Summer Training at

State Health Resource Centre,

Raipur(CG)

(26th March 2015- 25th May 2015)

"To study the gaps and causes contributing to child mortality in rural Chhattisgarh using Verbal Autopsy tool"

by-

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MBA-HM

(2014-2016)

INSTITUTE OF HEALTH MANAGEMENT AND RESEARCH

JAIPUR

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

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that Dr. Meenakshi Agrawal has undergone her Summer Training in State Health Resource Centre, Raipur(CG) from 26th March 2015 to 25th May 2015. The candidate herself carried out all the studies related to her Summer Training. Her approach to the study has been scientific and analytical.

The summer training is in partial fulfilment of the course requirement recommended for the award of Master of Business Administration-Health & Hospital Management.

I wish her success in all her future endeavours.

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SHRC/ 385 / HR/ 2015 Date: - 25/05/2015

COMPLETION CERTIFICATE

This is to certify that **Dr. Meenakshi Agrawal** from IIHMR, Jaipur has successfully completed summer training at **State Health Resource Centre, Chhattisgarh.**

She has undergone the summer training from **26.03.2015 to 25.05.2015** and assigned data analysis work for the study **"Verbal autopsies to study the gaps and causes contributing to child mortality in rural Chhattisgarh".** The assignment was completed well and we appreciate her sincere & competent effort.

25/5/15

Sr. Programme Coordinator
(Admin & HR)
SHRC, Chhattisgarh

Acknowledgment

The success of any task would be incomplete without the expression of gratitude to the people who made it possible. I express my sincere gratitude towards everyone who helped directly or indirectly in completion of my summer training from State Health Resource Centre, Raipur (Chhattisgarh).

At the onset of report, I would like to acknowledge my sincere thanks to our University, Institute of Health Management and research, Jaipur, Rajasthan to provide us great platform to gain enough knowledge and skills in different aspects of health management.

I am indebted to Dr. Prabeer chattergee, Executive Director of SHRC Raipur, for providing me opportunity to work with organization and make my summer training a valuable experience.

I owe my sincere thanks to Project Associate (SHRC) Raipur, Mrs. Mahima Sethi and Ms. Pragya Singh to guide me all along the completion of my project providing me all required resources and information without which the completion of the project would not have been possible.

I express my gratitude towards my mentor Mr. Abhishek Dadhich, Assistant Professor, IIHMR Jaipur , for able guidance and useful suggestions which helped me in completing the project work.

Last but not the least I am forever grateful to my parents and family for their blessings, for having unwavering faith in me and for being an endless source of inspiration and support.

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ABBRIVIATIONS

ANM…….Auxilliary Nurse Midwifery

AWW……Anganwadi Worker

AAI……Action Aid India

CHW……..Community Health Worker

ICDS……..Integrated Child Development Services

MT…….Mitanin Trainer

PHC……Primary Health Center

RCH……Reproductive Child Health

SIP…….Sector Investment Programme

SHRC……State Health Resource Center

SPS…… Swasthya Panchayak Samaniyojak

VHSNC…….Village Health Sanitation and Nutrition Committee

ORGANIZATION PROFILE

State Health Resource Center

The State Health Resource Center, Chhattisgarh is an autonomous organization which was designed as an "additional technical capacity to the Department of Health & Family Welfare Chhattisgarh". Its main role is to provide in the process of health sector reforms.

This includes support in:

- Policy planning and strategic thinking
- Capacity development
- Development of innovative and adaptive programme designs
- Community based health programmes
- Conducting health system research
- Assisting the Department of Health & Family Welfare, Chhattisgarh to implement innovative strategies

To facilitate this, the SHRC has an innovative work charter, a special organizational structure and an appropriate positioning.

Formation of SHRC

In March 2002, RCH society, Chhattisgarh and the regional office (Raipur) of Action Aid India Society executed a Memorandum of Understanding. The MoU was signed in the context of European Commission and Sector Investment Programme (SIP). The State Health Resource Center, Chhattisgarh was founded as additional technical capacity to the Department of Health & Family Welfare, Chhattisgarh and as a state-civil-society body whereas the Action Aid's role was to coordinate civil society organizations in setting up such a body. During the following two years the initial team was put together and the institution was made able to stand on its own. Since 2004 the SHRC has been functioning as a fully autonomous institution.[1]

Vision and Mission

Vision: We as a State Civil Society Partnership Organization of public health professionals are an enabler in Chhattisgarh attaining for its every citizen highest attainable level of physical, mental, social and spiritual health and quality health care that is equitable universally accessible, affordable and gender sensitive through empowerment of communities and development of an accountable and responsive health system.

Mission: To aspire for achievement of the highest level of efficiency & quality in delivery system both Government & Non-government to provide the most professional technical support to Government, to act as a catalyst and innovator in public health, to inspire and sustain motivation of committed staff and civil society groups in community health.

Strategies:

1. Generating evidence for policy formulation & strategic planning of interventions in health
2. Conceptualizing and designing programmes addressing prioritized health problems
3. Piloting innovations for feasibility of up scaling
4. Community mobilization, organization and capacity building leading to empowerment
5. Training & skill up-gradation of health functionaries, stakeholders and partners and their networking
6. Monitoring and evaluation of programmes, services for quality, client satisfaction, impact and outcomes

Core values:

1. Upholding human dignity, universal brother hood and harmony
2. Equity & justice
3. Intolerance to corruption & exploitation of the weak
4. Preferential option for the poor and giving chance to the marginalized
5. Excellence and quality in everything we do

6. Convergence and networking rather than doing alone
7. Empowerment and system building for sustainability
8. Putting people and communities first above our own interest

One major example of SHRC roles has been in the Mitanin Programme where it built up an innovative and locally adapted programme design, helping to find and to support people within the government to play leadership roles and to bring in and to train the best within civil society. The SHRC scientifically took up the programme and based on feed back, improved the design, trained the trainers and even routed the funds the district health societies. Moreover it built up flexible but rigorous accounting procedure that ensured an expenditure and utilization in the desired manners.

