Summer Training at
National Rural Health Mission
Government of Rajasthan
(April 9-June 1, 2012)

Utilization of ANC Services in Urban Slums of Jaipur and an Overview of Various Components Undertaken in National Rural Health Mission, Rajasthan

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CERTIFICATE

This is to certify that Mr. Priyanshu Sharma, student of Institute of Health Management Research, Jaipur has undergone Summer Training at National Rural Health Mission, Government of Rajasthan from 9th April 2012 to 1st June 2012. His work involved: "Understanding various components under NRHM and a Project on Utilization of Ante-Natal Care services in urban slums of Jaipur". The candidate has successfully carried out the study task assigned to him during summer training and his approach to study has been sincere, scientific and analytical.

This Summer Training is in partial fulfillment of course requirement.

I wish him success in all his future endeavors.

Dr. P.R. Sodani
Dean, Academic and Student Affairs
IHMR, Jaipur

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ACKNOWLEDGMENT

At the onset of the report I would like to acknowledge my sincere thanks to my institute, **Institute of Health Management Research, Jaipur** *for providing me a platform to gain enough knowledge and skills in different aspects of health management.*

Most importantly I would like to thank **Dr. P. R Sodani** [Professor and Dean (Training)] *for providing me this golden opportunity to work with* Government of Rajasthan *as a part of my summer training.*

I would also like to thank my mentor **Dr. (Maj.) Vinod Kumar** *(IIHMR) for his able guidance and useful suggestions, which helped me in completing the project work, in time.*

I owe a great debt to **Smt. Gayatri Rathod (IAS), Mission Director NRHM** *for having permitted me to do my summer training with* Government of Rajasthan . *she was a constant guiding support and inspiration throughout the training period.*

I would also like to thank **Dr. P.K. Sarda (Director RCH)** *and* **Dr. Nupur (Joint Director RCH**) *without whom this training could never have been accomplished.*

This training wouldn't have been completed without a substantial support from a great number of people and so I would like to thank all the consultants in various departments and other staff members at NRHM for being so helpful all the time and making this summer training project an unforgettable experience.

Finally, most importantly, I would like to express my heartfelt thanks to my beloved parents for their blessings, my friends/classmates Vijay, Priyanka, Pawan, Hemlata, and Garima for their help and wishes for the successful completion of this training.

Priyanshu Sharma

PREFACE

Summer internship is an integral part of the PGDHM curriculum. As a part of the course; students of first year are required to undergo summer placement at any reputed organization to get in depth exposure of various departments in the organization and better understanding of the health care delivery system and its functions.

We did our Summer internship in NRHM, Government of Rajasthan. The period of summer training was from 9th April, 2012 to 1 June, 2012.

The major objectives of the summer training programme were as follows:

1) To better understand the existing health delivery system including public and private sectors.
2) To observe the implementation of various National Health Components at National/State/District levels.
3) To understand various functions of health systems by interactions with key stakeholders, policy makers, programme managers, academicians and researchers.
4) To work on the project/task assigned by summer training organization.

During our training period we had an **Overview of various Components** undertaken in National Rural Health Mission, Rajasthan including the current status of the components and our observations regarding the same.

In addition to that we carried out a small study on the topic **Utilization of ANC services in urban slums of Jaipur**. The purpose of the study was to assess the utilization of ANC services in urban slums of Jaipur and to identify the reasons for Under-utilization / No Utilization of ANC services by the community, if any and also to identify the Gaps in health delivery system related to ANC services utilization.

ACRONYMS

AIDS:	Acquired Immunodeficiency Syndrome
ANC:	Ante-natal care
ANM:	Auxiliary nurse midwife
ASHA**:**	Accredited social health activist
AWC:	Anganwadi Centre
AWW:	Anganwadi worker
BPL:	Below poverty line
HIV:	Human Immunodeficiency Virus
IEC:	Information, Education and Communication
IFA:	Iron Folic Acid
JSY:	Janani suraksha yojna
MCHN:	Maternal, Child Health and Nutrition
MDR:	Maternal Death Review
MMBPLJRK:	Mukhya mantri BPL jeevan raksh kosh
NRHM:	National Rural Health Mission
RCH:	Reproductive and Child Health
RHSDP:	Rajasthan Health System Development Project
RSACS:	Rajasthan State AIDS Control Society
RTI:	Reproductive and Child Health
SBA:	Skilled Birth Attendant
TT:	Tetanus Toxoid
VHSC:	Village Health and Sanitation Committee

Table 1 - List of Persons Interacted during the Training Period

S.No.	Name	Designation	Place
1.	Smt. Gayatri Rathod	Mission Director NRHM	NRHM, Swasthya Bhawan
2.	Dr. P. K. Sarda	Director RCH	NRHM, Swasthya Bhawan
3.	Dr. Nupur	Joint Director RCH	NRHM, Swasthya Bhawan
4.	Dr. Giriraj Sharma	Consultant Maternal Health	NRHM, Swasthya Bhawan
5.	Dr. Indra Gupta	Nodal officer- RTI/STI/SBA/MDR	NRHM, Swasthya Bhawan
6.	Miss. Shikha Sharma	Consultant Urban RCH/Quality Control Assurance/Anemia Control Program	NRHM, Swasthya Bhawan
7.	Vaishali Sharma	Consultant IEC	NRHM, Swasthya Bhawan
8.	Shri. Kishanaram Esharwal	Project Director, MMBPLJRK	NRHM, Swasthya Bhawan
9.	D.P.Kanungo	Consultant MMJRK	NRHM, Swasthya Bhawan
10.	Sushrita Roy	Consultant ASHA	NRHM, Swasthya Bhawan
11.	Vaidehi Agnihotri	Consultant VHSC/ARSH	NRHM, Swasthya Bhawan
12.	Naresh Kumar	Nodal Officer, JSY	NRHM, Swasthya Bhawan
13.	D.K.Shringi	Drug Controller	Swasthya Bhawan
14.	Dr. J.P.Dhamija	Director AIDS, Director(RSBTC), PD(RSACS)	RSACS, Swasthya Bhawan
15.	Jimeevas	Technical Support person for RSACS	RSACS, Swasthya Bhawan
16.	Dr. Ravi Gupta	PPTCT Consultant	RSACS, Swasthya Bhawan
17.	Dr. Raja Chawla	Deputy Director RTI/STD	RSACS, Swasthya Bhawan
18.	Sanjay Singhal	Quality Manager	RSACS, Swasthya Bhawan
19.	Ashish Verma	Programme Officer, State Mainstreaming Unit	RSACS, Swasthya Bhawan
20.	Prakash Narvani	M & E Officer	RSACS, Swasthya Bhawan
21.	Dr. L.L.Dautonia	Deputy Director Immunization	NRHM, Swasthya Bhawan
22.	Dr. R.S.Rathore	State Immunization Officer	NRHM, Swasthya Bhawan
S.No.	**Name**	**Designation**	**Place**

23.	Hardayal Singh	Deputy Director PCPNDT	NRHM, Swasthya Bhawan
24.	Archana Sharma	Health Manager, PNDT Cell	NRHM, Swasthya Bhawan
25.	J.P.Jat	State Demographer FW	NRHM, Swasthya Bhawan
26.	Prem Sharma	Statistical Inspector (Demographic cell)	NRHM, Swasthya Bhawan
27.	Vibha Sharma	Assistant State Demographer	NRHM, Swasthya Bhawan
28.	Dr. D.B.Gupta	PMO	Satellite Hospital, Sethi Colony
29.	Dr. G.S.Khatri	Joint Director (Blindness)	Swasthya Bhawan

Table 2 – Meeting attended during the training period

Date	**Meetings / workshops objective**
27/04/2012	Vitamin A campaign from 30-04-12 to 31-05-12

Table 3 - List of activities performed during the training period

Date	**Activity**
09/04/2012	Discussion on the objectives and Mission document of NRHM
16/04/2012	Discussion on the operational guidelines on maternal and newborn health
17/04/2012	Assisted Dr. Giriraj sharma (consultant-MH) in the monitoring of FRUs of Rajasthan – Monthly monitoring of State FRUs is done and Report is sent to GOI
18/04/2012	A brief study on implementation of Janani surakha yojna (JSY)
20/04/2012	A detailed analysis on number of maternal Deaths and their major causes in the financial year 2011-12
25/04/2012	A discussion on Alternate Vaccine Delivery System (AVDS) and gave some recommendation.
27/04/2012	Reviewed the Training modules of ASHA and suggested some improvements in the Modules for the next edition.

