

# Approach Paper

## Jharkhand State

2014-2015

Prepared by: Mr. Ambrish Kumar Chandan, Mr. Ritesh Kumar

Edited by: Mr. Dinesh Songara and Dr. Esha Sheth

Reviewed by: Dr. Nirupam Bajpai

**Model Districts Health Project**

**Columbia Global Centers | South Asia (Mumbai)**

**Earth Institute, Columbia University**

Express Towers 11<sup>th</sup> Floor, Nariman Point, Mumbai 400021

[globalcenters.columbia.edu/Mumbai](http://globalcenters.columbia.edu/Mumbai)

COLUMBIA GLOBAL CENTERS | SOUTH ASIA  
MUMBAI

THE EARTH INSTITUTE  
COLUMBIA UNIVERSITY

## Table of Contents

LIST OF ABBREVIATIONS .....	2
SUMMARY OF RECOMMENDATIONS.....	0
INTRODUCTION.....	2
DISTRICT PROFILES.....	3
PUBLIC HEALTH STRATEGIES.....	7
1. ASHA REFORMS- STRENGTHENING COMMUNITY LEVEL HEALTH SERVICES.....	7
2. STRENGTHENING LABOR ROOM OF SELECTED SUB-CENTERS AND COMMUNITY HEALTH CENTERS.....	11
3. IDENTIFICATION, LINE LISTING & MANAGEMENT OF HIGH RISK PREGNANCIES .....	16
4. STRENGTHENING NUTRITION SERVICES .....	22
5. PERFORMANCE MONITORING AND CONTROL CENTRE (PMCC) .....	26

## List of Abbreviations

AHS	Annual Health Survey
AIDS	Acquired Immuno-deficiency Syndrome
ANC	Ante-Natal Care
ANM	Auxiliary Nursing Midwifery
ASHA	Accredited social health activist
AWC	Anganwadi Center
BAM	Block Account Manager
BEmOC	Basic Emergency Obstetric Care
BP	Blood Pressure
BPMU	Block Program Management Unit
CBC	Complete Blood Count
CEmOC	Comprehensive Emergency Obstetric Care
CHC	Community Health Center
CMAM	Community-based Management of Acute Malnutrition
CS	Civil Surgeon
DC	District Collector
DH	District Hospital
DPMU	District Program Management Unit
EDD	Expected Date of Delivery
FDG	Focus Group Discussion
FRU	First Referral Unit
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information Systems
HRP	High Risk Pregnancy
HSC	Health Sub Center
ICCM	Integrated Community Case Management
ICDS	Integrated Child Development Services
IDFC	Integrated Diarrhea Control Fortnight
IFA	Iron Folic Acid
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
INC	Intra Natal Care
INT	Insecticide-Treated bed Net
IPD	In Patient Department
IPHS	Indian Public Health Standards
IPT	Intermittent Preventive Treatment
IYCF	Infant and Young Child Feeding
JSSK	Janani Shishu Suraksha Yojana
JSY	Janani Surksha Yojana
LAM	Lactation Amenorrhea Method
LR	Labour Room
MB	Multi Bacillary
MCH	Maternal and Child Health
MCTS	Mother and Child Tracking Systems
MDHP	Model District Health Plan

MNH	Maternal and Newborn Health
MO I/c	Medical Office In-Charge
MTC	Malnutrition Treatment Centres
MUAC	Mid-Upper Arm Circumference
NBCC	New Born Care Corner
NBSU	New Born Stabilization Unit
NGO	Non-government Organisation
NIPI	National Iron plus initiative
NLEP	National Leprosy Eradication Programme
NPCB	National Programme for Control of Blindness
NRC	Nutrition Rehabilitation Center
NRHM	National Rural Health Mission
NSSK	Navjat Shishu Surksha Karyakram
NVBDCP	National Vector Borne Disease Control Programme
OPD	Out Patient Department
ORS	Oral Rehydration Solution
PB	Pauci Bacillary
PHC	Primary Health Center
PHED	Public Health Engineering Department
PMCC	Performance Monitoring and Control Centre
PNC	Post Natal Care
RMNCH+A	Reproductive, Maternal, Neonatal, Child and Adolescent Health
RNTCP	Revised National Tuberculosis Control Program
SBA	Skill Birth Attendant
SNCU	Special New Born Care Unit
SS	Sahiya Sathi
TB	Tuberculosis
VHSNC	Village Health Sanitation and Nutrition Committee
WHO	World Health Organisation
WIFS	weekly Iron and Folic Acid Supplementation

## Summary of Recommendations

The following recommendations have the potential to improve service delivery for maternal and child care with changes monitored through process indicators. Engagement and support from governance at all levels (State to District) is crucial.

Please Note: The detailed rationale and description of recommendations is described in this paper, following the summary of recommendations. Please refer to specified page numbers for details.

### 1. [ASHA Reforms Based on Incentivization Assessment \(Page 7\)](#)

#### **Short term**

- **Sensitization of Medical Officers** on gains of timely submission and disbursement of incentives on the performance of Sahiya
- **Refresher training** which includes details about incentives during block or sectoral meetings
- **Sensitizing ASHAs on Filing** of required documentation which they find complex to fill out, to make incentive collection easier during the block or sector meetings.
- A **grievance redressal** forum as recourse for problems with payments and other aspects including lack of support, stock out of medicines in the kit, or being unfairly treated.
- **Extensive review** of status of payment of incentives during monthly meetings at Block and District level.

#### **Midterm**

- **Career Path:** Consider enrolling a Sahiya into a training school to become an ANM after five years of proven work and recommendations to motivate engagement and continued performance for sustainability.
- **Monitoring system for transaction of activity based incentives** into Sahiya's bank account. An online payment and monitoring system like ASHASoft in Rajasthan would help in streamlining payments and conduct data driven planning.

### 2. [Labour Room Strengthening \(Page 11\)](#)

- **Framework for prioritization** facilities established to improve service delivery based on criteria such as home delivery and distance from CHC, staff trained in Skilled Birth attendance.
- **Framework for assessment of gaps** to assess to shortfall on selected areas/points must be conducted, via check-list provided by the GoI or district tailored checklist based on their feasibility and requirement.
- **Plan to Address Gap:** The monitoring team would provide specific time to improve the gaps along with assigning the responsible person to address them.
- **Monitoring and Supervision** on regular basis, block and district team need to monitor the progress of the plan.
- **District and state level interventions:** Apart from facilities level gaps, there may be issues which need to be resolved from either district or state level. Example: training, rational

deployment of staff, etc.

3. [Identification, Line Listing and Management of High Risk Pregnancies\(Page 16\)](#)

- **Training** to strengthen basic ANC skills for quality ANC and identification of HRP cases.
- **Line listing** by ANMs and refer to CHC.
- **Examination** by doctor at CHC and suitable remedial measures put in place
- **Micro Birth planning** to be made, issues relating to referral transport to be sorted, patients from far flung areas to be admitted before EDD

4. [Strengthening Nutrition Services \(Page 22\)](#)

- **Training of ANM and Sahiya on Nutrition focused Activities:** Lack of knowledge about nutritional deficiencies and its consequences call for training to educate beneficiaries during outreach field visits.
- **Prioritize Nutrition Outreach** via home visits through of ICDS programming
- **Community based management of SAM:** Community Based Care program would complement the services delivered through indoor institutional care and create scope for the majority of children to be provided care in the community setting itself thus reducing the demand on resources and health facilities.
- **Strengthening Village health sanitation and nutrition committee (VHSNC):** VHSNC must facilitate early detection of malnourished children in the community through regular meetings. Sahiya has been provided with MUAC tape. She must measure MUAC of 0-5 age children during VHND. On the basis of findings she can prioritize referral of children to NRC in consideration with ANM & AWW.
- **Intersectoral Convergence** It is crucial that these 4 departments (Education, Health, PHED and ICDS) should ensure that the responsibility under them is implemented systematically. Additionally convergence is required to discuss barriers of implementation within the individual programs and collaboratively come up with the solutions which hold common consensuses. This is where convergence becomes crucial to participatory problem solving rather than neglecting initiatives.

5. [Performance Monitoring and Control Center \(Page 26\)](#)

- A central hub of information which monitors prioritized health indicators from single point and provides feedback. It can monitor the quality and functioning of the different programs in real time. State can directly interact with district and block personnel for resolving issues.

## Introduction

India is poised to become one of the three largest economies in the world by the end of this decade. As it moves from the bracket of a Middle-income country to that of a developed country, the country will not only need to project economic growth but also has to simultaneously invest in the social development. Health and Education form the basic pillars of social development.

As a country, India has taken huge strides in improving the health status of its populace. In line with its commitment to the Millennium Development Goals, the national government conceptualized and executed the National Rural Health Mission (NRHM) to strengthen the rural health care systems. As per the latest data available, India may just about reach its MDG Goals 4 and 5, but policy makers should strive towards Universal Health Coverage becoming a reality in India. The latest National health Policy 2015 (Draft version) has articulated the determination of the government to leverage economic growth to achieve better health outcomes and acknowledges that better health contributes to improved productivity and equity as well. One of the greatest challenges facing India's development is establishing an effective public health care system that can reliably deliver services to the population, particularly the nearly 70% who live on less than \$2 per day. India suffers from great inequalities in health, with the poor lacking even the most basic services while others in the country receive world-class health care. Women and children living in rural areas bear the brunt of this inequity in health.

The Model Districts Health Project by Earth Institute focuses on bridging the gap between policy and practice by delineating the gaps within the health system, piloting innovations to resolve these bottlenecks and conduct policy based research. The project's goal is to provide strategic support on strategies to improve the nutrition status of women and children and reducing maternal and child mortality. The Model Districts Project is also a designated high-priority district for RMNCH+A, and works closely with state leads (UNFPA, UNICEF, and USAID-MCHIP) and other development partners on this strategy.

The project is embedded at state and district levels to accelerate strengthening of facility and community-based health systems and service delivery, as well as enhancing district level capacity for data-driven planning and management. It supports formation of district level strategy, planning, and continuous facility improvement in each district. This paper will discuss some key public health strategies based on the experience and work in the two districts, Khunti and Simdega.

## District Profiles

### Demographic Profiles

#### Khunti District

The district headquarters is 40 kms from Ranchi, the state capital and is among the smaller districts in the state.

- Majority of the population lives in rural areas and there are no urban conglomerations in the district.
- The terrain is hilly and it is densely forested. This has limited the construction of roads and telecommunication infrastructure
- Absence of any major economic development coupled with an ongoing Maoist (Naxal) insurgency has forced people to migrate to urban settlements in Jharkhand and other states.
- Khunti has the highest concentration of tribal population in the state. Close to 73% of people belong to the *Munda*, *Ooraon*, *Kharia* tribal groups.
- Gender discrimination and patriarchal values are not as prevalent among tribal groups as with other communities in India, explaining the favorable sex ratio.

