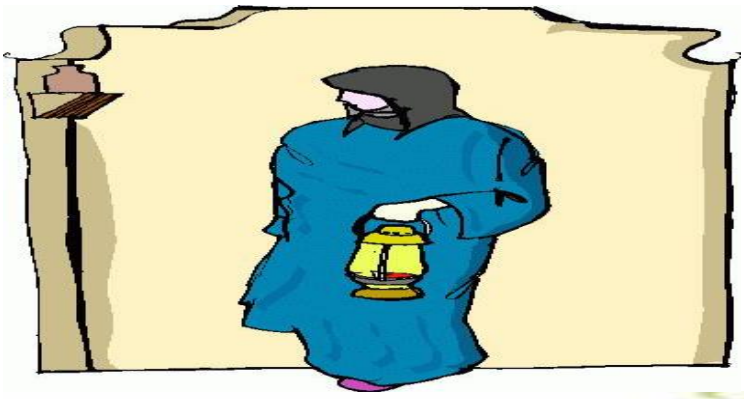
A JOURNEY OF A LITTLE LAMP



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ACRONYMS:

SOCHARA	Society for Community Health Awareness Research and Action
SAHAJ	Society for Health Alternative
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy
CEHAT	Centre for Enquiry into Health and Allied Themes
FEDINA	Foundation for Educational Innovation in Asia
NUHM	National Urban Health Mission
NGO	Non- Governmental Organisation
TB	Tuberculosis
ART	Antiretroviral Therapy
AAP	Aam aadmi Party
CMC	Christian Medical College
NACO	National AIDS Control Organisation
VHND	Village Health & Nutrition Day
VHAI	Voluntary Health Association of India
STDs	Sexually Transmitted Diseases
CID	Crime Investigation Department
Hb	Hemoglobin
WHO	World Health Oragnisation
ICDS	Integrated Child Development Scheme
NFHS	National Family Health Survey
MNCHN	Maternal Newborn Child Health & Nutrition

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PART A

A BRIEF NOTE ON WHY I WISH TO JOIN THE PROGRAM

Health is understood not merely the absence of disease, it is a state of complete physical, mental and social well being. Considering this statement in social work I would like to explore my knowledge in health learning so that contribution to individuals, families, and communities will be effective and meaningful. The practice of Social Work requires knowledge of human development and behavior; of social, economic, and cultural institutions; and of the interactions of all these factors. Generate knowledge from this program will help me as a teacher and as a social worker how to enhance the skills in problem-solving, coping and developmental capacities of people; also how to link people with systems that provide them with resources, services, and opportunities.

Community Health will be my one of the subjects for Bachelor of Social Work students I therefore felt the need and importance of having a clear concept and dept learning from the training what community health is about so as to impart knowledge back to the students and boosting my teaching career. I also interested in enrolling myself for PhD programme in my near future on which my topic will be in line with health issue. By participating in this Community Health Learning Program I hope that I will be able to deepen my understanding in community health and to enhance my analytical skills as well. Field work activities are immensely essential for increasing knowledge base and competencies in community health. Our social work students have their field work placement in different settings. Health setting, Social Welfare and Targeted Intervention projects to mention a few. By being a part of this program I strongly believe that I will gain skills, interactions, understanding the diversities and apply theories into practice. Importantly, I will be able to teach and supervise my students from health perspective in health settings. Martin Luther Christian University introduces 'Life Skills, Human Sexuality and Personality' as one of the activities and services for undergraduate and postgraduate students. The life skills team consists of trained facilitators and a medical doctor. My aim is to get involved in this activity so that I can teach the students, reach out to people in the community for sensitization and creating awareness in health issues and change positive attitudes towards health among them. In order to fulfil and achieve my aim is to join this program and learn from this program. Apart from all the points mentioned above, Vision and objectives of the SOCHARA inspired me to join the Program.

MY LEARNING OBJECTIVES ARE

- To learn and understand about community health
- To learn Social determinants of health through theory and field works (rural & urban settings)
- Enhance my knowledge various concepts such as Globalisation, Paradigm shift, Knowledge translation, Alternatives, etc.
- To visit public health facilities and experience field works in and outside Karnataka
- Conduct a research study

LEARNING FROM COLLECTIVE TEACHING SESSIONS:

Apart from other many topics covered in class the followings are the new terms/concepts for me but through the fellowship programme I am able to perceive and understand which in later life I will be able to use them in a meaningful way.

A) **Community Health**: Learning and gathering from class I understood that Community means Self-organized network of people with common agenda, cause, or interest, who collaborate by sharing ideas, information, and other resources. During my field works I realised that my community that I was concentrating with was women who face domestic violence, pregnant and lactating women, People Living with HIV/AIDS, and Urban Slum dwellers. When I think about community health I would say community health is the foundation for achieving all other goals because it addresses the health needs of populations as a whole instead of individuals, it is prevention rather than treatment of diseases. For me a healthy community reflects a sense of mental, physical, spiritual and economical well being not just the absence of disease or illness in the community.

B) **Medical pluralism/ Alternatives:** It is the adoption of more than one medical system, or the simultaneous integration of both orthodox (Western) medicines with alternative medicines. It is also the name given to the situation where a patient has a number of choices when selecting a system of treatment. As learning in class, alternative means a choice/option or available as another choice or shifted to another choice. Mind and brain of a person is the main programme that brings the ability to choose, anything he/she wants to change and choose is from his/her side not from someone else side. For instance, alternatives in nutrition people always prefer modern food such as fast foods, oily and spicy food, etc than traditional food items. Regarding health care, majority would choose facilities that have more technology for treatment or they can choose a kind of sustainable way of treatment, e.g. choosing knees modern replacement which last only for 10-12 years or can also take alternatives, that is, walking, do exercise which will last for long time.

   In this medical pluralism there is interconnection of home remedies, local health tradition, allopathy and AYUSH. Most of local healers in India are hereditary in nature e.g. Dai, traditional birth attendance and all the traditional healers are always certified and recognised by their community. In our daily life we always seek alternatives, we can choose local healers for treating our sickness and we also can choose allopathy for treatment. One of the reasons is that we have instinct, self regulating balance and balance to get something of which we would go with our intelligent mind. Instinct, intuition and intelligent should be allowed to operate in our life to have good health, if these three tell us that we need alternative in health care then we go with it. In our life we understand that every system of medicine can contribute to health care in their own way but the most important to understand is that there should be no conflict so that it can be utilised without discrimination.

C) **Social determinants of health:** As per my understanding there is no single definition of the social determinants of health, but there are commonalities, and many governmental and non-governmental organizations recognize that there are social factors which impact the health of individuals. The social determinants of health are the economic and social conditions – and their distribution among the population – that influence individual and group differences in health status. They are risk factors found in one's living and working conditions (such as the distribution of income, wealth, influence, and power). The World Health Organization says that "This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies, unfair economic arrangements [where the already well-off and healthy become even richer and the poor who are already more likely to be ill become even poorer], and bad politics"(Marmot, Friel, Bell, Houweling, & Taylor, 2008)."

Some of determinants of health that I have learned and linked direct or indirectly with field experiences are :- water &sanitation, Education, Housing, Maternal and child health, Caste system, social justice, Nutrition & Food supply, Health policy, Health economics, Urban & Rural issues, substance abuse, Chronic disease, Mental health, Health services, Discrimination, violence, aging, Disability, Ethnicity, Gender, Environment issues, Immigration, income & social status, culture and employment/ working conditions. These social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. The unequal distribution of these conditions across various populations is increasingly understood as a significant contributor to persistent and pervasive health disparities. If attention is not paid to these conditions, we will most surely fail in our efforts to eliminate health disparities. The question is what we as community health workers do to collectively assure the conditions in which people can be healthy.

D) **Globalisation and Health**: After brainstorming in class I understood that globalisation has a ranges of meanings, it depend on a group or individuals how to define it. After having many sessions on globalisation I understood that globalization is the flow of information, goods, capital and people across political and geographical boundaries. Many people would say that globalization has had an overall positive impact on peoples' health. In many ways, that is true. For instance, global transportation and the communications revolution enable rapid response to epidemics and catastrophes, saving thousands of lives. But there also is a downside to the health and well-being of people as a direct or indirect result of globalization. For instance, Non communicable diseases which I learned in class resulting from unhealthy lifestyles are now in places in the world where they were either unheard of or rare just 50 years ago. Obesity, hypertension and type2 diabetes are an enormous health problem today, and the incidences are increasing in developing nations. This rapid increase again illustrates the

globalized risks for conditions that are mainly caused by diet, even in less developed countries that have coexistent under-nutrition. There is no doubt that due to improved agricultural techniques and productivity combined with increased trade, malnutrition decrease. But looking at genetically modified food production, for example, can produce more food, but there are some negative aspects to it as well. The methodology for producing those crops, such as the use of pesticides, can have a harmful environmental side effect and if humans consumed these foods will definitely affect their health. I believed that all these are because of globalisation.

E) **Research (Qualitative and Quantative):** Qualitative research is concerned with non-statistical methods of inquiry and analysis of social phenomena by using detailed descriptions from the perspective of the research participants themselves as a means of examining specific issues and problems under study. After having session on this topic I gained my knowledge understanding that conducting qualitative research will help a researcher how many different causes and actions lead to specific outcomes, it helps how the detail counts by recording attitudes, feelings and behaviours and it helps to avoid pre-judgements.

   As per the knowledge I perceived Quantitative research means that the quantitative researcher asks a specific, narrow question and collects a sample of numerical data from participants to answer the question. The researcher analyzes the data with the help of statistics. Subjectivity of researcher in methodology is recognised less. The researcher is hoping the numbers will yield an unbiased result that can be generalized to some larger population. According to my experience in doing quantitative study in Gujarat I understood that Quantitative research is more reliable and objective and can use statistics to generalise a finding even though less detailed and miss a desired response from the participants.

   Learning about both Qualitative and Quantitative I would say that Qualitative methods might be used to understand the meaning of the conclusions produced by quantitative methods. Using quantitative methods, it is possible to give precise and testable expression to qualitative ideas. This combination of quantitative and qualitative data gathering is often considered referred good for more information.

F) **Communitisation under NRHM:** One of the main frame works and strategies of NRHM is communitisation. Communitizing the health care was the ongoing process of decentralization and people's involvement for making health care services effective. Development of village health plan through Village Health and Sanitation Committee (VHSC). Panchayat Raj Institutions (PRIs), self-help groups, and health, nutrition and sanitation committees have been activated to seek local accountability in the delivery of programs. During my field visit at Tamilnadu I can see that The NRHM also establishes accountability structures like the Village Health Water & Sanitation Committees (VHWSC) at various levels of facilities. Untied funds of all kinds under NRHM also are a part of the overall design of strengthening of 'Communitisation Processes' envisaged in the programme framework of NRHM, so they should not be

seen in isolation. What helped immensely is that Accredited Social Health Activist (ASHA)/Animators provide the link between monitoring and planning at the village level as the two processes go together for positive change. Learning from collective sessions and field visits I can say that the process of community involvement of the health institutions itself would enhance accountability, which places community at the central place in respect to planning and implementation. Involvement of voluntary Organizations is critical to ensure the communitisation process. The idea is to realise that decentralized planning, facilitation of implementation, oversight and monitoring through community involvement is likely to be more responsive to the healthcare needs of local communities and will be a step towards 'Communitisation'- a hallmark of the NRHM.

G. Knowledge Translation: Knowledge translation is defined as the use of knowledge in practice and decision making by the public, people (patients), health care professionals/Activists, managers, and policy makers. It is a relatively new term that is increasing in importance and use in the field of public health and medicines as well. Researchers have focused their attention on knowledge translation as both a process and a strategy that can lead to utilization of research findings and improved outcomes for consumers. Knowledge Translation in Health Care explains how to use research findings to improve health care in real life, everyday situations.

During my research study period, I conducted a study on the problem of Aneamia in three villages of Anand district, Gujarat. I was questioning myself what I'm going to do with my study, in my mind, my study will be in my bookshelf only. But learning about knowledge translation I realised that my study will be useful for health activists of SAHAJ, public health providers of these villages and of course my study will bring light to the participants. The significance of my study is to translate the evidence I have collected into the knowledge for further actions. My findings will be translated by health activists, health providers, field workers in to the knowledge of the participants and even to other people in those areas so that pregnant and lactating women in particular and other women in general will know their anaemic status and most importantly they will know how and what to do in order to upgrade their health status.

G) **Health economics:** Economics deals mainly with money and spending on health can be justified on purely economic grounds. Economics also helps in decision making how to manage, generate and prioritisation of resources. It gives us a tool to prioritise what is the most important for us whether it is primary care, surgery, etc. Health Economics is a branch of economics concerned with issues related to efficiency, effectiveness, value and behaviour in the production and consumption of health and health care. I also can say that it deals with issues related to the financing and delivery of health services and the role of such services and other personal decisions in contributing to personal health. Health economics in health helps how to allocate resources between various health-promoting activities and use for health purposes; it also helps in organising and funding of resources to be used in health delivery. Looking at our Indian health care

system it is characterized by low levels of public spending on health care; poor quality in health care services, with adverse effects on the population‘s health status; a lack of focus on preventative health care; and dependency of the population particularly the poor, on private health care providers and consequently high Out-Of-Pocket spending. Therefore learning of Health economics helps me in the future to know how to manage and prioritise the available resources for effective and meaningful utilisation.

