

Original Research Article

A Survey Report on Maternal and Child Health Status under Swa- Prerit Adarsh Gram Yojana in Budhera Village, Gurugram, Haryana

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ABSTRACT

Swa- Prerit Adrash Gram Yojana has been pioneered and implemented by Department of Community Medicine under which Budhera village has been adopted for health care activities by SGT University, Gurgaon. The Sansad Adarsh Gram Yojna (SAGY) has been launched by the Govt of India on 11th oct 2014 lays stress on their holistic development. It puts equal emphases on social, human and economic development. This scheme has been recently supplemented by Vidhayak Adarsh Gram Yojna (VAGY) by the Govt of Haryana. The state now expects the Corporate Houses, Companies, Corporations, Boards, Trusts and the NGO's to come forward for adopting Gram Panchayats for converting them into Adarsh grams. Thus SGT University has adopted Budhera village in district Gurgaon under this scheme Swa Prerit Adarsh Gram Yojna.

The Objectives:

- 1) Promote Maternal Health
- 2) Immunization:
- 3) Promote Child feeding Practices:
- 4) Promote Adolescent Health:
- 5) Reducing risk behaviours (Alcoholism, smoking, substance abuse) among all age groups
- 6) To provide basic health services at their doorstep
- 7) Identify chronic diseases and disabilities among the villagers and advise them accordingly

Material & methods:

Descriptive Research design was used for the survey. The survey was conducted at Budhera village, Gurugram, Haryana. A total of 750 houses were covered and data was collected through a structured questionnaire. The research tool consists of a questionnaire which includes socio demographic profile of family, various aspects of maternal and child health including the child feeding practices, other medical conditions and diet pattern in the family.

Results:

The results shows that out of the total eligible population 70% of antenatal mothers received TT vaccination while 30% did not received any vaccination, 84% of mother received IFA during their pregnant state while 16% did not received IFA, 81% opted for the institutional deliveries, 19 % were home deliveries. Out of total 84% mothers delivered an alive baby while 16% cases were either still birth or aborted.

Key Words: Swa- Prerit Adrash Gram Yojana, Vidhayak Adarsh Gram Yojna (VAGY), Sansad Adarsh Gram Yojna (SAGY), Maternal and Child Health.

INTRODUCTION

In many parts of the developing world, rural health presents particular challenges that require focused policy

attention. Rural areas are often characterized by worse population health outcomes and more difficult access to health care. In South Africa for example, the ten districts with the

highest (material and social) deprivation indices are rural. Contributing factors include poverty and lower education levels, limited services, geographic isolation and long distances to health services, as well as too few and under-resourced health facilities. A key concern remains that policies based on best practices for larger metropolitan centers are not always effective when implemented in rural contexts. Understanding and addressing the particular health needs of rural areas requires, among other things, access to reliable and representative health data specific to these contexts. However, conducting health survey research in remote rural areas comes with its own set of unique hurdles. In effect, the on-the-ground reality of conducting field research can be challenging in all settings, particularly in resource-scarce areas of the developing world. However, working in isolated rural areas may be especially daunting, as a result of factors such as relative geographic isolation, limited services and distrust of outsiders. Unless addressed effectively, challenges that arise during the course of field research may threaten to delay and even jeopardize the overall success of data collection. ^[1] Yet, despite a growing appreciation of the value of cross-country collaborative health research between practitioners and academic departments, and the usefulness of documenting its challenges and lessons learnt it is surprising how little published material health researchers will find, based on on-the-ground field experiences, to assist in informing and guiding their fieldwork plans and processes. ^[2] In present survey, we describe the phase I and planning and decisions made, the difficulties encountered in trying to implement these and the strategies we adopted to respond to these difficulties and also the activities planned for the phase II. We conclude by reflecting on the observed outcomes of strategies adopted, as well as lessons learned that may be of value in informing future rural health field research

and the proposed interventions for the phase II.

The aim of the field research was to collect data on the health issues specifically the maternal and child health issues, experienced by the people living in Budhera village and utilization of health services available to them by the Government of India.

