Summer Training at
Innovators in Health (India), Dalsinghsarai, Bihar
(April 3 to June 2, 2017)

Strengthening 99 DOTS in Dalsinghsarai Block of Samsatipur, Bihar

By
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Under the guidance of
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MBA Hospital & Health Management
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Institute of Health Management Research
The IIHMR University, Jaipur
2017

INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that **Dr. Ekta Bhagat** has undergone summer training in **INNOVATORS IN HEALTH, BIHAR** from **3rd April to 2nd June, 2017**.

The candidate herself completed the project assign to her during summer training. Her approach to the project was sincere and proactive. This summer training is in partial fulfillment of the course requirement recommended for the award of MBA in Hospital and Health Management.

I wish her success in all her future endeavors.

Col. (Dr.) Ashok Kaushik
Dean (Academic & Student Affair)
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31 May 2017

To whom it may concern,

It is to certify that Ekta Bhagat, a first year student in the MBA (Hospital and Health Management) program at the Institute of Health Management Research, Jaipur completed her summer internship with Innovators in Health. She worked in Dalsinghsarai, a block in the Samastipur district of Bihar, for 2 months from 3 April 2017 to 31 May 2017.

She showed keen interest in the Aahan TB program and the Maternal and Neonatal Health program of the organisation. The organisation recognises her contribution in the recruitment process of the field team, archiving of the patient records, conducting mahila mandals, and counselling women.

Her conduct was good and she made efforts to learn from the experiences of the team. She was enthusiastic to learn about the local culture, community, and program interventions.

We wish her every success in life.

For Innovators in Health (India),

Tushar Garg

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ACKNOWLEDGEMENT

I would take this opportunity to express my profound gratitude to my institute, Institute of Health Management and Research, for providing me a platform to gain enough knowledge and skills in different aspect of Health Management. I express my deep indebtedness to Mr. Manish Bhardwaaj, Mr. Manish Kumar, Dr. Tushar Garg, Dr. Pitamber Soren and the whole team of innovators in health for their advice,support,encouragement and guidance throughout my training.

My sincere thanks to my respected mentor, my guiding spirit, Dr.Nutan P. Jain, Professor for her support throughout the project. Without her guidance and support, this work would not have materialized.

Lastly, I wish to thank all the eminent people whose insights and experiences have shaped the content of this report.

Ekta Bhagat

Contents

ABOUT SUMMER TRAINING AT DALSINGHSARAI, SAMASTIPUR, BIHAR

Life is a challenge accept it, live it and face it besides this life gives us so many opportunities to learn from day to day activities, here training plays a vital role. Training is a learning process of developing skills, knowledge, improving ones capabilities, productivity and performance.

As a student got this wonderful opportunity to do summer training at Dalsingsarai Block of Samastipur. Doing training at this place gives me a wonderful real life experience in core health. Different tasks were assigned in day to day activities at this organization that will definitely help me in facing different challenges during career growth. Experience the pain of our community due to health related issues so, learned the importance of health management in building loopholes of our health system. I am sure this learning at summer training will definitely help me in future.

TASK ASSIGNED AND LEARNINGS

WEEK	MAJOR ACTIVITIES	LEARNINGS
1st WEEK	-Presentation about the organization -IHF(Indian health fund field visit) -visit to SDH hospital -Attended ASHA facilitator meeting. -Field visits -Participated in how to organize a camp for vulnerable section.	-understanding organization i.e. how it works, what are the role of different stakeholders within and outside the organization. -understanding organogram -understands the new concept how a private practitioner and chemist influence the health system in different and unique way.
2ND WEEK	-Data collection from IMIS (Integrated management information system) and transferred to excel sheet -Participated in counselor meeting and interaction with different councilors - Participated in mahilla mandal meetings -Participated in data collection for base line survey. -field visits and interaction with community -Visited SDH hospital -Interview with government ASHA	-learned about data management -understanding of the program running in the organization -learned about the importance of community engagement in health sector with the help of mahila mandal meetings. -appreciate real life experience -understanding of government hospital set up.
3RD WEEK	-Revise presentation -Participated in ASHA facilitator training. -mahilla mandal meetings -Understanding data archive record - Interview with ASHAs, ASHA	-improve presentation skills -learned about the importance of training from time to time of different stakeholders working with the

	Facilitators.	organization. -learned about ASHA perception related to her experience in health sector.
4TH WEEK	-Participated in focused group discussion -Mahilla mandal meetings - Manual data management -Participated in informal group discussion with community. -Participated in interview procedure held at organization for recruitment of new members for the startup of new project at different block.	-Learned the importance of focused group discussion i.e. how it is used to identify problem from within the society. -different interviews with different stakeholder helps to understand the core health region with real life experience.
5TH WEEK	-Participated in focused group discussion -mahilla mandal meetings - Participated in ASHA facilitator meeting -Done counseling with MNH patients at SDH hospital. -MDR patient case analysis -In-depth interview with community -Participated in training process of new members at Sarairanjan block -Field visit -Participated in baseline survey of TB patients -Participated in screening process of TB patients -participated in counselor meeting -Field visit for high risk case analysis of MNH patients. -visited CHC of Sarairanjan Block	-identify the various problems faced by the community in government hospitals -MDR patients case analysis -Give the exposure of startups of Aahan program at Sarairanjan block. -In depth interview with the community helps to identify the real life health related problems faced by community during service delivery. -learned the baseline survey, and screening process. -learned the importance of counselor – an active member of community in health sector and also learned about the importance of training for enhancing their skills. -learned the different intervention approach in managing high risk analysis of MNH patients.
6TH WEEK	-mahilla mandal meetings -visited PHC -Participated in the training process of new members -Visited CHC ,participated in ASHA	-participation in training process further helps in understanding of the program in better way.

	meeting -In-depth interviews with different ASHAs -Field visit for base line survey of TB patients at new panchayat. -Field visit for high risk case analysis of MNH patients.	
7TH WEEK	-Visit to PHC -In-depth interview with community, ASHA, ASHA facilitator. -Interview with panchayat coordinator. -Mahilla mandal meeting -Informal group discussion with community -visited SDH hospital -Counseling with community	- Interaction with community and counseling with them enhance the understanding of MNH program.
8TH WEEK	-Mahilla mandal meeting -Night duty at SDH hospital in emergency case handling of MNH patient -Interview with different stake holders of the organization. -Informal group discussion with community.	-Learned about the different interventions in emergency handling of MNH patients. -understands the work of different stakeholders influencing the program outcome -practical exposure in core health region.

