SHRC CHATTISGADH

A study for Assessment of health services provided by ANMs in rural and urban Bilaspur district of Chhattisgarh

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Prafull Singh Kushwah

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A study for Assessment of health services provided by ANMs in rural and urban Bilaspur district of Chhattisgarh

(February 03, 2012 to April 30, 2012)

at

State Health Resource Centre, Raipur (CG)

By

Prafull Singh Kushwah

Under the guidance of

Dr. Nitish Dogra

Post Graduate Diploma in Hospital and Health Management

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Contents

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I am thankful to *Rachana Tiwari and Randhir kumar Programme coordinator* for their co-operation and encouragement in conducting the study.

I would like to express my gratitude towards my *parents,* my wife *Poonam Singh* & my elder brother Sanjay *Singh* for their kind co-operation and encouragement which help me in completion of this project.

Last, but not the least, I take this opportunity to thank all *my friends & colleagues* for their love constant support & time, without which this project would have never been a success.

ABSTRACT

Introduction-

With large socio-cultural variations and second highest population in world, India was first country to have national family planning program. It has implemented the services under Reproductive and Child Health program. After its launch and coming under umbrella of NRHM, it has achieved the set targets and helped in improving health status of the community by providing health services at doorstep. For this we have created and maintained huge delivery system comprising of Primary Health Centres, Sub-Centres etc. These centres are served by Auxiliary Nurse Midwife (ANM). In this rural health delivery system ANM is a key person which works on ground level and functions with close co-ordination with the community. Role of ANM is to provide basic services to fulfil the needs of mother and child. ANMs were posted in sub centres for maternal child health besides treatment of common illnesses and were viewed as replacement of professional cadre of midwives in PHC. Within maternal care the emphasis was on antenatal care (ANC) and delivery care. Most ANMs were required to stay at the sub centre village and conduct deliveries. There were few private health facilities in rural areas. It was mandatory for an ANM to stay at the headquarter village.

Objective of the study- To explore the present functioning of ANM in urban and rural set up of Bilaspur district.

Methodology-

Study Design: It is observational cross sectional study conducted in the Bilaspur District of Chhattisgarh.

Sampling:

Total Number of ANM presently functional in Bilaspur district is 454 in rural and 27 in urban areas.

Finding and Result

There is a big difference between Rural ANM and Urban ANM functioning found in this study. Rural ANM covers most of the national programmes while urban ANM do not cover. In rural areas 20% ANM maintain only 5 register while 80% ANM maintain only 6 register. In urban area 60% ANM maintain 4 register while 20% ANM maintain 5 register and 20% ANM maintain 3

register only. 60% ANM reports monthly while 40% ANM report weekly in rural areas in urban areas 20% ANM report to weekly while 80% ANM monthly..

Recommendations: Training of ANM especially in urban areas for proper reporting and encourage them for timely reporting to their respective facility members. Develop user friendly reporting format which will be easily understandable to them. Number of functional ANM is also low in urban area which is leading work load over them. Timely meeting should be done for developing the repo and coordination between permanent ANM and contractual ANM. Higher authority should have proper command on work and reporting of ANM to avoid misreporting and underreporting in their reports.

Abbreviations

AIDS Acquired Immuno Deficiency Syndrome

ANC Ante Natal Care

ANM Auxiliary Nurse Midwife

AWC Anganwadi Centre

BMO Block Medical Officer

BP Blood Pressure

CHC Community Health Centre

CMO Chief Medical Officer

CNA Community Need Assessment

CS Civil Surgeon

DH District Hospital

IFA Iron and Folic Acid

IDSP Integrated Disease Surveillance Programme

MO Medical Officer

NACP National Aids Control Programme

NBCP National Blindness Control Programme

NIDDCP National Iodine Deficiency Disorder Control Programme

NLEP National Leprosy Eradication Programme

NVBDCP National Vector Borne Disease Control Programme

OCP Oral Contraceptive Pills

PHC Primary Health Centre

RTI Reproductive Tract Infection

Introduction

In late 19th century many Christian missions related hospitals were started especially for women called "Zanana" hospitals in the Hindi speaking areas of north India. These hospitals were in the rural areas, mainly run by nurses where courses to train women in midwifery were also started. This cadre of ANMs was registered under the Mid India Nursing Council which was an autonomous body in 1934. They were then absorbed in special hospitals for women in India. Some also practiced as midwives in the community under an umbrella of NGO hospitals. Auxiliary Nursing Service (ANS) was started in 1942 to provide nursing care in military hospitals in India. Hence, originally auxiliary nurses functioned as hospital attendants, as the government rural health system was not yet set up.

After independence in 1947 rural health services were established over time with primary health units(PHU) staffed by a doctor, a nurse midwife, a health visitor, a sanitary inspector and a female attendant (Aya). Trained nurse midwives were posted in hospitals or PHU. Their role in PHUs was to conduct deliveries and visit a population of 10,000. Sub centers were established below PHUs to provide basic medical care and delivery care at the field level. To place trained personnel in this newly instituted health centers, temporary workers with preliminary education were trained for shorter time and recruited at sub centers. These workers were called "Auxiliary Nurse Midwife" Auxiliary workers are technical workers in a particular field with less than full qualifications (WHO 1961). Shetty committee suggested training auxiliary nurses and midwives for short time to work under supervision for specific duties. Twelve training centers were established by 1954 to fulfill the requirements. Later on committees such as Bhore and Mudaliar suggested continuation of auxiliary cadre to provide basic health care at field level. Hence, ANMs gradually became permanent staff in public health system.

ANMs were posted in sub centers for maternal child health besides treatment of common illnesses and were viewed as replacement of professional cadre of midwives in PHC. Within maternal care the emphasis was on antenatal care (ANC) and delivery care. Most ANMs were required to stay at the sub center village and conduct deliveries. There were few private health facilities in rural areas. It was mandatory for an ANM to stay at the headquarter village. This requirement was strictly enforced by the medical officers and district health officers.

In 1966, Mukerjee committee suggested target system to achieve family planning goals and fourth fifth plan decided to integrate family planning with the MCH program. These two developments started the dilution of maternal health care services provision by ANMs. Finally in 1973, Kartar

Singh committee suggested changing designation of ANM to “Multi Purpose Worker” who would provide range of services including family planning and MCH at the field level. As a result, today the ANM is no longer a nurse and midwife, but the “Multipurpose worker” who provides family planning, immunization, sanitation, infectious disease prevention/care and antenatal/delivery care in that order.

The immunization, family planning and infectious diseases prevention activities requires the field worker to travel to villages to cover the target population and has reduced the time she spends at the head quarters. Targets given for family planning and immunization led to improved accountability to these activities and neglect of emergency services such as delivery care. Her activities for maternal and child health are limited to distribution of iron folic acid tablets and immunization to mothers and children.

Rationale of the Study

The study is significant from the view point of the planning of service delivery in urban areas. The comparison will reveal the changes that need to be made while deciding the roles and responsibility of the ANMs in urban areas. Our society is changing with a fast pace .People are moving from rural to urban areas. The urban decadal growth is 31.2% while rural decadal growth is 17.9% (According to census 2001). But the health care delivery system is working continuously with old strategies, which is needed to make change according to the present scenario. So there is a need to make strategy which might be in the form of functionaries of health providers. In this context this study will definitely provide a step.

So a comparison will help the programme planners and managers in understanding the measures those should be taken to overcome those difficulties. Finally the study will be useful in successful implementation of the plan by programme managers

Literature Review:

Demographic, socio-economic and health profile of Chhattisgarh:

Chhattisgarh is a land-locked state located in the middle of India surrounded by six other states – Madhya Pradesh, Andhra Pradesh, Orissa, Bihar, Jharkhand and Uttar Pradesh. This new state was formed on 1st November 2000 by carving out sections from the south eastern part of Madhya Pradesh. There are 27 districts and 20,000 villages. Chhattisgarh is rich in natural resources and has vast unexplored forest regions and a wide range of wildlife. A number of rivers flow through the State resulting in spectacular scenery. Chhattisgarh covers an area of 1,35,194 sq.km and has a population of 20.83 million (as per census of 2001). The population density is 154 per sq.km (as against the national average of 312 persons per.sq.km). People live a predominantly rural life with 79.9% of the population living in villages. In addition,

A large proportion of the population of Chhattisgarh belongs to tribal groups indicating that there is a vast vulnerable population in the State. Chhattisgarh lags behind the Country as a whole on several socio-economic and health indicators. The crude birth and death rates are higher than the national average. TFR, according to SRS 2007 is slightly higher. Chhattisgarh also lags behind the Country in terms of IMR and MMR. Only 14% of the total childbirths in the State take place in institutions indicating the critical need for improving access to public health services. Female literacy rates are almost on the same level as the national average. On the positive side, the sex ratio of the state is higher than the national average and indicates a more favourable climate for women.

Reported data from Gujarat indicates slowly rising trend of institutional deliveries but almost stagnant or somewhat declining trend of home deliveries by ANMs after sudden increase in 86-87. Study by Visaria in 1989 in four districts of Gujarat showed that only 5.3% of the deliveries were conducted by ANMs even though more than 70% of ANMs were living in the sub center villages. Data from Multi Indicator Cluster Survey (MICS) from 7 districts of Gujarat show that out of all deliveries only 0-4.3% occurred at PHC or the sub-centers and health workers attended only 2-22% of deliveries in these districts. It is interesting to note that attendance by health workers was only 2% and 6% in two districts where all the sub centers were constructed with USAID help in 1980s. In one of these districts the survey showed no deliveries conducted in PHC or the sub-center. The purpose of constructing sub centers was to facilitate the ANMs to stay there and attend deliveries and other care. This does not seem to have happened.

As seen in table-2, Less than 25 percent of women are given antenatal care by ANM and although the percentage of deliveries conducted by skilled attendant has risen, deliveries conducted by

ANM are stagnant. Proportions of deliveries conducted by doctors have increased from 22 percent in NFHS-1 to 35 percent in NFHS-3. More than half of these institutional deliveries are in the private sector which has shown sharper rise (8 percent) than public sector (3 percent) between NFHS-1 to NFHS-3.