The Swa- Prerit Adarsh Gram Yojana seeks to translate the Gandhian Vision of "reconstruction of villages of India so that it may be as easy for anyone to live in them as it is supposed to be in the cities" (Harijan, 7-3-1936), into reality. ^[3]

This scheme has been pioneered and implemented by Dept. of Community Medicine, SGT University under which Budhera village has been adopted for health care activities. The Sansad Adarsh Gram Yojna (SAGY) has been launched by the Govt. of India on 11th oct 2014 lays stress on their holistic development. It puts equal emphases on social, human and economic development. This scheme has been recently supplemented by Vidhayak Adarsh Gram Yojna (VAGY) by the Government of Haryana. The state now expects the Corporate Houses, Companies, Corporations, Boards, Trusts and the NGO's to come forward for adopting Gram Panchayats for converting them into Adarsh grams. Thus SGT University has adopted Budhera village in district Gurgaon under this scheme Swa Prerit Adarsh Gram Yojna. ^[3]

Promotion of maternal and child health has been one of the most important components of the Family Welfare Programme of the Government of India and the National Population Policy-2000 1 reiterates the government's commitment to the safe motherhood program within the wider context of reproductive health. Maternal care includes care during pregnancy and should begin from the early stages of pregnancy. Women can access antenatal care services either by visiting a health center where such services are available or from health workers during

their domiciliary visits. [4] The former gives an idea about the voluntary utilization of the services by women while the latter is related to the quality aspect of the services. One of the most important components of antenatal care is to offer information and advice to women about pregnancy related complications and possible curative measures for early detection and management of complications. [5]

OBJECTIVES:

- 1) Promote Maternal Health:
 - Promote ANC registration
 - Promote 2 doses of TT uptake
 - Educate them regarding nutrition and outcomes of nutritional deficiencies
 - Promote for 100 Iron folic acid(IFA) tablets uptake during pregnancy
- 2) Immunization:
 - To make mothers aware of Vaccine preventable diseases
 - Promote 100% immunization uptake.
- 3) Promote Child feeding Practices:
 - Promote exclusive breast feeding for first Six months.
 - Educate them regarding start of breast feeding within first 30 min of delivery
- 4) Promote Adolescent Health:
 - To educate adolescent regarding role of nutrition for their proper growth and development
 - To educate adolescent girls regarding maintaining menstrual hygiene
- 5) Reducing risk behaviours (Alcoholism, smoking, substance abuse) among all age groups.

6) To provide basic health services at their doorstep.

7) Identify chronic diseases and disabilities among the villagers and advise them accordingly.

MATERIALS AND METHODS

A descriptive research approach was adopted for the study. The survey was conducted at Budhera village, Farukhnagar Block of Gurugram district in Haryana.

Description of the Tool: The research tool consists of a questionnaire which includes socio demographic profile of family, maternal and child health conditions including the child feeding practices, other medical conditions and diet pattern in the family.

Data Collection: The data was collected from each family by prior permission from the concern authority. Oral consent from each family was obtained and data was collected by self administered questionnaire. To achieve the above objectives, it was planned to collect the basic data on each family. For better liaison and building rapport with community, a meeting was organized with village Gram Sabha, village panchayat, administrative authorities concerned with village like BDO, Panchayat secretary etc. A health committee was formed consisting of representative of Budhera villager nominated by Gram Sabha, and health team representatives. Composition of health Committee is as under:

Composition of Health Committee:

SGT University Representative	Budhera Village Representative
Dr BS Deswal- Community Medicine	Mohender Singh, sarpanch
Dr VP Gupta -Community Medicine	Gajraj Singh s/o Sh Vijay Singh
Dr Ved Prakash Yadav- Community Medicine	Raghu Nath s/o
Dr Br Chinmay – Dental	Under Lal
Dr Sachin Chand- Dental	Mool Chand Rohella s/o Sh Prabhati Lal
Sh. Surinder Kumar- Nursing	Smt Nikki
Ms Rashmi- Nursing	Smt Urmila
Ms. Ritu Yadav- Nursing	Smt Rina
Ms Richa – Nursing	Smt Geeta
Dr Mohit Gulati- physiotherapy	Surinder Kumar
Rattan Singh – Publicity /Marketing	
Ravi- Publicity /Marketing	