ORGANIZATION ROLE:

The SHRC, Chhattisgarh play the following roles:

1) Assist the department in evolving project and programme and in providing strategic analysis that would guide the process of planning.

2) Develop guidelines, communication material, and draft orders etc. for approved innovative projects and health sector reforms strategies that have to be implemented.

3) Locate and contract in suitable technical expertise to work with state teams to develop proposals, evaluate programme or assist implementation.

4) Undertake formative as well as operational research and hold rapid programme appraisals to make panning based on evidences and to assess programme towards initiating corrective measures

5) Support the directorate and implementation authorities in monitoring reforms measures, troubleshooting problems and building consensus and providing internal advocacy for reform measures at various

6) Sustain civil society participation in reforms process and ensure all support measures for the partnership programme success.

7) Undertake financial planning and management support for new and innovative programme of a sort that the department is unused to running. Such management functions mode with the

directorate enabled to take up the activity soon once them the system of management are established.

One major example of SHRC roles has been in the Mitanin programme where it built up an innovative and locally adapted programme design, helping to find and to support people within the government to play leadership roles and to bring in and to train the best within civil society. The SHRC scientifically took up the programme and based on feedback, improved the design, trained the trainers and even routed the funds the district health societies. Moreover it built up flexible but rigorous accounting procedure that ensured an expenditure and utilization in the desired manners

MITANIN PROGRAMME, CHHATTISGARH

Poor health education, poor access to health services and the prevailing cultural practices and socio-economic context of those living in rural area of Chhattisgarh has led to high levels of disease and a low utilization of health services .The community needed to be encouraged to address its own health needs by requesting and taking part in health programmes relevant to those needs and also using the health services already on offer. The first step was to organize and empower women in the community as well as Panchayati Raj Institutions. This was done by an establishing a state-wide Community Health Volunteering (CHV) programme which trained a deployed a CHV in every single hamlet of this state. The CHV is called as Mitanin (A special kind of friend in local tradition) and is a married woman from the local community, not necessarily formally educated though almost literate.[2]

This scheme involves some guarantees to the community from the Government, and some responsibilities, to be taken by the Community, and Panchayati Raj Institutions.

Role of Mitanins:

Her main role is to provide:

a. Elementary health education
b. Facilitate access to health services
c. First aid help and treatment of minor ailments with over the counter drugs
d. Prompt referral advice where necessary
e. Facilitate collective disease preventive action by the community
f. Organize and empower women

She is supported at the hamlet level by a women's health committee and by the health and Integrated Child Development Services (ICDS) workers.

Selection

Mitanins are selected by the Gram Sabha and the same is endorsed by the Panchayats. There is a specific set of processes for the selection, facilitated by a trained person for the purpose and supported by massive and rigorous social mobilization activities like Kalajathas.

Training of "Mitanins"

After a "Mitanin" is selected, and a formal agreement is signed between the "Mitanin" and the community of the habitation, and approved by the Gram Sabha, the Village Panchayat endorses the selection and in effect sends a request to the Block Medical Officer to train the "Mitanin". All the expenditure on the training is borne by the Government. "Mitanins" are provided training in many stages. First stage of the training, itself made of six rounds is institutional. The second stage of the training will be a series of refresher trainings organized at regular intervals at the panchayat or cluster level or PHC through suitable training institutions and training arrangements.

Functions of Mitanin:

Three main functions of Mitanin:

a. **Service provider**: She keeps and maintains a medicine kit and supplies medicines for common sign and symptoms
b. **Link maker**: She forms the link between the community and health system. Helps in transporting pregnant women to appropriate health facility
c. **Activist:** She makes people avail the right and stands for them. She keeps matters of community in front of block officer and higher authorities.

THE COMMUNITY HEALTH WORKER SCHEME

It is a generally accepted fact that improvements in Primary Health can be made only through the involvement of communities in the delivery of health services. Some of these different meanings are described below:

1) Community participation is whole hearted acceptance of Government schemes by the people. They feel Government knows what is best for the people, and therefore makes the policies and programmes, which are best suited for their good. If people do not benefit from

such programmes it is their own fault, as they do not participate fully in Government schemes.

2. Government should launch Information, Education, and Communication (IEC) programmes, so that people understand the importance of using the services. According to this view also the blame rests squarely at the people for not using services.

This scheme involves some guarantees to the community from the Government, and some responsibilities, to be taken by the Community, and Panchayat Raj Institutions These responsibilities are described below.

Responsibilities of community and panchayat:

1) Publicity of the scheme in the communities.

2) Mobilizing the communities for Health.

3) Helping the communities to identify one "Mitanin" for each habitation. The Mitanin can be any woman living in the habitation acceptable to the community

4) Helping the community in deciding a compensation package for the Mitanin. The Mitanin will be a volunteer, who will not get any honorarium or salary from the Government. However she will need to be compensated for her time and efforts by the community. The community may pay the Mitanin directly a fixed amount, either in cash or in kind (Form of grain)

5) Provide space in each habitation for health related activities, including immunization, labor, storing of medicines, etc.

