

**SUMMER TRAINING
AT NATIONAL HEALTH MISSION
MADHYA PRADESH**

(April 1-May 31, 2015)

By
Pratiksha pal
Roll No-1593

Under the Guidance of
Dr Shilpi mishra Sharma

MBA- Hospital and Health Management
2014-16



Institute of Health Management Research, Jaipur

CERTIFICATE

This is to certify you that Pratiksha Pal, a student of MBA Hospital and Health Management at The IIHMR University, Jaipur, batch 2014-2016 has successfully completed her summer training for the period from 1st April to 31st May at **National Health Mission, Madhya Pradesh** under my guidance. During this period she has completed the following study as a part of partial fulfillment of the course requirements recommended for MBA Hospital and Health Management.

All the data related to the study is primarily data collected by her. Her approach towards the study has been sincere, scientific and analytical.

I wish him all success for his future endeavors.



Col. (Dr) Ashok Kaushik

Dean (Academics & Student Affairs)

IIHMR University, Jaipur



Dr. Shilpi Mishra Sharma

Assistant Professor, Faculty Mentor

IIHMR University, Jaipur



National Health Mission State Health Society

Arera Hills, Bhopal Madhya Pradesh



TO WHOMSOEVER IT MAY CONCERN

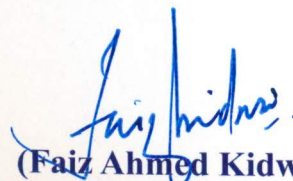
This is to certify that Dr. *Prateeksha Pal* student of MBA-Health & Hospital Management batch 2014-16 of IIHMR University, Jaipur (Rajasthan) has successfully completed his/her summer internship during 01-04-2015 to 31-05-2015.

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

Acknowledgement

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 Assistant Professor Shilpi Mishra Sharma, 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.

Table of contents

1.	About NHM	9
1.1	Goal	9
1.2	NRHM	9
1.3	NUHM	9
1.4	Financing	11
1.5	Health System Strengthening	11
1.6	RMNCH+A	12
1.7	Health Indicator	12
2	Task assigned -1	13
2.1	Objective	14
2.2	Methodology	14
2.3	Indicator	15
2.4	Psychometric analysis	17
3	Task assigned -2	19
3.1	Rationale	20
3.2	Objective	21
3.3	Research Design	21
3.4	Finding	24
3.5	Suggestion	24
3.6	Camp	24
4	Task assigned -3	25
4.1	Objective	26
4.2	Methodology	26
4.3	Key finding	28

List of Table

Table 1: Demographic, Socio-economic and Health profile of Madhya Pradesh State as compared to India	14
Table 2: indicators and their source.....	18
Table : 3 Comparison of districts on the basis of secondary data	27
Table.4 : Findings in districts	30
Table.5 : Facilities and area coverage.....	34

List of Figure

1. Oraganogram of NHM	16
2. Percentage distribution of RBSK Teams Members by their knowledge and practice	26
3. Percentage of distribution of children screened Treated and referred	27
4. Distribution of referred children by RBSK team to facilities	27

Abbreviation

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	Behaviour 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 centre 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.

National Health Mission

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.

Goal

Outcomes for NHM in the 12th Plan are synonymous with those of the 12th Plan, and are part of the overall vision. The endeavour would be to ensure achievement of those indicators. 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.

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

National Rural Health Mission (NRHM)

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

NRHM seeks to provide equitable, affordable and quality health care to the rural population, especially the vulnerable groups. Under the NRHM, the Empowered Action Group (EAG) States as well as North Eastern States, Jammu and Kashmir and Himachal Pradesh have been given special focus. The thrust of the mission is on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities.

NATIONAL URBAN HEALTH MISSION (NEW SCHEME)

The National Urban Health Mission (NUHM) as a sub-mission of National Health Mission (NHM) has been approved by the Cabinet on 1st May 2013.

NUHM envisages to meet health care needs of the urban population with the focus on urban poor, by making available to them essential primary health care services and reducing their out of pocket expenses for treatment. This will be achieved by strengthening the existing health care service delivery system, targeting the people living in slums and converging with various schemes relating to wider determinants of health like drinking water, sanitation, school education, etc. implemented by the Ministries of Urban Development, Housing & Urban Poverty Alleviation, Human Resource Development and Women & Child Development.

