASHA is a resident of the same village, she is one of the most important links between healthcare and community in the villages. Their work, by and large, involves creating awareness about health issues and services available in the village, and secondly, mobilizing people to adopt local health planning and utilization of existing healthcare infrastructure. Maternal healthcare is priority area for ASHAs. Among all the 240 villages from 12 districts, 236 villages had ASHAs. 4 villages from Fatehpur district (Gokan, Dighwara, Baraichi and Sadpur) didn't have an ASHA sanctioned.

### 7.2.1 ASHAs' Roles & Responsibilities as Perceived by Households

An investigation of the level of awareness among households regarding roles and responsibilities of ASHAs was undertaken on the basis of recall by respondents. The respondents in the household survey were asked about the expected roles and responsibilities of ASHA workers. The responses obtained have been presented in figure 7.3 ahead.

The most known activity of ASHA for these households was to conduct home visits to spread awareness about health and nutrition with over two-thirds of households recalling the same. Counseling on birth preparedness, feeding practices etc., helping women avail health services, and informing people about existing health services were other three prominent roles recalled by over two-fifth of respondents. Whereas, the other two functions including counseling on family planning and escorting pregnant women/ children to health centres were recalled by relatively fewer number of households.



### 7.2.2 Incentives received by ASHAs

When probed about the incentives received, it was found that many a times they are given incentives by government or other stakeholders as a recognition of their good work. 39 out of 240 ASHAs confirmed that they had received an incentive for their work. Government has given Certificate of Appreciation to ASHAs mainly for their good work in promoting family planning activities. Sometimes, District Magistrates (DMs) have also given incentives in the form of a cheque and certificate to better performing ASHAs.

### 7.2.3 Support received by ASHAs from different stakeholders

When asked about the support received from Panchayat more than one-fourth ASHAs agreed that Panchayat provided assistance by encouraging villagers to avail health services. A small number of ASHAs (9%) said that Panchayat provided all assistance for arrangement of logistics whenever needed. Among all, 60% ASHAs admitted that there was no cooperation and assistance provided by Gram Panchayat.

When asked about barriers being faced by ASHAs in doing their work, around one-fourth (24%) ASHAs said that local people were not cooperative towards the work performed by them. Unavailability of transportation facilities were also cited as a hindrance in doing their work. A small number of ASHAs (1.3%) said that ANMs did not visit their villages, which was a major concern for them.

#### 7.2.4 Expectations of ASHAs for Support from Different Stakeholders

ASHAs have expressed their interest in receiving higher cooperation and support from other stakeholders in the village. This should be in the larger interest of improving healthcare status of all in general and women and children in particular. Their expectations from different stakeholders are mentioned below.

