Situational Analysis of Reasons for Home Delivery and Assessment of Birth Preparedness Level of Home Delivered Mothers of Supaul District in Bihar

By

Apoorva Mahar

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2017-2019

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IIHMR UNIVERSITY

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr.Apoorva Mahar, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at CARE India from 4th-Feb-2019 to 4th-May-2019.

The Candidate has successfully carried out the study assigned to him during internship training and his approach to the study has been sincere, scientific and analytical.
The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

15-5-19

Mohan Bairwa

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The certificate is awarded to

Dr. Apoorva Mahar

In recognition of having successfully completed her
Dissertation in the department of

Bihar Technical Support Program

and has successfully completed her Project on

Study on reasons for Home Delivery and Birth Preparedness level in Home delivered mothers in Supaul District of Bihar

Date:4th May 2019

Care India

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

We wish her all the best for future endeavors

Deputy Director Human Resources

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled Situational Analysis of reasons for Home delivery and assessment of birth preparedness level of Home delivered mothers of Supaul district in Bihar and submitted by Dr. Apoorva Mahar Enrollment No. 0541 under the supervision of Dr. Mohan Bairwa for award of MBA in Hospital and Health Management in Health and Hospitals of the University carried out during the period from 04/02/2019 to 04/05/2019 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.

(Dr. Apoorva Mahar)

Signature

ABSTRACT

Study Title: Situational analysis of reasons for Home delivery and birth preparedness level in the home delivered mothers of Supaul District in Bihar

Author Name: Dr. Apoorva Mahar

Background: Increase in the number of Institutional deliveries has been one of the major factor in reduction of the maternal and neonatal mortality. This increase demands action on all the three delays which are mainly of two types: direct and indirect. The three delays namely (a)Delay in decision to seek care (b) Delay in reaching Care (c) Delay in receiving Care at the health facility. Management of maternal and neonatal complications during pregnancy and labour requires skilled birth attendance. Maternal or Neonatal complications requires immediate access to quality obstetric services equipped with life-saving drugs, including antibiotics, and the ability to provide blood transfusions needed to perform Caesarean sections or other surgical interventions necessary now. Thus, skilled birth attendance during labour is one of the key areas to prevent and manage complications. Labour followed by delivery of the baby is a critical event in the life of woman, a safe and skillful practice of the facility health worker at that time plays a crucial role in keeping their mother and baby future healthy. Government has implemented many initiatives to ensure skillful institutional delivery, a home delivery cannot provide the required safe environment for mother and baby during delivery, risk for any complications is always higher than in institutional deliveries. Birth preparedness plays a major role in providing required care to pregnant woman in prenatal, antenatal and postnatal period. Even planned home delivery mothers appropriate birth preparedness ensures availability of services in time of any obstetric emergencies. Many sociodemographic, socioeconomic and cultural factors play a role in birth preparedness status of the pregnant woman and her family. A good birth preparedness ensures proper care to the pregnant woman in time of need.

Objectives:

The objectives of the study are:

1)To assess the reasons for home delivery in recently delivered mothers

2)To assess the level of Birth Preparedness in the home delivered mothers

3)To analyze the quality of ANCs received by the home delivered mothers.

4)To assess the frequency of home visit and counselling status by the frontline workers of the area.

Methodology:

Study Design: Descriptive explorative design

Sampling Type: Purposive Sampling

Duration of Study: The study was carried out from the period of 4th Feb'19 to 4th May'19

Study Area: The study was conducted in Supaul district of Bihar.

Data Collection Methods: A semi structured schedule was prepared based on literature review and field experience. Women who have delivered in month of January, February and March were interviewed.

Data Analysis Procedure: Primary data was collected from the randomly selected home delivered women from each block of the Supaul district. Thereafter the collected data was filtered and coded. After that it was transferred to IBM SPSS version 21. Further analysis of the data was done using SPSS.

Results:

The study found that maximum number of respondents were in the age group of 25-29 years of age and nearly 90% of them were married at the age between 15-19 years. Only 9.09% of respondents were living in urban areas. Recorded reasons for home delivery were different block wise, the most prevalent of them was lack of companion to go to hospital and lack of transport at right time. Cultural and socioeconomic factors in the block played a significant role in deciding birth preparedness level of the pregnant women and her family. Majority of the families have had poor birth preparedness level, which again became one of the major reasons of home delivery. The frontline workers have very few home visits in majority of the

cases, in which there was no proper counselling on care during pregnancy, danger signs and birth preparedness.

Conclusion: One of the key functional area of Government of Bihar is reduction in maternal and neonatal mortality, it is already implementing action plans to reduce the 3 delays, but ground level implementation is still not efficient. This inefficiency can be reduced by effective implementation and monitoring of the services being provided and periodic client interview to ensure that they are receiving those services.

Key words: Home Delivery, Birth Preparedness, ANC Counselling

ACKNOWLEDGEMENT

To my parents, to whom I owe it all!

At this juncture of completion of my dissertation, I would take this opportunity to express my profound gratitude to the esteemed IIHMR University Jaipur for giving me this platform to learn, gain knowledge and skills in different aspect of health and hospital management.

My sincere thanks to my guide Dr. Mohan Bairwa , Assistant Professor, The IIHMR University Jaipur. Without whose guidance and support this project would not have materialized. I would also like to express my gratitude to all my professors who taught me during my journey at The IIHMR University Jaipur, their teachings and guidance has opened new avenues of knowledge for me.

It is my radiant sentiment to place on record my gratitude towards the DRU team at Supaul district in Bihar for their support and guidance

I owe my wholehearted thanks and appreciation to the entire staff of the organization for their cooperation and assistance during the course of my project.

I hope that I can build upon the experience and knowledge that I have gained and make a valuable contribution towards this organization and my alma mater in coming future.

CONTENTS

List of Abbreviations:

ANC	Antenatal Care
PNC	Post-natal care
BPCR	Birth preparedness and Complications Readiness
A.N.M.	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Aganwadi Worker
C.H.C.	Community Health Centre
H.S.C.	Health Subcenter
FP	Family Planning
I.C.D.S.	Integrated child Development Services
PHC	Primary Health Centre
FRU	First Referral Unit
DH	District Hospital
TBA	Trained Birth Attendant
IFA	Iron Folic Acid
DPMU	District Project Management unit
SPMU	State Project Management Unit
EIBF	Early initiation of Breast feeding
RH	Referral Hospital
WHO	World Health Organization
NFHS	National Family Health Survey
DLHS	District Level Health Survey
R.M.P.	Regional Medical Practitioner

L.S.	Lady Supervisor
C.D.P.O.	Child development project Officer
ENBC	Essential New borne Care
DCC	Delay Cord Cutting
EIBF	Early Initiation of Breast feeding
STSC	Skin to skin Contact
KMC	Kangaroo Mother Care

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CHAPTER-01
INTRODUCTION

1.1: BACKGROUND

In year 2015, pregnancy and childbirth related complications leading to deaths of women and girls went down from 532,000 in 1990 to 303,000 in 2015. These achievements are specifically remarkable considering rapid population growth in many countries where maternal deaths are reported to be highest. Despite of this achievement still over eight hundred women loses their life every day from complications related to pregnancy and childbirth.

In some areas of the world, high number of maternal deaths reflects inequities in access to health services highlighting the gap between different strata of socioeconomic structure of the society. Majority of maternal deaths (99%) happens in developing countries. Nearly all these deaths occurred in low-resource settings, and most could have been prevented.(1)

Even today hemorrhage remains the most prevalent cause of maternal mortality, causing over 25% of deaths. Almost comparable proportion of maternal deaths were caused indirectly by previously existing medical conditions which is aggravated by the pregnancy. Disorders due to hypertension in pregnancy, especially eclampsia, as well as sepsis, embolism and complications of unsafe abortion also account for a substantial number of lives.(2)

Prompt access is required in any complication, immediate accessibility to good quality obstetric services equipped with life-saving drugs, including antibiotics, analgesics and the ability to provide blood transfusions needed to perform Caesarean sections or other surgical interventions.(3).Timely availability and accessibility to emergency services ensure that life is saved. The mother and child outcomes are related to each other across the whole life-cycle as well as into the next generation, but the most critical effects of maternal mortality on child survival are in the pregnancy and neonatal period. It is observed that obstetric complications, particularly in labor, are a major source of stillbirths and early neonatal deaths.(4)

Birth Preparedness and Complication Readiness (BPCR) is an intervention included by WHO as an essential element of the antenatal care package. It is often delivered to the pregnant woman by the health care provider in antenatal care or initiated or followed up through a visit to the home of the pregnant woman by a community health worker. In addition to working with an individual pregnant woman, programmes often address efforts to her family and to the broader community to increase awareness on BPCR or to improve health workers' skills to provide BPCR as part of ANC.(5)

A birth and complications preparedness plan contains :- the desired place of birth; the preferred birth attendant; the location of the closest facility for birth and in case of a complication; funds for any expenses related to birth and in case of complications; supplies and materials necessary to bring to the facility; an identified labour and birth companion; an identified support to look after the home and other children while the woman is away; transport to a facility for birth or in the case of a complication; and the identification of copatible blood donors in case of emergency. Only 31.5% of women in rural areas register themselves in first trimester of pregnancy,11% have had 4 ANCs and only 3.2% had full antenatal care. Birth preparedness forms a critical part of ANC package and is one of the major reasons for home deliveries.

