Approach Paper Rajasthan State

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List of Abbreviations

AFHS	Adolescent Friendly Health Services
AHS	Annual Health Survey
ANC	Anti Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha & Homoeopathy
BHAP	Block Health Action Plan
BP	Blood Pressure
BSW	Banswara
CBR	Crude Birth Rate
СНС	Community Health Center
СМНО	Chief Medical and Health Officer
DC	District Collector
DH	District Hospital
DHAP	District Health Action Plan
DHFW	Department of Health and Family Welfare
DHKI	District Health Knowledge Institutes
DLHS	District Level Household and Facility Survey
DMHS	Division of Maternal Health Services
DTC	District Training Center
DUNG	Dungarpur
DWCD	Department of Women and Child Development
ECTS	Eligible couple tracking system
EDD	Estimated Date of Delivery
EI	Earth Institute
FRU	First Referral Unit
GOI	Government of India
HB	Heamoglobin
HBNC	Home Based New-born Care
HD	Home Delivery
HPD	High Priority District
HRP	High Risk Pregnancy
IAP	Indian Association of Paediatrics
ICDS	Integrated Child Development Services
ID	Institutional Delivery
IDR	Infant Death Review
IEC	Information Education and Communication
IFA	Iron Folic Acid
IM	Intramuscular

IMA	Indian Medical Association
IMNCI	Integrated Management of Neonatal and Childhood Illness
IMR	Infant Mortality Rate
JSSK	Janani Sishu Suraksha Karyakaram
JSY	Janani Suraksha Yojana
LR	Labor Room
LSAS	Life Saving Anaesthetic Skills
LSGI	Local Self Government Institute
MBBS	Medicine Baccalaureus and Bachelor of Surgery
MC	Medical College
MCHN	Maternal and Child Health Nutrition
MDR	Maternal Death Review
MDHP	Model District Health Project
MMR	Maternal mortality Rate
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MSLY	Mukhyamantri Subh Laxmi Yojana
NBCC	New Born Care Corner
NFHS	National Family Health Survey
NGO	Non Government Organisation
NHM	National Health Mission
NRHM	National Rural Health Mission
NSV	No-Scalpel Vasectomy
ОТ	Operation Theatre
PCTS	Pregnancy Child Tracking System
PG	Post Graduate
РНС	Primary Health Center
PIP	Programme Implementation plans
PNC	Post Natal Care
PPIUCD	Postpartum Intrauterine Contraceptive Device
PRTP	Pratapgarh
RMNCH+A	Reproductive Maternal New-born Child and Adolescent Health
RNT	Ravindra Nath Tagore
RSMD	Rajsamand
SBA	Skilled Birth Attendant
SC	Sub Centre
SDH	Sub District Hospital
SIHFW	State Institute of Health and Family Welfare
SRS	Sample Registration System
UDI	Udaipur
VHNSC	Village Health and Sanitation Committee

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 towards successful implementation of these strategies.

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.Accredited Social Health Activist (ASHA) - Reforms and Career Path (Page 11)

- Improve awareness of ASHA on PPIUCD, NSV and development of an innovative approach to talk about sterilisation with men.
- Refresher training should be organised every 6 monthly to ensure basic concepts, ANC, HBNC and HRP required knowledge and skills are up to the mark and being upgraded.
- Training ASHAs to include the "negative effects" of not following ANC advice while motivating and explaining pregnant women and mothers.
- "ASHA Radio", an innovation in Assam, to receive on going on-the-job training and information
- Introduce "ASHA SAMELANAM" a platform for cross learning and shared experiences
- Quality based ASHA supervision
- ASHA to ANM Career path- after proven performance to motivate ASHAs
- Provide ASHAs with waiting room facilities so that they have a comfortable place to stay when they accompany their patients for institutional delivery.

2. Strengthening of FRUs (Page 19)

- Functional FRUs within a radius of approximately 50 km for timely treatment and equitable distribution of work load and cases
- Considering human resource constraints at least one FRU per district should be made functional (excluding the one currently functional) based on feasibility and priority.
- Once the improvement in the district is assessed further FRUs can be taken up for strengthening based on need, in the medium term.

3. High risk Pregnancy- identification and tracking (Page 27)

Recommendations Identification of HRP:

- Refresher training to improve basic skills of ANM to detect HRP abdominal examination, BP measurement, Hb estimation, weight measurement
- ASHA incentivized for ensuring delivery of HRP at FRU, ensuring proper follow up and

treatment

Recommendations Management of HRP:

- Labour room staff at FRU's should be trained towards management of complications during pregnancy and basic facilities required should be procured.
- State should ensure availability of blood transfusion facility not only at tertiary care facilities but also at CHCs which are designated as first referral unit.
- Availability of iron sucrose injections at PHCs
- Focus of nutrition and dietary habits of HRP cases including IFA, through ANMS, ASHAs, MOs and community management
- State should use cell phones to provide reminders to severely anaemic women for facility visit on iron sucrose injections. Also, reminder call from 108/104 services at EDD for promoting institutional delivery.

4. Quality Training to build the Capacity of service providers (Page 33)

- Hiring of District Training Coordinators at district level will enable smoother and more focused trainings at district and block level, support in establishing all quality parameters for training like pre-post checklist, availability of required mannequins, skill stations and ensure availability of master trainer. This has been implemented by Chhattisgarh government previously.
- Evaluations- after completion of training within 3 month.
- Follow up after training- if any trained personnel found not performing, appropriate enquiry to understand what the reasons are and if any are associated to the training component.
- Inclusion of training in the appraisal mechanism.
- Master trainer for any training should be selected on specified criteria like commitment, teaching attitude, innovation, etc. and they should be provided regular training.
- Incentivization of Master Trainers for maintaining his/her level of commitment and motivation to contribute with quality

5. Sub Center strengthening (Page 34)

Short term recommendation:

- Identification of potential SCs for conducting deliveries
- Utilization of untied funds at the respective SC to ensure availability of basic logistics
- Priority basis training on SBA and NSSK provided to the staff posted in selected SCs
- Information about closest facility which is functional and conducts delivery provided to pregnant women and community members, to facilitate use of strengthened sub centers.
- Provision of deploying 104 ambulances at the SCs which are hard to reach
- Continuous monitoring by district, block and sector in-charge to ensure 24x7 availability of services at SCs

- Provision of stay for ANM at sub-center or close by that ensures that the facility can be accessed by her round the clock.
- A revision of delivery procedures for ANMs of strengthened sub-centr
- On site mentoring will provide training for the ANM to work within the constraints and availability in her work setting, will increase her confidence to take on the responsibility of conducting deliveries and understanding complications.

Mid-term recommendation

- Regular follow up by the sector Medical Officer In-charge is required to ensure functionality of the SC.
- Monitoring data for institutional and home deliveries in the catchment area will guide further changes and decisions
- Based on improvement in case load and ANM performance, rational deployment can be phased

6. Data Driven Planning in Health (Page 42)

- Analytical use of the data from the softwares like PCTS, ECTS and ASHA Soft
- Regular evaluation and discussion over reasons for maternal deaths and infant deaths. Further utilizing these information for bridging the gaps.
- Periodic health surveys, DHAP and systematic evaluation of schemes can also furhter help in data driven planning.

7. Intersectoral Convergence (Page 50)

- Convergence of various departments to improve health indicators related to malnutrition
- Using a collaborative and well defined framework that includes building political will
- Respective relevant heads under different departments listing out their key responsibilities related to nutrition; identifying and jointly stating areas of convergence and their role at different level.
- Designing a clear guideline that can be used by the district level for addressing various issues of malnutrition outlining the role of each partner for example Anganwadies center, VHNSC, Health department, School.
- Issues of joint directives to district collectors and respective heads about implementation of convergence at district level
- District officers under the chairmanship of DC initiate the model

8. Bridging the gap in Post Natal Care (Page 53)

- Monitoring quality of PNC
- Medical skills and capability of ANM and MO to detect postnatal complications must be taken into assessed and training implemented in accordingly.
- To ensure quality of PNC within JSY a separate Staff Nurse/ANM can be recruited for provision of postnatal care at the facility.

- MO and ANM should do regular monitoring of the quality of PNC done by ASHA.
- Community should be made aware of the referral mechanism for the PNC complications thus aiding in reducing the delay caused in decision making and transport.
- IEC strategy for improving the awareness and importance of PNC should be emphasized.

9. PCTS Recommendations (Page 56)

- Training of block and district officials to improve the data quality.
- Formation of information booklet providing clarity on the indicators included in PCTS.
- Software validation exercise should be conducted for rectifying the discrepancies in the software
- Validation of data: Supervisors and IA should regularly validate the data using the basic analytical skills

10. Evidence Based Practices (Page 61)

- A list of evidence based practices and best practices from different states

1. Introduction

The Earth Institute at Columbia University collaborated with the MOHFW to work towards the Model Districts Health Project to provide technical support in implementing the recommendations from the mid-term evaluation of NRHM, conducted by the Earth Institute. More specifically the focus was on the Millennium Development Goals 1, 4 and 5: improving the nutrition status of women and children and reducing maternal and child mortality by 2015. Currently Earth Institute supports three states- Rajasthan, Telangana and Jharkhand. Within these states EI works in two districts, one which was selected for the Model Districts Project and one High Priority District where EI is the lead development partner for RMNCH+A. In Rajasthan, Dausa and Rajsamand were selected for implementation of Models District concept.

The Model Districts Project focuses on health systems strengthening through implementation research, strategic technical advice, monitoring and evaluation, and policy advocacy to help ensure the successful scaling up of services. It is ultimately the district governments and district health units that are responsible for implementing the quality improvements, best practices, and innovations based on the situational analysis. State governments and NRHM offices have a key role to play in driving innovations at a district level, and providing additional funding on evidence based need.

<u>Tread of Neo-natal mortality rate, Infant mortality rate and Under Five mortality</u> <u>rate (SRS Data Series)¹</u>





¹ Regional Child Health Review Meeting of EAG States (8-10 May 2014, Jaipur, Rajasthan) Dairy



Looking at the trend of SRS data and AHS data (Annexure – 1), there is definite decline in neo-natal, infant and child mortality and other indicators. On observing the AHS trend from 2010 to 2013 it can be seen, both Rajsamand and Dausa have shown a gradual decline in under five mortality (AHS data). Also an increase of 18% and 14% has been respectively seen for ANC services i.e. mothers whose blood was taken for Hb measurement during ANC (AHS). In new born care improvement in birth registration has been noted for both the districts. But for children being exclusively breast fed both the districts lie below the state level achievement. According to the RMNCH+A sore card (2014-15) prepared based on the 16 indicators Dausa ranked 23 and Rajsamand was on 8 rank. It was found that Dausa had been lagging in indicators over pregnancy care, reproductive age group, maternal postnantal and new born care. This clearly depicts a need to strengthen theses services to improve the health indicators. Rajsamand, had performed appreciably well in 2014-15, still it being a HPD requires due consideration. Different strategies and need base planning are required for further improvement and make a dent at the IMR and MMR.

1.1 Approach Paper

In the approach paper, total 9 broad strategies are discussed to improve the maternal and child health indicators. These strategies are based on the ground experiences by the Earth Institute team, gap analysis, survey and literature review of available evidences. In these strategies, basically clear and implementable recommendations are provided. The basic recommendations aim to serve as a roadmap in providing guidance towards improving the service delivery and strengthening the public health systems to function with better efficiency.

If government feels that the Earth Institute facilitates in designing roadmap of any strategies in more detail with technical support, we are open to support it.

Introduction



2. Accredited Social Health Activist (ASHA) - Reforms and Career Path

Introduction

One of the key constituent of NHM was provision of a female health activist in every village of the country who is a resident of the village itself and was accountable to it. ASHA works as the interface between community and public health system, serving a population of 1000 in plains and 500 in hilly or desert areas². In Rajasthan, ASHA works both with Department of Women and Child Development (DWCD) and Department of Medical, Health and Family Welfare (DMH&FW). She plays a pivotal role in counselling, creating awareness on health, hygiene, sanitation and social mobilisation. Having an ASHA drug kit, she also renders Primary Health Care. She is a voluntary health worker and gets performance based incentives under NHM.

Rationale

ASHA being the grass root level worker of NHM, the success of NHM also depends upon how efficiently and effectively she is performing her chores. Her performance depends on her awareness and knowledge in health care provision. This study was conducted with the following objectives.

- To assess the knowledge of ASHA in the provision of health care services on specific indicators related to maternal and child health
- To assess ASHA's work satisfaction and career motivation

Methodology

- Cross sectional, descriptive study done using quantitative method.
- Conducted in Rajsamand and Dausa district during April-May 2014.
- Method of data collection- face to face interview using structured interview schedule.
- Interview schedule was designed in English and translated into Hindi to make it easy to be understood by the respondents.
- Universe of the study is Dausa and Rajsamand district.
- Sample size- total of 100 ASHA from both the districts
- Sampling technique- stratified purposive sampling. 10 from each block.
- Interview Schedule has been added as annexure 1.

Results

The results of the study conducted are as follows.

Background of ASHA

 50% of ASHA in the sample had an education between 9-12 standard.



².http://nrhmrajasthan.nic.in/asha-Resourcecenter.htm

Figure 2 shows year of recruitment of ASHA in both the districts.

- 20% of ASHA have been working since 2005.
- 21% of the ASHA interviewed had been working since 2007.
- 31% have been working since 2008.

Knowledge of ASHA

- Majority of ASHA were aware that ANC registration should be done within 12 weeks of pregnancy.
- Awareness on components ANC check up to be conducted by ANM- Figure 3 shows
 - 83 % of the ASHA's mentioned weight measurement
 - 78 % mentioned BP measurement
 - 94 % mentioned Heamoglobin estimation should be done by the ANM during ANC visits.
 - Only 20% were aware that height measurement and abdominal examination was part of ANC check-up. Knowledge on HRP



- Majority of the ASHA's had moderate knowledge regarding the identification of HRP signs.
- The most common signs quoted by them were anaemia, low weight, vaginal discharge, short height, fits, past obstetric history, age (too young or too old).
- 15% of interviewed ASHA were unable to convey even 2 signs of HRP, denoting their poor knowledge in this aspect.
- Analysis of their knowledge district wise it was found that knowledge of ASHA in Rajsamand district was better as compared to Dausa district (Figure 5,6)





 Majority of ASHA (84%) were aware about the dosage of IFA to be given to pregnant women and <u>65% were</u> <u>aware about the therapeutic dosage.</u>





Knowledge on HBNC

- 67 % of ASHA had average knowledge regarding identification of danger signs in infants as they were able to convey at least three danger signs. (figure 7)
- 11 % of the ASHA's had below average knowledge.
- Most common danger signs quoted by them were low weight, high fever, rapid breathing, pus from umbilicus, vomiting, diarrhoea, difficulty in being breast fed etc.
- On comparing district wise knowledge (Figure 8, 9) it was found, ASHA's of Dausa district had better knowledge as compared to Rajsamand district.



 This finding was contrary to the previous finding on knowledge on HRP signs. This raises the need for training of ASHA's on both the topics.





Knowledge on Breast feeding practice

- ASHA's had good knowledge on breast feeding practices
- Majority (98%) of them were aware about continuation of breast feeding even during diarrhoea.
- 95 % had an opinion that during the first six months child should be exclusively breast fed and no additional supplements should be given.
- <u>89 % had the view that colostrum should be given but the remaining 11 % said, it should be given after</u>
 <u>discarding few initial drops.</u>

Knowledge on immunisation

- Respondent had good knowledge on immunisation schedule even with 88 % of them being aware of all the vaccines and their respective schedule.
- Still according to PCTS data children aged 9-11 months who have received complete immunisation has declined both in Dausa and Rajsamand (Figure 11, 12)







Knowledge on Family planning

- Majority (94%, 92% and 91%) of them were aware about condoms, Mala N and copper T respectively are methods of family planning.
- Only few were aware over PPIUCD, emergency pills and NSV being methods of family planning.
- ASHA's of Rajsamand quoted Depo (contraceptive injection) which is prevalent in that district to be a family planning method. ASHA's of Dausa district were unaware about depo.