NUHM would Endeavour to achieve its goal through:-

- i) Need based city specific urban health care system to meet the diverse health care needs of the urban poor and other vulnerable sections.
- ii) Institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population.
- iii) Partnership with community and local bodies for a more proactive involvement in planning, implementation, and monitoring of health activities.

- iv) Availability of resources for providing essential primary health care to urban poor.
- v) Partnerships with NGOs, for profit and not for profit health service providers and other stakeholders.

NUHM would cover all State capitals, district headquarters and cities/towns with a population of more than 50000. It would primarily focus on slum dwellers and other marginalized groups like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, street children, construction site workers.

The centre-state funding pattern will be 75:25 for all the States except North-Eastern states including Sikkim and other special category states of Jammu & Kashmir, Himachal Pradesh and Uttarakhand, for whom the centre-state funding pattern will be 90:10. The Programme Implementation Plans (PIPs) sent by the states are appraised and approved by the Ministry.

Financing

Financial Management Group(FMG) working under NHM Finance Division of Ministry of Health & Family Welfare is involved in planning, budgeting, accounting, financial reporting, internal controls including internal audit, external audit, procurement, disbursement of funds and monitoring the physical and financial performance of the programme, with the main aim of managing resources efficiently and achieving pre-determined objectives. Sound financial management is a critical input for decision making and programme success. Accurate and timely financial information provides a basis for informed decisions about the programme, fund release and assists in reducing delays for smooth programme implementation. FMG tries to ensure that all programmes receive their funds in a timely manner after adhering to all the GFR provisions and DoE conditional ties. Under NHM, it is the Endeavour of the Government of India to build effective financial management capabilities for managing the funds provided to the State Health Societies. The States have also been encouraged to set up Financial Management Groups (FMG) at the State and Strengthen financial management capacities at District level.

Health Systems Strengthening

- **Adoption of the Indian Public Health Standards:** This defined not only the service package that each facility must provide, but also specified the minimum inputs required to ensure quality of care, in terms of infrastructure, equipment, skilled human resources, and supplies. It was an assurance to the states of financing the gaps between available levels of these inputs and the levels needed to achieve the IPHS norms. A substantial increase in these inputs was driven by facility surveys to identify gaps and then planning and financing to close these gaps.

- **Quality standards** have been defined with respect to clinical protocols, administrative and management processes and for support services. The Operational Guidelines for Maternal and Newborn care published by the Ministry of Health and Family Welfare comprehensively defined such quality standards for RCH care.
- **Skill gaps and Standard Treatment Protocols:** Skill sets and standard treatment protocols required for provide quality RCH services and training packages that would provide these skill sets were designed. These include the Skilled Birth Attendance (SBA) training package for ANMs, the Navjat Shishu Suraksha Karyakram (NSSK) and the IMNCI packages for ANMs, the Home Based Newborn Care (HBNC) for ASHAs, and the Emergency Obstetric Care (EmOC) package for doctors. These training packages also introduced the standard treatment protocols in each of these areas.
- **Hospital Management Societies (RKS) and untied funds:** The mandatory creation of a hospital management society (Rogi Kalyan Samiti) and empowering this body with untied funds has allowed public participation also contributed to improved quality of care. RKS members were trained and sensitized on quality of care issues. Before the onset of NRHM, many states generated funds from user fees, however the untied grants to all public health facilities were made available under NRHM which reduced financial barriers to access of health care. This is clearly evident from the increased utilization of indoor and outdoor services at health facilities
- **Quality Improvement Programme:** NRHM also supports initiatives for building quality management systems. These range from formation of quality assurance committees which use check lists and periodic monitoring visits to assess quality gaps, to more structured quality management systems leading to a third party audit and quality certification- either using ISO 9001: 2008 or NABH. Till date, 82 facilities have been certified by ISO, nine facilities have been certified by NABH and 446 facilities are under process of certification.

Reproductive, Maternal, Newborn, Child and Adolescent Health

RMNCH+A approach has been launched in 2013 and it essentially looks to address the major causes of mortality among women and children as well as the delays in accessing and utilizing health care and services. The RMNCH+A strategic approach has been developed to provide an understanding of 'continuum of care' to ensure equal focus on various life stages. Priority interventions for each thematic area have been included in this to ensure that the linkages between them are contextualized to the same and consecutive life stage. It also introduces new initiatives like the use of Score Card to track the performance, National Iron + Initiative to address the issue of anemia across all age groups and the Comprehensive Screening and Early interventions for defects at birth, diseases and deficiencies among children and adolescents. The RMNCH+A appropriately directs the States to focus their efforts on the most vulnerable population and disadvantaged groups in the country. It also emphasizes on the need to reinforce efforts in those poor performing districts that have already been identified as the high focus districts.