The lifetime risk of maternal death is the probability that a 15-year-old girl will die from complications of pregnancy or childbirth over her lifetime; it considers both the maternal mortality ratio and the total fertility rate (average number of births per woman during her reproductive years under current age-specific fertility rates). Thus, in a high-fertility setting, a woman faces the risk of maternal death multiple times, and her lifetime risk of death will be higher than in a low-fertility setting.(2)

High levels of perinatal (49 per 1,000 births), neonatal (39 per 1,000 livebirths), and maternal mortality (301 per 100,000 livebirths) remain major public-health challenges in India. About one-third of neonatal deaths occur on the first day of life, and most maternal deaths occur during labour, delivery, and within 24 hours postpartum. In context of Bihar, having approximately more than 28 lakh pregnancies per year of which nearly 26 lakhs deliveries. About 15% of these are likely to develop complications which is difficult to predict or prevent. Of 45000 maternal death per year in India,4400 occur in Bihar (Care India).

For Supaul district which has more than 70% of Rural household, there has been a steady rise in the institutional delivery to 63.8% (NFHS-4), and in rural areas to 62.7%. The Institutional births in public facility is 55.2%. The Home deliveries conducted by skilled health personnel (out of total deliveries) is just 11.5%(NFHS-4). A rise in institutional deliveries has significantly reduced maternal and neonatal mortality and morbidity

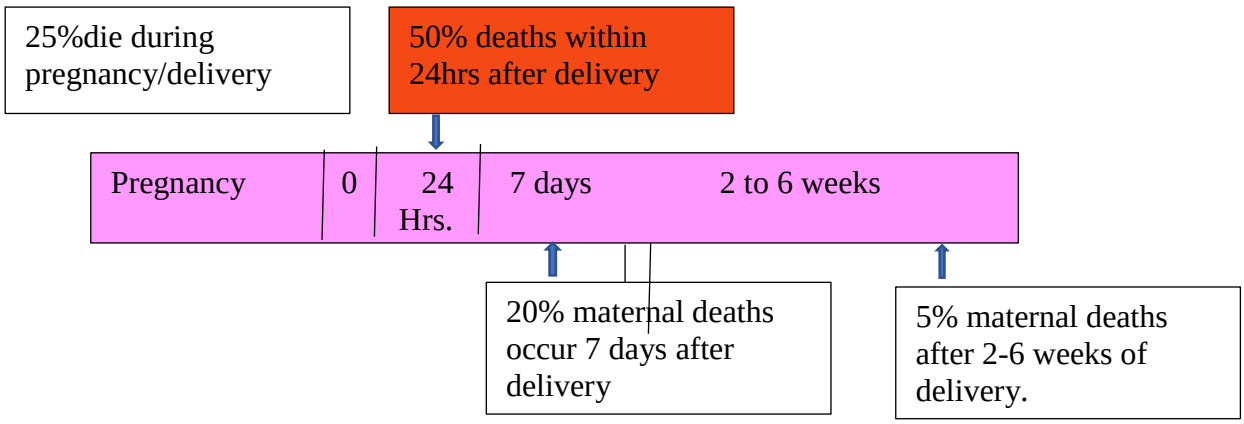


Fig:1. Risk of maternal death

Apart from medical causes, there are numerous interrelated sociocultural factors which delay care-seeking and contribute to these deaths. Care-seeking is delayed because of the delay in (a) identifying the complication, (b) deciding to seek care, (c) identifying and reaching a health facility, and (d) receiving adequate and appropriate treatment at the health facility

Table 1: Maternal and child health indicators in Bihar:

S no.	Indicators	NFHS-3 ('05-'06)	NFHS-4('15-'16)
1	Mothers who had antenatal check-up in the first trimester (%)	18.7	34.6
2	Mothers who had at least 4 antenatal care visits (%)	11.2	14.4
3	Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	6.3	9.7
4	Children born at home who were taken to a health facility for check-up within 24 hours of birth (%)	0.4	1.8
5	Children who received a health check after birth from a doctor/nurse/LHV/ANM/ midwife/other health personnel within 2 days of birth (%)	NA	10.8
6	Institutional births (%)	19.9	63.8
7	Home delivery conducted by skilled health personnel (out of total deliveries) (%)	8.2	9.7
8	Births assisted by a doctor/nurse/LHV/ANM/other health personnel (%)	58	70.0
9	Births delivered by caesarean section (%)	4.2	6.2

There has been an significant improvement in the Maternal and Child health indicators of Bihar from NFHS-3, yet much remains to be achieved. The services might have become more accessible in terms of affordability and acceptability, but the quality of services provided remains a major issue.

Table 2: Mortality Indicators in Rural Bihar

S No.		SRS 2015	SRS 2016
1	Neonatal mortality (per 1000 live births)	**29**	**28**
2	Infant mortality	**42**	**39**
3	Percentage of Neonatal death to infant deaths	**69.7%**	**72.5%**
4	Peri-Natal Mortality Rates	**24**	**25**
5	Maternal mortality ratio (per 100000 live births)	**219 (SRS 2010-12)**	**165 (SRS 2014-16)**

Table 3 : Key Indicators for Home delivery in Supaul District

S No.	Name of Indicators	2018-19	2019-20
1.	Number of Home deliveries	592	495
2.	Number of home deliveries attended by SBA trained (Doctor/Nurse/ANM)	63	53

3.	Number of home deliveries attended by Non SBA trained (trained TB/Dai)	529	442
4.	% SBA attended home deliveries to Total Reported Home Deliveries	10.6%	10.7%
5.	% Home deliveries to Total Reported Deliveries	6.9%	15%
6.	% Home deliveries to Total Reported Deliveries	3508	3291

Source: HMIS Bihar

1.2. Literature Review

Author Name/Year of publication	Title	Methodology	Summary of findings	Recommendations
1) Ashoke Gorain et al (6)	Preference in place of delivery among rural Indian women	Qualitative survey data consisting of twelve focus group discussions, conducted in a rural setting of West Bengal, India	It was found out that nearly 60% of women who delivered at home wanted to deliver at the institution, but could not do so because of either unwillingness of family members or misreporting of labour pains	To improve the birth preparedness of the family members through ASHA & village health workers
2) Shelah s bloom et al (7)	Does Antenatal Care Make a Difference to Safe Delivery? A Study in Urban Uttar Pradesh, India	300 low to middle income women who had given birth within the last three years in Varanasi. Composite measure for antenatal care use based on 20	A strong positive association between the level of care obtained during pregnancy and use of safe delivery care	Antenatal care could also be associated with reduced maternal mortality

		differ- ent input component		
3) Sapna Kaul et al (8)	Delivery at Home Versus Delivery at a Health Care Facility – A Case Study of Bihar, India	Program evaluation approach to estimate the treatment effects associated with deliveries at health care institutions. Propensity score matching is used to estimate the average treatment effect on the treated (ATT).	The study showed that there is an average gain from delivering baby at a health facility as compared to delivering at home for underweight women	To spread awareness about the positive health impacts of institutional deliveries using educational programs, more investment in health facility infrastructure to be made and health services should be made more affordable and accessible to poor households
4) Chandrashekhar T Sreeramareddy et al (9)	Home delivery & new born care practices among women in Nepal	Cross-sectional survey, semi structured questionnaire was administered to women who have delivered at home Sample size:240	58.3%planned and 41.7% unplanned home deliveries. Main reasons for home delivery: Preference (25.7%) Ease & convenience (21.4%)	Community based interventions should be implemented to improve birth preparedness of families. High risk traditional new born care practices need to be changed by culturally

