SummerPlacement

In

National Health Mission, Odisha, India

(April 2nd to May 28th, 2015)

A Report

By

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MBA IN HOSPITAL AND HEALTH MANAGEMENT (MBA-HM)

(2014 – 2016)

Under the Guidance of

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Jaipur

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

IIHMR UNIVERSITY

Certificate

This is to certify you that Dr. Kim Patras, a student of MBA Hospital and Health Management at The IIHMR University, Jaipur, batch 2014 – 16 has successfully completed her summer training for the period from 2nd April to 28th May 2015 at **National Health Mission, Odisha**, under my guidance. During this period she has completed **a study on the institutional preparedness for quality Parivar Kalyan Diwas in Koraput district of Odisha** as a part of partial fulfilment of the course requirements recommended for MBA Hospital and Health Management. All the data related to the study is primary data. Her approach towards the study has been sincere, scientific and analytical.

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Mission Directorate
National Health Mission, Odisha
Department of Health & Family Welfare,
Government of Odisha

Letter No: OSH &FWS/ 8993
124/13CP-1)

Date: 25.07.15

TO WHOMSOEVER IT MAYCONCERN

This is to certify that **Dr. Kim Patras** student of Masters in Business Administration in Health and Hospital Management, IIHMR, Jaipur has undergone summer internship under **National Health Mission, Odisha from 2nd April to 28th May'15 and conducted a study on "Institutional preparedness for Parivar Kalyan Diwas" in Koraput district, Odisha.**

As per the study design Dr. K. Patras has made a presentation at NHM Directorate under the chairpersonship of DFW, Odisha to share the major findings of the study. During summer study , she has collected required data from Koraput district and NHM Directorate. She has worked under the guidance of **Dr. D.K.Panda, Team Leader, SHSRC and Dr. B.Modak, Sr. Training Consultant, SHSRC.**

I wish her every success in all her future endeavours.

29/7.

Mission Director, NHM &
Ex-Officio Additional Secretary to Govt.

Acknowledgement

At the onset of the report I would like to express my special gratitude and appreciation Smt. Roopa Mishra, Mission Director (NHM, Odisha) for allowing me to pursue my summer internship from National Health Mission, Odisha.

I would also like to acknowledge with much appreciation the crucial role ofDr. Biswajit Modak, Senior Training Consultant, SHSRC, NRHM, who despite of other pre occupations and busy schedule was there to guide me and whose stimulating suggestions and encouragement helped me complete my training.

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Finally, and most importantly, I would like to thank God for allowing me to complete my project, my beloved parents and family for their blessings and my friends for their help and wishes for the successful completion of this training.

Dr. Kim Patras
1st Year, MBA-Hospital and Health Management
IIHMR University, Jaipur

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Abbreviations

ADMO	Assistant District Medical Officer
AIDS	Acquired ImmunoDeficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwifery
ASHA	Accredited Social Health Activist
AWW	Angan Wadi Worker
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
BPM	Block Programme Manager
CBR	Crude Birth Rate
CC	Contraceptive Condoms
CDMO	Chief District Medical Officer
CDR	Crude Death Rate
CHC	Community Health Center
CLMIS	Contraceptive Logistic Management Information System
CME	Continued Medical Education
CUG	Closed User Group
DPM	District Programme Manager
DHH	District Headquarter Hospital
DLHS	District Level Household Survey
DPT	Diptheria, Pertussis and Tetanus
ECP	Emergency Contraceptive Pills
FDS	Fixed Day Static Services
GIS	Global Information System
HMIS	Health Management Information System
HRMIS	Human Resource Management Information System
HR	Human Resource
HPD	High Priority District
IP	In Position
IPD	International Conference on Population And Development

IMR	Infant Mortality Rate
IPHS	Indian Public Health Standard
IT	Information Technology
ITEMS	Integrated Training & Evaluation Management System
IUCD	Intrauterine Contraceptive Devices
JSSK	Janani Shishu Surakhsha Karyakram
KBK	Kalahandi Balangir and Koraput
LFE	Left Wing Extremist area
MO	Medical Officer
MDG	Millennium Development Goals
MHU	Mobile Health Unit
MMR	Maternal Mortality Ratio
MoHFW	Ministry of Health and Family Welfare
NGO	Non-Governmental Organization
NHSRC	National Health Systems Resource Centre
NHM	National Health Mission
NPP	National Population Policy
NHM	National Health Policy
NRHM	National Rural Health Mission
NSV	Non Scalpel Vasectomy
OCP	Oral Contraceptive Pills
OSMIS	Odisha State Malaria Information System
OVLMS	Odisha Vaccine Logistic Management System
PHC	Primary Health Center
PHEO	Public Health Education Officer
PKD	Parivar Kalyan Diwas
PPIUCD	Post-Partum Intrauterine Contraceptive Devices
PPP	Public–Private partnership
PRI	Panchayati Raj Institutions
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti
RMNCH+A	Reproductive Maternal Neonatal Child Health & Adolescent
RTI	Reproductive Tract Infection

