Summer Internship Report

at

Piramal Swasthya Foundation

Summer internship at Piramal swasthya ,Bihar

(April 22nd – June 21st,2024)

A Report

By

Nisha sharma

On

Impact of social gender norms on the physical, psychological and emotional wellbeing of women and girls.

Under guidance of

DR. Divya Aggarwal

PGDM (Hospital and Health Management)

2023-2025

International Institute of Health Management Research, New Delhi

PGDM (Hospital and Health Management)

FEEDBACK FORM

(Organization Supervisor)

Name of the Student: NISHA SHARMA

Institute **Summer Internship Institution:** Piramal Swasthya Management and Research

Area of Summer Internship: RMNCHN

Attendance: Perfect adherence to internship norms

Objectives met:

Deliverables:

- Desk review on " Impact of social gender norms on the physical, psychological and
- emotional wellbeing of women and girls." made an evidence table, documented the findings, recommendations, and limitations of this study in the report.
- Participated in Data collection in mini household survey and analysis using SAS software on some key RMNCHN indicators in the context of Bihar.
- Field visits in Sub-District hospital in Danapur, Patna and Health and Wellness Center, Bhausala, Danapur interacted with CHO and ASHA workers in HWC.
- Documented the entire process and findings, including insights from the field visits in a detailed report.
- Basic introduction about SAS, data cleaning and management and research methodology concepts.
- Worked on a project titled "Girl Boss Rise."

Strengths:

Suggestions for Improvement:

Signature of the Officer-in-Charge (Internship)

Date:

Place: DELHI

Certificate of Approval

The Summer Internship Project of titled **"INTRODUCTION ABOUT RMNCHN IN CONTEXT OF BIHAR "** at **"PIRAMAL SWASTHYYA MANAGEMENT AND RESEARCH INSTITUTE"** is hereby approved as a certified study in management carried out and

presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed, or conclusion drawn therein but approve the report only for the purpose it is submitted.

Dr Aggarwal

Dr. Divya Aggarwal
(Associate Dean, IIHMR Delhi)

FEEDBACK FORM

(Organization Supervisor)

Name of the Student: NISHA SHARMA

Summer Internship Institution: Piramal Swasthya Management and Research Institute

Summer Internship Institution: Piramal Swasthya Management and Research Institute

Area of Summer Internship: Public Health with a special focus on RMNCH+N

Attendance: Perfect adherence to internship norms.

Objectives met: Learnt Literature Review, Evidence Table Generation, Reference Management, Tool Development, Epidemiological concepts, Digital Data Management & Quality control, Determining the Themes and Sub-themes, Developing Code Dictionary, Data Collection, Data Management, Basic Quantitative Analysis and Thematic Extraction of Information from Qualitative Data.

Deliverables:

- Desk review on " Impact of social gender norms on the physical, psychological and
- emotional wellbeing of women and girls." made an evidence table, documented the findings, recommendations, and limitations of this study in the report.
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- Documented the entire process and findings, including insights from the field visits in a detailed report.
- Basic introduction about SAS, data cleaning and management and research methodology concepts.
- Worked on a project titled "Girl Boss Rise."

Strengths: During this period, she displayed learning spree, eye for detail, proactiveness, punctuality, commitment, subject knowledge, writing skills, communication skills, sincerity and diligence with analytical progress. Based on her learning abilities and efforts, it appears that, given the level of effort and aptitude she has, if given chance she can become a valuable resource for the public health research and implementation sector of India.

Suggestions for Improvement:

Signature of the Officer-in-Charge (Internship)

Date: 12.12.24
Place: Patna

ACKNOWLEDGEMENTS

The internship opportunity with Piramal Swasthya Foundation in Bihar was an excellent chance for learning and professional development. I consider myself very fortunate to have been part of it and am grateful for the opportunity to meet so many wonderful people and professionals who guided me throughout the internship.

I would like to express my sincere gratitude to Dr. Tanmay Mahapatra (Director, Data and Learning, Piramal Swasthya Management and Research Institute), Dr. shuchi Akhouri and sweta kumari (Senior RMLE Leader) for their invaluable decisions, advice, guidance, and for arranging all the facilities that made my project easier. I gratefully acknowledge their contributions.

I am also thankful to Dr. Prabhas Kumar Mishra for his overall supervision, and to Mr. Kunal Ranjan and Mr. Alok Ranjan for their assistance and cooperation in providing essential information and guidance for this report's analysis.

It is my pleasure to express my deepest gratitude and best regards to Dr. Sutapa Bandyopadhyay Neogi (Director, IIHMR Delhi), Dr. Sumesh Kumar (Associate Dean of Academics and Student Affairs, IIHMR Delhi), and my mentor, Dr. Divya Aggarwal (Associate Dean, IIHMR Delhi(former), for their careful and invaluable guidance, which was extremely beneficial for my study both theoretically and practically.

I see this opportunity as a significant milestone in my career development. I will strive to use the skills and knowledge I have gained in the best possible way and continue improving them to achieve my career goals. I hope to maintain cooperation with all of you in the future.

Sincerely,

Name: Nisha sharma

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Acronyms/ Abbreviations:

- RMNCHN: Reproductive, Maternal, Newborn, Child, and Adolescent Health
- ANC: Antenatal Care
- SBA: Skilled Birth Attendance
- PNC: Postnatal Care
- SDG: Sustainable Development Goals
- NHM: National Health Mission
- RMNCAH+**N**: Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition
- HIV: Human Immunodeficiency Virus
- RNMCHA: Reproductive, Maternal, Newborn, Child, Health and Adolescent
- PNC: Postnatal
- GBV: Gender-Based Violence
- FGM/**C**: Female Genital Mutilation/Cutting
- FGC: Female Genital Cutting
- HIV/**AIDS**: Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
- SDG: Sustainable Development Goals
- UNICEF: United Nations International Children's Emergency Fund
- WHO: World Health Organization
- NGO: Non-Governmental Organization
- SRHR: Sexual and Reproductive Health and Rights
- PMTCT: Prevention of Mother-to-Child Transmission (of HIV)
- STI: Sexually Transmitted Infection
- VAC: Violence Against Children

OBSERVATION LEARNING:

A Journey of Growth: My Two-Month Internship with the Piramal Foundation

My two-month internship journey with Piramal Swasthya Foundation in Bihar was an enriching and transformative experience. It provided me with an invaluable opportunity for learning and professional development. Prior to joining, I took comprehensive orientation courses to familiarize myself with the objectives, tenets, and mission of Piramal Swasthya. This orientation was guided by renowned professionals Shuchi Sree Akhouri and Dr. Tanmay Mahapatra. They forwarded us things that were in the public domain and related to our interests. Each of us was also given a mentor and an overall analysis supervisor who would help and guide us throughout our whole stay at Piramal Swasthya. Their in-depth knowledge of the healthcare sector served as a solid foundation for comprehending Piramal's significant contributions. Additionally, we had the chance to get to know important team members like the researchers, medical staff, and administrative staff, which enhanced our comprehension of their roles within the organization.

Week 1-2: Orientation and Initial Training

The first days were a whirlwind of introductions and information. We gathered in a brightly lit conference room, eager to absorb everything about the Piramal Foundation’s mission and projects. The foundation’s leaders shared their vision, inspiring us with stories of real-world impact.

Classes (3 days a week): Our mornings were dedicated to intensive training sessions. We learned about project management, community engagement, and effective communication. Guest speakers, experts in social work and development, captivated us with their insights and experiences. These sessions laid the groundwork for the journey ahead.

Field Visits (2 days a week**):** Afternoons were spent in the field. Our first visits to local communities were eye-opening. We walked through bustling markets, sat in humble homes, and listened to the stories of resilient community members. These interactions were invaluable, grounding our theoretical knowledge in real-world contexts.