Table-2

Maternal Health Services by ANM in India[xii] Indicator in Percentage	**NFHS-1 (1992-93)**	**NFHS-2 (1998-99)**	**NFHS-3 (2005-06)**
Antenatal Care by ANM/LHV/Nurses	13	6	23
Deliveries conducted by ANM/LHV/Nurses	13	11	10
Deliveries Assisted by Skilled personnel	35	42	49
Post natal care	NA	NA	7.9

Data have not been systematically collected at national level for assessing what proportion of ARI and diarrhoea are treated by ANMs, but some small studies in selected districts show that this proportion is low. For example data from MICS in 6 districts of Gujarat in 1995 showed that among children under five who had diarrhoea 1.6% - 16.3% were treated by health workers. These statistics indicate changed role of the ANM from providing curative and delivery care to predominantly preventive care. Unfortunately data are not available at national level about the ANM's contribution to various health programs and how it has varied over the years.

At present the department of health in India has been facing the problem of non-resident ANMs. Only about 23% stay at the headquarters. Place of residence is the most important factor having a bearing on the reliability and availability of curative services provided by the staff. Service delivery is influenced by the place of residence of the ANM in two ways: quality of services and range of services. Those who stay at the headquarter are more likely to keep time of PHC/sub center and out patient work schedule because they save commuting time, and are less likely to take leave for personal work/ sickness in the family. Non-resident ANMs would not be able to provide 24 hours services such as delivery care.

Factors associated with the ANMs' changing role

It is important to understand why the role of ANM changed from primarily a midwife in 60s to a preventive health worker with focus on family planning and immunization. Changes in program priorities - emphasis on preventive services, lack of focus on curative/midwifery services, changes in monitoring mechanism, lack of supervision/training, weak management, neglect by international agencies and NGOs are major factors associated with this change.

1. Shifting program priorities from Maternal Health to FP and immunization

One of the major reasons for the change in the role of ANM is change in program priorities over past few decades. National programs have shifted the focus from comprehensive reproductive health services to preventive services. In the mid 60s family planning was integrated with MCH activities and projected as a program deserving the highest priority (GOI, Planning Commission 1968). A separate department and structures of family planning were created at the central, state and district levels with the sole function of promoting family planning through the PHC staff. This created an impression that the staff funded by FP program was to restrict themselves to only FP activities whereas in theory all the Sub centers and PHC doctors had similar job descriptions which included MCH too. The new ANMs employed under the FP program did not feel the need to stay at SC Village since their work did not relate to any emergencies such as childbirth.

During mid 80s the immunization program called the Expanded Program for Immunization (EPI) for children below five years started to receive priority. The implementation of the program at field level was assigned to the ANM. EPI was followed by Universal Immunization Program (UIP), again supported by UNICEF.

2. Neglect of Maternal Health within Reproductive Health programming

The National Child Survival and Safe Motherhood Program (CSSM) developed by Government of India and supported by World Bank and UNICEF was to provide child survival and safe motherhood services through the PHC system in India. It started in 1992 as follow up to the Universal Immunization Program. There were eight goals of the program out of which one was for maternal health viz. Reduction of maternal mortality from 4 to 2 per 1000 births. Although the package specified care at birth as a service, the work plan of the ANM at the sub centre level did not specify conducting deliveries in the list of critical activities. Similarly this was missing from the module for planning MCH services at the PHC and SC level and the sample work plan of the ANM given in the workers' manual. Unknowingly the program created a conceptual conflict through its fixed day schedule by giving more priority to routine preventive services compared to emergency services.

Reproductive Child Health-I (RCH-I) was implemented in 1997 had too many components and again ANM was key field level person for implementation. RCH-I had maternal health as one of the priority areas but due to various reasons government failed to provide round the clock delivery care at the field level. One major reason was non availability of ANM at the sub center and lack of coordination between different components.

RCH-II has been planned with aim to provide basic emergency obstetric care (BEmOC) at sub centre and PHC and comprehensive EmOC at CHC and district hospital level. Under National Rural Health Mission (NRHM), there is provision for additional ANM for sub center to provide delivery care and curative services. However, about 55% of the sub centers do not have own building and 78% do not have tap water, in absence of such basic facilities it is not possible to provide delivery care. Before increasing the number of field functionaries there is a need to improve management of human resources, logistics and infrastructure. Unless India learns from failures of past programs, it is not possible for ANM to revert to the role of comprehensive RCH service provider. The Government is increasing the density of ANMs from 1 to 2 per 5000 population in difficult areas. This would only help if it is ensured that this new ANM is staying in the SC village and has the confidence and competence to attend to deliveries and other emergencies. As seen in the past that in spite of the rapid increase in the number of ANMs in the last 30 years, the indicator on safe delivery does not show corresponding increase. Instead of increasing staff what is required is to improve the performance of the PHC system. Improving the skills of the ANM through training and support through supervision is equally important.

Objective

1. To explore the present functioning of ANM in urban and rural set up of Bilaspur district
2. To compare urban health services with rural health services existing in Bilaspur district
3. To describe present health system of urban area of Bilaspur

Methodology

Study Design: It is observational cross sectional study conducted in the whole Bilaspur District of Chhattisgarh.

Sampling:

Total Number of ANM presently functional in Bilaspur district is 454 in rural and 27 in urban areas.

Statistical tool for Sample Calculation:

Here sample size n and margin of error E are given

$$x = Z(^{c}/_{100})^{2} r(100-r)$$

$$n = {}^{Nx}/_{((N-1)E^{2} + x)}$$

$$E = \text{Square Root } [{}^{(N-n)x}/_{n(N-1)}]$$

Where N is the population size, r is the fraction of responses that you are interested in, and $Z(c/100)$ is the critical value for the confidence level c.

By applying this statistical tool,

Recommended Sample Size is 79 (59 from rural areas and 20 from urban area)

Where, Margin of error is 10%

Level of Confidence is 95%

Response Distribution is 50%

Sampling Technique:

There is Convenient sampling was done

Data Collection Technique:

Primary data collection technique is used for data collection by the close ended questionnaire.

Data Analysis:

It is a quantitative study for which SPSS 16 and MS Excel 2007 is used.

Results and findings :

Graphical representation of all the findings are annexed

- In rural areas 20% ANM maintain only 5 register while 80% ANM maintain only 6 register.

  In urban area 60% ANM maintain 4 register while 20% ANM maintain 5 register and 20% ANM maintain 3 register only.
- 60% ANM reports monthly while 40% ANM report weekly in rural areas in urban areas 20% ANM report to weekly while 80% ANM monthly..
- In rural 20% ANM said that they refer to PHC while 80% ANM refer to CHC.
- In rural area 20% ANM inform to MO regarding case of patch while 80% ANM inform supervisor. in urban area 40% ANM don't do anything while 60% ANM inform MO of their area.
- In rural area 60% ANM said that they visit Awc monthly while 40% ANM said that they visit AWC weekly in urban area 20% ANM visit AWC weekly while 80% ANM visit AWC monthly.
- 40% ANM utilised fund 5000/ rupees while 60% ANM utilised only 2000/rupees in rural area only.
- 60% ANM utilised fund in BP instrument, stetho ,ANC table while 20% ANM utilised fund in stationary while 20% ANM utilezed funds in other activities.
- 60% ANM said abot village level planning While 40% ANM guidance for Mitanin.
- In rural areas 80 % of ANM they do ANC checkups as well as ANC registrations and 20% ANM said ONY ANC checkups.
- In rural Area 80% of ANM refer complicated case of pregnancy to CHC while 20 % of ANM refer to PHC.
- In Rural area 40 % of ANM visits for PNC checkups two times while 60 % ANM visits for ANC tree times. In urban areas 40 % ANM visits PNC two times while 60 % ANM for PNC three times.
- In rural areas 20 % of ANM report to MO while 80 % ANM report to supervisors.
- In rural area 30 % ANM report to PHC while 70 % of ANM reports to CHC.
- In rural area 20 % of ANM don't do anything for HIV cases while 80 % said yes they do in urban areas 40% said yes while 60% ANM said no for the same.
-

- In rural areas 80 % of ANM go to CHC for meeting while 20 % of AMN go to PHC for meeting.
- In rural area 70 % of ANM go for meeting monthly and weekly while 30 % ANM go for meeting. In urban area 20% ANM go for monthly meeting while 80% ANM go for meeting as well as weekly.
- In rural area 70 % of supervisors presents in meeting while presence of MOS is 30%
- 10 % of ANM send formats to PHC while 90 % ANM send formats to PHC.
- In rural areas 60 % formats send with the help of supervisors while 40% send their self.
- In rural area 10 % of ANM said that in gram swaraj we to meetin only with the villagers while 90 of ANM do meeting with villagers and tell them about health schemes.
- In urban 20 % of ANM do not refer cases of MTP while 80% said that yes they refer caces.
- In urban 20% of ANM do not educate community while 80 % of ANM educate and spread awareness regarding septic abortion.
- In urban area 20% ANM do not informed community while 80% informed community regarding MTP services.
- In urban 40% ANM said no while 60% ANM said yes, they identify and informed concerned person.

