Summer Training at

Project Concern International (PCI)/India, (PARIVARTAN)
Bihar
(April 1-May 31, 2014)

Assessment of Health Behavior of Marginalized Community Regarding ANC, Institutional Deliveries and Post Natal Care

By
Kumari Anisha

Under the guidance of
Mr. Rahul Sharma

MBA- Hospital & Health Management (MBA-HM)
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The IIHMR University, Jaipur
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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

CERTIFICATE

This is to certify that **KUMARI ANISHA** student of Post Graduate Programme in Health Management, Institute of Health Management Research, Jaipur, batch 2013 – 15. She has done her summer training for the period **of April 1st to May 31st, 2014 with PCI India in District Samastipur, Bihar** under my guidance. During this period she has completed her study as a part of partial fulfillment of the course requirements, recommended for the Post Graduate Diploma in Health and Hospital with specialization in Health Management. Topic of study given by PCI Bihar (**PARIVARTAN**) during her summer training was **"Assessment Of Health Behavior Of Marginalized Community Regarding ANC, Institutional Deliveries And Post Natal Care.** All the data related to the study is the Primary data. Her approach to the projects has been sincere, scientific and analytical.

I wish her all the best for her future endeavor.

Col. (Dr.) Ashok Kaushik
Dean (Academic & Students Affairs)
IIHMR, Jaipur

Dr. Rahul Sharma
Associate Professor
IIHMR, Jaipur

PCI

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June 6th, 2014

To Whom It May Concern

This is to Certify that Ms. Anisha Shah, Student of IIHMR, Jaipur has successfully completed fifty days long (From 3rd april 2014 to 23rd May 2014) internship programme under the guidance of Mr.J B R Chakravarthy, Programme Manager at Project concern International India,Patna Branch. During the period of her internship programme with us he was found punctual, hardworking and inquisitive.

We wish her every success in life

Shruti.

H.R Officer (Parivartan Project)

Project Concern International/India

Head Office : C-32 Panchsheel Enclave, New Delhi - 110017, India
Bihar Office :
Nirmal House 2nd & 3rd Floors, Nalanda Nagar, I.E. Road, Kurji,
P.O. Sadaquat Ashram, Patna 800 010, Bihar
Ph. : + 91-612-2270211-12 / Fax : + 91-612-2270207
Registered as Project Concern International in India
www.pciindia.org

Acknowledgement

Working on this project proved to be the lifetime experience for me.

I would like to thanks all the study participants who openly shared their experiences in order to enrich my knowledge.

I thank Mr.Vikash Agarwal (Chief of Party), Parivartan Project for his guidance and support throughout the project. I also thank Mrs. Rajshree Daas (Team leader of the program) for giving me an opportunity to take part in their project. A very special thanks to Mr. JBR Chakravarty (Program manager) and Mr. Brijesh for providing their valuable time, support and guidance to me, without which I could have never been able to accomplish the task at hand.

I am grateful to those all who have supported and helped me during my project.

I also express my thanks to my mentor *Mr. Rahul Sharma*, Assistant Professor IIHMR Jaipur for his consistent guidance & knowledge.

I am thankful to God, My colleagues & all the persons concerned with this project with their blessings.

I hope that I can build upon the experience and knowledge that I have gained and make a valuable contribution towards the industry in coming future.

KUMARI ANISHA

LIST OF ABBREVIATIONS

Item	Description
MWRAs	Marginalised Women in Reproductive Ages
ANC	Antenatal care
PCI India	Project Concern International India
PM1	Parivartan Module 1
PM2	Parivartan Module 2
EmOC	Emergency obstetric care
PNC	Postnatal care

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BACKGROUND

Parivartan: Bihar Community Mobilization Project

Improvement of maternal and child mortality and morbidity outcomes, in a high-burden state like Bihar, are critical for India and its ability to achieve its goals of contributing to Millennium Development Goals (MDG) 4 and 5. To this end, the Bill and Melinda Gates Foundation (BMGF) supported the Ananya initiative and partnered with the Government of Bihar (GOB) to accelerate improvements in a broad range of priority health outcomes – emphasizing, maternal, and neonatal and child health (MNCH); nutrition; key infectious diseases; and sanitation and hygiene. Within Ananya, Project Concern International (PCI) – in partnership with PATH and the Foundation for Research in Health Systems (FRHS) – is implementing a community mobilization and social accountability grant (Parivartan). Parivartan provides a platform for empowering 8 high innovation districts to engage in processes that catalyze support networks and enable a shift in behavior and social norms, which contribute to improved and sustainable health and sanitation outcomes in Bihar.

- **Promoting Behavior Change on Key Health and Sanitation Behaviours.**
- **Working with Most Marginalized Communities for Social Accountability and Equity Providing.**
- **Linkages for Sustainability and Scale.**

Mobilizing Most Marginalized: Parivartan is currently working in 64 blocks from within 8 high innovation districts in Bihar, namely: Patna, Begusarai, Samastipur, East Champaran, West Champaran, Gopalgunj, Khagaria, and Saharsha (See map on the left-hand side). These blocks were selected using a vulnerability index, calculated based on three indicators: percent of Scheduled Castes and Tribes (SC/ST) population in a block, literacy rates among women, and proneness to flooding. Of the 64 blocks, 43 are designated as B-50 (bottom-50) and 21 as T-50 (top-50). B-50 blocks are those where the percentage of the SC/ST population is high, female literacy rates are low, and the areas are more disaster-prone. In these blocks, Parivartan created 18,000 community groups in more than 2,250 villages. Each community group typically contains 15-18 women of reproductive age group. Each village has approximately 5-6 community groups.

Saheli, at the grassroots level, Sahelis (village volunteers) act as catalysts of change and play a critical role as conduits of information for the target women. These Sahelis were selected from among the women in the target communities with a basic level of education, leadership and communication skills, and a willingness to work on the project.

Sahelis Performance Assessment Criteria:

Preparation/ operation

- Preparation and assessment of target audience
- Developing learning tools
- Testing learning tools

- Execution of learning tools/roll out

Confidence

- Perceived confidence to deliver the training at the field - before and after.

Learning

- Retention of the information/ knowledge, increase in knowledge from before to after the learning experience:

Skill and Performance

- Communication skills
- Use of Information material
- Message delivery
- Involving women in discussions
- Response to quires
- Feedback from the trainee
- Women attention retention

Challenges and opportunities

- Experiences of difficult situations and the role of training in overcoming these situations

Compendium: The Parivartan compendium consists of thirteen training modules pertaining to antenatal care, birth preparedness, postpartum and newborn care, exclusive breastfeeding, complementary feeding, routine immunization, postpartum family planning, sanitation, village entry, group formation, equity, social advocacy, and accountability. The modules were developed by the Parivartan core team, which included members from PATH and PCI. The core team worked on the content, language, methodology for disseminating messages, and the collective action (to be undertaken by the group members to ensure behavior change and facilitate service access). The team did a literature review of the technical content, tested the appropriateness of the messages in the context of Parivartan groups, developed messages with other Ananya grantees (such as CARE and BBC Media Action), and finalized the modules. The modules are used to train community group members through community cadres. It is expected that after receiving training, community members (particularly pregnant and lactating women) will practice appropriate behavior – related to maternal and child health, nutrition, and sanitation – and access health services from nearby facility and service platforms. The Equity and accountability modules are designed to generate community demand and make service providers and institutions, such as Integrated Child Development Scheme (ICDS) and health facilities, accountable. The village entry and group formation modules have been helpful with establishing rapport and in mobilizing communities to form groups in about 2300 villages in the 64 blocks of the eight Parivartan intervention districts. The group formation modules are introduced to form groups in line with the Jeevika concept. The group formation modules have been developed in line with Jeevika modules so that Parivartan groups can easily be transitioned into the Jeevika fold.

Parivartan has signed a Memorandum of Cooperation (MOC) with Bihar Rural Livelihoods Promotion Society (BRLPS), for health and sanitation integration with BRLPS' project Jeevika (Bihar Rural Livelihoods Project). Jeevika aims at enhancing the social and economic empowerment of the rural poor in Bihar by creating self-managed community microfinance institutions or self-help groups (SHGs) at the village level and enhancing income through sustainable livelihoods. Parivartan will help Jeevika to advance a health, nutrition, water and sanitation agenda within their community institutions. Parivartan is focusing on the process wherein all the Parivartan promoted community groups will become incorporated into the Jeevika framework with the retention of the ongoing Health and Sanitation Agenda. The transition process, initiated in the month of August 2013, would aim to cover all 18,000 community groups by June 2014. However, before groups can be incorporated within Jeevika, Parivartan has to work towards nurturing groups to practice five essential elements, (Panchsutras) as prescribed by Jeevika, namely: (1) weekly meetings, (2) weekly savings, (3) inter loaning, (4) timely repayment of loans, and (5) book-keeping at the group level; in addition to educating group members on health, nutrition and sanitation behaviours

Working Collaboratively with Jeevika :

- Joint Planning Exercise
- Joint Capacity Building Activities
- Supporting Bookkeeping
- Supporting Bookkeeping
- Community Resource Person (CRP) drive

Collaboration with Bihar Mahadalit Vikas Mission

Strengthening Village Health, Nutrition and Sanitation Committees.

Health and Nutrition Services, my right.

Monitoring, learning and Evaluation :

- GSAP- Group Service Access Platform
- Group Attendance Registers
- Data Validation Process
- Baseline Survey Results
- MIS Outcome Indicators Tracking
- Knowledge Management Framework
- Linking Data to Google Map

Parivartan Partners:

PCI is the Lead Partner and responsible for overall program implementation and compliance with Bill and Melinda Gates Foundation (BMGF) grant requirements. PCI also serves as a clearinghouse and synthesizer of lessons learned and promising practices. PCI leads the community-based action being implemented by 8 local NGOs, focusing on district-wide interventions to foster and strengthen community groups and community-based actions (CBA).

PATH serves as the Technical Advisory Partner, leading the efforts related to: learning, the transfer of learning for sustainability and scale up (KAT stream), and the collaboration with MLE partners to document and disseminate knowledge and learning. PATH advises and guides the CBA stream on proven models and interventions, such as Sure Start, assimilating knowledge and learning and transferring lessons and best practices to stakeholders to achieve sustained impact across Bihar.

FRHS functions as the Implementing Partner for Research, and focuses on implementing operational research pilots at select villages for strengthening community groups.

ABSTRACT

India's maternal and child health programs have not aggressively promoted institutional deliveries, except in high-risk cases. The reason is that provision of facilities for institutional delivery on a mass scale in rural areas is viewed as a long-term goal requiring massive health infrastructure investments. Institutional delivery is nevertheless desirable, in as much as it reduces the risk of both maternal and infant mortality.

This report examines the role of existing health awareness module PM1 and PM2 in promoting ANC, institutional delivery and post-natal care in rural areas Of Sarairanjan block of Samastipur district of Bihar. Currently, about three in six births in sarairanjan are delivered in medical institutions.

Because the likelihood of delivering in a medical institution is influenced not only by use of antenatal-care services but also by such potentially confounding factors as mother's age, education, exposure to mass media, household standard of living, and access to health services, these other factors are statistically controlled (i.e., held constant) when estimating the effects of health awareness module on antenatal Care, institutional delivery and postnatal care. Logistic regression is used for this purpose. The analysis is based on data collected from Sarainjan block through survey.