Table 4 – List of Places visited during the training period

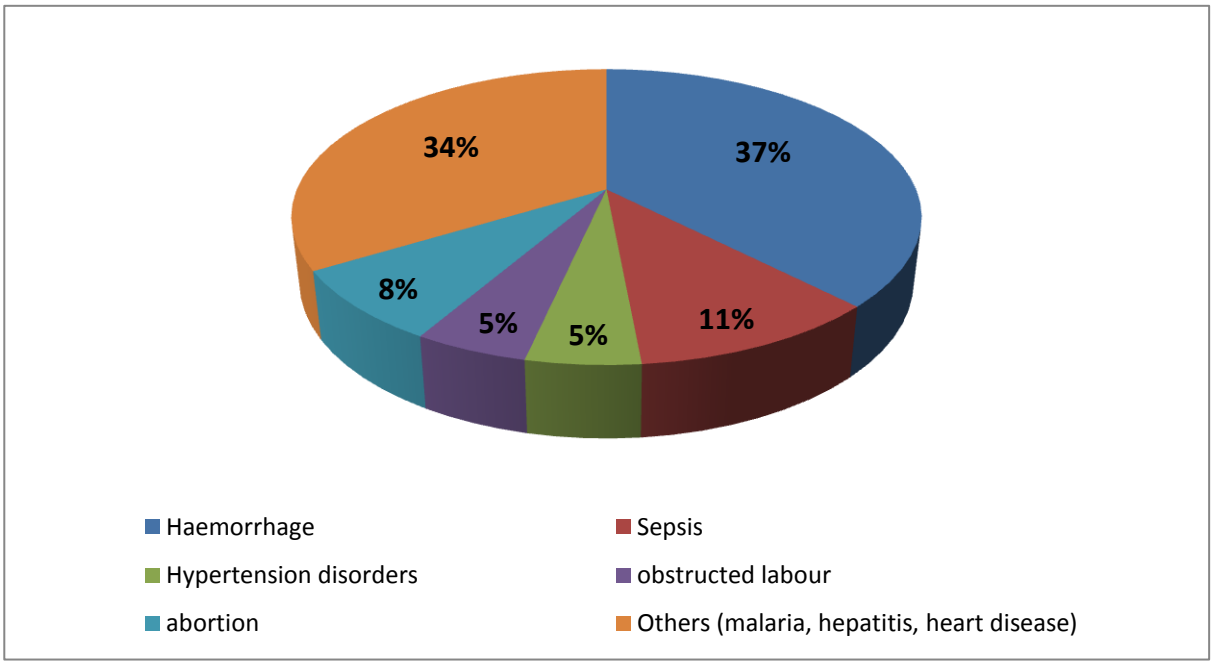
Date	Activity
19/04/2012	Kanwatiya hospital, Shastri nagar , Jaipur
15/05/2012	PHC Sundlak, Dist. Baran
16/05/2012	SC and AWC Melkhedi, Dist. Baran
17/05/2012	SC and AWC Ranwasi, Dist. Baran
18/05/2012	PHC koyla, Dist. Baran SC Badagaun, Dist. Baran
18/05/2012	CHC Amer, Dist. Jaipur
23/05/2012	CHC Sanganer , Dist. Jaipur
24/05/2012 - 26/05/2012	Jawahar Nagar Slums, Jaipur

SECTION – A: A STUDY ON UTILIZATION OF ANC SERVICES IN URBAN SLUMS OF JAIPUR.

1. INTRODUCTION

Ante-natal care is a type of preventive care with the goal of providing regular check-ups that allow doctors or midwives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefit both mother and child. The routine Ante-natal checkups play a part in reducing maternal death rates and miscarriages as well as birth defects, low birth weight, and other preventable health problems.

Figure 1 – Causes of Maternal Deaths



Source: SRS – 2001-03

Complete ANC Service includes:-

- Registration (within 1st trimester)
- Physical examination + weight + BP + abdominal examination
- Identification and referral for danger signs
- Ensuring consumption of at least 100 IFA tables (for all pregnant women) /200 (for anaemic women). Severe anaemia needs referral.
- Essential lab investigations (HB%, urine for albumin/sugar, pregnancy test)
- TT immunisation (two doses at interval of one month)
- Counselling on nutrition, birth preparedness, safe abortion

2. OBJECTIVES:

2.1 To assess the utilization of ANC services in urban slums of Jaipur and to identify the reasons for Under-utilization / No Utilization of ANC services by the community, if any.

2.2 To identify the Gaps in health delivery system related to ANC service utilization

3. METHODOLOGY

The descriptive cross-sectional study was carried out in Jawahar nagar urban slum, Jaipur during the period from May 21, 2012 – May 28, 2012. The sampling procedure adopted was convenient sampling. 30 females were chosen as primary respondents who were registered for ANC services during the period October'2011 to March'2012. These women were interviewed with the help of semi structured schedule. In addition to this, secondary data was also collected from the Anganwadi centres and dispensary in that area regarding ANC services. Also, a formal meeting was conducted with ASHAs, ANMs and AWWs to develop the understanding of the health delivery system and community behaviour regarding the ANC services in the slum. The minutes of meeting were recorded.

The total population of the Jawahar nagar slum divided in seven Tela was 33, 630.

4. RESULTS AND DISCUSSION

4.1 ANC Services

The secondary data of women who were registered during october1, 2011 to March31, 2012 for ANC services was collected from the Anganwadi centres. The Data comprises of total ANC registrations, registrations in first trimester and the total number of completed ANCs as shown in the Table 1.

In the given data the complete ANC include registration and two doses of TT with interval of one month.

