Summer Training at
NHM, Madhya Pradesh
(April 3 to June 2, 2017)

Study and Evaluation of Mahila Swasthya Shivirs 2017-18 at Village Level

By
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2017

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

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that **Ms. Priya Gokhale Koshta** has undergone summer training in **NHM, Madhya Pradesh** from 3rd April to 2nd June 2017.

The candidate herself completed the project assign to her during summer training. Her approach to the project was sincere and proactive. This summer training is in partial fulfillment of the course requirement recommended for the award of MBA in Hospital and Health Management.

I wish her success in all her future endeavors.

Col. (Dr.) Ashok Kaushik
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National Health Mission
State Health Society
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TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Priya Gokhale Koshta** student of Master of Business Administration(Hospital and Health Management) batch 2016-2018 of **IIHMR University, Jaipur, Rajasthan** has successfully completed his/her summer internship at National Health Mission, Bhopal from 03-04-2017 to 02-06-2017.

The project was undertaken by him/her in the division of:

Maternal Health – "*Study and Evaluation of Mahila Swasthya Shivir 2017-18 at village level*"

During the period of internship his/her performance has been found to be satisfactory.

We wish him/her all the success in his/her future endeavours.

A Mishra 3/6/17

Dr. Archana Mishra
Dy. Director – Maternal Health

Dr. B. N. Chauhan
Director, NHM, M.P

Acknowledgement

"Vital to every operation is cooperation"–

A wonderful quotation put forth by Mr. Frank Tyger.

The summer training opportunity we had with National Health Mission Madhya Pradesh was an enriching experience, it was a great chance for learning and professional development. It helped us in developing an ability to understand healthcare issues from various perspectives.

Bearing in mind the previous, we would like to take this opportunity to express our deepest gratitude and special thanks to our mentors, Dr. S.D. Gupta, Chairman of IIHMR and Dr. Seema Mehta, Associate Professor, IIHMR University, Jaipur, for guiding and keeping us on the correct path throughout the two months of internship.

It is our radiant sentiment to place on record our best regards, deepest sense of gratitude and indebtedness to Mr. V. Kiran Gopal, Mission Director, NHM Madhya Pradesh, for his immense support and faith and for allowing us to carry out the study with ease at his esteemed organisation during the internship.

We would like to gratefully acknowledge Dr. Archana Mishra, Deputy Director Maternal Health, whose deep sharing, and cooperation has moved us many levels beyond our own thinking.

Furthermore, we would like to express our deepest thanks to Mrs. Rohini Jinsiwale, Maternal Health Consultant, for providing us with her experiences and all the required information that helped us with our study.

Special thanks to the State as well as District Program Managing Unit of Bhopal and Raisen for supporting us through the whole project with traveling. Contribution of DPMs of both the districts was magnificent.

We perceive the opportunity as a big milestone in our professional development. We will strive to use the gained skills and acknowledgement on the best possible way, and will continue to work on their improvement, to attain the desired career objectives.

Sincerely,

Priya Gokhale Koshta

Dr. Rohit Singh Raghuvanshi

Contents

ABBREVIATION

ANM-Auxiliary Nurse Midwife	**LSCS-**Lower Segment Caesarean Section
ARSH- Adolescent Reproductive Sexual Health	**MH**-Maternal Health
ASHA-Accredited Social Health Activist	**MMU**-Mobile Medical Unit
AWW-Aanganwadi Worker	**MPW**-Multi Purpose Worker
BCC-Behaviour Change Communication	**MSS**-*Mahila Swasthya Shivir*
BMO-Block Medical Officer	**NCD**-Non-Communicable Disease
BPMU- Block Program Management Unit	**NDCPs**-National Disease Control Programs
CH-Child Health	**NPW**- Non-Pregnant Women
CHC-Community Health Centre	**NRHM**-National Rural Health Mission
CHN-Child Health Nutrition	**NUHM**- National Urban Health Mission
CMHO-Chief Medical Health Officer	**PCPNDT**-Pre-Conception & Pre-Natal Diagnostics
DCM-District Community Mobilizer	Techniques
DD-Deputy Director	**PFMS**-Public Finance Management System
DH-District Hospital	**PH**-Public Health
DPM- District Program Manager	**PHC**-Primary Health Centre
DPMU- District Program Management Unit	**PIH**-Pregnancy Induced Hypertension
FMIS-Finance Management Information System	**PIP**-Program Implementation Plan
FW-Family Welfare	**PW-**Pregnant Women
HMIS-Health Management Information System	**RBSK**-Rashtriya Bal Swasthya Karyakram
HPD-High Priority District	**SDH**-Sub-District Hospital (Civil Hospital)
HR-Human Resource	**SFM**-Senior Finance Manager
IEC-Information Education Communication	**SHC**-Sub-Health Centre
IRTS-Integrated Referral Transport System	**SMO**-Sector Medical Officer
IT-Information Technology	**SPM**-State Program Manager
LHV-Lady Health Visitor	**SPMU**- State Program Management Unit

1. NATIONAL HEALTH MISSION

The National Health Mission was launched by Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable, and quality health care to the rural population, especially vulnerable groups. The Union Cabinet vide its decision dated 1st May2013, as approved the launch of National Urban Health Mission(NUHM) as a Sub-mission of over-arching National Health Mission(NHM), with National Rural Health Mission(NRHM) being the other submission of National Health Mission.

The thrust of mission is on establishing of fully functional, community owned, decentralised health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standard for all health facilities.[1]

NHM has six financing components:

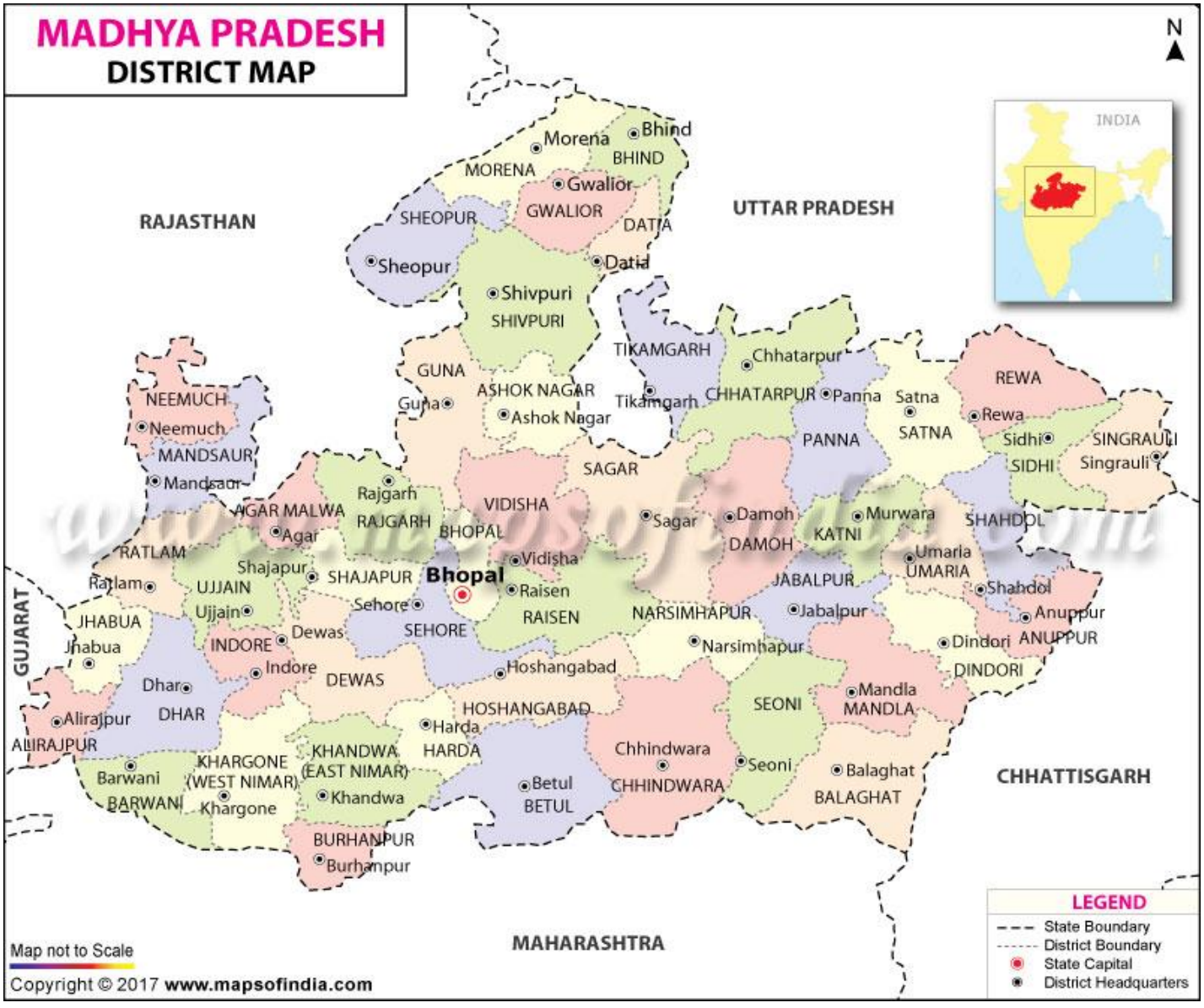
- NRHM-RCH Flexipool,
- NUHM Flexipool,
- Flexible pool for Communicable diseases,
- Flexible pool for Non-Communicable diseases including Injury and Trauma
- Infrastructure Maintenance and
- Family Welfare Central Sector component.