#### Simdega district

The district headquarters is 170 kms from Ranchi, the state capital and is among the smaller districts in the state.

- Approximately, 94% population lives in rural areas and there are no urban conglomerations in the district.
- Absence of any major economic development coupled with an ongoing Maoist (Naxal) insurgency has forced people to migrate to urban settlements in Jharkhand and other states. The district shares its borders with Odisha and Chhattisgarh and is a transit point by the Naxalities.
- Simdega has a high concentration of tribal population in the state. Close to 71% of people belong to the *Munda*, *Ooraon*, *Kharia* tribal groups.
- Gender discrimination and patriarchal values are not as prevalent as other communities in India explaining the favorable sex ratio.

Demographic profile	Khunti district	Simdega district
Population (Census, 2011)	531,885	599,578
Rural population (Census, 2011)	486,903	456,634
Children (0-6 years) (Census, 2011)	86,292	88,993
Sex ratio (Census, 2011)	1000	1000
Sex ratio (0-6 years) (Census, 2011)	966	997
Female literacy rate (Census, 2011)	51.38%	58.23%
Decadal growth rate (Census, 2011)	22.32%	16.58%
Population density (per square kilometer) (Census, 2011)	210	159
<b>Administration</b>		
Blocks (cluster) (Jharkhand.gov.in)	6	10
Panchayats (Jharkhand.gov.in)	86	94
Villages (Jharkhand.gov.in)	768	451



## Health System Profile

Particular	Khunti District	Simdega District
District hospital	1	1
Community health centres (CHC)	6	6
Primary health centres (PHC)	4	7
Health Sub-Centres (HSC)	108	149
First referral Units (FRU)	2	1
Sick newborn care unit (SNCU)	0	0
Newborn stabilization unit (NBSU)	1	0
Nutrition rehabilitation center (NRC)	3	4
Ambulances	6	7
ASHA (sanctioned)	855	726
<i>Above are sanctioned posts</i>		

### Khunti

Based on the *Health Management Information Systems (HMIS)* and *Mother and Child Tracking Systems (MCTS)* and *Civil Surgeon office*, the service indicators in Khunti are:

- Institutional delivery is around 71% (Source; HMIS 2014-15)
- At the national and state levels, there is a lot of emphasis on immunization coverage and targets, this could partially explain the high immunization rates in the district (94%) and may also possibly be due to over-reporting to avoid scrutiny. During the monthly Village Health and Nutrition Day, only immunization sessions are conducted instead of the mandated basket of MCH services.
- 108 Sub-Centers in Khunti of which 56 percent conduct deliveries (Source HMIS 2014-15)
- Primary Healthcare Centers (PHCs) are non-functional throughout the state and doctors are unavailable at Community Health Centre (CHCs) on 24\*7 basis.
- The District Hospital has to deal with a high case load to compensate for absence of functional facilities at the field level. Majority of the facilities are very old and need major renovations. Construction of few health facilities have been halted due to pending legal issues. In buildings that have been recently handed over, electricity and water connections are yet to be set up.
- There are only two facilities that offer C-Section services (Torpa CHC and District Hospital). Here too services are irregular and is dependent on the availability of the consultant surgeon (from private).
- The Blood Storage Unit is dysfunctional.
- Emergency and referral transport is managed under a State Program called *Mamta Vahan*. This system has encouraged many women access services in government facilities ,but due to poor telephone connectivity in many of forested areas, women are unable connect to the *Mamta Vahan* call centers to avail of services.
- Most of the facilities are understaffed by at least 50%.The state has been unable to fill up vacancies of specialists, nurses and para-medical staff<sup>1</sup>.
- Most medical staff in Khunti does not reside at the facilities during the night-time, but prefer to stay and travel back and forth from Ranchi (40-45 kms. away). Absenteeism is also strife across the

<sup>1</sup> Working for Government health services is not perceived as a lucrative option, qualified persons feel they are more likely to be under-paid, over-worked ,subject to political interferences ,forced to live in rural areas

district. Supervisory and monitoring visits are not institutionalized practices; hence staff tends to not be present at the facilities at designated hours.

- The Aanganwadi Centres (AWCs) operated by the Integrated Child Development Services (ICDS) are not functioning to the desired extent. In 2011, the HUNGAMA<sup>2</sup> report found that nearly 42% children in Jharkhand are underweight. There are three Malnutrition Treatment Centres (MTCs) in the entire district<sup>3</sup>, but referral through the AWC is very limited. Inter-departmental coordination between the Departments of Health and Child services has a huge lacuna that continues to affect any nutrition related interventions in the district.
- The districts health systems face a constellation of challenges such as lack of physical infrastructure, shortage of skilled technical and managerial manpower, irregular power supply, poor internet connectivity etc.

#### **Simdega District:**

- The institutional delivery rate in Simdega stood at 38.98% (HMIS 2014-15).
- 50.17% of women had undergone at least 3 or more Ante Natal Care (ANC) (HMIS 2014-15).
- 77% Children less than 12 months were fully immunized (HMIS 2014-15).
- Out of the 149 sub-centers in Simdega district 140 conducted deliveries in 2014-15 (HMIS 2014-15).
- 126 Sub-centers in the district do not have electricity supply (Office of Civil Surgeon, Simdega district).
- 67 Sub-centers do not have water supply (Office of Civil Surgeon, Simdega district).
- 7 PHCs are functional and deliveries are conducted, however lack of availability of doctors 24\*7 is an issue.
- Out of the 6 Community Health Centers (CHCs), 4 (Bano,Kurdeg,Kolebiera and Thetitangar) have moved to newly constructed buildings, while 2 (CHC Bolba and CHC Jaldega) function from old buildings.
- CHC Thetitangar is the First referral unit (FRU); however lack of functional blood storage unit and an anesthetist is a stumbling block in carrying out caesarean sections (C-section).
- The district hospital in Simdega is the apex public health care institution in the district, however many of the diagnostic procedures like Complete Blood Count (CBC) is not being done at the DH. Due to lack of fulltime hospital manager, the overall streamlining of services is hampered.
- Due to lack of overall development and infrastructural bottlenecks it has been difficult for the state and district administration to attract and retain specialists in the district. Simdega does not have a trained pediatrician either in public or private sector. Most complicated obstetric cases are referred to either Rourkela, an industrial city (76 km away) or to the state capital Ranchi.
- As with other sectors Left wing extremism has been a detrimental factor in the overall outreach of the health care services in the district.
- Uptake of Mamta Vahan –the state wide referral services has improved but on an average, only 50% of the women access it to come to the CHC and district hospitals. Reasons include poor mobile phone connectivity and frequent shutdowns/curfews in the districts due to insurgency during which vehicle movement is prohibited.
- In many of the tribal areas the custom of home delivery is preferred and practiced. The introduction of the *Janani Suraksha Yojana* has helped to increase institutional delivery; ASHAs have also been instrumental in

---

<sup>2</sup> Hunger and Malnutrition Report (HUNGAMA) report prepared by Naandi foundation focused on hunger and malnutrition in 100 rural districts across Jharkhand

<sup>3</sup> District Hospital(50 bedded) and Torpa CHC(30 bedded)

counseling women to access facilities. But people are very often discouraged due to the delay in payments and reimbursements. Awareness of entitlements under the *Janani Shishu Suraksha Karyakram* is very limited

- In family planning it is noted that the district only emphasizes on female and male sterilization, there is no data available on availability of temporary methods.

#### HEALTH Indicators of Khunti and Simdega districts

<u>KEY MATERNAL AND CHILD HEALTH INDICATORS</u>		Jharkhand	Simdega Gumla (rural) <sup>#</sup>	Khunti Ranchi (rural) <sup>#</sup>
Population	Maternal mortality Ratio	245	244 (Dakshini Chota Nagpur Zone)	244 (Dakshini Chota Nagpur Zone)
	Infant mortality rate	36	35	46
	Under-5 mortality rate	51	70	44
	Crude Birth Rate	23	25.6	24.8
	Natural growth rate	17.3	16.5	18.4
	Total fertility rate	2.7	3.5	2.7
Pregnancy Care	Mothers who had Antenatal Check-up in First Trimester (%)	62.1	62.0	71.0
	Mothers who received 3 or more Antenatal Care (%)	60.2	51.7	61.8
	Mothers who consumed IFA for 100 days or more (%)	16.9	16.1	21.0
	Mothers who received at least one Tetanus Toxoid (TT) injection(%)	91.8	94.6	95.6
Child birth	Delivery at home conducted by skilled health personnel (%)	27.4	21.3	30.0
	Institutional deliveries (%)	46.2	43.7	53.3
	Caesarean out of total delivery taken place in Government Institutions (%)	7.7	4.0	10.0
Post Natal Care	Children breastfed within one hour of birth (%)	43.3	45.0	57.1
	Mothers who received Postnatal Check-up within 48 hrs of delivery (%)	68.4	52.2	65.5
	Children with birth weight less than 2.5 Kg. (%)	28.1	32.2	34.8
	Children aged 12-23 months Fully Immunized (%)	69.9	80.8	84.5
FP	Female sterilization (%)	33.5	14.3	29.2
	Male Sterilization (%)	0.5	1.4	0.9
	Any Family Planning method (%)	57.5	41.3	49.9

Source: AHS 2012-13

Note: As Khunti and Simdega districts data not available on AHS, we have taken nearby districts rural data. For Khunti = Ranchi (rural) and Simdega = Gumla (rural)

## Public Health Strategies

Based on the ground experiences by the Earth Institute team, gap analysis, survey and literature review, evidence based strategies have been proposed in this paper to improve service delivery and strengthen the public health systems to function with better efficiency.

### 1. ASHA Reforms- Strengthening community level health services

#### Introduction

ASHAs, also called Sahiyas in Jharkhand, are the cornerstones of the National Health Mission and are trained to volunteer as the interface between the community and public health system at large. The success of NHM largely depends upon the optimum performance of the Sahiya. Under the NHM, Sahiya have been provided with activity based incentives for a wide range of activities related to Maternal & Child Health. The challenge in creating a balance between the voluntary and incentivized function of Sahiya is well understood and thus it becomes imperative to put in efforts so that ASHAs are well supported and timely and fully paid for the activities performed by her. Hence, it is critical to empower Sahiya and motivate her with all available means in order to achieve the maximum outcome.