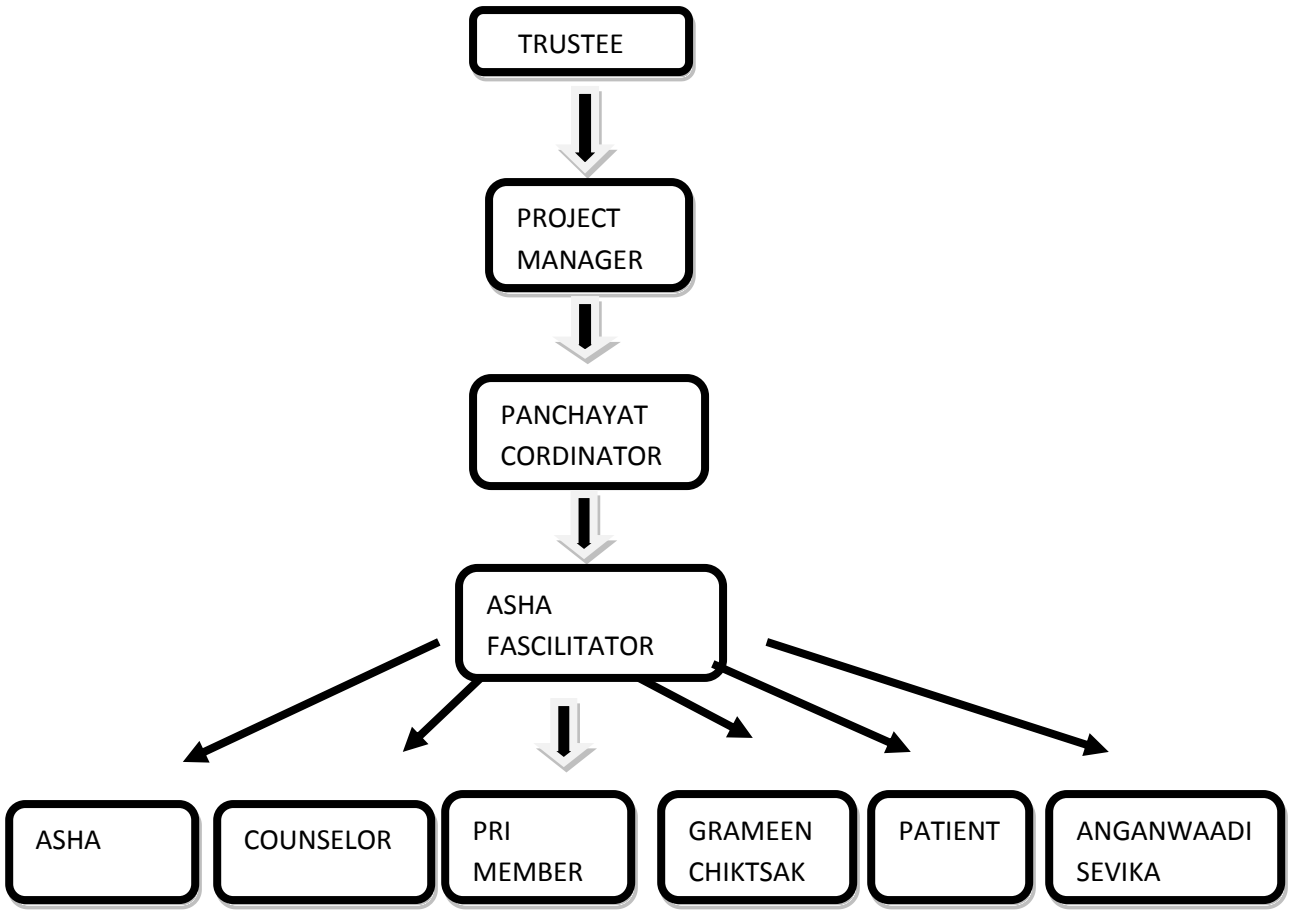
ABOUT THE ORGANISATION

The innovators in Health have been running a TB control program called Aahan in the Dalsinghsarai block since June 2010. The objective of this organization is to improve outcomes by strengthening the execution of the national TB program (RNTCP) and the local public health system. The program covers all 17 panchayats of the Dalsinghsarai block (pop. 208,000), and 14 panchayats in the adjacent Vidyapatinagar block. Aahan's interventions include community-led active case-finding, de-specializing management of complex diagnostic protocols by strengthening grassroots ASHA, engaging private medical care when public care is deficient, and most importantly doing all this by building grassroots staff and ASHA. These interventions have improved access TB reach.

Apart from these innovators in health is also working on Mother and Neonatal health care. Every year, far too many mothers and newborns die needlessly in India. Within India, Bihar is among the worst affected with an infant mortality rate (IMR) of 48 deaths per 1000 live births, and a maternal mortality rate (MMR) of 274 deaths per 100,000 births. The national IMR and MMR rates are 40 and139 respectively1. For every mother who dies in childbirth, there are approximately 20 others that suffer serious illness, injuries or disability2.These deaths and suffering are preventable, and there are examples of programs in resource poor

settings that have demonstrated so. Innovators in Health (IIH) has previously partnered with the Trust to improve access to tuberculosis (TB) treatment to a catchment of more than 200,000 rural residents of the Dalsinghsarai block in the Samastipur district in Bihar. IIH launched a program in May 2015 to expand this delivery platform to include maternal and newborn health (MNH.) The approach, as before, is to ensure access to PHS facilities, and fill gaps by strengthening the PHS where possible, and supplementing with private care when it is not. The main intervention themes include empowering pregnant women and their families, building the community's capacity including a local cadre of skilled birth attendants (SBAs), delivering ante- and post-natal care, and ensuring safe deliveries in partnership with public and private facilities.

ORGANOGRAM



Scheduled activities:

A no. of scheduled activity has been undertaken in this program:

- Social mapping
- Community engagement
- ASHA strengthening

- Staff growth-includes staff capacity building.
- ASHA facilitator initiative
- Active case findings
- Diagnosis
- Treatment
- Tracking adherence through mobile phone
- Access to TB treatment
- Community support for poor malnourished patients
- Building capacity of other NGOs
- Engaging youth
- Controlling the spread of TB in children
- Expanding catchment

New initiatives

- Involvement of counselors
- Involvement of chemists for referrals -IHF
- Involvement of private practitioners-IHF

99 DOTS

INTRODUCTION

Tuberculosis (TB) is an infectious, airborne disease caused by Mycobacterium Tuberculosis which typically attacks the lungs and is often fatal if untreated. The disease is cured by following a regimen of 4 antibiotics for 6-8 months. A cure was found six decades ago but delivery has continued to be a challenge, with unprecedented consequences: about 2 billion people have been exposed to the disease and carry a latent form of it. It is estimated that every untreated case of TB infects, on average, 10-15 additional people.

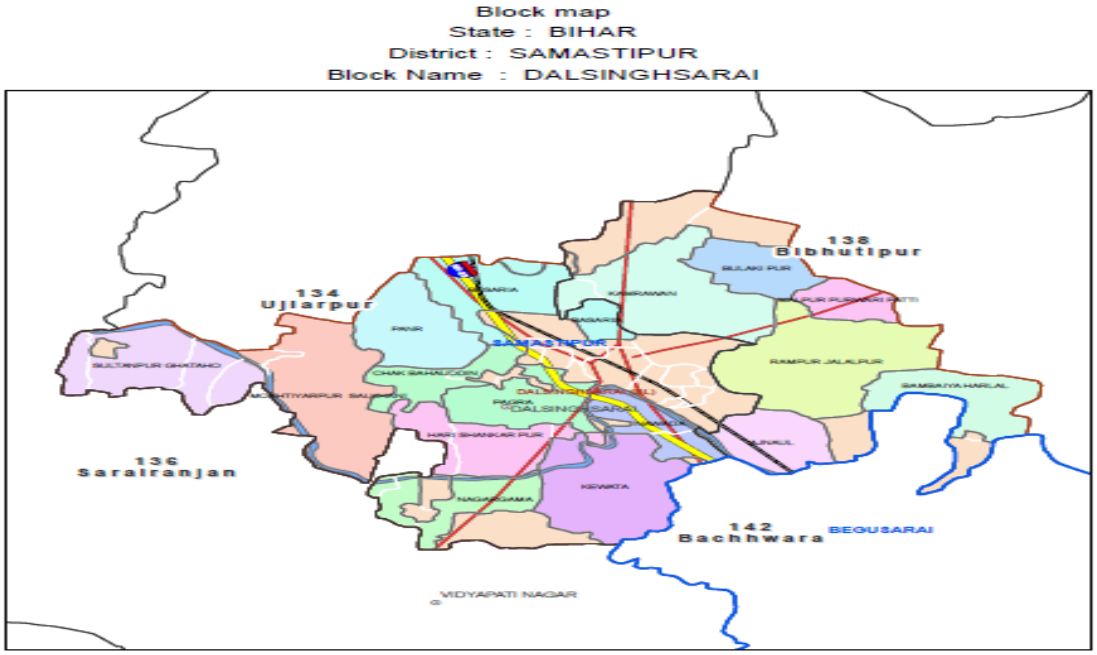
India bears the highest global burden of TB, adding 2.2 million new cases every year, and losing about 310,000 people, disproportionately the poor2. India's national TB program (NTP) known formally as the Revised National TB Control Program (RNTCP) has made significant headway, and the WHO credits it with saving over a million lives. However, success has been uneven, and while some states have done well, often the poorest continue to lag significantly. More than a decade and a half after the launch of the RNTCP, the incidence, i.e., the number of new cases added annually, has not declined in India. As a result WHO's South East Asia Region is the only one globally where incidence has not declined. [1]

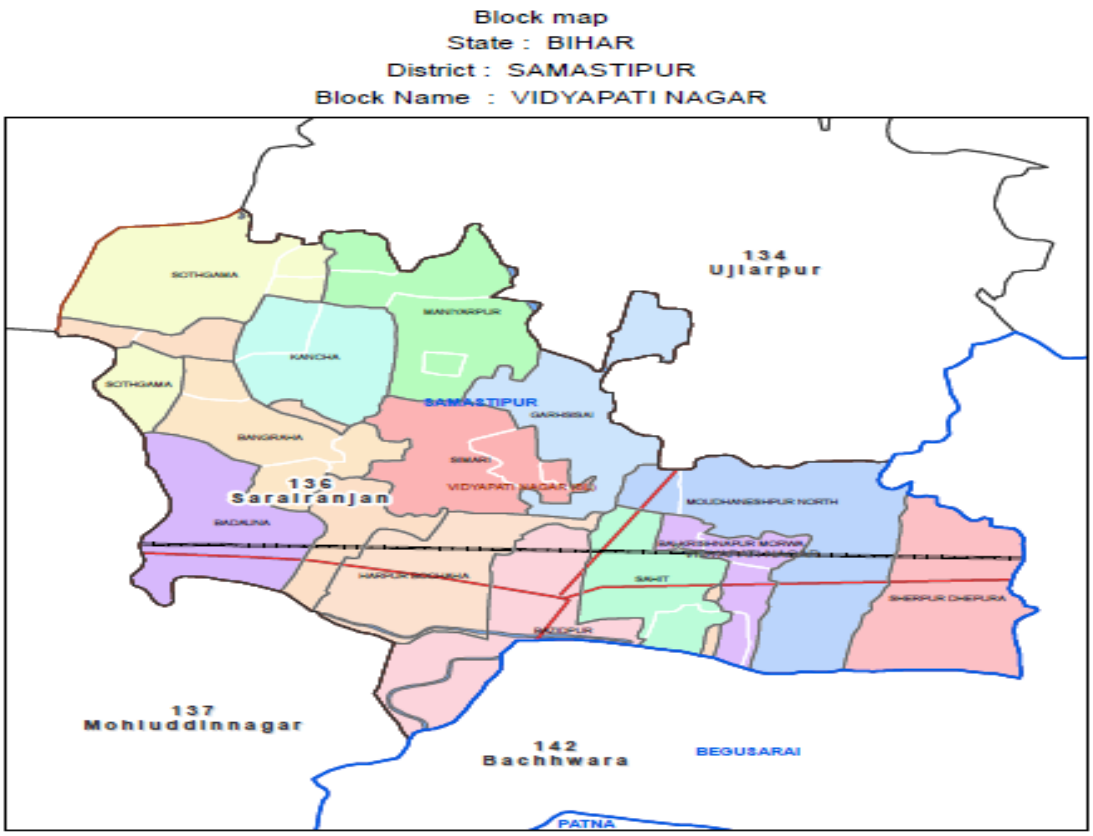
TB Reach at Dalsingsarai

In Dalsingsarai block, TB has been a factor for drain of wealth because of the loss of livelihood and other severe consequences the disease has brought.

