

Summer Training Report

National Health Mission, Madhya Pradesh

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IIHMR University, Jaipur

Submitted by: Richa Banzal

MBA Health Management – Batch 19th

IIHMR University

Certificate

This is to certify that **Miss Richa Banzal** student of Institute of Health Management and Research, Jaipur, Rajasthan, has done her summer training on the topic “**Comparative Study of Rashtriya Bal Swasthya Karyakram Implementation in two districts of Madhya Pradesh**” at National Health Mission, Bhopal, Madhya Pradesh from 1st April 2015 to 31st May 2015. She has carried out the activities related to her summer training alone and her approach to study has been sincere, scientific and analytical.

This summer training project is in partial fulfillment of course requirements.

I wish her success in all her future endeavors.



Col. (Dr.) Ashok Kaushik

Dean (Academic & Student Affairs)

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Professor

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National Health Mission State Health Society

Arera Hills, Bhopal Madhya Pradesh



TO WHOMSOEVER IT MAY CONCERN

Richa Banzal

This is to certify that Dr. student of MBA-Health & Hospital Management batch 2014-16 of IIHMR University, Jaipur (Rajasthan) has successfully completed his/her summer internship during 01-04-2015 to 31-05-2015.

The project was undertaken by him/her in the following divisions:

1. Human Resource - " To design a performance appraisal for ANM at sub-centre level (non delivery point) through HMIS and MCTS."
2. Rashtriya Bal Swasthaya Karyakram - "Comparative study of RBSK program implementation at Hoshangabad and Raisen district."
3. Maternal Health - "Rapid assessment of L1 non functional delivery point at Sehore District."

During the period of internship he/she has shown good conduct and would be a great asset to any organisation he/she works for in future.

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


(Faiz Ahmed Kidwai)
Mission Director, NHM
Madhya Pradesh



National Health Mission
State Health Society
Arera Hills, Bhopal
Madhya Pradesh

RBSK
RASHTRIYA BAL SWASTHYA KARYAKRAM
राष्ट्रीय बाल स्वास्थ्य कार्यक्रम
FROM SURVIVAL TO HEALTHY SURVIVAL

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr. *Richa Banzal* of MBA-Health & Hospital Management batch 2014-16 of IIHMR University, Jaipur (Rajasthan) has successfully completed his/her summer project under Rashtriya Bal Swasthya Karyakram titled "Comparative study of RBSK program implementation at Hoshangabad and Raisen district" during 01-05-2015 to 31-05-2015

During the period of project he/she has shown good conduct and would be a great asset to any organisation he/she works for in future.

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


Dr. Vinay Kumar Dubey
Deputy Director, RBSK
NHM, Madhya Pradesh


Ms. Neha Yadav
State Consultant, RBSK
NHM, Madhya Pradesh

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I wish to thank Dr. Faiz Ahmed Khidwai (IAS) Mission Director NHM for giving us the opportunity to do our summer internship at NHM Madhya Pradesh. I am thankful to Dr. Nikhilesh Chandra Director NHM for making it possible for me to learn as much as I can from the organization.

I would like to express our gratitude to Deputy Director HR, Dr. Rajeev Shrivastava Sir, National Health Mission (M.P) who has been my mentor and for giving me the opportunity to have this summer training experience and undergoing the process of learning at NHM, M.P. I thank him for all the trust and faith that he posed on me and I only hope that I have been able to live up to his expectations. His guidance and support was helpful in enhancing my work.

I extend sincere gratitude to Deputy Director RBSK, Dr. Vinay Dubey and Miss Neha Yadav (State Consultant, RBSK) who have been instrumental in helping me shape my study in a desirable way. I would like to thank Mr. Neeraj Shrivastav (State Consultant, HMIS), Mr. Umesh Sir and Dr. Anand Choubey (State Consultants) for their constant support and guidance. I am thankful to the entire staff of NHM, M.P for their support, co-operation and guidance.

I would like to express my gratitude and respectful regards to Professor Nutan Prabha Jain, IIHMR, Jaipur for her guidance and useful suggestions, which helped me in completing the project work. She was the biggest motivational factor behind my work.

I would also like to thank my institution and faculty members for enlightening me with the entire subjective knowledge so that I can apply it on my project. Finally and most importantly, I would like to thank almighty god for allowing me to complete my project. Last, but most importantly my sincere gratitude to my beloved parents for their blessings.

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Glossary

AEFI Adverse Events Following Immunization
AHS Annual Health Survey
ANC Ante Natal Care
ANM Auxiliary Nurse Midwife
ART Anti Retro-viral Therapy
AWC Anganwadi Centre
AWW Anganwadi Worker
BCC Behavior Change Communication
CAC Comprehensive Abortion Care
DH District Hospital
DLHS District Level Household Survey
EAG Empowered Action Group
EMOC Emergency Obstetric Care
FP Family Planning
FRU First Referral Unit
GNM General Nursing Midwives
GOI Government of India
HIV Human Immunodeficiency Virus
HMIS Health Management & Information System
HR Human Resource
ICDS Integrated Child Development Services Scheme
IMNCI Integrated Management of Neonatal and Childhood Illnesses
IPC Inter Personal Communication
IPHS Indian Public Health Standards
IUCD Intra Uterine Contraceptive Device
LBW Low Birth Weight
LHV Lady Health Visitor
LSAS Life Saving Anaesthesia Skills
MCH Maternal and Child Health
MCIS Multi Cluster Indicator Survey
MCTS Mother and Child Tracking System
MMU Mobile Medical Unit
MO Medical Officer
MTP Medical Termination of Pregnancy
MWCD Ministry of Women and Child Development
NBSU New Born Stabilisation Unit
NFHS National Family Health Survey
NRC Nutrition Rehabilitation Centre
NRHM National Rural Health Mission

NSSK Navjaat Shishu Suraksha Karyakram
OCP Oral Contraceptive Pills
ORS Oral Rehydration Solution
OT Operation Theatre
PCPNDT Pre-Conception & Pre-Natal Diagnostic Test
PHC Primary Health Centre
PIP Programme Implementation Plan
PHN Public Health Nurse
PPIUCD Post Partum Intra Uterine Contraceptive Device
PPS Post-Partum Sterilisation
PPTCT Prevention of Parent to Child Transmission
PRI Panchayati Raj Institution
RCH Reproductive Child Health
RGI Registrar General of India
RKS Rogi Kalyan Samiti
RPR testing kits Rapid Plasma Regain testing kits
RMNCH+A Reproductive, Maternal, Newborn, Child Health plus Adolescents
RTI Reproductive Tract Infection
SBA Skill Birth Attendant
SHC Sub Health Centre
SNCU Special Newborn Care Unit
SRS Sample Registration System
STI Sexually Transmitted Infection
TFR Total Fertility Rate
UT Union Territory
U5M Under Five Mortality
VHND Village Health & Nutrition Day
VHNSC Village Health Nutrition and Sanitation Committees
WHO World Health Organisation
WIFS Weekly Iron Folic-acid Supplementation

Preface

As a part of first year course students of IIHMR were supposed to complete two months summer internship programme in any organization. I joined NHM, M.P for my summer internship. For summer project my mentor in the organization asked to firstly, **“Develop a performance appraisal for ANMs (Auxiliary Nurse Midwives) at a sub center level non delivery point.”** This project was assigned to develop a hybrid system of performance appraisal in which largely the measures should be objective (based on ANMs performance) and some measures subjective. The KRA’s were derived from data obtained from triangulation of three data set, health management information system (HMIS), mother and child tracking system(MCTS) and dashboard indicators. Secondly, we were asked to do **“Comparative study of the RBSK implementation in two districts of Madhya Pradesh”**. This project was assigned to find the current status of RBSK implementation in Hoshangabad and Raisen district and find the gaps in the programme implementation. A knowledge and practice assessment was done for the team members of RBSK. Further, treatment was facilitated for the positively diagnosed children of cleft lip and palate out of the four most prevalent defects of birth taken for the study. Thirdly, we were asked to do a **“Rapid assessment of L1 and L2 functional and non-functional delivery points”**. A checklist was provided by the maternal health department and visit made to L1 and L2 facilities of Sehore district. The assessment was done to find out that whether these delivery points in the district have adequate Infrastructure, Skilled Human Resources, Capacity, Equipment And Commodities, Emergency Transportation to provide each of the strategic RMNCH+A interventions with quality.

Section A

ORGANIZATION- NHM, MADHYA PRADESH

A) INTRODUCTION

The national health mission (NHM) encompasses its two Sub-Missions, the national rural health mission (NRHM) and the newly launched national urban health mission (NUHM). The main programmatic components include health system strengthening in rural and urban areas-reproductive-maternal-neonatal-child and adolescent health (RMNCH+A), and communicable and non-communicable diseases. The NHM envisages achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs.

The Union Cabinet vide its decision dated 1st May 2013 has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission.

NHM has six financing components:

- (i) NRHM-RCH Flexipool,
- (ii) NUHM Flexipool,
- (iii) Flexible pool for Communicable disease,
- (iv) Flexible pool for Non communicable disease including Injury and Trauma
- (v) Infrastructure Maintenance and
- (vi) Family Welfare Central Sector component.

Within the broad national parameters and priorities, states would have the flexibility to plan and implement state specific action plans. The state PIP would spell out the key strategies, activities undertaken, budgetary requirements and key health outputs and outcomes. The State PIPs would be an aggregate of the district/city health action plans, and include activities to be carried out at the state level. The state PIP will also include all the individual district/city plans. This has several advantages: one, it will strengthen local planning at the district/city level, two, it would ensure approval of adequate resources for high priority district action plans, and three, enable communication of approvals to the districts at the same time as to the state.

The fund flow from the Central Government to the states/UTs would be as per the procedure prescribed by the Government of India.

The State PIP is approved by the Union Secretary of Health & Family Welfare as Chairman of the EPC, based on appraisal by the National Programme Coordination Committee (NPCC), which is chaired by the Mission Director and includes representatives of the state, technical and programme divisions of the MoHFW, national technical assistance agencies providing support to the respective states, other departments of the MoHFW and other Ministries as appropriate. All existing vertical programmes, shall be horizontally integrated at state, district and block levels. This will mean incorporation into an integrated state, district/city programme

implementation plan, sharing data and information across these structures. It shall also mean rationalization of use of infrastructure and human resources across these vertical disease programmes.