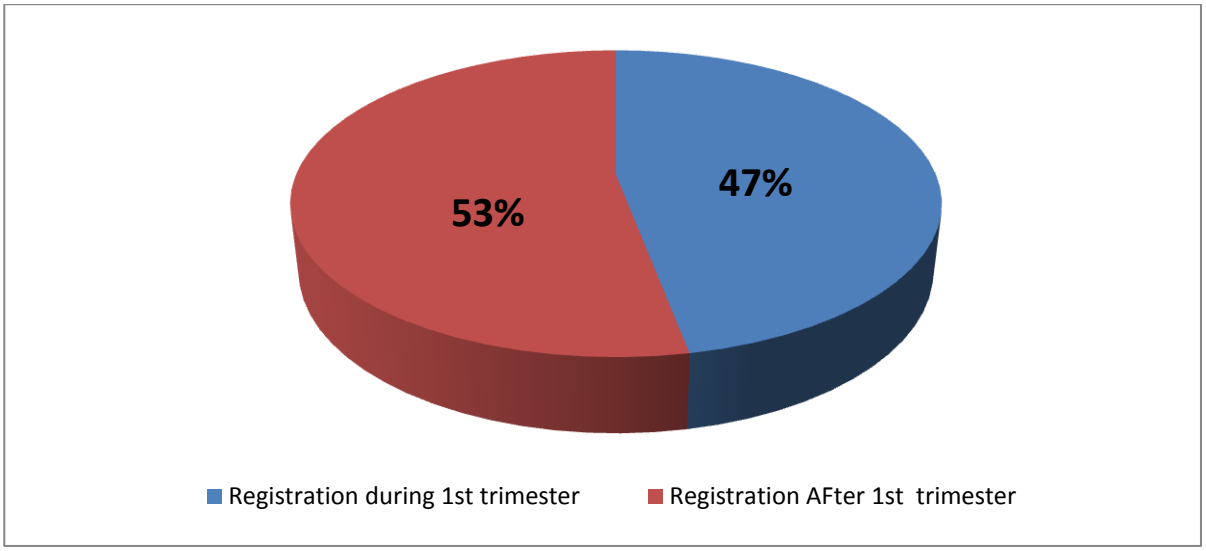
Table 5 - Profile of ANC Services in Jawahar nagar slum, Jaipur

Month	ANC Registered	Registration in 1st Trimester	Complete ANC*
OCT'11	39	22	31
Nov'11	47	20	31
Dec'11	41	15	30
Jan'12	47	18	35
Feb'12	67	30	38
March'12	104	57	60
Total	345	162	225

***** For this study Women with Complete ANC were those had been registered and had been administered two doses of TT

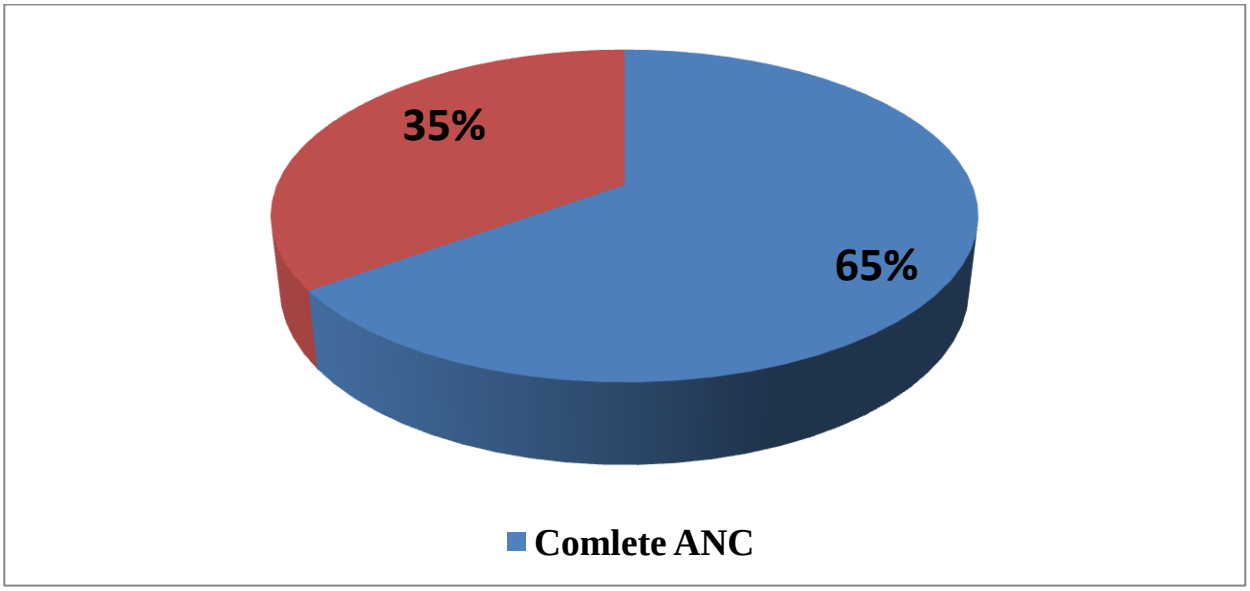
It was found that the registration in first trimester (Early registration) was almost half (47%) of total registration as shown in the Graph 2.

Figure 2 - ANC registration during October'11-March'12



The data also exhibit that the dropout rate was high as complete ANCs were only 35% in comparison of total registrations as shown in the Graph 3. The reasons for the high dropout rate was that women registered for ANCs were not accepting the TT dose due to various reasons and few of them were going to other health facilities for checkups as said by the health workers during the meeting with them.

Figure 3: ANC Status during October'11-March'12



4.2 Resources :

During the study, the health facilities were visited which includes Anganwadi centres in Jawahar nagar slums and D-health post(It is a dispensary dedicated to Jawahar nagar slum). The availability of the resources such as manpower, drugs and equipments were checked and they were found to be inadequate to cater the needs of the community.

There were only 7 ASHAs and 3 ANMs working in the population of around thiry three thousand which is quite less.

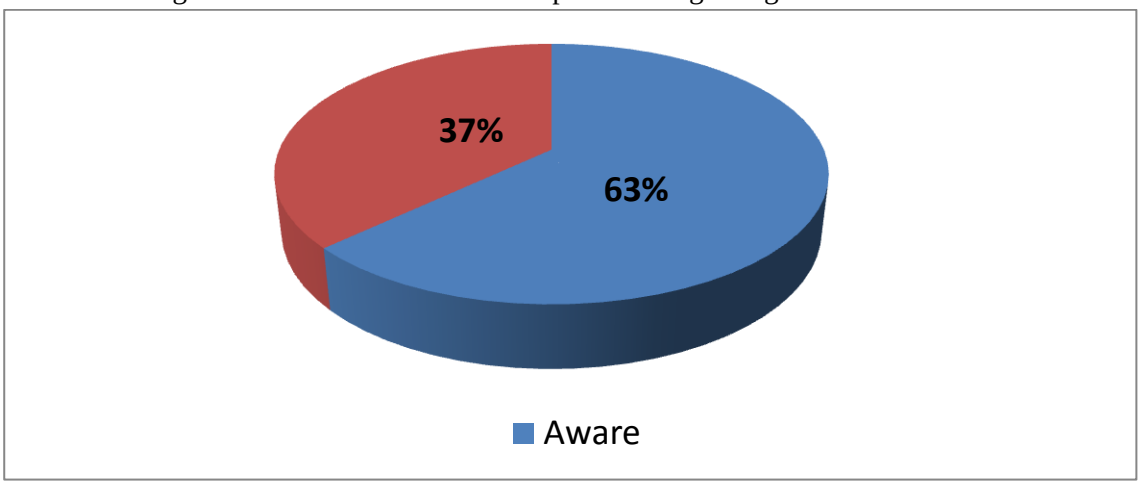
After formal discussion with health workers, it was found that they don't have adequate space to conduct MCHN day smoothly as the size of Anganwadi centre was too small. Alternate Vaccine delivery system is not functional in slums so ANMs are facing difficulties in getting the vaccines at right time and right place, they added.

It was also found in the discussion that there was no weight machine in the Anganwadi centre since last two years.

