Perceived Barriers to Utilization of Maternal Health and Child Health Services: Qualitative Insights from Rural Uttar Pradesh, India

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The study attempts to understand the individual and community factors and perceptions that influence women's behaviours and utilization of maternal and child health care (MCH) provided by government. An investigation of barriers and facilitating factors has been done, through 48 semi-structured in-depth interviews with women and 26 semi-structured in-depth interviews with providers at different level of rural health care facilities in selected villages of Lucknow district, Uttar Pradesh, India. A content analysis to ensure utilization of MCH care services has been performed using the Strengths, Weakness, Opportunities and Threats (SWOT) tecnique for the current public health care system. Support of household members, previous health care experiences and social networks in the village and interaction with health workers affect women's decision to seek care. Regardless of physical accessibility, acceptability of maternal health services in the community emerges as critical avenue for the utilization of both maternal and child health care services.

INTRODUCTION

Accessibility is one of the principles of "Health for ALL" stated in Alma Ata declaration on primary health care but still, due lack of universal access, equality in health status cannot be assured. Moreover, because there are other important social determinants of population health and its distribution, even with the increasing catchment of tertiary health care facilities, utilization of primary health care is low due to costs, attitude of health provider as well as location of facilities, etc. Making pregnancy safer has been the central to population policies since post ICPD regime, and keystone of second phase of Reproductive and Child health care programme. Pregnancy related women health include antenatal care during pregnancy, provision of safe delivery and post natal care after delivery. This magnitude clearly suggests that India's progress towards reducing maternal mortality will be crucial in the global achievement of Millennium Development (MDG-5). But inadequate maternal health care services with poor organization, huge rural-urban divide, and large interstate disparities coupled with stringent social-economic and cultural constraints demands a significant shift in programme priorities to increase service coverage and accessibility to all sections of population (Sunil et al, 2006; Ram and Singh, 2006).

While many strategies have attempted to address some of the economic, social, and physical factors and barriers contributing to poor maternal health outcomes, women's utilization of maternal health services is often influenced by perceived sociocultural, economic, and health system factors operating at the community, household, and individual level as well as within the larger social and political environments and health care infrastructure (Griffiths and Stephenson, 2001; Ram and Singh, 2006). These include inequitable distribution of facilities and/or infrastructure for primary healthcare and maternal healthcare services, inadequate referral services, lack of human

resource and overburdened healthcare facilities. It has been unequivocally shown that utilisation of ante-natal and skilled delivery services improve pregnancy outcome (Bloom et al, 1999). It is also known that several factors influence the utilization of these basic healthcare services. There is evidence to show that the demand side barriers to access services such as tradition, lack of knowledge, and financial constrains may be as important as supply factors in deterring patients from utilising services (Griffiths and Stephenson,2001; Ensor and Cooper, 2004).

The Rural Health Care System forms an integral part of the National Health Care System. Promotion of maternal and child health has been one of the most important components of the Family Welfare Programme of the Government of India and the National Rural Health Mission (NRHM) reiterates the government's commitment to the safe motherhood program within the wider context of reproductive and Child health (RCH) programme. The health care infrastructure in rural areas has been developed as a three tier. In the rural areas of the district under the primary health care delivery system there are Community Health Centers (CHC), Primary Health Centers (PHCs) and Sub Centers (SCs) that provide various health services and outreach services. Each CHC is supposed to cover 100,000 population and provide multi-functional services with 30 inpatient beds. Each CHC is to provide mainly specialized curative services in gynecology, pediatrics, surgery and medicine (IPHS for CHC, 2006). The PHC norm is that it needs to cover 30,000 rural population (in case of tribal areas 20000 population). Each PHC is supposed to have a minimum of 6 beds. An average health team at the PHC consists of 2 to 3 physicians known as medical officers, including one male health assistant, and one female health assistant, both of whom are multipurpose personnel providing the link between health workers at the SC /village level and the physicians, a Block extension educator, a number of female health workers/Auxiliary Nurse Midwives (ANMs) giving nursing care to out-patients and admitted patients, a laboratory technician, a computer/statistician, driver for the transport, store keeper and other ancillary staff and attendants. The PHC is the referral point for emergency cases and complications (IPHS for PHC, 2006). Each PHC has a network of SCs each serving a population of 5000 (3000 population in case of tribal areas). It is manned by a team of one male multipurpose health worker and one female multipurpose health worker. The female health worker/ANM provides maternal and child health and family planning services to women. MCH services comprise registration of women for ante-natal and postnatal care, distribution of iron and folic acid tablets to pregnant women, advice on diet, immunization of infants and children with BCG, polio, tetanus toxoid, diphtheria and anti-typhoid vaccines, distribution of vitamin A and treatment of minor ailments. Family planning includes motivation, contraception advice and follow-up. The male health worker is expected to prepare and maintain register of vital events and of eligible couples, undertake family planning advice and motivation and the distribution of condoms among men, take house to house malaria surveillance, immunization etc (IPHS for SC, 2006).

