Mahwa Block Public Health Strategies
An Action Plan

2014-2015

Model Districts Health Project
Columbia Global Centers | South Asia (Mumbai)
Earth Institute, Columbia University
Express Towers 11th Floor, Nariman Point, Mumbai 400021
globalcenters.columbia.edu/Mumbai

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The Earth Institute team in Rajasthan is led by State Technical Consultant, Mr. Dinesh Songara based in Jaipur, two District Project Co-ordinators Mr. Vinayak Sarolia and Dr. Akanksha Goyal based in Dausa and Dr. Esha Sheth based in Mumbai.

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List of Abbreviation

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Aganwadi Center
AWW	Aganwadi Worker
BAF	Block Asha Facilitator
BAM	Block Accounts Manager
BCMO	Block Chief Medical Officer
BCC	Behaviour Change Communication
BPM	Block Programme Manager
BSU	Blood Storage Unit
CMHO	Chief Medical and Health Officer
CHC	Community Health Center
DC	District Collector
DH	District Hospital
EI	Earth Institute
FRU	First Referral Unit
HD	Home Delivery
IEC	Information Education and Communication
ID	Institutional Delivery
IDR	Infant Death Review
IFA	Iron Folic Acid
IMNCI	Integrated Management of Neonatal and Childhood Illness
IYCF	Infant and Young Child Feeding

IUD	Intra Uterine Device
LR	Labour Room
LSAS	Life Saving Anaesthetic Skills
MCH	Maternal and Child Health
MDR	Maternal Death Review
MMR	Maternal Mortality rate
MNH	Maternal Newborn Health
MOHFW	Ministry of Health and Family Welfare
MOIC	Medical Officer In Charge
MoU	Memorandum of Understanding
MTC	Malnourishment Treatment Centre
NBCC	New Born Care Corner
NBSU	New Born Stabilization Unit
NSSK	Navjat Sishu Surakasha Karyakaram
PHC	Primary Health Centre
PNC	Post Natal Care
PPIUCD	Post-partum intrauterine contraceptive devices
RMNCH+A	Reproductive Maternal Newborn Child and Adolescent Health
SBA	Skilled Birth Attendant
SDM	Sub Divisional Magistrate
SDR	Service Delivery Register
SC	Sub Centre

Summary of Recommendations

The following recommendations have the potential to improve service delivery for maternal and child care with block level changes monitored through process indicators. Engagement and support from governance at all levels (State to Block) is crucial. Implementing this plan would provide a gauge of the amount of time required to efficiently implement basic recommendations which in turn can assist in evidence based planning for larger recommendations, taking limitations, constraints and strengths into account.

Please Note: The detailed rationale, advantages and description of recommendations along with primary body responsible for implementation is described in this paper, following the summary of recommendations. Please refer to specified page numbers for details.

1. Establishment of Malnutrition Treatment Center (MTC) at CHC Mahwa (Page 17)

- Utilization of untied funds for establishment of MTC
- Training ASHAs to identify malnourished children, refer them and counsel their families on negative impacts of under nutrition
- Provision of incentive to ASHA for identification and referral will be an added advantage

2. Strengthening of Sub Centers for provision of Delivery Services in of High Home Delivery Pockets (Page 19)

Short term recommendation:

- Identification of potential SCs for conducting deliveries based on feasibility criteria
- Utilization of untied funds for identified strengthening SCs
- A revision of delivery procedures for ANMs of strengthened sub-centers
- IEC Materials for high home delivery areas on relevant SC for delivery
- Availability of 104 in high home delivery pockets

Long term recommendation

- Regular follow up of strengthened sub centers by authority personnel
- Based on improvement in case load and ANM performance rational –deployment can be phased in.

3. Review of Maternal and Infant Deaths at Sector and Block meetings to Identify Systemic Gaps (Page 22)

Short term recommendation

- Review and discussion of maternal and infant deaths in block and sector level meetings to identify the gaps and subsequently corrective actions planned and taken
- Quality training of MOIC and BCMOs on conduction of social audit for maternal and infant deaths

- Skill building of ASHA to identify maternal and infant deaths
- Relevant IEC in the community towards 3 delays, hygiene post-delivery for mother and child.
- Reviews both infant and child deaths during DHS by DC, to bridge identified gaps

Long term recommendation

- ASHA should be incentivized on reporting of infant deaths which may help resolving the under reporting issue.
- Validation of social audit: it can be done through cross block/district exercise where one block/district validates information from another.
- A block level Samelan for Sarpanch and Ward Panch: sensitize them towards maternal deaths and participating in social audits

4. Functionalization of First Referral Units - Operationalization of Blood Storage Unit and Availability of Anaesthetist (Page 26)

Short Term Recommendation:

- Resolving HR gap in FRU through rational deployment or Hiring Private Specialist from Rajasthan Medicare Relief Society
- Ensure legal compliance of blood storage unit and expedite the process to get the blood storage unit license from state licensing authority.

Long Term Recommendation:

- Training of Existing Medical Officer on Life Saving Anesthetic Skills
- Rational Deployment - Policy Guidelines Formulation
- Multi-Skilling Training - programs and guidelines for the multi-skilling of doctors and paramedical staff.

5. Addressing the gaps affecting the Utilization Pattern of Untied funds (Page 29)

Short Term Recommendations:

- Timely release of funds should be ensured from central government
- Verifying the expenditure against the activity rather than vouchers only
- Strict monitoring of utilization of untied fund should be done every month in District Health Society and Block Meetings
- There should be provision of quarterly internal auditing of facility accounts
- In every financial year orientation of financial guidelines and accounting procedures should be given to facility in-charges.
- Block officials should call facility in-charges at block office and start reconciliation of previous unsettled account as a Camp approach.
- State government should issue directions to involve block accountant in a committee where tender process need to follow.

Long Term Recommendations:

- Un-tied fund allocation should be based on either population criteria, need based criteria or performance based criteria.
- Filling up of vacant post of accountants in the block to streamline the accounting system
- Include fund utilization in the performance appraisal mechanism
- State Pre-Spending for Central Govt, till money is released to avoid delay in utilization

6. Assessing ANM Skills to plan Training and Monitoring Activities and Optimizing their Functions (Page 33)

Short term recommendation

- Baseline assessment of the ANM's knowledge and skills
- Training though state district or block or on site coaching involving other medical institutions
- Post training assessment- to understand the improvement in skill and confidence level.

Long term recommendation

- Refresher training at regular interval
- Set up Skill labs at DH/CHC to impart skill up-gradation training to ANMs and nursing staff.

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 was 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.

An Action Plan – Mahwa Block, Dausa

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. It is a micro-level plan which is a building block towards designing a macro-level district based plan and can also have implications for the state level. The implementation aspect is the responsibility of the State, District and Block Health Units along with our technical support.

Rationale

Dausa district is divided into 5 blocks *viz.* Bandikui, Dausa, Lalsot, Mahwa and Sikrai. Although it lies close to Jaipur, indicators highlight some major gaps in health systems. Mahwa block has been selected for devising the road map, as the health facilities and the recruited public health cadre cater to a large population constituting of the block itself and the nearby districts of Bharatpur, Alwar and Karauli. Hence, strengthening the service delivery and public health systems of the block can have a direct impact on the health outcomes for many.

Method

The scope of this plan includes addressing some major gaps which include Human resource management, infrastructural gaps, and non-functional state of Malnourishment Treatment Center (MTC), which would lead to better functioning of service delivery in Mahwa. These have been drawn out on thematic analysis of indicators, review of block profile and discussion with district and block officials, the perspective of field worker, and challenges and issues faced by them.

Block Profile

Mahwa (27° 3′ 0″ N, 76° 56′ 0″ E) block is located 62 km from the Dausa main city. It lies on NH-11 and is surrounded by Bharatpur, Alwar and Karauli district. The block has a **population of 277471**, 2 census towns - Mahwa and Mandawar and 161 revenue villages.

Status of health facilities in the block:

Health Facilities	Sanctioned	Number Present	Functional	Remarks
District Hospital	0	0	0	
Sub District Hospital	0	0	0	
First Referral Unit	2	2	2	Mahwa, Mandawar
Blood Bank	0	0	0	
Blood Storage Unit	1	1	0	In CHC Mahuwa - NOT FUNCTIONAL
CHCs	3	3	2	Mahwa, Mandawar, Badgaon Khedla (non-functional)
PHCs	8	8	8	Kot, Rashidpur, Balahedi, Santha, Pawata, Khoramulla, Khedla Bhujurg, Talchidi
24X7 PHC	8	8	8	All PHCs
Sub Centers	38	38	31	Building not available at: Patoli, Pipalkheda, Salempur Thana, Ukarand, Dholakheda, Samleti, Dhand)
Delivery Points	12	11	11	All PHCs, 2 CHCs and 1 SC
MTCs	1	1	0	CHC Mahuwa
NBSU	1	1	1	CHC Mahuwa
NBCC	12	11	11	Available at all delivery points
Private Hospitals		5	5	Shri Vinayak Hospital (Mahwa), Vedant Hospital(Mahwa), Goyal Hospital (Mahwa), Rohit Hospital, Saini hospital (Mandawar)

Strengths of Mahwa Block

- Geographically the block has a favourable location, and is well connected with Dausa city and Jaipur.

