**Summer training at**

**National Rural Health Mission Rajasthan**

**Jaipur (April-May,2016)**

- **Kushal mangal programme**
- **Online JSY and shubhalaxmi payment system**
- **Social review of maternal death**

**by**

**Dr. Aanchal Bajaj**

**Under the guidance of**

**Mr. P.R Sodani**

**MBA Hospital and Health Management**

**(2015-2016)**


**Institute of health management research**

**Jaipur (2016)**

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 **Dr. Aanchal Bajaj** has undergone Summer Training in NRHM,Jaipur from 1st April 2016 to 31st May 2016.

The candidate himself completed the project under my guidance during his training.His approach to the project was sincere and proactive. This summer training is partial fulfillment of the course requirement recommended for the award of MBA in Health and Hospital Management.

I wish him success in all his future endeavors.

P.R Sodani

Dean(Training)

IIHMR, Jaipur

Col. (Dr.) Ashok Kaushik

Dean (Academic & StudentAffair)

IIHMR,Jaipur

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur-302029, Rajasthan, India.
Ph.: 0141-3924700, 2791431- 32, Fax:0141-3924738,E-mail: iihmr@iihmr.edu.in,Web: www.iihmr.edu.in

**Government of Rajasthan**
**National Health Mission, Rajasthan**
**Department of Medical, Health & FW, Swasthya Bhawan, Jaipur.**
**Tel. No.- 0141-2223862, E mail ID : projectdirectorch@gmail.com**

Completion of Summer Training under
National Health Mission, Rajasthan

The certificate is awarded to

**Dr. Aanchal Bajaj**

In recognition of having successfully completed his
Training in the department of

**Maternal Health**

And has successfully completed his Project on Surakshit Matratav Diwas, Ojas and Social Review of Maternal Death.

Date 23/9/16

Organization: **National Health Mission**

He comes across as a sincere person who has a strong zeal for learning

We wish him all the best for future endeavors

**Trainee Mentor**

23-9-16

**Director RCH**
**Directorate of Medical & Health Services**
**Jaipur, Rajasthan**

## Acknowledgements

I would like to express deepest gratitude to my mentor Mr. P.R Sodani for his full support, expert guidance, understanding and encouragement throughout my study. Without his incredible patience and timely wisdom and counsel, my project work would have not been possible.

I owe a great debt to Dr Tarun Chaudhary, Dr indra gupta, Ms Nalini Khatri and Mr Hemendra for showing their interest and sharing their valuable views inspite of their busy schedule. It has been my privilege to work under their dynamic supervision.

I am highly grateful to all the departmental heads and staff of National Health Mission, Rajasthan for giving us time inspite of their hectic schedule. Without their active cooperation and participation it would not have been possible to accomplish my task.

# ACRONYMS

| S. No. | ACRONYMS | FULL FORM |
|---|---|---|
| 1. | MMR | Maternal mortality ratio |
| 2. | ANM | Auxillary nurse midwife |
| 3. | ASHA | Accredited social health activist |
| 4. | HRP | High risk pregnancy |
| 5. | PHC | Primary health centre |
| 6. | CHC | Community health centre |
| 7. | JSY | Janani suraksha yojna |
| 8. | SLY | Shubha laxmi yojna |
| 9. | KMK | Kushal mangal karyakram |
| 10. | SMD | Safe motherhood day |
| 11. | MDR | Maternal death review |
| 12. | BMNO | Block medical nodal officer |
| 13. | Hb | Haemoglobin |
| 14. | AIDS | Acquired immune deficiency syndrome |
| 15. | IFA | Iron folic acid |
| 16. | AWW | Anganwadi workers |

# PREFACE

Summer training is an integral part of the PGDHM curriculum. As a part of the course , students of first year are required to undergo summer placement at any reputed organization to get in depth exposure of various departments in the organization and better understanding of the health care delivery system and its functions.

The major objectives of the summer training programme are as follows:

1. To better understand the existing health delivery system including public and private sectors.
2. To observe the implementation of various national health components at national/state/district levels.
3. To understand various functions of health system by interactions with key stakeholders, policy makers, programme managers, academicians and researchers.
4. To work on the project/task assigned by summer training organization.

During our training period we had an overview of various components undertaken in national rural health mission, Rajasthan including the current status of the components and our observations regarding the same. We also carried out a small study on the different topics assigned to us.

**About Rajasthan:**

The Total Fertility Rate of the State is 3.1. The Infant Mortality Rate is 47 and Maternal Mortality Ratio is 244 (SRS 2011 - 2013) which are higher than the National average. The Sex Ratio in the State is 928 (as compared to 943 for the country). Comparative figures of major health and demographic indicators are as follows:

**Demographic, Socio-economic and Health profile of Rajasthan State as compared to India figures**

| Item | Rajasthan | India |
|---|---|---|
| **Total Population (Census 2011) (In Crore)** | 6.86 | 121.01 |
| **Decadal Growth (%) (Census 2011)** | 21.44 | 17.64 |
| **Crude Birth Rate ( SRS 2013)** | 25.6 | 21.4 |
| **Crude Death Rate ( SRS 2013)** | 6.5 | 7 |
| **Natural Growth Rate ( SRS 2013)** | 19.1 | 14.4 |
| **Infant Mortality Rate ( SRS 2013)** | 47 | 40 |
| **Maternal Mortality Rate (SRS 2011-13)** | 244 | 167 |
| **Total Fertility Rate (SRS 2013)** | 2.8 | 2.3 |
| **Sex Ratio (Census 2011)** | 928 | 943 |
| **Child Sex Ratio (Census 2011)** | 883 | 914 |
| **Schedule Caste population (in crore) (Census 2001)** | 0.97 | 16.67 |
| **Schedule Tribe population (in crore) (Census 2001)** | 0.71 | 8.43 |
| **Total Literacy Rate (%) (Census 2011)** | 66.10 | 73.00 |
| **Male Literacy Rate (%) (Census 2011)** | 79.20 | 80.90 |
| **Female Literacy Rate (%) (Census 2011)** | 52.10 | 64.60 |


**Health Infrastructure of Rajasthan**

| Particulars | Required | In position | shortfall |
|---|---|---|---|
| **Sub-centre** | 15172 | 11487 | 3685 |
| **Primary Health Centre** | 2326 | 1528 | 798 |
| **Community Health Centre** | 581 | 382 | 199 |
| **Health worker (Female)/ANM at Sub Centres & PHCs** | 13015 | 17638 | * |
| **Health Worker (Male) at Sub Centres** | 11487 | 1592 | 9895 |
| **Health Assistant (Female)/LHV at PHCs** | 1528 | 1420 | 108 |
| **Health Assistant (Male) at PHCs** | 1528 | 201 | 1327 |
| **Doctor at PHCs** | 1528 | 1755 | * |
| **Obstetricians & Gynaecologists at CHCs** | 382 | 14 | 368 |
| **Pediatricians at CHCs** | 382 | 11 | 371 |
| **Total specialists at CHCs** | 1528 | 148 | 1380 |
| **Radiographers at CHCs** | 382 | 260 | 122 |
| **Pharmacist at PHCs & CHCs** | 1910 | 551 | 1359 |
| **Laboratory Technicians at PHCs & CHCs** | 1910 | 2639 | * |
| **Nursing Staff at PHCs & CHCs** | 4202 | 11926 | * |

**About the organization**

The National Rural Health Mission (NRHM) was launched by the Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups.

The NRHM is basically a strategy for integrating ongoing vertical programmes of Health & Family Welfare and addressing issues related to the determinants of Health like Sanitation, Nutrition and Safe Drinking Water

NRHM seeks to provide effective health care to the rural population, especially the disadvantaged groups including women and children, by improving access, enabling community ownership and demand for services, strengthening public health systems for efficient service delivery, enhancing equity and accountability and promoting decentralization.

The NRHM covers the entire country, with special focus on 18 States where the challenge of strengthening poor public health systems and thereby improving key health indicators is the greatest.

The States of Uttar Pradesh, Uttaranchal, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Orissa Rajasthan, Himachal Pradesh, Jammu and Kashmir, Assam, Arunachal Pradesh, Manipur, Meghalaya, Nagaland, Mizoram, Sikkim and Tripura are covered under NRHM.

NRHM subsumes key national programmes, namely, the Reproductive and Child health II project (RCH II), the National Disease Control Programmes (NDCP) and the Integrated Disease Surveillance Project (IDSP).

**Core strategies of NRHM**

- The core strategies of NRHM include
- decentralized village and district level health planning and management.
- appointment of Accredited Social Health Activist (ASHA) to facilitate access to health services.
- strengthening the public health service delivery infrastructure particularly at village primary and secondary levels.
- mainstreaming AYUSH.

- improved management capacity

- to organize health systems and services in public health.
- emphasizing evidence based planning and implementation through improved capacity and infrastructure.
- promoting the non-profit sector to increase social participation and community empowerment.
- promoting healthy behaviours and improving intersectoral convergence.

**The supplementary strategies of NRHM include**

- regulation of the private sector to improve equity and reduce out of pocket expenses.
- foster public-private partnerships to meet national public health goals.
- reorienting medical education.
- introduction of effective risk pooling mechanisms and social insurance to raise the health security of the poor and taking full advantage of local health traditions.

The Mission outcomes are expected to follow a phased approach and are at two levels:

**1. National Level**

• Infant Mortality Rate to he reduced to 30/1000 live births.

• Maternal Mortality Ratio to be reduced to 100/100,000.

• Total Fertility Rate to be brought to 2.1.

• Malaria mortality reduction rate -50% up to 2010, additional 10% by 2012.

• Kala Azar to be el iniinated by 2010.

• Filaria/Microfilaria reduction rate: 70% by 2010, 80% by 2012 and elimination by 2015.

• Dengue mortality reduction rate: 50% by 2010 and sustaining at that level

until 2012.

• Japanese Encephalitis mortality reduction rate: 50% by 2010 and sustaining at that level until 2012.