Despite the efforts, utilization of RCH services by the rural community has not reached the desired level. Recently, efforts to address these issues have gained momentum with the formulation of National Rural Health Mission (NRHM-2005-12), which seeks to provide effective healthcare to rural population throughout the country. Under each SC for a population of 1000 there is Community Health Volunteer – who is supposed to promote access to improved healthcare at household level through the female health activist- Accredited Social Health Activist (ASHA). The ASHA mostly is a woman chosen by the community. ASHA would act as a bridge between the ANM

and the village and be accountable to the Panchayat. The ASHA functions includes encouraging acceptance of neo-natal care and immunization, use of weight charts for children upto the age of 6 years, nutrition, health education related to hygiene and infectious diseases, simple curative care, identification of pregnant women and children at risk and collection of information on births, deaths, eligible couples etc. She will facilitate preparation and implementation of the Village Health Plan along with Anganwadi worker, ANM, functionaries of other Departments, and Self Help Group members, under the leadership of the Village Health Committee of the Panchayat (NRHM, 2005). Janani Suraksha Yojana (JSY) launched in April 2005, is a demand driven intervention for promoting safe delivery with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women (NRHM, 2005; UNFPA,2009). In India, ASHA had been evolved as the new band of community based functionaries in addition to Anganwadi workers(a health worker chosen from the community and given 4 months training in health, nutrition and child-care) and Auxiliary Nurse and Midwives (ANMs) with the implementation of National Rural Health Mission. They are recognized as the first port of call for any health related demand by the community and they also identified as an effective link between the Government and the poor pregnant women. ASHA has been assigned the duty to identify beneficiaries and facilitate receipt of adequate antenatal, natal and postnatal care.

Another strategy to improve utilization rates is to make health services more responsive to the public by seeking to raise the public's perception of health services. Various determinants of user perceptions of health service quality have been highlighted in the literature. These include provider behaviour (Peters *et al*, 2002), respect for privacy, short waiting times (Aldana et al., 2001; Singh *et al*, 2010), availability of drugs and staff competence (Fomba *et al*., 2010). Other Evidence also indicates that user perception of quality is an important determinant of utilization when user fees are concerned though there are no studies related to user fees at present in India. The success all these efforts in terms of policies and programmes for deployment of human resources etc have been assessed quantitatively several time using household survey data but they does not provide through information on users perspective on facilities available, the process through which they make decision for utilization of non-utilization of services etc and what happen on providers' part is often left out. So, this study is an attempt to understand key factors that may influence their decision to use MCH services along with accessibility of services vary in villages of Uttar Pradesh.

Several previous studies have examined the factors contributing to poor maternal and child health outcome and access to care (Stephenson and Tsui, 2002, 2003; Pathak and Mohanty, 2010). Reviewing these, component of maternal health care i.e. antenatal care (ANC), delivery and postnatal care (PNC) services are key features of health interventions for reducing maternal and newborn morbidity and mortality are define in Table 1. Although the current rate of ANC uptake is encouraging, detailed information about the actual quality and effectiveness of ANC in practice is scant (Rooney, 1992; McDonagh, 1996, Vlassoff *et al*, 2010). This is largely because the packages vary so much from place to place in terms of components, timing, frequency of visits, and provider. Similarly, little evidence is available for the packaging of interventions for routine PNC for mother and newborn.

Table 1: Components of antenatal, delivery and postnatal care.

