Assessment of Knowledge, Attitude, Behaviour and Practices in Relation to Maternal Health among Women in Rural Areas of Anand District, Gujarat

A dissertation submitted in partial fulfilment of the requirements

For the award of

Post-Graduate Diploma in Health and Hospital Management

By

SHILKI SONI

International Institute of Health Management Research

New Delhi -110075

April, 2011

Assessment of Knowledge, Attitude, Behaviour and Practices in Relation to Maternal Health among Women in Rural Areas of of Anand District, Gujarat

A dissertation submitted in partial fulfilment of the requirements
for the award of

Post-Graduate Diploma in Health and Hospital Management

by

SHILKI SONI

Under the guidance of

Dr. Pawan Kumar Taneja
Designation: Associate Professor
Organization: IIHMR, New Delhi

International Institute of Health Management Research
New Delhi -110075

April, 2011

Table of Contents

ACKNOWLEDGEMENT.

I'am very much indebted to Ms. Indu Capoor, Director CHETNA for giving me the opportunity to work with such a renowned organization.

I acknowledge the support rendered by Vd. Smita Bajpai in organizing the field visits to carry the study in the community.

I'am extremely grateful to my mentor Mr. Pawan Kumar Taneja and teachers at IIHMR, New Delhi for taking time to share their vast knowledge with us. It is just because of these great teachers and guides; I 'am able to stand tall and able to complete this project.

I'am also very greatful to Dr. Bhalla, Dean, IIHMR New Delhi for rendering support for completing my dissertation.

My heartfelt thanks are due to Ms. Triveni, MNGO coordinator, Ahmedabad and Ms. Anita, training coordinator at Gujarat Voluntary Health Association (MNGO Ahmedabad) for assisting me in the field work particularly in translation of Gujarati language to Hindi and vice versa .

I 'am extremely thankful to my colleague Ms. Arpita , without her support , help and cooperation it would have been impossible for me to complete the project.

Last but not the least ,I'am honoured to have the privilege to thank my family for their unparalleled love and for providing me all the opportunities and amenities I ultimately desired for.

To owe the debt individually would be an endless task.

SHILKI SONI

PGDHHM (IIHMR, NEW DELHI)

ABSTRACT

Childbirth is one of the important events affecting health of a woman, especially in developing countries likes India. According to National Family Health Survey-3 (2005-2006) Antenatal care (ANC) coverage in India is still very low. This study examines knowledge, attitude, behavior and practices in relation to maternal health among rural women which will help to identify the barriers in reducing the maternal mortality in India. Women lack the empowerment to take decisions including number of children they want or the use of contraception, decision to use reproductive health services. Millennium Development Goal Five aims to reduce by three quarters the maternal mortality ratio between 1990 to 2015 and current status of MMR reduced to 254 (NFHS-III) from 424 per 100,000 live (NHFS1992-1993) .

Women lack the empowerment to take decisions including number of children they want or the use of contraception, decision to use reproductive health services. Postnatal care remains the most neglected area with only 42% of women receiving. The total institutional deliveries remain just 34%. The educational and economic status of women influences the use of maternal care. Illiterate mothers and mothers from BPL families used basic maternal healthcare much less than their literate and wealthier counterparts were far less likely to see a doctor. Only 18% of 101 illiterate mothers had institutional deliveries compared to 86% of 33 mothers with 12 or more years of education. Knowledge on post delivery entitlements for mother and children was found to be poor among women.

List of Figures

List of Abbreviations

CHETNA	Centre for Health Education, Training and Nutrition Awareness
ANM	Auxillary Nurse Midwife
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
CHC	Community Health Centre
CHP	Community Health Promoters
CHV	Community Health Volunteers
CMW	Currently Married Women
DPT	Diphtheria Pertusis Tetanus
FNGO	Field NGO
FP	Family Planning
FHW	Female Health Worker
GSS	Gayatri Sixan Samaj
HIV	Human Immuno Deficiency Virus
HMIS	Health Management Information System
ICDS	Integrated Child Development Scheme
IFA	Iron and Folic Acid
IUD	Intra Uterine Device
JNET	Jayshree Nathji Education Trust
LW	Link Worker

MNGO	Mother NGO
NFHS	National Family Health Survey
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
PEG	Peer Educator's Group
PHC	Primary Health Centre
PNC	Post Natal Care
RCH	Reproductive and Child Health
RTI	Reproductive Tract Infection
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
TT	Tetanus Toxoid
VHSC	Village Health and Sanitation Committee
GO	Governmental organization
NGO	Non Governmental Organization

PART I

1.1 Introduction to Organization: Centre for Health Education, Training and Nutrition Awareness

CHETNA* meaning "awareness" in several Indian languages and an acronym for **Centre for Health Education, Training and Nutrition Awareness**, is a non-government support organization based in Ahmedabad, Gujarat. Beginning its activities in 1980, CHETNA addresses issues of women's health and development in different stages of her life from a "Rights" perspective.

Vision: CHETNA envisages an equitable society where disadvantaged communities are empowered to live healthy lives.

Mission: To empower children, young people and women, especially from marginalised social groups, so that they become capable of gaining control over their own, their families' and communities' nutrition, health and wellbeing.

CHETNA supports Government and Non-Government Organizations (GO and NGOs) through building the management capacities of education/health practitioners/supervisors/managers enabling them to implement their programmes related to children, young people and women from a holistic and gender perspective and advocate for people centred policies. Geographically CHETNA works in Gujarat and Rajasthan states.

CHETNA develops need-based training and education materials, which are widely disseminated at the State, National and International levels. CHETNA's Information and Documentation Centre (IDC) is a rich source of information for the needs of individuals, organizations, academicians, researchers and students working on health, education and development concerns.

CHETNA has also been identified as a Regional Resource Centre (RRC) for Gujarat State and the Union Territories of Daman, Diu and Dadra Nagar Haveli to provide technical assistance to NGOs to improve RCH, facilitate GO-NGO partnership, document and disseminate successful approaches and provide inputs to GoI to ensure effective implementation of policies.

---

* CHETNA is an activity of the Nehru Foundation for Development, which is a public charitable trust, registered under the Bombay Public Trust Act 1950

Issues addressed by CHETNA

- Improving Access to Food and Enhancing Nutrition: Every individual has the right to adequate food and nutrition, a foundation for healthy living. The increasing prevalence of under nutrition indicates the need to safeguard this right across the life cycle.
- Ensuring Health and Development in Childhood: Every child has the right to survival and dignified life. To safeguard this right, there is need to ensure that children have a healthy and equitable social environment within and outside the family. They should have access to adequate nutrition, health and
- developmental services. Within the age group of 0-10 years, specific intervention is required at different ages.
- Saving the Girl Child: The skewed sex ratio in the age group of 0-6 years indicates the need for social transformation to stop the heinous practice of sex selection and promote an enabling environment for valuing the girl child.
- Participatory approach: In enabling environments, children can and do become partners in their own nutrition, health and development processes.
- Range of stakeholders: It is essential to work with parents, care-givers, teachers, social leaders and policy makers to ensure the right to survival and dignity of children.
- Learning by exploring: Through an interactive, exploratory approach to health education, children can learn how to actualise their right to healthy growth and dignity.
- Promoting Sexual Health of Adolescents and Youth: Adolescents and Youth are a heterogeneous group and constitute 22% of India's population. This phase of transition from childhood to adulthood requires significant efforts from all stakeholders. Information regarding their health and development, along with life skills, helps them to adopt healthy and responsible lifestyles.
- Partners in development: By analysing their needs and articulating the challenges, Adolescents and Youth can contribute in policy formulation, programme planning, monitoring and evaluation.
- Knowing one's body and mind: Learning how one's body and mind works builds confidence and self-esteem. It enables young people to take decisions related to reproductive and sexual health with responsibility and sensitivity.
- Acquiring life skills: Enhancing skills for decision making and negotiating gender-power relations ensures that young people can adopt practices that protect their own health and that of others.
- Improving Maternal and Newborn Health: The high rates of maternal and neonatal mortality indicate the need to address the right to life and survival of women and newborns. Poor maternal nutrition has a

direct impact on pregnancy outcomes. Empowering women and community stakeholders to access their entitlements from the public health system is critical.