The state would be responsible for district action plans, and activities to be performed in state level. The state Program Implementation Plan (PIP) will also include individual district plan. It will strengthen local planning at district level, ensure approval of adequate resources for high priority districts plans and communicate plan to districts and state at the same time.

The state PIP is firstly appraised by the National Programme Coordination Committee(NPCC). NPCC includes Mission Director as a chairman and representatives of the state, technical and programme divisions of the MoHFM, national technical assistance agencies providing support to the respective states, other departments of the MoHFW and other Ministries as appropriate. After appraisal state PIP is approved by Union Secretary of Health & Family Welfare as Chairman of the EPC.[2]

1.1 STATE PROFILE

Madhya Pradesh is also known as the "heart of nation" covering an area of 3,08,252 sq. km, making it the second biggest state in the country after Rajasthan, bordering five other states- Uttar Pradesh, Chhattisgarh, Maharashtra, Gujarat, and Rajasthan. As per the census 2011 the state has a population of 7.27 crores. There are 51 districts, 313 blocks and 393 villages.[3]



Source:www.mapsofindia.com

1.2 GOAL

Outcomes for NHM in the 12th Plan are synonymous with those of the 12th Plan, and are part of the overall vision. The endeavour would be to ensure achievements of those indicator in Box 1. Specific goals for the states will be based on existing levels, capacity, and context. State specific innovation would be encouraged. Process and outcome indicators will be developed to reflect equity, quality, efficiency, and responsiveness. Targets for communicable and non-communicable disease will be set at state level based on local epidemiological patterns and considering the financing available for each of these conditions.

Box 1

1. Reduce MMR to 1/100000 live births
2. Reduce IMR to 25/1000 live births
3. Reduce TFR to 2.1
4. Prevention and reduction of anaemia in women aged 15-49 years
5. Prevent and reduce mortality & morbidity from communicable, non-communicable; injuries and emerging diseases
6. Reduce household out of pocket expenditure on total health care expenditure
7. Reduce annual incidence and mortality from Tuberculosis by half
8. Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts
9. Annual Malaria Incidence to be <1/1000
10. Less than 1% microfilaria prevalence in all districts
11. Kala-azar Elimination by 2015, <1 case per 10000 population in all blocks

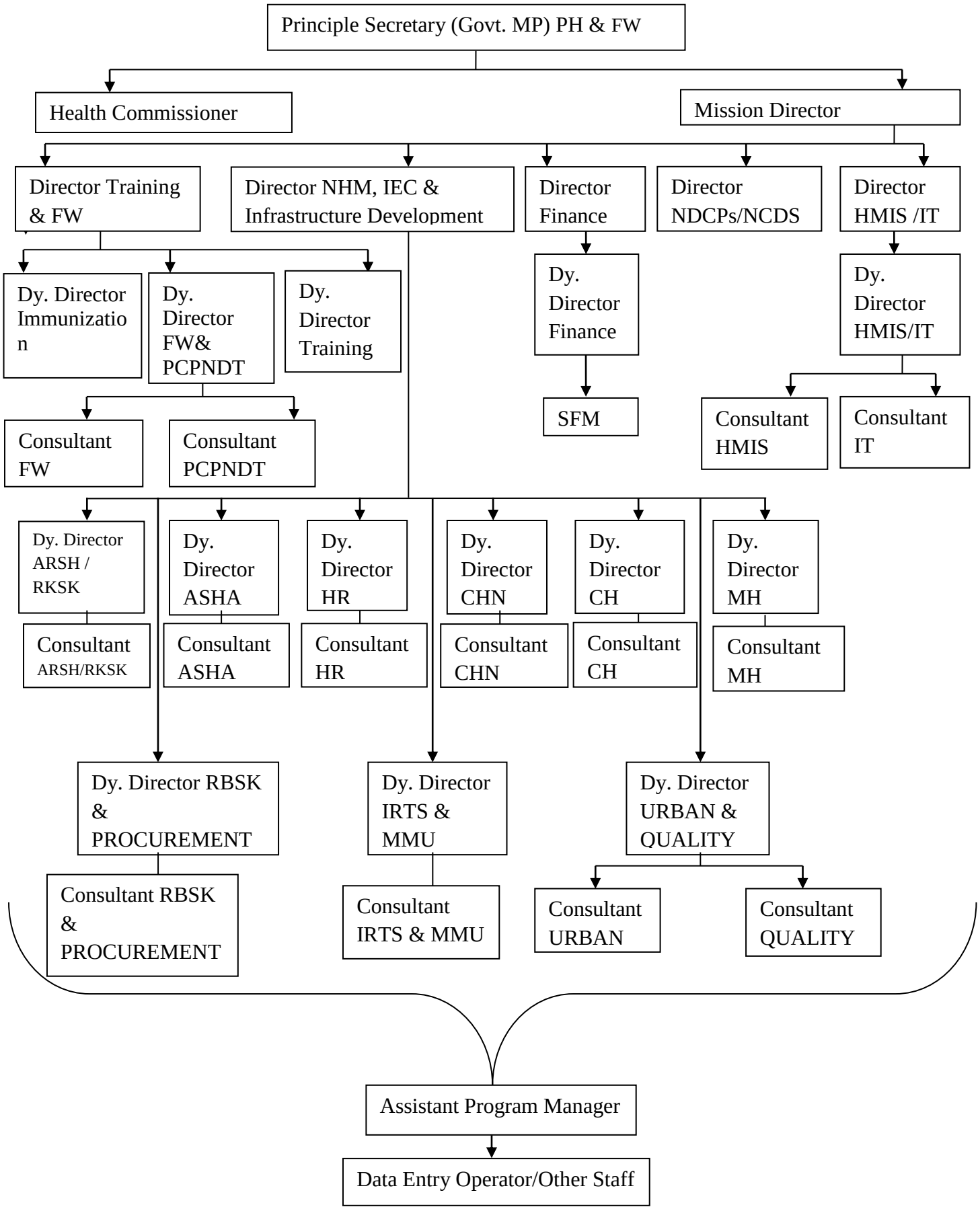
1.3 VISION OF THE NHM

"Attainment of Universal Access to Equitable, Affordable and Quality health care services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health."