- Agreeable sanctioned versus available human resource in terms of number. Further, the workforce is skilled and dedicated at majority of the health facilities. Block NHM unit is well versed and has an appreciable hold over the block. Periodic training of the field staff is being organized by the block officials to enhance their skills, confidence and empower them.

- Protocol posters are available in the Labour rooms of all the health facilities. All the labour rooms are well equipped. Record maintenance, for example OPD, IPD register and delivery register is appreciable at majority of the facilities. **However, SDR and high risk pregnancy register are still a concern[1].**

- The state launched online software ASHAsoft is being successfully implemented in the block. It has enabled regularisation of the payment for ASHAs directly in their bank accounts and keeps a track of their activities and has also led to an improvement in the health indicators.

- The block has improved on 12 week ANC registration, 114.35% achievement against the target), female sterilization, 79.29% achievement against the target, BCG vaccination, 122.63% against the target (Source District Health Office).

[1] Validation during Block Monitoring Visits and comparison with the PCTS highlights inconsistencies in the Service Delivery Register at majority of the facilities.

Situational Analysis

A basic thematic situational overview of Mahwa block has been organised over the RMNCH framework to identify the gaps and select specific areas to be addressed.

Major area	Core Issues	Actual status of the activity	Recommendations to improve the situation	Responsibility
Reproductive Health				
Family Planning	PPIUCD	Improvement in uptake can be seen from 0 (2012-13) to 258 (Apr2014-Feb15), still the contribution in family planning methods is low (PCTS)	-Inclusion of choice of family planning method in Mamta card thus the decision of the female can be accomplished after delivery. - IEC and BCC in the community through ASHA and ANM for family planning method	State
	Fixed Day Static Service	Sterilisation camp in Mahwa on every Monday, IUD available in all CHCs and PHCs on all days. Male sterilisation not being conducted (PCTS)	BCC for improved uptake among the community	District officials
Maternal Health				
ANC	12 week ANC Registration	Analysis of three year data of PCTS reveals an improvement in 12 week ANC registration. However the coverage is only 57% against the number of ANC registered. (Apr 2014-Feb 2015 PCTS)	-BCC for improved uptake among community and skill development of ASHA to counselling on early registration	State District officials
	3 ANC check ups	Figures for 3 ANC check-up have declined in the past 3 years from 77% (2102-13) to 69% (Apr2014-Feb15) against the total number of ANC registered (PCTS)	- Regular monitoring of ASHA work -Motivation of good performing ANM from each block through certificate and monetary incentive in DHS meeting	-MOIC -DC and CMHO
	-Poor skills in prescribing the IFA at SC	-ANM is not able to identify the difference between therapeutic and prophylactic dose -Lack of counselling over when and how to consume IFA	***Short term:*** -Knowledge enhancement of ANMs (identification between therapeutic and prophylactic and counselling) at sector level	MOIC District

Major area	Core Issues	Actual status of the activity	Recommendations to improve the situation	Responsibility
		(Observed during MCHN session monitoring)	meetings	-MOIC and BCMO
	Lack of proper counselling to pregnant women during MCHN session	- No counselling on diet, family planning and institutional delivery has been observed on MCHN session -ANMs are not educating the pregnant women towards identification of danger signs suggesting risk and complications (Observed during MCHN session monitoring)	-Emphasize on importance of counselling in sector and block meeting -Random checking on MCHN session by MOIC -Developing adequate IEC material showing danger sign in pregnant women and their distribution on MCHN session along with Mamta Card - Training on HRP identification and its management	-BCMO and MOIC -State/ District
HRP	Inability to identify high risk pregnancy	-Lack of skills and confidence among ANMs -No register at facility level -Red stickers on Mamta card is not being prioritized at facility level -HRP is not being prioritized in the eyes of community (Observed during BMV and MCHN)	- Incentive for identification to ASHA -Strengthening of skills of ANMs through supportive supervision - Developing a HRP register with pre-defined columns -IEC for HRP and BCC through ASHA	-State -District officials and developing partners -State -State/ District
	Tracking	No tracking mechanism	-Development of online tracking mechanism (PCTS/new software) -Unique marking of the house of HRP thus easy identification and follow up by ASHA	-State -District
	Management	-Iron sucrose camps are being held at CHC level only -Unavailability of blood transfusion facility at First Referral units.	-Iron Sucrose injection can also be administered by MOIC of PHCs -FRU should be fully functional (for C-section facility, blood storage unit) -Blood transfusion facility should be made available at DH/FRU -Proper referral channel should be pre decided	-State

Major area	Core Issues	Actual status of the activity	Recommendations to improve the situation	Responsibility
			to avoid 2 delay – transport and seeking care -Reminder calls to HRP cases for attending the camp -Training and skill development of LR staff on management of HRP	-Concerned facility staff
PNC	Follow-up post delivery	-Compromised quality of PNC (observed during field visit)	-ASHA should be trained perfectly to fill newly implemented yellow cards (HBPNC) -Random assessment of the quality of PNC by MOIC	- District
FRUs	Fully functionality of FRUs in a block	-Both the CHCs in the block are not fully functional FRU as per norms -Caesarean section is not being done on any of the CHC -Non availability of anaesthetist -Blood storage unit available but non-functional due to pending license -Availability of Operation Theatre but used only for family planning	- District may sign a MOU with private hospitals running near CHC Mahwa and CHC Mandawar to provide anaesthetist through RMRS fund -training of few MOs in LSAS training - Fulfil the requirements for blood storage unit and take license from state licensing unit.	-DC and CMHO -State
Labour Room	Quality in LR	-Disinfection protocols are not being followed (Observed during LR assessment) -Partograph not being filled/incorrectly filled (Observed during LR assessment)	- Monthly monitoring of LR by Block Officials - Training over disinfection to MOIC, LR staff and class IV -Training of LR staff on filling of partograph	-Block Officials -District
Home Delivery	Mapping of HD	- Considerable decline has been observed in home deliveries from 367 (2012-13) to 133 (April2014- Feb15) (PCTS)	-Identification of areas with high home deliveries. -Strengthening of SC of those areas as potential delivery points with the help of untied funds -Counselling on institutional delivery during	- District and developing partners

Major area	Core Issues	Actual status of the activity	Recommendations to improve the situation	Responsibility
			ANC visits where home deliveries are high	
MDR (Maternal Death Review)	MDR	-MDR at DHS needs to be conducted in a comprehensive way, as per guidelines -Still there is under reporting of maternal deaths due to fear among ANMs and ASHAs	-Coordination between health department and birth and death registrar office to extract the information on maternal deaths - Discussion of MDR findings in DHS meeting for corrective actions - Training on importance of social audit at block level for ANM and ASHA	-District -DC
Institutional Delivery	Quality of services rendered	-Institutional deliveries at public institutions has decreased from 3721 (2012-13) to 3240 (April 2014-Feb15), while deliveries at private institution has increased from 2657 (2012-13) to 3815 (April2014-Feb15) (PCTS)	- improving the quality of services rendered at public health facilities by implementation of quality models (ISO, FFHI, NABH) - Feedback from discharged patients over the services rendered and development of accountable grievance redressal mechanism - Community Survey on regular basis over why private institutions are being preferred over public	-State -District - District and Developing partner
Child Health				
NBCC	Development at potential delivery points and strengthening at existing delivery points	-non availability of radiant warmer at some delivery points -low availability of Inj. vitamin K -Some of the staff deputed in labour room are not trained in NSSK (BMV visits)	- provision of traditional bulb system at facilities where radiant warmer not available -ensure availability of Vitamin K at all level especially at delivery points -prioritize the training of untrained LR staff in NSSK	-District -District Drug Warehouse -State/District
NBSU	Development at CHC Mandawar and CHC Mahwa	-Increase in number of newborns weighing less than 2.5 Kg at birth from 1108 (2012-13) to 2574 (April2014-Feb15) (PCTS) -Only one NBSU is available at CHC Mahwa,	-Trained staff should be made compulsory to be posted in NBSU unit - Development of new NBSU unit at CHC Mandawar	-State -CHC In-Charge

