Internship Report

1.1 Introduction to Organization:

History:

In the summer of 1980 CARE, Gujarat placed an advertisement for a nutritionist for their Community Development Program, in collaboration with The Vikram A Sarabhai Community Science Center (VASCSC). Not mentioned in the advertisement, the three criteria for selecting the candidate were willingness to travel 20 days a month to remote rural and tribal areas, knowledge of the local language and capacity to drive a four wheel jeep!

A fresh graduate from Maharaja Sayajirao Univesity (M.S.U.), Vadodara with a post graduate degree in Foods & Nutrition, Indu Capoor responded to the advertisement with enthusiasm and was subsequently appointed. Indu's first assignment was to coordinate the nutrition and health education program developed by a senior scientist started in 1978, for the slum children who visited the science centre. Minaxi Shukla who was working on the nutrition programme at VASCSC volunteered to assist her in translating documents into the local language. With a specialization in Nutrition Indu could address problems and doubts concerning these and was therefore frequently consulted. Her involvement was encouraged and appreciated by others, particularly by the Managing Trustee, Nehru Foundation for Development, Dr. Kartikeya Sarabhai.

Following this, a pilot program was proposed, which would cover 100 villages, spread across ten blocks, all over Gujarat, including tribal, rural and urban centers. This was proposed with the view to develop suitable educational strategies for the entire state. The name given to the program was INHAP (Integrated Nutrition And Health Action Program). A year later Pallavi Naik, who had been a junior of Indu at MSU joined the project to share responsibility. Later, Minaxi who had started volunteering time joined the project formally. The team came to be known as the 'Trio'. and the **organization known as Centre for Health Education, Training and Nutrition Awareness (CHETNA)** emerged as a independent activity, under the umbrella of Nehru Foundation for Development.

CHETNA is identified as a Regional Resource Centre (RRC) for Reproductive and Child Health (RCH) for Gujarat state and the Union Territories of Daman, Diu and Dadra Nagar Haveli by Government of India. As the RRC, CHETNA extends its support to Non Government Organizations to systematically and effectively implement the programmes related to women, young people and children. RRC-CHETNA is an important link between the CBO/NGOs and the Health department both at the state and national level.

CHETNA has completed 30 years journey and empowered herself with knowledge and skills related to capacity building of organizations working on the issues of women, young people and children, developing health communication material, networking and advocating for comprehensive and gender sensitive women, young people's and children's policies and programmes.

Vision

CHETNA envisions an equitable society where disadvantaged people are empowered to live creative, fulfilling and healthy lives.

Mission

CHETNA works to empower children, young people and women, especially from marginalized social groups, to take control of their own, their families and their communities' health.

Valuing Our Space

CHETNA envisions an equitable society where disadvantaged people are empowered to live creative, fulfilling and healthy lives.

Commitment

To the cause, taking initiative to achieve the vision and mission and the sustainability of the organization.

Honesty and Transparency

With each other and the partners; in expression of views and opinions, in work and use of resources, readiness for receiving and giving feedback, for an open and enabling work environment thus enhancing organizational integrity.

Enhancement of Capacities

Believing in people, their capacity to learn and deliver and an understanding of their strengths and limitations, instilling self worth and confidence in them.

True Value of Resources

Time, human resource, funds and assets resulting in optimal utilization of resources.

Non-Discrimination

Equal opportunity to express is heard, to growth and development, access to resources, observance of culture and norms within the organization, thus creating a feeling of fairness/ non-discrimination.

Accountability and Sincerity

In work, deliverables; ensuring optimum quality of output in the most cost effective way.

Location/area

CHETNA is situated at Ahmedabad, Gujarat. In August 1984, CHETNA received a core grant from Ford Foundation on child survival project CHETNA moved to a rented building on drive-in road behind drive-in cinema which was fondly called Parde-ke-peeche (behind the curtains). Current address is:

B-Block 3rd Floor SUPATH-II,
Opp. Vadaj Bus Terminus Ashram Road, Vadaj Ahmedabad-380013, Gujarat India.

Number of departments/programmes:

Several programmes were conducted in Ahmedabad with St. Xaviers, Non-Formal Education Trust at Gulbai Tekra (urban slum) for increasing awareness about nutrition among women managing homes in different housing societies.

UNICEF, Delhi approached the team to develop an educational kit on Childcare, emphasising the Growth Monitoring, Oral rehydration, Breastfeeding, Immunisation, Family Planning & Female Education (GOBIFF) messages. CHETNA conducted

extensive field testing in various districts of Uttar Pradesh. It was basically to be prepared for the Hindi speaking belt.

CHETNA designs illustrative print education material in simple local languages. The materials are extensively field tested among the community members before mass production. More than 50 IEC materials developed by CHETNA, effectively integrate relevant technical information with gender-sensitive messages and are perceived to be user-friendly and successful in creating desired behaviour change in the community. Many of the printed health education materials have been mass-produced by Government of India and Government of Gujarat to be used in their programmes. CHETNA is a pioneer in designing innovative health communication strategies which are being mainstreamed in government and non government programmes and schemes. Different Projects has been planned at CHETNA, these are as followed:

- SUMA (Rajasthan Surakshit Matritava Gathbandhan)
- Child Rights Projects
- Youth Related Projects
- Improving Health in Mangrol Dist., Surat
- Communication for Health- Gujarat and Rajasthan
- Action Research on Improving Maternal & Child Health Focussing on Nutrition in Banaskantha
- Valuing the Girl Child
- Women's Access to Maternal Health Care Services in Navsari District of Gujarat State
- Partnership and Advocacy for Women's Health Rights
- Improving Health of Mother & Child
- Health Communication

1.2 The Project where I was engaged in:

I was engaged in SUMA-Birth Preparedness and Complication Readiness Project. **(Rajasthan Surakshit Matritava Gathbandhan)**

SUMA – Rajasthan White Ribbon Alliance for Safe Motherhood was initiated by CHETNA in February 2002. It aims to create awareness, action and advocacy for reduction of high maternal and neonatal mortality in the state.

During Jan 2008- August 2009, SUMA plans to implement an awareness and advocacy initiative with five partners: Seva Mandir (Udaipur), JATAN (Rajsamand), Hadoti Hasta Shilpa Sansthan (Kota), Gram Vikas Navyuvak Mandal (Tonk) and Public Education Development Organization (Mada, Dungarpur). Plans have been made to organize a total of 2500 women to form Safe Motherhood (SUMA) groups and work with 100 elected representatives and 5 MLAs of five districts.

Current efforts

Right now from January 2011 Birth Preparedness and Complication Readiness Project under SUMA is going on in Jodhpur district, Rajasthan.

1.3 The managerial tasks I did:

- Coordination with partner NGOs and field NGOs
- Coordinating and facilitating Training of Trainers
- Facilitating Workshop on "National Safe Motherhood Day"
- Field visit and monitoring visit
- Report Writing (English and Hindi)
- Developing frameworks for field level activities
- Developing monthly action plan for field NGOs
- Checking Financial documents/bills/vouchers related to the project given to me
- Preparing Quarterly Progress Report
- Coordinating any National and International visit
- Organizing and facilitating meetings
- Representation of CHETNA in National and International Conferences
- Preparing Presentation for National and International Conferences and Meetings
- Any other specific work given by my supervisor, etc.

1.4 Reflective Learning during Internship

CHETNA is providing very good exposure to me. It is my pleasure that I am working with CHETNA team. My supervisor and other team members always guide me whenever it is required.

- Understanding different aspects of Health Care Projects and Research
- Report Writing Skills
- Understanding of National and International Issues related to Health
- Team work and co ordination with field NGOs and partner NGOs

Health Seeking Behaviour for Ensuring Safe Delivery and Preventing Obstetric Complication

Chapter 1 - Introduction

Safe delivery is promoted primarily through the encouragement of all families to seek the care of skilled birth attendants for all births, because all pregnant women are at risk of life-threatening complications, many of which are unpreventable and unpredictable. Most childbirth complications cannot be predicted, and therefore, pregnant women and their families need to know what to do when an obstetric emergency occurs.

The statistic of a maternal death every eight minutes places Indian women at a risk 200 times higher than that of women in the developed world. In marginalized communities across rural India, a maternal death is just a number. More than 40% of pregnancies in developing countries result in complications, illness, or permanent disability for the mother or child. [1]

A woman dies from complications in childbirth every minute – about 529,000 each year -- the vast majority of them in developing countries. [2]

Childbirth is one of the important events affecting health of a woman, especially in developing countries likes India.
As with other countries, most of the maternal deaths in India can be prevented, and many are due to a lack of appropriate care during pregnancy and childbirth and to inadequate services for identifying and managing complications, according to the World Bank. [3]

In Rajasthan it is a common feature in most of the households for women to bear the major chunk of the household chores. However, this work is not supplemented by proper diet due to gender bias against women. The situation does not change even during pregnancy thus leading to various problems during pregnancy.
This accompanied by malnutrition is responsible for various problems during pregnancy.
Other than nutrition another important factor influencing the health of women during pregnancy is her health-seeking behaviour, especially antenatal checkups. Antenatal care

(ANC) refers to pregnancy-related health care provided by a doctor or a health worker in a medical facility or at home.

However, a large proportion of women still do not receive antenatal checkups, even though such care can detect and treat existing problems and complications, provide counseling on symptoms of problems, help the woman prepare for birth, and advise her on where to seek care if complications arise.

Women among rural population who received antenatal care were increased from 59% (NFHS-1), 60% (NFHS-2) to 72% (NFHS-3). Institutional deliveries increased by 7 percentage points between NFHS-2 and NFHS-3 (29%). [4]

Rajasthan has trailed in many health care indicators such as, maternal mortality (388 per 100,000 live births, SRS, 2006), infant mortality rate (63 per 1000 live births in 2008, SRS). Even the exclusive breast-feeding practices and full immunization figures are not very encouraging. Only 65.5% of women exclusively breast feed their children between 0-5 months of age (DLHS-3) and 48.8% of the children are fully immunized (DLHS-3).

This is sure that maternal death is an avoidable tragedy. Centre for Development and Population Activities (CEDPA), in collaboration with other NGO partner, has been implementing a model of community based preparation for emergency at before pregnancy, during the delivery, after the delivery and newborn child birth and preparation for birth in the selected areas in Jodhpur district of Rajasthan by White Ribbon Alliance Rajasthan member with the purpose of encouraging pregnant women, their families, and communities to plan for normal pregnancies, deliveries, and postnatal periods and to prepare to deal effectively with emergencies if they occur.

Rationale:

The National Rural Health Mission (NRHM) aims to improve the availability of and access to quality health care by people, especially those residing in rural areas, the poor, women and children. It aims to bring down the Maternal Mortality Ratio to 100 per 100,000 births and Infant Mortality Rate to 30 per 1000 live births. The main strategy adopted by the Ministry of Health and Family Welfare (MoHFW), Government of India,

to achieve this goal to reduce the countries high maternal mortality is promotion of Institutional deliveries. This is being done through incentive based scheme like Janani Surksha Yojana (JSY) as well as creating a cadre of Skilled Birth Attendants (SBAs) like Auxillary Nurse Midwives (ANM) and Medical Officer (MO). Although strategies like JSY have resulted in many more institutional deliveries, many women still continue to give births at home. Rajasthan is among the states of India with high Maternal Mortality Rates. The District Level Health Survey estimates MMR of Rajasthan at 335 per 100,000 live births (DLHS-2008), still a long way from the NRHM Goal of reducing MMR to 100 by 2012. [5]

To prepare for emergency at before pregnancy, during the pregnancy, after the pregnancy and newborn child birth and preparation for birth at the household and community levels also helps mitigate some of these barriers and reduce delay in accessing skilled services, thereby improving maternal survival, preparation for child birth promotes active preparation and decision-making for births, including pregnancy/postpartum periods, by pregnant women and their families.

In diverse socio-cultural and geographical settings in the state of Rajasthan, it is essential to look for evidence based interventions for these preparations that work in different contexts and have the potential to be taken to scale. There is also a need to generate evidence regarding specific interventions that are the most effective in reducing the three delays in pregnancy that contribute to delivery-related deaths – delays in deciding to seek care, reaching timely care, and receiving care.

SUMA-Rajasthan White Ribbon Alliance for Safe Motherhood proposes to introduce a project for preparation of emergency at before pregnancy, during the pregnancy, after the pregnancy and newborn child birth and preparation for birth in one block in the State of Rajasthan.

Problem statement

In Rajasthan it is a common feature in most of the households for women to bear the major chunk of the household chores. However, this work is not supplemented by proper diet due to gender bias against women. The situation does not change even during pregnancy thus leading to various problems during pregnancy.

This accompanied by malnutrition is responsible for various problems during pregnancy.

Other than nutrition another important factor influencing the health of women during pregnancy is her health-seeking behaviour, especially antenatal checkups.
Safe delivery is promoted primarily through the encouragement of all families to seek the care of skilled birth attendants for all births, because all pregnant women are at risk of life-threatening complications, many of which are unpreventable and unpredictable.

Review of Literature

Childbirth is one of the important events affecting health of a woman, especially in developing countries likes India.