Outreach: Activities are primarily focused in the states of Gujarat and Rajasthan in India. Networking, advocacy and programme planning is done at the Local, State, National, Regional and International levels.

CHETNA is recognised by the Ministry of Health and Family Welfare, Government of India, as a Regional Resource Centre (RRC) for Gujarat State and the Union Territories of Dadra Nagar Haveli and Diu, to support the implementation of Reproductive and Child Health (RCH) programme. The RRC provides technical support to 20 partner NGOs for enhancing access to health services in areas underserved by the public health system.

Strategic interventions by CHETNA:

1. **Policy and Programme level**

- Generation of field level evidence on nutrition and health status of marginalised communities.
- Demonstration of innovative strategies to enhance access to nutrition and health services.
- Facilitation of people's participation in policy and programme formulation and monitoring of action plans at state and national levels.
- Media advocacy to generate public opinion on issues affecting nutrition and health status of marginalised communities.
- Networking with stakeholders for consensus building on identified issues.

2. **Community level**

·Capacity building of community based organisations on nutrition and health issues. The programmes are based on specific learning needs and realistic action plans are developed to facilitate effective implementation. Development and dissemination of a wide range of gender-sensitive nutrition and health communication and training material. The material is innovative, culturally sensitive and undergoes extensive field testing. It is widely disseminated at State, National, Regional and International levels. CHETNA's Information and Documentation Centre has a rich collection of material on diverse issues of women, young people and children.

Working with stakeholders such as elected representatives of Panchayat, members of Self Help Groups, families and communities, influencing health-seeking behaviour.

CHETNA provides an open and interactive space to facilitate continuous dialogue, sharing and learning. The space enables participation of community, partners, programme and policy level stakeholders and CHETNA

team. The vision serves as a reference point to brainstorm on ideas for developing strategies, which facilitate processes to achieve the vision.

1.2. **Programme/Project**

During my dissertation period I was appointed as Project Coordinator particularly for Women Health and Rights Advocacy Partnership (WHRAP) project but since this project was in its initial phase I worked in other project which was on "Safe Motherhood" or " Surakshit Matritva-SUMA" which was implemented in Jodhpur district, Rajasthan. Currently I have been deputed to CHETNA Regional Resource Centre (CRRC) as Training Coordinator. During my intership period I had a lot of experience of working in the community.

1.3. **Managerial Tasks Performed**

- Organized Training of Trainers (ASHA, TBA, AWW and local Health workers)
- Organized and Participated in the meeting of AYUSH and IGNOU on Certification of Traditional Healers.
- Presented on Issues related Rural Women's Sexual and Reproductive Health in Asian Rural Women's Coalition conference, Chennai.
- Organized study tour for the Members of European Parliaments to Udaipur.
- Field appraisal of Partner NGOs
- Gujarat State MIS Data Analysis under RCH programme.
- Documentation of all the tasks and field visits.

1.4. Reflective Learning

This internship period was definitely a great learning experience for me. On the very next day of joining the organization I got a chance to organize Training on "Safe Motherhood" or " Surakshit Matritva) for the TBA's, ASHA's, ANMs and Health Workers of the Osian Block of Jodhpur District, Rajasthan and also visited all the ten villages of Osian. During the training I learnt the technical aspects of Maternal and Child Health like the Complications during Pregnancy.

I also learnt Documentation including Report writing, Writing Formal e-mails and letters. Organizing and Managing meetings and field visits.

As a Training Coordinator in Regional Resource Centre of Gujarat, I learnt how to conduct trainings and how to coordinate with other partner organizations and I also learnt to read and understand "Gujarati"

I also got a chance to manage and analyze the Maternal and Child Health data for the entire state of Gujarat and to give my inputs/feedbacks on the same.

Part II: Dissertation on "Assessment of Knowledge, Attitude, Behaviour and Practices in Relation to Maternal Health among Women in Rural areas of Anand District, Gujarat"

Chapter 1: Introduction

Maternal death is defined as death of women while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by pregnancy or its management. The maternal mortality ratio is maternal death per 100,000 live births in one year. The Millennium Development Goals (MDGs), which set internationally, agreed development aspirations for the world's population to be met by 2015 have underlined the importance of improving health, and particularly the health of mothers and children, as an integral part of poverty reduction.

Though the maternal mortality (MMR) rate has dropped by *34 per cent from an estimated *5,46,000 in 1990 to* 3,58,000 in 2008, it continues to be a major problem in India with the highest maternal deaths occurring due to severe bleeding after childbirth, infections, hypertensive disorders and unsafe abortion

Over *300 million women in the world currently suffer from long-term or short-term Illness brought about by pregnancy or childbirth. Most of the deaths and disabilities attributable to childbirth are avoidable, because the medical solutions are well known. Immediate and effective professional care during and after labour and delivery can make the difference between life and death for both women and their newborns. Each and every mother and each and every newborn needs skilled maternal and neonatal care provided by professionals at and after birth – care that is close to where and how people live, close to their birthing culture, but at the same time safe, with a skilled professional able to act immediately when largely unpredictable complications occur. The challenge that remains is therefore not technological, but strategic and organizational.

India has made significant development in health indicators. However, challenges related to maternal mortality and morbidity continue to remain a major public health concern. In rural areas, where a majority of Indians still live, it is often difficult to access Emergency Obstetric Care facilities in case of need, as most of the public providers are running short of qualified gynaecologists and obstetricians as well as anesthetists1. In such cases, women in need of EmOC services have to travel several kilometres up to District Hospitals (DH) where the obstetrician and anaesthetist might be available, but then the barriers such as distance, transport cost, problems with supplies of medicines at the district hospital and poor staff attitudes towards the poor remain. Due to these barriers, many women hesitate to travel and seek care at a faraway place and die at home or in transit if they decide to travel.

(Source: *World Health Report 2005)

Review of Literature

Even though the Indian rate of maternal deaths is declining, at the present rate neither India nor any of its states will reach their MDG maternal mortality targets for 2015 (UN 2008). WHO estimates show that out of the 529,000 maternal deaths globally each year, 136,000(25.7%) are contributed by India. This is the highest burden for any single country.The provision of services did not ensure that women used them they had to first perceive them to be beneficial to their health and that of their unborn child.

Birth preparedness as a conceptual framework provides an opportunity to address the three delays but is contingent on other external factors such as existence of functioning referral services. Birth Preparedness is a process through which (pregnant) women and their family members are provided with key messages associated with pregnancy and childbirth to ensure a healthy outcome for both mother and newborn. In addition to Birth Preparedness, it is necessary to ensure or enhance the quality of emergency obstetric care at the referral facility while also making provision for emergency transport in the event of an emergency.

India has accounted for at least a quarter of maternal deaths reported globally. India's goal is to lower maternal mortality to less than 100 per 100,000 livebirths but that is still far away despite its programmatic efforts and rapid economic progress over the past two decades. Geographical vastness and sociocultural diversity mean that maternal mortality varies across the states, and uniform implementation of health-sector reforms is not possible.

