IMPLEMENTATION OF YASHODA SCHEME AS A QUALITY INTERVENTION IN HARYANA STATE

A dissertation submitted in partial fulfillment of the requirements for the award of

Post-Graduate Diploma in Health and Hospital Management

by

Dr. Tushar Purohit

International Institute of Health Management Research

New Delhi -110075

May, 2012

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Certificate of Internship Completion

Date: ……..

TO WHOM IT MAY CONCERN

This is to certify that Dr. Tushar Purohit as successfully completed his internship in our organization from 12January, 2012 to 31May, 2012. During this intern he has worked on Implementation of Yashoda scheme as a quality intervention in Haryana State under the guidance of me at NRHM Haryana. During the project he was found to be sincere and his work was found satisfactory.

We wish him good luck for his future assignments.

(Signature)

_____ (Name)

_____Designation

Certificate of Approval

The following dissertation titled "**Implementation of Yashoda Scheme as a quality intervention in Haryana state**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award **of Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
DR DHARMESH LAL	

Certificate from Dissertation Advisory Committee

This is to certify that **Mr. Tushar Purohit**,a graduate student of the **Post-Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. He is submitting this dissertation titled" **Implementation of Yashoda Scheme as a quality intervention in Haryana state**" in partial fulfillment of the requirements for the award of the Post- Graduate Diploma in Health and Hospital Management.This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

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This is to confirm that I have reported to my internal advisor regarding my dissertation and internship placement. During my internship I will regularly keep in contact with my advisor and keep him updated about my progress. I will also carry out a special study (or, dissertation) on Yashoda scheme in consultation with the concerned authority of the organization. I will prepare a brief study proposal on the agreed topic and send to my advisor before February 15, 2012 for approval. I understand that the general internship report and the special study report needs to be approved by my advisor before the presentation and subsequent submission of the final report before April 24, 2012.

Signature of the graduate student: (Dr. Tushar Purohit) **Date:**

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Abstract

IMPLEMENTATION OF YASHODA SCHEME AS A QUALITY INTERVENTION IN HARYANA STATE

By

Dr. Tushar Purohit

Most of the infant deaths occur within 28 days of delivery and around 2/3 deaths of neonates occur within 2 days of delivery so it is crucial to take care of mother and child in first 48 hrs. Effective, low-cost interventions to reduce neonatal deaths can be implemented at family, community and health-facility levels. Most maternal and neonatal deaths occur during childbirth and the immediate post-natal period. The Haryana state have decided to engage 'Yashoda' at the facility level for facilitating the initial care that the newborn and the mother require during their stay at the facility, there by addressing the above gaps to some extent.

The objective of the study is to understand the functioning of facility based Yashoda initiative & to identify key obstacles/problems if any in the effective implementation of these initiatives so as to provide recommendations to improve the program. This study has helped us to understand perspectives of communities that are being targeted under the NRHM interventions on childcare and birthing practices.

Prospective data on Yashoda functioning were collected from convenient sampling method from intervention and control districts. Total sample size was 136. Target population was recently delivered women in district hospital.

Yashodas were positioned in the health facilities to be a mother's aide; however, there seemed to be push for Yashodas to become a nurse's aide. . Limited interactions with ASHAs were reported. Yashodas also highlighted the need for more frequent trainings.

Role of Yashoda as sympathetic friend and mother's aide needs to be strengthened in her training vis-à-vis her current perception as a nurse's aide. The presence of ASHAs at registration provides an excellent opportunity for Yashodas to interact with them and take over the mother's care from ASHA to themselves (through sharing of the ANC card information) at the facility. Similarly, at discharge, Yashodas could provide similar information about the mother to the ASHAs to continue care through postnatal visits at home.

Acknowledgement

I owe a great many things to a great many people who helped me and supported me during the dissertation period.

I would like to take this opportunity to express my sincere thanks to **Sh. Pradeep(IFS), Director Administration** for giving me the opportunity to undergo dissertation training at **NRHM, Haryana**.

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Words are inadequate in offering my thanks to **Dr. Amit Fogat** for his encouragement and unwavering support in carrying out the project work.

Finally, yet importantly, I would like to express my heartfelt thanks to **Sh. Rajeev Seth, Technical Assistant** and **Sh. Ajay and Ms. Nisha, Data Entry Operators** for their help for successful completion of dissertation Project.

My sincere acknowledgement goes to **Associate Dean, Dr. Dharmesh Lal** for their kind assistance and support throughout my dissertation period.

Finally, I would like to show my greatest appreciation to my colleagues and family for their tremendous support and cooperation while working on this project.

The guidance and support received from all the members who contributed was vital for the success of the project. I am grateful to them for their constant support and guidance.

Thank You

Dr. Tushar Purohit

NRHM, Haryana

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Abbreviations

ANC- Ante Natal Care
ANM- Auxiliary Nurse Midwives
ASHA- Accredited Social Health Activists
ASNI- Assessing and Supporting NIPI Interventions
AWW- Anganwadi Workers
BPL- Below the poverty line
BPMU- Block Project Management Unit
CHC- Community Health Centers
CHS- Child Health Supervisor
DCHS- Deputy Child Health Supervisors
DH- District Hospitals
DLHs- District Level Household Survey
DPMU- District Project Management Unit
FGD- Focus Group Discussions
FMR- Financial Management Review
GoI- Government of India's
HBNC- Home Based Newborn Care
HBPNC- Home Based Postnatal Care
HMIS- Heath Management Information Systems
IASAM, University of Oslo - International Health, Faculty of Medicine
IBF1- Initiation of breastfeeding within 1 hour
IDIs- In-depth Interviews
IMNCI- Integrated Management of Neonatal and Childhood Illness
JSY- Janani Suraksha Yojana
MDG- Millennium Development Goal
NIPI- Norway - India Partnership Initiative
NRHM- National Rural Health Mission
PHFI- Public Health Foundation of India
PIP- Program Implementation Plan
PNC card- Postnatal Checkup card
RCH-II Reproductive and Child Health Programme phase II
SNCU - Sick Newborn Care Unit
SIHFW- State Institute of Health and Family Welfare
SUM- Centre for Development and the Environment

Internship Report

The National Rural Health Mission (NRHM) was launched by the Honorable Prime Minister on 12th April 2005, to provide accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions. The detailed Framework for Implementation that facilitated a large range of interventions under NRHM was approved by the Union Cabinet in July 2006 (two years ago). Under the NRHM, the difficult areas with unsatisfactory health indicators were classified as special focus States to ensure greatest attention where needed. The thrust of the Mission was on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities. From narrowly defined schemes, the NRHM was shifting the focus to a functional health system at all levels, from the village to the district.

About NRHM

The National Rural Health Mission (NRHM) aims to provide for an accessible, affordable, acceptable and accountable health care through a functional public health system. It is designed to galvanize the various components of primary health system, like preventive, promotive and curative care, human resource management, diagnostic services, logistics management, disease management and surveillance, and data management systems etc. for improved service delivery. This is envisioned to be achieved by putting in place an enabling institutional mechanism at various levels, community participation, decentralized planning, building capacities and linking health with its wider determinants. It also aims to expedite achievements of policy goals by facilitating enhanced access and utilization of quality health services, with an emphasis on addressing equity and gender dimension.

Vision:

• 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.

• To increase public spending on health from 0.9% GDP to 2-3% of GDP, with improved arrangement for community financing and risk pooling.

•To undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country.

•To revitalize local health traditions and mainstream AYUSH into the public health system.

•Effective integration of health concerns through decentralized management at district, with determinants of health like sanitation and hygiene, nutrition, safe drinking water, gender and social concerns.

• Addresses inter State and inter district disparities.

• Time bound goals and report publicly on progress.

• To improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care.

Objectives of NRHM

• Reduction in child and maternal mortality

• Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization

• Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.

• Access to integrate comprehensive primary health care.

• Population stabilization, gender and demographic balance.

• Revitalize local health traditions & mainstream AYUSH.

• Promotion of healthy life styles.

Components of NRHM

NRHM has the following five components

• Part "A" deals with RCH -II and FP Programs

•Part "B" deals with new components / additionalities of NRHM. This part contains untied funds to Subcentres, Up-gradation of institutions to IPHS, RKS, AYUSH mainstreaming etc.

• Part "C" consists of Immunization Strengthening interventions

• Part "D" contains all the National Health Programs and IDSP

• Part "E" deals with Convergence of activities with the Health

Determinant Departments whose activities are indirectly connected with Health activities

Core Strategies of the Mission

• Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.

• Promote access to improved healthcare at household level through the female health activist (ASHA).

• Health Plan for each village through Village Health Committee of the Panchayat.

• Strengthening Sub-centre through better human resource development, clear quality standards, better community support and provision of untied fund to enable local planning and action.

• Strengthening existing health facilities through better staffing and human resource development policy, clear quality standards, better community support and an untied fund to enable the local management committee to achieve these standards.

• Provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard. (IPHS defining personnel, equipment and management standards, its decentralized administration by a hospital management committee and the provision of adequate funds and powers to enable these committees to reach desired levels)

• Preparation and implementation of an inter sector District Health Plan prepared by the District Health Mission, including drinking water, sanitation, hygiene and nutrition.