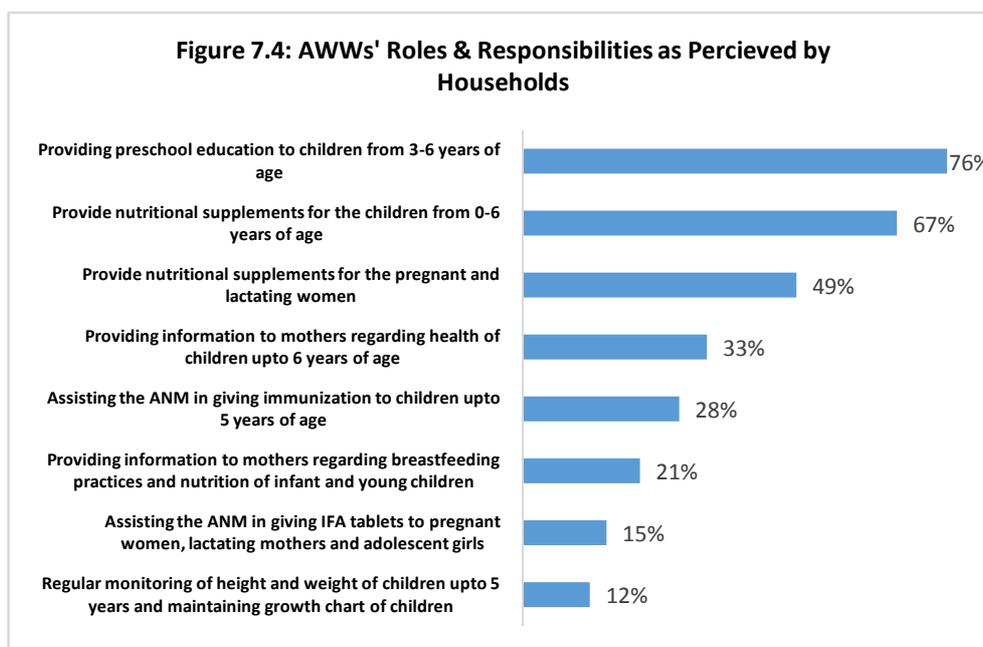
<b>Table 7.2: Expectation of ASHAs regarding Support from Different Stakeholders</b>	
<b>Stakeholders</b>	<b>Expectations</b>
From the Community	Villagers should cooperate with ASHAs by listening to the information attentively and having faith in her
	ANM should share information regarding healthcare issues with other people
From Gram Panchayat	Support for making Mothers' groups functional and encouraging people for institutional deliveries
	Panchayat members should themselves seek information regarding different healthcare issues and then encourage villagers to adopt better healthcare behaviour, such as- hand washing etc.
From Health Department Functionaries	Offering training in pertinent areas, and providing hand holding support as and when desired
From ICDS Department	More cooperation in promoting immunization, nutrition and ANC related activities
From NGOs	Help by organizing camps for creating awareness among masses.

### 7.3 Anganwadi Workers (AWWs)

Anganwadis have been set up in each village as a part of Integrated Child Development Scheme (ICDS). Anganwadi Worker (AWW) and Anganwadi helper are 2 women generally selected from that village itself to conduct the Anganwadi activities. Their main responsibilities include providing nutrition supplements to young children and young girls (at the onset of puberty), promote routine immunization and provide all health & nutrition related services to pregnant & lactating women, children under 6 years of age and adolescents.

### 7.3.1 AWWs' Roles & Responsibilities as Perceived by Households

When probed about the roles and responsibilities of AWWs, highest proportion of them recalled Pre-school education (76%) and providing nutritional supplements (67%) as the activities done by AWWs. The following graph presents perception of households regarding work of AWWs.



As is evident from the figure above only a small proportion of respondents could recall services like monitoring of height & weight of children, assisting ANM in distributing IFA to pregnant women and adolescent girls, and undertaking IEC measures to educate mothers about IYCF practices.

### 7.3.2 Services provided in Anganwadis

The AWWs were probed about services that they were offering through their centres. It was an open ended question and no hint was offered to the AWWs. Over 90% of AWWs affirmed to be providing key services like supplementary nutrition, pre-

Services provided at AWC	Percentage
Supplementary nutrition	100%
Pre-school education	95%
Immunization	90%
Nutrition and health education	78%
Health check-ups	66%
Referrals	28%

school education and immunization. Whereas, services like nutrition and health education, health check ups and referrals were missed by a considerable proportion of AWWs which is reflective of their lack of focus on these activities.

### 7.3.3 Incentives Received by AWWs

Like other key functionaries, AWWs were also probed if they received any incentive for their good work from any one. In response to this, a total of 23 Anganwadi workers out of 240 confirmed to have received some incentive for good quality services in the community. Anganwadi workers have been mostly awarded with Certificate of Appreciation (Adarsh Karyakarti) for their good work by government functionaries.

### 7.3.4 Support Received by AWWs from Different Stakeholders

When asked about support received from Panchayats, one-fourth of the AWWs said that Panchayat members helped by encouraging households to send their children to AWC. Around 7% AWWs said that many a times Panchayat provided them with extra human resources to assist in the functioning of AWC. A significant number of AWW (67%) said that they didn't receive any support whatsoever from Panchayats.