FIELD VISITS:

During the fellowship my co-fellows and I went to visit Siddapura and Old Byapannahalli slums, Domasandra Public Health Centre, Well-being centre and Sakkalawara Community Health centre of National Institute of Mental Health and Neuro Sciences (NIMHANS), Foundation for Revitalisation of Local Health Tradition (FRLHT), Snehadan, Association of People with Disability (APD) & Basic Needs India (BNI). Field visits helped me interact with what I am learning; they also give me the opportunity to experience new venues. The experience goes beyond reading about a concept; I was able to see it and participate in it physically.

Together with co-fellows I also had fun while going to field and from these field visits I realised that Learning and fun make a great combination. I was so touched by facilitators who supervise fellows during a field visits carried a great amount of responsibility on their shoulders. I realised that the connections established during field visits encouraged fellows to come to the facilitators with any problems they may experience during the fellowship. Most importantly field visits helped me to have an in-depth understanding about health systems and services delivered by health providers and also understanding more the health status of people, their social determinants and their real life situation.

FIELD INTERNSHIPS:

Apart from having field visits the fellows had to do their internships according to their area of interests. My first field internship was at Vimochana, Bangalore where I had chance to learn about how women face domestic violence even if they are educated and wealthy and how rehabilitating those women helps them to rejuvenate their health problems which affect them physically and mentally. When I was placed at shelter home, a home for women who face domestic violence I had an opportunity to do a case work and also taught those women how to make greeting cards, sold those cards and donate the amount to Vimochana which is mainly for those women at the centre. Introducing this activity helped these women to switch off their tensions for a while and switch on their joyful moment to a conscious mind by concentrating on the activity. Another field placement was at SAHAJ, Baroda, Gujarat. In this organisation I had a chance to learn about Village Health and Nutrition Day, services provided by health workers and health seeking behaviour among the women in the villages. During my field work I also have learned about entitlements (JSSK) that women get from the government which helped them to have a better health care. Most importantly I had a great opportunity to conduct a study on **‘The dietary practices and Ante-natal care**

among pregnant and lactating women in Bedva, Rasnol & Sarsa of Anand district, Gujarat'. From this study I understood that anaemia is still the problem not only in Gujarat but also in the whole country.

My last field work was in St John Medical Hospital, Medico social work department and at Swathi Mahila Sangha organisation. In St John I had a chance to visit in the dialysis ward together with the students of Christ University. I also attended a gathering organised by the Social workers of Medico Social Work department for the support group of dialysis patients. During the process of treatments these dialysis patients faced lots of challenges and problems as their family abandoned them due to financial difficulties and loose hope on these patients. In order to make them feel accepted and have hope in their life, social workers took initiative in forming a support group for dialysis patients. On the day that I attended the gathering social workers and some doctors facilitate these patients the discussion of how to improve their health status. It so inspiring and interesting session because these patients came up with lots of constrains they see during the process of treatment and at the same time they discussed of how to solve the problems and achieve the gaps and constrains.

Another field work I did was at Swathi Mahila Sangha organisation (SMS). Its head office is in Sanjaynagar and target interventions I visited are in Bommanahalli and in Shivajinagar. SMS, a community based organisation of women in sex work formed in 2003. Experiencing in this organisation I have learned that it was initiated to holistically address issues of women in sex work, with respect to health, risk of HIV infection, various forms of crises and economic and social insecurity that increase their vulnerability to HIV. Providing necessary support to these women who engage in sex work industry helped them to overcome various challenges they face every day. This will help building relationship among themselves and also maintain their regular contact for effective services.

Reflecting these field internships I have learned that Internships are a proven way to gain relevant knowledge, skills, and experiences while establishing important connection in the field. Field internships make me understand that staying and working with the community "It's not what I know, but who I know". I also realised that internships helped me how to apply knowledge from classroom to connect and relate to the workforce that I will be undertaken. While observing the staff of these organisations I have learned and realised that I will surely be able to do a networking with professionals in the future. I really learn how to get to know the people, live with them, learn from them with what they know especially those who are in the field; learn their traditions, health status, their challenges, eating habits and their mindset at some point. Apart from these above mentioned points I also gained my insights how to set my goals, how to keep my positive attitude and try new things such as food, dress, language, etc.

CASE STUDIES:

The followings are some of the case studies conducted during my field internship at Vimochana, Kolar district:

1. A case study was conduct with Asha who is staying at shelter home (we conducted at her room as she is not comfortable talking in front of other women in the shelter). Originally she is from Mysore but after getting married she stayed with her husband in Mumbai. Her husband was a manager at Air port; they have a flat where both of them, their two daughters and a son were staying. After some years her husband got married to another woman and left Asha alone because her children got married and they are staying in their own place.

   In order to kill her loneliness she decided to do a business, selling sari imported from Kolkatta and transport to Mumbai. Her business was good enough so she employed two boys from Kolkatta of whom she treated them as her own children. Greediness penetrated the minds of these two boys. According to her sharing these two boys gave her something to drink which make her weak, dizzy and sleepy. When she was in that kind of condition these two boys graph their opportunities to let her sign the documents of her flat and sold it to someone else, they also took all her jewellery and fled away with a huge amount of money.

   When she became conscious again she realised that she was betrayed by those two boys whom she loves them as her own children. Without delay she informed her family and her brother-in-law who is staying in Mumbai and working in CID department. They filed a complaint to Kolkata police station and also to the court. The case on this issue is still going on till now.

   During the sharing she said that maybe because of that drink she consumed in Kolkata her mentality is not right always, sometimes she spoke correct and nicely but sometimes talked nonsense and not correct. Seeing her in such condition her family brought her back to Mysore where they also ill treated her. She sadly said that when I was rich everybody treated me well but now when I am in this condition they never accept me and they even blame me for what had happened.

   Her brother in-law knows one judge very well and he used to tell that judge about the problem that Asha faces then the judge called her and listened her story. Fortunately, that judge knows Ms Shakun from Vimochana quite well and the judge passes the same story to Ms Shakun. Hearing this story Ms Shakun called Asha and let her come to Vimochana by later encouraging her to stay in a shelter home which is in Bangalore and after that she was transferred at shelter home, Kolar. She ended her story by saying that her brother in-law called her back to Mumbai to stay with his family and continues the case for justice. She is planning to go to Mumbai on the third week of the month of November, 2013.

2. Bhagya an 18 year old mother hails from Mesahagatte completed her education till class VII. She was once working in one house doing household works where she met a man who she became to know that he has a family. In spite of knowing that he is married she continued having an affair with him and got pregnant. When she got pregnant she never had courage to tell her own family, she seeks help from the house owner instead.

Fortunately the house owner is a very good person and she took Bhagya to St Martha Church, Bangalore. In this church they help pregnant women but when they gave birth to their babies they will send away the mother but keep with them the babies. So it happened to Bhagya also, after 15 days of giving birth to twins (boys) the church is taken care of the babies and sent away the mother. Even in this condition the same lady (house owner) still helped Bhagya by telling to Ms Donna, Vimochana, Bangalore to help Bhagya in any way she can. Bhagya was sent and admitted at Shelter home, Kolar in August, 2013. She said that she is already talked to the staff of Vimochana about her job after going out from the shelter but she doesn't know what kind of job yet. Bhagya said that after she is settle with the job she will go home but to visit her babies is not possible right now as the church does not allow her to visit her children. But she still have hope that she will be able to visit and meet her own kids in the future, she is happy because her children are in the good hands, she said.

3. Another case study was conducted with Ms Rupa. The case was studied during evening time at the office of shelter home as it was convenient for the client. Ms Rupa hailing from Thalagudha, Kolar district was a repeated client (her third time in shelter home) of shelter home. She completed her studies till standard IX. Without having admission for class X she married a man (arranged marriage) from Bangalore who doesn't have any concern about her. Her husband was working as an electrician.

   During her stay in Bangalore she went to a tailoring class but her husband and her in-laws never allow her to do the course. Pressurising by in laws she discontinued the class and stayed at home where her husband and in-laws harassed her mentally and physically. Since she is the daughter of a mother from the second marriage no one bother her and her life. Ms Rupa does not know till now where & how her mother is (as the mother married to another man whom Rupa don't know). The father never considers Rupa as his daughter because he has sons from his first wife whom he is staying with.

   Fortunately Rupa has a grandmother whom she is always shared her problems with. When her grandmother knows about the condition of Rupa she came to Vimochana office to seek help from Ms Shantama. Since the place where grandmother and Rupa are staying is not far from Vimochana, Kolar immediately Rupa was admitted at Shelter home for the first time in 2012, second and third time was admitted in 2013. During her stay in shelter home she was counselled by the counsellor and by the members of the panchayat to go back to her husband house. She could stay there only for few days because her husband and her inlaws continued harassing her every day. With the help of Vimochana she is planning to continue her studies (class X) in government school where books, uniform, accommodation and food was free of cost. She will join the school in June 2014. At present she is helping in cooking and cleaning at shelter home. Rupa proudly said that she is happy now, don't want to go back to husband house but continue her studies and become a teacher to teach others how to be strong in fighting injustice.

READING LISTS AND INSIGHTS GET FROM READINGS

Apart from many other books, articles, journals, reports, magazines, etc followings are the readings which I found inspiring and relevant to health and social issues directly and indirectly:

1. "Behind Closed Doors: Domestic violence in India", Edited by Rinki Bhattacharya, published by Vivek Mehra for SAGE Publications India Pvt Ltd,New Delhi, 2004. Rinki Bhattacharya is former victim of domestic violence, a well-known critic, columnist, women's rights activist, writer, freelance journalist and a documentary film maker based in Mumbai. CHARDIWARI, her documentary film on domestic violence received international acclaim. She has worked as a volunteer at the Nari Kendra (Mumbai) and later founded a crisis hotline for battered women called HELP. Presently, Rinki is Chairperson, Bimal Roy Memorial Committee, Mumbai. This book is dedicated to women trapped in abusive relationships...and those of us who escaped, Rinki said.

   The book puts together the life stories of 17 women from diverse cultural, class, education and religious backgrounds in India who were victims of domestic violence. This powerful book is a tribute to the courage and determination of women who decided to break their silence. It will inspire other victims of this 'hidden crime', to speak out, share their plight and change their fate.

To be assaulted, abused and raped by someone as intimate as a husband, or lover is the most degrading experience for a woman. Not recognised as 'real' violence, abuse of this nature is experienced daily by countless women in every culture. Behind closed doors of family, custom, values, traditions that are taken for granted and never questioned - are muffled voices of terror and trauma, which do not reach beyond the threshold nor attract the attention of lawmakers or redress agents.

2. Shepherd, Bruce. D and Carroll A. Shepherd "The Complete Guide to Women's Health". New York: New American Library, 1985. This book offers a good amount of practical information about such subjects as pregnancy, birth control, STDs, menopause, sterilisation, hysterectomy, preventive health concerns, nutrition, exercises and drug problems. Specialists assist women in choosing and using services within the often-confusing health care system. In each of the chapters, step by step diagrams are used to indicate whether home treatment or medical care represents the best choice.

   Women seeking a complete and up-to-date health guide for the 1980s will find this thoughtful, professional volume a most valuable resource. The Shepherds, a husband-wife, doctor-nurse team, have taken a humanistic perspective that is oriented to women as informed users of health care services. The authors talk as people talking with other people about medical issues that are important to all women concerned about their health. The wide range of problems covered in this book will enable readers to identify warning signs and take appropriate measures when health problems are in their early

stages. Use of this book will go a long way toward helping a woman better understand her body, her health and her options when she needs medical care.

3. **Pink Sari Revolution:** A Tale of women and Power in India written by Fontanella Amana Khan and published by Picador in London, 2013. Fontanella is a contributor for The New York Times, The Financial Times, The Financial Times Weekend Magazine, Slate Magazine, The Christian Science Monitor, The Daily Beast, Conde Nast Traveller and is formerly a Contributing Editor at Vogue India.

   This book is about fierce, frank and courageous work of the Pink Gang in freeing Sheelu, a 17 year old girl from the clutches of a powerful local legislator who ended up in jail. Shahbajpur, Atarra, Bundelkhand and Chitrakoot in Uttar Pradesh are the main places in this book. The Times of India headline mentions "Even God can't control crime in UP". In such notorious situation Sampat Pal, leader of the Pink Gang and her 20,000 strong all-women vigilante group operating from Bundelkhand crusading for the rights of groups or individuals who were dealt an unjust hand. Sampat Pal's extraordinary courage will inspire, delight and fill the readers with hope. In this book the reader finds the story as an inspiring story of self-reliance and female grassroots activism.

4. **Genocide in Gujarat 2002** impact on health and women, produced by CEHAT, Mumbai and prepared in May 2002. Reading this book there is a realisation that the issue of sexual violence is grossly under reported, especially in rural areas. Women's health was physically and mentally affected. Till today Women continue to be markers and cultural symbols of a community. To dishonour women is seen as an easy way to dishonour a community, people need justice because justice still has not taken place for the victims of this genocide.

5. **Where there is no doctor:** A health care handbook contributed by David Werner and published by VHAI in New Delhi, 2010. Reading this book I understood that it is not strictly to medical professionals only, it is for other health workers or even to ordinary people who can take the lead in their own health care, it is like a first aid book. In this book traditional forms of healing and home remedies are focused of which I personally love to apply in taking care of myself and others in my future. I also have learned that this book was written for anyone who wants to do something about his or her own and other people's health. I love reading this book because it explains in simple English with drawings which is easy to understand.