Findings:

1. **Graphical representation of data obtained for Urban ANM:-**

Chart-1: Records maintain by ANM (No. Of registers)

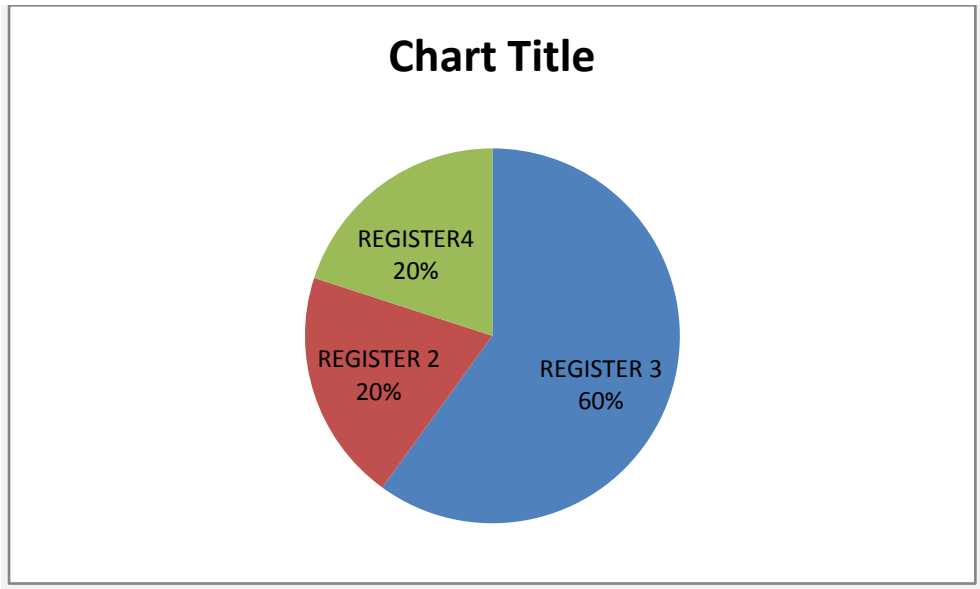


Chart-2 : whom they (ANM) report

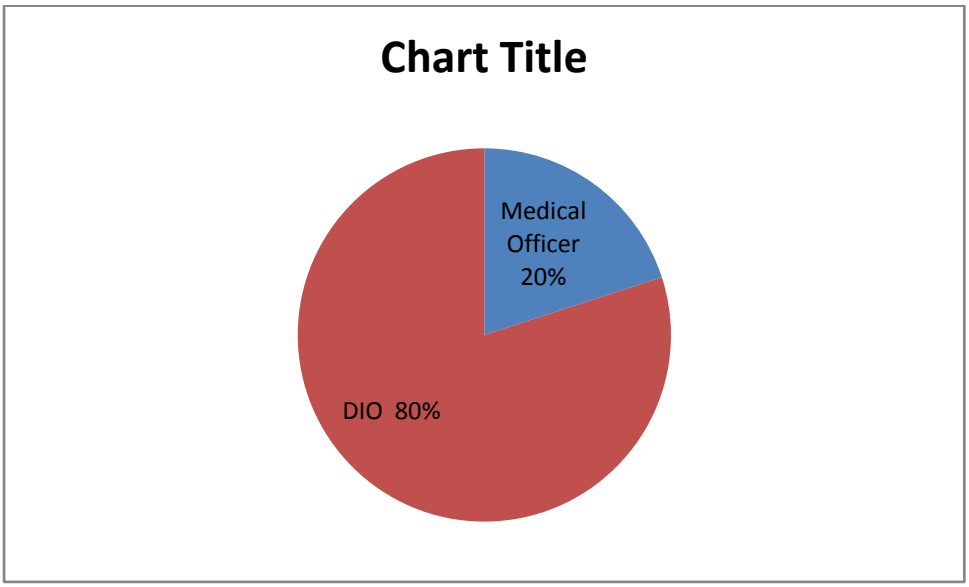


Chart- 3: Frequency of their reporting period

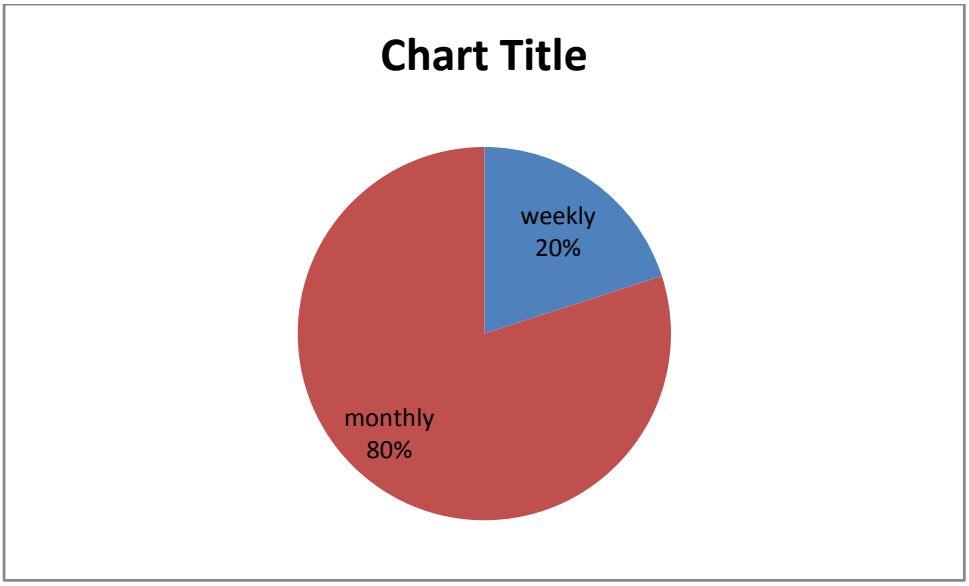


Chart- 4: whom they inform about leprosy case

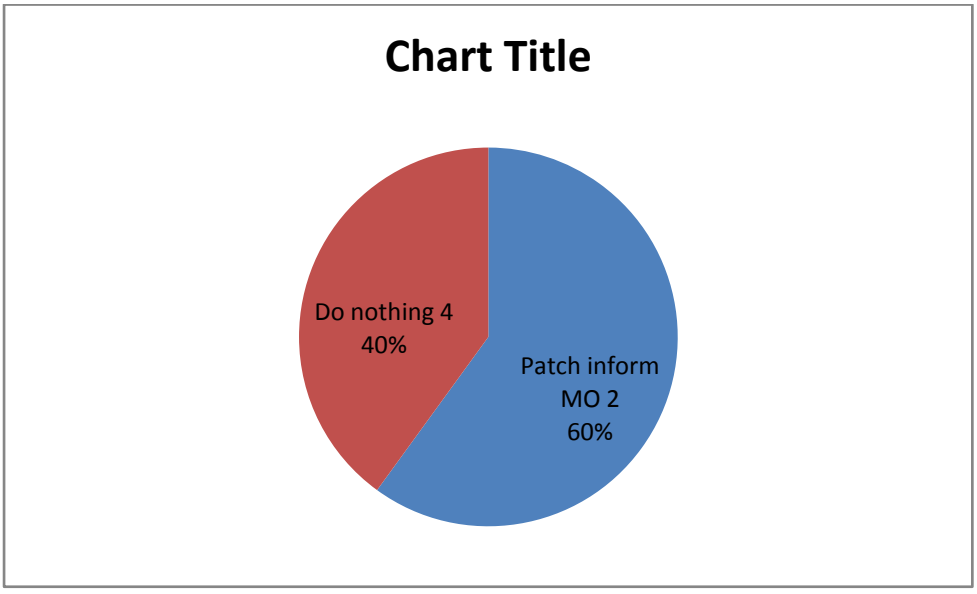


Chart- 5: Visits to AWC

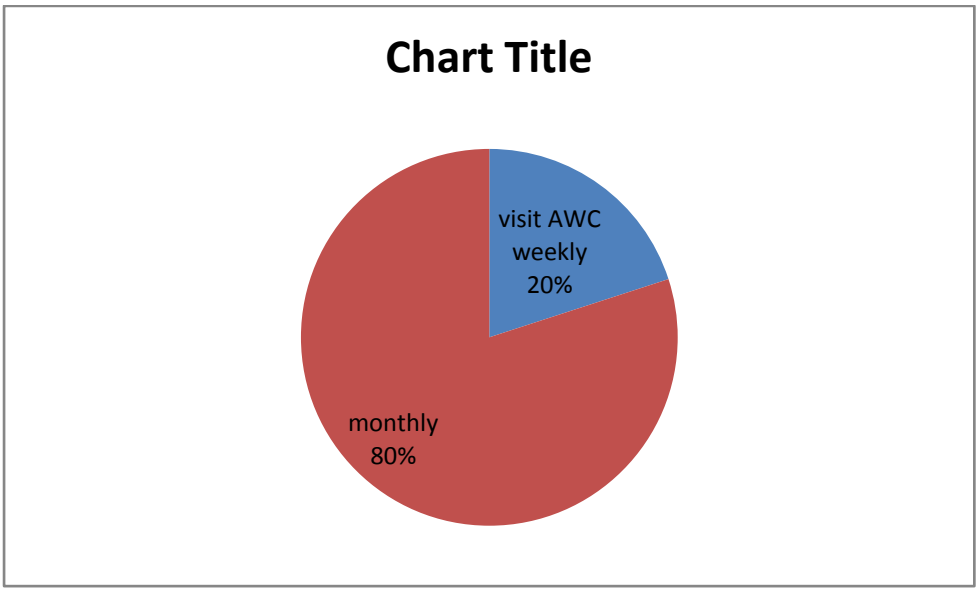


Chart- 6 PNC visits with frequency

