Situation Analysis of GRAM AROGYA KENDRA at Bhopal District of Madhya Pradesh

By

Barunesh

Dissertation submitted for the partial fulfillment of the

MBA Rural Management

Academic year, 2015-2017

The IIHMR University, Jaipur

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INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that **Barunesh** student of **MBA Rural Management** from The IIHMR University; Jaipur has undergone internship training at National Health Mission, Madhya Pradesh from **February 6th, 2017 to May 5th, 2017**.

The Candidate has successfully carried out the study designated to his during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish him all success in all her future endeavors.

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OFFICE OF THE CHIEFMEDICAL & HEALTH OFFICER
DISTRICT BHOPAL (M.P.)

Ref.No./NHM/....6974 Bhopal, Date 11/05/17

// CERTIFICATE //

The Certificate is awarded to **Barunesh** In recognition of having successfully completed his dissertation in the department of District Health Society, Bhopal and has successfully completed his study on "Situation Analysis of Gram Arogya Kendra" Duration of three Months (February-April) Organization National Health Mission, Madhya Pradesh He comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning. We wish him all the best for future endeavors.

CHIEF MEDICAL & HEALTH OFFICER
DISTRICT BHOPAL

Chief Medical & Health Officer
Distt. BHOPAL

IIHMR UNIVERSITY

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **Situation analysis of Gram Arogya Kendra at Bhopal district of Madhya Pradesh**and submitted by **Barunesh**Enrollment No.**IIHMR-U/03/2015-17/0001**under the supervision of **Dr. AlokMathur**for award of MBA in **Rural Management**of the University carried out during the period from **6th feb to 5th may 2017**embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

Barunesh.

Signature

Barunesh

MBA-RM-04

IIHMR University

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that all ethical issues have been considered while collecting data for my dissertation titled **"Situation analysis of GRAM AROGYA KENDRA at BHOPAL district in Madhya Pradesh"**

Signature of student

ACKNOWLEDGMENT

Words are indeed inadequate to convey my deep sense of gratitude to all those who have helped me in completing this dissertation to the best of my ability. Being a part of this project has certainly been a unique and a very productive experience on my part.

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Place: - **Signature**

Date:- **(**BARUNESH)

Table of Contents

List of Abbreviations

ANC	Ante Natal Care
AS	ASHA Sahyogi
ASHA	Accredited Social Health Activist
AW	Aganwadi Worker
BCM	Block Community Mobilizer
BP	Blood Pressure
GAK	Gram Arogya Kendra
ICDS	Integrated Childhood Development Services
IFA	Iron Folic Acid
LHV	Lady Health Visitor
MPTAST	Madhya Pradesh Technical Assistance Support Team
NHM	National Health Mission
ORS	Oral Rehydration powder
URI	Upper Respiratory Infection
VHND	Village Health and Nutrition Day

1.Introduction

1.1 About Madhya Pradesh

Madhya Pradesh is the heart of Central India. It has geographical area of 308 thousand sq. km and a population of 7.27 Crore (as per census 2011). Rural population of India is 52557404 i.e. 72.37 percent of total population. This rural population populated in 52117 villages of 313 blocks in 51 Districts. Many villages peoples are unwilling to go to nearby or distant public health facilities. In remote, far jungle villages (van gram) access to medicines and medical care by trained health personnel is a dream for them and a big challenge for the govt. Making provisions of 24 X 7 days, for providing basic primary health care services and measure to medicines to above inhabitant villages is a big challenge.

If medicines are made available & administer in right time to them many ailments are curable. A simple example is availability of ORS packet for diarrhea patient, Tab Paracetamol for fever patient and Tab Septran for URI etc. Above examples many times proves to be lifesaving provided, if referral made available at right time. Provision of basic minimum health services at village level ensures that all who need health care can access it freely and secondly to reduce the burden of out of pocket expenditure of the people up to the last mile. Gram Arogya Kendra as an establishment re-enforces the commitment of MP government for providing Universal Health Coverage to its people. Moreover, the efforts are made through the HEALTH SERVICE GUARANTEE Scheme.

1.2 About Bhopal

In terms of its area, Bhopal, the city of lakes, is second largest one in Madhya Pradesh after Indore. The city is divided into two major areas, the old and the new city. Muslim population of the city is largely concentrated in old city most of whom find employment opportunities from certain small scale industries. The district is highly urbanized with nearly 80% of its population marked as urban; it also has a sizeable chunk of the population residing in villages many of whom retain their rural characteristics. Administratively, the district of Bhopal is divided into two subdivisions, Berasia and Huzur. Of this, Huzur, is more urbanized with nearly 90 % of its population residing in urban areas. Most of Berasia subdivision is rural comprising of nearly 285

villages. Minority religious groups together comprise close to 26% of the district's population. In terms of their population share, Muslims constitute the principal community among the religious minorities of Bhopal. Despite their predominance, Muslims seem too have lagged behind all other groups. This is made obvious by their relatively poor performance in literacy. Yet Muslim literacy in Bhopal is higher than their literacy rate computed nationally. Amongst minority groups, Jains and Christians together with Sikhs have near total literacy.

1.3 About GRAM AROGYA KENDRA

In Nov. 2012, Dept. of Public Health & Family Welfare along with the Dept. of Women & Child Development started a new initiative under the "Health for all" campaign was to provide essential health and nutrition services at the village level through the establishment of "Aganwadi – cum - Gram Arogya Kendra" in each village. Today 49489 Gram Arogya Kendras were well established in 52117 villages of MP. Majority of GAKs are situated in Aganwadi, few were in sub center and Panchayat bhawan.

1.4 Implementation and Monitoring system for GAK(s)

A strong monitoring and supportive supervision mechanism is necessary to ensure effective delivery primary health services at village level. Initially in 2012-13 ANM, LHV and Sector supervisors of public health system are responsible and accountable for imparting primary health care services at village level.

In year 2014-15 in conjunction with above the ASHA support system were also formed in National Health Mission Madhya Pradesh. ASHA support system at state level constitute ASHA Resource System Cell, NHM, Bhopal and At Districts appointed 51 District Community Mobilizer and in 313 blocks by appointed Block Community Mobilizer and 3999 ASHA Shahyogi who do handholding supervision of 59036 ASHAs working in rural villages of MP. Later on, the supervision and accountability of GAK(s) shifted on shoulders of this ASHA support system.

1.5 Instruments, Equipment, Materials, and Medicine's available at GAK

S no	Instruments of GAK	Equipment for Investigations in GAK	Medicines of GAK	Equipment for Examination in GAK
1	Table	Glass Slides Box	Tablet Paracetamol 500 mg	ANC examination table, with Footsteps for climbing
2	Chairs	Lancets	ORS packets	BP instrument
3	Bench	Test tubes	Tablets Chloroquine (150 mg base)	Stethoscope
4	Alimarh	Rapid Diagnostic Kit for Malaria,	Tablets IFA (Adult, Pediatric)	Infant Weighing Machine
5	Stationary	Pregnancy test kit	Tablets Co-trimoxazole	Child Weighing Machine (Salter- 25 kg)
6	Waste bin	Urine for sugar & Albumin test strips	Gentian violet solution	Adult Weighing Machine
7	Drinking water container	Hemoglobinometer	DT Zinc Sulphate (dispersible tablets)	Thermometer
8	Long handled mug	BP Instrument	Tablets Albendazole 400 mg	Fetoscope
9	Tumblers		Tab Dicyclomine HCl 10 mg	Hub cutter
10			Povidone Iodine solution	Torch
11			Cotton bandage	
12			Absorbent cotton	

There is no inventory management system exist in such a huge no of 49489 established GAKs in MP. Distribution of drugs to ASHAs is through ANMs but no record keeping is maintained between them. This project study aims to reduce pilferage of drugs distributed to

ASHAs from Govt. hospital so as to establish a proper inventory system and to keep an eye on drugs consumed by the community.

1.6 About GAK

Gram Arogya Kendra initiative was conceptualised and rolled out in the year 2011-12 by the then Collector Dr.Sanjay Goyal in Sehore district of Madhya Pradesh, which fortunately is also the home district and assembly constituency of Hon. Chief Minister and is part of Parliamentary constituency of Hon. Union Minister for External Affairs, Ms. Sushma Swaraj. The initiative was subsequently implemented all over the state of Madhya Pradesh. Principal Secretary, Health &Family Welfare, Mr. Pravir Krishn ensured its implementation to about 50,000 villages across the state. A decentralized service delivery system which caters to the last mile population with basic health services and provides a platform for convergence of health and nutrition services. Gram Arogya Kendra (GAKs) are established at existing Anganwari Centers.Functional in about 49000 villages in the state. The health services are delivered by ASHA (Accredited Social health Activist) on regular days and by ANM (Auxiliary nurse and midwife) on the village health and nutrition day (VHND). Moving ahead in the direction of universal health coverage, the Dept. of Public Health and Family Welfare of the Government of Madhya Pradesh has taken various initiatives. With a plethora of service additions, widespread public welfare schemes and better monitoring systems, a new platform for health service delivery was launched in the year 2013. The platform aimed at decentralization of basic health services up to village level and utilized the existing platform of Anganwadi Centers and resource pool of ASHAs which already existing in villages providing nutrition and health services separately. The innovation brought in a much sought after convergence of the department of ICDS , Health and Panchayti Raj and foundation for development of village level health units called *GramArogya Kendra* (GAK) was laid down. The *Gram Arogya Kendra* were establishedat the existing Anganwadi centres and ASHAs were trained to the new role envisaged for them.

2. REVIEW OF RESEARCH AND DEVELOPMENTS IN THE SUBJECTS

1. GRAM AROGYA KENDRA is an innovation in health service delivery for universal health coverage. This innovation was brought in has been in actively promoting the convergence of health and ICDS and also in strengthening community ownership of programs at the village level. This is being sought to be achieved through the establishment of Aganwadi-cum-Gram Arogya Kendra (Village Health Centre) in each village. The main objective in opening these health centers is to make the community aware of their health and environment, increase community ownership of village level programs, and ensure proper delivery of health and nutrition services through the involvement of, and supervision by the community.
2. The two main areas of focus of activities are – treatment of minor ailments and early referral for more serious illness; as well as health education towards a healthy lifestyle.
3. Objectives of the GAK:

a. Provide essential health and nutrition services to the community at the village level itself.
b. Make the community aware of their health and environment and thus involve them in taking care of their own health.
c. Strengthen quality of health services through training of the Gram Sabha Swasth Gram Tadarth Samiti.
d. Improve co-ordination between frontline workers of various departments at the village level for better provision of services.

4 GAK(s) has high acceptability among the villagers, with women appreciating the fact that there is a place where pregnant women can be examined properly and in privacy and those having other health problems can be solved here or needs treatment for minor ailments being taken care off.

"I have been there several times. Once to get medicine for fever for myself, once to get "ghol packet" (ORS) for my daughter who had diarrhea, and once when my older son had a cough. We always get better with the medicines. I don't have to go to the ASHA's house which is far away".

Malati Bai, resident, JATKHERI, Bhopal

In addition to the provision of basic health services provision in GAK it serves as a single unit for all village health records. All health-related records include total population of village,

list of eligible couples, pregnant and lactating women and under-five children, list of children for immunization, vital statistics, as well as the tour programmed of the ANM – are available at the center.

A folder of health education material is also available at the center for the ASHA and ANM to use during meetings and interactions with the community. Lists of patients on treatment for chronic diseases are also available at the center. The names of the members of the SHG providing the meals to the AWC children; names of the GSSGTS members; minutes of the meetings of the GSSGTS; as well as names of health and ICDS functionaries of the village are available. The contact details of the CDMO, the Collector, District Community Mobilizer, and District Executive Officer are displayed on the wall of the health center.

The potential of the Gram Arogya Kendra is a unique concept to promote village based health and nutrition activities and promote community participation for their own health. By co-locating the AWC and GAK, all women and child-related services will be available in one place, and the community can more easily understand the links between health and its determinants like nutrition, water, and sanitation.

It is also in line with the 12th Plan priorities for system strengthening through decentralization, community involvement, and by improving interdepartmental co-ordination. The GAK has the potential to be the hub of health-related preventive, promotive and curative activities in the village. It also enhances interaction between the AWW, the ANM and ASHA. All activities related to women and children (which fall under the mandate of both the ICDS and health departments) can now take place at one location. Antenatal and lactating women can come to the same centre for their checkups and to collect the THR. There is a place to keep an examination table for pregnant women, a table for records and for keeping vaccines for immunization.

The profile of the AWC as a place where health services are also provided is enhanced. The community also knows that the ASHA is available for treatment of minor ailments at a particular place at a fixed time on specific days of the week. The visibility and access of the ASHA worker as a village contact person for treatment of common ailments has also improved since she now has a place to sit and keep the medicines properly. This is particularly so when her home is in one corner of the village and the AWC is more centrally located. The centre can develop as a place for health education to all sections of the community – to mothers during VHND, to pre-scholar in the AWC, to community members through the Gram Saba Gram

Tadarth Samiti and peer group activity to adolescent be the focal point for positive community action for health.

The Gram Arogya Kendra is a unique concept to promote village based health and nutrition activities, and for involving the community in their own health. By co-locating the AWC and GAK, all women and child-related services are made available in one place, and the community can more easily understand the links between health and its determinants like nutrition, water and sanitation. It is also in line with the 12th Plan priorities for the strengthening system through decentralization, community involvement, and by improving interdepartmental co-ordination. The support provided by the MPTAST has been instrumental in establishment of these centers in the supported districts. Further, the district teams catalyzed mobilization of essential instruments, drugs and consumables. Amongst all the unstructured and regular support provided to the district, the structured efforts started from the month of April onwards, which essentially have improved the functional status of the Gram Arogya Kendras. The major changes have been brought about in improving the functionality of VHSCs, through the availability of essential equipment's like BP machine, Stethoscope, Thermometers, Uristics for testing glucose and albumin in urine, Malaria testing kits, medicines like Albendazole, co-trimaxazole and family planning material.

These changes have been further translated into better service delivery by hands on trainings to ASHAs and ANMs. Further a regular follow up with the supportive supervision cadre of the GAKs which includes Block Community Mobilizer, Sector Supervisors and Sector Medical Officers at this point of time, the efforts are still continued to further keep improving the service availability, access and quality of services.