• Integrating vertical Health and Family Welfare programmes at National, State, District and Block levels.

• Technical support to National, State and District Health Mission, for public health management

• Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.

• Formulation of transparent policies for deployment and career development of human resource for health.

• Developing capacities for preventive health care at all levels for promoting healthy life style, reduction in consumption of tobacco and alcohol, etc.

• Promoting non-profit sector particularly in underserved areas.

(a) **The key features of NRHM include**

- Making health delivery system fully functional & accountable to the community Convergence of National Health Programme at all levels of health system
- Improved management through capacity building
- Involvement of community
- Monitoring progress against standards
- Flexible financing for optimum fund utilization
- Inter-sectoral coordination for financial enhancement

(b) Objectives of NRHM

- Reduction in maternal and child mortality.
- Universal access to affordable and quality health care services.
- Prevention & control of communicable & non-communicable diseases.
- Access to integrated comprehensive primary health care.
- Population stabilization.
- Promotion of healthy life styles**.**

The 5 main approaches under NRHM are given below –

(a) Communitization – For ensuring better community participation; committees / organizations have been formed at various level viz. Village Health & Sanitation Committee at village level, Panchayati Raj Institutions at village/block level, Rogi Kalyan Samitis at PHC and CHC and the ASHA , a community volunteer for every village.

(b)Flexible Financing – For improved finance, the mission has brought all the schemes of health & family welfare within the overarching umbrella of NRHM. Financing through the NRHM budget head provide the much needed funds to the districts to facilitate better functioning of health programme. Based on needs of the district, funds are allocated to states. The untied funds are also available under NRHM at various levels. The expenditure on public health has been raised from 0.9% to nearly 3% of GDP.

(c) Improved management through capacity building– Management skill at block, district & state levels have been increased under NRHM. Post of public health managers has been created at district level and accountant at block level for accounts work. Various NGOs are involved in capacity building and continuous skill development of health functionaries at various levels is being carried out.

(d) **Monitor progress against standards** – Progress of activities is being monitored according to the Indian Public Health Standard. Health facility surveys are conducted at regular intervals to monitor facilities available at sub-centres, PHCs and CHCs. Independent monitoring committees are also being formed to monitor progress.

(e) **Innovation in human resource management** – To increase the pool of human resource, additional manpower like nurses, MO are being provided at PHC and CHC. Local residents of remote areas are trained and developed for providing basic health services. Multiskilling of health functionaries especially of doctors and paramedics is being carried out so that a person could carryout multiple tasks.

Under the NRHM, institutional mechanisms have been created at each level to support National Health Programmes & improve delivery of health care services. The programme may seek support of NRHM as below-

(a) Village Health & Sanitation Committee (VHSC) a multi stake holder at village level, create public awareness about the programme and ensure community involvement. These committees analyze the health problems, decide the health priorities and take appropriate action to overcome the problems. The committees also help in managing village health funds in the village. These committees can be utilized to discuss leprosy problem like stigma and discrimination against persons affected by leprosy and their family members and seeking collaboration from the health services.

(b) Accredited Social Health Activist (ASHA) is selected for every village. She is a female volunteer belonging to the same village, selected by the community. During her routine home visits, ASHA can identify suspect cases of leprosy and refer such cases to nearest health centre for diagnosis and treatment. ASHA can also ensure timely completion of treatment by the diagnosed leprosy cases by conducting regular follow up of these cases. An incentive is being paid to ASHA in endemic states for referring suspect leprosy cases to health facility and ensuring treatment completion of diagnosed cases referred by them. During her visit, ASHA can also identify ulcer patients & persons with leprosy related disability and refer such cases to nearest health centre for further management.

(c) Rogi Kalyan Samities (RKS) at PHC and CHC are autonomous registered bodies constituted at each level to facilitate in day to day management of hospital activities and delivery of quality care to patients. These samities have the authority to procure medicines required for emergency conditions.

(d) Panchayati Raj Institutions (PRIs) also work at PHC & CHC level which can help in planning & implementing programme including IEC activities like organizing health melas, IPC workshops/meetings and orientation camps.

A single budget head for activities with separate subheads for various programme have been formed under NRHM which provide state the flexibility to direct funds to those areas where they are needed the most. The funds flow through integrated health society at the state & district level. The funds allocation is on the basis of integrated State/District health action plans. The district health action plans are first drawn up. Based on district plans, the state health action plan is prepared and submitted for sanction of GOI.

(e) Finance Management Group (FMG) is formed under NRHM at States & Districts. Services of FMG should be utilized for release of funds from states to districts and from districts to blocks, monitor programme expenditure and maintaining programme accounts. **Untied Funds** are made available under the mission at various levels which can be utilized by any programme based on the requirement.

During my dissertation period I was engaged with Child Health Division. I have done day to day routine work of office and also completed various assignments which were particularly given to me. I was involved in several activities which are mentioned below:

- Mentor for First batch of 3 days Yashoda TOT
- Coordinator for 2nd and 3rd batch of 3 days Yashoda TOT
- Coordinator for 1st & 2nd batch of 4 days FBNC training in PGIMS,Rohtak
- Coordinator for 1st & 2nd batch of 4 days FBNC training in PGIMER,Chandigarh
- Attended one Civil Surgeons meeting
- Monitoring for National Immunization Day
- Monitoring for Yashoda
- Participated in 2 days WHO Measles surveillance workshop
- Participated in 2 days NSSK training

My dissertation period was very knowledge enhancing and full with practical experience. I was taught many ways to overcome obstacles and I also had to learn how and when to be a leader & when and how be a team work.

Dissertation Report

IMPLIMENTATION OF YASHODA SCHEME AS A QUALITY INTERVANTION IN HARYANA STATE

EXECUTIVE SUMMARY

The Millennium Development Goal of reducing child mortality by two thirds by 2015 will only be met if there is a significant improvement in newborn survival. Most of the infant deaths occur within 28 days of delivery and around 2/3 deaths of neonates occur within 2 days of delivery so it is crucial to take care of mother and child in first 48 hrs. Effective, low-cost interventions to reduce neonatal deaths can be implemented at family, community and health-facility levels. In Haryana state according to DLHS-3 mothers who received PNC within 2 weeks of delivery is only 49.5%, children under 3 year breastfed within one hour of birth are 17.4% and children who exclusively breastfed are only 9.4%. Most maternal and neonatal deaths occur during childbirth and the immediate post-natal period. These indicators shows requirement of major intervention in form of support staff after delivery, who can assist medical staff and take care of mother and child for first two days in institutions. The Haryana state have decided to engage 'Yashoda' at the facility level for facilitating the initial care that the newborn and the mother require during their stay at the facility, there by addressing the above gaps to some extent.

CHAPTER 1. INTRODUCTION

Who is Yashoda?

The Yashoda may be said to be a team comprising the Yashodas, Matron, other Nurses, Yashoda Supervisors and Medical Officers. The individual "Yashoda" is a Mother's aid, a non clinical incentivized support worker who has eight years of schooling and is placed in hospitals with a large delivery load in the ratio of 1 Yashoda for 5 deliveries. The non clinical support and counseling by Yashodas focuses on motivating mothers to weigh and immunize the newborn, initiate exclusive and immediate breast feeding, spacing of child birth and information on post natal care services access.

Yashoda process introduced under NIPI in 2008 is a quick response by the State Health Societies of MP, Bihar, Orissa and Rajasthan for addressing quality of newborn and related maternal care starting with maternity wards of the district hospitals with high delivery load.

These non clinical support services by Yashodas have begun to contribute to longer stay of the mothers at the facility, thus adding value to the JSY investments at a nominal addition of 7-10 %. Experience shows that a dedicated support at the facility level can significantly contribute to the quality of care and achieving the optimum advantage of delivering in a facility.

Yashoda is a process and does not denote a person. The objective of the process is to enhance a joint ownership for care coordination at the facility with 'Yashoda' as part of the larger system, where the pregnant women feels welcome as she enters the facility and leaves with a feeling of being cared and looked after with her newborn baby. The value addition that the Yashoda process brings is the demand generation of services for care for newborn and improved accountability at the facility level. While Yashoda fills a critical gap for counseling the mother on newborn care and coordinate services within the maternity ward, her success depends a lot on the support, ownership and leadership given by the hospital team including the matron, nurses, hospital manager and hospital administrators.

Yashoda engagement

- The total annual delivery averaged out to a daily/monthly load will be the basis for calculation of Yashoda requirement. This may be different from the situation at Block Hospital where a separate approach has been suggested.

- Yashoda should be clearly informed of the temporary and voluntary nature of the engagement without any ambiguity

- Each Yashoda will get an incentive of around Rupees 3000 - 3500 for 23-24 shifts of work in a month. This could be lower in a Block hospital with partial delivery load.

- In order to improve performance efficiency, Yashoda will be given every fourth day off after completion of night duty.

- The non clinical support and counseling role of Yashoda must be communicated clearly and continuously to all the hospital staff and district team including the fact that Yashoda is not a substitute for the nurses.