Facility Visits (1 day a week): One day each week was reserved for touring the foundation's facilities. We visited healthcare canters and educational initiatives, observing the dedicated efforts of the on-ground teams. These visits helped us understand the operational aspects of the foundation’s work.

Week 3-4: Deepening Understanding and Initial Data Collection

By the third week, we were more confident and ready to dive deeper into our tasks.

Classes: Our training sessions now focused on advanced topics like data collection and analysis techniques. Workshops on cultural sensitivity and ethical considerations in fieldwork

equipped us with the skills needed to interact respectfully and effectively with the communities.

Field Visits: Armed with our new skills, we began conducting surveys and interviews. Each visit was a treasure trove of information as we gathered data on various aspects of community life. Organizing focus group discussions allowed us to delve deeper into specific issues, revealing nuanced insights.

Facility Visits**:** During facility visits, we spent more time in healthcare and education centres, understanding their challenges and discussing potential improvements. These interactions with facility managers and staff members were crucial for our upcoming strategic planning.

Week 5-6: Analysis and Strategic Planning

As the midpoint of the internship approached, our focus shifted to making sense of the data we had collected.

Classes: We learned techniques for data analysis, identifying trends, and drawing actionable insights. Strategy development classes taught us how to craft effective action plans based on our findings.

Field Visits**:** We returned to the communities for follow-up visits, sharing our initial findings and gathering feedback. Testing small-scale interventions provided a glimpse into the feasibility and potential impact of our proposed solutions.

Facility Visits: Meetings with facility managers and local stakeholders helped refine our strategies. Their insights and feedback were invaluable as we finalized our action plans, ensuring they were practical and aligned with the community's needs.

Week 7: Finalizing Plans

The penultimate week was a flurry of activity as we prepared to present our work.

Classes: Training on presentation skills and report writing helped us package our findings and plans effectively. We spent hours rehearsing us.

Learnings from the Different Sessions: My Internship Journey

During my internship with the Piramal Swasthya Foundation in Bihar, each session was a story, filled with moments of discovery, challenge, and growth. Here's how these experiences unfolded:

Monday Sessions: Basic Analysis with SAS

Every Monday evening, I logged into our virtual classroom, eager to dive into the world of data analysis with SAS. Shuchi Ma'am, Manoj Kumar Singh, and Ashish Kumar guided us through the intricate features of this powerful software. They made the complexities of statistical analysis accessible, breaking down each concept into manageable pieces.

I remember the excitement of our first practical session, where we worked on real datasets. The screen was filled with numbers and codes, and initially, it felt overwhelming. But with each passing week, I became more comfortable navigating the interface, inputting data, and performing various analyses. By the end of the internship, I could confidently use SAS to uncover insights from data, a skill that I knew would be invaluable in my future career.

Wednesday Sessions: Research Methodology and Field Visit Supervision:

Wednesdays were dedicated to understanding the backbone of our work: research methodology. Kaushik Chakraborty's sessions were a blend of theory and real-world application. He took us through the nuances of designing research studies, explaining the differences between qualitative, quantitative, and mixed methods approaches.

One session that stood out was when we discussed data collection methods. We learned to craft surveys and conduct interviews, skills that would soon be tested in the field. Kaushik emphasized the importance of ethical considerations, like obtaining informed consent and maintaining confidentiality. His stories from the field brought these lessons to life, showing us the impact of ethical research on communities.

In the afternoon, we set out for our field visits. Under Prashant Sir's supervision, we navigated local communities, applying our classroom knowledge in real settings. I vividly recall my first interview, feeling both nervous and excited. But as we interacted with community members, their openness and resilience inspired me. These visits were more than just data collection; they were about building connections and understanding the human aspect of our research.

Friday Sessions: Literature Review and Data Management:

Fridays were intensive but immensely rewarding. The morning began with literature review classes led by Md Irshad Ali Sir. He taught us the art of navigating through vast amounts of academic literature. Initially, the sheer volume of information was daunting, but Irshad Sir's guidance helped us streamline our searches and critically analyses sources. I remember the satisfaction of finally synthesizing the literature into a coherent review, a task that once seemed insurmountable.

In the afternoon, Kunal Sir took over with data management and cleaning sessions. He stressed the importance of clean, reliable data and taught us various techniques to achieve this. Handling missing values and identifying outliers became routine tasks. I recall the

meticulous process of data cleaning and the patience it required. These sessions taught me that data management is as crucial as data collection and analysis, ensuring the integrity of our research.

Topic Mentorship and Discussions:

Throughout the internship, I had regular discussions with my mentors, Shuchi Ma'am and Sweta Ma'am. These sessions were like compass points, guiding my research journey. They helped me refine my topic, frame my research questions, and develop a robust methodology. I remember the detailed feedback they provided, each suggestion a stepping stone towards improving my project.

One memorable moment was when I presented my initial findings to them. Their constructive criticism was both challenging and encouraging, pushing me to think deeper and strive for excellence. These mentorship sessions were not just about guidance; they were about growth

and professional development, teaching me the value of collaboration and continuous improvement.

Field Visit Report

Date: April 25, 2024
Village: Selhauri
Block: Dulhin Bazar, Patna

First Home Visit:

Household Information:

- **Number of Household Members:** 5
    - Mother (Head of Household)
    - Mother-in-Law
    - Husband
    - Self
    - Children:
        - Daughter: 1 month and 3 days old
        - Son: 5 years old

Information about the Girl Child:

- **Age:** 1 month and 3 days
- **Birth Date and Time:** March 22, 2024 (Confirmed via MCP card)
- **Mother Child Protection Card:**
  - **Issuance:** Confirmed during ASHA worker visit.
- **ASHA Visits:** Approximately 7-8 visits during pregnancy, encouraged ANC check-ups.
- **ANC Checkup Related Questions:**
  - **Doctor's Notes and Tests:** Detailed records including ultrasound, tetanus injections, and iron tablets.
  - **Iron Tablets (Post-Delivery):** Confirmed receipt and consumption.
  - **ASHA Information:** Provided guidance on tablet use.
- **Ration During Pregnancy:** Received ration support.
- **God Bharai Ceremony:** Conducted.
- **Child's Weight and Height Information:** Provided by ASHA worker.
- **Calcium Tablets Timetable:** Followed schedule during and after pregnancy.
- **Health and Delivery Related Questions:**
  - **Health Issues During Pregnancy:** No significant issues.
  - **Delivery Details:** Prearranged and planned.
  - **Kangaroo Mother Care:** Practiced, received uterotonic drug.
- **Newborn Feeding (First 24 Hours):** Detailed feeding information.
- **PNC Related Questions:**
  - **Complementary Feeding:** Advised to start after 6 months.
  - **Exclusive Breastfeeding:** Advised to exclusively breastfeed.

The first mother demonstrated comprehensive knowledge and clear recall of her maternal and child health experiences.

Second Home Visit:

Household Information:

- **Child's Age:** Approximately 6 months (Boy child)
- **Vaccination and Health Check Within 14 Days:**
  - **First Vaccination:** The infant received their first BCG vaccine shot within 14 days of birth.
  - **Other Vaccines:** Rotavirus, 9-Month Measles (Khasra), Japanese Encephalitis (Japanese Fever), RN Vitamin
  - **ASHA Related Information:** Mother unaware of specific vaccines, confirmed ASHA visits.

Observations:

- The second mother lacked specific knowledge about administered vaccines, indicating a potential gap in healthcare worker communication or record-keeping.

Summary: The field visit to Selhauri village on April 25, 2024, highlighted varying levels of maternal health awareness. The first mother exhibited a thorough understanding of ANC, delivery, and postnatal care. In contrast, the second mother's uncertainty regarding vaccination details underscores the importance of improved communication and education by healthcare providers, particularly concerning vaccination schedules and their significance in child health.

