**Internship Training**

at

**Indian Health Action Trust (U.P. Technical Support Unit)**

on

**"Assessment of knowledge, perceptions and practices of Ante Natal Care in pregnant women; their mothers-in-law and husbands in Etah."**

by

**GyanikaNarayanaswamy**

Enroll No. PG/14/021

Under the guidance of

**B.S. Singh**

Post Graduate Diploma in Hospital and Health Management

2014-16


# International Institute of Health Management Research New Delhi

## CERTIFICATE OF APPROVAL

The following dissertation titled **"Assessment of knowledge, perceptions and practices of Ante Natal Care in pregnant women; their mothers-in-law and husbands in Etah."** at **"Indian Health Action Trust (U.P. Technical Support Unit)"** 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 Healthcare 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 |
|---|---|
| 1. Dr S.B. Arora | |
| 2. Dr. B.S. Singh | B S Singh |
| 3. Dr. Preetha QS | |

**INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH**

**NEW DELHI**

## CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"Assessment of knowledge, perceptions and practices of Ante Natal Care in pregnant women; their mothers-in-law and husbands in Etah."** submitted by **Gyanika Narayanaswamy** Enrollment No. PG/14/021 under the supervision of **Mr Mithilesh Pathak** for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from **03rd Feb 2016 to 19th May 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.

Signature

**TO WHOMSOEVER IT MAY CONCERN**

This is to certify that **Gyanika Narayanaswamy** 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 **Indian Health Action Trust (U.P. Technical Support Unit)** from 03rd Feb 2016 to 19th May 2016.

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

The Internship is in fulfilment of the course requirements.

I wish her all success in all her future endeavours.

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

B.S. Singh
Associate Professor
IIHMR, New Delhi

## CERTIFICATE FROM DISSERTATION ADVISORY COMMITTEE

This is to certify that **Gyanika Narayanaswamy,** a graduate student of the Post- Graduate Diploma in Healthcare Management has worked under our guidance and supervision. She is submitting this dissertation titled **"Assessment of knowledge, perceptions and practices of Ante Natal Care in pregnant women; their mothers-in-law and husbands in Etah."** at **"Indian Health Action Trust (U.P. Technical Support Unit)"** in partial fulfilment of the requirements for the award of the **Post- Graduate Diploma in Healthcare 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.

B.S. Singh
Associate Professor
IIHMR, New Delhi

Mr. Mithilesh Pathak
Zonal Community Specialist
Indian Health Action Trust

## FEEDBACK FORM

**Name of the Student:** Gyanika Narayanaswamy

**Dissertation Organisation:** "Indian Health Action Trust (U.P. Technical Support Unit)"

**Area of Dissertation:** Identifying existing gaps in Ante Natal Care.

**Attendance:** 100% (Full)

**Objectives achieved:** Understood the working of the organization and its structural framework. The organization's achievements thus far and future goals were also understood. Gyanika has been now oriented to her roles and responsibilities and has been conducting them to her fullest efforts. She has been conducting field trips, evaluated the current status of the blocks she is in charge of and has developed plans to implement new strategies.

**Deliverables:** Mentoring of Block Community Specialists and Community Resources Persons, monitoring and evaluating VHND sites, Cluster meetings and AAA meetings. Conducting monthly meetings to review the status of the five indicators of the block. To develop strategies for improvement and co-ordinating with government bodies for better functioning.

**Strengths:** Gyanika is highly motivated, shows initiative and is driven to understand the challenges that need to be resolved in the district of Etah. She has an inquisitive mind and has been able to work successfully with her team of CRPs and BCS.

**Suggestions for Improvement:** Gyanika requires guidance in co-ordinating with sister organizations and with time she will need to develop a smoother process of communication with the Government. Gyanika is new to her environment and is adjusting well. She will in time gain the skills and knowledge to conduct her responsibilities with ease.

Mr Mithilesh Pathak

Zonal Community Specialist

Indian Health Action Trust

Date: 14th May 2016

Place: Etah

**INDIA HEALTH ACTION TRUST**

# (Completion of Dissertation from Indian Health Action Trust)

The certificate is awarded to

**Gyanika Narayanaswamy**

In recognition of having successfully completed her
Internship in the field of

**Community Processes in RMNCH+A**

and has successfully completed her
Project on

**"Assessment of knowledge, perceptions and practices of Ante Natal Care in pregnant women; their mothers-in-law and husbands in Etah."**

**03rd Feb 2016 to 19th May 2016**

**Indian Health Action Trust (U.P. Technical Support Unit)**

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

We wish her all the best for future endeavours.

**Training & Development**

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# Abstract

**Background:** Utilization of antenatal care (ANC) continues to be low in Uttar Pradesh with average being 55% in Etah amongst the IHAT project blocks. Antenatal care has been proven to be a preventive method to improve the outcomes for the pregnant woman and her baby. This study aims to understand one of the many determinants of antenatal care utilization. Mothers-in-law play a vital role in decisions about accessing healthcare services in a household. Husbands and their views have not been investigated thoroughly in literature as they too influence the woman's decisions. The objectives of the paper is to understand the (a) knowledge, (b) perceptions and (c) practices of the pregnant women and her family members towards ANC.

**Methods:** In depth interviews were conducted of 16 households (which consisted of pregnant woman, her mother in law and husband) in the four blocks of Aliganj, Sakit, Sheetalpur and Nidhauli Kalan of district Etah, UP.

**Results:** The findings suggest that none of the participants have a complete understanding of antental care. Knowledge level of the pregnant woman, the perceptions of the mother-in-law and husband, the education level of the husband and the parity of the woman are key influencers of whether or not the woman seeks antenatal care. ANC non users are influenced negatively by their mothers-in-law's and husbands perceptions about what should and should not be done during pregnancy. Accompanying the woman for check-ups is very rare regardless of whether her family members are supportive or not.

**Conclusions:** Awareness levels about ANC is low in the blocks of Etah. Women need to be given a better understanding of how ANC keeps their child's and their own health safe. Health education and promotion intervention programs must include mothers-in-law, husbands and other family members to ensure a holistic system.

# Acknowledgements

I would like to take this opportunity to show my appreciation for individuals that have been instrumental in making it possible for me to conduct this study and complete my dissertation report.

I would like to show my greatest appreciation to Mr. Bharat Lal Pandey, Team Leader, Community Processes Department, IHAT, UP-TSU for discussing with me the opportunities of my topic and how it can be improved further. I would also like to thank Mr. Mithilesh Pathak, Zonal Community Specialist, IHAT, UPTSU under whose mentorship I successfully completed my dissertation. Without their encouragement and support my efforts would not have materialised.

I would like to extend my gratitude to Asst. Prof. Mr. B.S.Singh at IIHMR, New Delhi who guided me at every step to make this dissertation report a success.

