

Dissertation Synopsis

on

"Roles and Responsibilities of Field Monitors in Supporting High-Risk Children: A Study in Udaipur and Salumbar Districts in Rajasthan"

Submitted in partial fulfillment of the requirements of
MBA in Healthcare and Hospital Management

Under the Supervision and Guidance of Dr. Nutan P. Jain

By

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1) Title:

"Roles and Responsibilities of Field Monitors in Supporting High-Risk Children: A Study in Udaipur and Salumbar Districts in Rajasthan "

2) Background:

Field Monitors play a crucial role in community health initiatives, particularly in regions with limited access to healthcare services. As the first point of contact between healthcare workers and Khushi Baby, Field Monitors have several key responsibilities. They train ASHAs and ANMs on using the CHIP application, including updates. They maintain and update data sheets, conduct home visits for high-risk pregnant women and children, and support the referral process to higher facilities. Additionally, they conduct Maternal and Child Health and Nutrition (MCHN) visits, attend block meetings, and assist healthcare workers with the application. These responsibilities are essential for the effective functioning of Khushi Baby's health monitoring system, ensuring timely and adequate care for high-risk children and pregnant women. Employed by Khushi Baby, they conduct home visits and monitor the health of high-risk children, identified based on specific criteria indicating a higher risk for adverse health outcomes.

Khushi Baby defines high-risk children identified by system as being at higher risk for adverse health outcomes based on specific criteria such as:

- Age-weight ratio below SD3 as per WHO weight criterion where child below SD2 to SD3 is in moderate category; and child below SD3 is categorized as severe
- Mid-upper arm circumference (MUAC) below 13 cm, where child with MUAC 11.5-12.5 cm is moderate; and MUAC below 11.5 cm is severe
- Low Birth Weight (wt < 2500g) where child weighted 2-2.5 kg is classified as moderate; and child weighted less than 2 kgs is considered as severe
- Any other illness since birth such as Thalassemia

3) Research Questions:

- What role do Field Monitors play in supporting high-risk children?
- What are the influencing factors for Field Monitors in effectively identifying and addressing the needs of high-risk children?

4) Objectives:

- To review the roles and responsibilities including referral mechanisms of the field monitors in supporting high-risk children
- To study high risk children by reasons and by blocks
- To study the facilitating and hindering situations faced by field monitors in identifying and managing high-risk children in the community.
- To study referral system followed by the Field Monitors.

5) Methodology:

a) Study Design-

Exploratory Study using mixed methods approach

b) Study Setting-

The study will be conducted in District Udaipur and Salumbar, Rajasthan

c) Study Population-

Field monitors under the Khushi Baby's system

d) Duration of Study-

The study will be conducted during March-June 2024

e) Sampling and Sample Size-

The Intern will identify the high-risk children from the database of the Khushi Baby HMIS by 12 blocks of Udaipur and 4 blocks Salumbar districts.

The respective Field Monitor of the first high-risk child who has been referred to the higher-level health facility in all the blocks will be interviewed.

Therefore, a total of 16 Field Monitors will be interviewed.

The respective FM supervisor will also be interviewed.

f) Data Collection Procedure-

The study will use both secondary and primary data collection methods. The secondary data collection for quantitative analysis for profiling the high-risk children will be used. The qualitative approach will be used for primary data collection.

- Review of roles and responsibilities of the Field Monitors in general and for managing high risk children in specific
- Review of HMIS database of Khushi Baby for profiling the high-risk children by blocks
- In-depth interview with Field Monitors
- Observation method for understanding how the field monitors interact with the families of the high-risk children
- Process mapping of referrals
- In-depth Interview with supervisor of FMs

Secondary data collection

Field Monitors will use data entered by ANMs into the application. Based on this data, a composite high-risk score is generated from the child's last check-up details. If the high-risk score is above 50, a report is generated and shared with Field Monitors. Field Monitors then conduct home visits to verify the accuracy of the ANM's data. If a high-risk child is confirmed, Field Monitors assist in the referral process through the concerned authorities.

This process ensures that high-risk children are accurately identified and receive timely and appropriate care.

Data Collection Tools-

- Checklist for reviewing roles and responsibilities
- Datasheet for profiling the high-risk children by reasons and blocks
- In-depth interview guide for FMs
- In-depth interview guide for supervisor
- Flow chart of referral process

g) Operational Definitions

High-Risk Children: Children identified by Khushi Baby's system as being at higher risk for adverse health outcomes based on specific criteria such as malnutrition, muac, vaccination status, frequent illness or developmental delays.

