Summer Training at
UNICEF,
Rajasthan
(April - June, 2013)

A STUDY ON EFFECTS OF GEOGRAPHICAL BARRIER IN AVAILING INSTITUTIONAL DELIVERY AND HEALTH SERVICES IN JOGESHWAR MAHADEV VILLAGE

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Post Graduate Diploma in Hospital and Health Management
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Institute of Health Management Research,
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Certificate

This is to certify that **Mr. Rohit Raina**, student of Post Graduation Diploma in Hospital and Health Management and Research, jaipur has undergone summer training in UNICEF, jaipur Rajasthan, from April 8th to June 8th, 2013.

The candidate has successfully carried out the study assigned to him during summer training and his approach to study has been sincere, scientific and analytical.

28/10/2013

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TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr. Rohit Raina** student of PGDHM (2012-14), Institute of Health Management Research, Jaipur has successfully completed the summer Internship programme **from 06th April, 2013 to 08th June, 2013 at** United Nations Children's Funds, Rajasthan.

During the training period he carried out an assessment on "**Barrier's for availing institutional deliveries and other general medical services**", along with learning the health care delivery system of PHC Jasol.

He had laid hands in training and supervisions of ASHA's for the pilot project *e-ASHA*.

We highly appreciate the quality of his work and acknowledge the sincerity and conduct displayed.

We wish him success in all his future endeavors.

13/11/2014

Dr. Anil Agarwal
(Health Specialist)
(UNICEF, Rajasthan)

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ACKNOWLEDGEMENT

Keeping up with the tradition of torch bearer of nation, I would like to express my special gratitude and appreciation to UNICEF Rajasthan and all those who gave me the possibility to complete this report.

A special thanks to our project coordinator Dr. Anil Agarwal who despite of other pre occupations and busy schedule was there to guide me in my training.

I owe my sincere gratitude and humbleness to my respected mentor Dr.Sushmeet Jain, IHMR, Jaipur for his able guidance and useful suggestions ,which helped me in completing the project work .I would also like thanks my institute and faculty members without whom this project would have been a distant reality.

I would like to thank Dr. Vishnu Agarwal (M.O), PHC Jasol village for his support and Mr.Shyam Sundar (ASHA SUPERVISOR) for his help at various stages of my project.

At last I would like to thank Mrs.Dela (ASHA) and her family for co-operating with me and giving their valuable time from their busy schedule.

Dr.Rohit Raina

ABBREVIATIONS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi centre
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BPL	Below poverty line
DOTS	directly observed treatment, short-*course*
DPM	District Project Manager
FGDs	Focus Group Discussion
FRU	First Referral Unit
HOF	Head of family
IEC	Information education and communication
IFA	Iron and folic acid tablet
IMR	Infant Mortality Rate
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
MHU	Mobile health unit
MMR	Maternal Mortality Ratio
MDG	Millennium Development Goals
NRHM	National rural health mission
PHC	Primary health centre
PNC	Post natal care
SC	Sub-center
SPSS	Statistical Package for the Social Sciences
ST	Schedule tribes
TT	Tetanus Toxoid
UNICEF	United Nation Children's Fund
URTI	Upper Respiratory Tract Infection

PREFACE

Summer internship is an integral part of the PGDHM currriculum.As a part of the course, students of the first year are required to undergo summer training at an organization to get in depth exposure of various departmenrs in the organization and better understanding of the health care delivery system. The major objectives of the summer training programs are to better understand the existing health delivery system including public and private sectors,to observe the implementation of various National Health Programmes at National/State/District levels,to understand various functions of health systems by interactions with key stakeholders,policy makers, programme managers,academicians and researchers,to work on the project/task assigned by summer training organizations.

During my training period I had an an opportunity to work for UNICEF in their ongoing project of E- ASHA. In this project, I have done a study on "Barriers for availing institutional deliveries and general medical seriveces".

Part A-
Organizational Profile

CHAPTER 1

UNICEF

1.1. Introduction

UNICEF has been working in India since 1949. The largest UN organization in the country**,** UNICEF is fully committed to working with the Government of India to ensure that each child born in this vast and complex country gets the best start in life, thrives and develops to his or her full potential. The challenge is enormous but UNICEF is well placed to meet it. The organization uses quality research and data to understand issues, implements new and innovative interventions that address the situation of children, and works with partners to bring those innovations to fruitarian. UNICEF uses its community-level knowledge to develop innovative interventions to ensure that women and children are able to access basic services such as clean water, health visitors and educational facilities, and that these services are of high quality. At the same time, UNICEF reaches out directly to families to help them to understand what they must do to ensure their children thrive. What makes UNICEF unique in India is its network of 13 state offices. These enable the organization to focus attention on the poorest and most disadvantaged communities, alongside its work at the national level. UNICEF knows that key to addressing these challenges are its partnerships with sister UN agencies, voluntary organizations active at the community level, women's groups and donors.

The organization also works with an array of celebrities, including members of the Indian cricket team and leading actors from the Indian film industry, as well as hundreds of thousands of unnamed volunteers who tirelessly give their time and influence to ensure that, together, they are able to help every child realize his or her full potential.

1.2. UNICEF in Rajasthan

Rajasthan is generally considered a conservative society that still values long-held beliefs and attitudes. Although the state is home to a number of large cities, most people live in rural areas, farming and herding as they have for centuries. Although women now head many village councils in Rajasthan and female literacy has doubled in recent decades, challenges remain.The Government of Rajasthan is committed to tackling urgent issues concerning children and women

and achieving accelerated progress on social development indicators in partnership with UNICEF. Some of the major issues confronting the state are high student dropout rate, a large number of children in labour, particularly in the cotton industry, girls being married before the age of 18 and becoming pregnant soon after, putting the lives of both mother and child at risk. Malnutrition is pervasive across all age groups, especially among girls.UNICEF support is largely around the demonstration of models of empowerment for generation of demands, strengthened local self-governance, and improved coverage and quality of basic services to children and women

New Born Care Units piloted with UNICEF support are being established across the state in a phased manner. As a high percentage of children under three are underweight and anaemic, which puts them at risk of serious illness and even early death, the State Government is working with UNICEF to train anganwadi workers to encourage families to adopt appropriate child care and feeding practices to prevent and reduce malnutrition. Special centres for severely malnourished children have been set up by government with assistance from UNICEF in all the districts of the state.

1.2.1. Challenges and Opportunities

In Rajasthan, more than a third of children younger than three are underweight, and almost 80 per cent are anemic. Malnutrition is one of the major causes of morbidity among young children in the state.

The number of children in Rajasthan who has been fully immunized against common childhood diseases such as tuberculosis, polio and diphtheria is very low and barely a third of children who suffer serious bouts of diarrhoea receive life-saving oral rehydration treatment.

1.2.2. UNICEF in Action

Being a partner of choice for the Government of Rajasthan, UNICEF is working on a set of models and demonstrations of delivery of essential interventions and approaches in select priority districts, such as Tonk, Baran, Dungarpur and Udaipur, aimed at statewide scale up. Initiatives include programmes to ensure better nutrition for children, and provide assistance to

those already malnourished.

This includes improving the skills of village anganwadi , or child care, workers, assessing the weight and healthy growth of children and referring them for extra nutritional help and medical care when needed. UNICEF is also working to save the lives of mothers and newborns threatened by inadequate childbirth practices by encouraging institutional deliveries.

UNICEF is supporting a range of interventions in two broad areas: 'Child Survival and Development' and 'Learning and Protective Environment for Children' in partnership with various government departments.

1.3.1. E-ASHA-

Rajasthan one of the big states of India, having relatively poor maternal and child health indicator compared with other developing bigger states in country, there is improvement in MCH indicators observed since last few years, but this improvement is not satisfactory, So it is important that maternal and child health services should be provided more effectively to people who are not able to avail these services due to different reasons, this is a bigger challenge to our health system.

So taking this background into consideration, UNICEF Rajasthan come up with pilot project E-ASHA. There is decline in Under 5 Mortality Rate in Rajasthan since last decade, still long way to go to achieve desired goals, more than half deaths of under 5 deaths take place in first month after birth, it has observed than even if there is decline in under 5 mortality rate, there is no change seen in infant mortality rate, it is still higher in tribal districts.

UNICEF Rajasthan come up with TABLETs having special software for data collection and counseling of mother, provided to 22 ASHA under Jasol PHC in Barmer distict.

1.3.2. Focus of E-ASHA

- Promotion of utilization of quality antenatal care services
- Promotion of quality institutional delivery
- Promotion of timely referral linkage

- Promotion of Maternal Death Audit

1.3.3. Benefits:

1st Benefit: Local Decision making and counselling

• These tablets are Simple systematic tool, simple to use for ASHA

• ASHA can do appropriate counselling according to the responses by the mother

• ASHA can optimally use audio visual aids for counselling

2nd Benefit: Identification of high risk cases

• This tool has colour coded system for classification of danger signs of pregnancy or danger signs in newborn.