B) STATE PROFILE

Madhya Pradesh lies in the heart of India. It covers an area of 3,08,245 sq. km, making it the biggest state in the country, bordering seven other states- Uttar Pradesh , Bihar, Orissa, Andhra Pradesh, Maharashtra, Gujarat And Rajasthan. Madhya Pradesh consists largely of a plateau streaked with the hill ranges of the Vindhya and the Satpuras with the Chhattisgarh plains to the east. The hills give rise to the main river systems- the Narmada and the Tapti, running from east to west, and the Chambal , Sone, Betwa, and the Indravati west to east. The state has a population of 72.59 million. There are 51 districts, 313 blocks and 393 villages.



C) GOALS

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

Box 1

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

D) VISION OF THE NHM

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

E) CORE VALUES

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

F) HEALTH INDICATORS OF MADHYA PRADESH

The Total Fertility Rate of the State is 3.2. The Infant Mortality Rate is 59 and Maternal Mortality Ratio is 269 (SRS 2007 - 2009) which are higher than the National average. The Sex Ratio in the State is 930 (as compared to 940 for the country). Comparative figures of major health and demographic indicators are as follows:

Table I: Demographic, Socio-economic and Health profile of Madhya Pradesh State as compared to India figure

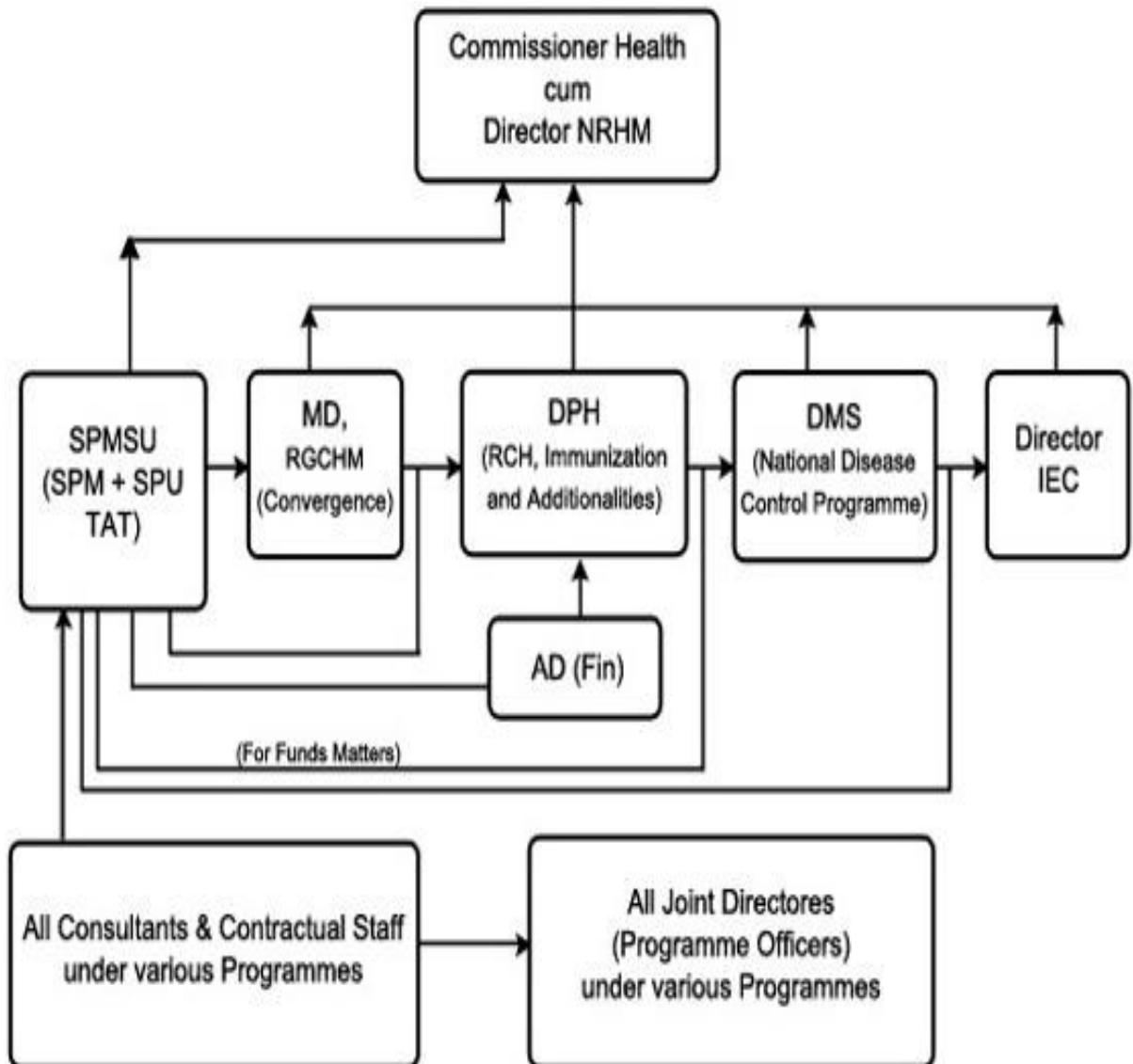
Indicator	MP	India
Total Population (In Crore) (Census 2011)	7.26	121.01
Decadal Growth (%) (Census 2011)	20.30	17.64
Crude Birth Rate (SRS 2013)	26.3	21.4
Crude Death Rate (SRS 2013)	8	7
Natural Growth Rate (SRS 2013)	18.4	14.4
Infant Mortality Rate (SRS 2013)	54	40
Maternal Mortality Rate (SRS 2010-12)	230	178
Total Fertility Rate (SRS 2012)	2.9	2.4
Sex Ratio (Census 2011)	930	940
Child Sex Ratio (Census 2011)	912	914
Schedule Caste population (in crore) (Census 2001)	0.91	16.6
Schedule Tribe population (in crore) (Census 2001)	1.22	8.43
Total Literacy Rate (%) (Census 2011)	70.63	74.04
Male Literacy Rate (%) (Census 2011)	80.53	82.14
Female Literacy Rate (%) (Census 2011)	60.02	65.46

Table II: Health Infrastructure of Madhya Pradesh

Particulars	Required	In position	shortfall
Sub-centre	12314	8869	3445
Primary Health Centre	1977	1156	821
Community Health Centre	494	333	161
Health worker (Female)/ANM at Sub Centres & PHCs	10025	10204	*
Health Worker (Male) at Sub Centres	8869	3733	5136
Health Assistant (Female)/LHV at PHCs	1156	546	610
Health Assistant (Male) at PHCs	1156	293	863
Doctor at PHCs	1156	814	342
Obstetricians & Gynecologists at CHCs	333	73	260
Pediatricians at CHCs	333	67	266
Total specialists at CHCs	1332	267	1065
Radiographers at CHCs	333	192	141
Pharmacist at PHCs & CHCs	1489	678	811
Laboratory Technicians at PHCs & CHCs	1489	609	880
Nursing Staff at PHCs & CHCs	3487	2491	996

(Source: RHS Bulletin, March 2012, M/O Health & F.W., GOI)

G) ORGANOGRAM



Director IEC, Training, Immunization Mission Director Director Secretary (GoMP, PH&FW Dept) Health Commissioner Director Finance

Director NRHM Director Family Planning, National Programme

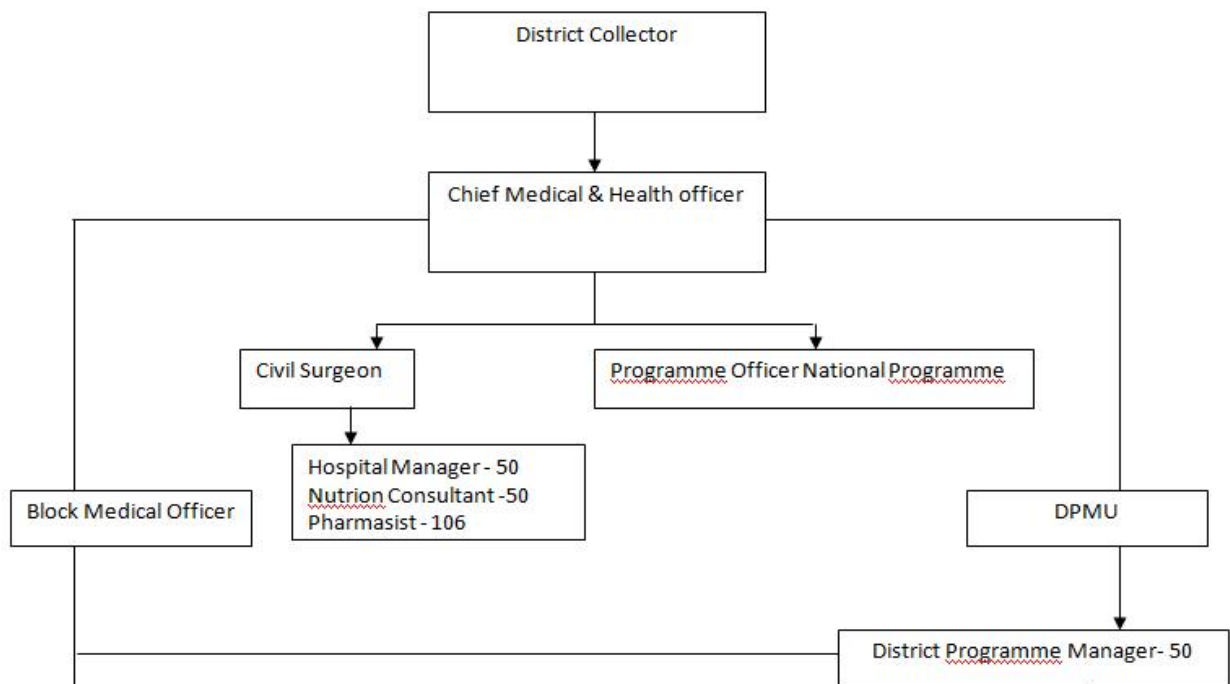
Joint Director Immunization Joint Director FW, PCPNDT, IDSP, Malaria Chief Engineer Joint Director RCH/NRHM