#### Rationale

Payment of performance based incentive to Sahiya is delayed due to various causes. The time lag between filing of incentive claim and receiving payment is quite high. Sometimes it may be as high as 6-7 months. Sahiya is a volunteer and thrives on meagre amount she gets as an incentive. She doesn't receive any note/slip about the amount of incentive which is credited to her bank account. The overall incentive mechanism is not efficient and transparent. Based on interactions with Sahiya, it was decided to explore how the incentivization structures had an impact on their performance.

#### Study conducted for a detailed assessment of situation and gaps in relation to incentives for ASHAs

#### Objectives

The objectives of the study were as follows:

1. To assess the knowledge levels of Sahiya Sathi (ASHA supervisor) on their activity-based incentives
2. To explore the causes for delay in payments and how it affects performance

#### Methodology

- **The sample size:** 46 - ASHA Supervisors in the district
- **Sample Type:** Purposive sample considered representative for Sahiyas
- **Study Sample:** 42 Sahiya-Sathis are in position against approved 46 positions. All of them were consented to be part of the study.
- **Study conducted:** September 2014
- **Quantitative Component:** A Self-administered questionnaire containing 17 multiple choice questions on activity based incentive was provided to Sahiya for marking their responses. Aim of questionnaire was to assess knowledge of Sahiya about activity based incentives.

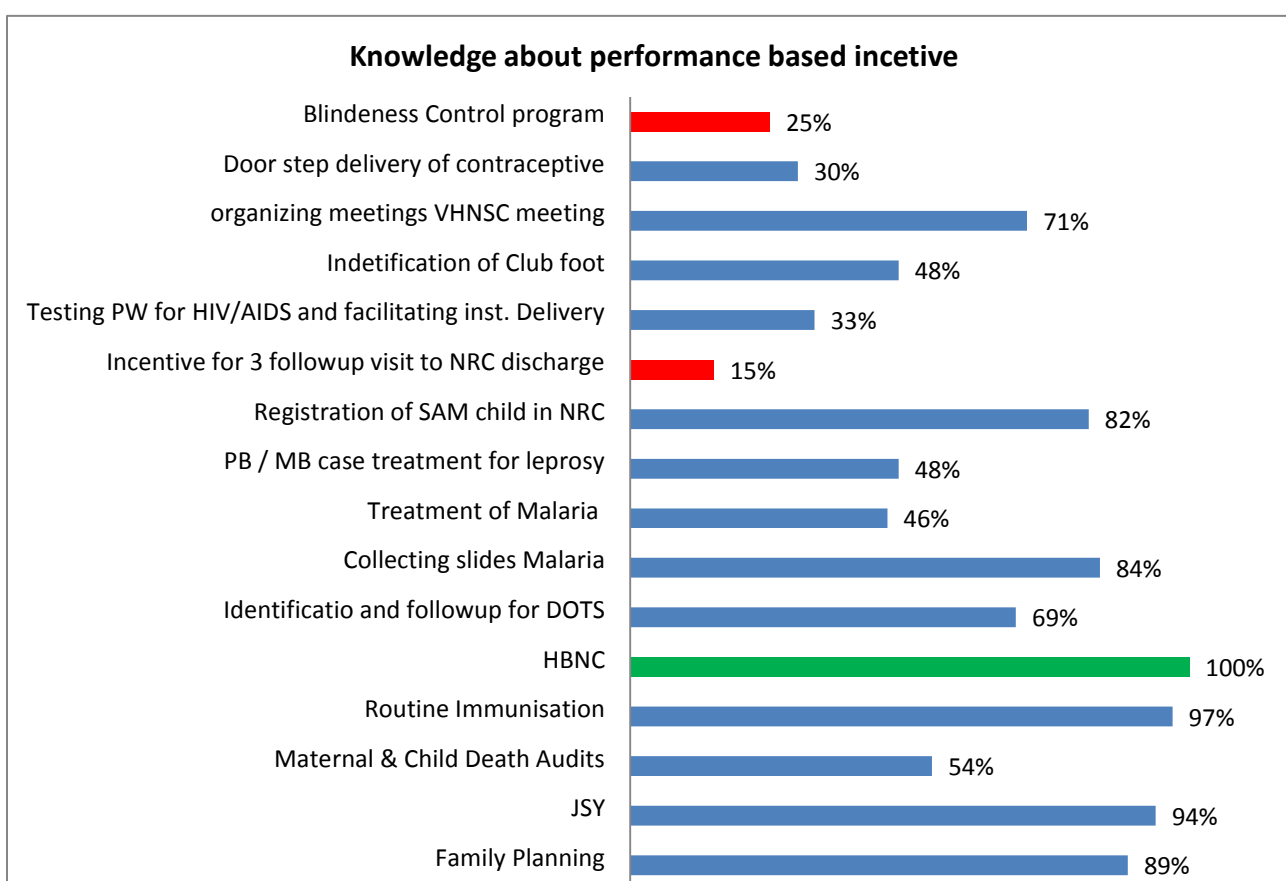
- **Qualitative Component:**

Focus Group Discussions (FGD) were conducted with Sahiya Sathis of two blocks namely Murhu and Khunti Sadar covering different aspects of the incentive

- Knowledge and structure
- Process and timeline for filing
- Fund flow mechanism
- Grievance-redressal
- Non-monetary incentives

Discussions were recorded, information were picked and analyzed to draw out the findings.

## **Results**



### **a) Knowledge gaps:**

- Information of performance based incentive for Family planning, Janani Suraksha Yojana, incentive to deliver in an institution, Immunization, ante natal check-ups were known to most of the Sahiyas.
- 15% Sahiya knew about an incentive for 3 follow up visit after discharge from NRC. *This is important towards the management of malnutrition.*
- Only 33% Sahiya knew about incentive for testing of pregnant woman for HIV/AIDS and facilitating institutional delivery.

- d. Only 54% Sahiya knew about incentive of maternal death reporting and just 41% knew any incentive for Child deaths reporting. Higher reporting is imperative to the process of creating awareness and understanding the causes of deaths through data collected after reporting.
- e. Incentive for treatment of Tuberculosis was known to 69% Sahiya and 46% Sahiya knew the incentive for treatment of Malaria. Better understanding can improve screening and in turn affect maternal morbidity.
- f. 48% Sahiya have information for incentive of Club foot.
- g. Less than 30% Sahiya knew clearly about incentives for doorstep delivery of contraceptives. Awareness would potentially motivate them towards encouraging family planning, provided they are taught to counsel keeping the social norms and barriers in mind.
- h. 25% knew about any incentive for National program for control of blindness. Only 48% and 38% Sahiya knew about incentives for PB or MB case treatment for Leprosy.

**b) Gaps to receive incentive:**

- a. Sahiya submits incentive sheet once in a monthly cluster meeting to Sahiya Sathi (SS).
- b. SS verifies the filed incentive sheet and submits it to BTT who verifies that and submits it to BAM.
- c. The time lag between filing of incentive claim and receiving payment is quite high. Average delay is 3 months and in many cases it is greater than 6 months to 1 year.
- d. The district and block authorities often cite non-availability funds are quoted as the reason behind delay of payment.
- e. Sahiya doesn't receive any note/slip about the amount of incentive which is credited and the type of incentive.

Giving Sahiyas more detailed information would empower her to assess the incentives she receives and help her better focus on the gaps.

**c) Gaps within redressal mechanism:**

- a. No grievance redressal mechanism and support from supervisor for complaints and problems faced by Sahiya in spite of them highlighting these at cluster and block meetings.
- b. No boarding and lodging support provided during accompaniment of pregnant woman. This is a challenge when they travel to health facilities and have to stay over-night.

**d) Dissatisfaction with Incentive Amount:**

- a. Sahiyas expressed that they were not satisfied with the present incentive amounts under various categories as they felt they worked in challenging conditions.
- b. Apart from receiving incentives for activities like Routine Immunization and JSY, the payments for other activities were received very rarely. Reasons quoted for non-payment are non-availability of funds for particular activity, not providing supporting documents in evidence of activity performed.
- c. Incentive for ensuring spacing of birth under Family planning has got a tedious process of documentation which is required as proof of work.

*Through the study, we sought to highlight the importance of timely payment of incentive, status of incentive payment, awareness of the Sahiya regarding payment she receives along with the major reasons for delay in payments. The findings are used by the MDHP team for advocacy of streamlining payments for Sahiya.*

## **Recommendations**

### **Short term**

- **Sensitization of Medical Officers:** On potential gains of timely submission and disbursement of incentives on the performance of Sahiya.
- **Refresher training to include details about incentives:** Sahiyas should be given information pertaining to their roles and responsibilities and guidelines of all national health programs. During training sessions, include lessons for Sahiya on how to convey complex information in a simplistic manner (in addition to content-based training), so that they can further initiate incentive based activities linked to sensitive topics like family planning. They should be re-sensitized on the amounts received for different activities during block or sectoral meetings.
- **Sensitizing ASHAs on Filing claims:** A re-sensitization on required documentation which they find complex to fill out, to make incentive collection easier. This could be implemented during the block or sector meetings.
- **A Grievance redressal forum:** This is essential for Sahiya as recourse for problems with payments and other aspects including lack of support, stock out of medicines in the kit, or being unfairly treated. A helpline could be established<sup>4</sup>.
- **Extensive review of status of payment** of incentive during monthly meetings at Block and District level.

### **Midterm**

- **Career Path:** Consider enrolling a Sahiya into a training school to become an ANM after five years of proven work and recommendations. Providing increased opportunity for upward movement for Sahiya, in order to motivate engagement and continued performance is crucial for sustainability.
- **Monitoring system for transaction:** This must be established to monitor the transaction of activity based incentives into Sahiya's bank account. Direct payment to their bank account as done by the Rajasthan government<sup>5</sup> will help improve efficiency of the overall system. An online payment and monitoring system like ASHASoft in Rajasthan would help in streamlining payments and conduct data driven planning.

---

<sup>4</sup> Rajasthan government has established the ASHA's helpline where any ASHA can raise complaint, ask any question about their payment, gain knowledge on different scheme, etc.

<sup>5</sup> Rajasthan government has initiated online debit the ASHA's entire claim through ASHASoft program. It's not only reduced the delay but improved the accountability who need to process the claim of ASHAs in a timely manner.

## 2. Strengthening Labor room of selected Sub-centers and Community Health Centers

### Introduction

“Maternal health is important to communities, families and the nation due to its profound effects on the health of women, immediate survival of the newborn and long term well-being of children, particularly girls and the well-being of families. Maternal death and illness have cost implications for family and the community because of high direct and indirect costs, the adverse impact on productivity and the tremendous human tragedy that every maternal or child death represents. Maternal mortality and morbidity indicators reflect not only how well the health system is functioning, but also the degree of equity in public service delivery, utilization of services, and the social status of women<sup>6</sup>”. Maternal mortality ratio of Jharkhand is 245 (AHS, 2012-13).