The results indicate that, even after statistically controlling for other factors, mothers who received antenatal check-up are more likely to give birth in a medical institution than mothers who did not receive any antenatal check-up. Among the other factors considered, Mother's age and education and child's birth order also have strong effects on the likelihood of institutional delivery.

Household standard of living also has a substantial effect in most cases. Contrary to expectation, access to health services, as measured by availability of a hospital within 5 km of the village and by availability of an all-weather road connecting the village to the outside, does not have a statistically significant effect on institutional delivery in most cases.

Overall, antenatal care is the strongest predictor of institutional delivery, a finding that has important program implications. It suggests that it is possible to promote institutional delivery by promoting antenatal check-ups and associated counseling. Given that distance to a hospital does not have a significant effect on institutional delivery, it may not be necessary to create new hospitals (at least not for the purpose of encouraging institutional delivery), but rather to focus on expanding the availability and quality of services at existing facilities, as well as counseling and educating mothers about the importance of giving birth in medical institutions under the supervision of trained professionals. Because a much higher proportion of institutional deliveries take place in private-sector facilities than in public-sector facilities in Bihar . In addition, awareness and practices of postnatal health behavior contributed in reducing the maternal and infant mortality rate. Efforts should also be made to strengthen safely to facilitate the health awareness module among those community those are still lacked such awareness in order to promote maternal and child health. Since some of the deliveries in this district still occur at home, so there is need of efforts to roll on these health awareness module routinely by targeting those who are still unaware of the benefits of health behavior practices in some innovative way to make them more understandable.

INTRODUCTION

It is well established that giving birth in medical institution under the care and supervision of trained health-care providers promotes child survival and reduces the risk of maternal mortality.
In Bihar, both despite the many benefits associated with institutional delivery, India's maternal and child health program have not aggressively promoted institutional deliveries, except in high-risk cases. The reason is that providing facilities for institutional delivery on a mass scale in rural areas is viewed as a long-term goal requiring massive health infrastructure investments.

In recent years, however, there has been a shift in this policy with the establishment of the Child Survival and Safe Motherhood (CSSM) and the Reproductive and Child Health (RCH) programs. Child mortality (especially neonatal mortality) and maternal mortality are high. Despite the uniformity in program design throughout the country, there is considerable regional diversity in the availability and quality of health services, including maternal health services. In 1992–93, according to NFHS-1, the proportion of mothers receiving antenatal check-ups ranged from 31 percent in Bihar to 94percentin Tamil Nadu. Actual utilization of health services occurs when this generated demand overlaps with availability. In the Indian context, the situation is further complicated by women's perceptions of illness, which are affected by women's cultural conditioning to tolerate suffering. Because of this tolerance, which varies considerably across regions of India, the perceived need for health services can be small even when the actual need is great.
PCI is an integrated health and development organization, working where the need is the greatest—in the poorest communities and least developed nations in the world.

PCI will become a leader in building community capacity, resiliency and self-sufficiency as the preferred partner of private donors, NGO's, communities, businesses and governments.

Parivartan is the ongoing project in the eight districts of Bihar namely Patna, Begusarari, Khagria, Saharsha, Gopalganj, Samastipur ,East Champran and West Champran by Project Concern International.
Goal:
Catalyze collective community action to promote shifts in social norms and behaviour changes to increase family health and enhance accountability and equity of health services across Bihar by 2016. Parivartan's theory change is to overcome the barriers to driving health among most marginalized (MM) communities in Bihar by organizing MM women in to participatory group, training them to influence on health and empowering them to lead their communities to improved family health behaviours, as well as greater accountability and equity services.

Parivartan is a 60 month project which is being implemented by PCI-India. Parivartan works to address inequities by ensuring that the poorest of the poor enjoy full access to the same services as all Indian citizens. PCI envisions that the Parivartan model will not only be embraced by and impactful for the target communities, but will also be made sustainable and scalable through systematic documentation, knowledge sharing, diffusion and replication.

Objective:-

1. Districts to improve family health and sanitation practices.

2 Strengthen accountability mechanisms for health, sanitation and welfare services and schemes through community structures that work to advance equity, service access, quality and utilization in the 8 innovation districts.

3Establish a knowledge base of successful approaches to scale up community mobilization and build partnerships and mechanisms to support state-wide scale up and sustainability of community mobilization interventions.

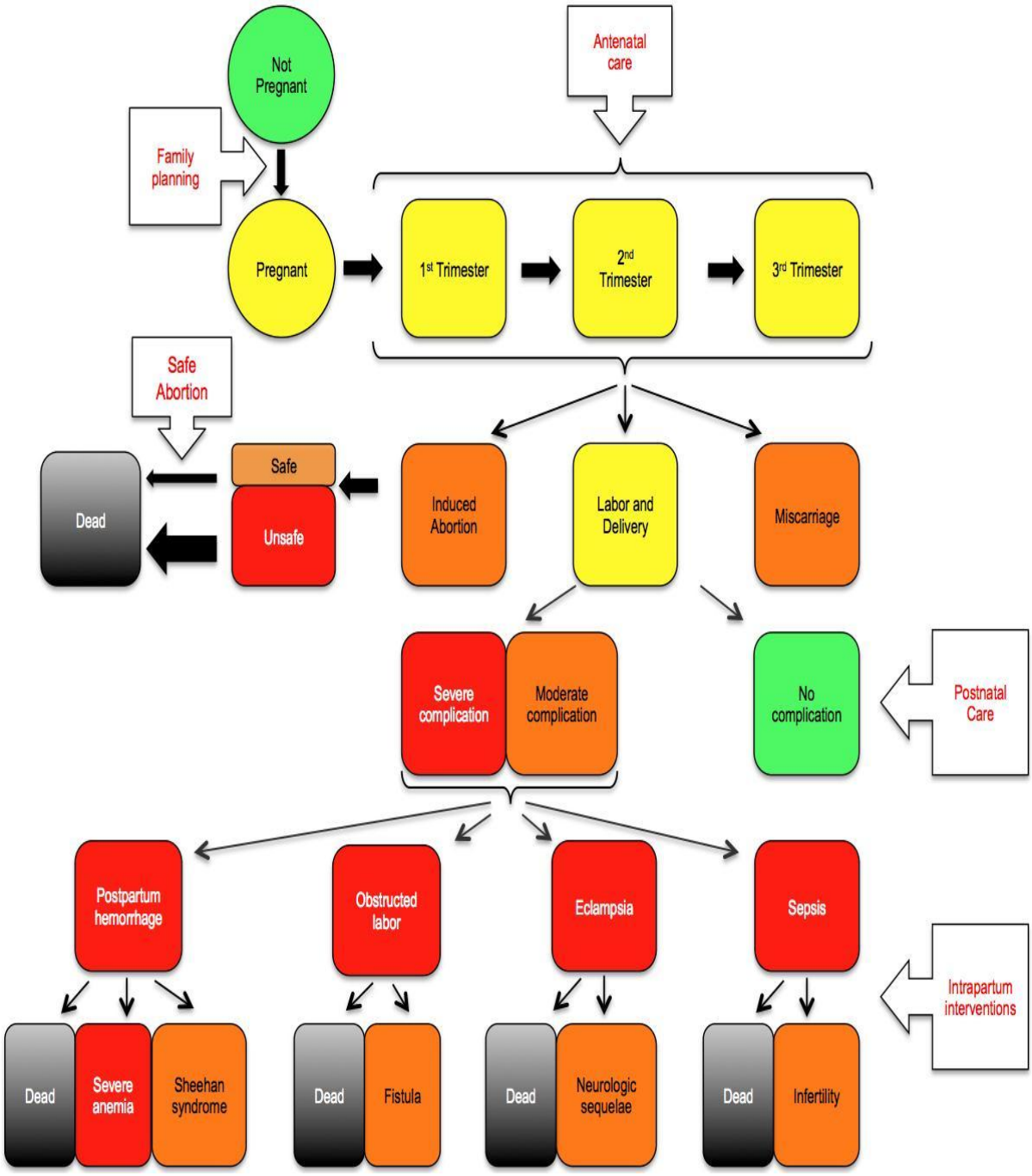
Component of maternal health

In order to reduce maternal morbidity and mortality:

1. Antenatal services

2. Internatal services

3. Postnatal services


Not Pregnant
Family planning
Pregnant
Antenatal care
1st Trimester
2nd Trimester
3rd Trimester
Safe Abortion
Dead
Safe
Unsafe
Induced Abortion
Labor and Delivery
Miscarriage
Severe complication
Moderate complication
No complication
Postnatal Care
Postpartum hemorrhage
Obstructed labor
Eclampsia
Sepsis
Intrapartum interventions
Dead
Severe anemia
Sheehan syndrome
Dead
Fistula
Dead
Neurologic sequelae
Dead
Infertility

Intervention taken by government (Health policy and schemes)

- Family welfare program (1984)
- Reproductive and child health program (RCH-1997)
- NRHM (2005)

- Universal access to skilled birth attendant (SBA)
- EmOC through network of FRU & 24*7 PHCs
- Improving access to EmOC through PPP
- Access to early and safe abortion services
- Strengthening referral systems, e.g., 108 ambulance service, Janani Express
- Janani suraksha yojana (JSY)

Targets	Pregnant Women: -9 months
Core interventions	1. Adequate diet 2. Iron/folate supplements 3. Tetanus toxoid immunisation 4. Malaria prevention and intermittent preventive treatment 5. Healthy timing and spacing of delivery 6. De-worming 7. Facilitate access to maternal health service: antenatal and postnatal care, skilled birth attendance, Prevention of Mother-to-Child Transmission, HIV/STI screening

Review of literature

As this brief review of literature illustrates, previous research provides conflicting evidence on the relative importance of programmatic (supply) and non-programmatic (demand) factors affect in health-seeking behavior.

In particular , there is no research that we know of that examines how utilization of antenatal-care services affects the likelihood of giving birth in a medical institution , which is the topic of the present study. In 1992–93, according to NFHS-1, the proportion of mothers receiving antenatal check-ups ranged from 31 percent in Bihar to 94percent in Tamil Nadu, and the proportion giving birth in medical institutions ranged from 11 percent in Rajasthan and Uttar Pradesh to 88 percent in Kerala (IIPS1995)

In 1998–99, according to NFHS-2, the proportion receiving antenatal check-ups ranged from to 34–36 percent in Uttar Pradesh and Bihar to 98 percent in Kerala and Tamil Nadu, and the proportion giving birth in medical institutions ranged from 22–23 percent in Uttar Pradesh and Bihar to 95 percent Kerala (IIPS and ORC Macro 2000a).

Recent analysis of the third National Family Health Survey (2005/6) shows 13% of women in the lowest wealth quintile accessing institutional delivery care compared with 84% in the highest. Among the least privileged households, those with poorest access, wealth and education, only 10-15% of births were delivered in a medical facility. This proportion rises to 32% among households living within 5 km of a hospital, to 44% among the richest households and to 67% among the small minority of households where the mother has tertiary education. The probability of an institutional delivery rises from 9% in high order births to 39% in first births. Huge regional differences are apparent. In the South 59% of births were institutional compared with only 16% in the North.

The proportion of all institutional deliveries that occur in private-for-profit sector medical facilities rises from 30% in poorest households to over 50% in the richest quartile.