• This tool helps ASHA in identification of high risk pregnancies and facilitation of prompt local actions.

• Danger signs of Newborns can be identified by ASHA, timely management of such newborns and referral for further treatment can be done.

3rd Benefit: Real time data and tracking

• This system works on both online and offline mode.

• Data entered in this system is automatically transferred to the server.

• Action plan for ASHA can be prepared through line listing of beneficiaries who are due for the month.

4th Benefit: Service Reminders

• System generated SMS can be sent to the beneficiary and functionary at the time of contact.

• Similarly system generated SMS can be sent to the beneficiaries and functionaries two days prior to due service.

Part B-
My Assigned Project

CHAPTER 2

EXECUTIVE SUMMARY

This report is about a village, jogeshwar Mahadev in Barmer, Rajasthan in which home deliveries are completely dominating institutional deliveries due to various geographical barriers and attitude of the villagers. Transportation being the main culprit for the village which is restricting them for availing institutional deliveries, which has resulted in still births, neonatal mortalities. Apart from levels of delivery in the village, transportation has also affected the various other aspects of their lives which includes practice of mothers towards their own health and health of their children. This even reflects the reasons for their decision making which healthcare facilities to visit during any sickness, in which children sickness was given more significance.

And after assessing the distribution of sickness in the village, children were found to be more prone for malaria, compare to their parents, during rainy season and several other sickness were found in all groups and married females were less affected. It has also effected the education level of villagers especially of children, in which most of the students complete primary education and then drop out from the school as only primary education is available in this village. Because the village is in desert, even electricity is not there, in addition to it, availability of water is the other challenge to villagers. lack of transportation gives a big challenge to even working people as they don't have any other source of income, except farming that too only if it rains, so they have to walk 5 to 6km everyday upto the main road to go to work.

Most of the families in the village are of ST, SC category and most of the families in them belong to bheil caste. In overall the village is far from development and the improvement from last 40 years is not at all satisfactory. So after understanding the roots of current situation in the village, we met effective personalities like ward panch, sarpanch, pradhan and at last when we were not much convinced with them, we met sub divisional magistrate and spoke with MLA over the phone and tried to find out the loop holes in the way of transforming that village. After the completion of our data collection, with the help of MO of the respective PHC and with help of UNICEF, we established a team of members and arranged an immunization plus awareness camp in the village. Along with it, a meeting was arranged between villagers and sarpanch to find out solutions. Thus helped in community mobilization. But still the question arises, whose

fault it is that even after the financial sanction of various projects in that village, still everything is being delayed? Is this villager's fault that they are not much educated, so they can't fight for their rights, thatswhy people like sarpanch is taking advantage of them or its just carelessness of our delivery system?

CHAPTER 3

INTRODUCTION

Home deliveries by traditional birth attendants (TBA/dais) are a cultural norm in India especially in rural areas. It is a common traditional belief that childbirth is a natural process which does not require any medical attention and should be conducted at home by the family dai who is a well known trusted figure for the family, is easily available and is not very expensive. This study is about a village, jogeshwar mahadev in district barmer in Rajasthan. This village comes under PHC jasol, and is 18km from it. It came into existence before 45 years but was considered village in 2008.The village is situated in a desert and is 5 km away from the main road. Upto the main road there is no medium for travelling because of the absence of road and proper vehicles, so villagers have to walk everytime, except few times if they can get water supplying tractors to reach to main road.

Water supplying tractors are the only medium to travel upto main road but they are also available only sometimes. So the impact of lack of transportation has affected the various aspects of living of the villagers. On assessment, it has affected their knowledge, their attitude and because of these two impacts, ultimately it has even affected their practice in availing health facilities. From last 38 years, home deliveries have been dominating the villagers which has resulted in so far 92 percent of home deliveries and merely 8 percent of institutional deliveries over there. Even if we compare the levels of deliveries till far with last 8 years, that is after the launch of NRHM, still institutional institutional deliveries have just touched the states of only 13 percent, that means still the percentage of home deliveries are of a greater concern in this village. Even if we keep the topic of institutional deliveries on a side for a minute, and talk about deliveries facilitated by skilled birth attendants, only one dai who is a certified attendant has attended very few deliveries over there and she is so old that from last 15 years, she is having trouble with her vision, which is getting blurred every day and she is not doing anything for it.

Most of the people have even stopped thinking about institutional deliveries even after knowing the benefits of JSY scheme, because there is no way that they can reach to hospital on time. Because of their attitude, ANC, PNC and neonatal care is also getting significantly affected which is leading to unhealthy mothers and unhealthy children and infant mortalities. Apart from this, lack of transportation is also affecting other aspects like, diversity in their practices

according to different age groups and different sexes when they fall sick and the distribution of sickness among them. It has also affected the education status of the villagers especially the children. Awareness about family size is very poor over there, most of the families are having more than three children and some families even 8 to 10 children, which in turn is affecting the living standard of the whole family. As far family income is concerned, most of the people earn 6000 to 7000 per month and in case if it rains sufficiently then they earn from farming also but that completely depends on size of land available to each family

CHAPTER 4

4.1. Aim of the Study

To find out whether the barrier faced by villagers in availing institutional deliveries and health services is perceived or actual and what is it effect on their knowledge and practices.

4.2. RESEARCH QUESTIONS

- What is the level of practice of villagers regarding institutional delivery and health services?
- What is level of knowledge and awareness of villagers regarding health services related to institutional delivery?
- Whether geographical barrier is perceived or actual and its effect on their knowledge and practices?

4.3. OBJECTIVES

- To study the effects of geographical barrier on the practices of institutional delivery and health services in the village
- To assess the level of knowledge and awareness of the villagers regarding health services related to institutional delivery
- To find out whether the barrier is perceived or actual in the village

CHAPTER 5

5.1 METHODOLOGY

5.2 Study Area

Jogeshwar Mahadev village under P.H.C. Jasol, Barmer Rajasthan

5.3 Study Design

Descriptive Study (retrospective), study employed both qualitative and quantitative techniques of data collection.

5.4 Sampling procedure

49 Beneficiaries were selected purposefully for the study.

5.5 Tools

Tools used for quantitative and qualitative data collection was semi structured questionnaire, objectives of study were kept in mind while setting questionnaire. Questions were framed in such a way that barriers faced by beneficiaries which influences their practices in availing general health services, can easily be captured.

5.6 Data collection method

Primary data collection was done by Survey Schedules (Performa containing a set of structured questions) asked to the respondents (mothers who delivered in last three months) by putting the questions verbally from the Performa in the order the questions are listed and record the replies in the space meant for the same in the Performa during the survey. Visits to households were made for data collection with the help of ASHA. In total, 49 households were interviewed using an interview schedule, the following aspects were enquired from the respondent of each household in Hindi: a)provision of type of deliveries b)Provision of immunization status of pregnant women and children c)provision of general facilities like education, transportation, electricity d)Provision of illness and its treatment

d)Provision of family planning status. Unprompted spontaneous responses were sought out from the respondent and verification of records by requesting them to show the recorded cards was also conducted.

5.7 Field work

All the data was collected between 20th April 2013 and 16th May 2013; all the beneficiaries and their decision maker that were interviewed were contacted at their respective house and the questions were asked after establishing a good rapport .The average time taken for each interviewee was observed 2hrs.

5.8 Data analysis

For quantitative data different variables are coded .Data entered in SPSS 16.0 version. Univariable analysis was conducted, frequency and percentage analysis was done for the categorical variables cross tabulation have been used to describe the data in terms of a combination of back ground variables (level of education, parity, decision maker), bivariant analysis done to indentify the factors affecting the mother in receiving antenatal, neonatal, and postnatal care.

5.9 Ethical consideration:

Informed consent in the respondent's own language was taken before eliciting information from each respondent (Mother, HOF).

Of the family from the same village were selected and interviewed and in few families where

CHAPTER 6

RESULT AND DISCUSSION:

Pursuant to the objectives, study was carried out to identify the barriers for availing institutional deliveries and other medical services. Along with it to understand the knowledge, attitude and practice of the villagers regarding the levels of deliveries and other health related indicators in general due to the impact of barriers.

BENEFICIARIES

49 Beneficiaries which included ever pregnant women and their respective husbands as head of the family from the same village were selected and interviewed and in few families where ever any old person were available, they were also interviewed.