Arima Mishra conducted a study about the role of the Accredited Social Health Activists in effective health care delivery in South Orissa finds that there should be more involvement of community in recruiting and discussing responsibilities of the ASHAs. This will enable ASHAs to effectively act as a bridge between the community and the formal healthcare services Planning commission, Government of India conducted study of National Rural Health Mission (NRHM) In 7 States Programmed Evaluation Organization about role of ASHA turns out to be extremely important in promoting utilization of public health care facilities for MCH care, Family Planning, and treatment of Chronic Diseases. ASHA‟s home visits and counseling promotes utilization of family planning services primarily from public health facilities. An evaluation study in Madhya Pradesh and Uttarakhand has been pointed out that there is a great urgency to

speed up establishment of support structures and implementation of the programmer. All these states will benefit a great deal while having a skilled ASHA at the community level to promote maternal, new born and child health and family planning Gosavi SV and Raut AV ASHAS' awareness & perceptions about their roles responsibilities: a study from rural wardha Comments that though the NRHM focuses on reducing the maternal & child mortality & morbidity, creation of functional infrastructures & up gradation of services. We found out that the public health machinery is not successful in generating awareness and creating a cadre of functional frontline workers in the form of ASHA. ANC services at the village level were affected because of lack of participation of ASHA in village health & nutrition day (VHND) & because of lack of clarity in their roles in health care provision.

3. OBJECTIVES

This study tries to inform the health planners and manager about the Gram Arogya Kendra (Village Health Centers) running in Madhya Pradesh as a mechanism for Universal Health Coverage by:

1. To assessment of utility of and acceptance of Gram Arogya Kendra's in village residents and health workers
2. To understanding operational challenges in service delivery at GAKs
3. To Assessment of functionality of Gram Arogya Kendra

3.1 OPERATIONAL DEFINITION:

1. Operational challenges: operational challenges are the application of operationalization used in terms of a process (or set of validation tests) needed to determine the nature of an item or phenomenon (e.g. a variable, term, or object) and its properties such as duration, quantity, extension in space etc.

In this study the operational challenges of the Gram Arogya Kendra workers is measured by using job challenges.

2. Gram Arogya Kendra: decentralized service delivery system which caters to the last mile population with basic health services and provides a platform for convergence of health and nutrition services.

4. MATERIAL AND METHOD:

SETTING:

The study will be conducted at the venue of Gram Arogya Kendra in an identified district of MP.

STUDY DURATION:

3 months (Feb 2017 to April 2017)

SAMPLE SIZE:

In this study the sample size will be 100 Gram Arogya Kendra.

TOOLS AND TECHNIQUES-

Quantitative data collection technique

TOOLS	TECHNIQUES	RESPONDANTS
Structured close and open ended Questionnaire (self-stated importance questionnaire)	structured Questionnaire guidelines	ASHA, ANM, And community
Interviews	Interview guidelines	ASHA,ANM,and community

Sample selection:

INCLUSION CRITERIA

1. Anganwadi workers, ASHA and ANM working at BHOPAL district of MP.

2. Anganwadi workers, ASHA and ANM who are willing to participate in the study.

EXCLUSION CRITERIA

ASHA workers and ANM who are:

- Not available during the period of data collection and study.
- Sick or ill at the time of study.

Source of data:

ASHA workers, Aganwadi workers in selected Gram Arogya Kendra at Bhopal.

Research design:

Exploratory survey design.

METHOD OF DATA COLLECTION

SAMPLING PROCEDURE

Systematic sampling will be used to select the sample.

DATA ANALYSIS PROCEDURE:

Data will be analyzed by using the descriptive and inferential statistics.

Limitation of the study

- GAKs were selected randomly because of limited mobility.
- Lack of timing because of Overlapping of different health program (like MAHILA SWASTHYA SHIVIR and MISSION INDRADANUSH)
- Job responsibility cannot be delegated so at this situation it was very hard to manage time to visit GAK at official timing.

Areas of Future Study

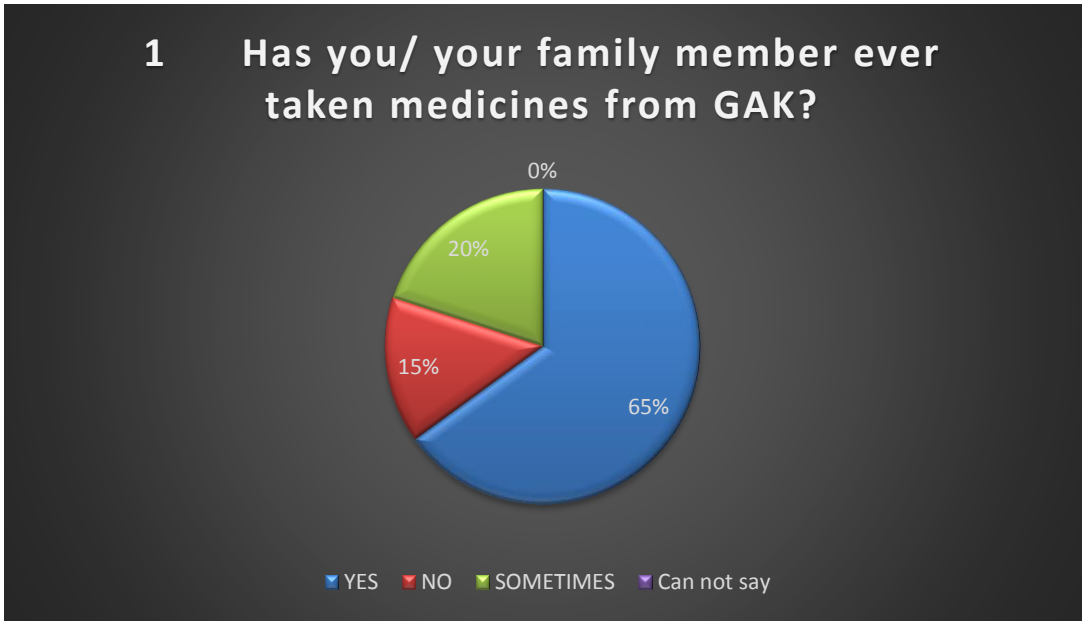
A. Change in the level of health awareness of community due to GAKs (KAP level of VHSNC members as well as public).
B. Any substantial decrease in patient load in SHCs & PHCs. Can it be a substitute for sub health center (SHCs)?
C. Has it led to reduced dependence on quacks / so called "Jhola chhap doctors"?
D. Does the information regarding epidemics & diseases reach faster to block/district headquarters after establishment of GAKs?
E. Did it help in improving health indicators? Did the lag time for pregnant women & ill children reaching to Health Centre decreased? Did the number of average visits of pregnant & lactating mothers & under-five children as well as general clients to higher health facilities decreased and Co-ordination between workers responsible to run GAKs-ANMS, MPWs. ASHAs & AWWs. (Level of convergence).

5. Result and discussion

Personal interview and structure questionnaire with villagers, ASHA workers and ANM and observation generated important results and major ones are presented in the GRAPH form below.

Figure 5.1 Villagers taken medicine from GAK

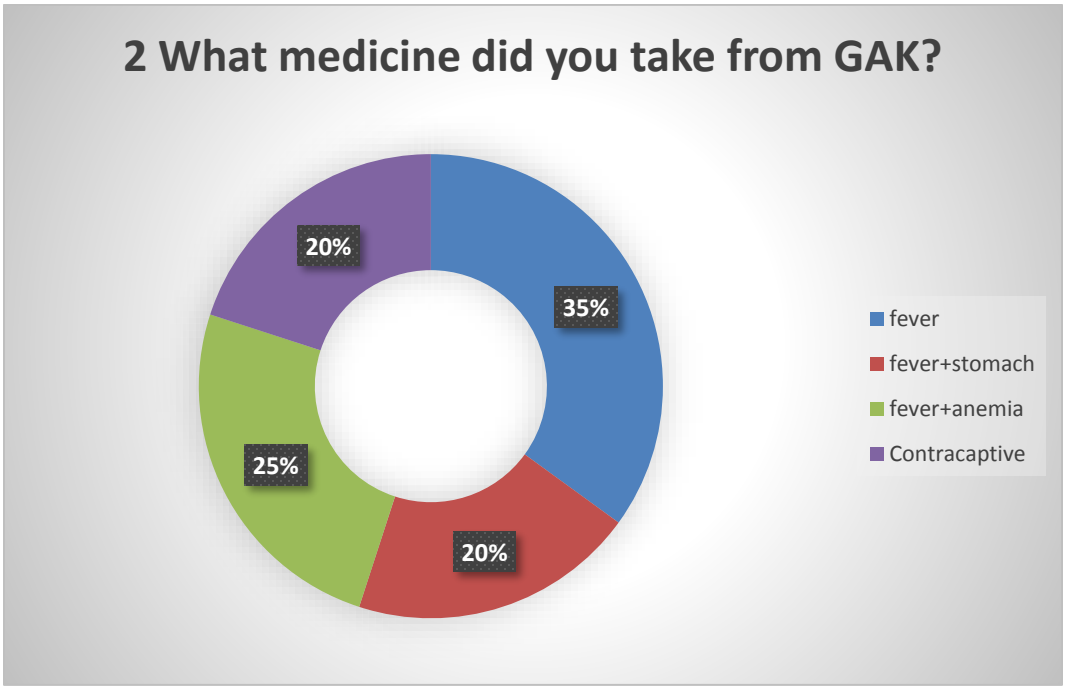
Figure 5.1 shows that 65 percent villagers taken medicine from GAK and 15% villagers Nevers taken medicine from GAK and 20% villagers taken medicine from GAK sometimes. The interesting thing in this data is those who have never taken medicine from GAK was mostly those people who are upper caste and their source of income is also good so they prefer to go to private hospital irrespective of GAK or PHC. 20 Percent villagers taken medicine from GAK sometimes and with personal talk with them they said that when we need fever or ORS packet then we prefer to go GAK.



Source: primary data

5.2 Types of medicine villagers mostly preferred

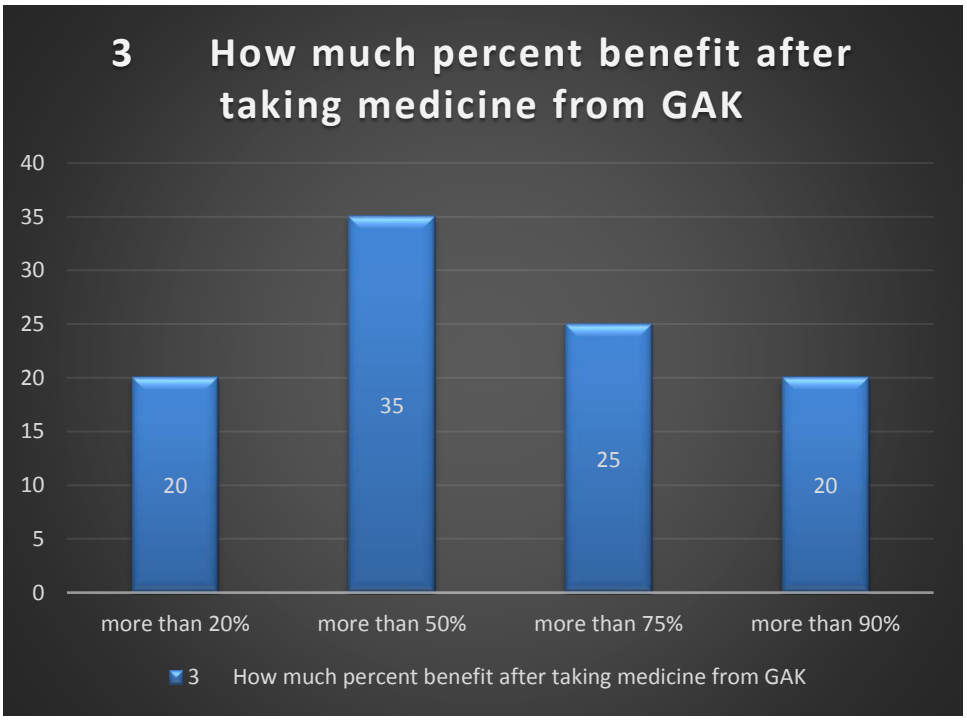
Figure 5.2 shows that percentage of medicine generally villagers taken from GAK. 35 percent villagers taken fever medicine like paracetamol tablet because this medicine have trusted among villagers and they know that this medicine easily available at GAK. 20 percent villagers went GAK to take medicine like fever and stomach and 25 percent villagers taken medicine from GAK of fever and IRON tablet and iron tablet is also very high number among villagers to take from GAK. 20 percent villagers who take condom or female condom from GAK. In family planning ASHA role to aware the women in village is very important and generally women who regularly in touch with ASHA workers frequently visited at GAK from taken these medicine at GAK.



Source: primary data

5.3 Opinion among villagers about benefit of medicine taken from GAK

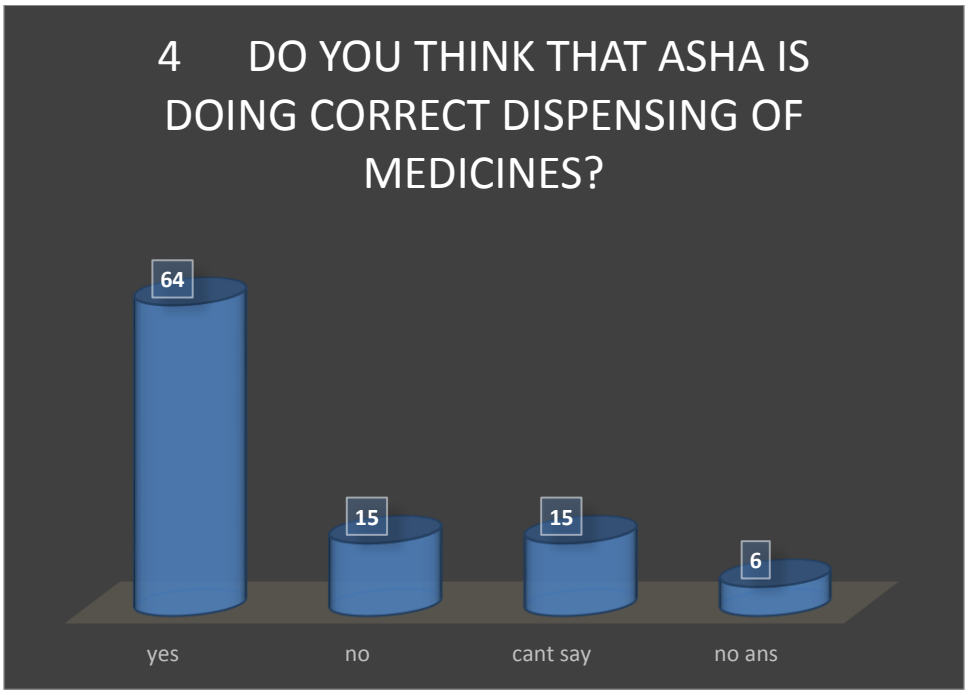
The popularity of GAK among villagers is reflect in this data. Around 20 percent villagers who said that more than 90% benefit after taken medicine from GAK and these villagers who are poor and schedule caste. Around 25 percent villagers said that more than 75% benefit after taken medicine from GAK. 35 percent villagers said that more than 50% benefit after taken medicine from GAK and these patients are generally referred to PHC or CHC because they are suffering from various diseases. 20 percent villagers.