Major area	Core Issues	Actual status of the activity	Recommendations to improve the situation	Responsibility
		and staff trained in NBSU is posted in other department -No provision of NBSU at CHC Mandawar		
Infant Death Review	Status of IDR	-Performa for IDR not available and no orientation given on how to conduct it. -Under reporting of Infant Deaths -No review of IDR reasons in DHS	-Incentivizing ASHA for reporting of infant deaths (as done in Banswara) -Discussion of IDR findings in DHS meeting for corrective actions	-State -DC
Breast Feeding	Early breast feeding	-Amrit Kaksh was not available in JSY ward in both the CHCs	-District should ensure establishment of Amrit Kaksha in both the CHCs	-District
MTC	Functionalization of MTC Mahuwa	-There is no infrastructure for MTC -Funds not available for setting up of MTC -Unavailability of trained staff	-Proposal for functionalization of MTC at CHC Mahwa in PIP 2015-16	-District
Immunisation	Full Coverage	-Decrease in children with full immunization from 4863 (2012-13) to 4475 (April2014-Feb15) (PCTS)	-Monthly special catch up round for drop out children -BCC for community by ASHA	-District
ARSH Clinic	Functionalization	- Unavailability of ARSH clinic in block	-Establishment of ARSH clinic in both the CHCs	-District
Miscellaneous				
MCHN Session	Quality of MCHN sessions	-Unavailability of logistics -Lack of counselling -ANM skills (Hemocheck) -Less equipped AWC for MCHN Sessions -Incomplete SDR -No Adolescent meeting on MCHN day due to discontinuation of funds given by government for adolescent monthly meeting -No take home ration (ICDS)	-ANM should ensure availability of missing logistics through untied funds -Regular monitoring of MCHN session by the sector MOIC -Strengthening of ANM skills through block meetings -Review of MCHN findings in Block meetings	-concerned ANM -MOIC -BCMO

Major area	Core Issues	Actual status of the activity	Recommendations to improve the situation	Responsibility
		-No VHSNC meeting after session (observed during MCHN session visit)		
HR	Rational Deployment and deputation of staff in other departments	-Information Assistant posted in Bhamashah Yojana instead of his relevant department -Head quarter stay for staff (ANM/Staff Nurse/Doctors): Either not being used by currently assigned or not available	-IA should be relived from other government department -In case deputation of IA required then DC should make such an arrangement for equal distribution of time for both departments -Head Quarter stays not being used should be monitored (Performance of facility should be consider before giving head quarter allowances)	- District
Referral Linkages	Proper referral system	-Few 104 vehicle should be deployed near to those SC where delivery load is high -There is no system to utilize the base ambulances	-Need based deployment of 104 and 108 ambulances -Base ambulances should also be connected with centralized call center and can be used for intra-facility transportation -Base ambulances should be upgraded to BLS and can be used as a referral transport for critical cases	-District -State -State
Fund Utilization (NHM)	Fund Utilization	-Lack of Utilization Certificate development skills among health staff -Pending reconciliation of previous year expenditures -Fund from the district are disbursed under 3 major heads (RCH flexipool, NRHM flexipool and Immunisation) rather than individual budget heads of PIP	-Training should be given by block accountant for managing accounts -Ensure reconciliation of previous year expenditure through camp approach at block office -BHAP on the similar line of DHAP should be developed and fund should be disburse according to individual budget heads of PIP	-Block Officials -State

Selected Focus Areas - Potential for Impactful Change in a Short Term

1. Establishment of Malnutrition Treatment Center (MTC) at CHC Mahwa

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 school[2][3][4]. Birth weight is also an important indicator of child's health. Low birth weight babies are at higher risk of being undernourished.

Rationale:

- Undernourishment is associated with high levels of morbidity and mortality rates for children. According to PCTS data among the 7125 children born in the block in 2014-15, 2574 (36.12%) weighed below 2.5 kg and were at a higher risk of being malnourished.
- There is lack of identification of Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) children at the field level which leads to lack of referral to MTC located at the district hospital.
- Another reason which may lead to lack of referral of SAM children may be unavailability of MTC at the block level. As the district hospital is around 60 km away from the block, even the identification of SAM children does not lead their successful admittance.
- PCTS data for April 2014-Feb 2015 reveals 59 admissions in district MTC for 0-2 years and 19 admissions for 2-5 years children. The data also shows marginal admissions, against the estimated children having low birthweight.

Strengths and Gaps:

A MTC has been sanctioned for the CHC Mahwa. Interaction with CHC authorities revealed presence of an empty room in CHC at G+1 floor which can be potentially developed as MTC (therefore space has been identified). The room is of adequate size with an attached toilet. However the infrastructure needs to be put in place and materials and equipment procured to establish a functional MTC.

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[2] 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.

[3] 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.

[4] 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*.

Advantages of Establishing MTC:

- Establishment of MTC can lead to increase in ground level referral as the services will be easily accessible
- Availability of the services can also act as a medium for motivation for the field level workers to screen and identify SAM children as there will be access to treatment
- The CHC has geographically favourable location and is well connected with the sectors of block. Hence MTC functionalization there will also lead to reduction in travel time and travel cost.

Recommendations:

- **Utilization of untied funds**: The funds at the level of CHC can be utilized for establishment of the infrastructure. The identified room can be partitioned to establish a nursing station and kitchen. Material procurement for kitchen, nursing station and play area is possible via CHC funds.

Table1: Estimate of MTC Functionalization

Sr. No.	Items	Total cost (Rs.)
One time expenditure		
1	Kitchen	20,000
2	Cots and Mattress	40,000
3	Essential ward equipment	50.000
4	Other ward equipment	35,000
5	Kitchen equipment	30,000
Recurrent expenditure		
6	Kitchen supplies	75,000
7	Drug and consumables	75,000
8	Contingency	20,000
Human resource		
9	Medical officer(1)	3,60,000
10	Nurses (4)	4,80,000
11	Nutritional counsellor (1)	1,80,000
12	Cook cum care taker	60,000
13	Attendant (2)	84,000
Total		**1,509,000**

- **Training ASHAs to identify and refer malnourished children and counsel their families on the 'negative impacts of under nutrition':** ASHA's inability to identify SAM and MAM children at field level is another lacuna which needs due consideration. On interaction with ASHA's the reasons that were drawn were, lack of confidence for usage of MUAC tape, lack of motivation because even the identification won't ensure the treatment of

the children as MTC is non-functional. Further, there are no added incentives for identification and referral which also acts as a demotivating factor.

- There are 193 ASHA's in the block. Strengthening their basic skills during sector level meetings can help improve referral. Provision of incentive to ASHA for identification and referral will be an added advantage.
- Counsel families on the impact of under nutrition on cognitive and physical development of their child which in turn impacts school performance.

Recommendation	Responsibility
Utilisation of Untied funds	District
Training of ASHA for identification of SAM children	Block
Incentive for ASHAs-identification of cases	State Consideration

2. Strengthening of Sub Centers for Delivery Services in High Home Delivery Pockets

Rationale:

In Mahwa block deliveries are not being conducted and new born care is not being provided at sub-center level. There are certain areas with a high number of home deliveries. Based on the PCTS data (April 2014-Feb 2015) 133 reported home deliveries have occurred this year. Therefore it is imperative to provide delivery care services at SC level in these areas. 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. Thus strengthening of the services at these centers may lead to a decline in home deliveries and also promote institutional deliveries.

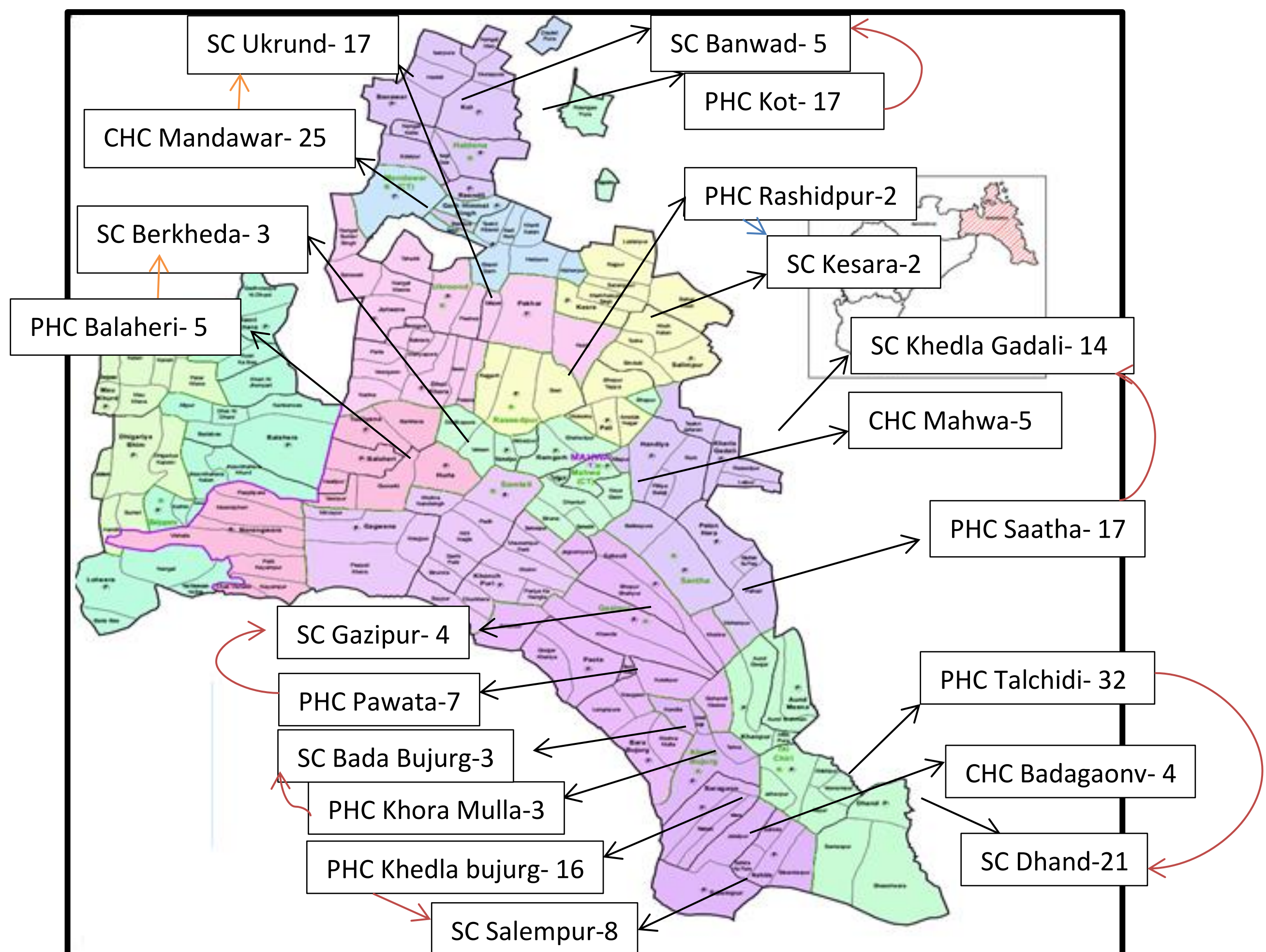
Key Advantages of providing delivery services at Sub Centers:

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

Strengths and Gaps:

- Out of 133 (April 2014-Feb 2015) home deliveries 110 were conducted by Skilled Birth Attendants. This highlights the existence of skilled personnel in the field which are available and willing to conduct deliveries at a sub center level.
- Currently deliveries are being conducted at SC Ramgarh highlighting the potential of certain subcenters to function as delivery points
- ANMs have conveyed their willingness and confidence to conduct deliveries, and this will be re-assessed before strengthening specific centers
- However labor rooms need to be created and equipped to conduct deliveries at sub centers- infrastructure updated to provide services related to delivery and newborn care

Reported Home Deliveries in Mahwa (sector wise details based on PCTS): PHCs and CHCs depict home deliveries for that particular sector, while related SC shows the areas with highest contributing burden.



Short term recommendation:

- **Identification of potential SCs for conducting deliveries:**
  1. Sectors/areas that have high number of home deliveries identified
  2. Basic infrastructural facilities which include building, water supply and electricity should be present
  3. Willingness, skill and confidence of concerned ANM scrutinized

Identifying SC's for Strengthening

Sub-centers	Haldena (CHC Mandawar)	Berkheda (PHC Balaheri)	Vishala (PHC Balaheri)	Jatwara (CHC Mandawar)	Konchpuri (PHC Pawata)	Pakhar (PHC Rashidpur)	Gehnoli (PHC Saatha)
Building available	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Labour room	Yes	Yes	Yes	Yes	Yes	Yes	Yes

available							
Electricity	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Water	No	No	Yes	No	Yes	No	No
ANM available and Willing[5]	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nearest high home delivery area	Banwad Kot	Itself a high home delivery place	Baijupada, Balaheda, Digriya Bheem (PHC Lotwara, Bandikui block)	Ukroond	Gazipur	Kesara	Khedla Gadali

- **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

- **A revision of delivery procedures for ANMs of strengthened sub-centers:**

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

- **IEC Materials for high home delivery areas:**

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

- **Availability of 104 in high home delivery pockets:**

The possibility of 104 being deployed in areas if high case load should be explored

Long term recommendation

- **Regular follow up of strengthened sub centers**:

1. 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.
2. Monitoring data for institutional and home deliveries in the catchment area will guide further changes and decisions
3. Based on improvement in case load and ANM performance rational – deployment can be phased in.

[5] Interviews conducted by EI and data have shown how conducting deliveries at sub centers can be successful if an ANM is willing and confident. Trust is an important factor in people accessing particular health personnel for care.

Recommendation	Responsibility
Identification of potential SCs for conducting deliveries	Development Partners and District
Utilisation of Untied funds	District
Revision of delivery procedures for ANMs	BPM, District
IEC Materials for high home delivery areas	BPM, District
Availability of 104 in high home delivery pockets	State
Ensuring functionality of SC	MOIC
Monitoring of data for home and institutional delivery	BPM, DPM
Rational deployment of ANM based on case load	CMHO

3. Review of Maternal Deaths and Reporting of Infant Deaths at Sector and Block Meetings

Maternal Deaths:

As per the AHS data the MMR of the state has decreased from 331 (2010-11) to 208 (2012-13). Dausa lies in the Jaipur zone. At the zonal level the MMR has declined from 319 (2010-11) to 152 (2012-13). Although this is a positive decline, it still constitutes a large figure and needs to be addressed. According to PCTS data the 9 maternal deaths have occurred in Dausa District from April 2014- Feb 2015. As compared to the AHS (2012-13) data on maternal deaths this number is marginal. There is under reporting of maternal deaths in PCTS even. One of the potential reasons could be under reporting of maternal deaths, which in turn could be related to fear in field level workers about judging the quality of their services. This compromises data quality and designing evidence-based solutions.

Maternal Deaths in Dausa District (April 2014-Feb 2015 PCTS)

Block	CHC/PHC	SC	Village	Name	Age	Death Reason
Dausa	Alooda	Ladli Ka Bas	Ladli Ka Bas	Pinki	21	Other reason
Dausa	Bapi	Maheshwara Kalan	Maheshwara Kalan	Alka	25	Bleeding
Dausa	Charred	Charred	Charred	Priti	24	Bleeding
Dausa	Lawaan	Nagal Govind	Nagal Govind	Mamta	22	Other reason
Dausa	Sainthal	Boroda	Choti Basari	Rukmani Devi Meena		Other reason
Dausa	Titarwada	Kali Pahadi	Kali pahadi	Prem	28	Other reason
Lalsot	Didwana	Salempur	Arnia kalan	Mamta	23	Abortion
Mahwa	Kot	Kot	Munnapura	Kalavati Meena	28	Bleeding
Mahwa	Rashidpur	Pakhar	Pakhar	Asha	20	Bleeding

<u>As highlighted in the table the clinical cause, if described, does not point to what was the specific health system gaps related to cause of death.</u>
<u>Additionally stating 'Other Reasons' brings out no critical finding to proceed with evidence based planning .</u>

Infant Deaths:

According to AHS data the infant mortality rate for the district shows a small decline from 57 (2010-11) to 53 (2012-13). The figure is still large requiring due consideration.

PCTS data reveals 75 neonatal deaths in the district out of which 7 took place in Mahwa. A total of 97 infant deaths occurred in the district (April 2014- Feb 2015). On the other hand 'infant death report' shows 114 infant deaths in the district. **This also highlights data discrepancy in the PCTS.**

Comparison of Block and district for neo-natal, infant and under 5 year child deaths

(Source PCTS, data Apr 14 to Feb 15)

Indicator	Mahwa block	Dausa district	Contribution of Mahwa block to Dausa district
No. of Neo-natal death	7	75	9.3%
No. of Infant death	9	97	9.3%
No. of Under 5 years death	10	105	9.5%

Details of infant deaths in the district and block during April '14-Feb '15 (Form 9 and 9A)

Details of infant death with probable cause	April 2014- Feb 2015					
Infant death before 24 hrs of birth					District	Block
					26	1
Infant death up to 4 weeks by cause	Up to 1 Weeks of Birth		Between 1 Week & 4 Weeks of birth		Total	
	District	Block	District	Block	District	Block
Sepsis	6	1	0	0	6	1
Asphyxia	1	0	0	0	1	0
LBW	9	0	1	0	10	0
Tetanus	0	0	0	0	0	0
Others	27	5	5	0	32	5
Infant/Child death up to 5 years by cause	Between 1 months and 11 months		Between 1 year and 5 year		Total	
	District	Block	District	Block	District	Block
Pneumonia	8	0	0	0	8	0
Diarrhoea	1	0	0	0	1	0
Fever related	0	0	0	0	0	0
Measles	0	0	0	0	0	0
Diptheria	0	0	0	0	0	0
Others	22	2	8	1	30	3

Details of Infant deaths in Mahwa Block April 2014- Feb 2015 (Infant death report)

Name	Age	Sex	CHC/PHC	SC	Reason
Kejriwal	6 months	Male	CHC Mandawar	DNA	Other
Krishna	4 months	Female	PHC Rashidpur	SC Pakhar	Other
Natik	DNA	DNA	CHC Mandawar	DNA	other
Baby	DNA	DNA	CHC Mandawar	DNA	other
Baby	1 day	Male	CHC Mandawar	DNA	Infection
Lacky	1 day	Male	CHC Mandawar	DNA	Other
Baby	2 day	Male	CHC Mandawar	DNA	Other
Baby	I day	Male	PHC Khora Mulla	DNA	Within 24 hours of birth
Kesri	4 days	Male	PHC Rashidpur	SC Pakhar	Other

*DNA = Data Not Available

The reason for 8 out of the 10 deaths was 'others' which limits policy makers at state level to discuss and draw out the system gaps. Even if cause was detected as infection, it does not describe if the infection occurred at hospital or home, type of infection, treatment and involvement of ASHA and ANMs.