SECTION A: GENERAL INFORMATION:

A.1. Socio-economic and demographic characteristics:

Table no.1 Socio-Demographic characteristics of beneficiaries

S.no	Socioeconomic demographic characteristics		Percentage
1.	Age Group of mothers	20-29 years	30
		30-39 years	46
		Above 39	24
2.	Age group of head of family	20-29 years	19
		30-39 years	40
		Above 39	41
3.	Religion	Hindu	98
		Muslim	2
4.	Caste	Scheduled Tribe	82
		Other Backward Classes	16
		Others	2
5.	Sub Caste	Bhil	82
		Jaat	8
		Others	10

6.	**BPL**	Availing	37
		Not Availing	63
7.	**Literacy status of Mothers**	Literate	4
		Illiterate	96
8.	**Literacy status of HOF**	Literate	27
		Illiterate	73
9.	**Education status of children**	Uneducated	31
		Primary level	30
		Secondary level	13
		Not Applicable	25
		Others	1
10.	**Source of lightening**	Handmade lamp	100
		Solar panel	14
		Electricity	6
11.	**Annual income**	Less than 50,000	37
		50,000 to 1 lakh	53
		Above 1 lakh	10
12.	**Source of income**	Laboring, seasonal farming	84
		Selling wood, seasonal farming	6
		Others	10
14.	**Type of houses**	Kacha	82
		Semi pakka	10
		Pakka	8

The mothers interviewed were mostly in the age group of 30-39 years(46percent),the rest were in the age group of 20-29 years(30percent) and above 39(24percent) from the study village.Where as number of their husbands(head of family) in the same age group of 30-39 years(40percent) were slightly higher and rest of them were of above 39 years(41percent) and in the age group of 20-29years(19percent).Head of family were also interviewed to cross check the information given by mothers for validity of the study.Religionwise, Hindus were dominating in the village

,the Muslim category were merely 2percent. Only one third of the beneficiaries were provided with BPL facilities, but the fact is that almost 90percent of the beneficiaries belong to BPL in the village. Education is the key to knowledge.

During analysis of study, it was alarming to see that 96 percent of beneficiaries were uneducated and when compared to their husbands, even only 27 percent of their husbands are educated, where as 73percent of them are uneducated. This is directly affecting their standard of living and also affecting the future of their children. One third of the children were uneducated, one third of the students complete their schooling till primary level, and out of them only half of the students reach to secondary level, as the school in the village teaches only till primary level. After that most of the students drop out, as the higher level schools are in other village and for that they don't have transportation facilities.25 percent children are those who are awaiting to get enrolled/there age is less than 4years and merely only one percent opt for graduation.

49 Households of the village are still using kerosene lamps(made out of empty bottles).Only 7 Households are those who anyone managed to buy a solar panel as they believe that they will never be getting electricity supply. Though government has implanted electric poles in that village but still only 2 Households out of 49 were supplied with the facility. Regarding their economical conditions, the source of their income is occupations like seasonal farming and laboring (84percent), selling wood, selling cow dung. Through their occupations they don't get much earnings, seasonal farming is the only main source of their income on which they lye for the whole year. Earnings from the farming depends on the amount of land a family posses and on the rainfall during the season. Among the beneficiaries, 90 percent of them were having annual income below one lakh with their family size ranging from four to twelve persons per household. More than 80 percent of the beneficiaries were living in Kachha houses under very unhygienic conditions.

SECTION B: INSTITUTIONAL DELIVERY RELATED PRACTICES:

B.1. Delivery practices:

According to targets under NRHM, one of the most important target is achieving 100 percent of skilled birth attendance and nearly 85 percent of institutional deliveries. But the levels of institutional deliveries in this village were far behind from the national targets. In last 38 years, home deliveries (92percent) have dominated the village where as only 8 percent of institutional deliveries have taken place in this period. Though after the launch of NRHM, institutional deliveries have increased to 13% in last 8 years, but still the improvement is very far from satisfactory. Though the government has launched many schemes, incentives, services for maternal and child health but still beneficiaries are not utilizing them in expected levels.

Graph No.1 Levels of delivery in last 8 years (N-110)

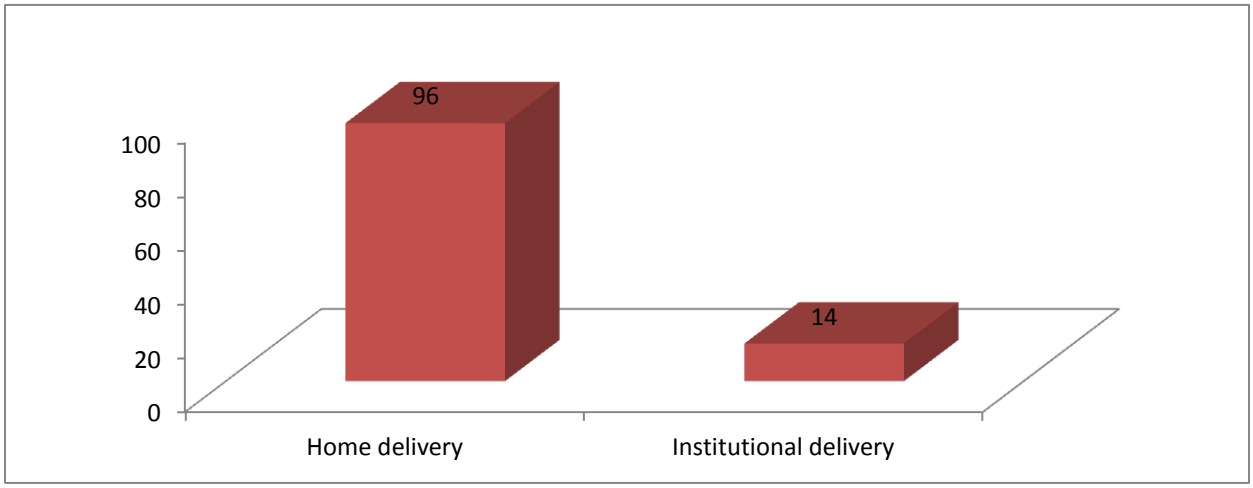


Table no.2 Type of delivery:

Types of deliveries	No. of deliveries(overall 38 years)	%	No. of deliveries(in last 8 years)	%
Home delivery	227	92%	96	87%
Institutional delivery	21	8%	14	13%
Total	248	100%	110	100%

B.2. Reasons for home delivery:

General legacy was one of the most dominating reason for home deliveries in the village.85 percent of mothers gave this reason. Besides this there were multiple reasons for home deliveries. According to them as taught by their mothers and as they have experienced during their adolescence that home delivery is practiced almost in every dani in the village, they all have a impression that *giving birth is a natural phenomenon*.60 percent of the mothers said, even we could have delivered at hospital also, its same as home but we don't have transportation facilities here and even some of them said most of the males used to be out during day for work, there is no one to take us to hospital even if we get complications during delivery. Almost half of the mothers said they didn't had any complication during delivery thatswhy they didn't visited hospital. Another reason which most of them said that giving birth is spontaneous, we don't get time to decide other ways which means beneficiaries are not aware of birth preparedness. Some respondents gave reasons *we didn't get incentives during last delivery, Mother's are more active at home than hospital.*

Table no.3 Reasons for home delivery

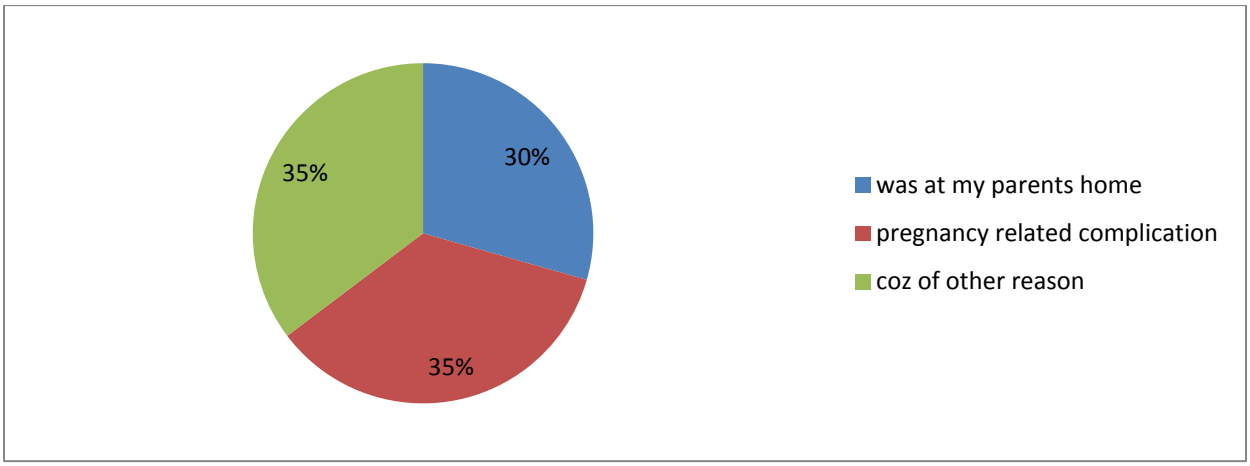
Reasons	Frequency	Response Percentage
generational legacy	42	85
transportation problem	29	59
didint had any complication	27	55
males are out of house	22	45
spontaneous delivery	22	45
i feel shy	19	39
afraid of hospital	12	24
never been to hospital	7	14
sub center not functional	6	12
financial problem	5	10
others(no incentives, more active at home)	3	6