Why Yashoda intervention:-

The sudden influx of beneficiaries in public health institutions due to JSY has added to the challenge to provide quality maternal and neonate health care. However, it provides a window of opportunities to improve the RCH services at the facilities.

Women have complex needs during childbirth. The In addition to the modern obstetrical care, women need consistent, continuous reassurance, comfort, encouragement and respect. They and their newborn need individualized care and more so when a poor rural women chooses to deliver in an alien environment like a district or block facility.

The scientific evidence for emotional support and hand holding during delivery and immediate post natal care comes from the United States, Drs. John Kennel and Marshall Klaus while investigating ways to enhance maternal-infant bonding in the late seventies, they found, that introducing a 'doula' (a mother's companion) into the labor room not only improved the bond between mother and infant, but also seemed to decrease the incidence of complications. (Kennel, JH et all) Since their original studies, published in 1980 and 1986, numerous scientific trials have been conducted in many countries comparing usual care with usual care plus a 'doula'.

Analysis of the numerous scientific trials of labor support led the Cochrane Collaboration's Pregnancy and Childbirth Group to state: "Given the clear benefits and no known risks associated with intra partum support, every effort should be made to ensure that all laboring women receive support, not only from those close to them but also from specially trained caregivers. This support should include continuous presence, the provision of hands-on comfort, and encouragement." (McGrath,SK et all)

Tamil Nadu has successfully demonstrated the need and usefulness of a woman who 'holds hands' and provides the much needed emotional support besides helping the women to navigate through the complex processes in the hospitals. The more recent example of 'Breast feeding counselor' in Madhya Pradesh provides a further example of improving the quality of care for the women coming in for institutional deliveries.

Surveys on JSY show that many of the women stay in the institution for less than 24 hours after delivery, regardless of a normal delivery or a difficult delivery. Concurrent assessment of Janani Suraksha Yojana (JSY) scheme in selected states of India, 2008 sponsored by UNFPA raised several issues about its benefits and processes for the women. These include: the duration of stay

at the facility, the quality of services, the facilities available at the hospital, the safety of mother & child, and the availability of counseling on follow up visit, breastfeeding, immunization, family planning, newborn care and diarrhoea management, etc.

The first 24-48 hours after delivery offer a golden opportunity for integrating neonatal care with postpartum care. Many of the conditions responsible for the mother and/or neonate's death are recognizable in the first 48-72 hours after delivery. Therefore the government of India norms requires that mothers stay in the hospital with the newborn for 48 hours after delivery

Can a person from within facility be found to make the pregnant women feel welcome, to make her feel comfortable after delivery, initiate exclusive and immediate breast feeding, counsel the mother on basic newborn care, and to motivate the mother to stay at the facility for a longer duration? The hospitals, with increasing volumes of deliveries per day, have not been able to use this opportunity fully due to a shortage of nurses and a poorly managed logistics system. While there are prescribed standards regarding the availability of number of qualified nurses by the Medical Council of India, in the Medical Colleges, and penalties for non compliance no such standards are available for the maternity ward in a District hospital, which are chronically understaffed. The Indian Public Health Standards are not tied to penalties. While these long-term HR processes are still debated, the Yashoda process provides a quick response to help the hospital system to cope with the increasing demand for quality care for the newborn by having dedicated team to take on non clinical tasks and free up the time of the nurses to focus on curative tasks.

Why Yashoda, and why not ASHA?

It has been observed that in almost 30-40% of cases, ASHAs do not accompany the pregnant women to the hospital. Even those who accompany do have other responsibilities under NRHM and cannot be away from the community for over 24 hours. If we assume that ASHAs accompany pregnant women to a District hospital where 20-30 deliveries take place a day, in the course of two days, there will be 40-60 ASHAs at the hospital. There is no arrangement for their stay, food, or security. These additional people in an already stretched infrastructure could create chaos. Also, it will be difficult for the RCH nurses, doctors etc in a district hospital to relate to 1000 strong ASHA force in a district; while their ability to organize support and counseling

through Yashodas who are to become regular features of the maternity ward over a period of time will be considerably smoother. Accountability can be organized much better.

Yashodas have a range of responsibilities; Ensuring cleanliness and functionality of the ward, be a friend to the mother, to counsel the mother on nutrition for self and newborn, immunization and family planning choice etc. Since Yashodas, will be on duty 24 hours they will provide a closer watch over the mother and the newborn, and alert the nurse or the doctor immediately for any difficulty faced by the newborn or the mother. As a support worker for improving quality of care, Yashodas also have the responsibility to facilitate safety, security, dignity and privacy of the mother and special and dedicated attention to the newborn. Since each healthy mother and newborn leaving the hospital will be an ambassador for spreading the message of improved care at the institution, Yashoda's role in building confidence of the mother becomes crucial.

A congenial environment

Yashoda makes the mother feel welcome and makes her stay comfortable by being friendly and cordial. She will function as an interface between the hospital staff, the mother and her family. She will link with the ASHA accompanying the pregnant woman and gather basic information on completion of ANC check up, any problem etc, and inform the nursing staff for necessary action. She will assist the nurses in bed making and avoid crowding in the ward.

Newborn and mother care

Yashoda will make arrangement to ensure cleanliness of the area, prepare the bed for the mother and baby, manage the food and other ancillary requirements of the mother and baby, and keep the paper work ready.

Assist in pre and post delivery care

Yashodas function as an emotional support to the pregnant woman in the labor room; subsequently assist the nurse in receiving the newborn, cord care, putting identification tags, taking the weight of the newborn, cleaning and draping the newborn in adequate sheet and blankets as per the weather. She will assist the mother to initiate immediate and exclusive breastfeeding and ensure all Zero dose immunization from the institution.

Counsel the mothers

Motivate the mother to stay at the facility for 48 hours as per the guidance of the doctors. During the stay at the health facility the Yashoda will counsel the mother on:

- Breastfeeding and complementary feeding and nutrition requirements for mother.
- Details about further immunization requirements, schedule, availability.
- Preparations to be made in case of illness of the baby and mother.
- Prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/ STIs).
- Family planning advice as required including spacing, contraception.
- Accessing institutional care in future, if the need would arise for the baby/child, whom to contact, etc.

- Personal hygiene

Initiate birth registration / procuring birth certificate:

Yashoda will assist in filling of the forms for registration of birth and still birth and explain the rationale for registration to the mother and family members.

Provide information on the follow-up after discharge from the health facility

Provide information on the need for regular weight checkups, weight gain for the baby in the ensuing months, immunization, feeding of the baby (exclusive breast feeding till 6 months and introduction of complimentary feeding thereafter); contact points such as ANM, AWW, and other support systems in the community.

Informing family members present at the health facilities about:

- Basic care for mother and newborn after leaving the facility including rest, nutrition, basic sanitation & hygienic practices.

- Existing health services, immunization days, and other maternal child health care services, especially for post natal care (provided by ANM and ASHA, supplementary nutrition services available at the Anganwadi centers).

Record Maintenance

This innovation requires appropriate follow up of the services rendered to improve quality. Monitoring effectiveness of Yashoda intervention contributing to increasing the duration of the stay of mothers, by initiation of immediate and exclusive breast feeding and zero dose immunization in addition to mothers receiving appropriate information on care for self and newborn after leaving the facility. Towards this, it is suggested that Yashoda capacity is built to maintain appropriate daily records, which are expected to facilitate the nursing staff as well as the Child Health Supervisors to take suitable measures to improve the quality of service.

Suggested criterion for Selection:

- A local woman living within the municipal limits
- Has completed 8th grade as a minimum.
- She agrees to work as a volunteer
- She will receive performance-linked incentives.
- Her engagement as volunteer worker does not entitle her to claim the regular position in the system.
- Free from communicable diseases, subject to clearance by the Medical Officer.
- Willing to work on rotational basis including night shifts.

Decisions on the criteria are to be finalized at the district level by the DHS and / or Rogi Kalyan Samiti (RKS) of the hospital. These agencies must have a process for screening of the applications within a limited time since large numbers may apply for a few positions.

Determining the required number of Yashoda in a District Hospital

District Hospitals with a high delivery load are taken for implementation of Yashoda process since they have the ability to support the mentoring and monitoring of the Yashoda intervention. The calculation of the Yashoda requirement should be based on the total delivery in a year in the given facility. Observe and record if the fluctuations are more than 10-15% either way.

It is well known that the delivery status varies from month to month and some months with very high load and some with low load. During these months, the quantum of incentive generated will vary but not the number of Yashodas. The facility should calculate the optimal number of Yashodas required functioning as a core pool of workers on whom investment is made in terms of training, uniform, supervision, consumables etc.

The calculation of the Yashoda requirement should be based on the total delivery in a year in the given facility.