Gyanika Narayanaswamy

Batch 2014 – 16

IIHMR (Delhi)

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# List of Abbreviations

| ACRONYM | FULL FORM |
|---|---|
| TSU | Technical Support Unit |
| GoUP | Government of Uttar Pradesh |
| RMNCHA | Reproductive, Maternal, Nutrition, Child Health and Adolescents |
| GOI | Government of India |
| IHAT | India Health Action Trust |
| UoM | University of Manitoba |
| JSI | John Snow India |
| MoC | Memorandum of Co-operation |
| FLW | Front Line Workers |
| NRHM | National Rural Health Mission |
| ICT | Information Communication Technology |
| G2P | Government to Person |
| PHC | Primary Health Centre |
| PIP | Programme Implementation Plan |
| MCTS | Mother and Child Tracking System |
| HMIS | Health Management Information System |
| FRU | First Referral Unit |
| HR | Human resource |
| ORS | Oral Rehydration Solution |
| UNICEF | United Nations International Children's Emergency Fund |
| PPP | Public Private Partnership |
| VHSC | Village Health Sanitation Committee |
| RKS | RogiKalyanSamiti |
| NGO | Non Government Organization |
| ANC | Ante Natal Care |
| ICMR | Indian Council of Medical Research |
| UPTSU | Uttar Pradesh Technical Support Unit |
| ASHA | Accredited Social Health Activist |

# Organization Background

**UTTAR PRADESH TECHNICAL SUPPORT UNIT**

**INDIA HEALTH ACTION TRUST, UTTAR RADESH**

**BACKGROUND**

A Technical Support Unit (TSU) is established for the Government of Uttar Pradesh (GoUP), with the **goal** of providing techno-managerial support to the GoUP to improve the efficiency, effectiveness and equity of delivery of key RMNCHA interventions. This will be accomplished by supporting the state in the implementation of the nationally launched NRHM RMNCH+A strategy, and in the scale-up of agriculture and financial inclusion services.

The TSU's activities will be focused on the twenty-five most underserved districts in the state, where the aim is to improve RMNCHA service delivery and outcomes within 75 priority blocks. These districts have been selected and agreed upon jointly by GOI, GoUP and the foundation.

The India Health Action Trust (IHAT) will have overall responsibility for executing the TSU project in Uttar Pradesh. The University of Manitoba (UM) will provide key technical and managerial support to all RMNCHN areas, and financial inclusion/agriculture. John Snow International Research & Training Institute Inc. (JSI) will provide technical inputs in the areas of strategic planning and donor/stakeholder coordination, supply/cold chain management, new born care, and immunization. The JSI will also facilitate linkages and alignment of project activities to the Government of India (GoI) policies by providing support at national level.

## ORIGIN AND HISTORY

Uttar Pradesh is India's most populous state, with approximately 200 million people, and with weak health infrastructure and poor health outcomes. There is a tremendous opportunity to improve the state execution capacity to enhance the efficiency, effectiveness and equity in health and development. This is the basis upon which the Bill & Melinda Gates Foundation (the foundation) has collaborated to provide techno-managerial assistance to the Government of Uttar Pradesh (GoUP) and this proposed to set up a Technical Support Unit (TSU) to execute against the Memorandum of Cooperation (MoC) signed by the foundation and GoUP in December 2012. The Government of India (GoI) has launched a renewed campaign to improve RMNCH+A performance across India, and the GoUP has followed up the national launch with its own show of commitment through the state RMNCH+A effort.

## VISION

To reduce the adverse health and development outcomes to families, mothers, new-borns and children by achieving high reach, coverage and quality of effective interventions and services for health (reproductive, maternal, neonatal and child health and nutrition in communities and at health facilities), agriculture and financial inclusion

## MISSION

The mission of the TSU is to support the government, not to implement on its own. Building the capacity of the health system to execute according to its own mandate, with strong political, bureaucratic and administrative ownership

**OBJECTIVES**

- Support the GoUP to improve the quality and quantity of FLW interactions at the community level and within households to drive the eight priority RMNCHN behaviors
- Support GoUP in improving its RMNCHN related primary care services at facilities.
- Support GoUP to improve strategies and systems required to deliver improved FLW capabilities and service delivery at primary care facilities
- Support the GoUP in improving its capacity to fund, contract, and regulate/ mandate private providers
- Support the GoUP in improving the scale and quality of community accountability mechanisms

**CORE VALUES:**

The four core values to address the major barriers like poor accountability, poor focus on outcomes, lack of skilful planning and poor policies are as follows:

1. Efforts to improve leadership and outcome-focus by ensuring bureaucratic ownership of innovations, strong political will under the foundation-GoUP MOU.
2. Strengthening of internal and external accountability mechanisms through developing strong coaching, mentoring and supervisory systems within NRHM and the Directorate of Health/Family Welfare in the GoUP and by creating concurrent monitoring systems using data, dashboards and feedback loops to effect mid-course corrections.
3. Improving the skills and capabilities for FLW and primary care performance by ensuring trainings are conducted with high quality by GoUP and the skills and practices are enhanced

through appropriate supportive supervision mechanisms and use of Information Communication Technology (ICT) based solutions to improve FLW and facility performance.

4. Improving policy, planning and coordination by improving private sector stewardship, funding and contracting processes (such as providers for family planning services, developing new incentive schemes and contracting more management capacity out to the private sector for issues like accreditation), supply chain and G2P (Government to person) payment improvements, select human resource and infrastructure improvements at the field level, better annual planning and fund flow mechanisms.

**STRATEGIES**

Six structural components which define the *modus operandi* of the TSU have been identified as follows:

1. Strengthen FLW skills/capabilities: Strengthen FLW skills/capabilities through supportive supervision and job-aids to improve quality and quantity of interactions in households, at VHNDs and facilities, to increase service access and improve the eight key behaviors around MNCH, nutrition, and FP.
2. Build skills/capabilities of providers at facilities: Improve availability of services and quality of care at first level facilities (e.g., block PHCs) and referral facilities by offering improved training and on-site skills building (e.g., nurse mentors and skills labs) combined with improved case sheets, checklists and workflow management tools.
3. Improve health system management capabilities to support efficient and effective execution to support the above two areas.
    - Ensure robust project planning and funds flow (e.g., PIP processes)

- Establish appropriate roles and responsibilities for supportive supervision at the block, district and state levels
- Leverage ICT to improve data, dis-intermediation, demand and to drive performance efficiencies, especially among FLWs and facilities
- Create robust systems for data collection, analysis, and planning to improve management of the program (e.g., MCTS, HMIS)
- Create robust concurrent monitoring systems to validate data collection by the system and feedback information for immediate and mid-course correction
- Assist the government to execute existing incentive schemes at scale by improving data management, planning and streamlining payment systems

4. Support critical infrastructure improvements at the health system level in collaboration with other DPs: support select cross-cutting areas of the health system that act as critical bottlenecks to the first two areas listed above

- Improve supply chain and cold chain management to minimize stock out of essential drugs
- In our role as the state lead partner, ensure alignment with donor/partner efforts in the state; coordinate with other 'units' to catalyze the overall response especially around creating critical infrastructure (e.g. PHCs, FRUs) and HR (staff nurses, supervisors, etc.)