In rural areas the condition of maternal health is worse as owing to agricultural economy women also help in the fields apart from performing the household chores. This accompanied by malnutrition is responsible for various problems during pregnancy. Other than nutrition another important factor influencing the health of women during pregnancy is her health-seeking behavior, especially antenatal checkups. Antenatal care (ANC) refers to pregnancy-related health care provided by a doctor or a health worker in a medical facility or at home. A review of literature shows that women who do not avail of antenatal care are more likely to suffer from problems during pregnancy. However, the health-seeking behavior of women is again the function of the interplay between various socio-economic conditions including caste, place of residence, education level of both woman and her husband, work status of woman and standard of living.

Women remain at increased risk of death for some time after childbirth. Maternal deaths have conventionally been defined as those occurring up to 42 days postpartum,18 although recently a new category has been proposed to include late deaths up to 1 year postpartum. This change in defi nition is important since there is evidence that risk of death is increased for up to 6 months postpartum.3,19,20 Mortality rates can be especially high after an abortion or stillbirth.

Since the beginning of the Safe Motherhood Initiative, India has accounted for at least a quarter of maternal deaths reported globally. India's goal is to lower maternal mortality to less than 100 per 100,000 livebirths but that is still far away despite its programmatic efforts and rapid economic progress over the past two decades. Geographical vastness and sociocultural diversity mean that maternal mortality varies across the states, and uniform implementation of health-programms is not possible.

Physical access can be a major challenge as transportation was limited and the health facilities were far. Most of the communities are engaged in cultivation and labor. To track these women and link them with the health services is a major challenge. Motivating men for contraception is a major challenge. The social structure is such that men would not discuss even among men or accept contraception.

Sources:

*Knowledge gaps in scientific literature on maternal mortality: a systematic review- Bulletin by WHO.

*www.thelancet.com Vol 368 September 30, 2006

*Pregnancy complications and health-seeking behavior among married women, India. (Research and Practice in Social

*Sciences Raj, P Vol.1, No.1 (August 2005) 48-6348)

*Research and Practice in Social Sciences Raj, P Vol.1, No.1 (August 2005) 48-63

*Review of global literature on maternal health interventions and outcomes related to provision of skilled birth attendance.

The state of Gujarat has a population of 50.67 million (2001 census). There are 26 districts, 170 blocks and 18539 villages. The State has the decadal growth rate of the state is 22.66% (against 21.54% for the country) and the population of the state continues to grow at a much faster rate than the national rate. The Total Fertility Rate of the State is 2.6(SRS 2007), Infant Mortality Rate is 52 and Maternal Mortality Ratio is 160 (SRS 2004 - 06) which are lower than the National average. The Sex Ratio in the State is 920 (as compared to 933 for the country).

Anand district comprises 8 talukas Umareth, Petalad, Sojitra, Borsad, Anklav, Khambhat, Anand and Tarapur. The district is spread in an area of 2941 Sq kms and has a total population of 18,56,712(2001 census). It is a low lying plain, dry region and has moderate climate. It has a sex ratio of **910 women per thousand men. The literacy rate is **64% with **53% literacy rate among women. Anand district is one of the average performing districts of Gujarat state.

Rationale of the Study

Identification of barriers in reduction of maternal mortality in rural areas.

Objective of the Study

Assessment of Knowledge, Attitude, Behaviour and Practices in relation to Maternal Health among Rural Women in Rural areas of Anand district, Gujarat.

Specific objectives of the Study

- Assess the knowledge of maternal health services and entitlements in women
- Identify the cultural barriers for women in availing maternal health services
- Assess the birth preparedness and complication readiness among women
- Identify the Health seeking behavior of women.

**DLHS III

Chapter 2: Data and Methods

Study Area

The Research study was conducted in five villages of Anand District of Gujarat State. Name of the villages are: Fathepura, Tarakpur, Indranaj, Khanpur and Deivil. These villages were selected on the basis of accessibility.

Study Methods

Both quantitative and qualitative methods of investigation were used for the research. Questionnaires and focused group discussions were used for data collection.

Target Group: The study population included pregnant women and recently delivered women for quantitative data collection and women of reproductive age (15-49 yrs.) were included in the focused group discussions.

Study Tools

A questionnaire was developed for recently delivered women as well as for currently pregnant women. Along with this, a discussion guide was also developed to conduct focused group discussions on KABP and barriers related to maternal health, services and entitlements.

The study tool was developed covering following set of indicators:

Project indicators

- Knowledge of danger signs in pregnancy, child birth, post partum and new born
- Number of women planning for where to give birth
- Number of women with a pre-identified skilled birth attendant
- Number of women with transportation plans for institutional delivery.
- Number of women with savings for emergency and birth
- Number of women with pre-identified blood donors
- Number of women receiving JSY /Cheeranjivi
- Number of women receiving 3 Post Natal Checkups.

- Number of early registration of pregnancies
- Number of women taking vaccine during pregnancy
- Number of pregnant women receiving Janani Suraksha Yojana benefit in 7th month of pregnancy
- Number of women receiving 3 Ante Natal Checkups
- Number of institutional deliveries accompanied by Dai.

Sampling Strategy

- In the project 5 villages were selected randomly.
- In each village all pregnant women and recently delivered women in the village were surveyed for the quantitative data collection. List of all the pregnant women was given by the Link worker of the village working under MNGO scheme (RCH II) helped in meeting all the women.

For Focused group discussions a cluster of 10 women of 15- 49 years of age from each village was selected randomly

Sample Size

From each village all the currently pregnant and recently delivered women were selected with the help of link worker of the village.

Figure 2.1

Quantitative Survey		
Name of Village	**No. of pregnant Women**	**No. of recently delivered women**
Fathepura	13	11
Tarapur	13	09
Deivil	12	21
Tarakpur	17	11
Khanpur	13	14
Total (68+66= 134)	**68**	**6**

Figure 2.2		
Qualitative Survey		
Number of women in each Focused group discussions	10	Total number of women=10*5= **50**
Total number of FGD's	5	

In total **184** (134+ 50) women were covered during this research study

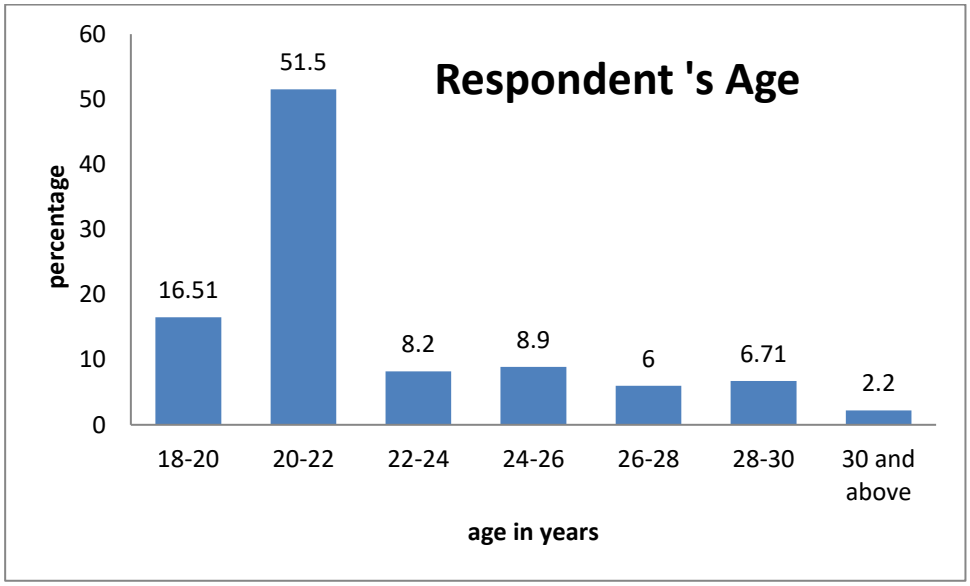
Data Processing and Analysis

Analysis of data was done using SPSS Version 16.0 and Microsoft excel. The data have been presented in percentages.