4.3 Community awareness and behaviour :

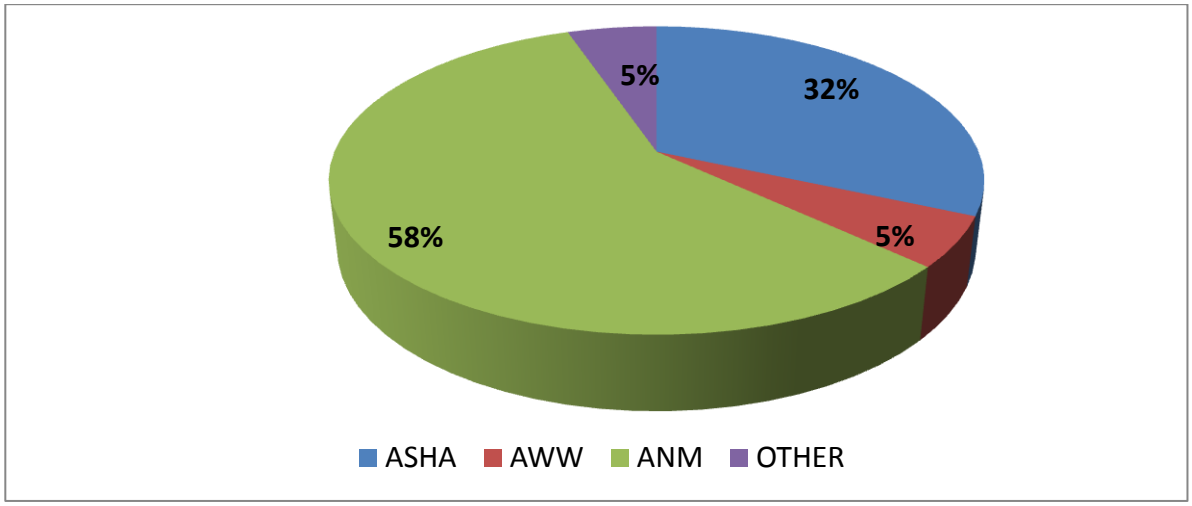
A face to face interview was conducted with 30 women with the help of semi structured schedule who were registered for ANC services during Oct'11-March'12. The purpose was to find out the common reasons for under utilization of the ANC related services, if any. Community behaviour plays a major role in availing the health services. It can be seen in the Graph 4 that awareness level regarding ANC services is around 2/3rd (63%) which is quite satisfactory among community

Figure 4 – Awareness Level of respondents regarding ANC Services



Health worker plays a major role in increasing the awareness level of community. Respondents who knew about the ANC services were asked about the source of information. Around 60% respondents said that awareness is due to ANM as shown in Graph 5. Thus, we can say that ANM played a major role in increasing awareness level in community than any other health worker.

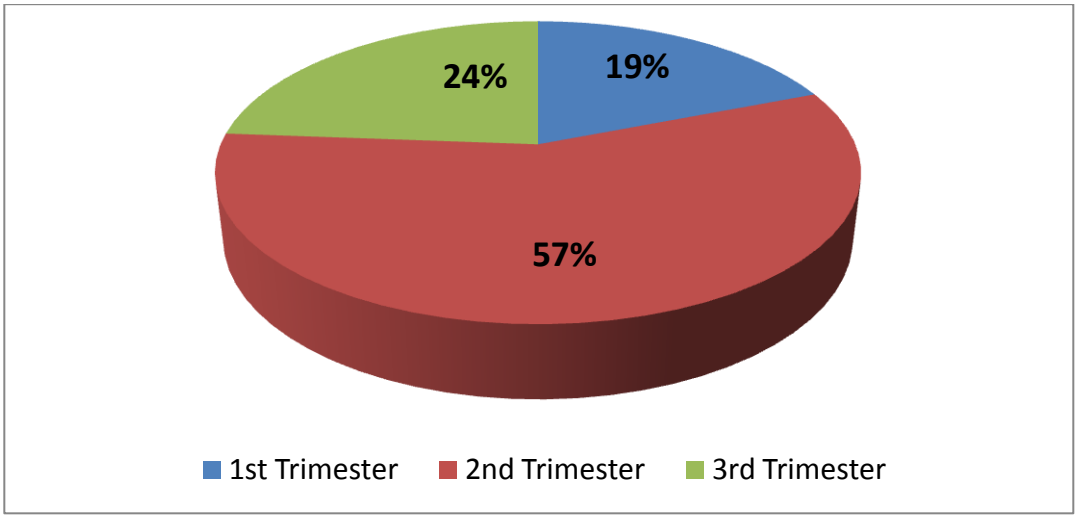
Figure 5 - Awareness provided by Health worker



Though ASHA is the first link between community and the health system and she is primarily responsible for awareness and behaviour towards ANC services utilization in the community but she contributed only one third (around 33%). The reasons for contributing less in providing the awareness in the community could be that they are not sensitised and also not trained. ANM told that no training of ASHAs in Jawahar Nagar Slum has been conducted till now except the first Induction programme of fifteen days so this could be the reason for incompetency in their work.

Early registration is the registration within first trimester of the pregnancy. It was found that only there were 20% registrations in first trimester. Majority of the registrations took place in Second trimester. It is interesting to note that about 1/4th registrations were during the last trimester of pregnancy(In 6-8 months of pregancy) as shown in the graph below.

Figure 6 - Time of Registration for ANC

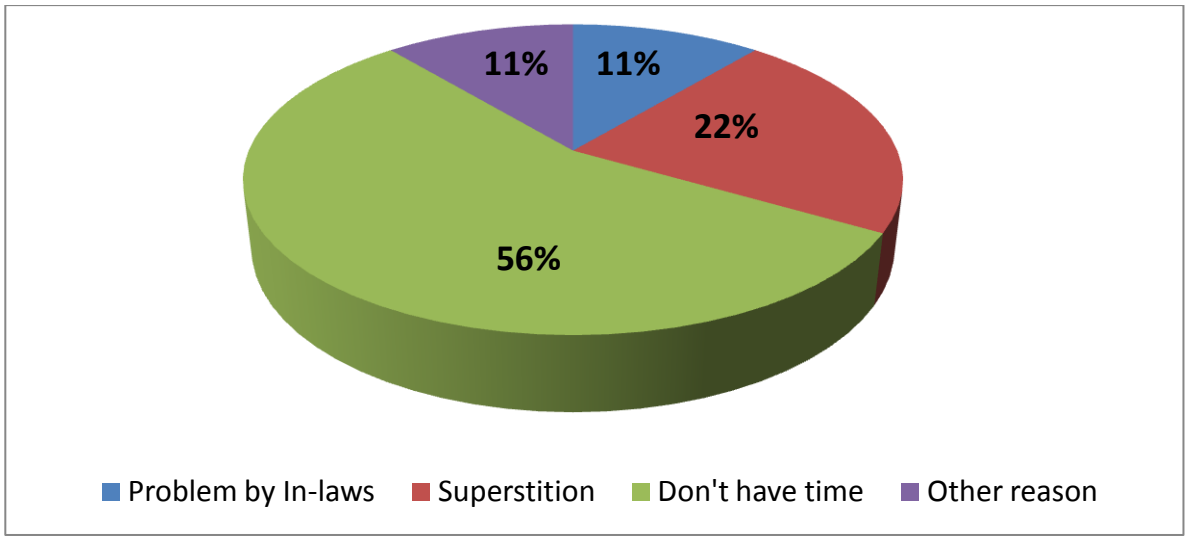


Superstition appeared to be one of the main reasons for not registering the pregnancies early. It is considered inappropriate to reveal the pregnancy status in the first trimester. This also seems to be an important reason for underutilization of ANC services as shown in Graph 7. Around 22% respondents told this reason for underutilization of ANC services. The time problem was the main reason for underutilization of ANC services in slums.

This reason was responded by around 56% of the women as shown below in Graph 7.