Antenatal Care
• Focused ANC Visits and referral: 1st visit: before 16 weeks of gestation, 2nd visit: from 20 to 24 weeks of gestation, 3rd visit: from 28 to 32 weeks of gestation & 4th visit: from 36 to 40 weeks of gestation, referral and follow-up should be given to pregnant women with complications. • Early detection and diagnosis of disease/abnormality ie quick check, history taking, physical examination, laboratory investigation & decision making. • Components of ANC includes Weight measured, Height measured, Blood pressure checked , Blood tested, Urine tested, Abdomen examined, Breast examined, Sonography/ultrasound need to be examined. • At least 2 doses of tetanus toxoid vaccination, consumption of atleast 100+ iron folic acid (tablets/syrup). • Counseling on health promotion: personal hygiene, diet and nutrition, danger signs.
Delivery Care
• Birth and emergency preparedness: Identify place of birth, preparing essential items, identify danger sigh of delivery • Institutional Delivery, safe delivery with held of skilled ANM, ASHA or Doctor at home.
Postnatal Care
• Promotion of healthy behaviours, danger sign recognition and family planning • Promotion of healthy behaviours – hygiene, warmth, breastfeeding, danger sign recognition and immunizations • Extra care for low birth weight babies or babies born to HIV-positive mothers and babies with other special needs. • Check up by doctors within 48 hours of delivery.

METHODOLOGY

The present study based on the qualitative data collected from Lucknow district of Uttar Pradesh in Central India, during March- May2010, primarily as part of the doctoral work. The study has been employed through qualitative data collected by in-depth interviews and focus group discussions with health care providers and women informants in 8 villages in order to capture diverse population of the sub districts of Lucknow.

Study Area

Lucknow district has four tehsils (Sub districts) and eight blocks and nine Community Health Centres (CHCs), out of which one is non-block and others are block level CHCs. According to Chief Medical Officer, Lucknow, only three CHCs are located in the rural area of the blocks namely - Mal, Bakshi ka Talab and Mohanlalganj. Only four percent villages have any type of health facility in the village itself, while only three percent villages have facility at the distance of one Km, 32 percent villages have facility between one to five Kms and approximately 64 percent villages were distant from the facility by more than five kms. Distance from the facility is higher in Mal, Malihabad, Bakshi ka Talab and Mohanlalganj(GoI,2008).

The most rural tehsil**- Malihabad** has been selected for the study, both of its CHCs has been covered to interview its health care providers which included Superintended, Lady Medical Officer, Lady Health Visitor/ Head-ANM. In Each CHC two PHCs will be selected randomly. In each PHC all the SCs covered will be listed and two SCs will be selected purposively according to their functioning and distance to the PHC (i.e. one good SC and more functional while the other relatively non- functional type).