SC	Sub Center
SHSRC	State Health Systems Resource Center
SIHFW	State Institute of Health and Family Welfare
SP	Sanctioned Position
STI	Sexually Transmitted Infection
TB	Tuberculosis
TFR	Total Fertility Rate
TT	Tetanus Toxoid
UGPHC	Up Graded Primary Health Center
VH&SC	Village Health &Sanitation Committee
VHND	Village Health & Nutrition Day

Introduction

National Health Mission ,Odhisa

The Hon'ble Prime Minister of India Dr.Manmohan Singh launched NRHM(National Rural Health Mission) on 12 April 2005 in the country, with special focus on 18 states including Odisha. Itrecognizes the importance of health care in the process ofeconomic and social development and improving the quality oflives of our citizens. It provides effective health care to ruralpopulation throughout the country with focus on 18 states, whichhave weak public health indicators and weak infrastructures.

The Hon'ble Chief Minister of Odisha Shri Naveen Patnaik in presence of the Union Minister Health & Family Welfare, Shri Anbumani Ramadoss launched the NRHM programme throughout the state on 17th June 2005 with goal of "Healthcare to All"

The first phase of NRHM was from 2007-2012. This is the second phase of NRHM(2013-2017).In 2013 it was named National Health Mission.NationalHealth Mission (NHM) encompasses two Sub-Missions, National Rural Health Mission(NRHM) andNational Urban Health Mission (NUHM).

Goals of NHM

The endeavor would be to ensure achievement of those indicators given below. Specific goals for the states will be based on existing levels, capacity and context. 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.

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 anaemia 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

Vision of 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".

Core Values of NHM

. 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.

The state of Odisha has an area of 155,707 km²and population of 41,947,358. Odisha is the ninth largest state by area in India, and the population. There are 30 districts; each district is subdivided into blocks, the total being 314. Blocks consist of *Panchayats* (village councils) & town municipalities. The state has population density of 270 per square kilometeras against the national average of 382 per square kilometer). The decadal growth rate of the state is +15.94 percent (against 21.54 percent for the country) and the population of the state is growing at a slower rate than the national rate.

In Odisha, more than 85 percent of the population live in rural areas and depends mostly on agriculture. The percentages of SC & STs constitute 16.53 & 22.13 percent respectively of the total state population. Nearly 45 percent of the state area in as many as 13 districts has been declared as Scheduled castes dominant areas. Considering that good health is an important asset of livelihood and illness a major cause of impoverishment, the health and allied sector in the state has made noticeable improvements in leprosy control, Polio eradication, IMR, MMR, Malaria, CBR, CDR, Life Expectancy at Birth, Nutritional Status, Literacy, drinking water supply and sanitation.

The NRHM primarily seeks to provide preventive, promotive, curative and rehabilitative health services to the people through primary health care approach that has been accepted as one of the main instruments of action for

development of human resources, accelerating the socio-economic development and attaining improved quality of life.

In the rural areas services are provided through a network of integrates health and family welfare delivery system. The primary health care infrastructure has been developed as a three tier system-sub-centers, Primary Health centers and Community Health Centers. Sub-Centers is the most peripheral contact point between the Primary health care system and the community and is manned generally by Multi- Purpose Health Workers(Male & Female), AWW and ASHA. Medical Officer supported by Para-Medical and other staff operates primary Health center. Some of the PHCs are running under PPP model.

NRHM working on five main Approaches:

1) **COMMUNITIZE**
    - HMC/RKS / PRIs at all levels
    - Untied grants to community/PRI Bodies
    - Funds, functions & functionaries to local community organizations
    - Decentralized planning, VH&S Committees
2) **MONITOR,PROGRESS AGAINST STANDARDS**
    - Setting IPHS Standards
    - Facility Surveys
    - Independent Monitoring Committees at Block, District & State levels
3) **FLEXIBLE FINANCING**
    - Untied grants to institutions
    - NGO sector for public Health goals
    - NGOs as implementers
    - Risk Pooling – money follows patient
    - More resources for more reform
4) **IMPROVED MANAGEMENT THROUGH CAPACITY**
    - Block & District Health Office with management skills
    - NGOs in capacity building
    - NHSRC / SHSRC / DRG / BRG
    - Continuous skill development
5) **INNOVATION IN HUMAN RESOURCE MANAGEMENT**
    - More Nurses – local Resident criteria
    - 24 X 7 emergencies by Nurses at PHC. AYUSH
    - 24 x 7 medical emergency at CHC

Objectives of NRHM Odisha

RCH Objectives

- To reduce Total Fertility Rate from 2.47 to 2.1 by 2010 in the State of Orissa
- To reduce Infant Mortality Rate from the present level of 71 /1000 live births to 50/1000 live births by 2010 in the State of Orissa
- To reduce Maternal Mortality Rate from the present level of 358/100,000 to 250/100, 000 by 2010 in the State of Orissa.