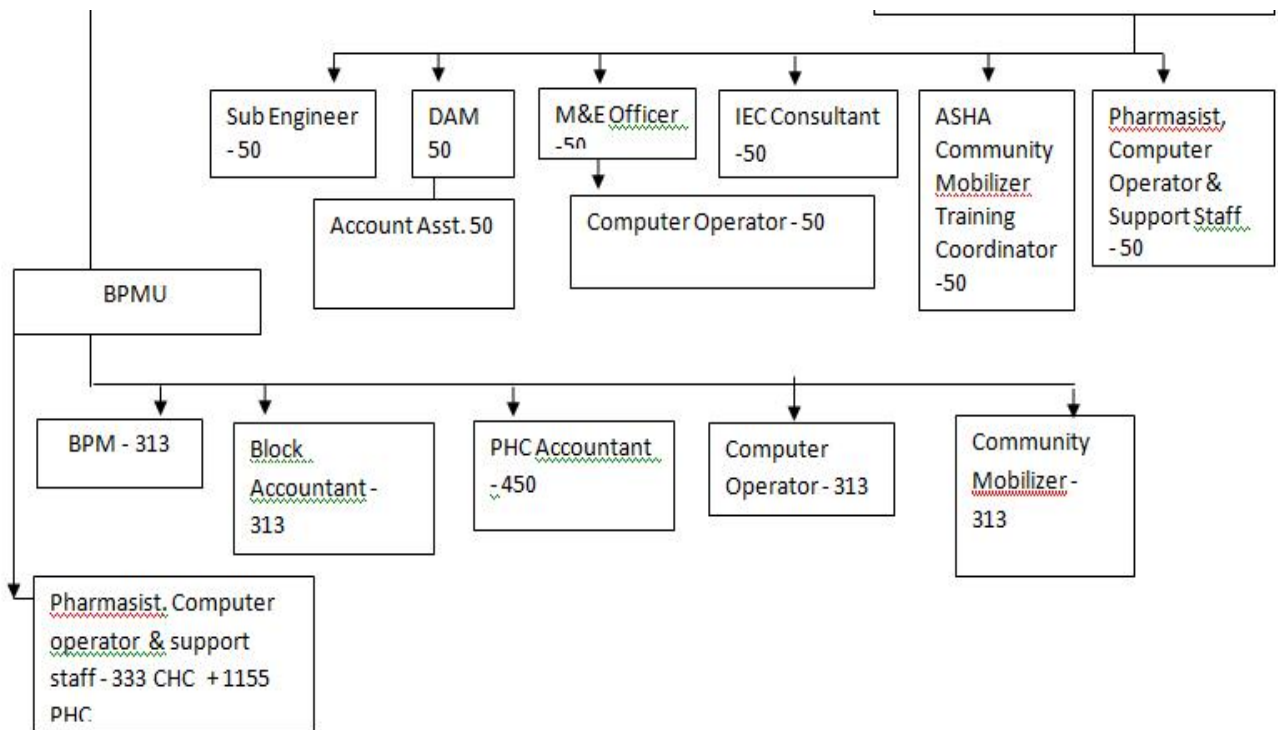
Dy. Director HR Dy. Director Immunization Dy Director PCPNDT Dy Director ASHA, VHSC Dy. Director HMIS, EMRI, PPP Dy. Director Maternal Health Dy. Director Nutrition Dy. Director Child Health SPM

Consultant HR State Routine Immunization Coordinator Consultant ASHA, training, Community Mobilizer Consultant SDA Consultant Training Consultant t, Consultan t, Consultan t, Asst. Audit Officer SFM, SFA, CA, SAM, Account Asst.

Assistant Programme Manager & other Staff

I) DISTRICT ORGANOGRAM:





J) COMPONENTS OF NHM MP

- 1) NHM FINANCE
 - 2) HEALTH SYSTEM STRENGTHENING
 - 3) RMNCH+A
 - 4) NATIONAL DISEASE CONTROL PROGRAMME
-
- 1) FINANCE SYSTEM
 - 2) HEALTH SYSTEM STRENGTHENING
 - a) MMU'S
 - b) EMRI
 - c) INFRASTRUCTURE
 - d) HUMAN RESOURCE
 - e) DRUGS LOGISTICS
 - f) TELEMEDICINE
 - 3) RMNCH+A

- a) MATERNAL HEALTH
 - b) FAMILY PLANNING
 - c) ADOLESCENT HEALTH
 - d) CHILD HEALTH AND IMMUNIZATION
 - e) COMMON ORDERS
- 4) NDCPs
- a) NDDCP
 - b) NVBDCP
 - c) RNTCP
 - d) NPCB
 - e) NLEP
 - f) IDBP

K) MAJOR INITIATIVES UNDER NRHM

- A. **ASHA:** More than 8.94 lakh community health volunteers called Accredited Social Health Activists (ASHAs) have been engaged under the mission to work as a link between the community and the public health system. ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services in rural areas. ASHA Programme is expanding across States and has particularly been successful in bringing people back to Public Health System and increase in the utilization of their outpatient services, diagnostic facilities, institutional deliveries and in-patient care.
- B. **Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Society:** is a simple yet effective management structure. This committee is a registered society whose members act as trustees to manage the affairs of the hospital and is responsible for upkeep of the facilities and ensure provision of better facilities to the patients in the hospital. Financial assistance is provided to these Committees through untied fund to undertake activities for patient welfare. 31,109 Rogi Kalyan Samitis (RKS) have been set up involving the community members in almost all District Hospitals (DHs), Sub-District Hospitals (SDHs), Community Health Centres (CHCs) and Primary Health Centres (PHCs) till date.

- C. The Untied Grants to Sub-Centres (SCs)** has given a new confidence to our ANMs in the field. The SCs are far better equipped now with Blood Pressure measuring equipment, Hemoglobin (Hb) measuring equipment, stethoscope, weighing machine etc. This has facilitated provision of quality antenatal care and other health care services.
- D. The Village Health Sanitation and Nutrition Committee (VHSNC)** is an important tool of community empowerment and participation at the grassroots level. The VHSNC reflects the aspirations of the local community, especially the poor households and children. Untied grants of Rs. 10,000 are provided annually to each VHSNC under NRHM, which are utilized through involvement of Panchayati Raj representatives and other community members in many states. Till date, 5.12 lakh VHSNCs have been set up across the country. In many states, capacity building of the VHSNC members with regards to their roles and responsibilities for maintaining the health status of the village is being done.
- E. Health care service** delivery requires intensive human resource inputs. There has been an enormous shortage of human resources in the public health care sector in the country. NRHM has attempted to fill the gaps in human resources by providing nearly 1.69 lakh additional health human resources to states including 7,659 GDMOs, 2,973 Specialists, 71,946 ANMs, 38,339 Staff Nurses etc. on contractual basis. Apart from providing support for health human resource, NRHM has also focused on multi skilling of doctors at strategically located facilities identified by the states e.g. MBBS doctors are trained in Emergency Obstetric Care (EmOC), Life Saving Anaesthesia Skills (LSAS) and Laparoscopic Surgery. Similarly, due importance is given to capacity building of nursing staff and auxiliary workers such as ANMs. NRHM also supports co-location of AYUSH services in health facilities such as PHCs, CHCs and DHs. A total of 12,357 AYUSH doctors have been deployed in the states with NRHM funding support.
- F. Janani Suraksha Yojana (JSY)** aims to reduce maternal mortality among pregnant women by encouraging them to deliver in government health facilities. Under the scheme, cash assistance is provided to eligible pregnant women for giving birth in a government health facility. Since the inception of NRHM, 7.04 crore women have benefited under this scheme.
- G. Janani Shishu Suraksha Karyakarm (JSSK):** Launched on 1st June, 2011, JSSK entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section. This marks a shift to an entitlement based approach. The free entitlements include free drugs and consumables, free diagnostics, free diet during stay in the health institutions, free provision of blood, free transport from home to health institution, between health institutions in case of referrals and drop back home and exemption from all kinds of user charges. Similar entitlements are available for all sick infants (up to 1 year of age) accessing public health institutions. All the 35 States and Union Territories are implementing this scheme. In 2012-13, Rs.

2107 crore was provided to states under JSSK and in 2013-14 more than Rs. 2000 crore has been approved for implementing the free entitlements under JSSK.

- H. **National Mobile Medical Units (NMMUs):** Support has been provided in 418 out of 640 districts for 2127 MMUs under NRHM in the country. To increase visibility, awareness and accountability, all Mobile Medical Units have been repositioned as "National Mobile Medical Unit Service" with universal our and design.
- I. **National Ambulance Services:** NRHM has supported free ambulance services to provide patients transport in every nook and corner of the country connected with a toll free number. Over 16,000 basic and emergency patient transport vehicles have been provided under NRHM. Besides these, over 4,769 vehicles have been empanelled to transport patients, particularly pregnant women and sick infants from home to public health facilities and back. 28 states have set up a call centre for effective patient transport system.
- J. **Mainstreaming of AYUSH:** Mainstreaming of AYUSH has been taken up by allocating AYUSH facilities in 8425 PHCs, 2374 CHCs, 324 DHs, 3715 health facilities above SC but below block level and 512 health facilities other than CHC at or above block level but below district level.
- K. **Mother and Child Tracking System:** It is a name based tracking system, launched by the Government of India as an innovative application of information technology directed towards improving the health care service delivery system and strengthening the monitoring mechanism. MCTS is designed to capture information on and track all pregnant women and children (0-5 Years) so that they receive 'full' maternal and child health services and thereby contributes to the reduction in maternal, infant and child morbidity and mortality which is one of the goals of National Rural Health Mission. MCTS relies heavily on information technology tools and techniques and promotes its usage by grass roots level health service providers and even by the beneficiaries at large. MCTS is a centralized web based application, which facilitates in real time entry of the information related to pregnant women and children and subsequent health care services provided to them. This tool also facilitates in generation of work plan for the field level health care service providers, to ensure timely and full range of services to them. MCTS employs mobile based SMS technology to alert health service providers and beneficiaries about the service delivery and for providing the due services on time. The system also facilitates with status note and actionable messages to policy makers, health managers and health administrators at different tiers of health care delivery system for necessary action on time. A total of 2,06,77,184 pregnant women were registered in MCTS during 2013-14 as on 31st March, 2014, which indicates a registration of 69.43 % as against estimated number of pregnant women in 2013-14. A total of 1,64,10,571 children have been registered in MCTS during 2013-14 as on 31st March, 2014, which indicates a registration of 60.61% as against estimated number of infants in 2013-14.