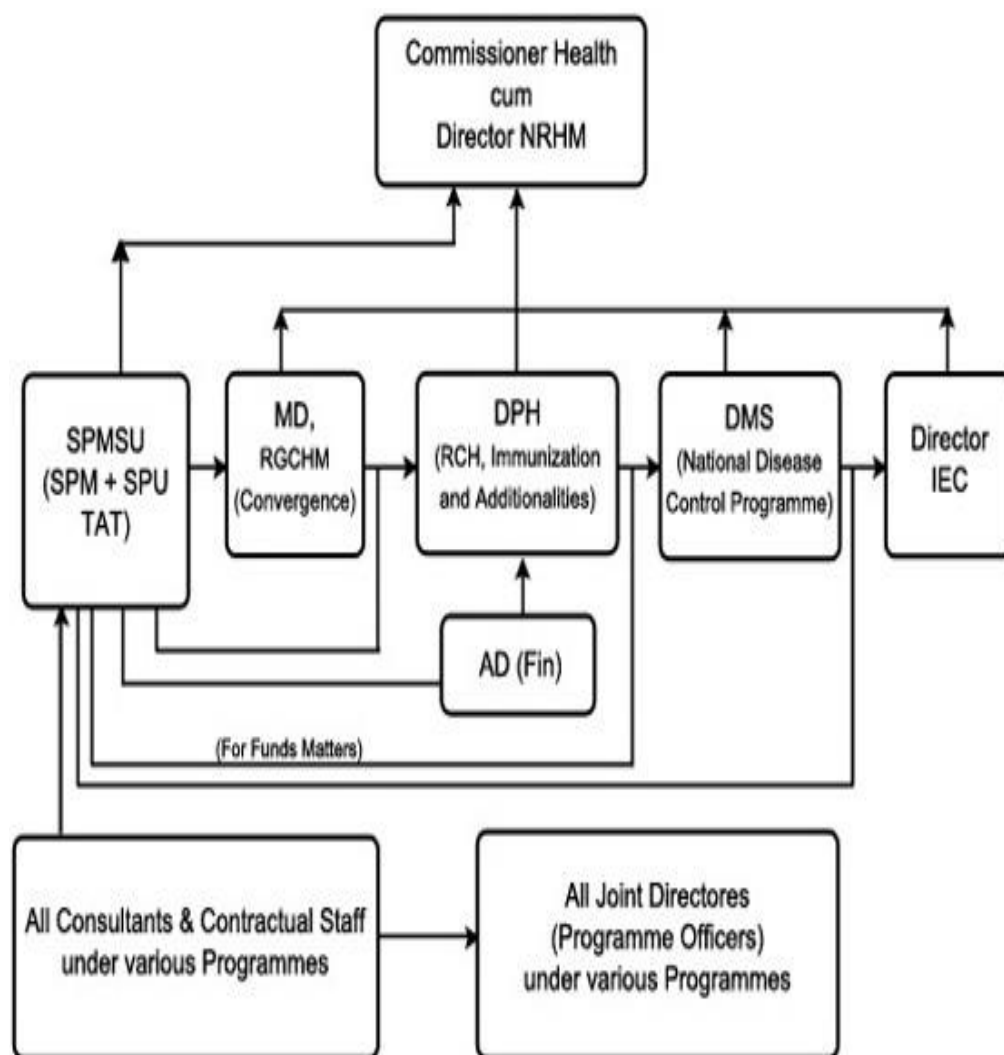
HEALTH INDICATORS of MADHYA PRADESH:

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 1: Demographic, Socio-economic and Health profile of Madhya Pradesh State as compared to India figures

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

Fig 1: Organogram of NHM (M.P)



Task Assigned

i) **HUMAN RESOURCE:**

To design a performance appraisal for Auxiliary Nurse Midwife at a sub centre level non delivery point through HMIS and MCTS

ii) **RASHTRIYA BAL SWASTHYA KARYAKRAM:**

Comparative study of RBSK program implementation in two districts of Madhya Pradesh

iii) **MATERNAL HEALTH:**

Rapid assessment of non functional L2 level facility

TASK -1 Make an performance appraisal for an ANM at sub centre level (non delivery point)

Objective

- To make a performance appraisal for an ANM , which is more objective in nature so that her performance can be assessed directly and compared meaningfully with the other ANM.
- The KRA's (Key Result Areas) to be taken out through HIMS and MCTS.
- A psychometric analysis to be done to assess her role efficacy.