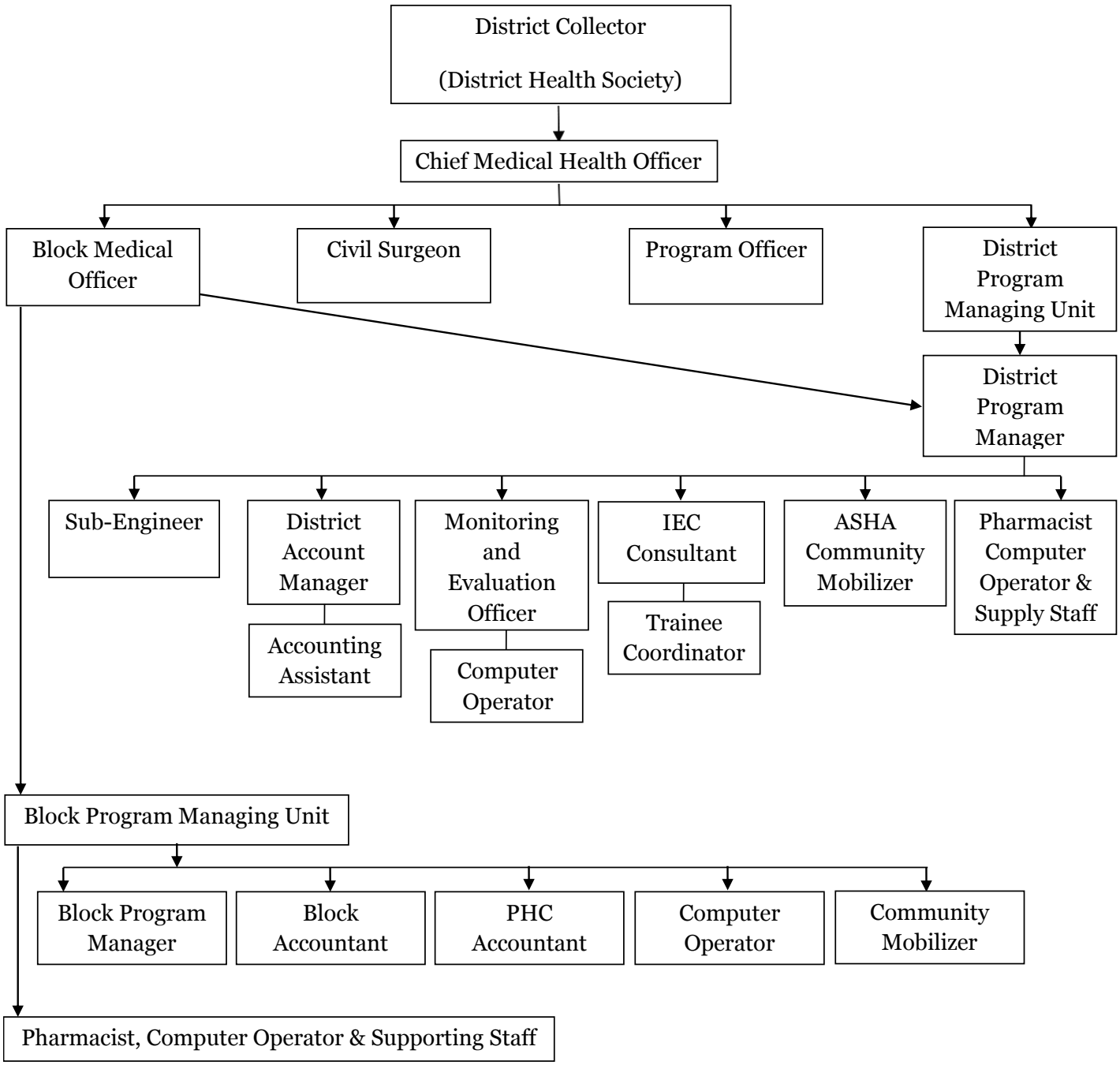
1.4 CORE VALUES

- Safeguard the health of the poor, vulnerable and disadvantaged, and move towards a right based approach to health through entitlements and service guarantees.
- Strengthen public health systems as a basis for universal access and social protection against the rising costs of health care.
- Build environment of trust between people and providers of health services.
- Empower community to become active participants in the process of attainment of highest possible levels of health.
- Institutionalize transparency and accountability in all processes and mechanisms. Improve efficiency to optimize use of available resources.

2. STATE PROGRAM MANAGEMENT UNIT: ORGANOGRAM



3. DISTRICT HEALTH SOCIETY: ORGANOGRAM



4. MAHILA SWASTHYA SHIVIR

4.1 INTRODUCTION

Consistent and coordinated effort of the Government of Madhya Pradesh has ensured that basic infrastructure and institutional mechanisms for health care delivery is prevalent across the State. Still there is scope for improving services for preventive health services.

The *Mahila Swasthya Shivir* (MSS) is the vision of Shri Shivraj Singh Chauhan, Hon'ble Chief Minister Govt of Madhya Pradesh.MP envisions achieving the goal of reduction of MMR to 100 by 2017 as per the 12thfive year plan. Under **RMNCH+A,** identification of **17 high priority districts (HPDs)** which are low performing in terms of process indicators (HMIS) are the focus districts in terms of HR, Infrastructure for achieving overall improvement in health indicators of MP. Envisaged to extend a wide range of health care services to women of all age groups and across all remote, rural areas of the State, going beyond addressing urgent health concerns and serving as a panacea to afflicted women, the *Shivir* has enabled create a rich, area-wise profile of the State. This will go a long way in drafting efficient policies and making impactful interventions, based on prevailing shortcomings.

The Government of Madhya Pradesh had launched the ***Mahila Swasthya Shivir*** (MSS) across each of its 51 districts for the women right from adolescent age to geriatric age. Mahila Swasthya Shivir has planned in 3 Phases:

First phase: Screening of Cases at village level. In each village of state the camps were organized. A team of Sector Medical Officer/ AYUSH female Doctors/RBSK Female doctor along with ANM, LHV and ASHA visited the village as per the micro plan prepared. Prior to village camp ASHA had done Preliminary screening of women suffering from Gynaecological problem, Diabetes, Hypertensions, Breast Cancer, Cervical Cancer, Anaemia, based on a checklist provided. On the day of camp ASHA mobilized the listed cases at camp site for further diagnosis by Medical Officer including all pregnant women.

Second Phase: At all Cases screened by doctors had been referred to Block level. The cases of Anaemia, Hypertension, Diabetes, High Risk Pregnant women had been referred to block level and cases of Gynaecological problem (Prolapsed Uterus, Dysfunctional Uterine Bleeding (DUB), Fibroid Uterus), Suspected Cases of Breast Cancer and Cervical Cancer had been referred to District Hospital for further investigation and before treatment**.**

Third Phase: Treatment initiated at Roshni clinic for cases of Gynaecological problem (Prolapsed Uterus, Dysfunctional Uterine Bleeding (DUB), Fibroid Uterus), Suspected Cases of Breast Cancer and Cervical Cancer after diagnosis. The investigations which have not been available at hospital made available through accreditation of Pvt Institution under CGHS rate.

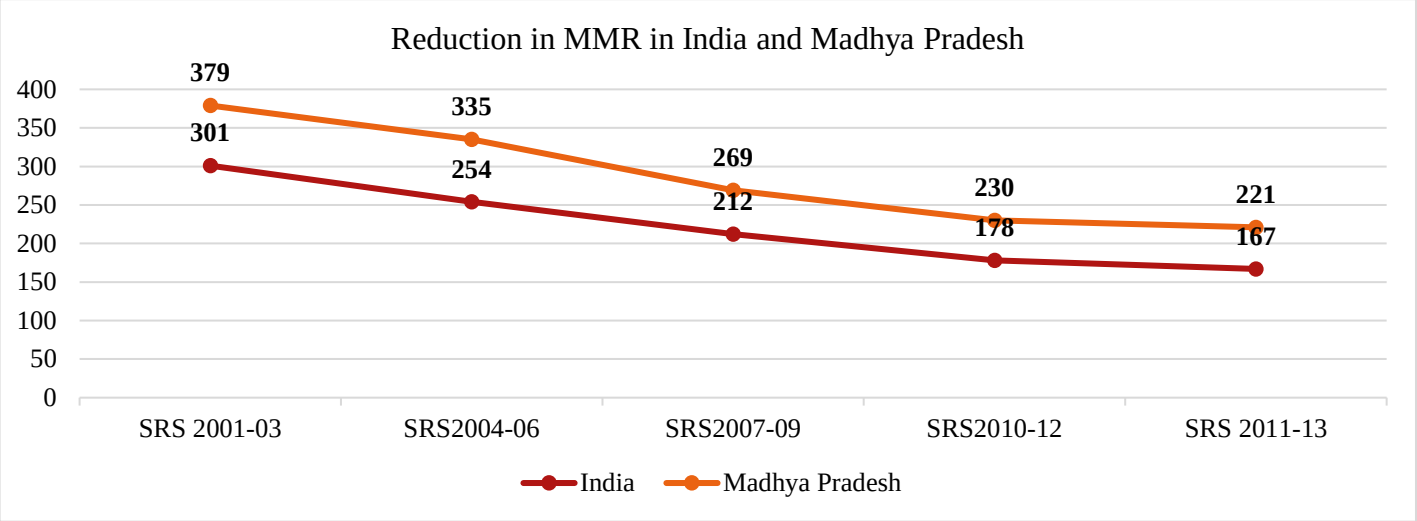
Though PMSMA (**Pradhanmantri Surakshit Matritva Abhiyaan)** department is intended for timely identification and management of high risk among pregnant women and providing full range of services. The constraint of PMSMA is mobilization of pregnant women from remote and hard to reach area. Mahila Swasthya Shivir is an opportunity for the department to reach out to these women.