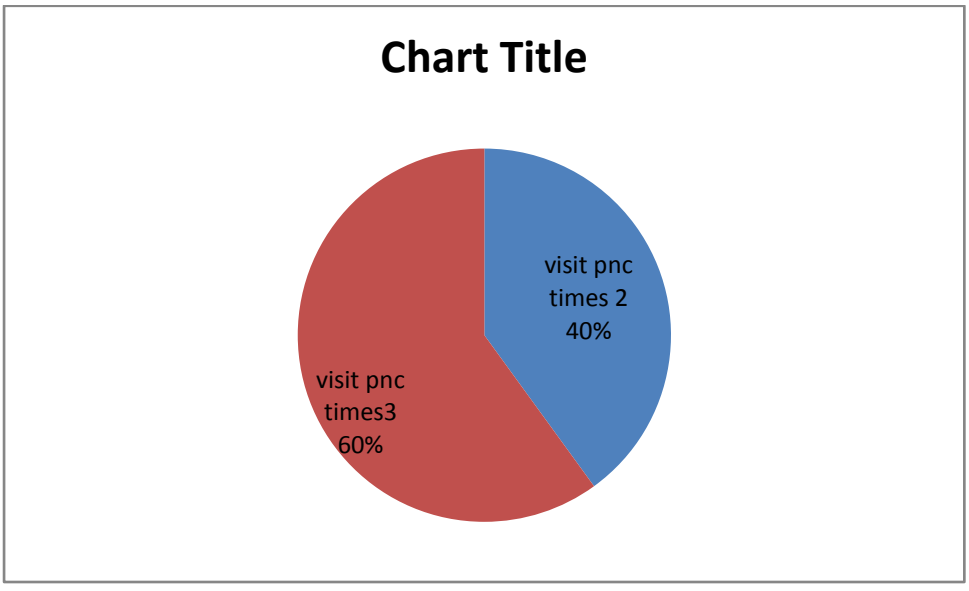


Chart- 7 Referrals for MTP

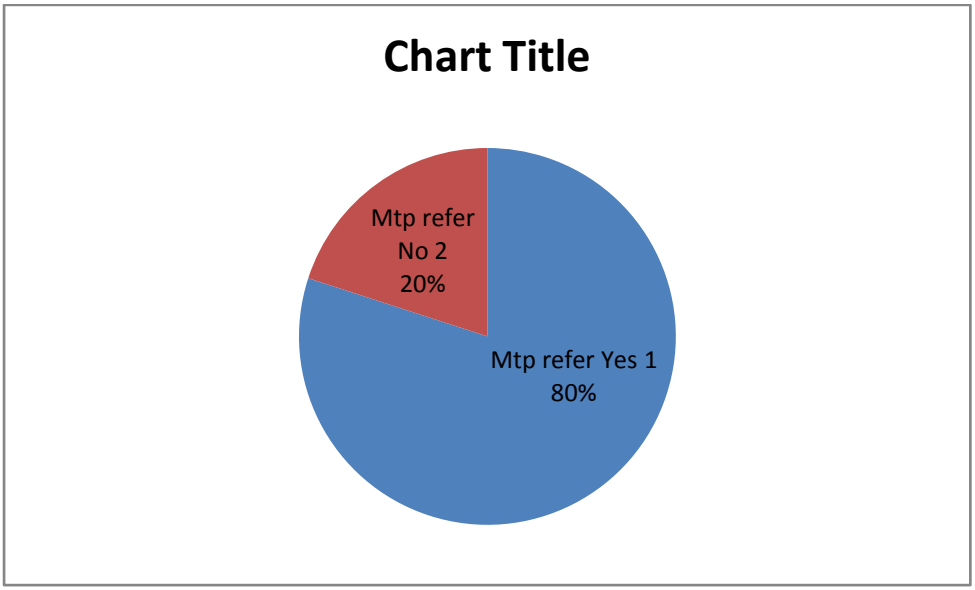


Chart- 8 Spread awareness regarding septic abortion

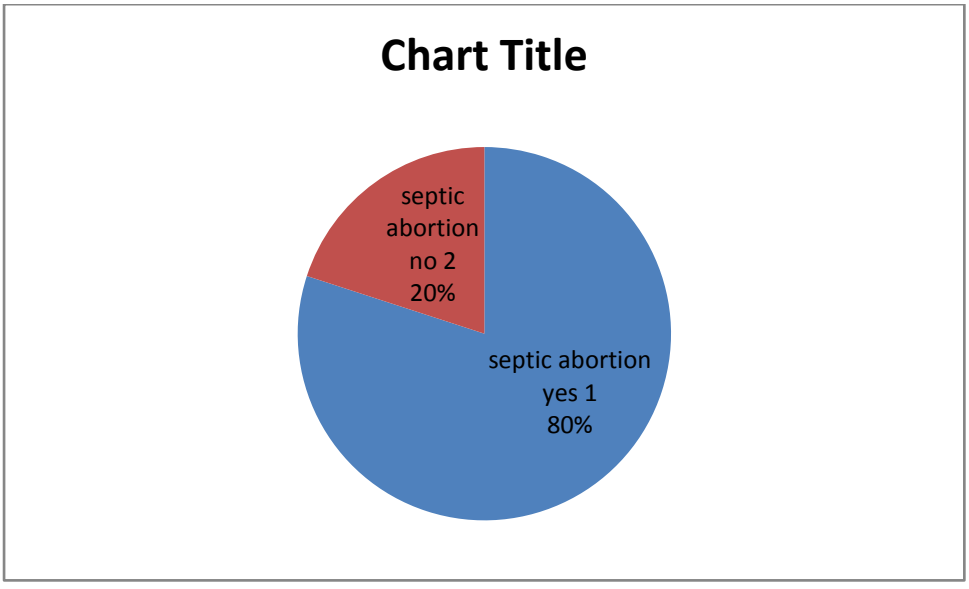


Chart- 9 Spread awareness regarding MTP

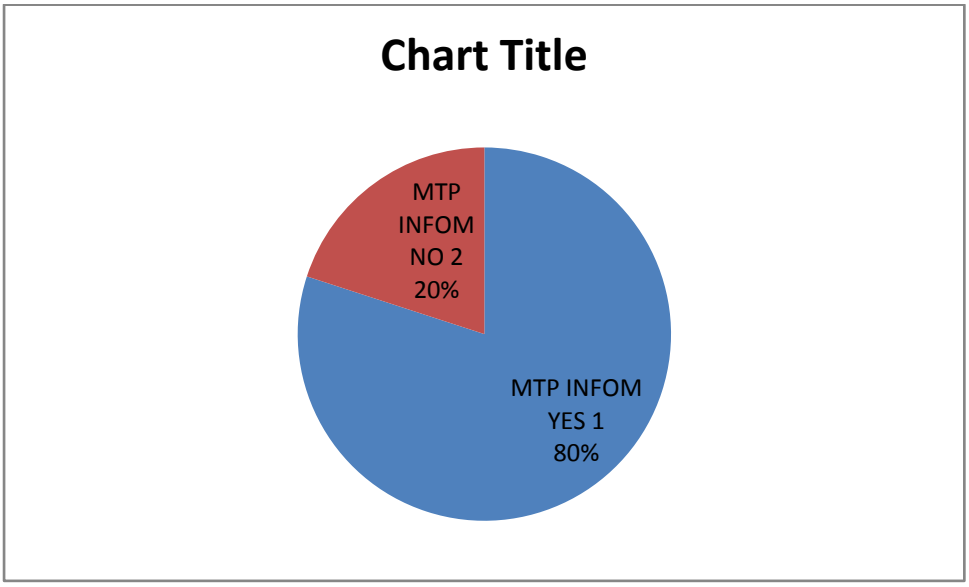


Chart- 10 Identification of skin patch cases

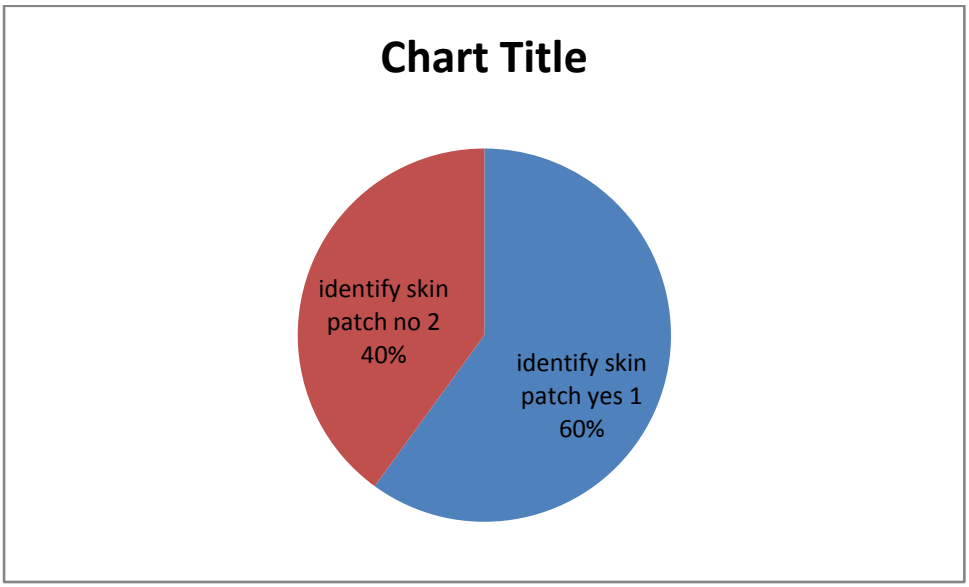


Chart- 11 Spread awareness regarding HIV

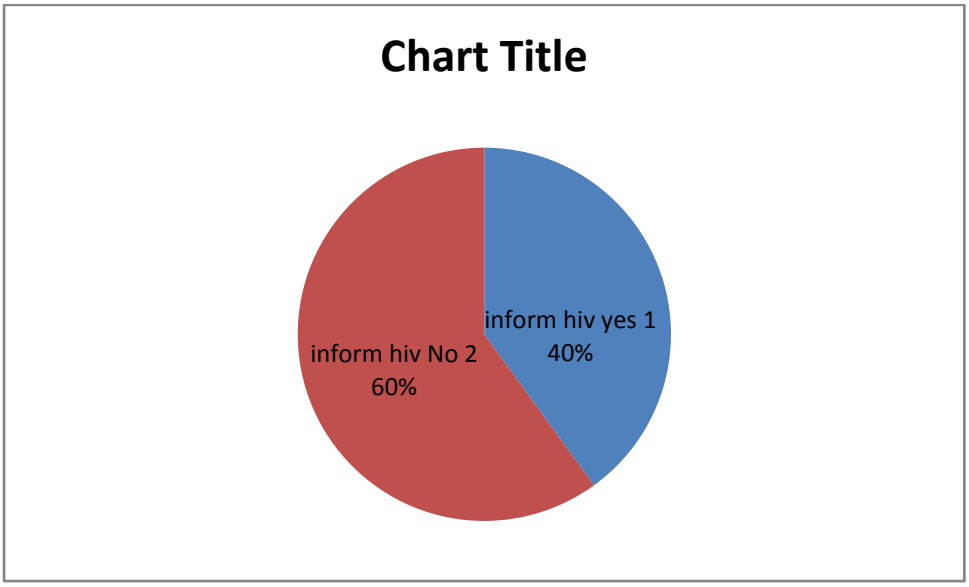
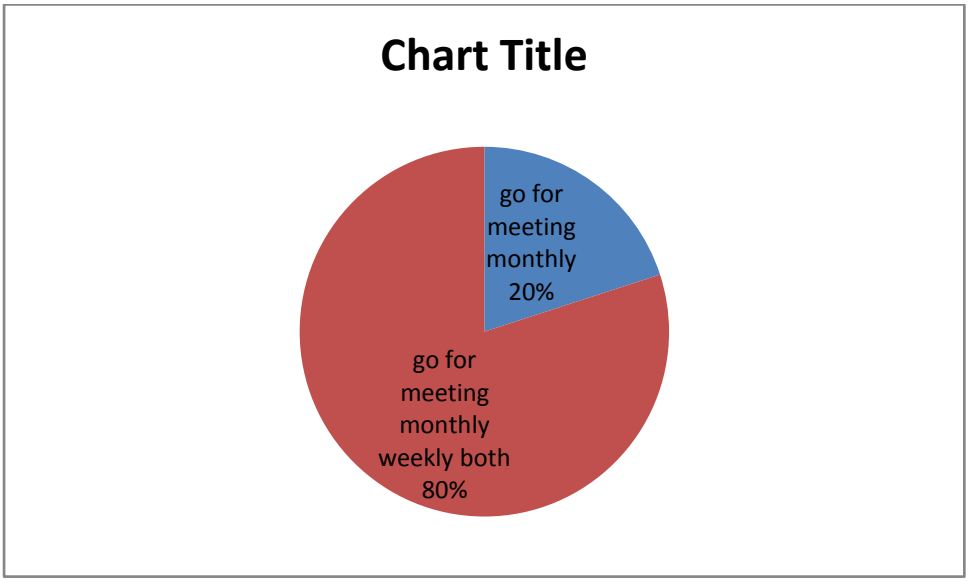