6. **Speaking tree,** Women speak Asia-Pacific court of women on the violence of development, Edited by Corinne Kumar, Donna Fernandes, Madhu Bhushan,Celine Saguma, Gowramma, R.L Kumar, etc., produced by Asian women's Human rights Council and Vimochana, Bangalore, 1995.

   Reading this book I understand that it talks about Asian Public hearing on crimes against women related to the violence of development will hear women victims speak.

It also talks about issues of dowry, female infanticide, devasis and sex trafficking and witch hunting, displacement of people by mega-development projects like big dams, migration and on shelter and homeless in the cities. The effects of nuclear radiation and the violence of modern science and technology.

When I read these books, it feels great to put myself into a different world that the writers have created. As I reflecting on what I read, I start forming my own thoughts and values. Readings challenge my mind and my thoughts, customs and traditions that I have grown up with. Through reading, I understand properly what I have read and reflect upon it, I expose myself to new things, new information, new ways to solve a problem, and new ways to achieve things. When I'm reading, I'm actually gaining the knowledge and experiences of someone that inspired my life so as to inspire others as well.

WATCHING DOCUMENTARIES WITH REFLECTIVE DISCUSSIONS:

Fellows were not confined to lectures and presentations only but also spent their time in watching meaningful documentary films which are about health, environment and social issues. Documentary films we watched were – violence against women, VHND before going to Gujarat, Ramaka story, non- communicable diseases (Diabetes), Social exclusions (caste), Climate change: heat wave/cold wave, disasters & GMO. During class session there were topics which are difficult to grasp so Documentary Films are like lectures that help in visualizing the contents we are trying to understand and discuss. Documentary film helps me to enhance my knowledge, develop my analytical and thinking skills.

METHODS FOR RECAPS

The fellows were very creative in doing recaps. They used to have a recap every morning and sometimes in the evening. Most of the time the recap was oral recap where each fellow had to produce key learning points and also reflect on those points learned the previous day and previous week. The most creative way of doing recap is 'role play'. In this role play the fellows had to collect and gather learning points from all the topics taught, combine and arrange together those topics and did a recap in the form of role play. The role play was directed by Dr. Yuvraj, facilitator & programme coordinator and was played by the fellows and watched by SOCHARA team.

INVITING OF QUESTS IN THE CLASS ROOM

Introduction: quest lectures are mostly sharing of experiences than power point presentations which I love the most because by learning from other experiences we speed up our own evolution. During these kinds of sessions we had sharing from both the quests as well as from the fellows. Sharing session was also done during Kumar's class where all the fellows shared their experiences which are so emotional but confidentiality is maintained.

Some inspired quest lectures and sharing are:

Ms Vallarie Kaur: Ms Kaur is from USA, she came to SOCHARA with her friends to tell stories about issues that need to tell. She shared about Civil rights and movements in US context. She also shared about the shooting in Sikh community happened in the temple at Oak Greek (USA), this incident which happened on August 5, 2012 was known as a domestic terrorist type situation. Listening to her sharing I recollect back the incident when I was at home watching the news on this issue and about condolences. After shooting there were many condolences from government officials as well as from general public. President Barack Obama offered his condolences calling the Sikh community 'a part of our broader American family' but I think is not enough just to feel pity without action. I hope that through the journey of Ms Valarie and her team in playing their role to tell story on any particular event I believe actions will be more than words.

From her session I realised that story telling should be told for the benefit of the oppressed. The role of story tellers is to figure out the situation of the people who are abandoned, who face harassment and who have no voice to raise for their problems. Most importantly, storytelling is to tell the story that provokes universal movement which provide a chance to experience a variety of emotions without the risk of those emotions themselves. I also understood that storytelling provides the soil wherein empathy for others takes root and grows.

Mr Elango: On the first day of resuming our class after coming back from field work we had a sharing session shared by Mr. Elango who is working at Sam Raksha since 1993. He shared that he was found positive in 1988 but since no NGO working for HIV/AIDS persons that he knew about and also because of stigma attached to HIV, he was just kept silence about the problem until he met Mr Kumar, SOCHARA. Mr. Elango reminded the fellows about the basic knowledge of HIV, he also mention that in America AIDS only is identified not HIV but in 1983 in Fransisco the virus was identified and the first case in India was in 1986 in Chennai (CMC, Vellore) and in Karnataka the case was identified in 1987. The government started NACO in 1992 and from 1995 onwards NGOs were coming up to work for HIV/AIDS. The first ART drug (single drug) was provided in 1996 and from 2004 the government is providing ART free of cost.

From Mr Elango's sharing I have learned that people considered HIV/AIDS as a dreadful and fatal disease which in fact is not, this is due to wrong and fearful messages that Health providers and NGOs spread during awareness programme. This is the reason why general public have lots of stigma and discriminate those HIV positive. Reflecting to this issue, it is a high time for us as Community health workers to educate ourselves first then give correct information to others. I feel that NGOs and health workers have to motivate the particular community so that they will have self esteem and strong enough to face any challenges.

Reflecting to the real situation, majority of positive people would prefer to go to private hospitals for treatment. It would be helpful if there is a private –public partnership as it happens in St. John Medical hospital (govt provided kits) so that services will be reaching out to many. Communitisation is very important, when positive people stand together for a cause no one can take their rights and no one can discriminate them. One inspire thing that this particular community had done is strengthening Labour policy. According to this policy no one can remove from the job or position which a positive person is holding. This is a good sample that other marginalized communities also to take and follow for their future security. If the virus has a skill to change its shape we humans also should have an extra skill to change and stop stigma and discrimination of any sort. HIV positive persons should get more motivation and correct information. It is a high time to the general public also to make an effort to get correct message on this particular issue.

Basic Needs India: Dr. Mani Kalliath and Mr. Gururaghavendra, staff from BNI shared their knowledge with the fellows about Mental health. During the session we had a group discussion in which we had a chance to share our experiences related to the topic we discussed within the group. Personally I'm so thankful to Dr Mani for giving me a chance to share my personal life experience I faced several years ago which make me feel relax after my sadness and anger is gone. My experiences were really affecting my mental health but because of his class I'm Ok now.

OPPORTUNITIES IN PARTICIPATING OTHER PROGRAMMES:

Apart from class sessions and from any programmes that scheduled by SOCHARA there were other programmes that fellows attended and participated which personally I gained my knowledge on many issues related to health and social issues.

Mental health session at NIMHANS:

Under the guidance of Dr Yuvaraj fellows attended a session on mental health presented by Dr Girish, Additional Professor and Mr Mathew Vanghese, MD, Professor of Psychiatry, NIMHANS. Learning outcomes from this session were understanding of global key determinants such as poverty, low education, unemployment, deprivation, homelessness are the risk factors which affect the mental health of a person especially to vulnerable groups such as women, children and elderly. The new learning from this session is brain injuries can also cause mental disorders which directly affect the mental health of people. Hoping the Indian government will give a strict enforcement of Helmet Law uniformly to all the Indian states not just some parts of the country.

Mfc meeting:

During mfc meeting held in New Delhi in February 2014 I observed and graph some important things which I understood mfc as a 'current thought' which discussed the topics that are socially relevant such as cast, religion, gender, etc. Participants who attended the meeting feel relax and flexible because children of some participants can also attend the meeting with their parents. It

was a nice thing to see that many background papers are circulated and presented for further discussions. Gathering the key points from lectures, presentations, sharings, quest lectures, group discussions I have learned that social exclusion and discrimination on the basis of caste, class, gender and religious minorities is still rampant in our society. This kind of unfair treatment affects the health of individuals physically, mentally and spiritually. Since mfc has always supported in people's movement for health, responding to such problems by the members of mfc and by people themselves will bring a healthy environment and a healthy society.

Mela:

During the fellowship I had an opportunity to attend two mela i.e, Mahila mela at Lowry College Campus, Bangalore organised by Headstreams. Mr Naveen coordinated this mela where 25 SHGs were taken part. Reflecting at how those women participated I would personal say that they performed with enthusiastic spirit, their happy faces tell like they are saying 'this is my day, I enjoyed it, I strongly believed that when women are empowered, they really are independent. Another mela is NGOs mela organised by Social work department students at Christ University, Bangalore where all the NGOs had their stall for self presentation to those who visit their stall. Having interaction with all the members/ staff of these 21 NGOs I realised that running an NGO has lots of sacrifices to what things need to be done and achieved, I was really impressed by their aim and objectives, their vision to extend their helping hands towards underprivileged and marginalised groups.

Summer camp:

Headstreams organised a summer camp in May, 2014 in government school in A. Narayanpura, Bangalore where SOCHARA fellows attended the programme. In this camp, children from low economic background participated with the help of volunteers. Attending the closing ceremony of the camp was interesting and enjoyable. Seeing those kids dancing I felt happy and most importantly I understood that we the agent of change should keep in mind that these kind of children need not only financial support but also psychological support for their bright future.

Protests:

The fellows are not confined only in class room, we also participated in protests organised by NGOs such as FEDINA protesting against injustice done to unorganised sectors such as construction & domestic workers and elderly.

Vimochana protests against all types of violence and harassments such as domestic violence, it also conducted a protest against racist and sexist attacks against Ugandan women entertained by AAP minister. Another NGO is Green peace protests against Genetic Modified Organism which genetic foods are considered dangerous and harmful if people who consumed these foods, farmers are bind by Monsanto's regulations. Participating these protests I realised that

concern for others is important, it doesn't matter we know those people who are the victim or not. I was inspired by William Faulkner who says "Never be afraid to raise your voice for honesty and truth and compassion against injustice and lying and greed. If people all over the world...would do this, it would change the earth."

Documentary film:

SOCHARA fellows attended a discussion session conducted at St John Medical College Conference Hall, Bangalore. After watching a documentary film on 'Empathy' directed and produced by Alex Gabbay. Medical professionals and fellows had a discussion that doctors miss opportunities to express empathy in conversations with patients of which I also had a chance to share my experiences on this particular issue. During the discussion I have gained my understanding that clinical empathy is important because showing empathy can actually save doctors time and improve patient satisfaction and even outcomes.

Launching of Nation Urban Health Mission:

NUHM was launched on 20th January, 2014 at Freedom Park, Bengaluru where Sri Ghulam Nabi Azad inaugurated the function. Experiencing from field visits at urban setting and having a chance to attend a launching of NUHM helped me to understand how government of India should concentrate according to the needs at different context. By covering up the unorganised sectors (slum dwellers, street children, homeless, etc) half of the problems such as clean water and sanitation, housing, waste disposal, Anganwadi centre and other public infrastructures in urban areas will be probably solved. But the most important thing I feel is people need to be empowered for better accountability.

Chennai and Bangalore trips:

Under the guidance of Karthik SOCHARA team from Bhopal and Bangalore had a Chennai trip where we visited Dr. Chandra Agency, PHC and Panchayat visits. From the visits I realised that health care services and health status in this area differs from our state (Meghalaya). People in Tamil Nadu are more involve in local institutions (Panchayati Raj Institutions) and utilise public health system meaningfully, health is decentralised and localised. Due to this trip a close relationship was build among the fellows and a sense of belonging to one family was created in fellows' mindset. Another trip was in Bangalore where SOCHARA fellows under the guidance of Ms Shani visited some important places such as museum and shops run by SHGs. Self reflecting on these SHG I gained knowledge on how strong the functions of SHG are. Women are more financial independent which leads them to have better self-esteem and better life in their future.

During the trip we also enjoyed travelling by Metro at M.G Road because it was so comfortable and not crowded. While travelling in this Metro I was pondering to myself that this Metro rail system adds to the beauty of Bangalore skyline and I hope it will reduce carbon emission effectively and most importantly I hope it will function according to the need of people at large

not just for sight seeking. These trips foster a sense of teamwork and community among fellows as they experience a field trip together.

WORKSHOPS

Attending workshops both in St John and Ashirvad make me aware of various issues connecting with health. These workshops conducted as part of the initiative where participants discussed and reflected their experiences in depth and meaningful manner for possible directions to be taken in the future. In a workshop 'Social justice in Health' there was one new term which I considered another important aspect in our generation i.e,. Social vaccine. As per my understanding Social vaccine is an encouragement the bio-medically oriented health sector to recognise social and other determinants of health for improving health equity. Another workshop conducted at Ashirvad, St Mark Street was about promoting patients rights and ensuring social accountability of the private medical sector and Clinical establishing Act. Listening to the discussions and final suggestions made in this workshop I understood that in India privatisation is so rampant and health care is commercialised.

The noble profession which should be devoted to the service of human kind is now being converted into a profit making industry. In order to bring health for all, public health systems should be strengthening and should enshrine patients' rights, there also should be a promoting and upgrade of all the existing public health systems. There was another workshop I attended was in Mumbai where maternal health and social autopsy were mainly discussed. Social autopsy refers to an interview process aimed at identifying social, behavioural, and health systems contributors to maternal and child deaths. It is often combined with a verbal autopsy interview to establish the biological cause of death. Two complementary purposes of social autopsy include providing population-level data to health care programmers and policymakers to utilize in developing more effective strategies for delivering maternal and child health care technologies, and increasing awareness of maternal and child death as preventable problems in order to empower communities to participate and engage health programs to increase their responsiveness and accountability.

NEW INNER LEARNING WHICH I CONSIDERED THE BEST TO APPLY IN THE FUTURE

Tap turner off: Even though I'm from Social work background I never realised what type of social worker am I but learning this community health I came to senses that turning off the flow of problems by addressing those problems appropriately will bring positive changes in the health of a person. When Dr. Ravi was asking the fellows to think about one room where there is an open tap in a basin with overflowing water. He asked us that when you enter the room and see the floor full of water, what will be the first thing you should do? Turn off the tap or mop the floor first?