AWW were asked about the barriers they were facing which hamper effective discharge of duties and fulfilling their responsibilities. 20% AWWs affirmed that no cooperation from ICDS is acting as a barrier for them. While approximately same number of AWWs cited the problem of non-cooperation from local people and workers. 60% AWWs said that they didn't face any barrier in doing their work.

### 7.3.5 Expectations of AWWs for Support from Different Stakeholders

Anganwadi workers have expressed support and cooperation expectations from different stakeholders. It will help them to perform their duties more effectively and improve health & nutrition scenario in the village. A summary of responses is tabulated below.

<b>Stakeholders</b>	<b>Expectations</b>
From the Community	The parents of children should trust and follow the advice of AWWs
	Community should send their children to the AWC
From the Gram Panchayats	Support in provisioning for proper drinking water and toilets in the village
	All the village related information should be disseminated by Panchayat members so that people readily accept them
From the Functionaries of Health Department	Cooperation should be provided at time of vaccination
From ICDS Department	More workers required to support for routine activities of AWC
	There should be a provision of promotion
From NGOs	Community mobilization during VHND and immunization drives

## 7.4 Experience of Household Respondents with Front Line Workers (FLWs)

The frontline workers are the last-mile healthcare delivery agents in a village. They are generally contacted on a priority basis for a healthcare related issue. If this is seen from an angle of social accountability it is an important point to probe, therefore, attempts were made to evaluate the behaviour and experience of service offered to the community by these FLWs by asking some pertinent questions to the households.

When asked whether the respondent was greeted and talked respectfully when she last met with the frontline worker, more than two-third respondents rated the experience with ASHAs as 'Very good' or 'good', while only 45% said so in case of Anganwadi worker. Similarly, when asked about clarity in explaining healthcare related issues, 55% rated ANMs' performance as 'Very good' or 'good', and 44% did so in case of Anganwadi worker. One important question asked the respondent to submit her opinion on whether AWW/ASHA/ANM were doing everything that they could for her and her child's health, most of the respondents replied positively. In case of ASHA 84% of respondents replied with either 'somewhat agree' or 'strongly agree', whereas, in case of Anganwadi worker such proportion was only 66%. A summary is presented in the following table-

S. No	Questions	Proportion of Respondents rating experience as 'Very good' or 'Good'		
		ASHA	ANM	AWW
1	How would you rate your experience of being greeted & talked to respectfully?	67%	48%	45%
2	How would you rate your experience of clarity in things explained?	66%	55%	44%
3	How would rate the experience of being involved in making decisions?	64%	54%	43%
4	AWW/ASHA/ANM is doing everything that she can do for you and your child's health? **	84%	80%	66%

\*\* Responses offered as 'Strongly Agree' and 'Agree'

## 7.5 Unprofessional Conduct of Front Line Workers

Some of the respondents also reported that the FLWs at times behave in a highly unprofessional manner. Many such incidences were brought to light during focus group discussions with community members. In **Shahpur village of Fatehpur district**, it was revealed in an FGD that ASHAs take 50 rupees to call an ambulance for carrying pregnant women to the nearby hospital. The same was being done by ANM of

**Pokhara village of district Basti. In Gofa village of Dohrighat block, Mau district,** an incidence of hitting and abusing patients at time of delivery was reported.

It is also worth mentioning that in Fatehpur district, 32 out of 60 ANMs were absent on their respective sub-centres when first contacted for survey. The investigators pursued them and were able to interview them after lot of efforts in tracking them. Similarly, 17 ASHA workers and 8 AWWs were also absent in Fatehpur district at the time of visit. This goes on to indicate the level of regularity with which these frontline workers offer their services to the community.

The findings described in this chapter may serve as important input for the authorities to help them plan their capacity building initiatives, and ensuring systems for offering handholding support to frontline functionaries. In addition, some important areas of support desired by the functionaries have also been highlighted which may be considered for alleviating the overall health and nutrition scenario in the villages.