Therefore the following is suggested:

The calculation of required number of Yashodas

Calculation of Yashoda requirement should be based on:

- Total number of deliveries occurring in one year in the facility.
- Arrive at per day average delivery by dividing the total number by 365.
- To provide around the clock services, Yashoda will work in 8 hourly shifts.
- The calculation of required number of Yashoda must be based on clear understanding of the required shifts of work, rest, incentive payment and other costs involved in managing the intervention.
- Currently, Yashodas are taking care of five newborn babies per shift. The new born and mother are expected to stay for about 48 hours after delivery, so each Yashoda take care of about 10 newborns in a shift. However in reality each Yashoda often manages 5-6 mother baby cohort and not strictly 5 babies.
- The calculation to include the number of Yashodas required to ensure round the clock services allowing space for leave and absence by Yashodas; and to meet the high delivery load period needs. In some cases the layout of the wards may be such that, more Yashodas are required to cover the maternity wards.

Calculation of Yashoda Requirement

Calculation of Yashoda requirement should be based on:

Total delivery per year	2190
Daily delivery load	2190/365
Daily delivery load is	6
Number of Yashodas required per shift	
(each Yashoda looks after 5-6 newborn and mothers)	1
For three shifts	3 Yashoda

Additional 25% to meet the round the clock service 1 extra = total 4 Yashoda

Keeping in view that all the mothers and newborns receive the services of Yashoda, it must be ensured that the duty roster is prepared in such a way that work is distributed among all the Yashodas equitably. All Yashodas will be entitled for the same amount of incentives as per the duty roster.

Additionally it must be ensured that the Yashoda services are available in the ward all 24 hrs without any break. Currently, the three shift timings are: morning duty (0800 hrs -1400 hrs) afternoon (1400-2000 hrs) and night shift (2200-0800hrs).

The supervisory cadre must ensure that the shift timings are readjusted in such a way that there is no gap in service.

Incentive structure

The incentive for Yashoda may vary depending on the number of deliveries happening at the hospitals The number of deliveries will fluctuate per month so the incentive for Yashoda will vary through the year. Although variation is expected, the incentive structure needs to be designed in way which ensures a minimum of Rupees 3000 per month and a maximum of Rupees 3500 per Yashoda. However there are instances where Yashodas get more than rupees 3500 per month based on the delivery load; But have less number of Yashodas. In such cases the states need to revisit and examine the delivery pattern and calculation of Yashoda requirement. Conversely if the facilities have less delivery but more Yashodas, it needs to be rationalized.

In order to ensure quality each Yashoda would ideally look after 5-6 newborn and mother cohort and not more.

Training

Capacity building of Yashoda is a continuous and incremental process that is critical to enhance her effectiveness. The capacity building is seen an empowering process, which will enable Yashoda to gain competencies progressively. Yashodas with certain level of competency could be further trained to become 'newborn care aide 'in the Sick Newborn Care Units and the Stabilization Units in the District hospitals and Block hospitals respectively.

Induction training upon recruitment, continuous hands on training; refreshers training etc are to be carefully planned and designed to keep updating her knowledge and skills. Capacity building, in addition to the above training, must also include

- Exchange visits
- Sharing of lessons learned
- Documentation of best practices
- Mentoring and supportive supervision at the facility
- Access to certification courses and distance learning courses

The above will contribute to career progression, motivate Yashodas and likely to reduce dropout rates.

Overall supervision

Overall supervision is provided by the medical superintendent identified by the Civil Surgeon in the district hospitals.

This includes:

Yashoda engagement, approval of payment norms, and incentive disbursal, purchase of the supplies and consumables, monthly progress report, regular performance review, grievance redressing and related administrative matters.

Several potential outcome are expected out of the Yashoda interventions including longer duration of stay of mothers, more mothers initiating immediate and exclusive breast feeding, improved immunization, increased number of mothers get informed on basic newborn care, nutrition and feeding practices, increased utilization of outreach services such as immunization, referral services etc. in those villages that utilize the services of the hospital. The intervention is monitored at different levels in the hospital for achieving these expected outcomes.

Rationale for placing Yashoda in health facility

- In our country, Fifty children per 1,000 of those who are born die before completion of first year of life
- Most deaths occur in the first 28 days in life
- The most risky time for death is the first 24 hours
- Every second woman in India is anaemic
- Many women die during delivery of the baby
- Commonest reasons for maternal deaths especially in the first 48 hours after delivery is excessive bleeding especially in an anaemic woman

So Yashoda is required for:-

- Improve the quality of care given to mothers and newborns in the hospital by being Counselors for family for newborn and maternal care ; and
- Being a friend, guide and psychological supports for mother.

Role of Yashoda as Mother' Aid

Yashoda will:

• Work only in hospital setting for new born and maternal care

• Provide friendly support, comfort and counseling to mother and her family

• Give dedicated attention to the new born baby

• Assist the family in registering the mother as JSY beneficiary

• Help the family register the birth of the baby

Yashoda has neither technical knowhow to provide medical or nursing care nor is expected to provide medical or nursing care

What are the activities that Yashoda has to perform in the Labor room?

- Cleanliness
- Ensure the cleanliness of the delivery table
- Bed sheets covering the beds in the waiting room should be clean and fresh
- Ensure that any spills in the room are cleaned promptly by Aaya/Safai karamchari

  Are supplies available in the hospital for housekeeping?
- Broom, mop
- Disinfectant
- Bed sheets
- Mackintosh

Activities that Yashoda has to perform for housekeeping in the ward

- For Maintaining Cleanliness, Yashoda must do the following
- Take a round of the wards, labor room and toilets and ensure about the cleanliness.
- Ensure that the floor is mopped by the safai karmchari/Aayah with disinfectant in the water.
- Any spills of food, water, body fluids or any other material on the floor must be cleaned at once by the safai karmchari/Aayah to prevent flies from swarming in the ward.
- Other fittings in the ward like door handles, light switches, bedside counters and the bottom of all incubators, cots and cribs should be cleaned by the Aayah
- If Aayah is not doing her job, Yashoda should bring this to the notice of the nurse.

- Bed allotted to a new admission has a clean sheet and is made well. She must help the nurse in doing this and should be able to do this by herself.
- In case of soiling of the mother's bed sheet, the sheet should be changed at once.

Electrical Fittings and water supply

- Yashoda should ensure that all the electrical fittings in the ward are working. The store for electrical fittings should be visited.
- Procedure for accessing electrical fittings like bulbs, tube lights etc from hospital supplies should be explained.
- Inform trainees about water supply of the hospital. Yashoda should inform nurse in case there is shortage of water in the ward or toilet.

Broad Roles of Yashoda – the Supportive Care Provider in the hospital

a. Provides the missing psychological support to pregnant women and mothers who come to deliver in hospital

b. Makes efforts to provide physical comfort to pregnant women and new mothers in the hospital

c. Identifies and refers pregnant women who have had an abnormal Antenatal period

No. of Yashodas in Districts of Haryana:-

S. No.	**District**	**District Hospital**	**Cumulative**			Recommended no of Yashoda	Recommended no of supervisor
			No.	**Inst.**	**Del.**		
1	Ambala	GH Ambala City	3443			8	1
2	Bhiwani	GH Bhiwani	1835			4	0
3	Faridabad	BK Hospital Faridabad	4093			8	1

4	Fatehabad	GH Fatehabad	2113	4	0
5	Gurgaon	GH Gurgaon	4313	8	1
6	Hisar	District Hospital	2720	8	1
7	Jhajjar	GH Jhajjar	1533	4	0
8	Jind	GH Jind	2405	8	1
9	Kaithal	GH Kaithal	2435	8	1
10	Karnal	GH Karnal	3922	8	1
11	Kurukshetra	LNJP Hospital	2226	8	1
12	Mewat	GH Mandikhera	764	4	0
13	Narnaul	GH Narnaul	4879	12	1
14	Palwal	GH Palwal	1727	4	0
15	Panchkula	GH Panchkula	5310	8	1
16	Panipat	GH Panipat	2077	8	1
17	Rewari	GH Rewari	2077	8	1
18	Rohtak	GH Rohtak	1844	4	0
19	Sirsa	GH Sirsa + PPC	3218	8	1
20	Sonepat	DH Sonepat	3756	8	1
21	Yamunanagar	MLGH Hospital	2159	8	1

Cost of intervention: Total cost includes incentives to Yashodas, training costs, monitoring & training incentives for the Head Nurse, operationalization cost of Yashoda, mother and newborn kit, mother and child motifs and other incidental costs. A proposed unit cost of Rs 140 per delivery has been suggested for all these activities. Out of this Rs. 100 is paid as incentives to Yashodas and remaining Rs. 40 is spent on training, educational materials and other supplies.

Outputs expected from Yashoda

1. % increase in the mothers initiating breast feeding within one hour
2. % increase in newborn being weighed
3. % increase in newborn being immunized (BCG & polio)
4. % mothers staying at least 48 hrs at the facility.

One of the primary concerns in the healthcare sector centers around the issue of patient. In present scenario, individuals are faced with many different options when deciding on a specific healthcare provider. Due to the varying options, quality and service stand out as two essential elements that influence the selection process. Quality patient service is for many, a readily understood healthcare standard. Thus, a healthcare organization's reputation for its commitment to quality and patient-centered customer service stands as the main criteria for individuals in choosing a healthcare service provider. "Therefore, measurement of patient satisfaction and incorporating results to create a culture where service is deemed important should be a strategic goal for all healthcare organizations".