Source: primary data

5.4 Opinion about ASHA for dispensing of medicine

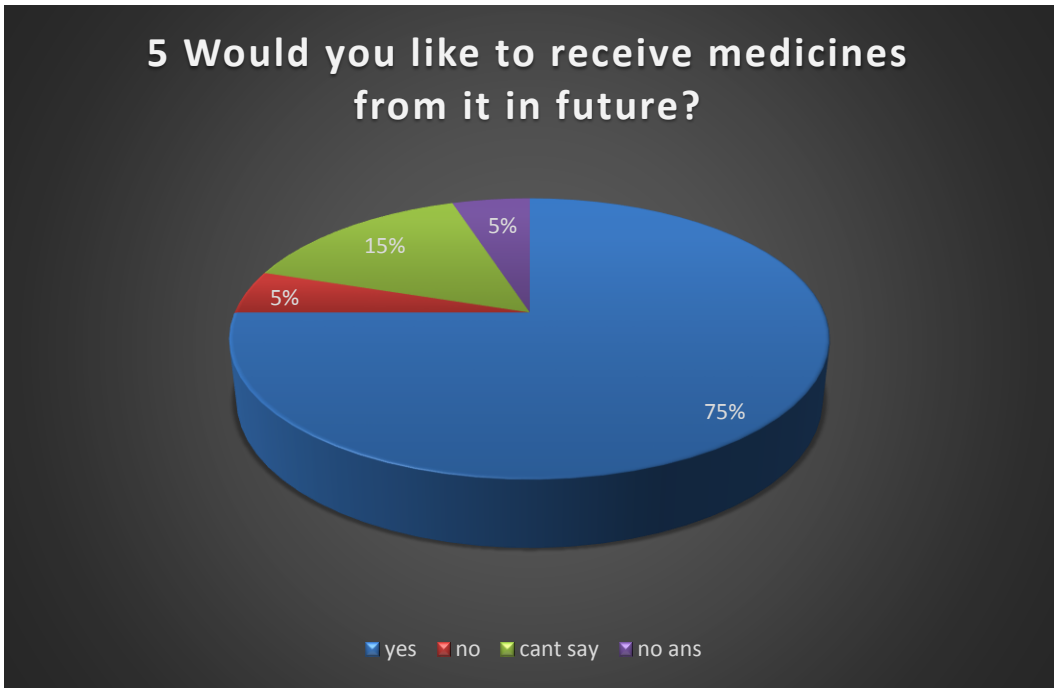
Figure 5.4 shows that 64 percent villagers thought that ASHA is correctly dispensing medicines and they said that generally ASHA gave medicine for minor disease like fever and iron. But in critical situation ASHA gives medicine after suggestion from ANM and in critical situation ANM will refer to patient in PHC. While on the other hand 15 percent villagers thought that ASHA have no knowledge about medicine and they were not correctly dispensing of medicine. On the other hand, 15 percent have no idea about it whether she is correctly dispensing or not because some villagers are illiterate. 6 percent villagers have given no response because they are not happy with the working performance of GAK.



Source: primary Data

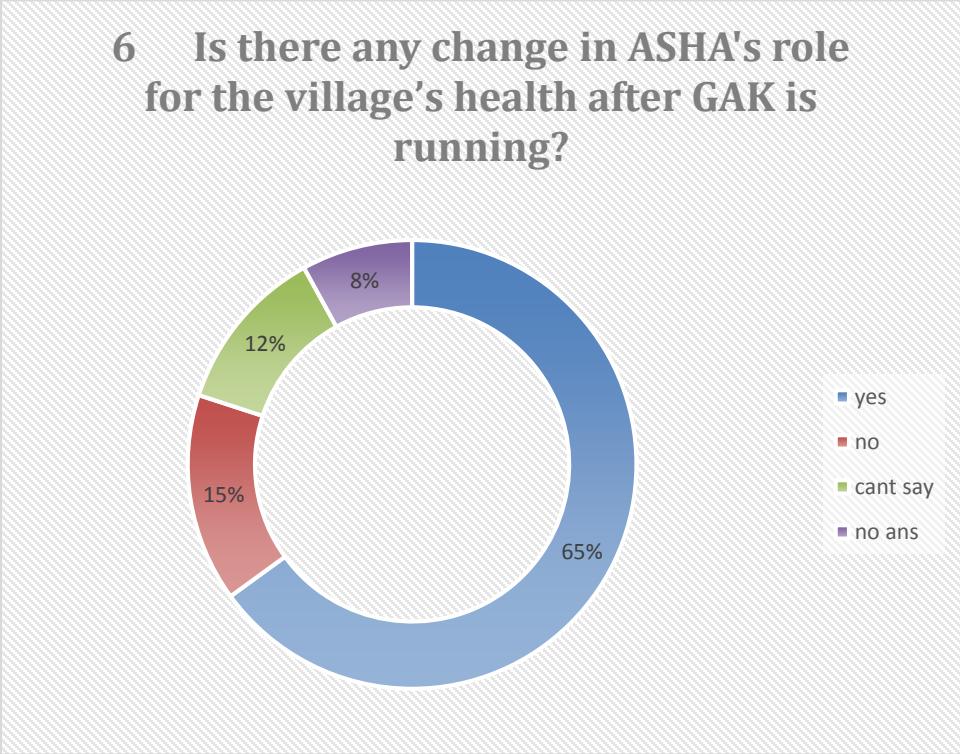
5.5 Opinion about popularity of GAK

The popularity of GAK among villagers is very high. Aound 75% villagers gave their opinion that they use to take medicine from GAK in regular interval. Only 5% villagers said that they will not take medicine from GAK in future. 15% villagers have given no response.



5.6 Opinion of the villagers about ASHA after running GAK

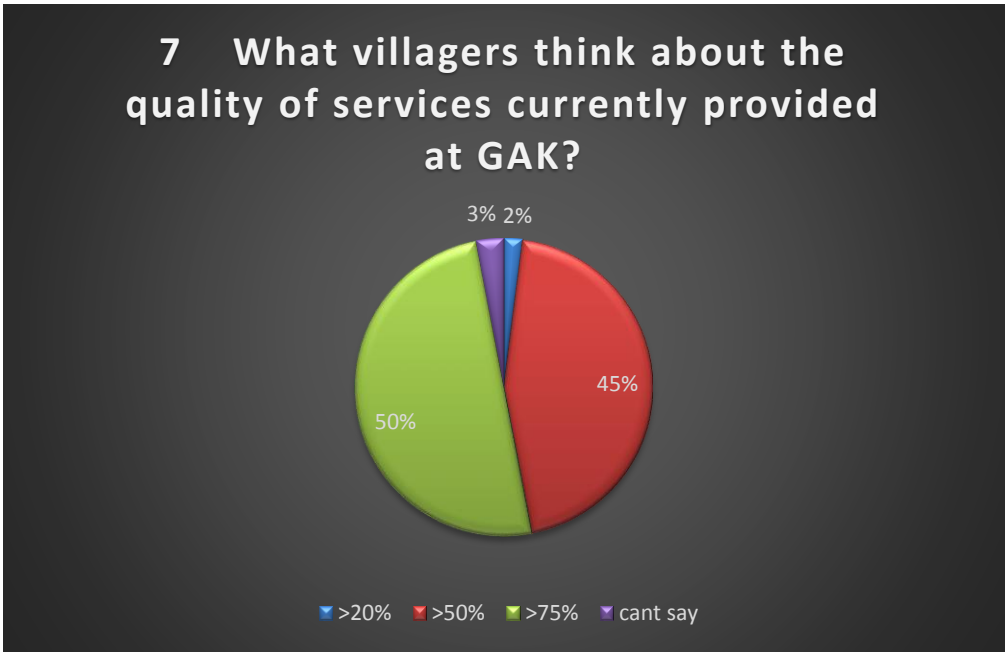
65% villagers thought that after establishment of GAK, ASHA role is much better. This platform is save not only villagers' time but also ASHA and ANM .15% villagers thought that ASHA's role is previously good and 12% have no opinion about this.



Source: primary data

5.7 Quality of services provided at GAK

45% villagers have opinion about quality of services at GAK is more than 75%. On one hand they have taken medicine from GAK, on the other hand they took protein of their child and pregnant women. 50% villagers thought that at GAK the quality of medicine is good but other facility like pregnancy checkup and other instrument is not good so they have given only 50% out of 100.2% villagers have given only 20% marks out of 100 because they monetary well and prefer private doctors instead of visiting GAK.3% villagers have given no opinion about GAK.



Source: primary data

6. Responses from ASHA

ASHA role at GAK is very important and through structure questionnaire there view about GAK is very important. In this section 100 ASHA have been interview through structure questionnaire at 100 different GAK at Bhopal district. In each segment of health program ASHA is key players and who is right mediator between government and community. ASHA works with ANM and aganwadi workers at GAK and at GAK each member has different job responsibility.

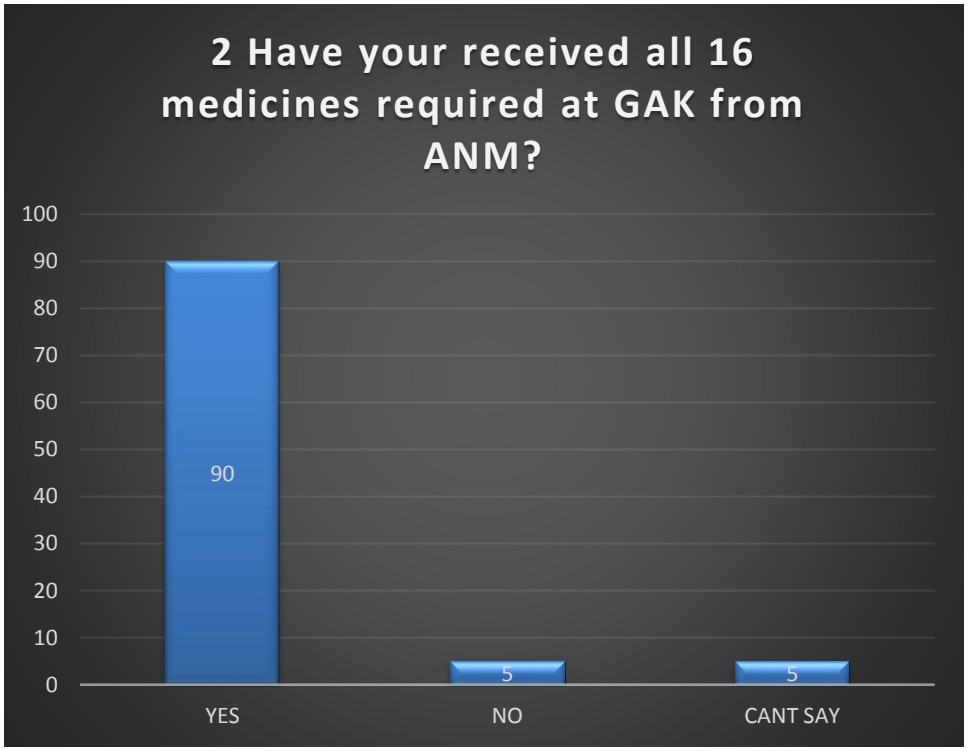
6.1 ASHA have provided orientation before setting at GAK

More than 80% ASHA have provided orientation before setting of GAK and they know their job responsibility about GAK. They are trained for dispensing of 16 medicine which are available at GAK and knows family planning method that how to aware the villagers especially women about family planning. 15% ASHA have not given any type of training about GAK and most of them are newly selected and in this situation ANM and aganwadi workers help them. Only 5% ASHA have given no opinion because they were absent at the time of visit at their particular GAK.

Source: primary data

6.2 All 16 Medicine available at GAK in the view of ASHA

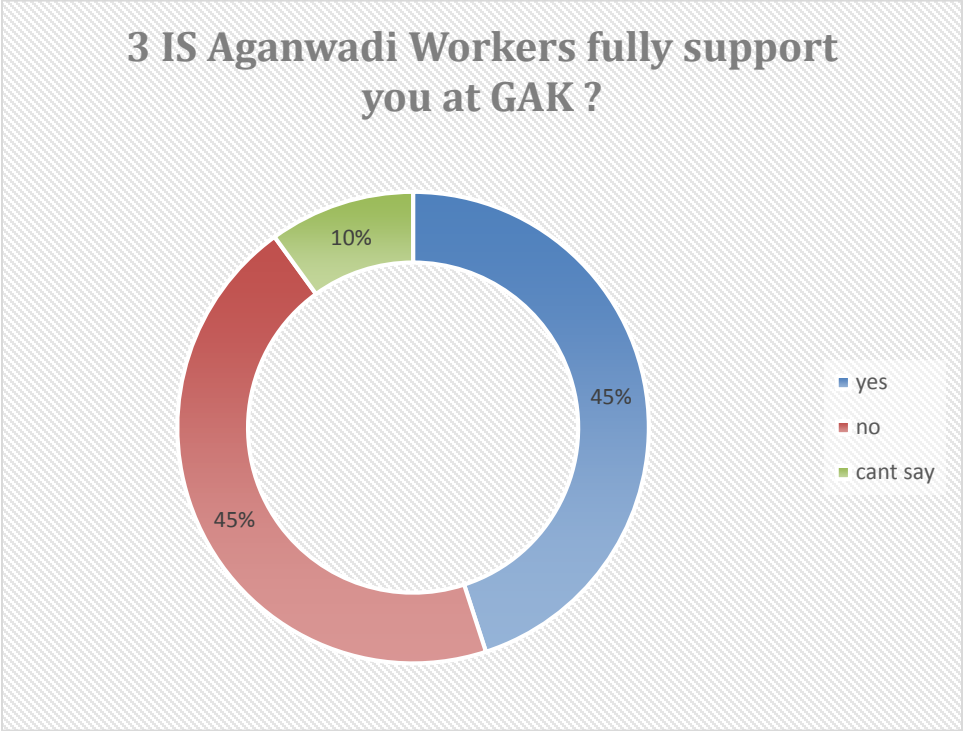
90% ASHA have knowledge about all 16-medicine available at GAK or not but on the other hand 5% ASHA who have newly appointed have no knowledge about 16 type of medicine. 5% ASHA said that in some situation we have not provided all medicine because stock is limited at block community mobilizer said that and when they demand then the provide medicine and in this situation, we have not received all medicine that is required at GAK.