# SUMMARY OF FINDINGS 8

The report brought to light many findings regarding the health status of mothers and children below 5 years of age and the health seeking behavior of the households. It further highlighted the situation of healthcare services available and accessible in the sampled villages and the presence of village level committees for looking after health and nutrition aspects of village communities. The point of view of healthcare service providers was also recorded to gain a perspective on the overall health scenario of the sampled villages in the survey. The previous chapters comprehensively covered the above aspects with detailed district-wise findings on each subject. The following chapter enumerates the key findings of this study which would be helpful in understanding the health situation in Category A and Category B districts and planning the social accountability intervention in these areas.

## 8.1 Key findings regarding the Status of Maternal Health:

Mothers of children less than five years of age were interviewed to determine the antenatal and delivery services availed by them during the birth of their last born child. The detailed analysis and findings have already been presented before. The key indicators pertaining to maternal health generated out of the baseline survey which may be useful for assessing the impact of intervention at a later stage are tabulated hereunder :

Indicators	Overall	Category A Districts	Category B Districts
<b>Antenatal Care</b>			
Mothers who Received 2 or more TT Injections during Pregnancy (%)	51%	46%	55%
Mothers whose Abdomen Examination was Done (%)	26%	26%	27%
Mothers whose Blood Pressure taken (%)	20%	20%	19%
Mothers whose Weight Measurements were taken (%)	18%	19%	18%
Mothers whose blood taken for Hb (%)	29%	28%	30%
Mothers whose urine tested (%)	25%	25%	25%
Mothers who underwent ultrasound (%)	34%	29%	38%
Mothers who went for at least 1 ANC Visit (%)	55%	55%	55%
Mothers who Received ANC at			

Indicators	Overall	Category A Districts	Category B Districts
Government Health Facility	38%	44%	33%
Private Health Facility	26%	17%	34%
Anganwadi Centres	22%	18%	25%
Mothers who went for 3 or more ANC Visits (%)	42%	43%	41%
<b>Delivery Care</b>			
Institutional Delivery (%)	73%	71%	75%
Govt. Health Facility	55%	60%	51%
Private Health Facility	17%	11%	24%
Home Deliveries by Skilled Birth Attendant (%)	4%	3%	5%
Safe Delivery (%)	76%	74%	79%

- Among the sampled districts, in category-A, Sultanpur was found to perform slightly better than Fatehpur which was socio-economically and developmentally poorer.
- In the Category-B districts, Banda and Sant Ravidas Nagar were seen to perform the worst in the above health care parameters while Hapur, Moradabad and JP Nagar were among the best performers.
- On caste-wise analysis of place of seeking ANC, it was found that in general community, more than two-thirds of the mothers had received ANC checkups at Govt. or private institutions, in OBC and SC communities AWCs were found to be an important place for these checkups. In ST households, about 30% reported that they had received the checkups at home.

## 8.2 Key findings regarding Status of Child Health

The sampled mothers were also probed about the immunization status of their last born children and incidence of diseases like diarrhea and fever in them. The key indicators pertaining to child health are presented ahead:

Indicators	Overall	Category A Districts	Category B Districts
<b>Mortality Indicators</b>			
Infant Mortality Rate	54.9	62.5	48.1
Neonatal Mortality Rate	36.0	42.8	29.9
<b>Immunization Status</b>			
Children aged 12-23 months having Immunization Card (%)	70%	72%	69%
Children aged 12-23 months who have received BCG vaccine (%)	80%	74%	86%

Indicators	Overall	Category A Districts	Category B Districts
Children aged 12-23 months who have received 3 Doses of Polio vaccine (%)	64%	57%	70%
Children aged 12-23 months who have received 3 Doses of DPT vaccine (%)	69%	62%	76%
Children aged 12-23 months who have received Measles vaccine (%)	71%	62%	79%
Children aged 12-23 months Fully Immunized (%)	58%	51%	64%
<b>Incidence of Diseases</b>			
Children Suffering from Diarrhea (%)	13%	13%	14%
Children Suffering from Diarrhea who sought Treatment (%)	89%	87%	91%
Children suffering from Fever (%)	22%	24%	20%
Children Suffering from Fever who sought Treatment (%)	65%	66%	64%