Chapter 3: Results and Findings

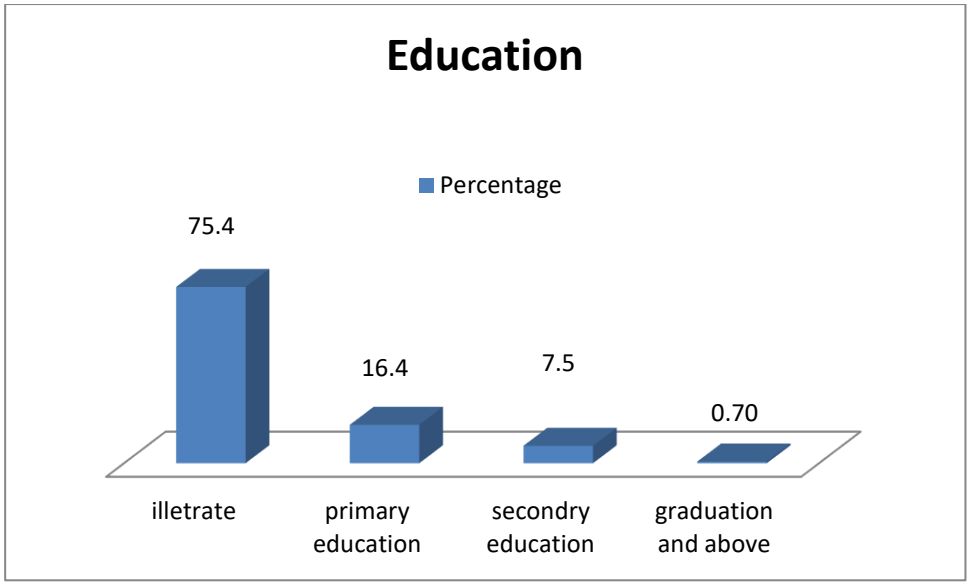
ABOUT THE RESPONDENTS:

Figure3.1



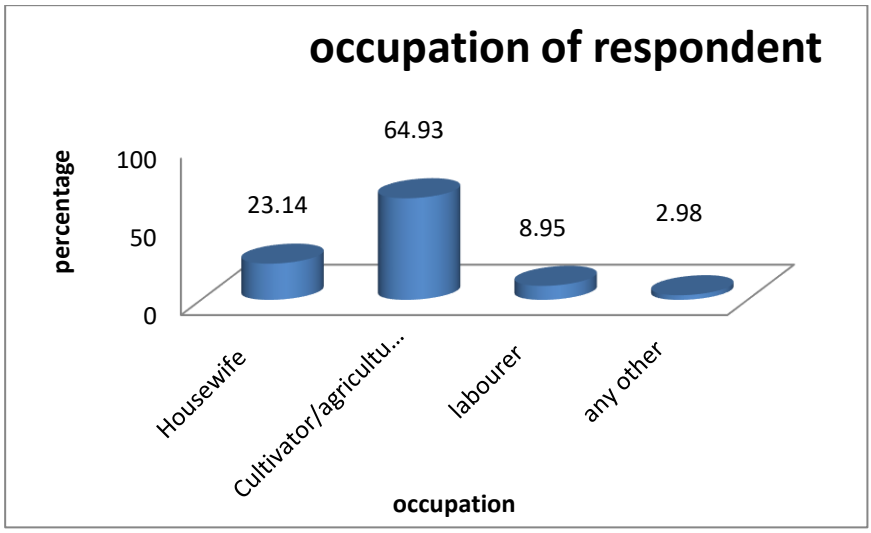
55% of the respondents were of the age group 20-22 years and 17% of women who were pregnant or recently delivered were of 18-20 years of age. And 80% of the respondents were illiterate and 21% of the respondents had primary level of education (Figure 3.2).

Figure 3.2



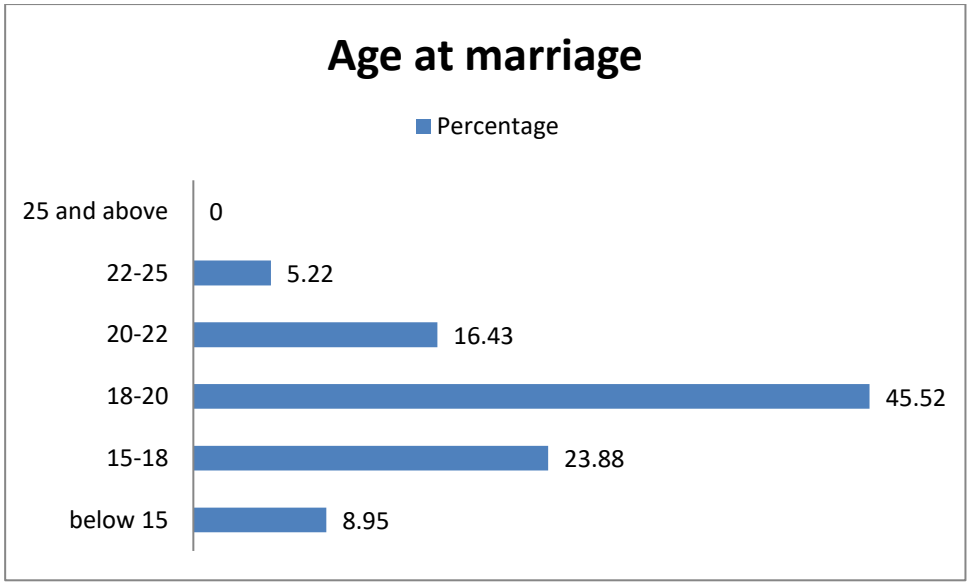
75.4% of respondents were illiterate and only 16.4% had primary level of education.

Figure 3.3



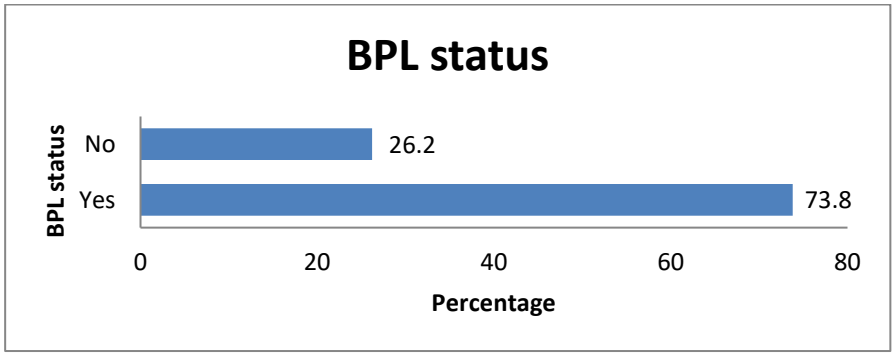
Around 65% of the women were working in the fields/farms and 23% were Housewives and 9% worked as labourers on daily wages (Figure 3.3)

Figure 3.4



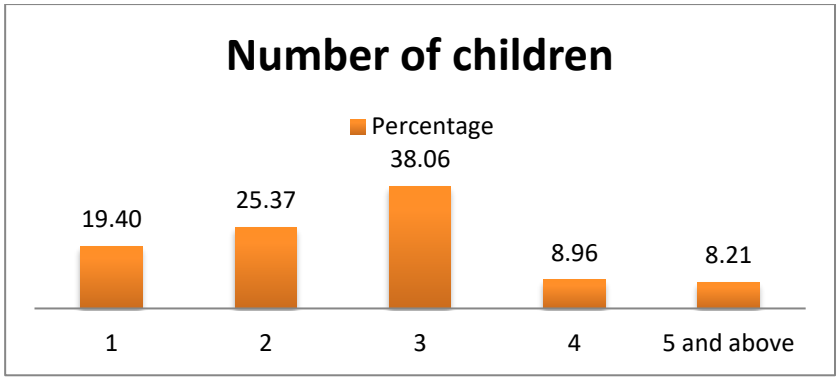
45% of women were married at the age of 18-20 years (Figure 3.4) and the mean age at marriage for girls in Rural Area of Gujarat is 19.2yrs. (Marriages that occurred during the reference period-DLHS III).