- Cataract Operation: increasing to 46 lakh per year until 2012.
- Leprosy prevalence rate: to be brought to less than 1/10,000.
- Tuberculosis DOTS services: from the current rate of 1.8/10,000, 85% cure rate to be maintained through the entire Mission period.
- 2000 Community Health Centers to be upgraded to Indian Public Health Standards.
- Utilization of First Referral Units to be increased from less than 20% to 75%.
- 250,000 women to be engaged in 18 states as Accredited Social Health Activists (ASHA).

**2. Community Level**

- Availability of trained community level worker at village level, with a drug kit for generic ailments.
- Health Day at Anganwadi level on a fixed day/month for provision of immunization, ante/post natal checkups and services related to mother & child healthcare, including nutrition.
- Availability of generic drugs for common ailments at Sub-centre and hospital level.
- Good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level.
- Improved access to Universal Immunization through induction of Auto Disabled Syringes, alternate vaccine delivery and improved mobilization

services under the programme

- Improved facilities for institutional deliver}' through provision of referral, transport, escort and improved hospital care subsidized under the Janani Suraksha Yojana (JSY) for the Below Poverty Line families.
- Availability of assured healthcare at reduced financial risk through pilots of Community Health Insurance under the Mission.
- Provision of household toilets.
- Improved Outreach services through mobile medical unit at district-level.

# PROJECT

# Study on impact of Kushal mangal programme with special focus on safe motherhood day

**Introduction**

Every year many women die due to the complications during pregnancy and child birth. Indian maternal mortality rate is reduced from 212 deaths per 100000 live births in 2007 to 178 deaths in 2012. The advance is largely due to key government interventions , a nationwide scaleup of emergency referral systems and maternal death audits and improvements in the governance and management of health services at all levels.

However adolescent and illiterate mothers and those living in hard to reach areas still have much greater chances of dying during child birth. Most maternal death occur due to haemorrhage, sepsis, toxemia, obstructive labour and unsafe abortions.

Efforts have been made to reduce maternal mortality and morbidity. National health mission has been launched with the vision to reduce the mortality by improving the quality of care in the public health institutions. After the advent of NRHM a lot of innovations have been designed nationally and by the states for combating the mortality.

Many steps have been taken by the govt of rajasthan to reduce the maternal mortality. Kushal mangal programme is one of such programme running in the state which focuses on high risk groups.

The health department had launched Kushal Mangal Karyakram (KMK) in July 2015 as an effort to achieve the millennium development goal of reducing MMR. Under the new scheme, the health department identifies high risk pregnancies. The KMK has been launched with an aim to address 1.9 lakh pregnancies every year. Women who are anaemic, suffering from high blood pressure are being categorized under high risk pregnancies by the department.

As per the programme a system is developed to identify high-risk pregnancies. After identification, they are referred to higher centres. The health department officials conduct follow-ups and keep tracking high-risk pregnant women. They are encouraged for institutional deliveries. The health department officials hope that the effort would bring down MMR in the state significantly. Millennium development goal, MMR should be brought down to 181 deaths over one lakh deliveries.

## High-Risk Pregnancy

### Definition

A high risk pregnancy is one in which some condition puts the mother, the developing fetus, or both at higher-than-normal risk for complications during or after the pregnancy and birth.

There are various factors

- severe anaemia i.e HB less than 7gm. %
- High blood pressure, pre eclampsia and eclampsia
- Height less than 140 cm
- Bad obstetric history
- Pregnancy before the age of 18 and after the age of 35
- History of PPH
- Medical conditions such as diabetes, kidney diseases, heart diseases etc.
- Multiple pregnancy
- Abnormally placed foetus
- History of foetal malformation
- Prior preterm delivery

### Diagnosis

A woman with a high-risk pregnancy will need closer monitoring than the average pregnant woman. Such monitoring may include more frequent visits with the primary caregiver, tests to monitor the medical problem, blood tests to check the levels of medication, amniocentesis, serial ultrasound examination, and fetal monitoring. These tests are designed to track the original condition, survey for complications, verify that the fetus is growing adequately, and make decisions regarding whether labor may need to be induced to allow for early delivery of the fetus.

**Treatment**

Treatment varies widely with the type of disease, the effect that pregnancy has on the disease, and the effect that the disease has on pregnancy. Additional tests may help determine the need for changes in medication or additional treatment.

Prognosis

The prognosis depends in large part on the specific medical condition. Some medical conditions make it difficult to get pregnant and lead to a higher risk of problems in the baby. An example of this type of condition is thyroid disease. In thyroid disease, the thyroid gland (located in the neck) may produce too much or too little thyroid hormone. Abnormal levels of thyroid hormone can cause problems in pregnancy and affect the health of the baby. Fortunately, thyroid disease can be treated with medication. As long as the level of thyroid hormone is controlled throughout pregnancy, there should be no problems for mother or baby.

There are many medical conditions that usually do not interfere with pregnancy, but are themselves affected by pregnancy. This group includes asthma, epilepsy, and ulcerative colitis. For example, some women with ulcerative colitis experience a worsening of their symptoms during pregnancy, while others will have no change or may get better during pregnancy. The same is true of asthma; some women notice that their asthma symptoms are better during pregnancy, some find their asthma worse, and some women notice no change in symptoms during pregnancy. No one understands why this is so, but due to this unpredictability, all women with chronic illnesses should be monitored carefully throughout pregnancy.

There is also a group of medical conditions that can have a major impact on pregnancy. Women with lupus (disease caused by alterations in the immune system that result in inflammation of connective tissue and organs) or kidney disease face real risks during pregnancy. Pregnancy can cause their symptoms to worsen significantly and can lead to serious illness. Because these diseases can affect the mother's ability to supply oxygen and nutrients to the baby through the placenta, they can cause problems for the baby as well. These babies may not be able to grow and gain weight properly (intrauterine growth retardation). There is also an increased risk of stillbirth.

Diabetes is a medical condition that is both affected by pregnancy and affects pregnancy. Diabetes can lead to miscarriages, birth defects, and stillbirths. When a woman monitors her blood sugar carefully and treats high levels with insulin, the risk of these negative outcomes drops a great deal. Unfortunately, pregnancy makes diabetes much harder to control. In general, blood sugar and the need for insulin to control it rise throughout pregnancy.

Most medical conditions do not lead to complications in pregnancy. With frequent visits to healthcare providers, and careful attention to medication, women with medical problems usually enjoy healthy, successful pregnancies. There are a few medical conditions that can cause health risks to both mother and baby during pregnancy. Women with these medical problems should consider these risks before deciding to become pregnant. Many of these women will benefit from the care of a perinatologist during pregnancy. Only rarely (in the case of severe heart disease, for example) are the risks to the mother so high that she should not consider pregnancy at all.

Prevention

A pre-pregnancy visit with a healthcare provider is especially important for a woman who has a medical problem. The doctor will discuss how women with this condition usually fare during pregnancy. For some diseases (such as lupus), pregnancy can mean increased risk of health problems for mother and baby.

Sometimes, the medication a woman needs to control a medical condition can cause problems for the baby. There may be another medication available that is safer for use in pregnancy. In some cases there is no other medication, and a woman must weigh the risks to the baby when deciding whether or not to become pregnant.

A woman who has not had a pre-pregnancy visit should contact a healthcare provider as soon as she learns she is pregnant. Often, the provider will schedule the first prenatal visit within a day or two, instead of waiting until eight to 10 weeks of pregnancy. This is because certain medical conditions can increase the risk of miscarriage. The provider will want to be sure that any medication is adjusted properly to increase the chance of having a successful pregnancy.

**Research question**

- What is the utilization of antenatal services in district sikar and Jaipur during SMD.

**Objectives of the study**

General objective

- To assess the utilization of antenatal services.

Specific objective

- To assess the antenatal services provided with a special focus on safe motherhood day.

**Methodology**

**Study design**- cross sectional retrospective study.

**Study area**-CHCs of district sikar, Jaipur 1 and Jaipur 2.

**Study population**- pregnant women in the age group between 15-49 years. ANM's ASHA's and CHC in-charge of the CHC's.

**Sampling and sample design**- non probability purposive sampling.

**Study duration**- from a period of two months.(april,may 2015)

**Sample size** – 54 pregnant women, 7 ANM's , 7ASHA's and 7 CHC in charge.

**Data collection tools**-semi structured questionnaire .

**Data collection technique**- face to face interviews and observations at the CHC's.

**Data collection procedure**- 7 CHC of district Jaipur and sikar were visited on safe motherhood day on scheduled Friday. All the pregnant women who came for the checkup were interviewed along with ANM's, ASHA's and CHC in-charge and functioning of safe motherhood day was observed.

