Summer Training

At

MPTAST, Bhopal

(April – June, 2015)

Designing a research plan for assessment of Gram Arogya Kendra and Tool Designing For Rapid Assessment of Anganwadi Centers

By

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IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that Soumya Vyas student of MBA Hospital and Health Management (PGDHM) from The IIHMR University, Jaipur has undergone summer training at Madhya Pradesh Technical Assistance and Support team (MPTAST), FHI360 from April, 2015 to June, 2015.

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

I wish him all success in all his future endeavors.

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CERTIFICATE OF COMPLETION

This is to certify that Soumya Vyas, student of MBA in Healthcare Management from The IIHMR University, Jaipur has successfully completed her summer training during May, 2015 to June, 2015. During this time, she has also accomplished completion of the projects assigned to her which are as follows.

- Preparing a Research Proposal for the impact Assessment of Gram ArogyaKendras
- Designing a tool of Assessment of AnganwadiCenters

Her work has been found satisfactory and she comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning.

We wish her all the best for future endeavors.

Col. RanendraGoswami
Deputy Team Leader
HR/OD

Dr. S Krishnaswamy
Team Leader

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The opportunity to be incorporate in an education program that leads promotes thinking and allows a student to carry out a research in areas that are of significance in the health system and industry is a boon in itself. For this, I am sincerely thankful to the IIHMR University for the rich knowledge it has provided and the curriculum of which this study is a result of.

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Lastly, I am thankful to all the people at GAKs an Anganwadi Centres for their tremendous patience and helped complete the process.

Soumya Vyas

CONTENTS

Abbreviations

AHS	Annual Health Survey
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWH	Anganwadi Helper
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BCM	Block Community Mobilizer
BMO	Block Medical Officer
CDPO	Child Development Program Officer
CMHO	Chief Medical Health Officer
CUG	Closed User Group
DCM	District Community Mobilizer
DD	District Director
DHO	District Health Officer
DPMU	District Program Management Unit
DPO	District Program Officer
DRC	District Rehabilitation Centre
FGD	Focus Group Discussion
HIS	Health Information System
HNWASH	Health, Nutrition, Water & Sanitation
ICDS	Integrated Child Development Scheme
IDI	In Depth Interview
IEC	Information, Education, Communication
IFA	Iron Folic Acid
JD	Joint Director
KAP	Knowledge, Attitude and Perception
MCH	Mother and Child Health
MDG	Millennium Development Goal
MPW	Multipurpose Worker
MUAC	Mid-Upper Arm Circumference
NHM	National Health Mission
OIC	Officer in charge
ORS	Oral Rehydration Solution
PHC	Primary Health Centre
PNC	Post Natal Care
PPS	Proportion to Population Sampling
RBSK	Rashtriya Bal Swasthya Karyakram
SAM	Severe Acute Malnutrition
SHC	Sub Health Centre
SPMU	State Program Management Unit
THR	Take Home Ration

USHA	Urban Social Health Activist
VHND	Village Health and Nutrition Day

BACKGROUND

The quintessential idea of a health and a healthy community encompasses the reach of services and information to each and every individual. It is the right of all to access and duty to be aware of health provisions and their utilizations. The Department of Public Health and Family Welfare (DoPH&FW) has put in various interventions to ensure the above. Madhya Pradesh Technical Assistance and Support Team (MPTAST) is a Family Health International (FHI 360) supported set up that backs up Government of Madhya Pradesh by assisting in strengthening of such interventions. As a part of the community, being dutiful towards it and having chosen a career in healthcare management- gives rise to the need and opportunity of studying the aspects of the system with the purpose of in-depth knowledge and proposing an enhancement in processes. It is also a necessary to undertake this study to effectively complete a carefully designed curriculum by integrating the theories and practicalities. Practise of applying the gained knowledge and leaning about the functioning aspects is what paves the way towards evolving as an efficient professional.

With the aim of increasing awareness and involvement of community, ensuring proper delivery of health and nutrition services and converging health and ICDS, the DoPH&FW along with Department of Women and Child Development (DWCD) has initiated the establishment of Anganwadi-cum-Gram Arogya Kendra at village level.

Fulfilling the health needs of the community requires the assessment of current situation to pave way for according improvements. The objectives of the training were to gather understanding about the health systems and their functioning scope of the project was designed in accordance with the above. It is as follows:

- To prepare a research proposal for conducting an assessment of the established Gram Arogya Kendras in 14 districts across Madhya Pradesh.
- To prepare a tool to assess and analyse the condition and functioning of 50 anganwadi centers.

REVIEW OF LITERATURE

Madhya Pradesh is one of the poorest states in India, with over 54% of its population living below the poverty line. Despite progress in recent years, MP is currently off track on MDG 1, 4 and 5 (nutrition, maternal and child mortality). (UNDP, 2015)

MP has the highest infant mortality rate of all states in India, although it has declined from 76 to 56 infant deaths per 1000 live births over 2006 to 2012. A high maternal mortality ratio of 335 per 100,000 births in 2006 has now declined to 230 per 100,000 births in 2012: however it is much higher than the national average of 178 per 100,000 births. An estimated 160,000 mothers and children die every year because of easily preventable and treatable medical complications. More than half (58%) the children in MP are undernourished. Important contributors to under nutrition include access and availability of food, poor infant and child feeding and caring practices, poor sanitation and repeated diarrhoea. (NHM, 2015)