Methodology

Data collection method - Secondary data collection.

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 centres under it.

Those sub centres were taken which were non delivery point and catered to a population of approximately 5000 (*source of population of each village under each sub centre 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 centre non delivery point.

Table 2: indicators and their source

Indicators	Source
Probable number of pregnancy	Population of area*birth rate of area
% 1 st trimester registration to total registration	HMIS,MCTS
% of women receive 3 ANC's to total registration	HMIS,MCTS
% of women receive TT2 or booster to total registration	HMIS,MCTS
% women given 100 IFA to total ANC registered women	HMIS,MCTS
% of institutional delivery to ANC registered	HMIS,MCTS
% of infants 0-11 month old received measles vaccine to reported live birth	HMIS
% of full immunization to total registered children	MCTS
% dropouts between BCG to Measles	MCTS
% dropouts between OPV1 TO OPV3	MCTS
% dropouts between DPT1 to DPT3	MCTS
% dropouts HEP1 to HEP3	MCTS
% of children below 3 years received vit. A	MCTS
% of children below 5 years received DT	HMIS
% of women diagnosed anaemic to total registered women	HIMS,MCTS
% of women diagnosed high blood pressure to total ANC registered	HMIS
Utilization of untied fund	

INDICATOR FOR ESTIMATING PROBABLE NUMBER OF PREGNANCIES

1. 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 = $1,00,000 \times 25/1000$

Probable number of Pregnancies=2500

2. 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.

3 Number of antenatal registration = $2500 + [(2500 \times 10)/100] = 2750$

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 = $2750 + [(2750 \times 15)/100] = 3162.5$.

3 Antenatal Cases Registered are Anaemic

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 anaemic women in population will be approximately $2750 \times 50/100 = 1375$.

4 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.

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

Task: 2

A COMPARATIVE STUDY OF RASHTRIYA BAL
SWASTHYA KARYAKRAM IN TWO DISTRICTS OF
MADHYA PRADESH

BACKGROUND

Rashtriya Bal Swasthya Karyakram (RBSK) is a new initiative which seeks to put together a systematic approach to child health screening and early intervention. It is well-known that the early years of a child's life are most critical for both survival and development and yet currently, there is no approach to screen structured children, identify health conditions warranting medical attention and ensure early intervention.

There is an unacceptably high incidence of birth defects, deficiencies, diseases specific to childhood and developmental disorders including disabilities in India and it is high time we started to pay attention to their early detection and intervention.

As per available estimates, 6% of children are born with birth defects, 10% children are detected with development delays leading to disabilities. This translates into more than 15 lakh new-borns with birth defects annually.

Further, 4% of under five mortality and 10% of neonatal mortality is attributed to birth defects. Needless to say, that 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.

Rashtriya Bal Swasthya Karyakram aims to roll out to over 27 crore children from 0-18 years of age. Screening of the new-born, both at public health facilities and at home, is an important component of the strategy. Regular health screening of pre-school children upto 6 years of age using Aganwadis as a platform is another essential component. Moreover, children from 6 to 18 years of age studying in Government and Government aided schools would also receive regular health check-ups. All those children who may be diagnosed for any of the 30 illnesses would receive follow-up referral support and treatment including surgical interventions at tertiary level free of cost under this programme.

RATIONALE

In a vast country like India, the need for ensuring a healthy and dynamic future for a large populace and creating a developed society, agile and able to compete with the rest of the world, stands as of paramount importance. The dream of such a healthy and developed society can be achieved through concerted efforts and initiatives undertaken in a systematic manner at all levels. Equitable child health, care and early detection and treatment can be the most pragmatic initiative, or rather solution, at this juncture.

The ‘Child Health Screening and Early Intervention Services’ Programme under National Rural Health Mission initiated by the Ministry of Health and Family Welfare, therefore, aims at early detection and management of the 4Ds prevalent in children. These are Defects at birth, Diseases in children, Deficiency conditions and Developmental Delays including Disabilities.