Problem by in laws especially mother in laws was also a reason for not utilizing ANC services.

Figure 7 - Reasons for underutilization of ANC services



5. RECOMMENDATIONS

Findings of the study shows that the gaps exist in health delivery system related to ANC services. Time problem and superstition among the community are also the reasons for underutilization of ANC services. Therefore, on the basis of findings following recommendations are forwarded by us:

1. Strict and continuous monitoring of ASHA and ANM as well as Anganwadi centres.
2. Training of ASHA should be conducted as soon as possible as they had only been oriented with induction programme four years ago.
3. Adequate space should be provided to Anganwadi centres so that they can properly carry out the basic activities intended to them including MCHN day.
4. There is a Need of some other methods such as IEC activity apart from counselling through ASHA and ANM to educate and aware community.
5. Health worker should tell the necessity of the ANC and immunization to the pregnant women and their families and try to convince them to come for Ante natal checkups.

6. SUMMARY AND CONCLUSION

A study on utilization of ANC services in urban slums of Jaipur was conducted as a part of summer training in NRHM, Govt. Of Rajasthan during May21, 2012 - May28, 2012. The purpose of the study was to assess the utilization of ANC services in urban slums of Jaipur and to identify the reasons for Under-utilization / No Utilization of ANC services by the community, if any and also to identify the Gaps in health delivery system related to ANC services utilization.

The study was carried out in Jawahar nagar urban slum. 30 females were chosen as primary respondents who registered themselves for ANC services during the period October'2011 to March'2012. These women were interviewed with the help of semi structured schedule. The secondary data of women who were registered during october1, 2011 to March31, 2012 for ANC services was also collected from the Anganwadi centres and then analysed.

The secondary data, when analysed, it was found that the ANC registrations in first trimester (also called as early registration) was 47% of Total ANC registrations. The data also shows that the drop outs were more as complete ANC was only 35% in comparison of total ANC registrations.

During the study, the health facilities were also visited and it was found that the resources which include manpower, drugs and equipments are not adequate to meet the needs of the community.

It was found that awareness level regarding ANC services is around 63% in community which was quite satisfactory and ANM played a major role in increasing awareness level in community than any other health worker.

There was also a proportion of women who did not registered themselves for ANC or Left the ANC services (Two Dose of TT) in between. Those respondents when asked for the reasons then the major response were time problem.

Findings of the study showed that the gaps exist in health delivery system related to ANC services. Time problem and superstition among the community were also the reasons for underutilization of ANC services.

SECTION – B: VARIOUS COMPONENTS UNDERTAKEN IN NRHM

1. ABOUT NATIONAL RURAL HEALTH MISSION

The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure. These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP. It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country. It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the Health & Sanitation Committee of the Panchayat; strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); and integration of vertical Health & Family Welfare Programmes and Funds for optimal utilization of funds and infrastructure and strengthening delivery of primary healthcare. It seeks to revitalize local health traditions and mainstream AYUSH into the public health system. It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health. It seeks decentralization of programmes for district management of health. It seeks to address the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure. It shall define time-bound goals and report publicly on their progress. It seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective.

2. REPRODUCTIVE AND CHILD HEALTH (RCH II)

The overall goal of RCH II programme is to reduce infant and maternal morbidity and mortality in the state. These goals will be achieved through improvement in quality, enhancing accessibility and availability, and coverage with the reproductive and child health services, including family welfare. The programme emphasizes empowerment of women and communities for enhancing health service utilization to achieve reproductive goals and population stabilization. The RCH-II programme includes the activities such as

Maternal health, Child health, Family planning, Adolescent reproductive and sexual health, urban RCH, tribal RCH and PNDT activitiy.

2.1 MATERNAL HEALTH

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death.. Maternal mortality and morbidity indicators reflect not only how well the health system is functioning, but also the degree of equity in public service delivery, utilisation of services, and the social status of women. Every year, in India, 28 million pregnancies take place with 67,000 maternal deaths, 1.1 million women left with chronic ill health, and 1 million neonatal deaths. The major direct causes of maternal morbidity and mortality include haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour.

Strategies for Ensuring Improvements in Maternal Health :

- **Provision of Quality Antenatal Care :**

All women must have access to a package of antenatal services provided in the Community or at the facility by a provider who is skilled and who has the necessary equipment and supplies.

- **Ensure Access to a Skilled Birth Attendant**

A Skilled Birth Attendant (SBA) is a professionally qualifi ed individual who can handle normal pregnancies and deliveries, identify obstetric and neonatal emergencies, manage complications as per their defi ned competencies, and undertake timely referral to a higher centre where comprehensive obstetric care can be provided.

- **Functional Facilities to Provide Institutional Deliveries**

Level 1 - A Skilled Birth Attendant (SBA) is a professionally qualified individual who can handle normal pregnancies and deliveries, identify obstetric and neonatal emergencies, manage complications as per their defined competencies, and undertake timely referral to a higher centre where
comprehensive obstetric care can be provided.

Level 2 - Institutional Delivery (Basic Level): Delivery conducted by a skilled
birth attendant in a 24x7 PHC level (PHC or CHC with Basic Emergency Obstetric and Newborn Care (BEmONC) or in a private nursing home with equivalent facilities. Newborn Corner and Stabilisation Unit.

Level 3 - Institutional Delivery (Comprehensive Level): First Referral Unit (FRU) or Comprehensive Emergency Obstetric and Newborn Care (CEmONC) and private hospitals. Neonatal Stabilisation Unit and Special Newborn Care Unit (SNCU).

2.1.1 JANANI SURAKSHA YOJNA (JSY)

Janani Surakha Yojana (JSY) is a centrally sponsored scheme under NRHM umbrella to benefit pregnant women & certified poor families. Janani Suraksha Yojna was launched on 2011 in India. In Rajasthan it was started on in all 33 districts.

Objectives of JSY

1. To decrease maternal mortality rate & infant mortality rate.
2. To increase Institutional deliveries amongst BPL & poor families.

Duties of ASHA - Sahayogini:

1. Registration of eligible beneficiary.
2. Antenatal checkups (3 times)
3. Arrange referral transport, Escort her to health facility & facilitate cash assistance from PHC/CHC/DH.
4. Post natal checkups (2 times).

2.1.2 JANANI SISHU SURAKSHA YOJNA (JSSY)

Janani Shishu Suraksha Karyakram was launched on June 11, 2011 in India. In Rajasthan it was started on September 12,2011 in all 33 districts.

Objectives Of JSSK

1. Entitlements and elimination of out-of pocket expenses for pregnant women and sick neonates
2. Enhancing access to public health institutions
3. Reduce MMR & IMR

Entitlements for Pregnant Women under JSSY

1. Free Delivery & C –Section
2. Free Drugs & Consumables before, during and till 6 months after the delivery
3. Free Diagnostics(Blood, Urine, USG etc)
4. Free diet during stay (up to 3 days for normal delivery & 7 days fro C-Section
5. Free transport: home institution, between health institution in case of referrals
6. Exemption from all kinds of user charges

Entitlements for Sick Newborn till 30 days after birth under JSSY

1. Free and zero expense treatment
2. Free drugs & consumables
3. Free diagnostics
4. Free provision of blood
5. Free transport from home health institution, between health institution in case of referrals
6. Exemption from all kinds of user charges

2.1.3 MATERNAL DEATH REVIEW

Maternal death and illness have cost implications for family and the community because of high direct and indirect costs, its adverse impact on productivity and the tremendous human tragedy that every maternal or child death represents. The program initiated as Community based Maternal and Infant Death Inquiry Response in 11 districts of 22 blocks in Year 2009-10. In which all the deaths of women between from 15 to 49 years of age and infant (up to one year of age) will be reported by Accredited Social Health Activist (ASHA), Anganwadi Worker, JMC, etc. and will be verified by a team of Medical officer and Lady Health Visitor from the respective PHC when death is maternal death it is investigated by the Block team which had been trained previously for verbal autopsy. After investigation block team send the report to CMHO and collectors where cause of death is analysis by the team of expert. The cause of death will be then review in DHS and Block level meeting. The cause will also share in simple language with community. In year 2010-11this program is initiated as a Maternal Death Review in all districts. On reporting of each maternal death incentive of Rs. 50 is given to ASHA, AWW & JMC , who so ever report the Maternal Death from Untied fund of respective institution.