Over the past several years, the issue of quality improvement has gained increasing attention from executives across the healthcare industry. As a result, industry leaders have been focusing their attention on improving patient/customer satisfaction through various initiatives. However, despite their many efforts and successes, evidence shows that more work in this area is still needed. One of the primary challenges has been in sustaining enthusiasm for and focusing on quality improvement projects in view of "competing priorities, shrinking resources, and an increasingly frustrated patient and employee /physician population". This seemingly national trend is apparent throughout the healthcare sector at the local level.

The key areas that determine the quality of services provided at a healthcare facility are:

- Clinical professionals
- Support personals
- Equipment
- Patients
- Environment of care

QUALITY IMPROVEMENT:

Before attempting to evaluate quality intervention, we need to know what the quality is. How we define quality improvement will help us structure an evaluation process that provides adequate measurements of the variables that contribute to a patient's level of satisfaction.

Although most patients are generally satisfied with their service experience, they may not be uniformly satisfied with all aspects of the care they receive. There is the challenge to management how much service is enough to elicit high satisfaction and keep them coming back?

Over the years there have been various definitions of quality improvement. Patient satisfaction is positive evaluations of distinct dimensions of the health care. (The care being evaluated might be a single clinic visit, treatment throughout an illness episode, a particular health care setting or plan, or the health care system in general.) The satisfaction must be understood within the context in which a variety of elements may be more or less satisfying to the patient. There are 10 elements that can be used to determine satisfaction:

1. Accessibility/convenience
2. Availability of resources
3. Continuity of care
4. Efficacy/outcomes of care
5. Finances
6. Humaneness

7. Information gathering
8. Information giving
9. Pleasantness of surroundings
10. Quality / competence

By knowing where strengths and weaknesses are, physicians, hospitals and other healthcare facilities can converge their efforts in positive areas to improve the quality of care and patient satisfaction.

SIGNIFICANCE OF QUALITY IMPROVEMENT:

The issue of quality improvement has gained increasing attention from executives across the healthcare industry. The measurement of quality improvement through patient satisfaction surveys has helped organizational leaders incorporate patient perspectives as a way to create a culture where service is deemed an important strategic goal for healthcare facilities. However, despite their many efforts and successes with satisfaction measurement, evidence shows that more work in this area is still needed. One of the primary challenges has been in sustaining quality improvement initiatives in the face of competing priorities and diminishing resources. There are ten key drivers of patient satisfaction identified to correlate most highly to a patient's overall satisfaction with an organization.

The modern approach to healthcare seeks to engage the attention of both patients and public in developing healthcare services and equity of access, but this is not easy to achieve, requiring time, commitment, political support and cultural change to overcome barriers to change. Improvement in selected aspects of health care delivery through quality assurance and outcome assessment has been driven by political expediency. While this is important, a 'bottom up' assessment of patient satisfaction seems preferable if service improvement is to be translated into improved quality of life.

Patients' satisfaction is related to the extent to which general health care needs and condition-specific needs are met. Evaluating to what extent patients are satisfied with health services is clinically relevant, as satisfied patients are more likely to comply with treatment and take an active role in their own care.

In addition, health professionals may benefit from quality surveys that identify potential areas for service improvement and health expenditure may be optimized through patient-guided planning and evaluation. Critics draw attention to the lack of a standard approach to measuring satisfaction and of comparative studies and so the significance of the results of surveys is often ignored. There is less controversy with respect to clinical outcome measures, as health-related quality of life is not only widely regarded as a robust measure of outcome but also is extensively used in several clinical areas.

PHYSICIAN'S ROLE AND BEHAVIOR:

Parsons has perhaps dealt more specially with the theoretical aspects of the Physicians role than any other social scientist. He defined it in terms of high technical competences, emotional neutrality, and orientation, to the collectivity i.e., to the others. Many Physicians are unable to meet patient needs at personal level because their training necessitates against their accepting a shift in responsibility from "healer" to "consoler role".

NURSES BEHAVIOR:

Edward while discussing about motivated nurses says that the nineteenth century angel of mercy has today been replaced by seemingly less angelic and considerably more mercenary counterpart, the increased technical skill has come to be an apparent lessening of sensitivity to doctors and hospitals they have lost their identity and status as a profession.

Ray attributes nurse failure to recognize psychological needs of patients to:

- Lack of adequate time.
- Inadequate knowledge and sensitiveness on the part of the nurses regarding patient care.
- Inadequate delegation of duties and responsibilities
- Nursing training stressing more on technical and academic aspects which hardens her to be a professional.

QUALITY IN HEALTHCARE:

The rapidly expanding scope of healthcare has led to increasing complexity in its delivery. Patient satisfaction is increasingly taken as an important measure of quality. The expectations of the people towards medical care are ever increasing and are limited not only to the clinical outcomes but also involve the delivery process, margin of safety and behavior of personnel. There is increasing willingness to provide protection against illnesses by way of healthcare insurance. This has made it pertinent that management of quality is done on a wider basis than mere medical audits.

There is need to use the principles of quality assurance systems covering all activities of the healthcare unit. Variations in the types of healthcare make it necessary that some form of grading is incorporated in assessment process in the ability to deliver the promised care.

Some of the reasons for the implementation of a formal quality system are:

1. Increased demands for cost effective and appropriate care.
2. Need for standardization.
3. Defining patient's needs and expectations.

Implementing quality system controls the cost by:

a. Reducing unnecessary interventions.

b. Getting it right first time e.g. cost of repeat surgery in angioplasties, revisions of hip replacements and unsuccessful key-hole surgery.

c. Avoidable complications e.g. post-operative infections.

d. Imbalances of resources: Lack of theatre time or lack of access to diagnostic facilities leading to increased length of stay.

e. Employee turnover and consequent training costs.

Quality system preconditions that 'good enough' should not be good enough.

Quality management should not remain a matter of opinion:

- Important to measure patient satisfaction and make it known to those involved in the process.

- Processes should be designed to sustain and cover the clinical activities with quality being central. Quality organization is not something you buy; it's something you grow: It is a continuous process and requires a change in attitude through out the organization.

Quality professionals across all segments of healthcare use resources to improve:

1. Quality of care.
2. Patient safety and satisfaction.
3. Organizational efficiencies.
4. The bottom line.

TYPES OF QUALITY:

Indifferent Quality, by performing at this level you is doing the absolute minimum to deliver the service on offer. Customers may get what they want, but it will have taken them a lot longer than they envisaged together with a series of chasing calls and possibly a complaint or two. Customer's expectations are missed by some distance and they will be dissatisfied.

Expected Quality, at this level of delivery customers will get what they expect, but there may be deficiencies against what they really want. They would not have been as aggressive as that experienced at the basic level of quality, but they will be left feeling something is missing. Customers expectations are met, but some of their needs will remain unfulfilled. They will give a 'neutral' satisfaction score.

Desired Quality, It is at level of service delivery that customers find that their needs from a service provider are being met. Customers are receiving an enhanced level of service, which will be greater than their expectations. These customers are receiving a service, which matches their needs and expectations. They will give a good satisfaction score.

Exciting Quality, at the best quality level, the supplier/customer relationship becomes interlocked. In order to delivery this level of service the supplier must understand the customers business needs and create special packages tailored to those specifics. The customer in turn will have faith in the supplier and will reward the relationship with continued loyalty and 'high' satisfaction scores.

THE DIMENSIONS OF QUALITY

Various dimensions of quality that need to be addressed are effectiveness, efficiency, technical competence, safety, accessibility, interpersonal relations, continuity, amenities. Healthcare quality does not mean that care is given by the most learned and highly experienced professors of medicine. But that the system is devised in such a way that in any situation most ordinary yet adequately trained doctor can deliver appropriate treatment to the needy patient. Quality is therefore based on the principles of cost saving. Quality calls for the principles of elimination of waste, elimination of re-work and elimination of duplication. Implementing quality in healthcare therefore means that the provision of training in quality methodologies, securing monitoring capabilities, measuring performance and improvement accomplishments and collection of necessary data for documentation of status and level of care.

To implement the Yashoda scheme in Haryana state, NRHM Haryana signed a Memorandum of Understanding with NIPI, UNOPS. The Norway - India Partnership Initiative (NIPI) is an outcome of a commitment by the Prime Ministers of Norway and India to reduce child mortality and improve child health with a view to attaining the Millennium Development Goal (MDG) 4 by 2015. This report is only a continuation of previous assessment of NIPI intervention in Rajasthan and Orrisa states. This report aims to assess Yashoda activities within a *continuum of care* approach focusing on the maternal & child care as well as the hospital staff side, and to strengthen Yashoda scheme to provide quality care in Haryana state.

LITERATURE REVIEW

In India, conditional cash transfer schemes under the National Rural Health Mission (NRHM) like the Janani Suraksha Yojana (JSY) have succeeded in increasing the number of institutional deliveries. However, these have not adequately addressed the quality of care and counseling needs of mother and infants within the facility. The doctors and nurses routine caregivers in a facility are often unable and not equipped to provide emotional support to mothers and non medical support for newborns. Besides, vacancies in the health sector necessitate the optimal use of specialized skills of workforce like doctors and nurses. Global policies encourage rational re-allocation of less specialized nevertheless important tasks to less-trained cadres of health workforce.