Indicators	2006	Progress
Maternal Mortality Ratio	335 per 100,000 births	230 (SRS 2010 -12)
Infant Mortality Rate	76 per 1000 live births	56 (SRS 2012)
Contraceptive Prevalence Rate	53%	59.3% (AHS 2012)
Under-weight children (0-5 year)	58%	52% (NIN 2011)
Deliveries taking place in health facilities	47%	79.7% (AHS 2012)
Children aged 12-23 months fully immunized	36%	59.7% (AHS 2012)
Children fully breast fed till 6 months of age	31%	39.7% (AHS 2012)

The performance of the public health delivery system faces several constraints: per capita expenditure of public health is low (at $8, against a global standard of $34 for a minimum package of essential healthcare) (DFID, 2014); high 'out of pocket' expenditures (on diagnostics and medicines); staff vacancies and infrastructure gaps; lack of drugs and other essential supplies at local levels; weak monitoring systems; poor accountability of health personnel, low motivation and management capacity.

GRAM AROGYA KENDRA

The 12th Five Year Plan for health builds on the achievements of the 11th Plan and takes forward the concept of Universal Health Coverage (UHC). The National Health Mission (with the components of the National Rural Health Mission and the National Urban Health Mission) seeks to improve the health of every Indian through various programs and strategies. It also recognizes that outcomes cannot be achieved without system strengthening measures. These include greater decentralization, strengthened community participation and ownership, as well as greater convergence of programs at the village level. (GoMP, Department of Planning, Economics and Statistics, 2015)

The Dept. of Public Health and Family Welfare of the Government of Madhya Pradesh implements various components of the NRHM throughout the state. The innovation brought in has been in actively promoting the convergence of health and ICDS and also in strengthening community ownership of programs at the village level. This is where the role of Anganwadi-cum- Gram Arogya Kendra (Village Health Centre) comes into play. (Directorate of Integrated Child Development Services, 2015)

The main objective in opening these health centres is to make the community aware of their health and environment, increase community ownership of village level programs, and ensure proper delivery of health and nutrition services through the involvement of, and supervision by the community.

Universal Health Coverage & Health Service Guarantee:

Gram Arogya Kendra as an establishment re-enforces the commitment of MP government to Universal Health Coverage. Provision of basic minimum health services at village level ensures that all who need health care can access it freely and reduces the burden of out of pocket expenditure on the people of last mile. Moreover through the HEALTH SERVICE GUARANTEE scheme Gram Arogya Kendras establish first layer of provision of health services through ASHA and ANM, which is further supervised by the sector supervisors and sector medical officers (Medical officer of the PHC of the area). (Directorate of Health Services, 2013)

The two main areas of focus of health services at GAK are – treatment of minor ailments and seasonal diseases and early referral for more serious illness; as well as health education towards a healthy lifestyle. It is also an initiative to improve convergence between the health and ICDS services at the village level.

Services by ANM	Services by ASHA
Conducting the VHND ANC & PNC services Tests (Hemoglobin, Urine Pregnancy test, Malaria test by RD kit, Urine albumin and Sugar test), Immunization	Dispensing medicines for minor ailments and seasonal diseases Maintaining village health register- Details of village health problems, target couples, pregnant mother, high risk mothers, births, deaths etc Meeting of adolescent girls & health counselling Meetings of Village health & sanitation committee / Gram Sabha Swasth Gram Tadarth Samiti

Services provision at GAK under Health for all:

Conducting VHNDs:

Gram Arogya Kendra is a place to conduct village health and nutrition day, which is held once a month in every village. ANM is the main driver for the VHND along with ASHA. Organisation of VHND includes ANC checkups, Immunization of children, Health and nutrition counselling of expectant mothers, distribution of IFA tablets, Tests for hemoglobin, malaria, Urine sugar & Albumin and treatment of minor health problems by the ANM. Establishment of Gram Arogya Kendra has been fruitful for smooth functioning of GAK as the ANM doesn't have to carry lot of equipment, drugs and consumables with her to the village as these are already available at the GAK. Moreover, the problems of privacy for ANC checkup and waiting area for the beneficiaries have been taken care of

Health services for children and treatment of seasonal illness:

GAKs are proving to be a very good platform to ensure timely availability of child health services. Apart from immunization and midday meals being provided at the Anaganwari to pre-school children, the village ASHA dispenses medicines like Albendazole to treat worms; demonstrates, prepares and provides ORS and Zinc to the children with Diarrohoea; helps early identification of pneumonia and dispenses antibiotics like Cotrimoxazole.

Moreover GAK serves as a center point for the villagers for any referral need including calling Janani Vehicles and 108, Emergency Ambulance. The ASHA keeps contact numbers of these vehicles.

The GAK is equipped with the following instruments and medicines to provide the above mentioned health services:

(Instruments have been procured from the untied fund of Rs. 10,000 which is with the Gram Sabha Swasth Gram Tadarth Samiti. This relieves the ANM of having to carry instruments, weighing machines and test kits to each VHND site.)