			Precipitate labour (51%) Lack of transport (18%) Lack of escort in planned deliveries (11%)	acceptable community-based health education programme.
5) Niveditha et al 2014 (10)	Why women choose to give birth at home: a situational analysis from urban slums of Delhi	Cross-sectional survey using Qualitative and quantitative methods Sample size n=32034 for house to house survey. Data on birthing place and sociodemographic characteristics n=6092 Information on pregnancy and post-natal care n=160 Focus group discussion and in-depth interview with stakeholders from community	Fear of hospitals (36%), comfort of home (20.7%) and lack of social support for child care (12.2%) emerged as the primary reasons for home births.	To practice improvement in the health services provided, such that it satisfies the client. Promote practices of better family support to the pregnant women

6) Monica Munjial et al 2009 (11)	A comparative analysis of institutional and noninstitutional deliveries in a village of punjab	Comparitive study Sample size:200 One to one interview using interview schedule	Main reason of delivering at a health facility or home was delivery being easy and convenient (74%) or cultural factors (68%)	Depite of many efforts by government, implementatiof of various schemes are still poor. This need to be improved through proper monitoring and ensuring effective implementation of the scheme.
7) Thind et al 2008 (12)	Where to deliver? Analysis of choice of delivery location.	A sample size of 5391 ever-married females between the ages of 15 to 49 years. Data were abstracted for the most recent birth. Multinomial logistic regression analyses were conducted to assess the association of predisposing, enabling and need factors on use of home, public or	37% (n=559) deliveries at home and 31%(n=493) in public and 32%(n=454) in pvt. Institution	There is the need for government to facilitate insurance to manage high Out of pocket expenditure in health. Also strengthen public health facilities accessibility and availability wise for the beneficiaries.

		private sector for delivery.		
8) Singh Prashant et al (13)	Factors associated with maternal healthcare services utilization	Multilevel analysis for 3 maternity outcomes:4 or more ANC visit, skilled birth attendance, post-natal care	House hold level and district level factors both influence the pattern of utilization of maternal healthcare services significantly	Strengthening of public health infrastructure and promoting awareness about available schemes.
9) Bang et al (2004) (14)	Maternal morbidity during labour and the puerperium in rural homes and the need for medical attention: A prospective observational study in Gadchiroli, India.	Prospective Observational Study Sample Size:772	15% of women who deliver in rural homes potentially need emergency obstetric care. Frequent (43%) postpartum morbidity, and its association with adverse perinatal outcome, suggests the need for home-based postpartum care in developing	The results suggested the need for home-based postpartum care in developing countries for both mother and baby.

			countries for both mother and baby.	
10) K. S. Sugathan et al (15)	Promoting Institutional Deliveries In Rural India: The Role of Antenatal-Care Services	Systematic analysis of NFHS 1 and 2 data. The analysis was based on births during the three-year period before each survey to ever-married women in the four states of Andhra Pradesh, Gujarat, Bihar, and Rajasthan		
11) Véronique Filippi et al 2006 (4)	Maternal health in poor countries: the broader context and a call for action	comparative analysis of various characteristics pertaining to institutional and non-institutional deliveries	Long-term consequences of maternal health are: the psychological consequence of maternity like depression and stress that cause impaired functionality in women. Second, women may	To promote childbirth in health facilities as the most fitting strategy to prevent maternal deaths. Prevention of the death of a mother is the single most important intervention for the health of a child. Collaborative

			undergo physical changes like damage in the pelvic structure and anaemia that results in increased risk of maternal morbidity and mortality, lower work productivity and fatigue Third, households face an economic burden due to expensive maternal health care. Lastly, there are sociological consequences, which arise due to the stigmatism associated with maternity and marital discord.	action is needed at all levels, from governments to the international community, health professionals to academics, individuals to civil society.

1.3. Rationale Of study

Many experts agree that the risk of stillbirth or death due to intrapartum–related complication can be reduced by about 20 percent with the presence of a skilled birth attendant.(16) Reflecting its importance in reducing maternal morbidity and mortality

Non-skilled attendants, including traditional birth attendants, can neither predict nor appropriately manage serious complications such as hemorrhage or sepsis, which are the leading killers of mothers during and after childbirth.

Government of Bihar has tried ensuring that the necessary healthcare services to the people are provided on time and is of good quality, but the implementation of this ambition still requires much effort for the desired output. Unsafe and unhygienic home delivery practices pose a significant threat to the mother and newborn health. There are many sociocultural and socioeconomic, sociodemographic reasons which has led to home deliveries in Supaul district.

This necessitates study on reasons for home deliveries which will help in targeting our efforts on planned actions to reduce maternal and neonatal mortality.

1.4. Research Question

1. What are the reasons for Home delivery in the recently delivered mothers in Supaul district of Bihar?
2. What is the Birth Preparedness level in the recently home delivered mothers?

1.5. Research Objectives

1)To assess the reasons for home delivery in recently delivered mothers

2)To assess the level of Birth Preparedness in the home delivered mothers

3)To analyze the quality of ANCs received by the home delivered mothers.

4)To assess the frequency of home visit and counselling status by the frontline workers of the area.

CHAPTER-02

METHODOLOGY

2.1. Study setting description:

The study was conduct in Supaul district which has a population of 26.3 lakhs. The majority of the population, nearly 95% (about 21.2 lakh) live in Supaul District rural part and 5% (about 1.1 lakh) population live in the Supaul District urban part. Rural population density of Supaul district is 889.

Map of the district:

Fig 02: Map of District

There is a total of 9 PHCs 3 Referral hospital and 1 District Hospital.

Supaul is divided into 11 Community development blocks namely Supaul sadar, Kishanpur, saraigarh bhaptiyah, Pipra, Raghopur, Basantpur, Tribrniganj, Nirmali, Marauna

2.1.1 Study area: The study was conducted in the 11 community development blocks of Supaul district. Supaul has nearly 70% of rural population,who were the main respondents. Only recently delivered mothers in past three months werer selected for interview

2.2. Study Design: The study design is Descriptive explorative type using mix method of qualitative and quantitiave type.

2.3. Study Tool

A semi structured interview schedule was used to interview the recently home delivered mothers. It had the following key domain areas:

- Sociodemographic profile of the woman
- Gravidity of the woman
- Number of ANC's received, and the quality of ANC received with respect to the examinations done of the woman
- Number of home visits by the frontline worker and quality of counselling given.
- Birth preparedness level of the home delivered mother
- Reasons for Home delivery.

2.4. Sampling Frame: Home Delivered mothers of recent 3 months from January '19 to March '19 for all the HSCs. in the district.

2.4.1. Sample size: From the line listing 20 home delivered mothers from each of 11 blocks were chosen randomly for the interview. A sample size of 220 was taken.

2.4.2. Sampling methodology at a glance:

Listing of all the ASHA Facilitators block wise and sector wise

⬇

Collection of their Monthly review format of past three months which has data on type of deliveries in the area Health Subcenter wise.

⬇

Line listing of the home delivered mothers through crossmatching with the help of ASHA facilitator, ASHA and AWW of that area. Only mothers who have delivered in last three months that is January, February and March were selected.

Random selection of home delivered mothers from the line listing

Interview of the selected mothers through semi structured interview schedule

2.4.3. Study participants

Inclusion Criteria: Women who have home delivered in January'19, February'19March'19

Exclusion Criteria: Women who have had institutional delivery either in Government hospital or Private Hospital.

2.5. Data Analysis Plan:

The collected data after filtering and entering in the SPSS was analyzed and results are reported in form of frequent, percentage tables,bar graphs,pie charts and crosstabulation tables.

