INTERNSHIP TRAINING

AT

CARE INDIA, BIHAR

POST-NATAL CARE AND BREAST FEEDING PRACTICES AMONGST THE RECENTLY DELIVERED MOTHERS IN HALDI CHHAPRA VILLAGE OF MANER BLOCK OF PATNA DISTRICT, BIHAR

BY

MAYANK JOSHI

PG/14/031

UNDER THE GUIDANCE OF

MRS DIVYA AGARWAL

POST GRADUATE DIPLOMA IN HOSPITAL AND HEALTH MANAGEMENT

2014-16

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

INTERNSHIP TRAINING

At

Care India, Bihar

Post Natal Care and Breast Feeding Practices amongst the recently delivered mothers in Haldi Chhapra village of Maner block of Patna district, Bihar

By

Mayank Joshi

PG/14/031

Under the guidance of

Mrs. Divya Agarwal

Post Graduate Diploma in Hospital and Health Management

2014-16

International Institute of Health Management Research, New Delhi

CARE INDIA
Solution for Sustainable Development
14, Patliputra Colony
Patna 800 013, Bihar
Tel +91-612-2274957, 2274389, 2270464
Fax +91-612-2274957
www.careindia.org
CIN : U85100DL2008NPL178133

Completion of Dissertation from Care India, Bihar

The certificate is awarded to

Dr Mayank Joshi

In recognition of having successfully completed his Internship in the department of

Nutrition - Technical Support Unit

And having successfully completed his Project on

Post-Natal care & Breast feeding practices among the recently delivered mothers in haldi-chhhapra village of Maner Block of Patna District

Date: 12th May, 2016

Care India, Bihar

He comes across as a committed, sincere & diligent person, who has a strong drive & zeal for learning

We wish him all the best for future endeavours

CARE INDIA PATNA BIHAR

Training & Development

for

Head-Human Resources

13/5/16

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Mayank Joshi**, a student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at **Care India, Bihar** from **11th April, 2016** to**10th May, 2016**.

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfilment of the course requirements.

I wish him all success in all his future endeavours.

Dr. A.K. Agarwal
Dean (Academics and Student Affairs)
IIHMR New Delhi

Divya Aggarwal
Assistant Professor
IIHMR, New Delhi

Certificate of Approval

The following dissertation titled **"POST-NATAL CARE AND BREAST FEEDING PRACTICES AMONGST THE RECENTLY DELIVERED MOTHERS IN HALDI CHHAPRA VILLAGE OF MANER BLOCK OF PATNA DISTRICT, BIHAR"** at **"CARE INDIA, BIHAR"** 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 dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Dr Dharmesh Lal	
Prof. Pradeep Panda	PK Panda
Dr Preetha GS	

CARE INDIA
Solution for Sustainable Development
14, Patliputra Colony
Patna 800 013, Bihar
Tel +91-612-2274957, 2274389, 2270464
Fax +91-612-2274957
www.careindia.org
CIN : U85100DL2008NPL178133

Certificate from Dissertation Advisory Committee

This is to certify that **Dr Mayank Joshi** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. He is submitting this dissertation titled **"Post-Natal care & Breast feeding practices among the recently delivered mothers in haldi-chhhapra village of Maner Block of Patna district at "CARE INDIA, BIHAR"** in partial fulfilment of the requirements for the award of the **Post-Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge. No part of it has been reproduced from any other dissertation, monograph, report or book.

Ms. Divya Agarwal
(Institute Mentor),
Assistant Professor,
IIHMR-Delhi

CARE INDIA PATNA BIHAR

Mr Sharad Chaturvedi
(Organization Mentor)
Deputy Director, N-TSU
Care India, Bihar

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH,
NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "**POST-NATAL CARE AND BREAST FEEDING PRACTICES AMONGST THE RECENTLY DELIVERED MOTHERS IN HALDI CHHAPRA VILLAGE OF MANER BLOCK OF PATNA DISTRICT, BIHAR**" and submitted by **VARUN KUMAR**, Enrolment No. **PG/14/031** under the supervision of **Mrs. Divya Agarwal** for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from **11th April, 2016** to **12th April, 2016** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Mayank Joshi
PG/14/031
PGDHM (2014-16) - Health

8

Acknowledgement

Every successful story is a result of an effective team work, a team which comprises of a good coach and good team players. Likewise this project report is no exception. This has been a meticulous effort of a group of people along with me. I want to take this opportunity to thank each and every one who has been a part of this report.

To start with, I take immense pleasure to thank **Dr. A. K. Khokhar** (*Director-International Institute of Health Management Research-Delhi*) and **Dr. A. K. Aggarwal** (*Dean, International Institute of Health Management Research- Delhi*) for placing me in such an esteemed organization (Care India) to perform my dissertation and start my career with; and my mentor, Mrs Divya Agarwal for her timely advice and encouragement for the successful conduction of my project.

I am highly indebted to Dr. Sunil Babu, Director, Nutrition Technical Support Unit, Care India, Bihar and Mr. Sharad Chaturvedi, Deputy Director, Nutrition Technical Support Unit, Care India, Bihar, for providing me with this opportunity to be a part of Nutrition TSU team at Care India, Bihar and giving me time and space from the induction and training schedule, to perform my fieldwork.

Also, I wish to thank Smt. Indira Devi and Mr. A. K. Mohan, for their continuous guidance in the training programme and arranging transport and other requirements for the completion of our desired field visit.

I then take this opportunity to thank the Front line workers, i.e. AWWs and ASHAs in Haldi Chhapra village, for being a constant source of support and guidance during the data collection in their village.

Lastly, I thank Mukhiya ji, Sarpanch ji, other dignitaries and the residents of Haldi Chhapra village, for being highly co-operative and for helping me in collecting the data for this report.

Table of Contents

DISSERTATION PROJECT

TABLE OF FIGURES

22	Visits by any FLW
23	Cord management
24	Age till only breastfeeding
25	MCP Card

LIST OF ABBREVIATIONS

MDGs	Millennium Development Goals
LQAS	Lots Quality Assurance Sample
FLW	Front Line Worker
FRU	First Referral Unit
ASHA	Accredited Social Health Activist
PHC	Primary Health Centre
CHC	Community Health Centre
BCC	Behaviour Change Communication
MLE	Monitoring Learning Evaluation
AWW	Anganwadi Worker
AWH	Anganwadi Helper
ICDS	Integrated Child Development Services Scheme
ORS	Oral Rehydration Solution
INHP	Integrated Nutrition and Health Programme
SHGs	Self Help Groups
N-TSU	Nutrition-Technical Support Unit
ANM	Auxiliary Nurse Midwife
WHO	World Health Organization
MMR	Maternal Mortality Ratio
PNC	Post Natal Care
MCP	Maternal Child Protection
DDK	Disposable Delivery Kit

MoHFW	Ministry of Health and Family Welfare
MoWCD	Ministry of Women and Child Development
DPO	District Programme Officer
CDPO	Child Development Programme Officer
LS	Lady Supervisor
IEC	Information Education Communication
THR	Take Home Ration
HSC	Health Sub Centre
DRG	District Resource Group
BRG	Block Resource Group

Organization Profile

CARE INTERNATIONAL

CARE International is a leading humanitarian organization fighting global poverty. It places special focus on working alongside poor women because, equipped with the proper resources, women have the power to help whole families and entire communities escape poverty. Women are at the heart of their community-based efforts to improve basic education, prevent the spread of disease, and increase access to clean water and sanitation, expand economic opportunity and protect natural resources. The organization also delivers emergency aid to survivors of war and natural disasters, and help people rebuild their lives.

In the fiscal year 2015, CARE worked in 95 countries around the world, supporting 890 poverty-fighting development and humanitarian aid projects to reach more than 65 million people.

CARE International is a global confederation of 14 National Members and one Affiliate Member with the common goal of fighting global poverty. Each CARE Member is an autonomous non–governmental organization and implements program, advocacy, fundraising and communications activities in its own country and in developing countries where CARE has programs.

At the beginning, there was a package: a CARE package, aimed to reduce hunger and show solidarity with the people of war-torn Europe.

At the end of World War II in 1945, twenty-two American charities, a mixture of civic, religious, cooperative and labor organizations got together to found CARE. Originally known as the *Cooperative for American Remittances to Europe*, it began to deliver millions of CARE packages across Europe. This was basically a small shipment of food and relief supplies to hungry recipients - with a huge impact on people's lives.

During the next three decades, CARE shifted its focus from helping Europe to delivering assistance in the developing world. It started programs in the areas of education, natural resources management, nutrition, water and sanitation, and healthcare in Southern Africa,

South Asia and South America. Broadening the geographic focus and expanding beyond the original food distribution programs, CARE started to assist people affected by major emergencies – from famine in Ethiopia to hurricane recovery in Honduras.

Over the previous decades, Care has continuously developed its approach to reducing poverty. In 1945, CARE was established on the premise that poverty was mainly due to a lack of basic goods, services, and healthcare. As the organization grew, so did their understanding of poverty. CARE's scope widened to include the view that poverty is often caused by the absence of rights, opportunities and assets, largely due to social exclusion, marginalization, and discrimination. In the early 1990's, its work grew into what they call a 'rights based approach' to development.

In 1993, in an effort to reflect the wider scope of its programs, vision and impact, CARE changed the meaning of its acronym to *"Cooperative for Assistance and Relief Everywhere".* By 2007, it started focusing on women's empowerment realizing that women are the key: by empowering women entire families can be lifted out of poverty.

Some key networks in which CARE is involved or is a signatory to are:

- Code of Conduct for the International Red Cross & Red Crescent Movement at NGOs in Disaster Relief
- The Sphere Project
- Humanitarian Accountability Partnership International (HAP)
- Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP)
- People in Aid
- INGO Accountability Charter
- CARE is a signatory to and holds itself accountable to internationally accepted humanitarian standards and codes of conduct, and works with other aid organizations and United Nations agencies to improve humanitarian action and to influence policy.

CORE VALUES

Respect: Affirm the dignity, potential and contribution of participants, donors, partners and staff.

Integrity: Actions consistent with the mission. Being honest and transparent in what they do and say, and accept responsibility for their collective and individual actions.

Commitment: Work together effectively to serve the larger community.

Excellence: Constantly challenge themselves to the highest levels of learning and performance to achieve greater impact.

VISION AND MISSION

Their vision is to seek a world of hope, tolerance and social justice, where poverty has been overcome and people live in dignity and security. CARE will be a global force and partner of choice within a worldwide movement dedicated to ending poverty, and will be known everywhere for its unshakeable commitment to the dignity of people.