C.H.C. PHULWARISHARIF, PATNA-facility visit

Date of Visit: May 16, 2024
Location: Phulwarisharif, Patna, Bihar
Population Served: Approximately 350,000 per month.

I. Introduction

This report outlines a field visit conducted on May 16, 2024, to the Community Health Centre (CHC) located in Phulwarisharif, Patna. Serving a substantial monthly population of around 350,000 individuals, the CHC plays a critical role in providing primary healthcare services to the community.

II. Observations:

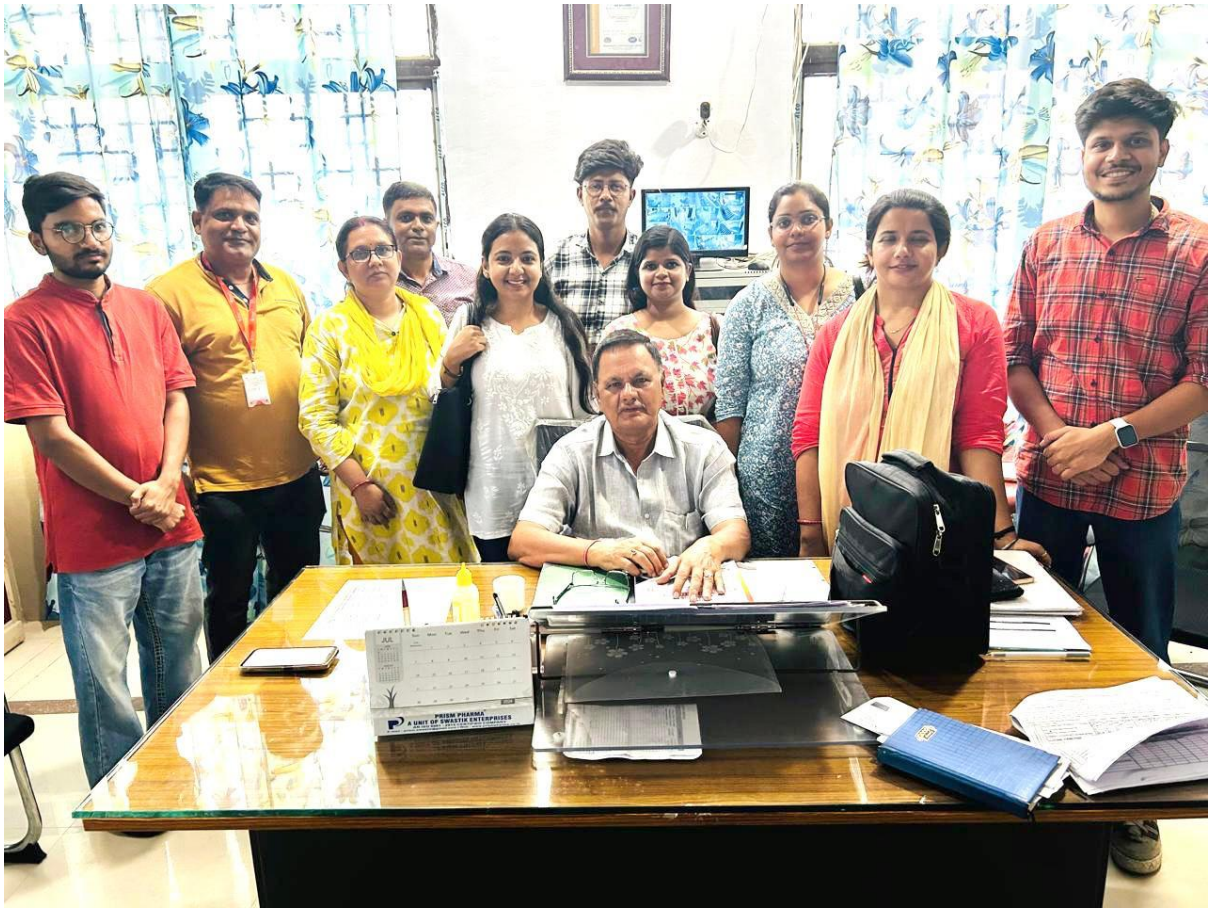
- **Ground Floor:**
    - **Registration Counter:** Implements QR code scanning for streamlined patient registration, especially beneficial for those with Ayushman Bharat Health Account.

ABHA stands for **Ayushman Bharat Health Account**. It is a digital health ID created under the Ayushman Bharat Digital Mission (ABDM) by the Government of India. ABHA aims to make healthcare services more accessible and efficient by providing a unique identification number to every citizen, which can be used to link and access their health records across various healthcare providers.

    - **Emergency Room:** Well-equipped with essential medical equipment to handle urgent medical cases effectively.
    - **Immunization Room:** Stocks a comprehensive range of vaccines for infants, ensuring timely and complete immunization coverage.
    - **Pharmacy:** Confirmed availability of essential medications; however, a detailed inventory was not provided during the visit.
    - **Cold Chain Storage:** Maintains a robust cold chain system to preserve the potency of vaccines.
- **First Floor:**
    - **Antenatal Care (ANC) Room:** Dedicated space staffed by healthcare professionals to monitor maternal health and provide prenatal care services.
    - **Non-Communicable Diseases (NCD) Cabin:** Focuses on managing chronic health conditions such as diabetes, hypertension, and cardiovascular diseases.
    - **Family Planning Counter:** Offers counselling on various family planning methods, supporting informed decision-making for reproductive health.
- **Third Floor:**
    - **Triage Room:** Dedicated area for triaging patients based on the severity of their conditions, ensuring prompt medical attention.
    - **Labor Room:** Equipped to handle childbirth procedures safely within the CHC premises.
- **Outreach Activities and Routine Immunization Process:** Discussions with CHC officials highlighted ongoing outreach efforts and routine immunization programs. However, specific details regarding the frequency, scope, and scheduling of these activities were not fully disclosed.

III. Conclusion

The Community Health Centre in Phulwarisharif serves as a cornerstone in delivering essential healthcare services to a sizable population. Its comprehensive facilities and services, ranging from emergency care to maternal and child health services, underscore its commitment to public health. Further exploration and implementation of the recommendations provided can enhance the CHC's operational efficiency and its ability to meet the evolving healthcare needs of the community effectively.



Facility Visit Report: CHC Phulwari Sharif, Bhusaula, Danapur

1. Facility Overview:

- **Community Health Centre (CHC) Name:** Phulwari sharif
- **Location:** Bhusaula, Danapur
- **Chief Health Officer (CHO):** Rajini Kumari
- **Auxiliary Nurse Midwives (ANMs):** Anupam Kumari, Sanju Kumari, Rani Kumari
- **Telemedicine Services:** Available through the eSanjeevani platform
- **Toll-Free Helpline Number:** 14416
- **Total Population Served:** 10,206 people
- **Number of Villages Covered:** 6

2. Healthcare Services and Facilities:

- **Outpatient Department (OPD):**
  - Provides regular medical consultations to the community.
  - Services include diagnosis and treatment of common illnesses and injuries.
  - Managed by trained healthcare professionals ensuring quality care.
- **Laboratory (LAB):**
  - Equipped to perform essential diagnostic tests such as blood tests, urine tests, and other basic investigations.
  - Supports accurate diagnosis and effective treatment plans.
- **Hand Wash Basin:**
  - Available within the facility to promote hand hygiene among staff and patients.
  - Helps in preventing the spread of infections and maintaining a clean environment.
- **Reverse Osmosis (RO) Water Supply:**
  - Ensures safe and clean drinking water for both patients and healthcare workers.
  - Helps in preventing waterborne diseases.
- **Telemedicine Consultations (Last Month):**
  - 250 telemedicine consultations conducted.
  - Provides remote medical advice and consultations, especially beneficial for patients who cannot visit the facility in person.
- **Non-Communicable Disease (NCD) Patient Follow-up (Last Month):**
  - 33 follow-ups conducted.
  - Regular monitoring and management of chronic diseases such as diabetes, hypertension, and cardiovascular conditions.