There is great regional variation in choice, with only 13% of institutional births taking place in the private-for-profit sector in the Eastern States, compared with 44% in the North and over 50% in West and South. Unless the pace of change accelerates, it will take until 2025 for half of all rural births to be institutional and mid-century before 75% coverage is reached. The national goal of achieving 80% coverage by 2010 is extremely optimistic and results from the 2005-6 NFHS-3 show a continuation of the slow rise but no sign of acceleration About 82% of the mothers had ANC follow up; out of those who attended ANC it was only 18% that had institutional delivery.

Table shows percentage of beneficiaries after intervention

	NFHS 3			NFHS 2	NFHS 1
	Total	urban	rural	Total	Total
Mother who had at least 3 antenatal care visits for their last birth(%)	50.7	73.8	42.8	44.2	43.9
Birth assisted by doctor/nurse/LHV/ANM/other health personnel(%)	48.8	75.3	39.9	42.4	33
Institutional birth (%)	40.8	69.4	31.1	33.6	26.1
Mother who received postnatal care from a doctor/nurse/LHV/ANM/other health personnel within 2 days of delivery for their last birth(%)	36.8	60.8	28.5	NA	NA
Women whose body mass index below normal (%)	33	19.8	38.8	36.2	NA
Ever-married women aged 15-49 who are anaemic (%)	56.2	51.5	58.2	51.8	NA
Pregnant women aged 15-49 who are anemic (%)	57.9	54.6	59	49.7	NA

SCOPE OF STUDY

- Desired degree of behavior change among MWRAs after informing them about health awareness modules regarding Antenatal care & postnatal care.
- Barriers which influence the Marginalized women in reproductive age for institutional delivery.

RESEARCH QUESTION

- Is there any change in health behavior of MWRAs regarding ANC & postnatal care after getting health information through community cadre of Parivartan project?
- Whether these services influence their decision regarding the place of delivery?

OBJECTIVE

- To identify the degree of behavioral changes among targeted community after implementation of parivartan regarding ANC, Institutional Delivery and Post Natal Care.

METHODOLOGY

- **Study type**: Exploratory type
- **Study approach**: Qualitative approach.
- **Study duration**: 2 months.
- **Study area** : 1 Block of Samastipur (Bihar)
- **Study population-** Marginalized women in the age group 15-49 years belonging to SC, ST and Pasmanda Muslim category.
- **Sample**– Pregnant ladies and lactating mothers.
- **Sampling technique**: Stratified sampling.
- **Sample size: 80**

Data for this study are collected from Sarairanjan block of Samastipur district of Bihar through survey conducted from 1st to 10th may 2014 among marginalized women in reproductive ages (MWRAs).

The sample design was such that certain categories of respondent to preserve the total numbers of households and ever-married women interviewed in each self help group.
Three types of questionnaires were administered in the survey are pregnant women Questionnaire and lactating mother's Questionnaire and collective action questionnaire .This report uses data from all two questionnaires. This Questionnaire provides basic Antenatal care health behavior and postnatal health behavior practices and followed by the marginalized community.
In addition Woman's Questionnaire provides, for ever-married women of reproductive age, information on socioeconomic and demographic characteristics, reproductive history, fertility preferences, and maternal and child health. The collective action Questionnaire provides information on whether community are helped by the group or not, in what way group member helping each other. Mothers who gave birth during the two years preceding the survey were asked if their delivery was assisted by a health professional, such as a doctor, auxiliary nurse midwife (ANM), lady health visitor (LHV), or other nurse/midwife. Mothers were also asked if they delivered at home or in a medical institution, such as a government or private hospital/clinic, primary health centre, or maternity home. Whether the mother delivered in a medical institution (yes or no) is the primary response variable in our analysis.
Each survey also collected information on utilization of specific antenatal-care
Services for each pregnancy that resulted in a live birth during the two years preceding the survey. Mothers were asked whether they had received any pregnancy related check-up from a doctor or a health worker in a health facility or at home (yes or o). They were also asked whether they had received two or more doses of tetanus toxic vaccine during the pregnancy (yes or no). These two antenatal-care variables are the primary predictor variables in our analysis.
As mentioned earlier, estimation of the effects of the antenatal-care variables
on the likelihood of institutional delivery requires statistical controls for other factors that may be correlated with the antenatal-care variables. Failure to control for these variables

could bias the estimates of the effects of the antenatal-care variables. The following demographic, socioeconomic, and health-services variables are included as controls in the analysis: age of the mother at the time of survey (15–19, 20–24, 25–29,30–49), birth order of child (1, 2, 3, 4+), religion of household head (scheduled caste or scheduled tribe, Pasmanda Muslims) .Bihar as socially and economically backward and in need of special protection from social injustice and exploitation. Mother's education (illiterate, literate but less than middle school complete or higher. Decision making about one's own health (self, family with others, not involved) and quality of health-care services in the primary sampling unit in which the mother resides (low, high)—are also included in the bi variant analysis of variables that may be correlated with institutional delivery. But because the decision making and quality of care variables show little correlation with institutional delivery.

We defined two pregnancy-complications variables. The first specification defines pregnancy complications as 1 if the mother mentions any of the following and 0 if none are mentioned: night blindness; blurred
vision; convulsions not from fever; swelling of the legs, body, or face; excessive
fatigue; anaemia; or any vaginal bleeding. The second specification defines pregnancy complications more restrictively as 1 if the mother reports convulsions not from fever or any vaginal bleeding and 0 if neither of these complications is reported.
As discussed earlier,the pregnancy-complications variable is considered because the correlation between antenatal care and institutional delivery may arise not because of a causal effect of antenatal care on the likelihood of institutional delivery but instead because pregnancy complications have positive effects on both the likelihood of ante-natal care and the likelihood of institutional delivery. However, neither of the pregnancy-complications variables has a statistically significant effect on the likelihood of delivery in a medical institution, nor does its inclusion or exclusion in the statistical models alter the estimated effect of antenatal care on delivery in a medical institution. Mother's age and child's
birth order are included because they are correlated with utilization of antenatal- and delivery-care services. Religion and caste/tribe variables help control for cultural variation in health seeking practices.

FINDING AND DISCUSSION

C	VILLAGE	GROUPS	RESPONDENTS
Sarairanjan	B.Alloth	Aarti, Moti, Sita, Sehnaaz, Tara, Taj	17 lactating + 3 pregnant
Sarairanjan	Bakri Bujurg	Fatima, Hazrat	3 lactating + 1 pregnant
Sarairanjan	Gangapur	Bharti, Saraswati, Durga jeevika SHG, 786 jeevika SHG	9 lactating , 5 pregnant and 1 both pregnant +lactating
Sarairanjan	Kishanpur yusuf	Aditya, Maa-kali, Ansaari, Jagdamba, Badshah, Maa- sharda, Durga, Mansoori, Kalam, Bhagwati,Baba, Baba Sailesh, Hussain	20 lactating ,10 pregnant and 1 both pregnant+lactating
Sarairanjan	Gaunpur/Nauaachak	Bhagwati community grp, Sri Krishna	2 lactating + 2 pregnant
Sarairanjan	Jeetvarpur kumraihya	Allah SHG, 786	6 lactating + 2 pregnant
Sarairanjan	Total=6	Total =30	Total= 80

1. Types of Respondent: The research includes only three types of respondents which includes lactating (70%), pregnant (27%) and rest of them were pregnant as well as lactating (3%).

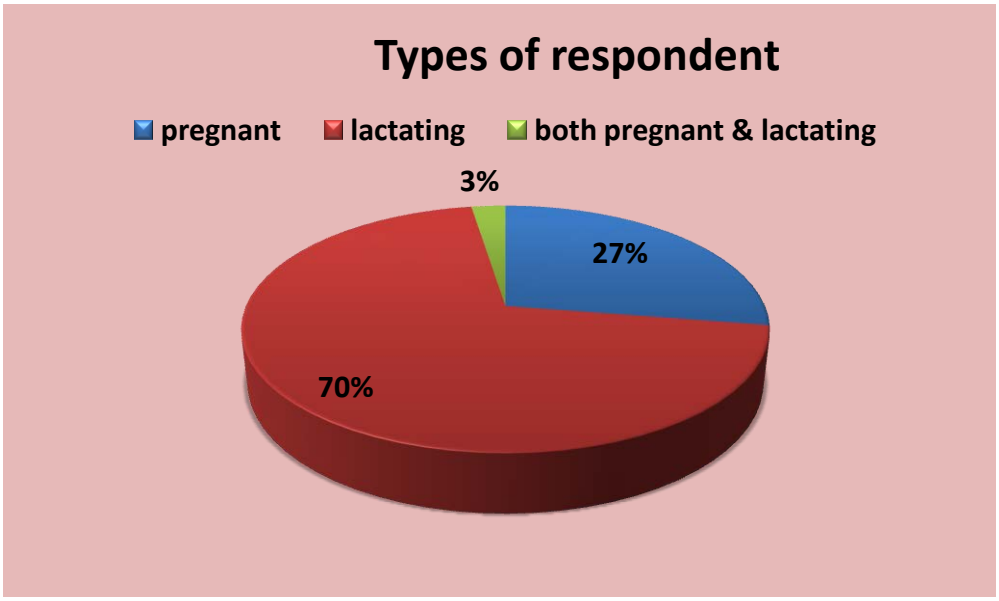


Fig.1

2. Total Number of Children of Respondents:

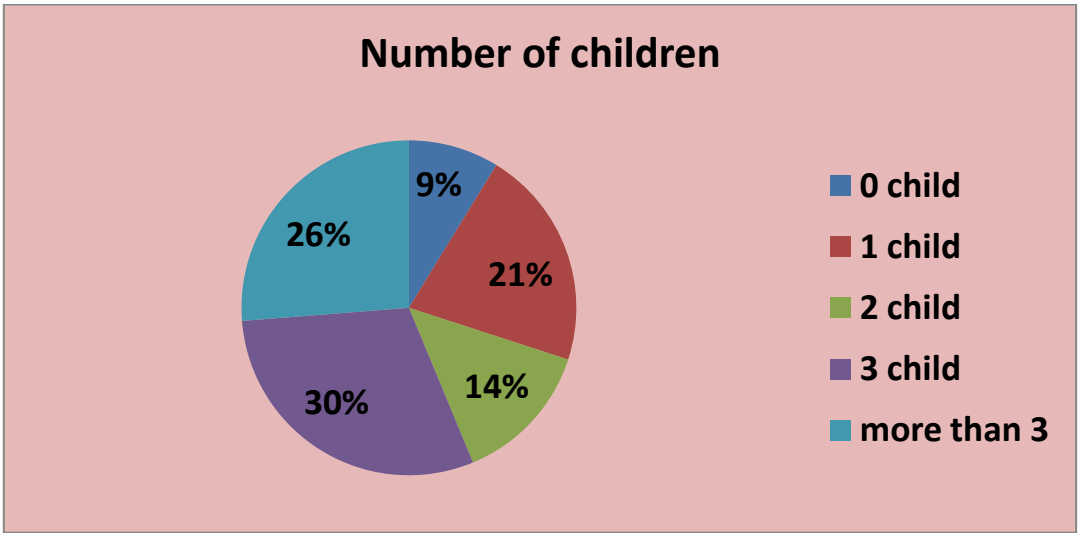


Fig.2

According to data, most of the respondents were having three or more than three children and this shows that still there is a greater need of awareness about family planning in the community so that they can understand the benefits of family planning.