NRHM Initiatives General Objectives

- Reduction in child and maternal mortality.
- Universal access to public services for food and nutrition, sanitation and hygiene with emphasis on services addressing women's and children's health and universal immunization.
- Prevention and control of communicable, non-communicable, and locally endemic diseases.
- Access to integrated comprehensive primary health care.
- Population stabilization, gender and demographic balance.
- Revitalization of local health traditions and mainstream AYUSH.
- Promotion of healthy life styles.

Objectives of ASHA scheme are-

- Create awareness on health and its social determinants.
- Mobilize the community towards local health planning.
- Increase utilization and accountability of the existing health services.
- Promote good health practices.
- Provide a minimum package of curative care as appropriate and feasible for that level.
- Undertaking timely referrals.

Objective of Mainstreaming of AYUSH:

- Mainstreaming of AYUSH in the health care service delivery system to strengthen the existing public health system.

Objectives of United Fund for Sub Centers

- To increase functional, administrative and financial resources and autonomy to the field units.
- To develop the physical infrastructure and centre specific activities for PHCs.

Objectives of RKS

- Ensure compliance to minimal standard for facility and hospital care and protocols of treatment as issued by the Government.
- Ensure accountability of the public health providers to the community.
- Introduce transparency with regard to management of funds.
- Upgrade and modernize the health services provided by the hospital and any associated outreach services.
- Supervise the implementation of National Health Programs at the Hospital and other institutions that may be placed under its administrative jurisdiction.
- Organize outreach services/ health camps at facilities under the jurisdiction of the hospital
- Display a Citizen's Charter in the Health facility.
- Generate resources locally through donations, user fees and other means
- Establish affiliations with private institutions to upgrade services
- Undertake construction and expansion in the hospital building
- Ensure optimal use of hospital land as per govt. guidelines
- Improve participation of the society in the running of the hospitals
- Ensure proper training for doctors and staff
- Ensure subsidized food, medicines and drinking water and cleanliness to the patients and their attendants.
- Ensure proper use, timely maintenance and repair of hospital building equipment and machinery.

Objectives of Mobile health Units:

- Every district will have at least operational mobile medical unit t for delivering health services in terms of preventive, promotive, curative and effective to rural population especially to poor woman, children and old.

Objectives of Strengthening of PHC/CHC/UGPHC to Indian Public Health Standard:

- To provide optimal expert care to the community.
- To achieve and maintain an acceptable standard quality care in terms of Assured Services.
- To make the services more responsive and sensitive to the needs of the community.

Objectives of Immunization

- Districts will provide equitable, efficient and safe immunization services to all infants and pregnant women. Aim is to achieve 100% full immunization status by 2009-2010 and to maintain it for long.
- **2005-06---------50%**
- **2006-07---------60%**
- **2007-08---------75%**
- **2008-09---------95%**
- **2009-10---------100%**

- Contribute global eradication of Polio by 2007.
- Elimination of Neonatal Tetanus, Diphtheria and Pertussis by 2009.
- Measles mortality and morbidity reduction to 80% by 2010, compared to 2000 estimates.
- Achieve and maintain vitamin A supplementation coverage >80% under the age of 3 yrs
- Establish sufficient sustainable and accountable fund flow at all levels.
- Ensure there is sustained demand and reduced social barriers to access immunization services.

Mission Inderdhanush

Ministry of Health and Family Welfare (MOHFW) has launched Mission Indradhanush on 25th December 2014 with the aim of expanding immunization coverage to all children across India by year 2020.

The Mission Indradhanush, depicting seven colours of the rainbow, targets to immunize all children left out of routine immunization and those who have received partial vaccination along with new onesagainst seven vaccine preventable diseases namely Diphtheria, Pertussis, Tetanus, Childhood Tuberculosis, Polio, Hepatitis B and Measles.

Objectives:-

- The government intends to cover 201 high focus districts in the first phase of year 2015.
- These districts have nearly 50% of all unvaccinated or partially vaccinated children.
- Out of these 201 districts, 82 districts lie in just four states of India namely, UP, Bihar, M P and Rajasthan.
- Ten districts of Odisha have been included: Balangir, Boudh, Gajapati, Kalahandi, Kandhamal, Koraput, Malkangiri, Nuapada, Nabrangpur and Rayagada,

Objectives of the NIDDCP

- Assess the magnitude of IDD by periodic surveys.
- Re-survey after every 5-years to assess the extent of IDD and the impact of Iodized Salt.
- Laboratory Monitoring of Iodized Salt and Urinary Iodine excretion.

