RURAL HOUSEHOLDS:
Understanding Health Care-Seeking Decision Making
**Partners for the report**
Stanford India Health Policy Initiative
Institute of Socio-Economic Research on Development and Democracy (ISERDD)

**Authors**
Alison Baskin
Nicole Dalal
Veena Das
Priyanka Goyal
Sophie Harkins
Charu Nanda
Geeta Nanda
Sara Silberstein
Chinar Singh
Manraj Singh
Rajan Singh
Jacob Svenson

**Editing and content review**
Liz Ogbu
Teal Pennebaker

**Graphic Design**
Sheetal Kalidindi
This field work would not have been possible without the steadfast collaboration and support of Veena Das and the Institute of Socio-Economic Research on Development and Democracy (ISERDD). We are also grateful to Liz Ogbu for contributing her design thinking expertise.

It is our hope that these insights and suggested opportunity areas will encourage policymakers, health care professionals, researchers, and non-government organizations to pay further attention and pursue additional study on the topics and insights proposed in this report.
# TABLE OF CONTENTS

1. Executive Summary..................................................................................................5
2. Background...............................................................................................................7
3. Research Methodology...............................................................................................12
4. Observed Household Provider Choices....................................................................14
5. Undesirable Attributes of the Public Healthcare System.................................16
6. Preferred Provider Attributes..................................................................................18
7. Individuals Who Influence Provider Selection....................................................23
8. Conclusion.................................................................................................................28
9. References...............................................................................................................29
10. Appendix...............................................................................................................31
**Executive Summary**

Rural health care resources in Uttar Pradesh, India include a complex network of providers with a spectrum of training, skills, and services. This leaves Indians living in rural areas with many options for choosing health care providers. In recent years, government policies like Janani Suraksha Yojana (JSY), which provides subsidies for women who have institutional births, and Rashtriya Swasthya Bima Yojana (RSBY), a public health insurance program for impoverished families, have tried to extend health care coverage to rural areas and incentivize the use of public health facilities. Despite India’s push towards government-provided universal health care, the majority of rural Indians still seek care from private, as opposed to public, providers. Most rely on local informal providers, who do not have government-recognized degrees in allopathic medicine, for health care.

The government policies that promote formalized, public health care in rural India warrant further exploration. By studying the influencing factors in household health care-seeking decisions, policymakers might better understand the outcomes of policies and programs intended to improve health care access.

The aim of this study is to identify and explore factors influencing household health care decisions. Findings are based on field work conducted in rural villages in Uttar Pradesh. We focused our research on how households choose health care providers. We also provide readers with opportunity areas for further research on the health care network and community dynamics in rural India.

*Findings are organized into broad thematic areas. We first lay out observations about household provider choices, which help orient the reader and provide context for further observations. We then introduce insights into what influences provider choices.*

**Observations of Household Provider Choices**

Households reported creating their own perceived hierarchy of health care providers’ quality of care. For the typical medical concern, community members started at the bottom of this hierarchy, using local, non-degree providers as their first points of contact. The decision to first seek care from local providers was generally based on a combination of factors, including the reportedly high barriers to accessing care from public facilities, trust in local providers, and the low costs and practical convenience of seeking care from a community member.

Households moved up their hierarchies, seeking care from other providers based on the persistence and severity of the patient’s medical condition. Exceptions to this typical care-seeking behavior are also detailed in this section.

**Undesirable Attributes of the Public Health Care System**

Households consistently reported being deterred from using public hospitals because of negative attributes. The reported attributes included rampant bribery and corruption within the public health care system, difficulties navigating public facilities, inconvenient referrals to outside clinics or pharmacies, extra fi-
nancial costs from using public facilities, public health employees’ lack of systematic accountability, and lack of individualized care. These attributes reinforced the tendency to seek care from local providers outlined in Section 3.

**Influencers of Provider Choice:**

*a. Preferred Provider Attributes*

When choosing a provider, households judged providers’ clinical efficacies within their immediate network. Proxies for clinical efficacy included households’ general trust of providers and the degree of satisfaction with medicines obtained from providers. Satisfaction with medicines was judged based on ostensible improvements in symptoms, perceived speed of improvements, and the number and severity of side effects. In weighing their options of whom to visit for medical needs, households generally did not take into consideration the formal degree status or training of providers. Instead, they tended to consider how much clinical experience a provider had.

*b. Individuals who Influence Provider Selection*

Particular actors within the health care environment greatly influenced households’ selection of health care providers. In some instances, a community’s relationship to its designated community health workers (CHWs) shaped community members’ use of the public health care system. CHWs who were particularly active and built a favorable reputation among households tended to be particularly strong influencers of household decisions. Fellow community members also impacted household health care-seeking behavior. Households reported discussing their health experiences and perceptions of both public and private providers with one another. Within the household, individual players could determine health care decisions. This report looks at the roles of spouses, elderly family members, educated family members, and financially responsible family members.
Introduction: Outlining the Rural Health Care System

As one of the most populous and fastest developing nations in the world, India has complex health care needs. While urban India has seen rapid improvements in health care infrastructure, rural India still lags behind in many key health measures, including maternal health, infectious diseases, bacterial diarrhea, and a lack of access to quality health care. The Indian government began to focus on the improvement of all states’ rural health care infrastructure with the development of the National Rural Healthcare Mission (NRHM) in 2005. The NRHM aims to address all facets of rural health, from infectious diseases to non-communicable injuries, in eighteen identified Indian states including Uttar Pradesh. As a part of the broader National Health Mission (NHM), the NRHM has declared eleven health indicators to target to ultimately provide “accessible, affordable, and quality health care to the rural population, especially the vulnerable groups.” Some goals for NRHM programs include: reducing the maternal mortality ratio to 1/1000 live births, reducing the infant mortality ratio to 25/1000 live births, reducing the total fertility rate to 2.1, preventing and reducing anemia in women aged 15-49 years, preventing and reducing morbidity and mortality from communicable and non-communicable injuries and emerging diseases, and reducing household out-of-pocket expenditures on total health care expenditures. In addition to initiatives that introduced Accredited Social Health Activists (ASHAs) into rural states, provided health care contractors to underserved areas through enhanced skilled nursing staffs, and integrated AYUSH practices into the National Health Care Delivery System, NRHM has implemented other programs such as JSY, RSBY, and ambulance services as described in greater depth below.

This report focuses on health care systems in rural Uttar Pradesh, which has a unique set of health care issues. Based on 2012-2013 data from the NRHM, Uttar Pradesh has an infant mortality rate that is 1.25 times the national average and a maternal mortality rate that is about 2.2 times the national average. Additionally, in Uttar Pradesh (UP), nearly 77 percent of deliveries happen at home, indicating low rates of institutional deliveries and suggesting that there are relatively greater rates of deliveries by informal providers, especially in rural settings (Table 1).