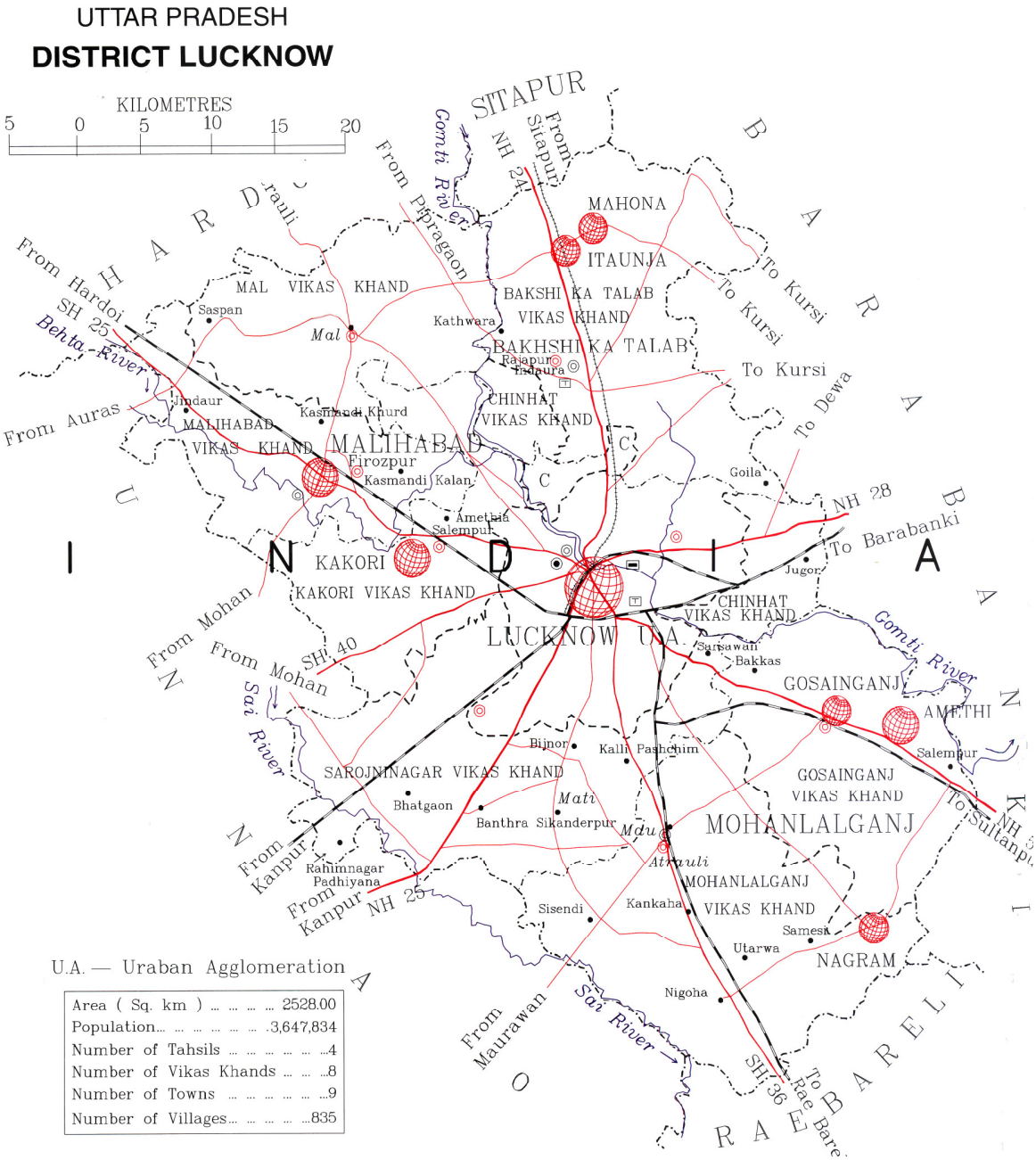

Table2. Sub-district (Tehsil) wise Public health facilities in Lucknow district, Uttar Pradesh, India.

Sub-district(Tehsil)/District	**Malihabad**	Bakshi Ka Talab	Lucknow	Mohanlalganj	Lucknow
% of Rural Population[1]	**95**	87	16	92	
No of Villages[1]	**185**	207	205	225	822
No. of CHC in Rural Area[2]	**2**	1	-	1	3
No. of PHCs in Rural Area[2]	**6**	8	7	5	26
No. of SCs in Rural Area[2]	**75**	49	119	85	328

Note- 1. Census of India, 2001
2. Bulletin of Rural Health Statistics, India, 2008

Selection Criteria for Women beneficiaries/nonusers from the 8 selected SC villages-

- ANM of the village prepares A list of all recently delivered women (RDW) in last one year which has been updated using Rapid appraisal technique. Then according to the information available with ANM about RDW's Antenatal Care (ANC), delivery and Postnatal Care (PNC), women has been categorized into three categories-

1. Full utilizers (ANC, Delivery and PNC from public health facility)
2. Partial utilizers (used any of the services from public health facility)
3. Non- utilizers

3.1 Those who used from private facilities MCH care.

3.2 Those who had not used any kind of facility for any MCH care.

- Two women have been selected randomly from each group in order to conduct IDIs.

i.e. 2*3*8=48 women. As the study is exploratory type, thus, if selected woman did not showed up at study time or not ready to participate in the study then she was replaced by a woman from the same category and with similar socio-cultural characteristics.

Methods

In-depth interviews were also carried out with women from different categories defined above. Interviews were conducted within a private setting, often at the interviewee's house, to ensure the confidentiality of the responses and the convenience of the respondents, especially those who never had any contact with the public health system. The study investigates the individual, community and provider level barriers influencing women's utilization of maternal health services through 48 semi-structured in-depth interviews with women who had given live birth in last one year and 26 semi-structured in-depth interviews with providers at different level of rural health care facilities in selected villages. Based on qualitative data collected from both providers' as well as clients', their perspectives on barriers and facilitating factors have been acknowledged .We triangulated responses from in-depth interviews (IDIs) with ANMs/ASHAs and lady doctors as well as IDIs with mothers of infants. We found that the responses were in accordance with each other for most of the results, with few exception for barriers to delivery care at facility and suggestions for improvement of postnatal care.