3. Registration status at anganwadi center by the MWRAs in rural areas of Bihar.

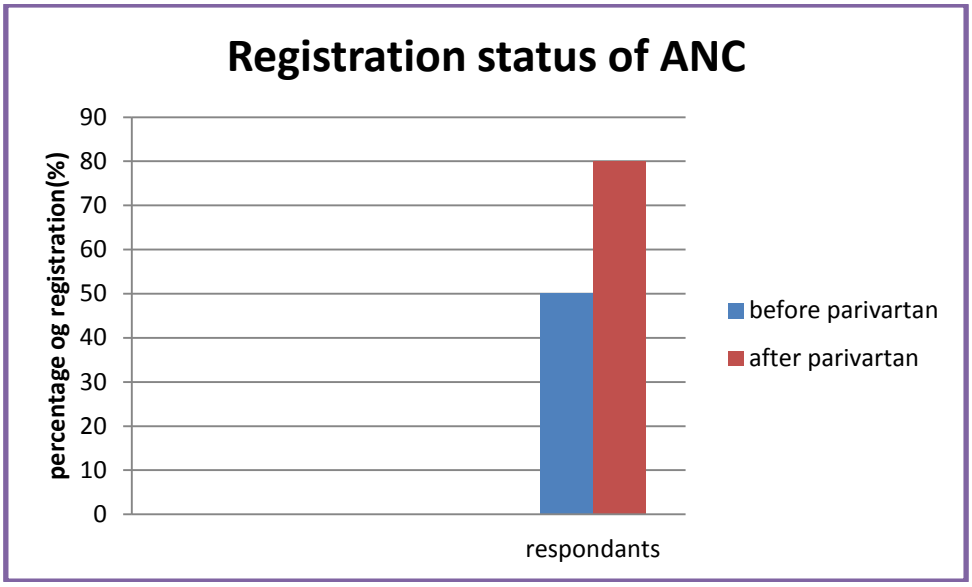


Fig.3

- The given data depicts that majority of community is having knowledge about benefits regarding registration of their pregnancy at Anganwadi center and they are practicing it.

- Some of the community is not doing registration for ANC check up because of the given flowing reasons.

4.Reasons for not doing registration of ANC:

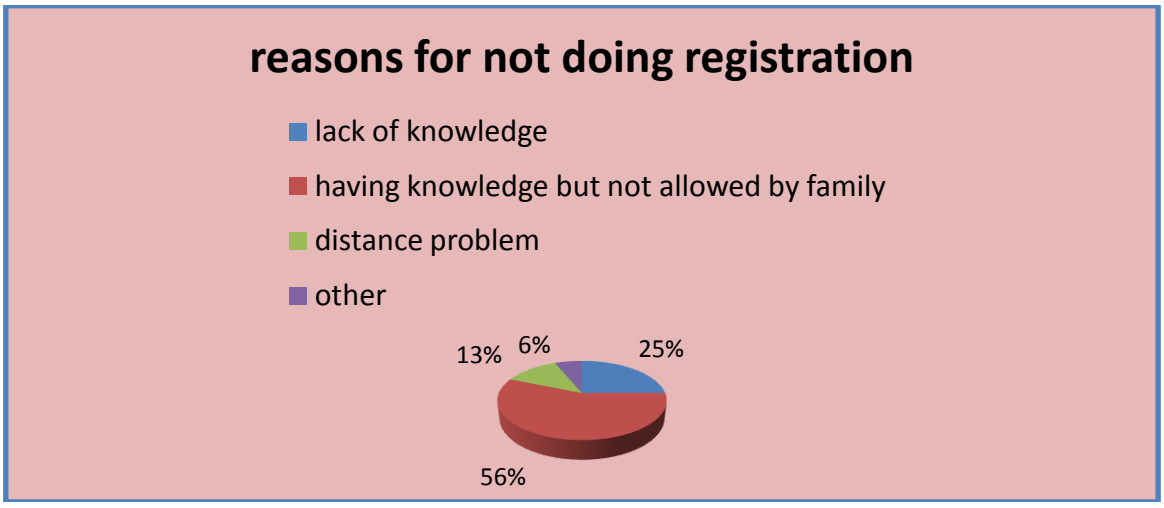


Fig.4

5.Saheli are contributing more in giving information to community about benefits of registration of their pregnancy at Anganwadi center.

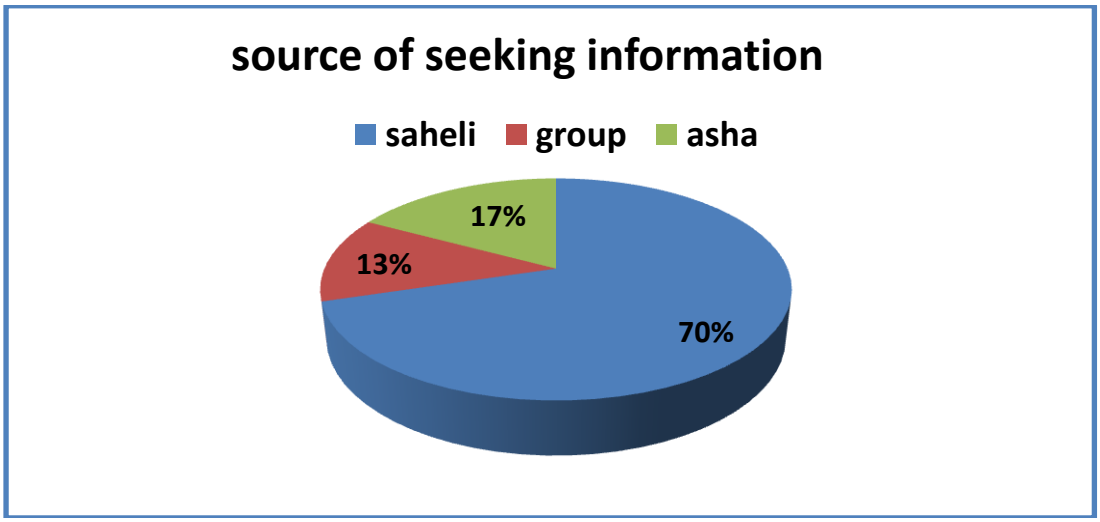


Fig.5

The given data depicts that saheli playing major role in spreading awareness regarding benefits of registration of ANC check up at government health center**.**

6.Important precautions should be followed during pregnancy stage are nutritive food, T.T vaccine and consuming 100 iron tablet.

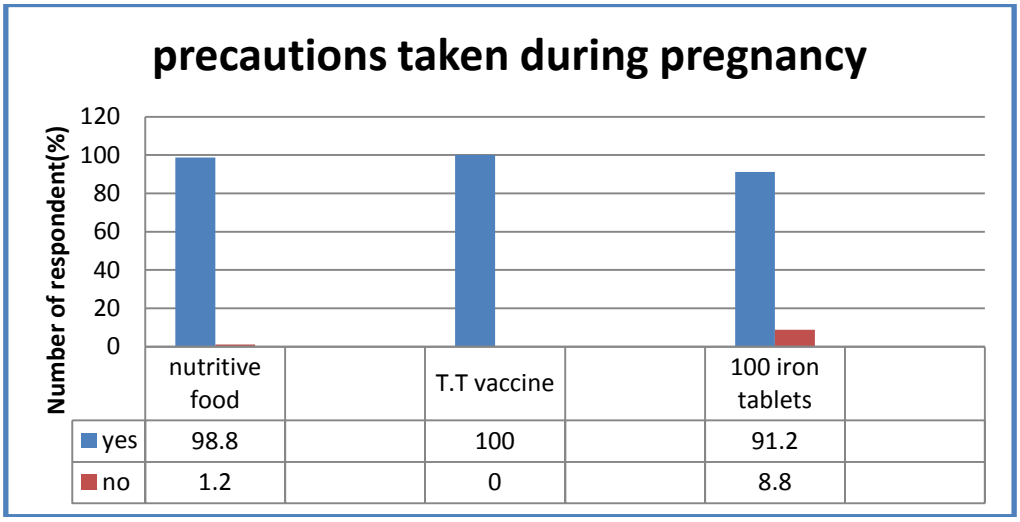


Fig.6

7.ANC check up status among marginalized community of rural bihar (samatipur district):

Majority of the community have done their registration at Anganwadi center for ANC check up but the important thing which is the matter of concern that they are not following it routinely for regular ANC check up because some of them are not considering so much important, some said their family didn't allowed for that.

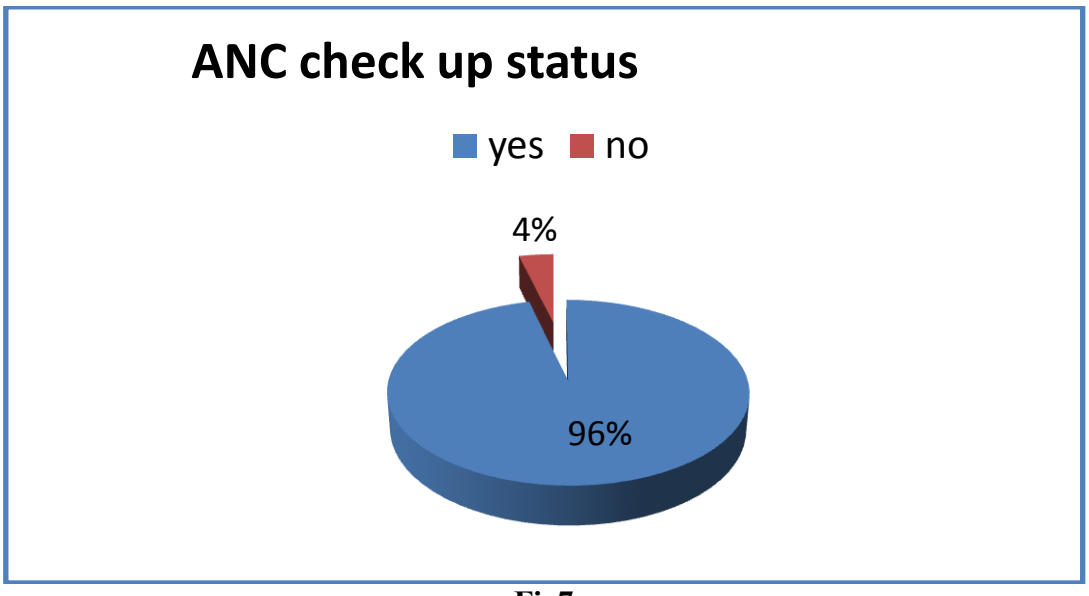


Fig7

8.Due to awareness of the health awareness parivartan module 2 ,Good proportion of Community are doing early necessary preparation for the delivery.