In rural India, 70 percent of health care visits are to informal providers. The Indian government has focused on providing medical care through formal public sector providers such as Bachelor of Medicine, Bachelor of Surgery (MBBS) degree holders. However, there is a large unmet need for health care, which is often filled by non-degreed, informal providers. A 2011 study published in the Indian Journal of Medical Research found that the majority of rural Indians name informal providers as their first point of contact for almost any health issue. In a 2011 study, Gautham et al. found that survey respondents in the Indian states of Orissa and Andhra Pradesh were more likely to choose non-degree holding informal providers due to their proximity and willingness to make house calls.

Despite the various successes of the NRHM program, existing research continues to highlight the weaknesses of the rural health care system. A 2013 study conducted by Das et al. used standardized patients to demonstrate the poor quality of medical care in parts of Madhya Pradesh. The study found that less than one third of sampled providers reported any formal qualifications at all, and that there were very few differences between qualified and unqualified providers in the care patients received. In both groups, correct diagnoses were rare and incorrect treatments were widely prescribed.
Public Facilities and Government Policies

Past research suggests that people in rural areas more often seek treatment in private hospitals than they do in public facilities. According to a survey conducted in 2010 by the Centre for Policy Research, 19 percent of rural residents who had visited a health care provider in the last month visited public medical staff, while the remaining 81 percent turned to the private sector. This trend existed even among the poorest 20 percent of households, where 61 percent of visits were to private providers. Data from the India National Family and Health Survey showed that 70 percent of married women experiencing gynecological symptoms chose to seek treatment in the private sector, regardless of socioeconomic status.

To respond to these trends, the Indian government created numerous incentive programs, many of which are under the NRHM, to promote use of public facilities and reduce the use of “unqualified” providers in the private sector. Examples of these programs include:

Janani Suraksha Yojana (JSY) Institutional Delivery Scheme

Janani Suraksha Yojana (JSY, ‘Safe Motherhood Scheme’) is a centrally funded program that aims to improve prenatal, perinatal, and postnatal care for poor women. The government provides a cash incentive of up to Rs. 1400 (USD 22.02) to mothers who deliver their babies at select government institutions.

Rural Health Care Structures

| Primary Health Centers (PHCs) | • The first tier of India’s health care system.  
• They service 20,000-30,000 people.  
• These centers have four to six beds and a Medical Officer who oversees the facility.  
• PHCs generally provide very basic, and mostly prenatal, care.  

Subcenters | • Health care facilities that serve roughly 5,000 people  
• Anganwadis are based here.  
• Auxiliary Nurse Midwives (ANMs) routinely come here to administer vaccinations.  
• Subcenters typically provide nutrition packets, basic medications, infection control, and treatment for diarrhea.  

Community Health Centers (CHCs) | • Serve populations of 100-300,000.  
• Provide one level of care above PHCs.  
• Typically have 30 beds including normal deliveries and some specialty care.  

Poorly performing states with low rates of institutional deliveries, including UP, are designated as high focus states under JSY. These states offer larger incentive packages (Rs. 1400) to all rural women -- irrespective of socioeconomic status -- who deliver in a public institution, as well as Rs. 600 (USD 9.44) to the community health workers (known as ASHAs) who accompany the women.9

While policies such as JSY have aimed to increase rates of institutional deliveries, women and their families still encounter barriers to participating in institutional delivery schemes. For example, some women prefer to deliver at private institutions due to their perceptions of the quality of care they will receive there compared to at private institutions. Others would prefer to participate in the JSY program, but ancillary costs of transportation or bribing nurses deter them from going to public facilities, reducing the potential efficacy of these programs.9 Increased JSY use is associated with increased antenatal care use, increased institutional delivery rates, and decreased neonatal mortality. However, there are no indicators that JSY and institutional deliveries have led to significant changes in maternal mortality.10

In 2014, an important change was made to the JSY payment distribution system -- women would no longer receive bearer’s checks, but would instead receive direct deposits into their bank accounts. Due to its recent implementation, not much literature exists detailing the impact of this change. While our field research cannot assess the impact of this change, households were aware that the government had altered the program.

Rashtriya Swasthya Bima Yojana (RSBY) Insurance Scheme

In 2008 the Indian government launched the RSBY program to provide reliable health insurance coverage for below poverty line (BPL) families. According to the guidelines of RSBY, beneficiaries are entitled to hospitalization coverage up to Rs. 30,000 (USD 471.81) for “most diseases that require hospitalization.”11 As part of the program, certain illnesses and ailments are assigned “treatment packages” pre-negotiated by the government for a fixed rate. Entitled families pay only a Rs. 30 (USD .47) registration fee, while the government pays the insurance premiums to preselected firms.11 Local providers expressed varying levels of satisfaction with the program’s funding schemes, and some reported that they did not always receive reimbursements for treating RSBY patients.

102 and 108 Government Ambulance System

As part of the NRHM, the Indian government also developed the National Ambulance System (NAS) in an effort to provide much-needed transportation services to and from local public hospitals for rural residents, who would otherwise not have access to free transportation. This prevented some from getting to a hospital quickly and safely after an emergency.12 Within the NAS, two ambulance branches exist: 108 and 102.

Officially known as the Samajwadi Swastha Sewa, the 108-ambulance system was started in 2005 in Hyderabad and was adopted by UP in August 2012.13 14 The 108 service is predominantly an emergency response system for patients in critical condition and for trauma victims. As of December 2013, 7,239 ambulances were operating in UP under this system. In January 2014, a new ambulance system known as 102 was launched in Uttar Pradesh.15 It provides basic transport to and from the hospital, meant to fulfill guidelines outlined in the government’s Janani Shishu Suraksha Karyakaram (JSSK) incentive program.

Non-Degreed and Degreed Providers:

For the purpose of this report, we distinguish between formal and informal providers.
We define informal providers as those who practice medicine for which they do not have a degree. Most commonly, this occurred when providers lacking degrees or providers with Ayurveda, Yoga and Naturopathy, Unani, Siddha, or Homeopathy (AYUSH) degrees reported that they practiced allopathic medicine. Although some AYUSH doctors gain exposure to allopathic medicine during training, the legality of mixing medicines is unclear. Villagers often visit these providers for common problems such as a cough, fever, and pain. They can sometimes act as unlicensed pharmacists, giving out medications and injections to patients.

