

**Assessment of Health Seeking Behavior of Community in relation
to Maternal Newborn Child Health Nutrition (MNCHN), under
Mobile Health Unit Project in South District of Delhi**

**Internship Training
at
Save the Children, Delhi
(February 3 to May 2, 2014)**

**By
Bhavna Nahata**

**Under the guidance of
Dr. Neetu Purohit**

**Post Graduate Diploma in Hospital & Health Management
2012–14**

 **IIHMR UNIVERSITY**
Institute of Health Management Research
Jaipur
2014

**INSTITUTE OF HEALTH
MANAGEMENT RESEARCH**

1, Prabhu Dayal Marg
Sanganer Airport, JAIPUR - 302 029, INDIA
Tel. : 3924700, 2791431-32
Fax : 91-141-3924738
E-mail : iihmr@iihmr.org
URL : <http://www.iihmr.org>
Gram : HEALTHINST

TO WHOMSOEVER MAY CONCERN

This is to certify that Bhavna Nahata, student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from Institute of Health Management and Research, Jaipur has undergone internship training at Save the Children, Delhi from 3 February to 2 May 2014.

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

The Internship is in fulfillment of the course requirement.

I wish her all the success in all her future endeavors.



Dr. Ashok Kaushik
Dean, Academics and Student Affairs
IIHMR, Jaipur



Dr. Neetu Purohit
Associate Professor
IIHMR, Jaipur



Save the Children
Bal Raksha, Bharat

May 2, 2014

TO WHOM SO EVER IT MAY CONCERN

This is to certify that Ms. Bhavna Nahata has volunteered with Save the Children at Delhi State Programme Office from 3rd February 2014 to 2nd May 2014 in health project.

We found Bhavna to be compassionate and a quick learner. We wish her all the best for all her future endeavors.



Pooja Mathur
Manager – Human Resources

Head Office:
3rd Floor, Vardhaman
Trade Centre, 9, 10, 11
Nehru Place
New Delhi 110019
Society Registration No: S/51101/2004

Telephone +91-11-4229 4900
Fax +91-11-4229 4990
Email: info@savethechildren.in

www.savethechildren.in

FCRA Registration No: 231660869

All donations are exempt under 80G of I.T. Act 1961

**INSTITUTE OF HEALTH
MANAGEMENT RESEARCH**

1, Prabhu Dayal Marg
Sanganer Airport, JAIPUR - 302 029, INDIA
Tel. : 3924700, 2791431-32
Fax : 91-141-3924738
E-mail : iihmr@iihmr.org
URL : <http://www.iihmr.org>
Gram : HEALTHINST

INSTITUTE OF HEALTH MANAGEMENT RESEARCH, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "Assessment of Health Seeking Behavior of Community in relation to Maternal Newborn Child Health Nutrition (MNCHN), under Mobile Health Unit Project in South District of Delhi" has been successfully completed and submitted by Dr. Bhavna Nahata Enrolment No. IIHMR/PGDHM/2012-14/17-1302 under the supervision of Dr. Neetu Purohit for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from February 03, 2014 to May 2, 2014 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Signature:



Date: 28.05.14

Acknowledgement

Any accomplishment requires efforts of many people and this project is no different. I have received munificent help from many quarters for developing this report, which I would like to put on record here with deep gratitude and immense pleasure.

First and foremost, I am glad to acknowledge my guide Dr. Neetu Purohit, Professor, IHMR, for incorporating right attitude in me towards learning and for helping and supporting whenever required.

It has been a proud privilege for me to work with Save the Children, New Delhi and I am highly obliged to Mr. Sanjib Kumar Behera, Program Coordinator for giving me the opportunity to work under his due guidance. I express my sincere gratitude to Mr. Padmanav Dutta and Mr. Rakesh Kumar, Project Coordinators to encroach upon their precious time from the very beginning of this work till the completion. Their expert guidance, affectionate encouragement and critical suggestions provided me necessary insight into the project and paved the way for meaningful ending of this report.

In addition I remain enormously thankful to all the Community Health Workers and Supervisors for their cooperation during the field visits and providing various data and information. Lastly, I am thankful to all the staff members of Save the Children and partner organizations who helped me during this project in any ways or means.

This project gave me an opportunity to learn about some very important aspects of Health, Nutrition, Water and Sanitation particularly in urban slums. I hope the lessons learnt by me while working on this project will help me in achieving a remarkable level in my future endeavours.

Bhavna Nahata
PGDHM

Contents

List of Tables	5
List of Figures	6
Abstract	7
1. Introduction.....	9
1.1 Health and Nutrition Services in Delhi	9
1.2 Situation Analysis-Urban poor of Delhi	10
1.2.1 Neonatal, Infant and Child Mortality	10
1.2.2 Childhood Morbidities and Health Services	10
1.2.3 Maternal Health.....	12
2. Background of the Project.....	14
3. Review of Literature	17
4. Methodology	18
4.1 Study Type	18
4.2 Study Area	18
4.3 Study Population.....	18
4.4 Sampling Design.....	19
4.5 Sample Distribution	20
4.6 Data Collection Tool	20
4.7 Data Quality	21
4.8 Data Analysis.....	21
5. Results & Discussions.....	22
5.1 Pregnant Respondents	25
5.2 Lactating Mothers	31
5.3 Mother of Child under 5 years of age	33
6. Conclusion	37
Annexure	38
Bibliography	49

List of Tables

Table No.	Description	Page No.
1	Mortality Rates in Delhi	9
2	Immunization Coverage in Delhi	9
3	Intervened Slum Clusters in South Delhi	17
4	Family Size of Households	21
5	Income of Sampled Households	21
6	Respondents Age at the time of Marriage	22
7	Number of Pregnancies	23
8	Preference for ANC Services	25

List of Figures

Figure No.	Description	Page No.
1	Sampling Design	19
2	Distribution of Delivery Level	22
3	Number of Miscarriages	23
4	Child Parity	24
5	Utilization of ANC Services	24
6	ANC Checkups	25
7	Distribution of Motivation Source	26
8	Distribution of Preferred Place to get IFA Tablets	27
9	Percentage of Pregnant women Consuming IFA Tablets	27
10	Reasons for not consuming IFA Tablets	28
11	Percentage of Women received TT Vaccination	28
12	Awareness level about High Risk Pregnancy	29
13	Distribution of factors leading to High Risk Pregnancy	29
14	Preferred Place for Delivery	30
15	Distribution of Persons who encouraged Practice of Colostrums Feeding	31
16	Distribution of Responses in regard to Exclusive Breast Feeding	31
17	Percentage of Ever Immunized Children	32
18	Preferred Place for Immunization	32
19	Proportion of Completely Immunized Children	33
20	Prevalence of Diarrhea	34
21	Preferred Place for Diarrhea Treatment	34
22	Awareness about reasons leading to Childhood Diarrhea	35
23	Prevalence of Pneumonia	35

Abstract

Assessment of Health Seeking Behavior of Community in relation to Maternal Newborn Child Health Nutrition (MNCHN), under Mobile Health Unit Project in South District of Delhi

Bhavna Nahata, PGDHM (Health)

Introduction

Save the Children-India, has set up a system of comprehensive healthcare delivery in urban slums of Delhi. The project focus is on empowering by equipping community with health related awareness, thus catalyzing community level actions to increase demand for quality healthcare services. There are two key components; To catalyze community level actions for sensitizing people about the importance of health (specially maternal, child health, nutrition and sanitation) services and behaviors and to meet the resultant demand for services in the selected slum communities of Delhi, by providing services through Mobile Health Units

Almost half of the mothers did not avail ANC services before the intervention and 82% women chose to deliver at homes. It has been three years since the implementation of aforementioned project and there was a need to generate evidences and assess the current health status of the population covered under project. Further, to understand the overall improvement in the intervened area in relation to demand and awareness of MNCHN services.

Objectives

The key objective of the study was to assess the current health seeking behavior of the community living in the intervened slum clusters of South Delhi, in relation to MNCHN services.

Methodology

A cross sectional descriptive study was conducted in ten intervened slum clusters. Lot Quality Assurance sampling method was adopted to draw a sample size of 190 households. The respondents were further categorized into pregnant women, lactating mothers and mothers of child under 5 years of age. Quantitative data was collected using the structured questionnaire to gather information about current health seeking behavior in relation to ANC, breast feeding, growth monitoring, immunization and childhood illnesses.

Results

An increase in the utilization of ANC services from 50 to 88%, home deliveries has reduced from 82% to 33%. More than 67% visit to MHU for ANC checkups. Only 56% pregnant ladies were actually consuming IFA tablets in spite of a distribution rate of 80%.

More than third fourth of sampled women were unaware of factors that can lead to high risk pregnancy.

Almost 80 % children were completely immunized. There was 67% prevalence of Diarrhea and 36% of households were following self treatment approach for recurrently occurring diarrhea in children.

Only 13% out of 70 mothers were keeping record of their child growth and 40 were unaware of the reasons that can lead to malnutrition.

Conclusion

The utilization of ANC has increased to a remarkable level by meeting the demand with the aid of MHU. Therefore, it has brought a positive change in the health seeking behavior of the community. Further, there is a need to more sensitize the community about MNHCN practices and aware them about preventive health seeking behavior with the help of counseling session and community level groups.

1. Introduction

1.1 Health and Nutrition Services in Delhi

Compared to other states, Delhi as a whole has a well developed health infrastructure. Delhi Government and the Municipal Corporation of Delhi (MCD) form the backbone of the public health service delivery system in the city providing most of the health services in the public sector. Private health providers too are key players in the overall provisioning of the care services.

At the primary health care level, Delhi has a wide network of 969 dispensaries providing primary health care through Delhi Government, the MCD, the NDMC, the Cantonment Board and CGHS, ESIC, Railways etc. Besides there are a number of supplementary health services available like the School Health Clinics, Mobile Dispensaries etc.

At the secondary and tertiary health care levels, there are 706 hospitals including 550 registered nursing homes with 33711 beds. There are 118 hospitals in the Govt. sector in Delhi. 31 hospitals are being run by the Govt. of NCT of Delhi, 53 by the MCD, 4 by the NDMC. There are also 24 Central Government Hospitals including ESIC, Railway Hospitals etc. Delhi's bed-population ratio is 2.07 beds per 1000 population which is better as compared to the national average of one per 1000.

Though the situation of health services in Delhi is much better than in other states, there are certain areas which require attention. This includes provision of health services to the large and rapidly growing urban poor habitations in the city which include JJ clusters, unauthorized colonies, resettlement colonies and pavement dwellers which have very poor access to health services. The hospitals in Delhi also cater to a large number of patients from other states. It is estimated that nearly 33 per cent of the load in secondary facilities in Delhi is from neighboring states. This leads to further strain on the existing infrastructure in the city.

In May 2007, the Cabinet of the Delhi Government approved, the deployment of 5,450 ASHAs to cover 109 lakh residents of slums, JJ cluster, resettlement colonies, unauthorized colonies and rural villages.

Despite these investments in health, the access and acceptability for health is grossly inadequate. Though the aggregate health statistics of Delhi are considerably better than the national averages, not only are the urban poor in Delhi considerably worse off than their better off neighbors in Delhi, but are significantly worse off than their urban poor counterparts in other states.

1.2 Situation Analysis-Urban poor of Delhi

1.2.1 Neonatal, Infant and Child Mortality

Infant and child mortality rates reflect the level of socioeconomic development and quality of life and are used for monitoring and evaluating population and health programs and policies. The neonatal, infant and child mortality rates for Delhi's urban poor at 35.6, 54.5 and 73.6 speaks about the disparities between urban poor and non-poor in this city.

Table1. Mortality Rates: Delhi, as per NFHS-3

Mortality Rates	Urban poor	Urban non poor
Neonatal Mortality Rate	35.6	27.8
Infant Mortality Rate	54.5	37.5
Under five Mortality Rate	73.6	41.8

1.2.2 Childhood Morbidities and Health Services

The greatest risks to life are in its beginning, but they do not disappear as the newborn grows into an infant and young child. Programs to tackle vaccine preventable diseases, malnutrition, diarrhea or respiratory infections still have a large unfinished agenda among vulnerable slum communities in Delhi.