2.6. Ethical Considerations:

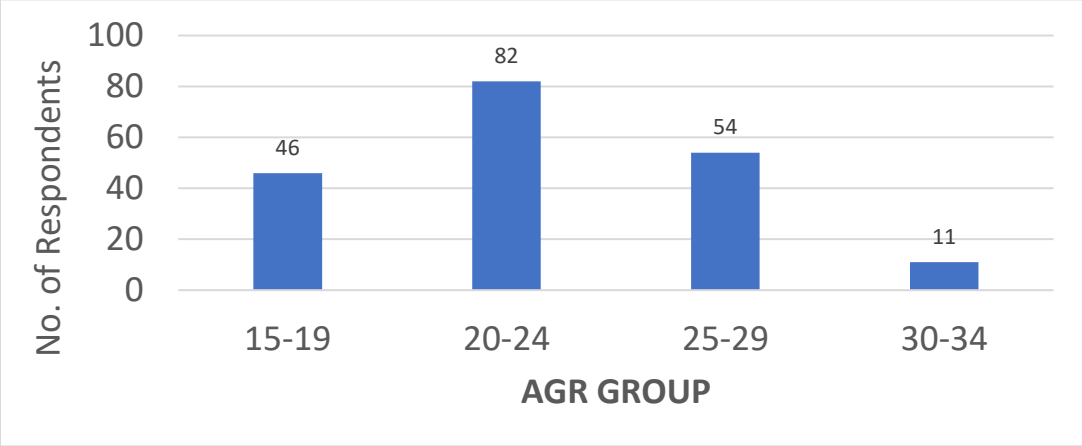
Written informed consent was taken from the participants before any data collection. Assuring them of the confidentiality of the data collected, also that the data collected is for academic purpose only. Permission to conduct the study was taken from the administrative office of Supaul.

CHAPTER:03

Results

3.1. **Sociodemographic Profile of the respondents:**

This section presents the Sociodemographic profile of the respondents in Supaul district of Bihar. A total of 193 participants were selected randomly from the whole district ensuring that there are at least 16 participants from each of the 11 blocks



Graph 1: Current age in Completed years

Most of the respondents were of the age group 20-24 years. They constituted nearly 55% of the total sample.

3.2 Occupation of Husband

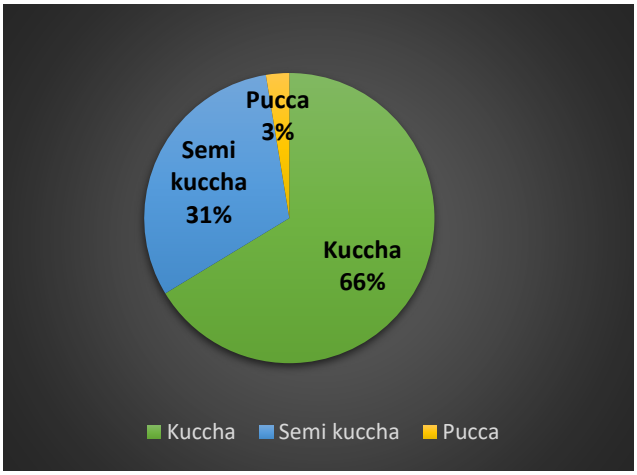
Table 3: Occupation of Husband of the interviewed respondents

Occupation of Husband(n=193)					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1. Labourer	86	44.6	44.6	44.6
	2. Ice cream seller	12	6.2	6.2	50.8
	3. Shopkeeper	9	4.7	4.7	55.4
	4. Farmer	61	31.6	31.6	87.0
	5. Pvt Job	17	8.8	8.8	95.9
	6. Electrician	5	2.6	2.6	98.4
	7. Business	1	.5	.5	99.0
	8. Tailoring	2	1.0	1.0	100.0

Nearly all the women interviewed were house wife. Though women having husband as a farmer used to help in the fields (31.6%). Most of the husbands were working as Laboure's (44.6%), these men also used to migrate to other cities for work. This migration due to work was also found one of the reasons for poor birth preparedness of the family of pregnant woman, as in absence of her husband the family care less for the pregnant woman.

3.3. Type of House:

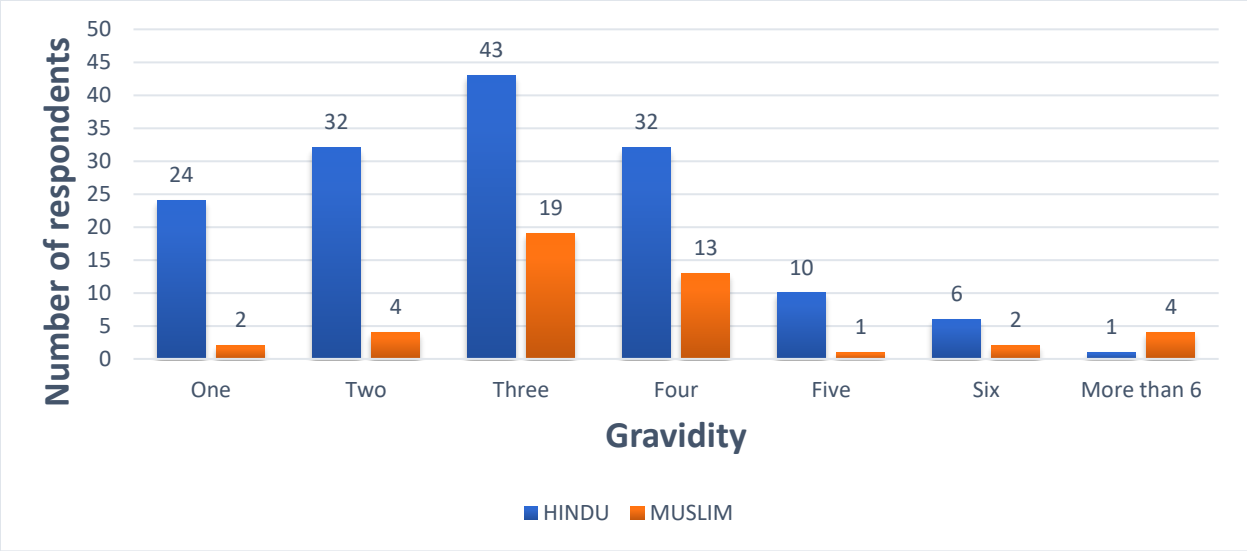
Most of the respondents had Kuccha house (66%) 31% of the total respondents had Semi kuccha house which had a kuccha roof. The kuccha type of house had mud flooring which was cleaned by broom only. This indicates absence of any proper clean area in the house to deliver the baby.



Graph 2: Type of house of the respondents

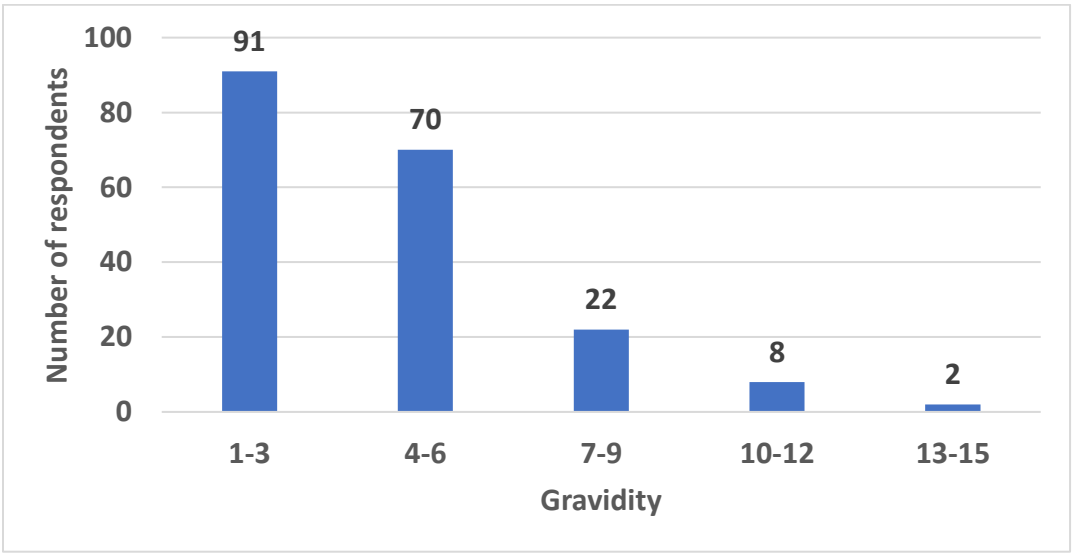
3.4. Religion and Gravidity of respondents:

HINDU	MUSLIM
148 (76.7%)	45 (23.3%)



Graph 3: Gravidity vs Religion for the respondents

Most of the respondents were Hindu by religion. For Gravidity vs Religion nearly 29% had gravidity of three for Hindus.in Muslim 33.3% women had gravidity of three. Among Muslim women 8.8% had gravidity of more than 6 whereas it was 0.67% among Hindus. Nearly 70% of the respondents belong to Schedule Caste.