RESULTS

The SCs at any village did not seems to be working at first glance but regular observation suggests that ASHAs and ANMs used to visit the village-SCs mostly on Wednesday as it has been allocated as the day of Immunization. Laboratory facilities at most of the PHCs were not present. We also did not find privacy in consultant room of the physician. Both of the CHCs lacked ortheopediatrician and Anesthetists for surgery. Fund for Patient and Facility infrastructure-*Rogi Kalyan Samitis (RKS)* (Patient Welfare Committee) were mostly functional at CHC level. PHCs get funds from CHC level RKS. Ultrasound facility was not available at any CHC. Many programs and plan of NRHM have been implemented at these centres but complexity attached to the system, due to lack of proper information and availability of medicines many people do not turn up to use it.

Table 3. Antenatal care utilization and place of delivery in Malihabad, Lucknow, 2010.

	Village	Age of Mother	No. of Children	Received prenatal care at facility	Place of Delivery	Stayed at hospital after delivery
1	Gahdoh	24	2	Yes	DH	Yes
2	Gahdoh	35	3	Yes	CHC	No
3	Gahdoh	28	3	Yes	HD	
4	Gahdoh	30	3	Yes	On way to hospital	No
5	Gahdoh	24	3	No	HD	
6	Gahdoh	25	4	Yes	HD	
7	Gahdoh	26	2	Yes	PVT	Yes
8	Gahdoh	28	2	Yes	DH	Yes
9	Gahdoh	27	2	Yes	HD	
10	Madwana	26	2	Yes	PVT	Yes
11	Madwana	27	6	Yes	CHC	No
12	Madwana	22	1	Yes	PVT	
13	Madwana	20	4	Yes	HD	
14	Madwana	32	4	Yes	CHC	Yes
15	Madwana	26	2	Yes	CHC	NO
16	Jamulia	21	1	Yes	CHC	NO
17	Jamulia	22	3	Yes	CHC	No
18	Jamulia	18	1	Yes	PVT	No
19	Jamulia	35	4	Yes	PVT	No
20	Jamulia	25	3	Yes	HD	No
21	Jamulia	25	5	Yes	HD	No
22	Jamulia	20	1	Yes	CHC	Yes
23	Ghumsena	25	3	Yes	CHC	No
24	Ghumsena	20	1	Yes	CHC	No
25	Ghumsena	26	2	Yes	CHC	No
26	Ghumsena	23	2	Yes	HD	No
27	Ghumsena	25	2	Yes	PVT	Yes
28	Ghumsena	24	1	Yes	CHC	No
29	Ghumsena	-	3	Yes	CHC	No
30	Ghumsena		3	Yes	CHC	No
31	Ghumsena	24	1	Yes	HD	No
32	Mujassa	21	1	Yes	HD	No
33	Mujassa	40	4	No	PVT	Yes
34	Mujassa	28	3	Yes	CHC	No
35	Mujassa		4	Yes	CHC	No
36	Mujassa	30	3	No	PVT	No
37	Mujassa	30	2	Yes	HD	No
38	Naya Kheda	26	3	Yes	CHC	No
39	Naya Kheda	35	5	Yes	CHC	No
40	Naya Kheda	20	1	Yes	HD	No
41	Naya Kheda	17	1	Yes	CHC	No
42	Hamirapur	20	1	Yes	HD	No
43	Hamirapur	25	6	Yes	HD	No
44	Hamirapur	22	2	Yes	PVT	Yes
45	Hamirapur	28	5	Yes	PVT	Yes
46	Hamirapur	30	7	Yes	CHC	Yes
47	Dilawarnagar	28	3	Yes	HD	No
48	Dilawarnagar	26	5	No	HD	No
49	Dilawarnagar	25	1	Yes	CHC	No
50	Dilawarnagar	22	1	Yes	PVT	Yes

Use of prenatal care and delivery services

Table 3 presents the patterns of maternal health care use among the women interviewed. The self-reported age of participants ranged from 17–40, with a mean age of 26 years. The mean number of children per woman interviewed was three. The overwhelming majority of women interviewed (46 out of 50,) reported seeking any prenatal care at health facilities. The mean total number of prenatal care visits among participants was two. While 46 women reported accessing prenatal care services, only 22 (44%) women delivered in public health facilities. Out of total 15

women delivered at home and 11 have delivered at private health facility, even though they have received prenatal care at public facility.