Support from government:

The Community and the Panchayat fulfil their responsibilities, they can make an application to the collector of the district for the Government to fulfil its guarantees, and the Government will then guarantee the following.

1) Government will give refresher training to the Mitanin as often as is necessary, and till such time as the Mitanin is fully competent to do her job well.

2) Government will integrate the Mitanin in the Government Health delivery system.

3) Government will provide all the free medicines, other materials, and services to the community through the Mitanin.

4) Government will provide an essential equipment and medicine kit to the Mitanin for Maternal and Child Health, Reproductive Health, Family Planning, safe drinking water, sanitation and epidemic control.

PROJECT OVERVIEW

STUDT TITLE- "VERBAL AUTOPSIES TO STUDY THE GAPS AND CAUSES CONTRIBUTING TO CHILD MORTALITY IN RURAL CHHATTISGARH"

BACKGROUND-

SHRC is involved in state wide research study on child mortality to find the reasons behind child deaths occurring in rural areas of Chhattisgarh. It is important to find gaps behind these death and level at which these gaps are taking place (Family level, transportation level and facility levels), so that necessary improvement steps can be taken at related levels.

Gaps identified through these audits will be presented in the meetings of VHSNC. By this, community will get clear about the reasons behind child deaths which will make them aware for preventing this death in future.

Information gathered through these audits will be put forward to state, district and block level officers so as to facilitate necessary actions from government side.

The study conducted by SHRC from March 2014 to February 2015 with objectives-

1. To identify gaps contributing to child deaths in Chhattisgarh in:
    a. Health seeking behavior of the family
    b. Access to referral transport
    c. Provision of healthcare services
2. To identify probable medical causes of child deaths
3. To compare the gaps and causes for districts showing different levels of child mortality in the state and to explain the reasons behind high child mortality rate in the districts of Sarguja, Jashpur, Koriya and Kwardha

4. Suggest a strategy to address the systemic gaps thus identified.

The data for this study came from verbal autopsy on child mortality to find the gaps and causes of child death that was conducted by SHRC Chhattisgarh, under the mandate of NRHM Chhattisgarh during march2014 to February2015. The data has been collected since Jan 2014. Data is collected at block level; three child death cases were randomly (chit system) selected every month for conducting household interviews. A predesigned questionnaire is used for recording the chronological events of child death. Block surveyors are trained to conduct verbal autopsies and fill up this questionnaire. These questionnaires are then submitted to SHRC every month for further analysis.

WORK ASSIGENED

As an intern at State health resource centre, Raipur(CG),was assigned data analysis work for the study "Verbal autopsies to study the gaps and causes contributing to child mortality in rural Chhattisgarh".

Assigned work Objectives-

1. To identify the risk factors and medical causes for neonatal and non-neonatal death.
2. To find the gaps at Community level.
3. To find the gaps at Facility level.
4. To list out the most common diseases for neonates and non-neonates death and their symptoms for educational purpose of Mitanin.

METHODOLOGY-

1. **Study period**: March 2014 to Fabruray2015

   Data collected period- January 2014 to December 2014

The data for assignment was collected from October 2014 to December 2014.

2. **Study area:** 27 districts of Chhattisgarh state covering all villages under 146 block.

3. **Sampling Technique**:

- Mitanin trainers (MT's) fill up the death register during monthly VHSNC meeting which contains details about child deaths. Efforts are made that recording of no deaths is missed in this register.
- These deaths are further compiled by all MT's in the Death register kept at block level.
- Out of this list, three child death cases are selected randomly every month for conducting household interview.

4. **Method of data collection and tool:**

Verbal autopsy is a method of finding out the cause of a death based on an interview with next of kin or other caregivers. In order for verbal autopsies to be comparable, they need to be based on similar interviews, and the cause of death needs to be arrived at in the same way in all cases. In recent years, verbal autopsies have been used more widely to provide information on cause of death in areas where civil registration and death certification system

are weak, and where most people die at home without having had contact with the health system; this type of interview is often the only way to find out about the cause of death.[3]

5. Process of data collection:

- A pre-designed questionnaire is used for recording the chronological events of child death.
- For conducting these interviews, facilitators (Swasth Panchayat Samanwyak) were trained from every block in verbal autopsies and fill up this questionnaire.
- These trained facilitators take interview of three child deaths every month.
- These questionnaires are then submitted to SHRC every month for analysis.

6. Analysis technique:

- Checking every questionnaire for each case reviewed.
- Assigning the most appropriate cause(s) of death based on WHO criteria for diagnosis.
- Segregate the case studies in neonates and non neonates.
- Preparing summery for every case in local language (Hindi) after interpreting the gaps and levels at which these gaps took place.(Annaxures:1 and 2)
- Discussing each case with the surveyors at the SPS meetings for getting complete information about the case
- Listing most common diseases causing child mortality (neonates & non-neonates) and their symptoms for the educational purpose of Mitanin.
- Quantitative analysis of these interpretations using MS Excel.