Innovators in Health in co-operation with the Prajnopaya foundation and Swasti Sewa Samiti have been working in Dalsinghsarai block since June 2010. ‘Aahan’ is a TB control program that is being implemented by a consortium of the above organizations.

It is the hard work of the whole IIH team that include Trustee, project manager , panchayat co-coordinator, ASHA facilitator ,ASHA, PRI member, grameen chikitsak, Anganwaadi sewika,and most important patients and all support from the PHC and District program cell that is reflected in the outcome.





Aahan Dalsinghsarai includes 17 panchayat and in Vidyapathi includes 14 panchayat 1,52,916(2011 census)

Emergence of drug resistance – A challenge.

A majority of poor who seek private care abandon treatment because of cost. Irregular treatment leads to emergence of bacteria that are resistant to the first-line drugs, causing multiple-drug-resistance TB, or MDR-TB. The WHO estimates that MDR-TB is up to 100 x more expensive to treat than drug-susceptible TB.

Literature review on MDR

India and China carry the greatest estimated burden of MDR tuberculosis, together accounting for almost 50% of the world's total cases. Even when the drugs are prescribed, those prescribing the drugs outside national tuberculosis programs may not abide by recommended regimens, and some patients may purchase only part of the prescription because of financial constraints. Prescription and dispensing of medicines in general and of antibiotics in particular, are poorly monitored and regulated in most countries. Even when regulations exist, their enforcement is often insufficient quarters of the estimated cases of MDR tuberculosis occur in previously untreated patients

Critical weaknesses in current approaches to the treatment and control of MDR tuberculosis and XDR tuberculosis have been identified and are being addressed at the global level.[1][2]

Drug-resistant TB has microbial, clinical, and programmatic causes. From a microbiological perspective, the resistance is caused by a genetic mutation that makes a drug ineffective against the mutant bacilli. An inadequate or poorly administered treatment regimen allows drug resistant mutants to become the dominant strain in a patient infected with TB.

The key to the successful prevention of the emergence of drug resistance is adequate case finding, prompt and correct diagnosis, and effective treatment of infected patients. This can be achieved through the use of DOTS.[2][3]

MDR-TB patients need at least 24 months of treatment in general and the severe cases may need 36 months of treatment, however, the cure rate is only around 50 to 60%, which makes the economic burden of MDR-TB as high as 10–100 times comparing with non MDR-TB cases. MDR-TB takes longer to treat with second-line drugs, which are more expensive and have more side-effects.[3][4]

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OBJECTIVES

- To learn about the concept of 99 DOTS
- To learn about the role of different stakeholders in active case finding and treatment adherence.
- To study the importance of community participation in strengthening 99 DOTS
- To learn new things everyday from various task assigned.
- To learn about the basic understanding of the organization, how it works, how a team participated in building this organization.

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[1] N Engl J Med 2010; 363:1050-1058September 9, 2010DOI: 10.1056/NEJMra090807

[2] Indian journal of community medicine 2008
[3] BMC journal 2017
[4] Indian journal of community medicine 2008
[5] BMC journal 2017

- To understand the role of each staff member and learn about the different work assigned to them under 99 DOTS.

To study how 99 DOTS can further be strengthen for more positive outcome.

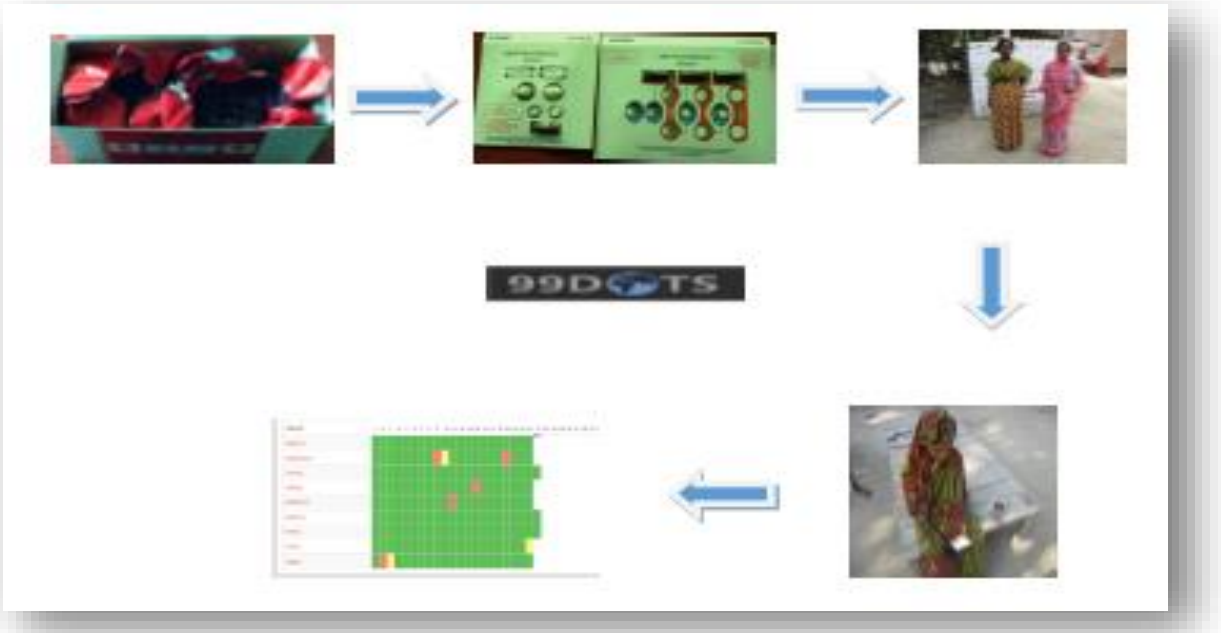
INTERVENTION FOR STRENGTHENING

TRACKING OF TB PATIENT UNDER 99 DOTS

AIM of tracking – Low cost monitoring and improving medication adherence -health care for the 99%.

A critical challenge in tuberculosis treatment is to ensure that patient adhere to full course of medication. In India, of Directly Observed Therapy (DOT) in the public sector has been associated with high treatment success. However, direct observation introduced challenges for patients and providers, who need to undertake frequent travel throughout the course of treatment. Far from a technology centric intervention, medication monitors are effective due to behavioral support: reminders to the patients, monitor by care provider, regular checking, patient counseling, ASHA training and meeting, moral support to patients and guide them during whole course of treatment all these approach add on the strengthening treatment adherence in tracking process.

STEPS UNDER TECHNOLOGIC CENTRIC ADHERENCE



OTHER APPROACHES IN STRENTHENING 99DOTS

IHF Approach

This approach helps in the involvement of chemists and private practitioners for referrals.

Involvement of chemists – chemists plays a vital role as they can act as a connecting link between provision of medicine to TB patient and treatment. They give information regarding certain patients who are not able to pay huge amount of money while undertaking treatment from the private sector as, high spending may force some patients to withdraw the treatment and thus further worsen the condition. Here IIH plays its important role to connect with such kind of patients with the help of chemists in order to strengthen treatment adherence.

Involvement of private practitioners- IIH approaches private practioners just for referrals that does not deteriorate their work but in turn helps to strengthen their treatment outcome as IIH team is providing tracking facilities to their patient further strengthening universal TB coverage.

June 5, 2017 project manager interaction with chemist

Key learnings-

- Learn the importance of chemist in active case findings.
- How to approach patient who withdrew medicine in between due to high cost in private treatment.
- Strengthening community engagement with the help of chemists and private practitioners and further strengthening the health system.

COUNSELORS A NEW INITIATION

Community counselor is an active member from within the community who provides counseling – a type of talking therapy that allows a person to talk about their problems and feelings in a confidential and dependable 76environment.

ROLE- Provides counseling – a comprehensive helping framework that is grounded in multicultural competence and oriented towards social justice.

Training of counselors at IIH

In IIH they are trained once in a month on different topics in a very interesting manner.

In last two months topics covered are – how to identify TB patients within in a community, identification of signs and symptoms and how to do counseling of such patients.