B.3. Reasons for institutional delivery:

Out of 17 beneficiaries who underwent institutional deliveries, most of the mothers (35percent) decided to choose hospital as delivery place because during the last month of pregnancy they met some pregnancy related complications otherwise they would have delivered at their home. And 30 percent mothers were those who really wanted to deliver at hospital because they were staying at their parent's house in other village during third trimester of pregnancy and it was nearby hospitals. Other reasons being *During the times when there was no rain in the village, so no farming, so few families migrated to Gujarat and everyone over there advised them to*

deliver at hospital, There were only few families for whom incentives were the driving force to avail institutional deliveries.

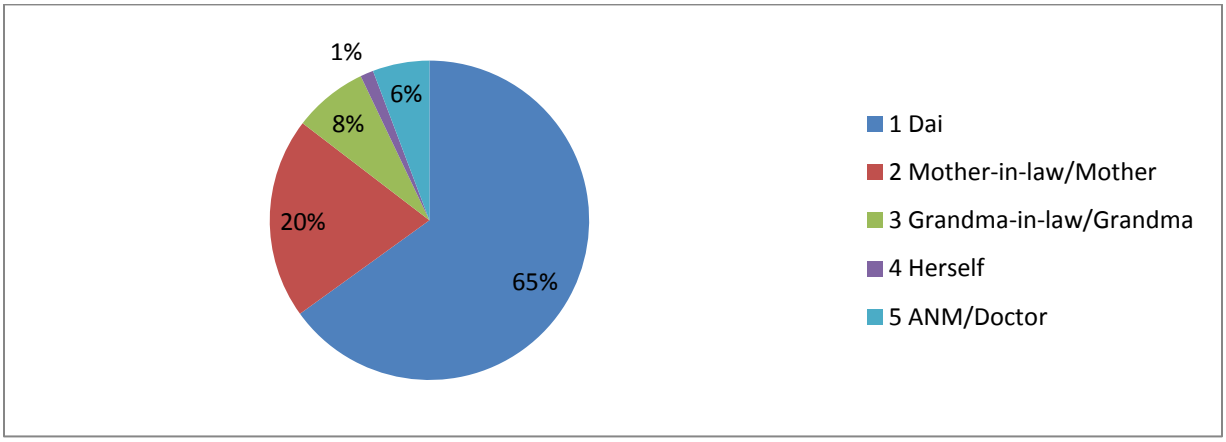
Graph No.2 Reasons for institutional delivery (N-17)



B.4. Delivery facilitation:

65 percent of deliveries in the village are facilitated by Dai. And the fact is that there were three dais in the village. Out of which only one is certified by the government and currently she is having problems with her vision from last 15 years. One of them is dead and other is so old that she only attends delivery if there are any serious complications or if delivering mother is her relative. There were few mothers (3) who had to facilitate their own delivery by themselves because there was no one at house. Some beneficiaries said they trust their mother/mother-in-laws more than anyone, so they prefer home and is economical also. Most of the people are not aware of birth preparedness, so which in turn results in spontaneous deliveries. *Dai said, while doing household work, especially working with chaki, the baby suddenly comes out itself*.

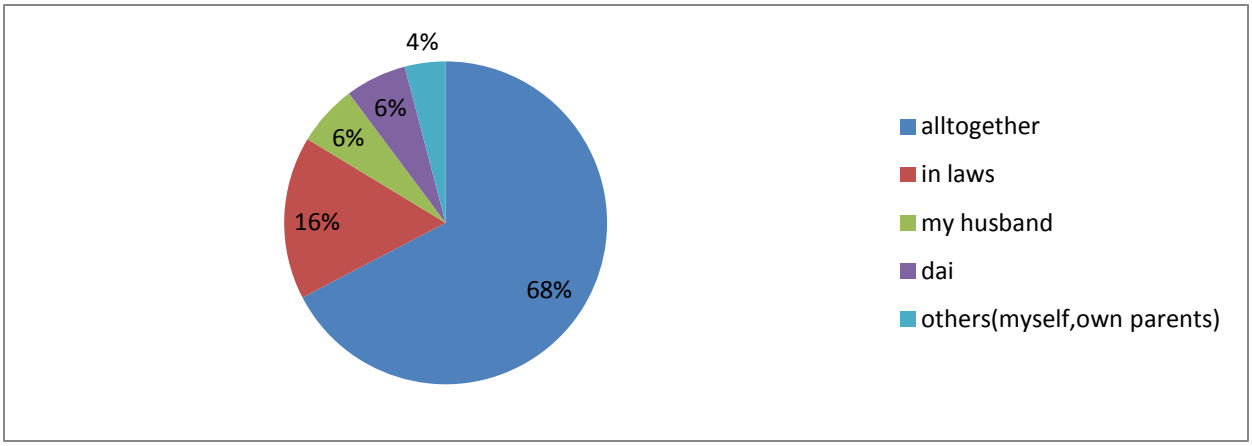
Graph No.3 Deliveries facilitation (N-110)



B.5 Decision for place of delivery :

Due to the dominance of generational legacy in the village, most of the family members have become habitual to this practice and adding to it beneficiaries have given up all the hopes for institutional deliveries because of lack of transportation. So most of the family members take mutual decision in various households (68percent) to deliver at home. And there are only 32 percent of deliveries in which beneficiaries are forced to deliver at home irrespective of their decision, in which in-laws count for 16 percent among the decision makers. *Most of the beneficiaries said that they trust dais and their mother/mother-in-laws more than anyone, so we don't oppose their decision, we don't have any other option because of lack of transportation so we have to go with the flow.*

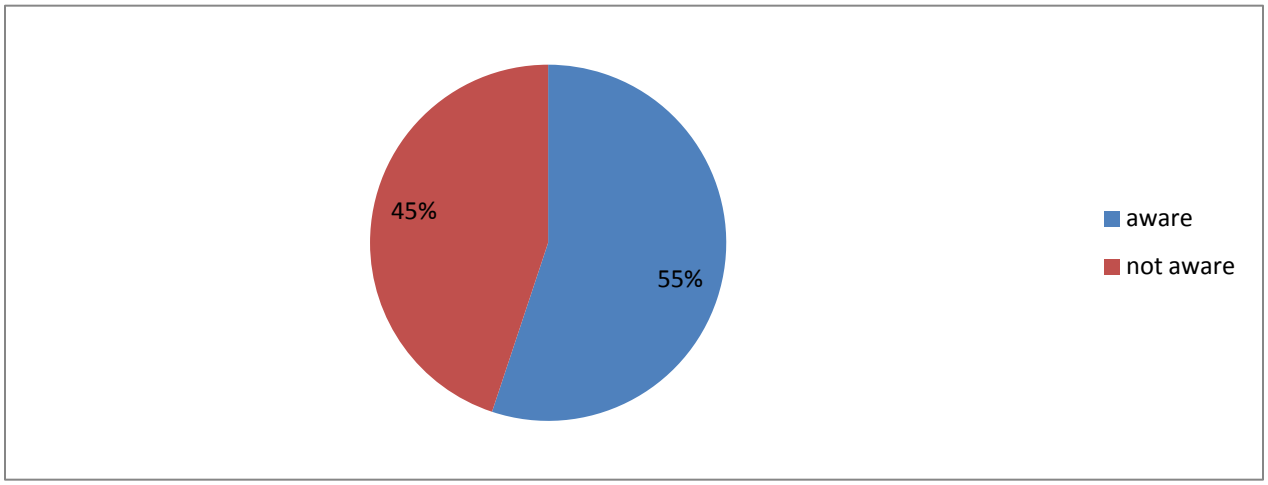
Graph No.4 Decision for place of delivery (N-49)



B.6. Awareness about incentives for availing Institutional delivery:

Though nearly half of the beneficiaries are aware of incentives for institutional deliveries, but when it comes to their practice regarding decision for delivery place, they prefer home deliveries due to the inconvenience caused to them by lack of transportation and because of it there adapted attitude towards it. They say when it can happen at our homes easily, then why to struggle so much to reach to hospital. And rest of the beneficiaries have never even heard about it, even neither from the beneficiaries because very few dhanis are close to each other, most of the dhanis are at a distance more than 2km from each other. And just two months ago, one ASHA has been appointed for the village, earlier there was only ANM, and she too was very irregular. Some facts: *In case very complicated deliveries, we use bull carts, if it is available, otherwise we only drag it, because it is impossible to carry pregnant women on our shoulders. Most of thebeneficiaries are not worried about incentives because they say pregnant women can't walk 5km under too bright sun, just to deliver at hospital which can be easily done at home also*

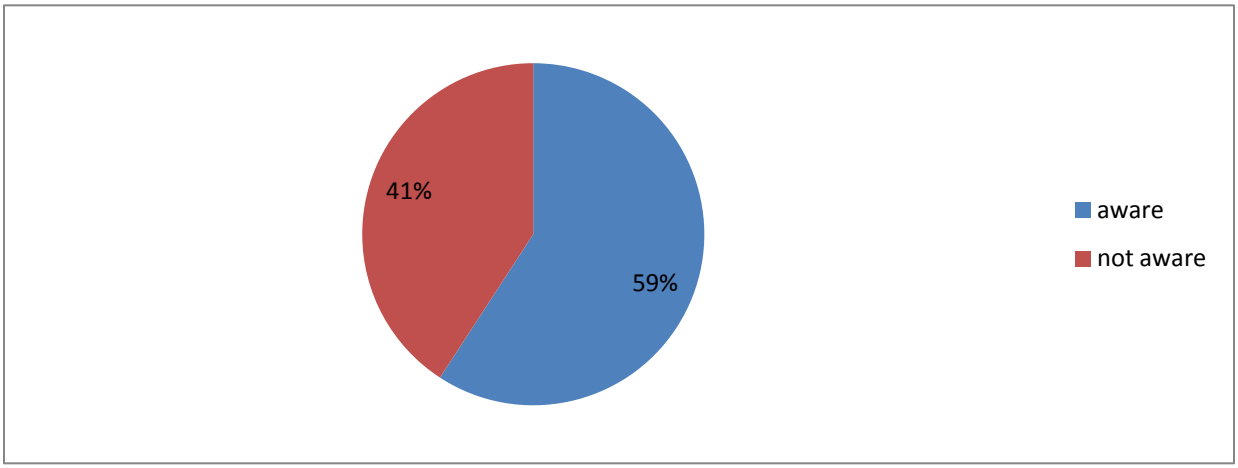
Graph No.5 Awareness about incentives for institutional deliveries (N-49)



B.7. Awareness about janani express:

Only 41 percent of the beneficiaries know about janani express. Even most of the beneficiaries in them think that they have to pay for it, where as around 60 percent of beneficiaries merely know anything about it. There is no way that ambulance can come inside the village because there is no road in the village and no ambulance wants to come in and drive in desert because it's full of thorns and its wheels can get caught in the soil. Even some of the times it has happened that ambulance arrived as beneficiaries has informed them regarding complications, but the ambulance used to stay at main road, never used to come in. *A lot of times it has happened that mothers used to deliver in their under the tree or any shed way to ambulance while walking or on bull cart. No matter how much the mothers are in pain or any complications, the driver of ambulance never accepts to come inside the village*.

Graph No.6 Awareness about janani express (N-49)



B.8. Utility of ANC services:

Antenatal care services includes antenatal checkups which includes checking weight, blood pressure, feotus examination and immunization (TT) and IFA tablets. Only 15 percent of antenatal mothers who received immunization received ANC checkups. Even these mothers who received antenatal care, underwent only two ANC visits and didn't received any IFA. Not even a single mother received IFA tablets because they think it's not needed. Infact there was no mother in the village who has received complete antenatal care.

Graph No.7 Utility of ANC services (N-49)

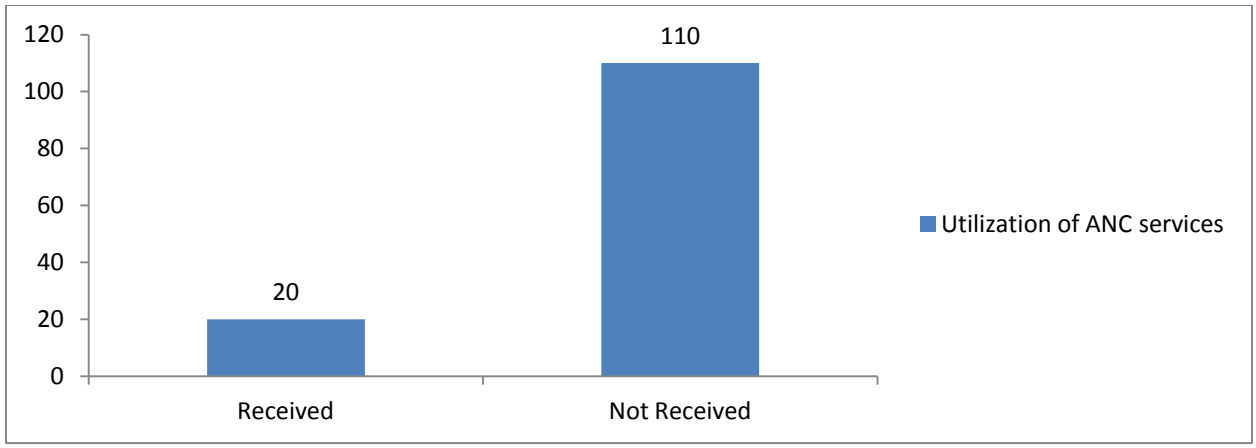


Table No.4 ANC Received

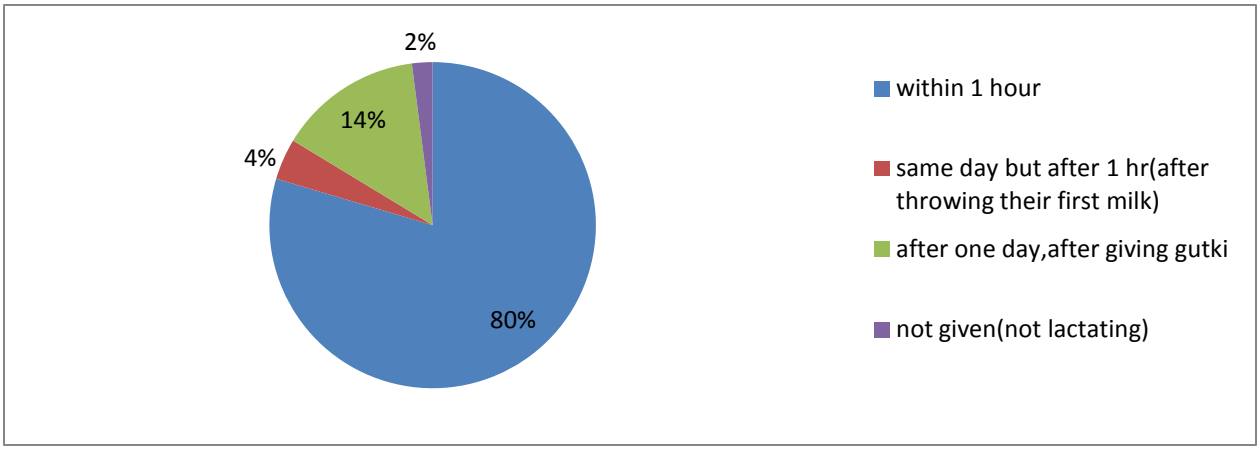
ANC	Frequency	Valid Percent
No ANC	110	85
Incomplete ANC	20	15
Complete ANC	0	0
Total	130	100

No ANC- Zero visits No TT immunization, No IFA taken and not even single test or investigations done required during pregnancy**.**
Incomplete ANC-incomplete visits or incomplete doses of IFA or only one or two tests/investigation is done
Complete ANC- Three or more than three visits and complete immunization with all investigation/tests done and IFA tablet taken for 90 days

B.9. Breast feeding practice:

Most (80 percent) of the mothers were found to follow a good practice of breast feeding newborn within one hour and almost half of these mothers didn't know importance of feeding within one hour but still they were practicing it because they were advised by their mothers.18 percent of the mothers were those who didn't agree with above mentioned practice and they were following a practice of throwing their first milk or feeding the infant with gutki first

