CHAPTER II

LITERATURE REVIEW

2.1 Health Promotion Program

According to Rogers et al (1987) "Health Promotion Programs are created to generate specific outcomes or effects in relatively well-defined group, within a relatively short period of time, often through a concentrated set of communication activities". (Rogers, E.M.and storey, J.D 1987) This is done through multiple channels of communication to bring about "changes in the people's knowledge, attitude and behaviors" (Valente.T.W. 2002) Different strategies are used for making a health promotion program successful like provider training; Community based out reach and Mass media advertising, (Valente.T.W. 2002)

So health promotion program during pregnancy are given to bring about positive changes (Rogers et al 1987), through multiple channels of communication to change the knowledge attitude and behavior. (Valente 2002)

Though health promotion programs are intended to bring about positive changes in a person, there are many factors that play a significant role in doing so. Some of the important factors that has been found in studies in other countries are socio economic

conditions, education level and social, cultural and demographic factors. (Becker,1974) and psychological factors. (Glanz et al,1997).

The success of the program also depends on how the program has been developed. According to Thomas Valente (2002) "a successful health promotion program should reach the intended audience, appeal to the audience, messages are easy to understand and culturally acceptable, appropriate media is used and it should be a continuous process to bring about behavior change. The result of the behavior change should be positive". (Valente.T.W. 2002)

The success of the program also depends on the content of the message. In health promotion programs most of the messages are to inform the patient about some diseases, but talking about risk may also cause anxiety.(Glanz, K 1997) but also may bring lasting behavior changes. (Gennaro S. 2002)

Health promotion programs during pre natal care are found to bring about changes in 'health beliefs and health practices' (Gennaro et al 2002) and reduces maternal and infant mortality and morbidity (Handmaker et al.2001) by taking preventive action to 'ward off, screen for' an ill health condition. (Glanz et al 1997) This is because, according to Faden and Hanna(1997) "during pregnancy a women is suppose to have positive attitude towards behavior change for the benefit of her health as well as for the health of her unborn child". (Faden VB. Hanna E.1997)

Every woman should understand the risk of pregnancy because every time they get pregnant they carry a huge risk of dying or suffering from permanent disability. (Koblinsky, M. et al,; 1993) and is one of the main cause of loss of healthy life among women of reproductive age group in south East Asia. (www.whosea.org)

According to safe motherhood fact sheet (2002) The "safe motherhood initiative" was started in the year 1987 (Kenya) where, maternal mortality and morbidity were identified as a 'public health priority', and leaders from around the world pledged to make women's health a priority, by ensuring 'universal access to a full range of high quality, affordable services, particularly to vulnerable and underserved population'. Since then safe motherhood initiative has become an important and 'unique partnership' among government and non-governmental organization, in trying to save women's life during pregnancy and childbirth. Advocacy on services like education on safe motherhood, maternal nutrition, prenatal care and counseling, care during delivery and post-natal period, care during obstetric emergencies, family planning counseling and neo-natal care has been initiated. (www.safemotherhood.Org. 2002)

Maternal mortality is more in developing countries because of scarcity of resources and health facilities, high fertility rate,(Bayer, A. January 2001) early marriage and teen pregnancies.(Tinker,A.Dec 1991,pp18).

The actual estimate of maternal mortality and morbidity in developing countries may be more than actually reported (Graham,WJ Feb. 23, 2002; page 701) due to poor reporting system(Zahr, Carla A. Wardlaw,T. 2001) or requirement of large sample size.

(Nancy, L. Solan,et al.;January 2003). This has led to inadequacy of information on trend and levels of maternal mortality. (Graham, WJ. Feb. 23, 2002; page 701).

Alternative method for measuring maternal mortality is measuring obstetric morbidity. (Waterstone,M. et al.;May 5, 2001. page 1089). Measuring the effect of intervention used for bringing down maternal mortality can also be an indicator of maternal mortality.

One important intervention that is used for bringing down maternal mortality is trained attendant at birth. (Ronsmans,C. et al.; 2002).Trained attendant are expected to diagnose and manage obstetrical complications.