All of us answered that we should turn the tap off first and then mop the floor, which is correct. Then again he asked us Are you a Floor mopper or a Tap turner off? All of us just kept silence. Interestingly he explained that the water that flows from the tap denotes various kinds of

diseases or illness that overflowing in our life whereas turn off the tap and mopping the floor means to tackle the problems but the question is what kind of methods we will use, turn off the tap or mopping the floor. Gaining knowledge from collective sessions and from field experiences I realised that most of health professionals are just floor mopping due to various reasons. One of the reasons, perhaps, is that we always think that only medicines/ drugs, technology (floor mopping) can cure the illness but we failed to understand that concentrating to other social determinants (turning off the tap) would even reduce the problem drastically. Therefore preventive, promotive, rehabilitative care approach is important to use not just curative alone if we want to tackle the challenges in health.

During my field internship I have learned about violence against women and the problem of anemia among pregnant and lactating women. Reflecting on this floor mopping and tap turning off I realised the government, health professionals, policy makers are tend to be the floor mopper because Iron Folic Acid was provided to those women who are anemic and not promoting or strengthening local nutritional foods available in kitchen garden or lower the price of foods products in the market, education for nutritional conscious, water and sanitation, etc. Looking at violence against women health providers tend to prescribe medicine for curing the mental illness for curing wounds or any physical injuries of women instead of looking at psychological health, Gender sensitivity, socio-economic and cultural condition of these women. Analyse and examine from all angle of understanding and experiences I realised that as Social worker and as Community health worker I should become a 'tap turner off' for better action in the future.

Paradigm Shift: Paradigm shift is a fundamental change in an individual's or a society's view of how things work in the world; it is a change from one way of thinking to another; it just does not happen, but rather it is driven by agents of change. Paradigm shift in health is about understanding from medicine/medical model to health/wellbeing model. When we say medicine we only think of modern/western medicine/allopathy, of course bio-medical way of thinking is not wrong but is not enough in every area of health system. In bio-medical we always think at individual, patients, but if we understand health as overall wellbeing we have to shift our way of thinking by showing and creating a sense of dignity from patient to person or group of people.

To have a better understanding on this paradigm shift further explanations can be given such as TB, Cancer, and mental retardation. When we think of TB, Cancer or mental illness in women immediately in biomedical we think of her physical body or pathology that means which part of her body that has cancer, which medicine to prescribe Mental illness, TB but in health/social model we have to think about social, economic and violence against women. In bio-medical we see virus, germs, bacteria, drugs, medicines, kit but in health model we have to understand and concentrate on unhealthy sexuality, enabling environment and empowerment that people themselves can do and bring positive changes in their lives as well changes in the society.

Important thing which change me after learning from this programme is understanding myself as a little light. I came to SOCHARA with the attitude of 'chandelier' but now I realised that I

am a ‘candle’ of which when I go back and work with community I will light other candles/lamps that I can reach out at my level; I also realised that I have to be a ‘tap turner off’ and to be ‘agent of change’ to shift from negative thoughts towards others to positive thinking. Learning about community health I believed that I’m able to change my way of thinking towards the community that people in the community are wise even though some of them are not literate, they know and understand everything, they have the ability to solve the problems of their own but they just need somebody to guide and to show them the way what and how to do. Motivation gets from VHND observations changes me to think things critically for the welfare of the community and make me personally to be a determined person to succeed.

OVERALL REFLECTIONS

Class sessions are educative, informative, interactive and reflective sessions. Facilitators and fellows followed a ‘teacher-student’ and ‘student-teacher’ approach which means facilitators impart knowledge to the fellows and at the same time gathered knowledge from fellows and fellows are not simply borrowed knowledge from facilitators rather collect insights from facilitators and sharing knowledge with facilitators. Having multitalented facilitators and fellows, who are from different background, different geographical area (South India, North East, North India, US) makes the fellowship programme more effective, creative and innovative and we can see this while performing in class and in the field.

I really love when Dr Ravi facilitating of how to be humble and down to earth person. When we are in the realm of hierarchical structure be it in educational Institutions, Health sectors, industrial sectors, religious realm, etc people who are in high position tend to feel superior of themselves and considered others as low and unimportant people but here in SOCHARA paradigm shift is applied by teaching & non-teaching staff and by fellows. Dr Ravi was always mentioned that wherever we are we should work together with the community and we should do the work in such a way the community will say to us “Namma (my) health worker”. We also should be the ‘lamp and not chandelier’ if we want to become real community health workers.

Another thing I was impressed by the member of SOCHARA is that every person at SOCHARA is important and equal, facilitators and fellows are not considered higher than the non-teaching staff and vice versa. When tea brought in the class everybody can stretch a helping hand to serve and collect back the tea without waiting the one who brought the tea to do his/her job. This is the biggest sign of positive attitude towards others.

All the members of SOCHARA are so approachable, friendly and caring. They create a sense of belonging to me, they create an enabling environment that makes me to say ‘I have a freedom to express anything whatever I feel necessary’. Another thing that I love is that we the fellows were never confined ourselves to academic part only we also had meaningful fun by having special celebrations and entertainments such as birthdays, best wishes to SOCHARA newly married couples, coming back from trips in the form of getting food items or gifts, sending off

former fellows, singing, etc. These celebrations make us relax and rejuvenate our energy from hectic schedule.

Apart from all the points mentioned above I find that giving presentations or attending others presentations enriched my knowledge and my skills. Whenever we read an article/journal or came back from NGO & field visits and did a study in the field all the fellows had to give presentations. Throughout the fellowship programme I realised that presentations helped me to be more confident, creative and knowledgeable.

CONCLUSION

Community health learning programme is one of the health learning programmes which a learner should have an understanding in using the knowledge of the community to understand health problems and to design activities to improve health care (interventions). Apart from all the issues learnt in the class Research also is so important in order to spread awareness and bring things into action. Research connects community members directly with how the research is done and what comes out of it and it also provides immediate benefits from the results of the research to the community that participated in the study. Community members are also involved in promoting the use of the research findings. This involvement can help improve the quality of life and health care in the community by putting new knowledge in the hands of those who need to make changes.

PART B

A STUDY ON THE DIETARY PRACTICES AND ANTE-NATAL CARE AMONG PREGNANT AND LACTATING WOMEN IN BEDVA, RASNOL & SARSA OF ANAND DISTRICT, GUJARAT

Nandaris Marwein

Background

Anaemia is still considered a major public health problem in the world. It is a important healthcare concern as it is estimated to affect approximately 2 billion people worldwide (Carley, 2002). Anaemia is a disorder is due to the deficiency of folic acid and iron in daily

diets. According to WHO definition Anemia is a condition in which the Hb concentration is lower than the normal level of Hb.(Nisha,2006).

It is one of the main nutritional problems affecting all sections of population especially pregnant and lactating women. The world Health Organization estimates that 58% of pregnant women in developing countries are anemic and out of different countries India was one of the highest.(McLean, Cogswell, Egli, Wojdyla, & de Benoist, 2008)

Continental wise, Asia has the highest prevalence of anemia in the world and about half of all anemic women live in the Indian sub-continent where 88% of them develop iron deficiency anemia during pregnancy (Gillespie & Haddal, 2003). The National Family Health Survey-3 (NFHS- 3) revealed a high prevalence of anemia among children is 78.9%, ever-married women is 56.2% and pregnant women is 57.9% in India. In Gujarat 61% of pregnant and lactating women are anemic (NFHS-3).

In spite of the fact that the Health and Family Welfare Department in India has policies to provide iron supplement to pregnant women to prevent maternal anemia; though the government of Gujarat introduced ICDS programme to provide nutritious food to pregnant women and children, evaluation from large scale programmes shows that maternal anaemia has not declined significantly (NFHS 3).

Our country still experiences the situation of malnutrition which constitutes a major socio-medical challenge for the country. It seems that deficiencies of total dietary calories, proteins, vitamins, iron, calcium and iodine are commonest in our country. Malnutrition is always being a reflection of unfulfilled dietary demands which occurs mainly in the period of pregnancy and lactating. It is natural to suppose that lack of nutrition is more prevalent among those who are coming from low socio-economic status due to the restrictions of diet (Shukla,1982). The diet of people who come from a low socio-economic status are predominantly based on cereals which in fact have to be supplemented with other nutritional foods for more balanced and adequate in all nutrients. But such foods are consumed only in small quantities and hence their diets are inadequate with respect to many nutrients particularly iron. Therefore no doubt that poor dietary can lead and cause anemia. In spite of having a chance to grow and produce nutritional of food items in rural areas yet the intake of protective and body-building foods are still inadequate in many respects. Even though anemia can be prevented by increasing of iron dietary items, there are however certain problems in making people consume foods that contain lots of iron due to cultural and economic barrier (Gopalan, 1991).

In India, the majority of maternal deaths are attributing both to indirect and direct causes such as haemorrhage, abortion. The main indirect cause is anaemia. VHNDs which are a major initiative under the National Rural Health Mission (NRHM) meant for improving access to Maternal, Newborn, Child Health and Nutrition (MNCHN) services at the village level. Gujarat is one of the states in India which implemented this VHND effectively. In Anand district of Gujarat VHNDs also known as 'Mamta Diwas' are organised in many villages where pregnant and lactating women check their Hb level which is one of many services provided by health providers. Sarsa (14200 population), Rasnol (8180) and Bedva (5444) are some of the villages where VHNDs conducted regularly either in Sub-centre, Anganwadi centre or PHC. Majority of people in these 3 villages engaged in agriculture, animal/cattle rearing, labour works and business and their economic status is poor (SAHAJ 2014).

Even though VHNDs are conducted regularly in these villages but to the best of my knowledge there is no studies conducted or published to know whether components of VHND package of this programme is effective or not. Despite of receiving nutritional foods and ANC during VHND women were not studied whether their anemia status is good or not. Thus, the aim of the study is to understand the dietary practices and Ante-natal care among pregnant and lactating women in Anand district, Gujarat.

Objectives

0. To assess the dietary practices in relation to anaemia and its prevention among pregnant and lactating women in those three villages of Anand district, Gujarat
1. To find out prevalence of anaemia among pregnant women and lactating women
2. To document their awareness level about anemia and about their Hb level
3. To know the ante- natal care services received by pregnant and lactating women

Methodology

Study Area: Sarsa, Rasnol & Bedwa villages, Anand district, Gujarat

Study Design: Cross sectional study

Study Period: April - May, 2014

Study Population: Study population of the study are pregnant and lactating women in the study area.

Sampling:

A sample size of 54 women (35 pregnant women, 19 lactating women) was selected as convenient.

Data collection tools and procedures:

Semi- Structured questionnaire will be using for interview. Haemoglobin was estimated by using mamta cards and registers. Data on socio-demographic characteristics, obstetrics history, ANC and dietary intakes were collected.

Data analysis:

Data was entered on SPSS and analysed. Tables were prepared using Microsoft excel. WHO (1968) cut offs for pregnant and non-pregnant women were used for classification of anemia and the cut offs are shown in the result section.

Ethical Consideration:

Before filling the questionnaire women will be also asked for consent.

RESULTS

Table 1. Demographic Characteristics of Respondents

	Pregnant Women		Lactating Women	
Demographic Characteristic	**N**	**%**	**N**	**%**
Village of pregnant women				
Bedwa	19	54.3	14	73.7
Rasnol	12	34.3	3	15.8
Sarsa	4	11.4	2	10.5
Education of respondent				
Non literate	3	8.6	8	42.1
Standard 1-4	1	2.9	4	21.1
Standard 5-8	14	40.0	5	26.3
Standard 9-10	7	20.0	1	5.3
Standard 11-12	8	22.9	1	5.3
College education (13-15 years)	2	5.7	0	0

Religion of the respondent				
Hindu	33	94.3	17	89.5
Christian	1	2.9	1	5.3
Muslim	1	2.9	1	5.3

Table 1 shows about the education, religion, and motherhood status of the respondents. There were 35 pregnant women and 19 lactating women in the respondents. Majority of pregnant women 54.3 % (n=19) and lactating women 73.7 % (14) are from Bedva whereas 34.3 % (12) pregnant women and 15% (3) lactating women are from Rasnol. Only 11.4 % (4) of pregnant women and 10.5% (2) of lactating women are from Sarsa.

Educational status of both pregnant and lactating respondents shows that majority are non literate where 40 % (14) of pregnant women were completed till middle school and only 22.9 % (8) completed till secondary school. Majority of lactating women 42.1 % (8) have completed their primary school and only 26.3 % (5) of them have completed their middle school.

Religion of the respondents shows that 94.3 % (33) of pregnant women and 89.5% (17) of lactating women were Hindu. Only 2.9 % (1) of pregnant women and 5.3 % (1) of lactating women were Christian where as 2.9 % (1) of pregnant women and 5.3 % (1) of actating women were Muslim.