Instruments / equipment	Medicines / articles
Table and chair, bench	Paracetamol tablet 500 mg
ANC examination table, step for climbing	ORS packets
BP machine and stethoscope	Chloroquine tablets, 150 mg base
Infant weight machine	IFA tablets (adult, pediatric)
Child weighing machine (Salter, 25 kg)	Co-trimoxazole tablets
Adult weighing machine	Gentian violet solution
Thermometer	Zinc sulphate dispersible tablets
Fetoscope	Albendazole tablets 400 mg
Slides, lancets , Test tubes	Dicyclomine HCl tablets 10 mg
Rapid Diagnostic Kit- Malaria, Pregnancy test kit, Urine sugar & Albumin test strips	Povidone iodine solution
Hub cutter	
Torch	
Almirah	Cotton bandage
Stationery	Absorbent cotton
Waste bin	All vaccines with diluents (during VHND)
Drinking water container, tumblers, long handled mug	

Implementation of concept and monitoring system for GAKs

The Swasth Gram Prahari Dal :

A strong monitoring and supportive supervision mechanism is necessary to ensure effective delivery of village level health services. A special supervisory cadre, The "GRAM SWASTH PRAHARI DAL" is formed to ensure that the health services at the village level are delivered smoothly, effectively and in a quality manner through the Gram Arogya Kendras. This has enable the state to create "HEALTH SERVICE GUARANTEE" scheme.[1]

Composition of Swasth Gram Prahari Dal:

Sector Medical Officer: Convener

Male multipurpose health Supervisor: Member

LHV: Member

MPW: Member

ANM: Member

Administrative structure:

The Gram Swasth Prahari Dal is being established as first unit of monitoring in the health system of the state. The Prahari Dal is mandated to visit the villages in its sector for at least 08 days every month. For this the sector medical officer can hire a vehicle. This is the responsibility of BMO to ensure vehicle availability with the sector MO for sector visits.

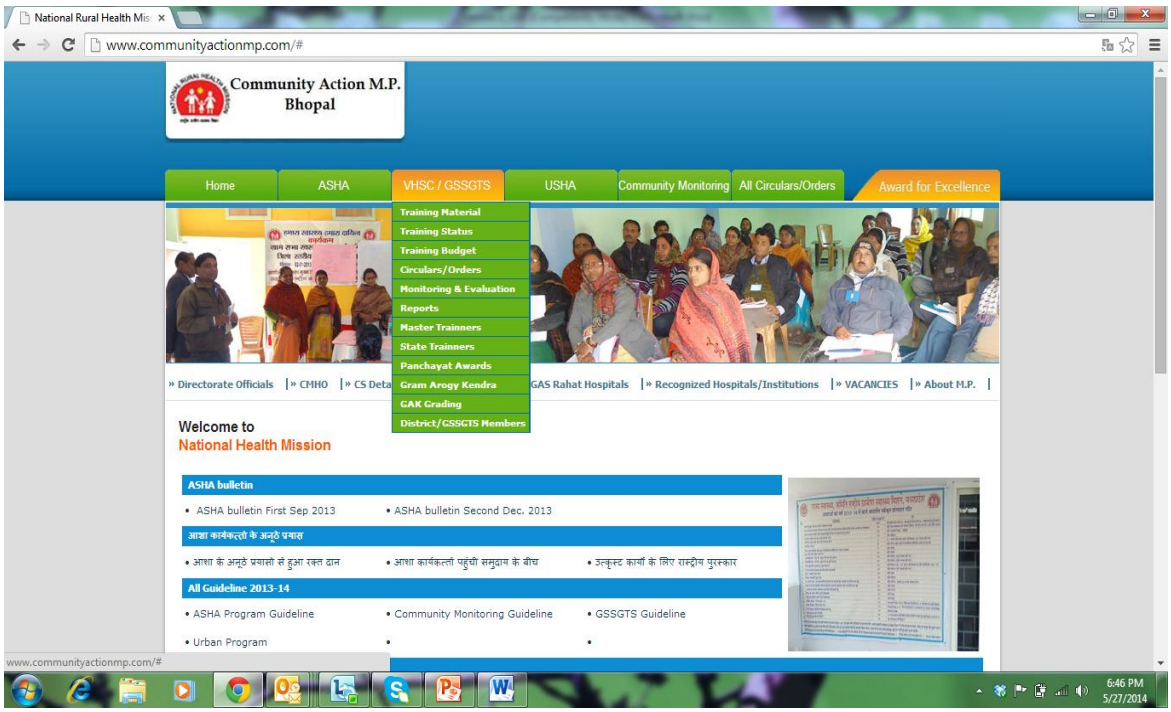
Roles and Responsibilities:

Gram Swasth Prahari Dal (GSPD) discusses and supervises the implementation of regular agenda of the GAK. It plays an important role in functionality of GAK for accessibility and monitoring of community based health services. Also it supports in preparing village level health plan. It guides the utilization of untied fund to VHSCs and SHCs, awareness among the community to prevent from seasonal diseases and focus on cleanliness. Sector MO and GSPD ensure coordination for providing quality health services. In association with BMO, the team identifies the SAM children and ensures health services in problematic areas.

GSPD is also responsible for selection of program themes, monitoring of IEC/ BCC activities and performance of local cultural hired groups. IEC activities are conducted on GSPD visit day. The team also organizes, implements and monitors community based training. VHSC reviews the work performance of ASHA, AWW and AWHs at GAK. GSPD checks and ensures the record keeping in village health register.

Software based monitoring:

A website has been developed by the state which tracks various activities being done at Gram Arogya Kendra along wih community monitoring and work of ASHA. The software is a web



based application and known as “Community Action” website.