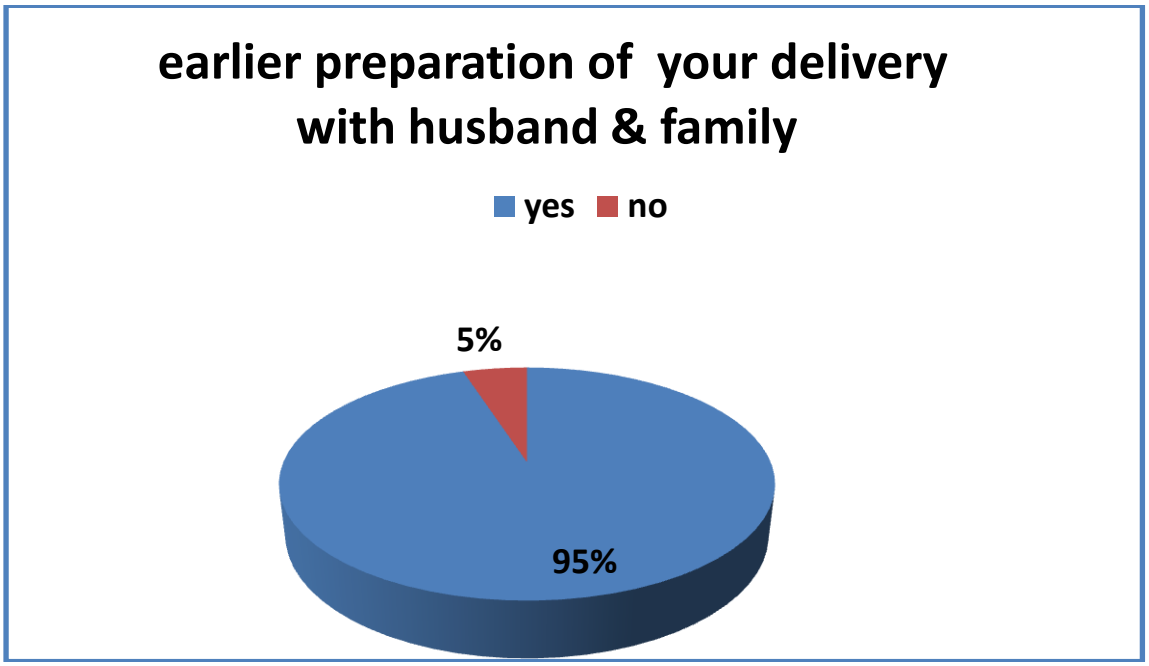


Fig.8

Emphasis given by the community on the types of preparation before delivery which are necessary to do.

Majority are prepared for the financial security compare to transportation and Asha mobile no. so there is a need of spreading the awareness about the benefits of having Asha mobile no. and role of transportation during delivery time.

Data depicts that only five percent of community didn't discussed and didn't planned for the necessary preparation for the delivery of the mother of their house.

Among those five percent , 50% community consider family didn't take interest in doing such preparation, some said that they not consider it necessary to have early discussion on it and some said they don't have time for discussion.

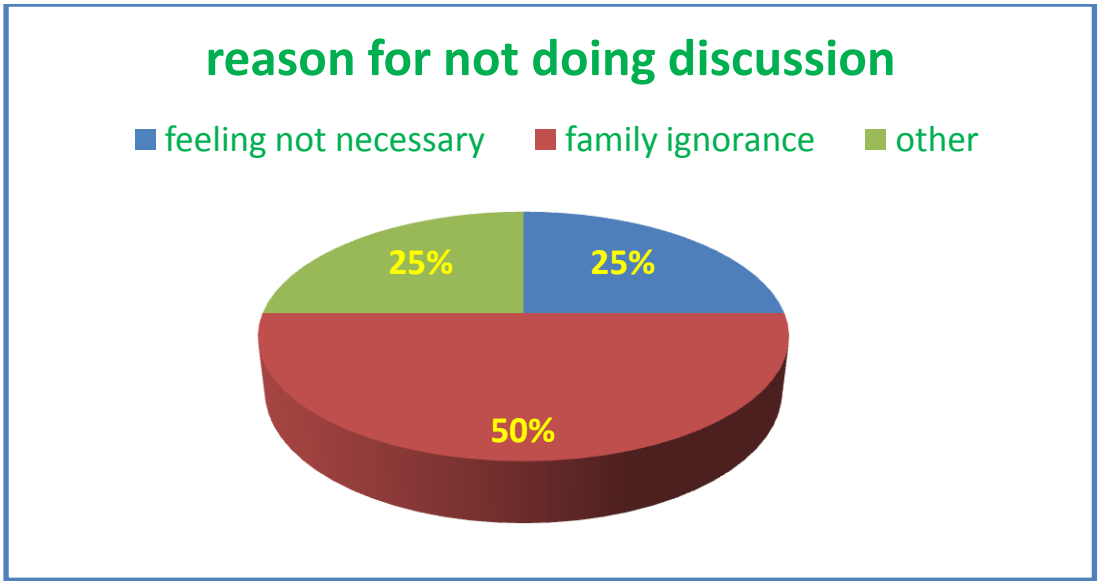


Fig.9

9.Decision taken regarding the place of delivery for the pregnant MWRAs mainly by their family members because of the better facility . some of community are taking their own decision , in some cases community taking decision for place of delivery.

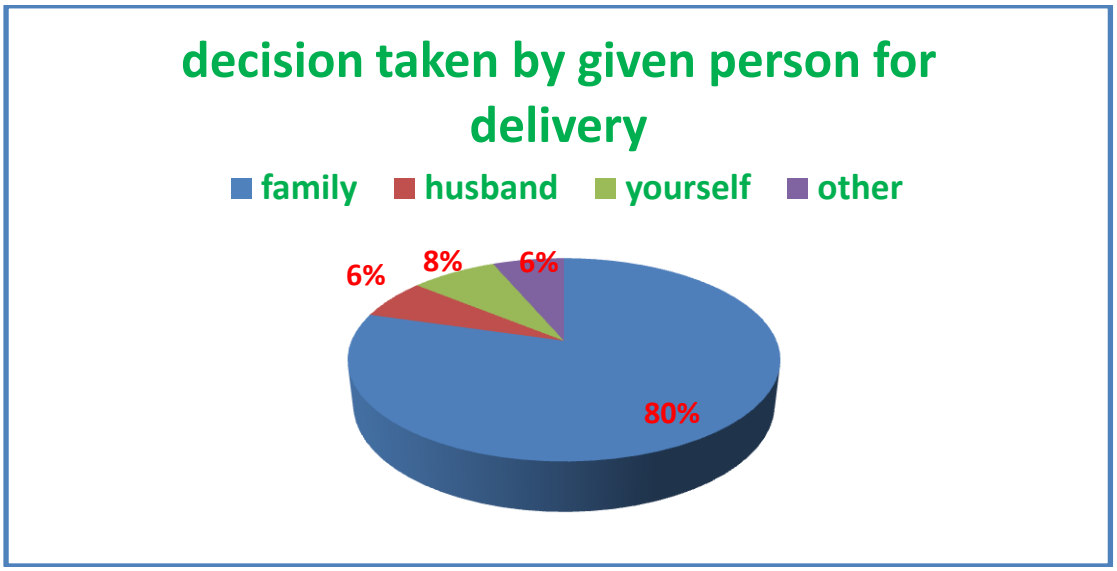


Fig.10

10. Reasons for not conducting institutional delivery:

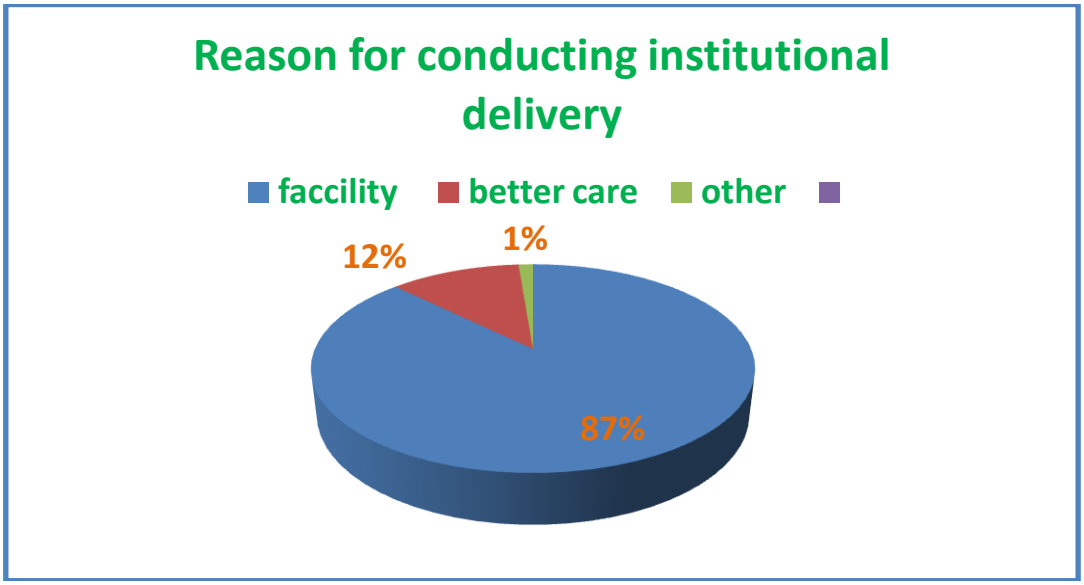


Fig.11

Reason for not conducting delivery in institution are the old tradition and myth associated with it that it is not so much important, women are for that and there is no matter of concern.

11.Important things followed by community during home delivery:

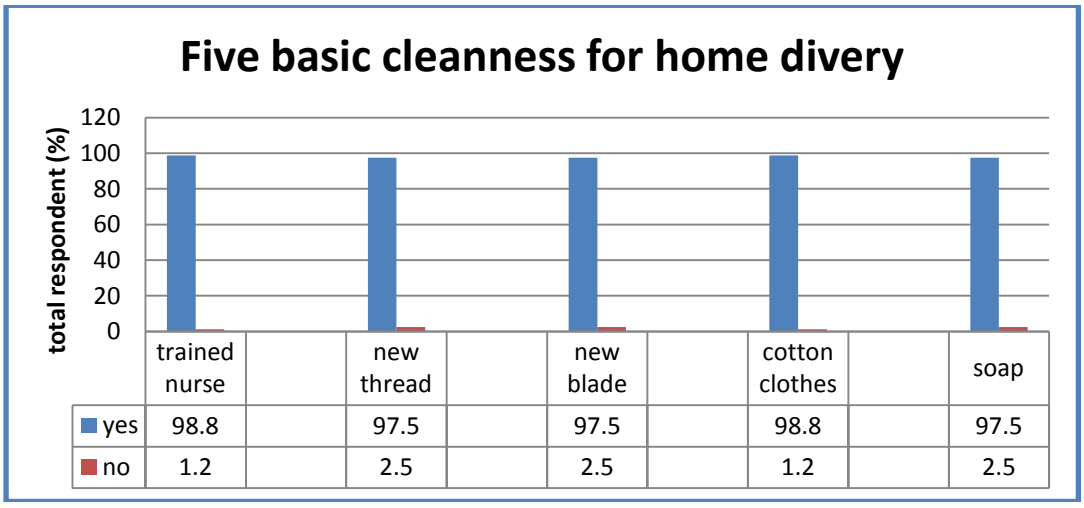


Fig.12

Most of the majority are aware of the five basic cleanness practices during home delivery and they are following it.