Table 2. Immunization Coverage in Delhi

Immunization Coverage in Delhi (NFHS-3)	Urban poor	Urban non poor	Urban total
Children completely Immunized (%)	39.5	69.2	63.0
Children receiving measles Immunization (%)	50.0	85.6	78.3

Dropout and left out rates are far higher among urban poor households (36.6 % and 25.9 % respectively), in comparison to the urban average (11.4 and 9.1 % respectively). The higher drop-out rate in comparison to left out rate in urban areas highlights the fact that though physical reach/access exists in urban areas, counseling of families who are resistant against immunization due to few minor symptoms after immunization, active outreach sessions, follow up and consistent quality of services need rigorous improvement.

Mother's lack of information is the major cause of non immunization. An important factor impeding immunization coverage is lack of awareness among the slum dwelling community about complete immunization schedule and its importance.

Diarrhea

Diarrhea is the second most important killer of under-five children worldwide, outnumbered only by acute respiratory infections. Diarrhea is very common among urban poor in Delhi

Occurrence of diarrhea can be directly attributed to the absence of proper water supply and sanitation facilities in the urban slums of Delhi. Majority of the urban poor areas, such as Shahdara North, do not have sanitation and drainage facilities on account of being unauthorized.

It is important to increase awareness among mothers and communities about the causes, prevention and treatment of diarrhea.

Practices during Diarrhea

Oral Rehydration Therapy (ORT), a simple, cost-effective treatment given at home using either packets of Oral Rehydration Salts (ORS) or a simple home-made solution of sugar, salt and water, has contributed significantly to reduce child mortality due to dehydration caused by diarrhea. The practice of giving ORS during episodes of diarrhea was found to be abysmally low among the urban poor of Delhi. NFHS-3 found use of ORS in diarrhea was reported in only 27.8% of cases here.

Acute Respiratory Infections

Acute respiratory infections—primarily pneumonia—are a major cause of illness and mortality among children throughout the world. In developing countries, an estimated 4.1 million children under age five die from acute respiratory infections (ARI) every year. In India, as in many other countries, ARI is the leading cause of childhood deaths. It is estimated that 60 percent of ARI deaths can be prevented by seeking health care immediately on developing signs of ARI and by selective use of antibiotics.

ARI assumes more significance in an urban slum setting where overcrowding and air pollution (both indoor and outdoor) are very common. The probable reason behind high rate of pneumonia in urban slums is not seeking proper treatment at the starting of infection and negligence of local practitioner or quacks.

Infant Feeding practices

Appropriate infant feeding practices have significant beneficial effects on both mothers and children. Early and exclusive breastfeeding up to 6 months of age improves nutritional status, immunity and provides warmth resulting in better chances of survival and growth of child. Mothers are benefited due to lactational amenorrhea (LAM) or contraceptive effect of breast feeding enabling longer birth interval, reduced risk of ovarian cancer and emotional bonding with the child.

Timely introduction of calorie rich complementary foods in an infant's diet has a bearing on his nutritional status allowing normal growth and development. Recent evidence documents breastfeeding and complementary feeding as the most valuable interventions for improving child survival.

Infant feeding practices among the urban poor in Delhi as revealed in further analysis of NFHS 3 findings are as follows:

- Only 13.6% of urban poor neonates are breastfed within one hour of birth
- Only 39.1% of children from urban poor families are exclusively breastfed for 6 months

Principle etiological factors for the causation of Protein Energy Malnutrition (PEM) in children between 6-12 months are non feeding of colostrums, lack of exclusive breastfeeding, late introduction of semi-solid and solid foods, dilution of top milk and faulty weaning practices.

1.2.3 Maternal Health

Pregnancy and childbirth are the leading causes of death, disease and disability among women of reproductive age. They account for at least 18% of the burden of disease in this age group – more than any other single health problem. Maternal health interventions in the form of antenatal care, skilled attendance during delivery and helping women prevent unwanted pregnancy are among the most cost-effective and life saving investments in public health.

Antenatal care

Lack of antenatal care is an important risk factor for maternal deaths. Women having developed contacts with the health system in the antenatal period may lead to earlier decision making about the place of care and therefore lower mortality. Women's tetanus immunization provided in the antenatal service package contributes to lower neonatal mortality due to tetanus. Iron and folic acid supplementation in the antenatal care package has reduced the prevalence of anemia among pregnant women and thereby lower maternal and perinatal mortality.

It is important to provide pregnant women with at least three antenatal checkups, two doses of tetanus toxoid vaccine and iron and folic acid supplementation during pregnancy for at least three months.

Only about 41% of the mothers in urban poor households received the recommended three or more antenatal check-ups as against the urban average of 75.1 percent .Only 11 percent urban poor mothers consumed IFA tablets as against the urban average of 41 percent. Recommended TT immunization coverage (at least 2 doses) was found in 74.3 percent

mothers. When the definition of complete ANC care, (i.e. three ANC visits, 2 doses of TT and consumption of 90 doses) was taken into account, alarmingly only 4.2 percent of mothers were discovered to have received it.

Care during delivery

Skilled care during childbirth is important because millions of women and newborns develop serious and hard to predict complications during or immediately after delivery. Skilled attendants—health professionals such as doctors or midwives possessing requisite midwifery skills—can recognize these complications timely, and either treat or refer them to health centers or hospitals immediately if more advanced care is needed. As many as 8% of all women might experience a potentially life threatening morbidity during delivery and 11% during the post partum period. Once a major obstetric complication develops, a trained traditional birth attendant or nurse can do little at home because surgical intervention is often necessary.

The practices among the urban poor in Delhi for delivery are as follows:

- Among the urban poor, domiciliary delivery is still the norm with more than two-thirds 83.4 percent of deliveries taking place at home.
- The deliveries attended by a health professional at home among the urban poor households are only 24.5 percent in comparison to the urban average of 64.2 percent.

2. Background of the Project

Save the Children-India, has set up a system of comprehensive healthcare delivery for the defined urban slums of Delhi, with focus on empowering by equipping them with health related awareness, and thus catalyzing community level actions to increase demand for quality healthcare services. Save the Children supports supply side through supporting provision of all basic maternal, newborn, child Health and Nutrition (MNCHN) services to the urban poor of Delhi through Mobile Health Units.

Currently, the project is operational in North, North-East & South districts of Delhi. These were selected based on various criteria including but not limited to the percentage of slum settlements, the rate of population growth, the operational feasibility and poverty hotspots.

The project has two key components-

- To catalyze community level actions for sensitizing people about the importance of health (specially maternal, child health ,nutrition and sanitation) services and behaviors
- To meet the resultant demand for services in the select slum communities of Delhi, by providing services through Mobile Health Units

Another element of the project is to strengthen the capacity of the field workers serving these areas, to deliver quality MNCHN services, with special emphasis on essential newborn care and community case management of diseases like diarrhea and pneumonia.

This project is implemented to support the healthcare delivery system for urban poor of Delhi, by setting up a model of comprehensive healthcare provision, with the objective to address the multitude of causal factors which are responsible for their abysmally poor health status.

Strengthening the supply side

In order to ensure delivery of quality general healthcare and maternal newborn, child health and nutrition services to the vulnerable segment of population living in urban slums of Delhi, a model of comprehensive (preventive, promotive and curative) service delivery has been functional through mobile healthcare units (MHUs) with a strong focus on community based actions to catalyze change of health nutrition and water sanitation related behaviors.

(a) Supporting healthcare service delivery

Mobile Health Unit

This is a van fitted with all basic facilities for examination of patients, and with essential diagnostic equipments. MHUs are staffed with general physician who are experienced in

delivering primary maternal and child health care. There are paramedical and other support staffs for delivery of comprehensive healthcare to the urban poor communities through these mobile units.

These MHUs conduct camps in the identified slums / slum clusters on a 'fixed-day fixed-site' basis. Each site gets covered once every week on the day and time fixed for that locality in consultation with the community members and the Municipal Corporation of Delhi.

The MHU have equipment and facilities for carrying out antenatal, postnatal and newborn checkups, growth monitoring of children, cold chain equipment for vaccines, and audio-visual equipments for film shows. These units have training and learning print, audio and videographic materials being used for on-job capacity building of the health workers.

The project is currently functional in three districts of Delhi. A total of 3 MHUs are operational across the three districts. Each MMU covers 10 locations in the slums. Besides diagnosis and treatment of ailments and infection, staff from these units also carries out Information, health education and communication activities for the population, focusing on maternal and child health.

(b) Enhancing skills of service providers

Another most important component of the project is to work closely with the health functionaries of the government system and improve their capacity on areas like essential home based newborn care, care during pregnancy, community case management (CCM) of common diseases like diarrhea and pneumonia, which are amongst the major causes of morbidity and mortality. The project impart reinforcement training to ASHAs, ANMs, AWWs on all key issues related to MNCHN. The reinforcement training under projects intends to improve upon the shortcoming of the government trainings. The project also works to refine the skills of these workers on effectively carrying out interpersonal communication around MNCHN issues.

Save the Children also working to strengthen community system by improving the awareness of the individuals and families, by setting up community based groups to take actions to improve health situation at the community level, engaging active volunteers from within the community to support service delivery and building their capacity.

Catalyzing Cohesive Community Actions

Cohesive Action Groups-The MHUs team have skilled communications, counseling and social mobilization staff, who have worked for formation of community level cohesive action groups (CCAGs) who have been trained on the importance of basic health, nutrition and environment sanitation related behaviors. Supposedly, these groups meet regularly to discuss the slum specific problems and to find local solutions through coordinated actions. For example, the members are supposed to sensitize the women and families to follow

recommended behaviors on Infant and Young Child feeding and monitor the actual practices on this.

Slum health and Sanitation Team (SHAST) The project has set up teams of adolescent boys, girls and other children who are supposed to actively work for improving the environmental sanitation of the slums, advocate against the open field defecation habits, The group members sensitize communities for following safe garbage disposal practices, personal and food hygiene practices, and also for availing the essential primary health care services for women and children as a high priority need. This Slum Health and Sanitation team work closely in coordination and with support from, Cohesive Action Groups.

Overall responsibility of these two groups is to monitor the behaviors related to health, hygiene, environmental sanitation, nutrition, and also to mobilize communities for availing essential health care services.

Purpose of the Study

All the described components of MHU project somehow affect the health seeking behavior of the community and lead to right MNCHN practices. The demand side is covered by providing primary MNCHN services and therefore aids in dealing with the unavailability issue. However the other components, specifically awareness and behavior change communication through community level groups, community health volunteer and by capacity building of frontline health workers will decide the ultimate fate of the project and its outcome. The sustainability for any project outcome can only be achieved by making the beneficiaries aware about the right approach and by sensitizing the community about their own health needs. Undoubtedly, availability and accessibility remains a major issue for any health need however, in a city like Delhi with adequate provision of primary, secondary and tertiary healthcare structures the more important aspect is to sensitize and empower the slum population about the right health practices and health seeking behavior to avail requires services.

The process of community mobilization is a time consuming and vigorous exercise but this can be achieved by continuous efforts and using behavior change communication methods. There is a need to actually bring out positive outcomes through community group meetings and discussions, especially the adolescents groups. This should be considered as a primarily focused activity to bring everlasting change among the community members, their practices and awareness level. It has been three years since the aforementioned project implemented in the selected urban areas and it has shown a remarkable difference in the health status of the people living in the intervened areas. However, there is a need to generate evidences and assess the current health status of the population covered under project. Assessment of current health seeking behavior of the community living in intervened areas will help in clearly depicting the impact of the project and to identify the gaps in implementation plan.

Research Question

- What is the current health seeking behavior in relation to MNCHN services in intervened slum clusters of South Delhi?
- What is the level of awareness in relation to High Risk Pregnancy among the community people living in intervened area?
- What is the level of awareness among the intervened community population about malnutrition and childhood illnesses?