Rationale:

Facility based audits of reported maternal deaths is being currently done in the district but unfortunately corrective actions on the basis of reasons identified are not being undertaken at either the block or district level. No audits according to GoI norms are being conducted for infant deaths, although they are being reported. 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. Preventive and corrective actions can be planned accordingly.

Advantages:

- Detailed discussion of Cause of Maternal Death
- Detailed discussion of Cause of Infant Death
- Discussion between health personnel at all levels: to prevent deaths and plan for future steps - short and long term.
- Complete Information reaching field workers which also serves as a feedback mechanism: so that there is a broader awareness of cause and greater engagement overall.

Short term recommendation:

- **Review and discussion of maternal and infant deaths in block and sector level meetings:** To identify the gaps and subsequent corrective actions planned and taken

- **Quality training of MOIC and BCMOs on conduction of social audit for maternal and infant deaths**
    - Train health workers in the use of the maternal and infant death audit form, as formal tools for the audit process and how to use the audit findings
    - Address the concerns and fears of health workers regarding maternal and infant auditing
    - Sensitize Maternal and Infant Death Review (MIDR) Committees- Local community representatives, including family member of deceased should participate during social audits. Meeting minutes should be shared with district officials.

- **Skill building of ASHA** to sensitize community towards maternal and infant deaths
    - Sensitize the ASHA with establishing how deaths can be identified.

- **Relevant IEC in the community** towards 3 delays and the crucial role they play, hygiene post-delivery for mother and child.

- **Reviews** both infant and child deaths **during DHS** by DC, to bridge identified gaps- family member of the deceased should be present. Responsible officers should be instructed to take necessary actions.

<u>**Long term recommendations:**</u>

- **ASHA should be incentivized** on reporting of infant deaths which may help resolving the under reporting issue.

- **Validation of social audit:** it can be done through cross block/district exercise where one block/district validates information from another. The validation should be discussed at DHS where quality of social audit can be discussed in length. In HPDs, it should be also discussed in RMNHC+A meetings.

- **A block level samelan for Sarpanch and Ward Panch:** It is recommended that Sarpanches and Ward Panches should participate in social audits.

Recommendations	Responsibilities
Training of MOIC and BCMO on conduction of social audits	State
IDR as per CDR guidelines	District
Review in Block and Sector meeting	MOI/C/Block official
Skill building of ASHA to sensitize community towards maternal and infant deaths	MOI/C /Block official
Relevant IEC for community	State
Discussion in DHS for corrective action	District

Incentive to ASHAs for infant death	State
Validation of social audit	State/District
A block level Samelan for Sarpanch and Ward Panch	Block official District

4. Functionalization of First Referral Units -Operationalization of Blood Storage Unit and Availability of Anaesthetist

Rationale:

The estimated maternal mortality for Jaipur Zone (*including Jhunjhunun, Alwar, Dausa, Sikar & Jaipur*) is 152 (AHS 2012-13). These include 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. The two CHCs in Mahwa block have been selected by the district and designated as FRUs based on the scoring guidelines of GoI. However they are not completely functional.

Strengths and Gaps:

The critical determinants of operationalization are either lacking or incomplete. These include 24 hours availability of surgical interventions, new-born care and blood storage[6]. The table below outlines the status of the FRUs highlighting the gaps and strengths to draw out its potential to become functional units.

Sr. No.	Particulars	CHC Mahwa	CHC Mandawar
1	**Availability of Services**		
2	Functional OT	Yes	Yes
3	Functional LR	Yes	Yes
4	NBCC	Yes	Yes
5	Blood Storage Unit	Yes **(No Licence)**	**No**
6	Referral Services (Public/ Private)	Two Base Ambulances, One 108 and One 104	Two Base Ambulances, One 108 and One 104
7	**Availability of Human Resource**		
8	Gynaecologist	Yes	Yes
9	Paediatrician	Yes	Yes
10	Anaesthetic	**No**	**No**
11	Medical officer	Yes	Yes

[6] Guidelines for Operationalising FRU: GoI (2004)

Sr. No.	Particulars	CHC Mahwa	CHC Mandawar
12	**Why functionalization is crucial**		
13	Distance from District Hospital	60 km	72 KM
14	Distance from First Functional FRU	60 KM	72 KM
15	Distance from Medical College	115 KM	127 KM
16	Catchment population it has the potential serve (District health office)	25964	36572
17	Estimated Pregnancies in block (District health office)	615	867
18	Estimated deliveries in block (District health office)	576	812
19	Number of maternal Deaths (APR14-FEB15)	2 (PHC Kot, SC Pakhar)	
20	Number of C- sections	0	0
21	Number of abortions	11	4

CHC Mahwa:

To start providing surgical services and emergency care the **blood storage unit needs to become functional and the anaesthetist position needs to be filled.** In fact the BSU already

exists at the CHC, but is non-functional due to licencing issue. For issuance of a licence, linkage of BSU to a Blood Bank is a pre-requisite. Currently a blood storage unit is located at district hospital, Dausa.

CHC Mandawar:
Establishment of **licenced blood storage unit and anaesthetist is required** for operationalization of FRU.

Short Term Recommendation:

- **Resolving HR gap in FRU:**
  - **Rational Deployment:** Re-deployment of personnel to fill the gaps could be transferred from within the districts or outside to ensure availability of specialized doctors. This could be from a low delivery load area to high delivery load or deployment on an on call basis from another facility based on feasibility of deployment.
  - **Hiring Private Specialist from Rajasthan Medicare Relief Society:** State could authorise the District Collector to hire an anaesthetist from private hospitals on an on call, in line with the policy guidelines for FRUs. The Collector can sign a MoU with private doctors to provide their services on call basis.

- **Ensure legal compliance of blood storage unit:** CHC authority should try to meet out the legal compliance and expedite the process to get the blood storage unit license from state licensing authority. Exploration and follow up on possibilities to tie up with a Blood Bank should be on a priority basis.

Long Term Recommendation:

- **Training of Existing Medical Officer:** Considering the general lack of anaesthetists at both the CHCs, it is feasible to train any one of the MBBS doctor from CHC in life saving anaesthetic skills. Such a training programme is being conducted by the Federation of Obstetrical and Gynaecological Societies of India (FOGSI) to train the MBBS doctors for management of obstetric emergencies (including C-section) and New-born Care.

- **Rational Deployment:** The State Government should formulate appropriate guidelines to enable the Chief Medical & Health Officers to identify and rationally deploy specialists and paramedical staff within the district to fill HR gaps at facilities where the requirement is minimal for establishing functionality of services and beneficial for a large catchment area.

- **Multi-Skilling Training:** Design appropriate training programmes and guidelines for the multi-skilling of doctors and paramedical staff. This will also enable future

positioning of staff to become slightly easier. A well outlined salary structure for multi-skilled staff could also help in retention of staff important facilities.

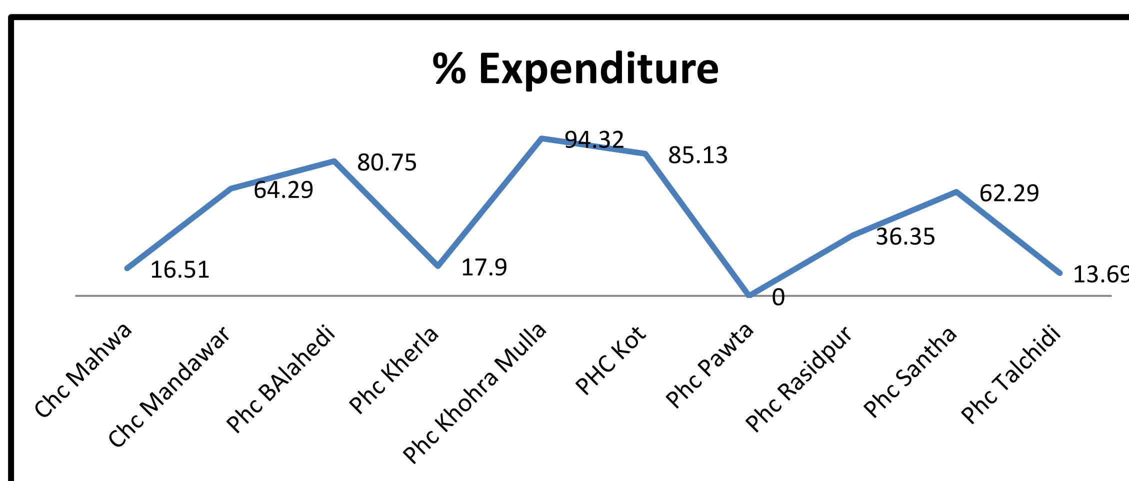
Recommendation	Responsibility
Deployment of specialist	State
Hiring Private Specialist from Rajasthan Medicare Relief Society	District/State
License renewal of blood storage unit	District
LSAS training of MO within block	SIFHW
Guidelines for rational Deployment	Sate
Multiskilling	State and SIHFW

5. Addressing the gaps affecting the Utilization Pattern of Untied funds

The Government of India launched the National Rural Health Mission (NRHM) in April, 2005 to carry out necessary changes in the primary health care delivery system. It focuses on to provide comprehensive and integrated primary healthcare to improve the health outcomes. To achieve above mentioned goals differential funding is needed from the center and state governments. Under the National Rural Health Mission (NRHM), there is a provision of innovative funds such as annual maintenance grant, annual corpus grant to Rogi Kalyan Samitis, and untied grant for maintaining infrastructure, patient welfare and other day-to-day needs which might not be addressed in the traditional funding.