Graph 4: Gravidity of the respondents at a glance

Respondents gravidity in blocks like Basantpur which are very far from the district headquarters was ranging from 4-6 to 13-15. In whole district most of the woman had 1 to 3 gravidity nearly (47%) .

3.5. Family size:

Table:4 -Family Size Percentage

Family Size	**Percentage(n=193)**
1-3	12 %
4-6	38.45%
7-9	27.55%
10-12	11%
13-15	10.04%

Family size was decided by the number of people living under one roof and taking food from the same kitchen. It was seen that 38.45% of the families were having 4 to 6 members.

3.6 ANC Status

Table:5 Number of ANCs Percentage

Number of ANC's	**Percentage(n=193)**
One	44.6%
Two	39.9%
Three	14.0%
Four	1,6%

3.7. Time of first ANC Registration:

Table:6 Time of ANC Registration

ANC Registration	Percentage (n=193)
First Trimester	10.05
Second Trimester	78.45
Third Trimester	10.75

Most of the pregnancies were registered in the second trimester.

Nearly 68.8% of the Home delivered mothers had MCP card, which was prepared either during the ANC checkup or during immunization of their child.

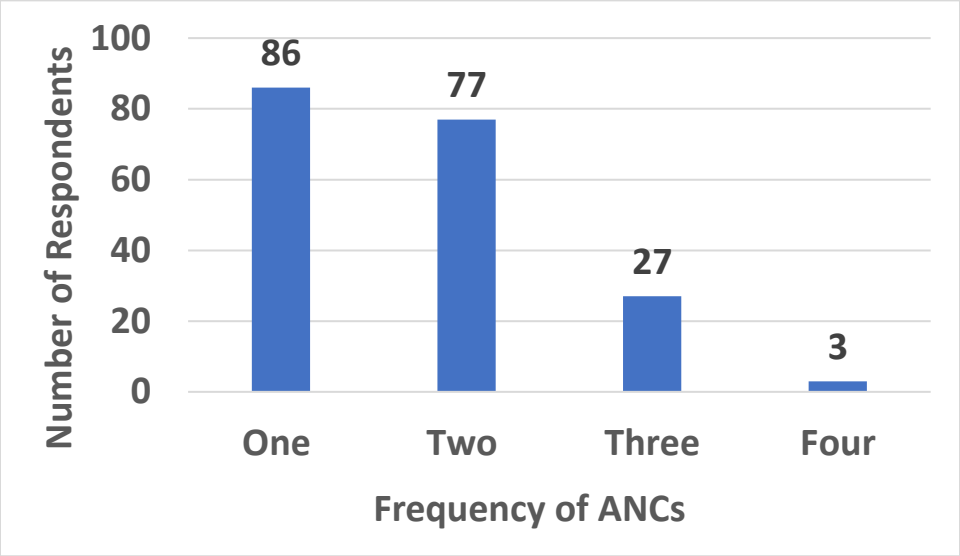
3.8. ANC Quality:

Table:7 Quality of ANC

Name of Examination	Percentage (n=193)
TT Injection	97.5%
Hemoglobin	18.2%
Pulse	10.9%
Temperature	1.6%
Weight	2.3%
Urine Albumin Test	43%
HIV Test	10.36%
Hep B Test	15.8%
MCP Card made	68.8%
Abdominal Examination	12.8%
History taking	5.7%

Overall most of the women were given TT injection. Rest tests required were not routinely done

3.9. ANC Visit distribution among Home delivered mothers:



Graph 5: ANC visits distribution among home delivered mothers

Most of the women nearly 44.5% were visited at least one time by the frontline health worker.

3.10. Quality of Antenatal Counselling given to the respondents:

Table:8 Quality of Counselling given by the Frontline workers

S No.	Counselling topics	Total(n=193)
1.	Care during delivery	14.2%
2.	Diet during delivery	11.8%
3.	Danger signs (vaginal bleeding, convulsions/fits, severe headaches with blurred vision, fever and too weak to get out of bed, severe abdominal pain, fast or difficult breathing.	20.8%

Respondents were asked about what all were they told about by the frontline worker during the home visit. The answers given were categorized under three broad heading of Care during delivery, Diet during delivery and Danger signs. Only 20.8% of the women were informed about the danger sign during pregnancy. Just 14.2% women were aware of care during pregnancy.

3.11. Delivery planning:

Table:09 Delivery Planning

Plan to deliver	Total (n=193)
At Home	20
At Govt. Hospital	77.42
At Pvt. Hospital	2.58

3.12. Assessment of the Birth Preparedness level of the Home delivered mothers:

Table:10 Birth Preparedness Level

Birth preparedness Indicators:	Total (n=193)
Pre-arrangement of vehicle to go to Hospital in time of need	10.55

Identification of Health worker for help to reach to facility on time	8.68
Having an emergency contact number	5.68
Identified Labour and birth companion	15.65
Decided the desired place of birth	3
Identification of Compatible blood donors in case of emergency	0
Identified support to look after at home while the woman is away	5.4
Funds for expense related to birth and in case of complications	10.9

The birth preparedness level was assessed through interview by noting down the preparations, if any, the woman or her family has done. The level was overall very poor in the interviewed women, because of which some of the deliveries happened at home despite of willingness to go to facility on time.

3.13. Analysis of reasons of Home delivery:

Table:11 Reasons of Home Delivery

S. No.	**Reasons for Home Delivery**	**Percentage (n=193)**
1	Preference for Home Delivery	6.2%
2	Home delivery is easy and convenient	22%
3	All my previous deliveries were at Home	24.8%
4	Worries about Cost in Hospital	11.4%
5	Financial problem at home	3.6%
6	Family members prefer Home delivery	8.9%
7	Bad experience of hospital	18.1%

8	Health worker lives close to house	2.6%
9	Lack of Transport during Labour	39.4%
10	Lack of Companion during Labour	36.3%
11	Onset of Labour before the expected date	10.4%
12	Hospital is Far away	20.7%
13	Fear of Hospital	5.0%

The most prevalent reasons reported for the Home delivery were lack of transport during labour and lack of companion during labour especially in those who planned to deliver at home.

In blocks like Kishanpur, Saraigarh, Pipra, Raghopur, Chattapur, Pratapganj which were near to the administrative unit Supaul, it was seen that many had the complaint of poor hospital experience.

Blocks like Nirmali, Marauna, Basantpur had lack of timely availability of transport during labour as main reason for home delivery.

3.14 Assessment of the Essential Newborn Care in the Home delivered babies:

Table:12 Heating of Birth place Percentage

Heating of Birth Place	**Total (n=193)**
Before Birth	5.85%
After Birth	4%
Throughout Birth	3.65 %
None	86.5%

Table:13 Time of Bathing the Baby percentage

Time of Bathing the Baby	**Total (n=193)**
Immediately after Birth within one hour	15.8%
A few hours after birth	10.2%

Next Day	65%
After 7 days	9%

Table:14 Dressing Applied on Umbilical Stump Percentage

Dressing Applied on Umbilical Stump	**Total (n=193)**
Ink	30.3%
Turmeric	2%
Oil	9%
None	58.7%

The essential new born care which starts with temperature maintenance of the birthing area so that there is no sudden temperature change of the newborn body. It was seen that in nearly 86% of cases there was no heating of the birthplace. Nearly 65% of babies born were given bath the next day.

Table:15 Instrument Used to cut the cord Percentage

What instrument was used to cut the Cord	**Total (n=193)**
New Blade	98.5%
New and boiled Blade	0.5%
Old blade	0%
Old and boiled blade	1%

In most of the deliveries nearly 98.5% uses new blade to cut umbilical cord. Though new blade was used but only in nearly no case the blade was boiled. In 1% of the case when using old blade, it was washed with hot water. This indicates poor infection control practices in home delivered babies.

Discussion:

As per study of different blocks in Supaull district, it was seen that the reasons for home delivery differs from block to block especially in cases of blocks which are near to Supaul main administrative unit.

Blocks like Basantpur, Nirmali and Marauna had main reason for home delivery as lack of transport on time during labour. Client interviews in areas which are far away from the PHC's has revealed that ambulances services hardly reach these areas. Even if they reach they charge money for it. Such practices discourage the client to avail the services.