Figure 3.5



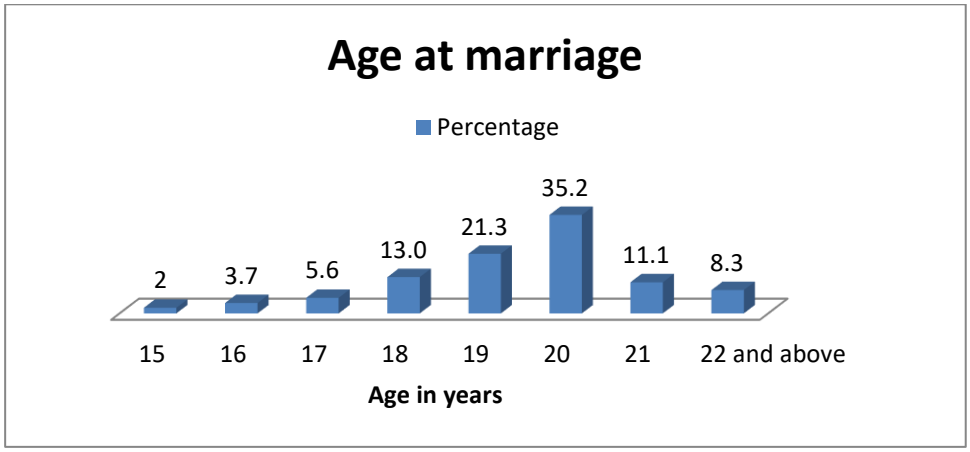
74% women belonged to BPL families (figure 3.5).

Figure 3.6



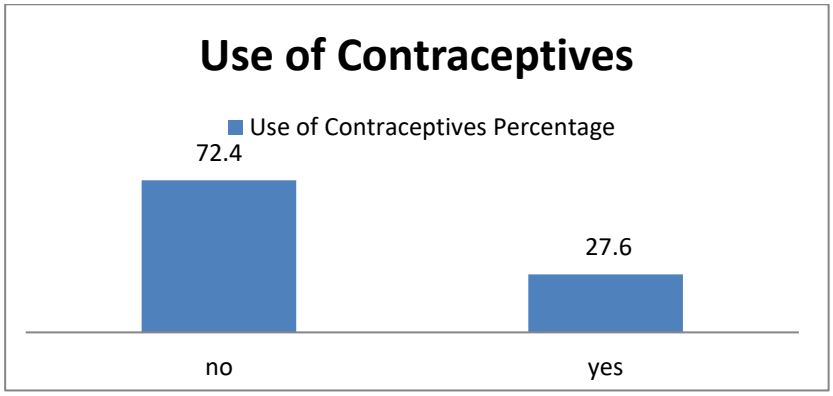
38% of women had three children and 25% women had two children 19% of women were pregnant for the first time (Figure 3.6)

Figure 3.7



35.2% of women had their first delivery at the age of 20 **(**figure 3.7)

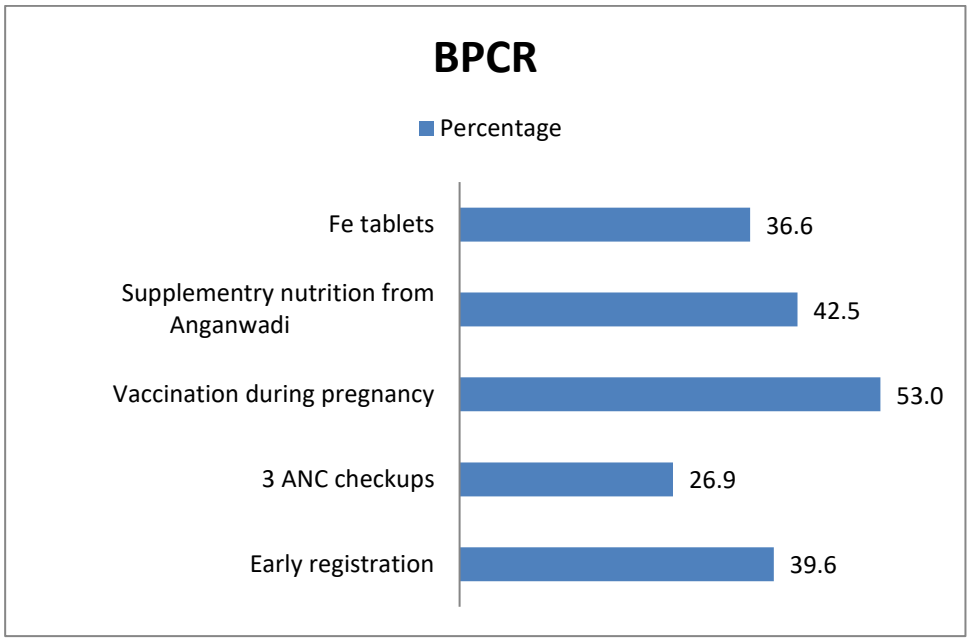
Figure 3.8



27.6% of women said that they use the contraceptives with their partners and 72.4% (Figure 3.8) while DLHS-III prevalence of contraceptive is 61.6% in state of Gujarat.

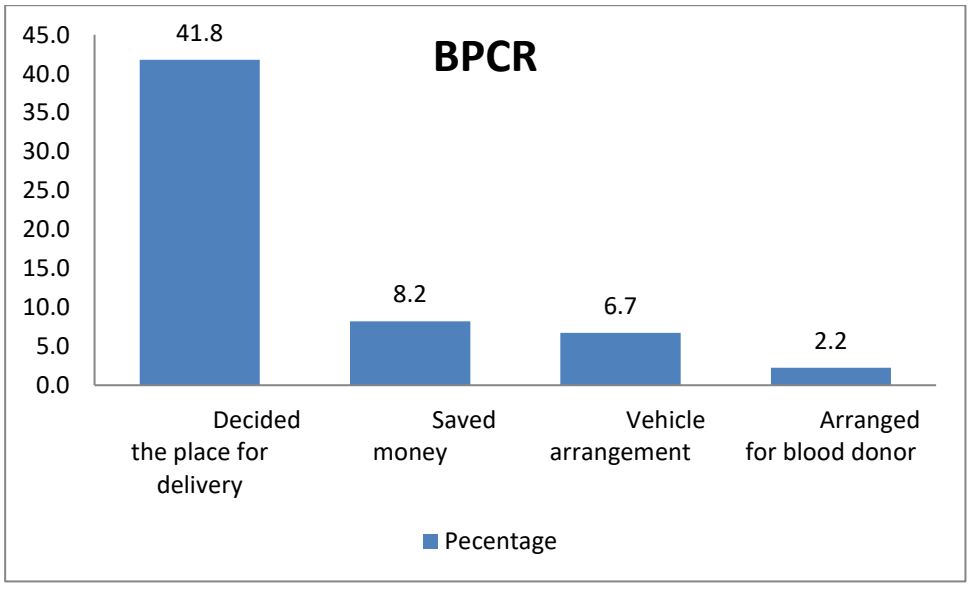
About Birth Preparedness and Complications Readiness (BPCR)