**Data analysis**- simple descriptive statistics were used to analyze the data using Ms excel.

### Health facilities visited

In Jaipur

- Sanganer CHC
- Chaksu CHC
- Baskho CHC
- Chomu CHC
- Govindgarh CHC

In sikar

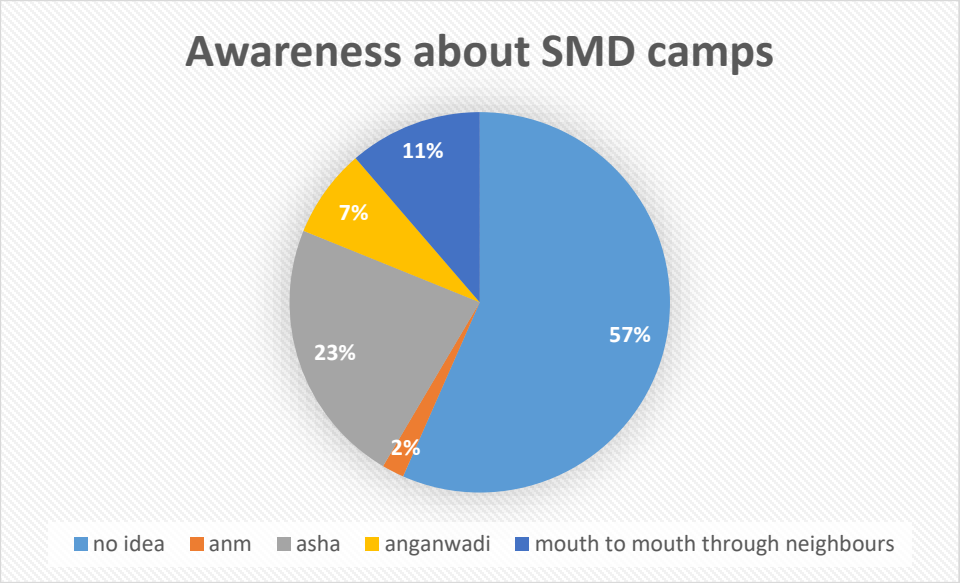
- Palsana CHC
- Reengus CHC

## Findings

### Awareness about safe motherhood camps

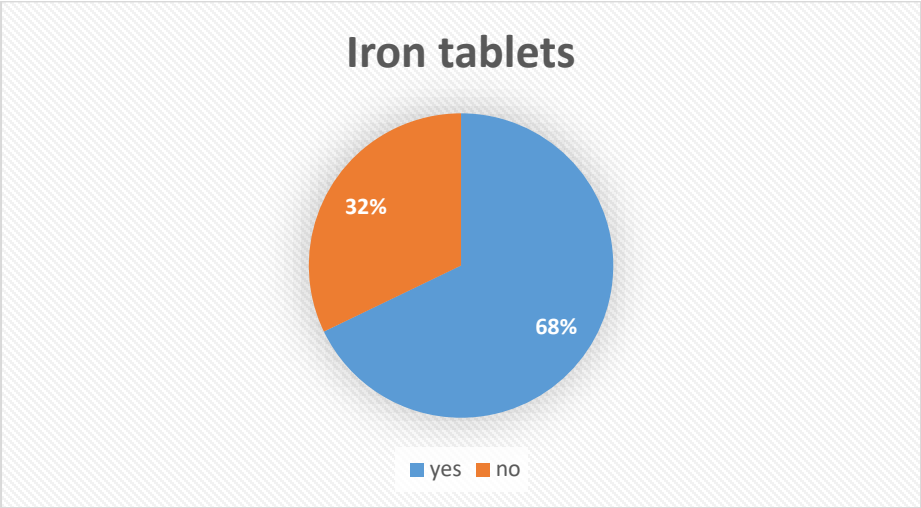
The data was collected by interviewing pregnant women about the awareness of safe motherhood day.

It was noticed that most of them, that is around 57% of the women were not aware about these camps. While 23% women had came to know about organization of these camps through ASHA workers of that area. And a minority of them had came to these camps through ANM's or through neighbours.



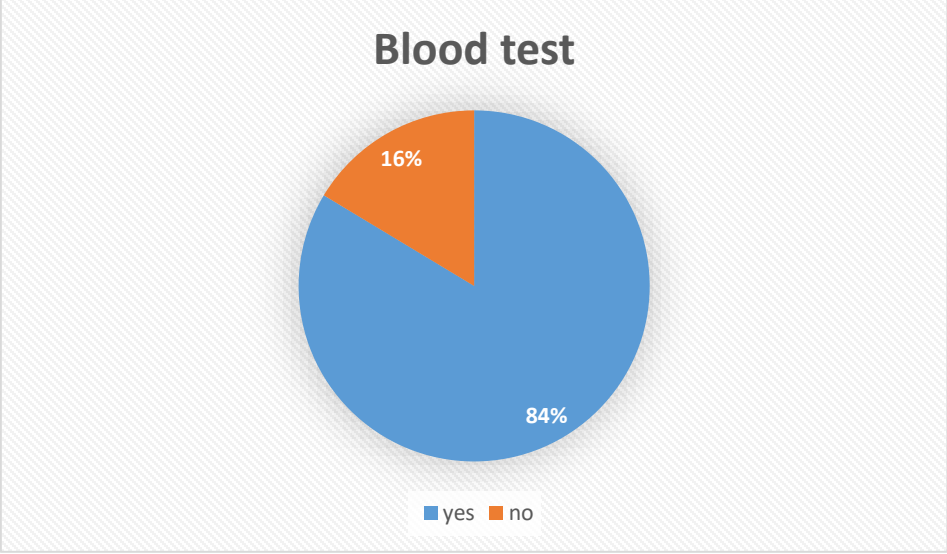
**Iron tablets**

Most of the women who came to the camp were taking iron tablets as advised by the gynecologist. While some of them came for the 1st time and some did not take tablets due to various reasons.




**Blood test**

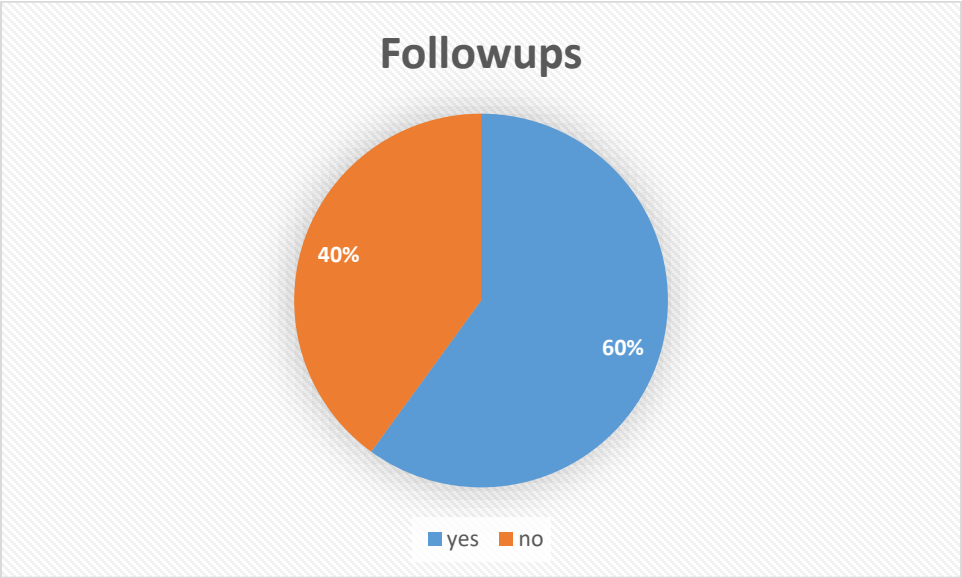
Most of the women that is around 84% had undergone blood test as advised. But some of them did not because they wanted the test done from some private labs because of trust issues with government facilities.



**Follow ups**

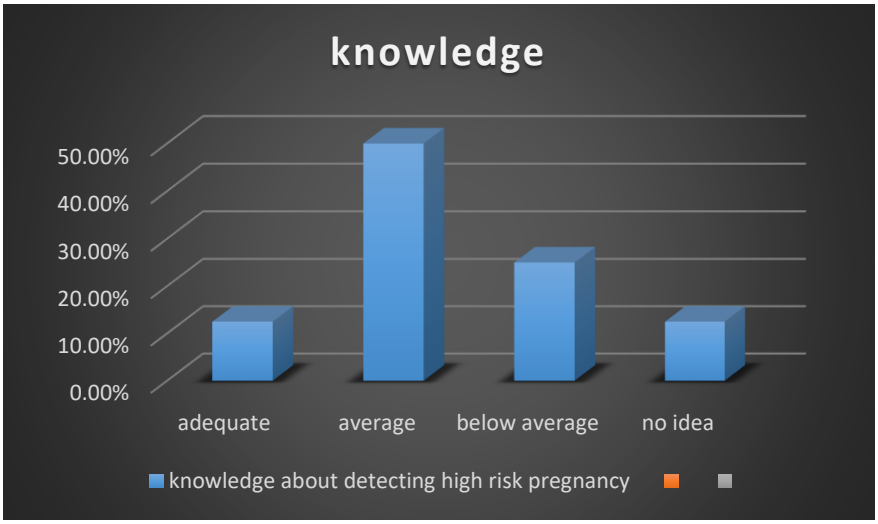
Around 60% of them were asked for the follow ups while rest were not.

Which shows that not all the women are properly treated and not given proper attention which is fairly necessary in high risk pregnancy groups.

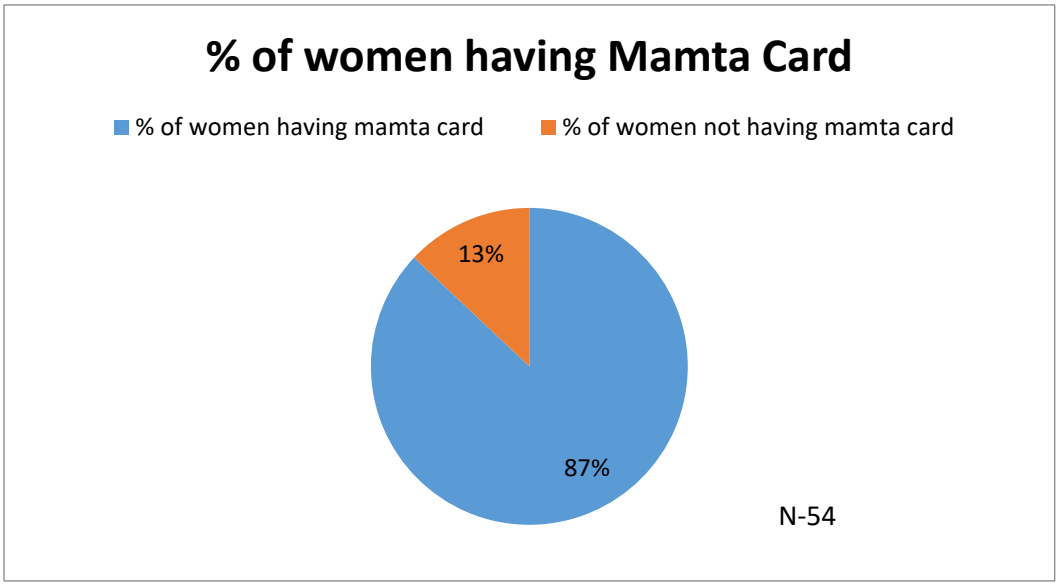



**About knowledge of detecting HRP**

While most of the ANM had knowledge about high risk pregnancy some of them were not aware about more than 2-3 criteria .