Training and career path

- 76 % became ASHA to improve the health services of their respective villages.
- 14 % became ASHA because of social prestige and financial incentive was a motivating factor for only 9 % of them.
- Other factors quoted by them were- for earning livelihood, pursuance of family members, to enter in the medical field, to learn etc.
- 98 % accepted that after being ASHA the community has become more respectful towards them.
- Last training: 48 % responded that the last training they had attended was an year back.
- Module 6: 85 % of the respondents had completed the training of both rounds on module 6
 - Only 3% had not received training on any round of module 6.
- **Module 7:** 59 % had completed their training for both the rounds of module 7.
 - 19 % had not received any training over module 7.
- Additional training desired: training on formation of malaria slide, HBNC, sterilisation, conduction of delivery, IMNCI, detection of malnourishment etc.





Supervision:

- 84 % said their supervisors visit them once in a month
- 3 % projected they have not been visited by the supervisors.
- Only 3 % said that their supervisors visit them every week.
- Qualitative discussion at field level revealed that majority of these visits during the month occurs on MCHN days. In few instances it was found that this visit was limited to handling of vaccines on MCHN day.
- Therefore there is a need to monitor the role of supervisor beyond the MCHN day and ensuring that the visits do occur which can help in improving the quality of services being rendered at the ground level.



Incentives

- 45 % of ASHAs had received between 3000-6000 Rs.
- 1 % had received more than 12000Rs.
- 5 % were unaware about the amount received by them.
- 59 % were satisfied with the incentives received by them.





Benefits of ASHA Soft

The aim of this question asked was to capture self-responses. Therefore it is highly probable that the proportion of each benefit captured might be under-estimated in comparison to if the benefits were listed out to them. Over all 75 % found ASHASoft to be beneficial from a sample of 97. (3 were excluded as they were urban ASHAS).

Benefits of ASHASoft:			
	Total	Rajsamand	Dausa
Reduces delay in payment	40	22	18
Report Submission is easy	16	12	4
Deposits incentive directly in bank a/c	23	13	10
Submission of claim form is easier	15	10	5
Helpful in Record complication	2	0	2
No dues	1	0	1
Increase in information	3	0	3
Payment based on work	1	0	1
Full payment	2	1	1
Surety in payment	1	0	1
Don't need follow up for payment	2	2	0
Entry is compulsory	1	1	0

Complains/Barriers related to ASHA Soft	Total	Rajsamand	Dausa
Don't know about ASHAsoft	10	0	10
Not useful	10	4	6
Payment blocked	2	0	2
Software does not take full data	1	1	0
Cut in the payment	4	2	2



Factors motivating ASHA

- 56 % of them prioritised the probability of becoming an ANM in future in their ranking list.
- 27 % gave recognition at village level to be their priority
- 6 % prioritised monetary incentive. This shows the concern of ASHAs about their career growth which should be considered by the state officials to ensure the efficient working of ASHA. (However we are unsure of the data as monetary incentive is being given the last priority but 49 % were not satisfied with the incentives)



Recommendations:

- Annual calendar for sector meeting should be prepared, where 50% time should be devoted for theme of that month, 25% in reporting and 25% general instruction and question - answer.
- Refresher training- Refresher training should be organised every 6 monthly to ensure the concepts and basics of ASHAs are through (particularly importance of abdominal examination, colostrum and height measurement, identification of HRP and HBNC, these gaps found during survey). Including PPIUCD and NSV.
 - \circ $\;$ Developing an innovative approach to talk about sterilisation with men.
- There is high need to orient Dausa district's ASHA on ASHAsoft and appropriate steps should be taken in about the problem raised at block and district level particularly the absence of IA or data entry in the software.
- "ASHA Radio", an innovation seen in Assam, in the state in order to provide ASHAs with a new and interesting avenue through which they receive on going on-the-job training as well as information about new illnesses and important events
- Introduce "ASHA SAMELANAM" to create a platform for cross learning and sharing of experiences earned at field level by ASHA.
- Inclusion of Risk Messaging: Training ASHAs to include the "negative effects" of not following ANC advice while motivating and explaining pregnant women and mothers. E.g. while advising on IFA intake benefits, the harmful effects of poor nutrition and anaemia of mother on her child such as low birth weight and poor cognitive development should be explained.
- Ensuring bimonthly field visits of the supervisors.
- Provide increased opportunity for upward movement for ASHAs, in order to motivate engagement and continued performance.
- Consider enrolling an ASHA into a training school to become an ANM after five years of work and successful recommendations.
- Provide ASHAs with waiting room facilities at PHCs, CHCs, and Hospitals so that they have a comfortable place to stay when they accompany their patients for institutional delivery.

3. Strengthening of FRUs

3.1 Rationale:

The estimated maternal mortality for Rajasthan state is 208 (AHS 2012-13). This includes complications like anaemia, haemorrhage, hypertension, obstructed labour, sepsis and infection and unsafe abortions. As per national policy and guidelines First Referral Units are established to handle and provide Emergency Obstetric Care for members of that community. Complications for mothers also may put the child at risk.



3.2 Gaps and Constraints

- Out of 290 sanctioned FRU (including DH, SDH and Satelite hospital), only 65 FRUs conducting minimum 1 caesarean per month in the state.
- Critical determinants of operationalization of FRUs are either lacking or incomplete. These include 24 hours availability of surgical interventions, new-born care and blood storage³.
- Lack of Human Resource especially Gynaecologist, Paediatrician and Anaesthetist to perform the surgical interventions
- Referral mechanism compromised due to non-functionality of FRUs where patients should be brought as per protocol

Note: In this document, we have assumed functional FRUs are those conducting C-section (at least 1 per month) regardless of its manpower or other related indicators.

3.3 Recommendation: An Approach to Functionalize FRUs for Even Distribution of Case Load and Timely Treatment

Looking at the available human resource constraint, we need to think differently.

- Distance: To make FRUs equally approachable for the catchment population we should have a functional FRUs within a radius of approximately 50 km for timely treatment
- Case Load: For equitable distribution of case load and making public facilities more approachable we consider C- Sections as an indicator which requires all 3 specialists. By doing so we assume that they would be available to handle other surgical complications.



³ Guidelines for Operationalising FRU: GoI (2004)

3. Incremental Strengthening: In the short term, considering human resource constraints at least one FRU per district should be made functional (excluding the one currently functional) based on feasibility and priority. Once the improvement in the district is assessed further FRUs can be taken up for strengthening based on need, in the medium term.

The below graph shows no. of C-section conducted in different facilities in the state. Mere 3 facilities are conducting more than 100 C-section and 38 facilities are doing between 10 to 1 C-section, from them majority are conducting only 1 C-section per month. The detail district wise analysis and share of private and public facilities for C-sections are attached in annexure – 3 and annexure – 4 respectively.



<u>3.4 A Case – Udaipur Zone – FRU Mapping – Suggestions</u>

To demonstrate the case, we have are proving example of Udaipur zone (next page), where distance has taken as a criteria to select non-functional FRU which need to be made functional. We have also mapped other zone's FRUs which can be seen from annexure -5.



From the above graphs, it clears that no. functional FRUs (conducting C-sections) against sanctioned FRUs are minimal in the Udaipur zone. Apart from that the presence of private clinics conducting C-section is also less. Looking to it, government has to focus more on institutionalising functionality of selected FRUs to conduct C-section in the pockets where there is no FRU which are conducting C-section.

1.5 <u>Mapping FRUs – Udaipur Zone</u> <u>Sanctioned, Conducting C-Sections and suggested FRUs to make functional</u> (PCTS 2014-15)



3.6 Udaipur Zone Status for FRUs

Based on the available data, we have proposed 9 facilities to be made functional FRUs in the Udaipur zone. These are for only reference unit. State can design similar exercise at zonal level and priorities facilities which can be made functional FRUs.

Detailed district wise FRU parameters are listed below. Majority of indicators are collected via telephone and C-section data collected from PCTS 2014-15.

P	Proposed FRUs to make functional									
Sr	District	Facility Name								
1	Rajsamand	CHC Deogarh								
2	Pratapgarh	CHC Dariyawad								
3	Dungarpur	CHC Galiakot								
4	Duligatput	CHC Simalwara								
5	Chittorgarh	CHC Rawatbhata								
6	Baswara	CHC Kushalgarh								
7		CHC Kherwada								
8	Udaipur	CHC Kotda								
9		DH Udaipur								

Note: The green colour marked facilities are those which are conducting C-section. Yellow marked facilities are proposed FRUs which need to be made functional.

Distr	ict – Rajsamand								
Sn.	Particulars	Khamnor	Deogarh	Bhim	Kelwara	Railmagra	Amet	SDH	DH
1	Functional OT	N	N	N	Ν	N	N	Y	Y
2	Functional LR	Y	Y	Y	Y	Y	Y	Y	Y
3	NBCC	Y	Y	Y	Y	Y	Y	Y	Y
4	Blood Storage Unit	Ν	N	N	Ν	Ν	Ν	Y	Y
5	Referral Services	Y	Y	Y	Y	Y	Y	Y	Y
6	Gynaecologist	0	0	0	0	0	1(BCMO)	1	2
7	Paediatrician	0	1	0	0	0	0	1	2
8	Anaesthetic	0	0	0	0	0	0	0	1
9	Medical officer	2	3	4	3	3	2	4	4
10	Distance from District Hospital	32	68	97	40	30	37	18	0
11	Distance from RNT Medical college – Udaipur	49	134	163	104	84	103	51	70
12	Conducting C- section p.m.	0	0	0	0	0	0	0	10

DH – Rajsamand is functional, CHC Deogarh should be made functional which will cover majority of unserved population for FRU management. CHC Deogarh has neither Gynaecologist nor Anaesthetic.

District	– Pratapgarh				
Sn.	Particulars	Arnod	Chhoti Sadri	Dariyawad	DH
1	Functional OT	Y	Y	Y	Y
2	Functional LR	Y	Y	Y	Y
3	NBCC	Y	Y	Y	Y
4	Blood Storage Unit	N(No Licence)	Y	Y	Y
5	Referral Services	Y	Y	Y	Y
6	Gynaecologist	0	1	0	1
7	Paediatrician	0	0	0	1
8	Anaesthetic	0	0	0	1
9	Medical officer	1	1(LSAS),Surgeon	1	7
10	Distance from District Hospital	18	50	42	0
11	Distance from RNT Medical college – Udaipur	196	130	132	179
12	Conducting C-section p.m.	0	1	0	7

In the Pratapgarh district, District Hospital and CHC Chhoti Sadri is performing C-Section. If CHC Dariyawad is made functional (42 Kms from DH) would cover majority of area.

Distric	t - Dungarpur							
SN.	Particular	Bichiwara	Galiakot	Damri	Aspur	Simalwara	DH	SDH
1	Functional OT	N	N	Ν	N	N	Y	Y
2	Functional LR	Y	Y	Y	Y	Y	Y	Y
3	NBCC	Y	Y	Y	Y	Y	Y	Y
4	Blood Storage Unit	N	N	Ν	Ν	N	Y	Y
5	Referral Services	Y	Y	Y	Y	Y	Y	Y
6	Gynaecologist	0	0	0	0	0	2	2
7	Paediatrician	0	0	0	0	0	1	1
8	Anaesthetic	0	0	0	0	0	2	1
9	Medical officer	1	1(LSAS)	1	1	1	5	1
10	Distance from District Hospital	24	61	20	49	40	0	45
11	Distance from RNT Medical college – Udaipur	108	166	108	96	145	105	129
12	Conducting C- section p.m.	0	0	0	0	0	19	40

District Hospital and Sub District Hospital Sagwara are conducting C-section. We are proposing CHC Galiakot and CHC Simalwara as functional FRUs as both are at distance from any functional FRUs and bordering area.

Dist	District - Chittorgarh											
CNI	Darticular	Beg	Rawatb	Bhopal	Gan	Kapas	Ras	Badi	Nimbah	Manda	Dung	рц
SIN	Particular	un	hata	sagar	grar	an	mi	Sadri	era	piya	la	υп
1	Functional OT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2	Functional LR	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3	NBCC	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4	Blood Storage Unit	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
5	Referral Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6	Gynaecologist	0	0	0	0	0	0	1	0	0	1	5
7	Paediatrician	0	0	0	0	1	0	1	2	0	0	4
8	Anaesthetic	0	0	0	0	0	0	0	1	0	0	2
9	Medical officer	1	2	1	1(LS AS)	3	1	0(Surge on)	0	1	1	4
10	Distance from District Hospital	66	128	160	25	39	46	85	35	42	63	0
11	Distance from RNT Medical college – Udaipur	183	245	210	136	87	109	101	105	86	79	117
12	Conducting C- section p.m.	0	0	0	0	0	0	7	0	0	0	147

District Hospital – Chhitorgarh and CHC Badi Sadri are conducting C-Section. We are proposing CHC Rawatbhata should be made functional. It is surrounded by Madhya Pradesh and near to Kota Medical College. If we developed this, it would reduce load on Medical College – Kota.

Dist	rict – Banswara									
S N	Particular	Ghato I	Ganod a	Bagidor a	Kushalgar h	Choti sarawa n	Talwar a	Anandpur i	Partapur i	DH
1	Functional OT	Y	Y	Y	Y	N	Y	Y	Y	Υ
2	Functional LR	Y	Y	Y	Y	Y	Y	Y	Y	Y
3	NBCC	Y	Y	Y	Y	Y	Y	Y	Y	Y
4	Blood Storage Unit	N	Ν	Ν	Y	Ν	N	Ν	N	Y
5	Referral Services	Y	Y	Y	Y	Y	Y	Y	Y	Y
6	Gynaecologis t	0	0	0	0	0	0	0	1	6
7	Paediatrician	0	0	1	0	0	0	0	1	2
8	Anaesthetic	0	0	0	0	0	0	0	1(BCMO)	2
9	Medical officer	1	1	1	1	1	1	1	1	1
10	Distance from District Hospital	30	35	30	55	2	15	73	73	0
11	Distance from RNT Medical college – Udaipur	149	131	191	217	164	153	177	216	16 5
12	Conducting C-section p.m.	0	0	0	0	0	0	0	1	21 4

District Hospital Baswara and CHC Partapuri are conducting C-Sections. Here we are proposing CHC Kushalgarh to be made functional FRU as it's on boarder area of Madhya Pradesh and there is no nearby functional FRU performing C-section.

Dis	istrict – Udaipur												
S n	Particular	Risha b devji	Kherw ada	Jha dol	Kot da	Mavli	Kanod	Bhin der	Jha dol sara la	Salum ber	Gogu nda	Hir en ma gri	DH
1	Function al OT	Y	N	Y	Y	Y	У	Y	DN A	Y	Y	DN A	Y
2	Function al LR	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3	NBCC	Ν	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4	Blood Storage Unit	Y	Y	Y	N	Y	Ν	Y	DN A	Y	Y	DN A	N
5	Referral Services	Y	N	Y	Y	Y	Y	у	DN A	Y	у	DN A	Y
6	Gynaecol ogist	1(Mo bile unit)	1	0	0	1	0	1	DN A	2	0	DN A	3
7	Paediatri cian	0	0	0	0	1	0	0	DN A	1	0	DN A	2
8	Anaesthe tic	0	0	0	0	0	0	0	DN A	0	0	DN A	1
9	Medical officer	6	2	3	2	1MD(LS AS),	1(Surg eon)	0	DN A	1(LSA S),1	3	DN A	1(LSA S),6
1 0	Distance from District Hospital	67	82	40	118	47	91	65	60	71	36	3	0
1 1	Distance from RNT Medical college Udaipur	67	82	40	118	47	91	65	60	71	36	3	2.5
1 2	Conducti ng C- section p.m.	0	0	0	0	0	0	9	0	0	0	0	0

• DNA = Data Not Available

CHC Bhinder are conducting C-section. CHC Kotda and CHC Kherwada should be made as functional FRU. DH Udaipur (Chandpol) is already having required specialists however the C-section for the year is zero. More emphasis to be given to DH hence Medical College – Udaipur's load can be decreased.