A team of Health professionals (Public health expert, Physician, Gynecologist, Dental surgeons, Physiotherapists, Nursing and allied health staff) visited the Budhera village twice or thrice weekly. One team of Health professionals conducts health camp at a place that is

easily accessible to all villagers. Two teams of Health professionals went house to house (H-t-H) according to the predefined micro plan and does following activities in each household:-

Gathered information on a structured questionnaire on socioeconomic profile, type of living conditions, water supply, H/O pregnant females within 24 months, any currently pregnant females, and immunization status of children, any chronic diseases or disabilities in the family.

Treatment for basic ailments is provided then and there and patients are referred to SGT hospital for specialized care.

Health talks given at every household

Every house is marked with a number

Revisits are done for missed out houses during the scheduled visits

Data analysis: The collected data was conveniently summarized and tabulated by using descriptive statistics.

RESULTS

Family Health Survey -Budhera village
Budhera is a village placed in Farukhnagar Block of Gurgram district in Haryana. Situated in rural area of Gurgram district of Haryana, it is one of the 53 villages of Farukhnagar Block of Gurgram district. According to the administration register, the village number of Budhera is 62808. The village has 750 houses. Village has approximately population of 3000 in 720 households. A total of 720 household were

listed out of which 584 could be contacted. As per village census data there were 659 households in Budhera. Some of the owners have more than one house that may be reason of variations in the No. of household. Houses found locked and revisited twice before presuming them permanently locked/migrated out of village. Factual, reasons from locked houses were also verified from neighborhood before presuming that not available.

According to Census 2011, Budhera's population is 3779. Out of this, 2001 are males whereas the females count 1778 here.

Description of selected personal variables of the population under study:

Table-1: Budhera village at a glance as per census 2015

Particular	Male	Females	Total
Total No. of houses			750
Population	2001	1778	3779
Children (0-6 yrs age)	285	216	501
Schedule cast	743	666	1409
Literacy	1556 (77 %)	1142 (64%)	2698 (82.31%)
Workers	965	209	1174

This village has 501 kids in the age bracket of 0-6 years. Among them 285 are boys and 216 are girls.

Table-2: Age and Gender frequency distribution of the total population in Budhera Village

Age (Yrs)	Sex	Male	Female
0-5	317	167	60
6-10	244	147	97
11-15	227	132	95
16-20	277	52	125
21-25	360	188	172
26-30	294	50	144
31-35	209	107	102
36-40	183	97	86
41-45	151	83	68
46-50	15	59	56
51-55	93	44	49
56-60	98	48	50
61-65	84	31	53
65+	107	63	44
Total	2769	1468	1301

Table -2 Frequency distribution marital status among population covered

Name	Total Number
Never Married	1318
Married	1283
Divorced/Widowed	142
Separated	26
Total	2769

Table-3 Frequency distribution of Educational Status of population covered

Education	Total Number	Male	Female
Illiterate	1010	461	549
Primary School	296	177	119
Middle School	304	146	158
10 th and 12 th	868	535	333
College	291	190	101
Total	2769	1509	1260

Table -4: Per capita income-Socio-economic classification (Modified BJ Prasad Scale)

Class	Per Capita Income	No of Families
Class-I	Rs 5570/- and above	255
Class-II	Rs 2785-5569/-	103
Class-III	Rs 1671-2784/-	73
Class-IV	Rs 836-1670/-	66
Class-V	Below Rs 835/-	30

Table-5 Environmental Conditions in Budhera Village

Types of Houses	
Kutchha	16
Pucca	321
Semi-Pucca	190
No of Living rooms	
1	35
2	141
3	132
4	75
>4	144
Overcrowding	
Present	139
Absent	388
Ventilation	
Adequate	416
Inadequate	111
Lightning	
Adequate	416
Inadequate	111
Kitchen Location	
Separate Room	464
Within room used for other Purpose	45
Outside room	18
Kitchen Type	
Smokeless	245
Smoky	69
Mixed (both)	213
Bathroom	
Present within the house	484
Present but not using	321
Absent	190
Drainage	
Closed	413
Open	107
Connected to Sewer system	7
Source of drinking water	
Hand pump	93
Municipal pipe	261
Public tap	38
Well within the house	2
Public Well, Ponds	1
Mineral/RO Water	8