- More than two-thirds of the households sought treatment for diarrhea at private health facility. About one-fifth took treatment from places like pharmacy or drugstore or shopkeeper or friends and relatives etc. About 6% took treatment from less than fully qualified people like Vaidya, Hakim and other traditional healers.
- Overall, more than three-fifths of the household reported to have sought treatment for fever from private facility whereas less than 10% went to Govt. centres. In about one-fifth of the households the children were attended to by less than qualified people, Neem, hakim or traditional healers.
- As regards nutritional status of children, one-third (33%) of the weighed children were found to be moderately or severely underweight. In males, the underweight percentage was 35%, while in females it was 30%.
- 13% of children were found to be severely underweight. The severely underweight proportion in male children was 14% while in females was 11%.

### 8.3 Key findings regarding the Performance of Frontline Workers

Major findings regarding the responsibilities and works performed by frontline workers and perception of households towards them have been enumerated ahead:

#### 8.3.1 Performance of ANMs:

- More than four-fifth (87%) of the households perceived routine immunization as the primary responsibility of ANMs. More than one-half (55%) also cited ANC services as one of the main tasks of the ANM. Services related to family planning,

PNC care, home visits and counselling were recalled by only a limited number of respondents showing their lack of exposure to such services from ANMs.

- About 55 of 240 ANMs reported that they had received incentives for their appreciable service. Most of them received incentives from Government/NRHM/WHO for services rendered during Pulse Polio Drive, Maternal Health and Family Planning Programmes. CMOs gave certificate of appreciation for their services.
- A vast majority of over two-thirds of ANMs said that they did not receive any cooperation from Gram Panchayats.

### **8.3.2 Performance of ASHAs:**

- More than two-thirds (68%) households felt that conducting home visits and providing counseling on nutrition, hygiene, birth preparedness and safe delivery was the main responsibility of ASHAs. Counselling on contraception, prevention of common infections and escorting women and children to health facilities for treatment appeared as neglected areas with lesser number of respondents being able to recall the same.
- 39 out of 240 ASHAs confirmed that they had received an incentive for their work. Government has given Certificate of Appreciation to ASHAs mainly for their good work in promoting family planning activities.
- A majority of three-fifth of ASHAs stated that they never received any support from the Gram Panchayats. About one-fourth ASHAs reported that Panchayat provided assistance by encouraging villagers to avail health services. 9% ASHAs said that panchayats provided assistance for arrangement of logistics whenever needed.

### **8.3.3 Performance of AWWs:**

- About 85% AWCs had Anganwadi helper along with AWW. Two-thirds AWCs were operating at Village School Premises while one-sixth had their own ICDS building. 17% AWCs were in dilapidated condition.
- More than three-fourths (76%) households felt that preschool education for children was the main work of AWW. More than two-thirds also mentioned providing nutritional supplements to children aged 0-6 years as one of the primary tasks of AWW. Growth monitoring, counseling related to IYCF and providing IFA to pregnant women and adolescent girls were quoted by very few respondents indicating possible neglect of these functions.

- 23 out of 240 AWWs confirmed to have received some incentive for good quality services in the community. AWWs have been mostly awarded with Certificate of Appreciation (Adarsh Karyakarti) for their good work by government functionaries.
- About two in every three AWWs quoted that they received no help of any sort from the Gram Panchayats. One- fourth of the AWWs said that Panchayat members supported them by encouraging households to send their children to AWC. Around 7% AWWs said that Panchayat members provided them with extra human resources to assist in the functioning of AWC.