L) NEW INITIATIVES

- A. Rashtriya Bal Swasthya Karyakram (RBSK):** This initiative was launched in February 2013 and provides for Child Health Screening and Early Intervention Services through early detection and management of 4 Ds i.e. Defects at birth, Diseases, Deficiencies, Development delays including disability. In 2013-14, an allocation of over Rs. 1100 crore under NRHM for 11839 RBSK Mobile Health Teams and 225 Districts Early Intervention Centre have been approved.
- B. Rashtriya Kishor Swasthya Karyakram (RKSK):** This is a new initiative, launched in January 2014 to reach out to 253 million adolescents in the country in their own spaces and introduces peer-led interventions at the community level, supported by augmentation of facility based services. This initiative broadens the focus of the adolescent health programme beyond reproductive and sexual health and brings in focus on life skills, nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse.

- C. **Mother and Child Health Wings (MCH Wings):** 100/50/30 bedded Maternal and Child Health (MCH) Wings have been sanctioned in public health facilities with high bed occupancy to cater to the increased demand for services. More than 28,000 additional beds have been sanctioned across 470 health facilities across 18 states.
- D. **Free Drugs and Free Diagnostic Service:** Extremely high out of pocket expenditure on health care due to high cost of drugs and diagnostics have proved to be a deterrent in provision of accessible and affordable healthcare for all. To address this, Ministry introduced an incentive to the extent of 5% of the state's Resource Envelope under NRHM for those states that implemented free essential drugs scheme for all patients accessing public health facilities. Under the National Health Mission - Free Drug Service Initiative and Free Diagnostics Service Initiative, substantial funding is being provided to state that implement these initiatives. States notifying policy for provision of free essential drugs and/or diagnostics to all patients accessing public health facilities, creates a robust procurement, logistics & supply chain system that is IT backed, has differential facility wise Essential Drug List/Diagnostic List depending on the nature of the facility, has sound drug regulatory and quality assurance system, Standard Treatment Guidelines and provides for prescription audits to ensure rational use of drugs. In 2012-13, Rs. 1540 crore was provided under NHM to states to support free drugs alone. In 2013-14, this support is about Rs. 2000 crore.
- E. **National Iron+ Initiative** is another new initiative to prevent and control iron deficiency Anaemia, a grave public health challenge in India. Besides pregnant women and lactating mothers, it aims to provide IFA supplementation for children, adolescents and women in reproductive age group. Weekly Iron and Folic Acid Supplementation (WIFS) for adolescents is an important strategy under this initiative. The operational guidelines for the same were unveiled in February 2013. WIFS (10-19 years) has already been rolled out in 32 States and UTs under the National Iron Plus Initiative. WIFS covered around 3 crore beneficiaries in December 2013.
- F. **Reproductive, Maternal, Newborn, Child and Adolescent Health Services (RMNCH+A):** A continuum of care approach has now been adopted under NRHM with the articulation of strategic approach to Reproductive Maternal, Newborn, Child and Adolescent health (RMNCH+A) in India. This approach brings focus on adolescents as a critical life stage and linkages between child survival, maternal health and family planning efforts. It aims to strengthen the referral linkages between community and facility based health services and between the various levels of health system itself.
- G. **Delivery Points (DPs):** Health facilities that have a high demand for services and performance above a certain benchmark have been identified as "Delivery Points" with the objective of providing comprehensive reproductive, maternal, newborn, child and adolescent health services (RMNCH+A) services at these facilities. Funds have been allocated to strengthen these DPs in terms of infrastructure, human resource, drugs, equipments etc. Around 17,000 health facilities have been identified as "Delivery Points" for focused support under NRHM.

- H. Universal Health Coverage (UHC):** Moving towards Universal Health Coverage (UHC) is a key goal of the 12th Plan. The National Health Mission is the primary vehicle to move towards UHC. India has charted a path that depends largely on provision of affordable, quality health care by the public health system as its main form of social protection, with supplementation from the private sector to close gaps. UHC pilot projects would be supported in at least one district of each state. Guidelines of the same have been issued to the states along with essential service package. The pilots are expected to demonstrate how access to care and social protection against the costs of care can be meaningfully expanded in the most cost effective manner, while at the same time reducing health inequity.
- I. Mother and Child Tracking Facilitation Centre (MCTFC):** MCTFC has been operationalized from National Institute of Health and Family Welfare (NIHFW). It is being operated by 80 Helpdesk Agents (HAs). It will validate the data entered in MCTS in addition to guiding and helping both the beneficiaries and service providers with up to date information on Mother and Child Care services through phone calls and Interactive Voice Response System (IVRS) on a regular basis. MCTFC will create awareness about Government mother and child health related programmes and seek feedback on services being provided. In addition, a module has been provided in the Mother and Child Tracking System (MCTS) portal so that States / UTs may utilise it to make calls for validation of MCTS data, getting feedback and raising awareness.
- J. Quality Assurance (QA):** The present strategy is shift in focus from fragmented approach of different quality systems to one comprehensive approach of Quality Assurance. Based on best practices of existing quality system such as NABH, ISO, JCI and other scientific literature, comprehensive operational guidelines on Quality Assurance has been launched wherein National Quality Assurance standards have been published. The road map for QA envisages development of a robust institutional mechanism within the states to make States self- sufficient and to have more sustainable system than existing systems. A total of 8 major areas of concerns- Service provision, Patient right, Inputs, Support Services, Clinical Services, Infection Control, Quality Management and Outcome have been identified. Standards have been developed for each area of concern and detailed checklist has been laid down to ensure conformance to these standards. All Public Health Facilities would be assessed, and Quality scored in a phased manner. Besides clinical care, due weightage has been given to issues of patients' right, confidentiality, privacy, compliance to National Health Programme Guidelines, cleanliness at health facilities, etc. The facilities having a credible system of quality assurance (verified through district & state assessment) would be assessed for National Level Certification. On successful attainment of the National certification, facilities would be given incentives and QA certification.
- K. ASHA Certification:** A proposal for certification of ASHAs to enhance competency and professional credibility of ASHAs by knowledge and skill assessment has been approved recently. The certification of ASHAs would be done by National Institute of Open Schooling (NIOS). The following components of the programme, namely, the Training

curriculum, State Training Sites/District Training Sites, Trainers and ASHAs and ASHA Facilitators would be taken up for accreditation/certification. The Certification of ASHAs and accreditation of associated agencies involved in ASHA Training is intended to enhance competency and professional credibility of ASHAs, improve the quality of training and ensure desired programme outcomes, provide an assurance to the community on the quality of services being provided by the ASHA besides promoting a sense of self recognition and worth for ASHAs.

- L. **NGO Guidelines:** Guidelines for NGO involvement under NHM during Twelfth Five Year Plan have been issued recently. The new guidelines envisage greater state ownership for NGO led programmes and are intended to provide a broad framework to the States to partner with NGOs and facilitate their participation in capacity building, support for community processes service delivery, develop innovations through research and documentation, advocacy, and for supplementing capacities in key areas of the public health system to improve health care service delivery.

SECTION B: PROJECT

A) Title

A comparative study of Rashtriya Bal Swasthya Karyakram in two districts of Madhya Pradesh (Hoshangabad And Raisen)

B) Background

a. Launching of RBSK

UPA chairperson Sonia Gandhi on 6 February 2013 launched a new health initiative **called Rashtriya Bal Sawsthya Karyakram (RBSK)** at Palghar town in Thane district of

Maharashtra. The RBSK is a part of the National Rural Health Mission of the Union Ministry of Health and Family Welfare.

b. The rationale for the RBSK program

Out of every 100 babies born in this country annually, 6 to 7 have a birth defect. In Indian context, this would translate to 1.7 million birth defects annually and would account for 9.6 per cent of all newborn deaths¹. Various nutritional deficiencies affecting the preschool children range from 4 percent to 70 percent. Developmental delays are common in early childhood affecting at least 10 percent of the children. These delays, if not intervened timely, may lead to permanent disabilities with regard to cognition, hearing and vision.

There are also groups of diseases which are very common in children e.g., dental caries, otitis media, rheumatic heart disease and reactive airways diseases which can be cured if detected early. It is understood that early intervention and management can prevent these conditions to progress into more severe and debilitating forms, thereby reducing hospitalization and resulting in improved school attendance.

The 'Child Health Screening and Early Intervention Services' will also translate into economic benefits in the long run. Timely intervention would not only halt the condition to deteriorate but would also reduce the out-of-pocket (OOP) expenditure of the poor and the marginalized population in the country. Additionally, the Child Health Screening and Early Intervention Services will also provide country-wide epidemiological data on the 4Ds (i.e., Defects at birth, Diseases, Deficiencies and Developmental Delays including Disabilities).

C) Introduction-

Defects at Birth, Deficiencies, Diseases specific to childhood and Developmental delays including disabilities, "4Ds", can either lead to untimely death of a child or a survival with poor developmental outcomes. Such long lasting adverse health outcomes can be addressed only through early screening and timely management.

Extending preventive and promotive health as an approach for selected health conditions along with provision of free curative management, will help the marginalized and under privileged population by reducing their out of pocket expenditure thereby influencing public health expenditure. This, in the long run, will improve the quality of our National human resource pool.