Objectives

- To assess the health seeking behavior in relation to ANC, Breast feeding practices, Immunization and Childhood illnesses.
- To assess the level of awareness among the households about malnutrition and childhood illnesses
- To assess the level of awareness among the households about high risk pregnancy.

3. Review of Literature

According to a study conducted in 2011 on maternal and child health in slums of Delhi, almost half (45 percent) the mothers did not avail antenatal services; and only about 16 percent women had received the optimal four antenatal checks during pregnancy. Knowledge with regard to nutrition, attention to health and awareness of possible complications during pregnancy was poor. As much as 12 percent of women continued to smoke even during pregnancy. 63 per cent mothers had been immunised with tetanus toxoid and 51 per cent were receiving iron and folic acid tablets during pregnancy.

Eighty-two percent women chose to deliver their babies at home; most deliveries were conducted by untrained birth attendants. The knowledge, attitude and practices of birth attendants with regard to pregnancy and childbirth were far from satisfactory. In fact, some of the practices relating to labour management and neonatal care were potentially harmful. The 'high risk' concept and referral practice were apparently unfamiliar to most birth attendants. Another study conducted in urban slums of Anand, Gujarat concluded that exclusive breastfeeding till 6 months was given in 6.5% of slum population.

Almost all health problems of the slum dwellers originated from the prevailing unhygienic environment of the slums and working/food habit of the slum population. Nonqualified allopathic drug sellers were found to be the main source of initial treatment for slum dwellers even when qualified practitioners were available. Drug sellers' service is associated with incorrect treatment and harmful practice.

Health seeking behaviour of urban poor in India is a product of morbidity pattern, income level, type of health system and location of the facility (distance). Cultural factors, illness and health service perception and informal consultation play a lesser role.

4. Methodology

4.1 Study Type

Cross-sectional descriptive study was followed to conduct the assessment in the intervened areas.

4.2 Study Area

Out of the three intervened districts, South district was selected to conduct the assessment. Since the state head office is located in the selected district, it was found to be most appropriate and feasible to conduct the assessment there.

The project is operational in 10 selected slum clusters of Okhala, namely:

Table3. Intervened Slum Cluster in South District

S.N	Slum Cluster	Ward No.
1	Transit Camp	196
2	V. P. Singh Camp	197
3	Rekha Camp, Yogshaala Camp, Mazdoor Camp, New Sanjay Camp Part 2	199
4	Indira Kalyan Vihar Part 1	199
5	Indira Kalyan Vihar Part 2	199
6	Janta Mazdoor Camp	200
7	New Sanjay Camp Part 2, Chawla Camp, Janta Jeevan Camp	200
8	Sanjay Colony Part 1	200
9	Sanjay Colony Part 2	200
10	Jeevan Jyoti Rajeev Camp	200

4.3 Study Population

The aforementioned clusters were specifically formed by merging closely located camps in the Okhala area for implementing the activities under MHU project. While forming the clusters a target population of approximately 10,000 households each cluster was considered and followed. Therefore, the universe for this project was approximately 10,000 households each cluster and hence a total of one lakh families per district.

Similarly, for this study the universe covers a population of approximately one lakh households.

4.4 Sampling Design

Sampling Technique: LOT Quality Assurance Sampling (LQAS)

Lot Quality Assurance Sampling (LQAS)

(LQAS) is a random sampling methodology, originally developed in the 1920s to control the quality of output in industrial production processes and further to assess the impact of any intervention or service.

- Involves taking a small random sample of intervened population and test the sampled cases for quality of services and intervention.
- The decision rule is based on the desired services standards and a statistically determined sample size
- A sample size of 19 provides an acceptable level of error for making management decisions; at least 92% of the time, it identifies whether a coverage benchmark has been reached or whether an SA is substantially below the average coverage of a program area
- Samples larger than 19 have practically the same statistical precision as 19. They do not result in better information, and they cost more.
- Sample sizes less than 19 however, see a rapid deterioration in the precision of the measure. This is particularly problematic when coverage benchmarks vary.

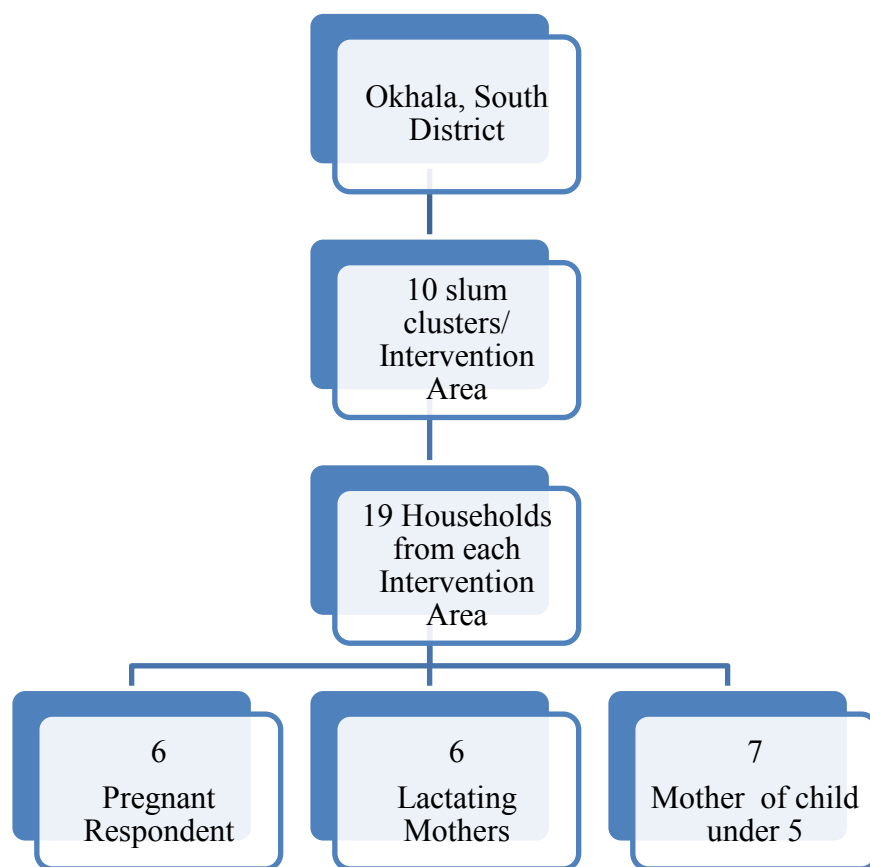


Fig1. Sampling Design

4.5 Sample Distribution

By following the above described design a total sample of 190 (19x10) households was drawn. Out of which three types of respondents were selected to get comprehensive results and for covering the three important categories of MNCHN viz.

- Pregnant Women
- Lactating Mothers
- Mother of Child under 5

Hence,

- Number of Pregnant women covered= 60
- Number of Lactating mothers covered= 60
- Number of Mother of child under 5= 70

4.6 Data Collection Tool

Structured Questionnaire was used to gather the relevant quantitative data in six major headings; ANC, Delivery, Breast Feeding, Immunization, Growth Monitoring, Childhood illnesses. The questionnaire was developed in a manner to collect comprehensive

information about the awareness level of the community and their approach towards listed health aspects.

A small section on water sanitation hygiene was also covered under it. As mentioned in background section of the project, it also emphasizes on few WASH issues in urban slums and has included some major activities under it. The WASH section in questionnaire was included to understand and explore the basic water sanitation and hygiene practices of households.

4.7 Data Quality

Pretesting of questionnaire was done to determine the quality of structured questionnaire. It was done by conducting interview with respondents, a kind of mock exercise to come across the loopholes in the data collection tool.

The pretesting was carried out in a area not covered under project. 2 questionnaires were filled to know the quality and subsequently required changes were incorporated in the final questionnaire before starting the actual survey.

4.8 Data Analysis

The collected data was entered into SPSS to perform analysis and accordingly required tables and graphs were generated and interpreted.

5. Results & Discussion

The key indicators which were analyzed to assess the current status of health seeking behavior of community living in the intervened area are described below:

Indicator	Status before intervention
ANC checkups	41%
Consumption of IFA	11%
Home Deliveries	83%
Completely Immunized	39.5%
Exclusive Breast Feeding	39%

To understand the basic profile and household characteristics of slum dwellers some questions related to their income, literacy, family size etc were included in the questionnaire. The data was analyzed to know the overall socio-economic scenario of sampled population.

Table 4. Family Size of Sampled Households

Family Size	Households
2-4	75
5-7	93
8-10	16
11 or more	6

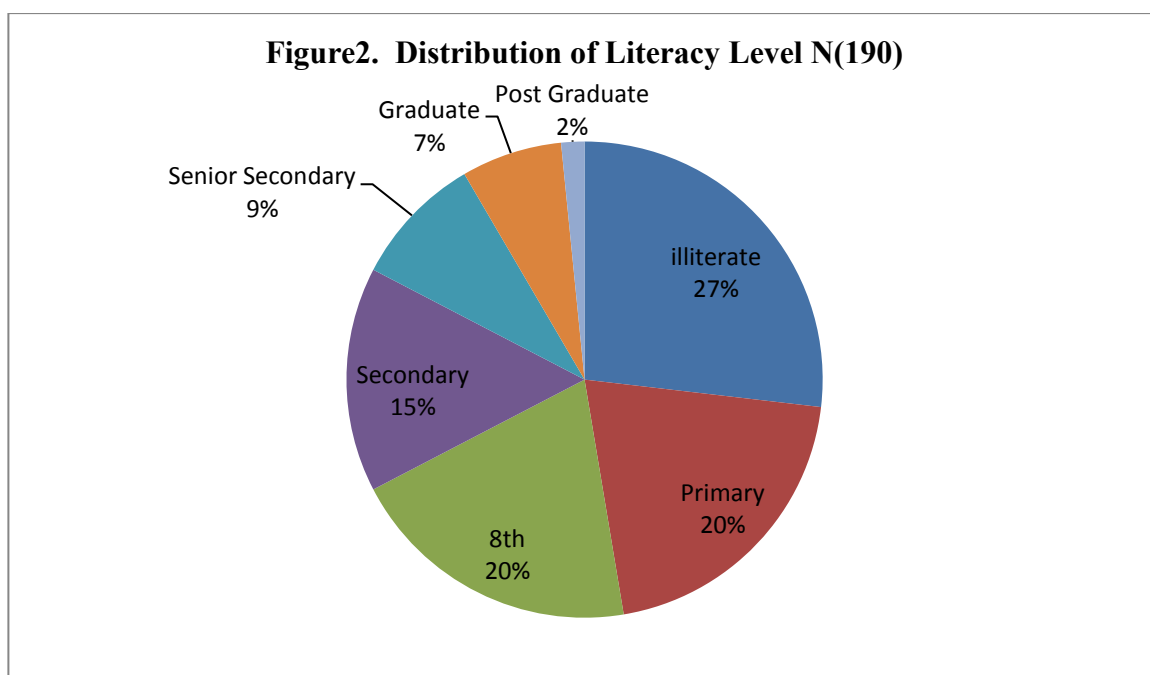
The majority of households have a family size of 5-7 that includes an average of 3-4 children per couple. However there are some cases of family size as high as 13 with 5-8 or more children.

Table 5. Income of Sampled Households

Income	Households
Less than 3000	5
3000-5000	12
5000-10000	107
10000-15000	59
15000+	7

Approximately 57 % of total sample households had a monthly income of 5000-10000 and only 4% have income more than 15000. The main source of income for majority of household is through labor work. The Okhala area has few garment industries, the head of the family either work in them on permanent bases or as a temporary labor. A permanent employee gets a benefit of availing healthcare services in the ESI Hospital as per

government norms. However, very few households were enrolled in ESI scheme due to frequent migration and temporary labor work. The other prevalent occupational options practiced by head of the family were driver, rickshaw puller, tailor etc in almost equal percentage.