Health screening of children is a known intervention under the School Health Programme. It is now being expanded to cover all children from birth to 18 years of age. The Programme has been initiated as significant progress has already been made in reducing child mortality under the National Rural Health Mission. However, further gains can be achieved by early detection and management of conditions in all age groups.

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 hospitalisation 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 marginalised population in the country. 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). Such a data is expected to hold
Relevance for future planning of area specific services.

OBJECTIVES

- To know the current status of RBSK implementation at Raisen and Hoshangabad districts.
- To facilitate positive diagnosed children under RBSK.

RESEARCH DESIGN

Study Area – Raisen and Hoshangabad districts

Study Design – Descriptive

Data Collection Method – Primary and Secondary

Primary Data - Interview schedule- Same structured questionnaire of 20 items to assess the knowledge and practice of health care personnel both the districts 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 answers a score of 0.

Total Scores – 20 (ranged 0-20)

<50 % (<10)- Inadequate knowledge

50-75 %(11-15) - Moderate knowledge

>75% (>15) – Adequate knowledge

Secondary Data -

- Monthly screening report
- Quarterly health card

Table : 3 Comparison of districts on the basis of secondary data

HOSHANGABAD	RAISEN
	
7 blocks , 14 health team Target screened children - 369600	7 blocks , 14 health team Target screened children - 369600
Number of children screened - 323674	Number of children screened - 159217
Number of surgery done - 87	Number of surgery done - 1

Findings -

**Fig. 2 : PERCENTAGE OF DISTRIBUTION OF RBSK TEAM MEMBERS
BY THEIR KNOWLEDGE & PRACTICE**

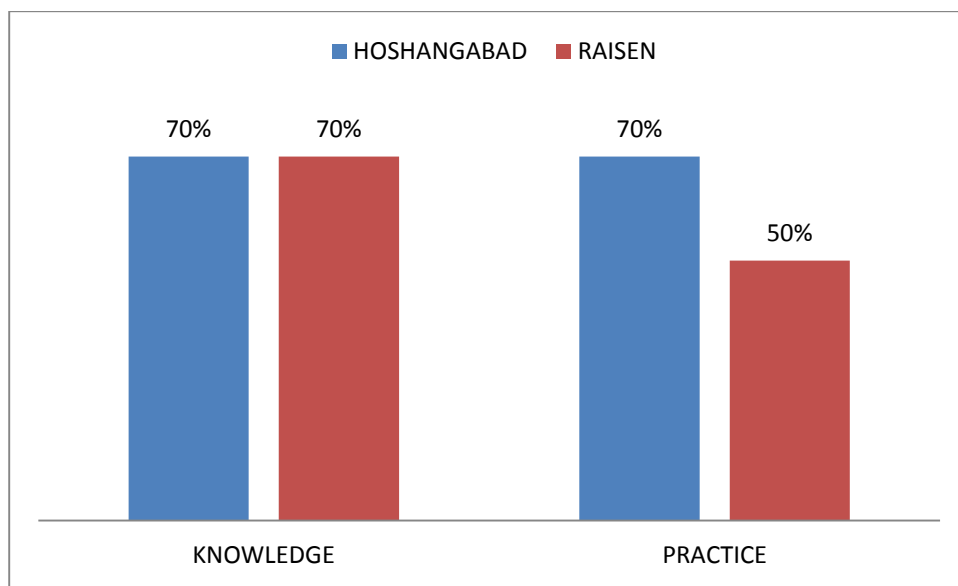


Fig 2 : The above graph shows that the knowledge level of both the teams is equal but practice level of Hoshangabad team is 20 % more than that of Raisen RBSK team