Rationale:
A detailed assessment is needed to understand the factors which can affect the pattern of fund utilization at facility level. Analysis will identify the best performing facility and worst performing facility in term of their utilization pattern and it will be easy to track the factors and reasons which led to slow down and speed up the fund utilization.

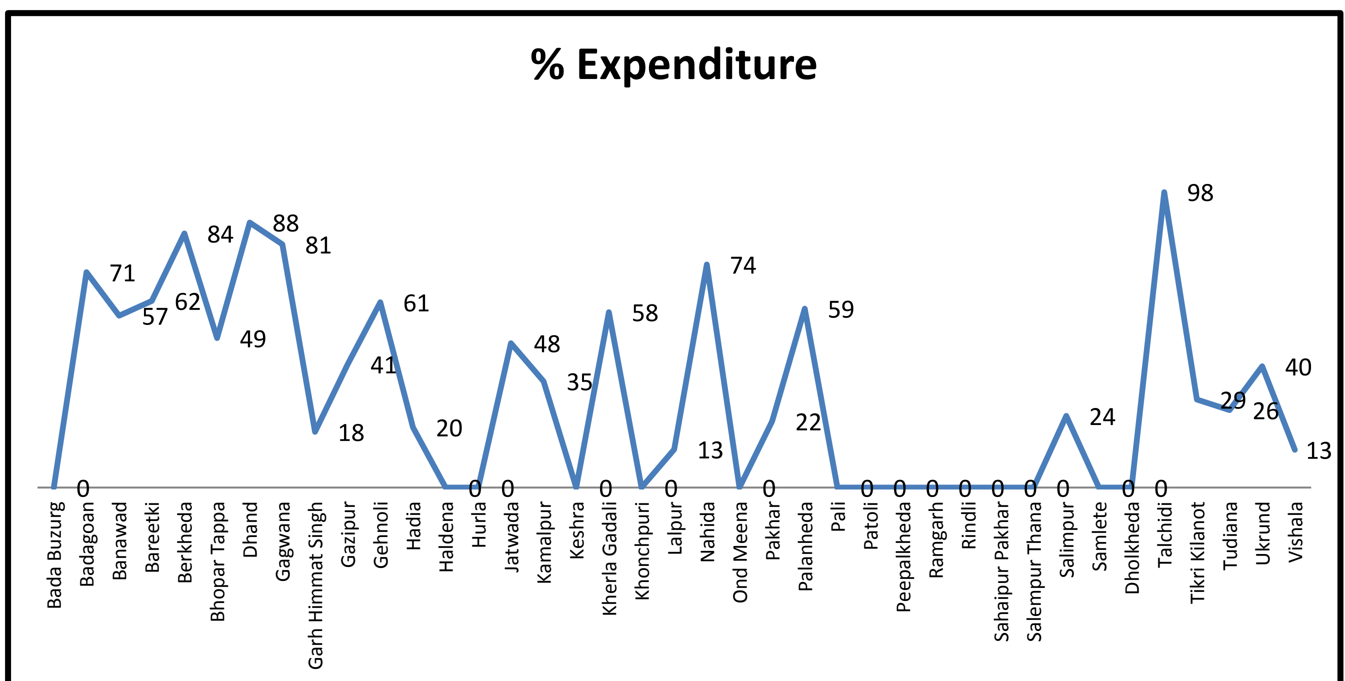
CHC and PHC wise untied fund utilization Apr 2014 to Feb 15



As evident from the above figure, three facilities in the block namely PHC Balahedi, PHC Khora Mulla, and PHC Kot has ensured more than 80% untied fund utilization for year 2014-15. These PHC were able to utilize more than 80% of funds because district authority and Earth Institute[7] has taken the task to ensure fund utilization at randomly selected facilities through gap analysis in core specific areas of labour room, infrastructure, cleanliness and availability of necessary services. On the basis of gap analysis, action plans were prepared in consensus of facility in-charge to bridge the gaps through available discretionary funds. District Collector has also extended his full support towards this initiative and he personally reviewed the utilization in district health society meeting.

On the other hand block has four facility namely as CHC Mahwa, PHC Kherla, PHC Pawta and PHC Talchidi has utilized less than 20% their untied fund.

SC wise untied fund utilization Apr-14 to Feb-15



Sub center wise fund utilization shows that 16 sub center out have 38 have not utilized their untied fund in year 2014-15. Rest of the sub centers have made efforts to ensure utilization to improve the basic services at sub center level.

Proper utilisation of untied funds helps to overcome any bottlenecks that arise in the delivery of public health services. Despite the availability of discretionary funds for each facility, many of the health facilities remain poorly maintained with major quality gaps due to improper and under-utilization of these available resources. It is essential to identify the

[7] Earth Institute has been requested for the assessment of CHC and PHC and support the district in preparing action plan for the un-utilise fund based on Indian Public Health Standards (IPHS).

major issues pertaining to no or less utilization of such funds at facility level and recommend possible solutions to resolve them.

Gaps:

- **Late release of funds:** Guideline issued by government clearly states the activities where these funds can be used. But, the guideline does not focus on timeline for such funds to be released to district, block, CHCs, PHCs and SCs. In current financial year 2014-15 these funds were released in the month of December 2014. This untimely disbursement of funds gives the health facility very less time to spend the funds.

- **Disinterest in financial matters extra burden:** At many health facilities MOs and ANMs shows disinterest towards finance matters which led to under-utilization or utilization in other activity which are not permissible in the guidelines. They also felt that handling administrative process to expedite the fund utilization will suffer they core medical work if they involve too much in these activities.

- **Poor Reconciliation:** It is a very common issue at most of the health institutions that poor accounting procedures results in missing of previous year expenditure vouchers. Due to this even though the facilities have received the funds and spent them correctly, it is very difficult to settle the accounts due to absence of original documentary evidence. In the future it leads to show large amount of fund lying un-utilized at the facility level and as a result less amount will be sanctioned from the central government.

- **Insufficient Accountants:** In the block most 11 accountant posts are sanctioned and out of this only 4 accountants are available which affects the settlement of accounts.

- **Poor Orientation:** The health functionaries handling financial matters lack an orientation on basic accounting practices. Facility In-charges try to book the expenditure in minor works but they hesitate to attempt to book the expenditure in major works like infrastructure repairing or purchase of expensive equipment. Main reason is they do not feel confident to follow the tender process due to lack of expertise in this area.

Short Term Recommendations:

- It is very important to have in place the practice of verifying the expenditure against the activity rather than simply verifying it against vouchers.

- Strict monitoring of utilization of untied fund should be done every month in District Health Society meeting and also similar monitoring system can be ensure in block meeting with the help of SDM.

- There should be provision of quarterly internal auditing of facility accounts. Such type of audits can be done by higher institutions e.g. PHC can do the audit of their sector SC.

- In every financial year orientation of financial guidelines and accounting procedure should be given to facility in-charges.
- Block officials should call facility in-charges at block office and start reconciliation of previous unsettled account as a Camp approach.
- State government should issue directions to involve block accountant in a committee where tender process need to follow.

Long Term recommendations:

- Untied fund allocation should be based on either population criteria, need based criteria or performance based criteria.
- Filling up of vacant post of accountants in the block to streamline the accounting system.
- Appropriate Fund Utilisation should be included in the performance appraisal mechanism of different cadres from ANMs to BCMHOs, hence accountability can be established and good performer can be acknowledged.
- Utilization of State Funds for Central Govt. allocated health spending to avoid delays of fund utilization and give sufficient time for spending over the whole financial year. The state may explore the possibility of pre-spending on the Center's behalf till those funds come in. In this way funds can be made available from first quarter to ensure timely utilization.