4.2 OBJECTIVES OF MSS

1) To ensure that Adolescent girl and women across the State have access to efficient health care systems
2) To identify high risk pregnant women and ensure early detection and treatment
3) To create an area-wise profile of patients with different ailments (cancer, anaemia etc.) to ensure sustainable area-specific solutions
4) To create awareness of so that women undergo regular check-up and complications, if any, are detected early on
5) To ensure that Ante Natal Care (ANC) through qualified doctors and medical professional is made available to all pregnant women
6) To ensure that pregnant women undergo necessary laboratory and other diagnostic tests
7) To conduct screening of women afflicted with cancer, to ensure timely treatment
8) To identify anaemic women and taking necessary steps to increase their haemoglobin levels.
9) To render the treatment and other diagnostic tests of high risk pregnant women under **Pradhanmantri Surakshit Matritva Abhiyaan** (9^{th} of every month) in Health Institutes.[4]

4.3 RATIONALE FOR MSS

Reduction of MMR has been the priority agenda of the State Govt. of Madhya Pradesh is showing the steady trend of decline in the MMR which is evident from various survey data. The MMR of MP was 230 in 2010-12 SRS (India 178) and with the constant decline in MMR, it is now 221 as per SRS 2012-13 (India 167).



Source:PIP2017-18 Madhya Pradesh

There is decline of 158 points in Madhya Pradesh since 2001-03 SRS as compared to decline of 134 points throughout the country. As per SRS 2011-13 Madhya Pradesh is at 5th position from bottom.

Most maternal deaths are avoidable, as the health-care solutions to prevent or manage complications are well known. Improving access to ante natal care in pregnancy, skilled care during childbirth, care, and support in the weeks after childbirth will reduce maternal deaths significantly.

56.4% of Pregnant women age 15-49 years and 53.7% of Non-pregnant women age 15-49 years are anaemic (<11.0g/dl), 21.8% of women have gone for Cervix examination,10.2% have gone for Breast examination,11% have gone for Oral Cavity examination in Rural area of Madhya Pradesh(NFHS-4).[5]

4.4 RESULTS OF MSS 2015-16

An overall 23.21 lakh women from 55, 216 villages across the State were screened and examined by medical professionals. Of the 3.5 lakh, pregnant women screened at the village level, nearly 67,000 women were identified as high-risk cases. That apart, 2, 10,564, of 19.51 lakh non-pregnant women, were examined for other complications and referred to the block level camps for further examination. Further, at the camps organized at the next level at 313 blocks across the State. 40, 250 pregnant women and 95,977 women were examined by doctors and specialists based on their condition. While maximum number of pregnant women suffered from acute anaemia, nearly 11,000 of them were treated with iron sucrose & blood transfusion at the CHCs and Civil Hospitals. Non-pregnant women afflicted with high BP, diabetes, menopausal problems, infertility, ENT issues and breast, uterus and oral cancer among others were also examined and treated or referred to the district hospital wherever it was found imperative. Through Camps 1340 cases of infertility and 412 suspected cases for cancer also identified and department is being tracking for their complete treatment and cure.

4.5 RESULTS OF MSS 2016-17

In the year 2016-17 State has organized 43, 519 village level camps. A total 16.95 lakh women visited in village level camp out of which 18% were the pregnant women, 18% were adolescent girls and 63% were non-pregnant women. 1.65 lakh women were referred to block level as well as Roshni Clinic of District Hospital for further diagnosis and treatment. 2.3 lakh pregnant women provided Albendazole for deworming. 55% of pregnant women are anaemic out of which 48% of women given Iron sucrose and 138 women provided blood transfusion. 508 Gynaec Surgery cases were operated. Ailment wise detail of referred cases is as below: -[6]

	Case Management Block Level		**Case Management at Roshni Clinic**	
	Referred	**Reached & Treatment Initiated**	**Referred**	**Reached & Treatment Initiated**
Gynae Problem	59599	22791	24169	5334
Anaemia	33425	13945	4550	1005
PIH	2510	1167	741	160
High Risk PW	14281	5996	4859	937
Hypertension	9408	2933	1782	301
Diabetes	1946	647	467	85
Infertility			16330	4473
Probable cancer			1157	215

5. RESEARCH QUESTION

- Is the Mahila Swasthya Shivir efficiently working to reach all the women with complications, if not then why?
- Is the Mahila Swasthya Shivir beneficial to increase the awareness among Women towards the Health Problems?

6. OBJECTIVES OF RESEARCH

- To know the number of ASHA workers trained for door to door survey before the program.
- To assess the services rendered by ASHA before the *Shivir* during door to door survey.
- To explore the Range of Services being rendered to Pregnant women and Non-Pregnant Women during the program.
- To Explore the benefits of the program.

7. LIMITATION OF THE RESEARCH

- Only a single village can be visited in a day.
- Difficulty in collection of data if ASHA and AWW of the village was not present or inactive.

8. RESEARCH METHODOLOGY

8.1 Research Design

Descriptive Cross-sectional Study-Observations were made during camps.

8.2 Study Area:

The study was carried out in camp area of 27 villages in district Bhopal and Raisen of Madhya Pradesh. Sub-centre, Aanganwadi, Government School and any possible spacious place were taken for the camp.

8.3 Duration of the study

2 months (from April,3,2017 to June,2,2017)

8.4 Type of Data collection

Primary data collection: - was done through checklist

Secondary data collection: - Micro plan (Schedule of camps with date and human resource information) collected from DPMU of district Bhopal & Raisen

8.5 Sample size:

n=27

Where n= Number of Mahila Swasthya Shivirs

13 villages of Bhopal district which is Non-High Priority District and 14 villages of Raisen district which is a High Priority District(HPD)under RMNCH+A.

8.6 Study Population:

17 Medical officers, 18 ASHAs, 27 AWWs & 17 ANMs present in the 27 camps. And 131 non-pregnant women from each village were interviewed.

8.7 Sampling:

Non-probability purposive sampling-because of limited time, money, and workforce, it was impossible to randomly sample the all villages of both districts. As only one camp could be visited on a day as well as distance of villages also significantly mattered. Visits to villages were done on the day of camp.

8.8 Method of data collection: -

Observation Method thorough the help of check-list. Guidelines of Mahila Swasthya Shivir used to explore the interesting issues in depth at field level.

9. ANALYSIS OF STUDY

9.1 Number of *Shivirs* with proper space

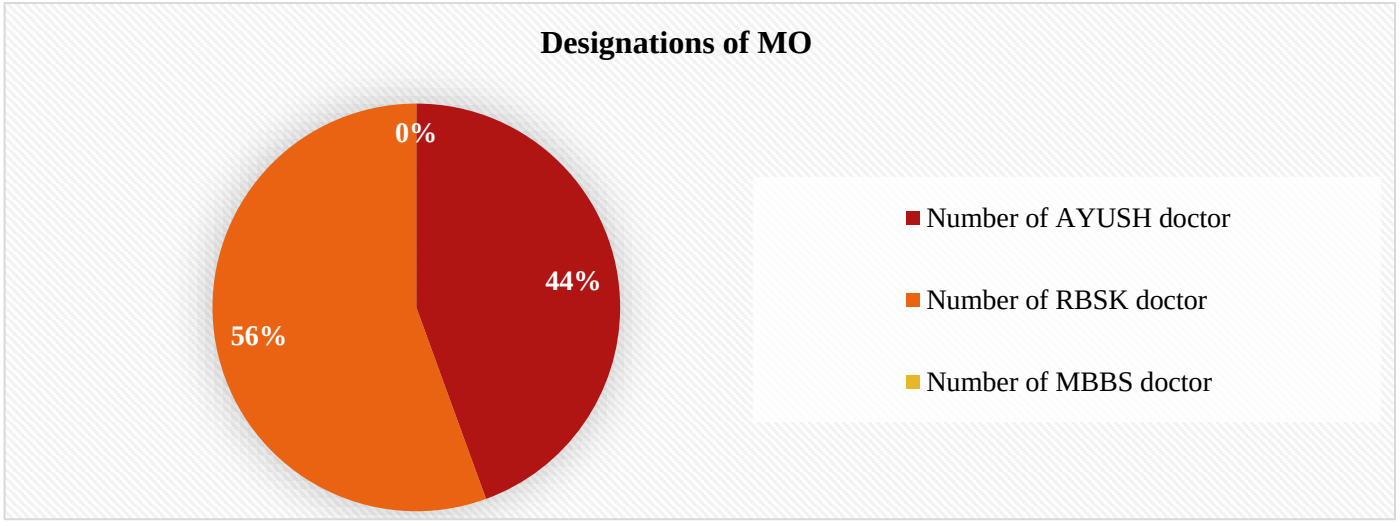
Taking into account the survey,78% of villages had adequate space to deliver the services. At 22% of villages,space for shivir was not adequate. Sitting arrangement for Doctor and staff was not proper .All the services like lab invetigation, examination and drug distribution were being done in a single room . These *Shivirs* were organised in Aanganwadi Centre.In addition to this it is not possible to have a Sub-centre in a village having less population.