3. Health Promotion and Waste Management:

- **Educational Posters:**
  - Displayed within the facility to educate patients on tuberculosis (TB), blood pressure (BP), and diabetes.
  - Aim to raise awareness and promote healthy living practices.
- **Color-Coded Dustbins for Waste Segregation:**
  - **Red Bin:** For infectious waste such as used syringes, bandages, and other medical waste that can cause infections.
  - **Yellow Bin:** For clinical waste like dressings, disposable gowns, and other items used in medical procedures.
  - **Blue Bin:** For non-infectious, recyclable waste such as paper, plastic bottles, and other recyclable materials.
  - **Black Bin:** For general waste including food wrappers, non-recyclable plastics, and other non-medical waste.

4. Community Engagement:

- **ASHA Name:** Hemanti Devi
    - **Educational Background:** Pursuing a BA (final year).
    - **Roles and Responsibilities:**
        - Acts as a bridge between the community and the healthcare system.
        - Educates the community about health, nutrition, sanitation, and family planning.
        - Helps pregnant women receive antenatal and postnatal care.
        - Ensures children receive immunizations and regular health check-ups.
        - Assists in the implementation of national health programs such as immunization drives and maternal health initiatives.
        - Provides basic medical care and first aid in the community.

5. Nutrition Rehabilitation Centre (NRC):

- **Purpose:** To provide specialized care and rehabilitation for malnourished children.

- **Services:**
    - Nutritional assessment and monitoring.
    - Therapeutic feeding programs.
    - Education for parents on proper child nutrition and feeding practices.
    - Regular follow-ups to ensure children achieve and maintain a healthy nutritional status.

Conclusion: The CHC Phulwari Dharif in Bhusala, Danapur, is a vital healthcare facility serving over 10,000 people across six villages. The center provides comprehensive healthcare services, including regular medical consultations, diagnostic tests, and telemedicine services through eSanjeevani. The staff, led by CHO Rajini Kumari and supported by ANMs Anupam Kumari, Sanju Kumari, and Rani Kumari, are dedicated to delivering high-quality care. Effective waste management practices, with color-coded bins, are in place to ensure a clean and safe environment. The facility also actively promotes health education through posters and community engagement activities. ASHA worker Himanti Devi plays a crucial role in connecting the community with healthcare services and supporting maternal and child health. The NRC further supports the well-being of malnourished children, ensuring they receive the necessary care and nutrition. Overall, the CHC Phulwari Dharif is a cornerstone of healthcare in the region, significantly contributing to the health and well-being of the local population.


आयुष्मान भारत
Health and Wellness Center
उप स्वास्थ्य केन्द्र, मुसौला दानापुर
REFRAL CENTER
स्वास्थ्य केन्द्र CHC फुलवारी शरीफ
का समय 9:00 AM से 5:00 PM तक
ANI KUMARI = 8825134293
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SANJU KUMARI = 8298853980
RANI KUMARI = 9142895580
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Phulwari Sharif, पटना, 801505, BR, भारत
Lat 25.561391, Long 85.038299
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Note : Captured by GPS Map Camera

Experience from the projects/activities:

Girl Boss Rise:

My Journey Through Projects and Activities

Participating in the Girl Boss Rise program was a life-changing experience, filled with meaningful projects and activities. At the outset, we cultivated a supportive community where we shared our personal goals and delved into entrepreneurial mindsets. We focused on recognizing our strengths and practiced self-reflection through the 4 Fs framework (Facts, Feelings, Findings, Future), which helped us understand our experiences and growth.

As we moved forward, I dedicated time to developing my personal brand and honing my communication skills. We learned the importance of confident body language and clear, effective speech. The financial planning sessions were incredibly valuable, teaching us how to budget and plan realistically to achieve our aspirations.

The Design Thinking projects were a highlight, as they encouraged us to solve real-world problems creatively and critically. These exercises not only boosted our problem-solving skills but also deepened our understanding of user-cantered design. Conversations on gender equality and self-advocacy equipped us with the knowledge and confidence to challenge societal norms and advocate for ourselves.

In the latter stages of the program, we crafted self-advocacy plans and prepared portfolios that showcased our journeys and accomplishments. This process was empowering, as it allowed us to reflect on our growth and present our achievements confidently. Overall, the Girl Boss Rise program provided me with a robust set of skills, a supportive network, and the confidence to pursue my future goals with determination.

Domains scale- DOMAINS SCALES

DESK REVIEW ON Impact of social gender norms on the physical, psychological and emotional wellbeing of women and girls.

BACKGROUND

Roles, responsibilities, activities, and characteristics that are thought to be typical or appropriate for men and women are examples of gender norms, which are socially and culturally defined expectations and behaviors that a society deems appropriate for individuals based on their assigned gender [2].

The rules governing how members of a certain group or culture should behave are known as s ocial norms. Any behavior that deviates from these standards is regarded as a norm breach. [1]

Global Highlights

- According to the 2024 Global Gender Gap Index, no nation has attained complete gender parity.

- After dominating the index for ten and a half years, Iceland (93.5%) is once again at the top of the list.

    - **Labour-force Participation:** Following a decline during the pandemic, women's worldwide labor force participation rate has increased to 65.7%, suggesting that female workforce participation is on the rise.
    - **Global Gender Gap Closure**: The world has achieved 68.5% progress in closing the gender gap, demonstrating advancements toward gender equality while emphasizing the need for ongoing efforts.

    - **Europe:** Europe exhibits the smallest gender disparities across various parameters, positioning it as the leading region in gender equality.

    - **Latin America and the Caribbean:** The region has attained its highest-ever economic parity score of 65.7% and ranks second in political empowerment with a score of 34%, marking notable progress toward gender equality..

- Global Gender Gap Report 2024: India ranked 129th out of 146 economies in the overall gender gap index. Ranked third lowest among South Asian economies, behind Bangladesh, Nepal, Sri Lanka, and Bhutan. [2]

India's newly formed cabinet includes only two women among its 30 Union ministers, with the overall number of female ministers in the central council dropping from 10 in the previous government to seven. This gender disparity, while disappointing, reflects the

country's significant gender inequality as highlighted by the Global Gender Gap Report 2024 from the World Economic Forum. In the report's 18th edition, India ranks among the lowest South Asian economies, falling behind Bangladesh, Nepal, Sri Lanka, and Bhutan.

India Gender Gap Index rankings by region, 2024

The underrepresentation of women in the current cabinet stands in contrast to India's relatively strong performance in the 'Political Empowerment' parameter, where it achieved its best rank of 65. However, in the other categories of the assessment, India faced some of the largest gender gaps, ranking poorly among 146 economies.:

- In the Economic Participation and Opportunity category, India ranked **142** out of 146 economies, highlighting a significant gender gap in this area.
- In the Health and Survival category, India also ranked **142** out of 146 economies, indicating a severe gender disparity in this domain.
- In the Educational Attainment category, India ranked **112** out of 146 economies, reflecting a notable gender gap in education.

Overall, India ranked **129** in this year's index, showing a slight decline compared to the previous edition. This regression was primarily due to small drops in the 'Educational Attainment' and 'Political Empowerment' categories, while there was a modest improvement in 'Economic Participation and Opportunity,"[3]

This study examined the relationship between beliefs about gender roles and indicators of female agency among married adolescents aged 15-19 in rural Bihar and Uttar Pradesh, India. The findings highlighted a connection between more equitable gender role beliefs and improved agency outcomes, even after considering caste and religious beliefs. Positive outcomes linked to these beliefs included greater female marital choice, involvement in economic decision-making, shared male responsibility in childcare, and the rejection of marital violence. More equitable gender role beliefs were connected to stronger social connections, greater freedom of movement, improved digital access, and increased protection from marital violence. Although accepting marital violence did not correlate with higher agency for married girls, it was significantly linked to experiencing marital violence.