When I was reviewing literature I could make out that safe delivery is promoted primarily through the encouragement of all families to seek the care of skilled birth attendants for all births, because all pregnant women are at risk of life-threatening complications, many of which are unpreventable and unpredictable. Most childbirth complications cannot be predicted, and therefore, pregnant women and their families need to know what to do when an obstetric emergency occurs. Nearly 46% of the home births in developing countries happen without a skilled attendant and expose women to these risks if clean practices are not followed. [6] Improving maternal health is one of the eight Millennium Development Goals (MDGs) adopted at the 2000 Millennium Summit. A key target is to reduce the maternal mortality ratio (MMR) by three-quarters between 1990 and 2015. More than 350 000 women die each year due to pregnancy and childbirth related complications. [7] Nearly a quarter of the world's neonatal deaths take place in India. [8]

Most maternal deaths can be prevented if births are attended by skilled health personnel – doctors, nurses and midwives – who are regularly supervised, have the proper equipment and supplies, and can refer women in a timely manner to emergency obstetric care services when complications are diagnosed. Complications require prompt access to quality obstetric services equipped to provide lifesaving drugs, antibiotics and transfusions and to perform Caesarean sections and other surgical interventions. Maternal and newborn mortality rates remain unacceptably high, especially where the majority of births occur in home settings or in facilities with inadequate resources. [9]

A woman dies from complications in childbirth every minute – about 529,000 each year -- the vast majority of them in developing countries. [2] In Rajasthan it is a common feature

in most of the households for women to bear the major chunk of the household chores. However, this work is not supplemented by proper diet due to gender bias against women. The situation does not change even during pregnancy thus leading to various problems during pregnancy.

The District Level Health Survey estimates MMR of Rajasthan at 335 per 100,000 live births (DLHS-2008), still a long way from the NRHM Goal of reducing MMR to 100 by 2012. [5]

A district-wide field trial of the preparation for emergency at before pregnancy, during the pregnancy, after the pregnancy and newborn child birth and preparation for birth, this Plan implemented through the government health system in a district in Nepal during 2003-2004 reveals that preparation for birth can positively influence knowledge and intermediate health outcomes.

However, there is only one such study in India to demonstrate the outcomes of preparation for emergency at before pregnancy, during the pregnancy, after the pregnancy and newborn child birth and preparation for birth.

Three hundred twelve mothers of infants aged 2-4 months in 11 slums of Indore, India, were interviewed to assess birth preparedness and complication readiness (BPACR) among them. One hundred forty-nine mothers (47.8%) were well-prepared. [10]

Objectives:

General objective

To assess the measures taken by Current Pregnant Women and Lactating Mothers and their families to ensure safe child birth without any complications.

Specific objectives

1. To determine the knowledge, attitude, and practices related to antenatal, intranatal and postnatal care among the pregnant women and their families/communities.
2. To know the knowledge of complications of pregnancy, during delivery, after delivery and new born.
3. To assess the measures adopted by the pregnant women /families/community for ensuring efficient and effective intrapartum and neonatal care
4. To provide key conclusions and recommendations for developing the key interventions that would yield the desired obstetric outcomes.

Chapter 2 Data and Methods

The Research Problem & Research questions:

Although strategies like JSY have resulted in many more institutional deliveries, many women still continue to give births at home. Many maternal and infant deaths occurred due to complications. One of the reasons is that there is no planning for safe birth at community level.

Rajasthan is among the states of India with high Maternal Mortality Rates. The District Level Health Survey estimates MMR of Rajasthan at 335 per 100,000 live births (DLHS-2008), still a long way from the NRHM Goal of reducing MMR to 100 by 2012.

Improving preparation for before pregnancy, during the pregnancy, after the pregnancy and newborn child and planning for safe delivery) at the household and community levels promotes active preparation and decision-making for births, including pregnancy/postpartum periods, by pregnant women and their families.

The Research Design:

The study design:

This study is quantitative and quanlitative in the nature.

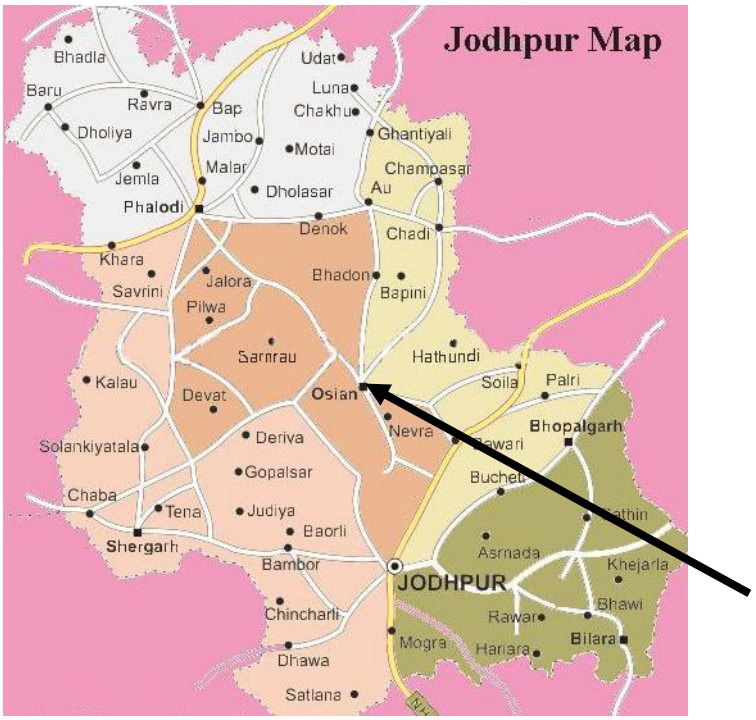
The variables

The study tools was pre-tested and finalized in consultation with the survey team members of GRAVIS Organization-Jodhpur prior to the actual data collection for this study. On the basis of these following variables the questionnaire was developed:

- Knowledge of maternal health services provided under Public Health System
- Knowledge of danger signs in at before the pregnancy, during the pregnancy , post partum and new born
- Number of couples planning for where to give birth
- Number of couples with a pre-identified skilled birth attendant
- Number of couples with transportation plans
- Number of couples with savings for emergency and birth
- Number of couples with pre-identified blood donors
- Number of early registration of pregnancies
- Number of women receiving Janani Suraksha Yojana benefit Rs. 500/- in 7th month of pregnancy for nutrition or Rs. 1400/- after the delivery
- Number of women receiving 3 Ante Natal Checkups
- Number of women had institutional deliveries accompanied by Dai/ASHA/AWW/ANM
- Number of women receiving 3 Post Natal Checkups

The mothers were asked whether they followed the desired five steps while pregnant: identified a trained birth attendant, identified a health facility, arranged for transport, and saved money for emergency, identified blood donor.

Study Area



The Jodhpur district covers 7 blocks (Phalodi, Osian, Bhopalgarh, Jodhpur, Shergarh, Luni, Bilara). The sample was collected from Osian Block of Jodhpur.

The study was conducted in five villages in Osian of Jodhpur district. The names of villages are **Khabada, Khetasar, Badala basani, Gopasaria and Maandiyai-kala.** This block was selected taking geographical spread, population demographics, health facilities, etc. into consideration.

The study would be conducted in 5 villages in **Osian block** of Jodhpur district.

Jodhpur:

Total Population: 28,86,505

Urban Population: 33.85% (9,77,082)

Rural population: 66.15% (19,09,423)

Osian Block: Osian is a tehsil of Jodhpur district in the Indian state of Rajasthan. According to Census 2001:

- Geographical area - 22,850 (sq km)
- Population – 352,935 Rural- 1,83,574 (Male), 1,69,361 (Female)
  Of this, 13536 (3.84%) are Scheduled Tribes (STs) and 58823 (16.67%) are Scheduled Caste (SC).
- Literacy rate – Rural: 63.92 (Men), 22.04 (Female**)**
- Health facilities; PHC-14, SC-56 and ONE - CHC,
- Distance from HQ -60km

Sample Size

Due to lack of support from my organization and other task assigned to me and time limitation, I could select only five villages in Osian block. But the sample size is largely determined by the level of accuracy and it covered each Lactating Mother and Current Pregnant Women. Hence, in five villages the sample of 100 was taken for quantitative household survey.

Sample Selection for quantitative:

1. Five villages from Osian block were selected through Lottery method of simple random sampling technique.
2. Every village is divided into various Hamlets (Tola or Dhani) based on caste and/or their agriculture field areas. I enquired about the number of Tolas/Dhanis, and approximate number of households in each Tola/Dhani of the selected village by meeting with local PRI members, local influential persons.
3. Once the villages were selected, I collected the list of Lactating Mothers and currently pregnant women (CPW) for each village from Auxiliary Nurse Midwife (ANM), AHSA and Anganwadi Worker (AWW)/AWW's helper. It was found that in each village there were 10-12 LM and 10-13 CPW.
4. A sample size of 100 will be equally divided into five villages. Thus, 20 women from each selected village have been covered.
5. In each selected village, 10 currently pregnant women and 10 Lactating Mother would be covered under this survey.

Sample Selection for qualitative:

1. Focus group discussion was conducted among 30 mother-in-law of CPW during National Safe Motherhood Day, April 11, 2011.
2. Randomly 6 mother-in-laws were selected from same 5 villages selected earlier.
3. FGD was conducted among total number of 30 mother-in-laws.

Target Group

The survey mainly consisted of household level interviews with the following groups:

1. Lactating Mother having children aged up to 6-12 months and their husband
2. Currently pregnant women and their husband
3. Mother-in-laws

Method of sampling

Five villages from Osian block were selected through Lottery method of simple random sampling technique. LM and CPW were covered under this study.

The data collection techniques

- In this block, 5 villages have been selected by Lottery method of simple random sampling technique.
- Once the villages would be selected, the list of Lactating Mother (LM) and Currently Pregnant Women (CPW) for each village was collected through Auxiliary Nurse Midwife (ANM), Accredited Social Health Activist (AHSA) and Anganwadi Worker (AWW).

  In Rajasthan, every village is divided into various Hamlets (Tola or Dhani) based on caste and/or their agriculture field areas. I enquired about the number of Tolas/Dhanis, and approximate number of households in each Tola/Dhani of the selected village by meeting with local Panchayati Raj Institution members, local influential persons.

  In addition to this, I also confirmed and verified the list of MBF and CPW procured from the AWW/ASHA.

Data Processing and Analysis

This study was quantitative in nature so questionnaire was developed. Study tools were developed for LM as well as CPW. All the surveyed formats were field-edited, and coding was done prior to the data entry. The data analysis of data was done using software SPSS Version 16. The data have been presented in percentages and study estimates have been established.

Chapter 3 Results and Findings

The present section discusses the results of the study based on the set variables for both Lactating Mother (LM) and Currently Pregnant Women (CPW).

In all, a total of 100 women were covered under this study. These 100 women were divided into 5 villages. Thus, 10 eligible LM (having child aged 6-12 months) and 10 CPW were covered from each village.

Profile of women

Age

Of all the covered LM, majority (78%) were in the 20-29 years age group. Median age was computed to be 24 years. Among CPW, 68% were in 20-29 years age brackets. 12% of CPW each were in 15-19 and 30-34 years age group. The median age was worked out to be 22 years.

Age at marriage

Median age at marriage for LMs was found to be 16.5 years. Among CPW, median age was found to be 17 years.

Religion

Almost all CPW were found to be Hindus—98 percent. Some Muslim women were also covered but very less in numbers. Among LM, a large proportion of CPW (95%) was Hindu. Around 5% were Muslims.

Educational Qualifications

Strikingly, the proportion of illiterate LMs was found to be very high (70%). Around 22 percent of LMs were educated up to primary. Almost same results were seen among CPWs. More than two-thirds of CPW (67%) were illiterate. Around 10% were educated up to either middle or higher levels.

Living conditions (Type of house)

Majority of LMs (67%) had either kutcha or semi-pucca house. Like LMs, more than two-thirds of CPW (70%) were staying in either kutcha or semi-pucca houses.

Occupation

Almost all the covered LMs 97% were housewives. One or two RDW were Angan Wadi Worker and school teachers. More than 98 percent of CPW were found to be housewives and had no meaning of earnings.

Household Monthly Income

The total household monthly income as perceived by the interviewed LMs was in the range of INR 1001-5000. About 11 percent of LMs had total household monthly income of INR 7000 or more. More than four-fifths of CPW (83-84%) had total household monthly income of INR 1001 to 5000.

BPL Status

Only 10 percent of LMs had BPL card. Of these, 36 percent of LMs showed their BPL card. Only 48 percent of LMs had their name printed on BPL card. Only 9 percent of CPW had BPL cards. Among those who had BPL cards, only 36 percent of CPW could show their BPL cards. About 57 percent of CPW had their name on the BPL cards.