CARE strives to serve individuals and families in the poorest communities in the world. Drawing strength from their global diversity, resources and experience, they promote innovative solutions and are advocates for global responsibility.

CARE INDIA

CARE has been working in India for over 65 years, helping alleviating poverty and social exclusion by facilitating empowerment of women and girls from poor and marginalized communities. In India, CARE focuses on the empowerment of women and girls because they are disproportionately affected by poverty and discriminations; and suffers abuse and violations in the realization of their rights, entitlements and access and control over resources. They do this through well planned and comprehensive programmes in health, education, livelihoods and disaster preparedness and response.

To be able to bring about lasting change, CARE India addresses underlying causes of poverty and social injustice. For example, they implement a gender transformative framework within their programmes to address unequal power relations at the grassroots level.

CARE in India works across 14 States and 38 projects, touching the lives of 37 million people.

Some of the notable initiatives of CARE India are:

- CARE India response on Cyclone Phailin hit on the Eastern Coast of India.
- CARE India Tsunami relief programme.
- CARE India response to floods in Uttarakhand

CARE India has been working extensively in different parts of India. They work with grassroots initiatives, state and district governments, communities and individual from all over the country.

As of now, CARE India is present in 14 states of India, with the head office being in Delhi.

Please see below for the list of the 14 states:

Fig 1. Fig. 1 CARE in India works across 14 States and 38 projects, touching the lives of 37 million people. (Headquarters in Delhi)

HISTORY OF CARE INDIA

CARE came to India in June, 1946 when one of its co-founder, Lincoln Clark, signed the CARE Basic Agreement in New Delhi at the Office of Foreign Affairs. The agreement was limited to contributions of technical books and scientific equipment for universities and research institutes. In November 1949, the first Chief of Mission, Melvin Johnson, arrived in India to establish operations. Subsequently on the invitation of the then President of India, he developed a CARE India Food Package that caused a renegotiation of the CARE Agreement to include importation of food through Indo-CARE Agreement on 6 March 1950. The CARE Office during 1950's in Delhi was a hutment (a long, thin building) located in Janpath, Connaught Place. CARE had three additional offices and warehouses in India located in Bombay, Madras, and Calcutta.

Fig.2 Early days of CARE India.

The initial programmes those days included assistance to educational institutions, relief camps and assistance to hospitals in form of books, laboratory equipments, tools supplies etc. When the Mid-Day Meal (MDM - school lunch) program started in 1960, state offices were established and the staff in Delhi and state offices increased. Since 1960's CARE has been supporting government's school feeding programs. CARE has been providing nutritious food for the beneficiaries of Integrated Child Development Services (ICDS) on the request of GOI since 1982. CARE supported the Government's ICDS in the states of Andhra Pradesh, Bihar, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and West Bengal. As a part of support from USAID, CARE implemented a long term project named Integrated Nutrition and Health Project (INHP) from 1996 till 2010 and reached to about 1297 blocks in nine major states of India. Recognized worldwide for its contribution in disaster response and rehabilitation operations, CARE in India has supported the efforts of Government of India and individual state governments as and when major disasters occurred in the country. CARE has provided relief to several natural disasters since 1966 with Jammu and Kashmir floods 2014 and Hud Hud in Andhra Pradesh being the most recent. Some of the efforts include response to flood relief in West Bengal in 1979, cyclone in Andhra Pradesh in 1977 and in 1996, and earthquake relief in Latur, Maharashtra in 1993, and Odisha super cyclone in 1999.

CARE India's current 'Programme' approach stems from a redrawn vision, under which, working with partners on projects has been overlapped with holistic, long term, deep impact

“programmes” that work directly with key populations to ensure that the root causes of poverty and marginalization of people, particularly poor women and girls, are tackled strategically and collaboratively.

As CARE India moves ahead, their key programming approaches will include social analysis and action, gender transformative value chain approaches, leadership and life skills strengthening, building capacities and leadership roles at multiple levels, advocacy on national and international platforms and facilitating links and dialogues between public, private and civil society.

FOUR MAIN FUNCTIONAL AREAS

Disaster Preparedness

Education

Health

Livelihood

CARE INDIA INITIATIVES IN HEALTHCARE

Delivering healthcare to over a billion people is a very complex challenge. CARE India works in close collaboration with State and Central Government and other partner organizations to secure accessible and quality maternal and child healthcare among

marginalized communities. It works towards identifying the root causes of healthcare challenges, provides innovative solutions, and helps implement secure and quality healthcare services in India. CARE India believes that a healthy mother and a healthy baby is the route to a productive and a developed nation. Hence, CARE has specially focused upon providing comprehensive solutions to address public health problems. CARE India promotes essential new born care and immunization, reducing malnutrition, preventing infant and maternal deaths and protecting those affected by or susceptible to HIV/ AIDS and TB. CARE works closely with its partners to achieve good health care for everyone.

Various programmes of CARE India are:

- **EnSIGN:** Enhancing the Sustainable Farming Initiative through Gender and Nutrition. (Bankura District, West Bengal)
- **RACHNA:** Reproductive and Child Health Nutrition & Awareness. (Rajasthan)
- **HEVS extending CHCMI:** Health Education among SHG & VHSNC Members. (Puruliya, West Bengal)
- **SEHAT:** Sustainable Education and Health among Tribal's. **(**Sidhi and Shahdol districts of Madhya Pradesh)
- **BRIDDHI:** Ensuring improvement in the nutritional status among severely malnourished children through growth monitoring, Behavior Change Communication, strengthening Health (including treatment) and Nutrition service delivery system. (West Bengal)
- **SWASTH:** Sector Wide Approach to Strengthen Health. (Bihar)
- **EMPHASIS:** Enhancing Mobile Populations' Access to HIV & AIDS Services, Information & Support. (Delhi NCR, West Bengal, Uttarakhand and Maharashtra)
- **OHSP:** Technical and management inputs to TMST, Government of Odisha Health Sector and Nutrition Plan. **(**15 districts of Odisha)
- **MDR-TB:** Treatment, adherence and follow up of Multidrug-resistant tuberculosis. (West Bengal)
- **SKEAP:** Strengthening Kala Azar Elimination Program. (Eight districts in Bihar)
- **Axshya:** Bridging one of the most challenging gaps in Tuberculosis control - diagnosis and treatment of DR-TB - through programmatic activities. (Madhya Pradesh, Chhattisgarh and Jharkhand)
- **BTAST:** Bihar Technical Assistance Support Team. (Bihar)

- **MPNP:** Madhya Pradesh Nutrition Project. (Tekamgarh, Panna and Chhatarpur districts of Madhya Pradesh)
- **Mother and Child Health Project**. **(**Odisha and Madhya Pradesh)
- **UHI:** Urban Health Initiative. (11 cities of Uttar Pradesh)
- **FHI:** Family Health Initiative. (Bihar)
- **N-TSU:** Nutrition Technical Support Unit. (Bihar)

DEPARTMENT WORKED IN:

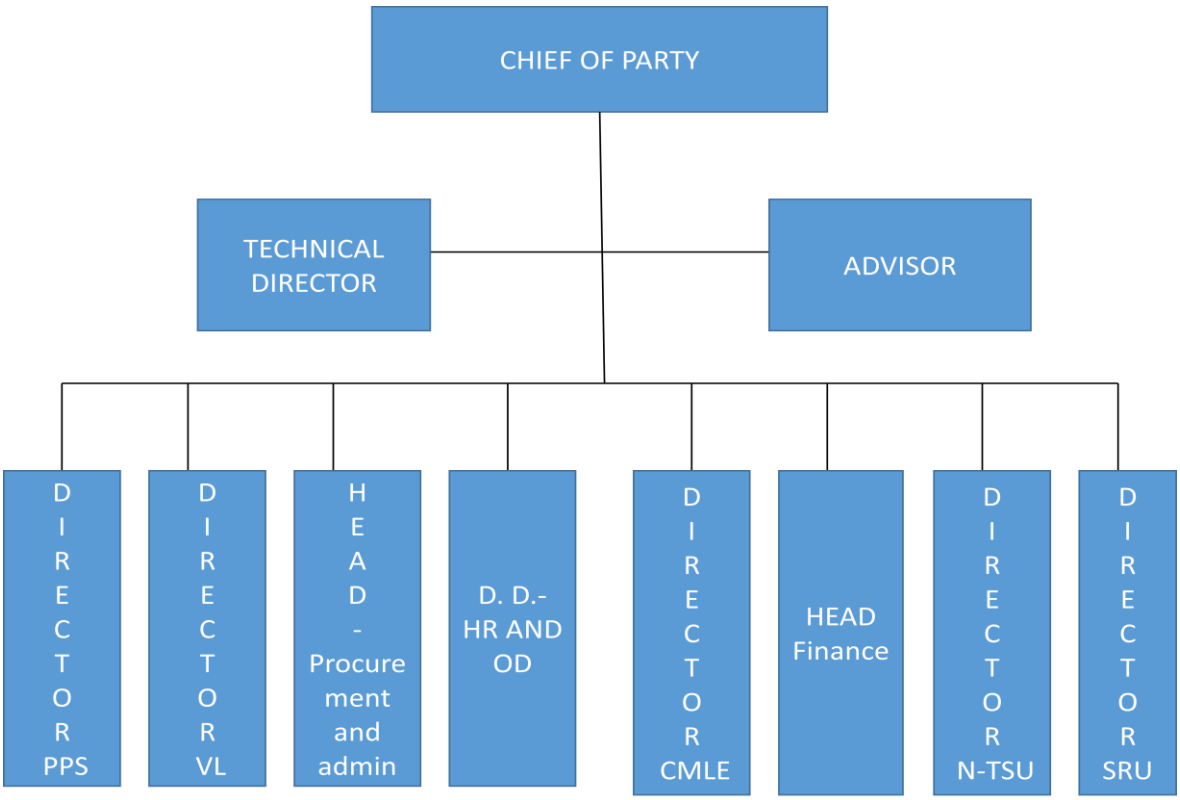
NUTRITIONAL TECHNICAL SUPPORT UNIT

For CARE India, the N-TSU project offers the opportunity to provide long term support to the Bihar state government's Integrated Child Development Services (ICDS) scheme. The ICDS scheme attempts to harness human, institutional and financial resources to do more, with high quality and with increased precision and efficiency. The goal of N-TSU is to achieve greater impact on the overall development of children in the state by addressing under-nutrition, especially focusing on Young Child Feeding practices, mainly through giving vigorous Home visits by the various stakeholders to the households of beneficiaries.