International evidence points towards the usefulness of birth companions who provide support to women during childbirth, ranging from psychosocial support to assistance with information and procedures. Birth companions were traditionally community women or family members who comforted and supported a woman emotionally as she went through the extremely stressful experience of childbirth. However, with technical advancements in modern medicine and stress on facility-based births with skilled birth assistance, the role of traditional birth companions was gradually sidelined. But research since the 1970s has proven the presence of a birth companion as being extremely beneficial in easing the trauma of childbirth for the woman and in helping her cope with her experience. The lack of emotional support or empathy by birth attendants can in fact make the whole process of childbirth a dissatisfying and painful experience for the mother. Birth companionship is now accepted as a low-cost intervention beneficial to labor outcomes, giving birth companions a renewed acceptance in the modern scenario as well. The professional birth companion or 'Doula' emerged consequently in the Americas. They are paid companions who accompany mothers during delivery and provide her the necessary support, guidance, information and encouragement.

Besides providing emotional support, birth companions help improve patient-provider communication, assist the mother in getting the requisite delivery care, advice regarding coping techniques, comfort measures (comforting touch, massages, promoting adequate fluid intake and output) and advocacy. There is a possibility of the role of birth companions clashing with those of obstetric nurses, but this could be minimized by ensuring that their roles are complementary and not conflicting. Birth companionship was found to be positively associated with reduced length of labor and improved maternal-infant interaction. A Cochrane review of sixteen trials involving female birth companions found that women who had continuous intra-partum support were likely to have a slightly shorter labor, were more likely to have a spontaneous vaginal birth and less likely to have intra-partum analgesia or to report dissatisfaction with their childbirth experiences. Birth companions' presence is also likely to lead to fewer newborn complications.

In India, the Government of Tamil Nadu initiated a "birth companion" scheme in 2004 in all public hospitals in the state, under which women getting admitted to facilities could nominate a female family member to be their birth companion. The companion should be aware of the labor process and should stay with the mother without interfering in the medical procedures. One of

the positive effects of the intervention was observed in a study on maternal care in Tamil Nadu which showed that the presence of a birth companion in the labour room may have reduced the likelihood of abuse by providers of women in labour. Most women agreed that a birth companion would not only support the woman in labour but could also act as her advocate and demand better quality of services on her behalf.

The Yashoda program: This program is designed such that local volunteers from the community assist mothers with their post-natal requirements and provide support for the newborn care in the maternity and post-natal wards of District Hospitals (DH). NIPI envisages Yashodas to provide the following support:

1. Receiving and supporting the pregnant woman at the facility.
2. Counseling the mother on immediate and exclusive breast feeding, nutrition for self and newborn, immunization and family planning choice and informing on accessing child health services after leaving hospital.
3. Ensures overall cleanliness of the beds and ward including toilets; ensures dignity and privacy of mother by avoiding crowding around the bed.
4. Gets the attention of the doctor or nurse if the baby is found sick.
5. Keeps records of all mothers and children born.

Goals and Objectives

The current study is an implementation research project, taken up by the NRHM Haryana. The general objective of the study is two-fold:

1) To understand the functioning of facility based Yashoda initiative

2) To identify key obstacles/problems if any in the effective implementation of these initiatives so as to provide recommendations to improve the program.

The specific objectives of the report are to:

Understand perspectives of communities that are being targeted under the NRHM interventions on childcare and birthing practices

Assess the facility based Yashoda program and its effect on maternal and newborn care

Assess the roles, responsibilities and value addition of various techno-managerial personnel for providing support for the program.

Identify obstacles and suggest recommendations for augmenting and scaling up existing initiatives to improve child and related maternal health

Currently, evidence from India on establishing a facility based health worker for maternal and child health care is limited. Hence, the innovative Yashoda programme under NIPI provides an opportunity to assess their additional value and an assessment of the same would provide valuable information to NIPI and to the state government.

CHAPTER: 2. RESEARCH METHODOLOGY

This study was conducted from January 2012 to April 2012 in Haryana. At the start of this study, Yashoda was functional in few districts in Haryana state. Thus, for the study, one intervention districts where Yashoda was functional and one comparable non-Yasoada districts in Haryana state was chosen. The intervention district was Gurgaon and non Yashoda control district was Panchkula. As part of the quasi-experimental design, mixed methods of data collection--qualitative and quantitative --were used to collect relevant data from both the side health care providers, administrators & community. Data was collected to understand the administrative side perspective of Yashoda through in-depth interviews, observation studies of providers and administrators including the techno managerial staff placed by NRHM. Interviews of the Yashodas and a facility based survey of mothers were also conducted.

To understand the benefits of the Yashoda program, a community survey of women who were about to discharge after delivery preceding the survey was done between February to April 2012. The sample size was 136 mothers. The analysis focused on comparison of important maternal and newborn care indicators between intervention and control groups.(Age, parity, income).

Research design and selection of study area

To assess the additional benefits of Yashoda interventions the study used a quasi-experimental design, wherein the intervention district (where Yashoda is functional) was compared to a non-Yashoda district (control district). The differences between the intervention district and control district in processes and in intermediate outcomes related to maternal and child health are assessed at the facility level and the community level.

Research design of the project

At the start of the study, Yashoda interventions were operational in most of the districts of Haryana. Thus, for this study, one intervention districts out of the 21 were chosen. The choice of the intervention districts for this study was done on the basis of the implementation status of Yashoda. Gurgaon was chosen since NIPI interventions.

The choice of the control district was done based on a comparison of various socioeconomic and epidemiological indicators across districts within a state. The main indicators that were used for comparison included population density, economic profile, literacy rates and health indicators relevant to maternal and child health such as Ante Natal Care (ANC), immunization rates, rates of institutional delivery. These were obtained from District Level Household Survey (DLHS) III, Census data, and supplemented using state-level Heath Management Information Systems (HMIS) data. The control district was Panchkula.

The assessment study looked at the Yashoda program's norms of appointment, operational issues in implementing the model viz., recruitment, training, supervision, integration of Yashoda in to existing NRHM model and the benefits of having such a cadre of workers from a provider and mother's perspective.

The study methods were a combination of both qualitative and quantitative techniques. Qualitative tools used in focused on largely programmatic and implementation perspectives, while the quantitative survey in aimed to measure benefits of the Yashoda interventions through a community survey of recently delivered women. Review of various government and NIPI documents combined with literature review of birth companions and FBNC programs was carried out, which facilitated the development of quantitative survey and qualitative tools (In-depth Interviews (IDIs) and Focus Group Discussions (FGDs)) for data collection.

Study Timeline: The study began in January 2012 with literature review. This was followed by development of the questionnaire & data collection tools. The data collection was done from February to March 2012, and the field data collection was also conducted between Feb-March 2012, followed by data analysis in April 2012. The report writing was completed in April 2012.
Informed consents were obtained from study participants and to ensure confidentially during data collection and management identification of respondents were not recorded. The access to data (both in soft and hard copy) is limited to study person.

In depth interview with various health care providers and health administrators helped in collection of information regarding the additional benefits of Yashoda intervention. In addition, they also focused on identifying road blocks and issues related to the successful implementation of the Yashoda program. Interviews and group discussions with mothers were also conducted to understand the community level perspective.
An observation study of the hospital ward focused on documenting the tasks done by Yashodas and other staff at the DH during the pre-delivery, delivery and post delivery periods. Facility surveys among mothers focused on their delivery experiences at the facility. The surveys done among Yashodas collected information related to their knowledge, training, and tasks performed by them.

The primary indicators for which data was collected in the questionnaire for the Yashoda program included initiation of breastfeeding within 1-5 hours after delivery, weighing of the baby, immunization (Polio + BCG), counseling on exclusive breast feeding, family planning, nutrition, danger signs cleanliness and length of stay at facility after delivery.
Explanatory variables included in the questionnaire were indicators of demographic and socio-economic status and maternal and child outcomes. Details of pregnancy history and birth experience were also collected, including antenatal, intra-natal and postnatal care, quality of care (cleanliness, availability of toilet & drinking water), trust and emotional support, cost of care and awareness and receipt of Janani Suraksha Yojana (JSY).

Data collection, checks and analysis

The hospital survey of recently delivered women was conducted during Feb-March 2012. Data collection, entry and tabulation were done afterwards. It was ensured that all responders be comfort during interview. To see the effect of gender on newborn care, four key indicators – length of stay in facility, initiation of breast feeding, immunization at the facility and referral were analyzed by sex of the newborn.

3.3 Limitations

The following limitations can be identified for the study methodology and field data collection:

Implementation research design does not enable collection of baseline information on the selected indicators. This affects the selection of a true control sample and thus potentially resulting in biased findings. However, this was partially addressed through the use of DLHS data to compare maternal and newborn care indicators across all districts of the study states and selecting a control that most matched the intervention district.

Final sample size was slightly less than the estimated required sample size for the study. The analysis on mothers who had a cesarean section delivery was limited due to small sample size, unlike expected, the number of c-section were not very high at district hospitals. Thus benefits of Yashoda for this subgroup could not be analyzed completely.