The result and finding are in percentage (%) on the basis of different variables. These are as follows:

Knowledge of Health facility for Antenatal/Natal/Postnatal Care

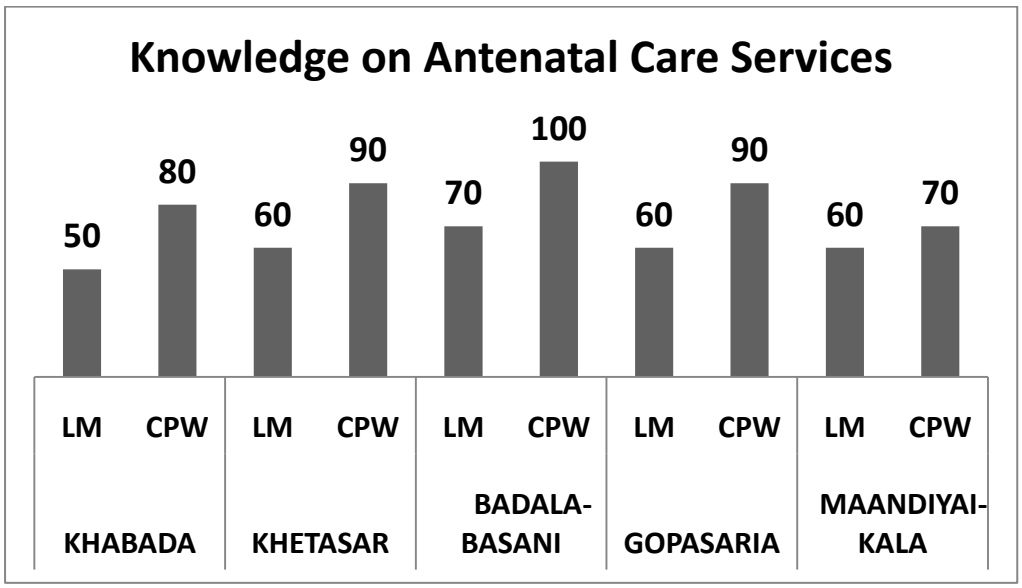


Figure No.1: Knowledge of Health facility for Antenatal care

Description: In the village Badala-basani all CPW were aware about antenatal care services. Status of knowledge of ANC was found better in Khetasar's (90%) and Gopasaria's CPM (90%). But Among the all LM from all villages was found poor especially in Khabada (50%).

Table No.1: Knowledge on antenatal elements (in numbers/frequency)

Antenatal Elements	Khabada		Khetasar		Badala-basani		Gopasariya		Maandi-kala	
	LM	CPW	LM	CPW	LM	CPW	LM	CPW	LM	CPW
Abdomen exam	5	8	6	9	7	9	6	9	6	7
Blood pressure	4	6	4	8	6	9	6	8	5	7
Weight meas-urement								9		
Blood test	4	6	5	7	6	8	5	8	5	6
Urine test	3	4	3	6	5	7	4	7	4	5

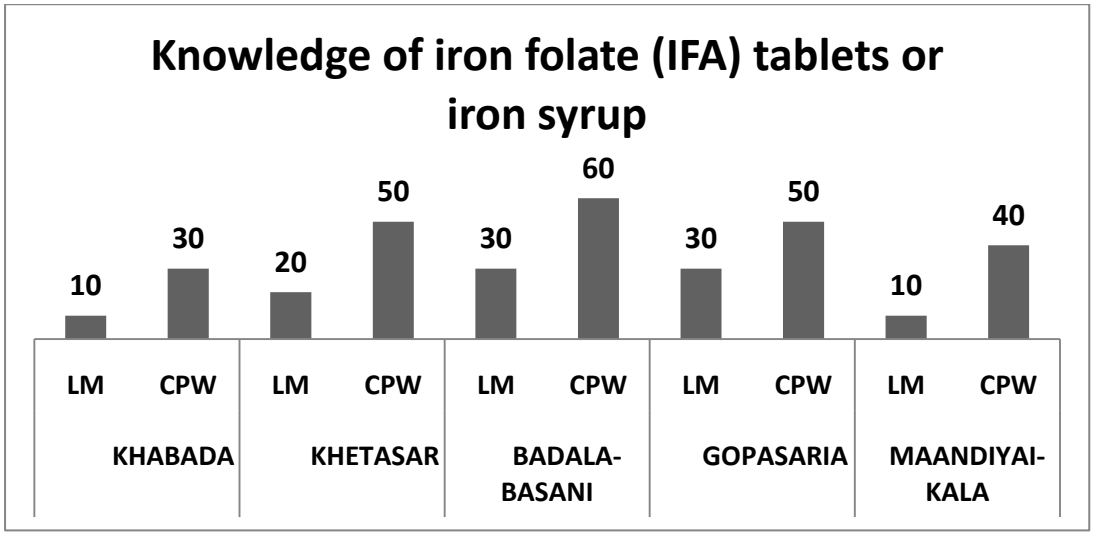


Figure No.2 : Knowledge of iron folate (IFA) tablets or iron syrup

Description: In village of Badala basani the CPW was highest (60%) knowledgeable among other. Lowest (10%) knowledgeable LMs were found in Khabada and Maandiyai-kala villages.

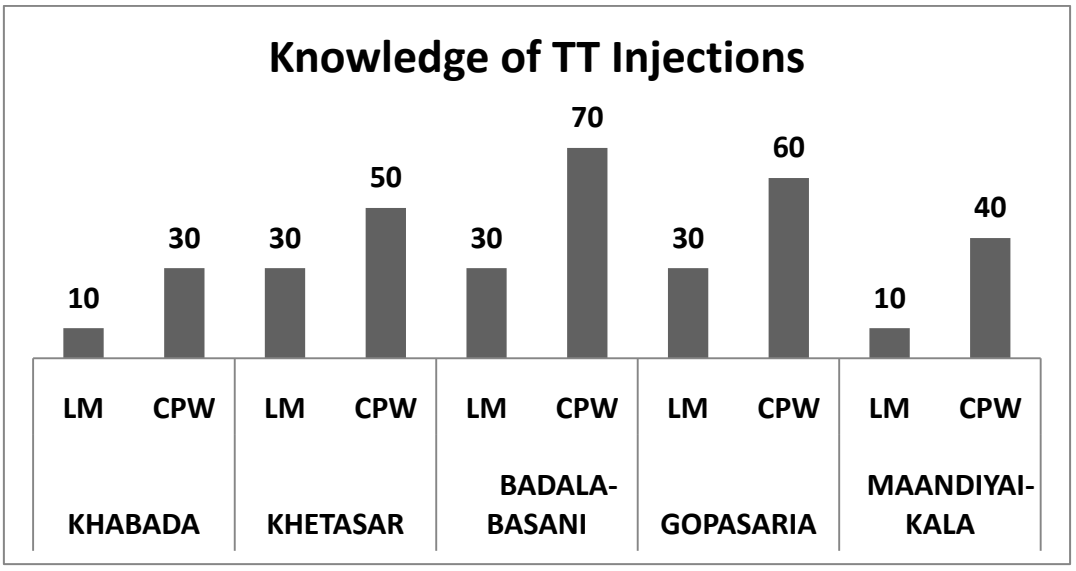


Figure No.3 : Knowledge of TT Injections

Description: Figure is showing that knowledge of TT injection was found high (70%) in CPW of Badala-basani then second highest (60%) in Gopasariya. Again it was found low (10%) in Khabada and Maandiyai-kala.

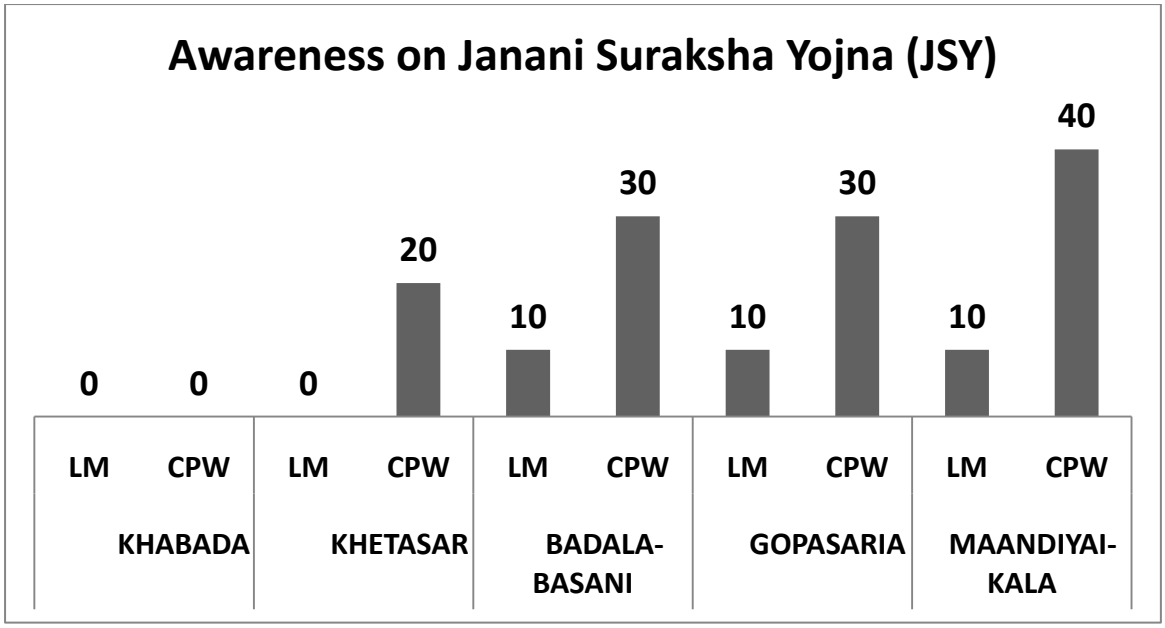


Figure No4.: Awareness on Janani Suraksha Yojna (JSY)

Description: In village of Khabada all LM delivered at home and they do not have heard about JSY. Due to illiteracy they could not able to read about JSY on the wall of Sub Centre.

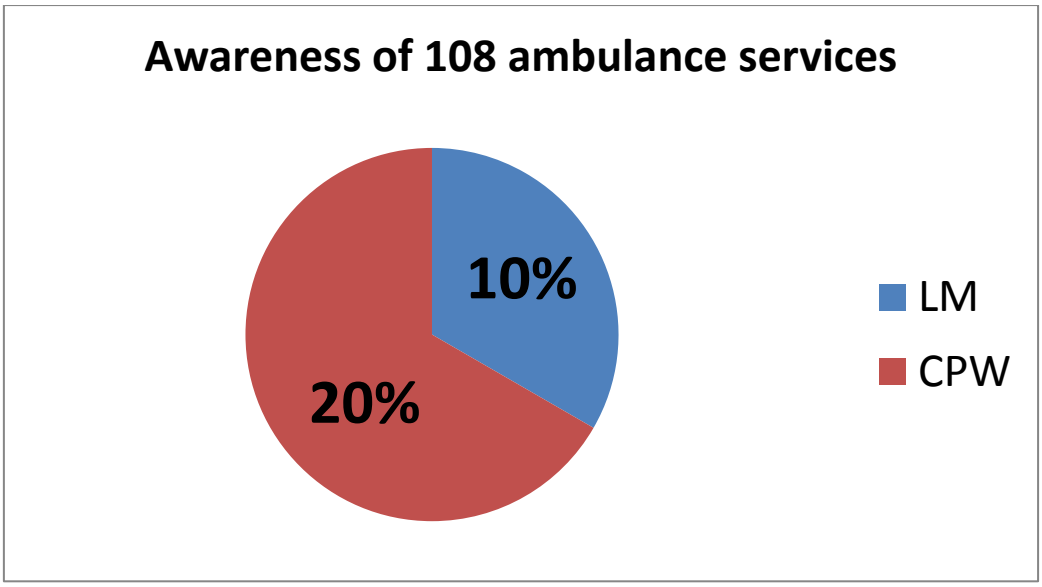


Figure No.5: Awareness of 108 ambulance services

Description: Figure is showing that awareness of 108 ambulance services is very less in LMs that is only 10% and even in CPM (20%).

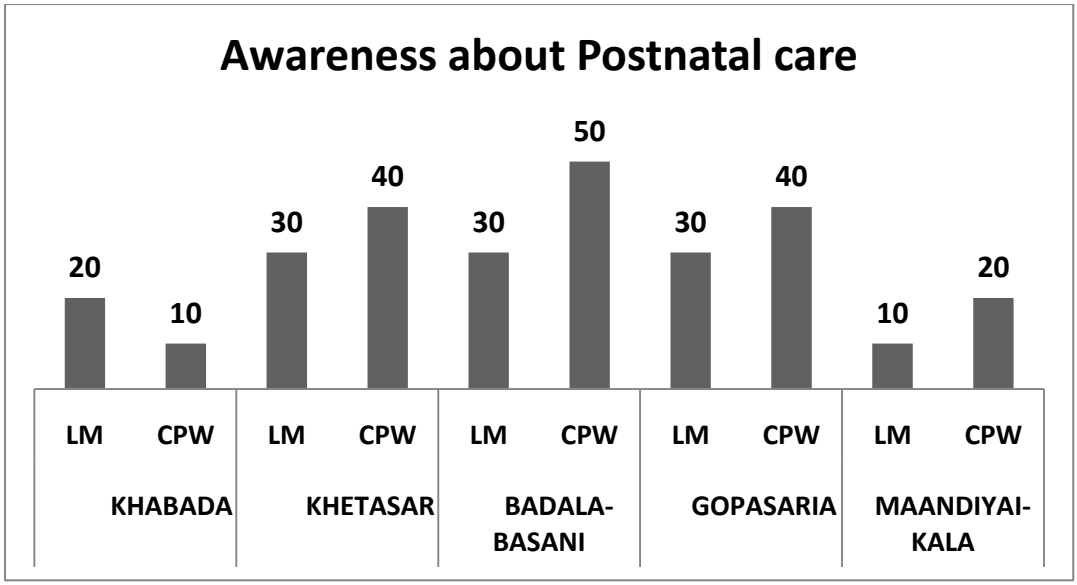


Figure No 6. Awareness about Postnatal care

Description: Figure is showing that in Khabada 20% LMs have more knowledge about PNC as compare CPW (10%). Inother villages like Khetasar, Badala-basani and Gopasaria 30% LMs were aware about PNC.