Formal providers are those who practice the medical discipline for which they have a government-recognized degree. This includes all AYUSH providers who practice their respective AYUSH medicine and who do not practice allopathy, as well as MBBS doctors who do practice allopathy. Those formally pursuing allopathic medicine will usually earn a Bachelor of Medicine and Bachelor of Surgery, or MBBS, degree. Training typically lasts 5.5 years, inclusive of a 1-year internship. This is analogous to pursuing a Medical Degree (M.D.) in the United States. The Indian Government recognizes formalized degrees in five traditional medical disciplines of AYUSH.

Community Health Workers (CHWs)

- Accredited Social Health Activists (ASHA workers) are government employed health workers supported by NRHM programming. They are usually local women who form a link between the public health services and the community. After training at a local CHC, they perform various roles that include encouraging local women to use public facilities for antenatal care and deliveries. ASHA workers are compensated up to Rs. 600 (USD 9.44) for accompanying a woman to a public facility for her delivery. They also help register pregnancies and provide general health counseling.
- Anganwadi workers are primarily concerned with immunizations and child nutrition. Oftentimes working in collaboration with ANM and ASHA workers, Anganwadis promote immunizations and counsel women on nutrition, pregnancy-related care, and other health topics in rural village settings.
- Auxiliary Nurse Midwives (ANM) are nurses in the public health care system who perform deliveries and provide other care to women and children. This includes acting as a resource for family planning and delivering immunizations. They often work in concert with and train local ASHA workers.

Patient’s Reliance on Medicines

The World Health Organization (WHO) defines the rational use of medicines as the scenario in which “patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community.” Inappropriate use and overuse of medicines waste resources and result in poor patient outcomes and adverse drug reactions. More specifically, the overuse of antimicrobials has been linked to increased antimicrobial resistance. While we did not distinguish what we observed as rational or irrational use of medicines, we did observe certain trends in related areas such as injection use.

There is some evidence indicating that individuals in rural, developing areas like Uttar Pradesh have a strong preference for receiving medicines in the form of injections. A literature review found that injection overuse, as well as unsafe injection procedures, is common in developing countries. In the specific context of Northern India, research has supported this notion. A 2005 report in the journal
Tropical Medicine and International Health looked specifically at two rural areas in northern India and found chronic, unsafe use of injections.\textsuperscript{21, 22} A 2003 study that looked at drug use in rural Varanasi (an area of Uttar Pradesh) also observed an overuse of injections. Despite such studies, our observations -- further discussed in section 5 -- did not consistently corroborate this trend.

**AIM OF OUR STUDY:**

Our goal is to understand what motivates rural Indians to choose their providers. This knowledge is important when considering policies and programs meant to improve provider quality of care and health care facilities.

While there is some knowledge about health care behaviors in rural India, many questions remain about the community and individual motivations behind these observed patterns. Understanding these perspectives is crucial to ensure proper implementation of health care policies and ultimately improve community health. Through our work, we examine some communities’ motivations that affect provider choice to document the realities of health care decision-making in rural India. Additionally, this report seeks to provide policymakers with the necessary insights to create effective, efficient programs that truly address the needs of the target population.
Identifying Districts, Blocks, and Villages

Data was collected in the district of Allahabad, Uttar Pradesh (UP). UP is one of the four colloquially named “BIMARU” states, which are northern Indian states with historically low literacy rates, economic growth rates, and health indicators. Among the four BIMARU states, Uttar Pradesh has had the slowest compounded annual growth rate over the past nine years. UP’s institutional delivery rates and other health indicators are some of the lowest in India. The NRHM has focused on health care programs in UP, including JSY, RSBY, and other government programs. Although public health care infrastructure and facilities exist in UP, these government programs have been slow and ineffective in improving health care measures.

This study focused on the district of Allahabad, which is located in southern Uttar Pradesh at the confluence of the Ganges and Yamuna rivers. Allahabad has a population of around 6 million people, 75% of whom live in rural villages. Allahabad district contains CHCs, PHCs, and Subcenters as well as an abundance of private providers and nursing homes. As illustrated in Table 1, the district of Allahabad’s health indicators, such as the percentage of institutional deliveries and mean maternal education, are in line with UP averages and representative of the state.

We categorized villages based on their demographics and on their proximity to Allahabad, the nearest major highway, and the nearest public health facility. We attempted to select a sample of villages that were representative of these different characteristics. To gain a broader understanding of the health care delivery system in rural UP, we visited a variety of health care facilities, including CHCs, PHCs, Subcenters, and village provider clinics that were referenced by participants in focus group discussions.

Qualitative Methods

For seven weeks, we employed an interview-based approach to collecting qualitative data through field work. Data collection consisted of semi-structured interviews with individuals, focus group discussions with both large and small groups of interviewees, and observations of working CHWs. Members of the research team interpreted between Hindi and English, with multiple researchers recording data during the same interview or observation period to minimize individual error and bias. At the end of every data collection day, the research team debriefed about the day’s findings. Raw data, individual interpretations, and group consensus on findings from the field were stored electronically on a regular basis. This was done to capture individual reactions, which were later explored during the data analysis phase. Raw data was used as concrete reference material during analyses.

Interviewee Profiles:

We interviewed community health workers, including ASHA workers, ANMs and Anganwadis. The CHWs’ experiences and observations were helpful in identifying problems in the villages and the health care system. Upon arriving in a new village, we first interviewed the ASHA or the ANM. These CHWs provided us with initial information about the village, such as the village’s primary education level, religion, and utilization of health facilities. They also provided us with introductions to other community members whom we then interviewed. The CHWs were trusted individuals within the village community, and their assistance in recruiting interviewees resulted in villagers’ increased willingness to speak candidly with us. While the CHWs were not the primary focus of this research, their perspectives did provide valuable context about the local health system.

The majority of the data we collected comes from interviews with villagers. We interviewed groups
of community members, ranging from about 10 to 25 individuals. At times we focused on one family in particular or a subset of men or women in a group interview. One member of our research team would initiate these focus group discussions with the help of a local villager or community health worker. When possible, we attempted to hold focus group discussions without community health workers, since we wanted to evoke honest discussion around local health resources, and did not want a CHW’s presence to bias discussion. We often separated men and women for large focus group discussions. At least one focus group interview was conducted in all villages visited.

Interviews were conducted in Hindi and ranged in length from about 30 to 90 minutes. Members of the team translated for the non-Hindi speakers, and multiple researchers took notes during each interview to capture more detail and increase accuracy of data. All data was written down in field notes and later transcribed into an online document. We often collected data from villagers directly, including estimates on statistics such as village population or distance from the nearest public facility. We attempted to independently verify these reports. Researchers also noted auxiliary observations. When visiting health facilities, for example, we observed the sanitation techniques, the hygiene of the workers, and other factors that affect the health care environment.