Link to the website: http://www.communityactionmp.com/

The website tracks and displays all activities related to ASHA, Village health & sanitation committee (VHNSC)/ GSSGTS and Gram Arogya Kendra (GAK). A few of these are listed below:

- State directives and guidelines related to ASHA, USHA , VHNSC/GSSGTS and Gram Arogya Kendra
- Data base of AHSA and GAK
- Training details related to ASHA
- Incentive details to ASHA
- Gram Arogya Kendra Status/grading and status of essential commodities (district wise and block wise details)
- Various announcements/vacancies/orders from state about community monitoring / ASHA and Gram Arogya Kendra

Provision of CUG sim for all ASHAs in the state:

The state govt. has provided mobile numbers through CUG sim cards to all the ASHAs in the state. This initiative has been taken for regular, smooth and two way communication with the ASHAs working in all the villages. SMS based IEC and reminders are being sent to ASHAs for their routine work, periodic reports, celebrating various important days and following up with the action plans provided by their supervisors.

What Gram Aarogya Kendra does?

At present there are over 55,000 GAKs in the state. The functioning of the GAK is monitored by the health supervisors during field visits, and also by the sector medical officer. The functioning of ASHA and reporting of GAK functional status based on a standardized checklist is further supervised by Block community mobilizers (BCMs).

"Impact Assessment of Gram Arogya Kendra's management and functioning in rural areas of Madhya Pradesh".

Background

The Madhya Pradesh Health Sector Reform Programme (MPHSRP) supports Government of Madhya Pradesh (GoMP) in six key elements to improve equitable access to quality public healthcare services, accountability of staff, organisational development and human resource management, adequacy of financial allocation and effectiveness of expenditure, participation and regulation of the private sector and integrated service delivery to reduce malnutrition. To strengthen the capacity of GoMP namely the Department of Public Health and Family Welfare (DoPH&FW), Department of Women and Child Development (DWCD) and Public Health Engineering Department (PHED), the Family Health International (FHI 360) led consortium including WaterAid, is providing long term Technical Assistance to MPHSRP through MP Technical Assistance and Support Team (MPTAST). The goal of MPHSRP is to improve the health status of people in Madhya Pradesh – especially the poorest. The purpose is "increased use of quality health services, especially by the poorest people and in underserved areas".

The DoPH&FW along with the DWCD started a new initiative under the "Health for all" campaign to provide essential health and nutrition services at the village level through the establishment of "Anganwadi –cum-Gram Arogya Kendra" (GAK) in each village. Gram Arogya Kendra as an establishment re-enforces the commitment of MP government to Universal Health Coverage. Provision of basic minimum health services at village level ensures that all who need health care can access it freely and reduces the burden of out of pocket expenditure on the people of last mile. Gram Arogya Kendras have been envisaged as an extension of health services at the village level with trained frontline workers (ASHA/ANM/MPW), to provide basic health and nutrition services, able to understand basic health problems, render first-aid treatment, identify high risk symptoms for referral of pregnant women, sick as well as malnourished children and at the same time send alerts to the department if increased incidence of any disease or outbreaks /epidemics is noted.

The purpose of these health centres is also to make the community aware of their health and environment, increase community ownership of village level programs, and ensure proper delivery of health and nutrition services through the involvement of, and supervision by the community. Gram Arogya Kendras establish first layer of provision of health services through ASHA, MPW and ANM, which is further supervised by the sector supervisors and sector medical officers (Medical officer of the PHC of the area). It is also an initiative to improve convergence between the health and ICDS services at the village level.

Objectives of Gram Arogya Kendra

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

To provide the essential health and nutrition services to the community at the village level, state government has set-up 48,958 Gram Arogya Kendras since 2012 in Madhya Pradesh.

Purpose of the Impact Assessment

The Objective of the assessment is to assess the impact of Gram Arogya Kendras established to provide quality health services at village level in the state of Madhya Pradesh and identify strengths and gaps in the implementation, so that mid-course corrections can be made and the program suitably by modified for greater impact on maternal and child mortality in Madhya Pradesh.

Specific Objectives: Specific objectives of the Gram Arogya Kendras impact assessment are:

1. To assess the efficiency of Gram Arogya Kendras in delivering health services at community/village level.
2. To take stock of the existing health facilities at GAK level with regards to infrastructure, manpower; training, knowledge, skills and competencies of service providers, drugs & supplies, equipment's supportive supervision, reporting at GAK.
3. To assess the role of Gram Sabha Swasth Gram Tadarth Samiti in functioning of Gram Arogya Kendras.
4. To assess the level of convergence and coordination amongst ASHA, ANM, MPW(M) and AWW.
5. To assess the beneficiaries' satisfaction, perception on health care at the GAK and assess the level of KAP on health care and HNWASH among beneficiaries.
6. To suggest broad recommendations for further strengthening Gram Arogya Kendra strategy in Madhya Pradesh.

SCOPE OF WORK & DELIVERABLES

This section provide details on the each objectives, research questions, methodology and sample coverage, activities to be conducted under GAK assessment, time line and deliverables expected. Some of the broad **areas of enquire/research questions** that the GAK impact assessment will cover are listed below:

AssessmentObjective1:*To assess the efficiency of Gram Arogya Kendras in delivering health services at community/village level.*

a) What type and extent of health services provided by GAK and what type of services of SHCs taken up by GAKs?

b) Whether GAK helped in improving the reach of health services and improvement in health indicators at village level?

c) Whether GAKs provided first-aid treatment and identifying high risk symptoms for referral services?

d) Whether GAKs reduced the dependency on quacks?

e) Whether GAKs contributed in reduction of patient load of SHCs and PHCs and can it be a substitute for SHCs?

f) Whether GAKs reduced the time lag for pregnant women and ill children to reach health facilities?

g) Whether GAKs are efficient in managing disease outbreaks by identifying outbreaks and sending alerts/information to SHCs and PHCs?

h) Whether GAK regularly conducting VHNDs as envisaged?