Neonatal mortality in Jharkhand is about 23/1000 live births (AHS, 2012-13) and neonatal mortality accounts for a large proportion of deaths of all children under five. Three quarters of all neonatal deaths occur during the first week of life. This is also the period when most maternal deaths take place. Thus, the provision of maternal and newborn care through skilled health personnel, ensuring care during critical periods of delivery and postnatal period, addresses the needs of the mother and the newborn through a seamless transition from home and village to the facility and back again.

### Rationale

Strengthening of services is required at every level i.e., Sub center level and PHCs (Level 1), 24X7 facilities PHC or CHC providing BEmOC services (Level 2) and at First Referral Unit/District health facility (Level 3) providing CeMOC services. As per the MNH tool kit the number of expected deliveries per annum are to the tune of 2.3% in a given population. Out of the expected deliveries 50% are expected to be conducted at CEmOC centres, 40% at BEmOC centres and the remaining 10% at the basic facilities. Approximately 20% of the 50% deliveries conducted at CEmOC centres are believed to need surgical intervention including C-Section<sup>7</sup>.

The human power and resources, equipment's needed for each level of the facility has been enumerated in detail in the Indian Public Health Standards (IPHS) and the minimum requirement for a facility to be functional has been enumerated in the Maternal and New born Health tool kit.

Deliveries at home by untrained *dais* are one of the reasons leading to maternal and child mortality and morbidity. Due to lack of facilities, infection control mechanism, there are high chances of both mother and child to succumb towards infection. Even though institutional deliveries have been highly promoted and various incentives are being provided by the government for institutional deliveries, still home deliveries persist in the current scenario. A Health Sub-Centre (HSC) is the most peripheral and first point of contact between the primary health care system and the community. To lower maternal and child mortality further, it is necessary that labor room of these peripheral units should be strengthened. They must be equipped for conducting normal delivery and essential newborn care services. It is also important to strengthen Community Health Centre/ CeMOC centres providing comprehensive emergency obstetric services. Mapping

---

<sup>6</sup> Operational Guidelines on Maternal and Newborn Health – GoI

<sup>7</sup> [http://nrhmp.gov.in/sites/default/files/files/MNH\\_Toolkit\(1\).pdf](http://nrhmp.gov.in/sites/default/files/files/MNH_Toolkit(1).pdf)



the remote, inaccessible areas and pockets and accord priority to strengthen the labor rooms of HSCs having referral linkages with CHCs providing CeMOC services is crucial.

**Purpose:** Khunti and Simdega are completely tribal districts of Jharkhand. In Khunti reported home deliveries were 47% and Simdega was 56% as per AHS 2012-2013. Strengthening of labor room of HSCs and CHCs would help in ensuring safe institutional deliveries and divert some of the home deliveries.

**Strategy used for strengthening of Labour Rooms in HSCs and CHCs**

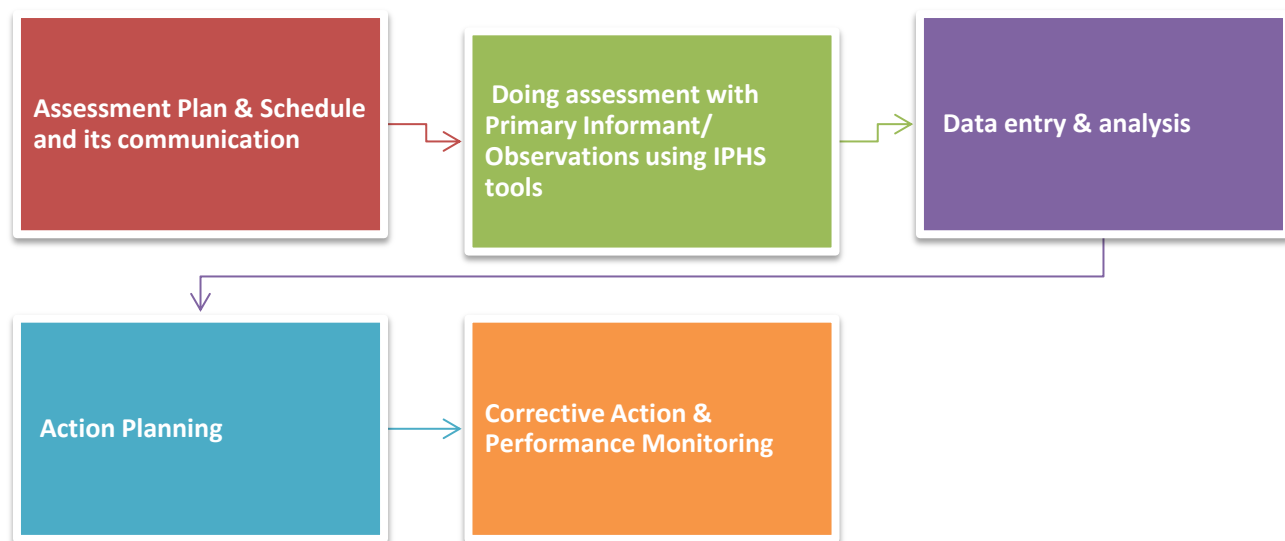
The data for home deliveries for the year 2012-13 and 2013-2014 was taken from HMIS. It was found that all of the blocks were having significant home deliveries. A discussion with the Civil Surgeon, MoIC and BPM of the respective blocks was done to ascertain the probable reasons for high home deliveries in their blocks. Strengthening of labour rooms of CHC and HSCs was prioritised for these blocks after gap assessment.

***Labour Room Assessment at HSCs in Khunti District:***

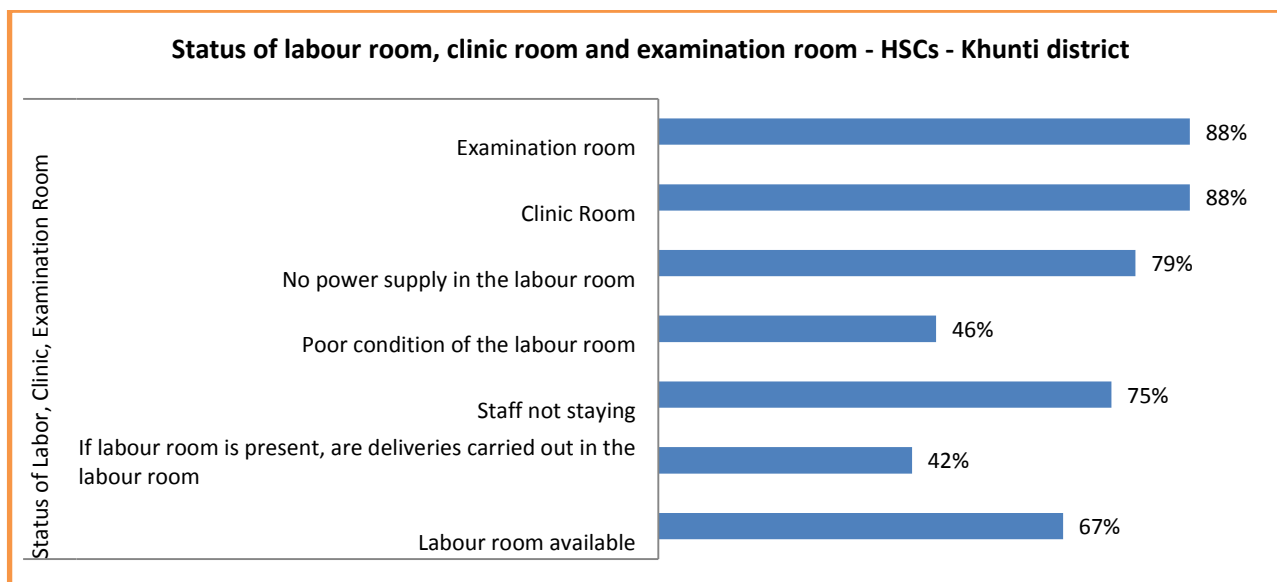
HSCs in Khunti district were selected for strengthening of Labor rooms on the basis of following criteria:

- a) Population/Delivery load on a health sub center
- b) Distance of center from CHC/FRU
- c) Availability of manpower
- d) Training status of staff

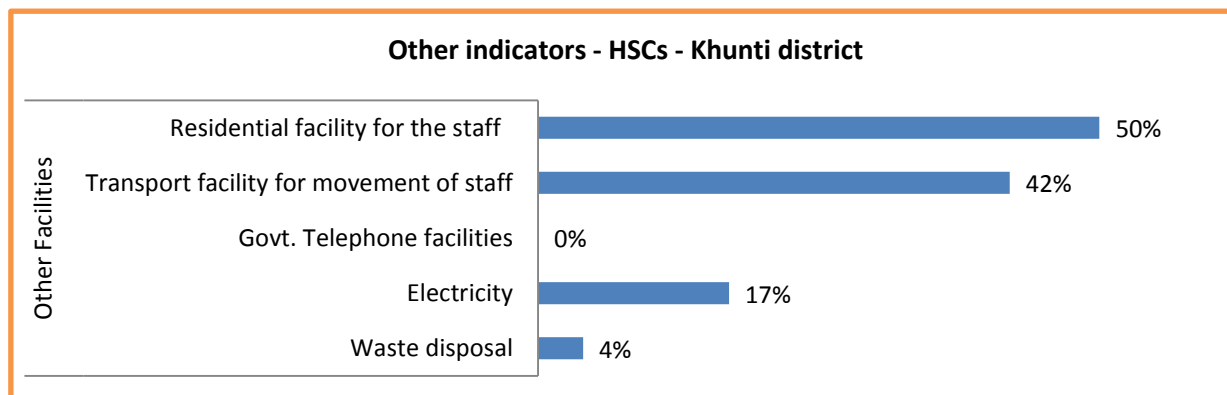
**The assessment plan for HSC**



## Assessment Results of HSCs –Khunti District



- 24% HSC among 6 blocks in Khunti were assessed
- 63% of the HSCs are functional in government buildings.
  - 16% were functioning in new building.
  - 16% HSCs are newly constructed and are to be handed over to Health Dept.
- Good cleanliness was observed in 25% HSCs and 46% of these were fairly cleaned.
- Labour room is available in 67% of these HSCs but, only 42% were conducting deliveries. Only 50% L1s have Labor Table.
- 58% of the HSCs were having 2 ANMs in position. Only 33% of the ANM at HSCs are SBA trained. It is preferred to have an SBA trained ANM in position at SC conducting deliveries.
- Delivery register were found in only 13% of labor rooms.
- In 75% HSCs, staff was not staying at headquarters. Guard/Grade 4 worker is available at only 4% HSCs. Considering the security reasons, unavailability of guard is one of the reason quoted by Lady staff for not staying at headquarters.
- 25% HSCs were having separate public utilities for Male and Female.
- Only 17% of HSCs were having electricity and overhead water tank



### ***Labour Room Assessments at CHCs in Simdega District***

Labor room of CHCs (Simdega district) was prioritized to be strengthened and referral linkages from HSC were ensured to deal with complicated deliveries.