In year 2010-11, 982 Maternal Deaths are reported out of which 472 Maternal Deaths are reviewed by the District Maternal Deaths Committees. 57% Deaths were Facility based and 43% deaths were community based.

Maternal deaths profile of Rajasthan state for the year 2011-12 is as given in Annexure

2.2 CHILD HEALTH

2.2.1 INTEGRATED MANAGEMENT OF NEONATAL AND CHILDHOOD ILLNESS (IMNCI)/ F-IMNCI:

IMNCI is a strategy for improving neonatal and child health and reducing infant mortality in the state. This strategy aims to improve neo-natal and childhood survival in the state through regular and appropriately timed *home visit* for newborns (3 visits are recommended for the newborns- on Day 1,3 and 7), counseling of caregivers, recognition and treatment/ referral of sick newborn; treatment/ referral of sick children to health facilities; and counseling on Immunization and Feeding.
In case of low birth weight child (less than 2.5 kg), there are 3 additional visits on Day 14, 21 and 28.

Implementing agencies: Department of Medical, Health & Family Welfare and Department of WCD are jointly responsible for implementing IMNCI in the districts. UNICEF is a technical support agency for the program.

Strategies: 10 strategic areas have been identified to achieve the Child Health Goal of reducing Infant Mortality below 30 thousand live births.

1. Provision for essential new born care (at facility level and home based new born care)
    - Establishment of NBCCs at MCH level I
    - Training in Essential New Born Care (NSSK)

2. Expansion of services for care of sick newborn and free referral transport
    - Establishment of SNCUs at District Hospitals/MCH level III and NBSUs at FRUs/MCH level II facilities
    - Free Referral Transport for sick newborns

3. Management of children with malnutrition
    - Early detection of children with malnutrition through MCP cards in convergence with MWCD
    - Facility based management of children

4. Infant and Young Child Feeding Practices (IYCF)
    - Initiation of Breastfeeding in first hour of birth
    - Exclusive breastfeeding till 6 months
    - Complementary feeding of children from 6 months onwards

5. Micronutrient supplementation
    - IFA supplementation for children 6 months to 10 years
    - Vitamin supplementation for children 6 months to 5 years

6. Management of Diarrhoeal Diseases
    - ORS and Zn supplementation
    - Behavioral interventions

7. Management of Acute Respiratory Infections
    - Early detection of respiratory infections
    - Administration of antibiotics

8. Improving Immunisation Coverage
    - Microplanning and Child Tracking System

9. Eliminating Measles related deaths
    - Increased coverage by measles vaccine

- Second dose of measles

10. IMNCI and Facility Based IMNCI
    - Training of frontline workers (ANMs and AWWs), SNs and physicians for the management of most common childhood illnesses i.e. sepsis, measles, malaria, diarrhea, pneumonia and malnutrition.

2.2.2 HOME BASED POST-NATAL CARE (HBPNC):

Rajasthan has initiated Home Based Post Natal Neonatal Care by ASHA in the three NIPI focus districts of Bharatpur, Alwar and Dausa. Under this initiative, mothers delivering at home are visited and monitored by ASHA-Sahyoginis wherein she visits her at least six times within 42 days, first visit is within 24 hrs; second visit on 3rd day, third visit on 7th day; fourth visit on 14th day, fifth visit on 28th and last visit on 42nd day of the delivery and provide Post Natal Care to the those women who delivered at Home. For complete Post Natal home visits, ASHA would be given incentive of Rs 200 per home delivery (six visits) and Rs 100 per institutional delivery (five).

2.2.3 MALNUTRITION TREATMENT CENTER (MTC):

Malnutrition Treatment Centers are established at all the District Hospitals of the state. Severely malnourished children are referred to the center by AWWs and ASHAs for rehabilitation.
After discharge of the children from MTCs, their tracking and follow-ups are done at the AWCs.
For care of sick children & severe malnutrition children 6 bedded MTC has been established in 36 DH & in 03 selected CHCs.

Key Challenges in Child Health:

1. Maintaining the quality of trainings at the district level
2. Placing effective monitoring and supportive supervision systems.
3. Ensuring adequate and regular supply of medicines and sundry supplies to practicing IMNCI skills.
4. Changing attitudes of the families towards their children - The IMNCI trained ASHA-Sahyoginis face stiff resistance from some families in getting their children treated. Sometimes it is impossible for her to handle such cases single handedly.
5. Underutilization of funds and services
6. MTC in charge when prepares the report does not fill all the parameters

2.3 THE PRE-CONCEPTION AND PRE-NATAL DIAGNOSTIC TECHNIQUES (PROHIBITION OF SEX SELECTION) ACT, 1994 (57 of 1994)

This is an act to provide for the prohibition of sex selection, before or after conception and for regulation of prenatal diagnostic techniques for the purpose of detecting genetic abnormalities or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex-linked disorders and for the prevention of their misuse for sex determination leading to female feticide and for matters connected therewith or incidental. Passed in the Parliament in the Forty-fifth Year of the Republic of India now it stands as THE PRE-CONCEPTION AND PRE-NATAL DIAGNOSTIC TECHNIQUES (PROHIBITION OF SEX SELECTION) ACT, 1994 (57 of 1994). Misuse of modern diagnostic facilities like ultra-sonography, amniocentesis, chorionic villi examination etc for the purpose of female feticide which is against the female sex and affects the dignity and status of women, dowry, Men Dominated Society, Son preference, Pind-Daan etc related matters were raised by the organizations working for the welfare and uplift of women therefore it was necessary to bring a legislation to regulate use of diagnostic techniques and to provided punishment to stop the misuse of

diagnostic techniques. It also prohibits advertisement of PNDT for detection & determination of sex. Permission & regulation of the use of PNDT for the purpose of detection of specific genetic abnormalities or disorders etc. only.

State PCPNDT Cell

Objectives of the state PCPNDT Cell:

- Collection & monitoring of various data related with PCPNDT Act, 1994 through district PCPNDT Coordinators.
- Awareness programme through Government agencies/MNGO/NGO to lawyers, Judiciary, PRI etc.
- To evaluate the local causes of female foeticide in various districts.
- To involve NGO/MNGO for effective implementation of PCPNDT Act, 1994.
- Online submission of Form “F” & Quarterly report with complaint loading.
- Up gradation of ultrasound machines for the purpose of storing various images.
- To identify unregistered centres & doctors engaged in unlawful activities.
- Registration of manufacturers of ultra sound machine suppliers.
- Organizing various meetings of advisory committee in the state.

3. IMMUNIZATION

Routine Immunization in India

Delivering effective and safe vaccines through an efficient delivery system is one of the most cost effective public health interventions. Immunization programmes aim to reduce mortality and morbidity due to vaccine preventable diseases (VPDs).