INTERPRETATIONS -

- During the 2 months of internship total 155 case-studies were reviewed and interpreted, out of which 106 were neonates and 49 were non-neonates - this data has been used as secondary data and then further analyzed using MS excel format. Particulars for these case studies as follows-
- Codes have been assigned for place of delivery and person assisted child birth.
- Data from predesigned formats (neonates & non-neonates) entered in MS excel for further quantitative analysis.
- Gap at community level and facility level has been interpreted together, while risk factors and medical causes were analyzed separately.
- There were certain finding and interpretations mentioned below-

Table1) Gender wise distribution of Neonates and Non-neonates

	Neonates		Non-Neonates		Total	
	No.	**%**	**No.**	**%**	**No.**	**%**
Male	53	50%	32	65%	85	**55%**
Female	53	50%	17	35%	70	**45%**
Total	106	**68%**	49	**32%**	155	100%

Overall proportion of male child is higher than of female Childs

INTERPRETATION 1-

When establishing the medical causes of neonatal death, Asphyxia has the largest (37%) share, while pneumonia and hypothermia shares the second largest part of neonatal deaths (22%).Other causes such as bacterial sepsis of newborn(9%),Jaundice(5%),congenital anomalies(4%) of neonatal deaths. Neonatal tetanus (2%) and Meningitis shares (1%) of neonatal deaths. While (12%) deaths causes remained unknown.

For the Non-neonatal death causes, Pneumonia shares the largest part (28%), diarrhea and meningitis are the second most common cause of non-neonatal death with (14%) each. Other causes included malaria (6%), measles (5%), Accidents(5%),congenital anomalies (2%),whooping cough (2%). While cause of death for (11%) child death remained unknown.

Overall Asphyxia and Pneumonia contributing the largest share of neonatal and non-neonatal deaths. While many times the cause of death remains unknown due to family negligence or unavailability of services.

INTERPRETATION 2-

Apart from the established cause many deaths as shown in the graphs (9%) in neonates and (5%) in non-neonates are due to others causes. Hemorrhagic disease of newborn found to be the most common other cause of death in both neonates as well as in non neonates. It's a disease with symptoms of nose or mouth bleeding and caused due to vitamin K deficiency. This puts forward a question whether vitamin k included in the immunization regimen is being followed in the health institution or not.

INTERPRETATION-3

In addition to direct causes of death, many newborns die because of their mother's poor health. At the time of pregnancy or child birth if mother did not take proper nutrition or did not care for illness during pregnancy may lead to low birth weight child or in future such child either failure to thrive or suffer from severe malnourishment. India ranks one in malnourishment. These is the major cause for unknown death. Malnourishment weakens the immunity of the child and making them vulnerable for disease. Table below shows the risk factor-

Table2) Risk factors causing child death

RISK FACTOR	
NEONATES	
Low birth weight	22%
Preterm	4%
Low birth weight + Preterm	12%
NON-NEONATES	
Severe malnutrition	41%

INTERPRETATION 4-

Though promotion of institutional deliveries is encouraged in rural areas yet home deliveries are conducted. Results show that more than one third (38%) of the deliveries took place in home by unskilled professionals such as untrained dais or unqualified personals. Despite of various attempts by government home delivery contribute to a larger share that poses a potential risk in child care as care may be compromised due to negligence or unqualified birth attendants during and after child birth.

INTERPRETATION 5-

GAP AT COMMUNITY LEVEL-

As depicted in the graph there is a huge gap exist at community level towards preventive and curative health seeking behavior. This can be describe as follows-

36% of families either did not take preventive actions

- In few newborn cases inappropriate child care practices such as application of powder or oil on cord, delayed wrapping after child birth and bathing the child just after birth or breastfeeding not initiated within an hour has been done. This makes a child vulnerable for the illness. Most of the time his negligence took place in home delivery where birth attendant was either a *dai* or unqualified health professional.
- In some cases mothers were found to have incomplete ANC. Some missed the 1st and 2nd trimester ANC and only registered during 3rd trimester. Some mothers had health issues during pregnancy but family did not seek any treatment.
- It was observed that in few cases weight of the child was not taken at the time of birth and immunization of child was not done at all or not completed according to the immunization schedule.

11% of family delay the treatment and 16% sought treatment from inappropriate provider—(Cultural beliefs and illiteracy)

- Cultural beliefs and practices often lead to self-care, home remedies and consultation with traditional healers in rural communities. This result in delay in treatment seeking and are more common amongst women, not only for their own health but especially for children's illnesses.
- Lack of knowledge and illiteracy leads families to approach the traditional healer as first type of treatment and then go for government hospitals.

18% Families did not seek any treatment- (Socioeconomic barriers)

- Due to lack of money or due to poverty both parents has to work for living in that case either they do not pay attention to mild symptoms or avoid taking treatment for mild symptoms and only approach a health facility at last stage because of this the disease becomes chronic and needs higher level of care to recover and families are not able to pay this.
- In many cases such as congenital anomalies child needs an operative treatment which is not available at government hospitals and for the private facility treatment is not affordable for the rural people, makes their child to wait for death.

19%Families did not approach mitanin-

- Some families don't approach mitanin during delivery and during sickness of the child.

INTERPRETATION-6

GAP AT FACILITY LEVEL-

It was observed that due to gap at community level many people do not even reached to facility level but those who approach to facility also confront with the problems

55% child did not get required services/procedures and 22% reported delay-

- Asphyxia remains the most common cause of death but many government facilities do not having oxygen for the newborn. Many cases reports unavailability of required medicine or tests leads burden on their pockets and delay in treatment. Sometimes this delay proofs to be fatal for the child.
- Sometimes a child needs specialist for the treatment such as pediatrician, but unavailability of these specialist leads to delay and excess expenditure in private hospitals. Even a physician is not present in some of the primary level facility.

22% reported proper care and attention was not given-

- Due to lack of supervision nurses and some doctors do not behave appropriate with the villagers. They left treatment in middle or do not pay attention to the symptoms a patient notify. This negligence causes unfaithful environment in government facility.