Table 2. Economic status of the respondents

Economic status (Multiple Responses)	**Pregnant women**		**Lactating women**	
	N	**%**	**N**	**%**
Occupation				
Housewife	35	100.0	15	78.9
government employee	0	0.0	1	5.3
agricultural labour	2	5.7	4	21.1
cattle rearing	9	25.7	5	26.3
business(small shops, vendors)	0	0.0	0	0.0
work on family farm	1	2.9	1	5.3
daily wage labour	0	0.0	0	0.0
Earners in the family				
Male				

1	16	45.7	9	47.4
2	10	28.6	7	36.8
3	8	22.9	2	10.5
4	0	0	1	5.3
5	1	2.9	0	0
Female				
1	8	22.9	2	10.5
2	0	0	1	5.3
3	1	2.9	0	0

Table 2 shows about the Economic status of the respondents which includes occupation, earners and family income. Majority of pregnant women 100 % (35) and 78.9% (15) of lactating women were housewives. Around a quarter of the respondents, 25.7% (9) of pregnant women and 26.3 % (5) of lactating women said that they also engaged in cattle rearing.

In about 45% of the households of both category of the respondents there was only one male earning member and only 22.9 % (8) of the respondents among pregnant women and 10.5 % (2) of the respondents among lactating women have only one female earner in their family.

Table 3. Monthly family income of the respondents

Monthly family income	**Pregnant women**		**Lactating women**	
(in Rupees)	**N**	**%**	**N**	**%**
0-3333	14	40	9	47.4
3334-6666	17	48.5	6	31.5
6667-10000	4	11.5	4	21.1

Table 3 shows the monthly income of the family where 40% (14) among pregnant and 47.4% (9) lactating women earn up to Rs 3333 a month and only 11.5% (4) among pregnant women and 21.1% (4) among lactating women earn up to Rs 10000.

Obstetrics history of the respondents

Table 4. Age of pregnant respondent when she got married

Age of the respondent when she got married	**Pregnant women**	
Age ranges in years	**N**	**%**
Below 18	0	0
18 to < 20	16	45.7
20 -23	19	54.3

Table 4 shows age of the respondents when they got married. The age of marriage of pregnant women ranges from 18 to 23. There are 45.7% (16) who are in the category of teenage got married at the age <20. Whereas 54.3% (19) got married at the age ranges from 20-23 years of age.

Table 5.Age of lactating respondent when she got married

Age of the respondent when she got married	Lactating women	
Age ranges in years	**N**	**%**
Below 18	1	5.3
18 to < 20	7	36.9
20-24	11	57.8

In table 5 the age of the respondents ranges from 17- 24 years of age. There are 5.3% (1) of lactating women age 17 years got married before the legal minimum age of 18. Majority 57.8% (11) got married at the age of 20-24 whereas 36.9% (7) got married at the age 18 to <20 years.

Table 6. Age of pregnant respondent during first pregnancy

Age of the respondent during first pregnancy	Pregnant women	
Age ranges in years	**N**	**%**
Below 20	5	14.3
20-25	30	85.7

Table 6 shows the age of the respondents during their first pregnancy. The age at first pregnancy among pregnant women ranges from 19 to 25 years. There are 14.3% (5) who are in the category of teenage had their first pregnancy at the age < 20 and 85.7% (30) of the respondents had their first pregnancy at the age ranges 20-25.

Table 7. Age of Lactating respondent during first pregnancy

Age of the respondent during first pregnancy	Lactating women	
Age ranges in years	**N**	**%**
Below 20	4	21.1
20-25	14	73.7
26-28	1	5.3

Table 7 shows the age of the respondents during their first pregnancy. The age at first pregnancy among lactating women ranges from 18 to 28 years. There are 21.1% (4) who are in the category of teenage had their first pregnancy at the age < 20 and 73.7% (14) of the respondents had their first pregnancy at the age ranges from 20-25. Only 5.3% (1) of the respondents had their first pregnancy at the age ranges from 26-28 years of age.

Table 8. Age of the last born child

Age of last born child	Lactating women

Months	N	%
1.00	1	5.3
2.00	4	21.1
3.00	6	31.6
4.00	3	15.8
5.00	2	10.5
6.00	1	5.3
8.00	1	5.3
11.00	1	5.3

Table 8 shows the age of the last born child of the respondents which a ranges from 1 month to 11 month of age. Majority 31.6% (6) of the respondents' babies among lactating women were in their third month of age.

Table 9. Number of months in pregnancy

Number of months in pregnancy	Pregnant women	
	N	%
3.00	5	14.3
4.00	5	14.3
5.00	4	11.4
6.00	6	17.1
7.00	4	11.4
8.00	9	25.7
9.00	2	5.7

This table 9 shows the number of months in pregnancy among pregnant women. Majority 25.7 % (9) of the respondents were in their eight month of pregnancy.

Table 10. Obstetrics history of the respondents

Number of pregnancies	Pregnant women		Lactating women	
	N	%	N	%
1.00	22	62.9	3	15.8
2.00	6	17.1	8	42.1
3.00	5	14.3	6	31.6
4.00	2	5.7	1	5.3
5.00	0	0	1	5.3
number of miscarriages or abortion of the respondent				
1.00	2	5.7	1	5.3
number of live births				
1.00	4	11.4	5	26.3
2.00	6	17.1	8	42.1
3.00	1	2.9	4	21.1
5.00	0	0	1	5.3

Table 10 shows the number of pregnancies, number of miscarriages or abortion and number of live births of the respondents. Majority 62.9% (22) of pregnant women and 15.8% (3) actating women were in their first pregnancies only 5.7% (2) of pregnant women and 5.3% (1) of lactating women experienced miscarriages. 17.1 % (6) of pregnant women and Majority of 42.1 % (8) of lactating women have two live births.

Table 11. Number of days working after delivery

Number of days working after delivery	Lactating women	
	N	%
2.00	1	5.3
20.00	1	5.3
30.00	8	42.1
35.00	3	15.8
40.00	2	10.5
45.00	4	21.1

Table 11 shows the number of days women started working after delivery. Majority of the lactating women 42.1% (8) said that they started working after thirty days after the delivery .

Table 12. Kind of works (lactating)

Kind of works	N	%
Agricultural work	1	5.3
Animal rearing	1	5.3
Households animal rearing	1	5.3
Household works	15	78.9
Office work	1	5.3
Total	19	100.0

Table 12 shows kinds of workundertaken by the respondents. 78.9% (15) of them said that household chores were undertaken by them some days after delivering their babies.

Table 13. Ante-Natal Care (ANC)

Place registered for ANC	Pregnant women		Lactating women	
	N	%	N	%
SC	25	71.4	14	73.7
PHC	8	22.9	3	15.8
private hospital	1	2.9	0	0
anganwadi centre	1	2.9	0	0
CHC	0	0	2	10.5

Table 13 shows the place where the respondents registered for ANC. 71.4 % (25) of pregnant women and 73.7 % (14) of lactating women registered for ANC at Sub-Centre.

Table 14. Services received during ANC (Multiple responses)

Services received during ANC	Pregnant women		Lactating women	
	N	%	N	%
per abdomen examination	35	100.0	19	100.0
measure of weight	35	100.0	19	100.0
HIV testing	17	48.6	10	52.6
Malaria testing	2	5.7	1	5.3
HIV & Malaria testing	16	45.7	8	42.1
BP measurement	34	97.1	19	100.0
Counselling about pregnancy care	35	100.0	19	100.0
information about entitlements	35	100.0	19	100.0
nutritious supplements	35	100.0	19	100.0
height measurement	35	100.0	19	100.0
Hb examination	35	100.0	19	100.0
Urine examination	35	100.0	19	100.0
referral to other centre	35	100.0	18	94.7
counselling about nutrition	35	100.0	19	100.0

Table 14 shows the services received by the respondents during ANC. All the respondents among pregnant and lactating women received. Majority of the required services during ANC Only 45.7% (16) of pregnant women and 42% (8) of lactating women did HIV & Malaria testing during ANC.

Table 15. Measurement of Hemoglobin

Number of Hb checked during pregnancy	Pregnant women		Lactating women	
	N	%	N	%
Once	7	20.0	0	0
Twice	23	65.7	5	26.3
Thrice	5	14.3	11	57.9
More than 3 times	0	0	3	15.8
Total	35	100.0	19	100.0

Table 15 shows the place and number of times Hb was checked by the respondents during pregnancy. Majority 65.7 % (23) of pregnant women and only 26.3% (5) of lactating women have checked their Hb twice. 58% (11) of the respondents among lactating women and only 14.3% (5) of the respondents among pregnant women have checked their Hb thrice.

Table16. Place where Hb checked

Place Hb checked	Pregnant women		Lactating women	
	N	%	N	%
at home	0	0.0	0	0.0
at PHC	16	45.7	8	42.1
at Mamtadiwas/ VHND (SC)	28	80.0	17	89.5
at private clinic/laboratory	12	34.3	5	26.3
CHC	0	0	2	10.5

The above table 16 shows the place where the respondents checked their Hb. 80% (28) of pregnant women and 89.5% (17) of lactating women checked their Hb level at SC during Mamta diwas.

Table17. Hb level of pregnant respondents

Pregnant women	N*	%		N**	%
First time			Most recently		
Non anemia: (11g/dl or higher)	2	6		2	6.6
Mild: (10-10.9g/dl)	4	12.3		8	26.7
Moderate: 7-9.9g/dl	26	78.7		20	66.7
Severe: lower than 7g/dl	1	3		0	0

*N=33, **N=30

Looking at the Hb level of pregnant respondents in this table 17, majority of them are in anaemic category and only 6% (2) who test for the first time and 6.6% (2) who test most recently are non-anaemic.

Tables 18. Hb level of lactating respondents

Lactating women	First time		2nd time		Most recently	
	N#	%	N##	%	N*	%
Non anemia: (12g/dl or higher)	0	0	1	5.2	1	7.1
Mild: (11-11.9g/dl)	1	5.5	2	10.5	3	21.4
Moderate: (8-10.9g/dl)	15	83.3	15	78.9	10	71.4
Severe: lower than 8g/dl	2	11.1	1	5.2	0	0

#N=18, ##N=19, *N=14

Table 18 shows that majority of the respondents among lactating women are in the category of anaemic and only 5.2% (1) who test for second time and 7.1% (1) who test most recently are non-anaemic.

Table 19. Iron Folic Acid

Number of IFA taken during pregnancy	Pregnant women		Lactating women	
	N	%	N	%
less than 100	30	85.7	8	42.1
more than 100	5	14.3	11	57.9
Numbers of tablets taken after delivery				
5.00	0	0	2	10.5
10.00	0	0	2	10.5
20.00	0	0	1	5.3
30.00	0	0	6	31.6
60.00	0	0	3	15.8
90.00	0	0	1	5.3
100.00	0	0	1	5.3
0	0	0	3	15.8
number of months taking IFA				
	N	%	N	%
0	0	0	4	21.1
1.00	2	5.7	6	31.6
2.00	2	5.7	7	36.8
3.00	24	68.6	2	10.5
4.00	7	20.0	0	0
Month of pregnancy received IFA				
before 3 month	26	74.3	0	0
on the third month	4	11.4	0	0
four to six months	5	14.2	0	0

Table 19 show the number of IFA taken by the respondents during pregnancy and after delivery. Majority 85.7% (30) of pregnant women and 42.1% (8) of lactating women took less than 100 IFA during their pregnancy. There were 31.6% (6) of lactating women took 30 tablets after delivery their babies. 68.6% (24) of pregnant women received tablets for three months and 36.8% (7) of the respondents among lactating women received tablets for two months. Majority 74.3% (26) of the respondents among pregnant women received IFA before third month of their pregnancy.

Table 20.Number of months taking IFA after delivery

Lactating women	Frequency	Percent
Month started taken IFA after delivery		
1st month	11	57.8
2nd month	3	15.8
3rd month	1	53
15 days	1	5.3
Not taken	3	15.8

Numbers of tablets taken after delivery		
0	**3**	15.8
5.00	2	10.5
10.00	2	10.5
20.00	1	5.3
30.00	6	31.6
60.00	3	15.8
90.00	1	5.3
100.00	1	5.3

The above table 20 shows the number of months started taking tablets and numbers of tablets taken after delivery. Majority 57.8 % (11) of the respondents started taking tablets during their first month after delivery and majority 31.6% (6) of the respondents took 30 tablets after delivery their baby.

Dietary practices contribute in anemia prevention

Table 21. Place getting nutritional foods (Multiples responses)

Place getting nutritional foods	**Pregnant women**		**Lactating women**	
	N	**%**	**N**	**%**
Home	29	82.9	10	52.6
anganwadi centre	35	100.0	19	100.0
Market	0	0.0	1	5.3
PHC	1	2.9	0	0.0

Table 21 show the place where the respondents get their nutritional foods. There are 100% (35) among pregnant women and 100% (19) among lactating women received nutritional foods from Anganwadi centre and only 2.9% (1) among pregnant women are also getting food from PHC.

Table 22.Nutritional foods received from Anganwadi (Multiples responses)

Nutritional foods received from Anganwadi	**Pregnant women**		**Lactating women**	
	N	**%**	**N**	**%**
Upma	19	100.0	19	100.0
Sukhdi	19	100.0	19	100.0
Shiro	19	100.0	19	100.0

The above table 22 shows about nutritional foods received by the respondents from Anganwadi centre. 100% (35 +19) of the respondents among pregnant and lactating women received nutritional foods such as upma, sukhdi and shiro from Anganwadi centre.

Table 23. Animals that the respondents have at home (Multiples responses)

Animals have at home	Pregnant women		Lactating women	
	N	%	N	%
Goats	3	8.6	2	10.5
Hens	11	31.4	1	5.3
Cows	19	54.3	9	47.4
Buffaloes	22	62.9	11	57.9
Nothing	5	14.3	4	21.1

Table 23 shows what kind of animals the respondents have at home. Majority 63% (22) of pregnant women and 58% (11) lactating women have buffaloes at their homes.