Blocks like Saraigarh, Raghopur, Chhatapur, Pratapganj had main reason of poor hospital experience, the respondents mainly complaint of rude staff and non availability of medical consumables. Kishanpur block had main reason of inaccessibility of health services among the respondents. Block Supaul sadar block had main reason as availability of health worker in the nearby area.

A study by Monica et al in the rural area of Punjab revealed that the main reasons cited by the respondents for delivering at an institution were delivery being easy and convenient followed by proximity to the hospital and cultural practice.

The Home visits by the front-line worker are very infrequent and less in number than required, this came out as one of the major reasons of poor birth preparedness among the families of pregnant women. The counselling that should be provided by the Front-line workers to the pregnant woman forms an essential part of birth preparedness. Many initiatives by the government like Godbharai, community meetings, Poshan mela, Health fair, VHSND days are crucial platforms to promote birth preparedness.

Strength of Study: This study provided quantitative estimates of the reasons of home delivery and Birth preparedness level of the home delivered mothers in Supaul district.

Limitations of Study: There was no comparative analysis to the institutional delivered mothers on the selected indicators.

Conclusion:

There are various factors which play a crucial role in a woman's decision for her delivery, moreover this decision is not her alone but is more impacted by the opinion of her family .

Government of Bihar has taken many initiatives in this regard to improve the health services accessibility, acceptability and accountability but still much remains to be achieved.

The main reasons of lack of transport and birth companion can be addressed by ensuring that ambulance services are monitored for the number of service request they receive and its client satisfaction level, for Birth companion a proper birth preparedness would ensure his/her availability which can be achieved through proper ANC counselling.

The Frontline health workers are the major link between the people and the health services provided, an active and effective participation from their side would ensure that required awareness to motivate people to avail services is generated.

To achieve reduction in Maternal and Neonatal mortality are a crucial goal for SDG-2020 also, for this goal to be achieved timely effort in the right direction is of utmost importance. Improving the health services available is one of its major agenda. A concerted effort by the Government and people will ensure timely achievement of the target.

Appendix:01

Home Delivery Schedule in Block:_____

Date:				
Seq No.				

Sr. NO	Questions
1	गाँव का नाम/टोला:
2	AWC:
3	नाम(महिला का नाम):
4	उम्र
5	शादी के समय उम्र
6	पहला बच्चा होने की उम्र
7	कहा तक पड़ा है
8	पति का नाम:
9	फोन नंबर
10	पति क्या कार्य करते है:
11	परिवार में कितने लोग है
12.	219.1 धर्म
13.	219.2 जाती ☐ SC ☐ ST ☐ ☐ OBC ☐ GEN OTHER

14	घर का प्रकार कच्चा.....1 Semi कच्चा.....2 219.3 पक्का.....3
15.	No. of Pregnancies: उन pregnancies की कहा डेलीवेरी हुई (H=home,I=hospital,P=pvt.) Live Birth (gender)..... Still Birth..... Abortion (Spontaneous/induced).....
16.	सबसे छोटे बच्चे की उम्र..... SEX.....
17.	How many ANCs you receive for Last delivery? .....
18.	पहली बार ANC registration गर्भावस्था के किस महीने में कराई?(for last baby).....
19.	ANC करवाने आप किसके बोलने पे गयी? खुद से पता था घर वालो ने बोला Health Worker ने बताया(किसने नाम लिखे.....) पड़ोसी के कहने पे Other(नाम लिखे).....

20.	ANC मैं क्या क्या जाच हुई? (History taking, TT Injection, Hb, Pulse, BP, Weight Temperature, Urine Albumin test ,HIV Test ,Hep B test, Abdominal examination FHR , LMP/EDD Record) .....
21.	क्या आपको किसी स्वास्ठ कर्मी (Health worker) ने गर्भवास्थ में care,खतरे के लक्षण etc के बारे में कोई जानकारी दी Yes.....क्या-क्या बताया..... No.....
22.	क्या आपको गर्भावस्था में IFA,CALCIUM की गोलिया दी गयी ? IFA tablets ..... /किसके द्वारा दी गयी..... Calcium tablets did you receive?...../किसके द्वारा दी गयी..... कोई गोलीय नहीं दी गयी .....
23.	क्या आप दूबारा गोलियां लेने गयी? Yes.....Amount..... No.....Why no.....
24.	क्या आपको किसी Health Worker द्वारा institutional delivery के बारे में जानकारी दी गयी ? (Other than monetary) Yes.....(1) No.....(2)

25.		Health worker ने कितनी बार आपको जानकारी दी(ANC OR about Institutional delivery)	Health worker आपकी गर्भावस्था कितनी बार आपके घर आए
		Twice a week……(1) Once a week……(2) Once a month……(3 Anyother……	Twice a week……(1) Once a week……(2) Once a month……(3 Anyother……
26.	आपके घर से अस्पताल(जहा delivery होती हो) कितना दूर है?(IN Kms or time) Govt. Facility…… Private Facility……		
27.	Where did you plan to deliver your baby? {आपने बच्चे को deliver करने के लिए कहा सोचा था?} At Home……(1) Govt. Hospital……(2) Pvt. Hospital…… Planned at institute but happened at home…… Not planned……		
27.1	Birth Preparedness: (0=No,1=Yes) Pre-arrangement of vehicle to go to Hospital in time of need…… Identification of Health worker for help to reach to facility on time…… Having an emergency contact number…… Identified birth companion…… Identification of Compatible blood donors in case of emergency…… Identified support to look after at home while the woman is away…… Funds for expense related to birth and in case of complications……		
28.	आपकी आखरी delivery कहा हुई थी? ……		
29.	Delivery घर पे क्यू हुई?(सभी कारणो को RANK करे जो महिला बताये) Preference for home delivery…….. Home delivery is easy and convenient…… All my previous deliveries were at home……		

	अस्पताल दूर है……. Worries about cost in the hospital…… घर में पैसे की दिक्कत…….. Family members prefer home delivery…… अस्पताल का बुरा अनुभव- …… जैसे- Rude Staff…… … -Medicines not available……. - Other…… …….. Fear of hospital…….. Health worker lives close to house…… **Lack of transport during labor**……. Lack of companion during labor…….. Onset of labor before the expected date…… Other reasons…… … क्या आपको delivery के समय कोई परेशानी हुई? हाँ,मेरे साथ हुई थी…….(1) मेरे बच्चे के साथ हुई…….(2) नहीं……(3) जो डेलीवेरी में परेशानी हुई वो लिखे _____
30.	क्या आपने नीचे दिया गया समान रखा था? Did You Use?

	disposable delivery kit…… clean cloth for baby and mother…….. New blade …….. New thread……
31.	क्या आपने किसी को delivery के समय मदद के लिए बोल के रखा ? हाँ(किसे)..... नहीं.....
32.	Date of Delivery ……
33.	घर पे कहा delivery हुई थी? कमरे में-घर के अंदर.....(1) घर के बाहार.....(2) आँगन में.....(3) others (name).....
34.	Was the Delivery area cleaned before delivery?.....
35.	Does any one assisted in the delivery- No, the mother gave the birth alone……(1) Yes……..(2)
36.	Delivery किसने कराई? पड़ोसी.....(1) सांस.....(2) माँ.....(3) Traditional doctor……(4) ANM……(5) ASHA……(6) Aganwadi worker……(7) ;दाई.....(8) Mamta worker……(9) ;Other……(10) Any other……(10) Name and occupation…… क्या उसने कोई पैसे or कुछ और लिया? Yes……(1)If Money -How much……

If anything else……

No……(2)

37. Cord किसने काटी?……

38. Newborn care

Heating of the birth place	Dressing applied to Umbilical stump	Time of Bathing the Baby	What instrument was used to cut the cord?
Before birth…… After birth …….. Throughout birth…… None…… ……..	Nothing…… Oil…… Oil turmeric…… Antiseptic Cream…… Other…… ……	Less than 5 min…… Less than 15 min…… Less than 30 min …… Less than 1 hr…… Other …… ……	new or boiled blade……. old un boiled blade ……. household knife …….. unknown…… …….. others (नाम लिखे)……

39. What was the baby fed first? (Delivery होने के कितनी देर बाद पिलाया लिखे)

breast milk/colustorums……..(1)

breast milk from other woman……(2)

formula feed-cow's milk……..(3)

glucose water……(4)

plain water……..(5)