Table-6 Diseases identified during House-To-House Visit of Budhera Village

Hypertension	35
Diabetes	16
Seizures	1
Rheumatoid Arthritis	2
Bronchial Asthma	3
Headache	1
Coronary Artery Disease	2
Otitis Media	1
Hypotension	1
Hypothyroidism	2
Fatty Liver	1
Cataract	5
Low Back ache	5

Literacy status of Budhera village:

Literacy ratio in Budhera village is 71%. 2698 out of total 3779 population is educated here. In males the literacy ratio is 77% as 1556 males out of total 2001 are literate while female literacy rate is 64% as 1142 out of total 1778 females are literate in this Village.

The dark part is that illiteracy ratio of Budhera village is 28%. Here 1081 out of total 3779 individuals are illiterate. Male illiteracy rate here is 22% as 445 males out of total 2001 are uneducated. Among the females the illiteracy ratio is 35% and 636 out of total 1778 females are illiterate in this village.

Maternal and Child Health Status In Budhera Village

Maternal and child health status in Budhera village was assessed. Data was collected through a structured questionnaire on maternal & child health practices which includes number of pregnancies, the vaccination & folic acid received, place of delivery & outcome of last pregnancy, number of checkups during pregnancy, choice of delivery place, registration of the cases etc. Collected data was analyzed and it was found that out of the total eligible population 70% of antenatal mothers received TT vaccination while 30% did not received any vaccination, 84% of mother received IFA during their pregnant state while 16% did not received IFA, 81% opted for the institutional deliveries, 19 % were home deliveries. Out of total 84% mothers delivered an alive baby while 16% cases were either still birth or aborted.

Child Feeding Practices

Child feeding practices in Budhera village assessed for the children below 2 years of age. Various aspects were assessed such as whether the child has received any kind of pre lacteal feed, type of feed, breast feeding initiation time after birth, for how long the baby was breast fed exclusively, when it was stopped completely. The data was collected and analyzed and it was found that in 93% of cases mother or the family member have not given any kind of pre-

lacteal feed to the newborn while 7% have given some kind of pre-lacteal feed. In 30% of cases breast feeding was initiated within 30 min after birth, 7% of cases newborn were breastfed after more than 4 hours of life, 40% mothers started breast feeding within an hour of delivery, 19% mothers started breastfeeding their child within 1-4 hrs of deliver.

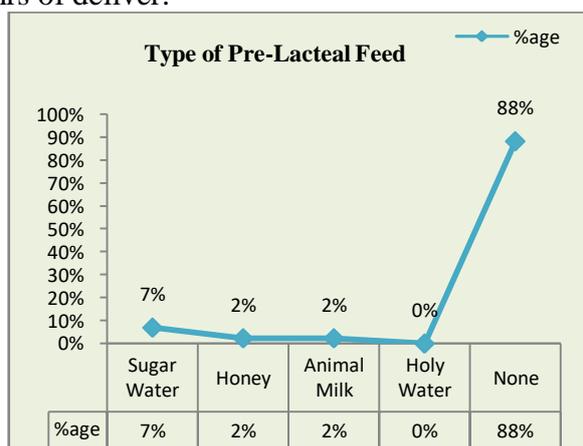


Figure 1: The line diagram represents percentage of type of pre-lacteal feed given to the neonate after birth