Following the successful global eradication of smallpox in 1975 through effective vaccination programmes and strengthened surveillance, the Expanded Programme on Immunization (EPI) was launched in India in 1978 to control other VPDs. Initially, six diseases were selected: diphtheria, pertussis, tetanus, poliomyelitis, typhoid and childhood tuberculosis. The aim was to cover 80% of all infants. Subsequently, the programme was universalized and renamed as Universal Immunization Programme (UIP) in 1985. Measles vaccine was included in the programme and typhoid vaccine was discontinued. The UIP was introduced in a phased manner from 1985 to cover all districts in the country by 1990, targeting all infants with the primary immunization schedule and all pregnant women with Tetanus Toxoid immunization.

India's Immunization Program is one of the largest in the world in terms of quantities of vaccines used, numbers of beneficiaries, and the numbers of immunization sessions organized, the geographical spread and diversity of areas covered. Under the immunization program, seven vaccines are used to protect children and pregnant mothers against Tuberculosis, Diphtheria, Pertussis, Polio, Measles, Tetanus and Hepatitis-B.

Monitoring at state level includes following components of Immunization

- Immunization & Vitamin A,
- Vaccine Supply
- VPD Surveillance,
- Status of Cold Chain Equipment
- AEFI (Adverse Event following immunization).

Challenges in Immunization

- Improving vaccine use and reducing wastage
- Safe injections
- Reduce Adverse event following immunization
- Alternate vaccine delivery system
- Left outs and Drop outs

Common reasons identified for left out and drop out:

- Parents not motivated to immunize children because of their poor understanding of its purpose and importance
- Session site too far away
- Cultural or Religious reasons for refusal of vaccination (myths, rumors and misconceptions
- Financial or gender barriers to immunization (e.g husbands disallow wives to attend sessions because of time/lost labor, expense and/or fear of side effects)
- AEFI in the community discourages parents to immunize their children

4. ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA) :

The Government of India and Government of Rajasthan have launched a National Rural Health Mission to address the health needs of rural population, especially the vulnerable sections of the society. The sub centre is the most peripheral level of contact with the community under the public health infrastructure. This caters to the population norm of 3000 - 5000. The worker in sub centre is an ANM who is directly involved in all the health issues of this population, which is spreaded over the wide area of many kilometres and covering 5 to 8 villages. Many a times the villages are not connected by public or private transport system making her more difficult to achieve the objectives and goals of providing quality health care for the poor and oppressed sections of the society. So the new band of community based functionaries, named as Accredited Social Health Activist (ASHA) is proposed in the NRHM who will serve the population of 1000 and 500 in hilly and desert terrene.

ASHA is the first port of call for any health related demands of deprived sections of the population, especially women, children, old aged, sick and disabled people. She is the link between the community and the health care provider.

Department of Medical and Health at State and at Centre is looking at ASHA as a change agent who will bring the reforms in improving the health status of oppressed community of India. The investment on ASHA will definitely result in to better health indicators of state and at large the country.

ASHA Sahayogini

(Convergence of DWCD and NRHM)

In each Anganwadi Centre apart from Anganwadi Worker and Sahayoka one additional worker named 'Sahyogini' is envisaged to provide door to door information and services of Nutrition, Health, preschool education. Her role is quite similar to the role of ASHA under NRHM. So to avoid duplication of workers providing same types of services in the same area, the decision was taken at State level, that there will be only one worker coterminous with Anganwadi, who will work with DWCD and DMHS. This worker is called as 'ASHA Sahyogini', selected by the community through Gram Panchayat and responsible to the community.

Criteria for selection

- One ASHA Sahyogini for each Anganwadi Center.
- Woman resident of that area, Married/ Widow/ Divorcee
- Age between 21 to 45 years
- ASHA Sahyogini should have effective communication skills, leadership qualities and be able to reach out to the community.
- ASHA Sahyogini should be literate woman with formal education up to eighth class, In Tribal and desert areas the educational qualification may be relaxed if the 8th pass Candidate is not available. This is permitted only after the approval of State level Committee.
- Adequate representation from disadvantaged population groups.

Factors Critical to the Success of ASHA

- Selection of ASHA by prescribed process as per the ASHA guidelines.
- Linkage with nearest functional health facility for referral services.
- Identified transport for referral of cases from village to facility
- Priority and recognition of cases referred by ASHA to MO / ANM.
- Successful organization of monthly Health and Nutrition Day (in every village with the ANM / AWW).
- Monthly meeting of ASHA at PHC.
- Timely payment of incentives to ASHA.
- Timely replenishment of ASHA kit.

Table 6 - Incentive plan for ASHA :

S.NO.	Activity By ASHA	Incentive
1.	From Anganwadi (WCD)	1000/- Honorarium
2.	Reproductive and Child Health	
2.1.	Early registration and complete ANCs	100/-
2.2.	Institutional delivery	
2.3.	Complete PNCs	100/-
2.4.	Home Based PNCs (HBPNC)	100/-
3.	Immunisation	
4.	Family Planning	
4.1.	Social Marketing	1/- Per condom 1/- Oral pills 2/- ECP
4.2.	Sterilisation	150/- Male 200/- Female
5.	National Programmes	
5.1.	Cataract Operation	175/-
5.2.	RNTCP	250/-(After sputum –ve)
5.3.	Malaria	50/-(After 14 days)
5.4.	NLEP	300/-PB 500/-MB
6.	VHSC Meeting	100/-
7.	MCHN Day	150/-
8.	Sector Meeting (At PHC)	100/-

Source:-DM&HS Rajasthan

5. VILLAGE HEALTH AND SANITATION COMMITTEE (VHSC)

The NRHM framework support decentralized planning & monitoring up to the grass root level. Therefore it was decided to entrust village level committees of the users group, community based organization for the planning monitoring & implementation of NRHM activities into the 41000 revenue villages of the State.

VHSC feed such groups, which is the fifth committee (Development Committee) of the Gram Panchayat. The VHSC will be the key agency for developing Village Health Plan & the entire planning of village Panchayat for NRHM. This committee comprises of Panchayat representatives, ANM, MTW, Aganwari workers, Teachers, Community health volunteers, ASHA.

The State is presently having 9189 Gram Panchayats where such committees exist. It is planned to organize the training of at least 25 % of these committees on village health need identification & local action under NRHM. It is also proposed to provide Rs.10000/- to all VHSC for supporting their efforts in developing Village Health Plans.

Table 7 – Zone wise VHSC Status till February'2012

S.no	Zone	No. of VHSCs to be constituted	No of VHSCs constituted till current month	No of VHSCs trained till Feb 2012	Total funds Alloted	Amount expenditure	Percentage utilization
1	Ajmer	5691	5689	5382	53329300	5608000	10.52
2	Bikaner	6342	6277	6215	45621100	5608000	40.12
3	Bharatpur	3895	3895	3455	35432300	2594000	7.32
4	Jaipur	7761	7624	6060	72836100	7374000	10.12
5	Jodhpur	7332	7318	6139	70333400	17855000	25.39
6	Kota	4318	4316	4229	35416100	20512000	57.92
7	Udaipur	8404	8321	6131	88096900	47080000	53.44
Grand Total		43743	43440	37611	401065200	119326000	29.75

Source:-DM&HS Rajasthan

Tools for monitoring at the village level

- Village health Register
- Records of the ANM
- Village Health Calendar
- Infant and Maternal death audit
- Public dialogue (Jan Samvad)

6. PREGNANCY & CHILD TRACKING SYSTEM / PREGNANCY, CHILD TRACKING & HEALTH SERVICES MANAGEMENT SYSTEM (PCTS)

Introduction :-

Pregnancy, Child Tracking & Health Services Management System is an online software used as an effective planning & management tool by Medical, Health & Family Welfare department, Govt. of Rajasthan. The system maintains online data of more than 13000 government health institutions in the state.