Table24. Foods available at home (Multiples responses)

Foods available at home	Pregnant women		Lactating women	
	N	%	N	%
Fish	0	0.0	0	0.0
Eggs	9	25.7	10	52.6
Tomato	34	97.1	17	89.5
Lentils	33	94.3	19	100.0
Almond	8	22.9	5	26.3
Chickens	0	0.0	2	10.5
wheat flour	34	97.1	19	100.0
green leafy vegetable	27	77.1	16	84.2
Banana	29	82.9	17	89.5
Cabbage	27	77.1	13	68.4

The above table 24 shows what foods available at home of the respondents. 100% (35) of pregnant women have tomato and wheat flour apart from other food items available at home where as 100% (19) of lactating women have lentils and wheat flour apart from other food items available at home. None of all the respondents said that they have fish at home.

Table 25. Food consumed by the respondents (Multiples responses)

Food consumed	Pregnant women		Lactating women	
	N	%	N	%
Greenleaf	24	68.6	15	78.9
Chapatti	24	68.6	18	94.7
Nuts	4	11.4	4	21.1
Eggs	2	5.7	7	36.8
Rice	33	94.3	19	100.0
corn ruti	23	65.7	7	36.8

Milk	31	88.6	17	89.5
bajara ruti	26	74.3	17	89.5

Table 25 shows what food items the respondents consumed. 100% (19) of lactating women and 94.3% (33) of pregnant women mainly consuming rice apart from other food items they used to eat.

Table26. Certain foods that are not allowed to eat (Multiples responses)

Certain foods not allowed to eat	Pregnant women		Lactating women	
	N#	%	N*	%
green leafy vegetable	0	0.0	0	0.0
Chappati	0	0.0	0	0.0
Nuts	18	90.0	8	100.0
Eggs	9	45.0	0	0.0
Rice	0	0.0	0	0.0
corn ruti	0	0.0	1	12.5
Milk	0	0.0	0	0.0
Fruits	0	0.0	0	0.0

N=20, *N = 8

Table 26 talks about certain foods which the respondents are not allowed to eat. There were 100% (8) among lactating women and 90% (18) among pregnant women said that nuts are not allowed to eat whereas 45% (9) among pregnant women said that eggs are not allowed to eat and only 12.5% (1) among lactating women mentioned that corn ruti is not allowed to eat.

Table 27. Consumption of eggs

How often eating eggs	Pregnant women		Lactating women	
	N	%	N	%
once a week	4	11.4	6	31.6
twice a week	2	5.7	2	10.5
Every day	0	0	2	10.5
never eat	29	82.9	9	47.4

The above table 27 shows how often the respondents eat eggs. Majority 83% (29) of pregnant women and 47.4 % (9) of lactating women never eat eggs.

Table 28. Persons eat last at home

Persons eat last at home	Pregnant women		Lactating women	
	N	%	N	%
Persons eat last				
parents-in-law	3	8.6	3	15.8
Husband	7	20.0	1	5.3
Myself	6	17.1	0	0
Together	19	54.3	15	78.9
wait till family finished				
Yes	7	20.0	1	5.3
stop eating				
Yes	5	14.3	2	10.5

Table 28 shows persons who used to eat last at home, who wait till family finished and who stop eating if food gets over. Majority 54.3% (19) of pregnant women and 79% (15) of lactating women said that they used to finish their meal together with the family and only 17.1% (6) of the respondents among pregnant women said that they were the one who used to eat last. 20% (7) of pregnant women and 5.3% (1) of lactating women used to wait till their family finished their food. 14.3% (5) of among pregnant women and 10.5% (2) of lactating women said that they stop eating if food gets over.

Table 29.Knowledge level about Anemia

Understanding the meaning of anemia	Pregnant women		Lactatingwomen	
	N	%	N	%
lack of blood	33	94.3	18	94.7
do not know	2	5.7	1	5.3
Total	35	100.0	19	100.0

The above table shows the knowledge level about anaemia. 94.3% (33) of pregnant women and 94.7% (18) of lactating women understand the meaning of anemia. **Table 30. Knowledge level on the causes of anemia (Multiples responses)**

Causes of anemia	Pregnant women		Lactatingwomen	
	N	%	N	%
blood loss due to heavy menstruation	3	8.6	2	11.1
medical condition	1	2.9	0	0.0
regular blood donation	2	5.7	0	0.0
poor diet	30	85.7	18	94.7

excessive blood loss during child birth	10	28.6	3	16.7
loss blood during surgery	0	0.0	0	0.0

Table 30 shows the level knowledge of the respondents on causes of anemia. Majority 85.7% (30) of the respondents among pregnant and 94.7 % (18) among lactating women believed that poor diet is one of the causes of anemia whereas 28.6% (10) among pregnant women and 16.7% (3) among lactating women believed that excessive blood loss during child birth also is one of the causes on anemia.

Table 31. Signs and symptoms of anemia (Multiples responses)

Signs and symptoms of anemia	Pregnant women		Lactating women	
	N	%	N	%
tired and weakness	35	100.0	18	100.0
Dizziness	10	28.6	11	61.1

The above table 31 shows the level of understanding on what are signs and symptoms of anemia. There are 100% both among pregnant and lactating women know that tired and weakness are signs and symptoms of anaemia where as 61.1% (11) among lactating women and 28.6% (10) among pregnant women said that dizziness also is one of the signs and symptoms of anemia.

Table 32. How anaemia affect women's health (Multiples responses)

How anaemia affect women's health	Pregnant women		Lactating women	
	N	%	N	%
damage organs	4	11.8	3	16.7
affect fertility	33	97.1	17	94.4

This above table 32 shows how anaemia affects women's health. 97.1% (33) of pregnant women and 94.4% (17) of lactating women said that anaemia affects the fertility of a woman and only 11.8% (4) of pregnant women and 16.7% (3) of lactating women said that anemia damage the organs in the body.

Table 33. Months women need to check their Hb

Number of months	Pregnant women		Lactating women	
	N	%	N	%
3rd,7th & 9th	32	91.4	18	94.7
1st to 2nd month	3	8.6	1	5.3

Table 33 shows the number of months that the respondents feel they need to check their Hb. Majority 91.4% (32) of pregnant women and 94.7% (18) of lactating women knows that on the third, seventh and ninth month were the months that women need to check their Hb level.

Table 34. Opinion which foods help prevent anemia (Multiples responses)

Opinion which foods help prevent anemia	Pregnant women		Lactating women	
	N	%	N	%
Fish	4	11.4	6	31.6
Eggs	11	31.4	16	84.2
Tomato	34	97.1	15	78.9
Lentils	32	91.4	18	94.7
Almond	12	34.3	12	63.2
Chickens	2	5.7	6	31.6
wheat flour	32	91.4	15	78.9
green leafy vegetable	34	97.1	18	94.7
Banana	29	82.9	16	84.2
Cabbage	25	71.4	12	63.2
Don't know	0	0	1	5.3

Regarding the knowledge level on food items which prevent anemia the above table 34 shows that the highest response among pregnant women is 97.1% (34) saying that green leafy vegetables and tomato can prevent anaemia and 94.7% (18) among lactating women believed that lentils help prevent anemia where as only 5.3% (1) said don't know.

Table 35. Opinion what can do for anemia prevention (Multiples responses)

Opinion what can do for anemia prevention	Pregnant women		Lactating women	
	N	%	N	%
eat veg fruits lentils	35	100.0	17	89.5
eat medicines	33	94.3	10	52.6
consume IFA regularly	34	97.1	17	89.5
go to temple and pray	9	25.7	4	21.1
Don't know	0	0	2	10.5

The highest proportion of pregnant women in table were aware that adherence of eating vegetables, fruits and lentil 100% (35), having iron pills supplement 97.1% (34) and eat

medicines 94.3% (33) is necessary anemia prevention whereas only 25.7% (9) said that going to the temple and pray can also prevent anemia. Among lactating women 100% (19) believed that eating vegetables, fruits, lentils and consume tablets regularly will prevent from anemia. The least response 21.1% (4) is going to temple and pray can prevent from anemia. Only 10.5 (2) said they don't know.

Table 36. Food items that have high iron content (Multiples responses)

Food items that have high iron content	Pregnant women		Lactating women	
	N	%	N	%
green vegetable	35	100.0	19	100.0
corn ruti/chapatti	33	94.3	17	89.5
food eggs	15	42.9	18	94.7
Moongdal	34	97.1	19	100.0
food rice	31	88.6	16	84.2
food fish	7	20.0	12	63.2

Regarding the level of awareness on food items that have high iron content all pregnant women 100% (35) and all lactating women 100% (19) believed that green vegetables have high iron content. There are 100% (19) among lactating women said that moongdal is also one the food items that have high iron content.

DISCUSSION:

According to Gujarat Human Development Report, 2004 the Alma Atta conference,1978 accepted nutrition and health as fundamental rights of people and as national concerns in the developing countries. In India health is considered as the concern of state governments, though some health programmes are funded by the central government (Gujarat report,2004).

Nutrition is one of the main areas that the government of India concentrated because it is understood that nutrition focuses on how diseases, conditions and problems can be prevented or lessened with a healthy diet. A poor diet may have an injurious impact on health, causing deficiency diseases such as Aneamia. In order to tackle this problem many National Nutritional Programs such as Integrated Child & Development Scheme, Nutrition Advocacy and

Awareness General Programs for Food and Nutrition Board, Iron and Folic Acid Supplementation of Pregnant women, etc are implemented in many parts of India. In the study conducted shows that 100% of pregnant and lactating women get their nutritional foods from Anganwadi centre of which they also consumed them. Most of them also have animals like goats, cows, buffaloes, hen that they can get best sources for iron such as milk and eggs. In short, the study confirm that in spite of implementing Nutrition Programs, have animals at home yet malnutrition and lack of Iron folic acid is still the main problem which contributes to Anaemia.

In Gujarat Anaemia is one of major health problems, especially among women and children. (NFHS -3). The 2005-06 National Family Health Survey (NFHS-3) is the third in the NFHS series of Surveys. In Gujarat, NFHS-3 is based on a sample of 3,216 households that is representative at the state level and within the state at the urban and rural levels. The survey interviewed 3,729 women age 15-49 from all the sample households to obtain information on population, health, and nutrition in the state. More than half (55%) of women in Gujarat have anaemia. Since anemia is diagnosed by measuring the levels of haemoglobin in blood the study tried to adopt WHO (1968) judgement of Hb level. Looking at the study the prevalence of anemia in the study was high among pregnant and lactating women. Majority of pregnant women are in anaemic category and only 6% who test for the first time and 6.6% who test most recently are non-anaemic. Among lactating women majority of them are in the category of anaemic and only 5.2% who test for second time and 7.1% who test most recently are non-anaemic.

In the report of NFHS 3 the median age at first marriage among women in Gujarat is 18 years among women age 20-49 years, Almost two-fifth (39%) of women got married before the legal minimum age of 18. Among young women age 15-19, 13% have already begun childbearing, Young women in rural areas (16%) are more than twice as likely to be mothers as young women in urban areas (7%). In contrast to the study only 5% of the respondents among lactating women married at the age of 17 which is not the legal age for marriage. 14% among Pregnant and 21% among lactating women had their first pregnancy at the age below 20 years which is considered high risk for their health as well was for their child's health. There are78 % rural mothers received antenatal care from a health professional during their pregnancy and for their last birth (NFHS- 3). Looking the NFHS 3 it is understood that there is utilisation of ANC before but

when comparing with the study visiting and utilisation of ANC increased after NRHM came into existence especially after the implementation of VHND.

In the study, majority of pregnant and lactating women received ANC services which reach 100% in almost of the ANC services provided. This shows that Ante-Natal Care provided during VHND improved in a massive way. Looking at individual characteristics of some women like age and education there have been found out that these characteristics make a significant impact on obstetric health care seeking behaviour and also facilitates utilisation of public health facilities for complete health care of both women and children.

In India rules applied to nutrition of women are often related to the reproductive cycle such as pregnancy and lactation are periods in which food taboos are very common .There are some areas where there is a belief that a woman who was just delivered a baby should not eat certain foods such as eat rice or chappaty with a water curry makes a woman weak and anemic. Of course there are certain foods that cannot be eaten because of diseases such as too much salt is not good for people with high blood pressure or too much greasy food, hot spices can make stomach ulcer and so on (Werner 1943). Similarly, eggs should be avoided because the child would be born bald. Customs and practices with regard to the quality of food intake have been reported in literature (Hutter).

In the study pregnant and lactating women are having harmful ideas about diet; they are not eating certain foods like eggs and nuts saying that if they eat they will have diarrhoea. 83% pregnant women and 47% lactating women never eat eggs as eggs are considered as non-vegetable.94% pregnant women and 89% of lactating women are from Hindu background so Non-vegetable items are never consumed. Even though 26% of pregnant and 53% of lactating women have eggs at home they will not consume rather sell out those eggs in the market. Foods available at home of these women should be consumed regularly like eggs, nuts for anaemia prevention as they are the best source of iron and protein.

During pregnancy or breast feeding a woman requires various nutritional food items so that she and her baby will grow strong and healthy. A new mother should eat lots of body-building foods like lentils, various kinds of beans, vegetables, eggs, chickens, rice, flour, milk products, meat, fish, fruits and All these foods are not harmful; all bring better health instead (Werner, 1943). The mother's diet should have a combination of body building and high-energy foods (oils and fatty food) not just rice or chappaties because fats also are used to make more milk while a woman is breast-feeding. If the mother gets enough nutritious food during pregnancy

and lactating she and her baby will grow strong and healthy. Majority of pregnant and lactating women of those villages carry out agricultural and other jobs in addition to household jobs. If these physical tasks are taken into account the energy deficit in the diet of these women should be high.