#### **8.4 Key findings regarding the Extent of Social Integration and Status of VHSNC & VHND :**

In the light of importance of this study for establishing systems for social accountability it was pertinent to assess the status of VHSNCs and VHNDs in the sampled villages. The important points that were highlighted during the survey have been outline ahead:

- The respondents were probed about the willingness to contribute towards tasks benefitting the community but not carrying any direct benefits for the household. To this, over 56% respondents expressed they were willing to contribute money, while only 30% were willing to contribute any time for the same.
- As regards decision making, it was found that a majority of 41% respondents expressed that it was the male members, particularly husbands who made important decisions in the family. Encouragingly 48% said the decisions were being taken jointly.
- As regards the presence of VHSNCs, there was a wide discrepancy in the responses obtained from different stakeholders. While 97% Village Pradhans reported the presence of VHSNC in their villages, only 55% of ANMs confirmed the same reflecting lack of awareness and coordinated action among key officials of VHSNCs. Further, only about 8% households reported the same reflecting the absolute lack of community involvement in such forums.
- 70% Village Pradhans were aware about most of the activities done in VHSNCs. Less than 30% Pradhans were aware about the management of village health untied funds through VHSNCs.
- A vast majority of community members were found to be aware of the conduct of 'immunization days' in the village, and the status of immunization coverage reaffirms that such days are being organized regularly in the villages. However,

when the respondents were asked about VHNDs a majority of them showed ignorance about any event named as VHND (termed as 'Gram Swasth Poshan Divas'. When further probed by asking if there was any day when all three functionaries including ASHAs, ANMs and AWWs gathered to offer maternal & child care services and counseling regarding health & nutrition in the presence of PRIs, less than one-fourth of the respondent mothers confirmed that such an event was being organized. While in a stark contrast 97.1% Village Pradhans said that VHNDs were being organized. This goes on to indicate that a vast section of the community has still not been exposed to a VHND being organized in its true spirit following the guidelines provided for the same.

The findings summarized in this chapter presents an overview of the status of study areas on certain pertinent aspects which are important from the point of view of designing a social accountability intervention and measuring its effectiveness at a later stage.

\* \* \* \* \*

## Chapter 9

### Recommendations

The report gave a comprehensive picture of the status of maternal health with respect to antenatal care and delivery services and that of child health with respect to immunization status of children below 5 years of age and occurrence of diseases like diarrhea and fever. Further, the status of VHND, VHSNC and performance of frontline workers in the sampled villages was also assessed. The previous chapter enumerated the major findings extracted from the survey. On the basis of assessment of the situation at sampled villages, few recommendations have been proposed to strengthen the social accountability mechanisms in the intervention areas.

#### **9.1 Utilize District Level Nutrition Committees under State Nutrition Mission to achieve Inter-sectoral Convergence at the Block and Village Levels:**

Since 2013, a State Nutrition Mission has been set up with the objective of scaling up the nutrition interventions in the state by acting as an advisory body for both ICDS and NHM. One of the main functions of this mission is to act as a coordinating body to facilitate inter-sectoral collaboration for nutrition action among convergent departments like ICDS, NHM, Rural Development, Basic Education, Panchayati Raj and others. A convergence strategy has been outlined in the Mission documents wherein a District Level Nutrition Committee (*PoshanSamiti*) is formed to facilitate convergence of ICDS and Health Departments at the District level and meets once a month. (Reference: GO: 66/60-2-14-2/3 (27)/05 T.C. dated 21-01-2014)

These committees can be utilized as a forum to enable convergence effects to percolate down the block level and village level. The intervention agencies may seek to facilitate meetings and support implementation of activities outlined at these forums within their intervention blocks and villages. It is believed that if such efforts flow down from the top level, the possibility of willing participation of officials of varied departments increases. Further, since the triple A (ANM, ASHA and AWWs) forum is also looked at an effective means of reaching out to grassroots level, therefore, a proper coordination with them under the ambit of already existing mechanisms would prove to be highly effective. The inter-departmental convergence envisioned under the Nutrition Mission will serve as an effective way to strengthen the village level committees and ensuring efficient use of VHND for offering complete package of services relating to Health and Nutrition of Mother and Child.