4. High risk Pregnancy- identification and tracking

4.1 Introduction:

A high-risk pregnancy is one in which some condition puts the mother or the developing foetus, or both, at an increased risk for complications during or after pregnancy and birth. Some of the physical, social, medical problems may complicate a pregnancy and may place the women in high risk pregnancy category (SBA guideline, 2010).

4.2 Rationale:

MMR of Rajasthan state is 208 (AHS 2012-13). Major causes of maternal mortality in India remain haemorrhage (38%), sepsis (11%), abortions (8%), hypertensive disorders (5%), obstructed labour (5%) and other conditions like anaemia (19%), medical disorders during pregnancy contributing to 34% of all maternal deaths⁴. According to the 2008 World Health Organization (WHO) report, anaemia affected 1.62 billion (24.8%) people with an estimated global prevalence of 42% in pregnant women. Identification of high risk pregnancy is a pre-requisite for improving maternal health. This will ensure safe delivery, timely and adequate referral, and will also play a major role in reducing premature deliveries and infant mortality.

With a directive to reduce the MMR and ensure safe motherhood, identification of high risk pregnancy becomes a mandate. Currently most the females falling under this purview remain unidentified or untracked. State Government has made successful efforts in declining the MMR. However HRP identification is crucial to further address this issue. In Rajasthan, anemia, a strong predictor of maternal morbidity, is prevalent within 54% of pregnant women (<11 gm/dl Hb) registered for ANC (April 2014-March 2015, PCTS). Incompetence to identify such cases was a common reason found during interaction with the field health workers.

4.3 Gaps in Identification of HRP

A) Observations and assessments during MCHN Days Monitoring in Dausa and Rajsamand that have implication to the identification of HRP cases:

The graph below shows availability of weighing scale (adult and baby) and immunisation card for registration, materials for privacy for ANC check-up and stethoscope during MCHN day. These are crucial to the identification of HRP. This is in line with the HB estimation data from AHS 2012-2013.

Less HB examination at the time of ANC: AHS data revealed poor HB estimation which has been also observed MCHN observations and field visits at 62.5%.



⁴Park K.: 'Park's Textbook of preventive and social medicine' 20th edition, M/s Banarasidas Bhanot Publishers, Jabalpur: 447 (200)



In the services offered by ANM vaccination of children has been found at all sites, whereas abdominal check-up was minimal, it may be directly linked to indicator related to privacy of pregnant mothers in the above graph.



B) Assessment of ANM Skills by SIHFW

Being the first interface between community and health services at a facility, the quality of services rendered by ANM is essential to achieve the health targets. Every state government should regularly assess their current levels of knowledge and skills so that quality of services is not compromised in the field and relevant training can be provided. The state institute of health and family welfare (SIHFW) conducted a random assessment of ANMs knowledge and skills on a pilot basis in 10 high priority districts (Rajsamand district is among them). SIHFW assessed 5 skills which included BP measurement, HB estimation and filling up of partograph relevant to HRP. The sample size was 1186 ANMs selected from randomly from the cluster of delivery points.



The results revealed:

Similar findings in Dausa (Block Monitoring Visits): Similar findings have been noted in Dausa (non-HPD) as well. Apart from it, lack of confidence, motivation and inadequate skills for provision of basic ANC services which include measurement of BP, urine test, abdominal examination, counselling over family planning, institutional delivery and PNC make it difficult to identify HRP cases. Labour room assessment in Dausa district revealed incomplete partographs at the facility level and lack of skills and confidence was seen in the labour room staff to fill a partograph.

C) Gaps Highlighted through AHS data:

Reason which came out that many ANMs are not confident in doing Hb estimation from hemocheck and sahils method, unavailability of the reagent. Also, at times ANMs do not carry their HB testing kit at MCHN session site.

D) Fewer BP examinations at the time of ANC: MCHN session assessment has revealed that all the ANCs are not examined for BP. Similar were the findings of AHS 2012-13 showing 77 and 78 percent of ANC being examined for BP in Dausa and Rajsamand district.



MCHN session assessment revealed measurement of BP done at 70 percent of the assessed sites. Reasons identified at field level were, lack of confidence in ANM for measuring BP, non-functional BP instrument or stethoscope, ANM not carrying the sphygmomanometer to the MCHN session sites. Further the entry of BP in the SDR was not being correctly at most of the sites.

E) Dearth in tracking of identified HRP cases- As per the state government, Mamta cards of identified HRP cases should carry a red sticker on the top to ensure their delivery at FRU. Further high risk pregnancy registers should be maintained at the facilities to keep a track of identified cases.

While the ground level observations of EI has revealed

- **a.** Pregnant females with red sticker on their mamta cards are not given due priority at the facility level.
- **b.** HRP registers even if present at the facility are not being adequately filled. Anaemia and hypertension were the most common reasons mentioned in the register.
- F) Low consumption of IFA and implications for anemia: AHS 2012-13 has shown alarming facts regarding consumption pattern of IFA among pregnant women.



Above depicted data shows that in Rajasthan only 12.7% pregnant women consumed IFA for 100 days or more and same figure is very low for Dausa and Rajsamand district.

- Reasons for such declining trend came out that pregnant women doesn't wanted to consume IFA tablets due to some side effects like red stools, nausea and stomach discomfort.
- Also, there is lack of proper counselling by ANM and ASHA about benefits of IFA consumption due to this IFA is being neglected by the community.
- Counselling for food and diet was found only at 45 percent of the MCHN assessed by EI.
- G) Administration of iron sucrose only at CHC level: pregnant women whose Hb level is beween 5.0 and 7.9 g/dl need to go for intramuscular (IM) iron therapy for correction of anaemia. Such type of services is only

available at CHC level due to this pregnant women residing in distant village don't prefer to go to distant CHC to avail it.

H) Limited Blood transfusion facility: pregnant women suffering from very severe anemia less than 5.0g/dl needs immediate blood transfusion facility. At present such facility are not available at CHC and is only available at SDH and DH.

With a directive to reduce the MMR and ensure safe motherhood, identification of HRP is a mandate and a priority for GoI and the state. Possible recommendations are as follows:

4.4 Recommendations Identification of HRP:

Design Comprehensive model for high risk pregnancy: Earth institute's interaction with service providers and beneficiaries has revealed the incompetence of service providers to identify HRP, followed by lack of a functional system to track and manage them. A basic foundation for tracking via the registers and PCTS should be encouraged to address these gaps. Below mentioned is a general framework which can be used to further develop the HRP model for state:



- Refresher training to improve skills of ANM: To ensure quality of services through the primary frontline service provider, there is a need to provide additional support for strengthening areas where knowledge and skills are weak. State can plan refresher training for ANMs to conduct basic procedures used for quality ANC checkup like BP measurement, HB estimation, abdominal examination, identification of danger sign, sugar test etc.
- Incentivizing ASHA: ASHA can be incentivized for ensuring delivery of HRP at FRU and ensuring its proper follow up and treatment.

4.5 Recommendations Management of HRP:

- Training of labour room staff at FRU's: Currently C-sections is being done only at DH and SDH. Labour room staff at FRU's should be trained towards management of complication during pregnancy and basic facilities required should be procured.
- Ensuring availability of blood transfusion facility at FRU's: State should ensure availability of blood transfusion facility not only at tertiary care facilities but also at CHCs which are designated as first referral unit.
- Availability of iron sucrose injections at PHCs: State should make a provision to administer iron sucrose injection from PHC level. Medical officer should be trained to handle if any adverse reaction followed by these injectable.
- Focus on nutrition and dietary habits of HRP cases including IFA intake, through ASHAs, ANMs, MOs and community management
- Reminder services: State should use cell phones to provide regular reminders for anaemic pregnant women to take iron sucrose injection. Also, reminder call from 108/104 services at EDD for promoting institutional delivery.

5. Quality Training to build the Capacity of Service Providers

5.1 Gap and Rationale:

Capacity building of staff is the core requirement to provide quality healthcare services. <u>ASHAs and ANMs role is</u> to a great extent interdependent on one another to provide the comprehensive ANC services. While an ASHA is responsible primarily to motivate, inform and explain the importance of accessing maternal services by providing information, the ANMs are responsible for providing basic quality services. Knowledge assessments of ASHAs focus group discussions highlight the gaps and barriers within the ASHAs role. In the field it was observed that ANMs and labour room staff do not perform up to the mark. Skills of ANMs in basic areas are lacking which is observed during field visits and SIHFW's assessment⁵ (2015). The government provided a 7 days refresher training to all field ANMs before the assessment of SIHFW. However the expected quality improvement was not achieved as per the data assessed. It reflects major gaps in delivering quality training and its evaluation. We have provided an example ANM and ASHA here, but the similar way, training of other staff is also important. It is very crucial to focus on quality of training hence quality of services can be improved by the service providers.

5.2 Recommendations:

To improve the quality of training, few major recommendations are as follow:

- Hiring of District Training Coordinators at district level
 - An independent contractual NRHM staff under the under the SIHFW and CMHO office will enable smoother and more focused trainings at District and block level. This has been implemented by Chhattisgarh government previously.
 - S/he will also do all managerial work related to training.
 - S/he will support in establishing all quality parameters for training like pre-post checklist, availability of required mannequins, skill stations and ensure availability of master trainer.
 - $\circ\quad$ DTC will do training follow up on regular basis.
- Follow up mechanism for training Evaluations
 - All the trainings must be evaluated as follow up after completion of training within 3 months
 - During the follow up, if any trained personnel found not performing, appropriate enquiry to understand what the reasons are and if any are associated to the training component.
- Training need to be included in appraisal mechanism
 - Training should be incorporated in the appraisal mechanism; furthermore, if someone is trained for particular skill, s/he should be appraised accordingly.
- Selection of Master Trainer and Performance:
 – selection regular training and assessment extra
 incentive
 - Master trainer for any training should be selected on specified criteria like commitment, teaching attitude, innovation, etc.
 - They should be provided regular training, regularly assessed and based on that their eligibility for trainers should be decided.
- 6. There should be an incentive system for Master Trainers to maintain his/her level of commitment and motivation to teach.

⁵ SIHFW has done assessment of 5 basic skills of ANMs in 10 HPDs

6. Sub Center strengthening

6.1 Rationale

In the Rajsamand district there has been decline in the number of home deliveries from 3503 against 30807 deliveries (PCTS 2012-2013) to 3113 against 23771 deliveries (PCTS 2014-2015). Similarly in Dausa there has been considerable decline in the number home deliveries from 2804 against 33211 deliveries (PCTS 2012-2013) to 684 against 30288 deliveries (PCTS 2014-2015). Although this decline has been positive, further steps are required to avert home deliveries and improve the current quality of services at sub centres. Additionally there is the concern of many home deliveries not being reported due to multiple factors.

The sub center is the peripheral and first point of contact between primary health care system and community, rendering the primary health care services to a population of 5000. Due to either unavailability of 24*7 staff or other essential logistics most of the sub centers are rendering only ANC and immunisation services. Thus strengthening of the services at these centers may lead to a decline in home deliveries and also promote institutional deliveries.

6.2 Key Advantages of providing delivery services at Sub Centers:

- Closer access to institutional deliveries in areas that have many home deliveries
- Access to more comprehensive maternal and child health services more easily
- Reduction in travel time to health facilities
- Decrease delivery load on other facilities, especially on CHCs and PHCs

6.3 Criteria for identification of potential SCs for strengthening:

- Sectors/areas that have high number of home deliveries
- Basic infrastructural facilities which include building, water supply and electricity should be present
- Willingness to conduct deliveries and receive further training for improvement in skills should be scrutinized
- Easy to reach and distance and from currently delivery performing facility
- Availability of SBA trained staff, if not then rational deployment of staff within the block
- Sub centres already performing deliveries can be given priority for strengthening

A CASE:

To make a case, both the districts block wise home delivery mapping has been done. Along with sector wise exercise for one each block has been demonstrated to provide clarity and the way to do the exercise. In the sector wise home delivery mapping, potential SC also selected to be strengthen based on certain criteria like building and labour room available, water and electricity available, presence of ANM, nearest home delivery areas and distance from nearest delivery conducting institution.

Apart from these two blocks examples, we have also plotted home deliveries for the rest blocks of both districts which can be seen from annexure - 6.



Mapping of home deliveries in Rajsamand district for 2014-2015 (PCTS)



Block	2012-13 (A)	2013-14 (B)	2014-15 (C)	Decline (from 2012-13 to 2014- 15) ((A-C)/A)
Amet	376	370	428	-14%
Bhim	798	834	645	19%
Deogarh	572	616	440	23%
Khamnor	604	512	384	36%
Kumbhalgarh	773	713	839	-9%
Railmagra	163	182	179	-10%
Rajsamand	217	153	195	10%
District Total	3503	3380	3110	11%
Please Note: For the mapping below the number against CHC or PHC depicts the total home deliveries for that sector and the SC mentioned under it contributes to highest burden in the sector.



Mapping of home deliveries in Bhim block 2014-15

Sub center selected for strengthening in Bhim block

Name of SC	Building available	Labour room	Electricity	Water	ANM	Nearest high home delivery area	Distance from delivery performing facility
Kala Guman (PHC Diver)	Yes	Yes	Yes	Yes	Yes	Itself a high home delivery place	5 km, Janawad SC
Barjal (PHC Chapli)	Yes	Yes	Yes	Yes	Yes	Itself a high home delivery place	12 km, Deogarh CHC



Mapping of home deliveries in Dausa district for 2014-2015 (PCTS)

Home deliveries in the district (PCTS)

Block	2012-13 (A)	2013-14 (B)	2014-15 (C)	Decline (from 2012-13 to 2014-15) ((A-C)/A)
Bandikui	681	567	197	71%
Dausa	603	367	172	71.4%
Lalsot	272	97	2	99.3%
Mahwa	367	298	136	62.9%
Sikrai	881	553	177	79.9%
District Total	2804	1882	684	76%

*As there were only 2 home deliveries in Lalsot block in 2014-15 the mapping and SC selection has not been done.

*There is appreciable decline in the home deliveries in the district; however this also raises a question over the credibility of the data. For example a decline of 99% has been recorded in Lalsot block in the past three years

which raises the concern. To validate the provided information, we have randomly called few ASHAs and AWWs of the Lalsot block and details are in the table below.

S. NO.	Name of Asha/AWWs	Contact No.	Village	Total Delivery 14-15	No. Home Delivery	Details of Home Delivery
1	Naveen Devi (ASHA)	9950091040	Badekhan	34	1	1. Sanja Devi w/o Pappu (02/12/14)
2	Anita Meena (ASHA)	9001550746	Ladpura	25	2	 Gita Devi W/O Rajendra (21-10-14) Dholi Devi W/O Ramesh Meena (23-08-14)
3	Surta (ASHA)	8952821754	Khanpur	18	1	 Foranta W/O Ramkhiladi (3-6-14)
4	Suman Saini (AWW)	7062638757	Shreema	18	5	 Lalita Bairwa (Dec- 2014) Mamta W/o Mukesh Bairwa (Nov-2014) Karjan W/o Manoj Bairwa (May-2014) Ladadevi W/o Ramjilal Bairwa (1.2.2015) Mamtadevi W/o Jitu Meena (3.2.2015)
Total				95	9	

Random called following	g ASHA/Anga	nwadies workers to	validate home d	delivery status of	f Lalsot block
Randolli canca lonowing	5, 10, 17, 97, 11, 54		vandate nome o	sched y status of	Earson Brook

Based on the above table, out of 95 total deliveries, 9 were home deliveries from random call data of Lalsot block. However in the PCTS that for whole year (2014-15) the block has only 2 home deliveries (both reported home deliveries are not part of above 9 home deliveries). It raises high concern of data validity at block level. Under reporting of home delivery may be due to fear of higher authorities.