Keeping this in view, the Ministry of Health and Family Welfare, introduced "Child Health Screening and Early Intervention Services" as Rashtriya Bal Swasthya Karyakram (RBSK)

under the National Health Mission. The services under RBSK are to cover all the thirty selected health conditions through their screening, early detection & free management, for children from birth to 18 years of age.

Selected Health Conditions for Child Health Screening &

Early Intervention Services under RBSK

<u>Defects at birth</u>	<u>Deficiencies</u>
1. Neural tube defect 2. Down's Syndrome 3. Cleft Lip & Palate / Cleft palate alone 4. Talipes (club foot) 5. Developmental dysplasia of the hip 6. Congenital cataract 7. Congenital deafness 8. Congenital heart diseases 9. Retinopathy of Prematurity (Not strictly a defect at birth, but presents itself early)	10. Anaemia especially Severe anaemia 11. Vitamin A deficiency (Bitot's spot) 12. Vitamin D Deficiency (Rickets) 13. Severe Acute Malnutrition 14. Goitre
<u>Diseases specific to childhood</u>	<u>Developmental delays</u>
10. Skin conditions (Scabies, fungal infection and Eczema) 16. Otitis Media 17. Rheumatic heart disease 18. Reactive airway disease 19. Dental caries	

	21. Vision Impairment 22. Hearing Impairment 23. Neuro-motor Impairment 24. Motor delay 25. Cognitive delay 26. Language delay 27. Behaviour disorder (Autism) 28. Learning disorder 29. Attention deficit hyperactivity disorder
30. Others: Congenital Hypothyroidism, Sickle cell anemia, Beta thalassemia (Optional)	

D) Objectives :

- To know the current status of RBSK implementation at Raisen and Hoshangabad districts

- To facilitate treatment of positive diagnosed children under RBSK

E) Problem statement:

- Despite of interventions of RBSK in both the districts having same number of blocks (seven) and same number of health teams (fourteen), the children being screened in Raisen district were half(159217) to that of Hoshangabad district (323674) out of same number of target children screened(369600) .
- Only one surgery was reported to be conducted in the year 2013-14 out of the screened children Raisen district .

F) Research Design : 1. Area of study:

1.1 (District Hoshangabad)

According to the 2011 census Hoshangabad District has a population of 1,240,975. This gives it a ranking of 387th in India (out of a total of 640). The district has a population density of 185 inhabitants per square kilo metre (480/sq mi). Its population growth rate over the decade 2001 - 2011 was 14.45%.Hoshangabad has a sex ratio of 912 females for every 1000 males, and a literacy rate of 76.52%. It is home to large number of Bhil's Adivasi people and Gurjars Hoshangabad is located at 22.75°N 77.72°E. It has an average elevation of 278 metres (912 feet) Northern boundary of the district is river Narmada. Across this the district of Raisen and Sehore lies. The district of Betul lies in the south, where as the Harda district faces with the western and south-western boundaries and Narsingpur and Chhindwara districts, close to the north-easter



1.2. (Raisen district)

Raisen district is situated between the latitude 22 47' and 23 33' north and the longitude 77 21' and 78 49' east. Sehore district lies in west, Vidisha district in the north, Sagar district in the east and south-east, Narsimhapur district in the south-east, Hoshangabad and Sehore districts in the south. It covers an area of 8,395 square kilometres (3,241 sq mi). Raisen district has eight tehsils

– Raisen, Goharganj, Begamganj, Gairatganj, Silwani, Bareilly, Udaipura and Badi. According to the 2011 census Raisen District has a population of 1,331,699. This gives it a ranking of 365th in India (out of a total of 640). The district has a population density of 157 inhabitants per square kilometer (410/sq mi). Its population growth rate over the decade 2001-2011 was 18.36%. Raisen has a sex ratio of 899 females for every 1000 males, ^[5] and a literacy rate of 74.26%.



1. STUDY PERIOD:

8 WEEKS (1st APRIL, 2015 to 31st MAY, 2015)

2. STUDY METHOD : Qualitative study .

3. **TOOL:** - Primary data · Interview with RBSK team
Direct observation
Review of guidelines, and RBSK MIS
- Secondary data

4.1. Secondary data analysis: From the state health report card April 2014-15 (figure1) showed that half (43 percent) number if children were screened in Raisen district when compared to Hoshangabad(88 percent). Despite of less screening the children referred to facilities were higher (17 percent) in Raisen than Hoshangabad. Yet, only one surgery was reported in Raisen.

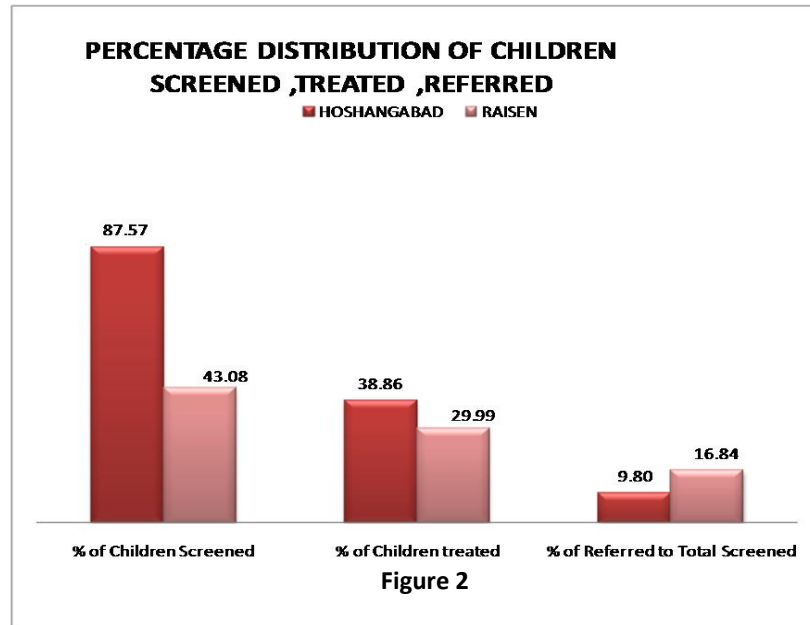


Figure 1

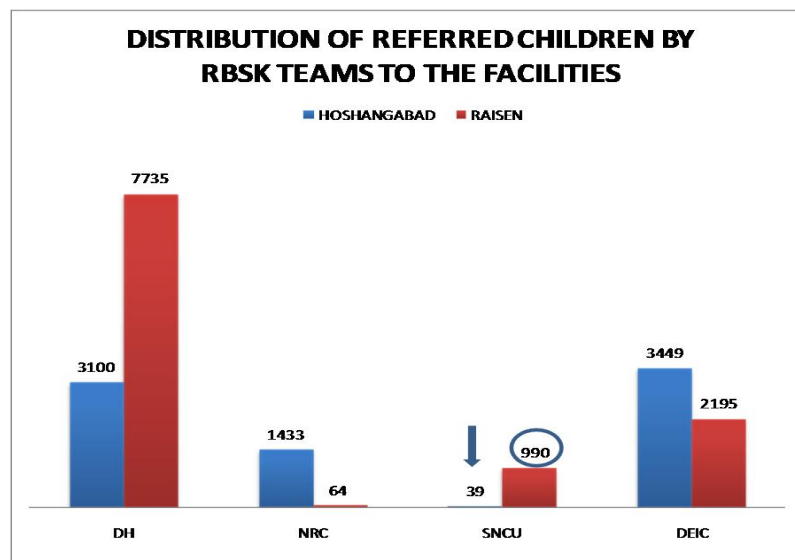


Figure 2, the monthly report format showed the wrong entry of RBSK health teams (119) in Raisen district, whereas Hoshangabad's report was correctly entered showing 14 health teams.

Similarly, the format showed that 990 children in the age 6 -18 were referred to SNCU in Raisen district and on 64 children were referred to NRC instead of a very high prevalence of SAM children in the district.

4.2. Primary data analysis :

- Interview with RBSK team
 - Direct observation
 - Review of guidelines, and RBSK MIS

Tools of data collection

- Interview schedule-Structured questionnaire of 20 items to assess the knowledge and practice of health care personnel based on operational guidelines. The content validity of the tools was established by requesting 1 expert to validate the tool and give their valuable suggestions. Each correct answer was given a score of 1 and wrong answer a score of 0.
- Total Scores – 20 (ranged 0-20)
- <50 % (<10) - Inadequate knowledge
- 50-75 % (11-15) - Moderate knowledge
- >75% (>15) – Adequate knowledge

No. of members - 60 members interviewed

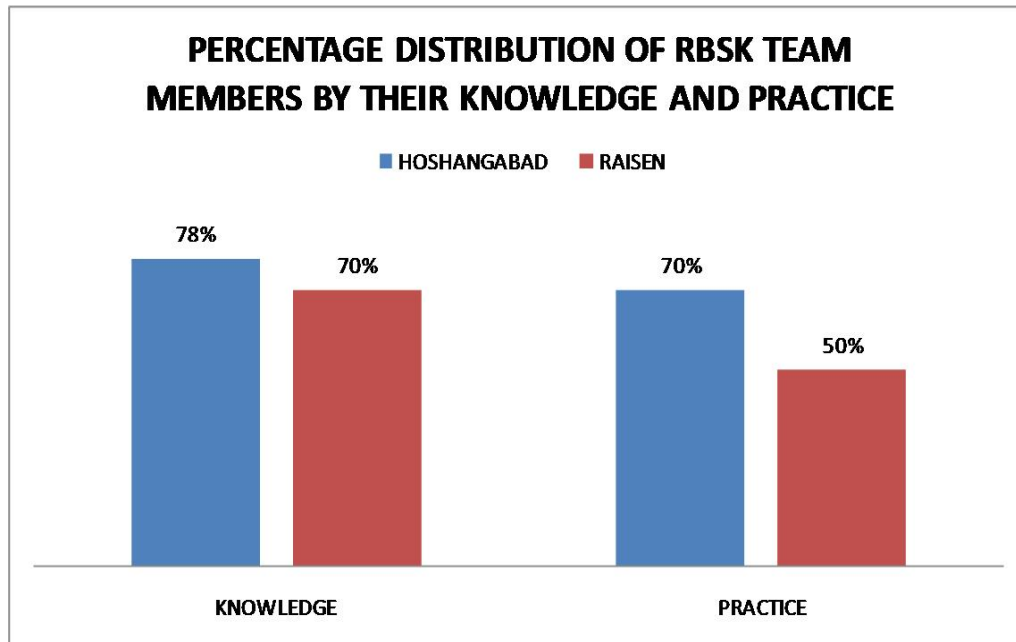


Figure 3

Figure 3, shows that the knowledge of RBSK teams members was 70 percent in Raisen and 78 percent in Hoshangabad. The practice was only 50 percent inspite of knowledge being adequate.