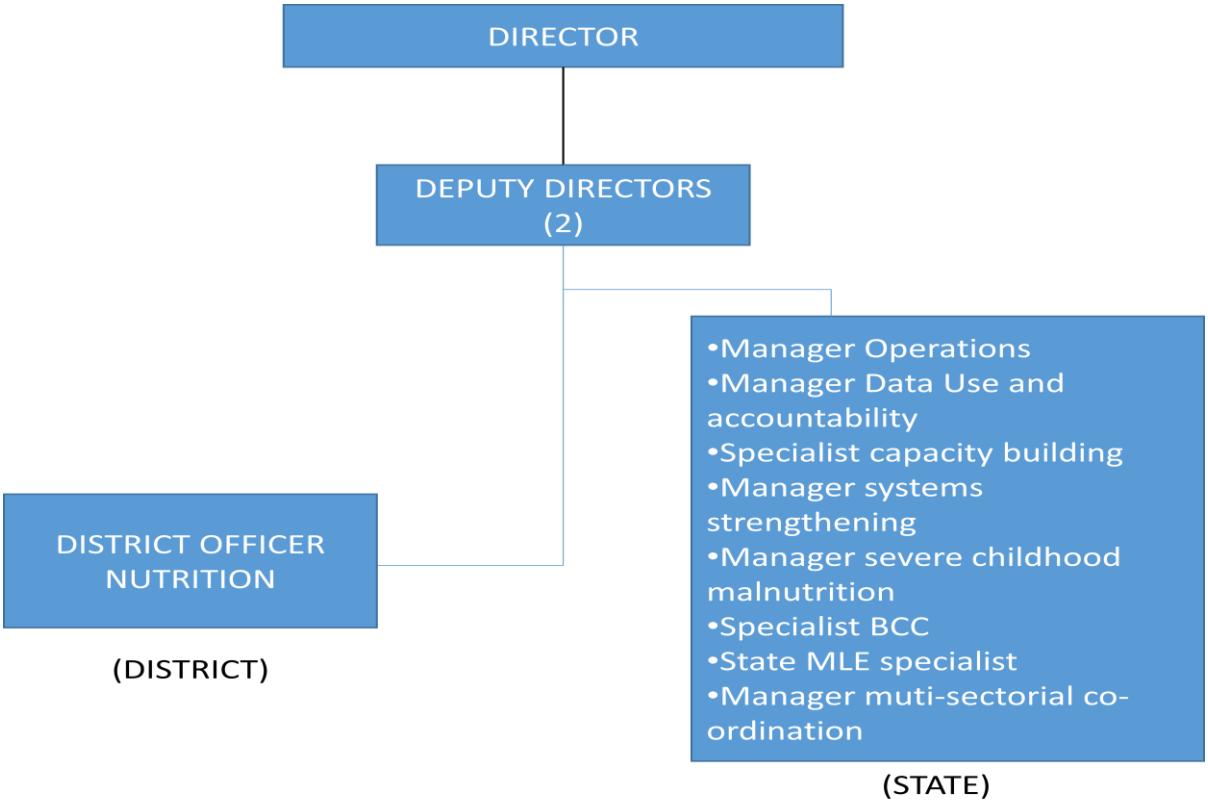
Recognizing that the Ministry of Women and Child Development alone cannot meet the needs of all children, CARE India is assisting the government to undertake convergence with other ministries and departments. CARE India is drawing from its field-tested, proven approaches to systematically create an enabling policy environment for ICDS, build trust across sectors, document models and promote convergence. Besides this, CARE India is facilitating training and capacity building of government functionaries, promoting safe drinking water, hygiene and sanitation at the household and community levels, promoting wheat fortification carrying BCC intervention, undertaking community mobilization and participatory governance. Finally, CARE India is responsible for working with block and district level ICDS personnel to improve their capabilities in data-driven management – using information to make evidence-based decisions to iteratively strengthen programs and improve outcomes.

Through monthly convergence meetings, N-TSU plans to re- establish the importance of convergence and coordination amongst the different government departments and other stake holders that contribute in reduction of malnutrition.

Bihar Management Team:-



N-TSU Project Team:-



KEY LEARNINGS

- An entire set of programmes are running under the MoHFW and MoWCD in the state of Bihar, but the ground level implementation and performance is in a miserable state.
- There is a huge communication gap and too much overlap and confusions in the work profiles of FLWs of ICDS and Health Department.
- Work profiles of government officials, i.e. DPOs, CDPOs and LSs in the Department of Social Work, Government of Bihar, is heavily loaded with add-on responsibilities like election duties, land issue resolutions, etc; which often results in a compromise with their actual job-specific work.
- The agony of cultural taboos is still widely prevalent in Bihar. Also, the caste system affects the functioning of the AWCs at large. There are a few communities like Mushahar and Passi, the presence of which is not acceptable to higher caste groups like Rajputs and Yadavs, which often results in preventing their children from going to AWCs if AWW or AWH belong to any other community or other caste groups are also benefitted at the same AWC.
- The physical state of AWCs is miserable, with unmaintained dust-filled registers, unreadable IEC on walls, no electricity and an acute shortage of space for the conduction of AWC functions, especially on VHSNDs.
- AWCs are equipped with Nutritional and Health education kits and materials, to be used by the FLWs on VHSNDs for educating women; but they are mostly unaware of the proper message to be communicated or the way to deliver it.
- People tend to look at an AWC as a spot to merely provide them ration and vaccinations, and thus are widely uninterested in the other services provided, and consider it to be a waste of time.
- There is a severe shortage of home visits by the FLWs, and this result in an improper knowledge of women on topics like exclusive breast feeding, complimentary feeding, family planning and birth preparedness.
- Since long, the entire focus in the field of healthcare in Bihar has been on immunization and institutional deliveries only, and thus the nutrition component was missed heavily, which has resulted in very high malnutrition rates in Bihar.
- There are huge gaps in the logistics or supplies of the essential materials like registers, growth charts, IFA tablets, THR, etc at the AWCs, which majorly affect their day to day functioning.

- A lot of meetings like ANM Tuesday meetings, HSC meetings, Sector meetings, DRG meetings, BRG meetings, etc are a part of general operations of the various stakeholders of health, but their regular conduction is a matter of question and a major challenge for the development partners like CARE.

PROJECT REPORT

Title of the study: **“**Post-Natal Care and Breast feeding practices in Haldi Chhapra village of Maner block of **Patna District, Bihar”**

INTRODUCTION

Of the 2.9 million new-born deaths that occurred in 2012, close to half of them occurred within the first 24 hours after birth. Many of these deaths occurred in babies born too early and too small, babies with infections, or babies asphyxiated around the time of delivery. Labour, birth and the immediate postnatal period are the most critical for new-born and maternal survival. Unfortunately, the majority of mothers and new-borns in low- and middle-income countries do not receive optimal care during these periods.**(1)**

In 2013, 2.8 million new-borns died in their first month of life—1 million of these new-borns died on the first day.[2, 3] Latest figures show that 9.2 million children under-five are dying every year, down from over 12 million in 1990. Most of these children are dying in developing countries from preventable causes for which there are known and cost-effective interventions. Unless efforts are increased there will be little hope of averting the additional 5.4 million child deaths per year, or a reduction of two-thirds, needed to achieve Millennium Development Goal (MDG) 4 by 2015.[4] In June 2015, UNICEF and the WHO launched a plan to end preventable new-born deaths and stillbirths by 2035.[5]

Adequate nutrition during infancy and early childhood is essential to ensure the growth, health, and development of children to their full potential.[6]It has been recognized worldwide that breastfeeding is beneficial for both the mother and child, as breast milk is considered the best source of nutrition for an infant.[7]

The World Health Organization (WHO) recommends that infants be exclusively breastfed for the first six months, followed by breastfeeding along with complementary foods for up to two years of age or beyond.[8]Exclusive breastfeeding can be defined as a practice whereby the infants receive only breast milk and not even water, other liquids, tea, herbal preparations, or food during the first six months of life, with the exception of vitamins, mineral supplements, or medicines.[9]

A proper assessment of the present statistics of Postnatal Care(PNC) and breast feeding practices in a state like Bihar (with a really high IMR and MMR) can help in giving direction for designing interventions to address the gaps in IYCF practices and contributing to tackle the maternal and Infant morbidity and mortality significantly.

Breastfeeding reduces the risk of:

- Infections, with fewer visit to hospital as result.
- Diarrhoea & vomiting, with fewer visit to hospital as a result.
- Sudden infant death syndrome (SIDS).
- Childhood leukaemia.
- Type 2 diabetes.
- Obesity.
- Cardiovascular disease in adulthood.

Breastfeeding lowers your risk of:

- Breast Cancer.
- Ovarian Cancer.
- Osteoporosis (weak bones).

PROBLEM STATEMENT

Deaths in the first month of life, which are mostly preventable, represent 45 per cent of total deaths among children under five.This makes focus on new-born care critical than ever before. In 2015, an estimated 2.7 million children died in their first month of life; almost 1 million or 36 per cent died in the first day of life.[11]

As per Millennium development goal indicator, global MMR (2015) is 217 deaths per 1, 00,000 live birth.[12] The World Health Organization (WHO) estimates that majority of maternal deaths occurs in the developing countries. Being a developing country itself, India is also facing the same challenges.

In 2015, 4.5 million (75% of all under-five deaths) occurred within the first year of life.The risk of a child dying before completing the first year of age was highest in the WHO African Region (55 per 1000 live births).Globally, the infant mortality rate has decreased from an estimated rate of 63 deaths per 1000 live births in 1990 to 32 deaths per 1000 live births in 2015. Annual infant deaths have declined from 8.9 million in 1990 to 4.5 million in 2015.[13]

Bihar is known to be one of the most populated states in India, and related are its various health indicators as well. As per reported by NRHM Bihar, MMR of Bihar state is 219 per 1, 00,000 live births (2015) & IMR is 42 per 1000 live births.[14]

RATIONALE

Every child & his mother is at a high risk of morbidity till 42 days. Carrying out improper postnatal care & improper breast feeding practices, can lead to complications that could lead to death or injury to the mother or to her infant. Hence, it is highly necessary to practice strategies to tackle these problems on time.

There is evidence from studies conducted in different parts of the world that promoting Postnatal Care & Breast feeding practices improves the health status of mother & infant, nutritional level of infant, improves knowledge of mothers about danger-signs, and leads to improvement in care-seeking during obstetric emergency. This study is being proposed, with the objective of assessing the status of PNC trends & Breast feeding practices amongst the women in HaldiChhapra village of Maner Bock of Patna, Bihar.

The study is intended to serve as a needs assessment survey, designed to determine the level of knowledge, attitude and practices of women and their families to postnatal care, and breast feeding practices.