There is a possibility of recall bias among women regarding Yashoda, as many times they were not able to differentiate the Yashoda from the staff nurses.

In Panchkula district, the sample was largely from urban areas as the DH in Gurgaon served the large urban as well as rural population surrounding it. Exposure and awareness levels of women in urban areas are quite different from women in rural areas, and could thereby affect their responses.

Certain sections of the questionnaire, such as relating to sexual intercourse or family planning, could not be spot-checked as respondents were not comfortable answering such questions.

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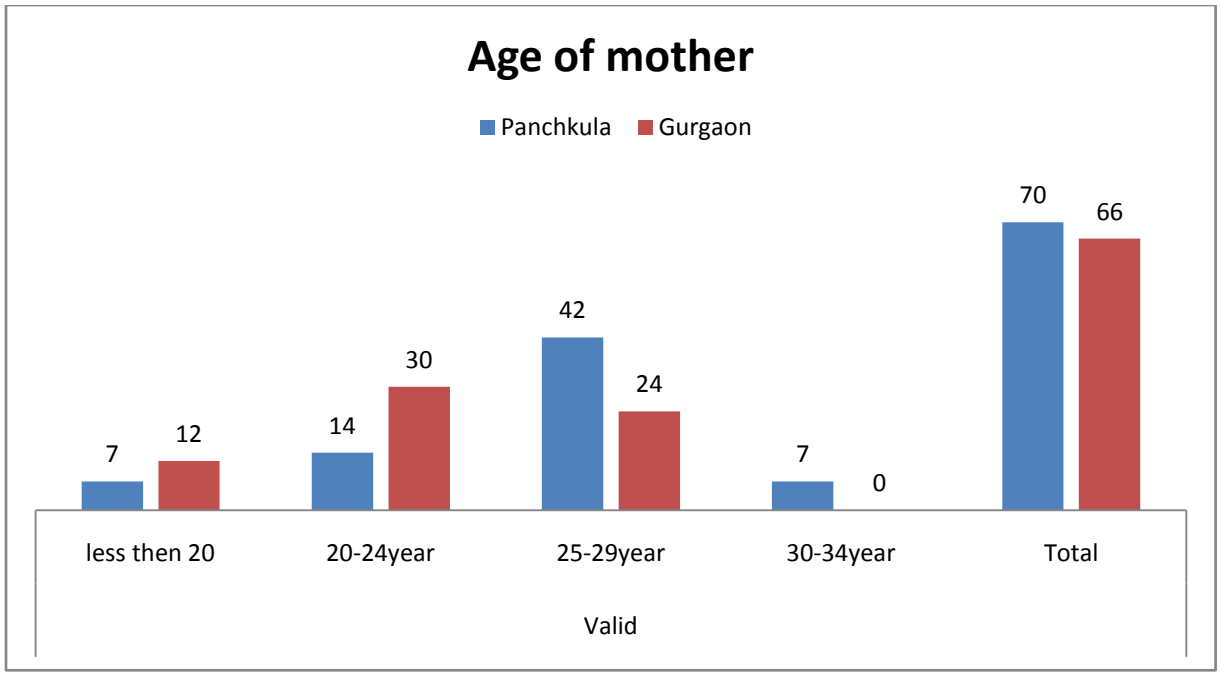
3. This was not an evaluation study, therefore did not measure impact of Yashoda interventions on neonatal mortality outcomes. Interpretation of the findings from this study thus should be limited to impact on counseling and practice indicators and not on neonatal mortality outcomes.

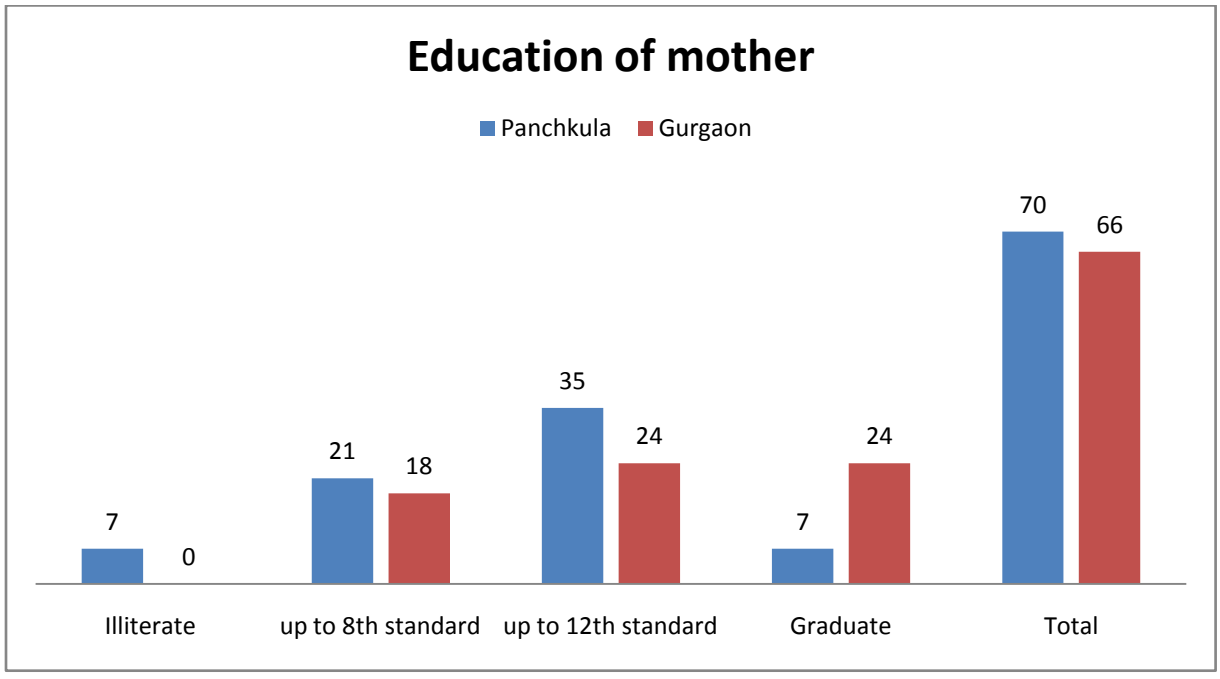
CHAPTER: 3. RESULTS & FINDINGS

Yashoda Program

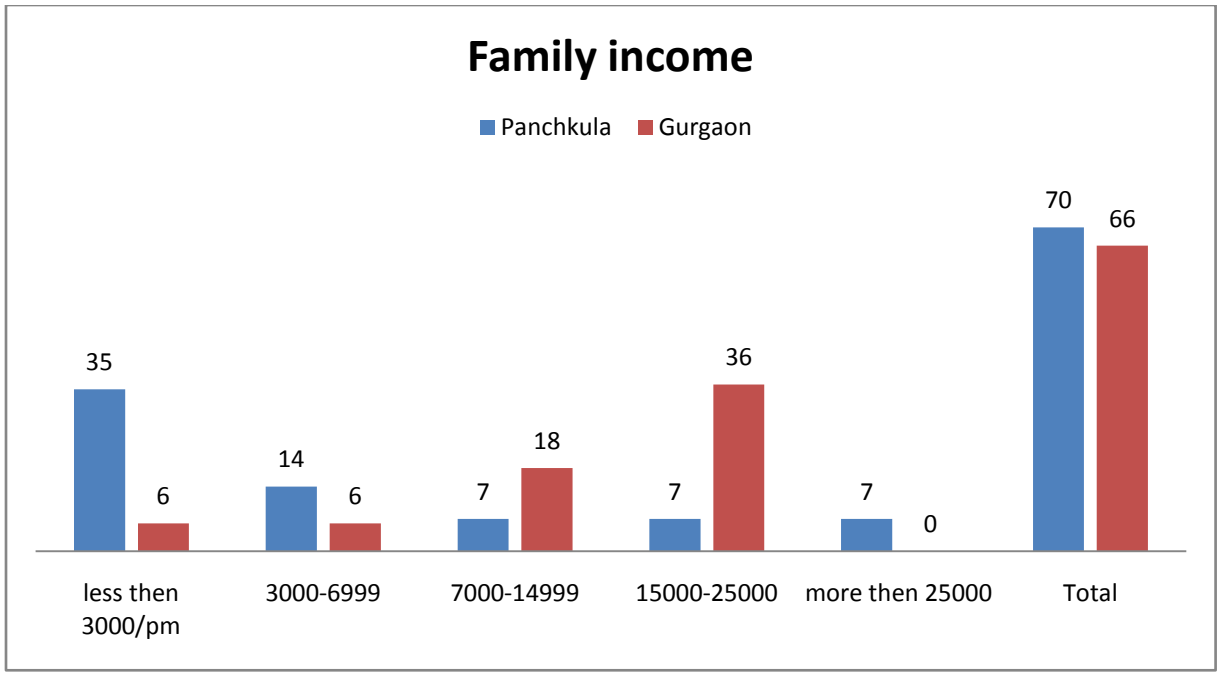
The study showed that the Yashoda program is functional at the district hospital (DH) in Haryana. The profile of Yashodas (in terms of age and educational status) at the two study districts matched the NIPI guidelines. Yashodas were positioned in the health facilities to be a mother's aide; however, there seemed to be push for Yashodas to become a nurse's aide. The current training also seemed to orient them more as a nurse's aide than a mother's aide in the facility. Yashodas spent majority of their time in the postnatal care (PNC) ward providing support to mother and newborn. Limited interactions with ASHAs were reported. Yashodas also highlighted the need for more frequent trainings. In terms of remuneration, Yashodas reported preference for a mixed system of remuneration (fixed amount plus incentive).