Attitude and Practice for Antenatal Care/Natal/Postnatal Care

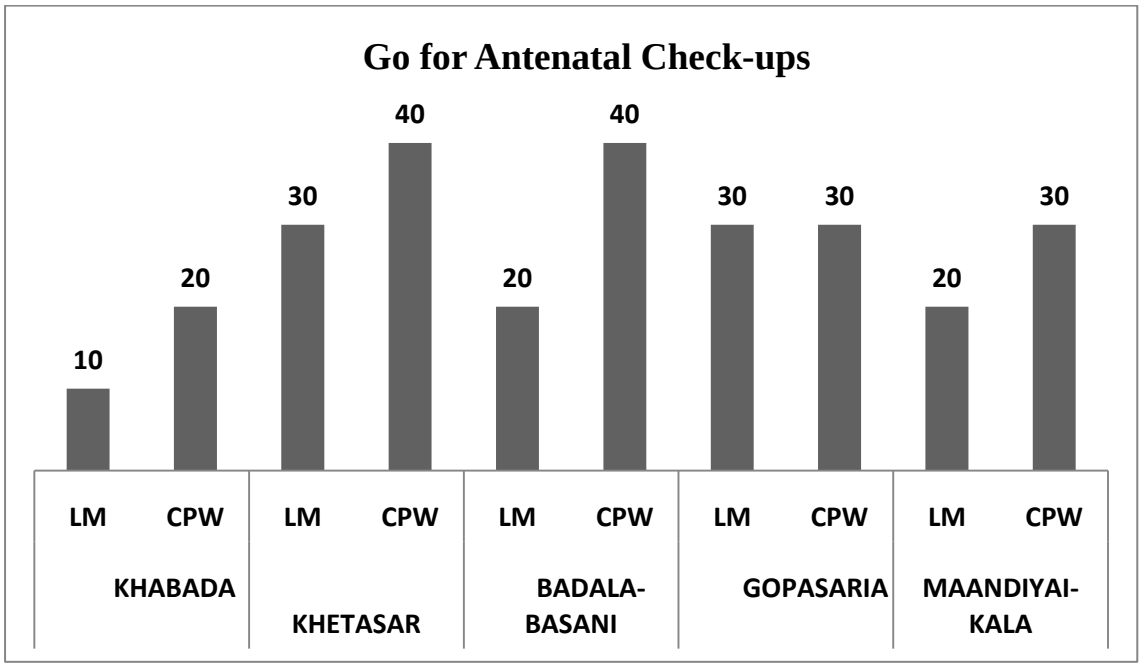


Figure No.7: Go for Antenatal Check-ups (% Women)

Description: Figure is showing that only 10% LMs of Khabada went for ANC that is very poor condition. Their knowledge of ANC was very high but as compare the knowledge LM and CPW were not going for ANC.

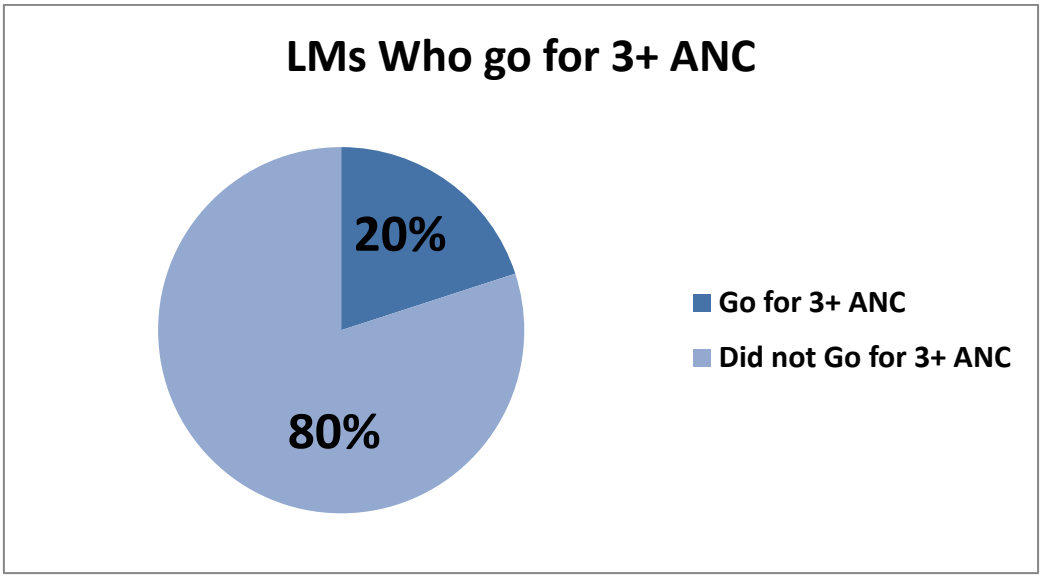


Figure No.8: LMs Who go for 3+ ANC (%)

Description: Only 10 LMs went for 3+ ANC out of 50.

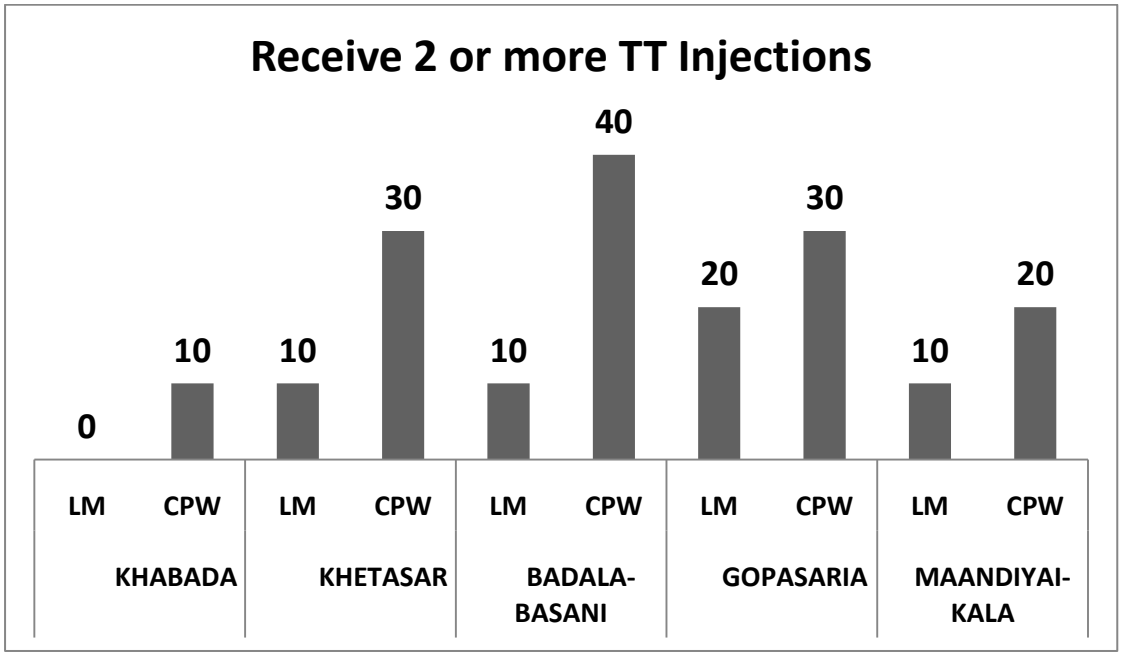


Figure No.9: Women Who Receive 2 TT Injections (%)

Description: Figure is showing that no LM in Khabada received 2 or more TT injections. Apart from Khabada in other villages only 10% LMs received 2 or more TT. This is low as compare to CPW.

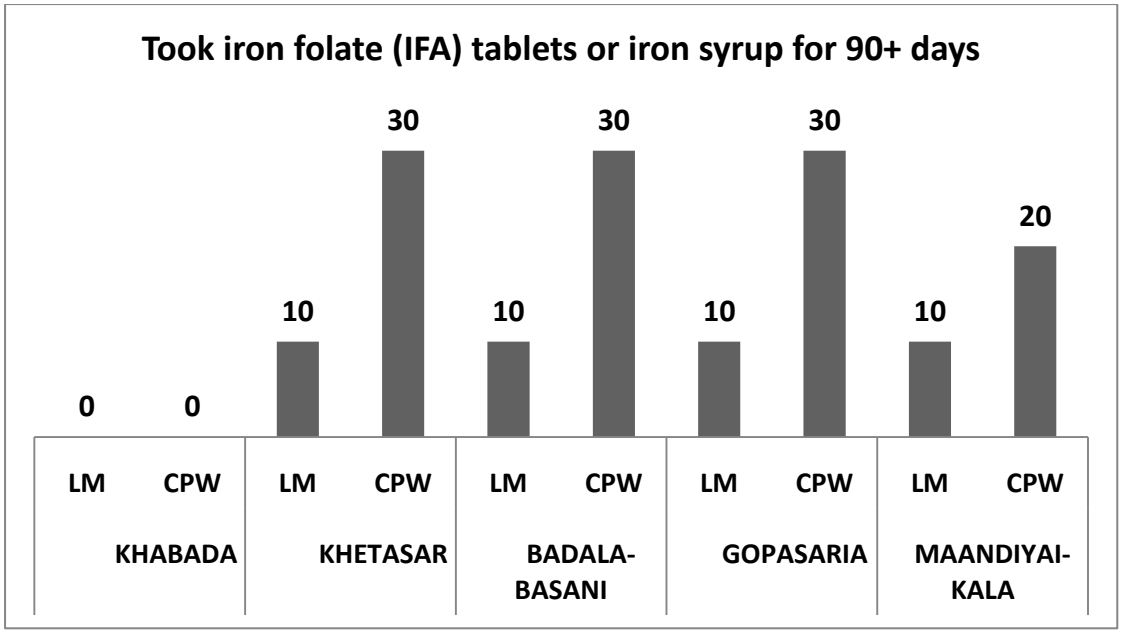


Figure No.10: Took iron folate (IFA) tablets or iron syrup

Description: Figure is showing that no LM and CPW consumed IFA tablets. Only 10% LMs in other villages consumed IFA tablets.

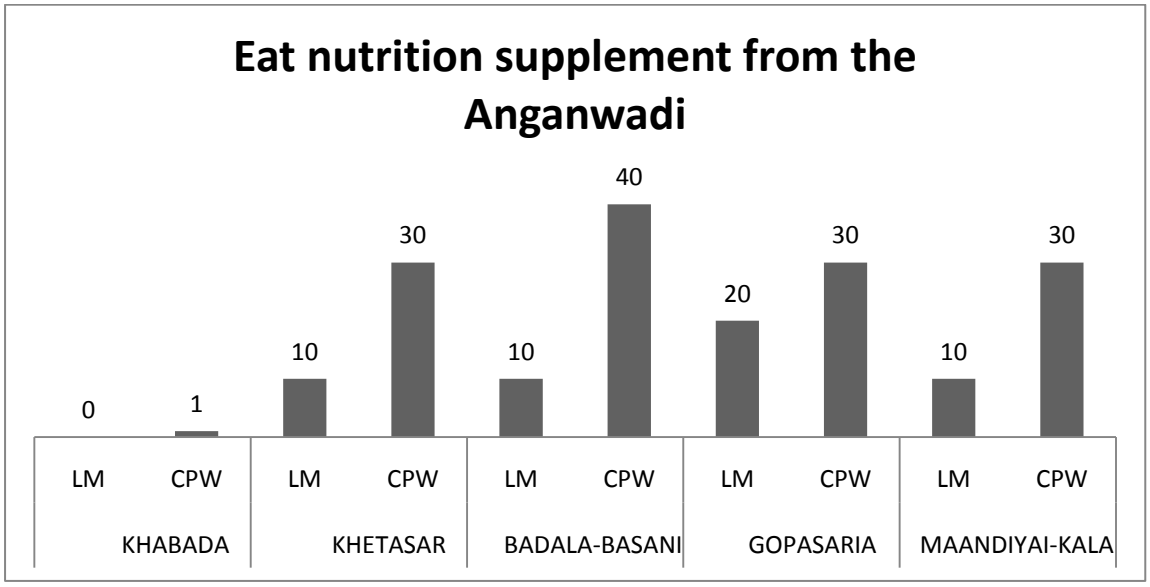


Figure No.11: Women Who Eat nutrition supplement from the Anganwadi

Description: Figure is showing that only 10% LMs and 30% CPWs Eat nutrition supplement from the Anganwadi. Women take nutritious food from Anganwadi but they do not eat they feed their pet animals like goat, cow etc.