While our research does not aim to assess health care quality, interviewees reported their assessments of different providers’ quality of care. These quality reports were taken at face value. Assessments of quality were often expressed as descriptions of a provider’s ability to “make a patient better” in comparison to another provider. Due to the absence of measurable quality standards, it is not clear whether quality deemed “higher” by patients is thereby a reflection of “stronger” medicines, a higher provider education level, and/or more provider experience. It is unclear what interviewees meant by “stronger.” This is discussed in greater detail in Section 5.

Data Analysis:
Upon returning from the field, we clustered data points from a representative selection of interviews and devised broad themes under which data points fell. We then identified patterns within each theme. This allowed us to develop insights into household motivations, decision-making processes, and behaviors about health care. Topics that we felt warrant further investigation by potential stakeholders or researchers are denoted as opportunity areas.

Figure 3: Flowchart Diagram of Research Methodology
Section 3: Observed Household Provider Choices

We first describe the care-seeking pathway. Next, we lay out households’ reports about public facilities’ undesirable attributes, which deterred households from seeking public providers’ care and made local providers more appealing as a first point of contact.

Community members generally first sought care from an informal, non-degreed provider. This provider was typically in close proximity to the home and located in the household’s village.

The number of informal providers in a village varied from about one to four. Community members were typically able to refer to these providers by name, with many individuals having a familiar relationship with a provider. Community members sought out care from such individuals before pursuing medical treatment from a public facility operated by the government or from a private doctor perceived to be of higher quality. Reasons for such behavior included convenience and accessibility, financial constraints, familiarity with the local provider, and negative opinions of public facilities.

Patients often pursued care from alternative providers when they experienced no symptom relief or when their conditions worsened after visiting a local, non-degreed provider. This movement toward providers of “higher quality” indicates that community members formulated their own provider hierarchies. Providers perceived to be of higher quality may charge higher fees or practice in more formal, larger facilities.

Parameters for “better quality” were vague, yet the willingness of villagers to seek more expensive treatment that may be less convenient indicates that they found this next tier of care worth the increased monetary or opportunity cost.

We did not find a pattern in the types of facility a community member would visit after leaving the local informal sector. Individual households’ decisions were shaped by the accessibility of a particular facility, the perceived quality of that facility, and the experiences of other community members at that facility.

Community members who moved from informal local providers to “better” alternatives for non-urgent, unexceptional cases generally did so after waiting one to two days from the time they visited their first point of contact. Community members reported taking children to see providers sooner, rather than waiting multiple days to see if symptoms would subside. The highest quality providers were often believed to practice in large private facilities. Thus, health issues of greatest priority were seen in these facilities earlier than other conditions that moved through the standard provider progression.

Households often formed their own barometers of illness severity. These barometers were reinforced when smaller-scale providers -- like local, non-degreed providers or providers at public clinics -- immediately referred patients to larger facilities outside of the community. These smaller-scale providers chose not to treat certain cases or simply did not have the ability to treat a particular medical condition because of their limited resources. A provider’s decision not to treat a certain case was often made out of fear of compromising his or her reputation (see Section 6 for further discussion of the reputations of providers).

Exceptions to Typical First Points of Contact

Although local, non-degreed providers were routinely the first points of contact, there were exceptions for cases of elevated urgency and/or impor-
tance. The most commonly reported and observed exceptions were those of emergency injuries, deliveries, or pediatric illnesses.

1. Emergency Injuries
   Local, informal providers generally did not treat emergency injuries. They did not appear to have adequate facilities or the resources required to treat serious injuries. Instead, community members reported traveling by either personal transportation or by ambulance to a nearby hospital.

2. Deliveries
   Community members did not generally seek care from local, informal providers for deliveries, unless the provider, often female, was specifically known for performing deliveries. Women typically reported going to public or private facilities for their deliveries, with many factors influencing which of the two options they would pursue.

3. Pediatric Illness
   Household members prioritized their children’s well being over their own. As a result, households took their children to local pediatric specialists or to other reputable providers perceived to be of higher quality. Parents often expressed wariness toward particular providers or facilities (most often public facilities) and did not want to compromise the care that a sick child would receive from providers in these places. This prompted some to alternatively visit formal private providers, commonly referred to as “child specialists.” In addition to expressing concern for their children, households reported feeling pressure to seek out higher levels of care for their children to avoid judgment from their community. Households did not want to appear to be “skimping,” seeking out less expensive and potentially lower quality care, to save money on care for their children.
Section 4: Undesirable Attributes of the Public Healthcare System

The public health care system is intended to provide low-cost health care services, especially for low-income households. The cost of health care is a major factor in the decision-making process of choosing providers. Despite lower upfront costs of government-run medical services, households consistently identified many undesirable attributes of these services, which seemed to deter use of the public health care system.

Non-clinical, negative attributes of public hospitals

Community members generally perceived public facilities and those who worked in them as corrupt, citing institutionalized bribery, physician absenteeism, and illegal referral to outside clinics. They also noted a systematic lack of channels to communicate these perceptions as well as a lack of accountability among public providers and staff.

Households reported witnessing corruption or hearing second-hand reports of corruption within the public system. Most often, these reports criticized non-physician staff at public facilities, such as nurses or administrative staff. They were identified as requesting bribes from patients in order to access physician care or for services such as cleaning a patient after child delivery. One woman even reported that she had to pay a bribe to a nurse to see her baby after delivery. One community member said in a focus group, “It is the age of corruption.” Community members noted that public facilities often seemed short-staffed. This was attributed to public providers ending their shifts in public facilities early, sometimes to practice in their own private clinics. Households noted that both absenteeism and practicing in private clinics illustrated violations of public provider’s duties.

This perceived absenteeism corroborates other negative perceptions of public health facilities. In public hospitals, patients experienced long lines, dirty facilities, and poor treatment from staff members, with no guarantee of being seen by a physician. Community members tended to associate these opinions more strongly with smaller Subcenters versus with larger public hospitals in the city, which they regarded to be of higher quality. There was a perceived lack of access to facilities within public hospitals, and some hospitals had reputations of being better able to treat or attend to certain medical situations. For example, large private hospitals were known to have more facilities and equipment for deliveries.

Generally, community members portrayed public facilities as difficult-to-navigate, poorly regulated institutions. Households reported that those with lower levels of education had greater difficulties seeking care at public facilities. Conversely, those with higher levels of education or with personal connections to public hospital staff members could more easily navigate the public health care system, partially due to higher rates of literacy and proficiency in reading signs and taking directions. Differential treatment between higher and lower educated individuals may factor into this, though this was not directly observed. Some reported that community members of lower castes had greater difficulties navigating the public health care system or received worse treatment from staff members, though this may be due to the correlation between education
level and caste.