AssessmentObjective2:*To take stock of the existing health facilities at GAK level with regards to infrastructure, manpower; training, knowledge, skills and competencies of service providers, drugs & supplies, equipment's supportive supervision, reporting at GAK.*

a) Whether the required infrastructure facilities like space for GAK, positioning of GAK, space for examination of patients (especially pregnant women), health check-up facilities etc. are available with GAKs?

b) Whether diagnostic, testing and treatment infrastructure are available with GAKs?

c) Whether sufficient drugs and supplies are available with GAKs and are regularly updated?

d) Whether service providers (ASHA, MPWs and ANM) have adequate training, knowledge, skills and competencies available to manage GAK?

e) Does ASHA have knowledge about all types of incentives and know how incentives can be maximized?

f) Whether Gram Swasth Prahari Dal (GSPD)/ ASHA Sahyogini / RBSK teams/ Sector Supervisors/ Block and district level officials providing supportive supervision regularly and resulted into improvement in skills and quality services?

g) Whether all registers and reports are maintained & timely update. Whether GAK also reduced the time lag for managing data from GAK to website entry?

AssessmentObjective3:*To assess the role of Gram Sabha Swasth Gram Tadarth Samiti (GSSGTS) in functioning of Gram Arogya Kendras.*

a) Whether GSSGTS members well trained and skilled on their role and responsibilities in health care?

b) Whether adequate support received of smaiti to GAK management and functioning?

c) Type and extent of support provided by the samite.

d) Do Samiti adopted any monitoring and review mechanism?

e) Whether the united fund utilized appropriately?

Assessment Objective 4: *To assess the level of convergence and coordination amongst GAK and AWC.*

a) Do both facilities coordinate during village micro-planning, identification of beneficiaries?

b) Do they coordinate for organizing VHND? Do they prepare dual list of beneficiaries jointly and mobilized them for VHND?

c) Do the relevant registers and information related to beneficiaries are matching with each other?

d) Do AWW, ASHA and ANM do coordination/review meeting for proper convergence and coordination and take action based on the meeting findings?

e) Have any process of joint review at supervisory cadre?

Assessment Objective 5: *To assess the beneficiaries' satisfaction, perception on health care at the GAK and assess the level of KAP on health care and HNWASH among beneficiaries.*

a) Whether the beneficiaries are satisfied with the services of GAK?

b) Whether beneficiaries are getting all village level health services, first-aid services, appropriate referral services and services of HSC at GAK level?

c) Do GAK is able to reduce dependency on quacks / Jhola Chhap doctors and medical stores?

d) Do services of GAK reduced the reaching/treatment time-lag of pregnant women and ill child at health centres?

e) Whether the level of knowledge, attitude and practices of beneficiaries changed on health issues due to GAK?

Assessment Objective 6: *To suggest broad recommendations for further strengthening Gram Arogya Kendra strategy in Madhya Pradesh.*

Submit a draft report which will include broad recommendations for mid-course correction for GAK functioning.

Assessment Framework

Sl. No.	Evaluation Objectives	Target Population	Evaluation Methodology	Key Research Questions	Key issues/indicators
1	*To assess the efficiency of Gram Arogya Kendras in delivering health services at community/village level*	GAK SHCs, State level SPMU/ OIC, JD Health and DD Program, M.O. in-charge, MHOs, DHO, DPMU, PO-MCH & Health, MPW, beneficiaries. BCM BMOs,	Both Qualitative and Quantitative Record and Register MIS data	What type and extent of health services provided by GAK and what type of services of SHCs taken up by GAKs?	• Registration of marriage, PW, Lactating mothers, Adolescent girls, Birth and death. • Maintaining and updating list of beneficiaries. • % of registered PW with five health checkup • % of registered children received complete immunization • % of GAKs providing health services to beneficiaries as envisaged in the guidelines. • % change in services provided by GAK before and after establishing GAK (reference period March 2012)
				Whether GAK helped in improving the reach of health services and indicators at village level?	% change in coverage, service delivery before and after establishing GAK (reference period March 2012) % change in key health performance indicators before and after establishing GAK (reference period March 2012)
				Whether GAKs provided first-aid treatment and identifying high risk symptoms for referral services?	• % of GAKs providing first-aid services and dispensing medicines for minor ailments and seasonal diseases. • % of GAK identifying high risk symptoms and referring to higher facilities.
				Whether GAKs reduced the	• % reduction of beneficiaries by type of disease who

				dependency on quacks?	are visiting quacks for first-aid, minor ailments and seasonal diseases.
				Whether GAKs contributed in reduction of patient load of SHCs and PHCs and can it be a substitute for SHCs?	• Change in % of patient load of GAK and HSC during last three year for different services. • % of GAKs are capable of being substituted for SHCs based on the types of services.
				Whether GAKs reduced the time lag for pregnant women and ill children to reach health facilities?	• Average time spent for to reach health facilities. • Distance of higher health facilities • Types of services available to GAK for transporting patient/beneficiaries to higher facilities.
				Whether GAKs are efficient in managing disease outbreaks by identifying outbreaks and sending alerts/information to SHCs and PHCs?	• % of GAKs have system for identifying disease outbreaks. • % of GAKs are sending alerts to SHCs and PHC by method of sending alerts. • % of GAK maintaining disease outbreak records, tracking the patients and compliance.
				Whether GAK regularly conducting VHNDs as envisaged?	• % of GAK preparing due list of beneficiaries, mobilizing beneficiaries for VHND. • % of beneficiaries participated in VHND. • % of GAK organized regular VHND. • % of GAK prepared with all logistic arrangements for VHND.
2	*To take stock of the existing health facilities at*	GAK SHCs,	Both Qualitative and Quantitative	Whether the required infrastructure facilities like space for GAK, positioning of GAK, space for examination of patients	• % of GAK have required space at AWC. • % of GAK have availability of health checkup facilities, space and equipment's. • % of GAKs have Kendra displayed board on AWC.