Source: primary data

6.3 Aganwadi workers supporting ASHA or not at GAK

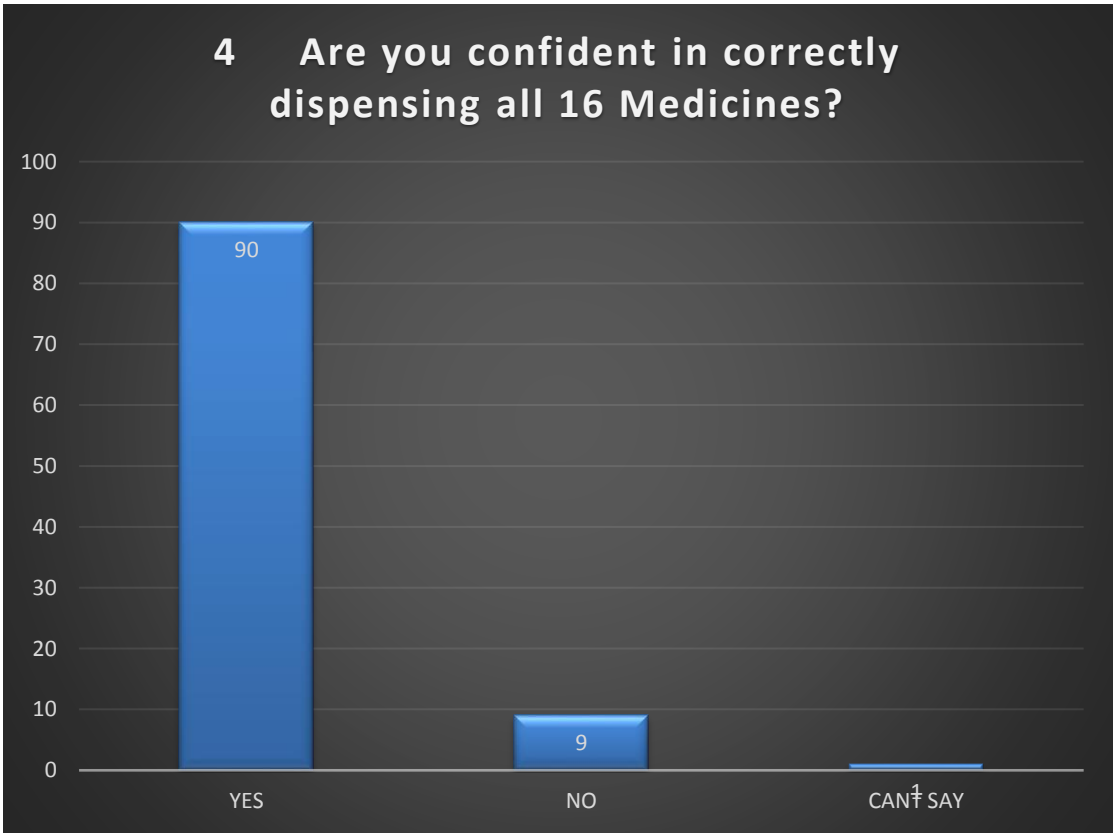
This data is very interesting because generally at GAK ASHA and aganwadi workers have different job responsibility at GAK and in some situation,they are not support each other. Around 45% ASHA said that aganwadi workers have not support and same number of ASHA said that all have done their work with mutual understanding and 10% ASHA said have not given their opinion because they have not much experience because they are new.



Source: primary data

6.4 ASHA is confident to dispensing all 16 medicine at GAK

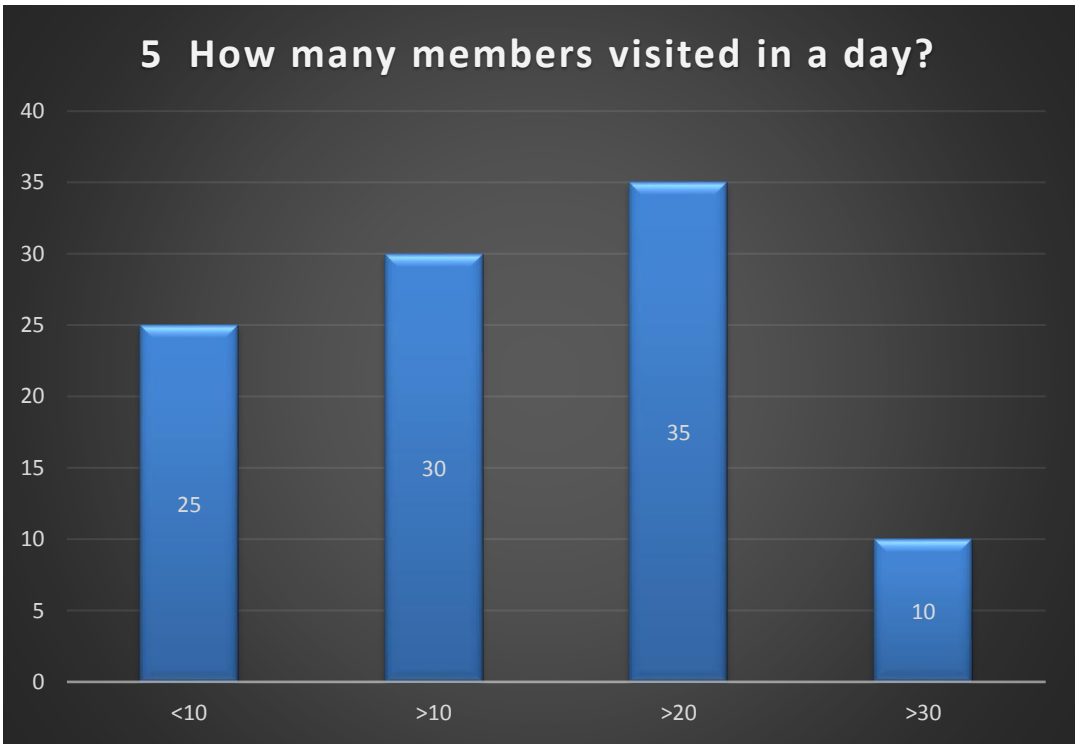
More than 90 % ASHA have confident to dispenses of 16 type of medicine at GAK and I have cross check about this I found that they are fully aware about all medicine and they know in which situation medicine have given to villagers and if they not understand they contact with ANM and ANM suggest her at difficult situation. 10% ASHA who have newly appointed have not much knowledge about all 16 type of medicine but they have dispensed medicine with coordination with ANM.



Source: primary data

6.5 Number of patient visited at GAK at a day

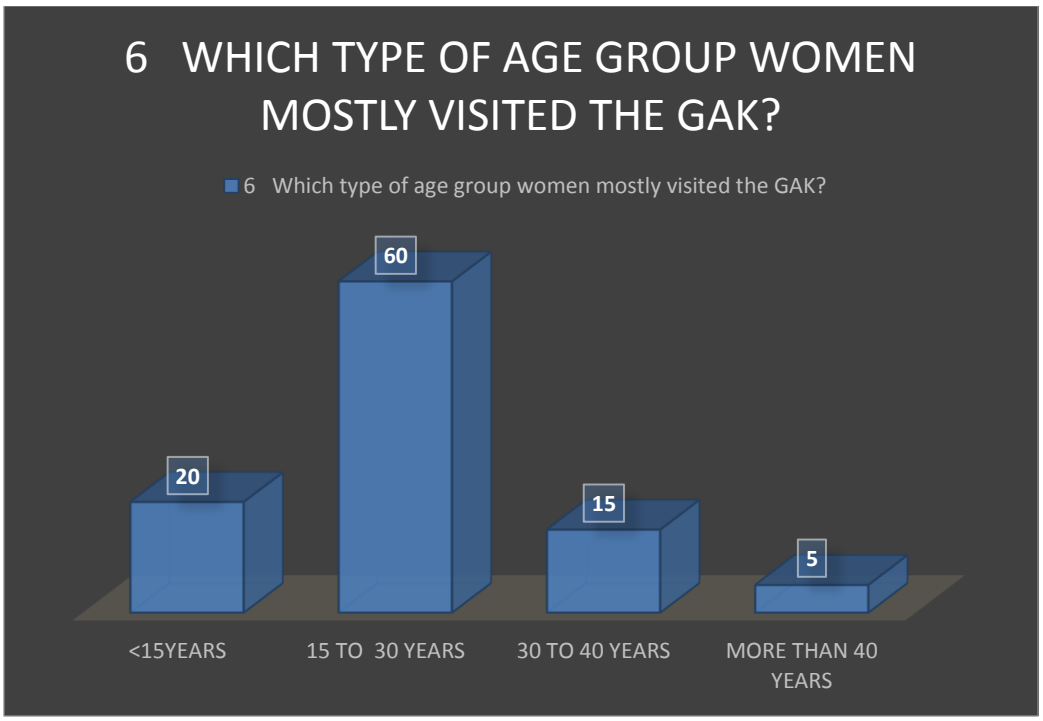
At 35% GAK around 20 patient have visited at GAK and those village where population is more than 1000 have more patient visited in a day and on the other village where population is less than 1000 have less patient visited in a day.25% GAK have less than 10 patient visited in a day. Where 10% GAK have more than 30 patient have visited at GAK.



Source: primary data

6.6 Age group of women mostly visited at GAK

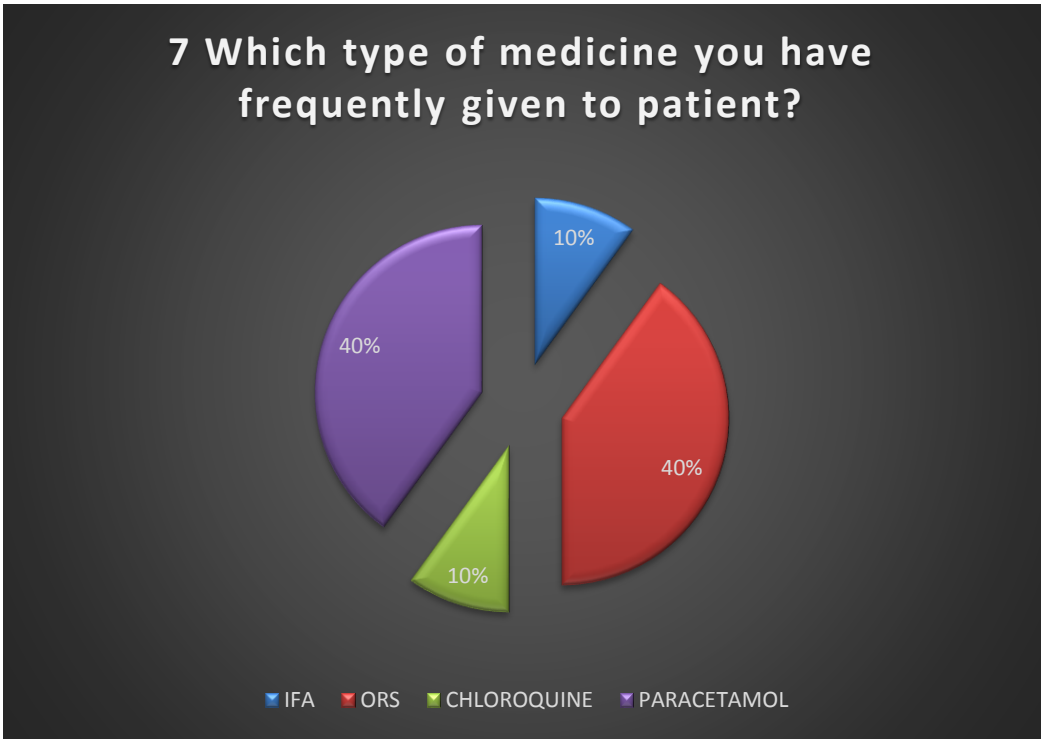
In this section I have not included children who have below 5 years old and in 5 to 10 years old girls or boys around 20% visited in a day and 15 to 30 years' age group women there are 60% belong to these group who have frequently visited at GAK and around 15% who have visited at GAK have age group of 30 to 40 years. Only 5% women who have age group of more than 40 years have visited at GAK. This section clearly shows that age group of 15 to 30 years have more interest in GAK because they are more aware because they are young.



Source: primary data

6.7 which type of medicine have more demand

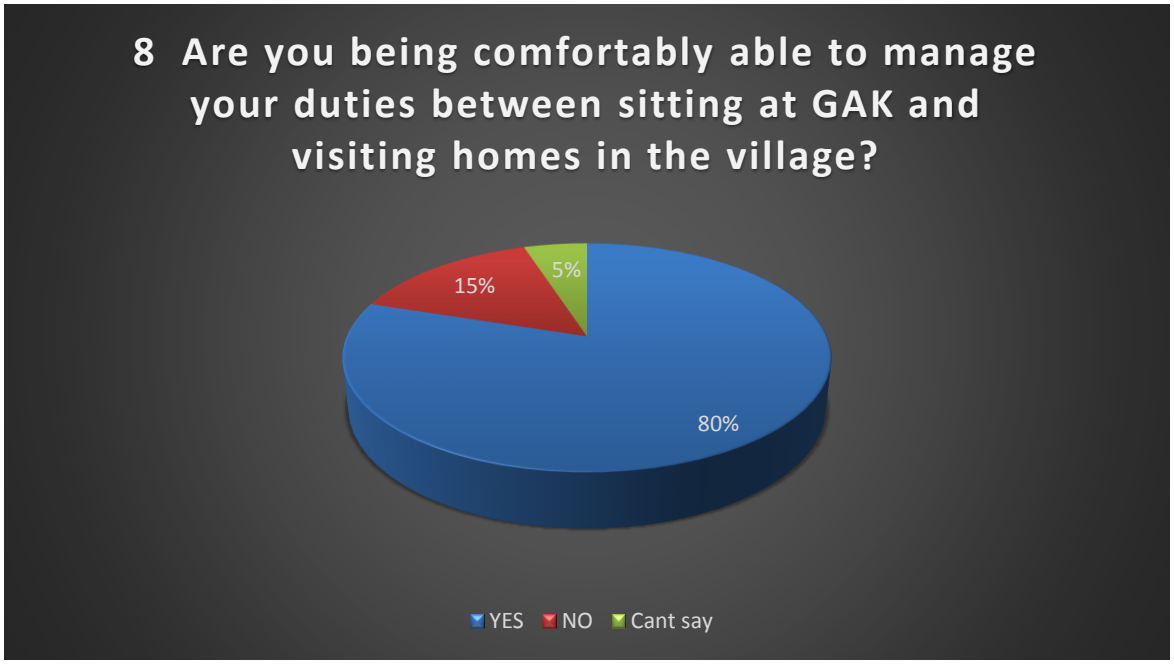
Figure 6.7 shows that around 40% villagers have taken medicine like Paracetamol and the ORS packet and this medicine have more demand in all season. Around 10% villagers have shown their interest in Chloroquine and Iron tablet.