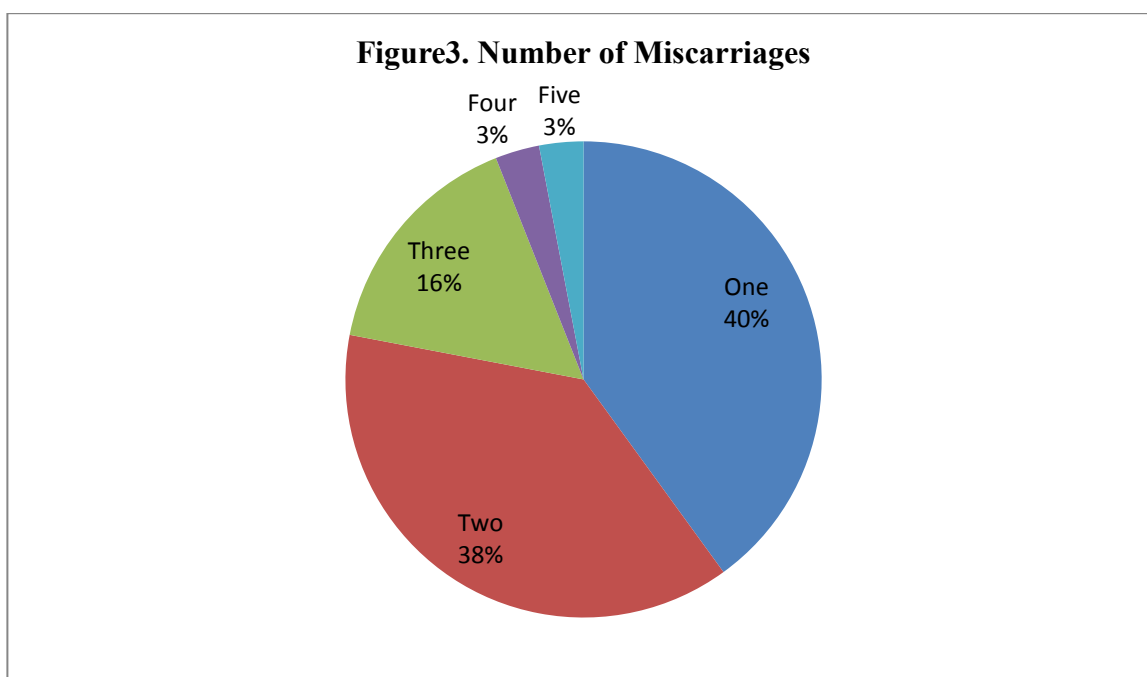


Literacy Level of Respondents: Out of 190 respondents under pregnant, lactating and MU5 category, 51 found to be illiterate without any formal education and 39 had studied till primary level. Only 17 ladies had completed her senior secondary and 13 respondent had done graduation. This may be one of the cause of low level of awarness about health and nutrition practices.

Table 6. Respondents Age at the time of marriage

Age at Marriage	Respondents
Less than 14	7
14-18	125
18-20	50
20-24	11
More than 24	2

Surprisingly, 64% of the respondents got married at a tender age between 14-18 years and only 32% got married after actual legal age of 18 years. This signifies the cause of high rate of miscarriages among women in urban slums.



71 respondent i.e. approximately 36% accepted occurrence of miscarriages predominantly in the 1st trimester and out of these, 16% had three times miscarriages till now.

The data for number of still births for last 5 years was also collected; 19 still births out of 195 respondents i.e. 10% of the whole sampled population. Similarly, 11% Child Mortality

Table7. Number of pregnancies

Number of pregnancies	Respondents
1	35
2	48
3	49
4	36
5	16
6	6
7 or more	5

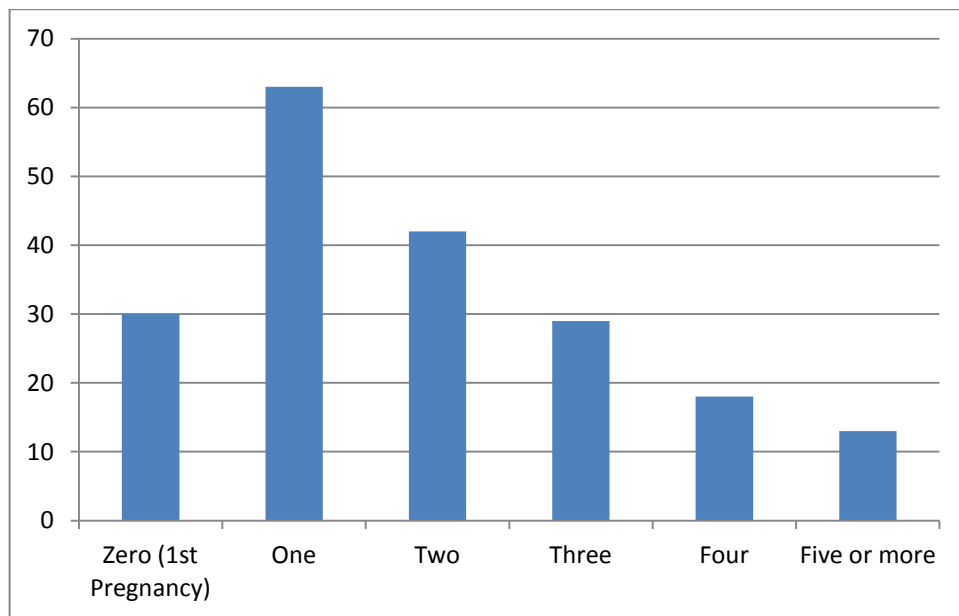


Figure4. Child Parity N (190)

5.1 Pregnant Respondents

As per set objective, it was important to understand the health seeking behavior of pregnant women of the community. Questions related to ANC checkups, TT vaccination, IFA and calcium supplements etc were included in this section.

Out of total 60 respondents 4, 19 and 37 were respectively in 1st, 2nd and 3rd trimester.

ANC Checkups

Only 7 i.e. 12% of respondents were not seeking any kind of consultation or checkups during pregnancy.

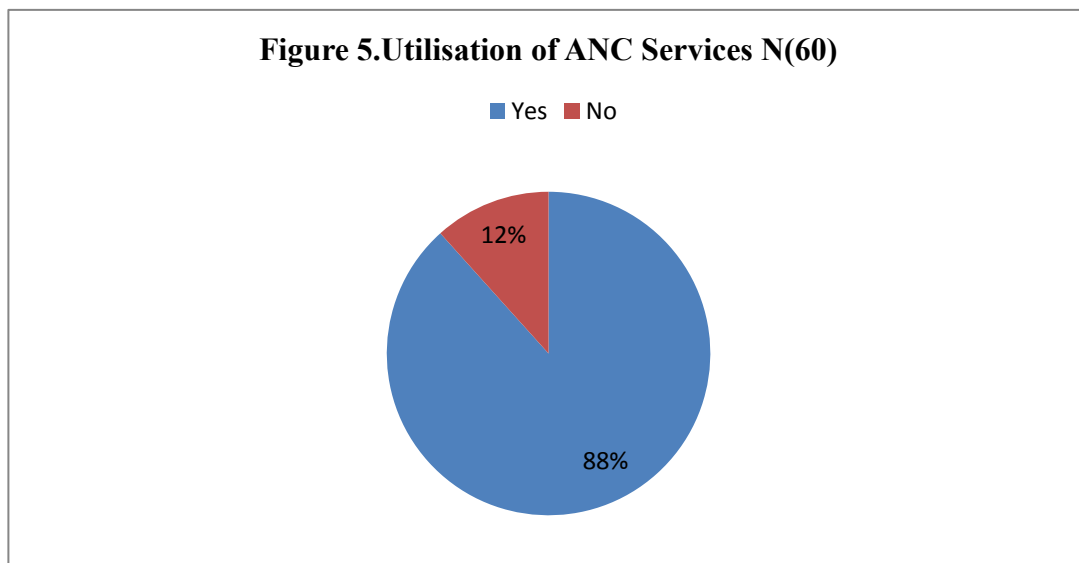
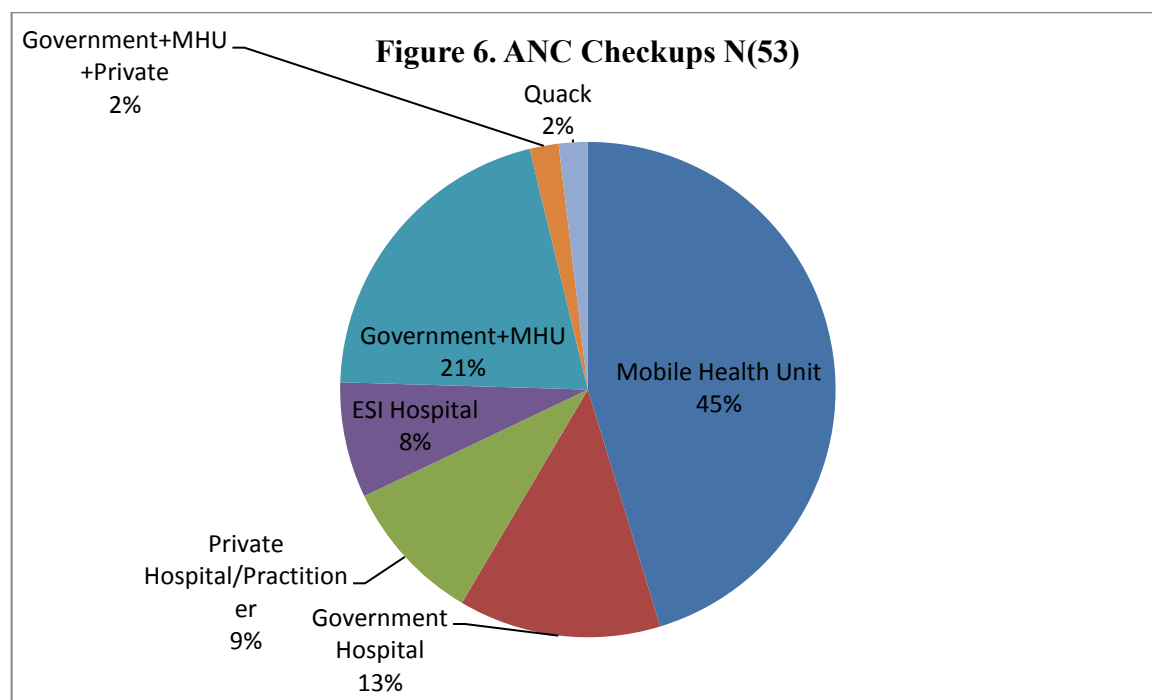


Table 8. Preference for ANC Services

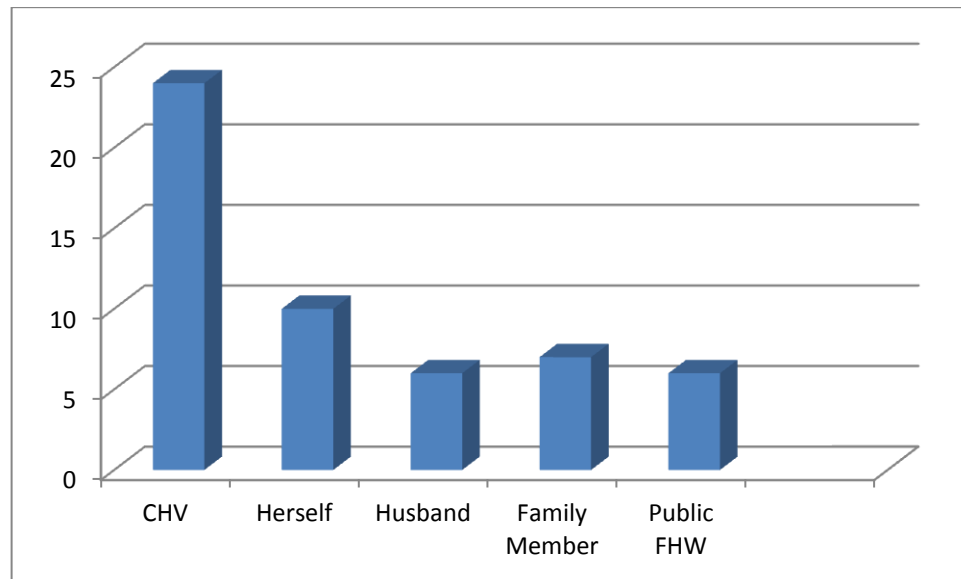
Place	Number of Respondents
Mobile Health Unit	24
Government Hospitals	7
Private Hospital/Practitioner	5
ESI Hospital	4
Government +MHU	11
Government +MHU +Private	1
Quack	1

Most of the respondent preferred MHU service for ANC checkups. The motive of MHU was to provide Maternal and Child Health Services at door step and as per set plan the mobile van visits each clusters once in a week, this makes the service easily accessible and available for the poor. Considering the distance of Safdarjung Hospital from Okhala, most of the respondent cited MHU a boon for pregnant women who cannot visit far by hospitals for regular ANC checkups.