Second topic was on Family planning, identification of need of family planning under mother and neonatal health.

JUNE 9, 2017 Training to counselors on how to identify TB patient within community

Key learnings-

How an active member from within the community can play a vital role in active case findings and strengthening universal TB coverage. Secondly, training of counselors is required from time to time in order to met different needs in treatment adherence.

ASHA STRENGHENING

ASHA- Accredited social health activist- is a connecting link between community and health care system. ASHA plays a very important role in reaching primary health to rural areas. She is an inevitable component in bringing health services to the grass root level by creating awareness in mobilizing the community towards local health planning.

ASHA AT IIH

Innovators in health does not replace the government ASHA but plays a vital role in capacity building, training for universal TB coverage, mobilizing ASHA in order to enhance their field visit, thus strengthening the 99 DOTS for effective TB treatment.

Incentives are given on regular basis without delay thus act as motivating factors for ASHA.

LEARNINGS –

Learned about the importance of ASHA at grass root level in health system. Secondly, importance of their training on regular basis a need for strengthening their capabilities.

In depth interviews was conducted with different ASHA one who is linked with IIH and another one who is working with the government only.

With the help of this approach challenges faced by the government ASHA was came to known- they were unsatisfied with the government incentives, as it was not on time, this thing affect their motivation to work in the field.

CAPACITY BUILDING OF ASHA

Role of AF (ASHA facilitator) in 99 DOTS

- AF is the active member chosen by IIH team in order to strengthen the TB reach under 99 DOTS.
- They are selected after clearing the examination and interview conducted by Aahan team.
- After their selection procedure they are trained time to time in order to enhance their capacity building.
- Regular meetings are conducted on weekly basis every Thursday so that they can interact with Panchayat coordinator and can able to discuss on different issues related to their work in the field.
- Data entry for electronic meter record is done on the same day.

Role of Panchayat Coordinator

Panchayat coordinator plays different role in strengthening TB reach-they are the active members who take care of every patient .They supervise the AF and ASHA whether the work is taking place appropriately or not panchayat coordinator.

Take care of data entry thus helps in maintaining electronic meter record. They are involved in counseling process, patient home visit from time to time and helps in solving any problem related to medication adherence faced by patient beside this they also help in solving various problems faced by ASHA and AF during their work. They are also involved in emergency handling of TB patient.

NUTRITION SUPPORT FOR TB PATIENT

- Mobilizing the community to take ownership
- Community supported nutrition

A total of 85 extremely poor and malnourished patients have benefitted from this initiative and have successfully completed their treatment. At present 10 such patients receive milk daily. Please refer to the report for the previous period for more details on the background and methodology.

This term IIH started a new initiative of engaging milk cooperatives to provide nutritional support to patients in need.

Catchment of IIH in Bihar has a successful chapter of "Operation Flood". Virtually every Panchayat has 2-3 milk cooperatives comprising small and medium farmers engaged in animal husbandry. Many of the individual donors to the nutrition initiative are members of such cooperatives. IIH discovered that each cooperative is constitutionally required to spend 10% of its annual profit in charitable activities. This is called the "Datavya Fund". It was found that cooperatives had no capacity to effectively use these funds, leading to ad-hoc utilization.

IIH engaged with a group of 15 milk cooperative secretaries in five panchayats of the Dalsingh Sarai block. We educated them about TB and Aahan, and the problem of malnourished patients who cannot afford adequate nutrition. We requested the use of the "Datavya Fund" to help such patients. After several meetings, they agreed and asked us for a formal proposal. Some milk cooperatives have already passed formal resolutions of support in their board meetings

COMMUNITY ENGAGEMENT in Focus Group Discussions

- FGD was found a good way to gather together people from similar experiences to discuss a specific topic of interest.
- The group is guided by facilitator who introduces the topic for discussion.

- Strength relies on allowing the participants to agree or disagree with each other so that it provides an insight into how a group thinks about an issue, about the range of opinion and ideas, and the inconsistencies and variation that exists in a particular community in terms of beliefs and their experiences and practices.
- Used to explore the range of opinions/views.

METHODOLOGY-

- Review of reports and records
- In depth interview with 25 ASHAs, 18ASHA Facilitators, 10 Panchayat
- Coordinators and 8 opinion leaders.
- Informal group discussions with community;
- 17 awareness sessions with mahilla mandals
- Observations of working of Aahan program.

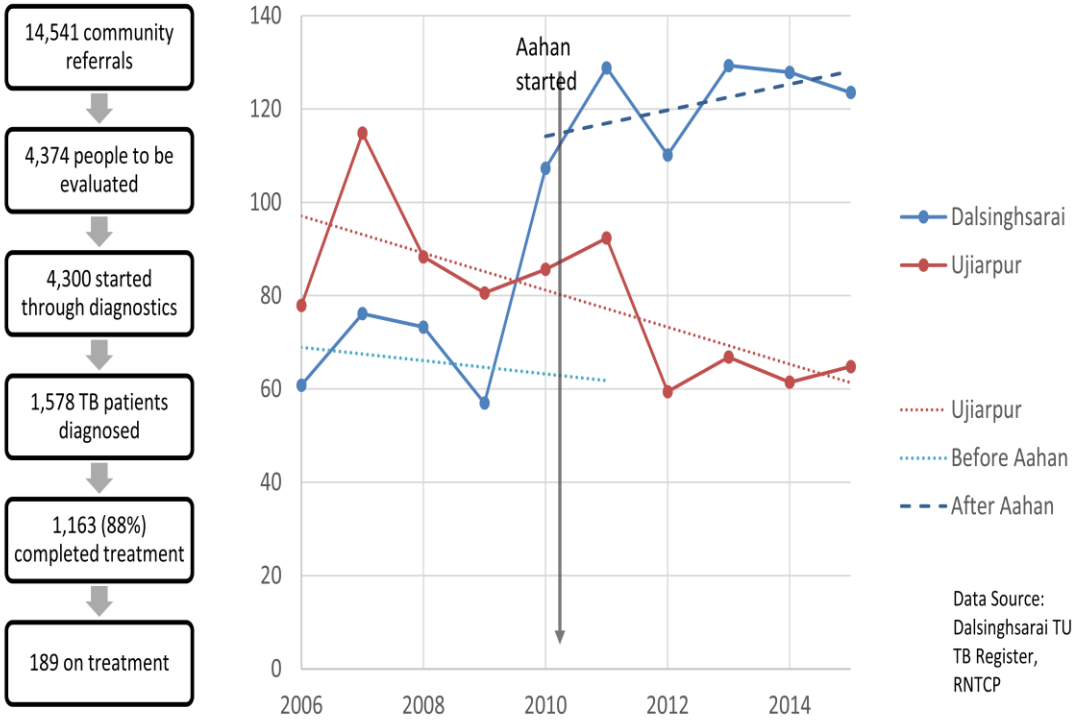
FINDINGS –

Case detection per lakh population

ANALYSIS	DALSINGHSARAI: (2010 TO 2017)	VIDYAPATINAGAR:(2014 TO 2017)
Population	2,08,818	152,916
TOTAL PANCHAYATS	17	14
EXPECTED TB PATIENTS ON THE BASIS OF BASE	14810	1715

LINE SURVEY		
SCREENING DONE	4436	561
PATIENT REACHED HOSPITAL	4397	502
PATIENT DIAGNOSED WITH TB	1632	298
PRESENTLY TOTAL NO. OF PATIENTS UNDERGOING TREATMENT	167	55
PATIENT CURED	1291	211