Keeping in consideration, the recall bias after a significant time lapse after delivery, and the criticality of this period after birth; the study is proposed to be conducted amongst the mothers of 0 to 2 months children.

OBJECTIVES

General Objective

To assess the status of Post -Natal Care and Breast Feeding Practices amongst the mothers of 0 to 2 months old children in Haldi Chhapra village of Maner block of Patna district, Bihar.

Specific Objectives

- To determine whether pregnant women in the village getting proper post natal care at required time.

- To determine the health status of lactating mother and her child whether women in the village get proper health services, required after delivery of child.
- To assess the breast feeding practices among mothers of 0-2 months child.
- To assess whether the women is properly feeding her child after birth in proper manner.
- To review the status of visits and counselling by FLWs.

LITERATURE REVIEW

David Osrin in their Cross sectional, retrospective study titled '**community based study of care of newborn infants in Nepal' inMakwanpur district, Nepal** published in **thebmj** conducted on 5411 married women aged 15 to 49 years who had given birth to a live baby in the past year. The findings highlight that 90% women gave birth at home & 85% women feed mother's milk at first but colostrum milk was discarded in 45% of total breast feeding cases.[15]

An article on 'The role of health extension workers in improving utilization of maternal health services in rural areas in Ethiopia: a cross sectional study' by **Araya Medhanyie*et al*(2015)** published in the **Bio Med Central**used Cross sectional survey is taken as a tool for data collection, conducted in Tigray region, Ethiopia. Results said postnatal care and especially assistance during delivery still seem to be a big problem. The majority of the women (81%) delivered their baby with the help of relatives or friends and only 7% were assisted by the HEWs (health extension worker).[16]

A research article titled 'Breastfeeding knowledge, practice, attitudes, and influencing factors: Findings from a selected sample of breastfeeding mothers in Bemidji, Minnesota' published in **Cornerstone Minnesota State University** Mankato**,** by **Hadeel Adnan Tanash (2014)**study used a cross-sectional design, written questionnaire was used to collect the data. Data were collected from a group of breastfeeding mothers in Bemidji, MN. The findings showed that the participants are knowledgeable about breastfeeding and that they have positive attitudes toward breastfeeding. Previous research has found that maternal age, maternal education level and family income have been shown consistently to be positively associated with breastfeeding in developed countries (CDC, 2010). In this study, it was found that all of the participants are educated, all of them had at least two years of college. [17]

METHODOLOGY

Study design and area

A cross-sectional observational study involving the mothers of recently born infants, residing in Haldi Chhapra village of Maner block of Patna district, Bihar.

Study population

The participant of this study would be the women who have delivered a child in the past 2 months 29 days (i.e. the child is 0 to 2 months of age), present in the village at the time of data collection, and consenting to participate in the study.

Sampling for the study

As per SRS 2011 population composition report, In Bihar, less than 4 year old children account for 10.2% of the population. Considering uniform distribution, children of 0 to 2 months of age will be approximately 0.64% of the total population.

The total population of Haldi Chhapra village is 25, 553, and considering the trends of population composition in Bihar, the approximate number of children in Haldi Chhapra in the age group of 0 to 2 months (and 29 days) would be nearly 160.

$$Sample\ Size = \frac{\frac{z^2 \times p(1-p)}{e^2}}{1+(\frac{z^2 \times p(1-p)}{e^2 N})}$$

Where, N – Population size; e – Margin of error; z – Z score (based on the desired Confidence Level)

Using the above formula of Sample size calculation,

In our case, sample size = 48 (at 90% Confidence level and 10% Margin of Error)

Considering the required sample size, the number of samples to be collected for the study is proposed to be nearly 50.

Plan of data Collection

Participants will be identified by convenience sampling of eligible present in the village at the time of visits. Data will be collected by the means of surveying the participants, by personally visiting the households of the eligible respondents in the village.

Data collection for the study will be spread over a period of 1 week duration.

Beforehand, all aspects of confidentiality will be reassured. Only those who will give a proper consent will participate in the study. In case a respondent feels tired or uncomfortable, she will be allowed to take a break, following which survey process can resume. The participants will be free to terminate the survey at any time.

Tools and techniques

The data collection technique would be survey-based, using the 'Post Natal Care and Breast Feeding Practices' section of a standard pre-tested questionnaire, called "LQAS+", used by the Bihar TSU, Care India; specifically designed to target the mothers of children aged 0 to 2 months.

Plan of data analysis

The collected data will be compiled and analysed using various functions in Microsoft Office Excel software. Bar Charts and Pie Graphs will be used to represent the findings of this study, as and when required.

LIMITATIONS

- **The sample size for this study is calculated by assuming a uniform distribution of children over the age group of 0 to 4 years, which is subject to contradictions.**
- **The population composition of Bihar state is assumed to be similar for the village as well, which may vary in reality.**
- **The sample size is calculated for a 90% confidence interval and 10% Margin of error, and thus, may not be very close representation of the population in study.**

FINDINGS

1) After the delivery of child did you ever experience any of the following health problems?

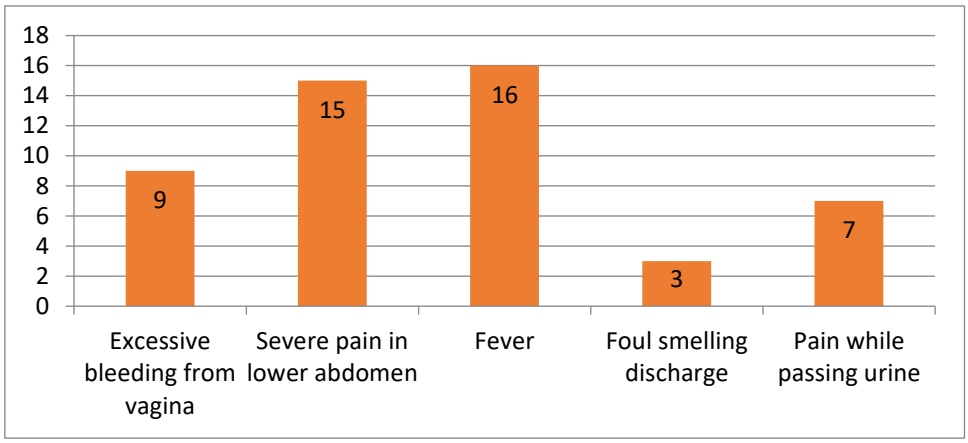


Fig.3 Bar graph shows the different health problem occurring to mothers after delivery.

2) Did you consult anybody or seek treatment for this problem?

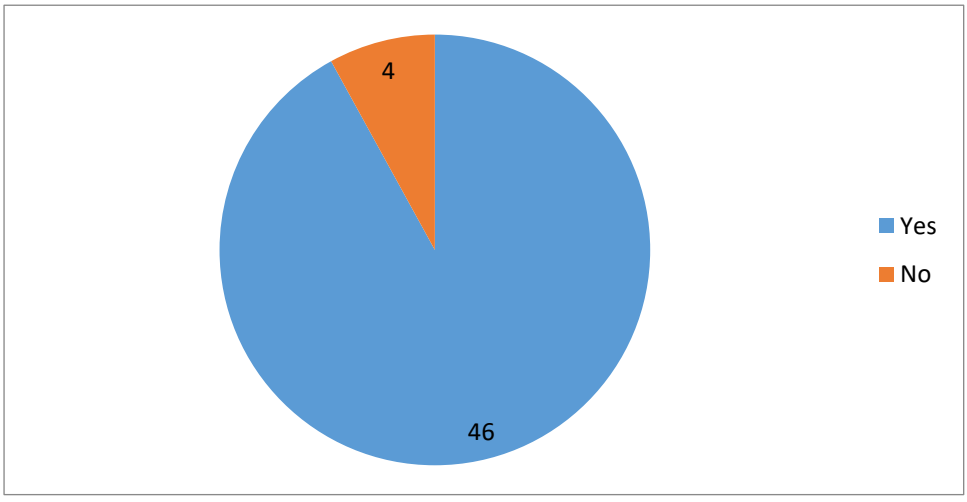


Fig.4 Proportion of those who looked for consultation after the delivery.

3) From where did you get consultation or treatment for this problem?

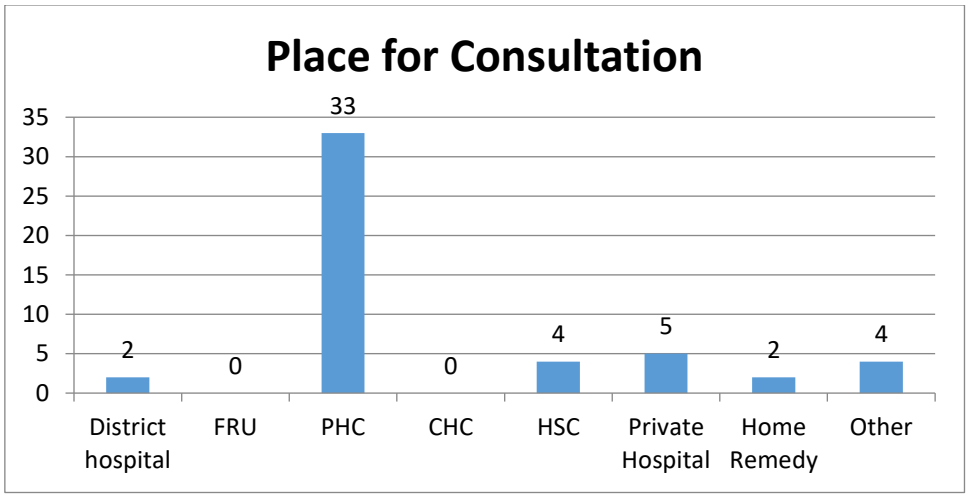


Fig.5 Shows up the facility used for consultation after delivery related problems.

4) Did child ever fall sick in first month after birth?