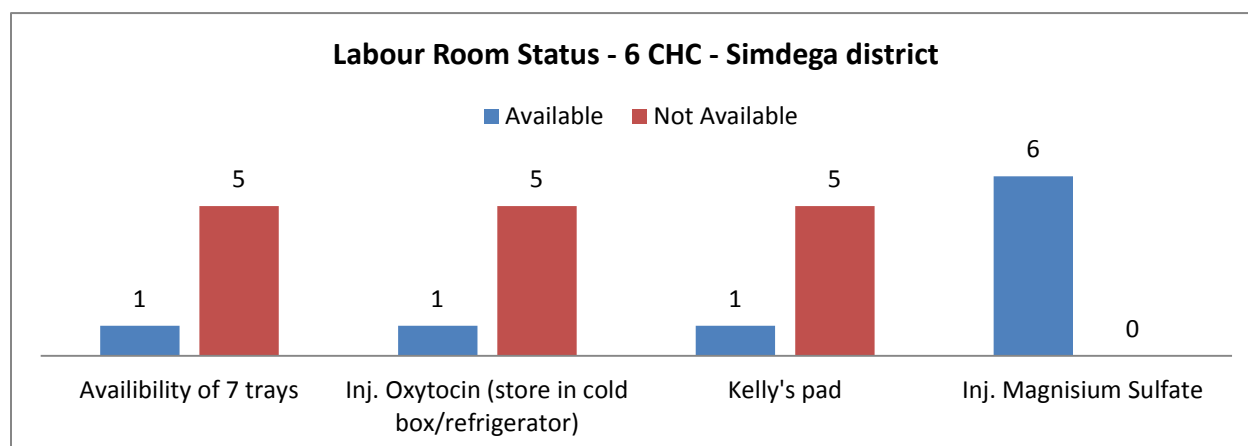
#### **Assessment Plan for labour room in CHCs**

1. A baseline study of the labour rooms was carried out during the RMNCH+A Supportive supervision visits
2. 6 CHCs of Simdega district were visited and gaps were identified.
3. The findings were shared with the respective medical officers- in charge, block programme management units, civil surgeon and district programme management unit.

#### **Assessment of results at CHCs:**

Assessment of labour room in CHC was done assessing few key elements. They are:

1. Availability of 7 trays (as per MNH toolkit)
2. Maternal health essentials like Injection Oxytocin, Kelly's pad, Injection Magnesium sulphate.
3. New-born health essentials like functional Radiant warmer, clean linen towels for receiving newborn, bag & mask
4. Privacy during delivery



- During the baseline assessment it was found that only 1 out of 6 CHCs had all the 7 trays with essential instruments or drugs available. (The labour room must have the following essential trays: 1. Delivery Tray, 2. Baby Tray, 3. Medicine Tray, 4. Emergency Drug Tray, 5. PPIUCD Tray, 6. Episiotomy Tray, 7. MVA/EVA Tray)

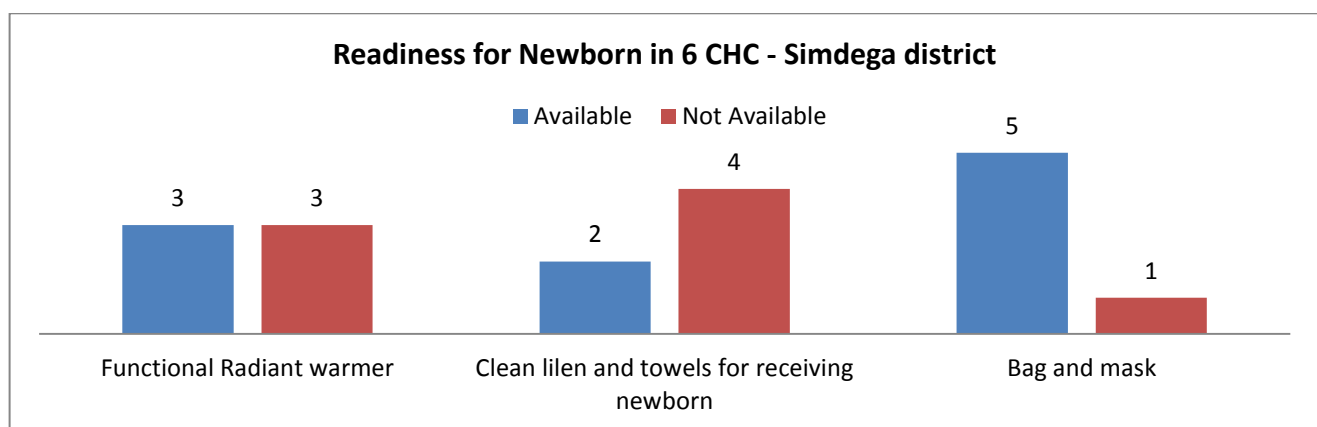
#### **Maternal health essentials**

- **Kelly's Pad** was available in only 1 out of the 6 CHC labour rooms.
- **Injection Magnesium Sulphate:** Magnesium sulphate injections are used for treating the cases of high blood pressure and thus are an essential component in management of Eclampsia. All the 6 CHC labour rooms were equipped with Magnesium Sulphate injections.

- Oxytocin injections should ideally be kept in cold box or refrigerator; however only one CHC labour room it was as per standard protocol.

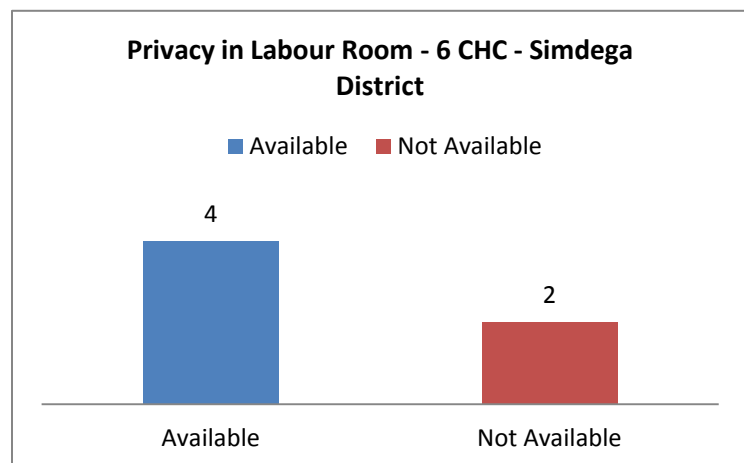
#### New Born health essentials assessment

- Functional radiant warmer is the most essential aspect of New Born Care Corner (NBCC) in the labour room. NBCC will be non-operational without a functional radiant warmer. It was found that 3 out of 6 CHC labour rooms had fully functional radiant warmers and in effect operational NBCC.
- Clean linen Towel for receiving the new born is the bare minimum essential that is required, however only 2 out of 6 CHC labour rooms had provision for clean linen and towels.
- Bag and Mask (Pre and Term Mask, Size 0,1): 5 out of 6 CHC labour rooms had bag and mask of both the sizes.



#### Privacy during delivery

Privacy during delivery is an essential right of the patient to have health care option with dignity and respect and is one of the important determinants of client satisfaction and quality of care at the institution. There should not be any compromise and no breach of privacy for the women who have come to deliver and every effort should be made to ensure that entry to labour room is a restricted and surrounding areas demarcated.



*It was found that 2 out of 6 CHC labour rooms did not have adequate levels of privacy during delivery.*

**Based on the gaps at the assessed facilities, plan was drawn for addressing them and where possible untied funds were used to procure required equipment.**

## Recommendations

Based on the intervention and learning by Earth Institute, following are few recommendations for the improvement of facilities.

- **Framework for prioritization:** First of all, district needs to prioritize facilities based on their need. For example, if they need to improve the quality of intra-natal services, more focus to improve the condition of labour rooms needs to be given. Here district will focus those facilities where deliveries are conducted on regular basis. If a facility needs to be functional to conduct deliveries, then priority must be given based on specific criteria like number of home deliveries and distance to functional CHC.
- **Framework for assessment:** Once district selects the facilities to improve, a gap assessment to understand shortfall on selected areas/points must be conducted. The assessment can be done through standard check-list provided by the GoI or district can build their own checklist based on their feasibility and requirement. Based on this district and block level team can do the assessment and identify the best practices and gaps.
- **Plan to Address Gap:** Based on the assessment, facility wise gaps would be identified. The monitoring team would provide specific time to improve the gaps along with assigning the responsible person to address them. This could include:
  - Procurement of Delivery Kit, Labor table and other necessary equipment for conducting deliveries should be made from untied funds, within 15 days. Responsible person MOlc.
  - Solar light should be used as an alternative light source, within 15 days. Responsible person ANM. Also, health centers should apply for Electricity connection within 2 months. Responsible person ANM and MOlc.
- **Monitoring and Supervision:** on regular basis, block and district team need to monitor the progress of the plan. In case, the areas have not been addressed, reasons should be identified and staff should be supported in dealing with the issues.
- **District and state level interventions:** Apart from facilities level gaps, there may be issues which need to be resolved from either district or state level. Example: training, rational deployment of staff, etc.

## 3. Identification, Line listing & Management of High Risk Pregnancies

### Rationale

According to the World Health Organization (WHO), approximately 800 women die every day from preventable causes related to pregnancy and child birth, out of which 99% occur in developing countries with Sub Saharan Africa and South Asia accounting for majority of the burden. The problem of maternal mortality is greater in rural areas and under privileged communities.

The Millennium development goals have laid great emphasis on reducing child mortality and maternal mortality in our country. According to report of Census (2011-13) document, the MMR for country stands at 167 per 100,000 live births and figures for the state of Jharkhand stands at 208 per 100,000 live births.

In a verbal autopsy study of 403 deaths conducted in 2008<sup>8</sup> showed the following patterns. Most of the deceased were poor (89%), non-literates (85%), and housewives (74%). Again, 80% died in the community/at home, 28% died during pregnancy while another 26% died during delivery. Any antenatal care was received by merely 28% women, and only 20% of the deliveries were conducted by skilled birth attendants (doctors and midwives). Delays in decision-making, travel, and treatment compounded by ignorance of obstetric complications, inadequate use of maternal healthcare services, poor healthcare infrastructure, and harmful rituals are the major contributing factors of maternal deaths particularly in Jharkhand. Identification of High risk pregnancies has the potential to avert pregnancy complications that can place the mother and child in jeopardy and also avert maternal and infant deaths.