RECOMMENDATION

- Most of those women were taking IFA less than 100 tablets. Taking IFA regularly along with the motivation and encouragement on kitchen garden will be more effective in perverting anemia
- There is a need to educate women about dietary supplement based on locally available foods can bridge the gap to a large extend.
- Determining food intake during pregnancy and lactation due to cultural and religious factors might be important food items for both the mother and the child. Diet of most of those women lack many kinds of other nutrients. Thus, using home iron sources (green leafy vegetables, sprouts, chickens, Fish) will help preventing anemia.
- Some of those women have constraints on food intake; few of them used to either stop eating or start eating the leftover food only after their family members have finished their meals. It is more effective if they are sensitised to prepare enough food for everybody at home or to cook again or to get food from Anganwadi centre.
- Malaria blood test is one of the services that those women received. But it seems that very few of them get themselves tested for malaria as they had to go to Sub-centre and PHC. It will be more effective if malaria testing could be done at Anganwadi centres.
- Nutritional goals in Gujarat is Reduction of iron deficiency anaemia in pregnant and lactating women from existing 50% (estimated) to less than 10% by 2000. In order to eliminate the problem, Health care services and distribution of nutritional food at health centres during VHND needs to be continued and promoted up to the extent that the nation is free from anemia.
- It is necessary to carry out further studies especially on the factors or reasons why pregnant and lactating women are anaemic in spite of receiving regular health care services and nutritional food during VHND.

CONCLUSION

Anemia during pregnancy is associated with multiple outcomes for both mother and infant. Adequate nutrition and taking regular IFA tablets is a vital need for everyone especially for pregnant and lactating women who are more prone to malnutrition that leads to anemia. The study focuses on the dietary practices and Ante-natal care among pregnant and lactating women so that haemoglobin level will be determined for their anemia status. According to the study findings, most of women are anaemic, therefore women are needed to be sensitised to be more nutrition conscious and to have a heath seeking behaviour.

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PART C

VILLAGE HEALTH AND NUTRITION DAY: OBSERVATIONS AND REFLECTIONS FROM EXPERIENCES IN GUJARAT

Scope of the report:

As an intern I had an opportunity to go to the villages named Ruparel, Baria block , Dahod district, Khanpur, Anand block, Anand district and Jabuvania, Ghogamba block, Panchmahal district to observe Village Health and Nutrition Days (VHNDs) together with the staff and field workers of Society for Health Alternatives (SAHAJ), Anandi and Prerna Organisations. This report will cover the observations and reflections from these experiences and the relevance of this to health systems in Meghalaya.

Background:

Maternal Mortality Rate and Infant Mortality Rate in particular, are problematically high in many places in India. The National Rural Health Mission which was launched on 12th April 2005, approved in July 2006 and fully operationalised in 2007-2008 marked an attempt to remedy the situation as regards quality of care in public health care facilities. But the aim of the government today is not just focusing in public facilities only but also beyond the facilities that is to provide universal access to health care. Therefore mission and vision of NRHM seeks to provide accessible, affordable, quality health and envisaged provision of effective health care to rural population throughout the country. In order to bring successful results NRHM focuses also on decentralisation and communitisation where outreach approach, an effective measure is applied to boost coverage of core maternal and child health interventions. In accordance with NRHM's goal, the goal of the State Health Mission, Gujarat also is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children in the state.

In Gujarat, the NRHM which is national program implemented health activities/ programs through the State Health and Family Welfare Dept. The Village Health Sanitation & Nutrition Committees (VHSNC) set up at the village level under the NRHM have been known to carry out activities, such as Sanitation drives and VHND. VHND also called Mamta Diwas' is one of the outreach approaches of the Indian government as well as the government of Gujarat which could help boost coverage by increasing coverage of basic health and nutrition services and by bringing services closer to communities. Importantly, it provides the first point of contact for essential primary health care. The main objective of VHND is to provide essential and comprehensive health & nutrition services to pregnant & lactating women, children (below 6 yrs) and adolescent girls.

VHND is conducted usually at Anganwadi centre or other suitable location once a month preferably mainly on Wednesdays which will ensure uniformity in organizing the VHND. Under this initiative, basic components of primary healthcare services provided by ANM, Male worker, ASHA and Anganwadi worker & helper to pregnant women, lactating mothers, adolescent girls and children under-five years of age include registration, counselling (breastfeeding, nutrition, hygiene, entitlements, etc), blood testing, distribution of IFA and supplementary food, identification and referral of high risk cases of children and pregnant women, as well as basic ANC and PNC. Apart from these above services, Mamta cards also

are provided to women so that they will know their own health status and it is easy to health workers to cross check women's health such as Blood pressure, weight, anemia status and referrals during complications.

Roles of Non-Government Organisations:

Communitisation is one of the pillars that bring positive changes in health status of the people. According to National Health Mission, NGOs and other civil societies have a great role to play in order to facilitate community based monitoring. Their main roles are to be as members of monitoring committees, as resource groups for capacity building and facilitation; and as agencies helping to carry out independent collection of information. During my internship period at SAHAJ and Anandi, Non- Government Agencies expands their services in monitoring of VHND with regular observation and on-site supervision. As part of the project titled 'Enabling Community Action for Maternal Health' funded by MacArthur Foundation, SAHAJ involved in observing VHND day for monitoring the quality of Maternal health Care in three districts of Dahod, Panchmahals and Anand. To monitor and evaluate the quality of services provided during VHND a certain Checklist was followed which is adopted from the Guidelines for Community Processes" introduced by the NRHM. Using checklist will enable to find out the gaps and achievements. This check list can be used by the community to dialogue with the health system sthat there is improvement in services It also enables the operationalization of NRHM's vision that the frontline workers and VHSNC are part of a continuum to strengthen community engagement for health and social determinants.

Objectives of the report

- Provide an account of the experience of VHND in three villages in Gujarat
- Reflect about the relevance and impact in Gujarat
- Reflect about the relevance to the state of Meghalaya

Methodology

- Experience of VHND was captured through: interactions, checklists, and observation
- Reflection was done through SWOC

<u>Case study of the VHND in Gujarat:</u>

Why VHNDs observations conducted in Dahod, Anand and Panchmahal districts.

VHNDs were implemented after the inception of NRHM but according to the situation analysis report regarding condition of maternal health in these districts especially in Panchmahal and Dahod districts are one of those backward areas where government's health services are very poor and irregular.

The report said that in villages, 'Mamta Divas' is not being conducted in a regular manner and no guidelines are being followed when it is carried out at all, e.g. A pregnant female is never examined as far as her HB, urine and height are concerned. At present, supply of BCG's and TT's vaccines is never adequate in stock at 'Anganwadis'. As a result kids and pregnant women

have to leave without getting their vaccinations done. BP checkups not so regular because measuring instrument is not working, PHC is far from the village and doctors are mostly found absent therein, because of this situation villagers normally have to leave without meeting doctors. Doctors normally explained such situation to be a result of work overload on them as they have been assigned 2 to 3 PHCs per doctor along with the load of administrative work because of which they are unable to provide sufficient time to each PHC. In absence of doctors, patients from nearby villages are compelled to visit private facilities. Moreover medicines and ivies are being sold at government clinic. If a group of people protests this practice, situation seems to get better for few days and then it gets back to its normal course of action again. No staff can be found till 12 noon in primary health centers which are supposed to stay open for 24 hours. Thus is absence of the doctor and staff members, patients are left with no option but to visit the private clinics.

Looking at the analysis, it is felt that there is a need to observe VHNDs in some villages under these mentioned districts so that gaps and achievements will be identified and what action should be taken for improvement. As part of this observation, I did an observation during VHND in three villages mentioned earlier. Certain objectives of the field visits during VHNDs are: To identify the quality of service package provided on VHND, to examine the role coordination between health workers during VHND and to observe the level of participation of beneficiaries.

Report of what observed during VHND:

Checklist is used during the observations of VHNDs (refer annexure). The observations were done in three villages, i.e., Ruparel, Khanpur & Jabuvania where staff and field workers of NGOs played a vital role in translating the information gathered from Mamta diwas.

The followings are the parameters/services provided during VHNDs:

1. Presence of health workers during VHND:

    a) According to the checklist ANM, ASHA, Anganwadi worker & helper are frontline health workers that should present during VHND. During observations all these health workers were available in all three centres.
    b) In sub- centre, apart from these health workers mentioned there were additional health providers such as Doctor, Male health worker, Female health worker, ASHA supervisor were also available during Mamta diwas.
    c) Venue: Ruparel Anganwadi centre, Khanpur Sub-centre and Jabuvania Anganwadi centre.

Day: Wednesdays in all the three centres

Services delivery and roles done by ANM during VHNDs in these villages are:

a) ANC checkups
b) Tetanus toxoid injection was given only in Khanpur
c) Blood pressure was measured only in Ruparel & Khanpur where in Jabuvania No BP measurement (as no blood pressure monitor available).
d) Weighing of pregnant women, blood test was supposed to do by ANM but in these 3 centres ANM did not measure weight those women
e) Blood test for anaemia using Haemoglobinometer done only in Khanpur by Male health worker not by ANM. In Ruparel Hemoglobinometer is available but no blood test. In Jabuvania only malaria blood test was done by ANM
f) Abdomen examination done by only in Khanpur, no bed and no separate room in Jabuvania and Ruparel.
g) Counselling on diet, rest and for institutional delivery in Ruparel and in Jabuvania. In Khanpur counselling did by FHW.
h) Danger signs such as swelling in whole body, blurring of vision, severe headeache were supposed to inquire by the ANM, unfortunately there was no inquiry about danger signs in all the three VHNDs.
i) Vaccination provided to children only in Jabuvania and Khanpur.
j) In all the three centres ANM provides medicines for common illness to those who come during VHND.
k) In Khanpur ANM referred a pregnant woman to Management Information System because her Hb level is low (8g/dl) and also referred a child with severe malnutrition. In brief, this MIS which is in CHC is where people get information about Village Child Nutrition Centre.
l) Prescribed IFA tablets to pregnant, lactating women and even to Adolescent girls. IFA available in all the centres

Services provided by ASHA

a) ASHAs of all three villages did help both ANM and AWW in organising the Mamta diwas
b) Only in Khanpur ASHAs motivated most of the beneficiaries to attend VHND
c) In Jabuvania and Ruparel ASHA did additional work by helping ANM in providing counselling on diet, rest, hygiene, family planning.
d) Extra work inWeighing of pregnant women and children below 5 years with AWW & helper.
e) Extra work in measuring of BP with ANM

Services provided by AWW & helper

a) Provided supplementary foods in Ruparel only
b) Distributions of take –home- rations were done in Jabuvania and Ruparel
c) Weighing of pregnant women and children below 6 years

Performance by other Health workers during VHND (sub-centre):

a) Male health worker did Blood test for anaemia using Haemoglobinometer
a) Female health worker did counselling on diet, rest, hygiene, entitlements, family planning, institution delivery given to pregnant &lactating women even to adolescent girls
b) ASHAs's Supervisor helped ANM in keeping the records in the register

Whom to share the gaps with?

SAHAJ in collaboration with partner NGOs such as Anandi contribute to the collection of information relevant to the monitoring process of child and maternal health in those rural areas by observing the quality of health care during VHNDs. In spite of organising these VHNDs regularly yet there are gaps in delivering services. Based on observations of the VHND the organisations shared the gaps with the health system but now that a check list has been prepared, they plan to share the gaps with both the health system and the community systematically based on evidence.

Action taken?

As per the follow up conversation with SAHAJ staff, some actions have been taken in some areas. Anandi, a co-partner agency of SAHAJ was constantly in dialogue with the Medical officers, in many Anganwadis, weighing machine has been brought where there were none, BP machines have been repaired or replaced, and cheques for entitlements are being issued to women. This is a continuous process- recently many women had not opened their bank accounts and their cheques(dated 6 months to one year back)were not deposited. So, Anandi is now trying to get their accounts opened.

Reflection on observation at the three villages:

- Before the programme begun, ANM & AWW made ready and arranged everything in place. This is very appreciative.

- VHND are observed on Wednesdays once a month. This is very good plan, no need for health workers to remind people again and again to come on this day, people remember the day for VHND. When interacting with ASHAs they proudly said that they don't need to inform the beneficiaries a day before about the date of VHND, they know and remember when to come for Mamta diwas.

- Role coordination between/among among health workers (ASHA, AWW, ANM) is highly appreciated, there was really a good coordination especially between frontline workers in all the three centres.

- Overall attendance during Mamta diwas was good but observing the attendance of women who registered for ANC is low comparing to the total number and the number of attending for ANC. In Khanpur the total ANC women registered was 32 and total ANC women attended was only 7, in Ruparel total registered was 14 and total attended was only 7 and in Jabuvania total registered was 10 and none attended for ANC. As told by the ANM and ASHA, the main reason is because women are still celebrating their Holi. During Festive seasons women hardly come to the centre. I personally feel that arrangement of vehicle from PHC/CHC level during VHND day, which means VHND that happened during festive period only will perhaps helpful to those women who need to come to the centre spending sometimes for services than not coming at all.