SUGGESTIONS-

- Government should appoint a statutory body for continuous auditing, monitoring and recommendations for priority diseases among children.
- Introducing a non formal education system in form of cultural events to understand the

disease process and difference between favorable and unfavorable health practices.

- To promote the utilization of the schemes such as RSBY smart card scheme awareness creation programmes and information campaign should be organized with the help of local NGOs to make people aware about the scheme, their benefits and for assistance.
- There needs to be emphasis on audit of care and outcomes as part of quality assurance program to ensure that all the medical and non-medical staff treats the patients with respect and empathy.

FIELD VISIT

Fulwari programme :

This is another initiative taken by the state. Generally Anganwadi is for children of age 3 to 6 years. If children between 0 to 2 years suffer from malnutrition then it becomes very difficult to recover and restore their original health. With this idea Fulwari programme was started for children from 6 months to 3 years which is managed by the village members themselves. Here mothers themselves cook and take care of their children. The aim of this programme is to fulfill the nutrition requirement of 6 months to 2 years age group children as well as pregnant mothers. 4 eggs are given in a week and the breakfast includes a nutrient mixture called **"ready to eat"** which is being supplied by the government. Funds are being handed over by the Sarpanch of the village who visits the programme once in a month. This programme has being awarded by the prime minister and has been a successful one.[4]

Aims of fulwari programme:

- To care for children between 6 months to 3 year and to provide balanced nutritious diet
- To protect children from communicable diseases
- To provide balanced nutritious diet to pregnant and mothers of the children between 6 months to 3 years
- To promote the consumption of vegetables ,fruits and other nutritious food in families of pregnant mothers and children below 3 years
- For strong functioning of panchayati raj institutions involved in the field of nutrition and health field

A regular time table is followed for everyday cooking and each day two mothers are given chance for managing the fulwari.

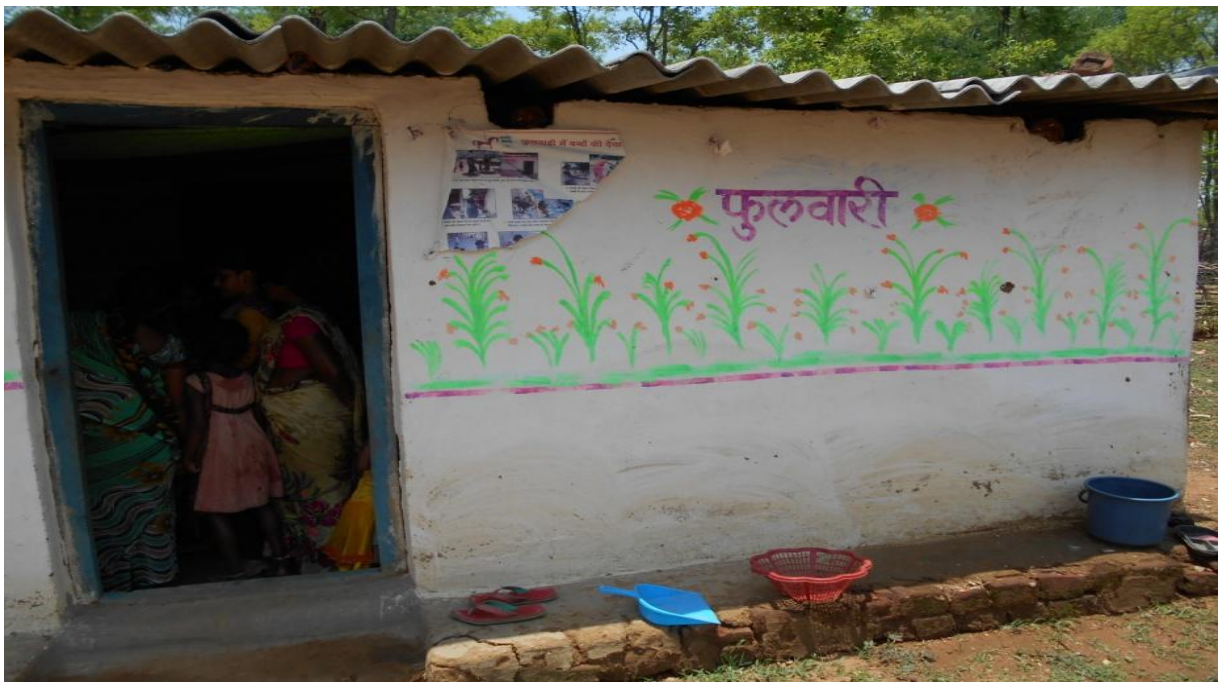
Observations in fulwari programme:

Visited two fulwari center (Mandhira Para & Jay Ambe) in the village of Salhetola and Dedhkohka in Charama block of Kanker district in Chhattisgarh with the help of fulwari coordinator and SPS of concerned area individuals, interact of the block officer/ in charge of the centers to know about the prestigious innovative programme in the rural area of Chhattisgarh. Conducted a meeting with day care center, mothers and village head on rational, functioning and funding source and achievement of the programme.

Dedhkohka : The fulwari in this area is running in a house which is being provided by one community member. Here a total of 7 children attended and one pregnant mother. No

electricity and bathroom facilities are present. Food is being cooked in ‘chullahs’ and served in plates. Hand washing is being practiced before taking food among the children and mothers.