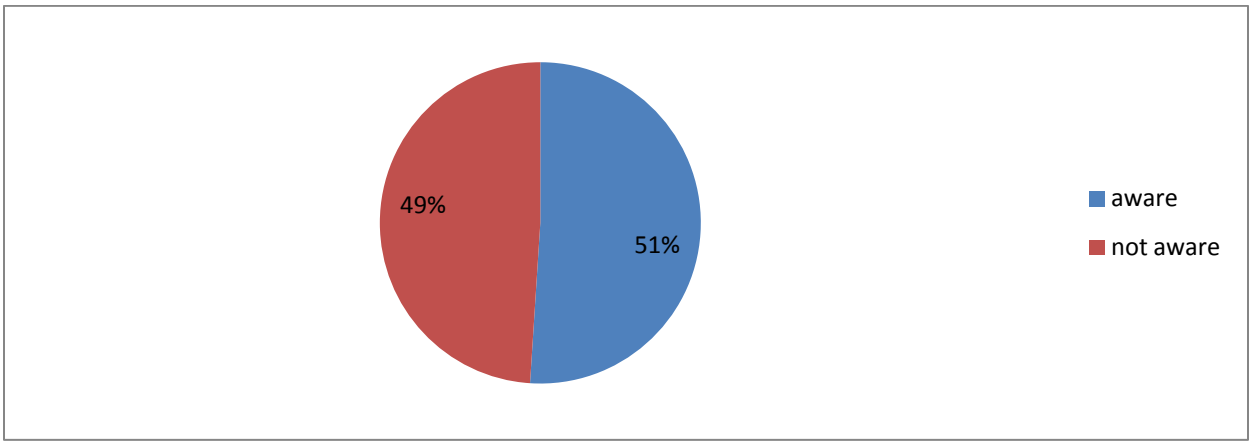
Graph No.8 Breast feeding practice (N-49)



B.10. Awareness about colostrum:

Colostrum being so important part of breast feeding practices. Though 80 percent of mothers were feeding their newborn within one hour, only half of mothers were aware of importance of colostrum. Even 18 percent of mothers who knew about colostrums but not its importance were those, who were practicing throwing their first milk because they think it's unhealthy for newborn

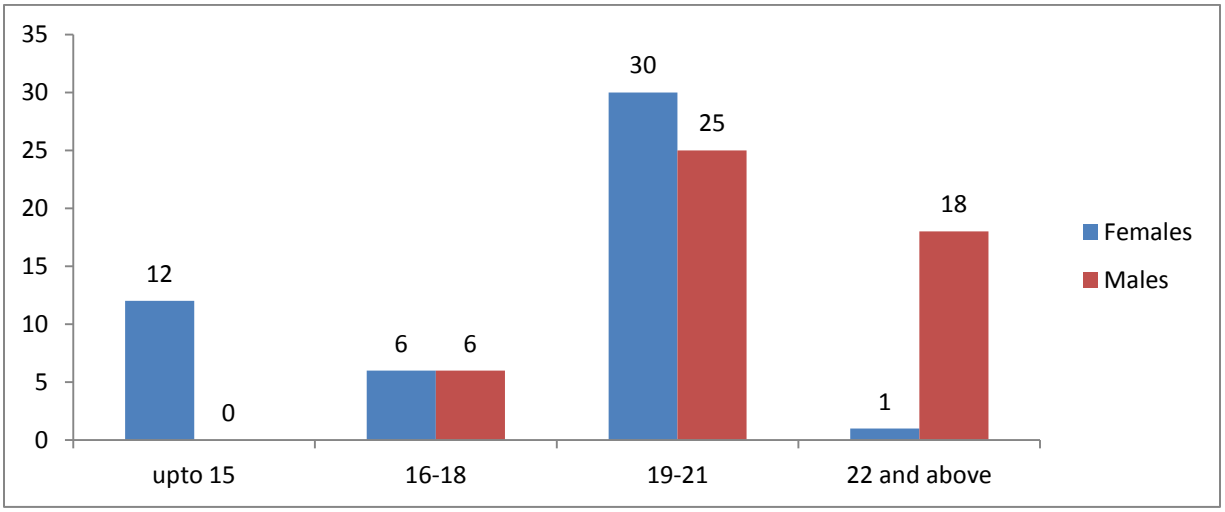
Graph No.9 Awareness about colostrum (N-49)



B.11. Comparison of Age at marriage between male and female:

According to the marriage Act in India, for girls marriage age is above 18 years and for boys its above 22.But the practice followed in this study area is quite different. One fourth of the females get married at the age group below 15 years, where as most of the females get married at the age group of 19-21 years (62 percent).And rest of them get married at the age group of 16-18 years (12percent) and merely very few at the age group of 22 and more than (2percent) it. Where as when compared to females, almost half of the males get married at age group of 19-21 years and nearly one third of them get married at the age group of 22 and more. And even 12 percent of them get married at age group of 16-18 years. *But the good practice is that if females get married at very early age, then almost 70 percent of females don't plan for pregnancy atleast for 2 to 3 years, as they are advised by their parents and most of them stay in their own parents house for few years.*

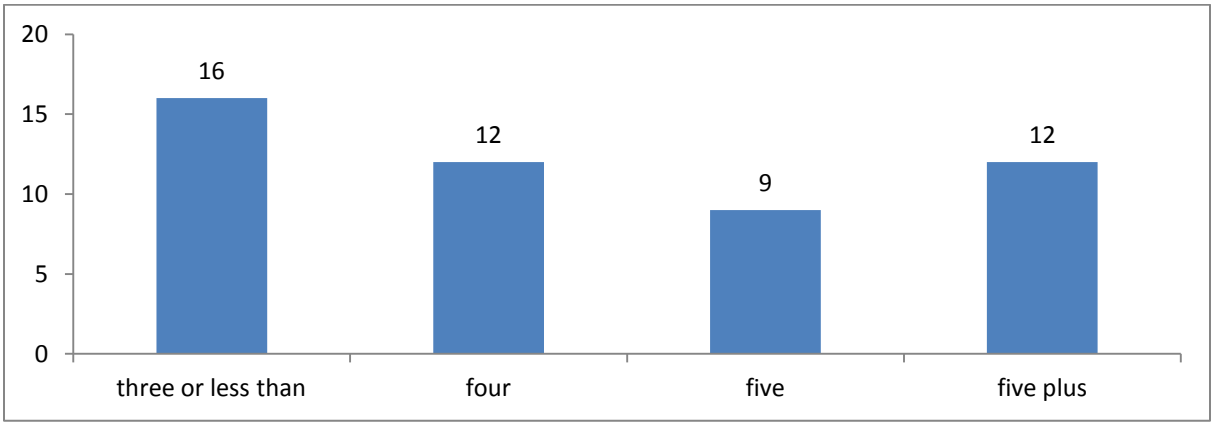
Graph No.10 Comparison of age at marriage between males and females (N-98)



B.12. Family size (children per couple):

As we know controlling population is a biggest challenge for India due to the diverse cultures, religious beliefs and several other reasons. This village is also a part of this culture because the status of family planning is very poor over here. According to the norms of family planning in India, a eligible couple should not have more than two children. Only one third of the couples were having three or less than three children, where as rest of the couples were having four or more than four children. And atleast 12 percent of families had seven or more than seven children.

Graph No.11 Family size (children per couple) (N-49)



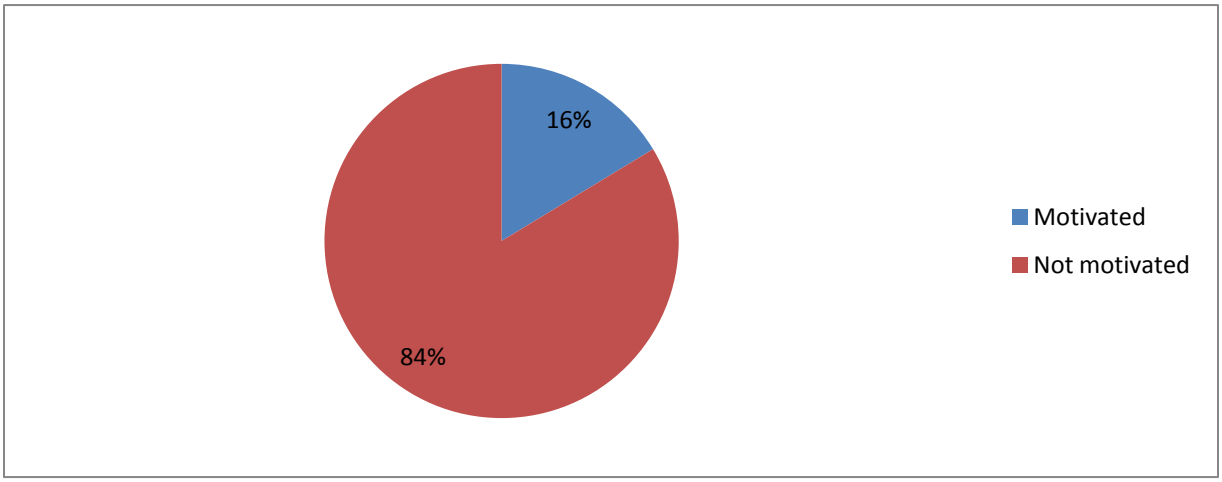
B.13. Reasons for having number of children:

- To grow family (no sex preferences) (47%)
- We want more boys (27%)
- We want less children to up bring them properly (12%)
- We want a girl (6%)
- Lots of her children died (4%)
- Others included our parents forced us to produce more children, even after undergoing permanent sterilization my last child was born.(4%)

B.14. Motivation by ANM/ASHA for Institutional delivery:

As we can interpret from the graph, 84 percent of beneficiaries said that they were never motivated by ASHA/ANM. According to them the ANM hardly visits the village, she came few times just to take sterilization cases and she visits only those dhanis where she gets those cases otherwise she doesn't visit anyone. But when asked to ANM, she said it's not possible to travel to that village frequently and even that villagers never attend immunization camps properly. Apart from ANM, even ASHA has been appointed to that village just two months ago. Lack of motivation and awareness has resulted in behavior change of villagers towards health care. And 16 percent of beneficiaries, who were motivated by ANM, said she informed us when we had attended immunization camp at the school. The other reasons for lack in motivation by health workers are *ASHA has been appointed to this village just two months ago, ASHA has been appointed to this village just two months ago, ANM says she wants to come frequently but the lack of transportation in that village is one of the biggest barrier to her and in addition to that attitude of the people towards immunization and awareness camps*

Graph No.12 Motivation by ANM/ASHA for Institutional delivery (N-49)



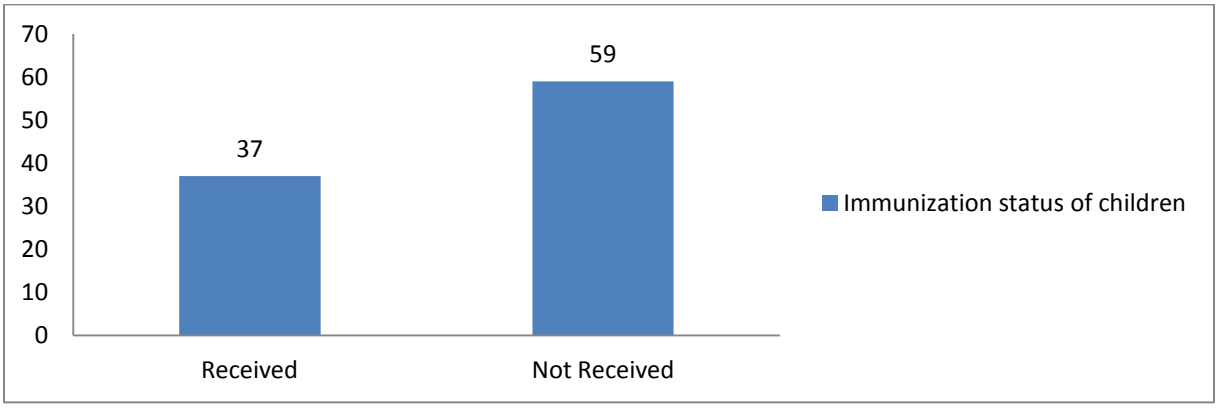
SECTION C: OTHER HEALTH SERVICES RELATED PRACTICES

C.1. Immunization practice for under 5 children:

Universal immunization is one of the eight goals of MDG and one of the important targets under NRHM to reduce infant mortality rate and under 5 mortality. But the level of immunization practice followed in this village is miles far from above listed goals. In last eight years even after the launch of NRHM, only one third of the children received immunization that too incomplete. Not even a single children child has received complete immunization. And rest of them except

polio drops have never availed it.80 percent of children have received polio drops because of the initiative taken by a primary school teacher in that village. Reasons for this practice are irregular ANM, least awareness regarding importance of immunization, some beneficiaries think immunization is not a good practice, children get sick if they utilize it and it is very painful for them.

Graph No.13 Immunization practice for under 5 children (N-96)



C.2. Awareness about contraceptives and there usage status:

Though all the eligible couples were aware of permanent sterilization and traditionally followed natural method but only 10 percent of respondents were aware of oral pills. And almost nobody knew about copper-T except one respondent who were actually using it.

84 percent of the respondents knew about condoms but only 27 percent of them were in fact using it. When being asked regarding condom usage, most of the respondents said that they don't use it because it's not free and few of them said why to use it, we don't get pleasure. *Few respondents replied that we use condoms if we are with other women apart from our wife.* After knowing about number of children per couples,90 percent of the couples were supposed to undergo sterilization but only 52 percent of them have utilized this service, as they were forced by ANM and they were informed about incentives.

Table no.5 Awareness about contraceptives (N-49)

Contraceptive methods	Awareness (%)
natural family planning method	100
permanent sterilization	100
Condoms	84
oral pills	10
copper-T	2

C.3 Sickness/illness status of the villagers in last 3 years:

Almost half of the married males have suffered from malaria, unknown pyrexia and one third of them have suffered from upper respiratory tract infections in last three years.13 percent of married males were having TB and were on DOTS treatment but all of them were taking it irregularly. One third of the married females and children were also suffered from malaria. Thus malaria prevalence is high in the village.

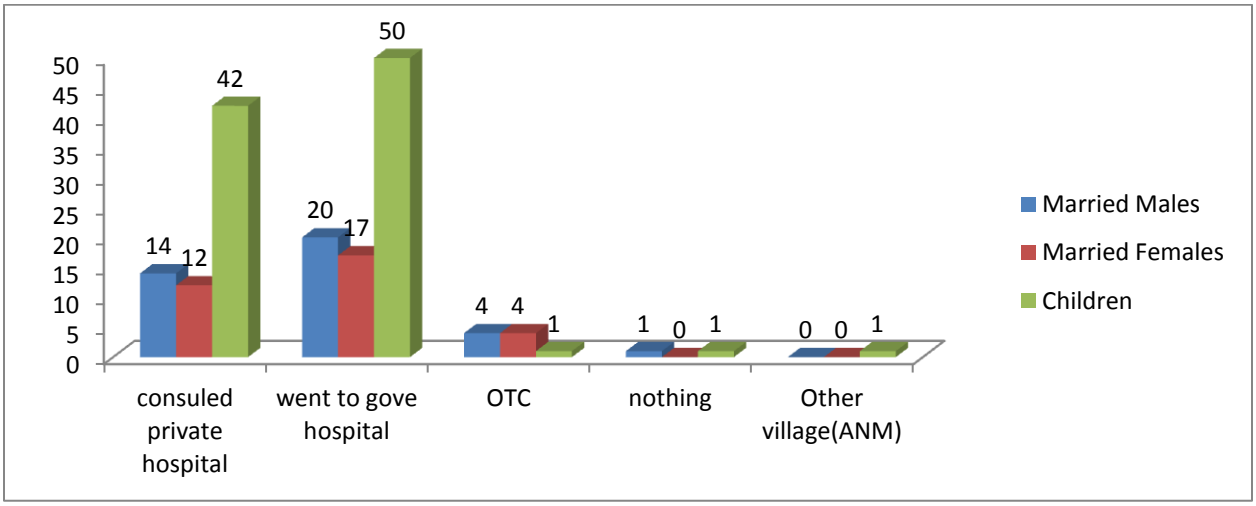
Table no.6 Sickness/illness status of the villagers in last 3 years

Sickness/illness	Married Males	Out of 47 cases	Married Females	Out of 46 cases	Children	Out of 195 cases
Malaria	23	49%	17	37%	56	29%
TB	6	13%				
URTI	17	36%	7	15%	30	15%
Pyrexia	26	55%	21	46%	65	33%
Abdominal pain	7	15%	10	22%	10	5%
Disability	2	4%			6	3%
Vertigo			5	11%		
Jaundice					8	4%
Others	9	19%	6	13%	12	6%

C.4. Preference of villagers for consultation during sickness:

Study found out that for consultation of children 44 percent beneficiaries prefer to visit private hospital/clinic followed by one third of married males where as only 24 percent of married females visit private hospitals. And second preference is been given to government hospitals.8 percent of males and females each also prefer to visit pharmacy for their sickness. Even financially they are not much strong but still they prefer private hospitals as they don't have much faith on government facilities which can be attributed to the disinterest and irregularity of the health workers in the village.