These findings align with prior research that links gender role beliefs to female agency in livelihoods, extending this understanding to include social connections and safety, especially within marriage. Identifying beliefs that lead to negative outcomes can help shape interventions to assist married girls. While efforts to influence gender role beliefs and norms have been successful in preventing child marriage, they have not yet been used to support married girls. The results highlight the need to address these norms and agency to enhance girls' resilience and psychological empowerment in marriage, supporting our theoretical framework.[4]

Rationale of the Study

This study aims to explore the relationship between equitable gender role beliefs and positive outcomes in female agency among married adolescents aged 15-19 in rural Bihar and Uttar Pradesh, India. Despite global efforts, significant gender disparities persist in India, which ranks 129th out of 146 countries in the 2024 Global Gender Gap Index. This research extends previous findings by linking gender role beliefs to social connectivity, digital access, and safety from marital violence. Identifying beliefs that support or hinder female agency can guide interventions to promote gender-equitable norms and empower young married women in these regions.

KEY FINDINGS– GENDER SOCIAL NORMS

- The study has pinpointed critical areas to enhance the health, nutrition, and well-being of adolescent girls in eastern India, including addressing violence, early marriage, and undernutrition, as well as improving mental health, contraceptive awareness, and school retention. While national government programs broadly address the key health issues for this group, it is essential to conduct local assessments of priorities and adapt program content to ensure their relevance and effectiveness.
- study illustrates the importance of integrating mental health perspectives into programming targeting child marriage. Equally, a narrow focus on mental health and suicide prevention, without taking into consideration the broader context of early marriage and inequitable gender norms, seems unlikely to be successful in shifting the mental health profile of girls and young women.

- Women played a significant role in exclusive sanitation decisions in peri-urban and rural areas of Bihar, presenting an opportunity to enhance women's participation in sanitation decision-making, especially in urban contexts. Their involvement in these decisions was broadly accepted across different settlement types. As more women take part in decisions regarding toilet construction, promoting this norm could encourage gender-equitable involvement in sanitation-related decisions in resource-limited settings.
- The two case studies, which appear to be successful examples of addressing nutrition and gender-based violence, have revealed key factors, roles, and processes related to

social determinants. This is illustrated in Figure 2, an explanatory framework for analytical generalization, which provides broader lessons for programs in similar contexts. Further qualitative and quantitative research on the Mitanni and ASHA programs should be conducted to explore the emerging themes in more detail.

- The two case studies, which seem to be successful in addressing nutrition and gender-based violence, have identified important factors, roles, and processes related to social determinants. This is depicted in Figure 2, an explanatory framework for analytical generalization, offering broader lessons for similar programs. Further qualitative and quantitative research on the Mitanni and ASHA programs should be conducted to delve deeper into the emerging themes.
- Focused efforts are required to bridge the gap between the legislative provisions of the HMA and societal attitudes and value systems surrounding marriage. Awareness programs about the nature and types of mental illness, advancements in treatment, and information on the positive outcomes of severe mental illness would be beneficial.
- Enhancing moral and religious values can help challenge and diminish negative attitudes and the patriarchal mindset towards married women with mental illness.

- The study findings strengthen the argument for incorporating the social, emotional, and mental health needs of girls into programs and policies addressing child marriage. Notably, 45% of girls in our sample were married before the legal age of 18 (the current legal marriage age for girls in India), while 21% were married at 18, emphasizing the urgent need for multipronged approaches to tackle the root causes of child marriage.[6]
- Survey-weighted logistic regression models were used to calculate the odds ratios (OR) and 95% confidence intervals (CIs) to examine the association between transitioning into marriage and mental health outcomes, such as depressive symptoms at wave 2, thoughts of suicide at least once, and suicide attempts at least once.[6]

SECONDARY DATA ANALYSIS ON RNMCH IN CONTEXT OF BIHAR

INTRODUCTION:

RMNCHN: Reproductive, Maternal, Newborn, Child, Health

Improving maternal and child health and ensuring their survival are central to achieving the national health objectives under the National Health Mission (NHM). In alignment with SDG Goal 3, the focus remains on reducing maternal, newborn, and child mortality. Over the years, innovative strategies have been developed to implement evidence-based interventions across various population groups.

The Ministry of Health & Family Welfare introduced the Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH+N) initiative to drive key actions aimed at reducing maternal and child morbidity and mortality.

Rooted in the continuum of care concept, the RMNCAH+N strategy takes a comprehensive approach, integrating interventions for reproductive, maternal, newborn, child, and adolescent health, as well as nutrition, within a cohesive framework. It emphasizes a lifecycle approach to ensure effective and sustained outcomes.

The RMNCAH+N strategy emphasizes integrating various interventions across thematic areas to improve coverage throughout the lifecycle, thereby enhancing child survival in India. The "plus" in the strategy highlights:

- Recognizing adolescence as a distinct life stage within the overall framework.
- Connecting maternal and child health with reproductive health and other components such as family planning, adolescent health, HIV, gender issues, and preconception and prenatal diagnostic techniques.
- Bridging home and community-based services with facility-based care.
- Strengthening linkages, referrals, and counter-referrals across different levels of the healthcare system to establish a seamless care pathway, ensuring additive and synergistic effects on overall outcomes and impact.

Reproductive Health

Reproductive health remains a pressing issue in Bihar, characterized by a high fertility rate and inadequate availability of contraception and family planning services. These challenges contribute to a high incidence of unintended pregnancies and associated health risks for women. Enhancing reproductive health services, including greater access to contraceptives and family planning education, is vital to reducing maternal and neonatal morbidity and mortality.

Maternal Health

Maternal health indicators in Bihar indicate considerable scope for improvement, as the state records one of the highest maternal mortality ratios (MMR) in India. Contributing factors include insufficient antenatal care, low institutional delivery rates, and limited access to skilled birth attendants. Improving maternal health outcomes requires strengthened maternal health programs, upgraded healthcare facilities, and greater awareness among the population.

Newborn Health

The neonatal mortality rate (NMR) in Bihar is alarmingly high. Many newborns die within the first month of life due to preventable causes such as infections, birth asphyxia, and complications from preterm birth. Improving newborn care, promoting early and exclusive breastfeeding, and ensuring timely immunizations are critical steps towards reducing neonatal deaths.

Child Health

Child health in Bihar is also a significant concern. The state struggles with high infant mortality rates (IMR) and under-five mortality rates. Immunization coverage is uneven, with many children missing out on essential vaccines. Additionally, malnutrition is widespread,

with high rates of stunting, wasting, and underweight children. Comprehensive child health programs that focus on nutrition, immunization, and early childhood care are vital for improving the health and survival of children.

Nutrition

Malnutrition is a pervasive issue in Bihar, affecting both children and women. Poor dietary practices, food insecurity, and lack of awareness about proper nutrition contribute to the high prevalence of malnutrition. Efforts to improve nutrition must include initiatives to enhance food security, provide nutritional supplements, and educate communities about healthy dietary practices.

Government and Non-Government Efforts

The Bihar government, in collaboration with various non-governmental organizations, has been actively tackling RMNCHN challenges. Programs like the National Health Mission (NHM), Janani Suraksha Yojana (JSY), and several nutrition initiatives focus on enhancing healthcare access and outcomes. Despite these efforts, substantial gaps persist, requiring attention to ensure equitable and high-quality health services for all.