In addition to that, under the Nutrition Mission, District and Mandal Level Nutrition Officers are required to adopt 2 *Gram Sabhas* in their area to facilitate and monitor the progress of nutrition

interventions in the adopted villages. It is suggested that if any of the adopted villages coincide with the ones selected for SA intervention, the intervention can be coordinated with the Nutrition Officers.

The Nutrition Mission also launches many interventions from time to time like a new programme which would be launched in September 2015 called as “*Vajan Diwas*”. This programme is specifically aimed at identifying malnourished children by weighing all the children at AWCs. Such interventions can be used as a forum to promote Social accountability practices in the community to extract maximum results.

### **9.2 Utilization of Village Level Groups like *Matr Samitis*, *Mahila Madals* along with VHSNC for delivery of Health and Nutrition Services:**

During the survey, it was found that Village Health Sanitation and Nutrition Committees had been set up in almost all villages. However, in many cases committee meetings were not conducted regularly. Further, some village Pradhans were unable to comprehend the proper way in which to utilize the Untied Fund of Rs. 10,000 that was disbursed to them for carrying out functions and activities of VHSNC. The households’ awareness about the committee was very poor leading one to believe that the committees were not able to perform their functions satisfactorily and had very less visibility in the villages.

In this context, it may be suggested that other groups operating in the villages may also be considered as a suitable platform for launching specific intervention like social accountability to elicit a better response and acceptance from the communities. There are many groups like *Matru Samitis* (Mothers Groups), *Mahila Mandals* (Women’s Groups), Women SHGs etc. which can be considered apt for interventions on maternal and child health as the target population for such interventions are present in the groups. These groups are formed for dealing with mother, child care and adolescent issues and their meetings are called and attended by the frontline functionaries like ANM and ASHA. Therefore these forums would be most suited to serve the objectives of social accountability interventions.

### **9.3 Hand Holding and Capacity Building of Panchayati Raj Institutions (PRIs) and Members of VHSNC for developing the Village Health Plan:**

One of the main functions of the VHSNC is to develop the village health plan according to the health problems being faced by their village and the priorities of actions that need to be taken at the local level to improve the situation. To achieve this objective, the committee needs to maintain records of deaths, disability, disease load and the causes for seeking health treatment

by the community and formulate action plans for health education, organization of local events for awareness generation etc. at the village level.

Since, the survey showed that the visibility of the committee in their villages was very poor and the awareness about functions of VHSNC among its members less, therefore, it can be surmised that the PRIs and VHSNC members need capacity building on the functions of the committee. It is therefore, recommended that capacity building programmes must be initiated for the VHSNC members with special emphasis and hand holding support for preparation of village health plans.

It is also recommended that all ASHAs and AWWs of a particular Gram Panchayat should be members of VHSNC and must be involved in formulation of the Village Health Plan so that a holistic plan is designed keeping in loop all the functionaries operating in the GP. Capacity building efforts for VHSNC must also target the frontline functionaries so that they are able to offer proper inputs for carrying out the activities of VHSNC.

To summarize, it may be said that many interventions targeting the improvement in maternal and child health of rural communities are being implemented in different districts of Uttar Pradesh. Convergence and coordination between different implementation agencies and departments working at the village level would help in providing a synergistic effect to the interventions and the overall objective and target of a healthy mother and healthy child would be much easier to achieve.