Table 2: Specific interventions for reducing maternal deaths.

Causes of maternal death	Percentage	Proven intervention
Postpartum hemorrhage	25%	Skilled attendant at birth: prevent and treat with appropriate drugs.
Sepsis	15%	Skilled attendant at birth: Clean practice and treat infection
Unsafe abortion	13%	Skilled attendant and manage the problems.
Eclampsia	12%	Detect and go to health center for treatment
Obstructed labor	8%	Detect in time and treat
Other direct obstetric causes	8%	Manage by trained personnel

Source http://w3.whosea.org/pregnancy/chap.3ht

But women in many parts of the world do not get the service of a trained attendant so training of traditional birth attendant was started. (Goldman, N. Dana, A. Glei. (2003) 685-700). But training of birth attendant is not a priority these days because it has to be supported by proper back up services. (Graham,WJ.Feb.23, 2002; page 701).

2.2 Factors for Utilization of Health Services

Even if there are very good health facilities but there are many factors that may prevent a woman from reaching that facility. There are three stages of delay. (www.worldbank.org)

Delay one: According to delay one of the three delay model women or their relatives tend to delay in going to the hospital for delivery and treatment of the complications of pregnancy due to lack of decision making power. This lack of decision-making power is because of the lack of knowledge on recognizing the danger signs of pregnancy. Other reason for lack of decision making power is because the decision making power lies in the hands of the mother in law or the husband. (safe motherhood 2001). Other factors that are responsible for decision making power of women are education level (Celik, Y. et al 2000) religion and cultural factors. (Brown SS, 1998),belief in witchcraft (Chapman RR, July 2003) or "Shame and guilt " (Griffiths P, Stephenson, July 2001).

Delay two: This delay is the delay in reaching appropriate care due to distance and lack of money for transportation. (Mwaniki.PK, et. Al. 2002) Study in Turkey has shown

that people owning a car utilize the hospital more than those who does not own a car. (Celik,Y et al.2000)

Delay three: Another reason for women not utilizing the hospital is explained by the third delay of the three-delay model. According to Delay three a women may not utilize the hospital because there may not be facilities in the hospital for treatment of complications of pregnancy (Afsana et al 2001) or it could be due to Poor quality of service in the health center (Griffith P, Stephenson R 2001), lack of cleanliness and delay in getting admission (Mwaniki. et.al 2002).

Other factors that have been found to be significant for hospital utilization are Women's occupation and their exposure to mass media, (Navaneetham, k et al. 2002) and Parity .(Celik Y, 2000, and Raghupathy. S.;1996) Need factor, that is the presence or absence of risk factors or symptoms was also one reason for utilization of health service in Central America.(Burks JA,1992) In Nepal bad attitude of the health worker was one discouraging factor for utilization. (WHO sea 2001)

2.3 Evaluation :

It has been defined as a "process of determining which program have been effective and hoe they achieved that effectiveness thus enabling researchers to plan and implement more effective programs in the future". (Suchman,1967). *Suchman,E.A. (1967). Evaluative research: Principles and practice in Public service and social action Programs. New york. Russel sage foundation.*

Evaluation also helps the researcher to understand if the program has fulfilled its objectives. (Valente,; 2002) and also helps to compare the program participant 'before and after the program.' (Weiss,1998).

Evaluation of an educational program can be done at three stages of the program. (Valente,TW; 2002)