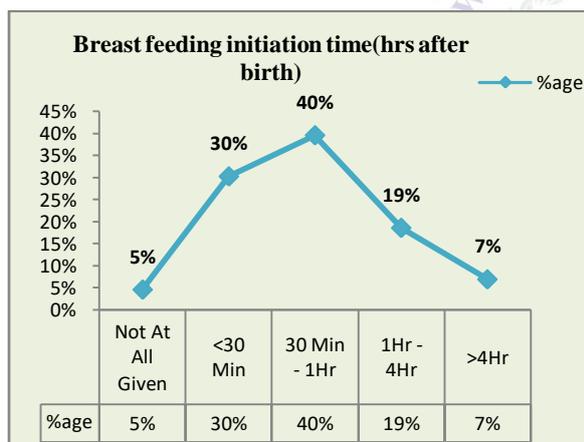


Figure 2: The line diagram represents percentage of breast feeding initiation after birth

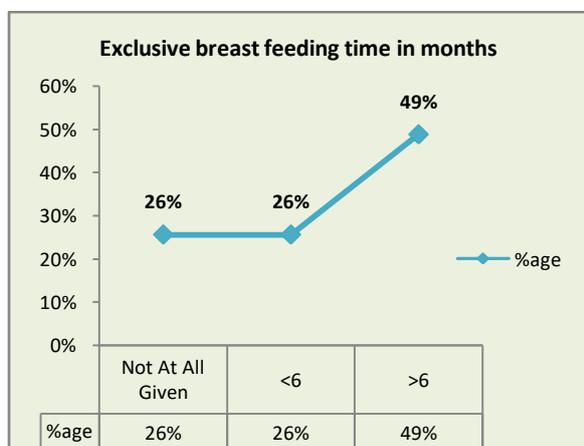


Figure 3: The line diagram represents percentage of Exclusive breast feeding time in months

Exclusive breast feeding was given for more than six months in 49% of the cases in 26% of cases child was not at all breastfed and 26% cases child was breastfed for less than 6 months.

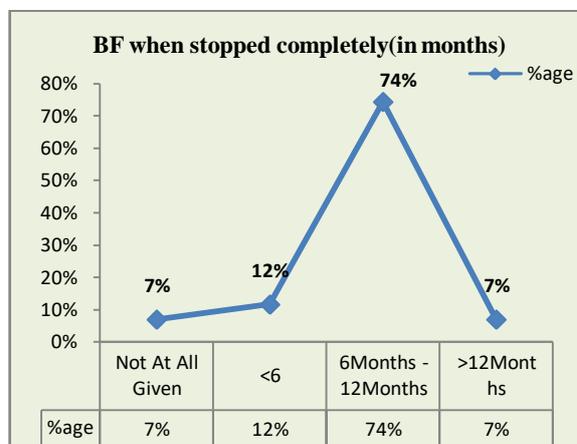


Figure 4: The line diagram represents percentage of breast feeding stopped completely

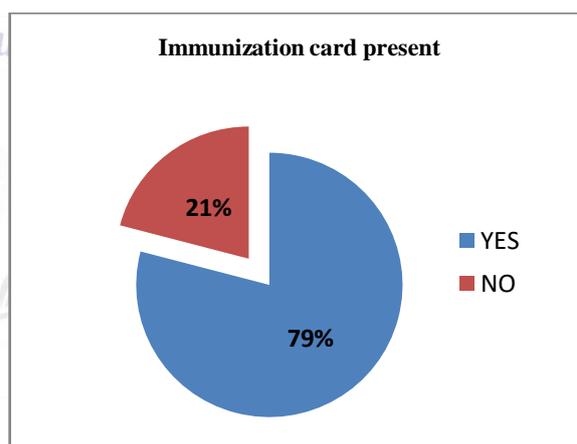


Figure 5: The pie diagram represents percentage of caregivers having immunization card

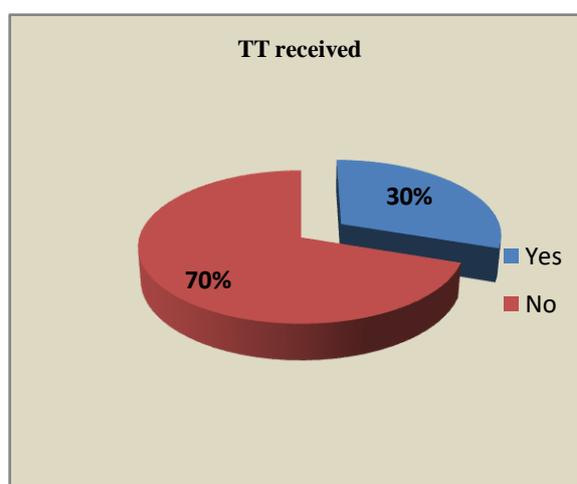


Figure 6: The pie diagram represents percentage of TT injection received (Antenatal mothers)