Figure 3.9



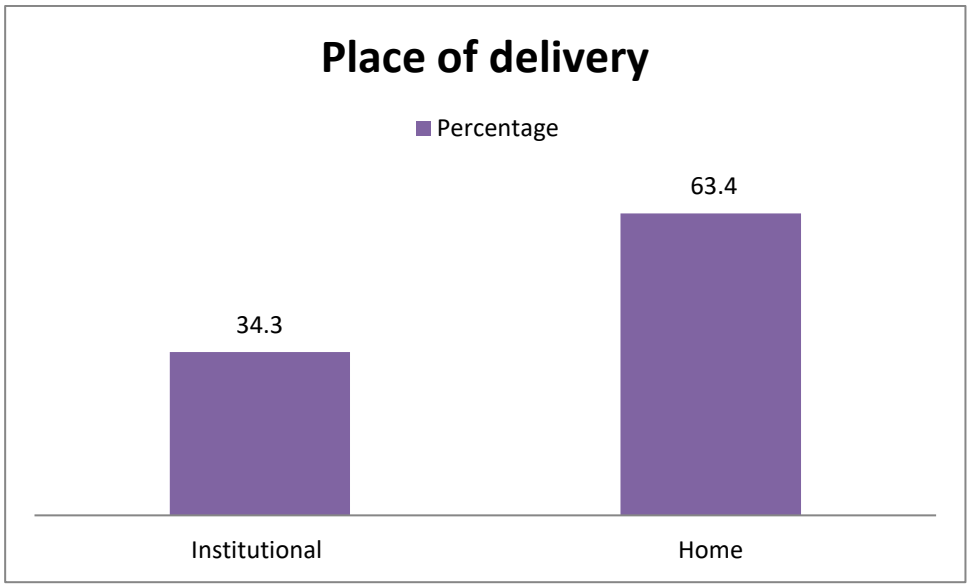
Only 26.9% had complete ANC (19.9%-DLHS-III-Gujarat), only 39% women were registered early i.e. within first three months of Pregnancy. 53% women had vaccination during delivery and nearly 37% women had Fe tablets during pregnancy. (Figure 3.9)

Figure 3.10



Only 41.8% decided the place for delivery in advance like hospital or home delivery. Only 8.2% women save money for the emergency expenses during delivery.

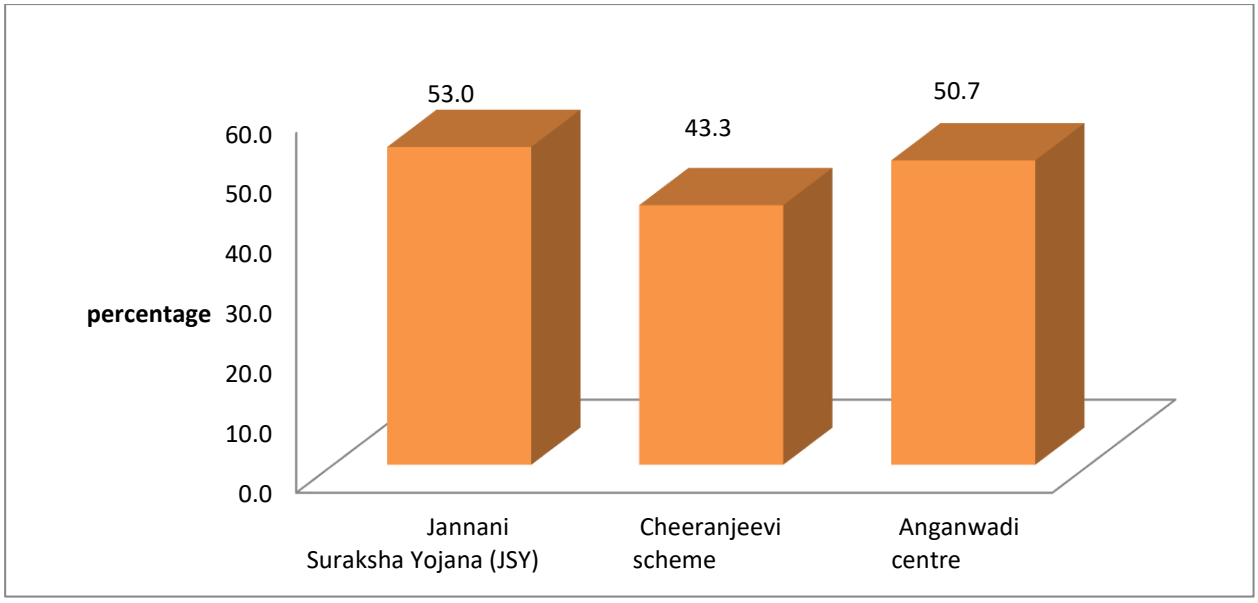
Figure 3.11



Among all the women interviewed 63.4 % delivered at home and only 34.3% delivered at institution (Figure 3.11)

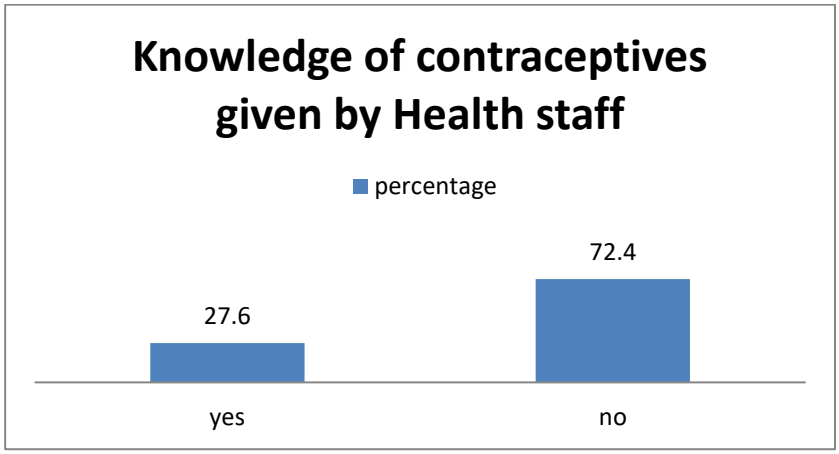
About the Health Facility Staff:

Figure 3.12



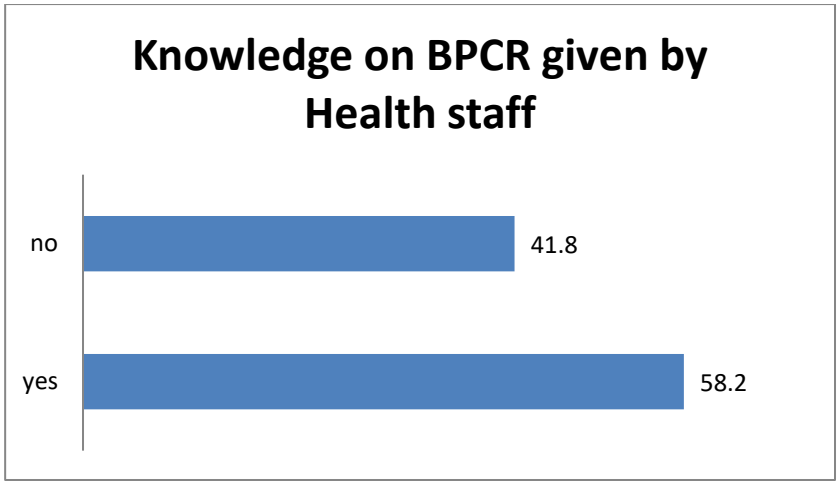
Nearly 60% of women knew about the maternal health entitlements under the public health system and 40 % were unaware of the Maternal Health services like JSY and Cheeranjivi scheme (Figure 3.12).