Fig . 3 : Percentage distribution of children screened , treated and referred

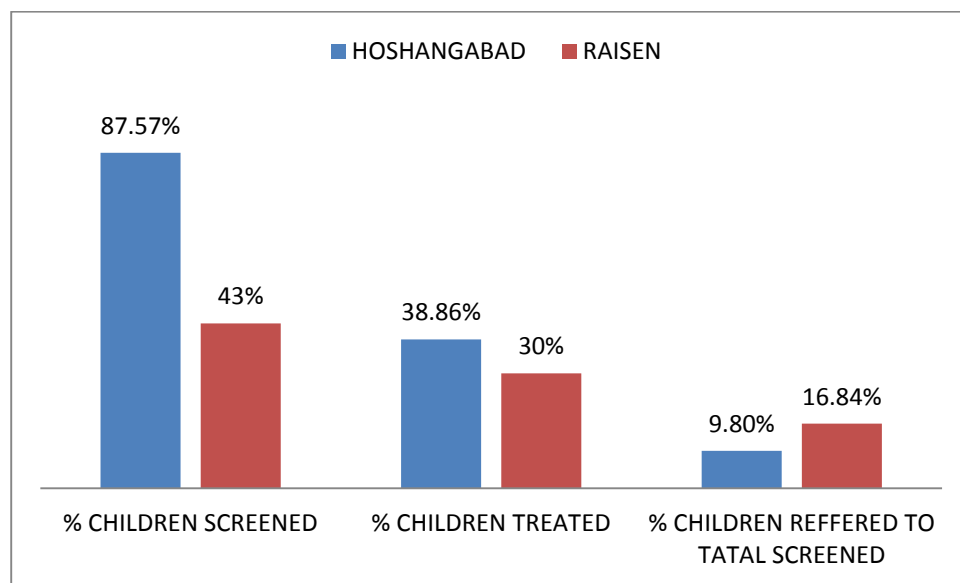


Fig 3 : The above graph shows that screening and treatment level of children is higher in ut hoshangabad but % of children referred is higher in Raisen than Hoshangabad

Fig. 4 : Distribution of referred children by RBSK teams to facilities

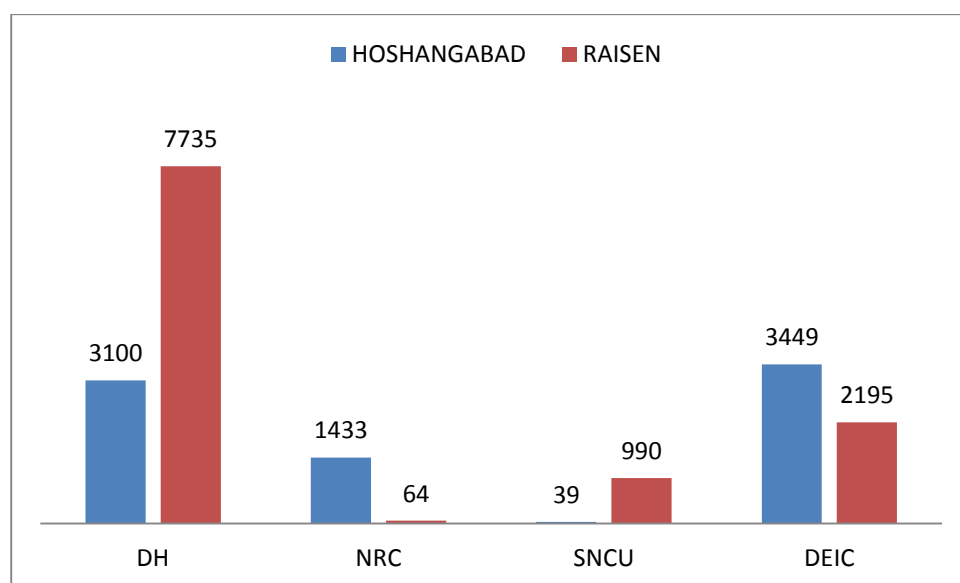


Fig.4 : The above graph shows that no of referral level is higher in Raisen than Hoshangabad

Table.4 : Comparison of RBSK program of 2 districts

	HOSHANGABAD	RAISEN
HUMAN RESOURCE	RBSK coordinator	Vacant position
INFRASTRUCTURE	Well established DEIC	DEIC is proposed
PLANNING	Well designed micro plan as per RBSK guide line Proper information flow to stakeholder	No scheduled micro plan Stakeholders lack information
TOOL	Availability of all functional tools and equipments as per guide lines	Tools and equipment inadequate as per guide lines
LEADERSHIP	Able leadership and cordial behaviour	lack of leadership skill

REASONS FOR POOR PERFORMANCE OF RBSK TEAM (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 who 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

Suggestions –

- Regular monitoring and supervision of mobile teams of RBSK.
- More and more spot treatments
- Software may help for easy and quality reporting .