Mapping of home deliveries in Sikrai block 2014-15



Name of SC	Building	Labour	Electricity	Water	ANM	Nearest high home	Nearest
	available	room				delivery area	РНС/СНС
Namner	Yes	Yes	Yes	Yes	Yes	Kalakho	CHC Geejgarh- 7
(CHC Geejgarh)							Km
MeenaSimala	Yes	Yes	Yes	Yes	No	Thikariya,	PHC Manpur- 10
(PHC Manpur)						Chandera	Km

Block	Name of SC	Building available	Labour room	Electricity	Water	ANM	Nearest high home delivery area	Distance from delivery performing facility
Rajsamand o	district							
Amet	Racheti ka Kheda (PHC Zilola)	Yes	Yes	Yes	Yes	Yes	Sakarada, Didwana	12 km, Amet
Deogarh	Mad	Yes	No	Yes	Yes	Yes	Togi, Tokara, Biyana	9 km, Amet CHC
Deogarh	Madariya	Yes	Yes	Yes	Yes	No (GNM available)	Madariya, puniyana	5 km, Anjna Subcenter
Kelwara	Jetaran (PHC Bardara)	Yes	Yes	Yes	Yes	Yes	Jetaran, Futadewal	19 Km, Kelwara CHC
Khamnor	Pakhand (PHC Akodara)	Yes	Yes	Yes	Yes	Yes	Namana	18 km, SDH Nathdwara
Khamnor	Godach (PHC Nedach)	Yes	Yes	Yes	Yes	Yes	Nedach, Usan, Pipawas	13 km, CHC Delwara
Railmagra	Rajpura (CHC Dariba)	Yes	Yes	Yes	Yes	Yes (2)	Itself a high home delivery place	10 Km, Railmagra CHC
Railmagra	Sindesar kalla (CHC Railmagra)	Yes	Yes	Yes	Yes	Yes (1)	Pachmata, Lachakhedi, Soniyana	6 Km, Rialmagra CHC
Rajsamand	Rajiyawas (PHC Mohi)	Yes	Yes	Yes	Yes	Yes	Itself a high home delivery place	16 km, DH Rajsamand
Dausa Distri	ct					-		
Bandikui	Nandera (PHC Badiyal Kalan)	Yes	Yes	Yes	Yes	Yes	Kheda khsri, Dhandholai	CHC Bandikui- 5 Km
Bandikui	Baijupada (PHC Lotwara)	Yes	Yes	No	No	Yes	Balaheda, Digriya bheem	PHC Lotwara- 7Km
Dausa	Jopada (PHC Kundal)	Yes	Yes	Yes	Yes	Yes	Kalota, Manga bhata	DH or PHC Kundal- 16Km
Dausa	Bishanpura (CHC Sainthal)	Yes	Yes	Yes	Yes	No	Itself a high home delivery center	CHC Sainthal- 7 Km
Mahwa	Haldena (CHC Mandawar)	Yes	Yes	Yes	Yes	No	Banawad, Kot	CHC Mandawar- 7 Km
Mahwa	Berkheda (PHC Balaheri)	Yes	Yes	Yes	Yes	No	Itself a high home delivery place	PHC Balaheri- 5 Km
Mahwa	Vishala (PHC Balaheri)	Yes	Yes	Yes	Yes	No	Baijupada, Balaheda, Digriya Bheem (PHC Lotwara, Bandikui block)	PHC Balaheri- 7 Km

Sub center selected for strengthening for the rest of blocks from both the districts (Rajsamand and Dausa)

6.4 Short term recommendations:

• Identification of potential SCs for conducting deliveries

• Utilization of untied funds

Utilization of untied funds at the respective SC to ensure availability of basic logistics, for the provision of delivery and new-born care services

• SBA and NSSK training for staff in selected sub centers should be ensured

Priority basis quality training on SBA and NSSK should be provided to the staff posted in the sub centers selected for the strengthening.

• IEC Materials for high home delivery areas

Information about closest facility which is functional and conducts delivery should be provided to pregnant women and community members, to facilitate use of strengthened sub centers.

• Availability of 104 in high home delivery pockets:

Provision of deploying 104 ambulances at the subcenters which are hard to reach

• Ensure 24 * 7 services at the facility

Continuous monitoring by district, block and sector in-charge to ensure 24x7 availability of services at sub center.

Provision of stay at sub-center or close by that ensures that the facility can be accessed easily by the ANM round the clock.

• A revision of delivery procedures for ANMs of strengthened sub-centre:

Utilization of untied funds at the respective SC to ensure availability of basic logistics for the provision of delivery and new-born care services

• On Site and Off Site Mentoring

On site mentoring will provide training for the ANM to work within the constraints and availability in her work setting. Additionally training at higher level facilities will increase her confidence to take on the responsibility of conducting deliveries and understanding complications and appropriate referrals.

6.5 Mid-term recommendation

- Regular follow up of strengthened sub centers:
 - After setting up of delivery services at identified sub centers regular follow up by the sector Medical Officer In-charge is required to ensure functionality of the SC.
 - Monitoring data for institutional and home deliveries in the catchment area will guide further changes and decisions
 - Based on improvement in case load and ANM performance rational deployment can be phased in.

7. Data Driven Planning in Health

7.1 Rationale:

As per the Annual Health Survey, Rajasthan has successfully brought down maternal mortality from 331 (2010-11) to 208 (2012-13). Similarly IMR has gone down from 60 (2010-11) to 55 (2012-13). Other related indicators have also shown positive results. However further improvement is still required. One contributing reason is the focus on public oriented schemes like JSY/JSSK/MSLY⁶ to ensure safe delivery services but not giving the desired attention towards data driven decision processes at every level. Available data in the system and also derived from other external agencies can help in identifying key areas which need to be addressed to achieve the desired health outcomes.

States have invested heavily in collection of data to understand the scenario – improvements and pitfalls. Further efforts should be directed towards utilization of the large amount of data at every level for data driven planning.



7.2 Recommendations - Current and potential data sources and its potential use in data driven planning:

7.3.1 PCTS

The State Government uses this software to monitor maternal and child health services and manages an information system about pregnant women/children. Based on the data captured by ANMs, State and district officials are using this tool to review ANC, immunization, delivery, post-natal care etc.

⁶ JSY = Janani Suraksha Yojana, JSSK = Janani Shishu Suraksha Karyakram, MSLY = Mukhyamantri Subh Laxmi Yojana

Gap: It is not being utilized in its completeness and in analytical way to identify the bottlenecks of the system. Additionally it is not being used in its full potential for tracking of cases which may actually throw light on some of the indicators in a more precise way.

Potential: Following are examples showing how the data from PCTS can be used to identify gaps and plan strategies addressing these gaps.

a) ANC registered cases in the PCTS but did not report delivery after completion of Expected Delivery Date

B) Number of children whose immunization not reported after passing of due date

S.No	Locations	ANC Cases	ANC Cases where delivery Not	No. of Cases after	whose delivery passing 40 days	not reported of EDD	% of Cases
			Reported	2013- 14	2014- 15	2015- 16	
Blocks	: Bandikui						
CHCs							
1	Bandikui	1399	439	328	104	7	31.38
2	Baswa	4058	1514	519	937	58	37.31
PHCs							
3	Abhaneri	1736	309	180	106	23	17.8
4	Arniya	1229	283	97	170	16	23.03
5	Badiyal Kalan	1429	775	515	226	34	54.23
6	Biwai	643	323	167	148	8	50.23
7	Golada	1069	448	221	205	22	41.91
8	Gudaliya	960	158	45	99	14	16.46
9	Gudhakatla	2626	216	78	116	22	8.23
10	Lotwara	2041	505	345	148	12	24.74
11	Pratappura	841	109	12	90	7	12.96
12	Pundarpada	702	132	87	39	6	18.8

ANC Registered Cases Not Reported Delivery after EDD

Mis	ssing Immunization	Period: April 2014 to March 2015
S.No	Bandikui Block	No. of Children whose Immunization not reported after passing due date
		Not Fully Immunized
1	CHC Bandikui	25
2	CHC Baswa	465
3	PHC Abhaneri	255
4	PHC Arniya	90
5	PHC Badiyal Kalan	192
6	PHC Biwai	59
7	PHC Golada	139
8	PHC Gudaliya	64
9	PHC Gudhakatla	550
10	PHC Lotwara	456
11	PHC Pratappura	65
12	PHC Pundarpada	115
	Block Total	2475

The tables clearly illustrate that current data recording system is capable to generate reports related missing deliveries and missing number of children whose full immunization is not reported after due date. Based on this information planning should be initiated to explore the reasons and sources of discrepancies for missing deliveries and missing children not fully immunized to increasing the coverage of institutional delivery and full immunization percentage respectively. It is possible that the missing deliveries could be home based or institutional based if person has migrated. Based on this planning for a strategy can be initiated.

7.3.2. Quality of Maternal Death Review and Infant Death Review and Social Audits

Facility based audits of reported maternal deaths is being currently done in the district. However the quality of audits needs to be improved to further and correctly understand the reason of deaths demarcating actual and associated causes. Based on the current audits sufficient corrective actions are not being undertaken at either the block or district level. A discussion and review of maternal and infant deaths at block and sector meetings could draw out health systems related information and gaps leading to the cause, apart from clinical cause of death. This should be rigorously followed up by preventive and corrective actions planned collaboratively addressing the system gaps and clinical causes.

7.3.3. Systematic review of public oriented schemes

State government is implementing various public welfare schemes JSY, JSSK, MSLY etc. Main aim of these schemes is to provide maximum benefits to the masses which results in the betterment of health indicators. These schemes will be successful only if the district reviews it in a timely manner to identify the bottlenecks and

resolve them. For example the review of JSY payments against the deliveries being conducted in the district can help in identifying the gaps and discrepancies in data to initiate exploration of the source of discrepancy. Ideally the JSY payment is given to those females who stay for 48 hour in the facility. The table denotes otherwise. This also points out to the potential misinterpretation and confusion in understanding the indicator.

		Perio	od : April 2014 to March	2015	
SN	District	Deliveries at Institution	Of which Number discharged under 24 hours of delivery	Of which Number discharged under 48 hours & above of delivery	Number of cases where JSY incentive paid to Mothers
1	Ajmer	46197	4734	35042	45369
2	Alwar	50568	7002	45652	49807
3	Banswara	41274	3190	37968	41177
4	Baran	22212	4219	17971	21295
5	Barmer	44136	7992	36128	40486
6	Bharatpur	45465	18675	30493	45049
7	Bhilwara	35501	2849	32235	35387
8	Bikaner	39121	5385	34790	37928
9	Bundi	19205	605	18514	19155
10	Chittorgarh	25103	2279	22457	24284
11	Churu	29029	1704	27262	28965
12	Dausa	19088	3936	17990	19092
13	Dholpur	26512	55	26457	24331
14	Dungarpur	24194	618	23625	24120
15	Ganganagar	23389	2540	20866	23385
16	Hanumangarh	19214	3976	16614	17313
17	Jaipur I	59509	11159	47081	56900
18	Jaipur II	19061	148	19031	18821
19	Jaisalmer	12367	2230	9992	11056
20	Jalore	21821	6889	16616	21506
21	Jhalawar	26755	21	25370	25810
22	Jhunjhunu	12446	2436	12164	11634
23	Jodhpur	59609	17818	35612	58191
24	Karauli	23062	1301	21073	22515
25	Kota	25489	128	25275	24815
26	Nagaur	43463	7259	35635	43087
27	Pali	31490	4563	27281	31490
28	Pratapgarh	18140	1647	16182	17963
29	Rajsamand	16155	143	16103	16082
30	Sawai Madhopur	21429	5974	16458	21000
31	Sikar	21220	5170	19312	19215

PCTS data showing public institutional deliveries Vs JSY incentive paid to mothers

		Perie	od : April 2014 to March	n 2015	
SN	District	Deliveries at Institution	Of which Number discharged under 24 hours of delivery	Of which Number discharged under 48 hours & above of delivery	Number of cases where JSY incentive paid to Mothers
32	Sirohi	17320	3534	13651	17305
33	Tonk	20175	86	19688	20048
34	Udaipur	55987	16282	41536	50138
	Total	1015706	156547	862124	984719

7.3.4. ASHA Soft

The figure shows the report on ASHAs without 6 and 7 module/ IMNCI/HBNC training and has received HBNC incentives. This kind of information can be used by district officials to plan for ASHA training. Similarly the list of non performing ASHAs can be derived from the software and reasons for zero performance should be addressed. Also head wise payment reports can help in analyzing sections where ASHAs are not working very actively and thrust can be laid over those services.

	Mast	er Reports 👘 🖓	Activity Reports	Payment Reports	Advanced Sea	rch Log out
		ASHAs Without	6 & 7th Module/IMN	CI/HBNC Training & R	eceived HBNC Incent	ives
ack						Month-year : Apr 2015
	S.No	District	Total No. of working ASHAs	ASHAs Trained in 6 & 7th Module or IMNCI or HBNC by NIPI	Sanctioned Issued for those ASHAs who received training of 6 & 7th Module or IMNCI or HBNC by NIPI	Sanctioned Issued for those ASHAs who have not received training of 6 & 7th Module or IMNCI or HBNC by NIPI
	1	<u>Aimer</u>	<u>1478</u>	<u>1252</u>	<u>620</u>	<u>37</u>
	2	<u>Alwar</u>	<u>2366</u>	<u>1466</u>	<u>784</u>	<u>437</u>
	3	Banswara	<u>1829</u>	<u>1821</u>	<u>712</u>	2
	4	<u>Baran</u>	<u>1230</u>	<u>1218</u>	<u>488</u>	4
	5	<u>Barmer</u>	<u>2040</u>	<u>1919</u>	<u>160</u>	4
	6	<u>Bharatpur</u>	<u>1593</u>	<u>1572</u>	<u>963</u>	<u>11</u>
	7	<u>Bhilwara</u>	<u>1713</u>	<u>1633</u>	<u>698</u>	<u>3</u>
	8	<u>Bikaner</u>	<u>1034</u>	<u>981</u>	<u>380</u>	5
	9	<u>Bundi</u>	<u>930</u>	<u>827</u>	<u>415</u>	<u>38</u>
	10	<u>Chittorgarh</u>	<u>1308</u>	<u>1283</u>	<u>524</u>	0
	11	<u>Churu</u>	<u>1372</u>	<u>1337</u>	<u>678</u>	1
	12	<u>Dausa</u>	<u>1274</u>	<u>1270</u>	<u>452</u>	2
	13	<u>Dholpur</u>	<u>841</u>	<u>828</u>	<u>360</u>	1
	14	Dungarpur	<u>1529</u>	<u>1269</u>	<u>322</u>	<u>33</u>
	15	Ganganagar	<u>1452</u>	<u>1418</u>	<u>682</u>	0
	16	<u>Hanumangarh</u>	<u>1050</u>	<u>1034</u>	<u>513</u>	4
	17	<u>Jaipur I</u>	<u>2116</u>	<u>2038</u>	<u>903</u>	<u>3</u>
	18	<u>Jaipur II</u>	<u>1477</u>	<u>1476</u>	<u>713</u>	0
	19	<u>Jaisalmer</u>	<u>391</u>	<u>341</u>	<u>31</u>	1
	20	<u>Jalore</u>	<u>810</u>	<u>763</u>	<u>383</u>	4
	21	<u>Jhalawar</u>	<u>1187</u>	<u>1093</u>	<u>385</u>	2
	22	<u>Jhunjhunu</u>	<u>1493</u>	<u>1482</u>	<u>955</u>	0
	23	Jodhpur	<u>1844</u>	<u>1273</u>	<u>385</u>	<u>21</u>
	24	Karauli	<u>1056</u>	<u>891</u>	<u>314</u>	<u>41</u>
	25	<u>Kota</u>	<u>1075</u>	<u>1060</u>	<u>496</u>	5
	26	Nagaur	<u>2287</u>	<u>2191</u>	<u>911</u>	<u>32</u>
	27	Pali	1444	1423	713	1

7.3.5. ECTS- Eligible Couple Tracking System

Eligible couple survey is conducted in April every year. Information from it can be used to calculate the IMR, MMR, unmet need for family planning.