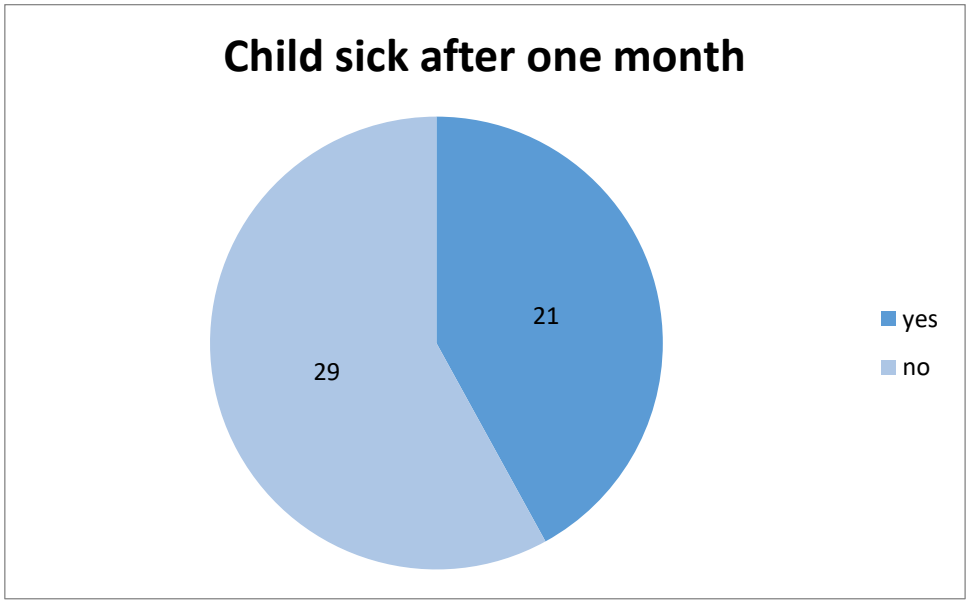


Fig.6 Shows the number of child those who were sick after one month.

5) From where did you get consultation or treatment for this problem?

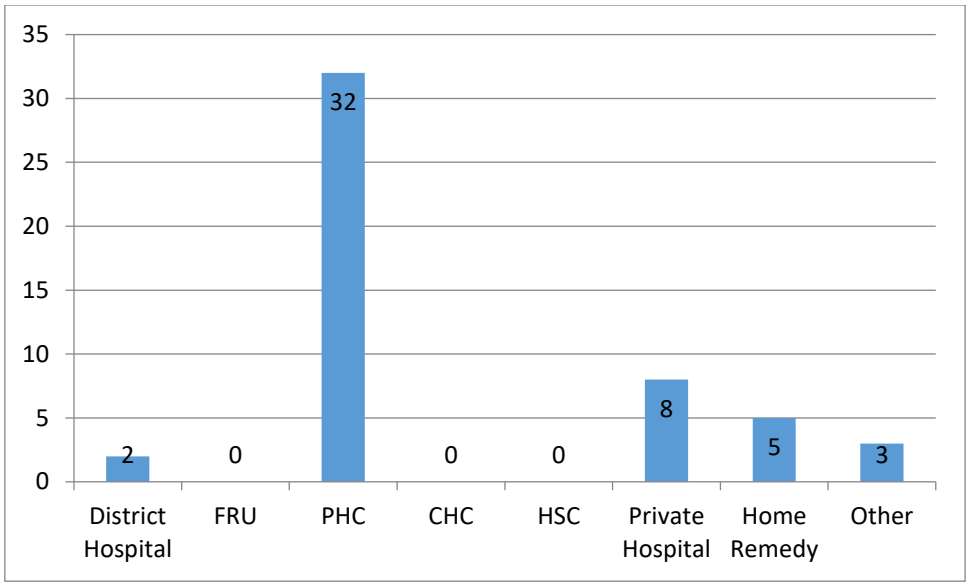


Fig.7 Facility type access by village people.

6) Has child had diarrhoea in last one month?

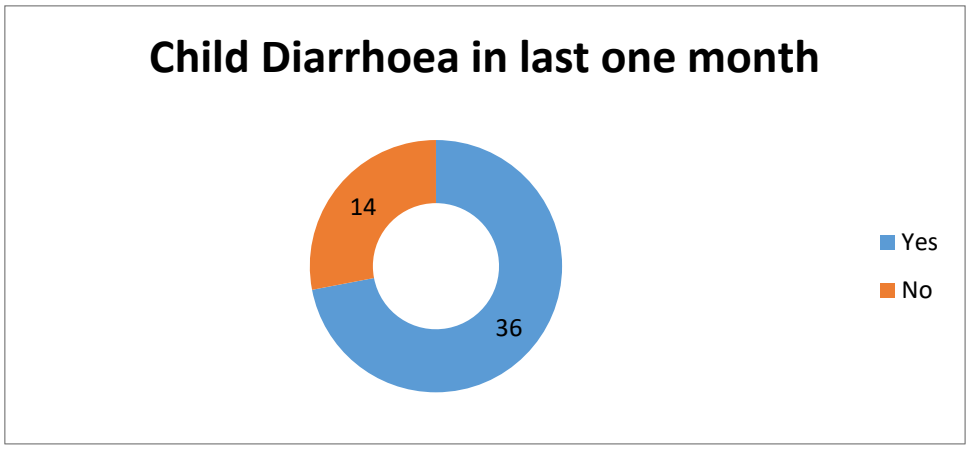


Fig.8 represents the child suffered from diarrhoea in last onemonth.

7) Which medicine was prescribed for diarrhoea?

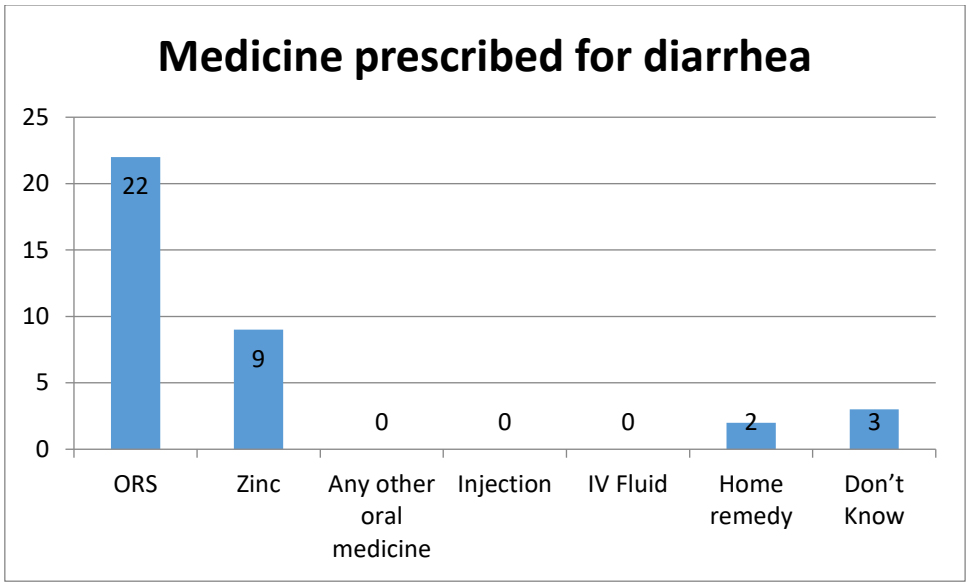


Fig.9 Medicine prescribed for diarrhoea

8) Has child had ARI (Acute Respiratory Symptom) in last two weeks?

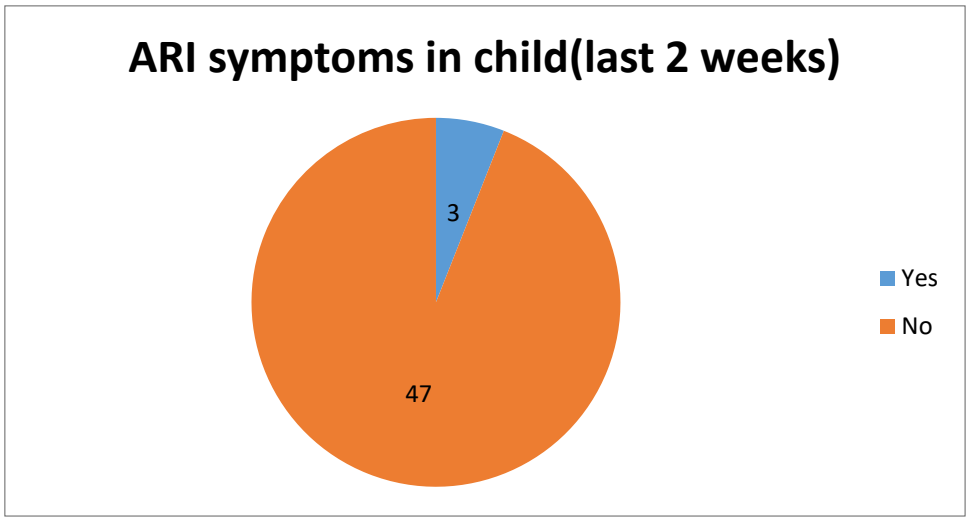


Fig.10 No. of child with ARI symptoms in last two weeks.

9) Have you ever breastfeed this child?

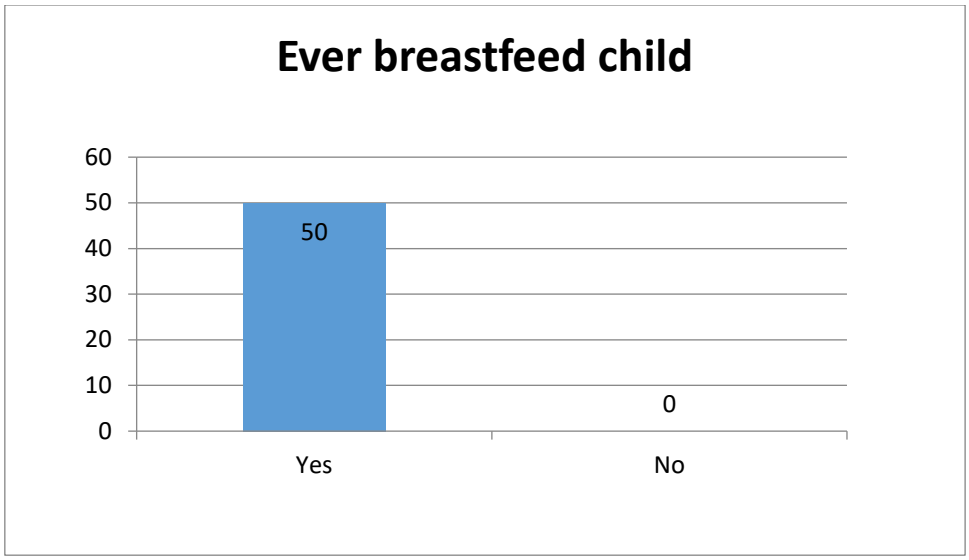


Fig. 11 No. of mothers breastfeed their child ever.

10) Are you currently breastfeeding this child?