Chart- 12 Frequency of attending meeting



Rural ANM

1. Graphical representation of data obtained for Urban ANM:-

Chart-1 Records maintain by ANM (No. Of registers)

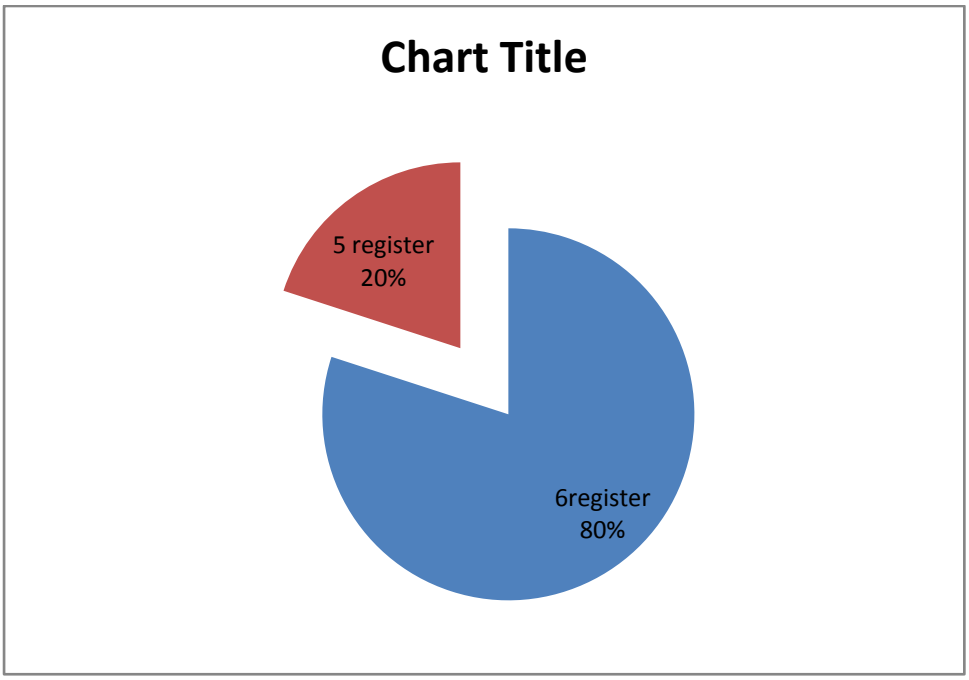


Chart-2 whom they (ANM) report

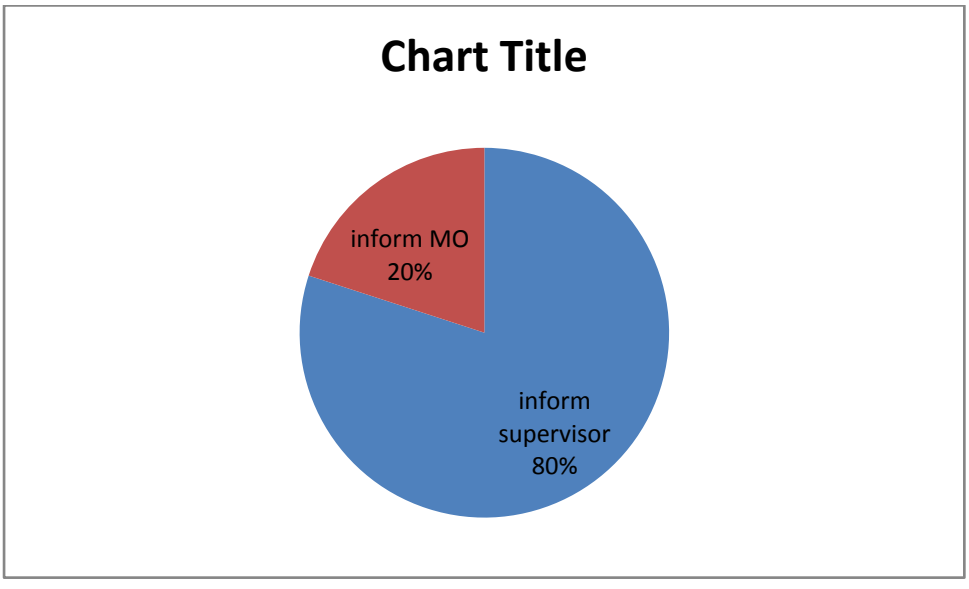


Chart- 3 Frequency of their reporting period

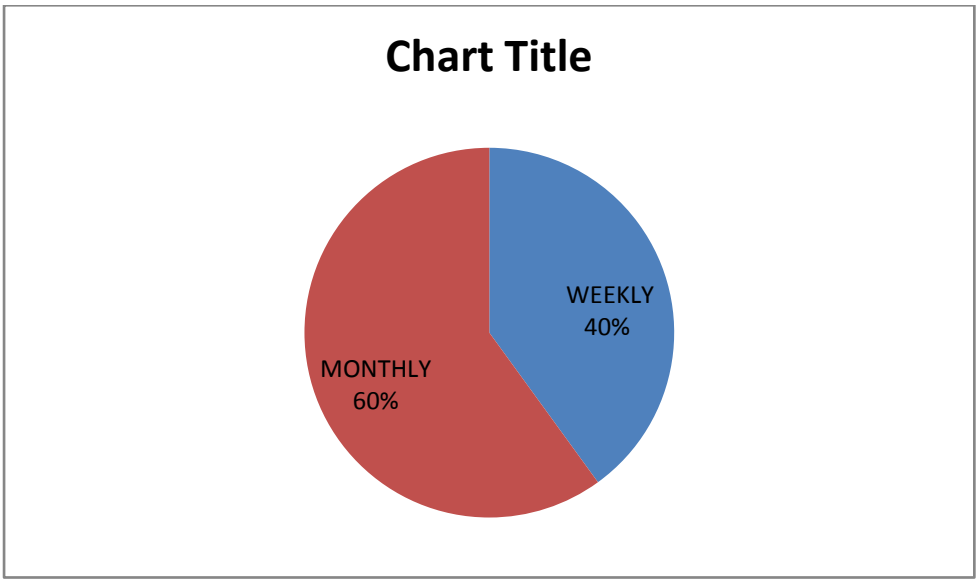


Chart- 4 whom they informed

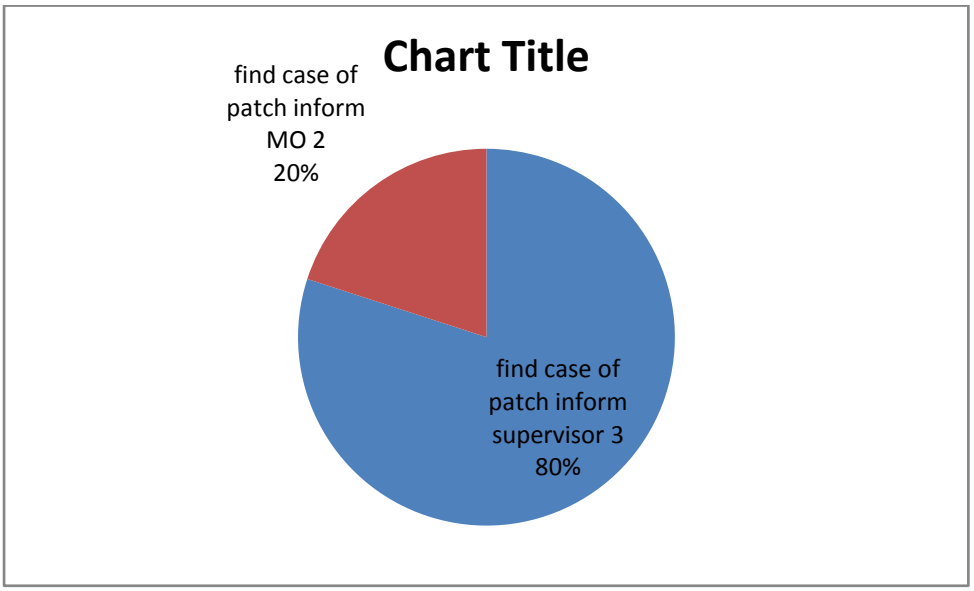


Chart- 5 NO of AWC visits

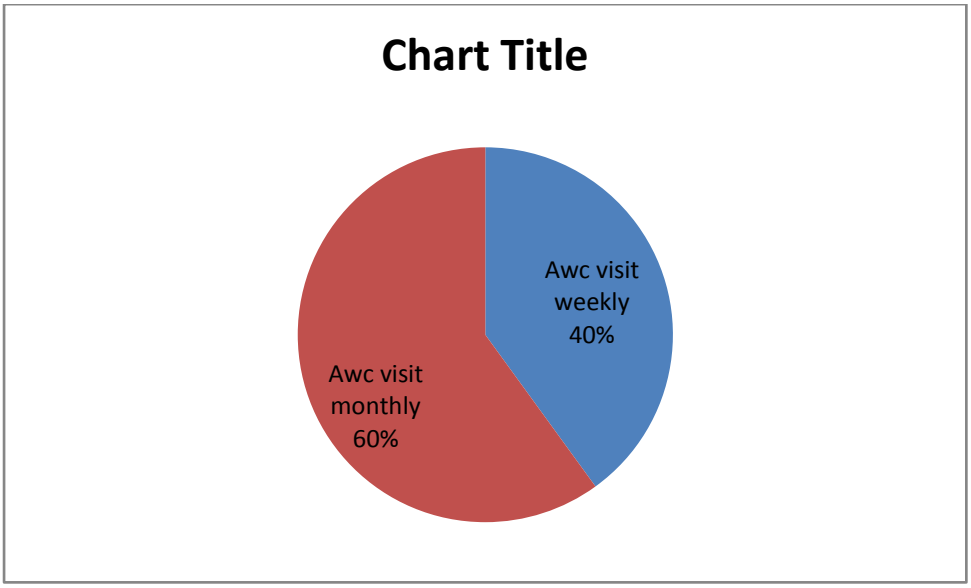


Chart- 6 Number of ANC checkups

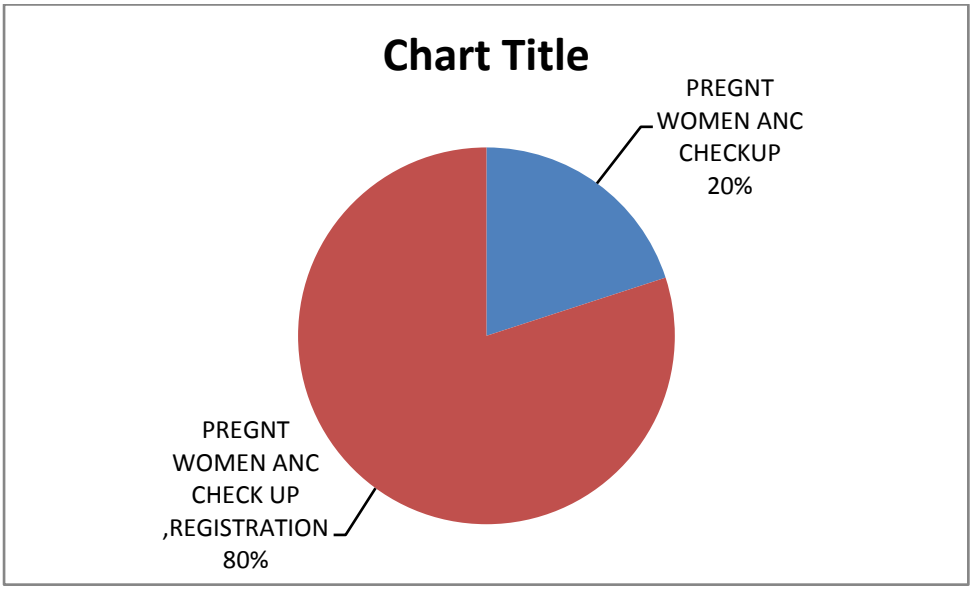


Chart- 7 Frequency of PNC visits

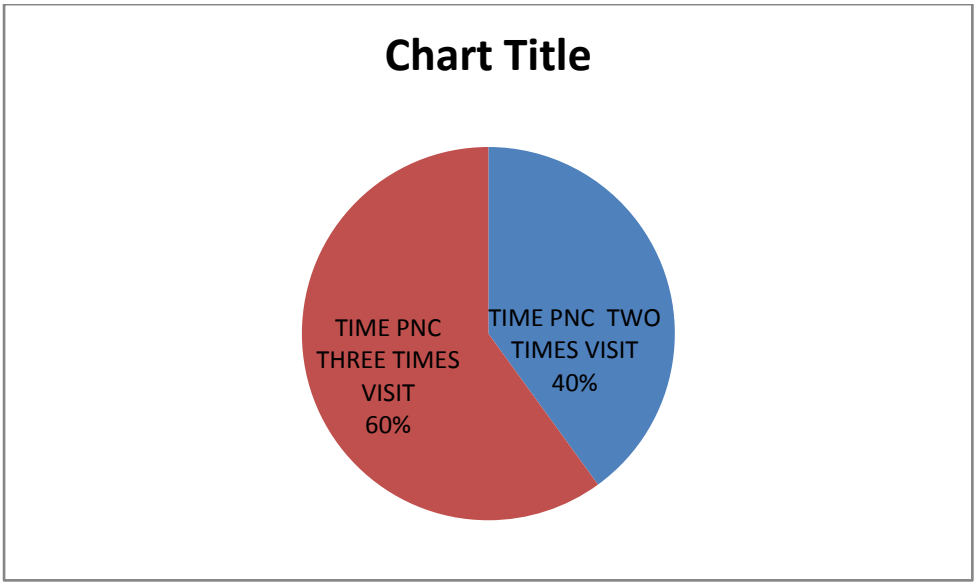


Chart- 8 Spread awareness regarding HIV

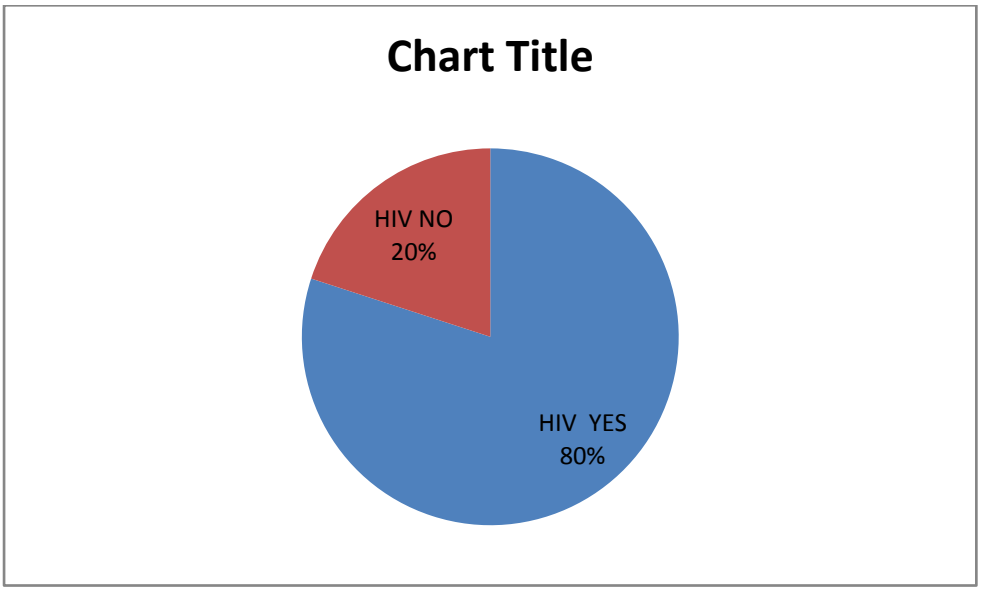


Chart 9 Frequency of their meetings

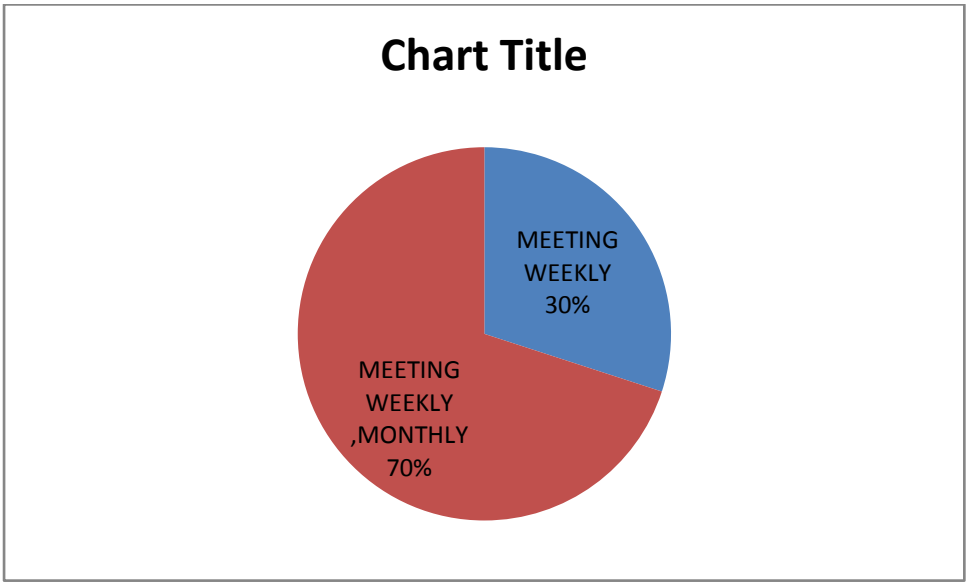


Chart- 10 where the they refer cases

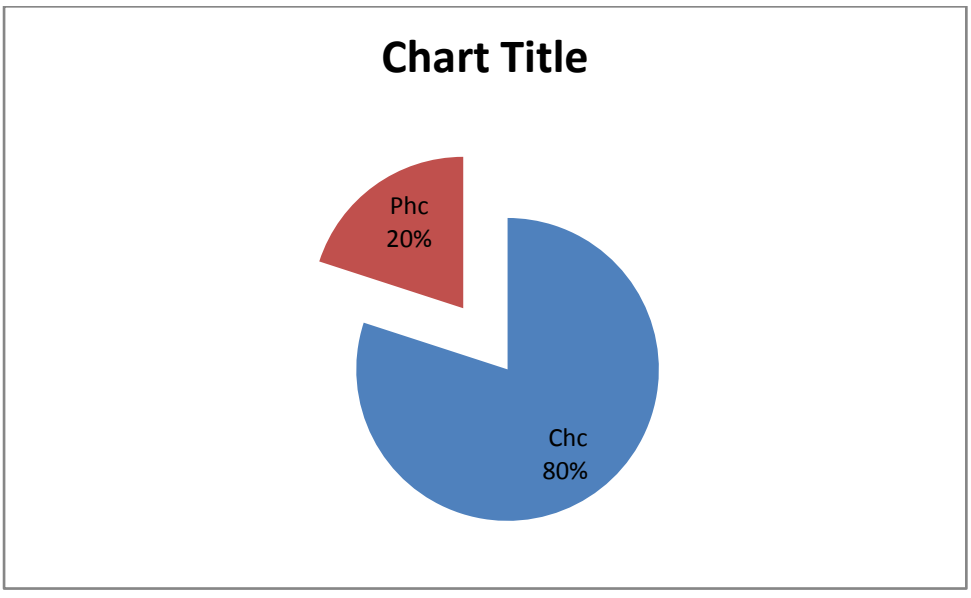


Chart- 11 where they attend meeting

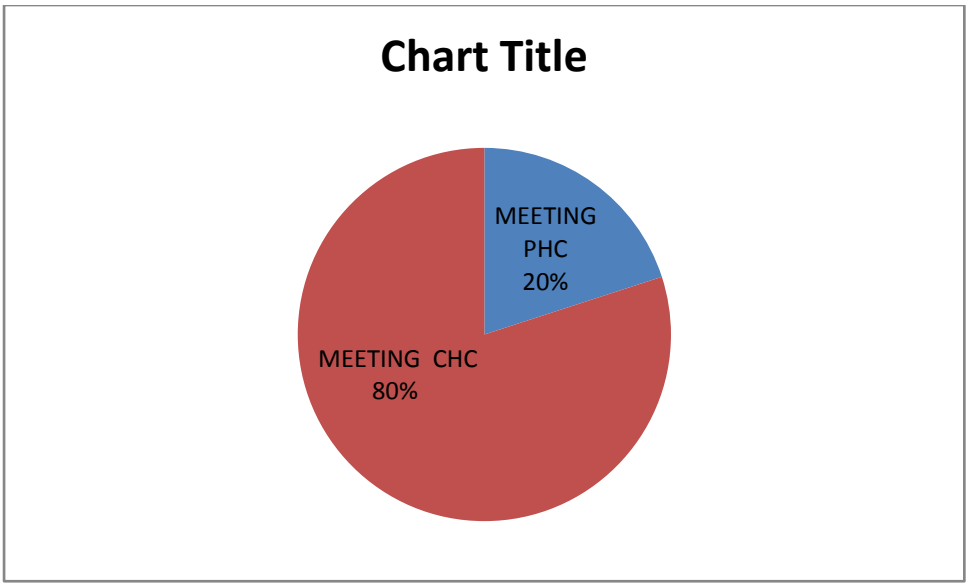


Chart- 12 to whom they report

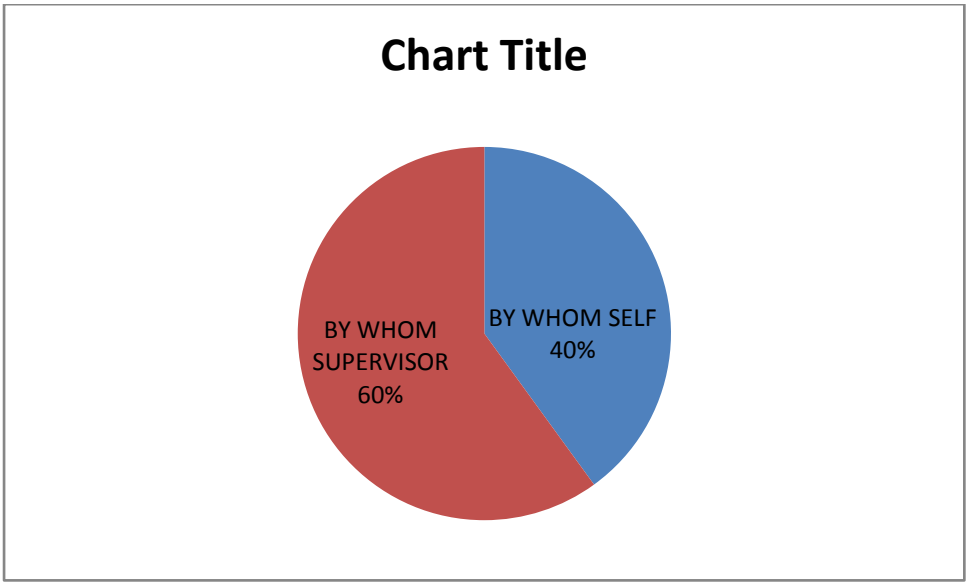


Chart- 13 Participation of ANM in Gramm Swaraj

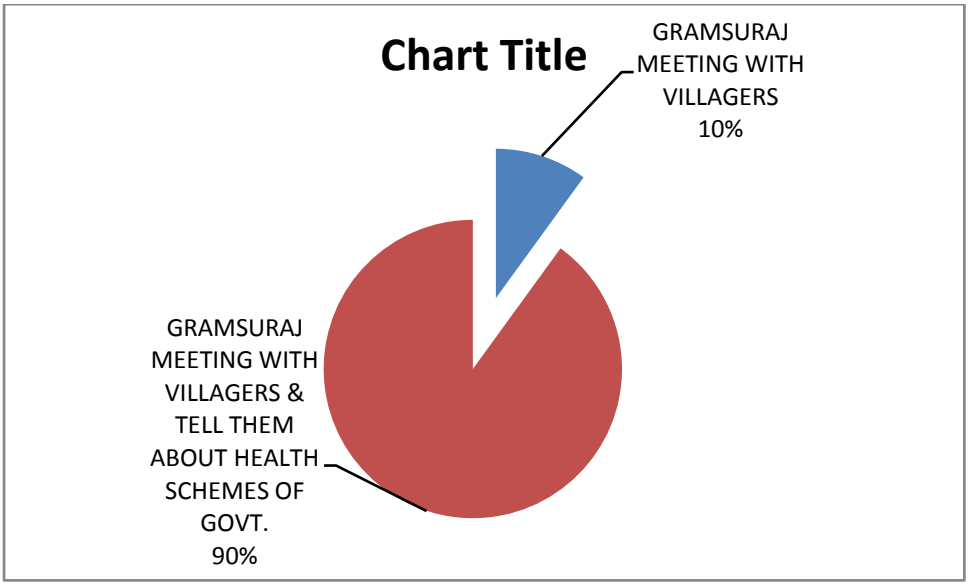


Chart- 14 Where to refer complicated pregnancy cases

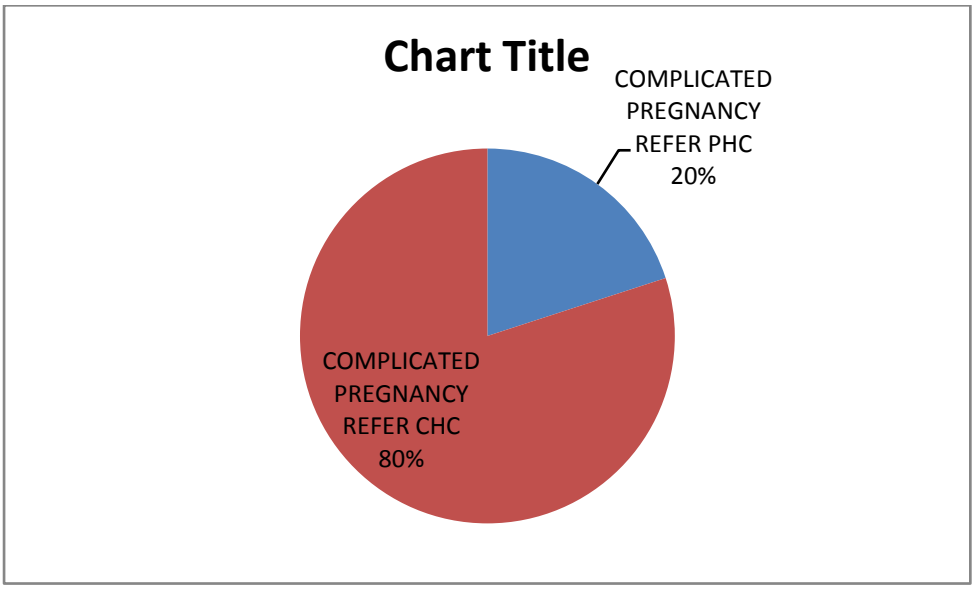


Chart- 15 Role in VHSC level planning

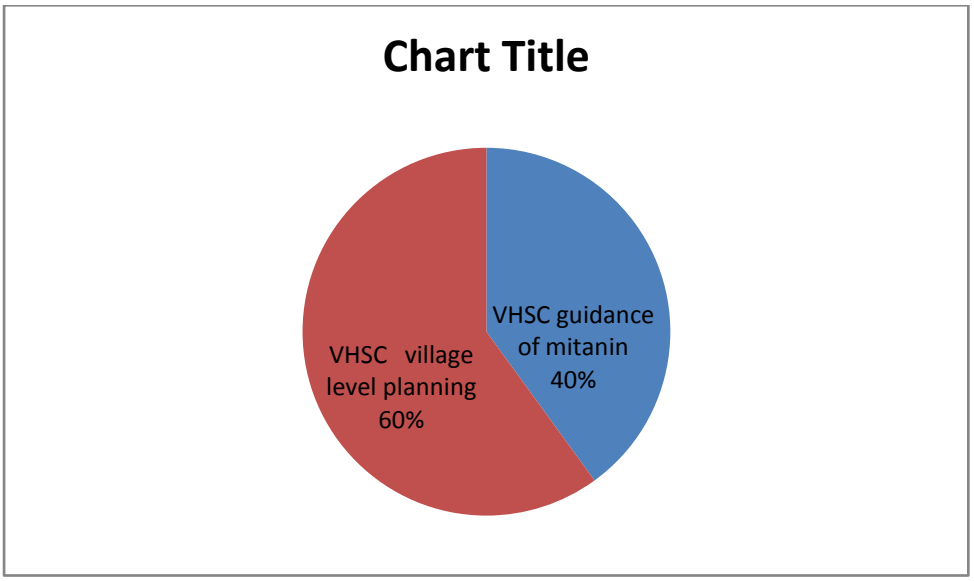


Chart- 16 Purpose of fund utilization

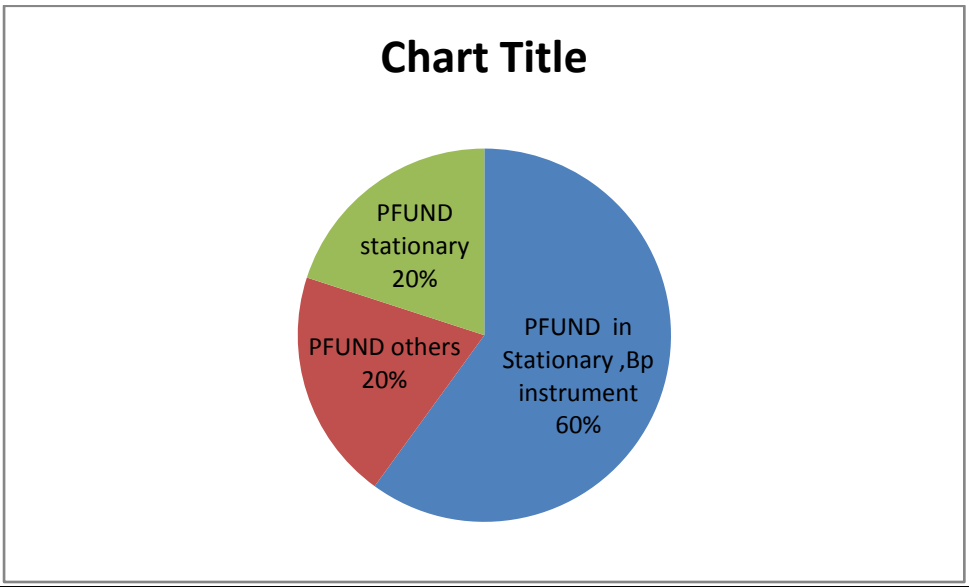
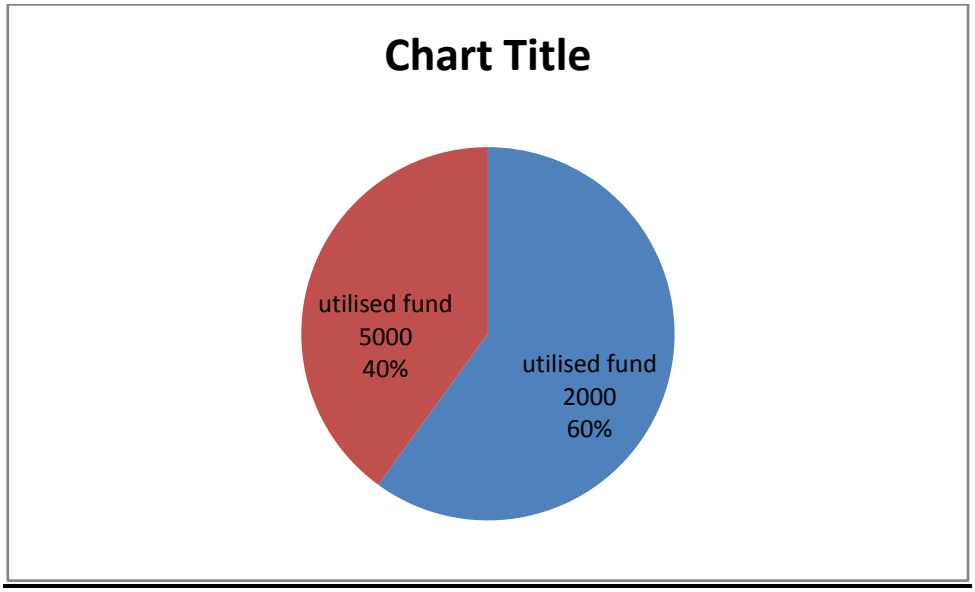


Chart- 17 Utilization of untitled funds



Limitation of the Study:

- Very few AWC were not covered.
- There is a difference in the activeness of newly appointed contractual ANM & old regular recruited ANM.
- There is a difference in block level activity, which definitely affect the overall performance of ANM.

Recommendations

- Training of ANM especially in urban areas for proper reporting and encourage them for timely reporting to their respective facility members.
- Develop user friendly reporting format which will be easily understandable to them.
- Number of functional ANM is also low in urban area which is leading work load over them.