ORGANOGRAM OF NRHM ODISHA

Figure No.1

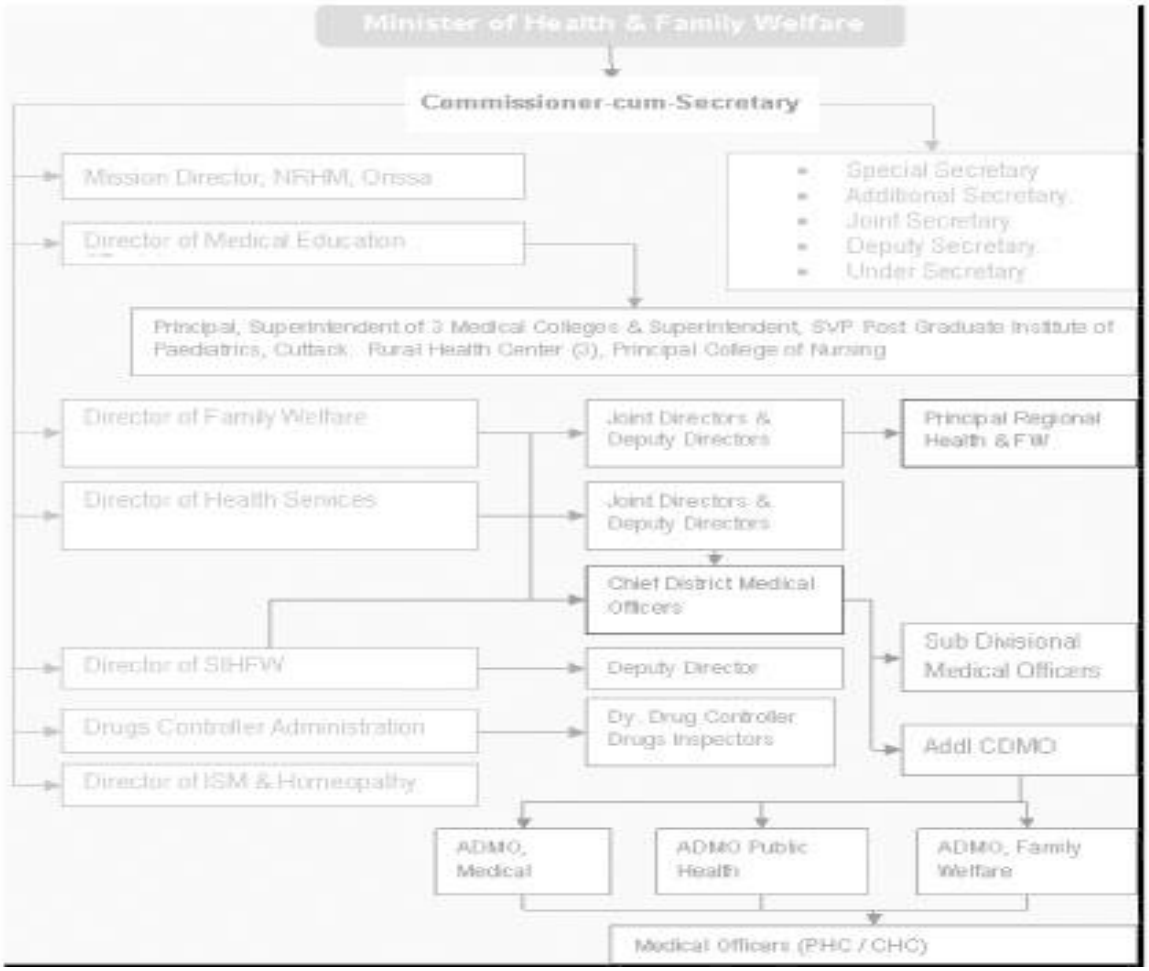

Minister of Health & Family Welfare
Commissioner-cum-Secretary
Mission Director, NRHM, Orissa
Director of Medical Education
Special Secretary
Additional Secretary
Joint Secretary
Deputy Secretary
Under Secretary
Principal, Superintendent of 3 Medical Colleges & Superintendent, SVP Post Graduate Institute of Paediatrics, Cuttack Rural Health Center (3), Principal College of Nursing
Director of Family Welfare
Director of Health Services
Director of SIHFW
Drugs Controller Administration
Director of ISM & Homeopathy
Joint Directors & Deputy Directors
Joint Directors & Deputy Directors
Chief District Medical Officers
Deputy Director
Dy. Drug Controller Drugs Inspectors
Principal Regional Health & FW
Sub Divisional Medical Officers
Addl CDMO
ADMO, Medical
ADMO Public Health
ADMO, Family Welfare
Medical Officers (PHC / CHC)