- Unavailability of the few basic amenities like carpet which was noticed in CHC chomu and sufficient number of chairs causes inconvenience to the HRP's. Inadequate sitting arrangement was the all-round observation in all the facilities visited. This limited availability even causes the hustle-bustle and unwanted confusion in the camp.
- Grueling and scorching summer heat, non working coolers which was noticed in CHC chomu and CHC govindgarh and frequent power cuts not only causes suffering for HRP's and their relatives but also causes job dissatisfaction among the health care providers which further reduces the serving standard of the care by them.
- Absence of few medical facilities like ambulance and the facility of sonography which are mandatory according to the guidelines of the camps were seen. This not only causes discomfort to the HRPs but also is unsafe because out of pocket expenditure in sonography and transportation of the HRP's to the higher centre will discourage the women to avail the proper diagnosis in appropriate time, causing already risky pregnancy even more dangerous.
- Few of the women were not even provided the Mamta card. Below is given the pie chart of the percentage of the women having mamta chart.




- After conducting the in depth interview of prospective mothers, it was determinedobserved only in those cases where it was their first pregnancy and

when they came for their first ANC. It clearly shows the nexus between the unawareness of the women and their first pregnancy.

**CONCLUSION**

- The anm and asha had a good knowledge about high risk pregnancy and were trained well for their part in the implementation of the program.
- People don't have knowledge of these camps so it hinders the success of these camps to some extent
- The IEC material for the camps are inadequate at most of the CHC's.
- The arrangements for the camps are not up to the mark.
- There is no proper counselling of the high risk pregnancy women.
- All the criteria for the detection of HRP are not taken into consideration.

## Recommendations

**Facility level**-

- The specialist should ask every HRP for follow up. Consistent monitoring of the HRP is a must.
- Scheduled Timings of the camps should mandatorily be followed.
- ANM/ASHA should be trained to measure blood pressure, hemoglobin etc so that they can identify the HRPs at a very early stage as they are the frontline health workers.
- A proper and safe transportation facility is required in all the CHC's conducting the camps for easy and early referral of the women to the higher facility.

**District/block level:**

- A streamlined and more structured monitoring at the block level is essential.
- An educative training for health care providers should be encouraged and planned on regular basis.
- Realignment of the procedures of identification of the HRP is must so that not even a single HRP go unnoticed.

Questionnaire

## SURAKSHIT MATRATV DIWAS

Questionnaire for ANM

Name –

Work place-

Contact no.-

1. Are you identifying all the pregnant women before 12 weeks i.e. in first trimester?
2. If No What are the reasons for not registering pregnant women?
3. Do you have HRP register?
4. Do you know how to identify HRP?
5. If yes how do you identify the HRP?
6. Do you escort HRP's to CHC for the follow up?
7. Are the following supplies available with you?

| | Availability | Functionality |
|---|---|---|
| Weighing scale | Yes/No | Yes/No |
| B.P machine | Yes/No | Yes/No |
| hb meter | Yes/No | Yes/No |
| Mamta card | Yes/No | Yes/No |

8. Do you think SMD camps are useful?
9. If Yes why and if no why?
10. What are the problems do you face in identification, Motivation and referral of High risk mother to CHC?

# SURAKSHIT MATRATV DIWAS

Questionnaire for ASHA

Name-

Work place-

Contact no-

1. Are you identifying all pregnant women before 12 weeks i.e.in first trimester?
2. If No what are the reasons for non identification of early pregnancies?
3. Are you entering every pregnant women in ASHA claim form?
4. Do you escort the HRP for the follow ups at CHC?
5. Do you think these camps are useful for high risk pregnant women?
6. After attending these camps do you think people of your area will go for institutional deliveries?

# SURAKSHIT MATRATV DIWAS

Questionnaire for Eligible Women

| |
|---|
| Name of the women- Age- |
| Husband's Name- |
| Address- |
| Contact no.- |

1. How many months pregnant are you?
2. Is it your first pregnancy?
3. How did you come to know about SMD camps?
4. How many of SMD camps have you attended?
5. Are you here with ASHA of your area?
6. Do you have your Mamta card?
7. Have you been asked for your Mamta card during your checkups?
8. Are you taking the iron tablets?
9. Have you ever undergone blood tests?
10. How many ultra sounds examination have you gone through?
    No/1/2/3/4
11. Where have you taken the ultrasound?
12. What was the cost of one sonography?
13. Are you given IV iron sucrose injection?
14. In how many days are you given the injections?
15. Are you being asked for the follow ups?
16. If yes are you coming?
17. If no why not?
18. Who is escorting you here?
19. Do you think privacy is maintained here?
20. How is the staff's behavior here?
21. Are you being provided by the proper information in understandable language?
22. Would you suggest visiting this camp to your relatives/friends?

# SURAKSHIT MATRATV DIWAS

Questionnaire for CHC Incharge

Name-

Designation-

Place of posting-

Contact number-

1. Are you conducting SMD camps every month on fixed day?
2. Footfall of the camps up to March?
3. Do you give the notification of the camps in the regional newspaper one week prior to the camp day?
4. What are your ways of publicity of the camps? Newspaper/Pamphlets distribution/Flex/Posters/ others
5. Are you using RMRS/untied Funds for promotion of these camps?
6. What are the timings of the camps?
7. Are you line listing the pregnant women who are at high risk?
8. And are you reporting the list to the block office and CMHO?
9. Do you always have specialists in the camps?
10. If No why?
11. Is the specialist from government or private sector?
12. If its from private sector how much are you paying to them for a day?
13. And what is the mode of their transportation?
14. Do you think SMD camps are useful?
15. What difficulties are you facing during organizing these camps?

# Online JSY and shubhalaxmi payment system

**Introduction**

OJAS is an online system which facilitates the user to capture beneficiary wise details of payment for JSY scheme and Shubhlaxmi Yojna, after due eligibility at CHC & above government health institutions. Online payment of JSY scheme and Shubhlaxmi Yojna to beneficiaries bank accounts and generate various kind of reports to monitor the progress of the programme and various health information's.

**Need felt for OJAS:-**

- JSY scheme was started in 2005, since beginning JSY payment is being paid by bearer cheque to the beneficiaries
- If the female child born, Shubhlaxmi Yojna's payment is also to be paid to beneficiaries.
- In the first phase of OJAS all MEDICAL COLLEGEs HOSPITALS/DH/SDH/SATTELITE HOSPITALs/CHC covering from 1st August 2015.
- For transparency payment online payment is required, on the same principal it is started in the state.

**Objectives of OJAS: -**

To ensure their timely and seamless online payment for JSY and Shubhlaxmi beneficiaries. The software popularly known "OJAS Software" has been conceptualized with following objectives:-

- On line payments for JSY and SLY
- To monitor the performance of each delivery including female child every day/ month.
- To identify the Gap area and need assessment at facility level as well as at community level.
- Timely and transparent payment for beneficiaries and system.

**Salient Features**

- "OJAS Software" is a web based system.
- This is the password protected system and run by the authorized user only.
- This system has been integrated with PCTS software. The master data base and users have been used for this system.

**The process flow of payment:-**

It is an unique initiative by NHM, Rajasthan. The software has been developed by NIC, Rajasthan state unit and the core group constituted by the Mission Director, NHM, Rajasthan. OJAS has been conceptualized and developed in a very short time span because of the keen interest shown by the authority to solve this major problem, which were being faced at grass root level. This online payment process has been implemented all over the state from 1 August 2015 at CHC and higher govt. health institutions. Various functionaries have been oriented for their responsibilities. Directions and circulars have been issued to States/Districts/Block/ PHC officials. Training for filling up the JSY claim forms J-1 , J-2 and J-3 has been done in all the districts up to CHC level and above level. For online payment, Bank of Baroda has been selected, which provides service without any additional charges.

**Advantages of OJAS**

- It would be possible to monitor the physical and financial progress under the programme.
- Simplification of payment system.
- No more multi-channel payment.
- Assessment of the health services provided at community level would be easier.

**Report now possible from OJAS**

- Thus, Rajasthan is the first state to start online payments of JSY and Shubhlaxmi scheme.
- Daily status of delivery at health institutes assessment is possible.

- Weight of baby can be watch at state level so to ensure follow up on LBWs babies.
- Hospital stay of delivered women can be watched.
- Daily ratio of birth of girl child can be watched at every institutes and district and state level.
- Modalities of referral transport can be watched.
- Death of women can be watched at stay in institutes.

**Way Forward...**

- Can be started up to PHC level soon.
- Time lag in payment to JSY and Shubhlaxmi would be further reduced.
- Second and third installments of Shubhlaxmi can be paid as assurance

**SLY (shubhalaxmi yojna)**

In order to check the maternal mortality ratio and and to encourage the birth of a female child this scheme was launched on 1st april 2013.

Under this scheme on or after 1st april 2013 if a female child is born in any Govt. Health Facility and accredited private hospital in JSY, the mother will be paid an amount of Rs 2100/- after her discharge. This amount will be in addition to the payment under the JSY scheme.

- After the completion of 1st year and all the scheduled vaccination to the child the mother will be paid an additional amount of Rs 2100/-.
- After the child is 5 years old and after she takes admission in a school the mother will be paid an additional amount of Rs 3100/-
- On the birth of the child the checque of Rs 2100/- will be given by the institution itself where the child is born.

**Janani Suraksha Yojana (JSY)**

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. The Yojana, launched on 12th April 2005, by the Hon'ble Prime Minister, is being implemented in all states and UTs with special focus on low performing states. JSY

is a 100 % centrally sponsored scheme and it integrates cash assistance with delivery and post-delivery care.