Space Availability	Number of villages
***Shivir* with sufficient space**	21
***Shivir* with insufficient space**	6
Total visited villages	27

9.2 Designations of Medical officers

HR Plans of the *Shivir* in both districts included the team of RBSK, and AYUSH doctors. In 56% of villages RBSK doctors and 44% of the villages AYUSH Doctors were providing services.

As per the mobility plan SMOs were not assigned any village for their rendering services at village camp.



9.3 Number of villages with trained staff

At 70% of villages, field workers received proper training to perform their responsibilities. They knew about the door to door survey, distribution of medicines and line listing of women with complications and follow up procedure.

At 30% of villages field workers did not receive the training because of either mobility issue or communication gap between ASHA and ANM. It was also noticed that some of staff had less knowledge about the meeting schedule.

Although staff needed training but they all show cooperation on the day of *shivir*. It is necessary to give proper attention to field workers to ensure the quality of services.

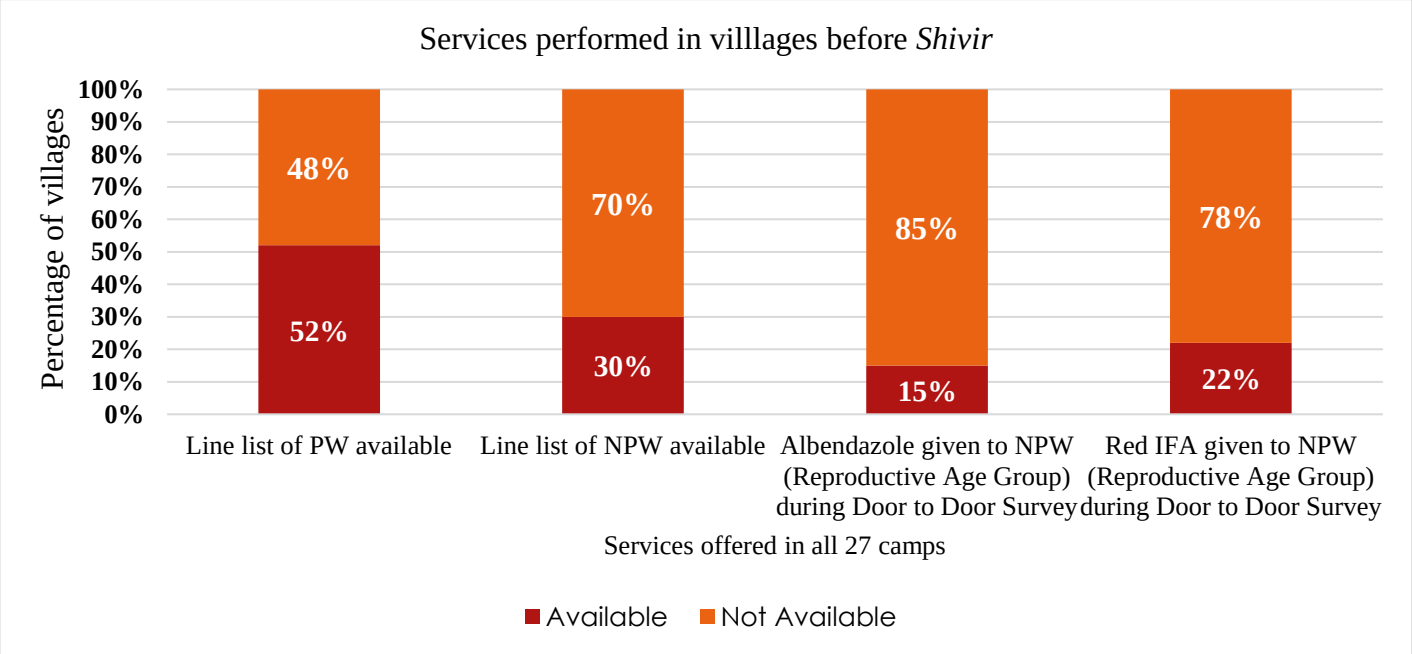
Training given to staff	Number of villages
Number of villages with trained staff	19
Number of villages with untrained staff	8
Total visited villages	27

9.4 Door to door Survey

At 59% of villages ASHA done the door to door survey. At 41% of villages door to door survey before the day of *Shivir* was not done because ASHAs and AWWs of some villages either didn't receive the training or made many excuses related to household work.

Door to door survey	Number of villages
Village where door to door survey was done	16
Villages where door to door survey was not done	11
Total Number of villages	27

9.5 Activities performed during door to door survey



At 52% of the villages, line listing of the pregnant women and at 30% of the villages, line listing of the Non-Pregnant Women(NPW)was present but at some villages, complications were not specified.

At 48% of the villages, line listing of PW and 70% of the villages, line listing of NPW were not available because in some villages ASHAs were not appointed or inactive.

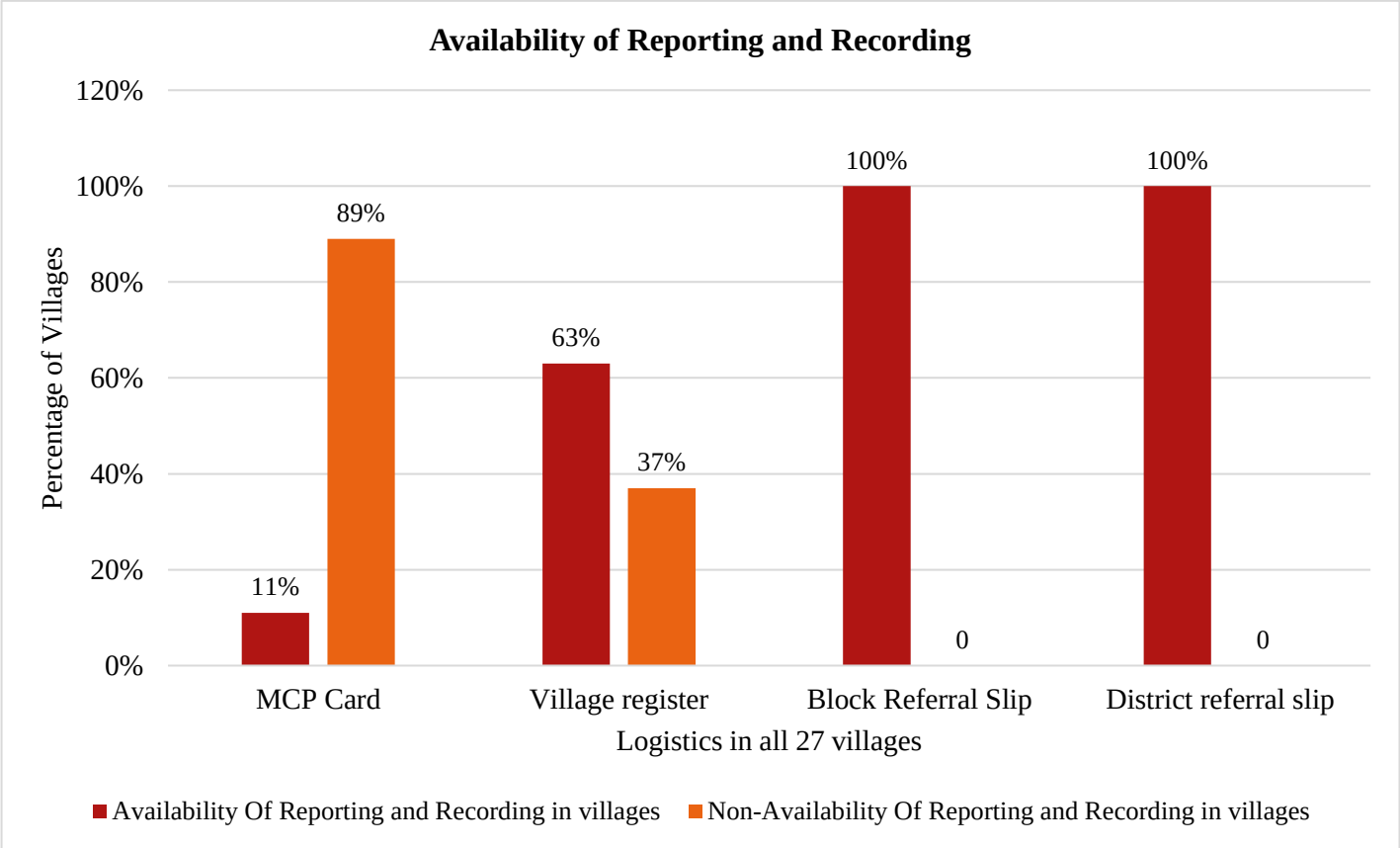
It can be interpreted that, lack of sincerity about the health problems was a reason to not perform the activities. As well as in many villages, attention was not given to NPW.AWWs alone are not sufficient to take the responsibility of whole village population.