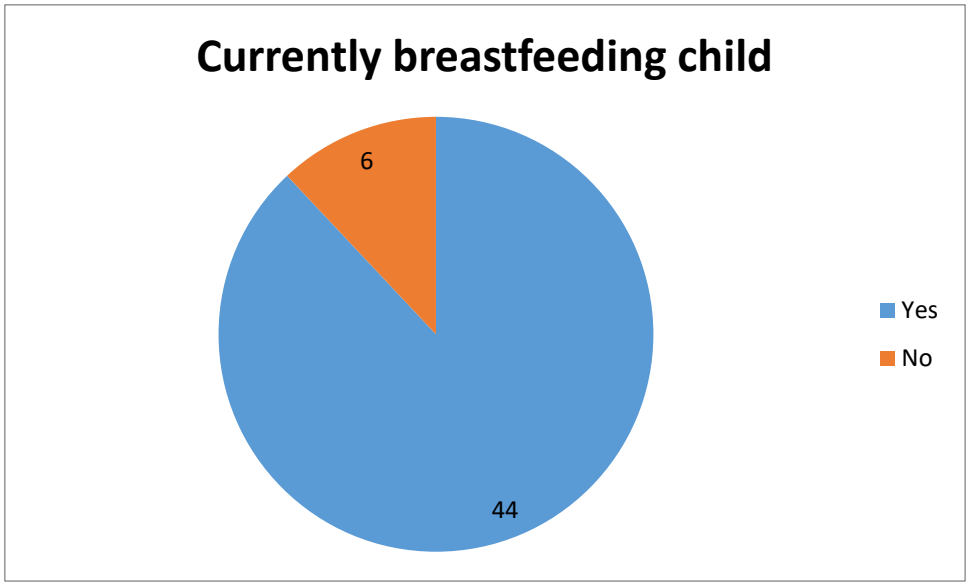


Fig. 12 No. of lactating mothers breast feeding their child.

11) How many times did you breastfeed your child in last 24 hours?

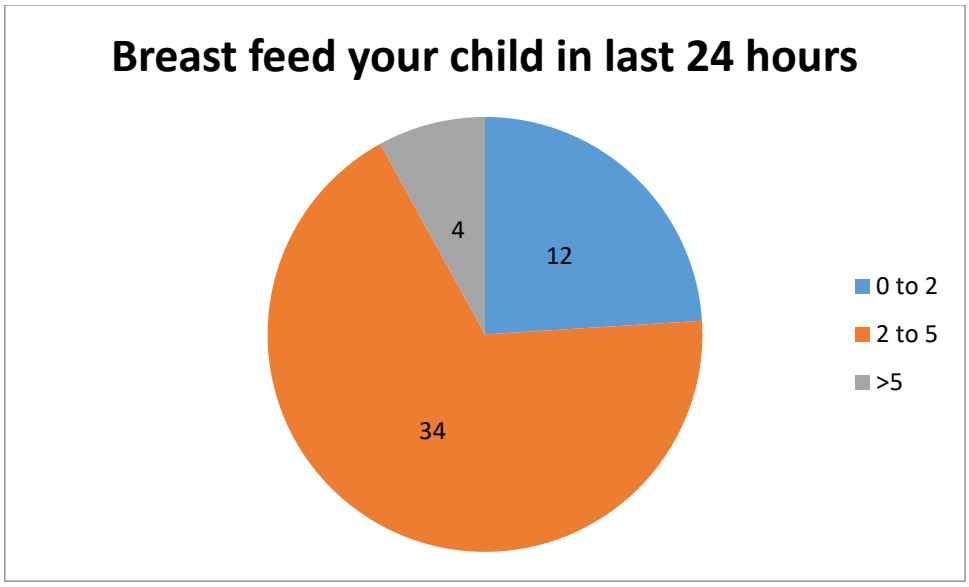


Fig. 13 No. of lactating mothers breast feed their child in last 24 hours.

12) Did child drink anything from bottle with a nipple yesterday during the day or night?

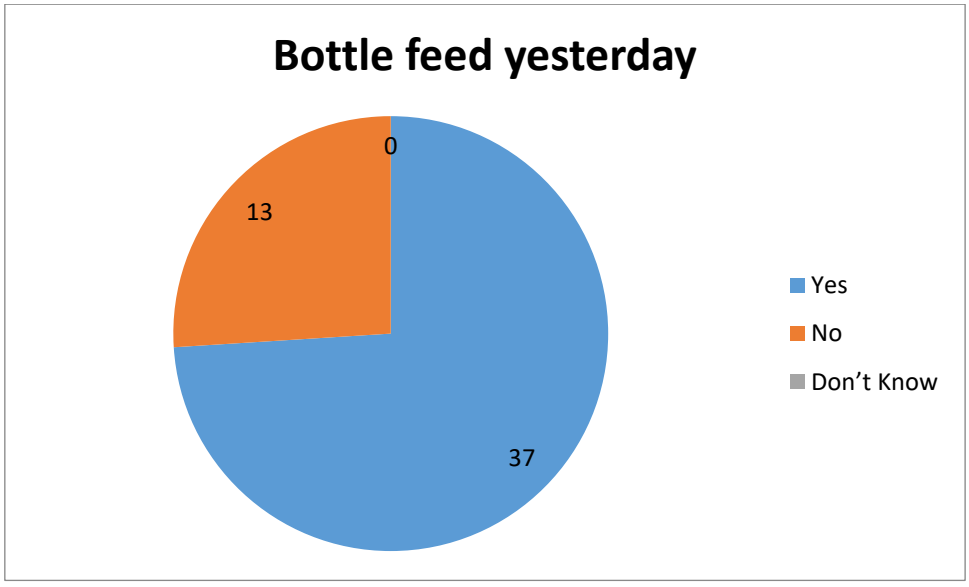


Fig. 14 No. of child bottle feed yesterday

13) Have you ever given any of these things other than breast milk at any time to child?

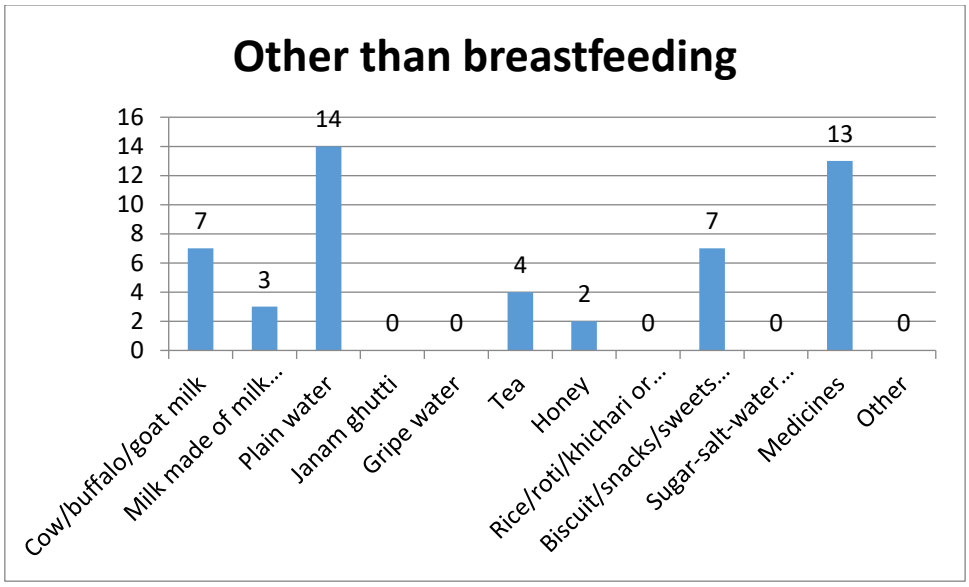


Fig. 15 Represent the data of if anything other than milk is given to child at any time.

14) When breastfeeding should be initiated after birth?

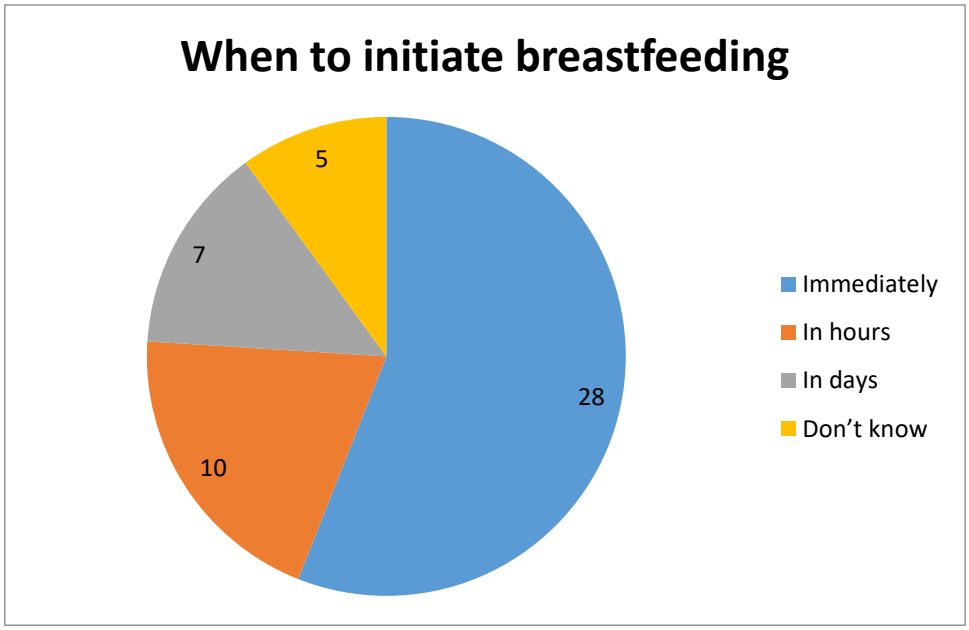


Fig. 16 Shows the knowledge about when to initiate breast feeding.

15) Till what age child should be exclusive breastfeeding?

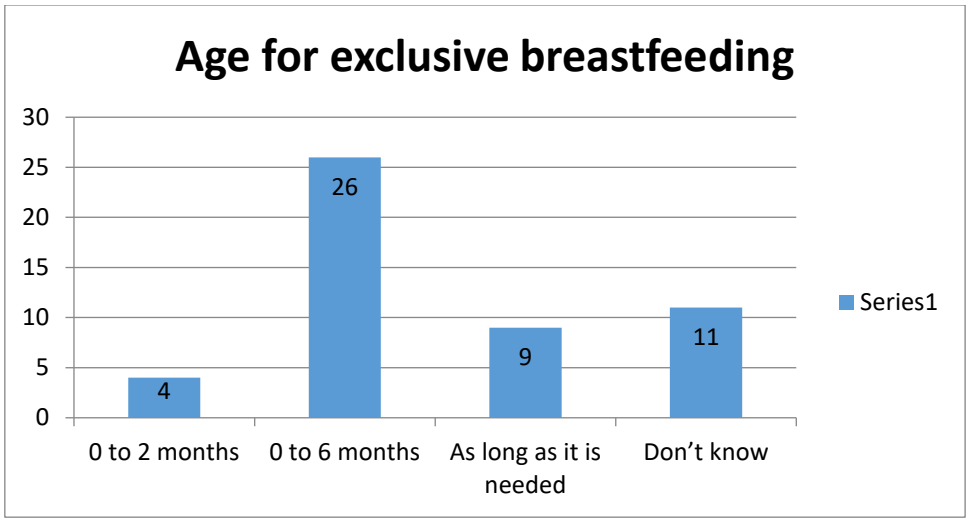


Fig. 17 Represents the age for exclusive breastfeeding.