GAK level with regards to infrastructure, manpower; training, knowledge, skills and competencies of service providers, drugs & supplies, equipment's supportive supervision, reporting at GAK.	DPMU, PO-MCH & Health, MO, BMOs, M.O. in-charge, Asha Sahyogini ASHA, AWW, ANMs, MPW	Record and Register MIS data	(especially pregnant women), health check-up facilities etc. are available with GAKs?	• % of GAK have displayed required IEC materials.
			Whether diagnostic, testing and treatment infrastructure are available with GAKs?	• % of GAK have all required diagnostic and testing equipment and materials. • % of GAK have availability of required treatment facilities and drugs. • % of GAK service providers have required skill and expertise to do diagnostic testing and treatment.
			Whether sufficient drugs and supplies are available with GAKs and are regularly updated?	• Assured availability of drugs for 5 health checkup- and 16 drugs • % of GAKs maintained stock of essential diagnostic supply and drugs as per GAK requirements
			Whether service providers (ASHA, MPWs and ANM) have adequate training, knowledge, skills and competencies available to manage GAK?	• % of service providers have adequate training on managing GAK • % of service providers have adequate training on health services. • % of service providers have required training on diagnosis, testing and treatment. • % of service providers have taken training as provided time to time by Government.
			Does ASHA have knowledge about all types of incentives and know how incentives can be maximized?	• % of ASHA worker have knowledge of all types of incentives. • Priority of ASHA on preferred types of incentive activities. • Innovative ways adopted by ASHA to maximize incentives.

				Whether Gram Swasth Prahari Dal (GSPD)/ ASHA Sahyogini / RBSK teams/ Sector Supervisors/ Block and district level officials providing supportive supervision regularly and resulted into improvement in skills and quality services?	• % of GAKs visited by Gram Swasth Prahari Dal (GSPD)/ ASHA Sahyogini / RBSK teams/ Sector Supervisors/ Block and district level officials for supportive supervision. • % of GAK has benefited by supportive supervision and resulted into improvement in skills and quality services.
				Whether all registers and reports are maintained & timely update. Whether GAK also reduced the time lag for managing data from GAK to website entry?	• % of GAKs have updated and maintained records and registers by type of registers and records. • % of GAKs have matching information with SHC and AWC centers required information and data. • Average time spent of transferring data/information from GAK to web-entry. • % of GAKs have reduced time for managing data from GAK to website entry.
3	*To assess the role of Gram Sabha Swasth GramTadarth Samiti (GSSGTS) in functioning of Gram Arogya Kendras.*	*Gram Sabha Swasth Gram Tadarth Samiti,* *ASHA*	Qualitative	Whether GSSGTS members well trained and skilled on their role and responsibilities in health care?	• % of GSSGTS are functional. • Average size and composition of GSSGTS. • % of GSSGTS members trained and skilled on their role and responsibilities in health care
				Whether adequate support received of smaiti to GAK management and functioning? Type and extent of support provided by the samite.	• % of member providing support to GAK. • % of GAK who received support of GSSGTS by type of services. • % distribution of types of support provided by GSSGTS

			Do Samiti adopted any monitoring and review mechanism?	• % of GAK have any monitoring and review system by GSSGTS. • % of GSSGTS monitoring the GAK functioning and frequency of monitoring.
4	*To assess the level of convergence and coordination amongst GAK and AWC.*		Do both facilities coordinate during village micro-planning, identification of beneficiaries?	• % of GAKs and AWCs have made common micro-plan for health and nutrition services. • % of GAKs and AWCs have matching number of beneficiaries for relevant health and nutrition services.
			Do they coordinate for organizing VHND? Do they prepare dual list of beneficiaries jointly and mobilized them for VHND?	• % of GAKs and AWC coordinated for organizing VHND? • % of GAK & AWC made common due list of beneficiaries for VHND. •
			Do the relevant registers and information related to beneficiaries are matching with each other?	• % of GAK and AWC have matched relevant registers and information related to beneficiaries and VHND
			Do AWW, ASHA and ANM do coordination/review meeting for proper convergence and coordination and take action based on the meeting findings?	• % of GAK and AWC organize common coordination / review meeting. • % of GAK and AWC took common action on health issues. • % of GAK and AWC.
			Have any process of joint review at supervisory cadre?	• % of place where process of joint review at supervisory level is in place.
5	*To assess the*	Beneficia	Qualitative	Whether the beneficiaries are	• % of beneficiaries are satisfied with the various/all

beneficiaries' satisfaction, perception on health care at the GAK and assess the level of KAP on health care andHNWASH among beneficiaries.	ries	satisfied with the services of GAK?	services of GAK? • % of beneficiaries are satisfied with the coordination and behavior of service providers
		Whether beneficiaries are getting all village level health services, first-aid services, appropriate referral services and services of SHC at GAK level?	• % of types of beneficiaries are getting all village level health services, first-aid services, appropriate referral services and services of SHC at GAK level.
		Do GAK is able to reduce dependency on quacks / Jhola Chap doctors and medical stores?	• % distribution of beneficiaries by taking services from various service providers. • Reasons for selecting service providers.
		Do services of GAK reduced the reaching/treatment time-lag of pregnant women and ill child at health centers?	• Average time spent reduced of pregnant women and ill child for treatment and or getting services by type of disease or services.
		Whether the level of knowledge, attitude and practices of beneficiaries changed on health issues due to GAK?	• % change in knowledge, attitude and practices of beneficiaries changed on health issues due to GAK.