Reasons for poor performance at Raisen

- Lack of convergence with WCD department and Education department.
- Inadequate human resources (attrition, vacant positions)
- Lack of efforts on continuous training
- Lack of communication with hospitals that are providing surgical assistance for RBSK.
- Lack of understanding of the guidelines for surgical treatment and referral procedures
- Discrepancies in data and human errors in reporting.

G) Key Findings:

	HOSHANGABAD	RAISEN
HUMAN RESOURCE	•RBSK Coordinator position filled	• RBSK Coordinator position vacant since one year
INFRA STRUCTURE	•Well established DEIC	•DEIC is proposed in third phase of construction
PLANNING	•Well designed micro plan • As per RBSK guidelines proper information flow to stakeholders	• No scheduled micro plan • Stakeholders lack information from District Hospital
TOOLS, EQUIPMENT	•Availability of all functional tools and equipments as per the guidelines	• Tools and equipments inadequate as per the guidelines
LEADERSHIP	• Able leadership and cordial behaviour of district level officials.	• Lack of leadership skills of district level officials

H) **INTERVENTION:** Facilitation of camp in District Hospital of Raisen.

After the gap findings the team of summer trainees and RBSK department took initiative to conduct a camp for children that were screened so that they can avail the facility.

Enlistment of four defects of the birth was done as they had a high prevalence in the region, namely,

- A. CLEFT LIP& PALATE
- B. CONGINITAL HEART DISEASE
- C. CLUB FOOT AND
- D. HEARING IMAIREMENTS

The camp was conducted with the help of smile train at the district hospital on 22nd May' 2015(MoU is signed by RBSK of the state with smile train)

The health teams of the seven blocks of Raisen district were asked to report to the district hospital along with the children screened for cleft and palate. 13 children turned up for screening and successful surgery was conducted for them.

I) Summery & conclusion

Rashtriya Bal Swasthya Karyakram (RBSK) is a new initiative by National Rural Health Mission (NRHM) aimed at screening over 27 crore children from 0 to 18 years for 4 Ds - Defects at birth, Diseases, Deficiencies and Development Delays including Disabilities. Children diagnosed with illnesses will receive follow up including surgeries at tertiary level, free of cost under NRHM. The task is gigantic but quite possible, through the systematic approach that RBSK envisages. Implemented in right earnest, it would yield rich dividends in protecting and promoting the health of our children.

It is concluded from this study that there are few loopholes in Implementation of RBSK and if we correct these the programme will be highly successful.

Needless to say, those dividends of early intervention would be huge including improvement of survival outcome, reduction of malnutrition prevalence, enhancement of cognitive development and educational attainment and overall improvement of quality of life of our citizens. Bringing down both out of pocket expenses on belated treatment of diseases / disabilities (many of which become highly debilitating and incurable) and avoidable pressure on health system on account of their management are among obvious benefits. Additionally, the Child Health Screening and Early Intervention Services will also provide country-wide epidemiological data on the 4 Ds (i.e., Defects at birth, Diseases, Deficiencies and Developmental Delays including Disabilities)

J) SUGGESTIONS

Obviously it's a wonderful programme with a huge mission to achieve, we have to make extra efforts and make some of the changes and additions to this programme to make it a successful edition of the National Rural Health Mission.

1. **Monitoring OF Mobile health team (MHT)-** Regular monitoring of mobile teams are very necessary on weekly or daily basis , to check they are screening children and students properly according to guideline s. In Madhya Pradesh GPS is fitted in RBSK vehicles to track their locations. But beside locations , there are many other important things which should be monitored like punctuality, presence and screening procedure. . The monitoring is not an easy task; every time state headquarters can't make a vigil on the working of field. The DEIC staff (DEIC manager and project coordinator) should be engaged in this activity.

- 2. More and More on the Spot Treatments-** We cannot wait for every detected screened child to come to DEIC and receive treatment, because there are many factors associated with it. The students we screen in the government schools are so poor to bear travel expenses to the DEIC, parents of children are daily wagers who cannot miss a single day of their work as they earn their daily bread from it, we have to bridge up that gap. On the spot treatments by DEIC staff should be made available on monthly basis, like organising DEIC camp in the area where most number of diseased children is found. Mobile dental van should be deployed in every district, the mobile dental vans from nearest dental colleges can be hired on weekly or monthly basis, because on the spot dental treatment for dental patients is nearly impossible without proper setup. And number of dental patients is highest among screened children. Roadways buses can be hired to transport students from their areas to DEIC. Students who can be treated in a single visit and could not bear travel expenses can be filtered out and they should be taken to DEIC.
- 3. Software's should be Designed for Easy Reporting-**The register system should totally be discarded. Because a lot of manpower and time is wasted in managing registers. There should be special software's designed for on the spot entry of the screened children that operate without internet connection. Because 3G internet connection or network is not everywhere, also it will cut off the expense that comes on the individual internet connections given to the Mobile Health Teams. Entries can be made easily in the specially designed software's and later on after week's end or month's end the software can be connected to internet in DEIC by all teams that automatically uploads all the data to the internet without manual entries. Digital Thumb Impression should be taken on the spot and should be saved in the software so that tracking of child can be easily done because the students' class change from year to year, time wasted in searching the child's card will be saved also the fake entries if any can be prevented, also it will be ensured that same child is receiving the treatment at DEIC or Tertiary Centres who is screened in field. See we have to make work more clinical not clerical. The whole reporting should be revised and made more efficient.
- 4. By Changing the Objective Diseases and Format of Reporting-** The present format contains only 29 or 30 diseases and also the diagnosis cannot be made on the spot by Mobile Health Team, because a pain in ear cannot be said Otitis Media on the spot. Also there are vast numbers of diseases which also need to be included in the screening format. The formats for the DEIC and mobile health teams need to be changed, instead going into complications of males females columns, age group columns, the main objective should be how many total are diseased and referred to DEIC and how many of them are treated or under-treatment. The format of the mobile health team should be in the form of organ systems, like we have in physiology and medicine subjects. There should be a list of organs systems, like if any child complains of weak eyesight the disease should be noted as provisional diagnosis in the

neurosensory system. Later on the disease should be diagnosed in the DEIC. This will help in thorough screening of children's organ systems and full body and will simplify the procedure and chief complaint of the child can be more properly understood and a final diagnosis is reached. The reporting format of DEIC should be disease wise because here the final diagnosis is made.

SECTION C:

A) TITLE

“To develop a performance appraisal for ANMs (Auxiliary Nurse Midwives) at a sub center level non delivery point.”

B) OBJECTIVE

This task was assigned to develop a hybrid system of performance appraisal in which largely the measures should be objective (based on ANMs performance) and some measures subjective.

C) INTRODUCTION

Performance appraisal system is used in the organizations to measure the effectiveness and efficiency of their employees. Performance Appraisal system is needed because every employee has a different attitude to handle the work. Performance Appraisal tends to improve the work performance, communication expectations, determining employee potential and aiding employee counseling. Employee's appraisal system may be considered one of the indicators of the quality of Human Resource Management in an organization. Properly designed and realized process of employees' appraisal is not only the necessary basis of successful employee performance management, but also provides valuable information for other human resource management functions. Performance Appraisal is important because it helps in Performance Feedback, Employee Training and Development Decisions, Validation of Selection process, Promotions & Transfers, Layoff Decisions, Compensation Decisions, Human Resource Planning (HRP), Career Development and Develop Interpersonal Relationship.

D) Methodology

- The detailed job description of an ANM was taken (*source booklet "The Swasth Gram Prahari", published by NRHM, MP*)
- The HMIS data was taken of Panna district (high priority area).
- Out of the five blocks Ajaigarh block was taken which has 22 sub centers under it.
- Those sub centers were taken which were non delivery point and catered to a population of approximately 5000 (*source of population of each village under each sub center was calculated from census 2011*)
- MCTS (Mother and child tracking system) data of Panna district was taken.
- The components of both HMIS and MCTS were analyzed thoroughly
- The KRAs were then taken out on which an ANM can be assessed at a sub center non delivery point.

The following are the KRA's:

Indicators	Source
❑ Probable number of pregnancies	population of the area * birth rate of the area/ district
❑ % 1 st trimester registration to total ANC registrations	HMIS and MCTS
❑ % Pregnant woman received 3 ANC check ups to Total ANC registrations	HMIS and MCTS
❑ % Pregnant women received TT2 or booster to total ANC registration	HMIS and MCTS
❑ % Pregnant women given 100 IFA to total ANC registration.	HMIS and MCTS
❑ % institutional deliveries to total ANC registration	HMIS and MCTS
❑ % Infants 0 to 11 months old who received measles vaccine to reported live births	HMIS
❑ % Children who received full immunization to total registered children.	MCTS
Indicators	Source
❑ % Dropouts between BCG to Measles vaccination	MCTS
❑ % Dropouts between OPV1 TO OPV3 vaccination	MCTS
❑ % Dropouts between DPT1 TO DPT3 vaccination	MCTS
❑ % Dropouts between HEP1 TO HEP3 vaccination	MCTS
❑ % of children below 3yrs received vitamin A (8% of total population)	MCTS
❑ % of children below 5 yrs received D.T doses (13% of total population)	HMIS
❑ % pregnant women detected of anemia to total ANC registration (50% anemic)	HMIS and MCTS
❑ % pregnant women detected of high blood pressure to total ANC registration (15% with high blood pressure)	HMIS
❑ Utilization of untied funds	

E) INDICATORS CALCULATION METHOD

➤ Indicator for estimating probable number of pregnancies

Probable number of pregnancies = population of the area * birth rate of the area/ district

Once the probable number of pregnancies is estimated this also will be the probable number of deliveries / live births that an ANM can expect in her area.