5. Improve the government's ability to be better stewards of the private sector, through better management and contracting approaches:

- Assist the government with devising and executing schemes and contracts to outsource select provision to the private sector (e.g., ORS/Zinc scheme to improve distribution, institutional deliveries, clinical services for FP, 'outsourced' management of FRU staff through 'mother NGOs')

- Assist with improving accreditation and payment systems to enable private providers to be paid by the government to increase coverage – e.g., contracting of agencies (such as Public Private Interface Agencies) to oversee accreditation processes and to streamline their function.
- Explore potential options for a primary care pilot involving government and private providers under a capitation-based model
- Work with the World Bank, UNICEF and other partners to ensure harmonization of efforts with other public private partnership (PPP) efforts in the state

6. Enable accountability measures to provide feedback on quality of services, improve external accountability and hence drive program change.

- The NRHM construct includes an external accountability framework that includes social audits and involvement of democratic grass root institutions (Panchayati Raj Institutions) and grievance redressal mechanisms. While progress has been slow, senior politicians and bureaucrats are committed to this vision.
- We would support government to strengthen the functioning of existing government-mandated accountability structures such as Village Health and Sanitation Committees (VHSCs), RKS (RogiKalyanSamiti) and grievance redressal mechanisms, where beneficiaries can directly register/log their complaints. Our grants would provide state level technical assistance for the state government to contract NGOs to build VHSC capabilities as has been done in other states.

# Introduction

The maternal mortality ratio of a country or its state gives a very clear indication of the health status of the mothers in the population. Mothers and their children are the most vulnerable to complications and diseases if not taken care of during the right time and in the right manner. Therefore it becomes vital to investigate processes that determine and mould the health seeking of beneficiaries and their social influencers. Research has shown time and again that the majority of maternal deaths occur to due to reasons that could have been prevented. Therefore seeking antenatal care during pregnancy becomes crucial.

Antenatal care is an important determinant of a heathy pregnancy and safe delivery. Antenatal care therefore provides an opportunity to the pregnant woman to deliver in the presence of a skilled attendant in a health facility. Several demographic and social factors influence the woman's decision to seek antenatal care. Apart from the woman's level of education, the husband's education and economic status; social influences such as the attitudes and views of the woman's mother-in-law, husband, friends and family members has a lasting effect on the pregnant woman's decision to seek care in time. Research from Pakistan and Bangladesh conducted by Syed et al; suggests that "mothers-in-law along with other family members significantly affect uptake of antenatal care". Syed et al found that "as mothers-in-law never utilized ANC during their pregnancy, they do not deem it necessary for their daughters-in-law. They believe that pregnancy and delivery is a natural process; health care services should be utilized only for a disease." Results of a study by Simkhada et al suggests that "mothers-in-law more often than not had a discouraging influence on their daughters-in-law's ANC uptake". The main reasons being "pregnant women need to first fulfil their household duties, based on their past experiences ANC was unnecessary and the fact that knowledge of ANC in mothers-in-law was much lower compared to their daughters-in-law."

As mothers-in-law play a crucial role in the woman's pregnancy and life, her thoughts and advice will be greatly respected and valued by the daughter-in-law. Therefore this paper will aim to explore the role of the mother-in-law in the pregnant woman's decision making process and will also investigate the ANC knowledge differences between mothers-in-law and their daughters-in-law.

Sternberg and Hubley highlight the lack of male participation in their female partner's reproductive health and illustrate that due to the lack of literature, programs specifically to involve males and to evaluate the impact have not been conducted. In order to understand the husband's role in a pregnant woman's decision making process, the study also aims to assess the knowledge, perceptions and practices of ANC in the husband. This information can help us understand how significantly do they influence ANC utilization in Etah, Uttar Pradesh.

# Review of Literature

1. "Determinants of antenatal care utilization in rural areas of India: A cross-sectional study from 28 districts (AN ICMR task force study)" was conducted by Chandhiok et al in 2006 to analyse the factors that contribute to women obtaining antenatal care services and to determine if these services influence their decisions regarding their chosen place of delivery. The study found that 73.9% of the women had conducted atleast one antenatal check up with an ANM or at a government health facility. The study found that as the age of the women, her parity and the number of children she had increased, her probability of seeking ANC decreased. The awareness of complications that can occur during pregnancy and delivery was very low. The study found that 51.7% of the women who availed ante natal care had preferred institutional delivery versus 27.8% of women who had not availed antenatal care. The study concluded that there needs to be more awareness on how antenatal care is connected to decreasing the probabilities of pregnancy relate complications. The study also added that community

awareness needs to be increased in terms of highlighting the importance of early registration of pregnant women with ANM, seeking antenatal care and delivering in a health institution.

2. “The role of mothers-in-law in antenatal care decision-making in Nepal: a qualitative study” by Simkhada el al investigates the importance of key family members such as the mother-in-law who plays a significant role in whether a pregnant woman seeks ANC. The paper explores the other-in-law’s role in (a) her daughter’s uptake of ANC and (b) the decision making process about using ANC services in Nepal. The study’s finding suggest that mothers-in-law when encouraging can have a positive impact on the pregnant woman’s health seeing behaviour. However, more often than not the influence the mother-in-law has is negative and discouraging. The study found that the majority of the mothers-in-law in the study population did not support or encourage their daughters-in-law to seek ANC due to the expectation of fulfilling household duties, believing ANC not to be beneficial based on their personal experiences of pregnancy and they controlled the release of financial resources under their control. The factors affected their daughters-in-laws ability to take an independent decision on whether she should avail ANC services or not. Mothers-in-law who had been previously educated on safe health practices or had participated in community health events were more supportive of their daughters-in-law using ANC. The study concluded that it is vital to understand the role of the mother-in-law if one wants healthcare interventions and service delivery to be effective. Healthcare promotion activities need to involve the family along with the women for optimal effectiveness.

3. “Evaluating men’s involvement as a strategy in sexual and reproductive health promotion” by Sternberg and Hubley evaluates 24 studies that have examined behavioural and media approaches to understand and bring a change in the way men participate in the reproductive and sexual well being of their female partner. The study found that there were very few interventions that targeted heterosexual men. The evaluative study suggests that when interventions are employed such as one in Mali where a

program was developed specifically to encourage men to accompany their spouses to family planning and gynaecological services, these men developed greater knowledge and enthusiasm towards antenatal care for their wives. The program in Mali resulted in men who not only had greater knowledge about antenatal care but also made greater number of visits with their partners to antenatal care clinics. The study concluded that there is a need for more research into the processes and outcomes of men's involvement in the reproductive and sexual healthcare of their female partners. Such studies can help to develop interventions that will better facilitate an improvement in both male and female reproductive and sexual health on a long term basis.