Results in Dalsinghsarai



OUT COME OF PROJECT UPTILL 2017

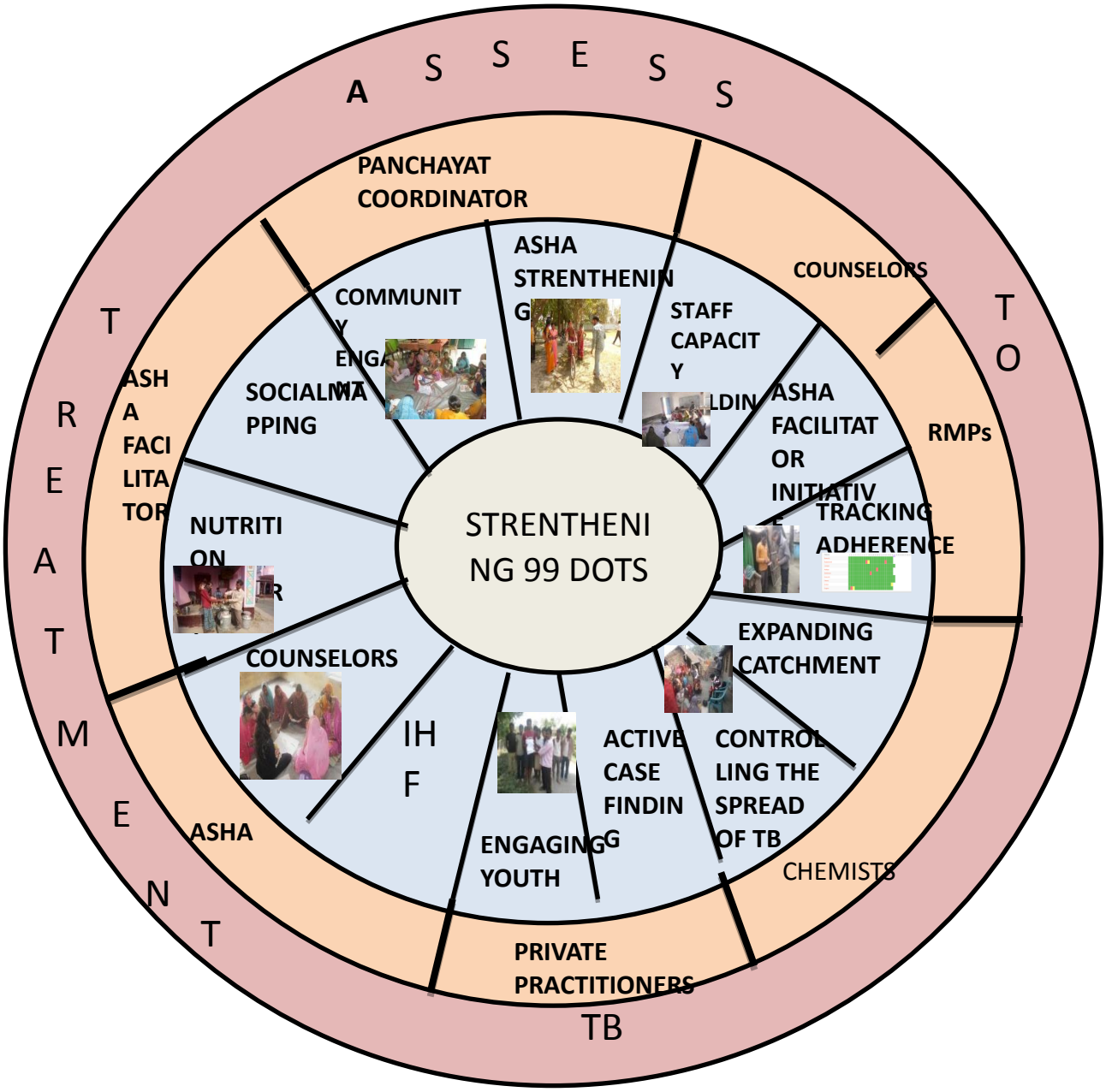
Outcome	DSS	Vidyapatinagar
DEFAULT	91	19
DIED	62	8
TRANSFER	15	2
FAILURE	6	3
TOTAL	174	32

STAKEHOLDER ANALYSIS

STAKEHOLDERS	ROLE	INFLUENCE	INVOLVEMENT	CAPACITY BUILDING	SRATEGY FOR ENGAGING STAKEHOLDERS
ASHA	-Active Case findings - Base line survey -Contact AF, PC in case of emergency.	HIGH	SUPPORT	-Meetings -Regular Training -ASHA Mobility	Incentives without delay act as motivating factor
ASHA FACILITATOR	-Facilitates ASHA -Screening -supervise ASHA -Problem solving related patient when not handled by ASHA -Support patient in full treatment course.	HIGH	SUPERVISION + SUPPORT	-Weekly meetings -Guidance -Problem solving -Training	Feedback meetings every week
PANCHAYAT COORDINATOR	-Supervise ASHA, AF -Data entry -Take care of missed call related issues. -Council patients -Handle emergency	HIGH	-DECISION MAKING - SUPERVISION	-Meeting -Training on regular basis	-Feedback Meeting
PRIVATE PRACTITIONER	Give reference of very few TB patients	VERY LOW	-Not much but sometimes refer the patients who needs counseling	-	Interaction on regular basis
GRAMEEN CHIKTSAK/RMPs		HIGH	REFERENCE	-	-Incentives based on refer patients. -Interaction

ANGANWADISEWIKA	**-Take part in Mahilla mandal -Support ASHA**	**LOW**	**SUPPORT**	**MEETINGS + FEEDBACK**	**-Meetings**
COMMUNITY	**-Give name of expected TB patient from within the community**	**MEDIUM**	**FEEDBACK + REFERENCE**	**-Awareness session -Informal group discussion**	**Monthly sessions in each panchayat**
CHEMIST	**Give reference of TB patients who are not able to continue private treatment due to high cost**	**MEDIUM**	**SUPPORT**	**Interaction on regular basis**	**Interaction on regular basis**
COUNSELOR	**Do council ling of TB patient time to time**	**LOW**	**Nutritional Support**	**Monthly training.**	**Take part in different sessions within the community -meetings**

A Comprehensive Understanding of 99 DOTS during the Training



MNH PROGRAM (MOTHER AND NEONATAL HEALTH)

INTRODUCTION

The program of MNH focused on –

- The capacity building of the team and ASHAs
- Understanding and communicating with community through *MahilaMandal*,
- Engaging with stakeholders like Auxiliary Nurse Midwife (ANM) and physicians,
- Developing a basic data tracking system.

The program was extended to 11 wards increasing the reach to almost 15,000 people. The two prongs of approach in the MNH program are complete service delivery and effective community engagement. **Ensuring quality** antenatal care (ANC), safe deliveries, and postnatal care (PNC), and facilitating access to the Public Health System (PHS) were given importance.

OBJECTIVES

-To understand the different approaches/interventions how to reduce MMR and IMR in Dalsingsarai Block of Bihar.

-To understand role of tracking the patient of vulnerable wards in order to take appropriate preventive measures for improving the quality of mother and child care.

COMMUNITY ENGAGEMENT

CE is defined as 'a process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations, with respect to issues affecting their well-being' [6][7]

Core principle of community engagement is working closely with local leaders, civil society members, and existing structures is a core principle of community engagement.[7][8]

[6] Butterfoss FD, KeglerMC.Emerging theories in health promotion practice and research.
[7] WHO study on community mobilization 2014

Engagement strengthens citizens' voices by involving them in the decisions that affect them. Community engagement can increase the impact of health programs and contribute to long-term sustainability. Women's groups convened for participatory learning and action is a methodology that has been tested across Latin America, Asia, and Sub-Saharan Africa. When certain key conditions are met, this approach has been shown to reduce maternal and newborn mortality risk[8].

[9][9]

In this study, the following variables of community engagement are taken into consideration to study its impact on mother and neonatal health.

It includes-FGD

-PLA approach with the help of mahilla mandal

- Counselor role

- ASHA, AF and PC

Over the past few decades, community engagement (CE) has emerged as an increasingly effective strategy for harnessing community potential, particularly in health improvement [10][10]

CE has been widely used by health interventionists to engage communities in health promotion, research, and policy making to address health issues[11].[11]

[8]WHO study on community mobilization 2014.

[9] WHO Study 2014

[10] Butter FD , kegler MC, Emerging theories in health promotion practice and research.

[11]NHS , community engagement to improve health.

LITERATURE REVIEW ON COMMUNITY ENGAGEMENT

According to systematic review of the effectiveness of community mobilization and participation that led to behavioral change and one or more of the following: child health, survival, and development.[12][12]

The Journal of health communication review concluded that programs working collaboratively or achieving shared leadership with a community can lead to behavior change and cost-effective sustained transformation to improve critical health behaviors and reduce poor health.Overall study of community engagement is understudied component of improving child health.[13][13]

The findings suggest that CE models can lead to improved health and health behavior among disadvantaged populations if designed properly and implemented through effective community consultation and participation. We also found several gaps in the current measurement of CE in health intervention studies, which suggests the importance of developing innovative approaches to measure CE impact on health outcomes in a more rigorous way.[14][14] There was a reduction in neonatal mortality (OR: 0.77, 95% CI: 0.65-0.90). The impact of the women's group intervention was considered plausible for neonatal mortality as other evidence suggests that improvements in home births and essential care of the newborn can reduce deaths.

Community based participatory research (CBPR) has emerged as a transformative research paradigm that bridges the gap between science and practice through community engagement and social action to increase health equity .CBPR expands the potential for the translational sciences to develop , implement , and disseminate effective interventions across diverse communities through strategies to redress power imbalance ,facilitates mutual balance to communities.[15][15]

The World health organization has drafted a strategy on integrated people centered health services that recognizes the importance of empowering and engaging individuals ,families and communities in the co production of care ,as well as in voicing their needs. The strategy also identifies gaps in the current knowledge around how to measure progress towards the establishment of people centered systems, including the role of community.[16][16]

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[12] WHO report on effectiveness of community mobilization and participation.

[13] J Health communication 2014 Sep 10

[14] *Cyril S, Smith BJ, Possamai-Inesedy A, Renzaho AM. Global Health Action. 2015 Jan; 8(1):29842.)*

[15] American journal of public health ;April 2010.

[16] WHO global strategy on people centric and integrated health services-interim report;2015

FINDINGS-

• **Encouraging early trends in neonatal mortality**: Mortality in the two earliest intervention wards has gone down from 7 deaths out of 81 live births (pre-intervention year) to 2 deaths out of 132. It is too early to say if these trends will continue, or if they will hold up in other wards.

• **Transformation in ante-natal care**: IFA consumption has gone from a base of 7%1 to virtually 100%. Fraction of required ANCs completed has gone up from 38%2 to 86%.