Perception about services available for Maternal and Child Health (MCH) Care

Mostly women recognized the importance of MCH care services, but when asked specifically about the advantages of ANC and services they rarely acknowledged it. A number of women told that they knew it is beneficial for mother and child but from what ailments and diseases it prevents them, they hardly recognized.

*"Yes, I have taken TT injections during my pregnancy, at my maternal home I have seen my relatives taking that and they told me that its necessary for my child but I do not know the how it works".-**A recently delivered women, Age- 21, Jamulia.***

It has been observed that government facilities have been thoroughly utilized for ANC care, however women prefers to delivers at home in many cases. No women to go primary health centre for delivery, either they go to community health centre (CHC), private hospital or deliver at home. There are some household which prefer to go nearby city for better facility. Mostly these families are from better off economic strata and belong to higher caste.

*"Brahmins and Thakurs go to Lucknow for any health related problems". –**An ASHA (Village health worker), Gahdoh.***

It has been observed that facilities are not very well equipped due to which women suffer and avoid going there. Many CHCs do not have delivery bed which may be a cause of this type of dissatisfaction.

*"At hospital ANM asked to me push in sleeping position during my labor pain and that was very uncomfortable as I am not so strong, so I refused to deliver there and run back to home where I by myself deliver the child while seating at floor."-**A 34 year old mother, Jamulia.***

*"I thought that if I deliver at hospital I 'll get some money which is good in this poverty but at the time labor pain nobody was at home so everything happened at home with help of Dhanuk (a local dai who know about delivery)".-**A 24 year old mother, Gahdoh***

Due to Cash benefits of institutional delivery many women inspire to deliver at CHC just to have 1400 Rs. as compensation but they do not have any other obligation for facility and its utilization.

Perception about the community participation and role of health care providers in MCH services utilization

Health and sanitation committee at village level is non-functional at all the eight villages. When asked about that almost all women do not understand what has been asked but after several probing they recognized that sometimes few cleaning drives have been done occasionally mainly during political elections etc and but Village Head (Sarpanch) rarely helps and no regular meeting kept.

*"It's all in paper, we never heard about health and sanitation committee".**-A 21 year old young mother, Mujaasa***

Similarly, no women recognized about 'Rogi Kalyan Samiti'-RKS (Hospital Management Society) and it significance for the improvement in health facility available in their PHC. However, ANMs do know about it and involved in utilization of united funds through RKS, but in most of the facility it is non functional and funds which should have been utilized for infrastructure improvements, are kept idle.

Barriers to Utilization of available MCH services

Financial barriers

Though all the MCH care services are theoretically free of cost but indirect and informal payments such as travel cost to and from the government facility, leaving work to seek care, and paying for prescribed medicines (as most of women reported that government facility were short of medical supplies) were reported as considerable barriers to accessing care and treatment. Women's perceptions of the cost of delivery care services, including the cost of going to health facility and staying there, contributed to their decisions to seek delivery care at facility. According to an ASHA (village level health provider), there are few women did not completed their ANC package but go for institutional delivery just to receive cash benefit. Most of these mothers were experienced of child birth and they already delivered two or three children and it does not make any difference to them if they deliver at home or at hospital.

"when ANM comes to our village, I gather all the women who all are pregnant and have children for ANC and child immunization, but there are some who never come for TT but they call me at last minute come at hospital with them so that they can receive JSY money and I also get something (Money) as a compensation for bringing them." ***-An ASHA, Naya Kheda***

"There are fixed rate of nurses, ANMs and other staffs like Dai, Sweeper at CHC if you delver there you are bound to pay whatever they ask otherwise you will suffer, last year my sister-in law was admitted to the block hospital for delivery and after delivery ANM asked for money to see the face of boy" ***- A 22 year old Mother, Madwana***

"I have never found any women deliberately come to me for postnatal check up after delivery , in case of home delivery when they face any complication, then only the rush to us for help."- ***An ANM, Mujaasa.***

Family practices and traditional norms

Household position and its environment are significant determinants of use of any MCH care either it is just a visit to village sub centre, choice of place of delivery or immunization of children. Few families of high social status has been captured in the study and women especially daughter in laws of family have very less say on their own health and child care , they use to do what their husband and other member tell them to do and they are the main decision maker regarding service utilization. Many of the women who did not seek prenatal or delivery care stated that they were not accustomed to using prenatal care and were familiar with delivering at home like other women in their families.