One of the efforts for which the MDHP advocates at district level is the identification, line listing, treatment and micro birth planning of high-risk pregnant women. This effort focuses on strengthening of the existing systems and putting special emphasis upon continuum of care at various stages of pregnancy by having a pro-active approach on part of the health care providers in order to have safe pregnancy outcomes.

### **What is high risk pregnancy (HRP)?**

A pregnancy is classified as High risk if it has any one or some of the following features<sup>9</sup>:

- Severe Anaemia (Haemoglobin level below 7g/dl in early pregnancy and below 8g/dl in later stage)
- High Blood pressure ( if BP above 140/90)
- Ante Partum haemorrhage
- Gestational Diabetes Mellitus
- Previous history of any obstetric complications

### **Gaps**

#### **1. Awareness on HRP**

The RMNCH+A Supportive supervision visits between October 2014 and February 2015 in Simdega pointed out that the ANMs or the respective Block Medical Officer in-charges were clueless on the number of HRPs under their facility areas. Quality ANC is crucial to identification. Therefore the gap on knowledge and skills of what constitutes a High Risk Pregnancy (HRP) needs to be addressed. ASHAs (Sahiyas) and ANMs to doctors and program management units at the block and district levels, they all fall into the continuum cadre of workers that require this knowledge to identify and track HRPs.

It is seen that a significant section of the health care providers are not suitably trained to carry out some of the activities of the ANC check-up and end up with wrong reporting of the physiological parameters.

---

<sup>8</sup> *Identifying Factors Associated with Maternal Deaths in Jharkhand, India: A Verbal Autopsy Study by Nizamuddin Khan et al*

<sup>9</sup> Park K.: 'Park's Textbook of preventive and social medicine' 20th edition, M/s Banarasidas Bhanot Publishers, Jabalpur: 447 (200)

An example of this was evident from the Anaemia study carried out in Simdega district with ANMs who reported that majority had never received any training on Anaemia control.

Special and continuous training programs on various components of HRP's need to be taken up rigorously in order to improve the knowledge levels of the health care providers.

## 2. Anemia

Severe cases of Anaemia account for a very large proportion of the High Risk Cases. A study was conducted on the knowledge and practices related to Anemia amongst ANM in Simdega between February-2015 and May 2015.

### Severity of Anemia:

Neelam is 4 months pregnant and her ANM has detected her haemoglobin (Hb) to be 8g/dl:

1. This is normal
2. She is mildly anemic
3. She is moderately anemic
4. She is severely anemic

Over 51% ANMs thought she was mildly anemic. This is a view into the knowledge status of in the field.

When asked about the recommended IFA dose for pregnant and lactating women, majority were not able to answer correctly. Majority (155 out of 191 respondents) was not able to answer correctly out of the following given choices:

1. 500mg of iron and 500mcg of Folic acid.
2. 500 mg of iron and 100 mcg of Folic acid.
3. 100mg of iron and 100mcg of Folic acid.
4. 100mg of iron and 500mcg of Folic acid.

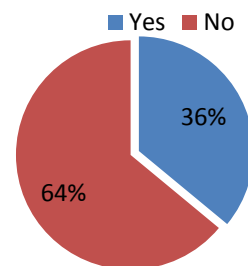
Only 36 respondents correctly answered option 4.

When asked Iron deficiency anaemia occurs due to:

1. Increased iron intake
2. Increased iron loss from the body
3. Increased iron requirement
4. Decreased iron intake

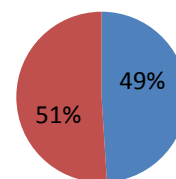
A majority of the respondents (168 out of 191) could not even give 2 correct options to the above mentioned question.

**Que. Have you receive any training on Anemia control program?**



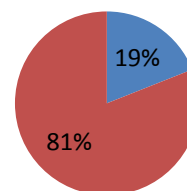
**Knowledge test - Anemia**

Correct Incorrect



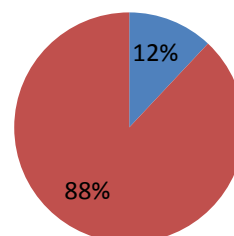
**Knowledge test - IFA Dose**

Correct Incorrect



**Knowledge test - Iron deficiency anaemia occurs due**

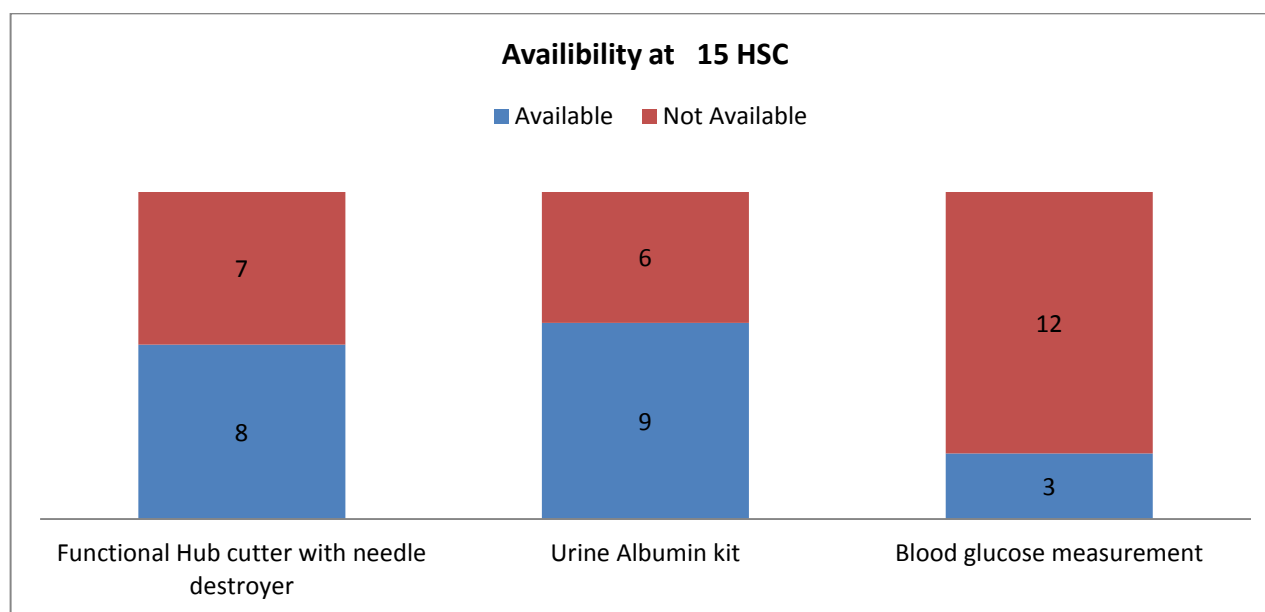
Correct Incorrect



### 3. Adequate availability of equipment's and other essentials for carrying out ANC's

Shortage of equipment and non-functional equipment's and reagents are a major hurdle in ensuring quality ANC check-up. For example please refer to the table below from Simdega district about the availability and functionality of some of the basic items for ANC's obtained from RMNCH+A Supportive Supervision visits carried out from January 2015 to April 2015.

Sr. No	Health sub centre (HSC)	Functional Hub cutter with needle destroyer	Urine Albumin kit	Blood glucose measurement
1	HSC Pidiyapoch	Not available	Available	Not available
2	HSC Malsara	Available	Available	Not available
3	HSC Kutmakachar	Available	Available	Not Available
4	HSC Kundurmunda	Available	Available	Not available
5	HSC Lachragarh	Not available	Available	Not available
6	HSC Letabera	Available	Available	Not available
7	HSC Lasia	Not available	Available	Available
8	HSC Konmejra	Not available	Not available	Not available
9	PHC Salgaposh	Not available	Not available	Not available
10	HSC Baghchatta	Available	Not available	Not available
11	HSC Taraboga	Available	Available	Available
12	HSC Kolomdega	Not available	Available	Available
13	HSC Konmerla	Available	Not available	Not available
14	HSC Kairbera	Not available	Not available	Not available
15	HSC Paledih	Not available	Not available	Not available



Now if at all there is chronic shortage of equipment's, it may not be possible to carry out quality ANC's, therefore it becomes imperative to have adequate functional equipment's at all the health facilities.



### Framework for HRP used in Simdega district

Quality ANC and identification of HRP cases and its line listing by ANMs, refer to CHC.

Examination by doctor at CHC and suitable remedial measures put in place, may refer further if required.

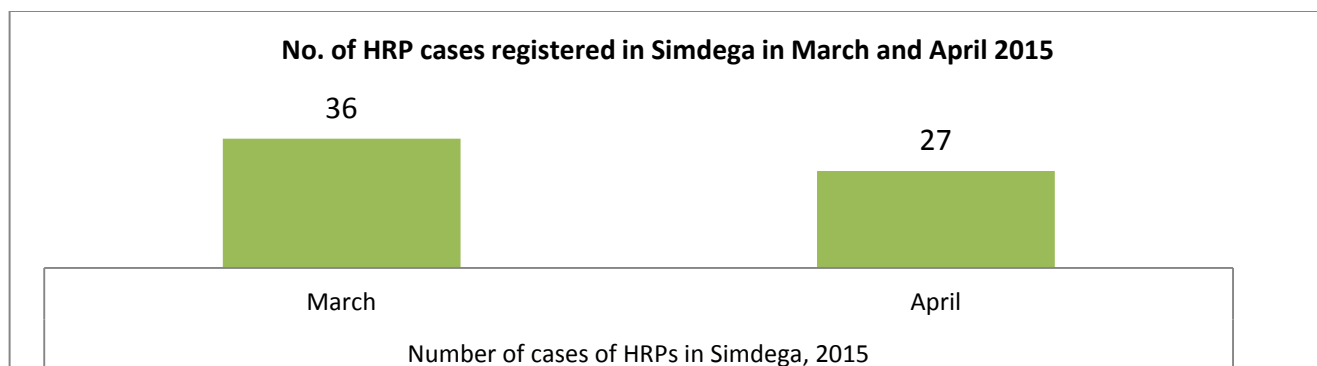
Micro Birth planning to be made, issues relating to referral transport to be sorted, patients from far flung areas to be admitted before EDD.

The MDHP team started a multi-pronged approach to sensitize the medical officers and the ANMs in Simdega district about timely identification of high risk pregnancies under their respective facilities. Special emphasis was placed on sensitizing the ANMs as to what constitutes a high risk case and ways to identify them, we have been involved in various training programs for the ANMs at the district level and have held sensitization workshops in monthly block level meetings on the need for timely identification and referral of high risk cases.