• **Transformation in skilled birth attendance**: Increased from 53% (baseline) to 90%.

The program's achievements include:

• **ANC:** The attention was on early registration, 4 standard ANC check-ups, iron- folate-calcium (IFA) supplementation, counseling and birth plan preparation, and identification and management of high-risk pregnancies.

• **Safe delivery**: 90% of the 120 deliveries were attended by a skilled birth attendant (SBA) in an institution. The home deliveries decreased from 18% in the pilot to 8%. The program failed to assist 30 women who migrated for their delivery. The emphasis was on reducing 3delays, ensuring delivery by an SBA, availability of appropriate supplies, immediate postpartum care, and identification of emergency cases and their management.

• **Home based care (HBC)**: The 120 women who delivered and their neonates were visited at their home. The home visits focused on screening for danger signs and counseling. A total of 33 emergencies were handled, including 25 and 8 related to neonates and post-partum mothers, respectively. The decreasing trend of neonatal mortality in the pilot wards i1 IIH baseline data from surveys in vulnerable panchayats. Comparable to NFHS-4 district-level data of 9.3%

IIH baseline data. Note that fetal heart rate and abdominal palpations are not being carried out.

• **Empowering the community**: *Mahila Mandal* was taken up as a routine monthly activity in all the intervention wards. A participatory pedagogy was designed to facilitate behavior change in MNH around issues like adequate nutrition and prevention of hypothermia. To leverage social capital, the program also identified influential women in the community. These women are community influencers and often relied upon for useful information. The team engaged them with an objective to build a cadre of community counselors.

• **Capacity building**: Capacity building of the core team members—8 panchayat coordinators and 18 ASHA coordinators—continued. All participated in weekly training on MNH. Training included sharing experience and learning, translating theory into practice, and data reporting.

• **Engagement with PHS stakeholders:** The program prioritized active engagement and advocacy with the District Magistrate, Primary Health Centre (PHC), Civil Surgeon, and District Program Manager for RMNCH.

Indicator		Previous period[1]	This period[2]
1	Program reach	(Nov'15-Oct'16) 11 wards (14929 *pop*.)	(Nov'16-Apr'17) 22 wards (incl. 11 new wards) (25068 pop.)
2	Eligible couples registered	2892	1844
3	Pregnancy registrations	447	652
	High risk pregnancies identified	42	35
4	High risk pregnancies treated	42	35
5	Neonatal deaths	4	2
6	Maternal deaths	0	0
7	Miscarriages	20	20
8	Still births	2	3
	Low birth weight neonates<2.5kg		
9	Total emergencies handled	64	39
9.1	Neonatal	35	29 (74%)
9.2.1	Maternal (during pregnancy)	14	5 (13%)
9.2.2	Maternal (Post-partum)	15	5 (13%)
10	Total deliveries (including both home and institutional)	167	293
10.1	Total institutional deliveries	146 (87.4%)	265 (90.4%)

Mahila Mandal

Community meetings are an effective way of discussing health related issues which would otherwise go unnoticed in the society. Through the *MahilaMandals*, the program tried to find out the maternal and neonatal health issues from within the community. It helps in generating awareness regarding various health related issues among the community.

Mahila Mandal is organized each month in every ward by the panchayat coordinator and ASHA and ASHA facilitator, councilors, Anganwaadi sewika also plays a vital role in forming part of Mahilla Mandal.

Learnings

The PLA approach includes activities which require active participation from the community. The facilitators felt that due to inhibitions, women would not participate in these activities. It was surprising to see that a little motivation from the group members encouraged them to come forward and take part in those activities. This method also helps the women to remember the discussions held in the meeting by associating the topics with the activities they had seen or performed.

Mahila Mandal in Basadhiya, April 2017

Considering the medium which attracts maximum attention of the community, audio visual methods were used to discuss certain topics such as kangaroo mother care and water, sanitation and hygiene (WASH) etc.

What the community has to say

The interview with community reveals that the overall response to the MahilaMandals is mixed. While some women come regularly for the meetings, some attend it only because the ASHA has called them. Some women seem very active and participated with interest in Mahilla Mandal.

There are still few barriers to mahilla mandal meetings-

- In some of the panchayats named Mukhtiarpur, women make bidi for a living and for them sparing one hour is equivalent to losing Rs. 50 due to which they refuse to attend the meetings.
- Newly married women are not allowed to participate in few meetings.

Community Counselors

Community counsellors are those women who play an active role in the society and are motivated to help others in their community. The program organises monthly meetings for around 40 such women from 17 panchayts. The average attendance of community counsellors in every meeting held at Aahan office for the training of community counsellors is around 15.

Every month they used to come at the organisation for regular meeting and training purpose

In two months stay of summer training they were given training on two different topics – related to different issues that was identified from within the community with the help of FGDs, mahilla mandal, informal group discussions within the community, base line surveys.

Topics covered for training in two months stay of summer training was-

- Family planning
- How to identify TB patient from within the community.

Sources used were-

- audiovisual aids,
- discussions lecture,
- Group activities.

Community counselors meeting

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ANNEXURES

CASE ANALYSIS AT Innovators in health

Story of few patients-

केस 1

यह कहानी केओटा गाँव के वार्ड नंबर १ की महिला अनीता देवी की है I अनीता देवी 26 वर्षीया महिला है ।उनकी शादी 2007 में हुई थी जब वो 16 वर्ष की थी । उनके पति बिहार से बाहर कपडे बनाने का काम करते है । वो पहली बार गरबवती 2008 में बनी जब उन्होंने एक लड़की को जनम दिया उस समय वो 17वर्ष की थी । 2011 में उन्होंने एक ओर लड़की को जनम दिया । फिर 2013 में उन्होंने तीसरी बार गरब धारण किया जिसमे उन्होंने एक लड़के को जनम दिया । फिर 2017 में वह चोथी बार माँ बनी । । इस बार वः अपने आप को काफी कमजोर महसूस क्र रही थीउन्होंने बताया की उनकी सारी डिलीवरी ठीक से हुई और पहले तीनो बचो को डिलीवरी के बाद कोई तकलीफ नही हुई थी । चोथी बार

गरबवती बनने का पता उन्हें 2 माह बाद चला। इसकी जानकारी उन्होंने केओटा गाँव के १ वार्ड की आशा मुन्नी जी को दी। मुन्नी जी ने उन्हें चारो ANC की जांच समय समय पर करवाने की सलाह दी। उन्होंने आशा दीदी के कहे अनुसार सारी जांच समय पर करवाईप्रसव से पहले उन्होंने आशा दीदी । । दुआरा दी गयी आयरन और कैल्शियम की सब दवा खायीयह बात 24 मार्च 2017 की रात के करीबन 1 से1 . 30बजे के बीच की है जब अनीता जी को अचानक पेट में दर्द उठा दर्द बहुत तेज था तब उन्होंने उसी वक्त आशा दीदी को फ़ोन किया आशा दीदी तुरंत वहां पहुँच गयी उन्होंने एम्बुलेंस की मदद से उन्हें हॉस्पिटल पहुँचाया। फिर लगभग सुबह11 . 30के करीब अनीता जी ने एक नवजात कन्या को जनम दिया। डिलीवरी नार्मल हुआ था उस समय बच्चे का वजन २ किलो ६०० ग्राम था। कुछ समय अस्पताल रुकने के बाद वो बच्चे को घर ले आई। बच्चा एक दम ठीक ठाक था। एक हफ्ते के बाद आशा मुन्नी वहां के वार्ड में घर घर जांच के लिए जा रही थी तभी उनके पास अनीता जी घबराई हुई आई की बच्चा बहुत जोर जोर से सांस ले रहा है यह लगबग १५ तरीक शाम को ५ से ५.३० बजे की बात है। उस टाइम उनके घर पर कोई आदमी नही था । आशा दीदी को जैसे ही पता चला वह सब काम छोड़ कर उनके पास आ गए और उन्होंने मीता जी जो की अहान संस्था में आशा फेसीलीटेटर का काम करती हैं उनको फ़ोन लगाया ।मीता जी १५ से २० मिनट के अन्दर अन्दर सिकंधर जी जो की माता और शिशु संभंधित इमरजेंसी में अहान संस्था में ड्राईवर का काम करते है तुरंत वहां आ गए।

मीता जी, मुन्नी जी और सिकंदर जी बच्चे और उसकी माँ को लेके तुरंत दलसिंहसराय अनुमंडलीय अस्पताल पहुँच गए। वहां पे बच्चे को ऑक्सीजन लगाया गया। डॉक्टर ने बच्चे का उचित इलाज किया और डॉक्टर का कहना था की अगर बच्चे को उचित समय पर वो अस्पताल ना लाते तोह बच्चे की जान को नुक्सान हो सकता थातारीक को दुबारा अनुमंडलीय 9 ।अभी बची बिकुल ठीक है और वह संस्था की ।।H अभी अनीता जी बहुत खुश है और । अस्पताल फॉलो अप के लिए दिखायेंगे बहुत आभारी है जिन्होंने उनकी बची को सही समय पर स्प्ताल पहुंचाने में उनकी मदद की । और जिसकी वजह से आज उनकी बच्ची बिलकुल ठीक है