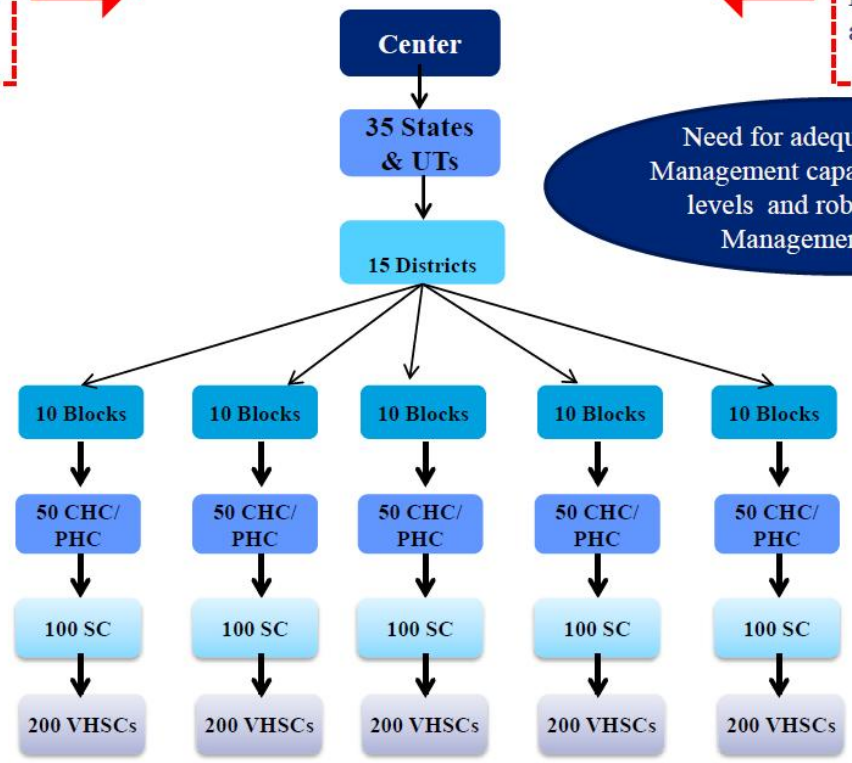
Figure No.2

NHM – A Multi-dimensional & Complex Programme

NHM is a complex programme with multi-layered supervisory & implementing units

Involves large no. of sub-programs including RMNCH+A, NDCPs, and NCDs

Typical Structure under NHM



Need for adequate Financial Management capacities at various levels and robust Financial Management systems

Under decentralized scenario, large quantum of funds are being disbursed to and spent at lower sub-district levels

Being a centrally sponsored scheme, there is a requirement of periodical reporting to GoI (at each level through their supervisory units)

Note: All number of Units are illustrative only.

STATE INITIATIVES

- *Swasthya Kantha* Campaign: To provide health related communication information to rural population by writing the information on specific walls meant for the purpose. The walls are located at strategic points in most villages. The major issues tackled are "maternal health, child health, malaria and tuberculosis".
  As a result of the *Swasthya Kantha* campaign, there is increased knowledge on health and sanitation issues of the village with improved health seeking behaviour of the people.

- Innovations in relation to ASHA workers
  - ASHA HBPNC: Home based post natal care for mother and infant by ASHA.
    ASHAs are being trained for home based post natal care which has increased record keeping of immunization, breast feeding and better reporting of LBW babies.
  - Bicycles to ASHAs: ASHAs have been provided with cycles so that they can deliver better services. Cycles help in easy commuting of the ASHAs to the areas that she covers, even in areas where roads are not available. After provision of cycles, there has been an increase in immunization coverage, ANC and institutional delivery.
  - ASHA fixed day payment: To address the grievances of payment of incentives, the government has come up with the policy of having a fixed day for payments of incentives. There are 32 different incentives for ASHA workers.
    With this innovation there has been an increased motivation of ASHA workers towards their work.
  - ASHA *Gruha* : It is a resting place for ASHAs, who accompanies pregnant women to the hospitals for their delivery.
    The ASHAs feels very secure to accompany pregnant women even at night, as she feels safety for herself during the visit to district hospitals.

- The Government of Odisha has started the 108 Ambulance Service in the year 2013
- *Gramsat* to promote health provisions was put up to disseminate innovations and information of health issues and to review the various programmes in place. It provides an excellent opportunity for discussions with block and district health officials.
- Public- private partnership:
    1. Urban Slum Health Project: Targeted for outreach and vulnerable areas. Provides services for health, hygiene, sanitation and nutrition.
    2. *AROGYA* Plus project: Specially targeted at Naxalite areas for providing health services to these areas. This project functions similarly as mobile health units
    3. PHC New project: 32 PHC (New) in very outreach areas
    4. Vulnerable Group Project : Meant for primitive tribe groups
    5. Maternity Waiting Home: Providing PNC support to pregnant women in outreach areas. Providing temporary home for expectant mothers living in hard to reach tribal areas, where they come 5-7 days before EDD and can wait for delivery

- Mobile Health Unit: To provide preventive, promotive & curative health services in the inaccessible areas and difficult terrains which are un-served /underserved under usual circumstances. With the advent of MHU's there has been an increase in the number of cases treated and referred. The MHU's function for 22 days in a month, reaching far of villages to provide quality services to them.

- *Janani* Express: Free referral transport system to promote institutional delivery and reduce out of pocket expenditure by providing nonstop free transport facility and contributing in reduction of infant and maternal mortality. The average patient load has been on a gradual increase.

- Mobile Boat Clinic: To provide basic health services to people of most inaccessible and difficult areas of *Malkanagiri* district (Naxalite area). But after its introduction, giving services to the outreach people has become easier.

- *Tika* Express: An alternate vaccine delivery system for children of difficult and tribal dominated pockets to enhance immunization coverage and strengthen routine immunization programmes. Due to this initiative, percentage of full immunization has been on a constant increase.

- Sick New Born Care Unit: To improve neonatal survival and provide special level- II care to neonates including low birth weight and sick neonates. Special initiatives like “autoclaved cotton dress”, “kangaroo care bag” and “oil cloth – with key message” are taken up. It has led to an increase in successful management of a huge number of babies.