Community members also reported the inconvenience of having to visit an outside pharmacy for medicines after receiving a prescription from a public hospital provider. This contrasted reported experiences of seeking care from private hospitals in which providers prescribed medicines that could be obtained in the same facility. Prescribing medicines that required patients to fill prescriptions outside the public hospital was reported to be an illegal practice, though we have not been able to corroborate that with other sources.

**Having to pay bribes to expedite service was one of the many reported hidden costs of seeking care at public institutions.**

Households consistently complained of long wait times in public facilities, which created a large opportunity cost for patients. One man told us, “Money and bribery won’t change the medicines you receive, [but] only decreases your wait time” in public hospitals.

Additionally, community members often had to incur extra costs for transportation to public facilities, although many community members were aware of the free ambulance system. Despite acknowledging that public facilities were cheaper than private facilities, the transportation costs to public hospitals and the necessary bribery involved in navigating public facilities often led community members to prefer private hospitals. Even in the instances when mothers would receive JSY benefits for delivering their babies at a public institution, the overhead costs of using the public system sometimes offset the JSY benefits.

**Clinical, negative attributes of public hospitals**

**There was a perception among households that public hospitals did not provide individualized or thorough care.**

We commonly heard community members use the term “PC, TC, BC,” an abbreviation for “Paracetamol, Tetracycline, B Complex.” This phrase was used to illustrate the lack of individualized prescriptions from public hospital providers. This seemed to negatively affect community members’ perceptions of public physicians. The idea that public physicians write prescriptions for one of three medicines for most ailments was disseminated through word of mouth within communities. For instance, in one village, some community members told us how they compared their actual prescriptions after going to a public facility. One man had a pain in his arm, while another had abdominal pain. They reported receiving the same prescription from a public facility. Other community members knew about this incident and seemed to weigh this when considering seeking care from a public facility.

**Opportunity Area**

Research the true costs of public treatment after taking into consideration transportation costs, pharmaceutical costs, bribes, and referral costs, and compare the average costs to those of private clinics.
Community members expressed dissatisfaction with their perceived lack of individualized care in public facilities, underscoring their desires for individualized care from private providers. Households reported that private providers spent more time assessing patients and were more thorough in making diagnoses compared to public providers. However, patients rarely reported that providers, either public or private, offered a thorough explanation of diagnoses. Instead providers only offered directions on which medicines to take and how to take them. Oftentimes, patients reported that private providers offered more thorough directions than public providers did.

Despite the perceived shortfalls of the public health care system, community members did not report having channels to communicate their frustrations, observations, and experiences.
Section 5: Preferred Provider Attributes

From a household perspective, a provider’s perceived clinical attributes were vital elements in provider selection decisions. Community members often had a network of providers from which to choose, even after taking into consideration barriers to care such as cost and transportation. The perceived efficacy of care became an important factor in the decision-making process. Multiple factors -- including clinical expectations, preferences for certain types of medicines, and patient-provider relationships -- were all important to community members and determined a community’s perception of a provider’s competence and performance.

Patient expectations of receiving medicine influenced care-seeking behaviors.

Community members consistently reported that regardless of medical condition or provider location, they received medication or a prescription for medication at every visit to a health care provider. In one interview, a woman said that she would never visit a provider without needing medicine. Because receiving medicine was a crucial part of the patient-provider interaction, it is possible that self-medication could undermine the necessity for a provider. However, when asked if they self-medicate, most households responded that they did not self-medicate due to a variety of concerns including: children obtaining access to the medications, being unaware of all effects or side effects of medicines, and the medicines expiring before use.

Additionally, the supposed quality or “suitability” of the given medicines was also a major factor determining provider choice. Community members often used the word “suitability” to describe medicines, but definitions varied among individuals. In general, the term “suitability” meant that the medicines were efficacious and quick in providing symptom relief. As one community member reported, suitability “simply depends on the person.” Preconceived notions of which providers offered “suitable” medicines were major factors in provider selection.

Household perceptions of the suitability of medicines varied across providers. For instance, some believed that the government hospitals had good medicines that suited patients. Other communities believed that public hospitals dispensed the same medicines to all patients. Though we did not assess the quality of medicines administered by different providers or facilities, in general, households tended to attribute widely prescribed medicines as low in quality and nonspecific to their particular conditions.
Some communities expressed the belief that all of the good or suitable medicines were “siphoned off” from the government hospitals. These perceptions drove individuals to seek care from other sources, including informal providers. In one community interview, individuals noted that although their local informal provider did not have a degree, they did not care because he gave good medicines for any small illnesses.

Some community members believed that branded medicines — those manufactured by a large company and branded by name — were stronger, faster, and led to fewer or no side effects. They reported that these medicines were more expensive. Providers who offered these branded medicines were consequently seen as providing superior care. For example, one community member reported that a bigger, more prestigious private clinic was probably more expensive because it gave “stronger medicine” leading to a higher imposed cost to patients. It was observed that the perception of the medicine as branded led to individuals reporting a desire to access these sources of care, despite higher associated costs. This suggests that the perception of which medicines a provider dispensed impacted the perceived clinical efficacy of this provider.

**Despite explicit demands for medicines, preference for injections was not as widespread as expected.**

Despite the evidence suggesting a preference for injections in rural areas in developing countries, this trend was not observed in our field research. Community members expressed diverse views about injections. Some claimed a preference for injections because of the belief that they worked faster than the same medicine administered orally. However, many did not exhibit a strong preference for injections, only opting for injections when their provider recommended them. Additionally, households expressed some negative views of injections. The most commonly expressed negative sentiment was that injections were dangerous because of their potential adverse side effects. Unsurprisingly, in communities where this belief was more prevalent, there was a stronger preference for oral medicines in place of injections. These community members considered injections a “last resort.” Because of the inconsistency of injection preference, it is difficult to conclude how a provider’s administration of injections may influence a household’s provider choice. Nonetheless, it appears that injections were not consistently a major factor in health care-seeking behaviors and decisions.

**In choosing a provider, community members often expressed that a provider’s experience was more important than whether they held a degree.**

A provider’s experience, as opposed to his or her degree status, was a major influencer of a community’s opinion of the perceived clinical efficacy of a certain provider. The experience of a provider is usually
considered more valuable to community members than any specific degree, and households used that experience to judge a provider’s quality of care.

Community members tended to have a good idea about their providers’ experience. This is because providers often freely shared their experiences in the medical profession with their patients. Impressions of provider experience could also come from a patient’s own interactions with a provider, or from when other community members visited the provider and shared their experience with the community. In contrast, their awareness of existing medical degrees and provider licenses varied considerably. When asked what types of degrees their preferred providers held, most community members tended to respond that they did not have the time or luxury to worry about which degrees their providers held.