Probable number of pregnancies = 1, 00,000 X 25/1000

Probable number of Pregnancies=2500

➤ Number of antenatal registrations to be expected

The number of antenatal registrations to be expected would be the probable number of pregnancies

with an additional 10% of that number to account for abortions.

Number of antenatal registration = 2500+ [(2500x10)/100] =2750

According the number of antenatal registration the MCH services e.g. ANC visits, TT doses, IFA administration can be estimated.

It has been observed that 15% of the antenatal women registered in a population are usually high risk.

Thus to estimate the number of high risk women that an ANM can expect she should compare her figures with a number which is 15% of the expected antenatal registration

15% of the antenatal women registered in a population are usually high risk. Thus to estimate the number of high risk women = 2750+ [(2750X15)/100]=3162.5.

➤ Antenatal Cases Registered Are Anemic

It has also been observed that 50% of the antenatal cases registered are anemic. Thus the ANM should compare her figures which is 50% of the expected antenatal registration

Expected number of anemic women in population will be approximately 2750X50/100 = 1375.

➤ **Number of Live Births to Be Expected**

The number of live births to be expected or deliveries to be expected is estimated by the following formula:

Number of live births = Population of the area X Birth rate of the area

It is noted that out of the total number of live births there are usually 10% of these which are sick or high risk and need referral. The ANM should compare her figures of high risk newborns with a number which is 10% of the number of live births.

No. of live births: Information on live births is very important and will help the state officer to calculate many RCH Indicators.

Total number of live births serves as a denominator for the following indicators:

- Antenatal Care Coverage.
- Percentage of pregnant women who have received 100 IFA tablets.
- Percentage of pregnant women who have received TT2 or booster.

To estimate the number of infants to be immunized in the coming year, it is necessary to estimate the number of infants alive at one year.

No. of infants who have died during the year (No of infants who have died during the year can be calculated by using the Infant Mortality Rate of the area).

Children below 3 year of age: can be estimated from the fact that the average population of children below 3 year is approximately 8 % of total population in most of the Indian States. This figure will assist the ANM in estimating no. of Vitamin A doses necessary.

Children below 5 years of age: This age group constitutes approximately 13% of total population. The estimation of this number would assist the ANM in estimating the number of D.T. doses to be used

A scored was prepared (Annexure)

Questionnaires for psychometric analysis (Annexure)

360 Degree Feedback Form (Annexure)

F) PSYCHOMETRIC ANALYSIS

PSYCHOMETRIC ANALYSIS will be done with the help of a structured interview schedule based on Nursing Role Efficacy Scale (A) (Pareek, 1997). The original instrument has already been tested for reliability and validity and proposes the following dimensions:

- 1) Integration (experience, technical training, special skills, and some unique contribution)
- 2) Pro-activity (to take initiative)
- 3) Creativity(to try new and unconventional ways of solving problems)
- 4) Confrontation (to confront problems and find relevant solutions)
- 5) Centrality (to feel that his role is important to the organization)
- 6) Influence
- 7) Personal Growth (any opportunity to grow)
- 8) Inter-role Linkage (joint effort in understanding problems, finding solutions)
- 9) Helping Relationship
- 10) Super ordination (to be of value to a larger group)

ROLE EFFICACY SCALE

Role Efficacy Scale is a structured instrument consisting of 20 triads of statement in each triad which describes his role most accurately.

A respondent marks one statement in each triad which describes his role most accurately.

These three alternatives are pre-weighted. There are two statements for each dimension of role efficacy.

Each aspect can be given one of the three scores: +2, +1, or -1. After trying out various ways of scoring, this was the method decided upon: give a score of 2 on each aspect, if that particular aspect is present; score of 1 when that aspect is present to some extent; -1 if the negative side of the aspect is shown.

ROLE EFFICACY INDEX (REI)

Role Efficacy Index represents the percentage of role effectiveness of a respondent in an organization. It ranges from 0 to 100.

A high REI indicates that the respondent perceives that he has a great deal of opportunity to be effective in the role.

To find out the REI, scores on all the 9 aspects of role efficacy may be totalled and then the relevant formula can be used.

Role Efficacy Scale: $[(\text{Total Score} + 10)/60] * 100$

ANNEXURE I

Score card:

Probable number of pregnancies = $5000 \times 33.1 / 1000 = 166$ (approx.)

Number of antenatal registration = $166 + (10\% \times 166) = 183$ (approx.)

Number of live births = $5000 \times 33.1 / 1000 = 166$ (approx.)

Indicator	Source	Workload (for a population of 5000)	Target achieved	Score ***
% 1 st trimester registration to total ANC registrations	HMIS	183		
% Pregnant woman received 3 ANC checkups to Total ANC registrations	HMIS	183		
% Pregnant women received TT2 or booster to total ANC registration	HMIS	183		
% Pregnant women given 100 IFA to total ANC registration.	HMIS	183		
% institutional deliveries to total ANC registration	HMIS	166		
% Infants 0 to 11 months old who received measles vaccine to reported live births (4% of total population)	HMIS	200		
% Children who received full	HMIS AND MCTS	400		

immunization to total registered children.				
Dropouts rate between BCG1 to Measles vaccination	MCTS	Number of children 0-11month who have received BCG1- MEASLES /number of children between 0-11 months (200-X)/200		
Dropouts between OPV1 TO OPV3 vaccination	MCTS	(OPV1-OPV3)/OPV1		
Dropouts between DPT1 TO DPT3 vaccination	MCTS	(DPT1-DPT3)/DPT1		
Dropouts between HEP1 TO HEP3 vaccination	MCTS	(HEP1-HEP3)/HEP1		
% of children below 3yrs received vitamin A (8% of total population)	MCTS	400		
% of children below 5 yrs received D.T doses(13% of total population)	HMIS	650		
% pregnant women detected of anemia to total ANC registration(50% anemic)	HMIS AND MCTS	92		
% pregnant women detected of high blood pressure to total ANC registration (15% with high	HMIS	27		

blood pressure)				
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Score ***

GRADE A =90-100%

GRADE B=75-89%

GRADE C= 60- 74%

GRADE D = BELOW 60%

ANNEXURE II

Each question has been carefully fabricated to evaluate the parameter to yield maximum inference.

1. __ a. My role is very important in this organization; I feel central here.

__ b I am doing a useful and fairly important work.

__ c Very little importance is given to my role in this organization; I feel peripheral here

2. __ a. My training and expertise are not fully utilized in my present role.

__ b My training and knowledge are not used in my present role.

__ c I am able to use my knowledge and training very well here.

3. __ a I have little freedom in my role; I am only an errand boy.

__ b I operate according to the direction given to me.

__ c I can take initiative and act on my own in my role.

4. __ a I am doing usual, routine work in my role.

__ b In my role I am able o use my creativity and do something new.

__ c I have no time for creative work in my role.

5. __ a. No one in the organization responds to my ideas and suggestions.

__ b. I work in close collaboration with some other colleagues.

__ c. I am alone and have almost no one to consult in my role.

6. __ a. When I need some help no one is available.

__ b. Whenever I have a problem, others help me.

__ c. I get very hostile responses when I ask for help.

7. ☐ a. I regret that I do not have the opportunity to contribute to society in my role.

☐ b. What I am doing in my role is likely to help other organizations or society.

☐ c. I have the opportunity to have some effect on the larger society in my role.

8. ☐ a. I contribute to some decisions.

☐ b. I have no power here.

☐ c. My advice is accepted by my seniors.

9. ☐ a. Some of what I do contribute to my learning.

☐ b. I am slowly forgetting all that I learnt (my professional knowledge).

☐ c. I have tremendous opportunities for professional growth in my role.

10 ☐ a. I dislike being bothered with problems.

☐ b. when a subordinate brings a problem to me, I help to find a solution.

☐ c. I refer the problem to my boss or to some other person.

11 ☐ a. I feel quite central in the origination

☐ b. I think I am doing fairly important work.

☐ c. I feel I am peripheral in this organization.

12 ☐ a. I do not enjoy my role.

☐ b. I enjoy my role very much.

☐ c. I enjoy some parts of my role and not others.

13 ☐ a. I have little freedom in my role.

☐ b. I have a great deal of freedom in my role.

☐ c. I have enough freedom in my role.

14 ☐ a. I do a good job according to a pre-decided schedule.

- ☐ b. I am able to be innovative in my role.
- ☐ c. I have no opportunity to be innovative or do something creative.

15 ☐ a Other in the organization see my role significant to their work.

- ☐ b. I am a member of a task force or a committee.
- ☐ c. I do not work on any committees.

16 ☐ a Hostility rather than cooperation is evident here.

- ☐ b. I experience enough mutual help here.
- ☐ c- People operate more in isolation here.

17 ☐ a. I am able to contribute to the company in my role.

- ☐ b. I am able to serve the larger parts of society in my role.
- ☐ c. I wish I could do some useful work in my role.

18 ☐ a. I am able to influence relevant decisions.

- ☐ b. I am sometimes consulted on important matters.
- ☐ c. I cannot make any independent decisions.

19 ☐ a. I learn a great deal in my role.

- ☐ b. I learn a few new things in my role.
- ☐ c. I am involved in routine or unrelated activities and have learnt nothing.

20 ☐ a. When people bring problems to me, I tend to ask them to work it out themselves.

- ☐ b. I dislike being bothered with interpersonal conflict.
- ☐ c. I enjoy solving problem related to my work.

ANNEXURE III

**360 degree Feedback form for Performance
appraisal of ANM**

Name:

Position:

Name of the Sub centre (village):

How long you held this position:

Rate of the performance in past three respectively:
(good/satisfactory/bad)

State some of the goals you achieved?

What are some of the things you achieved in the past years?

What were some of the drawbacks?

Which of these goals you achieved and which did you not and why?