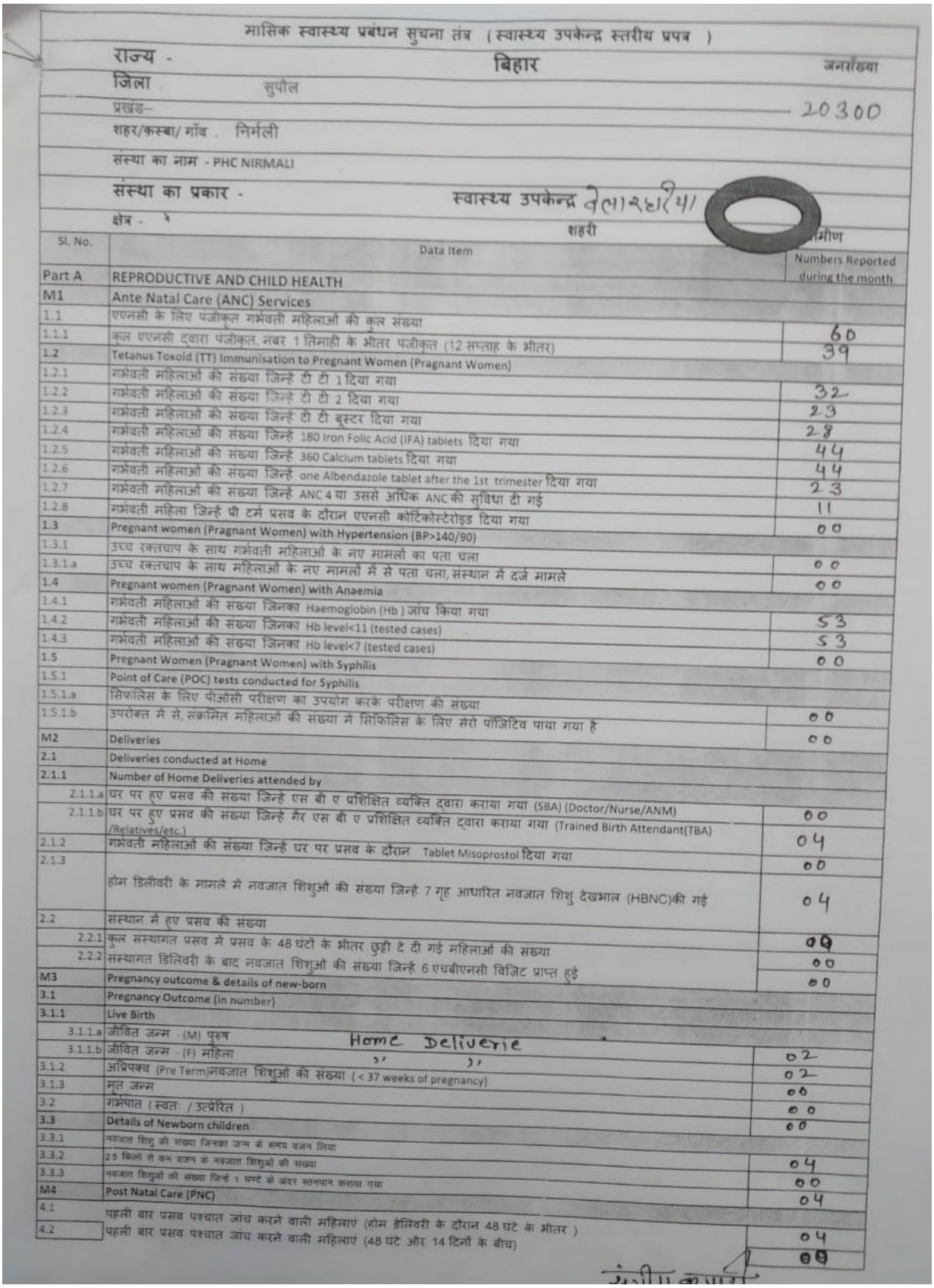
honey……..(6)

others (Name)……(7)

40.	After delivery did you have any problem?(excessive bleeding, Fever, pain while passing urine, pain in lower abdomen ,Foul smell) No…… Yes…….. If yes what treatment did you took……
41.	Do you use any Family Planning Method(बच्चो मैं अंतर रखने के लिए or if have taken permanent method) ? .....
42.	After Home Delivery were you visited by Any Health worker? Yes……..(1) If Yes How many times……. No……(2)
43.	If Yes what all do they talked about? (PNC, Dangerous Signs, How to take care of Baby) ……
44.	क्या आपको पता है कि अस्पताल में डेलीवेरी कराने के पैसे मिलते है? Yes……..(1) No……..(2) If Yes How Much……
45	In case of Planned home delivery were you willing to avail Facility services in time of emergency during Delivery? Yes……..(1) If Depends on Family advice(Name)……. Depends on Health worker advice…… Which Health worker……

	No.....(2)
46.	क्या आपके पास MCP कार्ड है (for your latest home born child)?..... कब बनाया गया..... क्या आपने MCP CARD में दी गयी जानकारी पड़ी?.....हाँ पड़ी..... बस देखी..... नहीं पड़ी.....

Appendix: 02 Reporting



मासिक स्वास्थ्य प्रबंधन सुचना तंत्र (स्वास्थ्य उपकेन्द्र स्तरीय प्रपत्र)

राज्य - बिहार

जिला - सुपौल

प्रखंड-

शहर/कस्बा/ गाँव - निर्मली

संस्था का नाम - PHC NIRMALI

संस्था का प्रकार - स्वास्थ्य उपकेन्द्र वेलाउदिया

क्षेत्र - शहरी

जनसंख्या 20300

Sl. No.	Data Item	ग्रामीण Numbers Reported during the month
Part A	REPRODUCTIVE AND CHILD HEALTH	
M1	Ante Natal Care (ANC) Services	
1.1	एएनसी के लिए पंजीकृत गर्भवती महिलाओं की कुल संख्या	
1.1.1	कुल एएनसी द्वारा पंजीकृत, नंबर 1 तिमाही के भीतर पजीकृत (12 सप्ताह के भीतर)	60
1.2	Tetanus Toxoid (TT) Immunisation to Pregnant Women (Pragnant Women)	39
1.2.1	गर्भवती महिलाओं की संख्या जिन्हें टी टी 1 दिया गया	
1.2.2	गर्भवती महिलाओं की संख्या जिन्हें टी टी 2 दिया गया	32
1.2.3	गर्भवती महिलाओं की संख्या जिन्हें टी टी बुस्टर दिया गया	23
1.2.4	गर्भवती महिलाओं की संख्या जिन्हें 180 Iron Folic Acid (IFA) tablets दिया गया	28
1.2.5	गर्भवती महिलाओं की संख्या जिन्हें 360 Calcium tablets दिया गया	44
1.2.6	गर्भवती महिलाओं की संख्या जिन्हें one Albendazole tablet after the 1st trimester दिया गया	44
1.2.7	गर्भवती महिलाओं की संख्या जिन्हें ANC 4 या उससे अधिक ANC की सुविधा दी गई	23
1.2.8	गर्भवती महिला जिन्हें प्री टर्म प्रसव के दौरान एएनसी कोर्टिकोस्टेरोइड दिया गया	11
1.3	Pregnant women (Pragnant Women) with Hypertension (BP>140/90)	00
1.3.1	उच्च रक्तचाप के साथ गर्भवती महिलाओं के नए मामलों का पता चला	
1.3.1.a	उच्च रक्तचाप के साथ महिलाओं के नए मामलों में से पता चला, संस्थान में दर्ज मामले	00
1.4	Pregnant women (Pragnant Women) with Anaemia	00
1.4.1	गर्भवती महिलाओं की संख्या जिनका Haemoglobin (Hb) जांच किया गया	
1.4.2	गर्भवती महिलाओं की संख्या जिनका Hb level<11 (tested cases)	53
1.4.3	गर्भवती महिलाओं की संख्या जिनका Hb level<7 (tested cases)	53
1.5	Pregnant Women (Pragnant Women) with Syphilis	00
1.5.1	Point of Care (POC) tests conducted for Syphilis	
1.5.1.a	सिफिलिस के लिए पीओसी परीक्षण का उपयोग करके परीक्षण की संख्या	
1.5.1.b	उपरोक्त में से, संक्रमित महिलाओं की संख्या में सिफिलिस के लिए सेरो पोजिटिव पाया गया है	00
M2	Deliveries	00
2.1	Deliveries conducted at Home	
2.1.1	Number of Home Deliveries attended by	
2.1.1.a	घर पर हुए प्रसव की संख्या जिन्हे एस बी ए प्रशिक्षित व्यक्ति द्वारा कराया गया (SBA) (Doctor/Nurse/ANM)	00
2.1.1.b	घर पर हुए प्रसव की संख्या जिन्हे गैर एस बी ए प्रशिक्षित व्यक्ति द्वारा कराया गया (Trained Birth Attendant(TBA) /Relatives/etc.)	04
2.1.2	गर्भवती महिलाओं की संख्या जिन्हें घर पर प्रसव के दौरान Tablet Misoprostol दिया गया	00
2.1.3	होम डिलीवरी के मामले में नवजात शिशुओं की संख्या जिन्हें 7 गृह आधारित नवजात शिशु देखभाल (HBNC)की गई	04
2.2	संस्थान में हुए प्रसव की संख्या	
2.2.1	कुल संस्थागत प्रसव में प्रसव के 48 घंटो के भीतर छुट्टी दे दी गई महिलाओं की संख्या	09
2.2.2	संस्थागत डिलिवरी के बाद नवजात शिशुओं की संख्या जिन्हें 6 एचबीएनसी विज़िट प्राप्त हुई	00
M3	Pregnancy outcome & details of new-born	00
3.1	Pregnancy Outcome (in number)	
3.1.1	Live Birth	
3.1.1.a	जीवित जन्म - (M) पुरुष Home Delivere	
3.1.1.b	जीवित जन्म - (F) महिला " "	02
3.1.2	अप्रिपक्व (Pre Term)नवजात शिशुओं की संख्या (< 37 weeks of pregnancy)	02
3.1.3	मृत जन्म	00
3.2	गर्भपात (स्वतः / उत्प्रेरित)	00
3.3	Details of Newborn children	00
3.3.1	नवजात शिशु की संख्या जिनका जन्म के समय वजन लिया	
3.3.2	2.5 किलो से कम वजन के नवजात शिशुओं की संख्या	04
3.3.3	नवजात शिशुओं की संख्या जिन्हें 1 घण्टे के अंदर स्तनपान कराया गया	00
M4	Post Natal Care (PNC)	04
4.1	पहली बार प्रसव पश्चात जांच करने वाली महिलाए (होम डेलिवरी के दौरान 48 घंटे के भीतर)	04
4.2	पहली बार प्रसव पश्चात जांच करने वाली महिलाए (48 घंटे और 14 दिनों के बीच)	09