- Single Window: *Janani Sewa Kendra* for JSY beneficiaries to reach upto a mark of 100% birth registration and to provide all major MCH related benefits at facility level. With this service in place, there has been an increase in distribution of birth certificates and delivering of other services to the beneficiaries.

- IT initiatives: Various IT applications have been used to achieve the desired objectives.

    - Program monitoring applications
        - *E Swasthya Nirman*
        - Drug Testing and Data Management System
        - *E Sanjog*
        - FRU Monitoring System
        - Contraceptive Logistic Management Information System (C LMIS)
        - Odisha Vaccine Logistics Management System (OVLMS)
        - Integrated Training & Evaluation Management System (ITEMS)
    - Human Resource Monitoring & Management
        - E Attendance
        - Human Resource Management Information System (HRMIS)
        - Govt. Doctor’s Information Management (GODMAN)
        - Mission Connect (CUG)
    - Citizen Centric Applications
        - E Blood Bank
        - Grievance Redressal System for JSSK Scheme
        - Telemedicine
    - Applications for Planning and Management
        - Odisha State Malaria Information System (OSMIS)
        - GIS in Odisha State Healthcare Planning & Management

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Study on

Institutional preparedness for quality Parivar Kalyan Diwas in Koraput, Odisha.

Research Study:-

To study the institutional preparedness for quality Parivar Kalyan Diwas in Koraput, Odisha.

Introduction:-

In 1952, the world's first National Family Planning Programme was launched emphasizing family planning to the extent necessary for reducing birth rates "to stabilize the population at a level consistent with the requirement of national economy".

Between 1951 and 2001, mortality decreased by two third, fertility declined by two fifth and life expectancy at birth doubled. India's population has more than doubled since 1961. Therefore in the mid-1960s, the government introduced method specific contraceptives target approach.[1]

Soon after the International Conference on Population And Development (ICPD) in 1994, a significant shift from "Specific Contraceptive Target" to "Target free" approach was made. It was a paradigm shift from Family Planning Programme to Family Welfare Programme. Reproductive And Child Health Programme (RCH) was launched in October 1997. The announcement of National Health Policy in February 2000, National Population Policy 2000 and also the setup of National Commission on Population [7]. These are some of the strategies adopted to ensure better coverage in spacing and permanent method of family planning. Another objective was to ensure family planning services at door step level. Keeping in view of above objective GoI initiated Fixed Day Static Service model (FDS). In Odisha it is called as Parivar Kalyan Diwas (PKD).

PKD is organized on Monday and Thursday of every week at PHC and CHC level.

PKD provides Temporary (spacing) and Permanent (limiting) method of contraception.

Temporary Methods	Permanent Methods

• IUCD 380 A and Cu IUCD 375
• Oral Contraceptive Pills
• Condoms
• Emergency Contraceptive Pills
	• Female Sterilization:
	  • Tubectomy:- a) Laproscopic
	  b) Minilap
	• Male Sterilization (Non Scalpel Vasectomy (NSV))

It is observed that the qualitative achievement of PKD is not as desired, quality is compromised at different level. It is also observed that there is lack of human resource, accommodation and consumables which are required to provide family planning services. Keeping in view of all the gaps the study is conducted to assess institutional preparedness for quality Parivar Kalyan Diwas.

Review of literature:-

- As per NFHS-III, In India, 50% of condom users and 42% of pill users discontinue its use in a year after they adopt the method.[2]
- As per the study conducted by Faujdar Ram, Chander Shekhar & Biswabandita Chowdhury, IIPH, Mumbai (2014) says that women using traditional contraceptive methods and those having unmet needs is around 53 million in India.[3]
- The paper published by Dr. Almas Ali, M.D, Ph.D. (public health and population expert) HDF (Human Development Foundation), India, for the year 2012 on the topic reproductive health in Odisha: Issues and challenges states that 7.5% & 15.5% of currently married women in Odisha have unmet need for spacing and limiting methods.[4]
- As per the Annual Report by HMIS-Odisha, In Koraput, total sterilization reduced from 100% in year 2013-14 to 70% in the year 2014-15.[5]
- It is reported that 8 women died and 50 hospitalized after sterilization surgery at Chhattisgarh (TOI, Nov 11, 2014)[6]

Research question:-

What is the institutional preparedness for quality Parivar Kalyan Diwas in Koraput, Odisha?

Objectives:-

1. To assess Human Resource (HR) available against the sanctioned strength of the institution.

Indicators

- % of HR availability against the requirement for PKD
- % of service providers trained within the available HR.

2. To assess the availability of required Infrastructure to organize quality PKD?

Indicators

- % of quarter (govt facility) available for service providers at present in the institution.
- Availability of OT for family planning operations.
- % of electricity backup available at institutional level.
- % of institutions where running water is available with overhead tank.