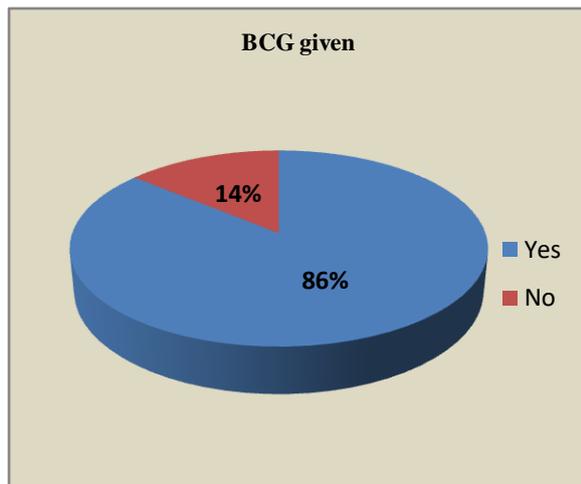


Figure 7: The pie diagram represents percentage of BCG vaccination received by neonates after birth

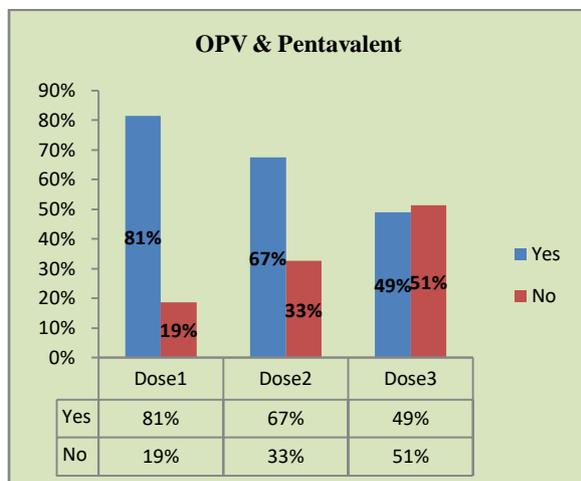


Figure 8: The Bar diagram represents percentage of OPV & Pentavalent vaccination received

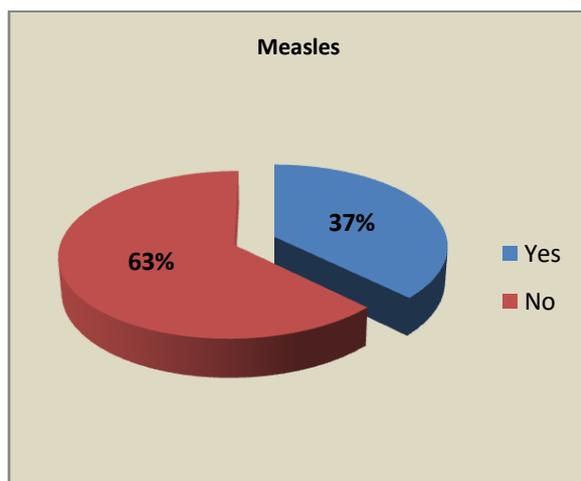


Figure 9: The pie diagram represents percentage of Measles vaccination received by neonate at 9 months

Immunization Status of Children

The immunization status of children aged between 12-24 months (during data collection) in Budhera village was assessed.

Survey was conducted regarding BCG vaccination at birth, OPV & pentavalent & measles vaccination received by the child and reason for not receiving any vaccination was ruled out. In 86% of cases, child received BCG vaccination while 14% newborns did not receive. Similarly 63% of children immunized with measles vaccination while rest 37% did not received any immunization.