Gap: But, unfortunately the information has not been updated in it since 2013. Further there is discrepancy in the data available in PCTS and ECTS. For example according to ECTS there were 44 maternal deaths in Dausa district during 2012-13 but according to PCTS the maternal deaths during that period is 12 and further the line listing was available for 2. Hence, it is necessary to ensure the credibility and reliability of data for realistic data driven planning.

	चिकित्सा,स्व	ास्थ्य एवं परिवा	र कल्याण विभाग	
		राजस्थान सरव	नार	
	वर्ष 2 Status a	2012 में मातृ मृत्यु is on 28/05/2015	ु की सूची 03:21:15 PM	
जिला	: दौसा		सर्वे का	वर्ष : 2013
क्रं सं.	ब्लॉक	सीएचसी/ पीएचसी	उपकेन्द्र	कुल मातृ मृत्यु
1	बादीकुई	अरनिया	ोकझ	1
2			बडवाली	2
3			डिगारिया टप्पा	1
4			पिचुपाडा खुर्द	1
5			श्यामसिंहपुरा	1
6		बसवा	बांदीकुई जागीर	1
7			श्यालावास खुर्द	2
8		लोटवाडा	मीनापाडा	1
9	दौसा	भाण्डारेज	सूरजपुरा	3
10		खारण्डी	बाणे का बरखेडा	1
11			चेन्या का बास	1
12			खारण्डी	1
13		ख्वारावजी	श्यालावास	1
14		कुण्डल	भेडोली	1
15			कुण्डल	1
16			पुरोहितों का बास	2
17			सिण्डोली	1
18		लवाण	बनियाना	1
19			लवाण	2
20		पापड्दा	आल्दा	1
21			गांगलियावास	1

22			ठीकरिया	1
23		सैथंल	बिशनपुरा	1
24	लालसोट	बगडी	बगडी	2
25		डीडवाना	रलावास	2
26	महवा	बालाहेडी	गगवाना	1
27			पीपलखेडा	1
28		खेडला बुजुर्ग	बडागांव	5
29		महवा	महवा	2
30		मण्डावर	गढ हिम्मतसिंह	1
31	सिकराय	भण्डारी	पीलवा कलां	1
			कुल योग	44
System	Designed & Deve	loped by National	Informatics Center,	Rajasthan

Maternal Death Cases

Report Taken At 28/05/2015 04:55:33 PM

State : F	Rajasthan		Period : April 2012 to March 2013
S.No	Locations	As per Reporting (From No 6,7,8)	Cases Of Maternal Death
Jt.Direct	orate Ajmer		
1	Aimer	71	<u>26</u>
2	Bhilwara	31	<u>52</u>
3	Nagaur	13	<u>16</u>
4	Tonk	27	<u>15</u>
Division	Total	142	109
Jt.Direct	orate Bharatpur		
5	Bharatpur	34	18
6	Dholpur	7	5
7	Karauli	25	<u>11</u>
8	Sawai Madhopur	26	<u>11</u>
Division	Total	92	45
Jt.Direct	orate Bikaner		
9	Bikaner	38	<u>18</u>
10	Churu	23	<u>24</u>
11	Ganganagar	23	<u>16</u>
12	<u>Hanumangarh</u>	7	<u>14</u>
Division	Total	91	72
Jt.Direct	orate Jaipur		
13	Alwar	67	23
14	Dausa	12	2
15	Jaipur I	90	20
16	Jaipur II	18	<u>10</u>
17	Jhunjhunu	22	<u>16</u>
18	Sikar	32	22

7.3.6. Periodic Health Surveys

In India, many health surveys are periodically conducted by government and semi government which gives health information on state and district on various types of indicators. Those conducted in India are NFHS, DLHS, AHS and SRS etc. census and vital (sample) registration system. The findings of these surveys are useful for making state and district specific action plans. There is scope that some relevant indicators could be compared within the PCTS system to understand the validity and gaps in data more thoroughly.

7.3.7. District Health Action Plan (DHAP)

The idea of the District Health Action Plan is ground up detailed planning by each district towards meeting the long-term goals of the Health Sector Strategy. The soul of the District Health Action Plan is a participatory and consultative process with involvement of a wide range of stakeholders. This does not take place in all districts. Although the bottom up approach is an inclusive planning process the State might not be in a position to include all required and recommended components in the state Program Implementation Plan. The state does take the initiative to review innovative and larger infrastructural requirements.

- To make the State PIP more comprehensive and inclusive, the State needs to provide training to district and block level officers for compilation of BHAP and DHAP and which factors to focus on to improve the efficiency and usefulness of this comprehensive and time consuming planning process.
- <u>A Multiyear DHAP</u> which includes a short term (2-3 years) and medium term (5 years) holistic plan would be beneficial to reach goals in improving health outcomes in a more systematic and focused manner. Priorities that are highlighted could be worked upon incrementally based on the constraints and strengths of the current health system.
 - a. The MDHP Project will aim to advocate this concept with the Central Government during the next year. Current assessment of the scenario underscores the value of this model being a practical approach to address the challenges of the health system.

7.3.8. Value of conducting Community Based Survey

The State Government can initiate the process of a Community Based Survey to assess service delivery provided by frontline workers and the health system to understand the barriers and validity of information being collated in the PCTS. This will also enable assessment of health personnel as per the community. It should be supplemented with a survey for Frontline workers to provide valuable information on the difficulty or ease with which households can access by existing family health services, perceptions and of the level of knowledge that households have in terms of reproductive health, and pregnancy and new-born related care and practices.

8. Intersectoral Convergence

8.1 Rationale:

The <u>current vertical programs</u> within health will be able to <u>attain positive health outcomes</u> to a certain extent. <u>To sustain and achieve further positive outcomes integration</u> of programs within different departments is crucial.

- The convergence of departments towards common goals has the potential to reduce the burden of demand on curative services by focusing on prevention.
- Cumulative impacts on multiple outcomes Convergence facilitates different functionaries and community to work together for efficient service delivery to improve indicators which are interrelated.
- Pooled budgets improve economies of scale

This hold true for further improvement of maternal and child health indicators, especially related to nutrition which affects the life cycle of a human from birth to adolescence to child bearing age and in turn on their children. As per the norms laid down by the NRHM and Government of Rajasthan, it encourages intersectoral convergence and describes which departments can work together.

We have been advocating for a model on Nutrition based on the similar concept. However State Level officials from different departments need to play a key role to enable implementation at ground level. Collaborative distribution of responsibilities to achieve a common goal is crucial to the success of convergence models.



8.2 Problem: Under nutrition/Malnutrition

The graph represents more than 50% pregnant women are anaemic and almost quarter of live births weight less than 2.5 kg. This underscores the importance to focus on anaemia. The State Government has initiated various service delivery mechanisms to tackle this issue. But a broader platform for engagement by various departments is required to address nutrition holistically.

Supplementary nutrition directly ties in to the health related indicators of a pregnant woman and her child. The first five years of life are important as they are the foundation to good health and nutrition for optimum physical and developmental growth. During this phase of life the child is vulnerable towards the vicious circle of malnourishment, infections, disease which may eventually result in disability. Nutrition is a multi-faceted problem and involves the role play of many factors

such as poverty, lack of purchasing power, ignorance, unavailability of health care, gender bias, illiteracy etc. Studies indicate nutrition affects the sensorimotor and cognitive development of a child and performance at school⁷⁸⁹.

8.3 Key departments that can play role in improving under nutrition:

- Department of Women and Children Development (DWCD):

This Department includes the Integrated Child Development Services (ICDS), to provide supplementary nutrition for pregnant and lactating mothers, children under six, and non-formal preschool education through Anganwadi center. Additionally they provide Iron tablets to girls who are not enrolled in school.

- Department of Medical, Health and Family Welfare (DHFW):

This department is responsible for care and treatment of malnutrition in women and children. The distribution of IFA tables, setting up malnutrition treatment centers and providing iron sucrose and blood transfusion are the key responsibilities along with counselling on health, nutrition and diet.

- Department of Education:

WIFS program is taken to ensure adequate iron status among adolescents (10-19), both males and females. Under this programme free of cost Iron and Folic Acid and deworming tablets are given along with testing and counselling. Additionally they must screen the target groups for moderate/severe anemia & refer these cases to the health facility.

Public Health Engineering Department (PHED)

Supply safe and clean drinking water and construction and maintenance of toilets is important to prevent faecal- oral route infections which have an effect on health of people.

Therefore it's crucial that these 4 departments 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.

8.4 Gaps identified based on previous intersectoral models:

- The major gap in the convergence of departments is the absence of a proper guideline for the convergence.
- Majority of the officials are unaware about the guidelines that do exist. Members who are supposed to monitor the convergence are also unaware about any such guidelines.

⁷ Rampersaud GC, Pereira MA, Girard BL, et al (2005). Breakfast habits, nutritional status, body weight, and academic performance in children and adolescents. Journal of American Dietetic Association. 105:743-760.

⁸ Walker, S. P., Wachs, T. D., Gardner, J. M., Lozoff, B., Wasserman, G. A., Pollitt, E., ... & International Child Development Steering Group. (2007). Child development: risk factors for adverse outcomes in developing countries. *The Lancet*, *369*(9556), 145-157.

⁹ Ghosh, S., Chowdhury, S. D., Chandra, A. M., & Ghosh, T. (2014). Grades of undernutrition and socioeconomic status influence cognitive development in school children of Kolkata. *American journal of physical anthropology*.

- Unavailability of sufficient number of staffs and budget for supervision.
- Political interference is also a barrier for the convergence of programs.
- Head of the different departments might not provide required support to each other

8.5 Framework for intersectoral convergence

- Building political will built on the benefit of intersectoral convergence to address malnutrition
- Participants: Chief Ministers, different ministers and chief secretaries and department secretaries

(Review meeting biannually)



- Respective relevant heads under different departments listing out their key responsibilities related to nutrition as discussed above; identifying and jointly stating areas of convergence and their role at different level.
- They design a clear guideline that can be used by the district level for addressing various issues of malnutrition outlining the role of each partner for example Anganwadies center, VHNSC, Health department, School.

- Review meeting quarterly



- Issues of joint directives to district collectors and respective heads about implementation of convergence at district level



Additional benefits:

- To improve maternal and child health by change in social determinants and using a medical approach for addressing the health issues.
- To reduce the inequities in maternal and child health focussing on the social determinants of health.

Intersectoral Advocacy Efforts: Earth Institute had advocated early last year. The health department at state level supported the model however its implementation was not successful because the political will at higher level and other departments was absent (annexure -7).

9. Bridging the gap in Post Natal Care

9.1 Introduction and Rationale

Postpartum period is the period beginning after delivery and extending up to 42 days. It is a time of heightened risk for both the mother and child. Lack of adequate care during this period can have grave implications on the health of the mother and the child. Post-natal care is a weak component in the RMNCH+A care continuum. According to AHS 2012-13, 79.6% females had received PNC check-up within 48 hours of delivery. However the PCTS data does not collaborate with the AHS data. Majority of the maternal deaths have also been recorded during the postnatal period based on recent social audit data analysis. This further highlights bridging the gaps in the postnatal care.

9.2 Gaps identified

PCTS data for the past three years for Dausa and Rajsamand reveals that the PNC has gradually declined over the period of time. This raises the question over both the credibility of data and the PNC coverage.

• 48 hours PNC against public deliveries





• 3 PNC against total deliveries





• 24 hours PNC against home deliveries

ASHA soft has further improved the monitoring and evaluation of PNC as ASHA's get payment only after their PNC visits are verified by the supervisors. Ideally an ASHA is supposed to have 6 PNC visits in case of institutional delivery and 7 PNC visits in case of home deliveries. The first visit in case of home delivery should be done within 24 hours of home delivery. PCTS data reveals the following.



It can be seen from both the graphs that PNC done within 24 hours of home deliveries is not equivalent to number of home deliveries occurring in the district. This raises the concern over the PNC services being rendered by health systems.

• Social Audit Data

Based on the available Social Audit Data of maternal death of Rajasthan, 66 % deaths occurred in the post-natal period. **56 maternal deaths were analysed that occurred either in transit or at home**¹⁰.



¹⁰ Analysis of Social Audit of Maternal Death done by the Earth Institute and submitted to the state government

Place of maternal death:

The below graph represents 33 maternal deaths occurred during transit; which may be result of complications, not reaching at appropriate facility and improper referral mechanism. It was also revealed that 7 cases of those were multiple referrals which suggest either service providers were not clear about appropriate referral destinations or poor capability to identify the reasons.

23 maternal deaths of 57 occurred at home. 11 home deliveries and rest are due to delay in decision making.



9.3 Recommendations:

9.3.1. Monitoring quality of PNC

• Importance of MO and ANM to provide PNC:

Although an ASHA is crucial to provide postnatal care, the role of MO and ANM can't be neglected. Their medical skills and capability to detect postnatal complications must be taken into consideration.

- 48 PNC at institution: Based on the monitoring visits it has been observed that ANMs and MOs are not engaging in quality postnatal care. It could be that they are overburdened and multitasking or they do not give priority to postnatal visits. Within JSY a separate Staff Nurse/ANM should be recruited postnatal care.
- PNC by ASHA: Current guideline suggests at least one postnatal visit should be monitored by ANM/MO, however this is not currently practise or there is no mechanism to monitor it.

9.3.2. Referral mechanism for complications:

Referral mechanisms will be compromised till FRUs are not functional delaying care. Furthermore the functionaries are less capable to manage basic obstructive care at PHC and CHC level. People are not aware about the post-delivery complications. Community has knowledge about available mechanism for referral particularly for ANC and delivery however they might not aware about the postnatal referral mechanism.

9.3.3. IEC for quality PNC

IEC strategy for improving the awareness of PNC should be emphasized.

10. Pregnancy Child Tracking and Health Services Management System (PCTS) Gap Analysis

10.1 Introduction

Pregnancy, child tracking and health services management system is an online web based application launched on 15 Sept. 2009. Its new version as per Government of India guidelines has been made functional since 1st July 2010. The objective of PCTS is case specific monitoring of every pregnant woman and her child to reduce maternal and infant mortality. PCTS has been endowed with National Award for E- Governance (2011-12), best project under e-Health category (2010), The Manthan Award (2009). It has also been acknowledged by Data Quest magazine (spotlight) 2010. The software undoubtedly helps in maintaining an online directory of health institutions, automatic data consolidation, online trend analysis and has made data management more efficient to a large extent. Although the software is user friendly, the technology is unable to percolate at the lower levels. Discrepancies in data can be seen thus compromising the quality of data.

10.2 Objective

To improve the data quality, both Earth Institute and Dausa district officials undertook an initiative in **July-August 2014** to:

- Identify gaps in data in PCTS recognise and comprehend the various issues faced in PCTS pertaining to data entry and management at all the levels
- Formulate strategies for strengthening of the data based on the gaps identified and proposing possible need based solutions to resolve the concerns.