On asking who had advised them to seek consultation for pregnancy, 24 said the Community Health Volunteer counseled them about the importance of ANC checkups and assisted them to come to MHU for regular checkups and also to get registered in government hospital for delivery. However, almost half of the respondent had sought ANC care on their own or because of their husband and family member.

Figure 7. Distribution of Motivation Source



Reasons for not seeking ANC checkups

The 7 pregnant ladies not receiving ANC checkups from any of the available means were unaware of its benefits and resistant to any kind of consultation. They claimed perfectly fine health condition and need not to consult any doctor.

Iron Supplements

A total of 48 women were receiving iron supplements from different sources, out of which maximum were getting it from MHU on monthly basis. There were respondents who were taking the medicines from more than one source. Since they get these tablets for free of cost, there was an apt demand for it. However, 12 of the total respondents were not taking such medications from any source, 8 claimed that they do not require any such medication while rest reported issue of non compliance and did not continue to take medicine.

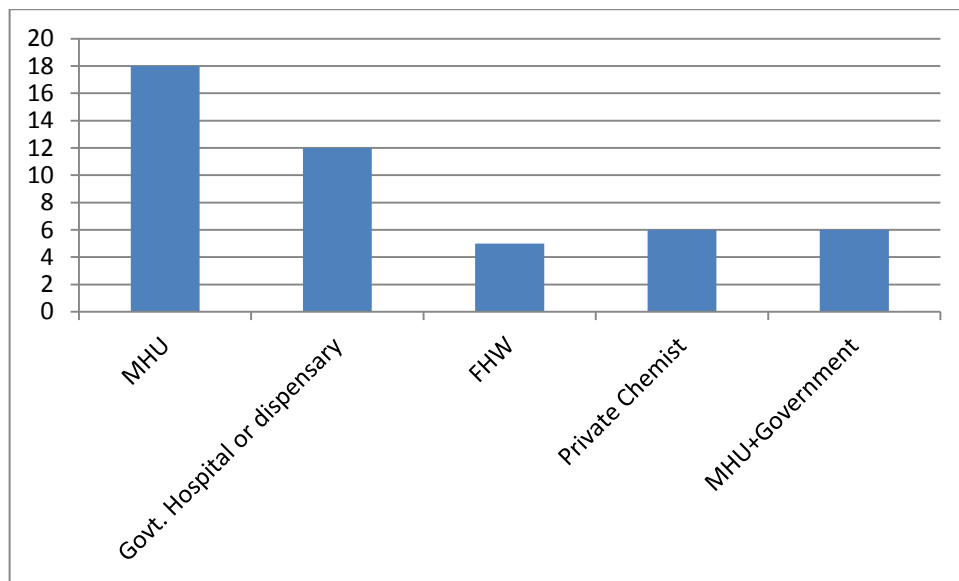
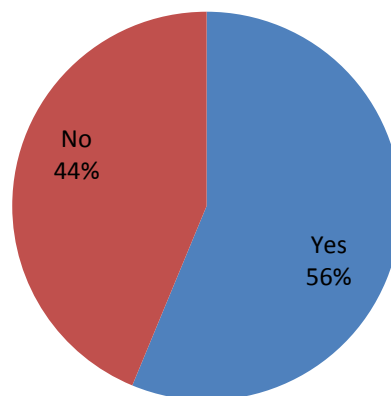


Figure 8. Distribution of Preferred place to get IFA Tablets

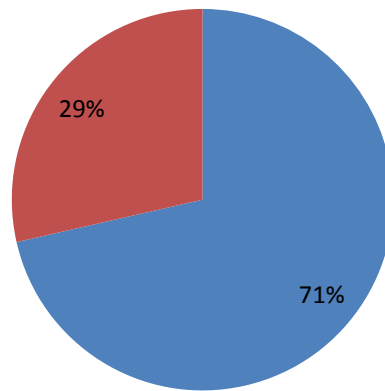
Figure 9. Percentage of Women Consuming IFA Tablets N(60)



Further, on in depth discussing the actual acceptance for IFA supplements and their adherence for it, only 56% i.e. 27 accepted that they have been actually consuming the tablets where as rest showed careless attitude and were not aware of the benefits of such supplements. 6 respondents said they discontinued the consumption because of minor discomfort felt while consuming the medicines. On counseling a few of them during the course of data collection exercise, they understood the importance of it and committed to genuinely consume it from that onwards. This fact throws a light on the available scope for generating importance of such medicines among the community and for regular follow up on their consumption of the same.

Figure 10. Reasons for not consuming IFA Tablets

■ Unaware of Benefits ■ Non compliance



Vaccination

80 % of the sample pregnant ladies had received both or first dose of TT vaccination from government hospitals, dispensaries and MNCHN camp. The percentage of women received vaccine from each source is given in figure 13.

Figure 11. Percentage of Women received TT Vaccination

■ Yes ■ No

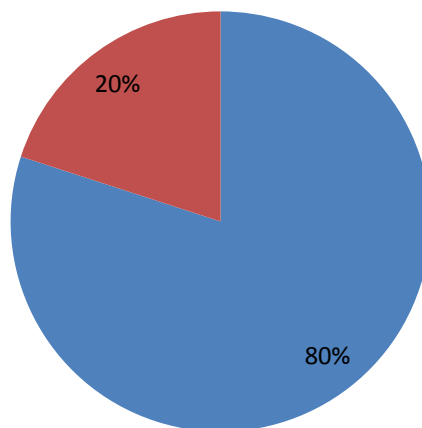
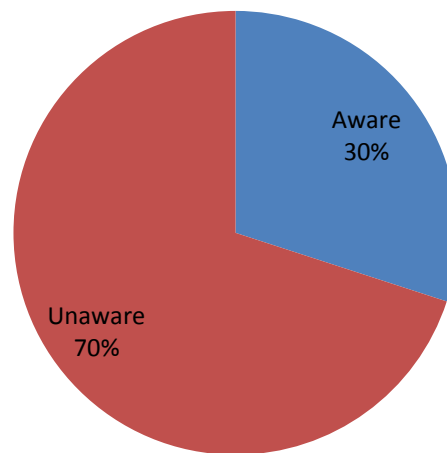


Figure 12. Awareness level about High Risk Pregnancy



This question was included to know the level of promotion of preventive care among the community people. To reduce the rate of miscarriages and subsequently infant and maternal mortalities it is important to aware community about factors and practice that can lead to such conditions. Promotion of Preventive Care was one of the main agenda of MHU project, with the help of CHVs and community level groups.

The assessment shows only 30% of respondents were aware of the factors related to High Risk Pregnancy and that 30% were also not thoroughly aware about all the factors but a few of those that too through their personal knowledge or experience. None of them received any counseling in this aspect.

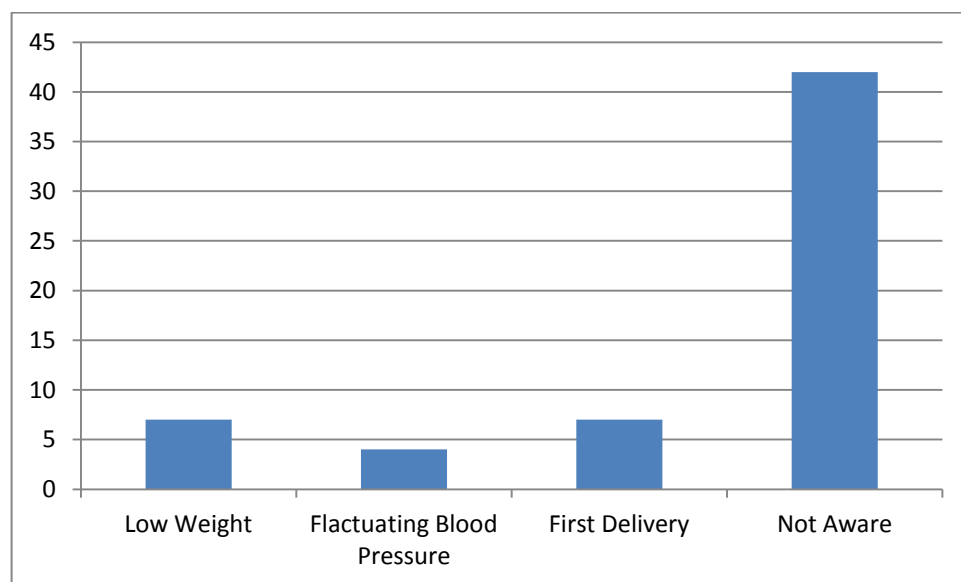


Figure 13. Distribution of factors leading to High Risk Pregnancy

Preferred Place for Delivery

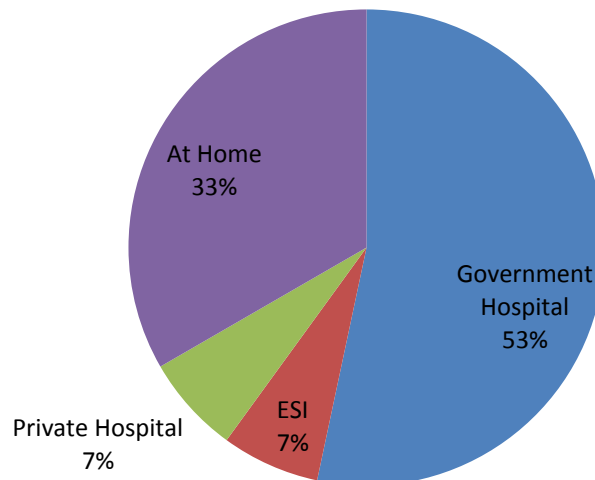
33% of the respondents i.e. 20 preferred home delivery over institutional delivery. The rest preferred government, private and ESI; the distribution is shown in Figure 16.

In spite of increase in demand for ANC checkups, vaccination, IFA distribution, home delivery is still preferred by community. The main reasons given by them were:

- Doctors and nurses rude behavior in Government Hospitals
- Convenient to deliver at home
- No complications so far therefore would deliver at home.
-

Here, interestingly majority of the women who are seeking consultation for pregnancy had got themselves registered in Safdarjung Hospitals for vaccination or other pregnancy related services. This is predominantly promoted by CHVs however they have not succeeded in influencing the preference for place of delivery to expected extent.

Figure 14. Preferred Place for Delivery



5.2 Lactating Mothers

Out of 60 respondents, 52 said they fed colostrums to the newborn and only 13% did not. The right practice of colostrums feeding was encouraged by attending doctors/nurses, herself, MHU doctor and family members.