- In Jabuvania all lactating mothers who came on this day were given new Mamta cards. The reason is that Mamta cards were not available since April 2013, they got this month (March) only. Government's fault needs to address in a serious manner as it is a matter of life and death of pregnant women.

- In Khanpur, provision of nutritional supplement distributions were not available as part of the VHND service because Mamta diwas was conducted in Sub-centre where only health care services will be provided, not food. After having an interaction with one of the ASHAs it was understood that food never distributing in sub-centre, women should go to Anganwadi for supplementary foods any day they feel like.

- In Ruparel, the quality of supplementary food distributed on this day was only puri which I personally felt that its quality is not that good; there were no other nutritional food items available.

- In Jabuvania Things provided by the governments are only rations, oil and small amount of salt but most of the things such as weighing machining (adult),medicines (paracetamol, cough syrup, ORS, Zinc tablets),etc provided by Village Health Committee. If the govt can extend its service up to the mark that all the basic needs (water, BP measurement, scale for height, bed & separate room for abdominal examination, etc) are availed regularly and extensively in each and every Anganwadi centre there is no doubt that half of the problems in the community will be solved.

- In Khanpur, the doctor was available at the centre but his role in this event was remained unclear, as it appeared that he didn't do any checkups or interact with those

women who came on that day. In Khanpur there was a mixing of roles by health workers which is not according to the check list e.g FHW played the role of ANM in counselling and in giving information about schemes and so on. In fact there was no shortage of human resources, there was a mutual understanding among themselves that they can play their own role and also they can help each other according to their own capacity. Another example is that the ASHAs' supervisor helped ANM in keeping records on that day where in Ruparel for example was done by ANM. Personally I feel that mixing of roles with no negative consequence is useful because as in the case at Khanpur ANM had to provide medicines, did ANC check up, gave injections, etc and if she had to keep records or give counselling I believed that she will not be able to finish everything on time.

Reflecting those VHND observations there are of course some differences between the services provided at Anganwadi centres and in Sub-centres. Sub-centres are far better in having facilities, infrastructures and giving services to women, children and adolescents. For example, in Khanpur there are two rooms, bed for abdominal check up where as in Ruparel and in Jabuvania there is only one room, in Ruparel bed is used for displaying medicines and other stuff. In sub-centre there are buckets for waste and syringes destroyers to destroy all syringes used. In Anganwadi centres such as in Jabuvania there is no measuring scale for height and no weighing machine for infants, infants had to measure altogether with the mother. Again when we think about nutrition Anganwadi centres are better place to conduct VHND because those who come on this day will get both nutrition and health care services.

Eventhough the observation was done only to three centres yet I can see a positive impact in the life of people there. Mamta diwas has been an effective way in reaching out to the people in those three villages to bring about the much needed behavioural changes which is from not taking IFA to consuming IFA or taking TT injections for instance. During the observation there was a health seeking behaviour among women because on those VHNDs women came along with their children, with their mothers and even with their husbands.

As per the information got from some of the health workers saying that there are some families have one meal a day but due to Mamta diwas those families could have two supplementary meals a day. Regarding institutional delivery, health workers said that women now starting coming out to deliver in hospitals due to awareness they got from ASHA & ANM during Mamta diwas. Thus there is no doubt to say that Mamta diwas has a positive impact in the community's life which in later life will lead to a better health outcomes.

Summary of SWOC analysis:

Strengths:

1. Availability of of mamta cards
2. Organised VHND on a fixed day
3. Good coordination among health providers
4. Distribution of IFA

Weaknesses:

1. Low awareness on entitlements (JSY/ JSSK,etc)
2. Wasting of human resource
3. Poor allotment of responsibilities
4. Provided health care without nutritional foods
5. Poor provision of facilities and adequate infrastructure (water, bed, number of rooms, etc)

Opportunities:

1. Integration with ICDS for supplementary food
2. Collaboration with NGOs in monitoring the quality of care using checklist
3. Support from Village health committee
4. Linkages with health providers of public health system
5. Networking with MIS at CHC for referrals

Challenges/Threats:

1. Non availability of certain equipments (measuring scale &weighing machines)
2. Poor quality of supplementary food
3. Poor attendance for ANC
4. Young age for pregnancy and lactation
5. No enquiry about danger signs

My overall reflection: Relevance to Meghalaya

Health status of women and children is still low in our country of which Anemia is one of the problems faced by all the states of India including Meghalaya not only Gujarat. Reflecting from the observation of VHND I would like to mention that most of women and children are anaemic. Since this problem can be prevented it is good perhaps if health workers spend more time in counselling about proper diet and discussing in utilising of resources (e.g vegetables) available locally not just providing them IFA tablets. It will also be prevented if nutritious foods are distributed both at Anganwadi centres and in sub-centres because in sub-centre food was not provided. In addition, I would like to think in a way that giving awareness on taking tablets is so important because providing repeated information makes them relate the tablets with the purpose. As per interaction with health workers another factor which contributes to anemia might be the age of those women who came for services because majority of them are in the age of 18 – 23 which is still considered as vulnerable age for pregnancy and lactation.

Regarding the food items and home rations distributed at anganwadi centres were according to the food that local people used to eat, it happens and applies in Meghalaya also where at present rice which is a staple food of local people is distributed, this is appreciated. But the only problem is that at Anganwadi centres there is no store room to keep all the food items. As per my experiences in visiting few Anganwadi centres in Tamil Nadu, Karnataka, Gujarat and Meghalaya I would say that none of Anganwadis in these mentioned states have store room or store house, foods get rotten easily especially in hot places. Another important thing which was observed was that in Anganwadi centres there is no separate room for ANC checkups or any partition of rooms for that matter. If the government wants that every state in India is free of malnutrition and ill health, sanctioning of building of Store room for food items and a separate room for ANC check up needs to be done with great responsibility. Information, Education and Communication (IEC) materials in local languages are very helpful in educating and providing information to women. It is commendable to say that most of health centres especially Anganwadis and Sub-centre in those villages as well as in Meghalaya are lacking in providing IEC materials to those concern people who need to understand the whole process of health care services providing to them. In spite of having weaknesses the government can still improve a lot of things and one of its strategies could be developing and providing more IEC materials such as in sub-centre and Anganwadis for the effectiveness of services especially for the behavioural changes among those target groups.

Reflecting about the doctor who was not playing any roles, one question that crosses my mind is why human resource is wasted? According to my experiences in other parts of Gujarat doctors are the main persons in delivering health care services, they even do counselling as well. In fact in India the major problem in Public health facilities is shortage of medical professionals. It is important therefore that this small but important issue should be analysed and rethink properly not only in this particular public health system (Khanpur SC) but also to other Public health systems in Gujarat, Meghalaya and in all other states of India.

The government of India wants to strengthen institution delivery. Therefore Janani Shishu Suraksha Karyakram (JSSK) & Janani Suraksha Yojana (JSY) are the schemes/ entitlements that were introduced for the welfare of the people. JSSK is an initiative of Govt. of India & Govt. of Gujarat to assure completely free and cashless services to pregnant women including normal deliveries and caesarean operations and sick Infants (up to 1 year after birth) in Government health institutions. This scheme is for all pregnant women. JSY is a safe motherhood intervention. The objective is to promote institutional delivery among the poor pregnant women. The Scheme has contributed immensely in increasing the Institutional deliveries among the BPL, ST and SC population. According to the observation, some women in sub-centre were informed about JSY but not JSSK. Some of them they don't even aware of what these schemes meant for. If pregnant women were not informed about entitlements definitely there will be less number of pregnant women who would opt for institutional delivery.

Out of pocket expenses in health care are the main challenges especially in the state like Meghalaya where Public health systems are low in performance and where various schemes and entitlements are not properly utilised. Therefore implementation of entitlements which aimed at mitigating the burden of out of pocket expenses incurred by pregnant women and sick newborns will be a major factor in enhancing access to public health institutions and help bring down the MMR and IMR. In order to reach out to people who need these schemes, VHND is the main platform in giving awareness on these entitlements for institution delivery because besides financial benefits they get, women can also be assured of preventing complications that can arise later

Experiencing VHNDs in Gujarat brought lots of insights realising that On the VHND, the villagers can interact freely with the health personnel and obtain basic services and information. They can also learn about the preventive and promotive aspects of health care, which will encourage them to seek health care at proper facilities. Since the VHND is being held at a site very close to their habitation, the villagers will not have to spend money or time on travel which is more or less to say health services is provided at their doorstep. The Village Health Committee such as in Jabuvania and VHSNC in other state of India comprising the ASHA, the AWW, the ANM, and the PRI representatives, if fully involved in organizing the event, can bring about dramatic changes in the way that people perceive health and health care practicesThere was a realisation from those observations made at those three villages that Anganwadi centres are the main and nearest centre that people can access health care services and get supplementary foods. In Meghalaya, since 1975 the Integrated Child Development Services program was implemented to combat malnutrition and to provide basic health care and Anganwadis are as part of the ICDS and as part of the Indian public health-care system. In Gujarat also ICDS plays a very important role in providing supplementary and nutritional foods at Anganwadi centres during VHNDs.

Analysing and commenting at organising of VHNDs, Gujarat is far ahead than Meghalaya since the inception of NRHM. As per the outcome of mission of Meghalaya ANC coverage is just 68%; about one-third of women received no antenatal care. In 2008-09 IMR is 58. Instead of declining it is getting increased in each year, which shows the measures taken is not effective in the grass root level. Moreover accessibility to Sub-centre where it is considered as primary

contact for health care is the challenge due to distance and lack of transportation because of difficult tarrain, costs because of distance. Therefore it is felt thatthe idea of conducting of Mamta diwas needs to be applied and strengthened in Meghalaya as well especially in all 3864 (as in 2010) existing Anganwadi centres of the state where ASHAs and Angawadi workers will be the main frontline health workers at Anganwadis especially during VHNDs.Even though India is suffering from a shortage of skilled medical professional yet when it comes to grass root level an Anganwadi worker and ASHA are also skilful in tackling some health issues, they even better equipped than professional doctors in many ways especially in reaching out to the local population, since the workers live with the people they are in a better position to identify the cause of the various health problems and hence counter them.

Reflection on methodology:

Interaction with health workers was one of the methods used during the VHNDs. It is immensely important for gathering maximum information but unfortunately there was no interaction with women and adolescent girls who attended this programme. The main reason was language barrier. Apart from observation of what is happening during the day, translation is needed (English to Gujarati for women and Gujarati to English for me). The field workers find difficult to help two tasks at a time, i.e., translating on what things happened during service delivery and translating of what those women have to say. In spite of having this barrier, observation was done successfully. In effect, there is scope for additional observations and interactions to enquire about the perceptions of the beneficiaries of the program. That will help get a more holistic understanding of the value of the program and associated challenges.

CONCLUSION:

Organising VHND raises nutrition and health consciousness among women who are living in rural areas and prevents both women and children from any sickness which leads to serious illness and even death. In conclusion, although VHND services take place regularly and health seeking behaviour from women's was good; there is still a long way to deliver truly convergent service and efforts should be made at policy level and sufficient resources allotted to deliver more and better services through VHND program.

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Annexure - II: Checklist for Village Health Nutrition Day

Name of block:_____

Name of PHC: _____

Name of Subcentre: _____

Name of village: _____

Sl. No.	Parameters	Assessment- Yes/No/Partial/NA- Not Applicable	Remarks
	Presence of Health Workers During VHND		
1	Was ANM present during VHND?		
2	Was ASHA present during VHND?		
3	Was AWW present during VHND?		
	Services Delivery During VHNDs by ANM		
1	Was ANM doing ANC check- up of pregnant women?		
2	What components of ANC were being provided?		
i	Tetanus toxoid injections		
ii	Blood pressure measurement		
iii	Weighing of pregnant women		
iv	Blood test for anaemia using Haemoglobinometer		
v	Examination of abdomen		
vi	Counselling of appropriate diet and rest		
vii	Inquiring about any danger signs like – swelling in whole body, blurring of vision and severe headache or fever with chills etc.		
viii	Counselling for institutional delivery		
3	Was ANM providing vaccination to children?		
4	Did she also provide medicine or referral in case of any sickness of any child below 2 years of age ?		
	Services Provided by AWW During VHND		
1	Was AWW weighing all the children of 0-6 years of age?		
2	Was AWW weighing the children correctly?		
3	Did AWW record the weight on the growth monitoring card correctly?		
4	Did AWW give take home rations to children 6months – 6 years of age?		
5	Did AWW give take home rations to adolescent girls?		

Sl. No.	Parameters	Assessment- Yes/No/Partial/NA- Not Applicable	Remarks
6	Did AWW give take home rations to pregnant women?		
7	Did AWW give take home rations to lactating mothers?		
	Quality of Services Delivered During VHND		
1	Weighing machine of ANM was in order		
2	Weighing machine of AWW was in order		
3	Thermometer was working accurately		
4	BP apparatus was working accurately		
5	Supplementary food was available		
6	Quality of supplementary food was good		
	Roles Played by ASHA		
1	Did ASHA make a list of potential beneficiaries who need either ANM or AWW services?		
2	Was ASHA able to motivate most (>75%) of the beneficiaries to attend VHND?		
3	Did she inform the beneficiaries atleast a day before about the date of VHND?		
4	Did she help ANM or AWW in organizing the VHND?		
	General Questions		
1	What was the venue of the VHND		
i	Anganwadi centre		
ii	Sub centre		
iii	Panchayat hall		
iv	Some other – open venue		
2	Was VHND held on a fixed date every month?		