Camp conduction at Raisen District Hospital –

A camp was conducted for positive screened Cleft lip and palate children. 13 children were mobilised and treated at Bisoniya Hospital;

Bhopal Post Surgery follow up was done

Task: 3

Rapid Assessment of Non Functional and Functional Delivery Point

Introduction

Public health facilities such as the District Hospital (DH)/Sub-district Hospital (SDH)/Community Health Centre (CHC)/Primary Health Centre (PHC)/Sub-district Health Centre (SHC) are categorized depending on the levels (1, 2 and 3) of maternal and child health care and service delivery. Among these levels, some have been categorized as delivery points based on their performance and case load. Provision of service for delivery in a facility generally serves as an important indicator to assess whether the facility is operational or not. The concept of delivery point emerges from this presumption. Among the facilities, designated as L1, L2 and L3 there are some facilities which are conducting deliveries above a minimum benchmark. These facilities are designated as **Delivery Points**. According to Government of India (GoI) mandate, these functional facilities should be the first to be strengthened for providing comprehensive reproductive maternal newborn and child health (RMNCH) services.

Objective

The main objective of this rapid assessment is to rapidly understand the gaps in the implementation of a set of strategic RMNCH+A interventions across delivery point, so that a baseline for monitoring the progress of RMNCH+A is established, that can also be used for setting targets and strategies by the district administration. More specifically, this rapid assessment aims at measuring the gaps in:

- Resource availability in terms of infrastructure, human resources, capacity, fund availability, needed to deliver a set of key RMNCH+A interventions in the facilities .
- Health systems capacities at district and state levels to manage infrastructure, human resources, capacity building, supportive supervision.

Direct observation and Primary data collection from delivery points in the district (Sehore, Madhya Pradesh) was done.

Assessment was done on the basis of checklist provided by Maternal Health department to find out that whether these delivery points in the district have adequate

1. Infrastructure
2. Skilled Human Resources
3. Capacity
4. Equipment And Commodities

5. Emergency Transportation to provide each of the strategic RMNCH+A interventions with quality.

Methodology

Study design

Study area- Sehore district

Study type- Descriptive

Method of data collection- primary data collection

Tool: Assessment was done on the basis of **checklist** provided by Maternal Health department. (Currently in use in the State)

The tool consists of following components:

- Equipments of labor room
- Equipments of maternity ward
- Availability of human resource
- Infrastructure

Facilities visited: Sehore District, Madhya Pradesh

- PHC Amlaha, Functional Delivery Point (Level 1)
- PHC Kotri, Non Functional Delivery Point (Level 1)
- PHC Ramnagar , Non Functional Delivery Point (Level 1)
- CHC Icchawar, Functional Delivery Point (Level 2)

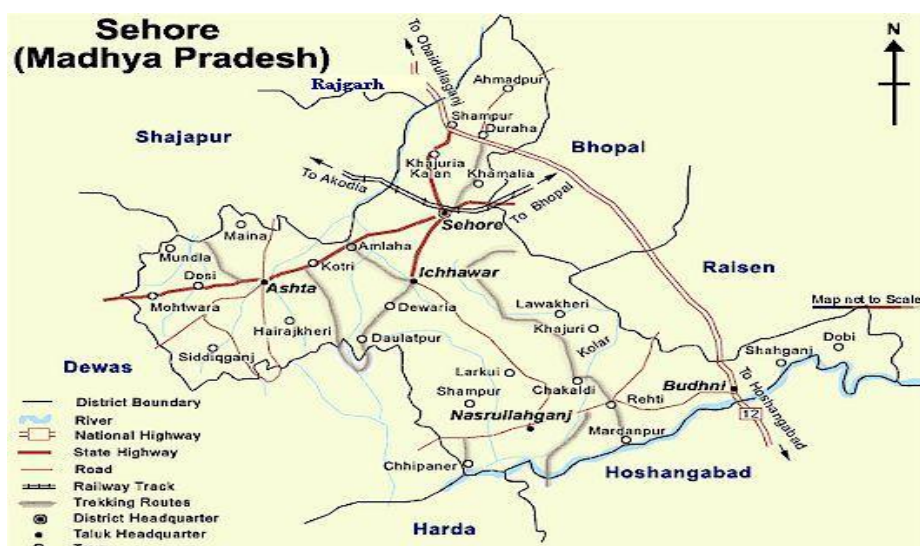


Table.5 : Facilities and area coverage

NAME OF FACILITY	TRAVELED (KM)	POPULATION	NUMBER OF VILLAGES	NUMBER OF DELIVERIES PER MONTH	NUMBER OF DELIVERIES IN 2013-14
PHC Amlaha, Functional Delivery Point (Level 1)	Bhopal to Sehore – 45 kms Sehore to Amlaha- 23 kms	23681	23	12-15	137
PHC Kotri, Non Functional Delivery Point (Level 1)	Amlaha to Kotri -10 kms	36400	36	0-2	50
PHC Ramnagar, Non Functional Delivery Point (Level 1)	Kotri to Ramnagar- 15kms	24590	21	2-3	44
CHC Ichhawa, Functional Delivery Point	Ramnagar to Ichhawa 45 km	1,60,000	Sub centers	100-150	1363