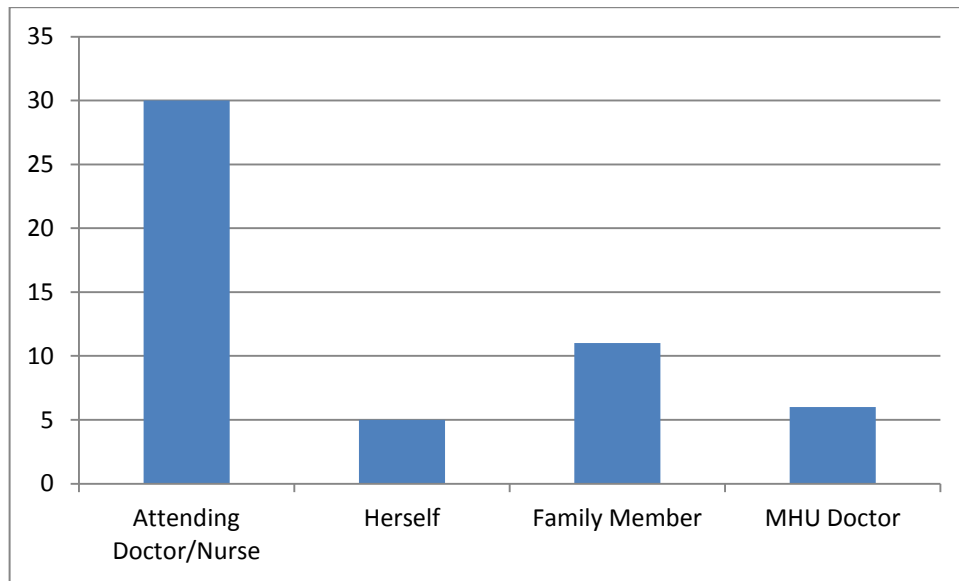


Figure 15. Distribution of Persons who encouraged Practice of Colostrums Feeding

The rest of the others who did not feed colostrums to their newborn cited that it is impure and not good for child health and few said that they had a custom of rendering the first milk to God, hence religious superstitions.

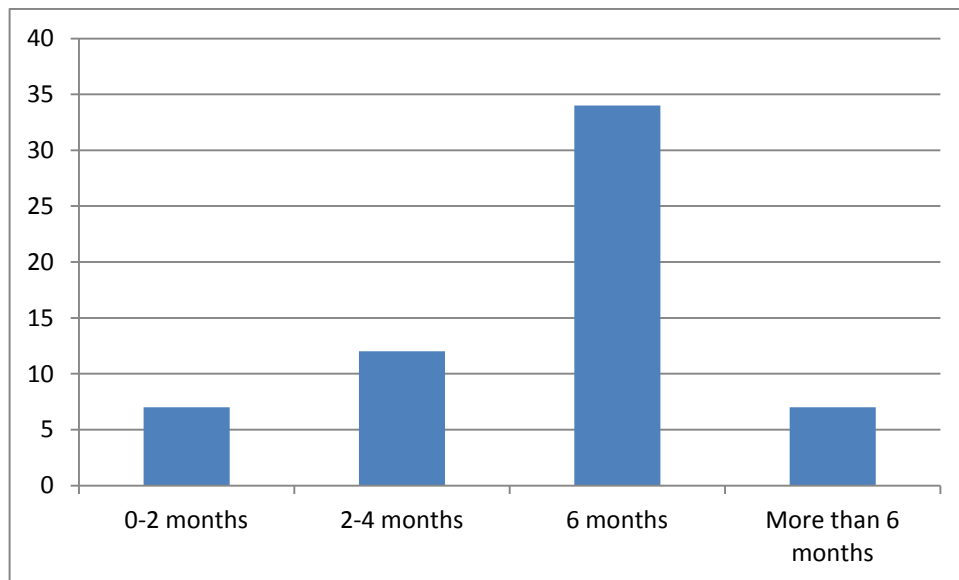


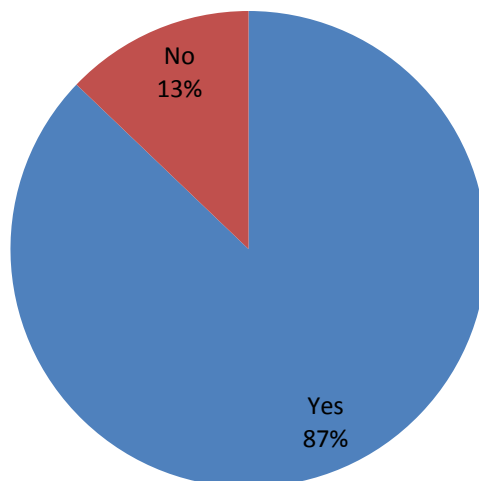
Figure 16. Distribution of Responses in regard to Exclusive Breast Feeding

The concept of exclusive breast feeding was found to be still weak among slum community. As illustrated in graph, only 57% women said that they had or will exclusively breast fed/feed their child, whereas 7 respondents even said that they will exclusively breast feed more than 6 months. This depicted the loop hole in health seeking behavior of community in terms of breast feeding practices.

The women who had delivered at institute generally given basic guidance about such issues, but as described earlier there is still high level of home deliveries at home by unqualified and untrained dais which leads to wrong health seeking behavior. Also, in some cases in spite of getting the right guidance, community does not follow it because of their own beliefs and practices.

5.3 Mother of Child under 5 years of age

Figure 17. Percentage of Ever Immunized Children



From the interviewed population 87% i.e. 61 got their child immunized and the preferred place for immunization were:

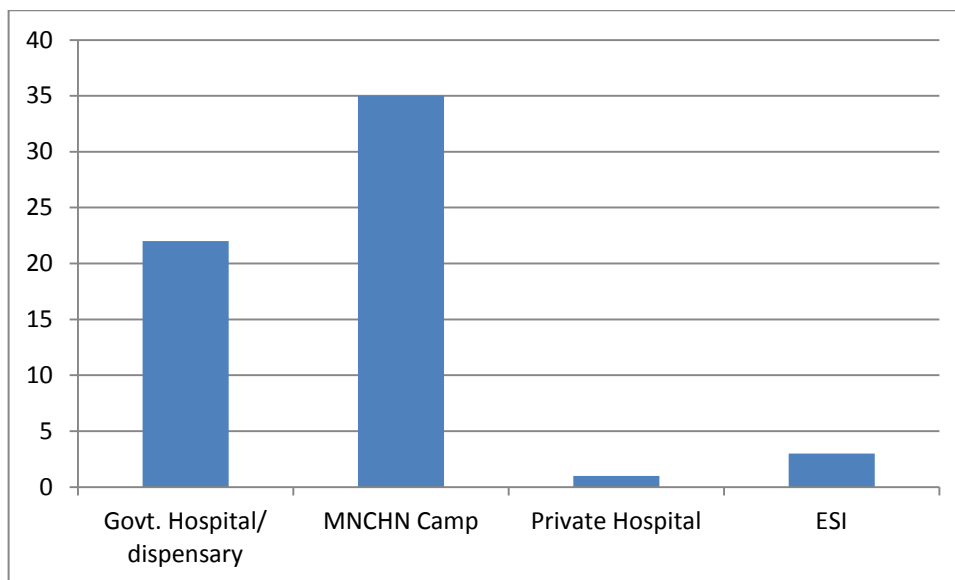
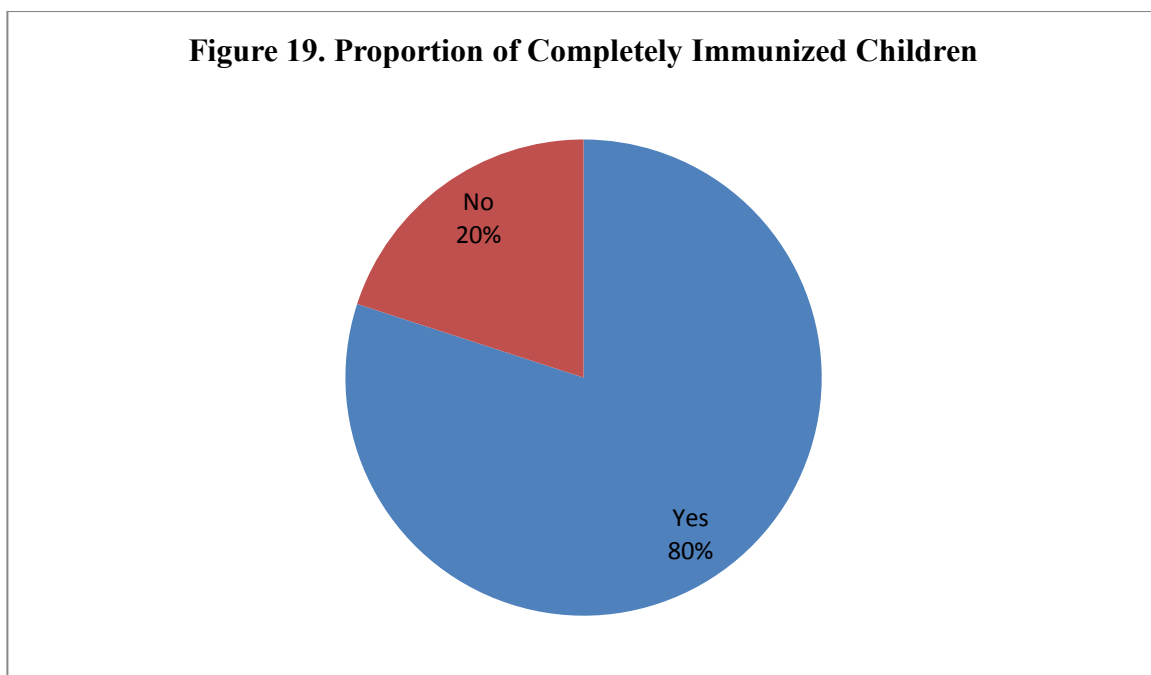


Figure 18. Preferred Place for Immunization

34 mothers preferred MNCHN camp organized once in a month in every cluster to get their child immunized. The MNHCHN camp is organized by FHW and the CHVs of Save the Children provides technical support to them for organizing camp. CHV and ASHA pre inform the households about the camp.

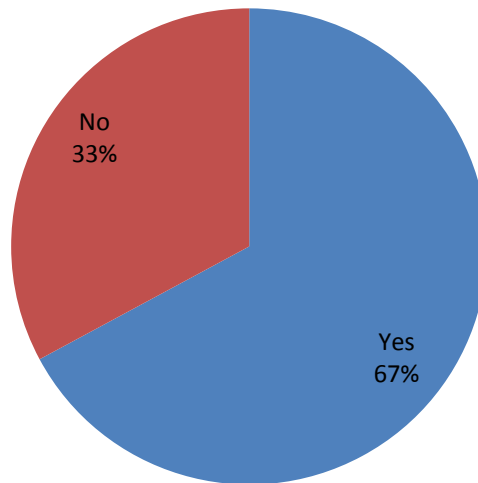
In some of the clusters government dispensary was situated nearby, therefore households of those clusters preferred it. Another reason for preferring dispensary based immunization over MNCHN camp in such clusters was availability of newly launched penta-valent vaccine in dispensaries.

Completely immunized



Though the percentage of ever immunized children is high but the percentage of completely immunized children is comparatively a little less. Reason behind this gap was Withdrawal, due to some minor side effects the child faced after vaccination. The households restricts to vaccination because of unawareness about its benefits.

Figure 20. Prevalence of Diarrhea



A large proportion of children suffer from diarrhea in early years of their life and this scenario is more prevalent in urban slums because of inadequate hygiene and sanitation provision and practices.