The ANMs have been requested to make a list of those pregnant women using the following criteria:

1. If a women is found to be severely anaemic (Haemoglobin below 8g/dl).
2. High blood pressure.
3. High blood sugar.
4. Previous history of any complication.
5. Ante Partum haemorrhage
6. Twin pregnancy
7. Any other illness or condition such as HIV, TB etc.

A lot of emphasis is being placed on improving the quality of ANCs and timely ANCs in order to identify the cases and start timely referrals. If a pregnant women is found to have any of the above mentioned conditions at the HSC level, she has been asked to refer such a patient to the block level CHC, where she could be examined by a medical officer and if need be can be referred to the district hospital, thereby establishing a continuum of care. The ANMs have also been asked to suitably sensitize and counsel the patients and their family members about the exact condition and timely referral to higher facilities. Some of the blocks have already started the process of identification of such cases and referrals.



## Recommendations

**The Framework outline above is a key to identification, tracking and management of HRP:**

- **Timely information about the HRPs to respective MO I/Cs and district health team**  
Once the HRP cases have been identified, the facility in-charge must make a line listing of all such cases with all the relevant information describing the various physiological parameters recorded during the ANC and refer such cases to their respective Community Health Centres (CHCs).
- **Examination of HRP by doctors at CHC**  
Once the pregnant women arrives at CHC, she should be duly examined by a trained doctor and suitable remedial measures started at their end and all the observations of individual cases should be discussed with the respective MO ICs. At any point of time if the doctors at the CHC feel that additional expertise or further diagnostic procedures are needed, the case must be referred to the District Hospital. It is also imperative for the block MOICs to share the data on HRPs with the district civil surgeon and district program management unit.
- **Special focus on Micro birth planning which includes referral transport**  
It is the duty of the MOICs and the ANM to make a micro birth plan for individual cases that will address the various issues related to the anticipated delivery, especially the referral transport which is a huge issue in far flung areas. The ANMs on their part must make a full proof plan involving the Sahhiya (ASHA) and suitably advise the family on early admission to the CHC. The ANM, respective MOICs , Sahiyas and Block program management units should ensure that 24/7 referral transport should be available from various points. In areas where referral transport may not be available all the time, such cases should be brought in early than the expected date of delivery (EDD).

This method should be scaled throughout Jharkand where it is not being implemented based on the assessed burden and potential to avert deaths.

## 4. Strengthening Nutrition Services

### Rationale:

*Malnutrition is a major issue in the state of Jharkhand.*

#### 1. Burden

**Underweight:** As per NFHS-3, about two in five adults (43% of women and 39% of men) in Jharkhand are underweight. The nutritional status of adult women in Jharkhand is worse than in all other states except Bihar and Chhattisgarh and of adult men is worse in Jharkhand than in all other states except Rajasthan and Madhya Pradesh.

**Anemia:** Anaemia among children is widespread in every group. About half of children are anaemic even if their mothers have 10 or more years of education or are in the highest wealth quintile (NFHS, 2005-06). 68% pregnant mothers (15-49 years) have anaemia in Jharkhand; the prevalence is high in no education segment of pregnant women (NFHS, 2005-06).

### Breastfeeding:

- Only 58 % of children under 6 months of age are exclusively breastfed (NFHS-3)
- Only 11 percent who started breastfeeding in the first hour of life (NFHS-3)
- HMIS 2012-13 & 2013-14 says 91.6 percent newborns are breast fed within 1 hour of birth, which does not corroborate with the NFHS rates, data validity being a concern here.
- Half of children in Jharkhand under age five are stunted and underweight and one-third children are wasted (NFHS-3)

#### 2. Nutrition Management in Khunti and Simdega

In lieu of any recent nutrition survey, current data about nutritional status is not available for Khunti and Simdega.

- 3 nutrition rehabilitation centers (NRC) are functional in Khunti at District hospital, CHC Karra, FRU Torpa. During a joint mapping exercise with the District programme management unit (DPMU), it was noted that districts doesn't have adequate facility based management units for providing services to children with severe acute malnutrition. NRC at Community health centre Karra was started with the technical support of CGC|SA.
- In Khunti, Bed occupancy rates of different NRCs for 2012-13, 2013-14 & 2014-15 are below 60%. *Various joint meetings between ICDS and health department have been organized at district and at block levels. However, referral of severely acute malnourished children from field has not improved much with all these interventions.* Though with limited capacity, the beds of these NRCs are not completely occupied and on the other hand malnourishment problem is widespread in the tribal villages.
- In Simdega district, 4 NRCs are working at District Hospital, Thetaitangar, Kolebira and Kurdeg. Based on the NRC data, average bed occupancy rate of these NRCs was 45% in the year 2014-15.

#### 3. Programs Addressing Anemia and Malnutrition and Gaps

**National Iron plus initiative (NIPI):**

- It brings together existing programs for IFA supplementation among pregnant and lactating women, adolescents and children which is a program targeted for providing micronutrient supplements to adolescents.
- The initiative aims to ensure provision of IFA supplements and therapeutic management of mild, moderate and severe anemia in the most vulnerable groups viz. children (6 months to 10 years), adolescents (10-19 years) both in and out of school, pregnant and lactating women and women in reproductive age group (15-45 years).
- The weekly Iron and Folic Acid Supplementation (WIFS) program covers adolescents enrolled in class VI-XII of government, government aided and municipal schools as well as 'out of school' girls.

However, implementation of NIPI suffers due to logistic supply issues of blue colored IFA tablets, lack of knowledge about programmatic guidelines to ANMs, AWWs & School teacher. Availability of reporting and monitoring formats at Schools, AWCs & health facilities are also not uniform.

**Annual Integrated Diarrhea control fortnight (IDCF):**

- This program envisages providing ORS and Zinc to prevent diarrheal death among 0-5 children.
- Monitoring of IDCF round revealed the lacunae present in supply chain of Zinc and ORS in field.
- Community health workers (Sahiya) were neither trained in IDCF guidelines nor in management of Diarrhea.

**Need for Integrated Nutrition Approach**

Nutrition is crucial during every stage of the life cycle. Low birth weight, leads to poor physical and cognitive development. Anemic adolescent girls are at risk of high risk pregnancies. High risk pregnancies in turn affect the child and the vicious cycle continues. Integrated nutrition approach, with convergence from various departments, has tremendous potential to improve the nutrition status across life stages.

**1. Women's' Nutrition**

- **For adolescents and women:** the importance of the healthy timing and spacing of pregnancy, consumption of diversified diet and/or of fortified foods (commercial and/or in-home fortification).
- **During pregnancy and lactation:** increased protein, caloric and micronutrients (Vitamin A, Iron, Zinc) intake, dietary change to increase iron absorption, rest during pregnancy, and the lactation amenorrhea method (LAM) of contraception.

**2. Breastfeeding** during the first 6 months of life: early initiation of breastfeeding (immediately within 1<sup>st</sup> hour of birth) and exclusive breastfeeding for the first 6 months, and infant feeding in the context of HIV.**3. Complementary feeding** from 6 months (appropriate quality, frequency, diversity) with continued breastfeeding for up to two years and beyond, consumption of fortified foods (commercial and/or in-home fortification), responsive feeding, food hygiene, and recommendations for HIV positive children

and children of HIV positive mothers who are unable to breastfeed. In addition, mounting evidence suggests it is necessary to give complementary feeding and feeding the sick child.

4. **Nutritional care of sick and malnourished children:** Kangaroo mother care for low birth weight infants, feeding more during and after illness, provision of vitamin A and treatment of diarrhea with low-osmolarity ORS and zinc supplements, integration of all aspects of the community-based management of acute malnutrition (CMAM) for treatment of moderate and severe acute malnutrition. Referral of SAM to Nutrition rehabilitation centres.
5. **Prevention and control of anemia:**
  - **Among women:** increased dietary intake of iron-rich or enhancing foods, iron-folic acid supplementation during pregnancy, post-partum and more routinely by women of childbearing age, intermittent preventive treatment (IPT) for malaria and de-worming treatment during pregnancy, use of insecticide-treated bed nets (ITNs), and delayed cord clamping at birth.
  - **Among children:** delayed cord clamping at birth, implementation of the Integrated Management of Neonatal and Childhood Illness (IMNCI) algorithm and integrated Community Case Management (ICCM) of malaria, diarrhea, pneumonia, anemia and acute malnutrition, de-worming from age 12 months, increased dietary intake of iron-rich or enhancing foods from age 6 months, and iron supplementation where indicated.
6. **Prevention and control of vitamin A deficiency** through breastfeeding, high dose supplementation of children ages 6-59 months and of women post-partum where appropriate, low dose supplementation during pregnancy where indicated.
7. **Prevention and control of iodine deficiency** through promotion of iodized salt or through supplementation in the absence of scaled up iodized salt program.
8. Actions includes promotion of safe drinking water (such as chlorine dispensers at water points), hand washing at five critical occasions (after defecation; after cleaning child who has defecated; before preparing food; before feeding child; before eating), safe disposal of feces, safe storage and handling of food, use of latrines and promotion of open defecation free communities, and creating barriers between toddlers and soiled environments and animal feces.

**All the above factors tie into maintaining the required nutrition status, especially for mother and child.**

## **Recommendations**

- **Training of ANM and Sahiya on Nutrition focused Activities**

It has been observed that ANM and Sahiya are busy in maternal and child health activities and are missing on critical nutrition interventions like early initiation of breastfeeding, exclusive breastfeeding, IYCF, micronutrients supplementation, anemia, community based management of severely acute malnourished child etc. These are due to lack of knowledge about nutritional deficiencies and its consequences. Training

should be provided to ANM and Sahiya on nutrition programs and effective communication, so that they can educate beneficiaries during outreach field visits.

- **Prioritize Nutrition Outreach**

It has been observed in studies that there are a gap in nutrition interventions that particularly require frequent follow-up and support, most notably safe infant feeding. At the same time, home visits are not the pillar of ICDS programming that they are intended to be (Nirupam ET, al 2011).

- **Community based management of SAM**

Approximately 85-90% of severely malnourished children who do not have complications can be taken care of on an outpatient basis in the community setting. In addition, those children discharged from the institutional care are also to be continued for care at community setting after stabilization and onset of recovery phase. Community Based Care program would complement the services delivered through indoor institutional care and create scope for the majority of children to be provided care in the community setting itself thus reducing the demand on resources and health facilities.