"We face a lot of problems in getting these women, they never come to Anganwadi/ sub centre, even for getting immunization to their children and want to have all the services at their home as they are big and high caste people, but now we refuse to go at their homes , we have lots of paper work to complete, then how to go door to door but they do not understand and overlook us and feel proud in going to private facility and spending money ".- ***A 54 year old ANM, Dilawarnagar.***

"Now there are new ANMs appointed and they do not live here so we have very little interaction with them as they rarely visit us at home and we cannot go outside without someone".-A 25 year old mother, Gumsena.

Women's constant disdain and distrust for health care workers, including *CHCs' lady doctors which may be of other religion* strengthened their desire to rely on familiar, traditional forms of care. While a majority of people in Lucknow, Uttar Pradesh maintain strong religious conviction, women often attributed health care–seeking behaviours and both positive and negative outcomes of past experiences to fate. Family's norm and strong beliefs in traditional practices were used to justify failure to seek care and reflected a sense of limited control over health outcomes of women by themselves.

Previous experiences with Health care provider

Women's past experiences with poor-quality care or unclear information in health facilities influenced future behaviours (Lubbock and Stephenson, 2008). Poor communication or miscommunication with ASHA and ANMs also contributed to women's misperceptions and lack of understanding regarding healthy behaviours and potential complications, as revealed in the interviews. Reported irregular visit to village and lack of communication from health workers and other women in the community have led to delayed antenatal care visits and home deliveries. Uncomfortable or negative past experiences at delivery facility –CHCs including lack of lady doctors, excessive waiting times, lack of agency regarding one's health, and embarrassing physical examinations—discouraged women from seeking care at health facilities.

"It troubles me because many women tell me that they were touching the tummy and its embarrassing, I also fear of the vaccinations, they do not care how you feel , I have been terrified of vaccinations during my last pregnancy ,they put so many injection, now I have decided not to go there " - ***A 30 year old mother, Jamulia.***

A few women who experienced complications and had to deliver via caesarean section believed returning to the health facility for a future delivery would result in the same outcome. Complications that resulted after having received care from a CHC have deterred women from seeking future care at facilities or from *government facility.* Many women reported that they do not want to immunise their children from the ANM as she brutally put injection and sometimes child get sick and cry for three-four days. Though, there were a lot of women who are satisfied with the behaviour of doctors at CHCs.

*"The new lady doctor at CHC is very polite, sometimes we have to wait for long but due to her behaviour I like to visit there only and she is very young and close to my age so I do not hesitate to tell her my problems"- **A recently delivered women, age 25 years, Dilawarnagar.***

Logistic Barriers from Health care Provider

Most of the respondents agree that type of services provided at government health facilities are not adequate. Some of the providers pointed out that due to lack of ultra-sound facilities it has become very difficult to chase population for ANC care. Transportation facilities have been rarely citied as they are not found even at CHC level. Some of the respondents believe that only those who are BPL card holder are supposed to get this facility so they rarely ask for it.

*"We provide counseling, TT injection and IFA tablets, but we cannot assess if there is some internal complicacy, patient do not come generally for the next time, some of them do not even seek the above care at all but due to introduction ASHA some of them turn-up for delivery care just because they knew that they will get 1400 Rs if they deliver here". –**A General Physician, PHC ,Kahala**.*

*"In government CHCs or PHCs we have qualified doctors, whose diagnoses of the disease is always correct, accordingly they give medicine which should be taken for some time as it has a course but people thinks that it is not working and they go for local jholachap (untrained) doctors who gave them strong medicines like steroids and injections which may show effect immediately but they don't understand the side- effect hidden behind it but after sometime they came back to us with worse situation".**-Superintendent, Community Health Centre, Malihabad.***

On the other hand private doctors and local NGOs claims that unavailability of medical staff and poor quality of care in terms of pathological services, privacy and unreliable medicines prevent many of the user from government facilities' utilization.