10.3 Methodology

Facilities were randomly selected and face to face interviews were conducted using an unstructured interview guide. 11 Auxiliary Nurse Midwives (ANM's), 5 Information Assistants (IAs), 1 Block Data Entry Operator and 1 District Nodal Officer (DNO) were interviewed at 7 Sub-centers and 5 Primary Health centers. Various levels in the hierarchy enabled understanding the flow of data in PCTS and identify the gaps.





Figure 1

- The Service Delivery Register (SDR) is filled by ANM. She uses this data to fill facility based forms 6, 7, 8 at SC PHC, CHC/DH level. They are uploaded in PCTS by the Information Assistant or Data Entry Operators. The last date for filling the form is the 10th of every month after which the data can't be changed. The line listing (area wise reporting for catchment population for ANC, delivery and immunization) continues for the entire month which constitutes the line listing of the figures mentioned in Form 6.
- The Form 6, 7, 8 are then checked at the block level by the Block Data Entry Operator to correct the discrepancies in the data. The discrepancies are made to be corrected at the respective facility. At the block level Form 9A is generated automatically.
- Similarly at the district level Form 9 is generated automatically which includes the information from all the blocks. Also, the information is uploaded in Health Management Information System (HMIS) which is checked by the DNO.

10.5 Gaps Identified at Different Levels resulting in data discrepancies

1. Level of ANM

In filling the SDR

- The SDR has 166 columns in the section 5 related to pregnancy and delivery. As a result ANM's often leave some of the columns empty, compromising the quality of data. For example Figure 2 denotes the entries are missing in 'Past Obstetric History'. These columns were not present in the older version of SDR thus the ANM's are not properly aware about what details are to be filled.
- ANMs were unable to fill columns asking about the number of iron and folic acid tablets given and also differentiate between therapeutic and prophylactic dose.

1	T	ीवित स की सी	संतानों ख्या	सबसे				Pas	Obstatrice	Hate									वर्ष	0 13 + 2	01 <u>4</u> fi	 वेरन्तर
		M	F	छाटे बच्चे की	9 2 a a	पहले हुई सामान बीमारी की जानकारी (कोड)	Total No. of	Last Pre	agnancy परिणाम	Last to Las	st Pregnancy	वीडीआरएस टेस्ट	एचआईवी टेस्ट	आखरी माहवारी	पंजीकरण कर	क्या 12 सप्ताह के मीतर	हिलीवरी की	प्रसव के लिए चिनित सम्मावित	प्रेरक आशा	गर्भावस्था से पहले परिवार कल्पाण का कौनसा	मा (ह	र्मपात वतः)
+	1	+	16	17	100	19	Pregnancy 20	जाटलता 21	. (कोड) 22	जटिलता 23	पारणाम (कोड)	Not Done	P/N Not Done	की ' तारीख	_{খন} दिनांक	किया गया हॉ/नहीं	अनुमानित तारीख	चिकि. संख्यान का नाम	सहयोगिनी का नाम	साधन अपना रखा था (कोड)	हॉ/नहीं	यदि हाँ तो सप्ताहों की संख्या
12	1	+	-	34		-	1000	616		sia		10	26	27	28	29	30	31 .	32	33	34	35
23	11		1 2	24		1		0	19 41 19 19 19 19 19 19 19 19 19 19 19 19 19	1				1/113	25,14/13	078	6/10/13	HANYC	सुरिाखान्यम	5	∎€'	
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1	F		1	8 '	-	-),		17		2		2/13	23/6/13		11/13	1				
20	0	0	-	0	-	-		2		•				3/13	23/5/13	24	11/12/13	1,	1	5		

Figure 2

In filling of form 6

- A section of form 6 requests number of live births to be included should be corresponding to the total of section on home and sub-center deliveries. However this fact is unclear and some ANMs were including the births conducted at 'other facilities' e.g. private, leading to data duplication and discrepancies.
- The total number of females registered for ANC services should be equal to the sum of TT1 and TT booster given while discrepancies have been noted in the form. (Figure 3)
- Also the total number of registered females should be equal to the sum of IFA tablets given. However mismatch in this data can also be seen. (Figure 3)

Chapter – 10 Pregnancy Child Tracking and Health Services Management System (PCTS) Gap Analysis

राजस्थान सरकार	F1E-07-1-70	पार्ज-6
- 05050 उप स्वास्थ्य केन्द्र का मासिव	म्रागति प्रतिवेदन	Ċ
HC-Manpur PHC HToryz	Subcenter Code 02140300116	Block - Sikrai Month- April 2014
पसवपूर्व सेवाये	(आह के तौरान	माह के अल्त तक
कुल पंजीकृत गर्भवती महिलाओं की संख्या		51
पथम तिमाही (12 सप्ताह पूर्य) में पंजीपत्त गर्भवती महिलाएँ		J.I.
जननी सुरक्षा योजना में पजीकृत महिलाएँ	91	51
मर्भवती महिलाएं जिनकी प्रसय पूर्व 3 जांचे हैं		10
गर्भवती महिलाओं को टी.टी.का टीका	0	+6
8.8.4	q	1.91
et.et11		5
थी. थी. यूस्टर	10	136
गर्भवली महिलाएँ जिन्हें 100 आई एफ ए गोली दी	18	119
गर्मवती महिलाएँ जिन्हें 200 आई.एफ.ए गोली दी (एनिमिक)		
उच्च रक्तचाप वाली गर्भवती महिलाएँ(बी.पी.140/90से अधिक)		
सस्यां में इस माह दर्ज नए केस(उच्च रक्तचाप वाले)		
खून की कमी वाली गर्भवती महिलाएँ		
जिलका हीमाग्लोबिन (Hb) स्तर 11 से कम है(जांच के बाद)		29
यूरिन टेस्ट	- 21	29
गर्भवती महिलाओं की संख्या जिन्हें जटिलाताओं के कारण उच्च संस्थाओं पर रेफर किया गया	-	



Difference in line listing

- A difference in the figures quoted in the form 6 and their corresponding line listing (area wise reporting of pregnancy delivery immunization etc.) has been noticed.

Classification of home deliveries

 Some of the deliveries which are being conducted at home are being entered under those conducted by 'Skilled Birth Attendants'. However on further probing it was found the *Dhais* who had conducted those deliveries were trained 5-10 years back. According to the Gol guidelines only ANM's are considered to be SBA trained.

Error in Last Menstrual Period (LMP)

- Females in village often do not remember their LMP. Thus, sometimes the difference in delivery date and their LMP becomes more than 9 months and this entry is not accepted by PCTS.

2. Level of data entry operator

Difference in line listing

The last date for filling the Form 6 is 10th of every month after which the information fed cannot be altered. The line listing however is open throughout the month and can also be filled later. Thus, the entries on the form are entered first to complete it. But whether the corresponding Delivery Line listing Report (DLR) or immunisation template is complete, if it has the line listing of all the figures mentioned in the form is checked at a later stage. It has been observed that the corresponding DLR or immunisation template does not have the line listing of all the figures mentioned in the Form 6.

Difference in couple number

 Each couple in PCTS is identified with a unique number. But, on filling of the Form 6 and 7 if the unique couple number varies the corresponding entries are not accepted by PCTS, and information from line listing is not completely entered. The variation in couple number can be due to mistake on the ANM's part or an error by the one doing data entry. To further complicate matters there is no provision for the correction of previously entered wrong couple number. Thus, the error continues and proper line listing cannot be achieved.

3. Gaps in the software

 Parts of the software need to be re-defined to avoid taking in manual errors or miscalculations. In Figure 4 the number of sterilization done in male for the month of May is 0 while the number of NSV conducted (which is a method of male sterilisation) is 1. A similar discrepancy can be seen in case of female sterilisation as well.

📔 Report on Major Indicator 🛪 🚺	17h	1 28 2	1987.26	A Map	A REAL	1	4-67 - 28	C ANA CA	
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🚻 Apps 🛛 Y Yahool India 🕅 Gmail: Email from	m G 🧌	Toxics Alert: Think b	2shared.com - fre	e f 🚊 PHSE	2012 - Google	f Facebook 🛛 4si	hared.com - free f	DTE Industry se	ts the rul 🛃 CFL Waste » Waste2 🦷
							Month :	May 2014	•
	S.NO.	СНС	Sterilization Done Male	Number of NSV conducted	Sterilization Done Female	Number of Laparoscopic Sterilizations	Number of TT Sterilizations	1. Number of PPIUD	
	District	: Dausa Block:	Bandikui						
	1	Bandikui	0	1	0	11	0	0	
	2	Baswa	0	0	0	0	0	1	
L	District	. Dausa Diock.	Dausa						Back
	3	Bhangdarej	0	0	0	0	0	0	Export to Excel
	4	Lawaan	0	0	0	0	0	0	
	5	Paparda	0	0	0	0	0	0	
	6	Sainthal	0	0	0	0	0	0	
	District	: Dausa Block:	Laisot						
	7	Laisot	0	0	0	5	0	0	
	8	Mandawari	0	0	0	0	0	2	
	9	Ramgarh Pachwara	0	0	0	0	0	0	
	District	: Dausa Block:	Mahwa						
	10	Badagaonv	0	0	0	0	0	0	
	11	Mahwa	0	0	0	13	0	0	
	12	Mandawar	0	0	0	0	0	7	
	District	: Dausa Block:	Sikrai						
	13	Gijgarh	0	0	0	0	0	0	
	14	Sikandara	0	0	0	0	0	0	-
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- The delivery reports generated from Form 6, 7, 8 (Facility based) against line listing, in terms of percentage may be misinterpreted. For example in the following figure for Gullana SC the delivery is 1 as per form 6. However since delivery of the women who registered at the SC was conducted elsewhere, as per line listing the number of deliveries in the catchment area is 6. This is leading to line list percentage of 600. According to Form 8, the deliveries being conducted at the CHC are 70, but only 48 women were registered to the CHC and might have conducted the deliveries elsewhere. Thus, the line list percentage is low showing 68.57%. This can lead to misinterpretation of the results, especially in terms of assessing the facility performance and load.
 - However, if the percentages of delivery are calculated against ANC registration at that facility, a clearer picture can be obtained of the facility performance.

JISTI	ict: Dausa	BIOCK: Band	ikui	Period: April 20	14 to June 201
		D	elivery Cases(R	eporting V/s Line L	.ist)
S.No	Districts	istricts As per Reporting List Difference (+/-		Difference (+/-)	LineList Percentage
CHCs	;				
1	Baswa	70	48	22	68.57%
Subc	enters				
1	Agawli	0	2	-2	0%
2	Bad Bishanpura	0	2	-2	0%
3	Bag ki dhani	1	2	-1	200.00%
4	Bandikui jageer	1	8	-7	800.00%
5	Gullana	1	6	-5	600.00 %
6	Gullana Thali	1	15	-14	1500.00%
7	Kaled	0	11	-11	0%
8	Karnwar	0	13	-13	0%
9	Kolana	4	13	-9	325.00%
10	Kuti	0	9	-9	0%
11	Mahadevpura	0	10	-10	0%
12	Phulela	0	2	-2	0%
13	Raipura	0	0	0	0%
14	Shyalawas Kalan	0	16	-16	0%
15	Shyalawas khurd	0	20	-20	0%
Total		78	177	-99	226.92%

Figure 5

 Another example observed was in Form 9A where 723 deliveries were conducted in accredited private hospitals in Mahwa block of Dausa. However, the number deliveries conducted till June 2014 in private institutions was noted as 815 and all these 815 private deliveries were given JSY payment. This gap in data could be due to software or a manual error and needs to be re-defined.

4. Gap at the MOIC level

 Checking of the Forms is also one of the responsibilities of the MOIC of the concerned facility. However, this is not being followed sincerely leading to errors in data. Therefore it is required to organise a training session for the higher level officials so that such gaps can be identified and corrective actions can be taken in a timely manner.

10.6 Recommendations

- Training of block and district officials to improve the data quality.
- Formation of information booklet providing clarity on the indicators included in PCTS.
- It would be crucial to re-orient all personnel on this so that they can in turn orient other staff such as ANM and IAs responsible for collecting and collating data.
- Software validation exercise should be conducted for rectifying the discrepancies in the software
- Validation of data: Supervisors and IA should regularly validate the data using the basic analytical skills.

11. Evidences of Best Practises:

1. <u>Recruitment and retention of Health workers in underserved areas¹¹</u>

• Regulatory and Educational Measures:

a) Pre-PG Compulsion

Below mentioned eleven states have made it mandatory for all the graduates to complete two to three years of rural service for admission to the PG degree programs (Arunachal Pradesh, Haryana, Himachal Pradesh, Jammu and Kashmir, Maharashtra, Manipur, Nagaland, Orissa, Sikkim, Tamil Nadu and Tripura).

Way to do:

Certain number of seats like 10 to 30% should be reserved for good performing MBBS doctors during their rural posting.

b) Rural Recruitment

Preferential admission to candidates from rural or tribal background for the nursing courses.

It should be made mandatory that nurses of private nursing colleges can only receive their registration certificate after completion of few years of rural services.

• Monetary compensation

Most common strategy used by many states to attract and retain the skilled health personnel in rural areas through providing financial incentives. These financial incentives generally provide as per "difficult area allowances" in addition to their regular salaries. In Rajasthan it is paid only to health work force working in high priority districts.

Rajasthan Govt. should not discriminate the districts on the basis of high priority and non-high priority districts. Instead of this state government <u>should identify the backward</u> <u>areas from each district</u> and provide similar type of allowances to doctors and nursing staff.

• Workforce management policies

State government should try to reduce the lengthy recruitment process of paramedical to hire regular staff. Many times this process takes almost 12 to 18 months to fill the regular posts. State government should make contractual nurses permanent/regular based on areas they are serving. (In Orissa and Tamil Nadu above mentioned cadres are automatically regularized after serving for two years in rural areas)

Government should adopt a strategy to employ retired doctors and nurses to meet the existing human resource gaps for functions that they might be capable to perform. (This system available in Gujarat, Manipur, Maharashtra, Nagaland, Orissa, Sikkim, Tamil Nadu and Tripura)

¹¹ Human Resources for Health in India, Strategies For Increasing The Availability Of Qualified Health Workers In Underserved Areas, 2011, Krishna D. Rao, Dr. Garima Gupta, Dr. T Sundararaman

State Government can take the initiative to provide group housing for health workers living in remote areas to enable them to live closer to their families and have basic amenities and security while working in isolation in far flung areas. (States like West Bengal, Uttrakhand and Chhattisgarh have set up group housing colonies for the staff)

Residential quarter set-up at block level: State government can establish colony of all the government officers at block level where school, bank, and all other necessary required shops available nearby. In this set-up, all the doctors are allowed to stay at block headquarter and regular day and night duty stay at PHCs can be provided. Government can also set up travel linkages to drop and pick-up the staff from the periphery. For the emergencies, at different locality, 104/108 ambulances can be set up hence community can use them in the emergency. This type of setup would retain the medical officers and specialist. It would build the peer support mechanism within block level which bring harmony and security by living together.

State Govt. should make a policy <u>to place specialists (paediatrician, Anaesthetist,</u> <u>Surgeon) first at district hospitals and at the functional CHCs that are providing</u> <u>comprehensive emergency obstetric care.</u> Many times it has been observed that above mentioned post of specialist are available at those CHCs which are not providing comprehensive emergency obstetric care. This irrational deployment results in nonutilization of their services.

First government should appoint doctors on the need basis. A strict transfer policy should be made for both specialists and MBBS doctors who have to complete a minimum tenure of three years at one location of posting. No transfers would be made until three years of term is completed at one centre of posting. (This norm followed in Haryana State)

State Government could explore the possibility of the 3 year rural health care practitioner's course to meet out the shortage of health workforce in underserved areas. (Similar course is going on in Chhattisgarh)

2. <u>Evaluation and Validation of existing schemes to identify the bottlenecks in</u> <u>implementation in the field</u>

Earth Institute has done evaluation and validation of JSY/JSSK/MSLY scheme in their two districts namely Dausa and Rajsamand. Such type of activities is helpful to identify the bottlenecks and perception of community related to government schemes. On the basis of validation findings corrective actions can be taken for effective implementation of beneficial schemes.