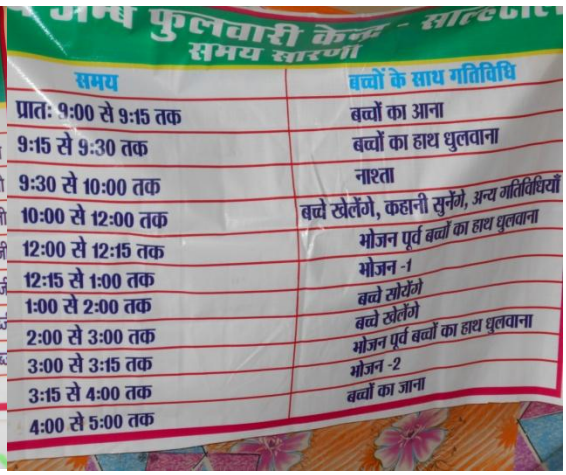
Salhetola: Here the fulwari is running in a hall provided by panchayat.9 children are attending and one pregnant woman. Mosquito nets are hanged while babies sleep. No electricity is provided and water is brought from the nearby hand pump. Hand washing is being followed here too.



मंदिर पारा फुलवारी केन्द्र - ढेड़कोहका
मीनू चार्ट

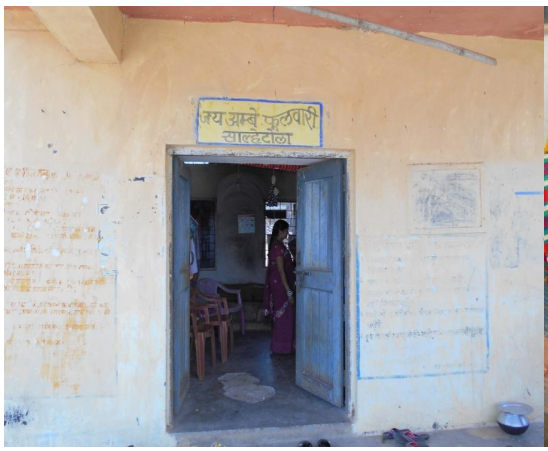
दिन	नास्ता	खाना - 1	खाना - 2
सोमवार	रेडी टू ईट से बना हुआ हलवा	चावल, दाल एवं अण्डा	चावल, दाल एवं हरी सब्जी
मंगलवार	पपीता, रेडी टू ईट से बना हुआ बड़ा	चावल, दाल एवं हरी सब्जी	चावल, दाल एवं हरी सब्जी
बुधवार	रेडी टू ईट से बना हुआ हलवा	चावल, दाल एवं अण्डा	चावल, दाल एवं हरी सब्जी
गुरूवार	केला, रेडी टू ईट से बना हुआ हलवा	भाजी से बनी खिचड़ी	चावल, दाल एवं हरी सब्जी
शुक्रवार	रेडी टू ईट से बना हुआ अन्य भोजन	चावल, दाल एवं अण्डा	चावल, दाल एवं हरी सब्जी
शनिवार	पपीता, रेडी टू ईट से बना हुआ भोजन	भाजी से बनी खिचड़ी	चावल, दाल एवं हरी सब्जी
रविवार	रेडी टू ईट से बना हुआ भोजन	चावल, दाल एवं अण्डा	चावल, दाल एवं हरी सब्जी

टीप:- बच्चों को दोनों बार के भोजन में अलग से एक-एक चम्मच तेल दिया जाना है।



फुलवारी केन्द्र - सोल्टा
समय सारणी

समय	बच्चों के साथ गतिविधि
प्रातः 9:00 से 9:15 तक	बच्चों का आना
9:15 से 9:30 तक	बच्चों का हाथ धुलवाना
9:30 से 10:00 तक	नाश्ता
10:00 से 12:00 तक	बच्चे खेलेंगे, कहानी सुनेंगे, अन्य गतिविधियाँ
12:00 से 12:15 तक	भोजन पूर्व बच्चों का हाथ धुलवाना
12:15 से 1:00 तक	भोजन -1
1:00 से 2:00 तक	बच्चे सोयेंगे
2:00 से 3:00 तक	बच्चे खेलेंगे
3:00 से 3:15 तक	भोजन पूर्व बच्चों का हाथ धुलवाना
3:15 से 4:00 तक	भोजन -2
4:00 से 5:00 तक	बच्चों का जाना



VHSNC meeting

One of the key elements of the national rural health mission is the village Health, Sanitation and Nutrition committee (VHSNC).The committee has been formed to take collective actions on issues related to health and it's social determinants at the village level. They are particularly envisaged as being central to "local level community action" under NRHM, which would develop to support the process of Decentralized Health Planning.

The committee is formed at the revenue village level and it should act as subcommittee of the Gram Panchayat. It should have a minimum of 15 members which should comprise of elected members of the Panchayat. It should have a minimum of 15 members who shall lead the committee, all those working for health and health related services should participate, community members/beneficiaries and representation from all community sub-groups especially vulnerable sections and hamlets/habilitations. ASHA residing in the village shall be the member secretary and convener of the committee.

Objective of VHSNC-

- To provide an institutional mechanism for the community to be informed of health programmes and government initiatives and to participate in the planning and implementation of these programmes, leading to better outcomes.
- To provide a platform for convergent action on social determinants and all public services directly or indirectly related to health.
- To provide an institutional mechanism for the community to voice health needs, experiences and issues with access to health services.
- To empower panchayats with the understanding and mechanisms required for them to play their role in governance of health and other public services and to enable communities.
- To provide support and facilitation to the community health workers – ASHA and other frontline health care providers who have to interface with the community and provide services.