Figure 3.13



Only 30% of women said that doctors/nurses discussed about contraception and family planning with them on their visit to health facility (figure 3.13)

Figure 3.14



58.2% of women said that the link worker and the female health worker of the village discussed with them about birth planning and complications during pregnancy.

- **Qualitative Findings: Focus Group Discussions**

A total of 5 villages were covered in Anand District wherein focus group discussions were conducted with women of age group 15-49 yrs. who were the local residents. In all 50 women participated and shared their views on various aspects of maternal health.

Regarding age at marriage, almost all groups mentioned that in their village marriage happens at the age of 12-13 years. “Gauna”, (a ceremony where a girl is sent to her in-laws), is done at the age of 17-18 years. The demand of a child comes early in a marriage. It can be aptly said that there exists no plan amongst the couples on when to have the first child as it is demanded as soon as the marriage takes place or the gauna is done. The groups also mentioned that “since there is not enough money therefore the choice on eating as per the likeness is almost restricted”. The group also mentioned that they go to the anganwadi centre for registration. Some groups mentioned that they go to the anganwadi centre to get nutritious food, where they get uncooked porridge.

There is very little information on the visits of the ANM in their villages. Almost all the groups mentioned that the ANMs do not visit their village but they mentioned that some medicine is given to them related to delivery which when probed further was the iron folic tablets. However, there seems to be very less information provided on ANC services. One group has though mentioned that in their area, the ANM comes once in 1 or 2 months but she doesn’t provide any service. Complaints regarding this have been made several times by them but no action has been taken. The groups also mentioned that if the ANM is called for delivery she takes Rs. 200-250 and for medicines she takes another Rs.200-250 and normally the total cost comes to around Rs. 500. Some groups mentioned that the ANM only sits at SC from 10:00am to 1:00pm. For the

purpose of delivery or check-up some also go to private clinics as they think that the services in private clinics are better than government hospitals.

On being probed upon the availability of Dai's, the groups have said that "the Dai's are available in the area but most of them are unskilled". None of these groups had any information on JSY. However, some groups did mention that if the delivery is done at a government hospital then they get Rs. 700 but in the hospital the expense comes around Rs. 1000-1500. The doctors or ANM do not take fees but if the delivery is caesarean then the charge is Rs. 10,000-15,000. For place delivery, all the groups mentioned that they go to CHC or district hospital, if any complication occurs. There is no ambulance which comes to their village. When asked about 108 ambulance service, it was said that it never reaches on time. Most of the women said that doctors ask for "informal payments".

Almost all the women said that they don't have any kind of cultural practices which adversely affect the maternal health. But when probed they shared that they have a practice of not eating "Ghee" or clarified butter and milk during pregnancy because it can cause complications during pregnancy. During discussion some of the women shared that in BPL card the name of the daughter-in-law (Bahu) is not mentioned and hence BPL card is of no use for widows. They also discussed about the immunization during pregnancy. One of the women shared that miscarriage can happen if we take vaccine during pregnancy.

They also shared that even during pregnancy they have to do all the household work alone and some of them also had to work in the fields/farms. Most of women were shy to talk about contraceptives and they also shared that they never use contraceptives as their husband's do not like it but some of the women of Muslim community also shared that after 3-4 children they use Cu-T as contraceptive but they don't share this even with their husband.

One most frequent cause of not going to health facility for the treatment was the distance of location of the health facility. Almost all groups said that lack of transportation facility is the biggest problem for them in going to the health centre/facility. Even the "Nurse Ben" or the Female Health Worker does not come to the village because she has problem of transportation.

Most of women discussed that they prefer home delivery because they had their earlier deliveries at home and even their mothers and mother-in law delivered at home without any consultation with health staff. The groups also shared that even during pregnancy women are not given any concession from the household work and there is hardly any improvement in their diet. In rural households not much attention is given to the food consumption pattern of women from her childhood.

Chapter 4: Discussion

Women lack the empowerment to take decisions including number of children they want or the use of contraception, decision to use reproductive health services. Postnatal care remains the most neglected area with only 42% of women receiving. The total institutional deliveries remain just 34%.

The educational and economic status of women influences the use of maternal care. Illiterate mothers and mothers from BPL families used basic maternal healthcare much less than their literate and wealthier counterparts were far less likely to see a doctor. Only 18% of 101 illiterate mothers had institutional deliveries compared to 86% of 33 mothers with 12 or more years of education. Knowledge on post delivery entitlements for mother and children was found to be poor among women. The study also suggests that the performance of each health worker/provider/staff should be reviewed with a focus on maternal health services.

Most of the women did not use any family planning method and were married at a very early and thus the child bearing age is also very low. Apart from this even the work load during pregnancy as most of the women work in the field/farms adds to the poor maternal health.

Accountability in the public health system is still lacking doctors and ANM's ask for informal payments from poor women. So there is a complex structure of the various factors which are interlinked such as early marriage, early pregnancy, high work load, low socio-economic status, poor nutrition, lack of transportation facilities and the cultural beliefs in rural areas which combinely contribute significantly towards maternal deaths.

Chapter 5: Conclusion and Recommendations

5.1 Conclusion

Based on this study it can be inferred that despite the multiple efforts of the Indian Government and State Governments to improve maternal health still the maternal health indicators not improved significantly.

Physical access can be a major challenge as transportation was limited and the health facilities were far. Most of the communities are engaged in cultivation and labor. To track these women and link them with the health services is a major challenge. Motivating men for contraception is a major challenge. The social structure is such that men would not discuss even among men or accept contraception.

A large proportion of women did not know about the availability of ambulance services. Even the proportion of women not aware of availability of Government supported 108 ambulance services.