3. To study the consumables required for quality PKD

Indicators:-

- Availability of family planning devices for spacing-

- % of Oral Contraceptive Pills (OCP) received against monthly requirement.
- % of Intra Uterine Contraceptive Devices (IUCD) received against monthly requirement.
- % of Condoms received against monthly requirement.

- Availability of limiting methods of sterilization

- % of female sterilization conducted against plan (motivated) during last 3 months.
- % of male sterilization (Non Scalpel Vasectomy) conducted against plan (motivated) during last 3 months.

Research Methodology:-

- Sources of data :- primary data collected in the form of personal interview for Medical Officer (MO)/ Lady Health Visitor (LHV)/ MO Incharge (if present)
- Tool used :Structured questionnaire
- Study design : Exploratory

- Study duration : 2 months
- Study setting : 30 districts of Odisha divided into KBK and Non KBK districts. KBK districts are HPD, LWE affected and more challenging. Koraput was selected out of the 3 districts because marked reduction in total sterilization of 30% in Koraput and literacy rate of 50% was seen than the other two KBK districts.

Sampling:-

Sampling technique: stratified random sampling.

Selection of respondent:

- The first target population taken is specialist (OG,Surgeons).
- In the absence of specialist MO in charge will be interviewed.
- Since LHV is in charge of Temporary methods of Family Planning so it was decided that they should also be interviewed.
- All the key service providers (specialist, LHV, MO in charge (if required) of 16 institutions (3 CHC and 13 PHC) willing to reply and were interested to participate in the study were interviewed.

Sample size :-

- This is a purposive sampling and total data collection is for 18 days.
- 14 blocks were divided into Good, Average and Low performing, One CHC from each category was taken along with all the PHC's under those CHC's.
- In Koraput, it is observed that PKD is conducted at PHC and CHC on Monday and Thursday.
- So keeping in view the time constraints only 3 CHC's and 13 PHC's have been taken under the study as total sample.

Technique : personal interview of key service providers(Medical Officer (MO) / Lady Health Visitor (LHV) / MO In charge (if present))

Tool : Semi structured questionnaire

Data Analysis Plan

1. Data will be analyzed based on the indicators taken against each objective.
2. Most of the indicators will be expressed in terms of percentage (%)
3. Data will be represented in a tabular form to find out the percentage (%).
4. Ms-excel will be utilized for data analysis.
5. Since it is an exploratory study data will be assessed in terms of percentage (%) and mean value.

Limitations:-

- Sample is small and the size might not represent the entire universe of the study.
- The Language barrier may act as a problem during communication with respondents
- There is a time constraint in the study.
- Cultural limitations.

Ethical Considerations:-

- The study will maintain the confidentiality of the respondents.
- Information received by the respondents will not be misused in any form.
- The study will ensure that information shared by the respondents would not put them in any kind of risk.

Table No 1: Time line of study

Work Plan:-

S. No.	Task	Duration (April & May, 2015) in weeks								Remark
		1st	2nd	3rd	4th	5th	6th	7th	8th	
1.	Literature review, Development of study design and Questionnaire									
2.	Field study and data collection									
3.	Data analysis and Report writing									
4.	Development of final report, presentation and final submission									
5.	Relieved from NHM, Directorate, Odisha									

Table No 2: Institutions visited during scheduled timeline of study

S No	CHC	PHC		
1	CHC Pottangi	Pukali	Chandaka	Chika Paru
		Kotia	Sunki	
2	CHC Boriguma	Kathargarha	Dengpadar	Kumuli
		B. Singhpur	Hardauli	
3	CHC Boipariguda	Ramagiri	B**aligan**	**Dasmantpur**

Results :-

The analysis of results mainly covers the availability of HR, Infrastructure and consumables under different indicators to conduct quality Parivar Kalyan Diwas. All the values for analysis

1. **% of HR availability against the requirement for PKD**

Fig3: Total HR available against the sanctioned position(CHC & PHC)

TOTAL: SP= 130 IP=88 IP=68% V=32%

Fig4: Total HR available against the sanctioned position (CHC)

2. **% of service providers trained within the available HR.**

Fig 5: Trained service provider within the available HR (CHC & PHC)

CHC & PHC

Fig 6: HR trained in IUCD, PPIUCD and NSV within the available Trained HR

3. Availability of OT for family planning operations.

Fig 7: Status of OT for Family Planning Operation

3. % of equipment's available for sterilization.

Fig 8a: Availability of Sterilization equipment (CHC&PHC) Fig 8b: At CHC only

4. % of Surgical kit available for sterilization

Fig 9: Availability of surgical kit (CHC)

5. % of institutions where running water is available with overhead tank.

Fig 10: Running water availability (CHC&PHC). (At CHC 100% availability present)

6. % of electricity backup available at institutional level.