## FACT SHEET : Maternal Health

Particulars	Mothers who Received 2 or more TT Injections during Pregnancy (%)	Mothers whose Abdomen Examination was Done (%)	Mothers whose Blood Pressure taken (%)	Mothers whose Weight Measurements were taken (%)	Mothers whose blood taken for Hb (%)	Mothers whose urine tested (%)	Mothers who underwent ultrasound (%)	Mothers who went for at least 1 ANC Visit (%)	Mothers who Received ANC at			Mothers who went for 3 or more ANC Visits (%)	Institutional Delivery (%)			Home Deliveries by Skilled Birth Attendant (%)	Safe Delivery (%)
									Govt Health Facility (%)	Private Health Facility (%)	AWCs (%)		Institutional Delivery (%)	Govt. Health Facility (%)	Private Health Facility (%)		
<b>Overall</b>	<b>51%</b>	<b>26%</b>	<b>20%</b>	<b>18%</b>	<b>29%</b>	<b>25%</b>	<b>34%</b>	<b>55%</b>	<b>38%</b>	<b>26%</b>	<b>22%</b>	<b>42%</b>	<b>73%</b>	<b>55%</b>	<b>17%</b>	<b>4%</b>	<b>76%</b>
SULTANPUR	47%	26%	18%	14%	30%	24%	34%	63%	52%	24%	13%	40%	80%	66%	14%	3%	82%
FATEHPUR	46%	26%	23%	23%	26%	25%	24%	48%	33%	8%	25%	48%	61%	54%	7%	4%	65%
AMBEDKARNAGAR	57%	28%	19%	14%	30%	25%	32%	61%	35%	49%	4%	42%	83%	55%	27%	3%	86%
BANDA	53%	8%	8%	12%	14%	8%	9%	34%	21%	3%	71%	45%	74%	73%	2%	4%	78%
BASTI	42%	25%	23%	18%	30%	24%	33%	60%	42%	44%	14%	60%	84%	80%	5%	5%	89%
CHANDAULI	49%	27%	17%	16%	23%	24%	29%	67%	38%	26%	16%	33%	74%	60%	15%	3%	77%
HAPUR	83%	38%	34%	40%	48%	41%	65%	48%	27%	33%	39%	60%	68%	24%	44%	7%	75%
J.P. NAGAR	79%	33%	18%	23%	38%	20%	62%	59%	9%	48%	41%	52%	67%	27%	40%	5%	72%
KUSHINAGAR	37%	25%	15%	11%	27%	26%	37%	56%	37%	35%	21%	24%	72%	50%	22%	5%	77%
MAU	51%	36%	24%	18%	41%	35%	47%	63%	43%	36%	10%	49%	83%	57%	27%	4%	87%
MORADABAD	92%	44%	33%	27%	49%	23%	71%	63%	17%	39%	40%	50%	71%	28%	43%	9%	79%
SANT RAVIDAS NAGAR	65%	19%	13%	15%	18%	18%	10%	35%	75%	14%	4%	39%	80%	50%	30%	3%	83%

## FACT SHEET : Child Health

Particulars	Children aged 12-23 months having Immunization Card (%)	Children aged 12-23 months who have received BCG vaccine (%)	Children aged 12-23 months who have received 3 Doses of Polio vaccine (%)	Children aged 12-23 months who have received 3 Doses of DPT vaccine (%)	Children aged 12-23 months who have received Measles vaccine (%)	Children aged 12-23 months Fully Immunized (%)	Children Suffering from Diarrhea (%)	Children suffering from Fever (%)
<b>Overall</b>	<b>70%</b>	<b>80%</b>	<b>64%</b>	<b>69%</b>	<b>71%</b>	<b>58%</b>	<b>13%</b>	<b>22%</b>
SULTANPUR	73%	78%	61%	64%	60%	52%	17%	27%
FATEHPUR	71%	70%	53%	61%	62%	50%	10%	22%
AMBEDKARNAGAR	72%	95%	75%	85%	88%	70%	17%	22%
BANDA	69%	75%	59%	66%	69%	52%	13%	22%
BASTI	83%	74%	65%	70%	65%	65%	17%	23%
CHANDAULI	62%	92%	64%	76%	84%	60%	8%	11%
HAPUR	73%	89%	85%	85%	86%	80%	16%	19%
J.P. NAGAR	70%	81%	76%	79%	76%	69%	14%	23%
KUSHINAGAR	61%	88%	70%	77%	80%	66%	11%	19%
MAU	72%	87%	65%	66%	78%	56%	19%	26%
MORADABAD	83%	78%	70%	78%	70%	61%	15%	28%
SANT RAVIDAS NAGAR	78%	81%	69%	66%	69%	59%	25%	19%