In the field visit attended VHSNC, meeting in Salhetola. Salhetola panchayat includes two villages which are Aashritgram and Kukari. The meeting is conducted on immunization day. After the immunization is over this meeting is held. This meeting is held on first Tuesday of every month. In Charama block there are total of 96 villages so 96 VHSNC meetings are conducted. In Chattisgarh Mitanin should convey the message of meeting to the respective members.[5]

Members of the meeting include:

1. Headmaster of primary school
2. ANM
3. AWW
4. All paanch members of the gram panchayat
5. Representative of mahila mandal & youth mandal
6. Boring mechanic
7. All mitanins

Matters that were discussed in the meeting were related to:

- Availability of medicines for fever, diarrhea
- To examine the status of immunization and sputum examination

- Nutritional status of food cooked in Anganwadi
- Weight monitoring status of children
- Number of malnutrition cases among children
- Matter related to pension for handicapped

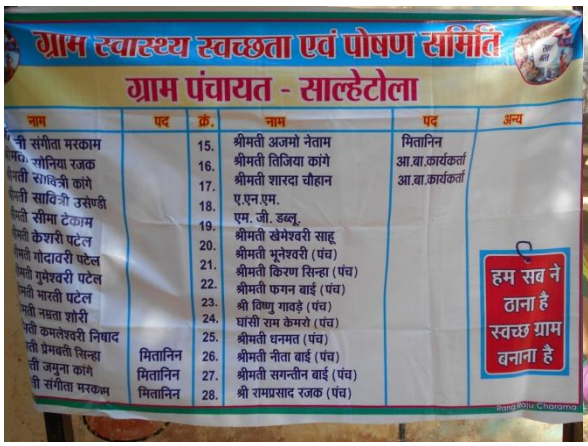
A register is being maintained for attendance of the members and various criteria are set according to which matters are being discussed.

Activities of VHSNC are divided into five broad categories:

- Monitoring and facilitating access to essential public services
- Organizing local collective action for health promotion
- Facilitating service delivery and service providers in the village
- Village health planning
- Community monitoring of health care facilities

Observations of the meeting

- All members of the meeting were not present. Many of them reached the meeting late as two more meetings were organized on the same day.
- The sarpanch had been elected for the second time in this panchayat and was not giving proper attention to the meeting.
- The SPS attending the meeting was putting forward the problems before everyone and was the person who argued the most in the meeting as no one else among the ladies were able to raise their voice.
- Some of the members did not participate in the meeting and the mitanins were advised to give the information of meeting beforehand to all the members of the team.



PARTICIPATION ON TRAINING OF SPS (SWASTH PANCHAYAT SAMANVAYAK)

Participation of SPS (Swasth Panchayat Samanvayak) training session for one week in SHRC training centre, New Rajendra Nagar the activities are conduct the interview of the SPS on verbal autopsy study and take detailed information on structured interview scheduled and cross check information and find causes, discus on health related events, causes and precautionary measures of diseases like malaria, snake bits, scorpion bits, EBF, diarrhoea, Detection of anemia, Antenatal care, Weighing of children, Recognizing malnutrition and being able to counsel the family on integrated management of childhood illness with a focus on malnutrition, Recognizing Acute Respiratory Infections, and giving specific drug from her kit when required, Recognizing fever and giving choloroquine presumptively identification signs of dehydration, and administration of ORT, in sever condition patient

should be referred to a hospital and Conducting local level health education meetings for specific groups.

- The primary focusing on Attitudes. This training is designed to bring in positive attitudes in the SPS about the power of people, empowerment of women, strength of community work etc.
- Second on knowledge he/she is given about basic concepts in Public Health, various Government schemes, National Health Programmes, Signs and Symptoms of common diseases, etc.
- Finally focused on Skills relating to communication, management, group behavior etc. will be developed during the course of the training. Skills relating to disease treatment are also developed.

Training are organized monthly at SHRC This training will concentrate on reinforcing what was learnt in the previous training session plus further practical aspects of diagnosis and treatment of common illnesses. The aim is skill development, practice, and community coordination and resource mobilization so that the SPS gradually develops confidence and is able to take care of the health needs of the community. This training will need to go on indefinitely it is a continuous process.

Observations-.

A time table was built district wise and particular day was set for the meeting of SPS. Apart from other matters, the formats of the study collected were distributed. They were advised to fill the form completely by going back to the respective family, which was in case of incomplete forms. Other complete forms were again discussed with the respective SPS to ensure that the data collected was done correctly and for correcting their mistakes. While discussing the formats with the SPS following observations were made-

- Most of the SPS do not fill the forms at field they maintain a diary and take complete information and then they fill the forms at their homes.
- Detailing of the ANC and immunization was done only on the basis of respondents answers they did not check the information from the cards provided.
- Few of the SPS do not visit villages and fill the forms on time that cause delay in study.
- Some of the formats are incompletely filled due to lack of the information provided by the respondents or lack of understanding of the SPS.