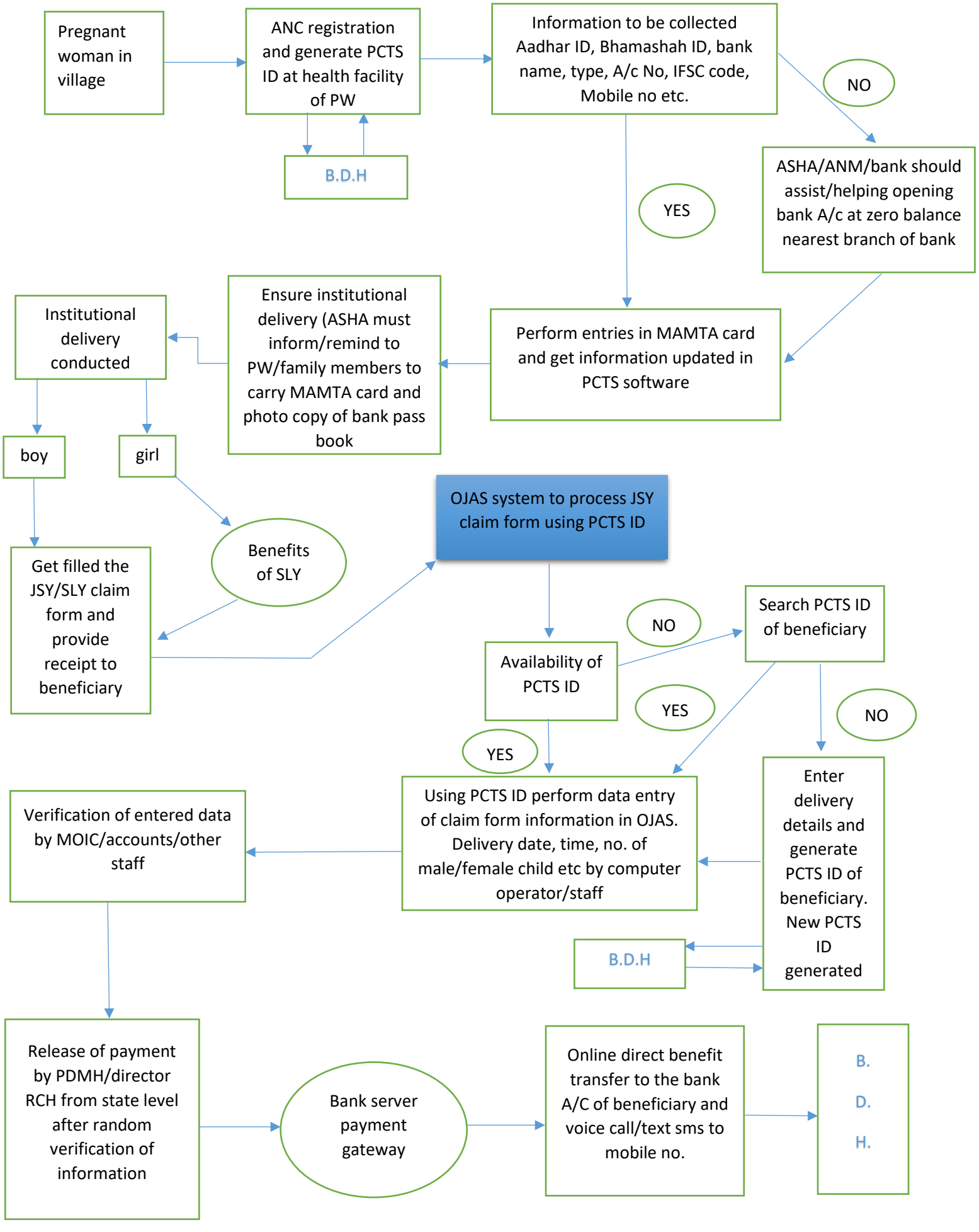
The Yojana has identified ASHA, the accredited social health activist as an effective link between the Government and the poor pregnant women in 10 low performing states, namely the 8 EAG states and Assam and J&K and the remaining NE States. In other eligible states and UTs, wherever, AWW ((Anganwadi workers )and TBAs or ASHA like activist has been engaged in this purpose, she can be associated with this Yojana for providing the services.

**Important Features of JSY:**

- The scheme focuses on the poor pregnant woman with special dispensation for states having low institutional delivery rates namely the states of Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa and Jammu and Kashmir. While these states have been named as Low Performing States (LPS), the remaining states have been named as High performing States (HPS).
- Tracking Each Pregnancy: Each beneficiary registered under this Yojana should have a JSY card along with a MCH card. ASHA/AWW/ any other identified link worker under the overall supervision of the ANM and the MO, PHC should mandatorily prepare a micro-birth plan. This will effectively help in monitoring Antenatal Check-up, and the post delivery care.
- Eligibility for Cash Assistance: BPL Certification – This is required in all HPS states. However, where BPL cards have not yet been issued or have not been updated, States/UTs would formulate a simple criterion for certification of poor and needy status of the expectant mother's family by empowering the gram pradhan or ward member.
- Disbursement of Cash Assistance: As the cash assistance to the mother is mainly to meet the cost of delivery, it should be disbursed effectively at the institution itself.

For pregnant women going to a public health institution for delivery, entire cash entitlement should be disbursed to her in one go, at the health institution. Considering

that some women would access accrediting private institution for antenatal care, they would require some financial support to get atleast 3 ANCs including the TT injections. In such cases, atleast three-fourth (3/4) of the cash assistance under JSY should be paid to the beneficiary in one go, importantly, at the time of delivery.

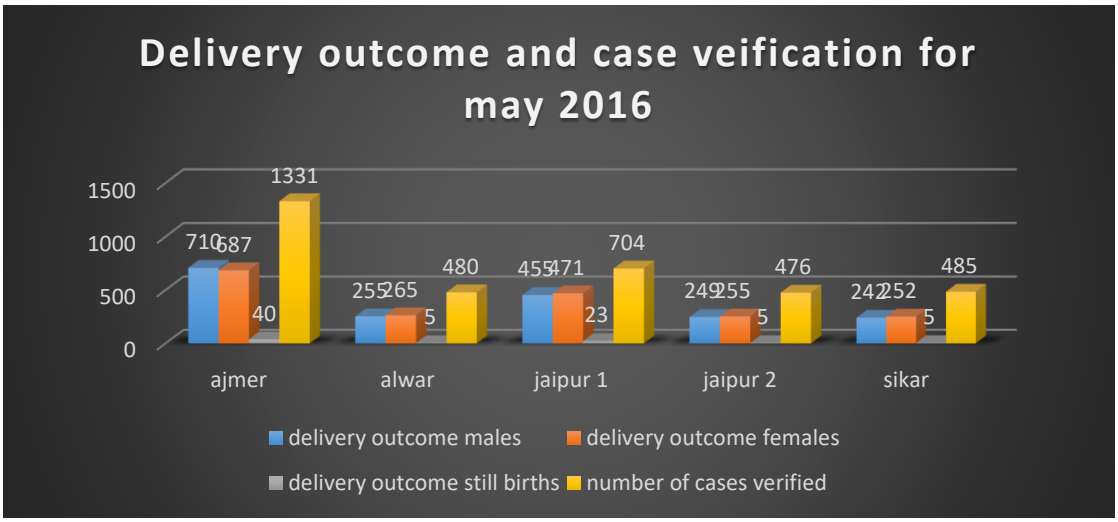

Pregnant woman in village
ANC registration and generate PCTS ID at health facility of PW
B.D.H
Information to be collected Aadhar ID, Bhamashah ID, bank name, type, A/c No, IFSC code, Mobile no etc.
NO
YES
ASHA/ANM/bank should assist/helping opening bank A/c at zero balance nearest branch of bank
Perform entries in MAMTA card and get information updated in PCTS software
Ensure institutional delivery (ASHA must inform/remind to PW/family members to carry MAMTA card and photo copy of bank pass book
Institutional delivery conducted
boy
girl
Benefits of SLY
Get filled the JSY/SLY claim form and provide receipt to beneficiary
OJAS system to process JSY claim form using PCTS ID
Availability of PCTS ID
NO
Search PCTS ID of beneficiary
YES
YES
NO
Using PCTS ID perform data entry of claim form information in OJAS. Delivery date, time, no. of male/female child etc by computer operator/staff
Enter delivery details and generate PCTS ID of beneficiary. New PCTS ID generated
B.D.H
Verification of entered data by MOIC/accounts/other staff
Release of payment by PDMH/director RCH from state level after random verification of information
Bank server payment gateway
Online direct benefit transfer to the bank A/C of beneficiary and voice call/text sms to mobile no.
B.
D.
H.

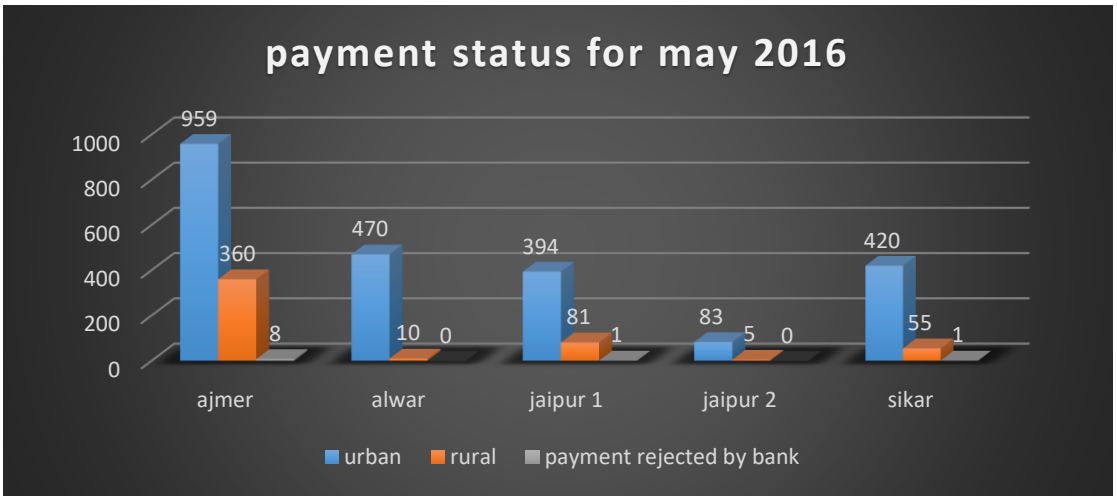
## Methodology

- **Research design –** research design for this study is quantitative research.
- **Data collection –** data type is secondary data.
- **Sampling unit-** all deliveries for the month of april and may 2016.
- **Study type-** retrospective and analytical.
- **Location-** district ajmer, alwar, Jaipur 1, Jaipur 2, sikar.