	Data Item	Numbers Reported during the month
6.5.3	Children more than 10 years received TT10 टीटी - 10	00
6.5.4	Children more than 16 years received TT16 टीटी - 16	10
6.6	**प्रतिरक्षण के पश्चात प्रतिकूल घटना (AEFI)**	
6.6.1	एईएफआई के मामलों की संख्या (फोड़े)	00
6.6.2	एईएफआई के मामलों की संख्या (मृत्यु)	00
6.6.3	एईएफआई के मामलों की संख्या (अन्य)	00
6.7	**Number of Immunisation sessions**	
6.7.1	Immunisation sessions planned नियोजित सत्र	15
6.7.2	Immunisation sessions held आयोजित सत्र	15
6.7.3	Number of Immunisation sessions where ASHAs were present सत्रों की संख्या जहाँ आशा उपस्थित थी	14
6.8	**बच्चों को 9 महीने से 5 साल के बीच विटामिन ए की मात्रा मिली**	
6.8.1	Child immunisation - Vitamin A Dose - 1 विटामिन ए खुराक 1	00
6.8.2	Child immunisation - Vitamin A Dose - 5 विटामिन ए खुराक 5	00
6.8.3	Child immunisation - Vitamin A Dose - 9 विटामिन ए खुराक 9	00
6.9	आईएफए सिरप के 8-10 मात्रा (1 मिली) (द्विपक्षीय साप्ताहिक) बच्चों की संख्या (6- 9 5 महीने) प्रदान की गई	00
6.10	12-59 माह के बच्चों की संख्या जिन्हें अल्बेंडाजोल की गोली दी गई	45
6.11	गंभीर रूप से कम वजन वाले बच्चों (0-5 साल) की संख्या जिनका स्वास्थ्य जांच किया गया	00
M7	**बचपन के रोगों की संख्या** (0-5 वर्ष)	
7.1	बचपन के रोग - क्षय रोग (टीबी)	00
7.2	बचपन के रोग - एएफपी (AFP)	00
7.3	बचपन के रोग - एएफपी खसरा	00
7.4	बचपन के रोग - अतिसार (डायरिया)	00
7.5	बचपन के रोग - एएफपी मलेरिया	00
M8	**National Vector Borne Disease Control Programme (NVBDCP)**	
8.1	**Malaria**	
8.1.1	**Rapid Diagnostic Test (RDT)**	
8.1.1.a	आरडीटी मलेरिया के लिए आयोजित	00
8.1.1.b	मलेरिया (आरडीटी) - प्लॉस्डियम विवाक्स परीक्षण सकारात्मक	00
8.1.1.c	मलेरिया (आरडीटी) - प्लामोडियम फाल्सीपेरम परीक्षण सकारात्मक	00
Part B	**स्वास्थ्य सुविधा सेवाएं**	
M9	**रोगी सेवाएं**	
9.1	**Out Patient Department (Outpatients) by disease/ health condition**	
9.1.1	Outpatient - Diabetes बाह्य रोगी - मधुमेह	00
9.1.2	Outpatient - Hypertension बाह्य रोगी - उच्च रक्तचाप	00
9.1.3	Outpatient - Stroke (Paralysis) बाह्य रोगी - पक्षाघात	00
9.1.4	Outpatient - Acute Heart Diseases बाह्य रोगी तीव्र हृदय रोग	00
9.1.5	Outpatient - Mental illness बाह्य रोगी - मानसिक बीमारी	00
9.1.6	Outpatient - Epilepsy बाह्य रोगी - मिरगी	00
9.1.7	Outpatient - Ophthalmic Related बाह्य रोगी - नेत्र सम्बन्धी	00
9.1.8	Outpatient - Dental बाह्य रोगी - दन्त सम्बन्धी	00
9.2	**Outpatient attendance (All)**	
9.2.1	Allopathic- Outpatient attendance एलोपैथी बाह्य रोगी उपस्थिति	114
9.2.2	Ayush - Outpatient attendance आयुष बाह्य रोगी उपस्थिति	00
9.3	आंगनवाड़ी केन्द्रों की संख्या जहाँ ग्रामीण स्वास्थ्य एवं स्वक्षता समिति (VHNDs)/ Urban Health & Nutrition Day (UHNDs)/ Outreach / Special Outreach का आयोजन किया गया	12
M10	**Laboratory Testing**	
10.1	**हीमोग्लोबिन जाँच का आयोजन**	
10.1.1	किये गए हीमोग्लोबिन जाँच की संख्या	53
10.1.2	हीमोग्लोबिन जाँच में कितनों का <7 mg पाया गया	00
10.2	**(Human ImmuNumber-deficiency Virus) HIV tests conducted**	
10.2.1	**एचआईवी के लिए प्रसवपूर्व मामलों का परीक्षण**	
10.2.1.a	HIV जाँच की संख्या	00
10.2.1.b	जांच की गई संख्याओं में से, संख्या एचआईवी एकीकृत परामर्श और परीक्षण केंद्र के लिए जांच की गई	00
10.2.1.c	HIV पॉजिटिव की संख्या (कन्फर्म)	00
M11	**Stock Related Data**	
11.1	**Drugs**	
11.1.1	आवश्यक दवाओं की आपूर्ति की अंतिम तिथि	03-2019
11.1.2	**Items**	पर्याप्त /अपर्याप्त
11.1.2.a	IFA tablets आई एफ ए की गोलियां	,,
11.1.2.b	IFA syrup with dispenser आई एफ ए सिरप	,,
11.1.2.c	Vit A syrup विटामिन ए सिरप	,,
11.1.2.d	ORS packets ओ आर एस पैकेट	,,
11.1.2.e	Zinc tablets जिंक की गोलियां	,,
11.1.1.f	Inj Magnesium Sulphate मैग्नीसियम सल्फेट इंजेक्सन	,,

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