Source: primary data

6.8 ASHA manage duties between GAK and village visit

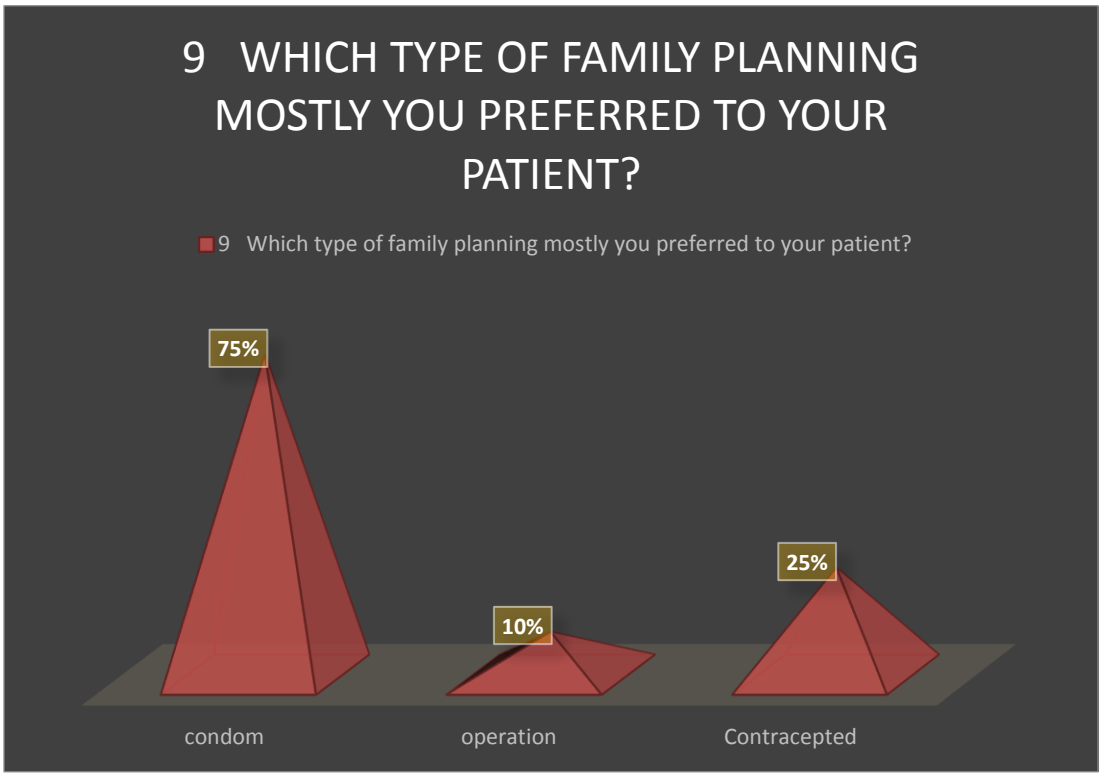
Figure 6.8 shows that ASHA is comfortably manage their duties between setting at GAK and household visit and around 80% ASHA were managed their duties and they have no problem and around 15% ASHA facing problem at setting at GAK and household visit because their village population is high. Around 5% ASHA have facing problem at setting of GAK and household visit because they are new.



Source: primary data

6.9 Awareness about family planning

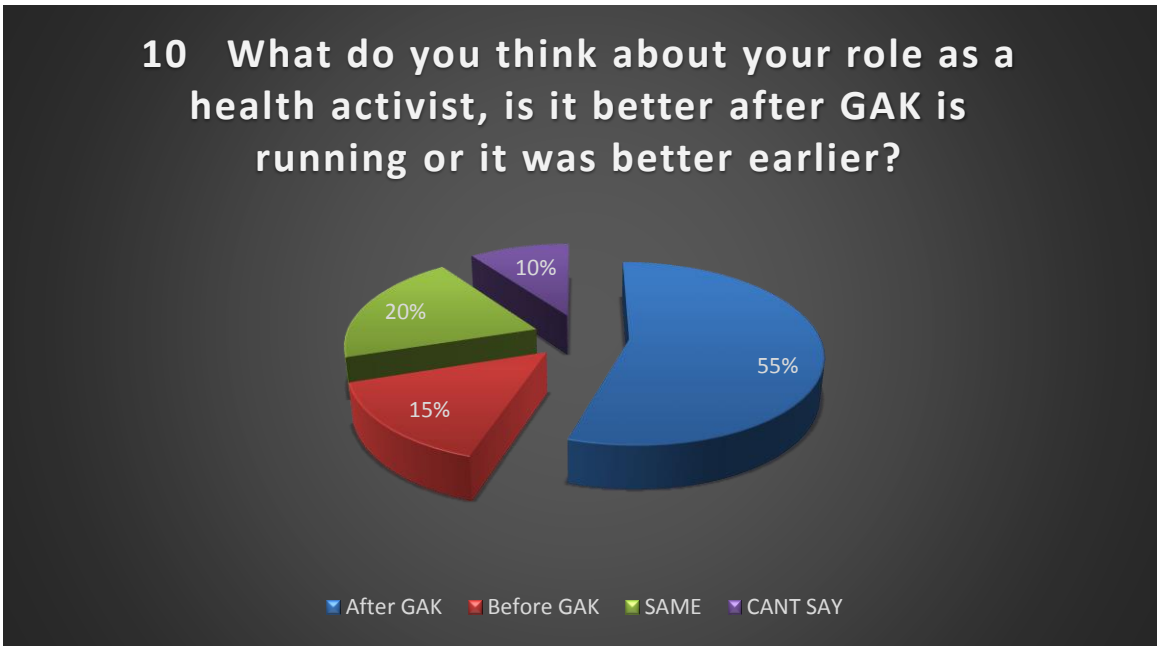
Figure 6.9 shows that in family planning method ASHA role is very important and they aware the villagers about family planning. 75% women who have visited GAK have given condom packet and 10% have suggested about operation and 25% women have used to contracepted.



Source: primary data

6.10 Changes of ASHA role after GAK is running

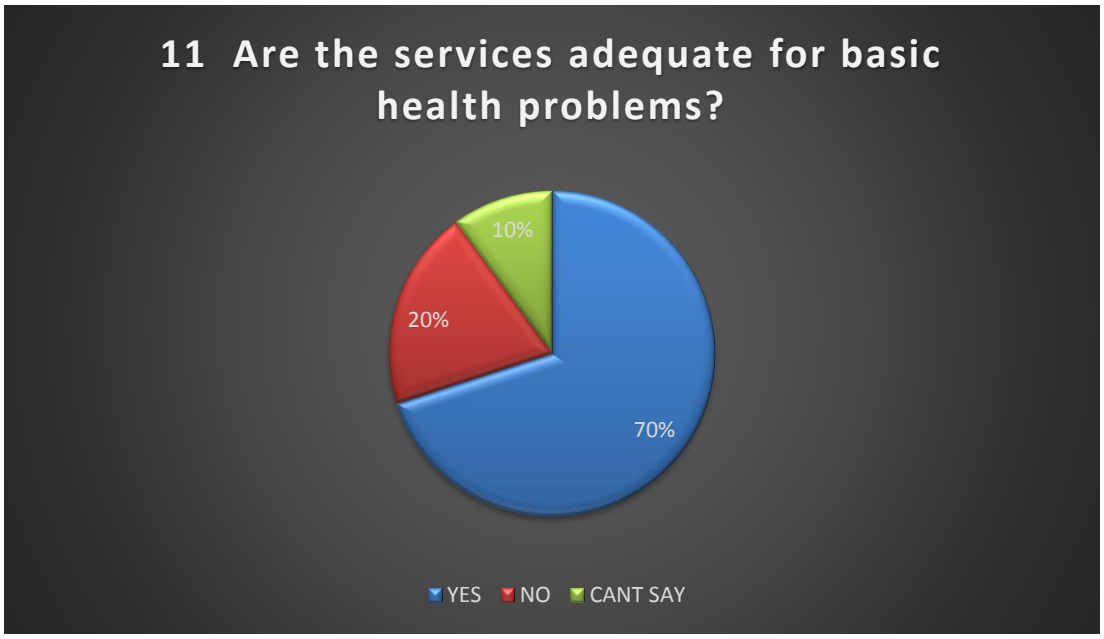
Figure 6.10 shows ASHA role after GAK is running is much better before GAK. Around 55% ASHA thought that as a health activist after running of GAK is comfortable manage their duties and villagers have touch with them and in one platform villagers have taken more facility regarding health issues.



Source: primary data

6.11 Services provided at GAK is adequate for basic health problem

Figure 6.11 shows that at GAK is adequate for basic health problem and 70% ASHA have same opinion about services provided at GAK and around 20 % ASHA have said that is services is not adequate for basic health services because there is proper mechanism of timely delivery of medicine. 10% ASHA who was not given their opinion because they are new.



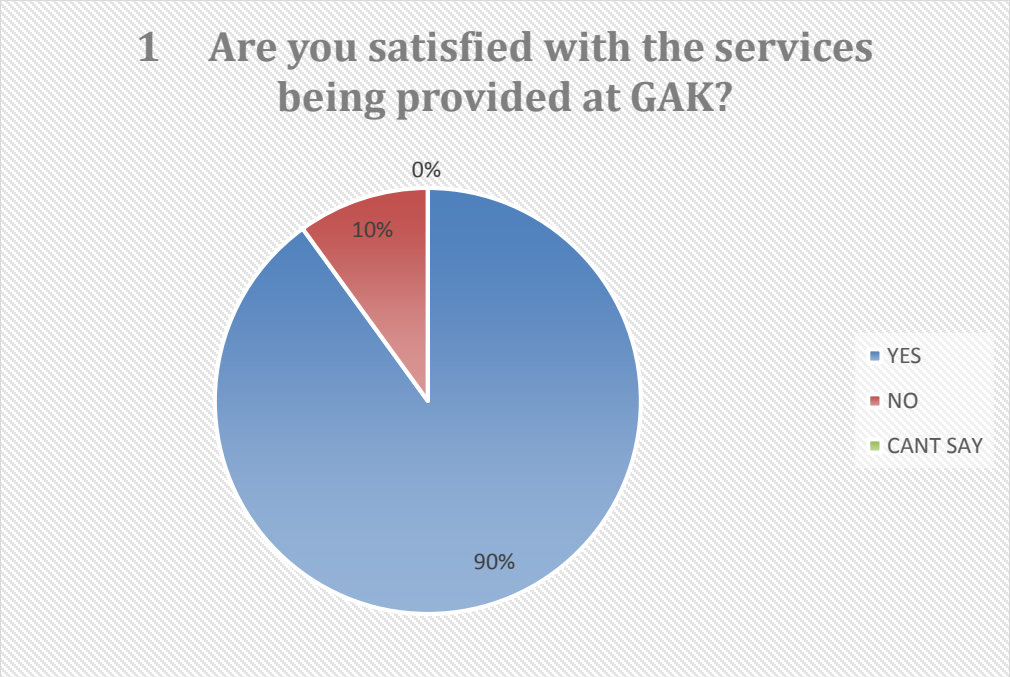
Source: primary data

7. Responses from ANM

ANM plays key role at GAK because they have adequate knowledge about health services. In this section 100 ANM were interview and data is collected through structure questionnaire.

7.1 How much you are satisfied with the services provided at GAK

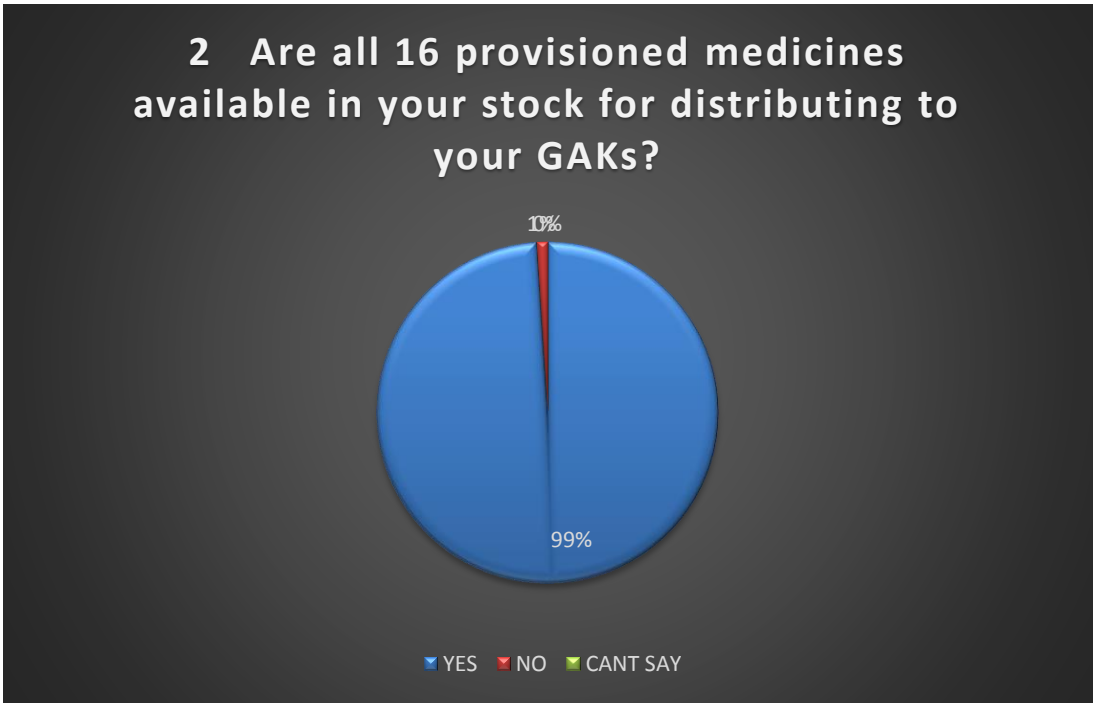
In figure 7.1 shows that the services provided at GAK is adequate and 90% ANM were thought the same. Only 10% ANM were not satisfied the services provided at GAK.