16) Should the first condensed yellow milk (colostrum) that is produced after giving birth be given to the child?

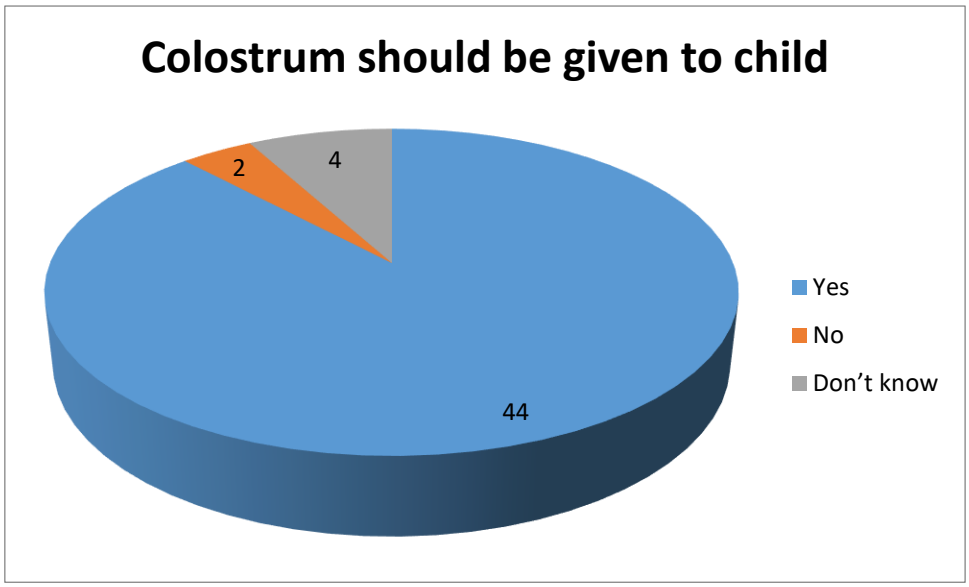


Fig. 18 Representing the no. of mother feed colostrums milk to their child after birth.

17) Unless doctor asked to stop should sick mother continue breastfeeding?

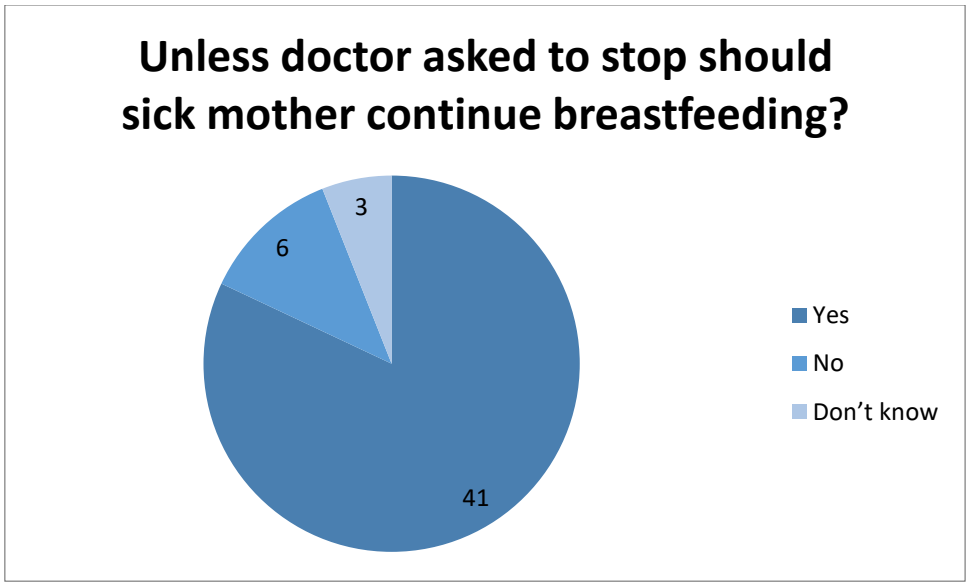


Fig. 19 unless doctor asked to stop should sick mother continue breastfeeding.

18) If the child is sick, should breastfeeding be continued?

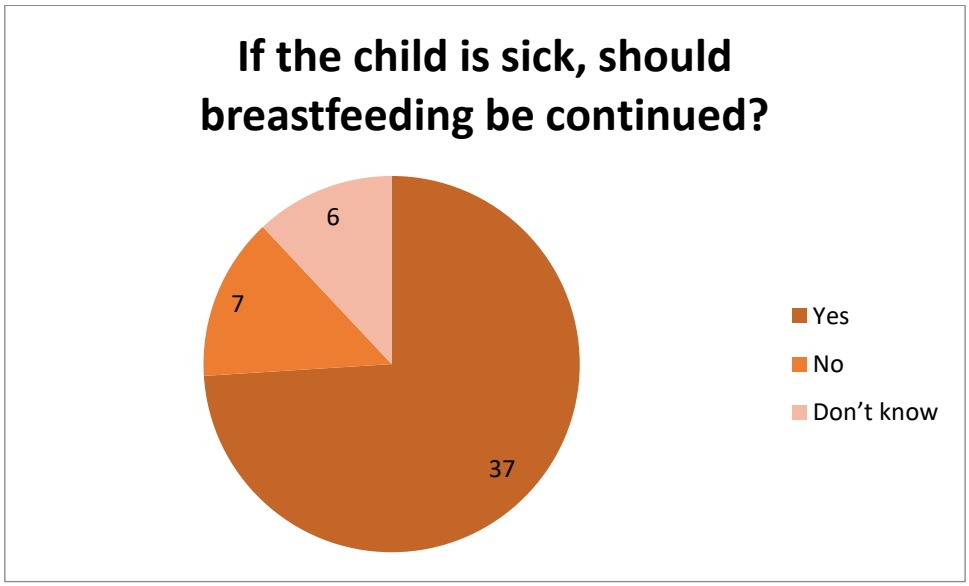


Fig.20 Represent the no. of mother feeding their child if he/she is sick.

19) Total number of visits made by any FLW in the first week of delivery.

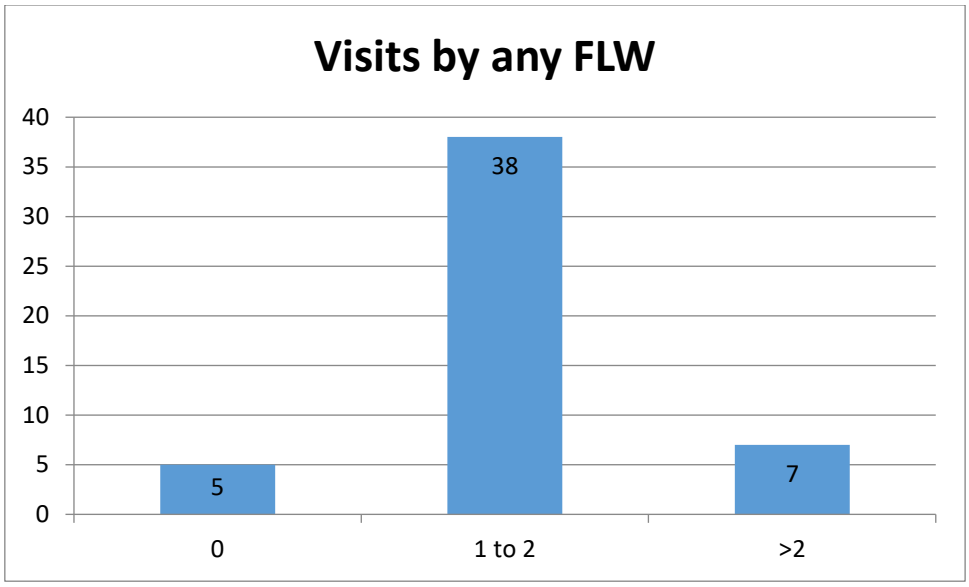


Fig.21 had shown the no. of visit by any FLW in village.

20) Did ASHA/AWW/ANM told you not to apply anything on the cord until it fell off?

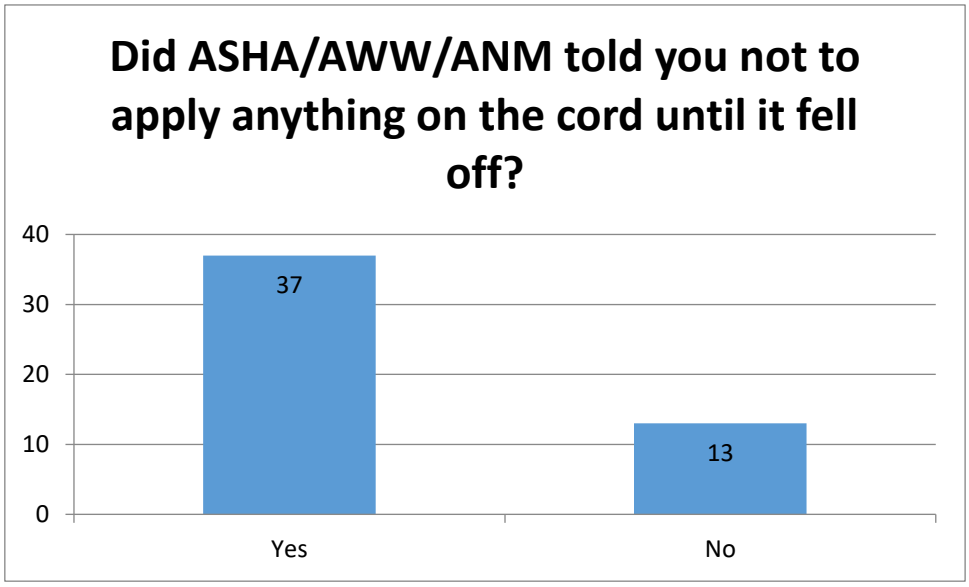


Fig. 22 shows the knowledge about the cord issues.

21) Has the ASHA/AWW/ANM told until a particular age of child you should only breast feed to child?