Ways to do:

State Govt. can instruct every development partners to assess the govt. programmes and schemes related to their mandate of work. This type of exercise can be done biannually.

3. <u>Poor quality practices followed in Labour rooms</u>

- Earth Institute has undertaken the task to assess the capacity of health facilities in order to deliver high quality maternal care services (essential equipment, trained human resources, protocols, quality of services etc.) and to identify best practices and gaps in the labour rooms of both the district (Dausa and Rajsamand). Main motive was to reinforce the facility and staff to provide sustainable quality services by setting benchmarks for other institution. This activity has shown remarkable result in the field which results improvement in the condition and services offered at labour rooms.
- If any district or development partner dedicatedly undertakes such type of activity with the collective support from district collector and district health officials, the results would be positive.

4. Non Functionality of AFHS Clinics

State government should try to first create the demand among adolescent to avail services available at AFHS clinics.

State government should make a proposal to hire retired medical officers to provide their services at AFHS clinics, so that shortage of manpower issue can be resolved.

AFHS team should interact with adolescent age in their schools and colleges to impart awareness about the health issues and if any further advice or treatment is require than services can be availed at AFHS clinics (Gujarat Model).

5. <u>To promote safe motherhood and institutional delivery¹²</u>

Birth Waiting Rooms

It's an intervention to ensure the provision of birth waiting rooms for pregnant women from distant tribal areas to reach the institutions a couple of days before the expected date of delivery in order to avoid complications. These birth waiting rooms can be built on high load delivery center. (Model from Tamil Nadu)

6. <u>To improve immunisation and young child feeding practices</u>⁹ Dular Strategy (Bihar Model)

The main goal of this project was to put in place interventions that would empower the family and the community, within selected areas of the Integrated Child Development Scheme (ICDS) purview, to make positive changes in health-related behaviours, as well as addressing the issue of malnutrition among women and children and reducing anaemia among adolescent girls. The interventions used consisted of behaviour change communication and interpersonal communication (IPC) strategies.

¹² Directory of innovations implemented in health sector, Dec 2008

Well Baby Campaigns (Andhra Pradesh)

Well Baby shows will be organised in all the Gram Panchayats where children below one year will be assessed on the basis of their immunisation status, nutritional status and milestones for growth and development.

Annual Immunisation Census (Andhra Pradesh)

Annual immunisation census to be conducted once a year to enable monitoring of 100% immunisation coverage of children. One week per year a dedicated tracking of all mothers and children for their immunisation status will be conducted in every habitation in the State. Quality control of the census process will be ensured by including sample checks by supervisors, done through house-to-house surveys. The women health volunteers, AWWs and ANMs will form teams and conduct the census, simultaneously giving mop-up immunisation for non-immunised children.

Catch-up Rounds for Immunisation and Zero Diarrhoea Programme (Jharkhand)

An activity for ensuring complete immunisation coverage; includes a package of services for vaccines, IFA, deworming, Vitamin A and surveillance for malaria and TB. The services in the catch-up round are being provided on a biannual basis to "the last person in the last household to the last village".

Immunisation drive (Kerala)

A campaign to strengthen immunisation coverage in the State through intensive IEC/BCC campaigns and intersectoral convergence of the Education and Health departments. A planning and review exercise will be undertaken through intersectoral co-ordination committees to be constituted at the district, education district, sub-district and school levels by involving officials from related departments such as Health, Education, Social Welfare and LSGIs and representatives of Parent Teachers Association, IMA, IAP, opinion leaders, religious leaders and NGOs. The campaign methodology includes various IEC activities:

- Special talks in schools
- Dissemination of the messages on immunisation during Immunisation Week in schools through brochures, posters, stickers, flip charts and pledges
- Cultural folk media programme
- Orientation training for teachers

7. <u>To improve the behaviour change communication</u>

Mother and Mother-in-Law Mela (Maharasthra)

A programme held at the village level for the orientation of mothers and mothers-inlaw on various aspects of reproductive health. Some of the issues addressed: premenopause, post-menopause, age at marriage, pregnancy, mother's nutrition, gender bias regarding children and importance of spacing.

8. <u>To overcome the shortage of poorly skilled manpower¹³</u>

Establish District Health Knowledge Institute

Government may propose the setting up of District Health Knowledge Institutes (DHKIs) in districts with a population of more than 500,000 in order to enhance the quality of health workers' education and training. These institutes should offer degree and diploma programmes, certificate courses, accreditation and standardized professional training. Their location, at the district level, should make them accessible to local candidates and facilitate uniformity in admissions, curricula and licensing.

9. Mainstreaming of AYUSH in current health system

- Facilitate the skill up-gradation of AYUSH doctors for the provision of primary health care at SHCs through a 3-6 month bridge course.
- State government should try to create posts of AYUSH doctors at the PHCs, CHCs and district hospitals. This gives patients the option of availing of AYUSH or allopathic services, as per their preference.
- Involve AYUSH practitioners in health promotion and prevention of noncommunicable diseases.
- Govt. should create career trajectories in public health and health management for this cadre.

10. <u>Mapping of High Priority Villages</u>

- Mapping of high priority or focussed villages has been prepared in context of the various health indicators (High CBR, High Home Deliveries, Villages with reported maternal/ infant death in last two years)
- Maps of all the sectors, SC, PHC, CHC, block and district has been generated indicating these areas.
- Such exercises are helpful in designing core strategies for specific areas (Done by CMHO – Rajsamand District)

11. Behaviour Change in Youth

To educate the youth in the school charts on environmental hygiene and personal health education has been developed by district health team & to inculcate in them basic health etiquettes so that they develop and become more health conscious individuals to create a healthy society (Done by CMHO – Rajsamand District).

¹³ HLEG report, planning commission of India, 2011

Annexure – 1 AHS Comparison

Indicator		2010-2011			2011-2012		2012-2013			% Increase/Drop			
Demographic Indicators	State	Rajsamand District	Dausa District	State	Rajsamand District	Dausa District	State	Rajsamand District	Dausa District	State	Rajsamand District	Dausa District	
Infant Mortality Rate (IMR)	60	65	57	57	61	55	55	59	53	-5	-6	-4	
Under Five Mortality Rate (U5MR)	79	89	87	76	84	85	74	80	82	-5	-9	-5	
MMR	331	364	319	264	285	238	208	265	152	-123	-99	-167	
Antenatal Care	State	Rajsamand District	Dausa District	State	Rajsamand District	Dausa District	State	Rajsamand District	Dausa District	State	Rajsamand District	Dausa District	
Mothers who had Antenatal Check-up in First Trimester (%)	53.2	54.5	57.1	58.0	55.8	61.1	62.8	57.6	70.6	9.6	3.1	13.5	
Mothers whose Blood taken for Hb (%)	51.5	53.9	42.4	57	63.4	46.9	63.5	72.3	56.3	12	18.4	13.9	
Mothers whose Blood Pressure (BP) taken (%)	68.6	64.9	80.6	70.9	73	77.2	72.7	77.9	77.1	4.1	13	-3.5	
Mothers who consumed IFA for 100 days or more (%)	12.3	12.5	9.1	12.8	17.9	8.9	12.7	18.7	7.9	0.4	6.2	-1.2	
Mothers who had Full Antenatal Check- up (%)	8.5	8.6	5.9	9.2	11	6.1	9.5	11	6.3	1	2.4	0.4	

Annexures

Delivery Care	State	Rajsamand District	Dausa District									
Institutional Deliveries	70.2	64.8	82.2	74.4	74.1	83.9	78	77.8	86.4	7.8	13	4.2
Delivery at Home (%)	29.5	34.8	17.3	25.2	25.2	15.6	21.5	20.9	13.0	-8	-13.9	-4.3
New Born Care	State	Rajsamand District	Dausa District									
Children (aged 6-35 months) exclusively breastfed for at least six months (%)	24.7	31.1	6.2	29.4	35.9	8.4	32.1	36.9	13.1	7.4	5.8	6.9
Children with birth weight less than 2.5 Kg. (%)	38.7	54.6	41.8	38.2	50.5	41.1	36.3	46.2	39.8	-2.4	-8.4	-2
Post Natal Care	State	Rajsamand District	Dausa District									
Less than 24 hrs. stay in institution after delivery (%)	38	42.9	23.5	30	28	22.9	24.9	21.4	20.1	-13.1	-21.5	-3.4
New borns who were checked up within 24 hrs. of birth (%)	70	70.4	80.3	73.4	71.2	81.6	76.3	73.1	81.9	6.3	2.7	1.6
Mothers who did not receive any post-natal Check-up (%)	23.0	22.7	16.8	19.9	19.7	14.2	16.8	18.7	9.4	-6.2	-4	-7.4
Mothers who received Post-natal Check-up within 48 hrs. of delivery (%)	73.3	72.2	82.5	76.6	75.6	83.7	78.8	76.1	87.5	5.5	3.9	5

Annexures

Immunization	State	Rajsamand District	Dausa District									
Children who have received Polio dose at birth (%)	74.9	78.2	79.0	78.6	81.5	81.6	80.9	81.2	86.3	6	3	7.3
Children aged 12-23 months Fully Immunized (%)	70.8	67.1	69.6	69.2	64.5	73.5	74.2	65.0	83.1	3.4	-2.1	13.5
Children who did not receive any vaccination (%)	5.9	4.5	8.3	5.4	4.5	6.7	5.8	5.9	3.5	-0.1	1.4	-4.8
Children (aged 6-35 months) who received at least one Vitamin A dose during last six months (%)	59.4	80.9	31.6	66.1	79.8	43.0	74.2	75.2	56.3	14.8	-5.7	24.7
Nutrition												
Children breastfed within one hour of birth (%)	48.6	50.0	78.0	50.1	47.9	73.9	54.1	46.6	68.4	5.5	-3.4	-9.6
Children (aged 6-35 months) exclusively breastfed for at least six months (%)	24.7	31.1	6.2	29.4	35.9	8.4	32.1	36.9	13.1	7.4	5.8	6.9

The above table shows comparison district and state AHS indicators. Improvement can be seen in the following years, however scope for further enhancement is still there. Approach paper attempts in providing strategies which can bridge the gaps in the health service provision and can strengthen health systems.

Annexure - 2

ASHA Interview Schedule

Sr no.	Question	Response
	Socio-demographic	
1	Name	
2	Education in STD	No school1
		1-52
		6-83
		9-123
		13 above4
3	Year of recruitment	
4	Village	
	SC	
	PHC	
	Block	
	District	
5	How many households are you assigned to visit on daily	
	(Write no. of nousenoid)(Open ended questions)	
6	In your frank opinion now many visit can be done per day?	
	(write no. of nousenoid) (Open ended questions)	
	Questions to test ASHA's knowledge	
7	Should initial broast milk (solostrum vollowish milk) bo	Voc 1
,	given to the new-born?	Ves but after discarding
		few drons 2
		No 3
		Don't know
8	Should additional supplements like honey/ water be given to	Yes1
	a baby who is being normally breastfed, within first six	No2
	months?	Don't know98
9	Should breastfeeding be continued if the baby has	Yes1
	diarrhoea?	No2
		Don't know98
10	How many IFA should be provided to pregnant women?	
	(Note: Write No. of IFA)	
11	How many IFA should be provided to anaemic pregnant	
	women?	
	(Note: Write No. of IFA)	
12	When registration for pregnancy should be done?	As soon as pregnancy
		confirmed1
		Within 1 to 2 week of
		pregnancy2
		Others 00
42		Others99
13	What types of tests are done by ANM for the ANC?	Weight1
	(Don't read the option and tick mark those where ASHA	Measure Height2
	provide the answer)	RL2
		HB4
1		оппе спеск-ир5

		Abdominal check-up6
14	What are the symptoms to identify High Risk Pregnancy?	
	Give any 5	
	(Open ended question)	
15	When mother should initiate the breast feeding?	
	(Open ended question)	
16	What are the high risk symptoms in the infant you must	
	(Open ended question)	
17	Please tell us vaccination schedule	If ASHA provide complete
17		immunisation schedule 1
	BCG – 0 and Polio – 0 and Vit K at Birth	If ASHA provide incomplete
	Pentavalent/DPT -1 and Polio -1 at 1 ½ months	immunisation schedule 1
	Pentavalent/DPT -2 and Polio -2 at 2 $\frac{1}{2}$ months	
	Pentavalent/DPT – 3 and Polio – 3 at 3 ½ months	
	Measles and Vit A at 9 months	
18	What are different methods of Family Planning?	MALA N/S1
	(Multiple answer question)(do not read the option)	Condom –2
		Copper T3
		PPIUCD 4
		E. Pill 5
		NSV 6
		Sterilisation/
		Other99
	Training and Career nath	
19	What prompted you to become an ASHA?	Financial incentive 1
10	(Multiple answer question)	Wanted to improve health
	· · · · · · · · · · · · · · · · · · ·	facilities in village2
		Social prestige3
		Any other (specify)99
20	After becoming an ASHA are all community members	Yes1
	respectful towards you?	No2
21	Have you completed ASHA Training Module 6 (2 rounds)	Yes both round –1
		Only round 1 2
		No3
22	Have you completed ASHA training module 7 (2 rounds)	Yes both round –1
		Only round 1 2
22	M/hon did you toko your loot turining?	NO3
23	when did you take your last training?	months) 1
		6 month to 1
		vear 2
		2 year ago 3
		3 year ago
		more than 3 year ago5
24	What additional trainings/refresher you would like to have-	,
	specific topic	
	(Open ended question)	

	Duties and supervision	
25	How often are you visited by you supervisor?	Once a week1 once in 15 days2 Once in a month3 once in a 3 month4 not visited5
26	How much incentive have you received on an average in the last 2 months? (Open ended question)	
27	Are you happy with the incentives given under the	Yes1
	programme?	No2
28	What are the benefits and advantages you have noticed after the introduction of ASHA Soft (do not read out the option)	Reduced delay in payment1 Report submission is easy 2 Deposit of incentive directly in bank account3 Submission of claim form is bit easy4 Others (Specify)99
29	Rank the following from (1-4) for what motivates you the most Recognition at village level1 Recognition at PHC, block and district level2 Incentive (monitory benefits)3 Career path to ANM course4	Rank1 Rank2 Rank3 Rank4
Annexure – 3 Zonal and District wise FRU status based on C-Section Distribution including (DH, SDH and Satelite Hospital) 2014-15 (source PCTS)

		No. of	No. of ERU	No. of FRU	No. of FRU		Total FRU
		Sanction	conducting	conducting	conducting	conducting	conductin
s		FRII	more than	hotwoon 99	hetween 19	hetween	g more
B	District	(including	100 C-	to 50 C-	to 11 C-	10 to 1 C-	than 1 C-
		DH+SDH+	section per	section per	section per	section per	section
		Satelite)	month	month	month	month	per
							month
	l		A	imer Zone	l		1
1	AJMER	12	0	1	1	1	3
2	BHILWARA	13	0	1	0	2	3
3	NAGAUR	13	0	1	1	1	3
4	TONK	7	0	1	0	1	2
	Total	45	0	4	2	5	11
			Bha	ratpur Zone			
1	BHARATPUR	10	0	1	0	0	1
2	DHOLPUR	5	0	1	0	0	1
3	KARAULI	6	0	0	1	0	1
	S			1			
4	MADHOPUR	5	0	1	0	0	1
	Total	26	0	3	1	0	4
			Bil	kaner Zone	1	1	
1	BIKANER	6	0	0	0	0	0
2	CHURU	7	0	0	1	1	2
	GANGANAG			0			
3	AR	10	0	Ŭ	1	0	1
	HANUMANG	-	0	1	0	0	
4		5	0		0	0	1
	Total	28	0	1	2	1	4
		10	Ja	ipur Zone			
1	ALWAR	18	1	0	0	2	3
2	DAUSA	7	0	0	0	1	1
3	JAIPUR I	10	0	0	0	4	4
4	JAIPUR II	9	0	0	1	1	2
5	JHUNJHUNU	9	0	0	0	2	2
6	SIKAR	11	0	1	0	1	2
	Total	64	1	1	1	11	14
			Joc	hpur Zone	1	1	ſ
1	BARMER	7	0	0	1	1	2
2	JAISALMER	5	0	0	0	1	1
3	JALORE	8	0	0	0	2	2
4	JODHPUR	11	0	0	0	2	2
5	PALI	12	0	1	2	1	4
6	SIROHI	4	0	0	0	3	3
	Total	47	0	1	3	10	14