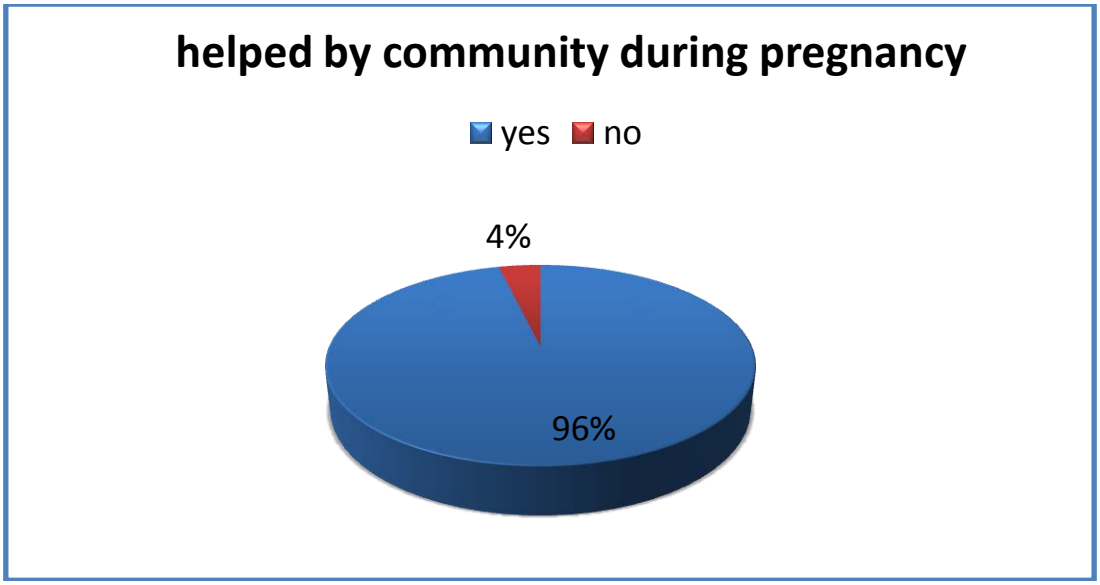


Fig.13

According to given data it was clear that majority of community helped by group during their pregnancy.

It shows that group are doing good job to bring changes in their upcoming life by helping each other.
Among target community, 24% of community having some kind of complication during pregnancy period.
Majority of them faced problem like swelling of feet and palm and unconsciousness in spite of so much awareness about the health seeking behavior.

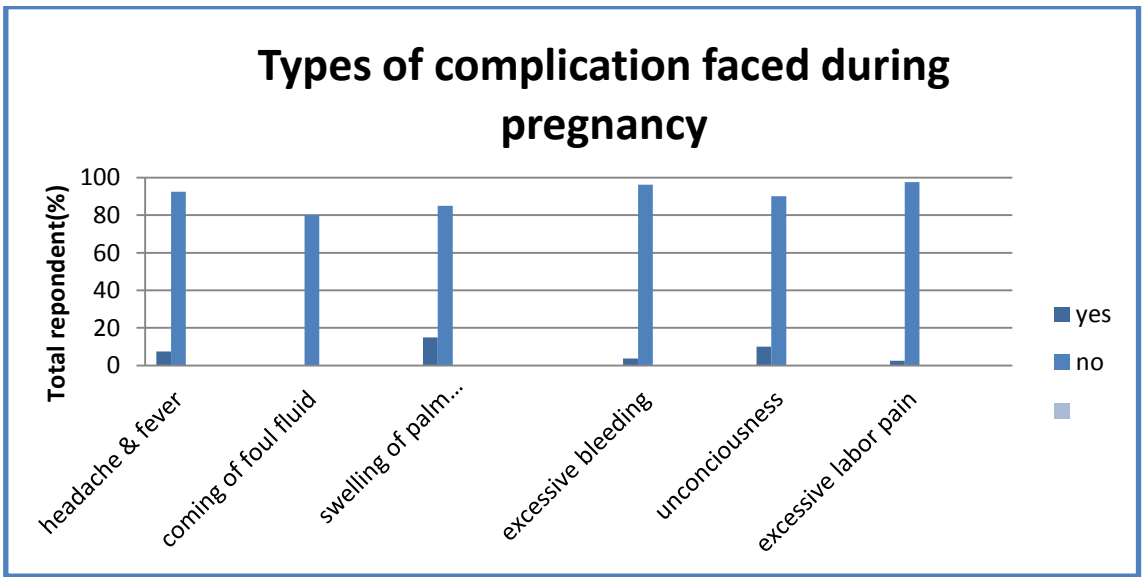


Fig.14

Places where MWRAs went to receive treatment during any complication of their pregnancy :

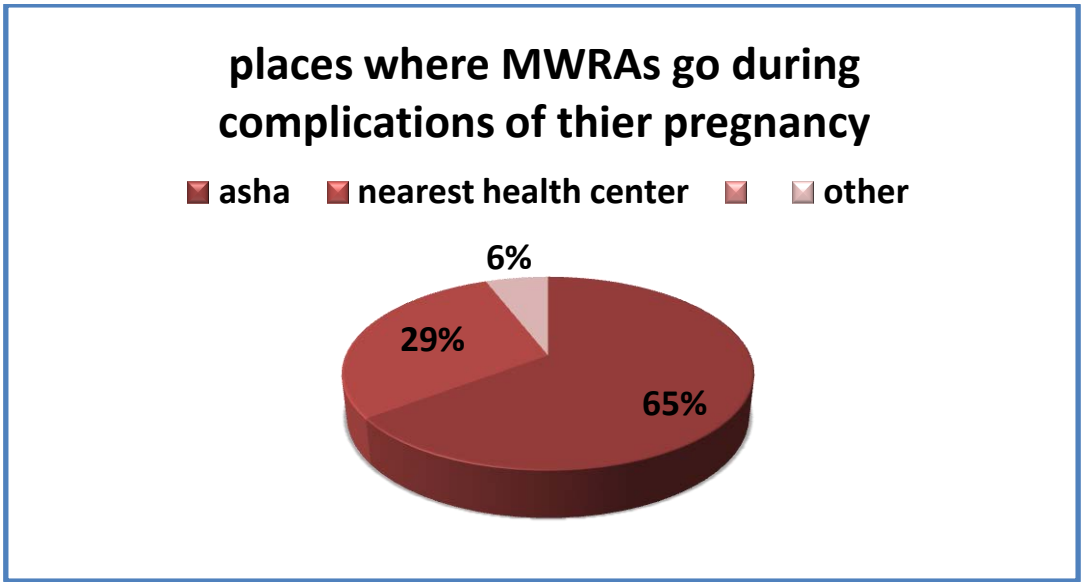


Fig.15

The given graph depicts that majority of community went to Asha during any kind of complication of their pregnancy.

30% went to health center for receiving treatment when they had any complication during their pregnancy.

13.Reasons for not going to received any treatment for mother & child regarding any complication after delivery:

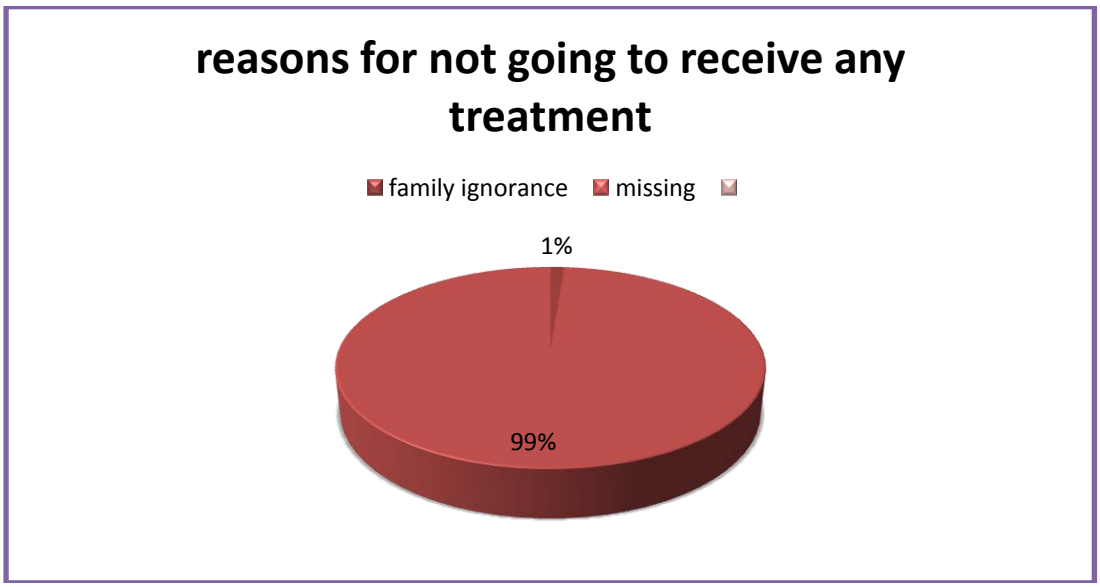


Fig.16

Due to family ignorance they are not taking mother and child to any treatment to the health center.

14.Places where community went after noticing any complication in mother and new born child after delivery within a week :

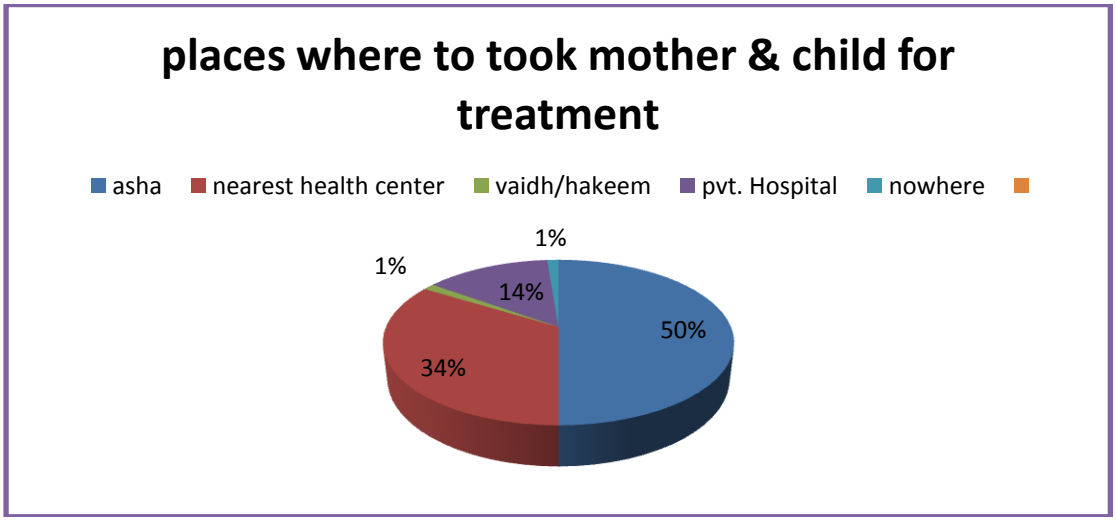


Fig.17

According to given information it is clear that most of the communities are seeking treatment from government health center.
But still some of them are going to receive treatment from old traditional practitioner like vaidh/Hakeem.
In spite of spreading health awareness regarding the postnatal care, the given data shows that some of the community is not aware of keeping baby warm in any season

15.Some of the community lacked knowledge of using of new thread and blade to cut the umbilical cord.