*"For common disease like cough-cold, fever and for immunization people use to go to government hospitals but in case of long duration disease or any specialist care they prefer private hospitals and doctors as at government hospitals these cares are generally available to those who had some approach there" **- A Private Doctor, Naya Kheda***

SWOT Analysis for MCH care for Policy recommendation

The PHC programme in India has its internal (organizational) strengths and weaknesses and the community and women household's environment poses opportunities and threats. Analysing this is crucial for strategy development (Mavalankar, 1996). Thus Summarizing MCH services and health program's strengths, weaknesses, opportunities,

and threats based on the analysis of Clients' and Providers' information, Table 4 gives us new insights for policy recommendations.

Table 4. Identification of Strengths and Weakness (Providers' perspective) as well as Opportunities and threats (Clients or potential users' perspective)

Strengths	**Weakness**
1. Performance-based incentives for staff **2.** Flexibility in financial management and untied fund utilization **3.** New policies of insurance for girl child **4.** Cash benefit scheme for institutional delivery **5.** Generous supply of Vaccine and TT injections for MCH care.	**1.** Low motivation among women and their families. **2.** Lack of transport facility **3.** Lack of building and cold storage in village sub centre and PHC. **4.** Poor performance of family planning programme due to cash benefit of institutional delivery **5.** Lack of community and support of local leaders**.**
Opportunities	**Threats**
1. Local health worker, i.e. ASHA, Anganwadi workers availability in village. 2. Husbands and Mother-in-laws motivation 3. Benefits of institutional delivery and cleanliness at hospital 4. Connectivity to road enables to use MCH services of distant facility.	1. Lack of Doctors 2. Waiting time at facility 3. Timing of the facility (opening hours) 4. Distance 5. Private practioner and local faith healers 6. Lack of medicine 7. Approach in the facility for secondary and tertiary level care 8. Lack of transport facility in village and CHCs 9. Lack of Infrastructure facilities in SCs, PHCs and CHCs 10. Poor quality of services

Discussion and Conclusion

This study examined the perceived barriers women confront when accessing maternal health services within the cultural context of Uttar Pradesh, India. The study has identified a range of barriers, beginning from individual distrust and cultural and family norm, provider's behaviour to women and children to seeking care that have also been shown to be important in other countries and cultural contexts (Thaddeus and Maine, 1994; Lubbock and Stephenson, 2008). The findings indicate that financial obstacles, especially in relation to transportation, time constraints, and availability of health care staff and services influence women's utilization of ANC and delivery services. While women who perceive prenatal and delivery care to be relevant overcome the logistical barriers with the support of family members, most notably their husbands and mothers-in-law. Various factors facilitate women's utilization of institutional-based maternal health services, especially the ASHA of village who go with them at time of delivery at well acquainted with the hospital management and formalities at facilities.

Through JSY (Cash benefit scheme), ASHAs- the village health workers are recognized as the drivers for promoting utilization of public health facilities. Being a local resident, they are more accessible and acceptable to clients in their communities, thus they are expected to improve the overall coverage of services as well as equity—increased service use by poorer individuals, women and other vulnerable sections. As demonstrated in this study, better understanding of community and individual perceptions about prenatal care, the quality of services, and women's health needs enable then to improve the efficacy of public health interventions and contribute to increased utilization and effectiveness of maternal and child health services.

The above discussion suggests that there is clear need to address the issue of responsiveness of health system in the hierarchical way. Regardless of physical accessibility, acceptability of maternal health services in community emerges as critical avenue for the utilization of both maternal and child health care services. Apart from reproductive and child care there are several other diseases mentioned which should be embedded in the public health care delivery system according to the local area needs. Barriers mentioned according to provider's perception are also numerous like doctors availability, waiting time, timing of facility and other supply side issues which should be complemented by client perspective also.

Role of field workers like ANMs and ASHAs needs more rigorous assessment to know whether they are able to fulfill their role and responsibility for which they introduced in the existing public health system. It has been observed that delays and non-utilization of MCH care during pregnancy are influenced not only by poor access to care and economic barriers but also by individual knowledge and position in the household. Support of household members, previous health care experiences and social networks in the village and interaction with health workers affect women's decision to seek care.

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