4. "Care seeking practices in South Asia: using formative research to design program interventions to save new born lives." by Syed el al summarizes the research findings of new born practices in poor and rural districts of Bangladesh, Nepal and Pakistan and explains how these findings were used to design behaviour change communication elements of newborn care programs. The study conducted interviews with mothers, mothers-in-law, healthcare providers, husbands and influential leaders. The study found that in Bangladesh and Pakistan, the purdah system was noted for being a common barrier to ANC care seeking. But other than purdah as the barrier, women were not aware of the benefits of ANC. In all three countries of Nepal, Bangladesh and Pakistan, pregnancy was viewed as a natural process and women and their mothers-in-law views as seeking care unnecessary unless a complication arose. ANC was seen as curative instead of preventive care. In conclusion the study stated that it is vital to involve mothers-in-law, husbands, religious leaders, the family member and influential leaders when promoting maternal and child health.

# Objectives

**General Objective :**

Assessment of knowledge, perceptions and practices of Ante Natal Care in pregnant women; their mothers-in-law and husbands in Etah.

**Specific Objectives:**

1. Assessment of knowledge of ANC in pregnant women, mother-in-law and husbands

2. Assessment of perceptions of ANC in pregnant women, mother-in-law and husbands

3. Assessment of practices of ANC in pregnant women, mother-in-law and husbands

# Research methodology

Key Research Questions:

What is the knowledge level of the pregnant woman, her mother in law and her husband on antenatal care?

What perceptions do the pregnant women, her mother in law and her husband have on antenatal care?

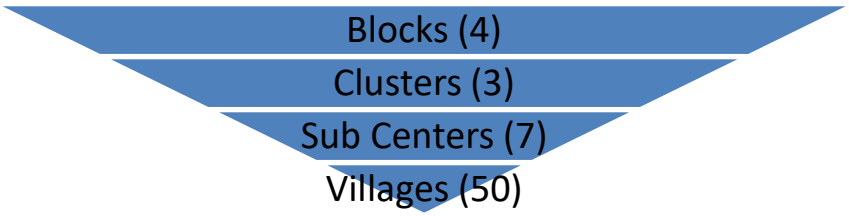
What practices do the pregnant women, her mother in law and her husband conduct for antenatal care?

Research Design

The study is a cross-sectional descriptive study. The study will be qualitative. The study will be investigating a representative sample of pregnant women, their respective mothers-in-law and husbands in the district of Etah. The participants will be assess on their level of knowledge of antenatal care, the perceptions they have developed about antenatal care and their practices regarding antenatal care.

The population under study was selected from the four blocks under UPTSU: Aliganj, Shitalpur, Sakit and Nidhauli Kalan. Aliganj is 41 km away from the Etah Centre, Shitalpur is 8km from Etah Centre, Sakit is 10km away from Etah Centre and Nidhauli Kalan is 34km from Etah Centre. These are IHAT intervention blocks and were accessible for the study.

Fig 1: IHAT intervention blocks are divided in the following manner:




The weakest clusters in ANC utilization was selected, from which 2 sub centers weakest in ANC utilization were selected. Two households at village level were selected from each sub center such that one household had an ANC user and the other household had an ANC non user. Each village had a population of minimum 900 and maximum 1400. ASHA of each of the villages had registered in her diary, a minimum of 2 and a maximum of 6 pregnant women at the time of the study.

Eligibility of household:

- The house should have available at the time of interview pregnant woman, her mother-in-law and her husband.

Eligibility of pregnant woman:

- Should be listed in ASHA Diary.
- The woman should be in the reproductive age of 15-49 years.

The clusters were chosen based on their performance on utilization of antenatal care services provided at the village level, block level and district level. This data can be viewed in Annexure A. The

antenatal care sought by the pregnant woman could have been either at the District Hospital, Comprehensive Health Centre, Primary Health Centre, Sub Centre or at the village level during a Village Health and Nutrition Day. Antenatal care sought at a private healthcare facility was also included. The status of ANC utilization by pregnant women at each of these levels was determined through the data obtained from the UPTSU server. ANC utilization percentage was broken down till the Sub Center level. If the pregnant woman had conducted even one ANC check-up, she is considered as having undergone antenatal care for her pregnancy. The data for ANC utilization until the Sub Center level for each of the four blocks has been illustrated in the Annexure.

The weakest clusters from each block and two weakest sub centers from the cluster were chosen based on the needs of the UPTSU Project in Community Processes. IHAT wanted an understanding of the behavioural aspects of the population that does not utilize ANC. Therefore the weakest sub centers were chosen. Sub Centers that have been chosen have the lowest percentages in ANC utilization at any level of healthcare service delivery.

The two villages from each Sub Center were chosen randomly. The households were chosen by convenience sampling. Two pregnant women were interviewed from each village. From the two pregnant women in each village; one was a pregnant woman who had sought ANC and the second pregnant woman was one who had not sought ANC. This was done specifically to learn if there were any differences in the knowledge and perceptions of these pregnant women and her family members, i.e. their mothers-in-law and husbands.

The sample size was based on previous qualitative studies where a sample of 15 pregnant women who sought ANC, 15 pregnant women who did not seek ANC, 10 mothers in law and 10 husbands were chosen. However, due to time constraints the sample size had to be reduced to 8 pregnant women who

had sought ANC: their 8 respective mothers-in-law and 8 husbands and 8 pregnant women who had not sought ANC: their 8 respective mothers-in-law and 8 husbands. The time frame for data collection was 16 days.

The mode of data collection employed was through an in depth interview guide which collected data on demographic information and led the participant through questions that collected data separately on knowledge, perceptions and practices. The interview was divided into four parts, the first being the demographic data, the second being questions on knowledge assessment of the participant, the third part assessed the perceptions of the participant and the fourth assessed the practices of the participant. Parts second thru fourth collected data strictly related to antenatal care. The interviews were conducted in Hindi and lasted for 20 mins per participant. Each participant was counselled on the importance of antenatal care after the interview. The interviews were conducted in their respective houses and each participant was interviews privately to avoid any discomfort or bias. Each participant was questioned only after acquiring their consent. They were advised that they can leave the interview at any time and could refuse to participate without penalty.

In depth Interview guide will be used to interview the participants. The data will be analysed by recognizing common themes. The clusters in the blocks have been chosen based on their performance of the indicator: % of pregnant women seeking ANC or undergoing atleast one ANC check up. The study will ultimately allow us to understand the processes at play concerning health seeking behaviour for first ANC and the following check-ups. The results from the study can be used to further develop the RMNCH+A program and modify it to bring changes in ANC uptake of weaker clusters of Etah.

## Results

The socio-demographic data of the women and her family members are illustrated in Table 1. Women

who were older than 26 years and have already 3 or more children are more likely to get an antenatal check up. Women who were younger, 20 years and younger or were pregnant for the first time were more likely not to seek antenatal care. Level of education in the pregnant women did not have a significant effect on her behaviour to seek antenatal care. The level of education in her husband had a positive relationship with the probability of the pregnant woman utilizing antenatal care. The higher the education of the husband the greater the probability of the woman to seek antenatal care.