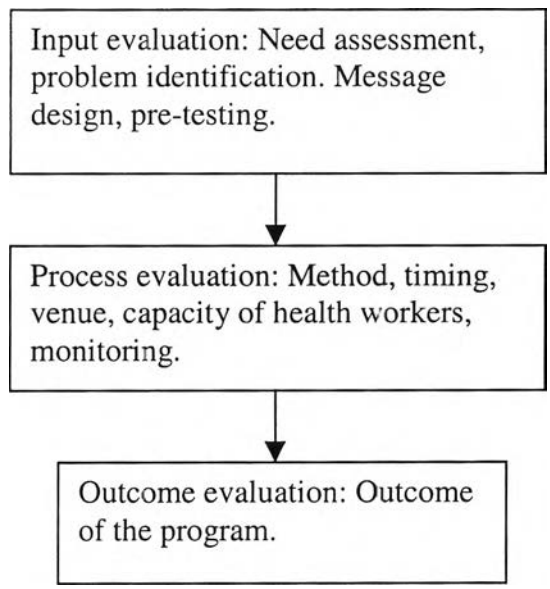

Figure 2: Framework for evaluation (Valente,TW; 2002)

Input evaluation: Input evaluation will look into how the planning of the program was done. It will mainly look at how need assessment and problem identification was done and whether these findings justify the intervention program. It will also look at message development and pre-testing and if some other methods were used to deal with the same problems.

Process evaluation: The process evaluation will look at how the program was implemented, whether timing, venue and selection of participant was done properly. Whether the people involved in conducting the education program were adequately trained and were capable of conducting the education program. If the program recipient were able to understand the program well, and the effect of the program on the service delivery. Process evaluation can be done at different stages of the program.

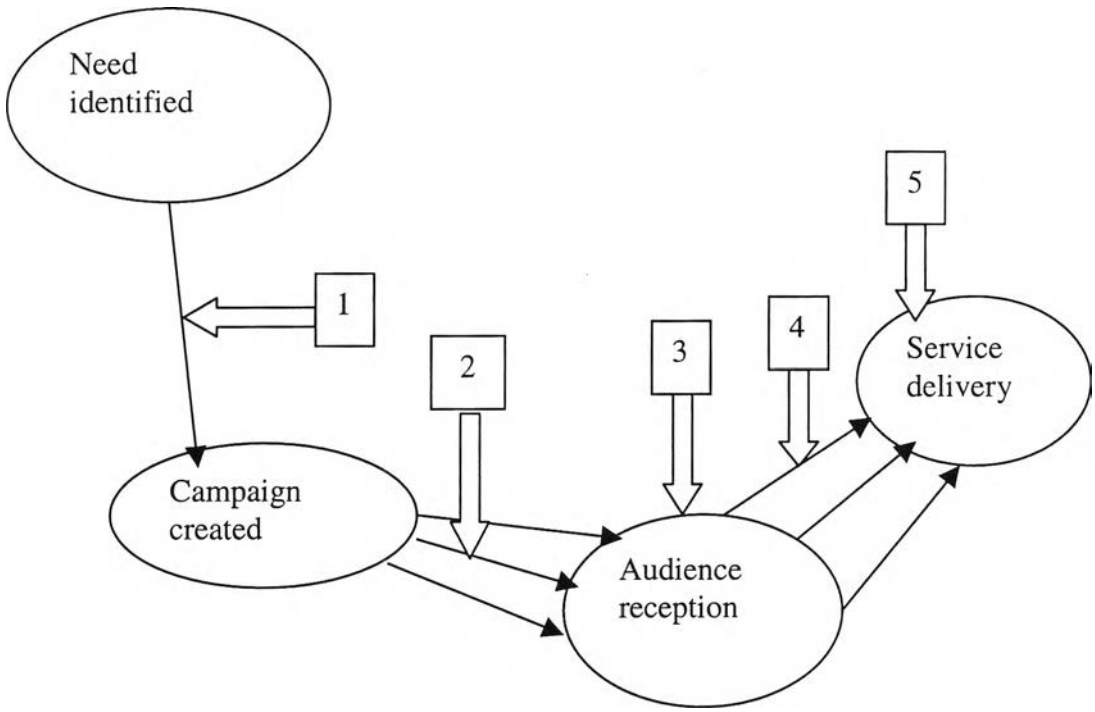

Figure 3: Process evaluation can be done at five points (Valente,T.W; 2002)

Outcome evaluation: The outcome evaluation is done to see if the program has fulfilled its objectives. This is usually done by comparing the data before and after the program. This will help the researcher if the program has been successful or not.