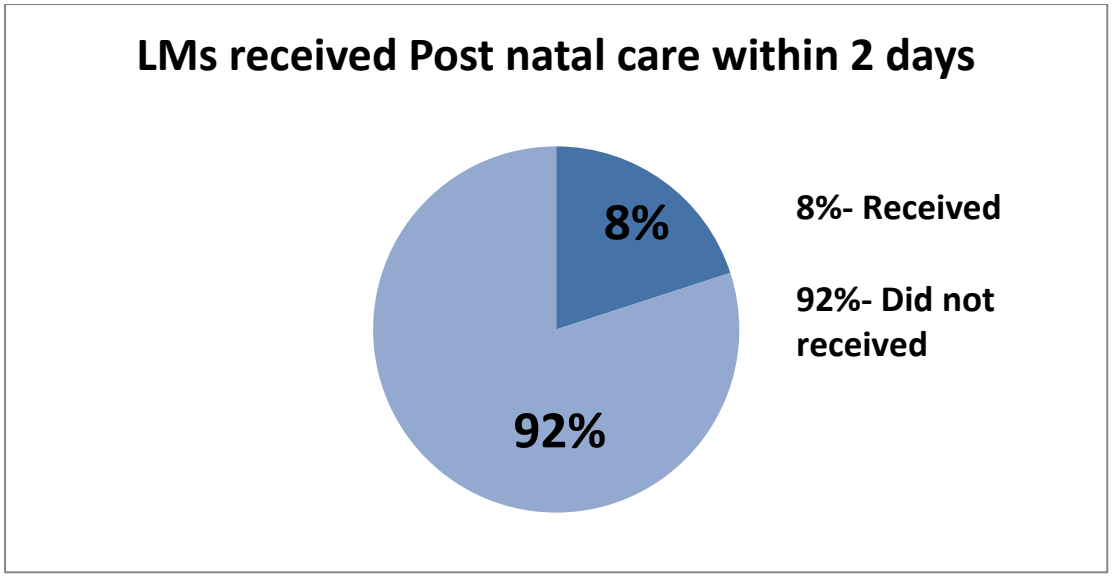


Figure No. 12: LMs received Post natal care within 2 days

Description: Figure is showing that only 8% that is 4 LMs received Post natal care within 2 days out of 50 LMs.

Knowledge of Danger Signs

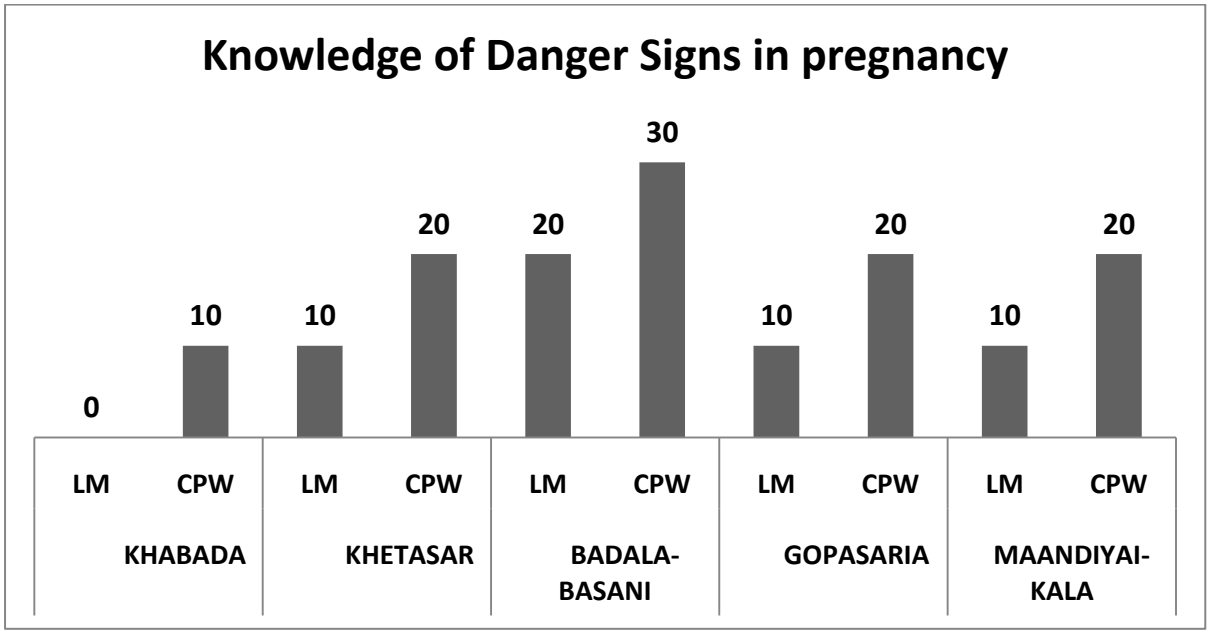


Figure No.13: Knowledge of Danger Signs in pregnancy

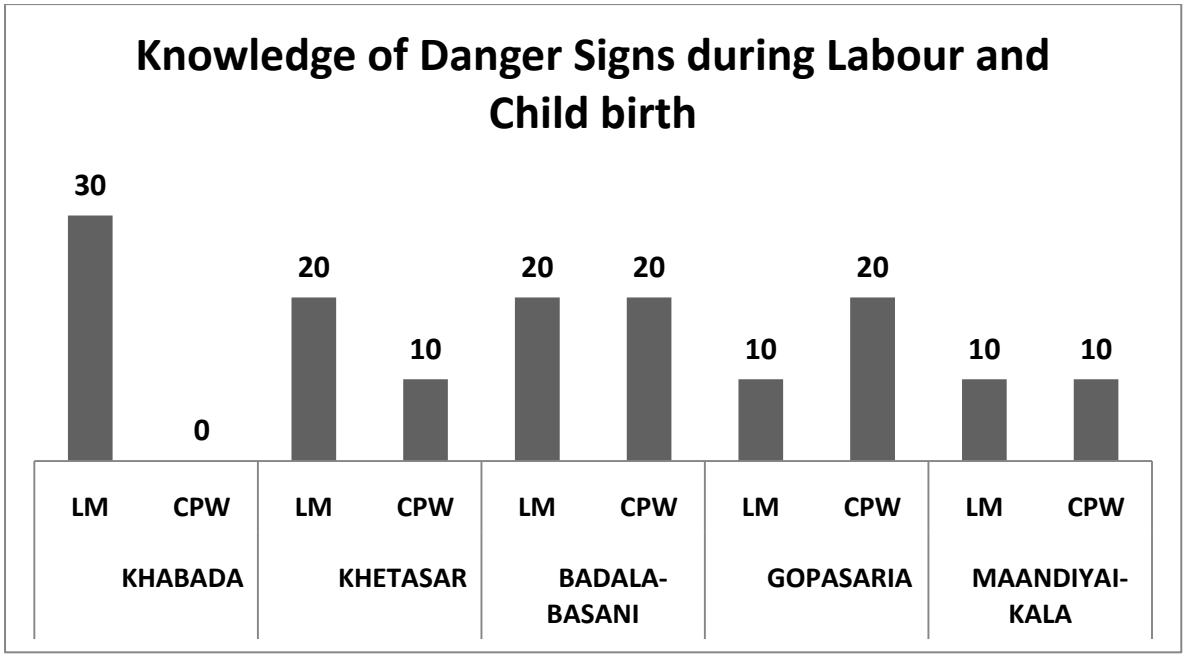


Figure No.14: Knowledge of Danger Signs during Labour and Child birth

In khabada there was more Lactating mother who faced complications during Labour that's why their knowledge was much more than CPW. Knowledge of LMs and CPW in other villages were low that is 20% and 30%.