Key Findings:

❑ PHC Amlaha , functional delivery point(Level 1)

EQUIPMENTS IN LABOUR ROOM

- One set of trays for delivery
- Adult ambu bag - Unavailable
- Adult weighing machine - Unavailable
- Spot light with stand was – Unavailable

EQUIPMENT IN MATERNITY WARD

- Unhygienic
- Bedside stools and locker – Unavailable

AVAILABILITY OF HUMAN RESOURCE

- One medical officer has to look after the phc
- He is not trained for conducting deliveries Infrastructure
- Unavailability of sweeper

• INFRASTRUCTURE :

- improper infrastructure resource allocation (three Storage rooms)

As per maternal health protocols the medical officer did not undergo a refresher training

❑ PHC Kothari, Non Functional Delivery Point (Level 1)

EQUIPMENTS IN LABOUR ROOM

- Labour room was in equipped
- No sterilization protocols were followed and no equipment for sterilization present.

EQUIPMENTS IN MATERNITY WARD:

Unhygienic condition

AVAILABILITY OF HR

- One Medical officer
- Non SBA trained staff nurse

INFRASTRUCTURE:

Poor condition of hospital building

❑ PHC Ramnagar , Non Functional Delivery Point (Level 1)**EQUIPMENTS IN LABOUR ROOM**

- Incomplete and unorganized trays
- No running water supply
- Pediatric Ambu bag - unavailable
- Autoclave- unavailable
- Spot light with stand – unavailable
- Examination table – unavailable
-

EQUIPMENTS IN MATERNITY WARD:

No attached washroom with maternity ward

AVAILABILITY OF HR:

Conflicts between new appointed contractual nurse and regular ANM

INFRASTRUCTURE: Average infrastructure

❑ CHC Icchawar, Functional Delivery Point (Level 2)**EQUIPMENTS IN LABOUR ROOM**

- Incomplete and unorganized trays
- Needle cutter not being used
- Broken needle and syringe lying on the floor
- The suction machine available but not present in the labour room
- Floor and walls not clean
- Almirah present in labour room
- No wall clock
- No adult weighing machine

NBSU

- No designated bed in the post natal ward
- No provision of hand washing area and containment of infection control

EQUIPMENTS IN MATERNITY WARD: Well Equipped

AVAILABILITY OF HR:

- less number of sweepers
- no RCH staff nurse

INFRASTRUCTURE: Good

REASONS for non functionality (Kothari level – 1 PHC (non functional))

- One medical officer who is frequently on leave
- Delivery is conducted by 1 staff nurse (non trained), 4 ANM and 1 LHV
- PHC is located on Indore-Bhopal highway and nearby delivery centres are Ashta (CHC) & Sehore (DH)
- Weak community mobilization by Medical Officer and staff

REASONS for non functionality (Ramnagar level- 1 PHC (non functional))

- Ayush medical officer
- Staff include Staff nurse -1, LHV- 1, ANM – 2 (deliveries were conducted by them)
- Nearest delivery centre is Icchawar CHC
- Geographical issues - A water body around Ramnagar PHC
- Conflicts between new appointed contractual nurse and regular ANM

Recommendations

Regular review at state and district level is critical for quality outcome of any programme.

Importance of improving quality of health care needs emphasis. Improved qualities have a positive impact on clients' willingness to accept and effectively use service

- Quality of care is ensured by adhering to professional standards
- Standardized processes and procedures should be followed to deliver services
- Improving the service quality by focusing on identified gaps
- Continuously review resolving of identified problems.

All these will ensure quality and lead to patients (clients) satisfaction.

Further,

- Making a team within the facility responsible for facilitating quality assurance
- Periodic assessment of various services and identification of strengths and gaps, based on standards
- Action plan with time line for addressing the gaps
- Adhering to and practicing established and standard technical protocols
- Continuous handholding and supportive supervision
- Ensuring IMEP practices
- Prescription audits
- Regular interaction with clients
- Reorientation training courses should be conducted at regular intervals