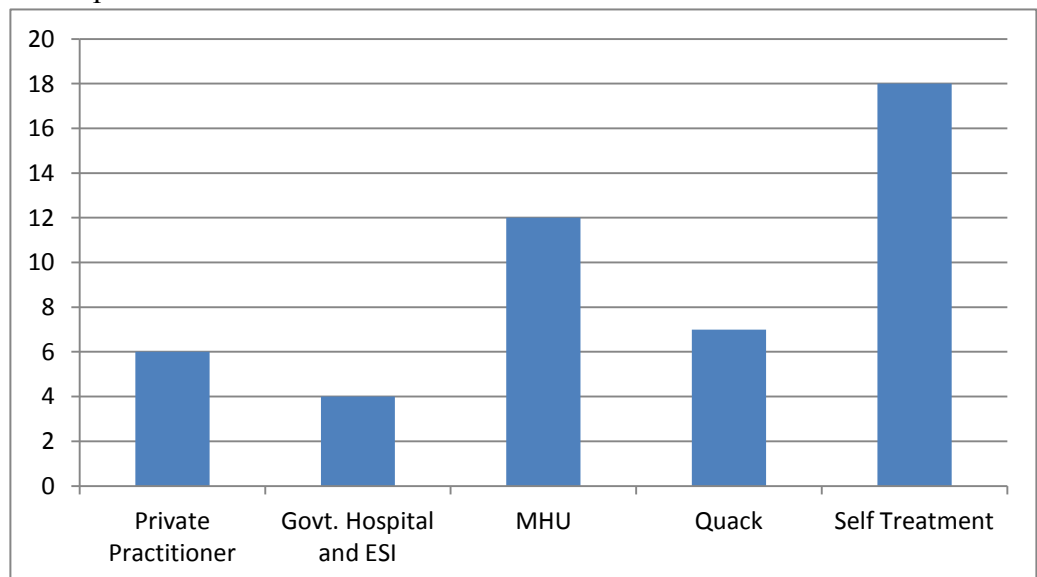


Figure 21. Preferred Place for Diarrhea Treatment

Due to recurrent occurrence of diarrhea in children, most of the households in sampled clusters preferred self treatment. They refill the earlier prescribed medicines by the private practitioner. However, if the illness occurs on the day or near to the pre scheduled MHU van visit day in the cluster then the household seeks treatment from MHU doctor and get medicine from there. In slums, the local quacks are quite commonly present in every block or so. This leads to households preferring convenient and cheap treatment for them.

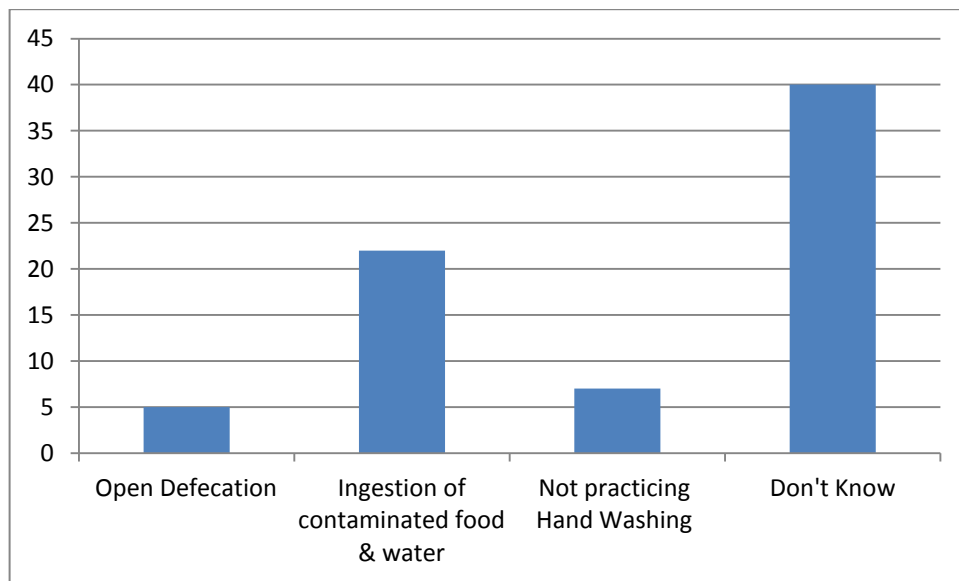
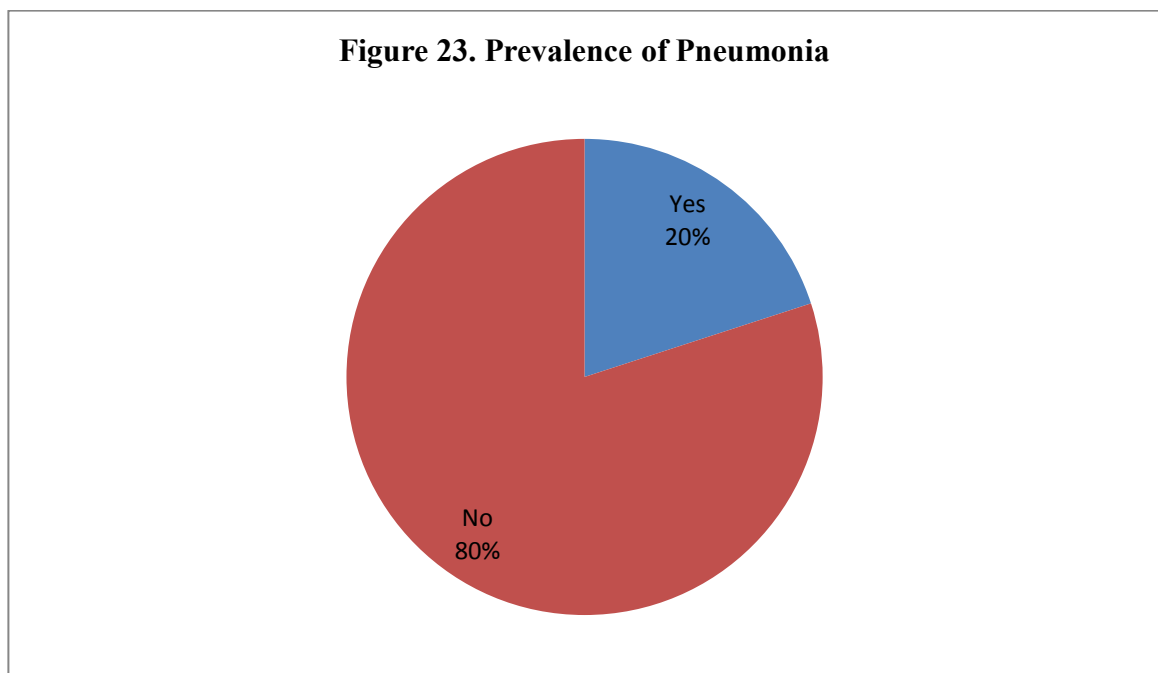


Figure 22. Awareness about reasons leading to Childhood Diarrhea

The community of intervened clusters had very low awareness level about the reasons that can lead to childhood Diarrhea. Out of 70 mothers, 40 were completely unaware about it and rests also were not thoroughly aware about all the leading causes. Maximum of mothers responded that ingestion of excess of oily or spicy food leads to diarrhea and very few said that infectious or opened food can be a causative of diarrhea.



The preference of place for seeking the treatment of Pneumonia is almost similar to that in Diarrhea. However the prevalence of pneumonia is low as compared to Diarrhea.

6. Conclusion

There has been a remarked increase in utilization of ANC services since the implementation of MHU Project, now almost 88% women seek for regular ANC checkups due to availability of services at their door step. 45% of the total proportion solely receives consultations from MHU and almost 65% go to MHU as well as Government Hospitals for regular checkups. However, the actual regular consumption of IFA and calcium supplements is low compared to total distribution of tablets. The gap is due to lack in awareness of its benefits. Similarly, the percentage of women receiving TT vaccination has increased because of the MNCHN camps in the slum clusters organized by government and facilitated by FHW and CHV.

There is a huge gap in the awareness level of pregnant women about high risk pregnancy. The average age of marriage in slums is less than 16 which leads to high rate of miscarriages. In such situation it is important to aware community about high risk pregnancy.

An increase in institutional delivery has been interpreted from analyzed data in the intervened clusters due to constant counseling done by CHV. However, still 33% of the respondents preferred home delivery over institutional deliver in spite of seeking ANC checkups, vaccination and other facilities at Safdarjung. This may be because of the discomfort they feel at Hospital. Many of the respondent referred that they don't want to deliver at Safdarjung due to the rude behavior of doctors and nurses.

There was a low level of awareness among mothers in regard to malnutrition and causes of childhood diarrhea which need to be addressed since the project was focused on preventive, promotive and curative approach to provide comprehensive solutions for the health need of urban poor.

The demand of community has been addressed to a satisfactory level with the aid of MHU and therefore, it has brought a positive change in the health seeking behavior of the community. Further, there is a need to more sensitize the community about MNHCN practices and aware them about preventive health seeking behavior with the help of counseling session and community level groups.

Annexure

Assessment of Health Seeking Behavior of Community in relation to Maternal Newborn Child Health Nutrition (MNCHN), under Mobile Health Unit Project in South District of Delhi

Data Collection Tool

Cluster: _____

Block : _____

Address/house no.: _____

Contact No. : _____

Name of the CHV: _____

Code: _____

I, Bhavna Nahata, currently working as an intern in Save the Children, Delhi conducting a health survey under the due guidance of Save the Children to assess the Health Seeking Behaviour of Community in relation to Maternal Newborn Child Health Nutrition (MNCHN), under Mobile Health Unit Project in South District of Delhi

I would like to ask you few questions related to health, nutrition, hygiene and sanitation and it will approximately take 10-15 minutes to complete. The information provided by you will be kept confidential and will be used for research purpose only. Participation in this survey is voluntary and if you feel uncomfortable during process, you can withdraw any time. However, I would appreciate your participation and contribution in conducting the study successfully.

Interviewer Signature

Interviewee Signature

Date:

Background Information:

1. From how long has the respondent been living here?

2. If the family has recently (in last 2 years) shifted to the current location, from which state/village/town they had shifted from?

3. How many members are there in the household?

4. Profile of Respondent and her Husband:

Name	Age	Sex	Occupation	Literacy level

5. What is the current monthly household income?

☐ Less than 3000 ☐ 3000-5000 ☐ 5000-10000 ☐ More than 10000

6. Is the household enrolled under BPL card scheme?

☐ Yes ☐ No

7. Was there any case of maternal death in the household?

☐ Yes ☐ No

(If No, skip to question no. 10)

8. If yes, when did the death take place?

☐ Recently; mention the month ☐ 1 year before ☐ 2 years before
☐ 2-5 years before ☐ More than 5 years before

9. What were the reasons behind the death?

☐ Accident ☐ Illness; specify
☐ Other, specify ☐ Do not know

10. Was there any case of child death in the household?

☐ Yes ☐ No

11. If yes, when did the death take place?

☐ Recently; mention the month ☐ 1 year before ☐ 2 years before
☐ 2-5 years before ☐ More than 5 years before

12. What were the reasons behind the death?

☐ Accident ☐ Illness; specify ☐ Other, specify ☐ Do not know

13. Was there any case of still birth in the household?

☐ Yes ☐ No

14. When did the recent case of still birth happen?

- ☐ Recently; mention the month before ☐ 1 year before ☐ 2 years before
☐ 2-5 years before ☐ More than 5 years before

- The study requires information specifically regarding the current maternal and child health practices and awareness, therefore the maternal profile has been categorized under three main categories viz. pregnant, lactating and mother of child under 5 years of age. It is preferential to seek information from the below mentioned types of respondent, as per the case.

Type of maternal respondent:

- ☐ Pregnant lady
☐ Lactating mother
☐ Mother of children less than 5 years of age

(If in case the respondent is pregnant as well as mother of child under 5 years of age, mark multiple options and encircle the most appropriate category as per your understanding)

1. What was the respondent's age at marriage?

- ☐ Below 14 ☐ 14-18 ☐ 18-20 ☐ 20-24 ☐ 24 or more

2. How many times the respondent has got pregnant?

- ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

3. Was there any case of miscarriage?

- ☐ Yes ☐ No

(If No, skip to question no.6)

4. If yes, how many times the pregnancies ended in miscarriage?

- ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more ☐ NA

5. If there was a case of miscarriage happened with the respondent, after how many months the foetus got miscarriage?

- ☐ 0-3 months ☐ 3-6months ☐ 6-9 months

6. How many children she has?

- ☐ Zero (1st pregnancy) ☐ One ☐ Two ☐ Three ☐ Four
☐ Five or more

Part I- Maternal Newborn and Child Health and Nutrition

1.1 Antenatal Care

(This section comprises of factors related to antenatal period basically regular checkups, medication, vaccination etc. It will help in analysing the overall ante natal care status in the area and the level of awareness among population.)

Note: In case of few questions there could be multiple answers for the asked question, mark multiple options wherever required.