At 15% villages Albendazole and at 22% villages IFA Tablets were distributed by ASHAs and AWWs. At 85% of the villages, Albendazole and at 78% of the villages, Red IFA tablets were not given during door to door survey.

The results confirm that the ASHAs of villages were not effectively working.

With MO teams, all the drugs were available and were being distributed during the camps like IFA Tablets, Calcium Carbonate, IU Vitamin D3, Folic Acid Tablets, Albendazole Tablets, Paracetamol, Amoxicillin, Ciprofloxacin etc.

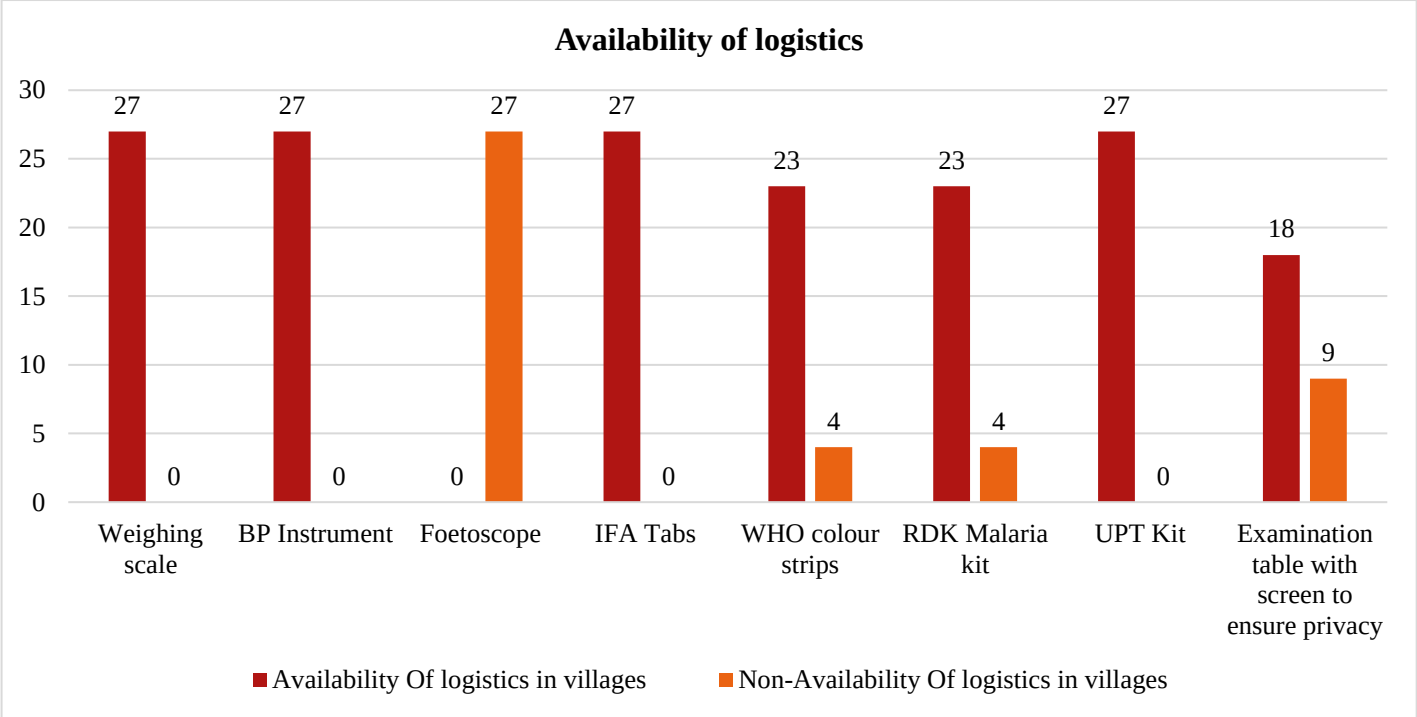
9.6 Availability of recording and reporting



All the camps had Block Referral Slips and District Referral Slips. At 63% of villages, Village register was also available but not updated.

At 89% of the villages, MCP cards were not present because these were not provided to MO teams. So, at some villages, newly pregnant women didn't receive the MCP card. At 37% of villages, Village register was not present.

9.7 Availability of Logistics



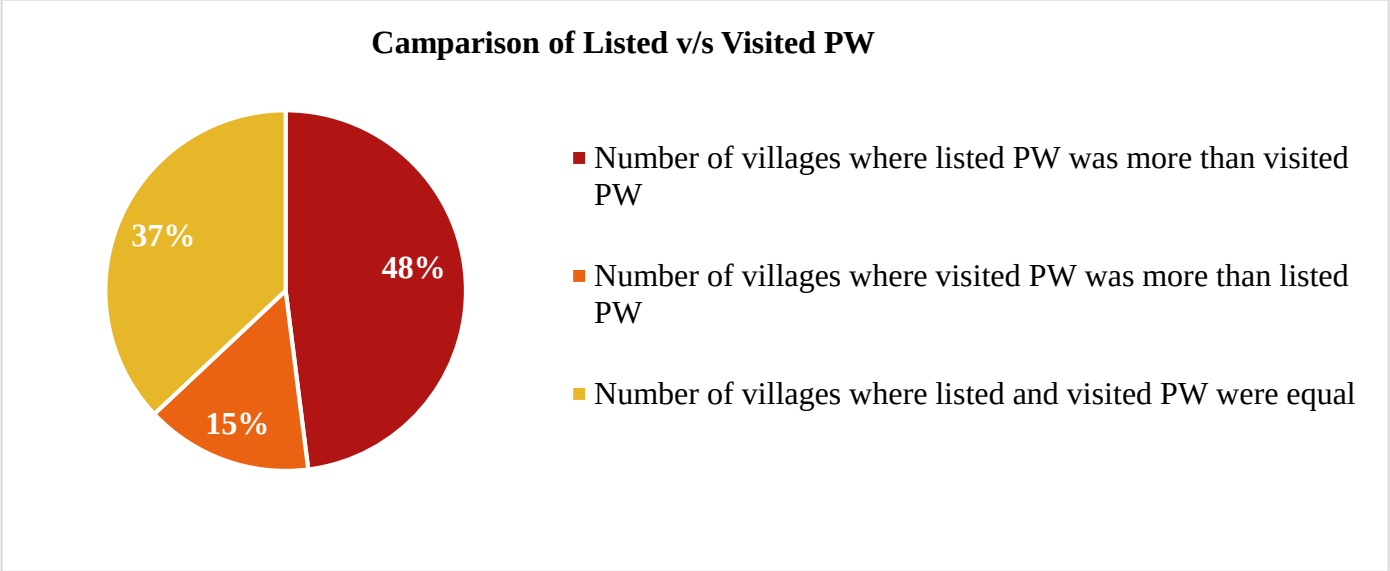
All the logistics like weighing scale, BP instruments, WHO colour strips, RDK malaria kit, UPT kit, which were necessary for the camps were available except the crucial one: Foetoscope.

The non-availability of Foetoscope in all villages shows that it was not provided in any of visited village.

9.8 Comparison of Listed and Visited Pregnant Women

Note-

- Listed Pregnant Women-Number of Pregnant women listed during the door to door survey by ASHA
- Visited Pregnant Women-Number of Pregnant women visited to camp on the day of camp.