Table 1: Socio demographic profile of pregnant women, mothers-in-law and husbands

| Variable | Category | ANC (N = 8) | ANC Non User (N=8) |
|---|---|---|---|
| Socio-demographic characteristics of women (N = 16) | | | |
| Age | 20 or less | 2 | 3 |
| | 21 - 25 | 2 | 3 |
| | 26 and over | 4 | 2 |
| Number of children | None but pregnant | 2 | 4 |
| | 2 or fewer | 2 | 3 |
| | 3 or more | 4 | 1 |
| Education | Illiterate | 1 | 1 |
| | Intermediate or less | 4 | 4 |
| | High School | 2 | 3 |
| | BA or higher | 1 | 0 |
| Socio-demographic characteristics of mothers-in-law (N=16) | | | |
| Education | Illiterate | 5 | 6 |
| | Intermediate | 3 | 2 |

| | | | |
|---|---|---|---|
| | High School | 0 | 0 |
| | BA or higher | 0 | 0 |
| Age | 45 yrs or less | 1 | 0 |
| | 46 yrs and more | 7 | 8 |
| Socio-demographic characteristics of husbands (N = 16) | | | |
| Education | Intermediate or less | 1 | 4 |
| | High School | 4 | 4 |
| | BA or higher | 3 | 0 |
| Age | 20 or less | 0 | 0 |
| | 21-25 | 3 | 4 |
| | 26 and over | 5 | 4 |

The common themes that were observed in the interviews are highlighted separately in terms knowledge, perception and practices.

Knowledge: Incomplete understanding of antenatal care, the lack of correlation between ANC knowledge and seeking ANC, the role of ANC in saving the mother's life and the child's life, source of information, level of knowledge in the mother-in-law and the husband.

Perceptions: the do's and dont's for safe health during pregnancy, the impact of safe health on the child versus the mother, lack of awareness on the relationship between ANC and safe delivery and development of the mother and the child, the number of times ANC should be conducted, mother-in-law's perceptions, husband's perception, family relationships and authority.

Practices: level of support given by the mother in law and the husband, mother-in-law's past experiences, site of ANC.

KNOWLEDGE

The pregnant women who have conducted ANC did not have a complete understanding about what ANC is. Pregnant women who had conducted ANC knew that “My ASHA told me that it is good to conduct ANC as it keeps my baby and me safe, which is why I went to do it.” The pregnant women’s knowledge about ANC was limited to what their ASHA has conveyed to them. There were women who had conducted ANC but had not been counselled properly by their ASHAs on the purpose and the benefits of ANC. The majority of the woman were unawareof how ANC can help save their lives before delivery and during delivery; “No I do not know how ANC will keep me safe during my delivery. I only know that the child will be healthy during pregnancy and after delivery.” The pregnant women knew that, “ANC means their blood and urine will be tested and that they will be weighed by the female doctor.” The mothers-in-law and the husbands were unaware of ANC. The majority of the mothers-in-law and the husbands expressed that, “I do not know what ANC is.” The few mothers-in-law who were aware expressed that, “ASHA said that ANC is good for the child’s health and therefore her daughter-in-law should go and get checked”. All participants had a common source of information which was their designated village ASHA.

Some pregnant women who had not conducted ANC expressed that, “I do not know what ANC is.” Some expressed that, “I know that ANC is supposed to help keep the mother and the child safe during pregnancy, but I am scared of the injection and therefore do not go.”

PERCEPTIONS

The pregnant women who had any information about ANC and had sought ANC during their pregnancy expressed that, “Yes, I should get an ANC check-up as it will help me keep my baby safe. It will also help the baby after delivery.” The women also expressed that a pregnant woman, “should not conduct physical activity, should rest frequently, should consume fruits and vegetables regularly to

remain healthy during pregnancy."The majority of the women however quoted incorrectly that; "A woman should attend 3 ANC check ups during pregnancy." The pregnant women who had sought ANC check up during their pregnancy expressed that, "the reason a pregnant woman should conduct ANC check up is to prevent any complications that can be threatening to her child." The women believed that, "they should go to the village hospital and the female doctor to get their ANC check up." The mothers-in-law who had information about ANC were supportive of their daughters-in-law and expressed that, "my daughter-in-law should go to the doctor during her pregnancy to ensure that her health and the child's health is safe." The husbands; due to their lack of understanding of what ANC is expressed that, "my wife should see the doctor is she wants to, I have heard that it is good to go to the doctor during pregnancy." The husbands who were supportive of their wives were not aware of ANC was but were aware that some women do go to the doctor during pregnancy. All three participants from households that conducted ANC expressed that, "A check up during pregnancy should be done and will save the life of the child and therefore should not be skipped."

Pregnant women who did not conduct ANC expressed that, "I am scared of the injection and therefore will not go for my ANC check up." Some pregnant women expressed that, "My mother in law says there is no need for ANC as she herself had healthy children without conducting ANC check-ups so I don't go for them either." Some pregnant women also expressed that, "there is too much work in the house and the farm, who will do all this work if I keep going for check ups." Mothers-in-law of pregnant women who did not conduct ANC expressed similar thoughts, "I gave birth to healthy children without conducting ANC, therefore I don't see why my daughter in law should go and have an ANC check up." Some mothers-in-law also expressed that, "She is the daughter-in-law of the house and should therefore make sure all the housework is done first before going outside the house for other matters." The perceptions of the husbands also influenced the decision of the pregnant woman to

conduct ANC. Many of the husbands of pregnant women who did not conduct ANC expressed that, "My mother gave birth to me and my siblings without ANC", another opinion was that "I cannot allow my wife to go outside the house, if the lady doctor comes to my house and conducts the check ups I will allow it, but my wife cannot leave the house." There is also the perception which was voiced by non users and their mothers-in-law that "Pregnancy is not an illness, therefore I do not see why I need to go to the doctor unless something serious happens."

PRACTICES

Pregnant women who have undergone ANC check up have expressed either going to the Block level hospital or the sub centre where the ANM conducts the ANC check ups. The pregnant women who sought ANC expressed that, "I eat healthy, do light work and take rest to ensure that I am healthy." Pregnant women seeking ANC have expressed that "ASHA takes me to the ANM or the hospital to conduct ANC check ups." The most common site of ANC check up expressed by the pregnant women was in the village on certain days of the week in the sub centre and is conducted by an ANM. The mothers-in-law and husbands of pregnant women who sought ANC expressed that, "No, I did not accompany her, I only told her to go and she went on her own for the check up."

Pregnant women who did not seek ANC expressed that, "I try to take rest, do less work and eat healthy to keep healthy." The mothers-in-law and the husbands of non users of ANC expressed that, "If we need to take her to the doctor we will."