- Timely meeting should be done for developing the repo and coordination between permanent ANM and contractual ANM.
- Higher authority should have proper command on work and reporting of ANM to avoid misreporting and underreporting in their reports.

Conclusion

ANM are the main contact point between the health care service users and health care delivery system. The work done by ANM is essential for future changes in the services provided by the facility and also for making change in the policy level. So the plane for the strengthen the capacity of the ANM in Urban Areas should be done because there is gap in reporting pattern of ANM from urban area and ANM from Rural area. In urban area they are not having proper command from their higher authority which is reflecting in their reporting pattern.

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Annexure

ANM

1) Whom do you report for your work?

   a) CMO
   b) Civil Surgeon
   c) Medical Officer
   d) Supervisor…….
   e) DIO

2) How many types of format do you use for reporting?

   (1)weekly

   (2) Monthly……..

3) When do you report weekly/monthly annually?

   a) Weekly---
   b) Monthly---
   c) Annually
   d) Any other…….(Please Specify)

4) How do you report?

   a) On Mobile Phone / landline
   b) Using any given Format
   c) Using Plain Paper

5) Do you make slide for malaria?

   a) Yes b) No

11) How much money you have utilised from Untied fund

(1) 5000

(2) 2000

(3)3000

(1) 10000

12) For what purposes you have used Untied Fund

(1). .Stetho,BP Instrument,ANC Table..

(2) BP instrument only

(3) Register/Stationary

(4) Others

13) What is the different measure/type of temporary methods of Family planning you are providing/ Counselling to the community people?

a) Condom b) Oral Pills

c) Copper T d) All of the above

14) How many people went for NSV in last six month (Approx)

(1) Less than 5

(2) 5-20

(3)21-50

(4) No-one

Maternal and child health:-

(1) What do you do for pregnant women when they come to you first time?

(a) Check-up?