OBJECTIVE:

To get an insight about some key RMNCHN practices among recently delivered women and children aged 0-23 months in rural Bihar during 20224.

METHODOLOGY

A brief overview of the methodology of study conducted to collect this data:

1. Study Area: 13 districts of Bihar selected randomly from 9 Commissionerate
2. Target population: mothers of 0-5, 6-11, 12-23 months old children
3. Sample size: of ~2,250 interviews per category (0-5 months, 6-11 months, and 12-23 months).
4. sas software is used for data analysis

SOCIO-DEMOGRAPHIC INDICATOR

1. Gende**r**- Gender of the children was categorized into two labels i.e. boys and girls. Frequency, percentage, lower confidence interval and upper confidence interval were calculated.
2. Religion- Religion of the recently delivered mothers was calculated according to the category of Hindu and Others. Similarly, Frequency, percentage, lower confidence interval and upper confidence interval were calculated.
3. **Age of the mother** - The mothers were categorized into three age groups: under 24 years, 25-34 years, and 35 years or older. For each group, the frequency, percentage, lower confidence interval, and upper confidence interval were calculated based on the total number of observations.
4. Caste- The variable caste was divided into two different labels categorized as marginalized and non- marginalized and distribution of Frequency, percentage, lower confidence interval and upper confidence interval were calculated.
5. Family type- Under socio-demographic variables type of family is another significant part. It was distributed into joint family and nuclear family type and similarly Frequency, percentage, lower confidence interval and upper confidence interval were calculated.
6. Education of the mother- The categories of distribution of mother's education was divided into three labels and those are illiterate, up to 8th class and more than 8th class. Frequency, percentage, lower confidence interval and upper confidence interval were calculated in total number of observations.
7. Education of the father- The same categories were also followed in father's education as illiterate, up to 8th class and more than 8th class. Similarly, Frequency, percentage, lower confidence interval and upper confidence interval were calculated.
8. Occupation of the mother- Mother's occupation was categorized into five sections such as unemployed, agricultural, non- agricultural, business and salaried employee. Under total observations Frequency, percentage, lower confidence interval and upper confidence interval of the labels were calculated.
9. Occupation of the father- Similarly father's occupation was divided into unemployed, agricultural, non- agricultural, business and salaried employee sections. Distribution of Frequency, percentage, lower confidence interval and upper confidence interval were calculated.
10. Migration of the husband- Women under the studied age group answered about whether their husbands are migrant or non-migrant. In accordance with the answer Frequency, percentage, lower confidence interval and upper confidence interval were calculated.
11. SHG membership- Women of the studied age group or any women of their family have membership in any social health group or not. Again, with the different labels Frequency, percentage, lower confidence interval and upper confidence interval were calculated.
12. Living children- It determines whether the women having one living child, two living children, three living children or more than three living children. With similar observations Frequency, percentage, lower confidence interval and upper confidence interval were calculated.

13. Place of the delivery- It shows the distribution of delivery place of the children whether it was in public facility, private facility or home delivery. Again, Frequency, percentage, lower confidence interval and upper confidence interval were determined.
14. Type of the house- House type was divided into three different categories whether it was kachcha, pucca or semi-pucca. Under total observations Frequency, percentage, lower confidence interval and upper confidence interval of the labels were calculated.

Definition of the RMNCH indicator:

1. MCP Card (Mother and Child Protection Card):

In the journey of motherhood, there's a vital tool known as the mother and Child Protection (MCP) card. This health care is provided to pregnant women and mothers, acting as a guardian for tracking the well-being and growth of both the mother and her child. In our study, women were grouped into two categories based on whether they had this card: those who proudly possessed an MCP card (Yes) and those who, unfortunately, did not have one (No).

2. ANC (Antenatal Care):

Ensuring the best possible health for both mother and baby during pregnancy involves a range of medical services collectively known as antenatal care (ANC). This care encompasses regular health check-ups and monitoring to support a healthy pregnancy. The mothers in our research were divided into two groups: those who received antenatal care (Received ANC) and those who missed out on this crucial care (Did not receive ANC).

3. ANC3 (At least 3 Antenatal Care Visits):

A crucial indicator of a healthy pregnancy is the number of antenatal care visits attended by the mother. In our study, we examined whether mothers had at least three antenatal care visits, categorizing them into two groups: those who met this criterion (Yes) and those who did not (No), highlighting the significance of regular prenatal check-ups.

4. ANC4 (At least 4 Antenatal Care Visits):

Regular check-ups during pregnancy are essential for the health of both the mother and the baby. Our study examined whether expectant mothers attended at least four antenatal care visits, which are vital for monitoring health. The mothers were divided into two groups: those who attended at least four visits (Yes) and those who did not (No).

5. IFA Received (Iron and Folic Acid Tablets Received):

Iron and folic acid tablets are vital for a healthy pregnancy, helping prevent anemia and supporting the baby's growth. Our study assessed whether mothers received these important supplements, categorizing participants as either having received the tablets (Yes) or not (No).

6. IFA90 Received (Received 90 or more Iron and Folic Acid Tablets):

Receiving enough iron and folic acid tablets is important. Specifically, we focused on whether mothers received 90 or more of these tablets during their pregnancy. We grouped the mothers into those who reached this milestone (Yes) and those who did not (No).

7. Number of IFA Consumed:

We also examined the actual number of iron and folic acid tablets consumed by the mothers. This data is usually recorded as a continuous variable, reflecting the exact quantity taken to promote the health of both the mother and the baby**.**

8. THR Received (Take Home Ration Received):

Take-home rations provide necessary nutritional support during pregnancy. Our study categorized mothers based on whether they received these rations (Yes) or not (No), ensuring we understood the extent of nutritional aid provided.

9. Institutional Delivery:

Giving birth in a health facility can significantly enhance safety for both mother and child. We examined whether the deliveries took place in such facilities. Mothers were divided into those who had institutional deliveries (Yes) and those who gave birth elsewhere (No).

10. STSC (Scheduled Tribe/Scheduled Caste):

In our study, we identified whether the individuals belonged to specific social categories such as Scheduled Tribes (ST) or Scheduled Castes (SC). These categories were crucial for understanding social stratification and its impact on health and development.

11. Baby Weight:

The birth weight of a baby is a key health indicator. Although it is usually recorded as a continuous variable, it can also be grouped into categories such as low birth weight and normal birth weight, which helps in evaluating the health of newborns.

12. TIBF Category (Timely Initiation of Breastfeeding):

Starting breastfeeding within the first hour of birth is beneficial for both mother and baby. We categorized mothers based on whether they initiated breastfeeding within this critical timeframe (Yes) or not (No).

13. EBF (Exclusive Breastfeeding):

Exclusive breastfeeding, where the infant is given only breast milk for the first six months, is strongly recommended. In our study, we examined whether infants were exclusively breastfed (Yes) or if other foods or drinks were introduced before the six-month mark (No).

14. Breastfeeding:

Beyond exclusive breastfeeding, we also considered whether mothers practiced breastfeeding in general. This variable had two categories: those who were breastfeeding (Yes) and those who were not (No).

15. Complementary Feeding:

Complementary feeding refers to the introduction of solid or semi-solid foods to an infant's diet after six months. In our study, we categorized infants as either having received complementary foods (Yes) or not (No), which is vital for their ongoing growth and development.

16. Contraceptive Method:

Understanding the contraceptive methods used by individuals is crucial. We classified these methods into three categories: non-use, traditional methods (such as rhythm or withdrawal), and modern methods (like condoms, pills, IUDs, or sterilization).

17. Use of Modern Contraceptives:

Modern contraceptive methods play a key role in family planning. Our study focused on whether individuals were using these methods (Yes) or not (No), highlighting the use of advanced reproductive health practices.