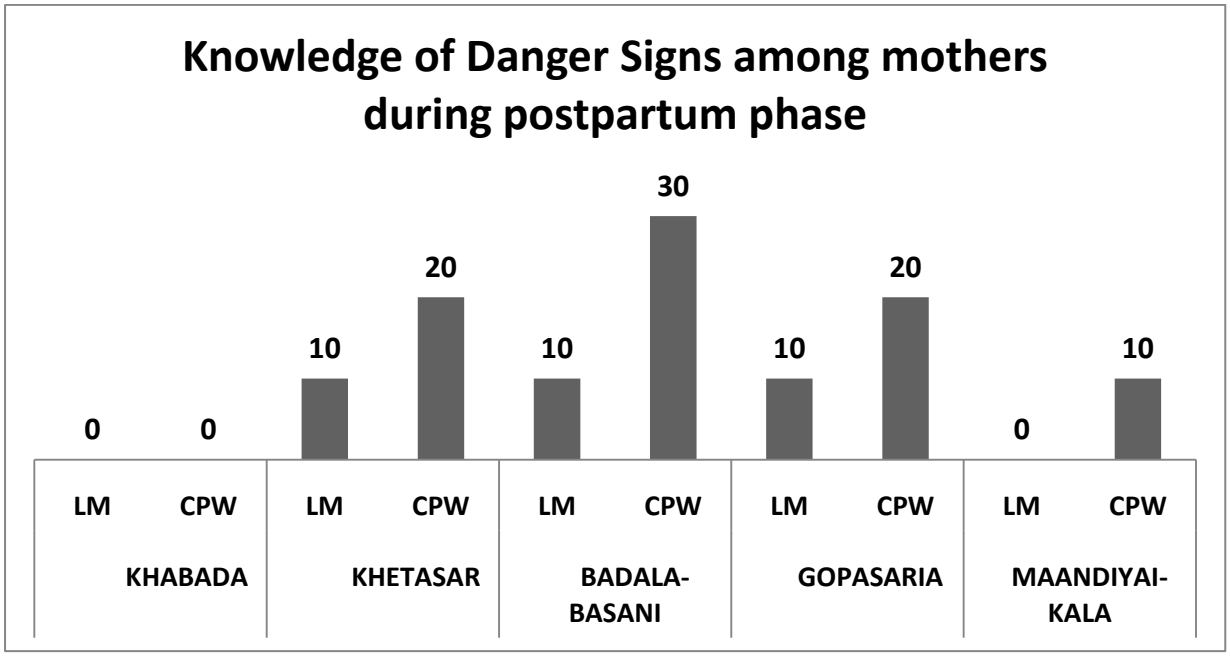


Figure No.15: Knowledge of Danger Signs among mothers during postpartum phase

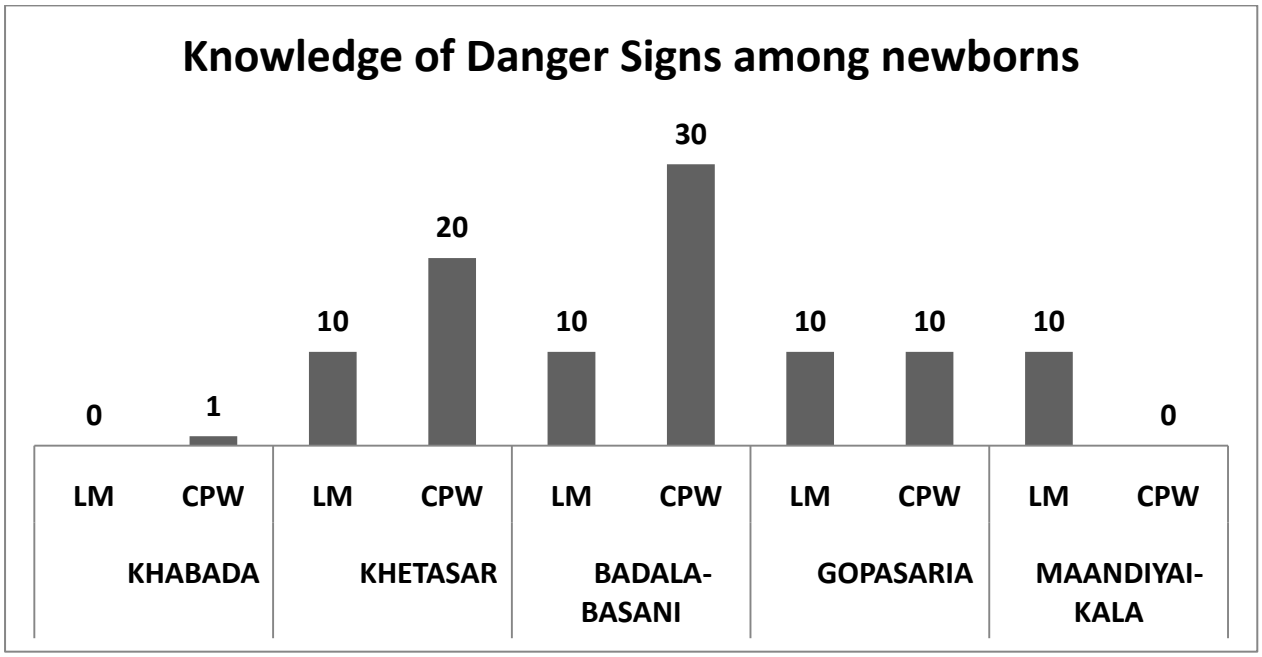


Figure No.16: Knowledge of Danger Signs among newborns

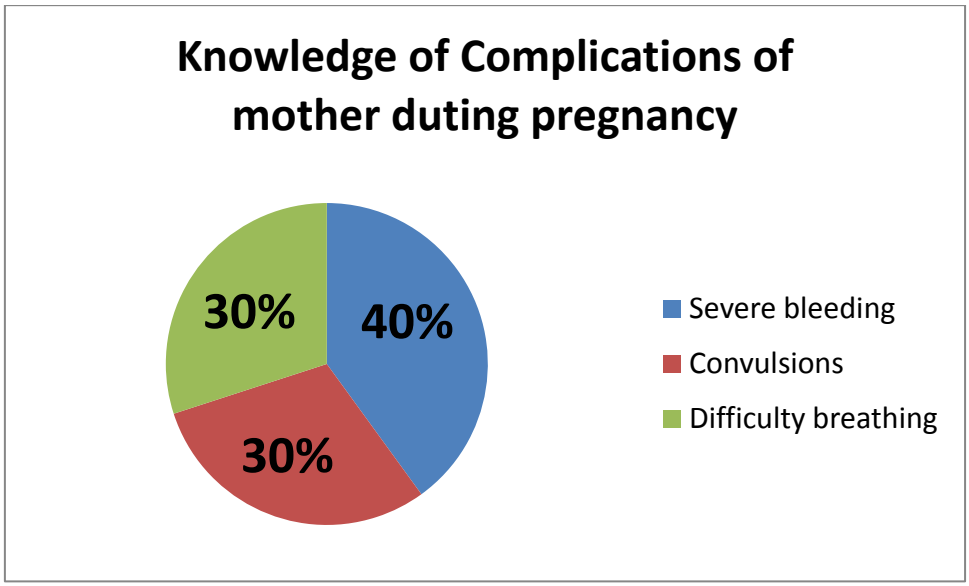


Figure No.17: Knowledge of Complications of mother during pregnancy

Description: Out of all the respondent, 40% women, 30% women and 30% women think major complication during pregnancy were severe bleeding, convulsion and difficulty breathing respectively.

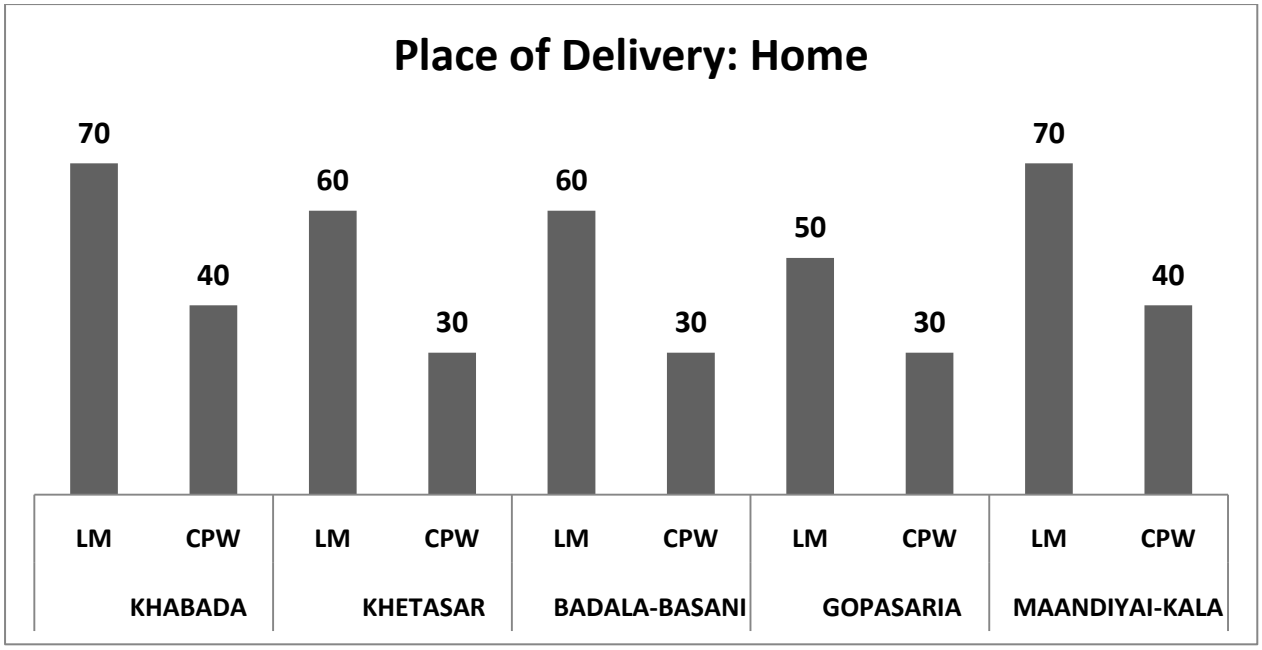


Figure No.18: Place of Delivery: Home

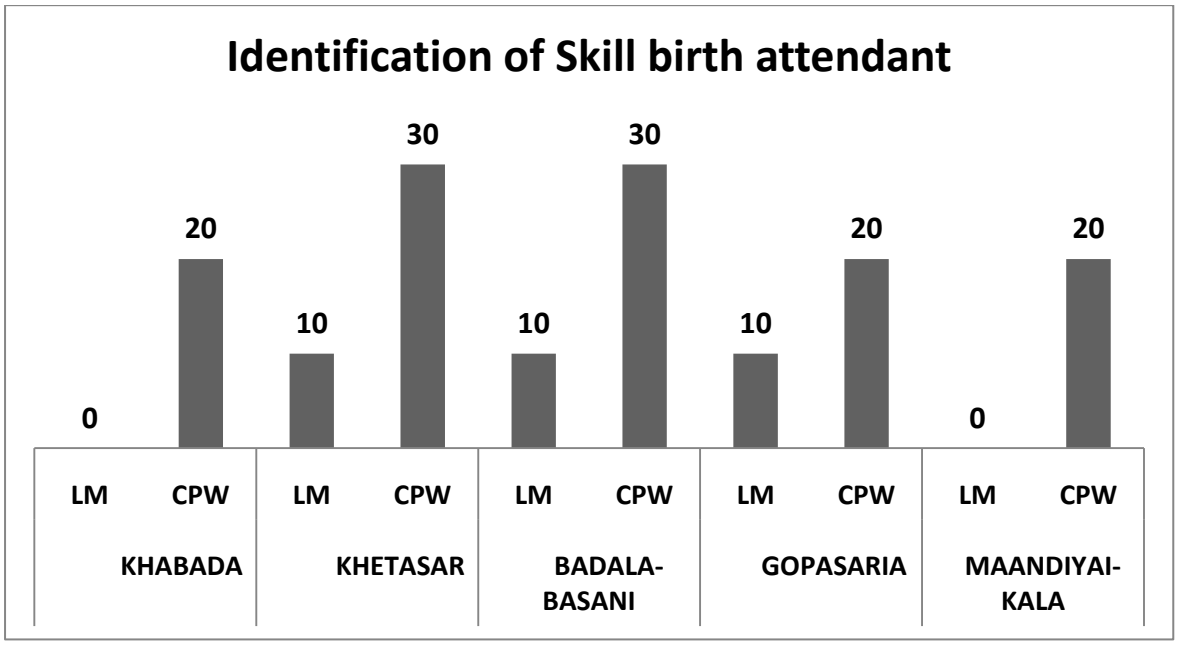


Figure No.19: Identification of Skill birth attendant

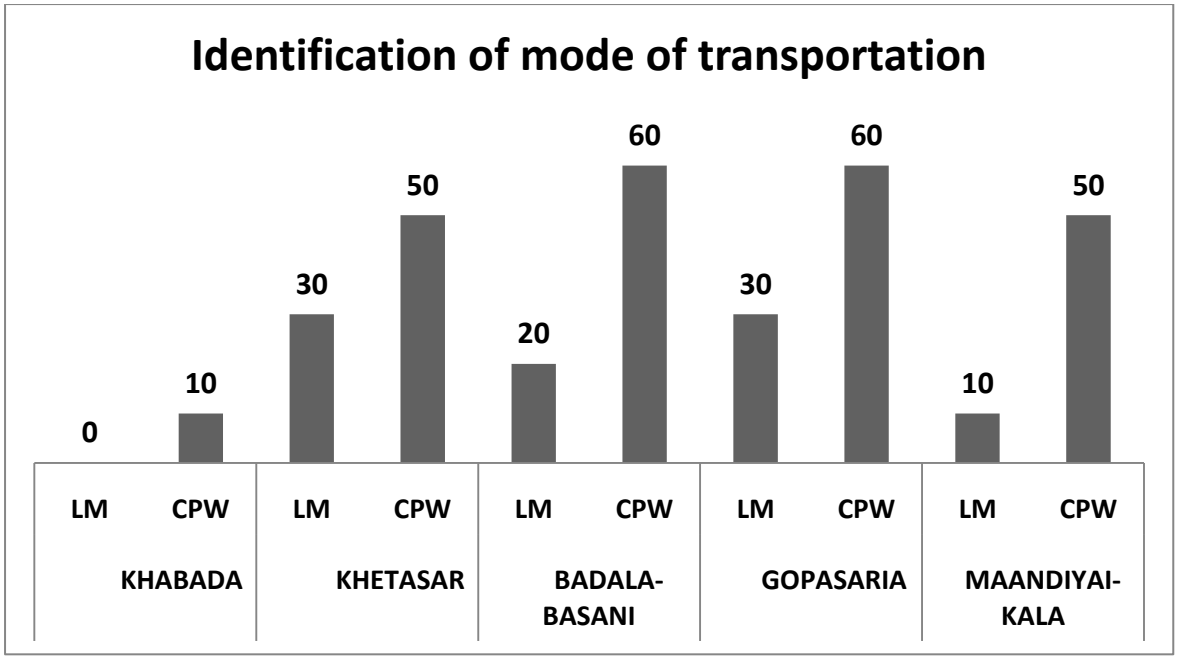


Figure No.20: Identification of mode of transportation

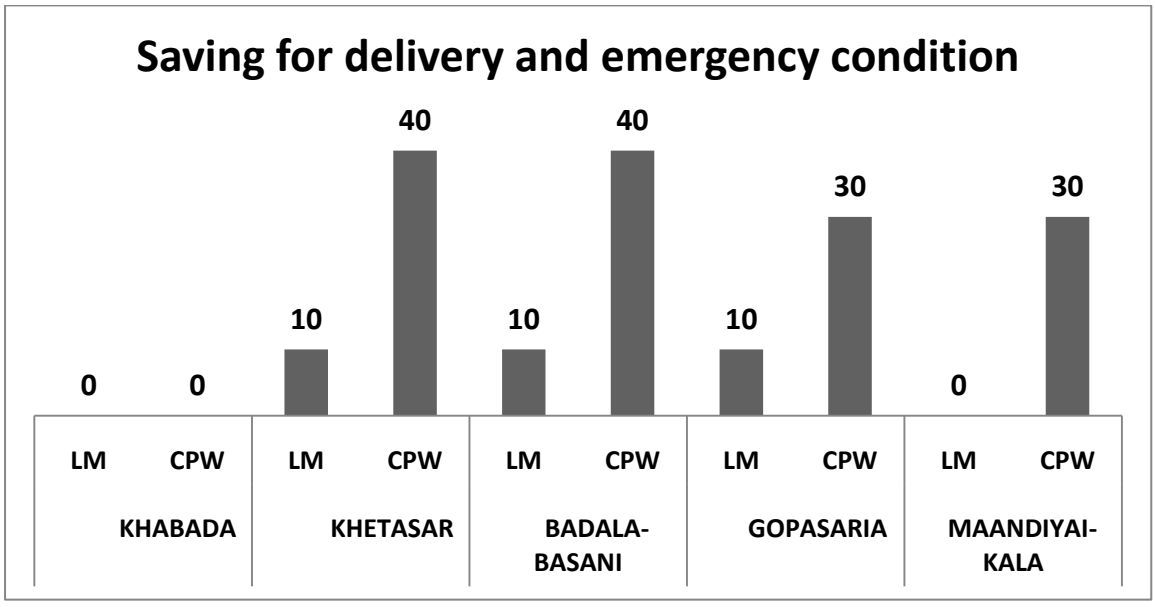


Figure No.21: Saving for delivery and emergency condition

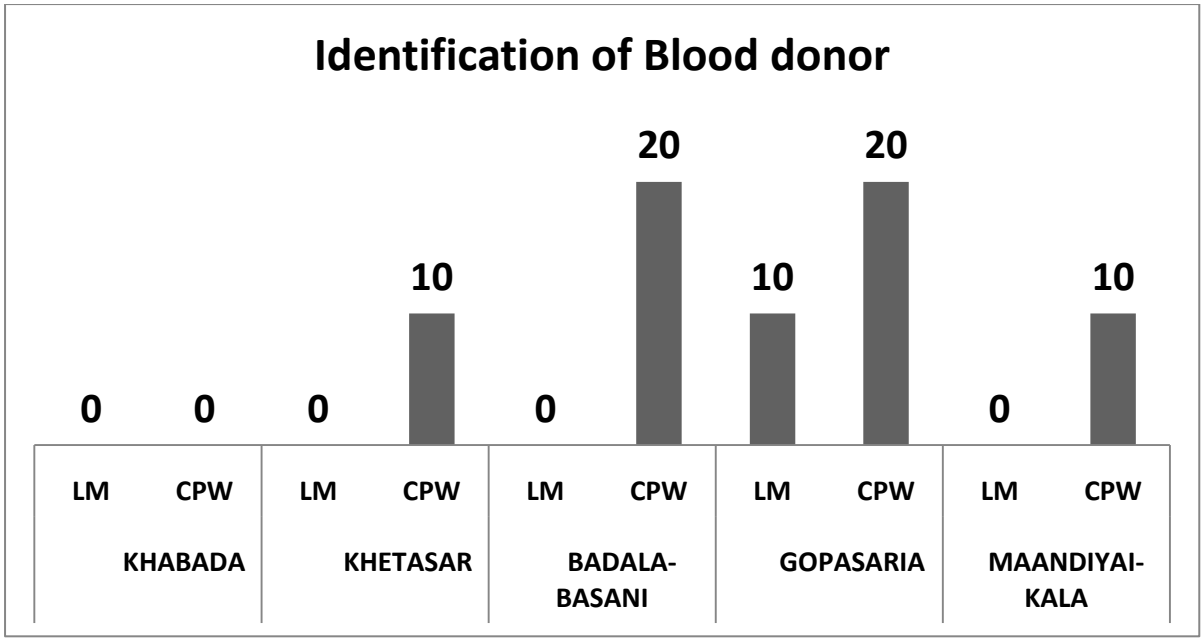


Figure No.22: Identification of Blood donor

Knowledge on closest health facilities: A substantially higher proportion (33-37%) of LMs as well as currently pregnant women do not have knowledge on closest health facilities available for antenatal services, managing normal deliveries and handling complicated cases of deliveries.