Source: primary data

7.2 availability of medicine at GAK

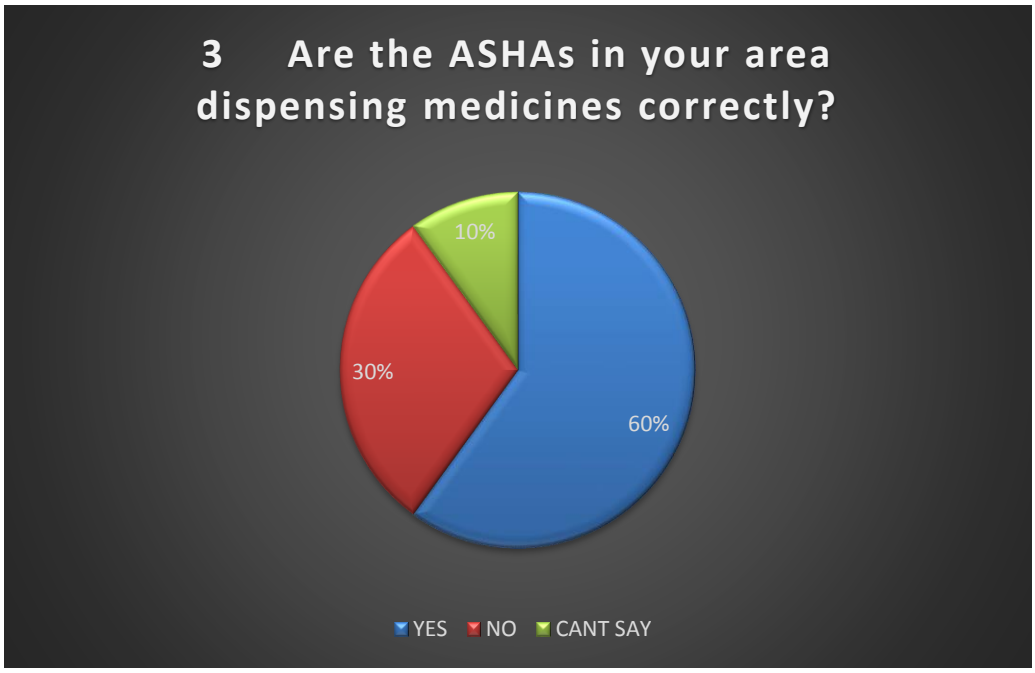
Figure 7.2 shows that all 16-type medicine are available at GAK and around 99% ANM said that medicine is regularly fill up by the support of BCM.



Source: primary data

7.3 Opinion about ASHA for dispensing of medicine

60% ANM thought that ASHA is correct dispensing of medicine one the other hand around 45% ANM said that ASHA have no knowledge about medicine. In personal interview with ANM they said that that ASHA who have newly recruited have little knowledge about medicine.



Source: primary data

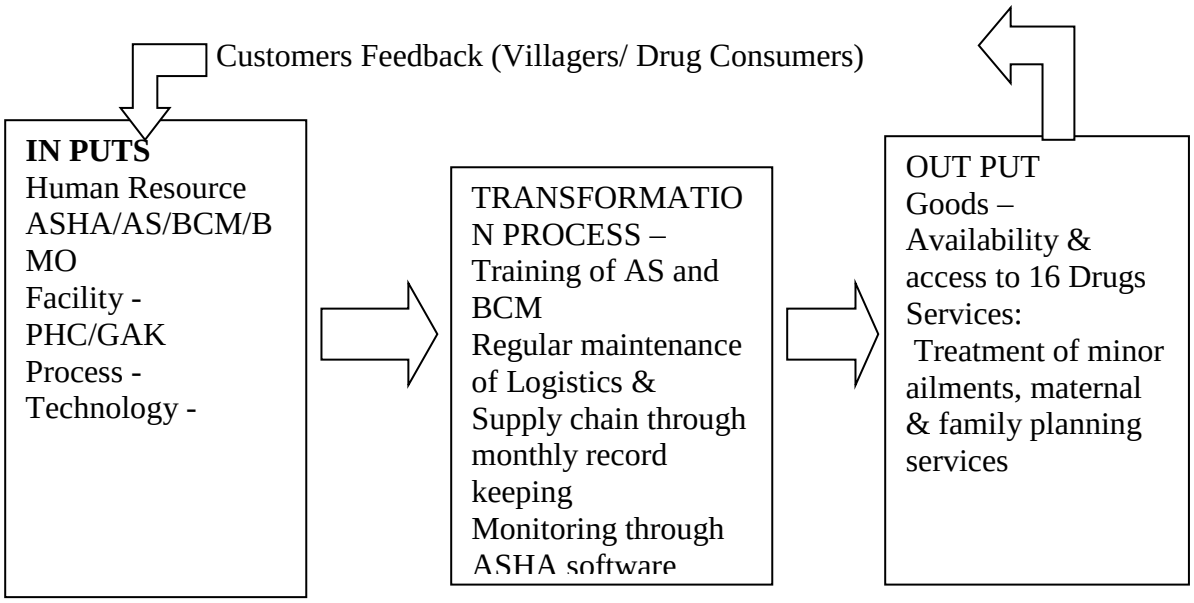
8. Result summary: acceptance

- An overall positive attitude and acceptance in village respondents observed, which is backed by good utilization of existing services as well as willingness of utilization in future.
- The ASHAs perceive their role better now with a responsibility of providing medication to villagers
- The ANMs find their workload to have reduced, however with added responsibility of monitoring ASHAs work
- The Sector Medial Officers appreciate the presence of GAKs and find it a good concept to reduce geographical limitation and out of pocket expenditure for basic health problems.

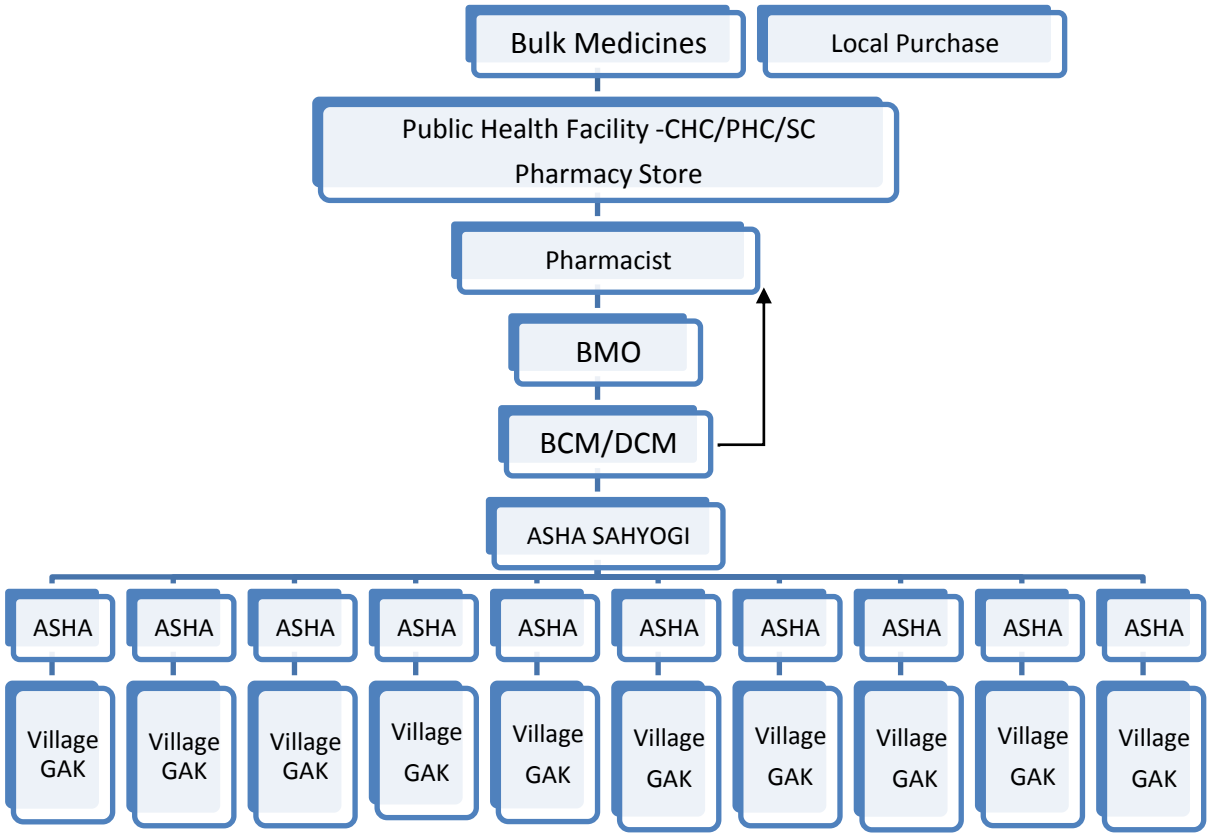
9. Results Summary: Challenges

- ASHA:
    - to manage their work
    - seek more support from ANMs
    - fixed remuneration for this activity with provision of more dedicated space.
    - Village residents:
    - demand for more medicines and for more time spent by ASHA
    - Medical officer's visit at least once a month.
- ANMs: Rrecord updating by ASHA at GAK remains a problem.
- Medical officers find management of supplies and monitoring visits by themselves and ANMs a challenge.

10. OPERATIONS MANAGEMENT FLOW CHART OF GAKs



Typical Organisation Setup of NHM



11. Operational Strategy for redistribution and replineshing the drugs in GAK

1.Village Drug Distribution Register is maintained by ASHA of GAK. Each drug is specified in one page and following entry in respective coloums are made so that consumpton of drugs at the end of the month will be recorded into ASHA sahyogi master drug sheet.

Paracetamol

S. No	Date	Name of pt	Age	sex	Symptoms / diseases	Inves - tigation	Drug dose	No of drug	Sign. of Pt	Expiry date	Balance left
1											
2											
3											
4											
5											

2. ASHA sahayogi who is handholding 10-20 ASHA (average 15) as per her tour plan she should keep the record the expenditure details of 18 drugs from village drug distribution register from the stock drugs at GAK.

3. She should submit the compiled expenditure to BCM in monthly meetings

4. BCM after verification on her demand format, submit the demand to pharmacist countersigned by BMO and recive the same & issuse the drugs to AS in montly meetings

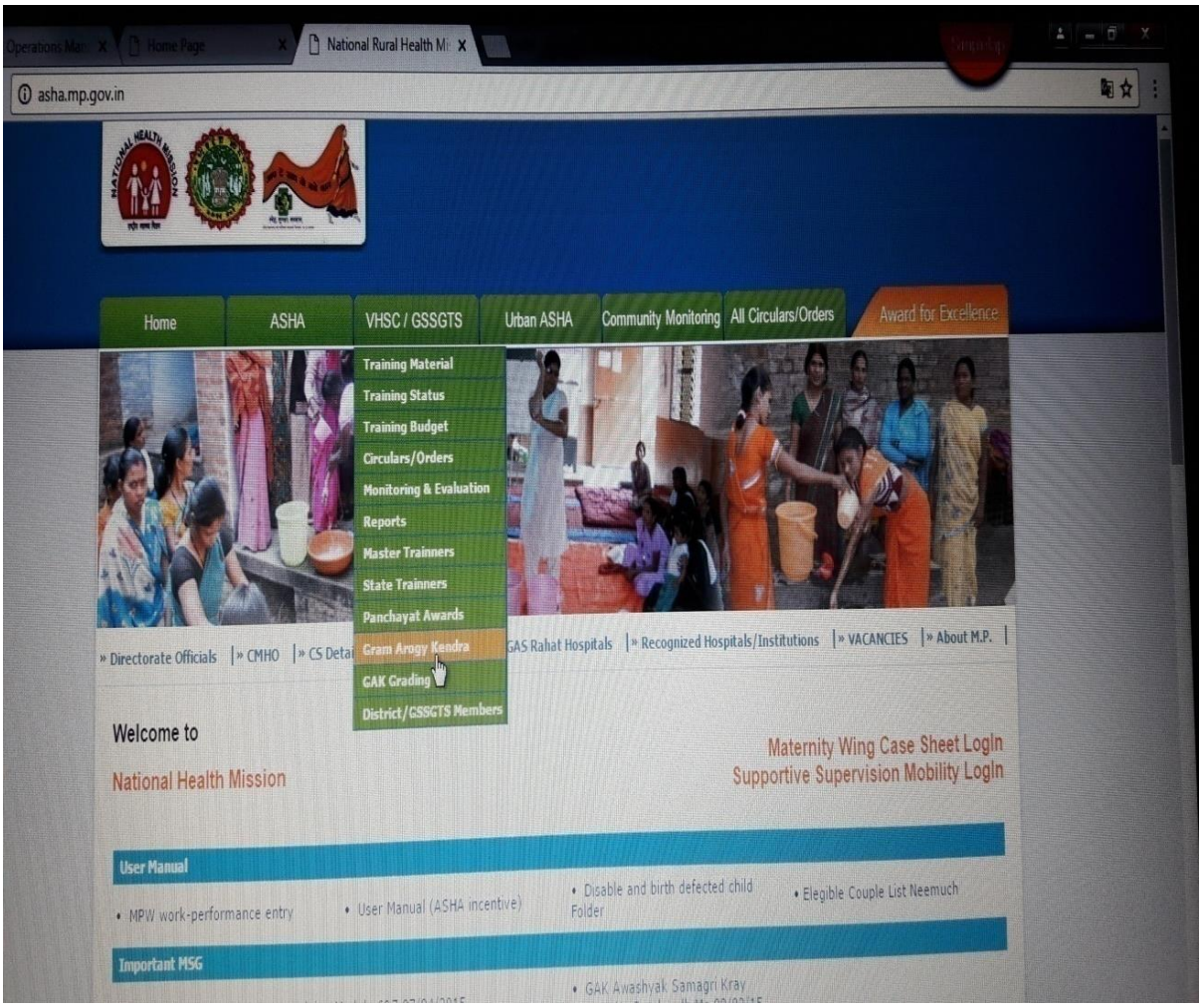
5 ASHA sahyogi as per demand /issuse handed over the drugs to ASHA who is looking after the GAK

6 ASHA as per need of patient or villagers distributes the medication for 1 or 2 days and takes the signature of person who is receiving particular drug(s).and keep the record in specfied formet.