## DISCUSSION

The level of knowledge that exists in the pregnant women about ANC can be credited to their village ASHAs who are the source of primary information. The pregnant women have incomplete information regarding ANC. This illustrates that the counselling provided by ASHAs does not relate conducting

ANC to having a safe delivery. The women are also unaware of how ANC is advantageous to not only their child but also their own survival. Culturally, the mother's role is to birth a child and take care of her family, which is why emphasizing maternal health is neglected in the villages of Uttar Pradesh. The interviews also highlight that conducting an ANC check up and being fully aware of its purpose and advantages are mutually exclusive. This highlights the fact that pregnant women who do seek ANC check ups are merely doing so on the advice of the village ASHA. Despite the trainings an ASHA receives, she has still not been effective in making the pregnant women in her village understand the purpose and benefits of ANC. Women who were older and had had three or more children were more likely to be convinced to avail ANC due to previous experiences of discomfort or complications during their first two deliveries. Women who are pregnant for the first time expressed their fear of injection of check ups as they have not been shown or exposed to such procedures through their mothers, aunts, sisters or mothers-in-law in the past. Mothers-in-law and husbands are completely unaware about ANC and are therefore unable to support their wives and daughters-in-law to the fullest extent. This suggests that ASHA interventions and counselling are not penetrating into the family of the pregnant women, especially the key decision makers of the house. Husbands of ANC users were usually more educated than that of non users which has a positive influence on the probability of the woman using ANC. The husband was very rarely available in the house when ASHA made her counselling visits resulting in low coverage of husbands on the village.

Knowledge level of the participant determines the perceptions they have developed about the benefits of ANC, where it can be availed and whether it is vital to the survival of the child and the woman. Therefore women who had experienced child birth and were now also aware of the benefits of ANC were more likely to perceive ANC has a necessary health intervention during pregnancy. Women who had become pregnant for the first time were more likely to perceive ANC as unnecessary. Perceptions

also based on the knowledge reflected that the safety of the unborn child was the main motivating factor for ANC users and their supporters to encourage them to seek antenatal care. Therefore the ANC users perceived the child to be at risk without ANC, but did not have the understanding that the ANC was also helping the mother to have a safe delivery which in turns prevents complications and saves her life. The main difference between ANC users and non users was the presence or lack of support from their family. ANC non users had mothers in laws who were of the opinion that ANC is a curative option versus a preventive option. Syed et al had similar findings where mothers-in-law expressed "going for ANC to be a waste of time especially when there was so much work to do in the house or the farm." Husbands of non users were also discouraging and were usually of the same opinion as their mother. Past experiences of the mother-in-law, if her deliveries that occurred without ANC further encouraged this attitude. This expectation from the family elders dissuaded the pregnant woman from seeking ANC.

Sternberg &Hubley (2004) provide evidence with their study that educating men on ANC increases the number of visits they conduct with their wife to ANC clinics, therefore playing a more active role in their wives' reproductive well being.

Despite getting moral support from their family, none of the mothers-in-law or husband accompanied the pregnant woman to the ANC check up. The pregnant women visited their ANC check up with the help of their ASHA. The majority of the ANC check ups were conducted in the village of the woman by the ANM. The ANC non users and the family members neither went for ANC check ups did not go for one even if it was happening in their own village and women who were scared of needles had not been motivated successfully to avail the service especially when their family members discouraged them from going for an ANC check up.

# Conclusion

The study has highlighted that the awareness level of ANC in the key decision makers of the family, i.e. the mother in law and the husband; and the pregnant woman herself is very basic. The gap in knowledge is the main contributing factor to low percentages of ANC utilization. If programs were developed to educate the household as a whole instead of on an individual basis the probability of ANC utilization by the pregnant woman would increase. Such interventions would make a marked difference in states like Uttar Pradesh which is still lacking greatly in health indicators such as IMR and MMR.

ASHA's knowledge should be assessed in the topic of antenatal care and the trainings provided to her for ANC should have a household approach. Due to time constrains the study could not be conducted on a larger sample which would have perhaps brought out more concrete results. The gap in knowledge witnessed in each of the participants needs to be addressed by health care workers. They need to keep in mind the generation gap in the mothers-in-law and counsel accordingly. Counselling the men of the household needs to be incorporated as a vital component of any program intervention.

# Bibliography

1. Chandhiok, N; Dhillon, B.S.; Kambo, I.; &Saxena, N.C. (2006) Determinants of antenatal care utilization in rural areas on India: A cross sectional stud from 28 districts (An ICMR task force study). The Journal of Obstetrics and Gynaecology of India, 56: 1. Pg 47 – 52.

2. Simkhada et al (2010). The role of mothers-in-law in antenatal care decision making in Nepal:a qualitative study. BMC Pregnancy and Childbirth, 10: 34.

3. Sternberg, P. &Hubley, J. (2004). Evaluating men's involvement as a strategy in sexual reproductive health promotion. Health Promotion International. 19: 3, Pg: 390 – 3964

4. Syed et al (2008). Care- seeking practices in South Asia: using formative research to design program interventions to save newborn lives. Journal of Perinatology, 28, S9 – S13

ANNEXURE

Annexure A: Sub Center wise data of district Etah for five indicators of IHAT intervention blocks (Including Antenatal care utilization)