CASE 2

यह कहानी नवादा पंचायत के वार्ड नंबर 4 की बबीता कुमारी की है। बबीता कुमारी 25 वर्षीय महिला है ।उनकी शादी2012 अक्टूबर में हुई जब वह 20 वर्ष की थी। शादी जल्दी होने के कारण उन्हें अपनी पढाई बीच में ही छोडनी पड़ी ।उनके पति ट्रांसपोर्ट का काम करते है जो ज्यादातर घर से बहार ही काम के सिलसिले में रहते है ।शादी के तीन महीने बाद ही उन्होंने गरब धारण कर लिया । पहला बचा उनका छोटा ऑपरेशन करवाने के बाद बिलकुल तंदरुस्त पैदा हुआ । 2015मार्च के महीने में उनका गरबपात हो गया और वेह दूसरी बार माँ नहीं बन पायी। फिर 2016 के जुलाई महीने में उनको तीसरी बार गरब धारण करने का सोभाग्य प्राप्त हुआ । उन्होंने बताया की इस बार उन्होंने बहुत ध्यान देने की कोशिश की , इसके लिए जैसे ही उन्हें पता चला की वो गरबवती है उन्होंने अपने वार्ड की आशा बेबी ख़ुशी जी को तुरंत सूचित कर दिया। आशा दीदी को जैसे ही पता चला तो वह उनको पास के आंगनवाडी केंद्र में जांच के लिए ले गयी 4 गरबावस्था के दोरान उन्होंने बताया की उनकी टोटल । बार जांच आशा के कहे अनुसार अंगनवाडी सेंटर में हुआ जिसमें समय समय पर उनका बी

वजन, पी.A.N.M दुआरा जांच किया गया ।बाकी जांच जैसे की HB, HIV, उन्होंने RH । अस्पताल दलसिंहसराय से करवाया SDH

यह बात फरवरी करीबन सुबह के टाइम की है जब उनका आठवाँ महीना चल रहा था 16 उस दिन वह सुबह उठी उसके बाद नहाने गयी तब उन्हें पता चला थोडा थोडा ब्लीडिंग हो दाई ने बोला की ऐसा होता है घबराने की । ।तभी उन्होंने पास की दाई को दिखाया रहा है पर उनकी माँ और भाभी के कहे अनुसार वह बबीता जी को प्राइवेट अस्पताल । बात नही है अस्पताल जाने के बाद उन्हें अस्पताल की कार्यकर्ता ने । घर वाले बहुत चिंतित थे । ले गयी बताया की शायद बच्चे की धड़कन रुक गयी है यह सुन कर परिवार वाले और भी घबरा गए जिससे पता , अल्ट्रासाउंड करवाया गया । ब्लीडिंग रुक नही रही थी, ऑक्सीजन लगा । फिर । घंटे बाद उनको बच्चे की धड़कन मिली 2 करीबन । चला की प्लेसेंटा नीचे आ चुका है थोड़ी देर बाद बबीता जी नार्मल हुई तभी उनके परिवार वाले उन्हें घर ले आये कारण यह था की प्राइवेट अस्पताल था और उन्होंने पैसे का इंतजाम नही किया था घर आने के थोड़ी देर । , खून बहुत बह रहा था , ब्लीडिंग बहुत ज्यादा था । बाद बबिता जी को बहुत ब्लीडिंग हुआ तभी उनका परिवा । तभी घर वाले बहुत परेशान हो गएर उनको पास के सरकारी अनुमंडलीय अस्पताल ले गए में माता और शिशु सबंदित ।।H जो की ,उस दोरान अमरनाथ जी । रात को । कार्यक्रम में पंचायत कोरडीनेटर के पद पर काम कर रहे हैं तुरंत वहां पहुँच गए फ ,बजे पानी चदाया गया 5 से 4 बजे के करीब दर्द थोडा कम हुआ फिर सुबह 12िर धीरे धीरे दर्द बडा और थोड़ी देर बाद प्रसव हो गया और एक बहुत प्यारी सी नन्ही सी बच्ची ने जनम लिया 2 उस समय बच्चे का जनम lkg 700gm था आखिर में सब ठीक हो गया । ।।H परिवार वालों का मान ना है की वह । घंटे बाद वो वापिस घर आ गए 12 फिर करीबन । संस्था के बहुतआभारी है क्यूंकि पूरी रात जो की एक मुश्किल की घडी थी उस टाइम संस्था के कार्यकर्ता उनके साथ थे और इमरजेंसी के लिए लिए उन्होंने समस्तीपुर जाने की । प्रसव के बाद भी आशा टाइम टाइम पे बबिता जी को और उनके बच्चे । तयारी क्र राखी थी अभी । को देखने के लिए आती रहीबबिता जी और उनकी नन्ही बच्ची एक दम तंदरुस्त है ।

Case 3

Story of TB patient

<u>Case analysis:</u> Smiling TB Patient with IIH team members.

यह कहानी मनोवर जी की है जो की पगडा पंचायत के बलोचक गाँव के रहने वाले हैं । एक फील्ड विजिट के दोरान मीता जी और अमरनाथ जी के साथ मनोवर जी से मिलने का मौका मिला ।

मिलने के बाद हमने उनके साथ कुछ बात चीत की , और उनका TB से सम्बंदित अनुभव पुछा । उन्होंने बताया की शुरू शुरू में वह बहुत ही ना उम्मीद थे , उनको लग रहा था की अब वह बच नही पाएंगे ,क्यूंकि उन्हें बहुत कमजोरी महसूस होता था ,वजन भी काफी कम हो चूका था । खांस खांस के बुरा हाल था । उस समय वह मुंबई में थे वहां पे काम करते थे , मुंबई में उन्होंने सरकारी अस्पताल में दिखाया ओर वहां के डॉक्टर की सलाह से दवा शुरू कर दिया , दवा काफी दिन खाने के

बावजूद भी उनकी सेहत में कोई सुधार नही दिखा । उन्होंने बताया की सेहत में परेशानी होने के कारण उन्होंने अपने घर वापिस आने का फैसला कर लिया । जब वो वापिस आये तो उनकी भेंट आशा दीदी से हुई जब, वो उनके नगर में घर घर जा कर पूश्ताश कर रही थी , आशा दीदी ने उनको बलगम की सलाह दी और आहन कार्यक्रम के बारे में बताया और अगले ही दिन उनको अस्पताल आने के लिया बोला गया ।

अगले दिन वो अस्पताल गए तो उनका आहन कार्यकर्ता दुआरा बलगम जांच हुआ । बलगम जांच में उन्हें पता चला की उन्हें TB है और उनको कम् से कम् 6 महिना दवा खाना पड़ेगा । मनोवर जी ने बताया की मुंबई में उन्हें किसी ने बलगम जांच के लिए नही बोला था । मनोवर जी को आशा दीदी और आहन कार्यकर्ता दुआरा समझाया गया की TB लगातार दवा खाने पर बिलकुल ठीक हो सकता है इसके लिए उन्हें आहन कार्यक्रम का साथ देना होगा और जैसे जैसे बोला गया वैसे दवा खाना होगा और इस दवा के कोर्स को बीच में छोड़ने का कोई सवाल ही नही है । उन्होंने बताया की आहन कार्यकर्ता दुआरा यह भी समझाया गया की अगर दवा खाते समय बीच में कोई परेशानी होगा तो वह और पूरा आहन परिवार उनके साथ है । मनोवर जी ने बताया की शुरू शुरू में उन्हें दवा खाने पे बहुत दिकत आया जैसे की पेशाब का रंग लाल हो जाना । पर आहन कार्यकर्ता उन्हें हमेशा टाइम टाइम पे समझाते थे और उन्हें दवा खाने के लिए प्रेरित भी करते थे । फिर धीरे धीरे ३ पत्ता खाने के बाद उन्हें अपनी सेहत में बदलाव नज़र आया ।मनोवर जी ने आगे हमे बताया की कैसे वो हमेशा मिस्ड कॉल देते थे और कभी भूल जाने पर कैसे आशा और उनके साथी उनसे पूरा पूछ ताश करते थे । घर आ कर दवा का पत्ता भी जांच किया जाता था ।

मनोवर जी आज बहुत खुश है उनका दवा का कोर्स पूरा हो चूका है और वह स्वस्थ है इसके लिए वो पूरी आहन टीम का धन्यवाद करते है की उन्होंने दवा खाने के टाइम पे उनका साथ दिया । उपर दी गयी तस्वीर में आप उनके चेहरे में ख़ुशी की चहक देख सकते हो की आज जब आहन टीम उनके फॉलो उप के लिए हाल चाल पूछने के लिए आई तो उनको कितना ख़ुशी हुआ ।

TOOL FOR TB PATIENTS

रिसर्च टूल

साक्षातकर्ता का नाम- उम्र-

पंचायत- वार्ड-

स्त्री/पुरुष- पड़ाई कहाँ तक-

Q1-क्या आपने कभी TB का दवा खाया है ?