Research Methodology, Assessment Framework and sample design

A cross-sectional assessment using mixed methods approach will be used for conducting the Impact assessment. Mixed method approach will including qualitative, quantitative and review of existing documents, reports and registers.

- Quantitative data about the quality of health care services provided through GAK or the scale and distribution of GAK and SHC providing these services
- Qualitative data to provide an in-depth understanding of the perception and experiences of various actors including community members, beneficiaries and service providers towards quality health care services at GAK.
- The target population will include ASHA, AWW, ANM, MPW, beneficiaries, community leaders and Block (CHC and PHC) and District Officials.

Sampling

In order to achieve the objectives of the study, multi stage stratified random sampling design will be used. The best performing districts and High Priority districts (poor performing) from each division will be selected based on Under Five Child Mortality Rate (AHS) indicator. From each district two blocks (best, and poor performing) will be selected through systematic random sampling technique and from each block 5 GAKs will be selected from selected blocks using Proportion to Population method (PPS).

The Impact assessment will overall cover 14 districts, 28 Blocks, 140 SHCs and 140 Gram Arogya Kendras (GAKs). Under Qualitative section, 3 State Level Officials, 14 divisional level officers from each division will be selected for In-depth Interview. From Selected Districts 2 officials from each district (total 28 officials), 2 Block/CHC Officials from each Block/CHC (total 56 officials), 2 PHC level Officials (members of Gram Swasth Prahari Dal) from each PHC (Total 168 officials), approx. 140 AHSA Sahyogini, all ANMs of selected Sub-Health Centres (Approx. 140 ANM) and 140 ASHA, 140 MPW, 2 health samiti members (Total 280) and 5 beneficiaries from each GAK (Total 700) will be selected for In-depth Interview. (Total – 1809 respondents)

In the first stage 14 districts have been sampled from 7 divisions. Sampled districts are: 1. Raisen, 2. Betul, 3. Sheopur, 4. Gwalior, 5. Jhabua, 6. Dhar, 7. Katni, 8. Balaghat, 9. Satna, 10. Dindori, 11. Panna, 12. Tikamgarh, 13. Ratlam, and 14. Shajapur

Sampled districts for GAK impact assessment (Source: As per AHS)

Division	Districts	Rural Under 5 Mortality Rate
Bhopal	Raisen	95
	Betul	75
Gwalior	Sheopur	105
	Gwalior	77
Indore	Jhabua	90
	Dhar	67
Jabalpur	Katni	93
	Balaghat	72
Rewa	Satna	138
	Dindori	95
Sagar	Panna	132
	Tikamgarh	87
Ujjain	Ratlam	120
	Shajapur	82

Impact Assessment Tools

Both qualitative and quantitative data collection tools and techniques will be used. Data collection tools will be developed, pre tested, and administered. The information from the study districts were collected through GAK facility assessment tool, beneficiaries interview schedule, Gram Swasht Samiti IDIs, ASHAs, AWW, ANM, MPW and ASHA Sahyogini IDI tools. IDIs with MO I/Cs/HEOs, BCM of concerned block PHC/CHC, CMOs/DMs, DCM and ACMOs/Dy. CMOs and District Community Mobilizers will also covered.

Qualitative Survey

Key aim for this component of the study would be to understand the perception of various stakeholders on various issues related to health practices and services in the community. Barriers and challenges while receiving these services would also explored. Total 7 FGDs will be conducted in 7 divisions. Four with beneficiaries and 3 with service providers.

The below mentioned matrix describes the data collection will be required to carry out the impact assessment:

S. No.	Key Objective	Methodology	Sample No. of Interviews per round
1	To assess the efficiency of Gram Arogya Kendras in delivering health services at community/village level.	Both Quantitative and Qualitative	14 Districts 140 Gram Arogya Kendra and approx. 140 SHCs IDIs with Health Care Providers/Officials – • 3 State level SPMU • 14 JD Health and DD Program

			• 56 CMHOs, DHO, DCM, DPMU, PO-MCH & Health • 168 MO, BMOs, BCM M.O. in-charge, • Asha Sahyogini ASHA, AWW, ANMs, MPW – each 140 • 700 GAK service providers (Sahyogini, ASHA, AWW, ANM & MPW).
2	To take stock of the existing health facilities at GAK level with regards to infrastructure, manpower; training, knowledge, skills and competencies of service providers, drugs & supplies, equipment's supportive supervision, reporting at GAK.	Both Quantitative and Qualitative	As stated above in S. No. 1 Review of HMIS data for trend analysis on key service delivery parameters
3	To assess the role of Gram Sabha Swasth Gram Tadarth Samiti in functioning of Gram Arogya Kendras.	Qualitative	280 Gram Swasth Samit
4	To assess the level of convergence and coordination amongst ASHA, ANM, MPW and AWW.	Qualitative	• 14 JD Health and DD Program • 56 CMHOs, DHO, DPMU, PO-MCH & Health • 168 MO, BMOs, M.O. in-charge, • Asha Sahyogini ASHA, AWW, ANMs, MPW – each 140 • 700 GAK service providers (Sahyogini, ASHA, AWW, ANM & MPW).
5	To assess the beneficiaries' satisfaction, perception on health care at the GAK and assess the level of KAP on health care and HNWASH among beneficiaries.	Qualitative	700 Beneficiaries