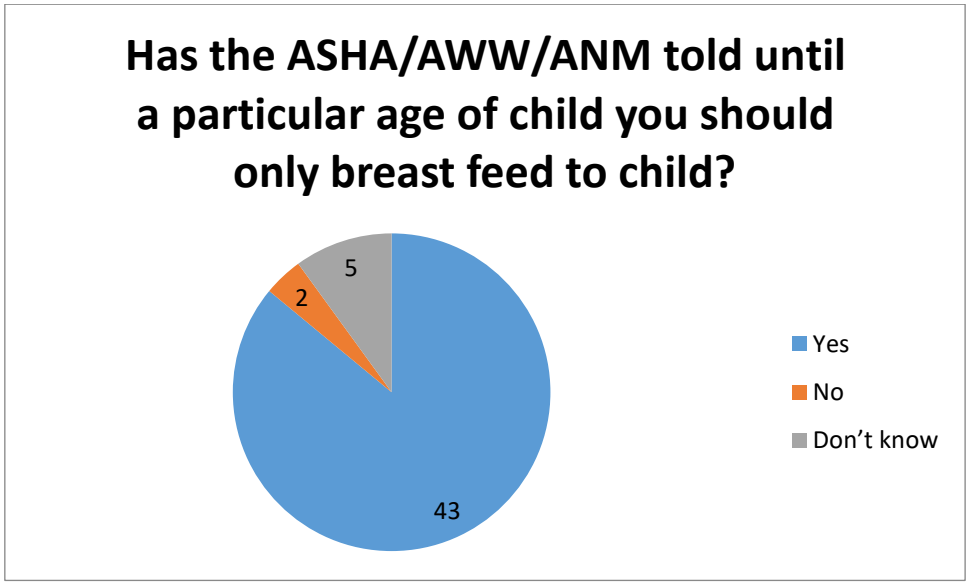


Fig. 23 Represent the data to which child should be breast feed provided by any FLW.

22) Do you have a MCP card or immunization card for child?

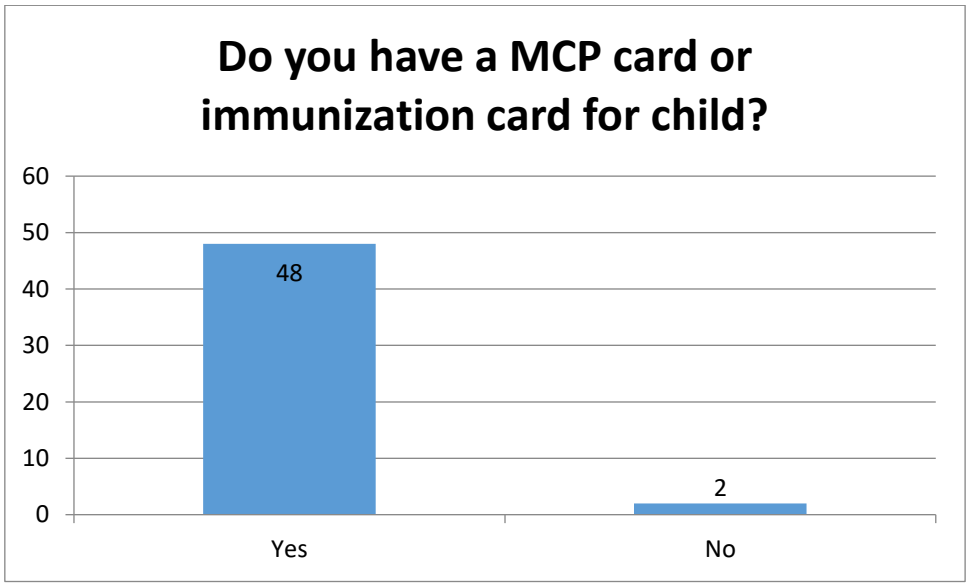


Fig. 24 No. of MCP card people having.

DISCUSSION

Most of the women after pregnancy has some or the other health related problem, mainly womens were suffering from severe pain in lower abdomen and some of them were suffering from fever. More then half of the women has consulted with doctor related to the health problem from which they were suffering after pregnancy. Some of them has told about the child suffering from some or the other disease after delivery within first one month after birth. Mostly child were treated at PHC because of un-availability of HSC & CHC and remaining have visited the private hospital situated at block and some of them were treated by quacks and these were considerd in others section.

Child were mainly affected by diarrhoea in the village in last one month, the reason which came to knew about the mainly about diarrhoea is unsafe drinking water practices and water has arsenic in it. Popular drung which was used by village people to treat diarrhoea is ORS and some also using zinc with it to cover fastly from the life threatning disease of child. Very less number of children were suffering from ARI(acute respiratory infection).

Noticed fully early initiation of breast feeding practices just after the birth of child and some of them have stoped breast feeding to child because of many reasons. Breast feeding is a regular practices but the number of feeding is lower because of mother doesn't having proper quantity of milk to feed her baby properly , because mother herself is malnourished. Mainly village people have opted out for bottle feeding because women have to contribute in farms with male members, and bottle feeding is the biggest source of infection for children beacuse of improper infection control methods opted. Some of the women has also started giving water to child because of increasing summer and heat waves and some were using milk powder and snacks,bisuits so that child remains busy with the biscuit and diffrent snacks and they can easily complete up their work easily. Along with this, they were aware of the time period till which exclusive breast feeding is to be done and Colostrum yellow milk which is produced just after the birth is properly feed to child in most of the houses.

Lack of FLW interaction is clear in the community, and it is a very big concern, as they are a major source of proper information and capacity building of the women in a village. Atleast amongst the one's who recieved any interaction from FLWs, these interactions were fair in terms of number it also indicates that the FLWs is little biased in her home vist because of the distance to houses of beneficiaries or due to untouchability prevalance in the the place they are living.

CONSLUSION

The indicators assessed in the study indicate an entire list of issues and problems associated with post natal care and breast feeding practices amongst the recently delivered mothers in Haldi Chhapra village. Since the study group consist of only mothers with 0-2 month's child.

A major gap was found in the availability of health centre , pregnant women has to travel for almost 1 hour approximately for the nearest health facility services , there is no health facility in village for any emergency during pregnancy. Our focus should be on providing proper

health facility and an emergency vehicle which can help them to reach district hospital in case of any emergency. Most of the child fall sick after birth because of improper hygiene practices during breastfeeding practices, this is an condition related to behaviour of the mother. More of increase visit of FLW with initiating behaviour change and inculcating proper hygiene practices during breastfeeding should be started. Number of time to breast feed her child is very less , it should be 8-10 times in a day but they are practising only half of it , to improve this proper knowledge of each and every aspects of breast feeding should told to them with the health benefit child will be getting if properly feed during crucial time of 6 months.

Majorly health problem to child and infection is because of improper feeding habits, and in place of exclusive breast feeding, mothers of children starting providing those snacks and biscuits to child. To combat with malnutrition and initiate exclusive breastfeeding practices proper home visits, learning sessions and proper monitoring should be done with proper community mobilization.

Visits of FLW is not proper , near to half of the FLW is working in field and spreading correct knowledge and practices of PNC & Breast feeding practices among the mothers of 0-2 months child. A larger number of women are still applying oil & other lotions on the cord. To improve all the indicators simultaneously community mobilizing, behaviour change and proper monitoring can help to improve these indicators.

There is a wide scope to work on the FLW interactions and her activity in operations in the community, which should be fairly available to all, irrespective of the social and cultural or demographic factors; and this can majorly serve to improve the picture of malnutrition in the community as a whole.

REFERENCE

1. **http://www.who.int/maternal_child_adolescent/topics/newborn/postnatal_care/en/maternal, new born, child and adolescent health.**
2. The Inter-agency Group for Child Mortality Estimation (UN IGME). 2014. Levels & Trends in Child Mortality, Report 2014. United Nations Children's Fund.
3. Lawn JE et al. 2014. Every New born: Progress, Priorities, and Potential Beyond Survival. Lancet 384:189–205.
4. **http://www.who.int/pmnch/media/press_materials/fs/fs_mdg4_childmortality/en/ child mortality, millennium development goal.**
5. **http://www.theguardian.com/global-development/2014/sep/16/infant-child-deaths-un-estimates global development, infant child death.**
6. The World Health Organization, Infant and Young Child Feeding, World Health Organization, Lyon, France, 2009.
7. C. Ku and S. K. Y. Chow, "Factors influencing the practice of exclusive breastfeeding among Hong Kong Chinese women: a questionnaire survey," Journal of Clinical Nursing, vol. 19, no. 17-18, pp. 2434–2445, 2010.
8. H. M. Hanif, "Trends in breastfeeding and complementary feeding practices in Pakistan, 1990–2007,"International Breastfeeding Journal, vol. 6, article 15, 2011.
9. T. E. Nkala and S. E. Msuya, "Prevalence and predictors of exclusive breastfeeding among women in Kigoma region, Western Tanzania: a community based cross-sectional study," International Breastfeeding Journal, vol. 6, article 17, 2011.
10. **http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/benefits-breastfeeding.aspx**health benefits of breastfeeding for mother.
11. **http://data.unicef.org/maternal-health/newborn-care.htmlmaternal health, new born care.**
12. **http://mdgs.un.org/unsd/mdg/SeriesDetail.aspx?srid=810 millennium development goal indicators.**
13. **http://www.who.int/gho/child_health/mortality/neonatal_infant_text/en/infant mortality, situation and trends.**
14. **http://nrhm.gov.in/nrhm-in-state/state-wise-information/bihar.htmlDemographic, Socio-economic and Health profile of Bihar State**

15. ***David Osrin et al***community based **Study of care of newborn infants in Nepal: Findings from Makwanpur district, Nepal** November 2002. BMJ 2002;325:1063 Available from http://www.bmj.com/content/325/7372/1063?goto=reply [Accessed on 05 May 2016]

16. Elizabeth Shaw et alandThe McMaster University Postpartum Research Group**Systematic Review of the Literature on Postpartum Care: Effectiveness of Postpartum Support to Improve Maternal Parenting, Mental Health, Quality of Life, and Physical Health.** **http://onlinelibrary.wiley.com/doi/10.1111/j.1523-536X.2006.00106.x/abstract;jsessionid=305B8F7F35D5BEB318F2024B8D42B8FE.f03t03?userIsAuthenticated=false&deniedAccessCustomisedMessage= [Accessed on 05-05-2016].**

17. ***Hadeel Adnan Tanash et al***published in **Cornerstone library Minnesota State University Mankato on 'Breastfeeding knowledge, practice, attitudes, and influencing factors: Findings from a selected sample of breastfeeding mothers in Bemidji, Minnesota'.** **http://cornerstone.lib.mnsu.edu/cgi/viewcontent.cgi?article=1382&context=etds [Accessed on 05-05-2016].**