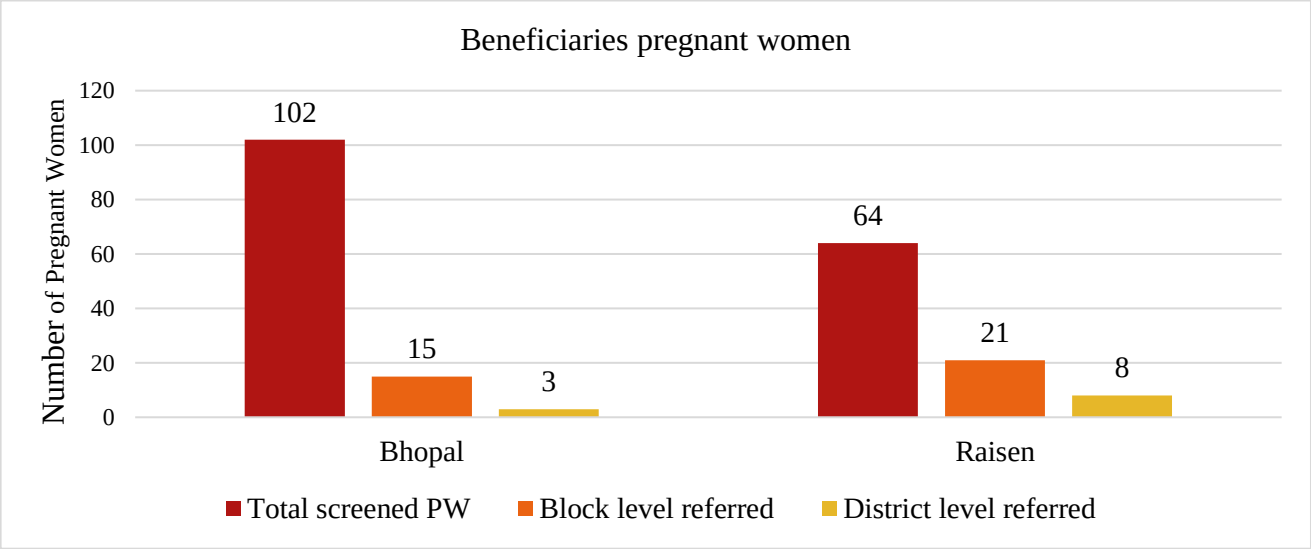
At 37% of villages, all the listed Pregnant Women(PW) came to the camp site. It was interpreted that ASHA did commendable job as she could bring all the listed pregnant women to the *shivir*.

At 48% of villages, Listed PW was more than Visited .PW were either getting treatment in private institution or busy in some household works and some PW were not present on the day of *shivir*. It can be interpreted that door to door survey was not done as per guidelines of MSS

At 15% of villages, visited PW was more than listed by ASHA because some PW either newly identified on the day of camp or some women were not registered during 1st trimester because in village people usually do not believe in revealing pregnancies of their daughters and daughter in laws.

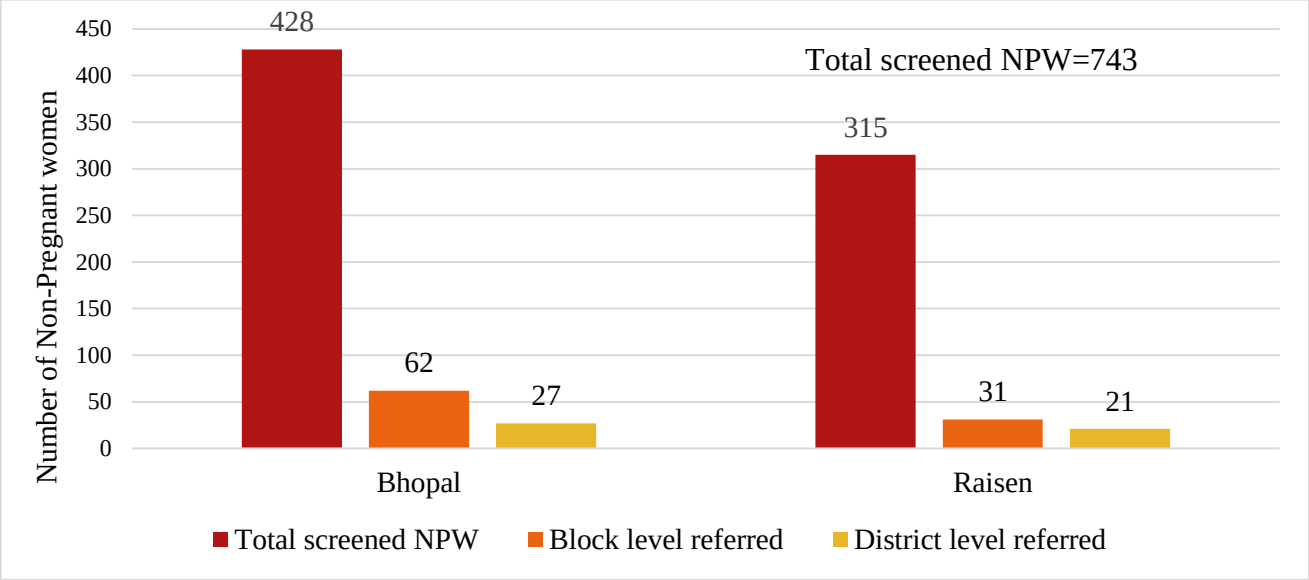
9.9 Percentage of identified High Risk Pregnant Women among screened

Among 166 screened pregnant women during *Shivirs*, 17% of high-risk PW women identified in Raisen District and 11% women identified as high-risk PW in Bhopal because geographically villages of Raisen are in remote areas where health facilities are not available, women of the villages are underserved.

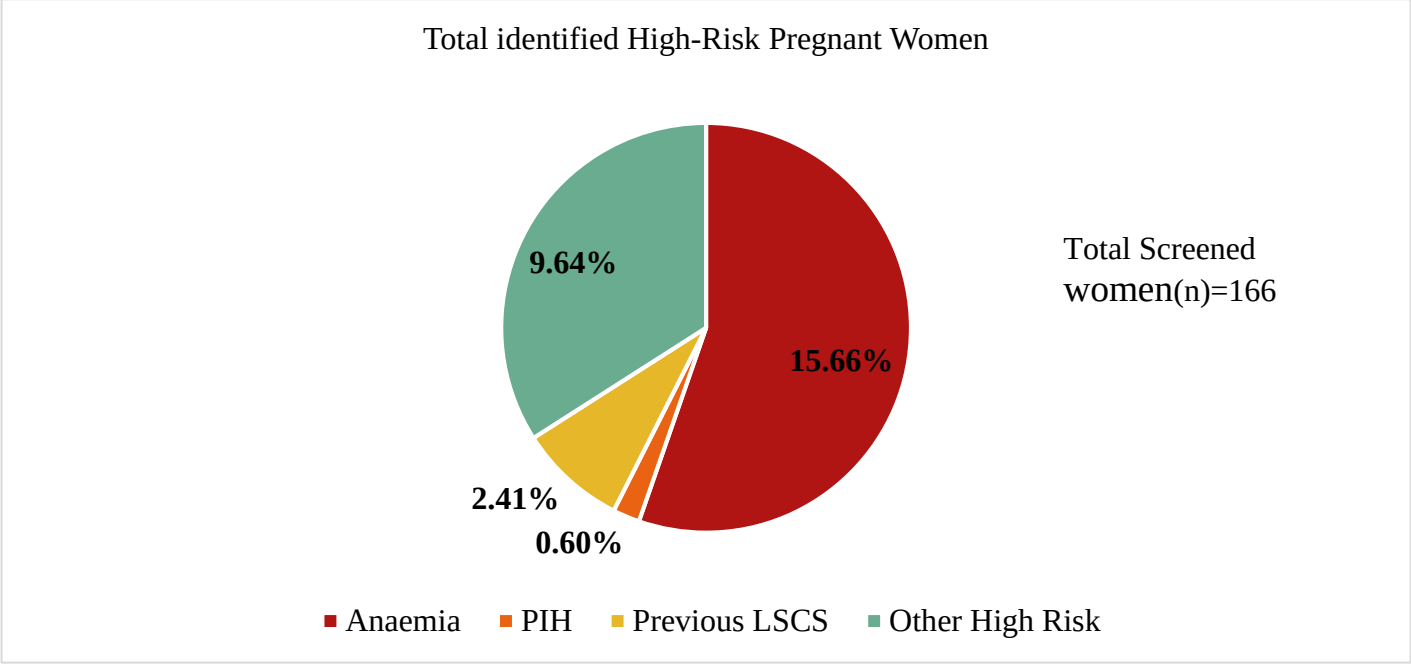


9.10 Percentage of identified High Risk Non-Pregnant Women among screened

Among 743 screened non-pregnant women during *Shivirs*, 0.07 % of high-risk NPW women identified in Raisen District and 12% women identified as high-risk NPW in Bhopal