1. Which trimester is the pregnant lady in?

☐ 1st trimester
 ☐ 2nd trimester
 ☐ 3rd trimester
2. Is she receiving any consultation or medical checkups for her pregnancy?

☐ Yes
 ☐ No

(If No, skip to question no.6)
3. If yes, whom is she consulting?

☐ Private Doctor/Hospital hospital

☐ MHU Doctor

☐ Government

☐ ANM

☐ Dai

☐ Quack

☐ Others, specify _____
4. Who advised her to seek consultation?

☐ Herself

☐ Husband

☐ Family member, specify the relation _____

☐ Auxiliary Nurse Midwife(ANM)

☐ Community Health Volunteer(CHV)

☐ ASHA

☐ CCAG group member

☐ Other, specify _____
5. How many sessions she has received till date?

☐ One
 ☐ Two
 ☐ Three
 ☐ Four or more _____
6. If No, then what are the reasons for not consulting any of the above?

☐ Unaware

☐ Inaccessibility

☐ Unavailability

☐ Non-compliance, reason :

☐ Other, specify _____
7. Is she receiving iron and calcium supplements?

☐ Yes
 ☐ No

(If No, skip to question no. 13)
8. From where does she get the IFA and calcium supplements?

☐ Private chemist

☐ Government hospital

☐ Government dispensary

☐ ASHA

☐ ANM

☐ MHU

☐ Quack

☐ Other, specify _____
9. If not receiving the supplements, what are the reasons?

- ☐ Unavailability ☐ Inaccessibility
- ☐ Non-compliance due to superstition (black coloured stool)
- ☐ Not required ☐ Don't know
- ☐ Other, specify _____

10. Is she really consuming the iron and calcium supplements?

- ☐ Yes ☐ No

11. If she is not consuming the supplements in spite of the availability, then what are the reasons behind it?

- ☐ Unaware of its benefits ☐ non compliance ☐ costly
- ☐ did not refill the dose ☐ others

12. Does she take any other pregnancy related medication?

- ☐ Yes ☐ No

13. From where does she get the medicines?

- ☐ Private chemist ☐ Government hospital ☐ Government dispensary
- ☐ MHU ☐ ASHA ☐ ANM ☐ Others, specify

14. Has she received any vaccination for her pregnancy?

- ☐ Yes ☐ No

(If No, skip to question no. 18)

15. If yes, tick the vaccinations received till date

- ☐ TT-1 (during early pregnancy)
- ☐ TT-2 (4 -8 weeks after TT-1)
- ☐ TT –Booster (if received 2 TT doses in a pregnancy within last 3 years)

16. From where did she receive vaccination?

- ☐ Private hospital ☐ Government hospital ☐ AWC
- ☐ MHU ☐ Immunization camp ☐ Others, specify

17. Who encouraged her to take vaccination for pregnancy?

- ☐ Herself ☐ Family member ☐ Private Doctor
- ☐ MHU doctor ☐ ASHA ☐ CHV ☐ Government Doctor
- ☐ ANM ☐ CCAG group member ☐ Other, specify

18. Which according to the respondent comes under the category of high risk pregnancy?(mark multiple options, if required)

- ☐ Low weight ☐ Fluctuating blood pressure ☐ Anaemic
- ☐ Short heighted ☐ Swelling in any body part ☐ Recurring Fever
- ☐ First delivery ☐ Under age(less than 18) ☐ Delivery after 30 years of age
- ☐ Inadequate birth spacing ☐ Other, specify _____

☐ Do not know

19. Where would the pregnant lady like to deliver the baby?

☐ Government hospital; Name:

☐ Private hospital; Name:

☐ At home

☐ Others, specify

20. How much the household has spent on ante natal care?

☐ Nothing

☐ 0-1000

☐ 1000-3000

☐ 3000-5000

☐ 5000 or more

1.2 Delivery & PNC (This section will cover the details related to delivery and the level of awareness among the community about the same)

1. Where did the lady deliver the baby?

☐ Government hospital; Name:

☐ Private hospital; Name:

☐ At home

☐ In transit, explain:

☐ Other, specify

2. Who advised the above chosen place for delivery?

☐ Herself ☐ Husband ☐ Family Member, specify the relation_____

☐ ANM ☐ CHV ☐ MHU Doctor ☐ ASHA

☐ Other, specify _____

3. What was the weight of baby at the time of birth?

4. Is the baby still alive?

☐ Yes ☐ No

(If yes skip to question no. 9)

5. If not, when did she/he die?

6. What were the reasons that led to newborn/child death?

- ☐ Premature birth ☐ illness ☐ accident ☐ other
7. Did the mother face any complications after giving birth?
- ☐ Yes ☐ No

(If No, skip to question no. 11)

8. If yes, what were the complications?
-

9. Who was consulted to get the treatment for aforesaid complications?

- ☐ private practitioner/hospital ☐ government hospital
- ☐ ANM ☐ MHU ☐ Home remedies ☐ CHV
- ☐ Quack ☐ Others, specify _____

10. How much did the household spend on :

- ☐ Delivery =
- ☐ Transportation =
- ☐ Post natal care =

1.3 Lactation

(This section is focused to know the lactation practices of mothers who have recently delivered)

1. When did the mother first breast feed the child?

- ☐ Within one hour ☐ In 4 hours ☐ After one day
- ☐ After two or more days ☐ Never, specify the reason_____

2. Did she feed the first milk/colostrums to the newborn?

- ☐ Yes ☐ No

(If no, skip to question no. 4)

3. If yes, who encouraged her to feed the first milk to the newborn?

- ☐ Herself ☐ Attending doctor/nurse ☐ Family member, specify the relation _____
- ☐ MHU doctor ☐ CHV
- ☐ ANM ☐ ASHA
- ☐ Other, specify_____

4. If no, who influenced her to not breast feed colostrums to the newborn?

- ☐ Family member, relation: _____ ☐ Herself ☐ Dai
- ☐ Attending nurse ☐ Attending doctor ☐ Other, specify_____

5. What were the reasons for not feeding the first milk to the newborn

- ☐ It is not good for child's health ☐ It is impure
- ☐ Other, specify_____

6. How long did/will she exclusively breast feed her child?
☐ 0-2 months ☐ 2-4 months ☐ 6 months ☐ more than 6 months

1.4 Growth Monitoring & Nutrition

(This section is included to draw the inference about the level of awareness of mother about growth monitoring and practices of the same)

1. Is there any AWC in the cluster?
☐ Yes ☐ No ☐ do not know
- \
2. If yes, Is the child registered in the AWC?
☐ Yes ☐ No
3. If No, then why?

4. Does the child eat supplementary food given in the AWC?(to be asked if the child is registered in AWC)
☐ Yes ☐ No
5. If No, what is the reason of not consuming the food provided in the AWC?

6. When the child was last weighed?

7. What was his/her weight at that time?

8. Who weighed him/her?
☐ ANM ☐ AWW ☐ CHV ☐ Private doctor
☐ MHU doctor ☐ Other, specify
9. Does the household aware about the reasons that can lead to malnutrition?
☐ Yes ☐ No
10. If yes, who told them about it?
☐ Is aware herself ☐ MHU doctor ☐ CHV ☐ ASHA ☐ AWW
☐ ANM ☐ Others, specify

1.5 Immunization

(This will help in drawing the information about immunization practices in the slums; to what extent they follow it, who encouraged them for it etc.)

1. Has the child ever been immunized?
☐ Yes ☐ No
(If yes, skip to question no.3)
2. What are the reasons for not getting the child immunized?
☐ Unaware ☐ Inaccessibility ☐ Unavailability
☐ Non-compliance, reason : ☐ Other, specify
3. Where is the child usually being taken for immunization?
☐ Private hospital ☐ Government hospital ☐ Government dispensary
☐ AWC ☐ MNCHN Camp ☐ Other, specify
4. Who generally gives the information to the household about immunization day?
☐ Doctor ☐ ANM ☐ CHV
☐ ASHA ☐ CCAG group members ☐ Other, specify _____
5. Does the mother have the immunization card of child?
☐ Yes ☐ No
6. What all vaccinations have been given to the child till date?
☐ BCG ☐ Hepatitis B ☐ OPV-0 ☐ OPV-1 ☐ OPV-2
☐ OPV-3 ☐ Measles ☐ DPT1 ☐ DPT2 ☐ DPT 3 ☐ Vitamin A
7. Is the child completely immunized?
 (To be asked if the child is above 1 year of age; check the immunization card to verify)
☐ Yes ☐ No ☐ NA

1.6 Child illnesses

(This section will provide the information require to assess the prevalence of diarrhoea and pneumonia in the children under 5 years of age and the actions households take to treat the child)

1. Did the child suffer from diarrhoea in last one year?
☐ Yes ☐ No
(If No, skip to question no. 4)
2. If yes, then how many times?
☐ One ☐ Two ☐ Three or more
3. When was the last time the child suffer from diarrhoea?
☐ 0-2 months before ☐ 2-4 months before
☐ 4-6 months before ☐ More than 6 months before
4. What did the household do to treat him?
☐ Consulted a private practitioner ☐ Consulted in government hospital
☐ Consulted ANM ☐ Home remedies ☐ MHU

- ☐ Consulted a quack
- ☐ Others, specify _____
5. What according to respondents are the possible reasons leading to diarrhoea?
- ☐ Open defecation
- ☐ Not practicing hand washing after defecation and before meals
- ☐ Ingestion of contaminated food ☐ Drinking impure water
- ☐ Other, specify _____ ☐ Don't know
6. If aware about the reasons, who told them about it?
- ☐ ANM ☐ ASHA ☐ CHV ☐ is aware herself ☐
- Other, specify _____
7. Did the child suffer from cold and cough in last 1 year?
- ☐ Yes ☐ No
8. If yes, whom did you consult?
- ☐ Consulted a private practitioner ☐ Consulted in government hospital
- ☐ Consulted ANM ☐ Home remedies ☐ MHU
- ☐ Others, specify _____
9. Did the child suffer from pneumonia in last one year?
- ☐ Yes ☐ No
10. If yes, how many times?
- ☐ One ☐ Two ☐ Three or more
11. When was the last time the child suffer from pneumonia?
- ☐ 0-2 months before ☐ 2-4 months before
- ☐ 4-6 months before ☐ More than 6 months before
12. What did the household do to treat him?
- ☐ consulted a private practitioner ☐ consulted in government hospital
- ☐ consulted ANM ☐ MHU ☐ Home remedies ☐ Quack ☐
- Others, specify _____
13. How much does it cost them to seek treatment for the child in case of diarrhoea?
- _____
14. How much does it cost them to seek treatment for the child in case of cold and cough?
- _____
15. How much does it cost them to seek treatment for the child in case of pneumonia?
- _____

Any other comments or observations:

Bibliography

1. Puri. R.K., Sachdeva H.P.S., Maternal and Child Health in Slums of Delhi
2. Nimbalkar Archana , Shukla Vivek , Phatak Ajay , Nimbalkar Somashekhar, Newborn Care Practices and Health Seeking Behavior in Urban Slums and Villages of Anand, Gujarat
3. Abdus Sabur Muhammod, Khodadat Hossain Sarker, Health Problems and Healthcare-seeking Behaviour in Urban Slums of Bangladesh
4. Yesudian C.A.K., Health Seeking Behaviour Of Urban Poor In India
5. Loughhead S et al., Urban Poverty and Vulnerability in India, New Delhi: Department for International Development
6. State of urban health in Delhi-A report by the Urban Health Division, Ministry of Health and Family Welfare, Govt. of India, and Urban Health Resource center
7. Fact Sheet on Key Indicators for Urban Poor in Delhi-Published by Urban Health Resource center, New Delhi
8. Mursaleena Islam, Mark Montgomery, Taneja Shivani, Urban Health and Care-Seeking Behavior: A Case Study of Slums in India and the Philippines
9. Moses K. Muriithi, The Determinants of Health-seeking Behavior in a Nairobi Slum, Kenya
10. National Family Health Survey Report, 2005-06