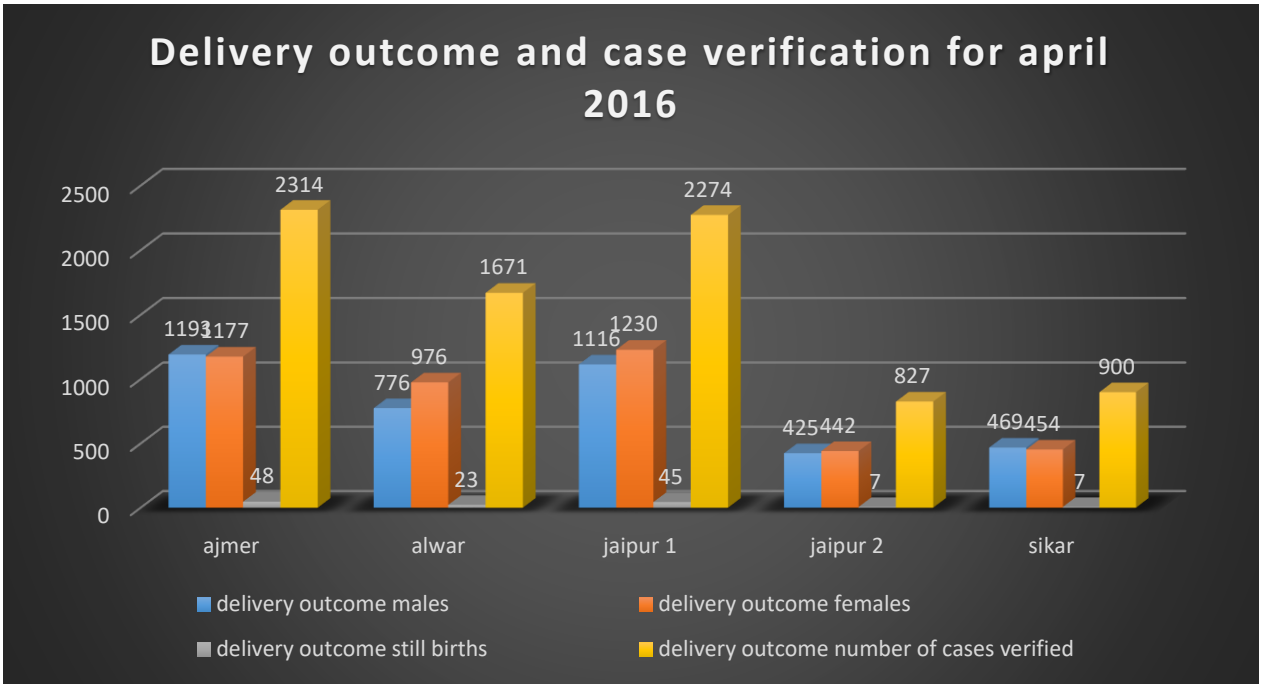
## Discharge and payment status for delivery cases of JSY