ANNAXURE:1

#	CAUSE	CODE	REMARKS
1. GAP AT COMMUNITY HEALTHCARE SERVICES?		**Yes /No**	**Code Yes if code for any of the categories between 1.1 to 1.5 is equal to 1, or else code No**
1.1	Family did not take preventive steps	1/0	Code 1 if any of the categories between 1.1.1 to 1.1.6 is 1 or else code 0
1.1.1	Improper instrument used for chord	1/0	Code 1 if umbilical cord was cut using rusted or unsterilized instrument. (Refer questionnaire Q46)

	cutting,		
1.1.2	Application of oil, powder or any other material on umbilicus	1/0	Code 1 if something was applied over chord. (Refer questionnaire Q47)
1.1.3	Wrapping the baby late after birth	1/0	Code 1 if baby was not wrapped within half an hour of birth (Refer questionnaire Q48)
1.1.4	Breastfeeding not initiated within 1hr	1/0	Code 1 if breast feeding was not initiated within 1 hr after birth. (Refer questionnaire Q49)
1.1.5	Bathing child after birth	1/0	Code 1 if child was bathed within 1 week after birth. (Refer questionnaire Q50,51)
1.1.6	Others	1/0	Code 1 if any other preventive measures were not opted except those covered (1.1.1-1.1.7) like incomplete/ no ANC, no treatment sought for high risk pregnancy or unhygienic handling etc. (Refer questionnaire Q35-Q40 and summary)
1.2	Family sought treatment with delay	1/0	Code 1 if family took delayed decision of seeking treatment after symptoms occurred or did not seek any treatment. (Refer Q19,20 and summary)
1.3	Family did not seek any treatment.	1/0	Code 1 if family took delayed decision of seeking treatment after symptoms occurred or did not seek any treatment. (Refer questionnaire Q120)
1.4	Family did not approach Mitanin	1/0	Code 1 if family did not approach Mitanin for reasons like she was not available at home, her home is far, lack of awareness about contacting Mitanin, Mitanin doesn't cooperate or any other. (Refer questionnaire Q116)
1.5	Mitanin did not give right advice to the family	1/0	Code 1 if Mitanin did not give appropriate advice for treatment or gave advice to seek treatment from inappropriate provider. (Refer questionnaire Q118)
1.6	Family sought treatment from inappropriate provider	1/0	Code 1 if family did not seek treatment from appropriate healthcare facility and went to quack and or faith healers. (Refer questionnaire Q125)
2. GAP AT FACILITY LEVEL?		**Yes/ no**	**Code Yes if code for any of the categories between 3.1 to 3.3 is equal to 1, or else code No**
2.1	The required service/ procedure were not available at the appropriate level.	1/0	Code 1 if a particular service required by child was not available at a particular level for which child was referred. Eg: lack of staff/ doctor, medicines, equipments, management of complications at birth or lack of treatment for neonatal diseases. (Refer questionnaire Q141,143)
2.2	Delay in treatment	1/0	Code 1 if doctor/ staff showed delayed response time towards providing necessary treatment. (Refer questionnaire Q133,136,137,151,154,155)
2.3	Proper care and attention was not given.	1/0	Code 1 if child was sent home without any treatment or prior to adequate recovery or ignored symptoms/problems or simply refused treatment. (Refer questionnaire Q134, 140,152, 158)

ANNAXURE:2

#	CAUSE	CODE	REMARKS
1. GAP AT COMMUNITY HEALTHCARE SERVICES?		Yes /No	**Code Yes if code for any of the categories between 1.1 to 1.5 is equal to 1, or else code No**
1.1	Family did not take preventive steps	1/0	Code 1 if any of the categories between 1.1.1 to 1.1.2 is 1 or else code 0

1.1.1	ORS was not given after first episode of diarrhea	1/0	Code 1 if ORS was not given to child after 1st occurrence of diarrhea leading to severity. (Refer questionnaireQ100)
1.1.2	Other	1/0	Code 1 if preventive steps were not taken towards child's immunization, nutrition, negligence leading to accidents, damp environment etc. (Refer Q60,61,113,114,115 and summary)
1.2	Family sought treatment with delay	1/0	Code 1 if family took delayed decision of seeking treatment after symptoms occurred (Refer questionnaire Q19, 20 and summary)
1.3	Family did not seek any treatment.	1/0	Code 1 if family did not seek any treatment. (Refer questionnaire Q120)
1.4	Family did not approach Mitanin	1/0	Code 1 if family did not approach Mitanin for reasons like she was not available at home, her home is far, lack of awareness about contacting Mitanin, Mitanin doesn't cooperate or any other. (Refer questionnaire Q116)
1.5	Mitanin did not give right advice to the family	1/0	Code 1 if Mitanin did not give appropriate advice for treatment or gave advice to seek treatment from inappropriate provider. (Refer questionnaire Q118)
1.6	Family sought treatment from inappropriate provider	1/0	Code 1 if family did not seek treatment from govt healthcare facility and went to private provider, quack and or faith healers. (Refer questionnaire Q125)
2. DELAY AT GOVT. FACILITY LEVEL?		**Yes/ no**	**Code Yes if code for any of the categories between 3.1 to 3.3 is equal to 1, or else code No**
2.1	The required service/ procedure were not available at the appropriate level.	1/0	Code 1 if a particular service required by child was not available at a particular level for which child was referred. Eg: lack of staff/ doctor, medicines, equipments, management of complications at birth or lack of treatment for neonatal diseases. (Refer questionnaire Q141,143)
2.2	Delay in treatment	1/0	Code 1 if doctor/ staff showed delayed response time towards providing necessary treatment. (Refer questionnaire Q133,136,137,151,154,155)
2.3	Proper care and attention was not given.	1/0	Code 1 if child was sent home without any treatment or prior to adequate recovery or ignored symptoms/problems or simply refused treatment. (Refer questionnaire Q134, 140,152, 158)

REFERRANCE-

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4. Caregiver managed nutrition and day care centers, Fulwari Scheme of Chhattisgarh state: Samir Garg, 2014.

5. Guidelines for Village Health Sanitation and Nutrition Committees(VHSNC)