Graph No.14 Sickness/illness status of the villagers in last 3 years



SECTION D: ATTITUDE OF THE VILLAGERS (views of villagers)

D.1. Inconvenience due to geographical barrier: *(Multiple responses)*

- Problems for pregnant women, sick females and old persons (100%)
- Problems for school going children (100%)
- Have to keep stock of eatables (100%)
- Problems for sick babies (39%)
- Problems for workers (33%)
- Ambulance doesn't come inside (29%)
- Can't reach to hospital on time (10%)
- We have to walk very long with our luggages (6%)
- Problems for social gatherings (6%)

- If emergency at night (6%)

D.2. Practices which can influence villagers to avail health services: *(Multiple responses)*

- Proper transportation (100%)
- ASHA/ANM visits frequently (90%)
- Someone to make us understand and motivate us (75%)
- Clinics/medical stores (61%)
- Anganwadi to be functional (18%)
- Incentives (10%)
- Its villagers own fault (4%)

D.3. What villagers need to modify their practices to increase their standard of life: *(Multiple responses)*

- Proper transportation (100%)
- Electricity for all (100%)
- Water for all (94%)
- ANM/ASHA should visit frequently (90%)
- Clinics/medical store (61%)
- Schools up to higher secondary (47%)
- Anganwadi to be functional (18%)
- Sabha bhavan to be functional (14%)
- General stores (8%)
- Concrete houses (6%)
- Its villagers own fault (4%)
- Shelter for animals (2%)
- Ration godown (2%)

CHAPTER 7

CONCLUSION:

Study shows that knowledge, awareness and utilization of institutional delivery services, maternal care, immunization, family planning is very low among the villagers. The possible factor which study has found out is accessibility and availability to these services which can be attributed to geographical barrier faced by the villagers which in turn has changed their behavior and practices towards the healthcare facilities. Because of the geographical barrier, there is great impact on their education level and standard of life. And at last loopholes in healthcare delivery system which are lack of facility at Anganwadi centre, subcentre and primary health centre etc, inconsistent staff.

This study shows that policy makers still have to concentrate on creating awareness among the community and make service easily available and accessible for them. Making community aware of maternal care services & empowering with knowledge of services would help in utilization of all these services which will eventually lead to increased institutional deliveries, improved maternal and child health and standard of life in the village.

RECOMMENDATIONS:

- Awareness of community regarding the benefits of institutional delivery
- Awareness of pregnant women, lactating mothers and their family members regarding maternal care services at all the stages, which can be facilitated through ASHA, ANM and community leaders.
- Proper counseling of pregnant women's and lactating mothers at the time of checkup along with their regular follows up by trained personnel.
- Anganwadi centers should be supplied with sufficient supply of IEC materials and contraceptives.
- Health promotions and health education for maternal care can be make more effective by delivering it through mass media like Tv, radio, newspaper, posters etc.
- At community level, community leaders, teachers, panchayat committee members can be involved in health promotions because people pay more attention to them.
- Emphasis should be given on increasing educational level of women as it grossly affects the health of mother.
- Intrasectoral cooperation of required departments to facilitate the transportation, school buildings, water and electricity supply in the village.

CHAPTER 8

Helped in community mobilization:

After getting the status about the village, related to immunization of pregnant mothers and newborns, children, related to the education of married males and females and their children, related to the sickness of these three groups and to their practice of family planning and at last their attitude towards health care system, we decided to do something for them. so we discussed this matter with UNICEF and MO over there. And we were successful in establishing a team which included us,2 ANM,4 Facilitators of PHC Jasol and we discussed all the matter regarding the village. And on , we arranged an immunization, awareness camp in the village and were successful in immunizing 43 children which included 25 female child and rest male child, and three pregnant mothers. All the required vaccination according to their age were given to them including paracetmol to take care of their fever after vaccination. Awareness of pregnant and postnatal mothers regarding immunization and neonatal care was done. And contraceptives were also distributed among the villagers.

A meeting was arranged between the srpanch of this village and the villagers which even included 2 ward punch of that village. Discussion in between them was first initiated by us and then villagers started interacting themselves with punch. The discussion was continuously monitored and controlled.

After reaching to the gravity of all problems, we planned our next action and we made a list of effective persons whom can be approached to find out the heart of the problem and to find out the solution to solve transportation problem in the village. Firstly we met wise pradhan of that village and discussed the problem with him but we were not convinced with his clarifications and promises. Then we decided to meet sub divisional magistrate of that district. The whole problems of the villagers was discussed thoroughly. Firstly he tried to resist all the information which we were sharing with him, then after having a talk with medical officer, he tried to understand the situation and handed over us the naraka project of whole balotra division, in which he highlighted the projects for jogeshwar mahadev. And we were surprised to see that even financial sessions has been approved for various projects in the village. So then srpanch

was then again contacted and through him MLA was also been approached and with him same matter was discussed with him to find out the loop holes in their service deliveries.

Annexure:

Annexure 1: List of people interacted during my internship.

S.No	Name	Designation
1)	Dr. Anil Agarwal, MBBS,	UNICEF Specialist
2)	Dr. Apporva	UNICEF Officer
3)	Dr. Manisha	UNICEF Officer
4)	Dr. Hemlata	Health Plan Consultant
5)	Dr. Vishnu	Medical officer, PHC Jasol
6)	Mr. Shayam Sundar	ASHA facilitator
7)	Mr. Vinod	Data analyst
8)	Mrs. Dela	ASHA for jogeshwar Mahadev Village
9)	Mr. Chayan Singh	Sarpanch of the village
10)	Mrs. Paramjeet	A.N.M of the village

Annexure2: List of Timeline study

S.No.	Task	Timeline	Duration
1)	Document study and development of study design and tools and Training ASHA under E-ASHA pilot project	8th April'13 to 21st April,13	2 weeks
2)	Field testing of tools ,field study and data collection	22nd April'13 to 5th May'13	2 weeks
3)	Data analysis	6th May'13 to 17th May'13	1.5 weeks
4)	Finalization of Data And presentations	18th May'13 to 22th May'13	5 Days
5)	Presentation	23th May '13 `	1 day
6)	Relieved from UNICEF	25th May'13	

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Barriers for availing Institutional Deliveries and General health facilities in Jogeshwar Mahadev Village

Demographic information

1.1 Name of the village ……

1.2 Name of dhani ……...

1.3 Distance from main road ☐

1.4 No. of families(per kitchen) ☐

1.5 Family No. ☐

1.6 Total income ☐

1.7 What are the sources of income?

_____

_____

_____

_____

1.8 Total Number of Family Members Male ☐ Female ☐ Children ☐

1.9 currently pregnant womens ☐

1.10 No. of ever pregnant womens in last 4years ☐

Details of gravida and delivery

1. Name …….

2. Age ☐

3. Occupation ……

4. Religion ☐ Hindu ☐ Muslim ☐ Sikh ☐ Christian ☐ Others

5. Caste ☐ General ☐ OBC ☐ S.T ☐ S.C ☐ Others

6. B.P.L ☐ Yes ☐ No

7. Education Status of women. ……. Husband……..

☐ ☐

8a) Currently pregnant Yes No

8b) No. of pregnancies ☐

8c). Delivery history :

a) Gravida	b) Home & facilitated by	c) Institutional & facilitated by	d) Sex	e) Outcomes
1				
2				
3				
4				
5				

9. Before delivery you were taken care by

1)Your own parents ☐ 2)your in-laws ☐ 3)only husband ☐

10. What facilities you prefer whenever anyone in your family gets sick and why your prefer it?

_____

_____

_____

_____

_____

11. Do you visit any hospital in case of illness,if yes then list out the conditions in which you visit the hospital and how you reach to that place?

_____

_____

_____

_____

12a) Decision for place of delivery was taken by ……

12b) What are the reasons for deciding home delivery?

_____

13.What are your views about hospital as delivery place?

14. Have you ever been motivated for institutional delivery by ASHA/ANM or any other health worker,if yes then what they have informed?

15.What you do if you face any problem during home delivery?

16a) Are you registered in J.S.Y scheme? Yes ☐ No ☐

16b) Do You know Institutional delivery at Govt Hospital is free ? Yes ☐ No ☐

16c) Do you know transportation expenses are reimbursed by Govt .Hospitals ?

Yes ☐ No ☐

17a) How many children you expect to have and who decides it?

17b) Do you know about contraceptive measures,if yes then what all u know about it?

18.Does any child of yours has any disorder/disease or has fallen ill in last 3years,if yes then what was it and whom did you visited and what was the expenditure incurred?

19.Have you or your husband fallen ill in last 3years,if yes then what was it and whom did you visited and what was the expenditure incurred?

20.Do you know when to start breast feeding the infant and how long to breast fed during his infancy?

21.What was your experience,if ever you have utilized hospital services for delivery or any other illness?

22.how much transportation is responsible for you in not opting institutional delivery and any other healthcare facility?

23.what are the ways which can influence you to positively opt for institutional delivery and MCH immunization programmes?