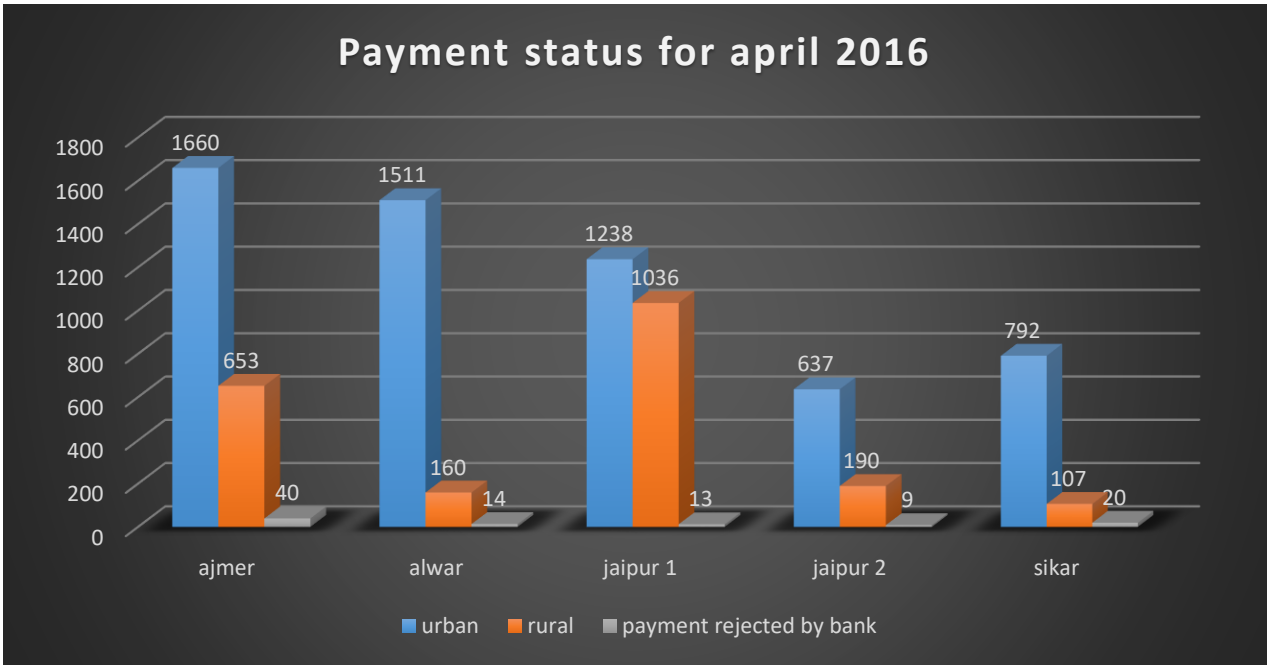
## Status of may 2016



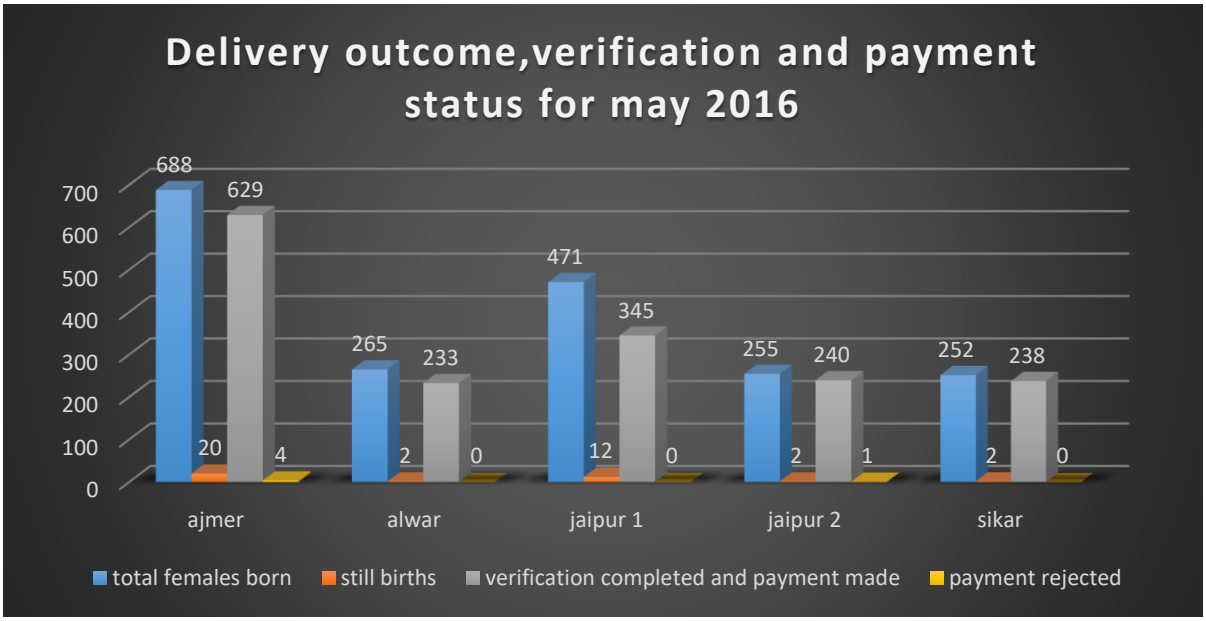



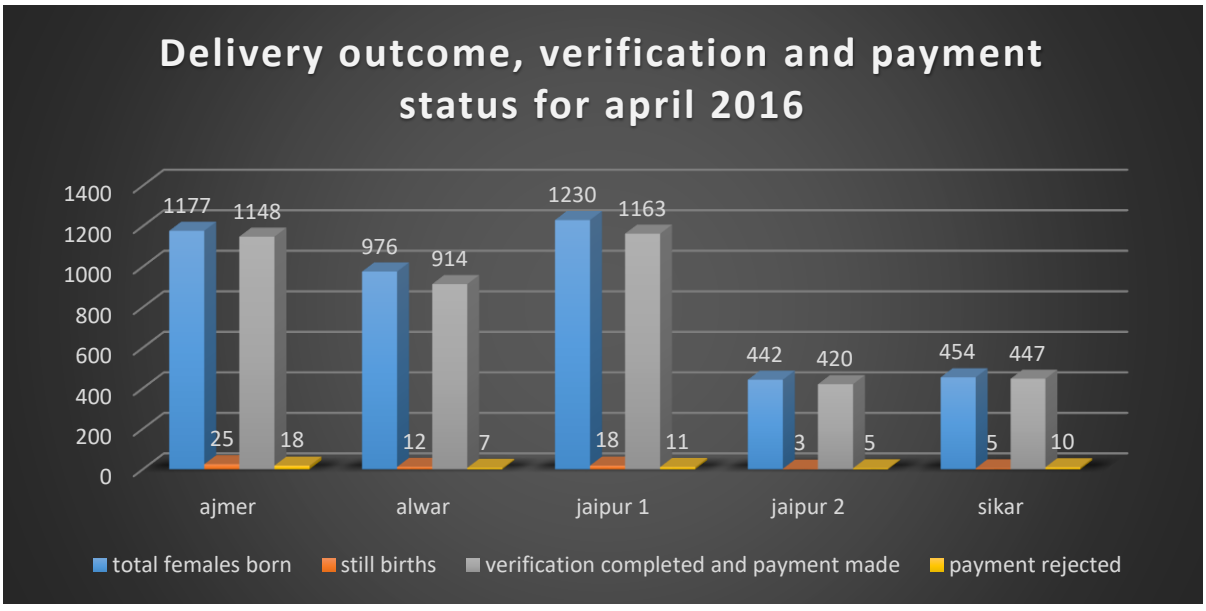
**For april 2016**



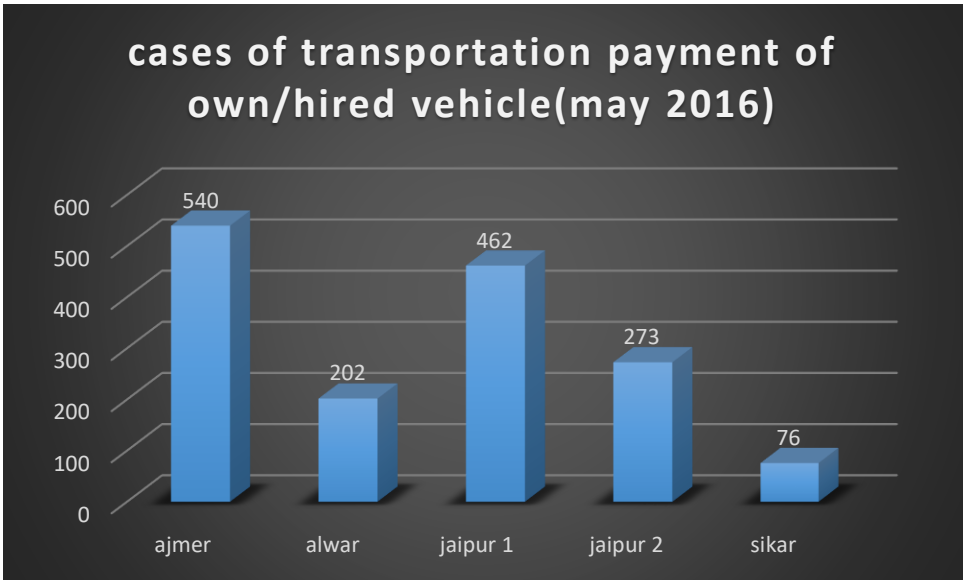



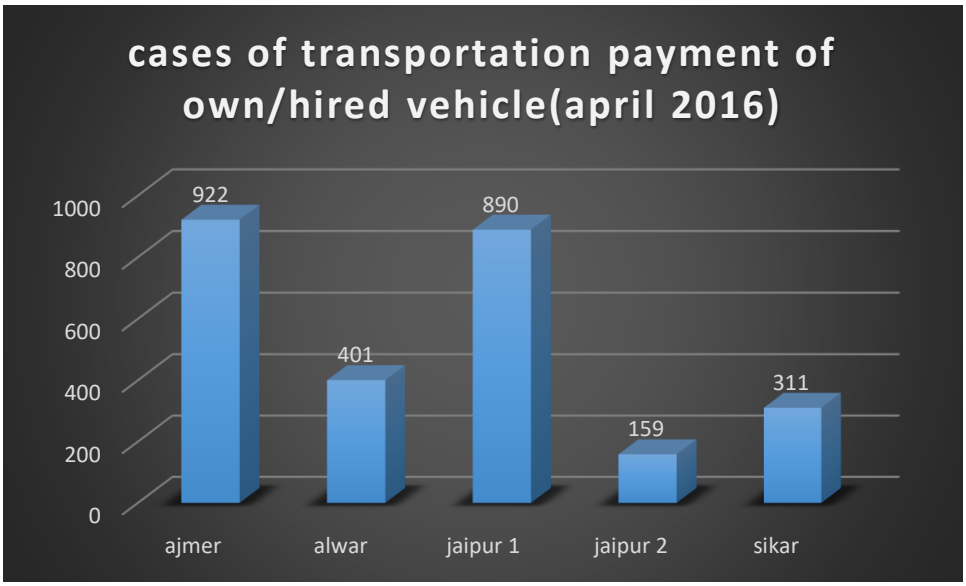
**Discharge and payment status for delivery cases of SLY**



**Case of transportation payment**



## Discussion

- In the month of may a total of 1426 cases were reported for the JSY scheme in the district of ajmer out of which 1331 cases were verified, that is around 93% cases were verified but verification could be completed of only 1319 cases. Out of which 959 cases were from urban areas and 360 were from rural areas and payment of 8 cases were rejected by bank.
- Similarly cases whose verification was completed for alwar, Jaipur 1, Jaipur 2 and sikar were 780, 704, 476 and 485 respectively.
- For the month of april 2314 cases were verified for the district of ajmer 1671 for alwar,2274 for Jaipur, 827 for Jaipur 2 and 900 cases for the district of sikar.
- Out of these cases more of the cases for urban population for which payment has been made.
- While few cases were rejected in the month of april also, that is 40 cases for ajmer district, 14 for alwar, 13 for Jaipur 1, 9 for Jaipur 2 and 20 cases for the district of sikar.
- For the SLY scheme in the month of april a total of 1149 cases were verified for the district of ajmer, 914 for alwar and so on.
- While most of the cases were verified and payment had been made some of them get rejected by bank also.
- Payment status for the transportation is as follows for the mont of april.
- 540 cases for the district of ajmer, 202 for alwar, 462 for Jaipur 1, 273 for Jaipur 2 and 76 for sikar.
- While in the month of may 922 for ajmer, 401 for alwar, 890 for Jaipur 1, 159 for Jaipur 2 and 311 cases for siakr were reported.
- From the data it is clearly visible that more of the people from urban areas are being given benefits of payment because the rural population is unaware of the scheme because of illiteracy.
- A lot of people go for the benefits of the scheme but many of them cant get the benefits because they do not opt for institutional deliveries which is mainly seen in rural areas.
- Another reason is that people from rural areas do not have bank accounts so they cant get the benefits of the scheme.

**Conclusion**

the payment through ojas is convenient and it directly goes to the beneficiary so it's a transparent system.

- If the operator commits a mistake during verification, it delays the payment to the beneficiary.but there are some challenges.
- Sometimes the entry gets duplicated.
- Some people do not have bank accounts.
- People in rural areas still do not go for institutional deliveries so they do not get the benefits of the scheme.
- Chances of error are there during the whole process.

**Recommendations**

- Data records should be properly maintained.
- People should be encouraged to have bank accounts.

# SRMD

# (social review of maternal death)

**INTRODUCTION**

India stands at third position among African and SEAR countries in maternal mortality figures which is 178 presently. As per AHS rajasthan has MMR of 208.

Maternal Death Review (MDR) as a strategy has been spelt out clearly in the RCH – II National Programme Implementation Plan document. It is an important strategy to improve the quality of obstetric care and reduce maternal mortality and morbidity. The importance of MDR lies in the fact that it provides detailed information on various factors at facility, district, community, regional and national level that are needed to be addressed to reduce maternal deaths. Analysis of these deaths can identify the delays that contribute to maternal deaths at various levels and the information used to adopt measures to fill the gaps in service. MDR has been conducted as an established intervention for the last few years by some states like Tamil Nadu, Kerala and West Bengal and Rajasthan.

Different approaches to investigation of maternal deaths

- Community based maternal death review(Verbal autopsy)
- Facility based maternal deaths review
- Confidential enquiries into maternal deaths
- Surveys of severe morbidity(near miss)
- Clinical audit

Government of India has decided to take up Community based maternal death review (CBMDR) and the Facility based maternal death review (FBMDR) which would help in identifying the gaps in the existing health care delivery systems, prioritize and plan for intervention strategies and to reconfigure health services.

Steps of community-based MDR Notification The ASHA/AWW/ANM will notify all women deaths in the age group of 15 to 49 years from her area by telephone to 104/E-mitra within 24 hour. The local panchayats and other relevant persons/ groups may also be encouraged to inform the 104/E-mitra about female deaths in their area. The ASHA/AWW/ANM will fill up the format for primary informer for all women's deaths (age 15-49) and send the format to the BCMO within 24 hours. Format for primary informer gives information whether the death is maternal or not. Line listing of maternal deaths should be submitted to the BMO by the ASHA, by the 5th of every month. In case no death has occurred during the month, the ASHA has to submit a nil report. The ASHA/AWW/ANM should also ensure the availability of the respondents during the visit of the investigation team. Investigation of the maternal deaths will be done using Verbal Autopsy Format). Narration on the various events which led to the death of the woman,

should be explained in detail.The BMNO is overall responsible for the MD review process at the block and will act as a supervisor for the investigation team. Responsibilities: Appoint the ANM/LHV to visit the family of the deceased to verify whether or not it is a maternal or non- maternal death, after receiving from the notifier. Report suspected maternal deaths to the state nodal officer by telephone within 24 hours Maintain registers of all women deaths (15-49 yrs) & maternal deaths Assigns interview team to investigate and fills the first page of the Format for Verbal Autopsy. The cause of the death can be filled based on the findings after the investigation. In his absence, he may nominate another medical officer from the block PHC to be a part of the team.