Community members’ main concern was whether a given provider made them feel better, either through the medicines they administered or prescribed or through other recommendations. Even for those who felt that degree-status likely influenced the quality of care delivered, there was a general unawareness about the types of degrees and their implications for practice. Many community members noted that public providers had more degrees and were more likely to be appropriately licensed than private providers, but that it did not really matter and the local providers were much more convenient. One driver of this lack of concern may be the inability to trust self-reported degree-holding status. Villagers reported that certain private hospitals often displayed misleading signs that claimed providers working there had certain degrees. Thus, it was not evident that specific degrees drew patients, significantly informed them of a provider’s clinical efficacy, or acted as an important behavior motivator.

**Patient trust in a provider and a strong patient-provider relationship -- instilled by strong communication and connections with a provider -- were important influencers of care-seeking decisions.**

A strong relationship with providers, bolstered by open communication, tended to increase patient trust in a provider and the health care network as a whole. Patients reported that their trust in a provider had a major impact on their decision to choose that provider. In many rural villages, local providers were often seen as trusted community members. Thus, the first point of contact was often this “reliable” provider.

Many community members reported a lack of so-called “trust” in the public system, despite acknowledging that public providers typically had Opportunity Area

*Determine why households discount degree status and instead favor provider experience. While it is clear that emphasis is placed on a provider’s experience rather than provider degree, the rationale is unclear.*
better training. However, others still reported trusting the public system. Some community members reported that they would only follow a provider’s recommended treatment if they had significant “trust” in the relationship. Patients often believed that they needed advice from a provider about which medicine they should take, viewing providers not only as drug dispensers but also as sources of information and advice.

Similarly, patient-doctor rapport was also important. For instance, many reported that public doctors, although qualified, were arrogant and talked down to patients. Community members were less likely to go to public facilities if they felt this way. For many families, this incentivized them to visit a friendlier local provider who would communicate more appropriately. Providers’ supposed experience and ability to create a sense of trust and rapport with patients greatly swayed care-seeking behavior.
Section 6: Individuals Who Influence Provider Selection

Several types of people have vested interests in directing patients to seek care from particular sources. Their opinions and knowledge are not only important when addressing a single illness -- they also shape ongoing provider selection patterns. These influences play out on an individual, family, and community level and visibly impact the public health landscape in rural areas surrounding Allahabad.

Members of the Household

When a family member gets sick, several individuals are involved in the decision-making process. While several groups indicated that the “head of the household” determined where to seek care, the designation of the decision-maker was often far more nuanced. Here, we have listed the various individuals within the household that might influence a family member’s pathway to seeking care.

Depending on the health condition, household provider choice was affected by several influencers who were members of the household.

Spouses
Spouses often reported consulting with each other about health care decisions, particularly related to reproductive health. In particular, men and women discussed sterilizations (specifically female sterilizations) with each other before consulting and subsequently seeking out this service with the guidance of a CHW. Men often had a vested interest in the reproductive health decisions of their wives, noting that women more typically received sterilizations than men. Particularly for Muslim couples, husbands and wives reported discussing sterilizations and contraception with each other and jointly making a decision, sometimes superseding the preference of the woman’s in-laws. Women typically accessed contraceptives such as birth control pills from ASHAs, sometimes keeping this a secret from their in-laws. In addition to discussing reproductive health, spouses jointly weighed health care options for other medical issues. They reported discussing together what they had heard from others in the community about public versus private facilities.

The Elderly
Within a village, community members often lived in large family units of three or four generations. The older individuals often shared their experience or advice with younger generations. Elderly individuals were regarded in one of two ways -- either as valuable sources of information or as being outdated. Younger family members sometimes regarded the elderly as relatively unhelpful or unaware about modern health care options. This suggests a possible generational or educational shift that partially explains generational differences in opinions about health care.

With respect to maternity care, older mothers-in-law were found to influence their daughter-in-law’s decision about the location of delivery. Consistent with previous findings, women reported that their delivery decisions were often influenced by a mother-in-law’s demands, despite a woman indicating a desire for an institutionalized delivery.
The Educated or Knowledgeable

Others indicated that they sought out advice from household members whom they perceived to be more educated or knowledgeable about where to seek treatment or care. This individual may be a well-educated member of the village, someone who might have more information about the types of care available in the area, or someone who may know more about relevant conditions. An educated individual may also decide which types of care to seek out for a given condition, ranging from the local informal village providers to private nursing homes or large public hospitals.

The Financially Responsible

For households without a designated member who makes health care-related decisions, households indicated that the family member who paid for the care decided where to go for treatment. Community members outlined the various costs associated with medical care in the private and public sectors, including costs of transportation, medicines, provider fees, bribes to receive care, and other associated costs. With such financial burdens of seeking care, oftentimes the individual who funded the medical care would determine which types of care were financially feasible, and subsequently directed the sick family member where to go.

Community Health Workers

As detailed previously, community health workers include Anganwadis, ASHA workers, and ANMs. These women deliver critical health resources to their communities, serve as representatives of the public health system, and provide an interface between the public health system and community.

The stronger the community's relationship with the CHWs, the more likely community members were to be advised to use the public health system.

Consistent with prior research,9 Muslim communities may experience isolation due to a religious and cultural barrier with their respective ASHA workers, leading them to access other avenues of care. For example, we observed that even in villages that were located within walking distance from one another, there was differential access to and utilization of a common ASHA. In one instance, one of two neighboring villages had greater access to the ASHA, who was more visible and communicative to community members, thereby dissuading the other village from utilizing this mutual resource. In one religiously divided village, the Hindu side of the village perceived the ASHA as a valuable presence, whereas the Muslim side reported that she was never accessible. In the Muslim side of the village, the ASHA's perceived absence allowed a Muslim dai to successfully become a primary resource for delivery services.

The majority of ASHAs, Anganwadis, and ANMs that we interviewed were Hindu women. Of all of the interviews conducted, only one ASHA was Muslim. When prompted, a few ASHAs acknowledged that only three ASHAs out of nearly 200 in the area were Muslim, which is disproportionate to the Muslim population in the area. When one of these Muslim ASHAs was asked why she felt the misrepresentation existed, she responded that it was very difficult for her, as a Muslim, to achieve the ASHA position, primarily because the pradhan, the village leader, was Hindu. With a Hindu pradhan, it is reportedly easier for Hindu women to
apply and be accepted into the role, regardless of similar education levels between Muslim and Hindu applicants. Furthermore, the Muslim ASHA cited everyday lifestyle and birth control perceptions as key differences between Muslims and Hindus. This religious divide may further contribute to the sense of disconnect that some communities feel from their ASHA workers.