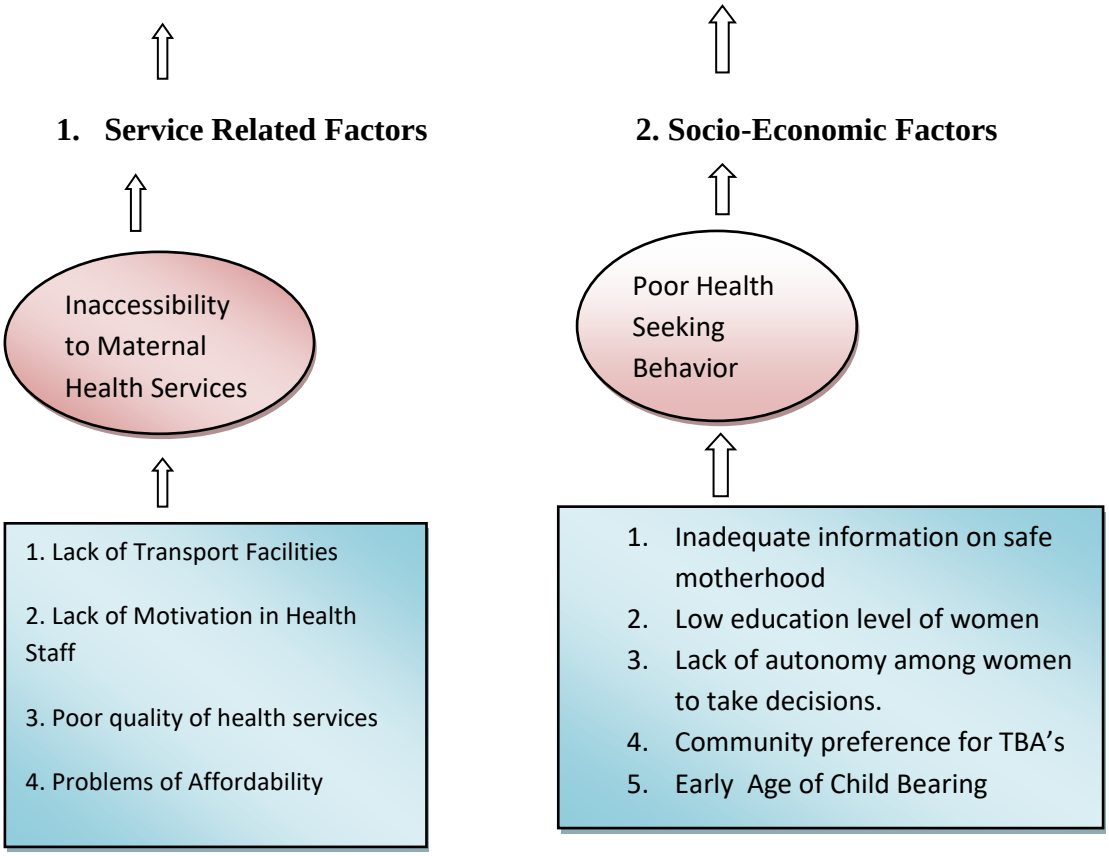
Since the Birth Preparedness and Complications Readiness indicators (saving money, deciding place of delivery, arranging for transportation, arranging for blood donors etc.) are very poor so it causes three delays at the time of delivery which actually are the main reasons for maternal deaths in rural areas.

These delays are classified as:

I. Delay In decision making at the household level.(husband or In Laws decide whether to go hospital for delivery or not.)
II. Delay In reaching the hospital due to delay in arranging transport for at the time of delivery.
III. And Delay in treatment at the health facility like if doctor/nurse is not available on time.

There is a need to increase the awareness for the maternal health services and entitlements among the rural women and also motivate them for utilizing these services. Apart from this there is also a need to motivate the health staff to work for good maternal health.

Possible Barriers in Improving Maternal Health causing High Maternal Mortality Rate



5.2 Recommendations

- Education is main key to improve the status of health indicators more campaigns or activities should be done to increase the awareness/ knowledge level of the women in rural areas. "Bhavai" shows can be organized in villages to educate women on maternal health.
- Birth planning and complications readiness should be focused to avoid delays at the time of delivery by motivating women for planning for birth in advance. Women can be given a calendar for Birth Planning.
- Special camps of gynaecologist for women of reproductive age should be organized to ensure complete ANC and PNC care of Pregnant and lactating women.
- Weekly a vehicle can be arranged by the FNGOs to take all the pregnant women from remote areas to the hospital/health facility for vaccination and other checkups.
- Refresher trainings can be organized for the health staff for motivating them and monthly review can be done for maternal health services.

PART III: ANNEXURE I

Questionnaire for Survey

1. Age……
2. Occupation: (i) Housewife (ii)Cultivator/agriculture (iii)labourer (iv)Any other
3. Age of Marriage……
4. Belong to BPL (i) Yes (ii) No
5. No. of pregnancies……..…
6. Age at first delivery……
7. Do you use contraceptives? Yes or no
8. Preparations for pregnancy:

i. Early registration
ii. 3 ANC checkups
iii. Vaccination during pregnancy
iv. Supplementry nutrition from Anganwadi
v. Fe tablets
vi. Any other……

9. Preparations for delivery

i.Decided the place for delivery
ii.Saved money
iii.Vehicle arrangement
iv.Arranged for blood donor
v.Any other…….

10. Place you delivered (i) Institutional (ii) home (if institution then go to 8b)

11a if home then Reasons for home delivery……

11b If institutional who accompanied for delivery……..

11c Problems during institutional delivery……

11. Did you receive 3 PNC after delivery (i) yes (ii) no
12. When Did you start breastfeeding your child (i) within half hour of delivery (ii) within one day of delivery (iii) later than one day of delivery
13. Do you know about the Maternal health services and Entitlements under the public health system

i.Jannani Suraksha Yojana (JSY)
ii.Cheeranjeevi scheme

iii.Anganwadi centre

iv.Any other……..

14. About **Health facilities/staff**

10a. Doctor/nurse talked about contraception at last visit to health facility (i) yes (ii) No

10b. Doctor/nurse talked about preparations during pregnancy (i) yes (ii) No

10c. Doctor/nurse talked about vaccination during last visit to health facility (i) yes (ii) No

10d. Doctor/nurse talked about HIV/RTI/STI during last visit to health facility (i) yes (ii) No

10e. Nurse/FHW visits your village? (i) Yes (ii) No

15. Where did you seek treatment (i) Pharmacy

(ii) govt. hospital

(iii) private hospital

(iv) home treatment

(v) any other……

16. Are your children immunized? (i) Yes (ii) No

13a If no then why ?.....

17. Whate are the traditional/Cultural practices and beliefs for maternal health in your village…….

18. What do you think are the Challenges for safe motherhood……

Annexure II

References

1. Gujarat state profile. (http://www.gujaratindia.com/stateprofile/profile1.htm, accessed on 30 December 2007).

2. India. Ministry of Health and Family Welfare. Family welfare statistics in India–2006: Table A-2. New Delhi: Ministry of Health and Family Welfare, Government of India; 2006. pp. A–7.

3. International Institute for Population Sciences. National family health survey-II: Gujarat report. Chapter 8: Maternal and child health. Bombay: International Institute for Population Sciences; 2000. pp. 175–99.

4. International Institute for Population Sciences. National family health survey (NFHS-2), 1998-99: India. Mumbai: International Institute for Population Sciences; 2000. p. 369 (http://hetv.org/india/nfhs/india2.html, accessed on 1 September 2007).

5. International Institute for Population Sciences. National family health survey-1: Gujarat report. Chapter 9: Maternal and child health. Bombay: International Institute for Population Sciences; 1995. p. 155..

6. International Institute of Population Science. India summary report. District level household survey (2002-04) & facility survey (2003). Annexure II. Key indicators. Bombay: International Institute of Population Science; 2006.

7. Gujarat. Department of Health and Family Welfare. State programme implementation plan: Reproductive and Child Health (RCH) II. Gujarat: Department of Health and Family Welfare, Government of Gujarat; 2007. p. 109 p

8. Hill K, Thomas K, AbouZahr C, Walker N, Say L, Inoue M, et al. Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data. Lancet. 2007;370:1311–9. [PubMed]

9. Gujarat. Health and Family Welfare Department. Outcome of Chiranjeevi scheme: mothers and newborn babies saved. Gujarat: Health and Family Welfare Department, Government of Gujarat; 2008. (http://www.gujhealth.gov.in/Chiranjeevi%20Yojana/pdf/CY-Feb-2008.ppt, accessed on 11 September 2008).

10. WHO (2001) 'Maternal mortality in 1995: Estimates developed by WHO, UNICEF, UNFPA', WHO Geneva.

11. WHO (2005) 'World Health Report: Working together for Health', WHO Geneva