Recommendation	Responsibility
Verifying the expenditure against the activity	State/District
Monitoring of utilization in DHS	District/Collector
Provision of internal auditing of accounts	District
Camp approach to reconcile previous year accounts	Block/District
Involve block accountants in tender process	State/District
Fund allocation should be on either population criteria, need based criteria or performance based criteria	Center (MoHFW)
Filling up of accountants post	State
Include fund utilisation in the performance appraisal mechanism	State
State Pre-Spending for Central Govt, till money is released	State

6. Assessing ANM Skills to plan Training and Monitoring Activities and Optimizing Functions

An ANM is the first interface between community and health services. She has responsibilities related to maternal and child health and family welfare. Additionally she keeps a record of all the relevant data associated with the services rendered, maintenance of logistics and funds at the sub center level. They are trained on SBA, routine immunization, NSSK, IMNCI, IYCF, IUD and Sterilization.

Rationale:

Formal assessment of various ANM skills is required so that the Block and District officers can plan training and monitoring activities for ANMs using evidence based data. The quality of her performance has an effect on crucial indicators of RMNCH+A activities. During the discussion with block officials they revealed that training data base of health personnel is not available with them.

Gaps:

- Our observations during MCHN sessions revealed lack of confidence, motivation and inadequate skills for provision of basic ANC services. This include measurement of BP, urine test, abdominal examination, counseling over family planning, ANC, institutional delivery, PNC etc.

- The SDR was also found to be incomplete at many of the Sub Centers. Columns which were generally empty were IFA prophylactic, IFA therapeutic, reason for high risk pregnancy, PNC follow up etc.

- It has also been noticed that ANM's were not aware about the reasons for high risk pregnancy nor were they confident in identification of such cases. Hence, this raises a need for strengthening the skills of ANM's which in turn can improve their confidence level also.

- Currently there are 47 ANM posts sanctioned in the block out of which 39 posts are filled.

Facilities with ANMs not present in required numbers

Name of the Center	Sanction	Available
PHC Kherla Bhujurg	2	1
PHC Santha	2	1
PHC Talchidi	1	0
Bhopar Tappa	1	0
Dhand	1	0
Peepalkheda	1	0
Sahaipur Pakhar	1	0
Salempur Thana	1	0

Short term recommendation:

- **Baseline assessment:** A baseline assessment of the ANM's assessing their knowledge and skills for ANC, Immunisation, basic examination (BP, Hb, abdominal examination), 3 stages of labour, and PNC should be done that an guide future planning.
- **Training:** The baseline assessment has the potential to identify the lacunae in knowledge and skills to organize training sessions. On site-coaching with the help of nursing college or medical colleges can also be conducted to mentor the ANMs.
    - Strengthening the skills of ANM will help in provision of better services, early recognition of high risk pregnancy and their tracking, improved neonate and child care services. Also, training on counselling aspect and ensuring counselling during ANC visits can improve institutional deliveries and utilisation of family planning services.
- **Post training assessment-** Another assessment after the training to understand the improvement in skill and confidence level.

Long term recommendation:

- **Refresher training at regular interval-** Refresher/Follow up training at regular intervals can be organized through state for maintaining their skills and confidence level.
- **Skill labs at DH/CHC:** State should strengthen DH or CHC so that it can be developed as skill labs to impart training to health personnel. These centers can impart skill up-gradation training to ANMs and nursing staff.

Recommendation	Responsibility
Baseline assessment	Development, Block Unit, District
Organisation of training	District
Post training assessment	Development, Block Unit, District
Refresher/Follow up training at regular intervals	State
Skill labs at DH/CHC	State

Conclusion

Each of the key focus areas and the recommendations discussed in this plan have the potential to improve service delivery for maternal and child care. Addressing labor and delivery, human resources responsible for maternal child services, ability of block to handle basic complications and nutrition for health and survival- encompasses some major components. Implementing these strategies would provide a gauge of the amount of time required to efficiently operationalize them. Based on an evaluation of these plans specific activities can be scaled up to the district and outside.

ANNEXURE

All the information provided in the annexures is from April 2014 to Feb 2015

Overview of Human Resource: (CMHO office, Dausa district)

Sr. No.	Name of the Post	Sanctioned	In Position	Vacant
1	BCMO	1	1	0
2	Senior Specialist	12	8	4
3	SMO	2	0	2
4	MO	17	15	2
5	Accountant	11	4	7
6	Staff Nurse I/II	37	28	9
7	GNM	23	21	2
8	LHV	10	6	4
9	ANM	47	39	8
	Managerial Post			
10	BPM	1	1	0
11	BNO	1	1	0
12	Block ASHA Facilitator	1	1	0
13	PHC ASHA Supervisor	8	8	0
14	LS	7	6	1
15	CPDO	1	1 (On Charge)	0
16	ASHAs	204	193	11

Facility Wise Human Resource (S- # Sanctioned P- # present) (CMHO office, Dausa district)

PHC	MO		MN-1/2		G.N.M		ANM/Add		LHV	
	S	P	S	P	S	P	S	P	S	P
Kot	1	1	2	2	2	1	1	1	1	0
Santha	1	1	1	1	2	2	1	1	1	0
Rashidpur	1	1	2	2	2	2	1	1	1	1
Khedla Bhujurg	2	1	2	2	2	2	1	1	1	0
Pawta	1	1	1	1	2	2	1	1	1	1
Balahedi	1	1	1	1	2	2	1	1	0	0
Khoramulla	1	1	2	2	2	2	1	1	1	1
Talchidi	1	1	2	2	2	2	1	0	1	1
Total	**9**	**8**	**13**	**13**	**16**	**15**	**8**	**7**	**7**	**4**

CHC	SS		JS		MO		MN-1/2		G.N.M.		ANM/Add.		LHV	
	S	P	S	P	S	P	S	P	S	P	S	P	S	P
Mahuwa	3	2	2	2	4	4	11	10	3	3	1	1	1	1
Mandawar	3	3	2	1	2	2	6	5	4	3	2	2	1	1
Badgaon Khedla (Non	0	0	2	0	2	1	7	0	0	0	1	1	1	0

Functional)														

Details of Ambulances: (BCMHO office, Mahwa Block)

P- Present (1) A- Absent (0)

Name of the facility	**Base ambulance**	**108**	**104**	**MMU/MMV**	**Remarks**
CHC Mahuwa	2	1	1	0	108 Off road (Condemn)
CHC Mandawar	2	1	1	0	
PHC Santha	0	0	1	0	
PHC Khedla Bhujurg	0	0	1	0	
Total	4	2	4	0	

ASHA Details: (BCMHO office, Mahwa block)

Sr. .No	Name of CHC/PHC	No. of AWC	No. of Sanctioned ASHA	No. of Working ASHA	No. Trained in Induction Training	No. Trained in Module 5	No. Trained in Module 6 &7 Round 1	No. Trained in Module 6 &7 Round 2
1	CHC Mahuwa	11	11	10	10	10	10	0
2	Mandawar	31	31	30	30	24	24	0
3	Badgaon Khedla	3	3	3	3	3	3	0
4	Kot	15	15	15	15	15	15	0
5	Khedla Bhujurg	8	8	7	7	7	7	0
6	Pawta	22	22	22	22	20	22	0
7	Santha	20	20	20	20	18	18	0
8	Rashidpur	25	25	24	24	23	24	0
9	Balahedi	42	42	40	40	38	40	0
10	Talchidi	11	11	11	11	10	11	0
11	Khoramulla	12	12	12	12	10	12	0
	Total	**200**	**200**	**194**	**194**	**178**	**186**	**0**

VHSNC Account Details: (BCMHO office, Mahwa block)

Sr. No.	Name of CHC/PHC	Total No of Revenue Villages	Total No of Functional VHSC	No. of VHSC where Separate Bank Account Opened	No. of VHSC where Separate Bank Account not Opened
1	Balahedi	30	30	30	0
2	Khedla bhujurg	9	9	9	0
3	Kot	18	18	18	0
4	Khora Mulla	11	11	11	0
5	Mandawar	14	14	14	0
6	Pawta	19	19	19	0
7	Rashidpur	21	21	21	0
8	Talchidi	10	10	10	0
9	Santha	15	15	15	0
Total		147	147	147	0

NHM Expenditure Details: (For Whole Block) (BCMHO office, Mahwa block)

Sr. No	Component	Up to Feb 2015			
		Opening Balance (1/April/2014)	Fund Received (2014-15)	Expenditure (up to Feb 2015)	% Expenditure
1	RCH Flexi Pool	-49,094	1,76,00,000	1,52,16,904	86.73%
2	NRHM Flexi Pool	27,61,206	49,59,435	53,72,815	164%
3	Immunization	98,269	1,00,000	4,53,572	551%

Untied Funds Details: For CHC, PHCs (CMHO office Dausa and BCMHO office, Mahwa block)