Field Monitors: Health workers employed by Khushi Baby responsible for conducting home visits and monitoring the health of vulnerable children.

Barriers: Challenges or obstacles faced by Field Monitors in effectively identifying and addressing the needs of high-risk children.

Cultural Influences: Traditions, customs, and beliefs held by the community that affect the perception and treatment-seeking behavior regarding child health.

Home Visits: Visits conducted by Field Monitors to the homes of high-risk children to provide health monitoring and support.

6) Data Analysis Plan

Step 1: Data Preparation

- **Transcription:** All recorded interviews with Field Monitors will be transcribed verbatim to ensure accurate capture of their responses.
- **Data Cleaning:** Transcripts will be reviewed for accuracy, and any identifiable information will be anonymized to maintain confidentiality.

Step 2: Coding and Categorization

- **Focused Coding:** Codes will be refined and grouped into categories that align with the research questions. For example, categories may include "barriers faced" etc

Step 3: Interpretation and Synthesis

- **Triangulation:** Data from interviews will be triangulated with observations to validate findings and provide a comprehensive picture.

- **Narrative Construction:** A narrative will be constructed to describe the experiences and challenges of Field Monitors, supported by direct quotes and examples from the data.

7) Ethical Considerations:

- Obtain informed consent from all participating Field Monitors.
- Ensure confidentiality and anonymity of the participants.

8) Implications of Research

Resource Allocation: Insights into the challenges faced by Field Monitors can guide policymakers in allocating resources more effectively to support these frontline workers.

Improved Health Outcomes: By understanding and addressing the barriers faced by Field Monitors, health interventions can be more effective, leading to improved health outcomes for high-risk children.

Community Engagement: The study highlights the importance of culturally sensitive approaches, encouraging health programs to engage more deeply with community beliefs and practices.

Field studies: The research identifies areas for future studies, such as longitudinal assessments of Field Monitor interventions and comparative studies in different regions.

9) References

Khushi Baby. (2020). Khushi Baby Health Monitoring Information System (HMIS) Manual. Khushi Baby Publications.

WHO. (2006). *WHO Child Growth Standards: Length/Height-for-Age, Weight-for-Age, Weight-for-Length, Weight-for-Height and Body Mass Index-for-Age: Methods and Development*. World Health Organization

Weight-for-age GIRLS

Birth to 5 years (z-scores)



Year: Month	Month	L	M	S	Z-scores (weight in kg)						
					-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
0: 0	0	0.3809	3.2322	0.14171	2.0	2.4	2.8	3.2	3.7	4.2	4.8
0: 1	1	0.1714	4.1873	0.13724	2.7	3.2	3.6	4.2	4.8	5.5	6.2
0: 2	2	0.0962	5.1282	0.13000	3.4	3.9	4.5	5.1	5.8	6.6	7.5
0: 3	3	0.0402	5.8458	0.12619	4.0	4.5	5.2	5.8	6.6	7.5	8.5
0: 4	4	-0.0050	6.4237	0.12402	4.4	5.0	5.7	6.4	7.3	8.2	9.3
0: 5	5	-0.0430	6.8985	0.12274	4.8	5.4	6.1	6.9	7.8	8.8	10.0
0: 6	6	-0.0756	7.2970	0.12204	5.1	5.7	6.5	7.3	8.2	9.3	10.6
0: 7	7	-0.1039	7.6422	0.12178	5.3	6.0	6.8	7.6	8.6	9.8	11.1
0: 8	8	-0.1288	7.9487	0.12181	5.6	6.3	7.0	7.9	9.0	10.2	11.6
0: 9	9	-0.1507	8.2254	0.12199	5.8	6.5	7.3	8.2	9.3	10.5	12.0
0:10	10	-0.1700	8.4800	0.12223	5.9	6.7	7.5	8.5	9.6	10.9	12.4
0:11	11	-0.1872	8.7192	0.12247	6.1	6.9	7.7	8.7	9.9	11.2	12.8
1: 0	12	-0.2024	8.9481	0.12268	6.3	7.0	7.9	8.9	10.1	11.5	13.1
1: 1	13	-0.2158	9.1699	0.12283	6.4	7.2	8.1	9.2	10.4	11.8	13.5
1: 2	14	-0.2278	9.3870	0.12294	6.6	7.4	8.3	9.4	10.6	12.1	13.8
1: 3	15	-0.2384	9.6008	0.12299	6.7	7.6	8.5	9.6	10.9	12.4	14.1
1: 4	16	-0.2478	9.8124	0.12303	6.9	7.7	8.7	9.8	11.1	12.6	14.5
1: 5	17	-0.2562	10.0226	0.12306	7.0	7.9	8.9	10.0	11.4	12.9	14.8
1: 6	18	-0.2637	10.2315	0.12309	7.2	8.1	9.1	10.2	11.6	13.2	15.1
1: 7	19	-0.2703	10.4393	0.12315	7.3	8.2	9.2	10.4	11.8	13.5	15.4
1: 8	20	-0.2762	10.6464	0.12323	7.5	8.4	9.4	10.6	12.1	13.7	15.7
1: 9	21	-0.2815	10.8534	0.12335	7.6	8.6	9.6	10.9	12.3	14.0	16.0
1:10	22	-0.2862	11.0608	0.12350	7.8	8.7	9.8	11.1	12.5	14.3	16.4
1:11	23	-0.2903	11.2688	0.12369	7.9	8.9	10.0	11.3	12.8	14.6	16.7
2: 0	24	-0.2941	11.4775	0.12390	8.1	9.0	10.2	11.5	13.0	14.8	17.0