18. Use of Traditional Methods (TM):

In addition to modern methods, traditional contraceptive methods are still used by some individuals. We categorized participants based on their use of these methods (Yes) or non-use (No), providing insight into different family planning practices.

RESULT

Our data collection focused on three age groups of babies born to new mothers: 0–5 months, 6–11 months, and 12–23 months. We analyzed the data in relation to sociodemographic variables and indicators associated with reproductive, maternal, newborn, child, and nutrition (RMNCHN) factors.

SOCIODEMOGRAPHIC INDICATOR

Description	Frequency(n)	Percentage (%)	Lower confidence limit (LCL)	Upper confidence limit (UCL)
Age of mother				
<=24	1426	63.38	61.39	65.37
25-34	770	34.22	32.26	36.18
>=35	54	2.40	1.77	3.03
Gender of child				
Boys	1194	53.07	51.00	55.13
Girls	1056	46.93	44.87	49.00
Religion				
Hindu	1930	85.78	84.33	87.22
Caste				

Marginalized	685	30.44	28.54	32.35
Family type Nuclear	883	39.24	37.23	41.26
Mother's education Illiterate Up to 8th More than 8th	782 510 958	34.76 22.67 42.58	32.79 20.94 40.53	36.72 24.40 44.62
Father's education Illiterate Upto 8th More than 8th	687 487 898	33.16 23.50 43.34	31.13 21.68 41.20	35.19 25.33 45.48
Mother's occupation Unemployed Agricultural Non-agricultural Business Salaried	2140 23 38 22 27	95.11 1.02 1.69 0.98 1.20	94.22 0.61 1.16 0.57 0.75	96.00 1.44 2.22 1.38 1.65
Father's occupation Unemployed	79 189	3.54 8.48	2.77 7.32	4.31 9.63

Agricultural	1063	47.67	45.59	49.74
Non-agricultural	308	13.81	12.38	15.24
Business	591	26.50	24.67	28.34
Salaried				
Husband's migration				
Non-migrant	1966	87.38	86.00	88.75
Migrant	284	12.62	11.25	14.00
SHG membership				
Yes	1120	49.78	47.71	51.85
No	1130	50.22	48.15	52.29
Living child				
1 child	758	33.69	31.73	35.64
2 children	674	29.96	28.06	31.85
3 children	461	20.49	18.82	22.16
More than 3 children	357	15.87	14.36	17.38
Place of delivery				
Public	1457	64.76	62.78	66.73
Private	484	21.57	19.81	23.21
Home	309	13.73	12.31	15.16
Type of House				
Kutcha	398	17.69	16.11	19.27
Semi-Pucca	1270	56.44	54.39	58.49

Pucca	582	25.87	24.06	27.68

Table 1 provides a detailed overview of the socio-demographic characteristics of the study participants.

Gender Distribution:

- Of all participants, boys made up 53.07% (n = 1194), and girls made up 46.93% (n = 1056).

  Mother's age
  • Among the mothers, 63.38% (n=1426) were 24 years old or younger, representing a significant portion of the population. Additionally, 34.22% (n=770) were aged between 25 and 34, while 2.4% (n=54) were 35 years old or older.

Religion.:
• Of the participants, 85.78% (n = 1930) identified as Hindu, representing the majority of the sample. The remainder, or 14.22% (n=320), came from religious backgrounds other than Hinduism.

Caste:

30.44% (n=685) of the population belonged to marginalized castes, while 69.56% (n=1565) of the population belonged to non-marginalized castes.

Type of family;

- Of the participants, the majority (60.76%, n = 1367) were from joint families, while 39.24% (n = 883) belonged to nuclear families.

Mother’s education:

• In terms of mothers' educational attainment, 22.67% (n=510) had completed up to the eighth grade, 42.58% (n=958) had completed higher education, and 34.76% (n=782) were illiterate.

Mother’s occupation:

At 95.11% (n=2140), the moms were unemployed in the vast majority of cases. 1.2% (n=27) of those in paid employment were salaried, 0.98% (n=22) worked in business, 1.69% (n=38) were non-agricultural workers, and 1.02% (n=23) were agricultural labourers.

Father education;

- As for fathers' educational backgrounds, 33.16% (n=687) were uneducated, 23.5% (n=487) had completed up to the eighth grade, and 43.34% (n=898) had completed higher education.

Father occupation:

3.51% (n=79) of fathers were unemployed. Fourteen percent (n=1063) worked as non-agricultural laborers, 84% (n=189) were agricultural laborers, 13% (n=308) owned businesses, and 27% (n=611) held salaried positions.

Place of delivery;

- Regarding the place of delivery, 64.76% (n=1457) of births took place in public health facilities, 21.51% (n=484) occurred in private health facilities, and 13.73% (n=309) were delivered at home or during transit.

House type

- Regarding the type of housing, 17.69% (n=398) lived in kachcha (temporary) houses, 56.44% (n=1270) in semi-pucca (semi-permanent) houses, and 25.87% (n=582) in pucca (permanent) houses.

Self-help group membership:

- The distribution of Self-Help Group membership was nearly even, with 49.78% (n=1120) being members and 50.22% (n=1130) not being members. The distribution of Self-Help Group membership was nearly even, with 49.78% (n=1120) being members and 50.22% (n=1130) not being members.

Number of living children:

- When examining the number of living children per family, 33.69% (n=758) had one child, 29.96% (n=674) had two children, 20.49% (n=461) had three children, and 15.87% (n=357) had more than three children.

• Label	FREQUENCY(n)	PERCENTAGE (%)	LCL	UCL
pregnant women received MCP cards	1851	82.2667	80.6873	83.8461
pregnant women received any antenatal checkup during your last pregnancy	2221	98.7111	99.2447	99.1775
pregnant women received 3 or more antenatal checkup during your last pregnancy	1519	68.3926	66.4575	70.3277
pregnant women received 4 or more antenatal checkup during your last pregnancy	964	43.4039	41.341	45.4667
pregnant women received IFA tablet during your last pregnancy	2035	90.4444	89.2288	91.6601
pregnant women received 90 or more IFA tablet during your last pregnancy	591	26.6096	24.7704	28.4489
pregnant women consumed 90 or more IFA tablet during your last pregnancy	339	83.1762	81.5415	84.8109
pregnant women received THR during your last pregnancy	908	40.3556	38.3268	42.3843
institutional delivery	1941	86.2667	84.8434	87.69
child aged 0-5 month received immediate Skin to skin care after birth	1295	65.4371	63.34	67.5342
child aged 0-5 month weighted at birth	1801	82.9572	81.3742	84.5401
child aged 0-5 month received Timely Initiation of Breast Feeding (TIBF) within 1 hrs.	1491	66.2667	64.3116	68.2217
child aged 0-5 month received exclusive breastfeeding (last 24 hours)	1136	50.4889	48.4214	52.5563
child aged 6-11 month Currently receiving breast feeding	2104	93.5111	92.4925	94.5297
children aged 6–11 months who Initiated complementary feeding	1472	65.4222	63.4555	67.389
recently delivered women currently using any contraceptive method	452	22.8629	21.0102	24.7157

recently delivered women currently using modern contraceptive method	438	22.1548	20.3226	23.987
recently delivered women currently using traditional contraceptive method	15	0.7587	0.3759	1.1416

According to the report, many expectant mothers actively participate in prenatal and postpartum care. Ninety-seven percent of women received some sort of prenatal checkup during their last pregnancy. Of them, 43.40% underwent four or more checkups, and 68.39% underwent three or more.

Ninety-four percent of women additionally took iron-folic acid (IFA) tablets. Only 26.61%, nevertheless, were given 90 or more tablets. Eighty-one percent of individuals who received ninety or more tablets took them all.