Fig 11: Availability of electricity with backup facility (At CHC 100% availability)

7. **% of quarter (government facility) available for service providers at present in the institution.**

39% 61%

Fig 12: Status of Quarter facility for staff In Position

Fig 13: Overall infrastructure availability at CHC

Fig 14: Overall infrastructure availability at PHC

8. **% of OCP, ECP, IUCD, CC received against monthly requirement**

Fig 15: Availability of Spacing methods (CHC)

9. **% of male and female sterilization conducted against plan (motivated) during last 3 months.**

Fig 16: Limiting method availability at CHC

Major Findings

Table no: 17

Category	Findings	Facts
PKD	Conducted without plan	15/16 Institutions
HR	1.High Vacancy in case of Specialist<LHV<AYUSH<MBBS<Staff Nurse	100% Specialist 62% LHV 56% AYUSH 42% MBBS 39% Staff Nurse
Trained HR	MBBS<Staff Nurse	67% ANM (IUCD) (5%PPIUCD) 64% MBBS(IUCD) (27%PPIUCD) 45% Staff nurse(IUCD) (9%PPIUCD)

Infrastructure	1.One CHC found with functional FP OT 2. Inadequate Equipment's (surgical kit) 3. Govt Quarter not available for all	(1/3CHC) Functional OT- CHC Pottangi Non Functional -CHC Boriguma Not Present -CHC Boipariguda Only 58% NSV KIT available 61% not available
Consumables	Irregular supply of consumables	(MalaN)0CP - 37% ECP - 98% IUCD 380A -114% CC - 5%
	More emphasis on limiting than spacing method	Sterilizations conducted at SDH&DH-70%achieved Limited consumables at CHC & PHC (CC,OCP)

Recommendations

- Koraput is a HPD, HR availability should be enhanced to provide required services.
- Mostly newly recruited staff nurses yet to be trained.
- Supply chain mechanism should be strengthened to avoid irregularities in consumables.
- All the required infrastructure may be ensured through campaign.

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Annexure:

S no.	Name	Designation
1	Dr Nirmala Kumari Dei	Director (Family & Welfare dept),Odisha
2	Dr. D. K. Panda	Team Leader(SHSRC)
3	Dr. Biswajit Modak	Sr. Training Consultant
4	Dr. B.P. Mohapatra	Jt. Director, Nutrition
5	Dr. PKB. Patnaik	Jt. Director, NCD
6	Dr. Bikash Patnaik	Jt. Director, CD
7	Dr. Ranjeeta Patanaik	Jt. Director, Rural Health
8	Dr. Pramila Baral	Jt.Director, Public Health
9	Dr. M.M. Pradhan	Deputy Director, NVBDCP
10	Mr. Sushant kumar Nayak	Sr. Consultant CTRC
10	Dr.M.K. Behera	AD(MH)
11	Dr. Aditya Mohapatra	Consultant Pediatrician
12	Mr. Adait Kumar Pradhan	State Programme Manager

Interview Schedule:-

1) Questionnaire for Medical Officer (MO)/ Lady Health Visitor (LHV)/ MO In charge (if present)

To study the institutional preparedness for Parivar Kalyan Diwas in Koraput district of Odisha

Information - My name is Dr. Kim Patras. I am a student of IIHMR University, Jaipur. I am pursuing my Summer Training under National Health Mission (NHM) on the topic "To study the institutional preparedness for Parivar Kalyan Diwas in Koraput district of Odisha". I would like to ask you few questions related to the respective topic. The responses will be kept confidential. This means that the interview responses will be shared only with the research team and we will ensure that any information that we include in our report does not identify you as the respondent. Remember, you don't have to talk about anything that you don't want to and you can end the interview at any time.

Consent - Igive my approval for the interview. All the things have been explained to me up to my satisfaction.

Interviewee Signature

Institutional Preparedness For Quality Parivar Kalyan Diwas

A. **General Information**

S. no.	Particulars	Details
1	Name of the district	
2	Name of the block	
3	Name of the institution	
4	Type of the institution	
5	Date (DD/MM/YY)	
6	Name of the respondent	
7	Designation of the respondent	
8	Phone number	
9	E-mail id (if present)	
10	Interviewee signature	

Questionnaire

B. **PKD Service Provision**

Plan	In last 3 months how many PKD conducted against plan?	Need	January		February			March		
			Plan	Organi-zed		Need	Orga-nized	Plan	Need	Organ ized

C. **Human Resource availability**

Q.No.2	**What is the HR availability against the sanctioned post?**				
S.no.	Category	Need	SP(sanctioned post)	IP(in position)	Reasons
1	Specialist				

1.	2.	3.	4.

D	**Infrastructure availability**			
Q.No.4	**Do you have quarter facility for staff?**			
S.no.	Staff	Total Human resource	Quarter Available	Not available
1	Specialist			
	DGO/MD (gynaecology)/ MS surgeon			
	Minilap surgeon			
	NSV surgeon			
2	Doctor(MBBS)			
3	LHV			
4	Staff Nurse			
5	OT Technician			
6	OT Attendent			
7	Sweeper			
	Male			
	Female			
Q.No.5	Do you have equipped OT for Family Planning?	Yes		No
Q. No.6	If no where do you conduct family planning operation?			
Q.No.7	How many OT tables you have?			
Q.No.8	Is it adequate?	Yes		No
Q.No.9	If no how many extra OT tables you require?			

P-Plan, C-Conducted