WHO Child Growth Standards

Weight-for-age BOYS

Birth to 5 years (z-scores)



Year: Month	Month	L	M	S	Z-scores (weight in kg)						
					-3 SD	-2 SD	-1 SD	Median	1 SD	2 SD	3 SD
0: 0	0	0.3487	3.3464	0.14602	2.1	2.5	2.9	3.3	3.9	4.4	5.0
0: 1	1	0.2297	4.4709	0.13395	2.9	3.4	3.9	4.5	5.1	5.8	6.6
0: 2	2	0.1970	5.5675	0.12385	3.8	4.3	4.9	5.6	6.3	7.1	8.0
0: 3	3	0.1738	6.3762	0.11727	4.4	5.0	5.7	6.4	7.2	8.0	9.0
0: 4	4	0.1553	7.0023	0.11316	4.9	5.6	6.2	7.0	7.8	8.7	9.7
0: 5	5	0.1395	7.5105	0.11080	5.3	6.0	6.7	7.5	8.4	9.3	10.4
0: 6	6	0.1257	7.9340	0.10958	5.7	6.4	7.1	7.9	8.8	9.8	10.9
0: 7	7	0.1134	8.2970	0.10902	5.9	6.7	7.4	8.3	9.2	10.3	11.4
0: 8	8	0.1021	8.6151	0.10882	6.2	6.9	7.7	8.6	9.6	10.7	11.9
0: 9	9	0.0917	8.9014	0.10881	6.4	7.1	8.0	8.9	9.9	11.0	12.3
0:10	10	0.0820	9.1649	0.10891	6.6	7.4	8.2	9.2	10.2	11.4	12.7
0:11	11	0.0730	9.4122	0.10906	6.8	7.6	8.4	9.4	10.5	11.7	13.0
1: 0	12	0.0644	9.6479	0.10925	6.9	7.7	8.6	9.6	10.8	12.0	13.3
1: 1	13	0.0563	9.8749	0.10949	7.1	7.9	8.8	9.9	11.0	12.3	13.7
1: 2	14	0.0487	10.0953	0.10976	7.2	8.1	9.0	10.1	11.3	12.6	14.0
1: 3	15	0.0413	10.3108	0.11007	7.4	8.3	9.2	10.3	11.5	12.8	14.3
1: 4	16	0.0343	10.5228	0.11041	7.5	8.4	9.4	10.5	11.7	13.1	14.6
1: 5	17	0.0275	10.7319	0.11079	7.7	8.6	9.6	10.7	12.0	13.4	14.9
1: 6	18	0.0211	10.9385	0.11119	7.8	8.8	9.8	10.9	12.2	13.7	15.3
1: 7	19	0.0148	11.1430	0.11164	8.0	8.9	10.0	11.1	12.5	13.9	15.6
1: 8	20	0.0087	11.3462	0.11211	8.1	9.1	10.1	11.3	12.7	14.2	15.9
1: 9	21	0.0029	11.5486	0.11261	8.2	9.2	10.3	11.5	12.9	14.5	16.2
1:10	22	-0.0028	11.7504	0.11314	8.4	9.4	10.5	11.8	13.2	14.7	16.5
1:11	23	-0.0083	11.9514	0.11369	8.5	9.5	10.7	12.0	13.4	15.0	16.8
2: 0	24	-0.0137	12.1515	0.11426	8.6	9.7	10.8	12.2	13.6	15.3	17.1

WHO Child Growth Standards