S R	District	No. of Sanction FRU (including DH+SDH+ Satelite)	No. of FRU conducting more than 100 C- section per month	No. of FRU conducting between 99 to 50 C- section per month	No. of FRU conducting between 49 to 11 C- section per month	No. of FRU conducting between 10 to 1 C- section per month	Total FRU conductin g more than 1 C- section per month
				Kota Zone			-
1	BARAN	8	0	1	0	2	3
2	BUNDI	5	0	1	0	0	1
3	JHALAWAR	9	0	0	0	2	2
4	КОТА	7	0	0	1	1	2
	Total	29	0	2	1	5	8
			Ud	laipur Zone			
1	BANSWARA	9	1	0	0	1	2
2	CHITTORGA RH	11	1	0	0	1	2
3	DUNGARPU R	7	0	0	2	0	2
Λ	PRATAPGAR H	Л	0	0	0	2	2
-+ 5		4 Q	0	0	0	1	1
6		12	0	0	0	1	1
	Total	<u> </u>	2	0	2		10
	State Total	290	2	12	12	38	65
	State Total	290	3	12	12	38	65

Annexure – 4 C-Section – Contribution of Public and Private Institution - % of C-Section against live birth

		Ca	aesarea	n (C-Secti	on)	% share	% share		% of
		De	liveries	performe	d at	of	of	Live	caesarea
SN	District		SDH/	Private		Govt.	Private	Birth	n
		CHC	DH	facilitie	Total	institut	institut	Bireir	against
				S		е	е		live birth
Jt. Dir	ectorate Ajme	r							
1	Ajmer	0	6301	2397	8698	72%	28%	56494	15%
2	Bhilwara	35	1039	415	1489	70%	28%	43540	3%
3	Nagaur	0	685	2300	2985	23%	77%	59340	5%
4	Tonk	24	737	250	1011	73%	25%	27059	4%
Divisio	n Total	59	8762	5362	14183	62%	38%	186433	8%
Jt. Dir	ectorate Bhara	atpur	-						
1	Bharatpur	0	929	2676	3605	26%	74%	56823	6%
2	Dholpur	0	873	0	873	100%	0%	27937	3%
3	Karauli	0	182	891	1073	17%	83%	29025	4%
4	Sawai Madhopur	0	677	291	968	70%	30%	31242	3%
Divisio	n Total	0	2661	3858	6519	41%	59%	145027	4%
Jt. Dir	ectorate Bikar	her	•	L					
1	Bikaner	0	3748	1092	4840	77%	23%	54298	9%
2	Churu	0	430	691	1121	38%	62%	36974	3%
3	Ganganaga r	0	585	1386	1971	30%	70%	36112	5%
4	Hanumang arh	4	814	1866	2684	30%	70%	41484	6%
Divisio	n Total	4	5577	5035	10616	53%	47%	168868	6%
Jt. Dir	ectorate Jaipu	r							
1	Alwar	21	2271	2483	4775	48%	52%	70612	7%
2	Dausa	0	26	566	592	4%	96%	30062	2%
3	Jaipur I	75	17855	9164	27094	66%	34%	107425	25%
4	Jaipur II	22	267	3919	4208	6%	93%	36042	12%
5	Jhunihunu	11	46	2647	2704	2%	98%	32410	8%
6	Sikar	118	827	4331	5276	16%	82%	46198	11%
Divisio	n Total	247	21292	23110	44649	48%	52%	322749	14%
lt. Dir	ectorate Jodhi	our							
1	Barmer	0	361	972	1333	27%	73%	65106	2%
2	laisalmer	0	89	44	133	67%	33%	16502	1%
3	Jalore	36	11	1452	1499	1%	97%	45854	3%
4	Jodhour	2	7860	6085	13947	56%	44%	79543	18%
5	Pali	280	935	280	1495	63%	19%	39076	4%
6	Sirohi	139	61	839	1039	6%	81%	24244	4%
Divisio	n Total	457	9317	9672	19446	48%	50%	270325	7%
1t Dir	ectorate Kota	1.57	5517	5072	10110	-070	5070	2,0323	770
1	Baran	12	002	165	1111	Q1%	15%	22032	5%
T	Daran	40	303	102	1111	01/0	10 VCT	23033	570

		Ca	aesarea	n (C-Secti	on) d.at	% share	% share		% of
SN	District	СНС	SDH/ DH	Private facilitie	Total	Govt. institut	Private institut	Live Birth	n against
				S		е	е		live birth
2	Bundi	5	606	197	808	75%	24%	19762	4%
3	Jhalawar	51	1569	895	2515	62%	36%	28829	9%
4	Kota	34	4679	4228	8941	52%	47%	37173	24%
Divisio	n Total	133	7743	5485	13375	58%	41%	108797	12%
Jt. Dir	ectorate Udaip	our							
1	Banswara	6	2564	0	2570	100%	0%	43992	6%
2	Chittorgarh	86	1765	101	1952	90%	5%	28152	7%
3	Dungarpur	0	703	8	711	99%	1%	31921	2%
4	Pratapgarh	15	89	0	104	86%	0%	18296	1%
5	Rajsamand	0	116	1244	1360	9%	91%	23559	6%
6	Udaipur	106	6568	881	7555	87%	12%	68623	11%
Divisio	n Total	213	11805	2234	14252	83%	16%	214543	7%
St	tate Total	1113	67157	54756	123040	55%	45%	1416742	9%

Annexure - 5 FRU Mapping Zone Wise





Bharatpur Zone - Mapping of FRU based on C-Sections conducted (2014-2015 PCTS)







Bikaner Zone - Mapping of FRU based on C-Sections conducted (2014-2015 PCTS)



Jaipur Zone - Mapping of FRU based on C-Sections conducted (2014-2015 PCTS)







Jodhpur Zone - Mapping of FRU based on C-Sections conducted (2014-2015 PCTS)







Kota Zone - Mapping of FRU based on C-Sections conducted (2014-2015 PCTS)





Annexure – 6 Mapping of Home deliveries block wise

Mapping of home deliveries in Amet block 2014-15

Sub center selected for strengthening in Amet block

Name of SC	Building available	Labour room	Electricity	Water	ANM	Nearest high home delivery area	Distance from delivery performing facility
Racheti ka Kheda (PHC Zilola)	Yes	Yes	Yes	Yes	Yes	Sakarada, Didwana	12 km, Amet



Mapping of home deliveries in Deogarh block 2014-15

Sub center selected for strengthening in Deogarh block

Name of SC	Building available	Labour room	Electricity	Water	ANM	Nearest high home delivery area	Distance from delivery performing facility
Mad	Yes	No	Yes	Yes	Yes	Togi, Tokara, Biyana	9 km, Amet CHC
Madariya	Yes	Yes	Yes	Yes	No (GNM available)	Madariya, puniyana	5 km, Anjna Subcenter



Mapping of home deliveries in Kelwara block 2014-15

Sub center selected for strengthening in Kelwara block

Name of	Building	Labour	Electricity	Water	ANM	Nearest high	Distance
SC	available	room				home	from delivery
						delivery	performing
						area	facility
Jetaran	Yes	Yes	Yes	Yes	Yes	Jetaran,	19 Km,
(PHC						Futadewal	Kelwara CHC
Bardara)							



Mapping of home deliveries in Khamnor block 2014-15

Sub center selected for strengthening in Khamnor block

Name of SC	Building available	Labour room	Electricity	Water	ANM	Nearest high home delivery area	Distance from delivery performing facility
Pakhand (PHC Akodara)	Yes	Yes	Yes	Yes	Yes	Namana	18 km, SDH Nathdwara
Godach (PHC Nedach)	Yes	Yes	Yes	Yes	Yes	Nedach, Usan, Pipawas	13 km, CHC Delwara

Mapping of home deliveries in Railmagra block 2014-15



Sub center selected for strengthening in Railmagra block

Name of SC	Building available	Labour room	Electricity	Water	ANM	Nearest high home delivery area	Distance from delivery performing facility
Rajpura (CHC Dariba)	Yes	Yes	Yes	Yes	Yes (2)	Itself a high home delivery place	10 Km, Railmagra CHC
Sindesar kalla (CHC Railmagra)	Yes	Yes	Yes	Yes	Yes (1)	Pachmata, Lachakhedi, Soniyana	6 Km, Rialmagra CHC

Mapping of home deliveries in Rajsamand block 2014-15



Sub center selected for strengthening in Rajsamand block

Name of SC	Building available	Labour room	Electricity	Water	ANM	Nearest high home delivery area	Distance from delivery performing facility
Rajiyawas (PHC Mohi)	Yes	Yes	Yes	Yes	Yes	Itself a high home delivery place	16 km, DH Rajsamand

Please Note: For the mapping below the number against CHC or PHC depicts the total home deliveries for that sector and the SC mentioned under it contributes to highest burden in the sector.





Sub center selected for strengthening in Bandikui block

Name of SC	Building available	Labour room	Electricity	Water	ANM	Nearest high home delivery area	Nearest PHC/CHC
Nandera (PHC Badiyal Kalan)	Yes	Yes	Yes	Yes	Yes	Kheda khsri, Dhandholai	CHC Bandikui- 5 Km
Baijupada (PHC Lotwara)	Yes	Yes	No	No	Yes	Balaheda, Digriya bheem	PHC Lotwara- 7Km

Mapping of home deliveries in Dausa block 2014-15



Sub center selected for strengthening in Dausa block
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Name of SC	Building available	Labour room	Electricity	Water	ANM	Nearest high home delivery area	Nearest PHC/CHC
Jopada (PHC Kundal)	Yes	Yes	Yes	Yes	Yes	Kalota, Manga bhata	DH or PHC Kundal- 16Km
Bishanpura (CHC Sainthal)	Yes	Yes	Yes	Yes	No	Itself a high home delivery center	CHC Sainthal- 7 Km

Mapping of home deliveries in Mahwa block 2014-15



Sub center selected for strengthening in Mahwa block

Name of SC	Building	Labour	Electricity	Water	ANM	Nearest high	Nearest
	available	room				home delivery	PHC/CHC
						area	
Haldena	Yes	Yes	Yes	Yes	No	Banawad, Kot	СНС
(CHC							Mandawar-
Mandawar)							7 Km
Berkheda	Yes	Yes	Yes	Yes	No	Itself a high home	PHC
(PHC						delivery place	Balaheri- 5
Balaheri)							Km
Vishala	Yes	Yes	Yes	Yes	No	Baijupada,	PHC
(PHC						Balaheda, Digriya	Balaheri- 7
Balaheri)						Bheem (PHC	Km
						Lotwara,	
						Bandikui block)	

Annexure – 7 Intersectoral Convergence Mechanism at District Level

Health and ICDS department will work on the cross cutting areas for first two months which are:

- **1. Sector alignment:** ICDS will align sectors based on Health sectors; hence both the sectors have common population and targets.
- **2.** Joint Review Meetings: At sector and block level, both departments will hold joint review meeting at DC's decided place on monthly basis.
- **3.** Joint Monitoring Visit: Lady Supervisor (ICDS) & PHC MO and CDPO & BMCHO will do joint monitoring visit to MCHN day once a month.

Six month implementation plan of Intersectoral Convergence with Health, WCD (ICDS) and Education for two programs MTC and WIFS

Health Department	WCD Department (ICDS)	Role of Earth Institute			
First Month					
1. Orientation of MTC and discuss design for next 6 months					
Assessment of MTC site: MTC I/c and PMO have to do assessment of MTC based on pre- define toolkit	Status check: Status of current training of AWW and ASHA and referral.	Earth Institute will provide MTC assessment and status check document to both department and provide orientation how to do that. El can also provide training to ASHA for identification of SAM children with the use of			
		MUAC tapes.			
Second Month		1			
Identifying the gaps by the PMO and paediatrician in charge. Making of strategies to fulfil the gaps. Reviewing by the DC and prepare deadline to complete the work.	Review: Based on data available on training status and community referral, DC will review them in depth Monitoring: Minimum 5 visits to AWCs by LS about MTC referred	EI will help hospital administration in formulating the strategy to make MTC as a functional unit.			
Third Month					
Visit to MTC by DC, PMO and PO ICDS to assess MTC and monitor the implementation of activities/strategies identified by the hospital administration	Joint visit to AWC by CDPO and BMCHO to MTC referred children	Checklist will be provided by Earth Institute			
Fourth Month					
Identification of gaps in data management of MTC and improving the data quality. Tracking of referral.	Monitoring of referral and follow up by ASHA in sector meetings. Review by DC	EI will help MTC unit in preparation of analysis on the basis of available data. They will also help in identification of major			

Malnutrition Treatment Center (MTC)

Health Department	WCD Department (ICDS)	Role of Earth Institute	
		gaps and issues in referral	
		and follow up of SAM	
		children, so that proper	
		strategy can be prepared	
Fifth Month			
Desk review of MTC facility level indicators	Desk review of community level indicators		
Sixth Month		•	
Re-assessment of MTC by the I/c and PMO. Monitoring of Data.	Review of referral data	Assessment tool will be provided by Earth Institute	

Health Department	Education Department	WCD Department	Role of Earth			
		(ICDS)	Institute			
First Month						
Orientation of WIFS and 6 months process by Earth Institute						
Assessment of present status about how many IFA tablets available in stock (minimum for 3 months) No. of visit to AWC and school by block and district level officers (based on WIFS checklist)	Assessment of tablets available at block, sector and school level (minimum for 3 month stock) No. of enrolled 6 th to 12 th standard adolescents vs no. of tablets consumed, sector wise	Assessment of tablets available at AWC level (minimum for 3 months) No. of non-school going adolescents enrolled at AWC vs no. of tablets consumed, sector	Assessment checklist will be provided by Earth Institute			
		wise				
Second Month						
No. of visit by ANM/MO/Block and district level officers No. of adolescents screen on anaemia by ANMs	No. of visit by health sector (ANM/MO/BMCHO) No. of visit by education department (based on WIFS monitoring format)	No. of visit by health sector (ANM/MO/BMCHO) No. of visit by LS/CDPO (based on WIFS monitoring format)	1.Monitoring format will be provided by Earth Institute 2.Presentation of analysis of current situation of coverage and availability of logistics and Medicines			
Third Month						
Joint Monitoring visit to AWC prepared by Earth Institute	Shared the findings and					

Weekly Iron-Folic Acid Supplementation (WIFS)

Health Department	Education Department	WCD Department (ICDS)	Role of Earth Institute		
			recommendation		
			to DC		
Fourth Month	Fourth Month				
Desk review on WIFS indicate	Analysis will be				
	prepared by Earth				
			Institute		
Fifth Month					
Assessment of stock	Assessment of stock	Assessment of			
position & review of	consumed and available	stock consumed			
indicators	stock review of indicators	and available stock			
		review of indicators			
Sixth Month					
Review of status based on W	IFS assessment				