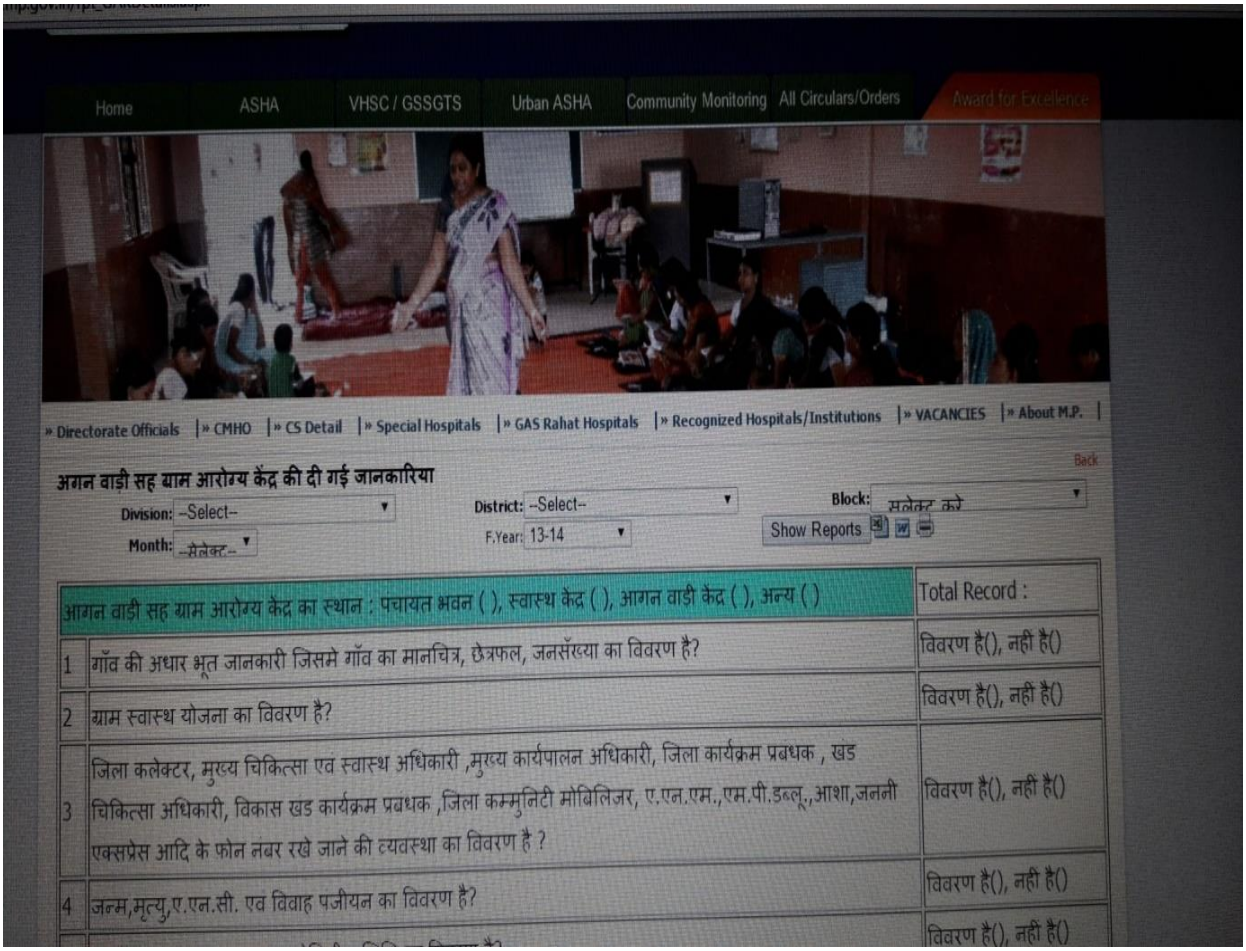
12. Software management system of Drugs (inventory Control)

Step 1 Open website asha.mp.gov.in page will open and look as below

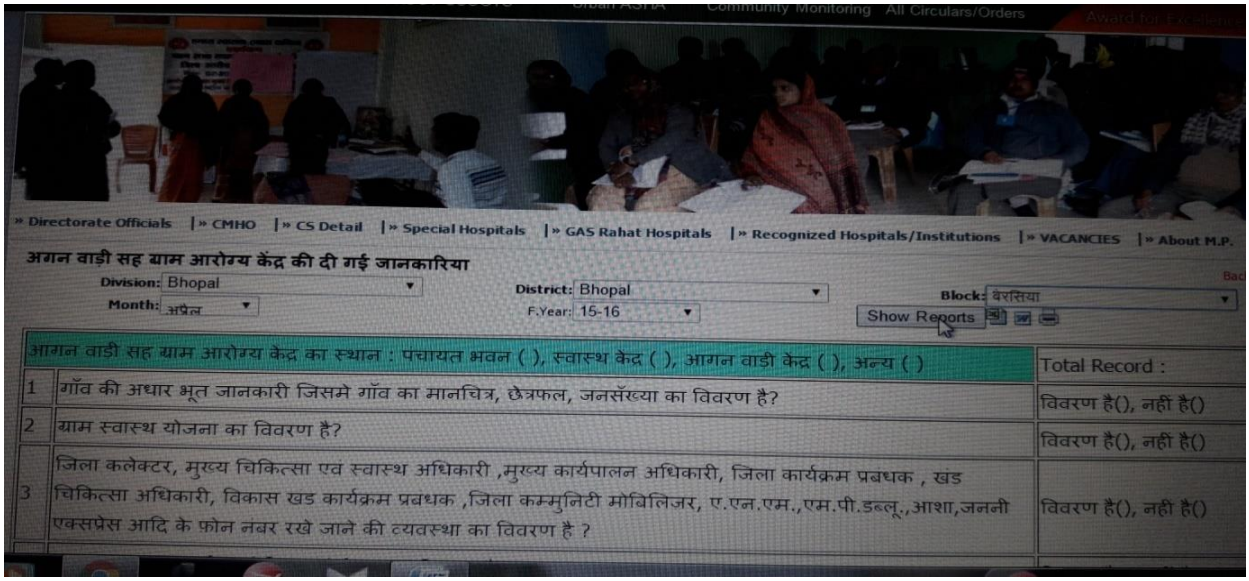
Step 2 Put cursor on Flag coloumn VHSC/GSSGTS sub menu option will open than click on Gram Aroygya kendra



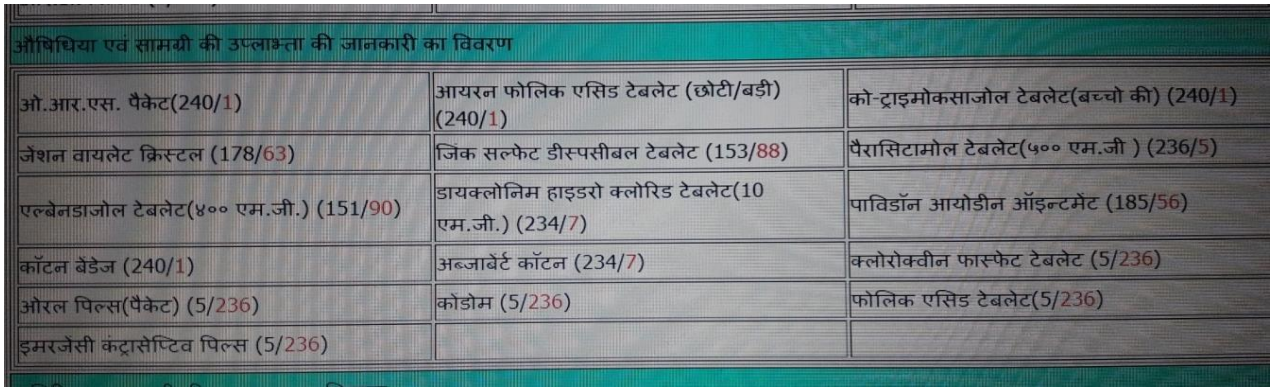
Step 3 A new window will open showing details of information required for GAKs Page show Dialogue box for Division, District, Blocks, Month, FY and text table of information that has to be fill and updated by BCM monthly



Step 4 Select one by one dialogue box, sub menu will be display.Then you can select Division, District, Block, Month and FY and get the required report.



Text table show the entries of the block GAKs cummutatively on the web page that can be analysed monthly. This helps in planning of drug demand of community.



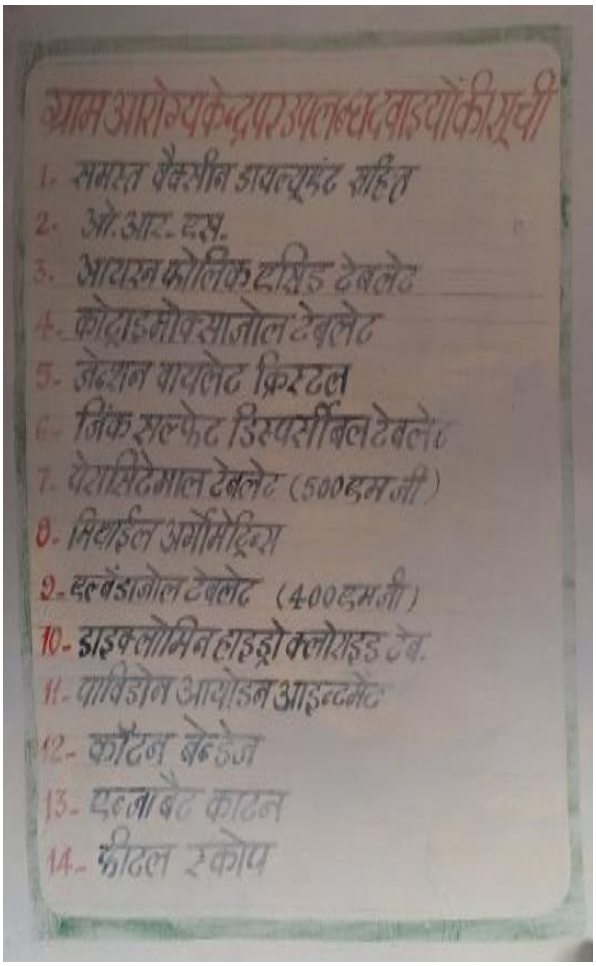
13.OBSERVATIONS/FINDING

14. ANALSIS OF EXISTING DRUG MANAGEMENT IN GRAM AROUGYA KENDRA (GAK)

AGANWADI- SAH -GRAM AROGYA KENDRA: Village- TILAKHEDI

- ASHA though she is low literate (5th pass) but her level of knowledge is good
- In above village GAK some drugs are kept open and some in white boxes on small table in unorganized manner. All drugs either in open or in boxes **they are in reach of small children** who are attending Aganwadi for pohsahan ahar (nutrition food)

2. AGANWADI-SAH-GRAMAROGYA KENDRA- Village KALAKHEDI



AGANWADI- SAH -GRAM AROGYA KENDRA : Village- KALAKHEDI

- ASHA though she is 5th pass but her level of knowledge is average
- In above village GAK drugs are kept in white boxes on small table in unorganized manner because drugs are kept in small room adjacent to Aganwadi container Boxes and not labeled properly no space of work for VHND sessions
- Drugs are kept **expose to sun light and humidity.**

3.

On examination / working table - Village - KUTHAR

On open racks

In rack between children toys

AGANWADI- SAH -GRAM AROGYA KENDRAs

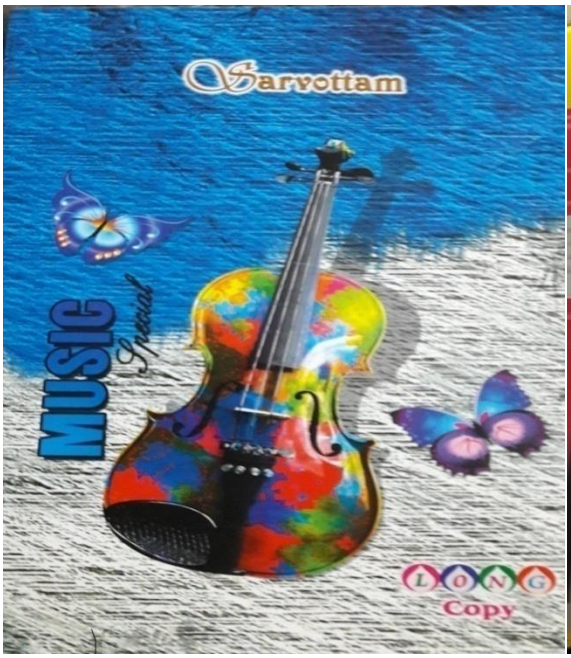
Drugs in GAKs are kept **unorganized in labeled/unlabelled transparent boxes**in working or examination tables or in open racks or in rack between children toys and not labeled properly.Drugs are kept expose to sun light and humidity. No space of work for VHND sessions

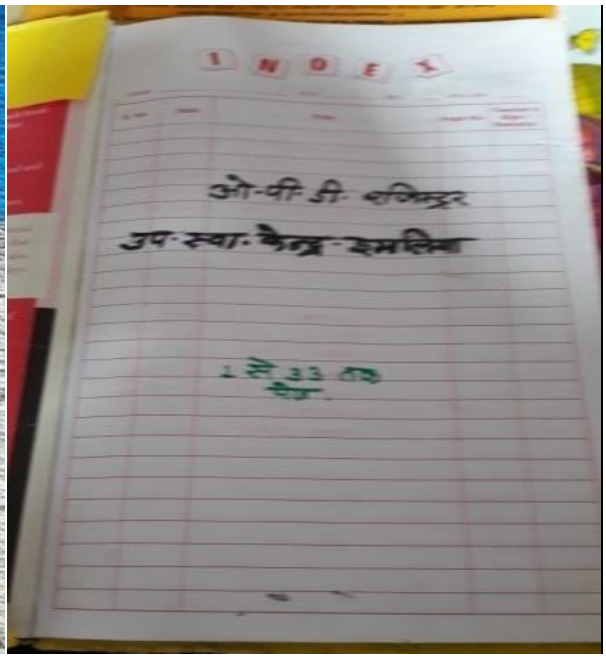
4. MISLEADING LABELS ON BOXES - Gram Arogya Kendra KALKHEDI

AGANWADI- SAH -GRAM AROGYA KENDRAs - KALKHEDI

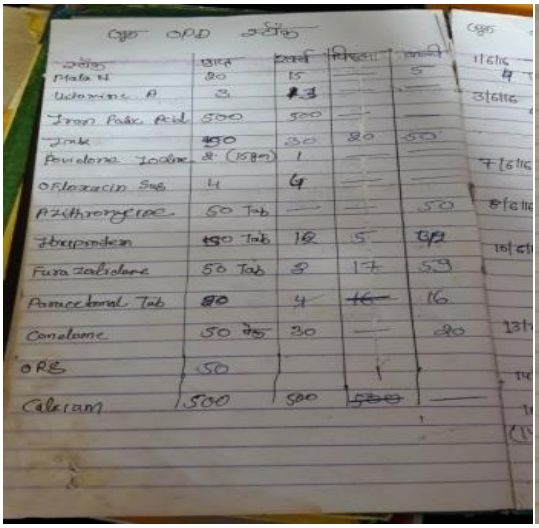
- In Kalkhedi GAK drugs are kept in transparent boxes on working tables. The sticker box labelled as Co-trimaxazole but inside the box along with packing box of co-trimaxazole three other antibiotics strips are also placed inside. **Misleading Labels on boxes**
- The labels are placed to identify the medicine either by putting name of drug on sticker label or by simply writing name of drug by marker pen on box. Secondly to identify the medicine they recognize by symptom as drug for fever or vomiting or abdominal pain or diarrhea
- They **do not write Expiry date & Batch no on labels**

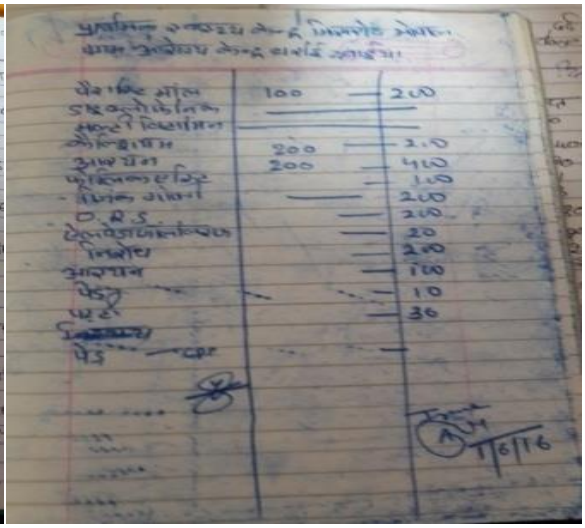
5. Recordkeeping of Drugs in GAK





Cover Page not covered and named Ist Page of Register not in formet





AGANWADI- SAH -GRAM AROGYA KENDRAs

Drugs stock register and drug distribution register (OPD register) are not separate. Register cover page has no cover& identification. The second page of register is not in format. Pages register were not numbered. OPD recorded show only of name of pt, amount of drug and signature of patient/recipient is recorded and stock keeping done on one page may or may not be signed by officer in charge