The Take-Home Ration (THR) program provided nutritional help to about 40.36% of pregnant mothers. Eighty-six percent of births took place in medical facilities. 65.44% of newborns ages Infants aged 0 to 5 months received immediate skin-to-skin contact, with 82.96% being weighed. Sixty-six percent of mothers initiated breastfeeding within the first hour. Over the past 24 hours, 50.49% of mothers exclusively breastfed their 0–5-month-old infants. Among infants aged 6 to 11 months, 93.51% continued to be breastfed, while 65.42% of mothers had started supplementing their babies' feedings.

22.86% of women who had given birth recently reported taking birth control of some kind. Of these, 0.76% used conventional methods and 22.15% used newer ones. These figures demonstrate that even if a large proportion of women in this group use modern contraception, mother and child healthcare still needs to be improved.

Conclusion:

The study reveals that many pregnant women actively engaged in antenatal and postnatal health practices, with nearly all (98.71%) receiving some form of antenatal checkup during their recent pregnancies. Notably, 68.39% attended three

or more checkups, and 43.40% attended four or more, indicating robust participation in prenatal care.

Iron-folic acid (IFA) supplementation was prevalent among pregnant women, with 90.44% receiving these tablets. However, adherence to the recommended 90 tablets was lower, as only 26.61% of women met this guideline. Among those who did receive 90 or more tablets, a substantial 83.18% completed the course, highlighting room for improvement in ensuring consistent intake.

Nutritional support through the Take-Home Ration (THR) program was accessed by 40.36% of pregnant women, demonstrating efforts to address maternal dietary needs during pregnancy.

A significant proportion (86.27%) of births took place in medical facilities, underscoring efforts to ensure safer delivery environments and access to skilled care for mothers and newborns.

Immediate postnatal practices were widely adopted, with 65.44% of newborns receiving immediate skin-to-skin contact and 82.96% being weighed promptly after birth, indicating a strong focus on early maternal-infant bonding and health monitoring.

Breastfeeding practices were encouraging, with 66.27% of mothers initiating breastfeeding within the first hour after birth. Additionally, 50.49% exclusively breastfed their infants aged 0-5 months in the past 24 hours, and 93.51% continued breastfeeding among infants aged 6-11 months, showcasing positive breastfeeding behaviours.

In terms of family planning, 22.86% of recent mothers reported using some form of contraception. Among contraceptive users, 22.15% opted for modern methods, while 0.76% used traditional methods. These figures suggest ongoing efforts are needed to ensure broader access to and utilization of effective family planning services.

References:

1. Ashraf S, Kuang J, Das U, Shpenev A, Thulin E, Bicchieri C. Social beliefs and women's role in sanitation decision making in Bihar, India: An exploratory mixed method study. PLoS One. 2022 Jan 27;17(1): e0262643. doi: 10.1371/journal.pone.0262643. PMID: 35085326; PMCID: PMC8794139.

https://pubmed.ncbi.nlm.nih.gov/26330650/

2. Gram L, Kanougiya S, Daruwalla N, Osrin D. Measuring the psychological drivers of participation in collective action to address violence against women in Mumbai, India.

Wellcome Open Res. 2020 Jun 29; 5:22. doi: 10.12688/wellcomeopenres.15707.2. PMID: 32551367; PMCID: PMC7281673.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7281673/

3. Sharma I, Tripathi CB, Pathak A. Social and legal aspects of marriage in women with mental illness in India. Indian J Psychiatry. 2015 Jul;57(Suppl 2):S324-32. doi: 10.4103/0019-5545.161499. PMID: 26330650; PMCID: PMC4539877.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539877/

4.Aggarwal S, Francis KL, Dashti SG, Patton G. Child marriage and the mental health of adolescent girls: a longitudinal cohort study from Uttar Pradesh and Bihar, India. Lancet Reg Health Southeast Asia. 2022 Nov 16; 8:100102. doi: 10.1016/j.lansea.2022.100102. PMID: 37384140; PMCID: PMC10306007.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10306007/

4. Rose-Clarke K, Pradhan H, Rath S, Rath S, Samal S, Gagrai S, Nair N, Tripathy P, Prost A. Adolescent girls' health, nutrition and wellbeing in rural eastern India: a descriptive, cross-sectional community-based study. BMC Public Health. 2019 May 31;19(1):673. doi: 10.1186/s12889-019-7053-1. PMID: 31151394; PMCID: PMC6544920.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6544920/

5. Khanna R, Sheth M, Talati P, Damor K, Chauhan B. Social and economic marginalisation and sexual and reproductive health and rights of urban poor young women: a qualitative study from Vadodara, Gujarat, India. Sex Reprod Health Matters. 2021;29(2):2059898. doi: 10.1080/26410397.2022.2059898. PMID: 35486102; PMCID: PMC9067967.
https://pubmed.ncbi.nlm.nih.gov/35486102/

6. Daruwalla N, Hate K, Pinto P, Ambavkar G, Kakad B, Osrin D. You can't burn the house down because of one bedbug: a qualitative study of changing gender norms in the prevention of violence against women and girls in an urban informal settlement in India. Wellcome Open Res. 2017 Nov 7; 2:48. doi: 10.12688/wellcomeopenres.11805.2. PMID: 29164180; PMCID: PMC5680532.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5680532/
7. Kane S, Joshi M, Mahal A, McPake B. How social norms and values shape household healthcare expenditures and resource allocation: Insights from India. Soc Sci Med. 2023 Nov; 336:116286. doi: 10.1016/j.socscimed.2023.116286. Epub 2023 Sep 27. PMID: 37797542.
https://pubmed.ncbi.nlm.nih.gov/37797542/

8. Dodd R, Shanthosh J, Lung T, Robaigau A, Perman ML, Rafai E, Poulos R, Zwi AB, John R, Palagyi A. Gender, health and ageing in Fiji: a mixed methods analysis. Int J Equity Health. 2021 Sep 14;20(1):205. doi: 10.1186/s12939-021-01529-9. PMID: 34521430; PMCID: PMC8439064.
9. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8439064/
10. https://cepr.org/voxeu/columns/how-gender-norms-are-perceived-across-world
11. Mmari K, Blum RW, Atnafou R, Chilet E, de Meyer S, El-Gibaly O, Basu S, Bello B, Maina B, Zuo X. Exploration of Gender Norms and Socialization Among Early Adolescents: The Use of Qualitative Methods for the Global Early Adolescent Study. J Adolesc Health. 2017 Oct;61(4S): S12-S18. doi: 10.1016/j.jadohealth.2017.07.006. PMID: 28915986.
12. Sedlander E, Talegawkar S, Ganjoo R, Ladwa C, DiPietro L, Aluc A, Rimal RN. How gender norms affect anemia in select villages in rural Odisha, India: A qualitative study. Nutrition. 2021 Jun; 86:111159. doi: 10.1016/j.nut.2021.111159. Epub 2021 Jan 24. PMID: 33636419; PMCID: PMC8209141.
13. Kiely KM, Brady B, Byles J. Gender, mental health and ageing. Maturitas. 2019 Nov; 129:76-84. Doi: 10.1016/j.maturitas.2019.09.004. Epub 2019 Sep 11. PMID: 31547918. https://pubmed.ncbi.nlm.nih.gov/31547918/
14. Luoto S, Rantala MJ, Del Giudice M. Gender norms and the wellbeing of girls and boys. Lancet Glob Health. 2021 Apr;9(4): e397. doi: 10.1016/S2214-109X (20)30550-7. PMID: 33740402.
15. https://pubmed.ncbi.nlm.nih.gov/33740402/
16. Cislaghi, Beniamino, and Lori Heise. "Gender norms and social norms: differences, similarities and why they matter in prevention science." *Sociology of health & illness* 42.2 (2020): 407-422.
17. https://onlinelibrary.wiley.com/doi/pdf/10.1111/1467-9566.13008

Annexure:

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