9.11 Ailment wise identified pregnant women

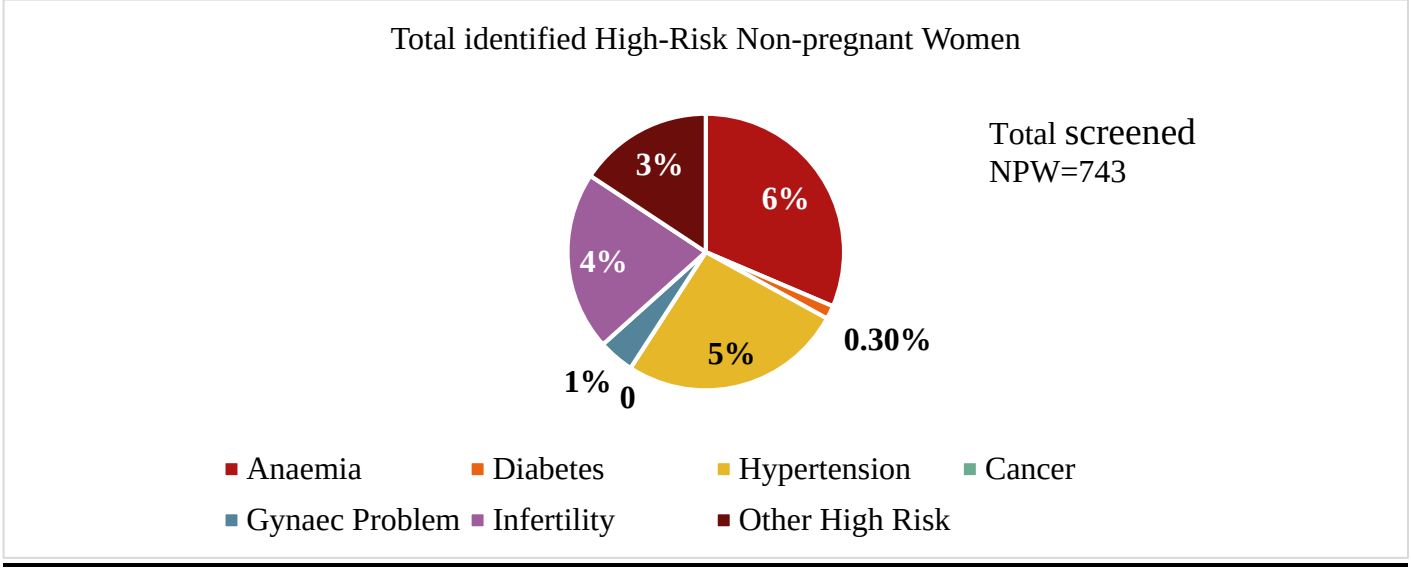


Anaemia is a root cause of higher MMR. Results of study also shows that 55% of the PW were anaemic and were referred to block level treatment.

34% of other high-risk cases includes diabetes, stunted PW, Low foetal weight, previous multiple abortion etc. These all the cases are not only prevalent in Madhya Pradesh but also in India.

There were also 9% cases of previous LSCS and 2% cases of PIH. MSS is an appreciable approach to identify and provide proper treatment to these type of high risk cases.

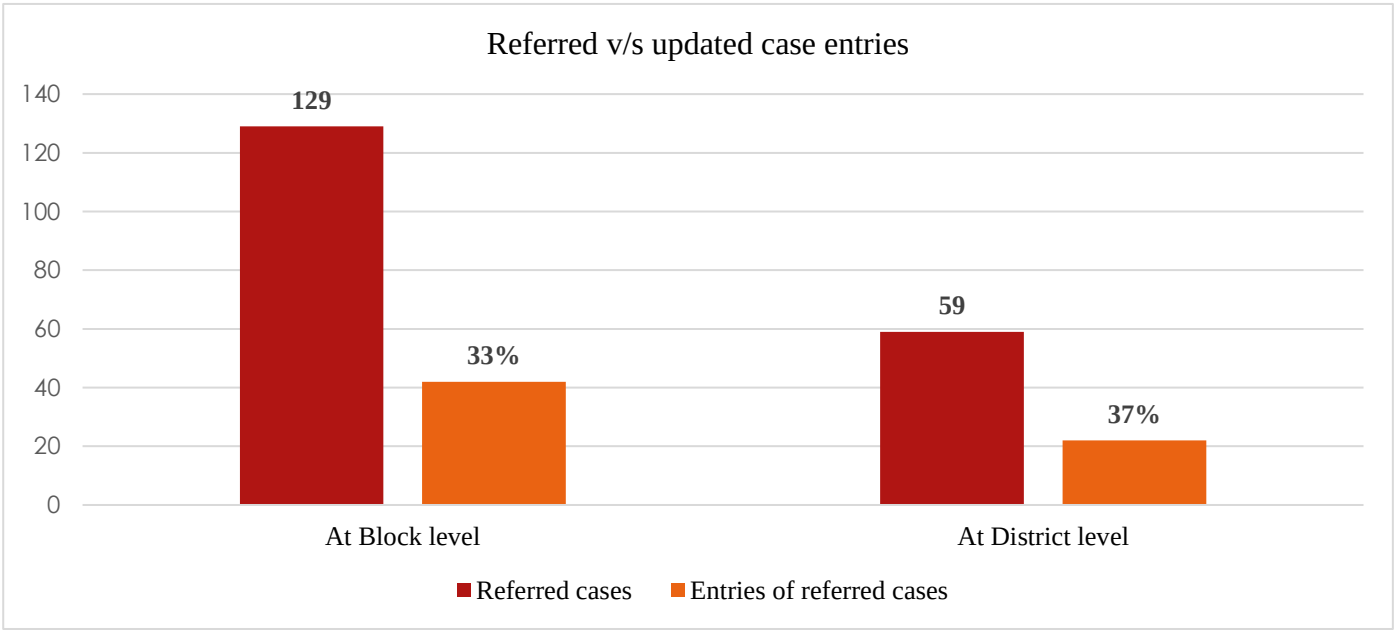
9.6 Ailment wise identified non-pregnant women



9.12 Gap in updating of referred cases in software

During the visit of *Shivirs*, all the cases referred to block and district level noted down with their names and compared with the software entries.

It was found that only 33% entries of block referred cases and 37% entries of district referred cases were done in software because data entries are done by an untrained person who has less knowledge about the system. Data entry operator is expected to do many entries in less time which creates inaccuracy in data



10. OBSERVATIONS

- During the study of MSS it was observed that the performance of ASHAs and AWWs was below the satisfaction level.
- The MO teams especially RBSK MOs well performed in both districts.
- All the team members necessary for the *Shivir* were available, cooperative, and well managed.
- Lack of coordination and communication seen among field workers and MO teams.
- It is appreciable that *Shivir* was conducted separately in two nearly located villages which were having population less than 500 *Shivir* was also conducted in those villages where it seemed impossible to reach.
- In the summer season, it was very difficult to gather the women for *Shivir* as they were busy in earning money from other sources of income so few number of women were screened.
- As per the guidelines of MSS, every kit has container but during visit it was not observed for urine collection.
- The role of examination table was hardly noticed as it was not used during check-up. Thus, underutilisation of all the present resources is also a hindrance in such type of huge activities.
- Follow up of cases after screening is most important to bring the client at logical end of treatment. Women with sterility who were in previous camps did not complete their treatment because of lack of field level workers follow-up.
- It was not possible for a woman of the village to communicate with a male doctor about her health problems.

11. SUGGESSTIONS

- It would be beneficial if the doctors will be given incentives for Village level camp.
- Communication directly affect the process of any program, so it would be good to reduce the communication gap between top management level and field workers for getting the positive results.
- Supervision is necessary to increase the effectiveness of ASHA's and AWW's work. Along with supervision, both should be also provided incentives based on the number of women surveyed, the number of the women brought to the camp and the number of women distributed medicines. It will create sense of belongingness in ASHAs and AWWs.
- A prior check of each centre where the camp was supposed to conduct to ensure the availability of all coordination.
- All the villages should be provided Foetoscope.

12. CONCLUSION

Screening and treatment of women with complications at village level through *Mahila Swasthya Shivir* acts as a connecting link between women and health institutions as well as creates awareness among community for women health especially pregnant women. Although implementation of the program was a challenge for stakeholders of the program but previous evidences of MSS 2015-2016 shows its huge contribution in reducing the MMR of Madhya Pradesh.

As the analysis and observational findings have demonstrated, a wide array of economic, social, geographical factors influences a woman's health, and many entities in health system share responsibilities for maintaining and improving a woman's health.

Accessibility, availability, and affordability are major 3As issues in Public health. MSS is commendable approach to reach the underserved women and provide them primary level of care and referral services (if required) by providing Accessibility (Camps at village level), Availability (Skilled Human Resource, Logistics and Supplies at village, block, and district level) and Affordability (Free of cost services).

13. REFERENCES

1. http://nhmmp.gov.in/
2. http://nhm.gov.in/nhm/about-nhm.html
3. *Census 2011*
4. Guidelines of *Mahila Swasthya Shivir 2017-18*
5. NFHS-4 fact sheet of Madhya Pradesh.
6. PIP 2017-18 Madhya Pradesh

14. ANNEXURE

checklist for Mahila Swasthya shivir.xlsx

MSS Data sheet.xlsx