Knowledge on distance of different health facilities: Apart from the availability of health facilities, LMs and CPWs have no knowledge on the distances of different types and levels of health facilities that can be reached in case of any emergency or for availing general health care services.

Qualitative Findings: Focus Group Discussions

A total of 5 villages were covered in Osian block from which focus group discussion among mother-in-laws was conducted. In all, 30 women participated and shared their views on various aspects included in the pre-developed and pre-tested discussion guide. The description of the details from the FGD has been discussed as follows:

Discussions with groups of Mother-in-laws were initiated to know several aspects of maternal health condition in their area. Most of the places the discussions began on the prevailing societal norms in their area with regards to marriage.

Regarding age at marriage, almost all MILs mentioned that in their village marriage happens at the age of 12-13 years. "Gauna", (a ceremony where a girl is sent to her in-laws), is done at the age of 17-18 years. The demand of a child comes early in a marriage. It can be aptly said that there exists no plan amongst the couples on when to have the first child as it is demanded as soon as the marriage takes place or the gauna is done. The MILs opine that, "the sooner the child is born, the sooner they will become grand-mothers and will get to play with their grand-children".

While discussing on the above aspects, the MILs informed that when their daughter-in-laws are pregnant they see that they get good food and eat what they like and that they allow them to rest and not make them work. However, the groups also mentioned that "since there is not enough money therefore the choice on eating as per the likeness is almost restricted". Further, the group has mentioned that they get nutritional supplement from the AWWs. The group also mentioned that they get uncooked porridge. They get 900gm uncooked porridge 4 times in a month. But they feed their cow and pet animals to increase milk.

There is very little information on the visits of the ASHA or the ANM in their villages. Almost all the MILs mentioned that the ANMs do not visit their village. They mentioned that AWWs gave some medicine to them related to delivery which when probed further was the iron folic tablets. However, there seems to be no information provided on ANC services. MILs from one village Khetasar have mentioned that in their area, the ANM comes once in 1 month that is Thursday, but she doesn't provide any service. Complaints regarding this have been made several times by them but no action has been taken. The ANM does not even make the immunization card is what the group added further. This group also mentioned that if the ANM is called for delivery she takes Rs. 200-250 and for medicines she takes another Rs.200-250 and normally the total cost comes to around Rs. 500. Many have mentioned that the ANM takes money for delivery and if she is not at home then she refers the case to Jodhpur. Some MILs mentioned that the ANM only sits at SC from 10:00am to 1:00pm and then she leaves for Jodhpur. For the purpose of

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

On being probed upon the availability of Dai's, the group have said that "the Dai's are available in the area but most of them are unskilled". None of these MILs had any information on JSY. However, some MILs did mention that if the delivery is done at a government hospital then they get Rs. 1400 but in the hospital the expense comes around Rs. 1500-3000. The doctors or ANM do not take fees but if the delivery is caesarean then the charge is 10,000-15,000.

For place delivery, only few MILs mentioned that they go to CHC Mathaniya/Osian or to Jodhpur district hospital, if any complication occurs. They mentioned that "mostly deliveries occurred at home, when complications happened they go to PHC/CHC or district hospital, but on the way mother expire". There is no ambulance which comes to their village. When asked about 108 ambulance service, it was said that there is no such ambulance that comes to their villages. However, few MILs said that 108 has started coming from the last few months but mostly it is at CHC Mathaniya/Osian. Some also mentioned that there are jeeps in their village and they keep the driver's number and use them during delivery or any emergency. But, they do not inform the jeep driver in advance. However, the transportation costs them around Rs. 800-Rs.1000 to go to Osian it costs Rs. 1000-1600 to go to Jodhpur. However, some prefer government hospital as the charges there are less.

On being asked about other Birth Preparedness and Complication Readiness related issues, the group mentioned that the arrangement for blood is not done in advance but if required, they pay for it and they get it. Few MILs also informed that "they themselves do the delivery sometimes as there are no Dai's available for the delivery". Further, half MILs mentioned that their son mostly work as labourers and therefore there is no saving that they can do but if money is required they borrow it from the landlord, any rich person in the village.

With regard to complications during pregnancy, the groups mentioned that if the child is not in the right position or if the bleeding is too much then they take the pregnant lady to

firstly PHC then CHC or district hospital. Sometimes they also go to Mathaniya CHC or Tiwari as its closer than Panchala.

With regard to the newborn child, the norm is to bath the child either 1 or 2 hours later or immediately after birth. Further, if the child does not defecate they immediately go to the hospital. The groups have also mentioned that though their daughter-in-laws eat during pregnancy but the child is born weak. The child is weighed when the AWW comes. In most of the areas it has been mentioned that immunization is done and sometimes two vaccines are given but the ANM does not explain them anything and they are not sure if the vaccines are of TT or not. The child is not breastfed for almost 2 days in some areas and is given Jaggery or ghee. It is only on the 3 day that the child is breastfed. Also, the cord is tied by the string used for peti-coats, moli or any ribbon. Earlier a knife was used to cut the cord but now a blade is used, but now blade is used.

From the focused group discussions held with the MILs, it is apparent that most of the indicators related to maternal health and specifically BPCR are low. There is very little awareness and knowledge with regard to BPCR issues and would therefore require strengthening of the same.

Chapter 4 Discussion

In khabada there was more Lactating mother who faced complications during Labour that's why their knowledge was much more than CPW. Knowledge of LMs and CPW in other villages were low that is 20% and 30%. In Khabada average number of children around 8-10 were there from one mother. There was few CPW were present who were LM also. So if these condition continue with this rate than it would be harder to do planning for safe pregnancy and birth.

Women feed cow, goat, and other pet animals from supplementary food provided in Anganwadi centre under public health system but what the irony they themselves do not eat that food. From above data showing that ASHA/AWW/ANM were not motivating CPW and LM for ANC and PNC. There were poor coordination among ASHAs, AWWs and ANMs, ANMs are staying in Jodhpur not in the villages, they are not doing their job with dedication, so this could also affect the result which NRHM aims.

Chapter 5 Conclusion and Recommendations

Conclusion

1. A substantially higher proportion (33-37%) of LMs as well as currently pregnant women do not have knowledge on closest health facilities available for antenatal services, managing normal deliveries and handling complicated cases of deliveries.
2. Apart from the availability of health facilities, LMs and CPWs have no knowledge on the distances of different types and levels of health facilities that can be reached in case of any emergency or for availing general health care services.
3. A large proportion of women (59 to 66 percent) did not know about the availability of ambulance services. Awareness of 108 ambulance services is very less in LMs that is only 10% and even in CPM (20%).
4. Proportion of women having knowledge on danger signs during pregnancy, labour and childbirth, during postnatal period and for newborns was found to be drastically low (23-28% among LMs and 30-34% among CPW).
5. Practices related to birth planning and complications readiness measures or components was observed to be very poor
6. Around 40-80 percent of women do not plan for place of delivery and additionally, almost more than half the women plan for Home delivery.
7. Identification of a skilled birth attendance prior to delivery has not given any preference and almost a quarter of women had done.
8. Despite knowing the fact that delivery expenses have to be met, the key component of saving under birth planning is missing. Only 10% LMs and 30%-40% CPWs have reported saving money for emergency.
9. Despite availability of community health workers at the village level such as AWW and ASHA and visiting ANMs, early registration has been found desperately low (22-27%).
10. Only 20 percent of LMs were found receiving 3 or more antenatal checkups which is crucial for women's health.
11. Postnatal visits are found almost negligible .
12. Entitlements like JSY are not reaching to women and could not found the proper coverage and it was only 18 percent.

Recommendations

The key recommendations that have been framed based on the drawn conclusions and other results which are as follows:

1. In future this kind of study is required to be conducted on the large scale for the further clarification.
2. In future perception of husbands and AWW/ASHA/ANM should be included in the study. So that their point of views would be taken.
3. Family Planning, No. of children, socio-economic status and other are affecting the health seeking behaviour for birth planning and safe delivery, so in further studies correlation between them needed to be calculated.
4. While designing the interventions, attention should be paid on those little things which are normally not considered as the meaningful or needful steps or actions. Hence, women should be informed about the type of nearest health facilities as per the services available with them, their distances, modes of transportation and time taken to reach the facility as well as availability of ambulance services. BCC material should be provided to LMs, CPWs, mother-in-laws and husbands.
5. There should be a resource people in the village those can be approached for planning for birth and prevention from complications. This can be done by identifying commonly known mode of transport at the village level, identification of people who can easily be accessible and can accompany the pregnant woman in case of emergency.
6. The study concludes that to improve child survival general education and awareness regarding safe delivery should be increased. Continuing cultural stigmas and misconceptions about birth practices before, during and after childbirth should be an important part of the awareness campaigns.
7. I conclude that if training is given to AWW/ASHA, for birth planning, this could significantly improve access to skilled maternal and neonatal care in rural areas.
8. Antenatal outreach sessions can be used for promoting preparation for safe birth planning and prevention from obstetric complications. It will be important to increase the competency of rural-based traditional birth attendants, along with promoting institutional deliveries.

Limitations

1. The sample is not representative of osian block, since I was allowed to visit only 5 villages. But the result is applied to those 5 villages.
2. In Osian Block, villages are divided into various hamlets and dhanis based on caste and accessibility to the agriculture lands. While undertaking the social mappingexercise, ANMs/ASHAs/AWWs/PRI members/opinion leaders/community might not have mentioned the presence of a few *Tolas/Dhanis* in their villages. Hence, the proper representation of all the *Tolas/dhanis* could not be ensured because of the same.
3. I had to work on behalf of my organization. There was no support from the organization, so I completed data collection simultaneously.
4. Husband of Recently Delivered Women and Pregnant Women could not be involved in this study which was suppose to involve; since they come from their job around 07:00 PM. Navratra occasion was there during data collection, so most of the husband were drunk.

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Annexure: 1

Health Seeking Behaviour for Ensuring Safe Delivery and Preventing Obstetric Complication in the communities of Osian Block in Jodhpur District, Rajasthan

The objective of the questionnaire is to collect information about the preparations made by Currently Pregnant Women and their families for childbirth and their access to health services. The collected information would help in analyzing the data and find out the result.

Date:……

SPEAK TO THE RESPONDENT: Namaste, my name is Jai Shree Soni. I am a research student, IIHMR-New Delhi and employee of CHETNA an NGO situated at Ahmedabad, Gujrat. I am conducting a study in your village related to Lactating mother and current pregnant women. I would very much appreciate your participation in this study, as this will help me know to appropriate community based interventions to address the health concerns of women here. The interview will take about 10 minutes to complete. During this interview I will ask you some questions about yourself and about family health. Whatever information you provide will be kept strictly confidential. I will not pass on your name or the information to any other persons. However we will use the findings of the study for wider dissemination and learning.

Your participation in the study is voluntary. However I hope you will participate as your views are important to us. At any point of time you can discontinue your participation. At this time, do you want to ask me anything about the survey?

ANSWER ANY QUESTIONS AND ADDRESS RESPONDENT'S CONCERNS.