- **Strengthening Village health sanitation and nutrition committee**

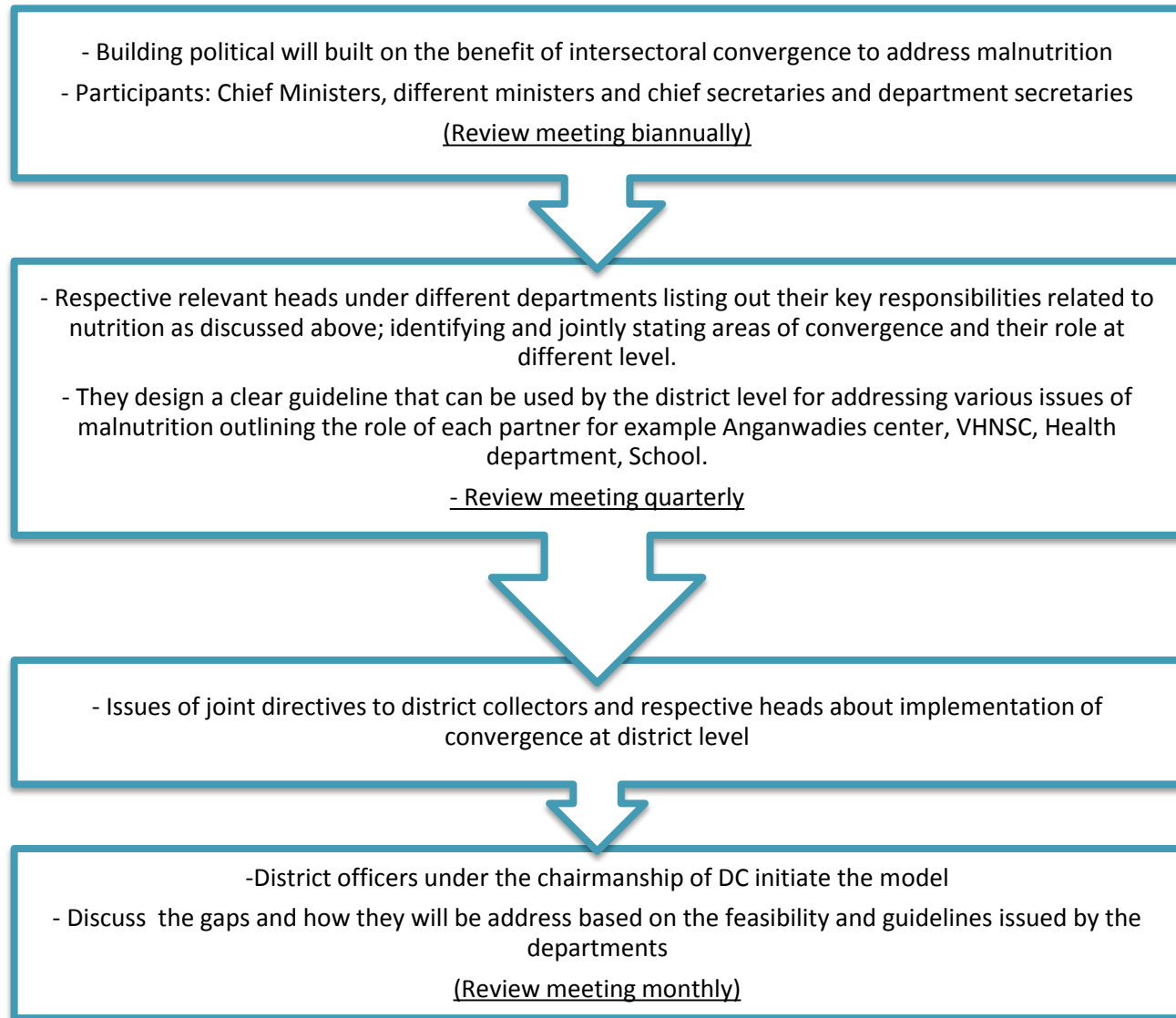
VHSNC has been envisaged to take collective actions on issues related to health and its social determinants at the village level. VHSNC must facilitate early detection of malnourished children in the community; tie up referral to the nearest Nutritional Rehabilitation Centre (NRC) as well as follow up for sustained outcome.

But, these VHSNC hardly meets to discuss this issue. If these VHSNC could be strengthened, nutritional status of every child in a village can be discussed during the meeting and SAM children can be referred to NRC. Sahiya has been provided with MUAC tape. She must measure MUAC of 0-5 age children during VHND. On the basis of findings she can prioritize referral of children to NRC in consideration with ANM & AWW.

- **Intersectoral Convergence**

It is crucial that these 4 departments (Education, Health, PHED and ICDS) should ensure that the responsibility under them is implemented systematically. Additionally convergence is required to discuss barriers of implementation within the individual programs and collaboratively come up with the solutions which hold common consensuses. This is where convergence becomes crucial to participatory problem solving rather than neglecting initiatives.

## Framework for Intersectoral Convergence



## 5. Performance Monitoring and Control Centre (PMCC)

### Background

Health care system must deliver high-quality care, comply with regulatory requirements and enhance patient/community satisfaction while trying to reduce costs and enhance efficiencies. It can improve performance through a Performance Analysis tool that continuously integrates transactional and analytical data across departments and service levels. The tool enables superior decision-making, planning and execution.

Enhanced real-time performance is based on superior operational planning and execution, real-time performance monitoring and improvement, and capacity and resource optimization. It demands better workflow management, performance monitoring on a real-time basis.

The government of Gujarat has developed PMCC system where the higher level officers monitor the certain indicators on monthly basis from program officers which are the support unit of state program unit cell.

### Rationale

With real-time information, the management can take the right decision at the right place and time - be it taking corrective measures, capacity or resource planning or clinical/quality initiatives. In addition, it enables system to monitor cost efficiency and quality performance for process adherence and outcomes. The Performance Monitoring and Control Cell (PMCC) could be conceived as an innovative initiative for the State of Jharkhand to integrate medical data analysis with real-time performance monitoring and reporting, advanced data warehousing and customizable executive and Information Dashboards. Different national health programs have been implemented by different branches. Therefore performance monitoring of the programs from system is mandatory.

### Objectives

- Present district program management unit lacks in requisite skills and capacities to handle day to day monitoring of activities. Many capacity building programs have been undertaken to train the DPMU and BPMU teams but desired results are not showing up. However, it has been observed that if some task is demanded and continuously monitored from an authorized body, the same DPMU provides the information and works with an improved efficiency. **Hence, PMCC will help in improving the work of DPMU/BPMU by ensuring continuous monitoring & technical support.**
- Rapid response to any unusual health event in the state
- Record and report keeping
- Central hub of information for Civil Surgeon which monitors prioritized health indicators from single point and provide feedback
- Single minded dedication to achievement of objectives
- Horizontal and vertical coordination
- Streamlining priority agendas and increasing productivity through role clarity
- Public grievance redressal

### Functions

- To monitor the performance and the progress of the various health programs on the basis of high prioritized performance indicators.
- To monitor trends of various health programs for their continuous progress with previous data and to identify any deviation.
- To encourage the feedback and responses from ground level for betterment of the services provided.
- To provide the suggestion/observation on basis of the field visits of CS and other officials from health department and continuous monitoring towards the compliance.
- Regular and periodic monitoring of the existing available Health and Medical services at different levels of service providers and beneficiaries.
- To ensure the availability, accessibility, quality and optimum utilization of the Human Resources, infrastructure and equipment, materials and services at all level of health care delivery system.



- Co-ordination with Voluntary Organizations, Churches and NGOs in effective implementation of programs.
- To monitor the Key Performance Health Indicators in liaison with Program Officer.
- To promote health in context of shared responsibility and individual accountability for achieving desired outcomes.
- To imbibe sense of accountability for use of resources among health staff for community-based health improvement process.
- To examine the effectiveness of health promotion and disease prevention activities and to determine whether the needs of all segments of the community are being addressed.

#### List of Indicators to be monitored through PMCC

Sr. No	Program	Indicator
1	Maternal & Child Health	Increase in no. of Public Health Institutional Deliveries
2	Maternal & Child Health	Maternal Death Reviewed by DC & CS
3	Maternal & Child Health	JSSK
4	Maternal & Child Health	Immunization
5	Maternal & Child Health	Monitoring of Village Health & Nutrition Days
6	Family Planning	No. of Sterilization after two/three children
7	Family Planning	No. of IUCD after one child
8	Family Planning	No. of PPIUCD
9	Family Planning	No. of counseling for FP of ANC, INC, PNC
10	NVBDCP	Blood Examination Rate
11	NVBDCP	Slide Positivity Rate
12	RNTCP	Case Detection Rate for New Sputum Positive TB Patients
13	RNTCP	Cure Rate for New Sputum Positive TB Patients
14	Sahiya	Payment of Incentives
15	Sahiya	Timely replenishment of Sahiya kit
16	NLEP	Rate of New Cases Detected
17	NLEP	Rate of New Cases with grade 2 disabilities per 1 lac population
18	NRHM Fund	Financial Monitoring of Rogi Kalyan Samitis, Village health sanitation & nutrition committee' fund & Grievance redressal
19	NPCB	No. of Cataract Operations
20	Nutrition	Bed Occupancy Rate of Malnutrition Treatment Centre & Follow up of Discharge cases
21	Facility Based Newborn Care	Management of admitted cases in NBCC/NBSU/SNCU

These all indicators are part of NHM umbrella. Continuous monitoring these indicators would certainly improve the program performance at Community level, Block, District, State & National level too.

**Potential issues which can be additionally addressed through PMCC**

- Strengthened communication with State, Regional, District, block and peripheral health teams.
- **Head Quarter stay of technical staff can be** monitored by random calling to Public Health facility.
- Strategic **action plan, for increasing institutional deliveries and OPD/IPD** at Public Health facilities can be monitored and feedback for improvising action plan can be provided to blocks which have improper planning.
- Abidance of medical officers and other health staffs to Quality of health care can be verified by randomly calling to field level staff and Sahiyas
- Drug stocks can be pulled out from all peripheral facilities to manage stock outs
- **Action Taken Reports** on the observations/suggestions during the State/Divisional meetings and field visits of Commissioner of Health can be asked from concerned blocks.
- Block authorities can be followed up continuously for identifying and preparing proposal in coordination with other concerned department for **Up-gradation of Sub center, CHC according to maternal newborn health toolkit 2013.**
- Compliance of **“Block MoIC”** regarding conducting field visit in block can be monitored by direct communication with concern MoIC. Feedback was given to civil surgeon for disciplinary action.
- Block authorities can be followed up continuously to complete **RBSK check-ups** & data entry.
- Unusual events have been monitored on daily basis by continuous follow ups with district control rooms.
- Timely payment of Sahiya incentive can be monitored by directly calling upon Sahiya.
- Beneficiaries of Janani Shishu Suraksha Yojana (JSSK) were contacted directly to evaluate the effectiveness of program implementation and provide feedback to concerned program officers.
- MCTS data entry can be regularized & updated
- Quality assurance program: Detail of improvement in Quality of health services can be asked from health facilities after supervisory monitoring visits.