Sr. No.	Name of the Facility	Opening Balance (1 April 2014)	Total untied fund received in 14-15	Total untied fund expenditure (up to Feb 2015)	% Expenditure
1	CHC Mahuwa	58256	456580	85000	16.51%
2	CHC Mandawar	85386	584874	430929	64.29%
3	PHC Balahedi	54311	187963	195660	80.75
4	PHC Kherla Bhujurg	13343	194730	37264	17.9
5	PHC Khora Mulla	19365	44333	60080	94.32
6	PHC Kot	22105	0	18818	85.13
7	PHC Pawta	29969	45357	0	0
8	PHC Rashidpur	10462	276893	104466	36.35
9	PHC Santha	108400	239594	216800	62.29
10	PHC Talchidi	42947	107375	20591	13.69

Un-tied Fund Status for Sub Center:

Sr. No	Name of the Sub Center	Opening Balance (1st April 2014)	Total Untied Fund received in 14-15	Expenditure (up to Feb 2015)
1	Uf. Bada Buzurg	60470	0	0
2	Uf.Badagoan	32342	0	23064
3	Uf. Banawad	20631	0	11748
4	Uf. Bareetki	57525	0	35587
5	Uf. Berkheda	-18158	25000	36316
6	Uf. Bhopar Tappa	-7344	22344	14688
7	Uf . Dhand	42942	0	37710
8	Uf. Gagwana	16744	0	13483
9	UF. Garh Himmat Singh	20146	0	3721
10	Uf. Gazipur	55551	0	22698
11	Uf.Gehnoli	28009	0	17188
12	Uf. Hadia	1866	23134	5000
13	Uf. Haldena	7581	2419	0
14	Uf. Hurla	10891	0	0
15	Uf. Jatwada	10531	0	5039
16	Uf. Kamalpur	-4082	19082	8164
17	Uf. Keshra	3916	16084	0
18	Uf. Kherla Gadali	28786	0	16727
19	Uf. Khonchpuri	33633	0	0
20	Uf. Lalpur	60221	0	7650
21	Uf. Nahida	44607	0	32950
22	Uf. Ond Meena	49719	0	0
23	Uf. Pakhar	1419	23581	5497
24	Uf. Palanheda	5898	4102	5928
25	Uf. Pali	7561	7903	0
26	Uf. Patoli	11974	0	0
27	Uf. Peepalkheda	2743	17257	0
28	Uf. Ramgarh	61482	0	0
29	Uf. Rindli	4301	15689	0
30	Uf. Sahaipur Pakhar	0	10000	0
31	Uf. Salempur Thana	15646	0	0
32	Uf. Salimpur	-2335	17335	4670
33	Uf. Samlete	15083	0	0
34	Uf. Sc Dholkheda	9204	796	0
35	Uf. Talchidi	21300	0	20850
36	Uf. Tikri Kilanot	16232	0	4734
37	Uf. Tudiana	-2582	17542	5164
38	UF. Ukrund	58210	0	23373
39	Uf. Vishala	6096	3904	1256

OPD, IPD, Deliveries for CHCs, PHCs, SCs (PCTS)

Sr. No	Name of the Facility	OPD Load	IPD Load	Deliveries Conducted at the Facility
1	CHC Mandawar	109262	4350	884
2	CHC Mahwa	180616	6882	1534
3	CHC Badgaon Khedla	635	0	0
4	Kot	6823	551	39
5	Khedla Bhujurg	35517	1684	417
6	Pawta	5379	78	38
7	Santha	9332	610	165
8	Rashidpur	13650	1168	30
9	Balahedi	12163	565	34
10	Talchidi	10776	715	41
11	Khoramulla	3684	179	2

Village Level Information under each facility (CMHO office – Dausa and PCTS)

Facility	Village	Population	Number of ANCs 2014-2015	Number of deliveries 2014-2015
CHC	Mahwa	25964	665	1534
CHC	Mandawar	12981	195	884
CHC	Badagaonv	4846	110	0
SC	Dholkheda	4466	78	0
SC	Garh Himmatsingh	7126	139	0
SC	Jatwada	6060	94	0
SC	Pakhar	-	77	0
SC	Ukrund	5939	91	0
PHC	Balaheri	5115	80	34
SC	Barkheda	5113	79	0
SC	Gagwana	3526	69	0
SC	Hudla	4471	69	0
SC	Kamalpur	3271	88	0
SC	Naurangvada	4653	45	0
SC	Patoli	3573	93	0
SC	Peepalkheda	5534	110	0
SC	Samleti	4400	57	0
SC	Tudiyana	2709	72	0
SC	Vishala	5374	70	0
PHC	Khedla Bujurg	7507	152	417
SC	Samalpur	4737	110	0
PHC	Khora mulla	3391	75	2
SC	Bada Bujurg	4288	99	0
SC	Oadmeena	6999	152	0
pHC	Kot	5906	94	39

Facility	Village	Population	Number of ANCs 2014-2015	Number of deliveries 2014-2015
SC	banavad	4728	89	0
SC	haldena	4106	48	0
SC	Reendli	3847	60	0
SC	Tikari Ki Lanoti	2601	47	0
PHC	Pawta	7510	124	38
SC	Baritaki	5723	106	0
SC	Gajipur	7239	176	0
SC	Khonchpuri	5090	107	0
PHC	Rashidpur	7407	140	30
SC	Bhopartapa	3481	57	0
SC	Kesara	3728	61	0
SC	Pakhar	5136	94	0
SC	Pali	4280	67	0
SC	Ramgarh	7377	145	56
SC	Salampur	5303	128	0
PHC	Santha	7215	123	165
SC	Ghanoli	8148	205	0
SC	Hadiya	4906	143	0
SC	Khedla Gadali	4733	98	0
SC	Lalpur	1960	21	0
SC	Palanheda	5338	117	0
PHC	Talchidi	6447	124	41
SC	Dhand	7760	188	0
SC	Nahida	5459	124	0

Maternal Deaths – 2014-2015 (PCTS)

Maternal Death	Village from where she was	Facility for the village	Details About Delivery and Death	Review Done	Audit Done
One	Pakhar	PHC Rashidpur	Death on 9th Feb 2015 due to vaginal bleeding	Yes	No
One	Munnapur	PHC Kot	Death on 30th Jan 2015 due to vaginal bleeding	Yes	No

Infant Mortality 2014-2015 (PCTS)

Mortality	Village From	Facility village under	Details about death	Review Done
One	Mandawar	CHC Mandawar	Infection (18/5/2014)	Yes
One	Mandawar	CHC Mandawar	Unidentified (13/7/2014)	No
One	Mandawar	CHC Mandawar	Unidentified (16/7/2014)	No
One	Mandawar	CHC Mandawar	Unidentified (18/2/2015)	No
One	Mandawar	CHC Mandawar	Unidentified (11/2/2015)	No
One	Mandawar	CHC Mandawar	Unidentified (30/1/2015)	No

One	Kesari	PHC Rashidpur	Others (12/8/2014)	No
One	Pakhar	PHC Rashidpur	Others (9/10/2014)	No
One	Noganve	PHC Khora Mulla	Others (17/6/2014)	No

Mapping Villages /Facilities with High Home Deliveries (Criteria = above x number of HDs)

(PCTS)

Facility	Done by SBA Trained	By Untrained	Reported HDs
CHC Badagaon	4	0	4
CHC Mahuwa	3	2	5
CHC Mandawar	25	0	25
PHC Balahedi	4	1	5
PHC Kherla Bhujurg	10	6	16
PHC Khora Mulla	2	1	3
PHC Kot	12	5	17
PHC Pawta	6	1	7
PHC Rashidpur	1	1	2
PHC Santha	11	6	17
PHC Talchidi	32	0	32
Total	**110**	**23**	**133**

Physical Status: (PCTS)

Indicators	2012-13	2013-14	2014-15
Antenatal Care			
ANC Registration	5953	5605	5555
Registration Within 12 Weeks	2792	2667	3166
3 ANC Checkups	4596	3917	3816
Women consumed 100 IFA	5392	5062	4978
Mothers who received at least one Tetanus Toxoid (TT) injection	4233	3726	3808
Delivery Care			
Institutional Delivery	3721	3562	3240
Delivery at Home	367	298	133
Delivery at home conducted by skilled health personnel	335	272	110
Caesarean out of total delivery taken place in Government Institutions	0	0	0
New Born Care			
Children received early initiation of breast feeding	5686	7338	7124
Children whose birth weight was taken	5670	7338	7112
Children with birth weight less than 2.5 Kg.	1108	2158	2574

Post Natal Care			
Less than 24 hrs. stay in institution after delivery	118	3	0
New borns who were checked up within 24 hrs. of Home delivery	363	298	132
Mothers who received Post-natal Check-up within 48 hrs. of delivery	4806	4556	3845
Children with full immunization	4863	5133	2763
Family Planning			
IUD insertion	963	955	1301
Total Male sterilization (VT/NSV)	0	0	1
Total female sterilization (Minilap/LT)	1371	1425	1261
Number of PPIUCD insertion	0	19	258