Non-Research Determination

This is a non-research project as it will generate data to improve existing program and will not be generalizable. The basic purpose of the Assessment is to identify facilitators, barriers and challenges in implementing the GAK program and provide recommendations to strengthen the program in Madhya Pradesh. Data and knowledge generated will not extend beyond the scope of the activity; and project activities are non-experimental.

Conduct of the Impact Assessment

GAK impact assessment will be conducted in collaboration with NHM, FHI 360 and MPTAST by an in-house team. A research committee will be consisting of MPTAST and NHM officials representative. Technical supervision and support will be provided by the FHI360 India Country Office team. MPTAST team in consultation with NHM Officials will be developing protocol, ethical approval, development and finalization of tools after pilot testing, identification and training of field research team, conduct of field work, quality assurance, engagement of data agency, quality assurance of data entry, analysis and report preparation.

Quality assurance at district level: MPTAST team and ASHA resource cell will provide and oversea the monitoring and the quality of data collection. Proposed persons responsible for quality assurance at district level are:

Division	**Districts**	**Designation**
Bhopal	Raisen	DCM
	Betul	DCM
Gwalior	Sheopur	DCM
	Gwalior	ASHA Cell
Indore	Jhabua	DRC, ASHA Cell
	Dhar	DCM/ASHA Cell
Jabalpur	Katni	DRC
	Balaghat	ASHA Cell
Rewa	Satna	DRC
	Dindori	DRC
Sagar	Panna	DRC
	Tikamgarh	DRC
Ujjain	Ratlam	DCM
	Shajapur	ASHA Cell

Data collection through Field Investigators: Fourteen teams of field investigators will be engaged for data collection. Each team will consists of two field investigators, these field investigators will be hired by FHI 360/MPTAST in consultation with NHM and DFID. Field Investigators will have at-least post-graduation degree and one /two years of experience in similar type of work.

Training of field investigators will be conducted at any district location by the research committee members. Field investigators will receive 3 days training including one day hand on practice on Impact assessment tools.

Time Plan

Assessment Start Date: 1st May 2015

Assessment completion date: 31st July 2015

S. No.	Deliverables	Time Line (Weeks)											
		1	2	3	4	5	6	7	8	9	10	11	12
1	Project Initiation Note	■											
2	Translated Draft Tools		■										
3	Pilot testing of all tools and guidelines and its Report			■									
4	Final tools for Survey				■								
5	Final list of Interviewers and Supervisors				■								
6	Training Manuals				■								
7	Training of researchers					■							
8	Analysis plan					■							
9	Training Report					■	■	■	■	■			
10	Data collection					■	■	■	■	■			
11	Field work progress report					■	■	■	■	■			
12	Topline findings										■		
13	Draft report											■	
14	Final Report												■

The assessment of 50 anganwadi centres selected using simple random sampling across eight districts was carried out. Eight parameters were taken into consideration which were score graded.

The sample of the tool is given below:

Description	Name	Code
1	2	3
District		
Project		
Sector		
AWC		
DPO Name		
CDPO Name		
Supervisor name		
AWW Name		
Sahayogini name		
Panchayat Name		
Panchayat Pramukh		
Village name		
Health Sub-centre name		
ANM name		
Asha Name		

Description	Number	Remarks
0-6 months children		
6 to 3yrs children		
3 to 5yrs children		
6yrs children		
Pregnant women		
Lactating women		
Adoloscent girls		
Description	**Total Score**	**Score Obtained**
Infrastructure	300	
Supplimentary nutrition	80	
Growth monitoring	110	
Referal services	80	
Pre School Education	50	
IEC & Community mob.	55	
Attitude and Behaviour	60	
Record and M&E	70	
Total	805	

		AWW/helper house	0		
	Score			**10**	
I.2	Type of building	Pucca	5		
		Kuccha	2		
		Open Space	0		
	Score			**5**	
I.3	Location of AWC	Centre of Village	5		
		Any corner of the village	2		
		Outside village	0		
	Score			**5**	
I.4	Availability of land for AWC premises	More than 2000 sq. ft.	10		
		1000 to 2000 sq. ft.	6		
		500 to 1000 sq. ft.	4		
		Less than 500 sq. ft.	0		
	Score			**10**	
I.5	Availability of adequacy of outdoor space	More than 1000 Sq. ft.	10		
		500 to 1000 sq. ft.	3		
		200 to 500 sq. ft.	2		
		Less than200 sq. ft.	0		
	Score			**10**	
I.6	Availability of adequacy of indoor space	More than 1000 Sq. ft.	10		
		500 to 1000 sq. ft.	3		
		200 to 500 sq. ft.	2		
		Less than200 sq. ft.	0		
	Score			**10**	
I.7	Availability of Kitchen	Permanent	5		
		Temporary	2		
		No	0		
	Score			**5**	
I.8	Availability of Storage Space	Sufficient	5		
		Insufficient	2		
		No	0		
	Score			**5**	
I.9	Available of toilet	Child friendly	10		

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