(b) Registration?

(c) Both

(d) Nothing

Do you visit village for PNC check-up

(1) Yes

(2) N0

(16) How many times do you go there?

(a) One

(b) Two

(c) three

(d) four

(2) Do you take urine sample of pregnant women to know about albumin & sugar?

(a) Yes

(b) No

(3) Do you refer cases of abnormal pregnancy?

(a) Yes

(b) No

(4) Where do you refer complicated case of pregnancy--

(a) Primary health center

(b) Community health center

(c) District hospital

(d) Nowhere

(5) Do you conduct deliveries in your area when called for?

(a) Yes

(b) No

(6) Do you supervise deliveries conducted by Dais and assist them?

(a) Yes

(b) No

(7) Do you identify pregnant women and counsel them in your area?

(a) Yes

(b) No

FAMILY PLANNING

(1) Do you maintain eligible couple registers?

(a) yes

(b) No

(2) Do you motivate couples for family planning?

(a) Yes

(b) No

(3) Do you distribute contraceptives to the couples?

(a) Yes

(b) No

MEDICAL TERMINATION OF PREGNANCY

(1) Do you identify women and refer them to nearest approved institution for termination of pregnancy?
   (a) Yes
   (b) No
(2) Do you educate community regarding consequences of septic abortion?
   (a) Yes
   (b) No
(3) Do you inform the community about the availability of services for MTP in our nearest approved institution?
   (a) Yes
   (b) No

NUTRITION

(1) Do you identify cases of malnutrition in your area and gives them necessary treatment/
   (a) Yes
   (b) No
(2) Do you distribute iron folic acid tablets to pregnant women?
   (a) Yes
   (b) No
(3) Do you give vitamin A solution to children?
   (a) Yes
   (b) No
(4) Do you visit Anganwadi center?
   (a) Yes
   (b) No
(5) When do you visit AWC---

   (a) Twice in a week---
   (b) Once in week
   (c) Once in a month

(6) What do you do at AWC?

(a)—immunisation, birth,death registration Anc checkup-

(b) Only immunization-

(c) Weight-

(c) weight and height-

UNIVERSAL PROGRAMME ON IMMUNIZATION

(1) Do you immunize pregnant women with tetanus toxoid?

(2) Do you administer any other vaccine?

(a) Yes

(b) No

DISEASES