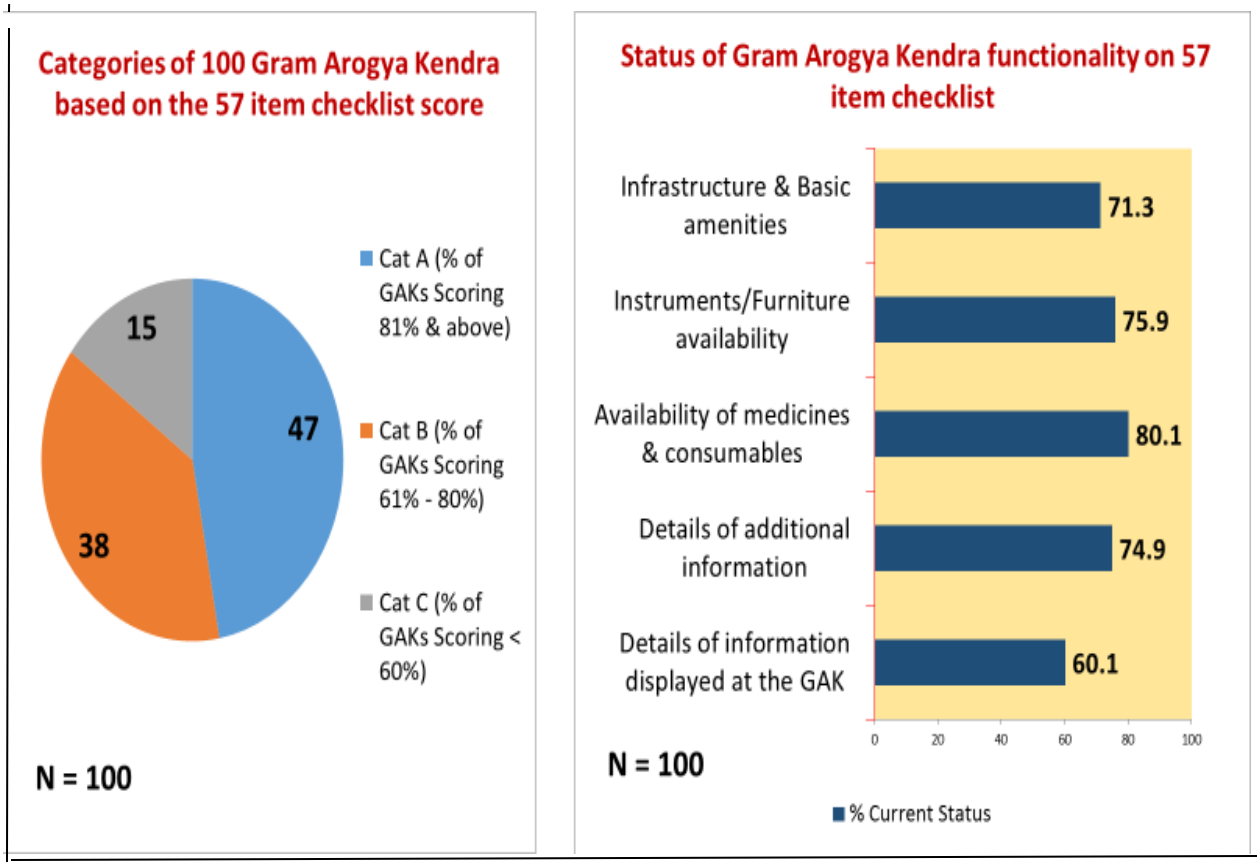
14. STRATEGY ADOPTED FOR DRUG MANAGEMENT CORRECTIONS

All learning's come from working with NHM and official software of ASHA. Practical knowledge of DPM and BCM about patient drug distribution register (record keeping), organized shelf arrangements of drugs in ward store and its inventory management linkage to main store has given the idea of planning management of drugs in GAKs

Goal is to reduce huge pilferage of unrecorded drugs in public hospitals especially when it is distributed to or through ASHA. ASHA is low literate and no practical training for drugs management was imparted to her. Her OPD drug register and management of drugs so that and yearly demand of drugs cannot be raised and No inventory drugs management system from GAK to public health facility is established.

15. ANALYSIS OF CROSS CHECK QUESTIONNAIRE

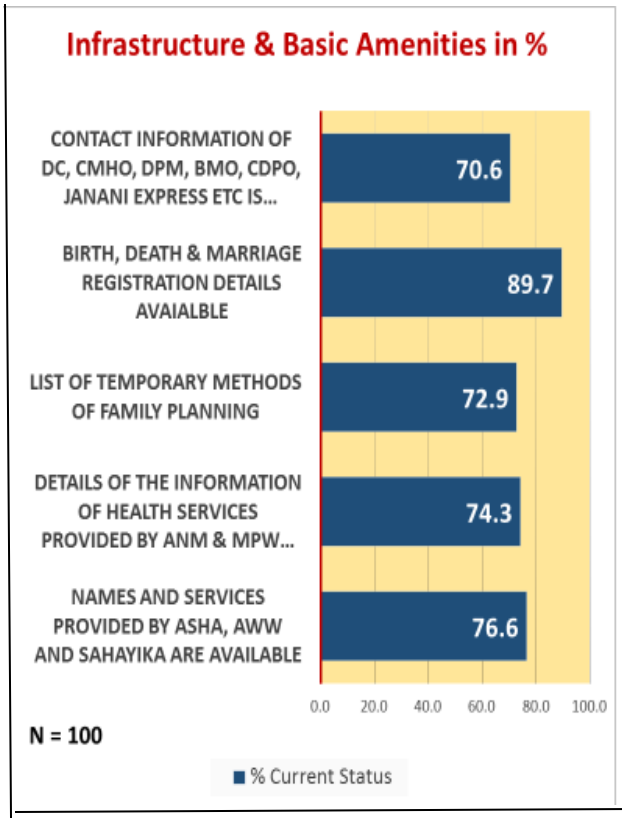
The bellow mention graph analysis of total 100 GAK and through proper structure questionnaire. 47% GAK who have in category A and which fulfill the checklist category. 38% GAK have in category B and 15% GAK have in category C and it means that in category B and C lots of improvement needed.

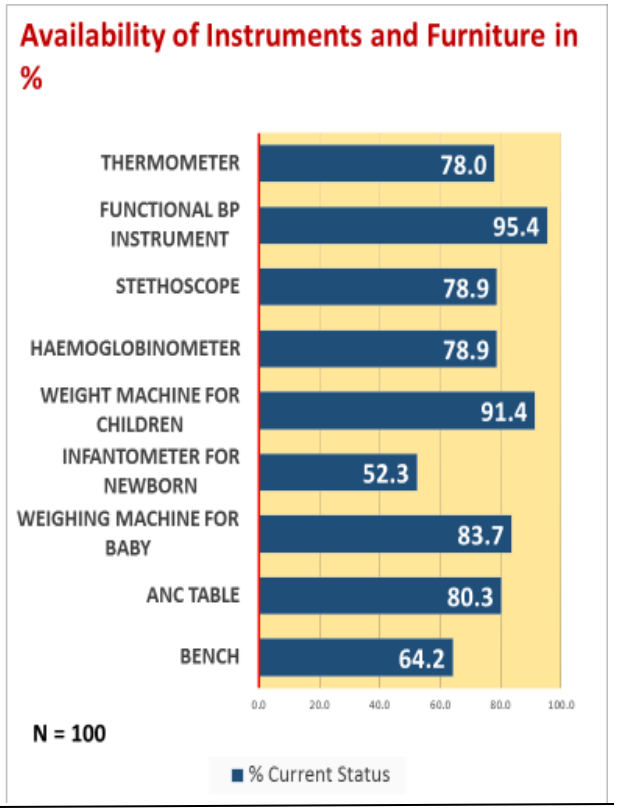


Source: primary Data

15.1 Facility at GAK:

The below figure shows that infrastructure and basic amenities and availability of instrument and furniture at GAK. There is provision of GAK that contact number of CMHO, DCM, DPM, BMO are display on wall or board and also registration details of villagers like birth, death and marriage were mention. There is also provision of availability of instruments like THERMOMETER, BP MACHINE, STETHOSCOPE, and weight machine. The below graph shows details of this facility that is available at 100GAK. 89.7% GAK have details of Birth, death and marriage registration details available and 70% GAK have details of CMHO, DCM, DPM number available. On the other hand availability of instruments like THERMOMETER data shows that around 78% GAK have available this instruments and 95% GAK have BP machine available.

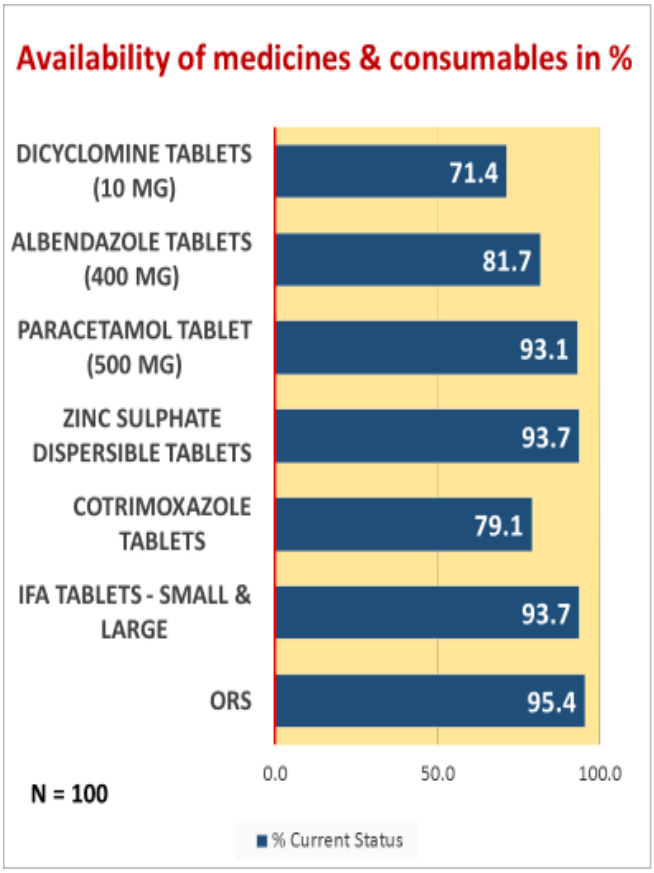


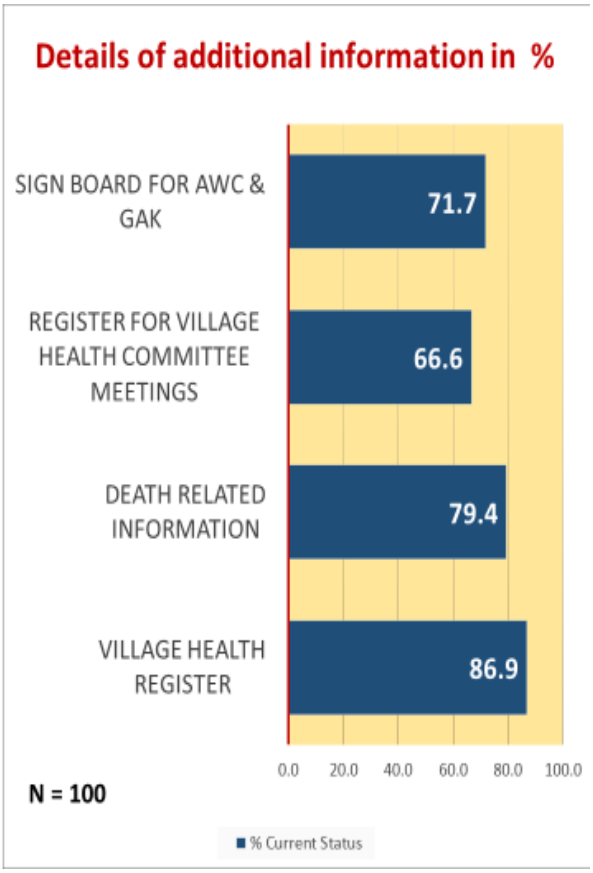


Source: primary data

15.2 Availability of medicine and additional information

The below data shows of availability of medicine and consumables like expiry date of medicine. In medicine around 71% DICYCLOMINE tablet have been available at each GAK and around 81% ALBENDAZOLE tablet have been available to each GAK. Around 67% register have been available for details of village health committee meeting at GAK.





Source: primary data

16. SUMMARY AND CONCLUSION

AGANWADI SAH GRAM AROGYA KENDRA innovation brought in by Govt. of MP has been actively promoting the health & nutrition services through convergence of health and ICDS Department. GAK is now building community ownership and high acceptability among villagers especially for treatment of minor ailments, family planning services and investigation facilities.

Strengthening of GAK through decentralization process is required. There is a need for establishment of a structured, regular support & monitoring system for availability of essential equipment like BP Machine, Stethoscope, thermometers Uristics for albumin and sugar, RDK kit for malaria and Nischay Pregnancy test kit and all 16 drugs for treatment of minor ailments between community and district health system.

1. Elimination of geographical barrier improves access of unreached. Reduce the travelling time for treatment of minor illness /health issues avoid local practitioners in order to reduces out of pocket expenditures and early symptoms when checked in time result in early referrals improves health outcomes and meets the objectives of Universal health Coverage which can be achieves with well functional GAK.

These changes have been further translated into better service delivery by hands holding training of ASHA support system BCM, DCM AS and ASHA.

Regular supervision and follow up of issued drugs to GAK helps in assessing demands of the drugs of community, and budget planning of the district. Consumption analysis helps in identifying fever and diarrheal morbidity pattern of community, may sometime help in preventing outbreaks.

Establishment of proper drug inventory management system of 16 drugs at GAK of 52117 villages of MP helps State Govt. to reduce budget expenditure on drugs, unnecessary storage of drugs in store, at ANM, AS or at ASHA level. It reduces the distribution of near expiry drug kept in health facility stores to low literate ASHA in large scale.

Thus, project meets the objective of decreasing pilferages of drugs before distributions to communities and ensures proper community drug utilization.

16. ETHICAL CONSIDERATIONS:

Ethical concern will be obtained from the concerned authority.

17. REFERENCES

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