The System facilitates:

- Online tracking of pregnant women
- Online tracking of infants & children
- Better health surveillance
- Better monitoring of immunisation programme
- Monitoring of institutional delivery
- Identification of cases for sterilization
- Better management of health institutions
- Online directory of health institutions
- Line list of infant deaths
- Swasthya Sandesh Seva (SMS Alerts to Citizen and Health Workers)

Components of PCTS :

a. Master reports :

- State at a glance
- District wise summary
- District wise details
- List of Hospitals, CHCs, PHCs and Sub centers
- Block wise Units
- ASHA details
- Mobile Registrations

b. Activity reports :

- Data Reporting
- Target Reporting
- State MPR
- Sub-centre's MPR (Form No. 6)
- PHC's MPR (Form No. 7)
- FRU's MPR (Form No. 8)
- Block's MPR (Form No. 9a)
- District's MPR (Form No. 9)
- Hospital Activity Format
- Monthly Report of sterilization
- Immunization coverage

- Institutional Delivery
- JSY Report

c. Reports on line list :

- Line list reporting status
- ANC cases
- ANC registrations
- Delivery Details
- Abortion Cases
- Cases of Maternal Deaths
- Cases of Infant Deaths
- Cases due for delivery
- Delivery Schedule for ANM
- Immunization Schedule for ANM

d. Monitoring Desk :

- At a glance
- ANC Registrations
- Abortions
- Deliveries
- Sterilization
- Sex ratio at birth
- Vaccine requirement

Challenges in the System :

1. Data entry problem at PHC level
2. Lack of staff to operate the software
3. Planning to provide this facility at Sub centre level but huge investment is required

SECTION-C: RAJASTHAN STATE AIDS CONTROL SOCIETY (RSACS)

RSACS was formed under Rajasthan society act 1958 on 19.12.1998. National AIDS Control programme (NACP) is being implemented by AIDS cell formed under the Directorate of Medical and Health Services, Govt. of Rajasthan, Jaipur. NACP third phase has been completed on 31-3-2012.

The AIDS cell receives all the AIDS funds from the National AIDS Control Organization (NACO), Ministry of Health and Family Welfare, Govt. of India in form of grant aid.

Prevalence of HIV in Rajasthan is 0.19%, Prevalence in STI patients is 2.33%, and in FSW it is 3.86%.

RSACS provides various services for HIV control and prevention. It includes ICTCs, STI and RTI control, Blood Safety, Care, Support and Treatment, Targeted Interventions, and Sentinel Surveillance

Integrated Counseling & Testing Centers are the gateway to HIV prevention a treatment. ICTC is a public health strategy that aims at reducing HIV transmission by:

- Increasing access to knowledge and understanding of HIV
- Facilitating early uptake of services for HIV-positive and negative people
- Providing tools for the adoption of safe behavior..
- Reducing and removing stigmatization and discrimination

Table 8 - Current facility based distribution of ICTS centers in the state

Total No of ICTCs	Medical Colleges	District Hospital	CHC/Sub District Hospital	24x7	PPP
	14	50	118	46	24

Services provided at ICTC

- Free counseling
- Free testing
- Free condom distribution
- Awareness
- Referral
- Follow up counseling

STI and RTI Clinics

Sexually transmitted infections and reproductive tract infections are important public health problems in INDIA. Studies show that 6% of the adult population in INDIA is infected with one or more STIs and RTIs, Individuals with STIs and RTIs have significantly higher chance of acquiring and transmitting HIV, Moreover STIs and RTIs are also cause to known infertility and reproductive morbidity. NACO has given the word Suraksha Clinic. Patients from STD Must be referred To ICTC

Blood Safety

87 Blood banks are there, NACO supported 47. 46 are state government. 4 central governments and 37 private. There are 21 blood component separation units in which 7 are government and 14 are private. The Blood Bank or Blood Transfusion Service should have its own constitution, which defines the responsibility and authority of the management.

Care, Support and Treatment

In order to provide care, support and treatment to people living with HIV/AIDS, Anti Retroviral Therapy centers, Link ART centers and Community Care Centers are working in the State.

Community Care Centers (CCC) & Home Based Care.

The goal of CCC is that an increased number of PLHIV have access to better quality of life and reduced vulnerability through improved clinical and care services, linking with relevant social services and community responses. Presently 7 Community Care Centers running in Rajasthan. Patients from all over Rajasthan visit these centers.

Service provided at Community Care Centre and Drop in Center are as follows :

- In-patient admission for 15 days
- Counseling Services
- Food and recreation facility
- Nutritional Counseling and support for inpatients
- Treatment and Patient Management
- Referral and Outreach services
- Drugs for opportunistic infections

Targeted Interventions

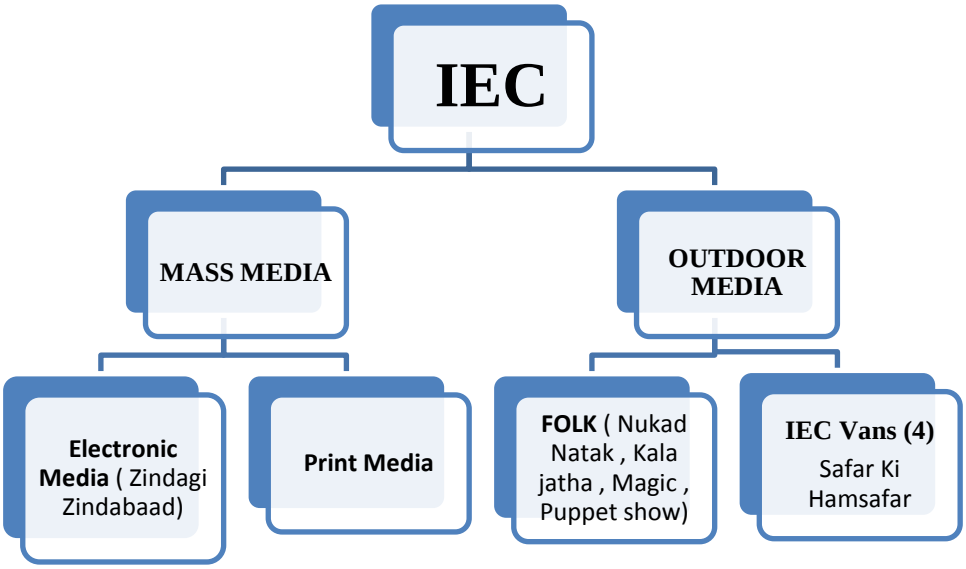
Targeted interventions for HRGs offer a "package" of services. This package of services varies for each major HRG, but broadly follows the components outlined below.

- Outreach and Communication Pearled,
- NGO supported outreach and behavior change communication.
- Differentiated outreach based on risk and typology

- Interpersonal behavior change communication (IPC)

Targeted intervention as a strategy for prevention has proved to be an effective means to reduce the prevalence of HIV in the state of Rajasthan. Currently there are 34 TIs working with core groups. Three TI are working with MSM & 3 with IDUs, 28 are working with FSW population and 7 are core composite intervention. 9 TIs are working with migrant population. Similarly, two TIs are working with truckers. Thus total number of TIs is 52.

Figure 8 - Various IEC Strategies for HIV/ AIDS



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