(1) When you visit your area (village) and you find any case of fever with rigors do you make blood slide for malaria?

(a) Yes

(b) No

(2) Do you identify case of skin patches with loss of sensation in your area?

(a) yes

(b) No

(3) Whom do you report for this?

(a) Sarpanch

(b) Medical officer

(c) BMO

(d) CMHO office

(e) Supervisor

(f) DIO

(4) Where do you report?

(A) Phc

(B) Chc

(C) DH

(c) CMO office

(d) Civil surgeon office

(5) Do you refer all suspected cases of Cataract?

(a) Yes

(b) No

(6) Do you educate, counsel and refer cases of HIV/AIDS?

(a) Yes

(b) No

VITAL EVENTS

(1) Do you register/record birth and death in your area and report them to health authority?

(a)yes

(b) No

(2) Do you go for meeting?

(a) Yes

(b) No

(3) Where do you go for meeting….

(a)Phc

(b)Chc

© DH

(d) CMHO Office

(e) Civil Surgeon office

(4) When do you go for meeting….

(a) Weekly --

(b) Monthly

(5)Who are present in meeting….

(a) Medical Officer

(b) Block Medical Officer

(c) CMHO

(d) DIO

(e) Supervisor

(5) Who gives you training…….

(a)MO

(b)BMO

© CMHO

(f) DIO

(g) Supervisor

(6) Do you maintain register?

1) Yes
2) No

(7) Do you maintain format?

(a) Yes

(b) No

(8) What kind of format do you maintain

(a)--Weekly----------

(b)--Monthly----------

(c) -Annually----------

(d)-Others----------

(9) Where do you send those formats?

(a) PHC

(b) CHC

(c) DH

(d) Cmho Office

(10) By whom do you send those formats?

(a) Self

(b) Supervisor

(c) Mitanin

(d) AWW

(11) When do you send those formats----------

(a)weekly

(b) Monthly—

©Annually

(12) What is your working time?

(a) 8-12

(b) 8-2

(c) 8-4

(d) 8-1

Other Activities

(1) What do you do in sishu suraksha maah?

(a)vit A syrup

(b) Measles vaccine

(c)IFA tablets

(d) Tab Albendazole

(e) All of the above

(2) When sishu suraksha maah held?

(a)daily

(b) Weekly

(c) Monthly

(d) Annually

(3) When do you go for VHND?

(a)daily

(b) Weekly

(c) Monthly

(d) Annually

(4) Where do you go for VHND?

(a) Anganwadi centre

(b) Subcentre

(c) PHC

(5) What do you do for NIDDCP?