May I begin the interview now? YES = 1 → Continue NO = 2 → END

Signature: _____

SECTION 1- BACKGROUND INFORMATION

Q No	Question	Response	Code
1.	Name of the Village	Khabada Khetasar Badala basani Gopasaria Maandiyai-kala	1 2 3 4 5
2.	Name of the respondant (Optional)	Name_____	
3.	Age (In completed Years)	☐☐	
4	What is your present marital status?	Unmarried Married Separated Divorced Widowed Do not know	1 2 3 4 5 88
5	Age at marriage	☐☐	
6	Higher level of education you have completed	Illiterate Till 10th Class Till 12th Class Diploma Graduate Post Graduate	1 2 3 4 5 6
7	Religion	Hindu Muslim Christian Sikh Buddhism Jain No religion	1 2 3 4 5 6 7

		Do not know	88
8	Caste/Tribe	Scheduled Caste	1
		Scheduled Tribe	2
		OBC	3
		General	4
		Do not know	88

SECTION 2: HOUSEHOLD DETAILS/SOCIO ECONOMIC

Q No	Question	Response	Code
9	Living conditions (Type of house)	Kutcha	1
		Semi kutcha	2
		Pukka	3
10	Who owns the house?	Self/Owned by family	1
		Rented	2
		Relatives' house	3
		Provided/built under IAY	4
		Do not know	5
11	Occupation	Petty business/ Small scale business	1
		Private service	2
		Government service	3
		Agriculture/farming on own land	4
		Teacher	5
		Others (Specify)……....	
12	Total Household monthly income (in Rs.)	Less than 1000	1
		1000-3000	2
		3001-5000	3
		5001-7000	4
		7,001-10,000	5
		More than 10,000	6
		Do not know	88
		Do not want to disclose	99
13	Could you please tell whether you posses any of the following	Tractor/ Car/Jeep/Four wheeler	1

		Modern agricultural equipments Bullock/any other cart Radio/transistor/tape recorder Color/television/ Refrigerator Telephone/ Mobile(cell phone) Bicycle Scooter/ motorcycle Livestock (Cows, Buffaloes) Others specify……	2 3 4 5 6 7 8 9
14	Below Poverty Line (BPL) Card holder	Yes No Do not know	1 2 88
15	Name printed in the BPL card	Yes No Do not know	1 2 88

SECTION 3: HEALTH CARE

Q No	Question	Response	Code
16	Status of Pregnancy	Current Pregnant Women Lactating Mother	1 2
17	Number of pregnancy	☐☐	
18	How many children you have alive	☐☐	
19	Months of current Pregnancy	Number of months _____	
20	Last mensaural period	☐☐ ☐☐ ☐☐☐☐ DD MM YYYY	
21	How old New born child is? (In months)	☐☐	
22	Who confirmed your pregnancy?	Gynaecologist	1

		Qualified Lady Doctor	2
		Traditional Dai	3
		AWW	4
		ASHA SHAYOGINI	5
		ANM	6
		Self Test (Strip test)	7
		Self assessment but never confirmed	8
		Relatives/Mother/Mother-in-law	9
		Any other……..	
		Not confirmed/no one	88

SECTION 4: Knowledge of Health facility for Antenatal/Natal/Postnatal Care

Q No	Question	Response	Code
23	Do you know about the entitlements available during pregnancy?	Yes No Do not know	1 2 88
24	Early registration	Yes No Do not know	1 2 88
25	How many times do you think should a pregnant woman get herself checked during her pregnancy	One time Two times Three times More than three times Should not go Do not know	1 2 3 4 5 88
26	Elements of antenatal care		
26(i)	Abdomen exam	Yes No	1 2

		Do not know	88
26(ii)	Blood pressure	Yes No Do not know	1 2 88
26(iii)	Weight measurement	Yes No Do not know	1 2 88
26(iv)	Blood test	Yes No Do not know	1 2 88
26(v)	Urine test	Yes No Do not know	1 2 88
27	Closest health facility from your residence that has provision for antenatal care services	Sub Centre PHC CHC District Hospital Any other Govt. health setup Private Clinic with qualified doctor Others (specify)……. Don't know	1 2 3 4 5 6 88
28	Closest health facility from your residence that can manage Normal deliveries	Sub Centre PHC CHC District Hospital Any other Govt. health setup Private Clinic with qualified doctor NGO/CBO/Trust health facility (hospital/clinic) Don't know	1 2 3 4 5 6 7 88
29	Closest health facility from your residence that can manage Complication in Deliveries	Sub Centre PHC CHC	1 2 3

		District Hospital	4
		Any other Govt. health setup	5
		Private Clinic with qualified doctor	6
		NGO/CBO/Trust health facility (hospital/clinic)	7
		Don't know	88
30	Closest health facility from your residence that has facilities for postnatal care for the mother and the newborn	Sub Centre	1
		PHC	2
		CHC	3
		District Hospital	4
		Any other Govt. health setup	5
		Private Clinic with qualified doctor	6
		NGO/CBO/Trust health facility (hospital/clinic)	7
		Don't know	88
31	How far is the facility you're your house that provides	Distance in Kms	
31(i)	Antenatal care services	1-5 Km	1
		6-10 Km	2
		11-15 Km	3
		16-20 Km	4
		More than 20 Km	5
		Don't know	88
31(ii)	Managing normal deliveries	1-5 Km	1
		6-10 Km	2
		11-15 Km	3
		16-20 Km	4
		More than 20 Km	5
		Don't know	88
31(iii)	Managing complications in deliveries	1-5 Km	1
		6-10 Km	2
		11-15 Km	3
		16-20 Km	4

31(iv)		More than 20 Km Don't know	5 88
	Postnatal care for the mother and the newborn	1-5 Km 6-10 Km 11-15 Km 16-20 Km More than 20 Km Don't know	1 2 3 4 5 88
32	What is the normal mode of transport to reach the facility that provides		
32(i)	Antenatal care services	Walk Cycle Motor- cycle or Scooter Auto Rikcshaw Bus/ Van Car/Jeep Bullock 108 ambulance Do not know	1 2 3 4 5 6 7 8 88
32(ii)	Managing normal deliveries	Walk Cycle Motor- cycle or Scooter Auto Rikcshaw Bus/ Van Car/Jeep Bullock 108 ambulance Do not know	1 2 3 4 5 6 7 8 88
32(iii)	Managing complications in deliveries	Walk Cycle Motor- cycle or Scooter	1 2 3

		Auto Rikcshaw	4
		Bus/ Van	5
		Car/Jeep	6
		Bullock	7
		108 ambulance	8
		Do not know	88
32(iv)	Postnatal care for the mother and the newborn	Walk	1
		Cycle	2
		Motor- cycle or Scooter	3
		Auto Rikcshaw	4
		Bus/ Van	5
		Car/Jeep	6
		Bullock	7
		108 ambulance	8
		Do not know	88
33	Does this village or nearby area has a facility of ambulance?	Yes	1
		No	2
		Do not know	88
34	Is there 108 ambulance services available in your area?	Yes	1
		No	2
		Do not know	88
35	How long will it take for you to reach the facility that provides	Yes	1
		No	2
		Do not know	88
35(i)	Antenatal care services	0-15 mints	1
		16-30 mints	2
		31-45 mints	3
		46-60 mints	4
		More than 60 mints	5
35(ii)	Managing normal deliveries	0-15 mints	1
		16-30 mints	2
		31-45 mints	3
		46-60 mints	4

		More than 60 mints	5
35(iii)	Managing complications in deliveries	0-15 mints 16-30 mints 31-45 mints 46-60 mints More than 60 mints	1 2 3 4 5
35(iv)	Postnatal care for the mother and the newborn	0-15 mints 16-30 mints 31-45 mints 46-60 mints More than 60 mints	1 2 3 4 5
36	IFA tablets/syrup	Yes No Do not know	1 2 88
37	How many IFA tablets should a pregnant women receive to prevent herself and the baby from getting tetanus	100 200 More than 200 Do not know	1 2 3 88
38	TT injections	Yes No Do not know	1 2 88
39	How many TT injections should a pregnant woman receive to prevent herself and the baby from getting tetanus?	One Two No TT injection	1 2 3
40	Janani Suraksha Yojana (JSY)	Yes No Do not know	1 2 88
41	Rs. 500/5 Kg Ghee in 7 months for nutrition/ Rs. 1400 after delivery	Yes No Do not know	1 2 88
42	Consume more nutritious food at	Yes	1

	home	No Do not know	2 88
43	Take More rest (2 hrs in Day and 8 hrs in night)	Yes No Do not know	1 2 88
44	Who attends deliveries in your village	Untrained dai Trained dai ANM Private doctor Private Nurse Do not know Others (Specify)……..	1 2 3 4 5 88

SECTION 5-Knowledge of Postpartum Care for Mother and Newborn Care

Q No	Question	Response	Code
45	Is there any need to have check-up of the mother after delivery even if the mother is not sick?	Yes No Do not know	1 2 88
46	How many PNC is recommended	One Two Three Do not know	1 2 3 88
47	Do you know when the first check-up for the mother is needed after delivery?	Within first 3 days after birth Other time frame Do not know	1 2 88
48	Is there any need to have check-up of the baby after delivery even if the baby is not sick?	Yes No Do not know	1 2 88

49	Do you know from whom a mother and new born can get postnatal natal check up?	Gynaecologist Qualified Lady Doctor Traditional Dai AWW ASHA SHAYOGINI ANM Other Specify…… Do not know	1 2 3 4 5 6 88
SECTION 6- Knowledge of obstetric complication			
50	In your opinion, what are some serious danger signs health problems that can occur after birth that could endanger the life of the mother, and for which she should seek medical care?	Severe bleeding Convulsions Swollen hands/face High fever Foul smelling vaginal discharge Less Hb. Difficulty breathing Severe weakness Other (Specify)……. Do not know	1 2 3 4 5 6 7 8 88
51	In your opinion, what are some serious health problems that can occur after birth that could endanger the life of a newborn baby and for which treatment is required?	Does not cry immediately after birth Turns Blue Baby very small Poor sucking or feeding Yellow skin/eye colour (indicative of jaundice) Pus, bleeding, or discharge from around the umbilical cord Convulsions/spasms/rigidity Lethargy/ unconsciousness Other Specify……. Don't know	1 2 3 4 5 6 7 8 88

SECTION 7: Attitude and practice for Birth Preparedness and

After a woman comes to know that she is pregnant, what are the actions that she should take to plan for the birth?

Q No	Question	Response	Code
52	Contact ASHA	Yes No Do not know	1 2 88
53	Confirm pregnancy by ANM	Yes No Do not know	1 2 88
54	Register at Anganwadi / Health Centre/Clinic/Hospital	Yes No Do not know	1 2 88
55	During which trimester of pregnancy did you register at the health facility or with ANM	First Trimester Second Trimester Third Trimester	1 2 3
56	Go for Antenatal Check-ups	Yes No Do not know	1 2 88
57	When you received ANC	First Trimester Second Trimester Third Trimester	1 2 3
58	How many ANC you received	One Two Three More than three Did not receive	1 2 3 4 5
59	Receive TT Injections	Yes No Do not know	1 2 88
60	How many TT injection you have received	One Two Did not receive	1 2 3
61	How many iron folate (IFA) tablets or iron syrup you received/purchased (Complete 100/200 during 3 month)	Yes No Do not know	1 2 88
62	Have you consumed iron folate (IFA) tablets or iron syrup. (Complete 100/200 during 3 month)	Yes No Do not know	1 2 88

63	Do/did you Eat nutrition supplement from the Anganwadi	Yes No Do not know	1 2 88
64	Do you/Did you rest for 2 hrs in Day and 8 hrs in night	Yes No Do not know	1 2 88
65	Ensure that you receives JSY money Rs. 500 for nutrition in the 7th month of pregnancy	Yes No Do not know	1 2 88
66	Decide on the place of delivery	Yes No Do not know	1 2 88
67	Where do you plan to deliver your baby?/ Where did you deliver the baby?	Own home Public hospital/centre/institutional Private clinic/private hospital	1 2 3
68	Identify a skilled birth attendant if you plan for home delivery/ Did you identified skilled birth attendant during your home delivery	Yes No Do not know	1 2 88
69	Make/made arrangements for Transport	Yes No Do not know	1 2 88
70	Save/saved or arrange/arranged for Medical Expenses	Yes No Do not know	1 2 88
71	Identify a blood donor	Yes No Do not know	1 2 88
72	Did you receive any information or advice from the ANM/ASHA/AWW regarding IFA dose?	Yes No Do not know	1 2 88
73	Who made this decision about the place of delivery of the baby?	Self Husband Self + Husband Mother-in-Law Father-in-Law Dai ASHA Others Specify……..	1 2 3 4 5 6 7

Would you like to ask any questions from me or if there is any query from you that I can answer. Thank and Terminate.

Annexure: 2

Guideline for Focused Group Discussion

For focus Group Discussion among, ask these specific questions and take their point of views.

1. The age of marriage and customs followed in their villages.
2. How many children a couple should have and the reason behind it.
3. What pregnant women eat during pregnancy and do they have supplementary food.
4. Do their daughter-in-laws go for ANC and from where.
5. What complications usually they found during pregnancy and delivery.
6. Who do delivery and what they practice.
7. Are they getting any benefits from JSY.
8. What is their planning for birth and complication readiness.

Thank you!