Comments of supervisor

Name
Signature of Supervisor
Date

Comments of medical officer

Name
Signature of Medical Officer
Date

Comments of block medical officer

Name
Signature of block medical officer
Date

Comments of Gram panchayat/S

Name
Signature of GRAM PANCHAYAT/s
Date

Suggestions to improve:

Madhya Pradesh														
Madhya Pradesh -> Panna														
Madhya Pradesh -> Ajaigarh														
Madhya Pradesh -> Marchhi Prad	Madhya Pradesh -> h	Madhya Pradesh -> h	Madhya Pradesh -> Beera	Madhya Pradesh -> Dewra	Madhya Pradesh -> Khora	Madhya Pradesh -> Kiratpur	Madhya Pradesh -> Kishanpur	Madhya Pradesh -> Nardaha	Madhya Pradesh -> Prades	Madhya Pradesh -> Prades	Madhya Pradesh -> Prades	Madhya Pradesh -> Prades	Madhya Pradesh -> Prades	Madhya Pradesh -> Prades
241 278 87	275	68	157	175	139	188	145	147	128	158	314	266	1	1
150 243 66	172	53	106	119	125	112	113	112	109	104	214	163	1	1
241 278 87	275	68	157	175	139	188	145	147	128	158	314	266	1	1
249 198 124	211	58	173	163	137	186	97	121	114	137	242	233	1	1
237 255 78	241	68	153	155	133	170	136	139	114	130	269	250	1	1
208 209 77	234	60	161	155	129	168	103	128	92	132	283	210	1	1
231 198 124	227	58	173	163	137	186	97	121	114	137	242	233	1	1
3 2 5	26	8	7	7	2	2	0	13	1	0	0	0	0	0
8 14 13	57	20	2	37	6	6	47	2	6	3	3	9	9	9
40 28 15	38	0	0	32	15	14	27	24	10	33	28	35	35	35
0 6 1	0	0	1	5	0	6	0	2	1	3	10	0	0	0
7 19 4	11	0	13	31	6	11	4	3	16	1	16	11	11	11
7 25 5	11	0	14	36	6	17	4	5	16	2	19	21	11	11
0 15 2	1	0	3	12	0	9	2	4	3	1	3	15	3	3
0 4 0	4	0	0	5	4	2	2	2	2	0	11	0	0	0
0 0 0	0	0	0	0	0	4	0	0	0	0	0	0	0	0
0 0 0	0	0	0	0	0	2	0	0	0	0	0	0	0	0
0 0 0	0	0	0	0	0	3	0	0	0	0	0	0	0	0
0 0 0	0	0	0	0	0	3	0	0	0	0	0	0	0	0
0 0 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6 11	6	0	7	18	3	10	2	4	8	2	11	13	6	6
1 14	5	0	7	18	3	11	2	1	8	0	8	8	5	5

Sr. No.	District	Health Block	Facility Type	Health Facility	Tehsil/Taluk a of Health Facility	SubFacility/S ubcenter	Tehsil/Taluk a of SubFacility/S ubCenter	Village
1	Panna	Ajaigarh	PHC	CHC Ajaigarh	Ajaigarh	SHC Aramganj	Ajaigarh	Aramganj (9514)
2	Panna	Ajaigarh	PHC	CHC Ajaigarh	Ajaigarh	SHC Aramganj	Ajaigarh	Bhujwai (9515)
3	Panna	Ajaigarh	PHC	CHC Ajaigarh	Ajaigarh	SHC Aramganj	Ajaigarh	Partappur (9513)
4	Panna	Ajaigarh	PHC	CHC Ajaigarh	Ajaigarh	SHC Aramganj	Ajaigarh	Singhpur (9511)
5	Panna	Ajaigarh	PHC	CHC Ajaigarh	Ajaigarh	SHC Aramganj	Ajaigarh	Taroni (9512)
6	Panna	Ajaigarh	PHC	CHC Ajaigarh	Ajaigarh	SHC Aramganj	Ajaigarh	Vishramganj (9516)
7	Panna	Ajaigarh	PHC	CHC Ajaigarh	Ajaigarh	SHC Guchhara	Ajaigarh	Bhairaha (9517)
8	Panna	Ajaigarh	PHC	CHC Ajaigarh	Ajaigarh	SHC Guchhara	Ajaigarh	Bhasuda (9518)
9	Panna	Ajaigarh	PHC	CHC Ajaigarh	Ajaigarh	SHC Guchhara	Ajaigarh	Chataini (9520)
10	Panna	Ajaigarh	PHC	CHC Ajaigarh	Ajaigarh	SHC Guchhara	Ajaigarh	Chunaha (9519)
11	Panna	Ajaigarh	PHC	CHC Ajaigarh	Ajaigarh	SHC Guchhara	Ajaigarh	Kalyanpur (9522)
12	Panna	Ajaigarh	PHC	CHC Ajaigarh	Ajaigarh	SHC	Ajaigarh	Salaiya

Equipments for Labour Room															Equipments	
at le h ss	Lab tabl wi fo	Spot Light with stand	Electric Horizont al Sterilizer	Radiant warmer	Neonatal Ambu Bag with Face	Adult Ambu Bag with Face	Oxygen cylinder with instrume	Normal Delivery Instrume nt Set	Doptone (Foetal Heart Monitor)	Instrume nt tray with cover -	Dressing Drum SS	Weighin g machine Adult	Weighin g machine Baby	Beds SS	Matres s of Foa	
		Available	Available	Available	Available	Available	Available	Available	Available	Available	Available	Available	Available	Available	Available	
	1	0	1	1	1	1	1	1	1	6	3	0	1	3	3	
	1	1	0	1	1	0	1	1	0	6	0	0	1	4	4	
	1	0	1	1	0	1	1	1	1	6	2	0	1	4	4	
	2	1	1	2	1	1	1	2	1	6	0*	0	1	16	16	

Availability of Human Resource (Names)													
Number	Contractual	Anesthetists		number of Gynaecologists				Number of LMOs (only MBBS				number of ayust	
		Bonded	LSAS Trained	Regular	Contractual	Bonded	EmOC Trained	Regular	Contractual	Bonded	Regular		Contractual
		0	0	0	0	0	0	0	0	0	1	0	1
		0	0	0	0	0	0	0	0	0	1	1	1
		0	0	0	0	0	0	0	0	0	0	1	1
		0	0	1	0	0	0	0	0	0	1	0	0

C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
Ministry of Health & Family Welfare													 Government of India	
Government of India														
Rashtriya Bal Swasthya Karyakram (RBSK)														
MONTHLY REPORTING FORMAT (Block/ District/ State) - Screening														
District:Hoshangabad						Block :All					Month & Year: April 14 to Mar 2015			
Number of children		Mobile Health team		No. of Functional Block MHT*		HR Training status			Screening visits organised (Monthly)					
No. of beneficiaries screened	Found positive for selected	Sanctioned	Functional				Training load	Trained		Desired Session	Planned	Held	Carried forward	
157568	17791	14	14	Doctors	339	Doctors	294	312	At AWC	1407	1742	1283	319	
166104	19321			Pharmacist	151	Pharmacist	138	146	At School	2118	2284	1879	194	
323672	37112			ANM/ Staff nurse	287	ANM/ Staff nurse	268	277		2509	2692	2191	330	
0-6 weeks						6 weeks to 6 years			6 years to 18 years			Total children		
Delivery points			ASHA, HBNC											
Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
363	309	673	120	245	365	47784	49598	97853	109301	115952	227092	157568	166104	323672
Number of children with selected health conditions														
0	0	0	0	0	0	4	6	9	0	0	0	4	6	10
0	5	5	0	0	0	4	12	16	2	1	3	6	18	24
0	7	7	0	0	0	5	1	6	7	15	22	12	23	35
0	0	0	0	0	0	12	20	32	27	12	39	39	32	71
0	0	0	0	0	0	10	2	12	0	1	1	10	3	13

Ministry of Health & Family Welfare Government of India Rashtriya Bal Swasthya Karyakram (RBSK) MONTHLY REPORTING FORMAT (Block/ District/ State) - Screening																	
State:		District: RAISEN TEAM 01 & 02					Block :				Month & Year:						
Number of children			Mobile Health team			HR Training status			Screening visits organised (Monthly)								
	Target No. of beneficiaries	No. of beneficiaries screened	Found positive for selected	Sanctioned	Functional	No. of Functional Block MHT*		Training load	Trained		Desired Session	Planned	Held	Carried forward			
Male	149409	95478	17753	110	96	Doctors	150	Doctors	37	101	At AWC	484	1492	1353	163		
Female	146518	98745	19448			Pharmacist	78	Pharmacist	30	37	At School	597	1347	1423	97		
Total	277749	194223	37201			ANMM Staff nurse	0	ANMM Staff nurse	11	0		342	0	820	38		
0-6 weeks 6 weeks to 6 years 6 years to 18 years Total children																	
Delivery points			ASHA, HBNC														
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total		
Number of Children screened in the month	2012	1772	3784	195	182	353	41711	42242	83953	51560	54549	107127	95478	98745	194223		
Sl No	Health Condition	Number of children with selected health conditions															
1	Neural tube	0	0	0	0	0	0	1	1	0	0	0	0	1	1		
2	Down's Syndrome	0	0	0	0	0	1	7	8	10	3	13	11	10	21		
3	Cleft Lip & Palate	0	0	0	0	0	3	10	13	6	7	13	9	16	25		
4	Club foot	0	0	0	0	0	14	23	35	20	25	45	34	48	82		
5	Developmental dysplasia of the hip	0	0	0	0	0	15	21	36	2	0	2	23	25	48		
6	Congenital cataract	0	0	0	0	0	7	3	9	7	2	9	13	5	18		
7	Congenital deafness	0	0	0	0	0	16	8	24	3	4	7	30	22	52		
8	Congenital heart diseases	0	0	0	0	0	30	8	38	11	12	23	38	22	60		
9	Retinopathy of Prematurity	0	0	0	0	0	0	0	0	1	2	3	2	2	4		
10	Severe	2	0	2	0	0	463	736	1199	1441	2948	4369	1827	3617	5444		