| Row Labels | Values<br>Sum of Q7 | Sum of Q8 | Sum of Q9 | PW | ANC | ID | PNC | FP |
|---|---|---|---|---|---|---|---|---|
| **Aliganj** | **160936** | **18781** | **12565** | **2308** | **2161** | **225** | **285** | **5108** |
| **ALIPUR** | **24609** | **3111** | **2753** | **419** | **406** | **35** | **45** | **745** |
| Alipur | 591 | 133 | 133 | 21 | 19 | 2 | 2 | 25 |
| Dadupur | 1907 | 217 | 217 | 40 | 40 | 3 | 5 | 60 |
| Kharsuliya | 3120 | 482 | 482 | 55 | 55 | 7 | 7 | 140 |
| Nawar | 6028 | 822 | 602 | 86 | 83 | 6 | 9 | 210 |
| NayaGaon | 2155 | 229 | 229 | 38 | 38 | 2 | 4 | 62 |
| SarayAgahat | 3123 | 439 | 439 | 76 | 76 | 9 | 11 | 110 |
| Ubhai | 7685 | 789 | 651 | 103 | 95 | 6 | 7 | 138 |
| **CHC ALIGANJ** | **63098** | **7418** | **2617** | **834** | **786** | **86** | **112** | **2023** |
| Aliganjkudesha | 9139 | 1158 | 396 | 107 | 100 | 10 | 12 | 294 |
| Angariya | 7514 | 768 | 185 | 107 | 107 | 6 | 9 | 307 |
| Bilasd | 7781 | 851 | 611 | 104 | 91 | 10 | 11 | 240 |
| DaheliyaPooth | 8637 | 991 | 320 | 120 | 112 | 14 | 18 | 232 |
| Dhatingara | 8238 | 975 | 227 | 114 | 110 | 18 | 20 | 225 |
| Moracha Road | 9667 | 1163 | 409 | 125 | 123 | 14 | 16 | 343 |
| Nadararala | 5289 | 665 | 271 | 75 | 68 | 8 | 13 | 136 |
| Pahara | 6833 | 847 | 198 | 82 | 75 | 6 | 13 | 246 |
| **KALINJAR** | **32243** | **3988** | **2931** | **450** | **383** | **39** | **50** | **1057** |
| AkbarpurKot | 10476 | 1277 | 890 | 161 | 127 | 12 | 18 | 387 |
| Amrauli | 7170 | 920 | 685 | 100 | 91 | 10 | 11 | 235 |
| Kailtha | 9245 | 1205 | 965 | 113 | 101 | 12 | 14 | 240 |
| Kalinjar | 5352 | 586 | 391 | 76 | 64 | 5 | 7 | 195 |
| **RAJA KA RAMPUR** | **40986** | **4264** | **4264** | **605** | **586** | **65** | **78** | **1283** |
| Farasaoli | 7623 | 661 | 661 | 105 | 101 | 8 | 13 | 131 |
| GadiyaJagannath | 3334 | 408 | 408 | 75 | 75 | 6 | 7 | 86 |
| Kher Pura | 9725 | 797 | 797 | 135 | 131 | 16 | 19 | 195 |
| MorachaNahar | 5292 | 551 | 551 | 68 | 65 | 8 | 9 | 255 |
| Raja Ka Rampur | | | | | | | | |
| Sumaor | 6937 | 869 | 869 | 101 | 97 | 9 | 9 | 254 |
| Taj PurAdda | 8075 | 978 | 978 | 121 | 117 | 18 | 21 | 362 |
| **Nidhaulikalan** | **91595** | **13680** | **7828** | **1173** | **975** | **124** | **168** | **2194** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **BARAI** | **41878** | **5978** | **2229** | **571** | **477** | **60** | **56** | **868** |
| Adhapura | 4262 | 459 | 242 | 53 | 43 | 5 | 5 | 104 |
| Bara | 5882 | 918 | 332 | 81 | 64 | 9 | 7 | 110 |
| Bhadwas | 3692 | 465 | 157 | 46 | 46 | 3 | 3 | 77 |
| Darabpur | 409 | 50 | 30 | 8 | 7 | 0 | 0 | 15 |
| Jogamai | 2561 | 424 | 110 | 29 | 29 | 2 | 2 | 61 |
| MohkamPurMuhara | 6524 | 902 | 388 | 84 | 64 | 12 | 12 | 108 |
| MuiidinPur | 4703 | 783 | 297 | 89 | 45 | 8 | 6 | 83 |
| Pilua | 10612 | 1495 | 466 | 134 | 132 | 13 | 13 | 213 |
| Songra | 3233 | 482 | 207 | 47 | 47 | 8 | 8 | 97 |
| **CHC NIDHAULIKALAN** | **31067** | **4617** | **3702** | **380** | **303** | **46** | **60** | **706** |
| Barigavan | 3054 | 470 | 403 | 45 | 31 | 2 | 2 | 67 |
| Bhoopalpur | 4017 | 541 | 479 | 44 | 37 | 5 | 6 | 62 |
| Dholeswer | 6519 | 1016 | 819 | 83 | 73 | 9 | 13 | 220 |
| Jitauli | 4097 | 644 | 275 | 62 | 35 | 7 | 11 | 137 |
| Main Center Nidhaulikalan | | | | | | | | |
| Manoura | 6942 | 988 | 879 | 90 | 79 | 11 | 13 | 109 |
| Margaya | 2686 | 347 | 301 | 26 | 20 | 5 | 7 | 46 |
| Sihori | 3752 | 611 | 546 | 30 | 28 | 7 | 8 | 65 |
| **VASUNDHARA** | **18650** | **3085** | **1897** | **222** | **195** | **18** | **52** | **620** |
| Gahetu | 1400 | 127 | 68 | 22 | 21 | 3 | 7 | 37 |
| Kamsan | 2688 | 443 | 326 | 27 | 19 | 1 | 4 | 36 |
| Majhrau | 1816 | 263 | 146 | 27 | 22 | 4 | 9 | 50 |
| MumiyaKheda | 1995 | 310 | 151 | 34 | 32 | 1 | 3 | 69 |
| Pipahra | 5211 | 984 | 618 | 52 | 47 | 5 | 17 | 192 |
| Vasundhra | 5540 | 958 | 588 | 60 | 54 | 4 | 12 | 236 |
| **Sakit** | **186516** | **24640** | **18038** | **2465** | **2224** | **246** | **313** | **4077** |
| **MALAWAN** | **51029** | **6275** | **4105** | **760** | **688** | **58** | **133** | **1285** |
| Aaspur | 9829 | 1191 | 878 | 139 | 102 | 11 | 72 | 254 |
| Ayar | 4797 | 556 | 374 | 85 | 77 | 11 | 11 | 98 |
| Chhachheina | 2286 | 290 | 226 | 39 | 33 | 2 | 2 | 48 |
| Kangraul | 4932 | 827 | 390 | 83 | 81 | 6 | 7 | 164 |
| Malavan | 7342 | 862 | 628 | 88 | 87 | 8 | 11 | 162 |
| Navada | 8496 | 1420 | 918 | 144 | 140 | 7 | 9 | 347 |
| NigohHasanpur | 7608 | 750 | 516 | 104 | 92 | 8 | 12 | 67 |
| Savnhar | 5739 | 379 | 175 | 78 | 76 | 5 | 9 | 145 |
| **RIJOR** | **58103** | **8221** | **6243** | **739** | **640** | **63** | **62** | **1211** |
| Fafotu | 8960 | 1414 | 1021 | 144 | 131 | 8 | 10 | 179 |
| Ghumariya | 8432 | 1268 | 886 | 121 | 106 | 9 | 9 | 225 |
| NaglaBhajua | 11916 | 1487 | 1186 | 121 | 94 | 13 | 13 | 248 |
| NidhauliKhurd | 8867 | 1322 | 990 | 113 | 99 | 8 | 8 | 229 |
| Rijor | 11580 | 1567 | 1243 | 127 | 114 | 18 | 15 | 197 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Saina Kalan | 2966 | 420 | 309 | 46 | 41 | 4 | 4 | 65 |
| Vaishya Kheriya | 5382 | 743 | 608 | 67 | 55 | 3 | 3 | 68 |
| **SAKIT ARBAN** | **77384** | **10144** | **7690** | **966** | **896** | **125** | **118** | **1581** |
| Begaur | 7402 | 1143 | 833 | 89 | 84 | 13 | 15 | 221 |
| Hiraundi | 10677 | 1694 | 1489 | 153 | 149 | 21 | 19 | 138 |
| IsharaPaschimi | 12168 | 1541 | 938 | 149 | 130 | 19 | 23 | 406 |
| Kawar | 9777 | 1305 | 984 | 140 | 132 | 12 | 14 | 189 |
| Lothra | 7091 | 1102 | 900 | 121 | 118 | 8 | 10 | 81 |
| Nain Center Sakit | 19534 | 1807 | 1388 | 192 | 165 | 29 | 14 | 224 |
| Riwadi | 10735 | 1552 | 1158 | 122 | 118 | 23 | 23 | 322 |
| **Shitalpur** | **144439** | **16975** | **12242** | **1937** | **1882** | **205** | **278** | **3454** |
| **BAGWALA** | **46406** | **5527** | **4104** | **603** | **567** | **60** | **85** | **1123** |
| Bagwala | 5685 | 728 | 554 | 61 | 61 | 4 | 9 | 131 |
| Harnavali | 5899 | 599 | 370 | 76 | 73 | 11 | 14 | 175 |
| Jamlapur | 2545 | 344 | 260 | 30 | 20 | 2 | 2 | 62 |
| Kansauri | 2276 | 288 | 200 | 27 | 26 | 3 | 5 | 74 |
| KILARMAU | 7708 | 1034 | 817 | 108 | 102 | 9 | 14 | 178 |
| Labhaita | 5264 | 627 | 439 | 74 | 67 | 11 | 12 | 158 |
| Lohakhar | 6589 | 675 | 551 | 91 | 84 | 9 | 12 | 94 |
| Parson | 4287 | 440 | 336 | 53 | 52 | 5 | 6 | 86 |
| Sonsa | 6153 | 792 | 577 | 83 | 82 | 6 | 11 | 165 |
| **KHADAUA** | | | | | | | | |
| Garhi | | | | | | | | |
| **LALGARHI** | **52985** | **6563** | **5170** | **744** | **729** | **88** | **99** | **1288** |
| ASARAULI | 3540 | 371 | 310 | 36 | 36 | 8 | 3 | 61 |
| Badriya | 2732 | 325 | 193 | 71 | 71 | 6 | 8 | 132 |
| Barthar | 8908 | 1114 | 901 | 136 | 131 | 20 | 23 | 258 |
| Bhagipur | 10002 | 1188 | 946 | 140 | 140 | 13 | 20 | 242 |
| GagipurPahor | 8741 | 1208 | 967 | 123 | 123 | 15 | 14 | 241 |
| Ganganpur | 3891 | 512 | 320 | 52 | 51 | 6 | 6 | 42 |
| Kakrawali | 6987 | 882 | 715 | 72 | 72 | 11 | 9 | 167 |
| Lalghariar | 2923 | 345 | 287 | 32 | 29 | 0 | 3 | 58 |
| Shainthary | 5261 | 618 | 531 | 82 | 76 | 9 | 13 | 87 |
| **NAGLA MUI** | **45048** | **4885** | **2968** | **590** | **586** | **57** | **94** | **1043** |
| Jirshami | 6635 | 676 | 386 | 68 | 68 | 8 | 10 | 162 |
| Kathauli | 8082 | 996 | 757 | 111 | 111 | 14 | 25 | 196 |
| Lohabadshahpur | 3304 | 356 | 202 | 50 | 50 | 3 | 9 | 101 |
| Mahuat | 4834 | 440 | 265 | 63 | 63 | 8 | 12 | 60 |
| Milawali | 3415 | 408 | 210 | 53 | 53 | 7 | 10 | 58 |
| NaglaJagroop | 7350 | 714 | 466 | 94 | 94 | 5 | 9 | 90 |
| Nagla Mui | 2200 | 335 | 144 | 36 | 36 | 3 | 7 | 91 |
| Nyorai | 4307 | 469 | 257 | 54 | 50 | 6 | 8 | 128 |
| On | 4921 | 491 | 281 | 61 | 61 | 3 | 4 | 157 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Grand Total** | **583486** | **74076** | **50673** | **7883** | **7242** | **800** | **1044** | **14833** |