हाँ /नहीं

Q2- क्या आपकी TB दवा का कोर्स पूरा हो चुक्का है याँ फिर अभी चल रहा है?

१.पूरा हो चुक्का है

२. अभी चल रहा है

3.अभ दवा नही खाते

अगर दवा नही कृपया कारण बताईये .....

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Q3- आपने TB का दवा कहाँ से खाया/खा रहे हो ?

१.ग्रामीन चकित्सक से

२.आहन कार्यक्रम के दोरान 99 डॉट्स के तेहत

३.सरकारी अस्पताल से

४.प्राइवेट से

५.कोर्स बीच में ही छोड़ दिया I

(अगर दवा 99 डॉट्स से खाया तो प्रश्न नंबर 4 जाईये वरना सीधेQ15 पे जाईये)

Q4- आपने आहन कार्यक्रम के दोरान 99 डॉट्स के तहत कब दवा खाना शुरू किया और कब तक खाया?

कितने महीने का कोर्स किया? .....

.....से.....तक /

या फिर ,

कब से खा रहे हो .....

Q5. अगर बीच में ही छोड़ दिया तो कृपया कारण बताईये ?.....

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अगर दवा छोड़ा तो छोड़ने के बाद आपको क्या दिकत आया ?.....

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Q6- क्या आप दवा खा के उसमें दिए गए नंबर पर मिस्ड काल देते थे ?

हमेशा देते थे

कभी कभी भूल जाते थे

नही दिया कभी

Q7 - मिस्ड काल ना देने पर क्या आपको आहन कार्यकर्ता दुआरा पुछा गया की आपने क्यों नही दिया काल ?

हाँ /नही

Q8 - दवा ना खाने पर / खाते समय आपका कोई कोउन्सल्लिंग होता था क्या ?

हाँ / ना

अगर हाँ तो कौन करता था.....

उसमें क्या बताया जाता था

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Q9 – TB के इलाज दौरान आपकी कौन निगरानी करता था?

आशा घर आ कर

पंचायत कोर्दिनाटर

दोनों

अन्य .....

कोई भी नही

Q10 – निगरानी में क्या पुछा जाता था ?

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Q11- घर पे आ के दवा का पत्ता चेक भी किया जाता था क्या ?

हाँ / नहीं

अगर हाँ , तो कौन करता था ?

आशा

पंचायत कोर्डिनेटर

सभी

अगर कोई ओर तो बताईये .....

Q12.दवा खाते समय आपको स्वास्थ सम्बंदित कोई परेशानी तो नही हुई थी ?

हाँ/ नहीं

अगर हाँ तो आप बता सकते है क्या परेशानी आई थी.....

.....

परेशानी आने पर आपकी मदद की गयी थी क्या ?

हाँ/नही

अगर हाँ तो क्या मदद की थी.....

Q13.अगर दवा खाते समय आपको दिकत आया तो आपने क्या किया ?

दवा बंद कर दी

दवा जारी रखी

आहन कार्यकरता को बताया

Q14- कोर्स पूरा होने के बाद क्या आपको स्वास्थ सम्बंदित कोई दिक्कत तो नही आया ?

हाँ / नही

अगर हाँ तो क्या कृपया बताईये .....

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(अगर 99 डॉट्स से नही जुड़े तो)

Q15- आपके दवा खाने का तरीका ?

कभी कभी खा लेते थे

जैसे बोला गया था वैसे

जब ठीक महसूस होने लगा तो छोड़ दिया

कभी कोई डॉक्टर से कभी कोई

Q16.अगर दवा ठीक से नही खाया तो कारण .....

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Q17- दवा छोड़ने के बाद आपको कोई दिकत आया ?

हां / नहीं

अगर हां , तो क्या दिक्कत आया .....

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Q18- अभी स्वास्थ से सम्बंदित आपको कोई परेशानी तो नहीं है

हाँ / नही

अगर हाँ तो कृपया बताईये .....

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TOOL FOR UNDERSTANDING IMPACT OF COMMUNITY ENGAGEMENT

रिसर्च टूल

साक्षातकर्ता का नाम -: दिनांक -:

मोबाईल नं-: . पंचायत -: वार्ड -:

उम्र-:

विवाह का उम्र-:

आपने कहाँ तक पड़ाई की है :

Q1नहीं/ हां ?क्या आपके नगर में आपको कोई स्वास्थ संबंदित जानकारी मिली है(.

अगर हाँ तो यह जानकारी आपको कौन देता है ,
?.....

आप बता सकते हैं की महिल्ला मंडल में मिली स्वास्थ सम्बंदित जानकारी और कहीं और से मिली जानकारी में क्या अंतर है ?

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महिला मंडल के बारे में

Q2) क्या आपने महिला मंडल के बारे में सुना हैनहीं / हाँ ?

अगर हाँ , तो आप ने कभी इसमें भाग लिया है हाँनहीं /

Q3) आपके नगर में महिला मंडल कितनी बार होता है,

१महिना में एक बार.

२हफ्ते में एक बार.

३कभी कभी.

Q4? इनमें से महिला मंडल में कौन कौन भाग लेता है(

१ आशा

२ काउंसलर

३ आशा कोडीनेटर

४ सभी

Q5आपने महिला मंडल में (कितनी बार बाग़ लिया है

१ हमेशा

२ कभी कभी

३ कभी नहीं

Q6)क्या आपको महिला मंडल से स्वास्थ संभंधित जानकारी मिलती हैनही / हाँ ?

Q7) अगर हाँ.....तो क्या जानकारी मिलती है ,

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Q8) क्या यह जानकारी आपको पहले पता थीनहीं/ हाँ ?

अगर हाँ तो कहाँ से और क्या पता था .....

Q9)क्या यह जानकारी किसी और को भी बताते हो नही/ हाँ ?

अगर हाँ, तो यह जानकारी किस को बताते हो १ सिर्फ अपने परिवार वालों को

२परिवार के साथ साथ साथ अपने आस . पड़ोस को

३ किसी को भी नही.

Q10 महिला मंडल में दी जा रही जानकारी क्या आप को समझ .अति है? हाँ नही/

अगर नही तो आपको कहाँ दिक्त आती है .....

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Q11क्या महिला मंडल में भाग लेने से आपके स्वास्थ में कोई बदलाव आ .या है नही/ हाँ ?

अगर हाँ .....तो उधाहरण दीजिये,

.....

Q12क्या महिला मंडल में भाग ल (ेने से आपके समुदाय की स्वास्थ में कोई बदलाव आया है नही/ हाँ ?

अगर हाँ .....तो उधाहरण दीजिये,

.....

Q13जब महिला मंडल नही होता था और अभी महिला मंडल के बाद आपने अपने समाज - ?में कोई बदलाव देखा

कृपया विस्तार से बताईये .....

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Q14? अगर आप को बदलाव के लिए बोला जाए तो आप क्या बदलाव देखना चाहोगे -

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बच्चे और माता के स्वास्थ संबंदित जानकारी के सवाल

Q14 नही/ हाँ? के बारे में सुना है ANC क्या आपने(

क्या आप बता सकते है की एक गरब्वती महिला को कितनी बार की जांच ANC ? करवानी चाहिए

१ सिर्फ एक बार.

२दो बा.र

३ तीन बार.

४ चार बार.

५नही पता.

यह जानकारी कहाँ से मिली .....

Q15नही / हाँ? क्या आपको गरब अवस्था में होने वाले खतरे के लषण के बारे में पता है(

यह जानकारी आपको कहाँ से मिली .....

Q16) क्या आपको नवजात में होने वाले खतरे के लाष्ण के बारे में पता है नही/ हाँ ?

अगर हाँ तो क्या पता है यह जानकारी आपको कहाँ से मिली ,

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Q17साफ़ सफाई क्यों जरूरी है क्या उसका स्वास्(थ से क्या समभंद है ?

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जानकारी कहाँ से मिला .....

Q18नही / हाँ ? देरी से संबंधित कोई समस्या के बारे में आप जानते हो 3 क्या(

देरी ना हो इसके लिए आप क्या करोगे?.....

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जानकारी कहाँ से मिला .....

Q19 ..... नही/ हाँ ? प्रसव पश्चात् केयर के बारे में जानते हो(

Q20 बच्चे को पहला माँ का दूध कब पिलाना चाहिए(

१ घंटे बाद 6

२तुरंत.

३ पहले कुछ और दे फिर.

४पता नही.

Q21/ब्रह्म/कोई भेद भाव/ माता को लेकर आपके समाज में कोई मान्यता या(प्रथा तो नहीं)cultural norms)-

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Q22/भ्रह्म/कोई भेद भाव/ नवजात शिशु को लेकर आपके समाज में कोई मान्यता या (प्रथा तो नहीं)cultural
norms).....
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आशा से पूछे जाने वाले प्रशन

Q23क्या फील्ड में दी गयी जानकारी और महिला मंडल में दी गयी जानकारी में आपको (? कोई फर्क नजर आया

कृपया उदहारण दे के बताईये
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Q24 आप क्या जानकारी देते हो महिला मंडल में(
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क्या यह जानकारी से कोई बदलाव देखा आपने
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.....s.....