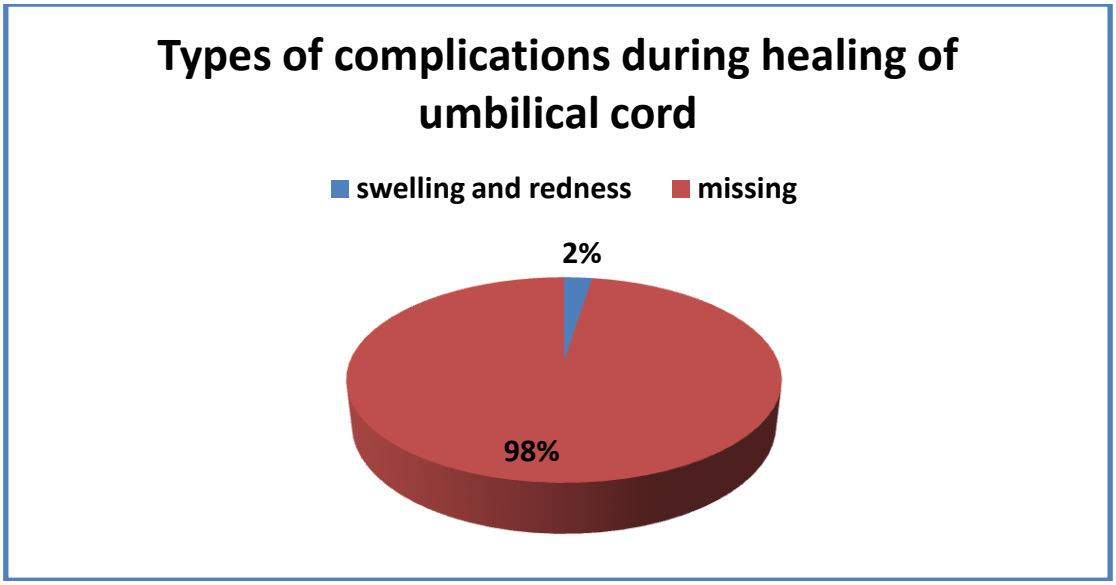


Fig.18

The given data depicts that in spite of awareness about postnatal care some of the community's child were facing some kind of complication during healing period of umbilical cord.

Places where mother take their child if they noticed any complication during healing period of umbilical cord:

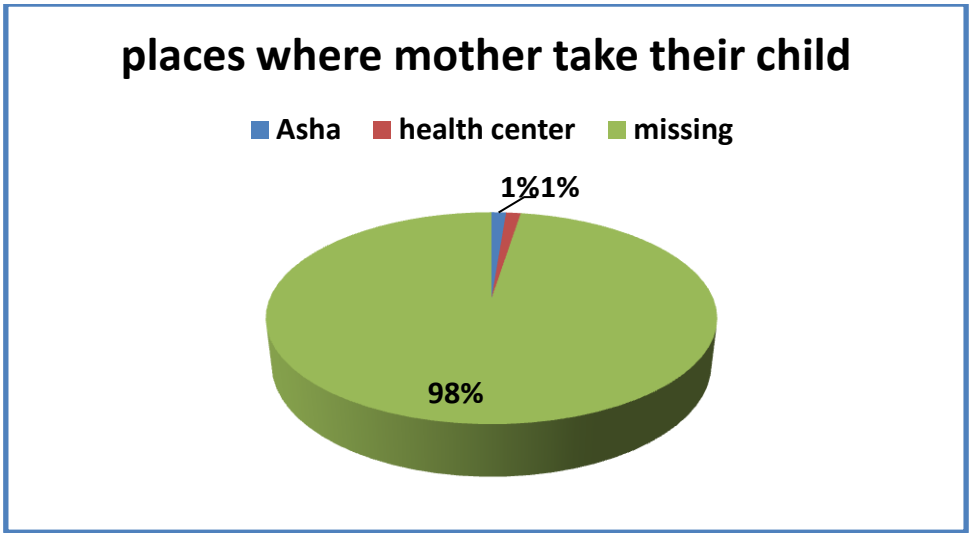


Fig.19

The given information shows that community is going to health center to receive treatment and some of them discussing it with Asha.

It also suggest that community are aware of taking their baby if any complication occur during healing period of umbilical cord of their children and so, we can say that here health aware modules are working effectively by saheli.

After delivery number of visit Asha done to MWRAs home:

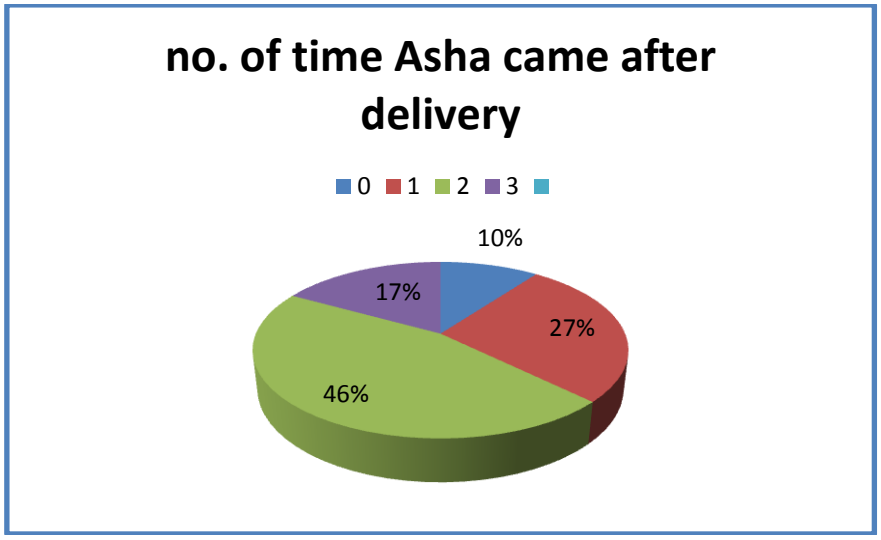


Fig.20

16.Awareness regarding skin to skin care (kangaroo vidhi) among MWRAs:

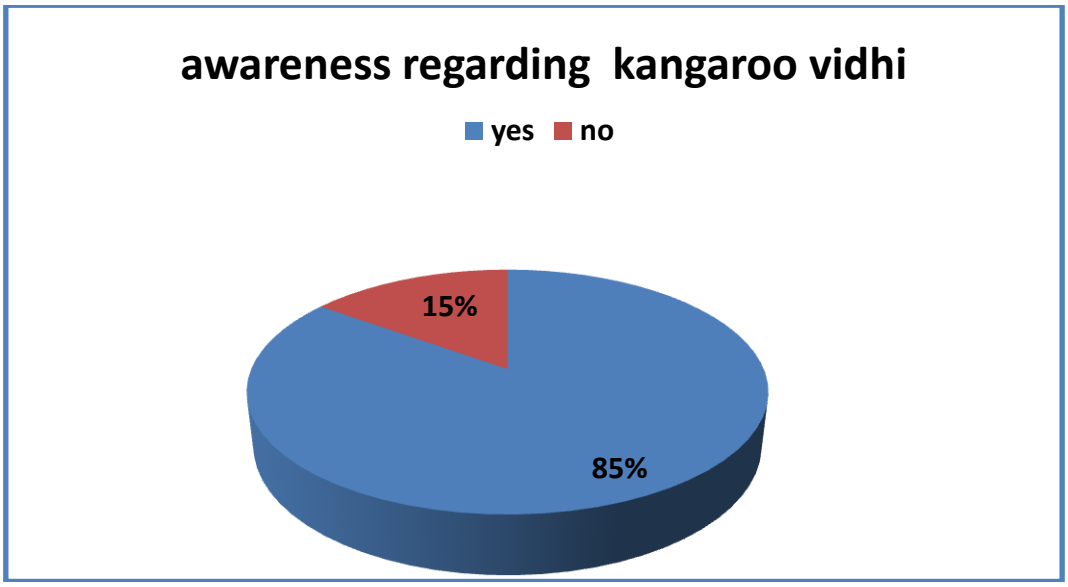


Fig.21

In spite of roll on of health awareness module by saheli some of the community still lacking knowledge about skin to skin care. So, there is need of roll on of this module time to time in order to spread this awareness among them who are unaware.

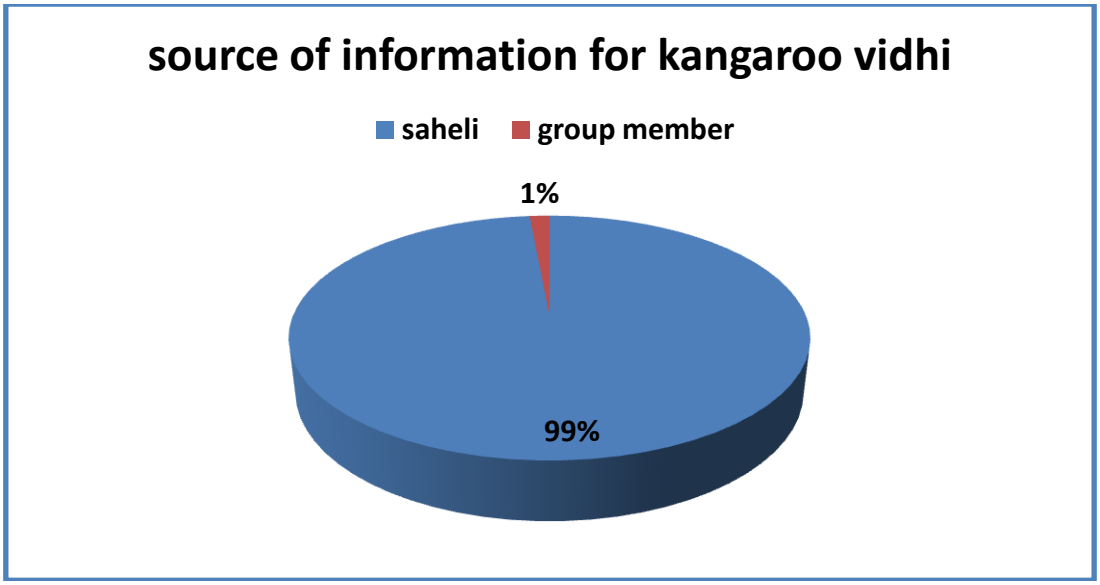


Fig.22

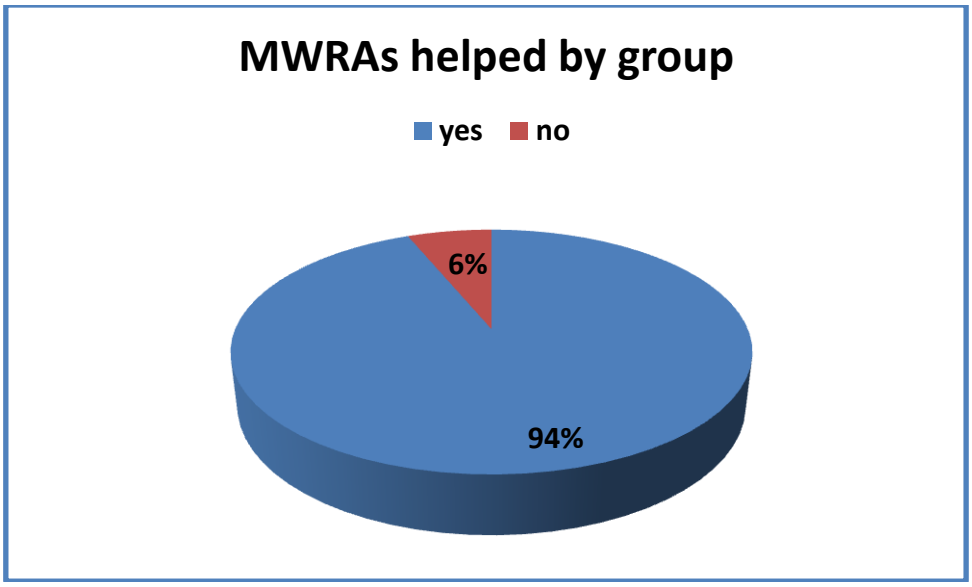


Fig.23

Majority of community are helped by the group but still some of them are not helped by them because of some reason which is a matter of concern.