Annexure B : Questionnaire

Please circle one: Pregnant woman / Mother-in-law / Husband

Age : Education level:

Income level: Occupation:

Ghar me kitnesadasyahain: Ye kaunsabachchahai : 1st / 2nd / 3rd / 4th / 5th / 6th

Kya aapneprasavpurv koi jaanchekihain: Yes / No (Saas, Pati: Kya aapneprasavpurvjaanchkarvaihaiapnebahu/patniki?)

Garabvati bane aapkokitnemahine hue?

Knowledge

1 Prasavpurvwalijaanchkiskokehlatehain?
2 Kitnejaanchehonichahiyeprasavkepehle?
3 Kin cheezonkijaanchehotihainprasavkepehle?
4 Kaunjaatahai in jaanchoonkokarvaane?
5 Prasavkepehlewaalijaanchekekyalaabhhain?
6 Kya prasavkepehlewaalijaanchonki koi durlaabhhain?
7 Aapkegaon me aapprasavpurvkijaanchkeliyekahanjaasakteho?
8 Kaunkartahaiprasavpurvjaanch?
9 In jaanchonkebaare me aapkokahan se jaankaarimili?
10 In jaanchonkebaare me aapko kiss se jaankaarimili?

Perceptions

1 Aapkekhayal me ekgarbvatimahilakokistarah se apnisehatkakhayalrakhnachahiye?
2 Kya usseprasavpurvjaanchekarvaanichahiye? Agar haantohkyun? Agar nahitohkyun?
3 Kitnebaargarabwatimahilakoprasavpurvjaanchkarvaanichahiye?
4 Kya prasavpurvjaancheekgarabwatimahilakeliyelaabhdaayakhain? Haantohkyun? Nahitohkyun?
5 Agar garabwatimahila ne prasavpurvjaanchenahikarvai, tohkyahoga?
6 Kya prasavpurvjaanchkizaroorathaiekgarabwatimahilaauruskebaccheko?
7 Kya prasavpurvjaanchonkebinaekgarabwatibinakhatrewaaliprasavkarvasaktihai?
8 Prasavpurvjaanchekarvaanekeliyeaapkepaaskaisidikateinaatihain?

Practices

1 Aapapnetabiyatkakhayalkaiserakhtiho?
Saaskeliye: Aapapnebahukakhayalkaiserakhtiho?
Patikeliye: Aapapnepatnikakhayalkaiserakhteho?
2 Kya aapne ab tak koi jaanchkarvaihai Doctor, Hospital ya ANM didikedwara?
Saaskeliye: Kya aapinko koi jaanchkeliyekahin le gayiho? (Agar haan: See 2a/ Agar Nahi: See 2b)
Patikeliye : Kya aapinko koi jaanchkeliyekahin le gayeho? (Agar haan: See 2a/ Agar Nahi: See2b)
2a Agar Haantohkyun? : - Aapnekahan se jaanchekarvai?

Aapne kiss se jaanchekarvai?
Aapnekistarahkejaanchekarvai?
Kitni door takjaanapada?
Kaunsidikateinaayijaanchekarvaane me?
2b Agar Nahitohkyun?