Scrutinize filled up forms to ensure the form is complete and filled correctly. Prepare Case summary for all the maternal deaths in consultation with the team which investigated and send it to the DNO along with the filled in investigation format, within a month of the date of notification. Conduct monthly meetings to review the whole process and take corrective actions at his level. Reporting system should be reviewed even if there are no cases in his block. The investigators could be the Block Medical Officer (BMO)/ other Medical Officers (MO), Lady Health Visitor(LHV), Block Public Health Nurse (BPHN), Sector Health Nurse, Health supervisor, Nurse tutor or Auxiliary Nurse Midwife (ANM). The investigating team should ideally comprise of 3 persons; one for conducting the interview, one for recording and the other to coordinate the process. The investigators must be properly trained to communicate with bereaved families.

Responsibilities: To investigate the maternal death using the format for Verbal Autopsy within 3 weeks of notification. Make sure all relevant information is captured during interview. If not, a follow up interview may be required. If needed, with another respondent. Assist the BMO in preparation of Case summary Hand over the filled up Format for Verbal Autopsy to the BMO for onward transmission to the District Nodal Officer (DNO) who will prepare a compiled Line Listing for Maternal Deaths of all maternal deaths from all blocks.

## Three types of delay

**1: Delay in decision to seek care due to;**

- The low status of women
- Poor understanding of complications and risk factors in pregnancy and when to seek medical help
- Previous poor experience of health care
- Acceptance of maternal death
- Financial implications

**2: Delay in reaching care due to;**

- Distance to health centres and hospitals
- Availability of and cost of transportation
- Poor roads and infrastructure
- Geography e.g. mountainous terrain, rivers

3:**Delay in receiving adequate health care due to;**

Poor facilities and lack of medical supplies

- Inadequately trained and poorly motivated medical staff
- Inadequate referral systems

### How we use the Three Delays Model

As we begin work in a new area or country we carry out a detailed needs assessment to identify which of these delays are affecting women accessing safe maternal healthcare. Our programmes are tailored the specific needs of the area where we are working. In general we address the issues identified by the Three Delays Model by;

**1: Delay in decision to seek care**

Provide communities (men and women) with information on pregnancy, childbirth and newborn healthcare so they know when to seek medical help.

**2: Delay in reaching care/transport**

Improving access to healthcare with the provision of health centres in rural and remote areas as well as outreach healthcare workers visiting villages to provide care. build

waiting houses next to health centres for expectant mothers to stay in before their due date so when they go into labour assistance is on site. Provision of motorbike ambulances for mountainous terrain to improve access to health centres.

**3: Delay in receiving adequate health care/treatment**

Training local midwives who will remain in rural areas when qualified, training nurses, doctors and healthcare professionals to provide safe births now and for future generations. Ensuring health centres are suitably equipped to provide safe deliveries and improving referral systems between health centres and hospitals.

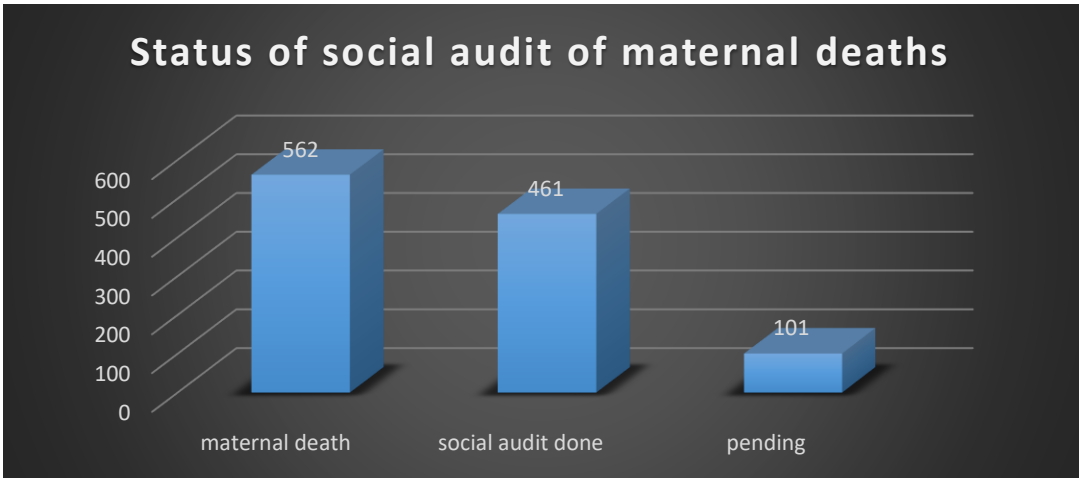
**Research Methodology**

- **Research design –** research design for this study is quantitative research.
- **Data collection –** data type is secondary data.
- **Sampling unit-** all maternal deaths since September 2014 for all the districts of Rajasthan.
- **Study type-** retrospective and analytical.
- **Location-** all districts of rajasthan.

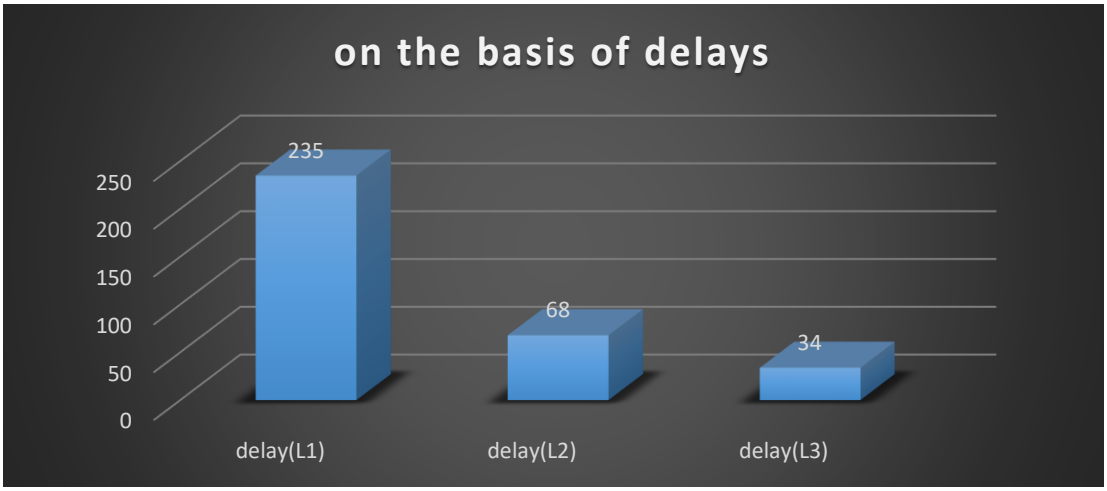
**Discussion**

A total of 562 maternal death were reported since sept 2014 to march 2016 in SRMD which covered all the districts of rajasthan.

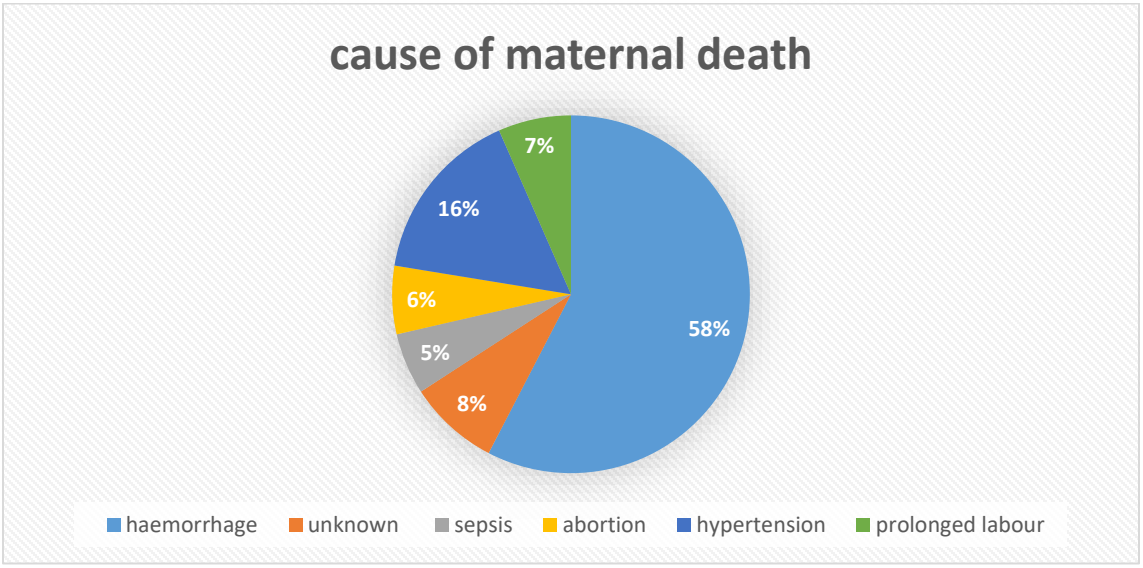
Out of 562 deaths, social audit of 461 deaths has was complete while social audit of 101 deaths was in process.



An assessment of the 3 delays was also done. It was found that the delay due to inability to make decision on time was highest with 235 maternal deaths. While delay due to lack of transport facility was the cause of 68 maternal deaths. So this data shows that the maternal deaths are majorly due to delay in takin the decision to seek the care by the family members.
While the second most common  delay is due to lack of transportation facility.




Maximum maternal deaths out of total were  due to  post partum haemorrhage which is around 58% followed by hypertension which is 16%.



**Observations**

- All social audits were be properly recorded with details like cause of death, past medical records etc.

**Recommendations**

- Plans to inferate ambulance services through MAS & steps of mass communication for knowledge change in behavior.
- To check whether HRP women participate in KMK, PND or not, takes IFA and covered under complete ANC or not.