So, there is a need of focusing on those reasons which creating hinders in helping the community by group**.**

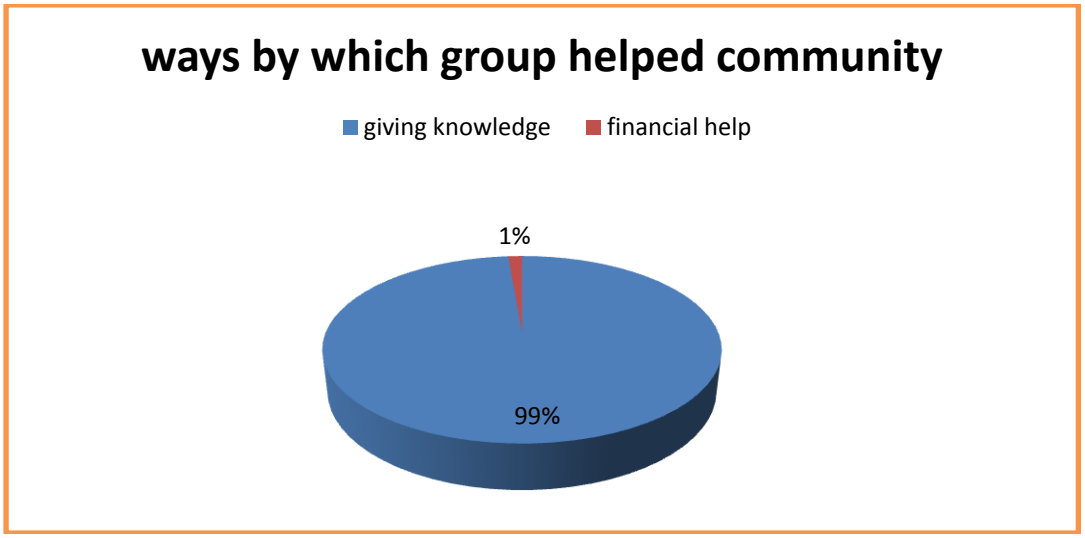


Fig.24

According to give information we can easily depict that group helped community by giving them knowledge about the health behavior practices along with convincing their family for institutional delivery.
This shows that there is issues of family which are not allowing their in-laws for institutional delivery and community still struggling with such issues.

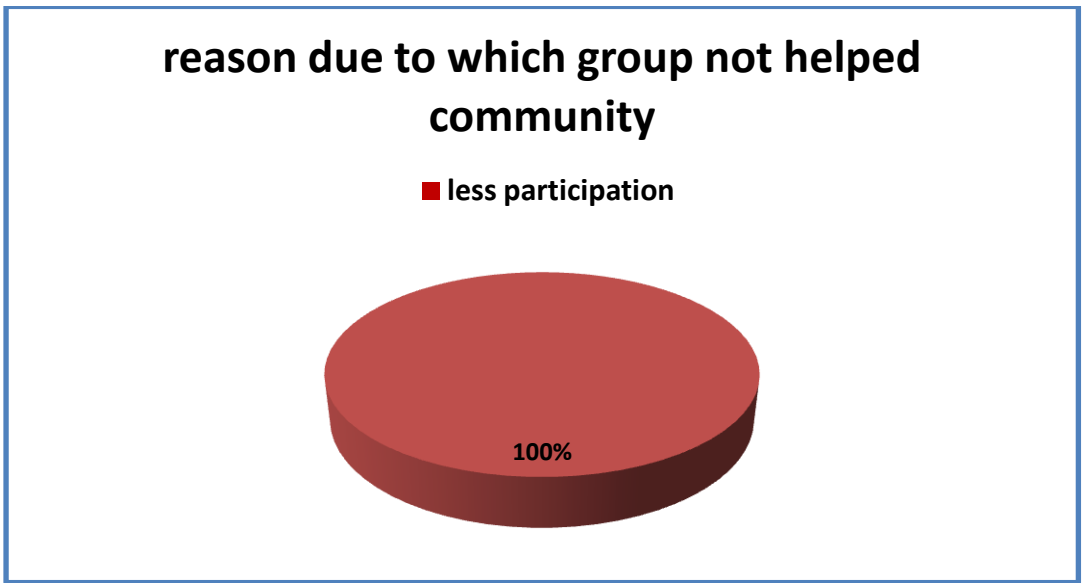


Fig.25

Community were not helped by the group because of their less participation in meeting so there is a need of motivating those community to attend the meeting attentively and regularly.

RECOMMENDATION

- Group member need to be motivated to attend the meeting regularly and attentively.
- Saheli need to be motivated for better roll on of health awareness modules by giving them some performance based incentives.
- Master trainers need to be very committed for their role during support on job of saheli.
- More focuses should be given to those community who are lacking the information of positive health behavior regarding ANC, Institutional Delivery and postnatal care.
- Along with roll on of health awareness module , saheli need to be trained to perform street play by involving that community member so that message or information should be convey in more convenient and understandable way.

CONCLUSION

There is association between the role of health awareness modules and promotion of institutional delivery in rural Bihar.

However, some of the community in spite of having awareness about health behavior module regarding ANC , institutional delivery and post natal care are still facing maternal and child health issues. And the factor which are creating hinders in receiving those health information need to be concern in some innovative way.

“Maternal health is a sound investment strategy & we believe that it is important to speak collectively, act quickly & bring about long- lasting change”.

ETHICAL CONSIDERATION

- Respect of people's right and dignity
- Voluntary participation
- The study will maintain the confidentiality of the respondents.
- Information received will not be misused in any form.
- The research work will try to maximize the benefits of the respondents.

LIMITATIONS

- All Group member are not present at the time of roll on of health awareness module by saheli.
- Some of the member are only interested in doing saving in Jeevika.
- Somewhere group member are present to attend meeting on given time and venue but saheli was absent .
- Master trainer was not supporting saheli during on job support because he was ordered by DRP to do some another task.
- Saheli was not satisfied with their salary.

WORK PLAN

Activities	week 1	week2	week3	week4	week5	week6	Week7
Orientation							
Literature review							
Draft proposal							
Revise and submit proposal							
Field visit							
Data analysis							
Exposure of different department							
Report writing							

ANNEXURE

Questionnaire

District Name: **Code :**
Block Name: **Block Code:**
Village Name: **Village Code:**
Group Name: **Group I.D:**
Type of the group: **Respondent name:**
Age: **Date:**

Q1. How many children do you have?
a) 0 b) 1 c) 2 d) more than 2

Q2. Are you currently pregnant?
a) yes b) no

2.1. If yes, did you registered your pregnancy at Anganwadi centre ?
a) Yes b) no

Q2.2. If yes from where you got the information about it?

a) saheli b) group c) ASHA d) other

Q2.3. If no, then what are the reason for that?

Q3. During pregnancy , did you taken care of all these given things ?
a) nutritious food b) T.T vaccine c) iron tablets

Q4. Did you visited to nearest health center for ANC check- up routinely?
a) yes b) no

Q4.1. If no then why?

Q5. Did you discuss plans for your delivery with your husband and family members?
a) yes b) no

Q5.1. If yes , then which kind of preparation?
a) transportation b) money c) asha's mobile no
d) all above
e) others

Q5.2. If anyhow delivery was not/would not be conducted in the institution then state the reasons for that.

a) family's old tradition and culture b) lack of transportation

c) financial problem d) other

Q5.3. If your delivery conducted at home then did you taken care of all these given issues.

a) skilled birth attendants such as ANM.
b) basic five practices of cleanliness.
(cotton clothe, soap, new blade, new thread)
c) all above
d) none of these

Q6. Did anyone from your community group told you where to go if you had any pregnancy complications?

a) yes b) no

Q6.1. . Have you experienced any complication during your pregnancy?

a) yes b) no

Q6.2. If yes , then which kind of the following

a) high fever & headache
b) swelling of hands, feet and face
c) coming of foul fluid from vagina
d) paleness, giddiness, weakness
e) prolonged labor
f) obstructed labor

Q6.3. If yes, where did you seek treatment?

a) Government hospital b) Private hospital
c) rural medical practitioner d) other

Q6.4. If no, then why?

Q7. Just after birth of baby have you taken care of which of the following things .

a) use of clean cotton & cloth to cover baby
b) give baby immediately to mother for skin to skin care.
c) protect baby from cold by using cap ,shocks and clothe
d) do not give bath to baby for one month.
e) use of new razor to cut the umbical cord
f) colostrums feeding

Q7.1 During healing of umbical cord did you noticed any complications?

a) swelling & redness
b) bleeding
c) other

Q7.2 If yes , then what you did?

a) visit to doctor b) asha
C) health center d) other

Q8.After delivery how many times Asha visited at your home ?

a) one b) two c) three d) more than three e) never

Q 8.1 what important facts she told you to consider for maternal & child health?

a) after washing hands touch the baby
b) use skin to skin care (kangaroo vidhi)
c) feed baby maximum times
d) other

Q8.2 Did you know about the kangaroo style of giving warmness to child?

a) yes b) no

Q8.3 If yes from where you know about it?

a) community group b) saheli c) ASHA d) other

Q9 When you noticed any danger sign & symptoms in mother and baby after delivery , where you preferred to go first?

a) asha b) health center c) rural medical practitioner
d) no where

Q10 Did you found any benefit regarding practicing of health behavior for ANC, institutional delivery, postnatal care after joining the community group ?

a) yes b) no

Q10.1 If yes then in what ways?

a) receiving information regarding benefits of institutional delivery.
b) convincing your family member for ANC, institutional delivery.
c) financially
d) arranging transportation
e) other
f) all above

Q10.2 To whom you got the information regarding practicing of such health behabvior?

a) saheli b) ASHA, ANM c) group member d) other
e) all above

Q10.3 If no then why?

REFERENCES

- **State health society report ,2013**
- **NFHS Subject report: November 20. December 2001**
- **Unicef report on institutional delivery, 2011**
- **WHO guideline for ANC and postnatal care**
- **PCI guideline and baseline,2011**
- **http://www.reproductive-health-journal.com/content/9/1/33**
- **http://www.biomedcentral.com/1471-2393/12/74**
- **Alemayehu Shimeka Teferra**, **Fekadu Mazengia Alemu** and **Solomon Meseret Woldeyohannes; Institutional delivery service utilization and associated factors**

among mothers who gave birth in the last 12 months in Sekela District, North West of Ethiopia: ***A community - based cross sectional study;2012***