While women frequently communicated with CHWs, men reported not having as strong of a connection with the ASHAs, Anganwadis, or ANMs. In one instance, when prompted for their opinions about these three CHW types, a group of men replied that they had very little experience with or knowledge of the ASHA’s work in the village. Nonetheless, they referred to the ASHA as “ASHA Bahu,” denoting her respected position as a daughter-in-law of the community.

**CHW interpersonal dynamics influenced patient health delivery as well as health education, as was observed on vaccination days.**

Despite religious divides that may alter community dynamics, community health workers played an integral role in health care delivery. In particular, the Anganwadi, ASHA, and ANMs worked cohesively in teams to deliver health care, specifically while administering vaccinations. Our team observed four separate vaccination days in different villages, which village members knew would reliably occur on a monthly basis. Vaccination days served as outreach events for the public health care workers, as they drew together many of the women and children in the community. They become opportunities for the CHWs to instill trust in the public sector. For example, the ANMs used these events to provide valuable information about cleanliness, medicines, vaccinations, and general advice about seeking out care.

During household interviews, villagers stated that public sector doctors often did not provide information regarding their conditions and quickly prescribed medicines, leading patients to seek out different sources of information. Contrary to this expressed dissatisfaction, the ANMs at the vaccination days explained each of the administered vaccinations or supplements, which allowed for better patient understanding. Additionally, the ANM coupled the distribution of iron tablets to pregnant women and chlorine tablets for water purification with explanations of their purposes. ANMs were vigilant about sick children arriving for vaccinations, strictly refusing to vaccinate those who were ill. These ANMs urged the parents or caretakers of the ill children to immediately go to the nearest public health care facility for medical attention, reinforcing the CHWs’ connection with the public health sector. Finally, ANMs sought to dispel health-related myths held by community members and assured them that allopathic medicines would “suit them” well and allow for quick recovery.

**Because ASHAs are linked to the public health system, their presence impacted the use of specific facilities and resources available to patients, like the ambulance system.**

Villagers often associated ASHAs’ work with that of the ambulance service, another facet of the public health system. The 102 and 108 ambulances were only available for transport to public facilities. Because this
is a public service, the villagers often felt dependent upon the ASHA for calling the ambulance in emergency situations.

There is still a lack of regional awareness about the newly instituted ambulance service, with some regions more aware than others. We found that there were inconsistencies in community members’ understanding of how and when to use it. Many households knew about these transport services even if they had not used the services themselves. Community members gained awareness of the ambulance service through observing others within the community using the ambulances, through communicating with community health workers (CHWs) who promoted the service, and through reading advertisements and notices in printed media.

However, even in villages where individuals knew about the free service and emergency number, many reported first calling the ASHA to access the ambulance service. They believed that without the help of the ASHA, the ambulance would not arrive. Among those who recognized that the ambulance would come whether or not the ASHA called, some of these individuals asserted that the ASHA could expedite the process. The community’s relationship with the ASHA determined whether or not they would seek out the service at all, demonstrating a critical role for ASHAs. ASHAs also accompanied pregnant women to hospitals and were expected to stay with the women until after delivery. Prior to the existence of the ambulance service, the ASHA often had to front her own transportation costs.

Word of Mouth and Reputation

The village level communication network in rural villages was critical to household provider choice. When asked about which hospitals or sources of health care they chose, villagers consistently responded that they went to practices in which they had personally had a good experience or to practices about which they had heard positive reviews from other community members. Word of mouth communication either served to connect patients to the appropriate sources of care or to sway them away from a particular provider.

Community members formed opinions of public hospitals, despite not having personal experiences there, and consistently relayed the stories of others as if they were their own.

Individuals reported that they often chose their health care providers based on the experiences of others who had openly shared their stories of seeking health care. Community members often spoke on behalf of others in their village, citing specific examples of others’ illnesses. When asked whether they had sought a particular form of care from either a public or private facility, individuals would respond affirmatively, only later clarifying that they were referring to the experience of another. This suggests that medical information is
often viewed as a shared experience. Community members described these cases with great detail, suggesting that community members were well versed in each other’s health histories and took great personal interest in them. Interviewees confirmed that they discussed their experiences with each other, commenting that they would approach each other both in times of happiness or sadness. Community members were relatively open about medical conditions in the village and could readily identify individuals who had been afflicted by different conditions. They would call upon specific individuals who they felt would be advantageous for us to speak to because of notable health conditions or experiences.

When asked if they had visited a public facility, community members would often respond that they always went to private facilities because other community members viewed them more favorably than public facilities. Public facilities were often looked down upon because of the perceived demeanor of hospital staff, particularly the staff tending to pregnant women. Several women relayed stories that they had heard through neighbors or family members about the mistreatment of women in labor, claiming that the staff nurses would yell at them, talk down to them, and hit them. Community members reported rampant absenteeism at many public facilities, ranging from small PHCs to large, well-known public hospitals. This perception spread via word of mouth, further deterring community members from pursuing care at government facilities.
Health care improvement in rural India is an important policy issue, which has recently garnered the attention of policymakers. Significant government investments in rural health through programs like JSY, NRHM, and others, coupled with investment in a web of government facilities and community health workers, have helped extend health services to chronically underprivileged rural India.

Although this work has produced benefits, there are still major discrepancies in health outcomes and health care access between rural and urban areas. Understanding the factors that motivate community members to choose the care that they do is critically important when considering improvements to the complicated rural health care structure. Interventions or programs aimed at improving health outcomes would benefit from greater enlightenment of the behavioral foundations of health care-seeking decisions.

Our work has attempted to paint a picture of some of the considerations and influences community members face in their health care-seeking decisions. It is not our intention to praise or disparage any type of care or behavior, rather to observe prospective areas for improvement and to document the authentic circumstances in rural India.