DISCUSSION

The concept of healthy mother and healthy baby is an important aspect of reproductive and child health programmes. In a developing country like India poverty, illiteracy, and multiple pregnancy take their toll of mother's health and that of the breast fed infants. High prevalence of anemia and malnutrition among the reproductive age group women particularly during pregnancy and lactation can have irrevocable effects on the infant's health. This necessitates development of field centers to monitors the nutritional status and anemia in the population. [6] Safe motherhood practices and child survival programmes are critically important in a country that is experiencing high infant and child mortality and maternal mortality. In the rural area of India maternal and child health services are mainly delivered by government run primary health centers and sub centers. Services for pregnant women and children can also be obtained from private and public maternity homes and hospitals. [7]

In the present survey report it was found that literacy ratio in Budhera village is 71%. 2698 out of total 3779 population is educated here. In males the literacy ratio is 77% as 1556 males out of total 2001 are literate while female literacy rate is 64% as 1142 out of total 1778 females are literate in this Village. The dark part is that illiteracy ratio of Budhera village is 28%. Here 1081 out of total 3779 individuals are illiterate. This village has 501 kids in the age bracket of 0-6 years. Among them 285 are boys and 216 are girls.

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This survey shows that in 93% of cases mother or the family member have not given any kind of pre-lacteal feed to the newborn while 7% have given some kind of pre-lacteal feed. In 30% of cases breast feeding was initiated within 30 min after birth, 7% of cases newborn were breastfed after more than 4 hours of life, 40% mothers started breast feeding within an hour of delivery, 19% mothers started breastfeeding their child within 1-4 hrs of delivery. Exclusive breast feeding was given for more than six months in 49% of the cases in 26% of cases child was not at all breastfed and 26% cases child was breastfed for less than 6 months.

Survey conducted reported that BCG vaccination at birth, OPV & pentavalent & measles vaccination received by the child and reason for not receiving any vaccination was ruled out. In 86% of cases, child received BCG vaccination while 14% newborns did not receive. Similarly 63% of children immunized with measles vaccination while rest 37% did not received any immunization.

In any community mothers and children constitute an important and priority group especially in developing countries like India where, their numbers (constituting up to 2/3rd of total population), vulnerability to morbidity and mortality (constituting as special risk group) and amenability to prevention of ill health and mortality, to a large extent, makes them candidate for special attention. By improving health of mothers and children in any society we contribute to a large segment of general population and it is because of

this special and usually combined health services for mother and child, the Maternal and Child Health (MCH) Services are considered globally more so in developing countries. The main aim of MCH Services remains to ensure that, throughout pregnancy and puerperium, every mother maintains optimal health and at the end of pregnancy we have a healthy mother and a healthy baby and promote the child health throughout the infancy and childhood. Delivery of MCH services to the vast majority of rural communities has been through Sub-centers that are manned by two Multipurpose Health Workers (one male and one female [ANM]) and cover a population of 5000 in plain areas and 3000 in hilly or difficult terrain areas. The functions of female worker are mainly confined to Maternal and Child health (essential obstetric care, new born care, child health promotion, family planning, health education. ^[6]

According to a report, the World Health Organization (WHO) estimates that, of 536,000 maternal deaths occurring globally each year, 136,000 take place in India. Estimates of the global burden of disease for 1990 also showed that India contributed 25% to disability-adjusted life-years lost due to maternal conditions alone. Unfortunately, there is little evidence that maternity has become significantly safer in India over the last 20 years despite the safe motherhood policies and programmatic initiatives at the national level. ^[7]

Proposed Interventions for Phase II

1. To achieve ANC registration from 81% to 100%, TT from 98% to 100% , Iron folic acid(IFA) from 84% to 100% and complete Immunization from 93% to 100%
2. Provide Nutrition extension Programme for behavioral change to have an outcome of reduction of nutritional deficiencies.
3. Water sample testing for physical, chemical and bacterial examination

and intervene the Govt. resources for provision of portable water.

4. Provide 100% school health activities and provision of spectacles free of cost through Govt. resources
5. Training of expectant mothers on exclusive breast feeding.
6. Counseling sessions to reduce risk behaviour (Alcoholism, smoking, substance abuse) among all age groups.

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