India’s rural health system could benefit from adjustments that consider the motivations and perspectives of its rural citizens. Continued investments in rural health, coupled with this understanding, could dramatically improve health access and outcomes.
Section 8: References


17. Humairah, I. “The Anganwadi Workers of India – Connecting for Health at the Grassroots.”


### Table 1: Public Health and Maternal Health Care Indicators for Allahabad and UP*

<table>
<thead>
<tr>
<th>Health Indicator</th>
<th>Allahabad</th>
<th>UP Averages</th>
</tr>
</thead>
<tbody>
<tr>
<td>% institutional deliveries</td>
<td>25</td>
<td>26.6</td>
</tr>
<tr>
<td>Mean maternal age at birth</td>
<td>19.6</td>
<td>19.7</td>
</tr>
<tr>
<td>Mean maternal education</td>
<td>1.59</td>
<td>1.60</td>
</tr>
<tr>
<td>Mean wealth index</td>
<td>0.054</td>
<td>-.054</td>
</tr>
<tr>
<td>% Villages with trained birth attendant</td>
<td>93.7</td>
<td>81.6</td>
</tr>
<tr>
<td>% Villages with SC</td>
<td>92.1</td>
<td>88.9</td>
</tr>
<tr>
<td>% Villages with PHC</td>
<td>26.3</td>
<td>31.9</td>
</tr>
<tr>
<td>% Villages with District Hospital</td>
<td>0</td>
<td>1.56</td>
</tr>
<tr>
<td>% Villages with Private Hospital</td>
<td>23.7</td>
<td>18.3</td>
</tr>
<tr>
<td>% Villages with primary school (govt)</td>
<td>89.5</td>
<td>87.4</td>
</tr>
<tr>
<td>% Villages with primary school (private)</td>
<td>84.2</td>
<td>91.6</td>
</tr>
</tbody>
</table>


### Table 2: Breakdown of Villages Visited Based on Relative Location (Data assimilated from GPS device)

<table>
<thead>
<tr>
<th>Village Name</th>
<th>Block</th>
<th>District</th>
<th>District from nearest PHC/CHC</th>
<th>Distance from major road (such as state or national highway or any busy connected road?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaudihar</td>
<td>Kaudihar</td>
<td>Allahabad</td>
<td>0 km</td>
<td>0</td>
</tr>
<tr>
<td>Bhagayapur</td>
<td>Kaudihar</td>
<td>Allahabad</td>
<td>7 km</td>
<td>3</td>
</tr>
<tr>
<td>Fathupur</td>
<td></td>
<td>Allahabad</td>
<td>7 km</td>
<td>3</td>
</tr>
<tr>
<td>Tikari</td>
<td></td>
<td>Allahabad</td>
<td>8 km</td>
<td>4</td>
</tr>
<tr>
<td>Hathgah</td>
<td></td>
<td>Allahabad</td>
<td>7 km</td>
<td>0</td>
</tr>
<tr>
<td>Naseerpur</td>
<td>Kaudihar</td>
<td>Allahabad</td>
<td>6 km</td>
<td>9</td>
</tr>
<tr>
<td>Korali</td>
<td></td>
<td>Allahabad</td>
<td>4 km</td>
<td>7</td>
</tr>
<tr>
<td>Malak Chaturlipuri</td>
<td>Soraon</td>
<td>Allahabad</td>
<td>4 km</td>
<td>0.5</td>
</tr>
<tr>
<td>Prashadpur</td>
<td></td>
<td>Allahabad</td>
<td>2.5 km</td>
<td>0.5</td>
</tr>
<tr>
<td>Phaphamou</td>
<td>Phaphamau</td>
<td>Allahabad</td>
<td>0 km</td>
<td>0</td>
</tr>
<tr>
<td>Karchhana</td>
<td>Karchhana</td>
<td>Allahabad</td>
<td>0 km</td>
<td>0</td>
</tr>
<tr>
<td>Shamri</td>
<td>Kondhiyara</td>
<td>Allahabad</td>
<td>7 km</td>
<td>3</td>
</tr>
<tr>
<td>Village Name</td>
<td>Block</td>
<td>District</td>
<td>District from nearest PHC/CHC</td>
<td>Distance from major road (such as state or national highway or any busy connected road?)</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------</td>
<td>---------------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Akoda</td>
<td></td>
<td></td>
<td>7 km</td>
<td>7</td>
</tr>
<tr>
<td>Kareha</td>
<td></td>
<td></td>
<td>3 km</td>
<td>3</td>
</tr>
<tr>
<td>Salempur</td>
<td>Saidabad</td>
<td>Allahabad</td>
<td>3 km</td>
<td>7</td>
</tr>
<tr>
<td>Fathuha</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Mohanganj</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Bhagwatpur</td>
<td>Kaudihar II</td>
<td>Allahabad</td>
<td>1 km</td>
<td>0</td>
</tr>
<tr>
<td>Barwa</td>
<td></td>
<td></td>
<td>1 km</td>
<td>0.5</td>
</tr>
<tr>
<td>Sallahpur</td>
<td>Chale</td>
<td>Kaushambi</td>
<td>6 km</td>
<td>0</td>
</tr>
<tr>
<td>Bahadurpur</td>
<td>Manjhanpur</td>
<td>Kaushambi</td>
<td>10 km</td>
<td>2</td>
</tr>
<tr>
<td>Malikpur</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bhagatpur</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naini</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3: Number of Public Health Facilities Visited in Allahabad District

<table>
<thead>
<tr>
<th>Facility Types</th>
<th>Visited</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Hospitals</td>
<td>1</td>
</tr>
<tr>
<td>Community Health Center</td>
<td>2</td>
</tr>
<tr>
<td>Primary Health Center</td>
<td>0</td>
</tr>
<tr>
<td>Subcenters</td>
<td>1</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>7</td>
</tr>
<tr>
<td>Private Clinic</td>
<td>20</td>
</tr>
</tbody>
</table>
### Table 4: Number of Interviews Conducted, by Actor, Interview Type

<table>
<thead>
<tr>
<th>Actor</th>
<th>Interview Type</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superintendent</td>
<td>Personal Interview</td>
<td>1</td>
</tr>
<tr>
<td>ASHA</td>
<td>Personal Interview</td>
<td>5</td>
</tr>
<tr>
<td>ANM</td>
<td>Focus Group</td>
<td>2</td>
</tr>
<tr>
<td>Anganwadi</td>
<td>Personal Interview</td>
<td>4</td>
</tr>
<tr>
<td>Dai</td>
<td>Personal Interview</td>
<td>1</td>
</tr>
<tr>
<td>Men</td>
<td>Focus Group</td>
<td>8</td>
</tr>
<tr>
<td>Women</td>
<td>Focus Group</td>
<td>10</td>
</tr>
<tr>
<td>Ambulance Staff</td>
<td>Personal Interview</td>
<td>1</td>
</tr>
<tr>
<td>Village Headman</td>
<td>Personal Interview</td>
<td>1</td>
</tr>
<tr>
<td>Formal Medical Providers</td>
<td>Personal Interviews</td>
<td>10</td>
</tr>
<tr>
<td>Informal Medical Providers</td>
<td>Personal Interviews</td>
<td>9</td>
</tr>
<tr>
<td>Paramedical Providers</td>
<td>Personal Interviews</td>
<td>10</td>
</tr>
<tr>
<td>Medical Representatives</td>
<td>Personal Interview</td>
<td>2</td>
</tr>
<tr>
<td>Medical Stockists</td>
<td>Personal Interview</td>
<td>2</td>
</tr>
</tbody>
</table>