The community survey findings focused on the community perspective and supported some of findings. The maximum no. of mothers were from 25-29 year age group.

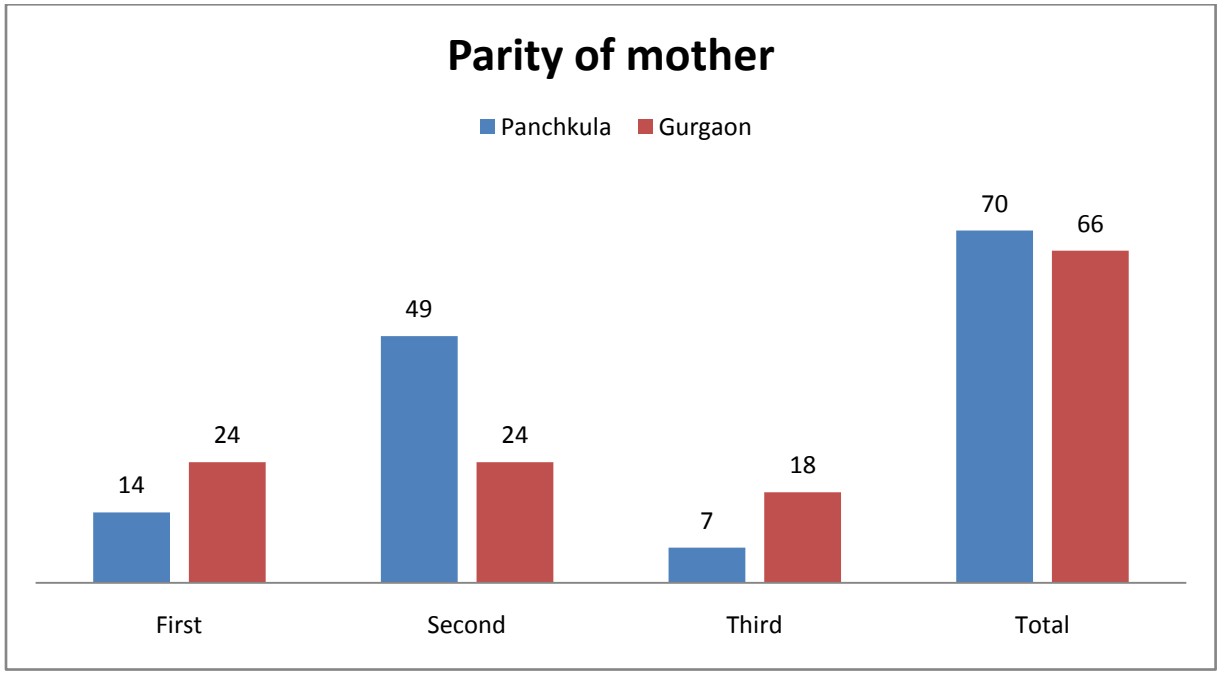


Most had senior secondary school education.

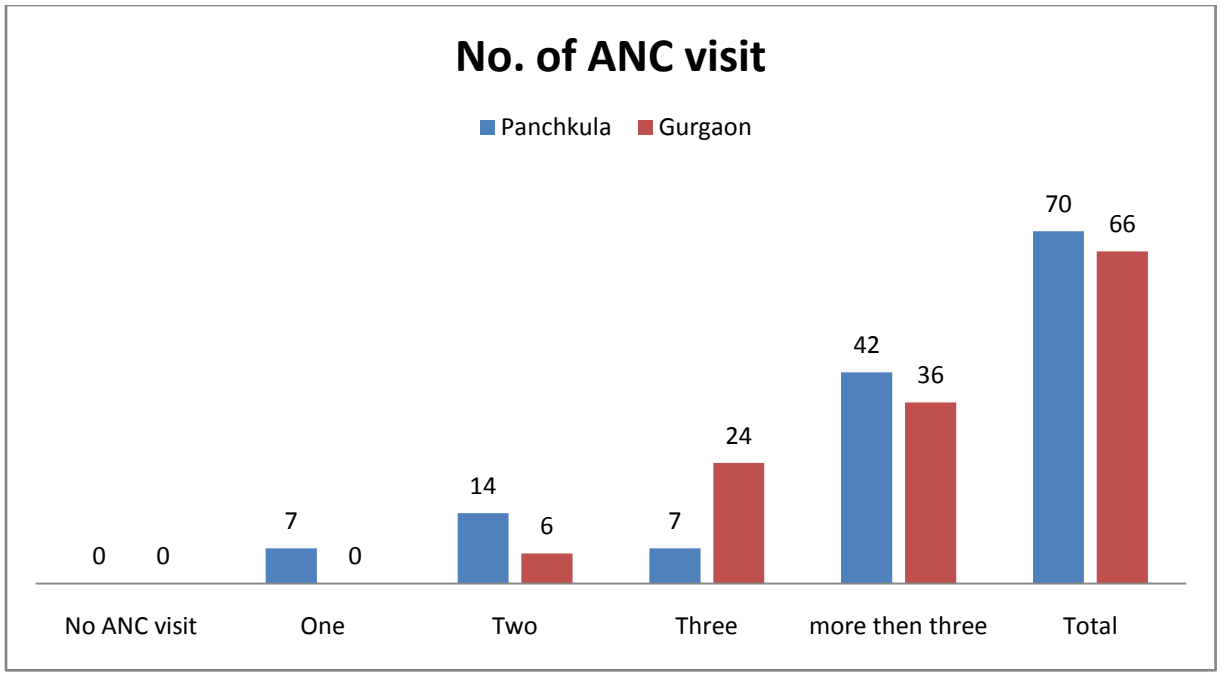


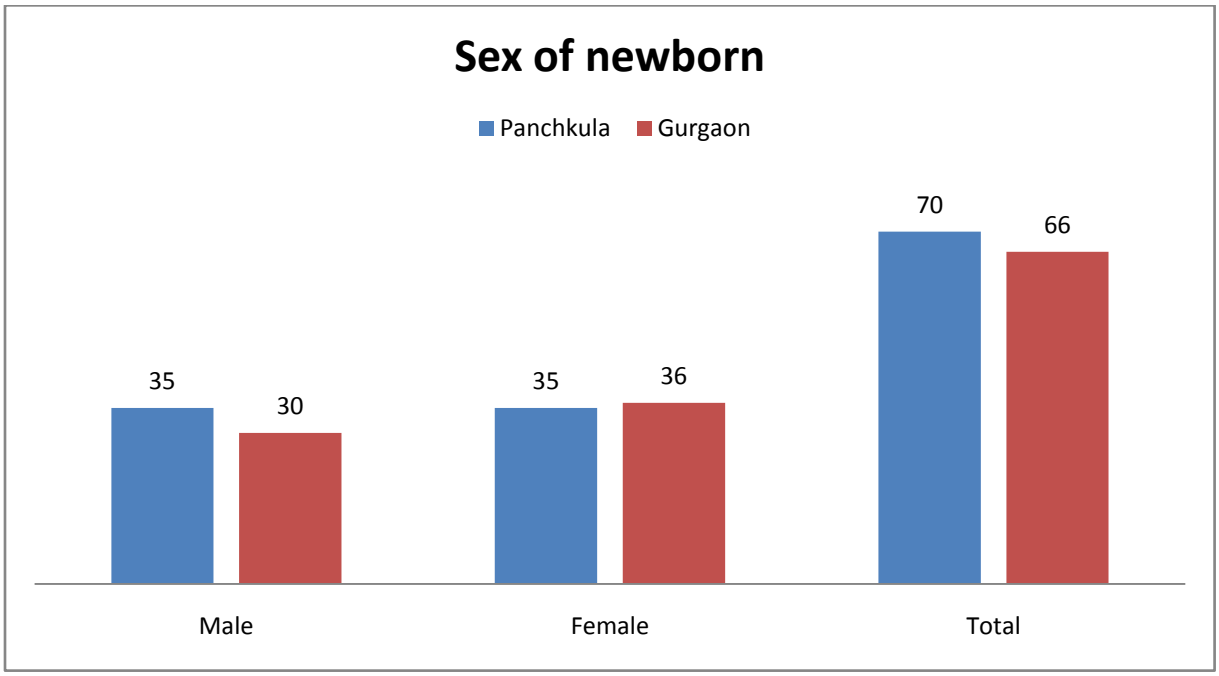
In Panchkula 50% mothers were from less than 3000 Rs/mt income group, but in Gurgaon 54% women were from 15000-25000 Rs/mt income group.

Maximum women in the sample were having second parity.

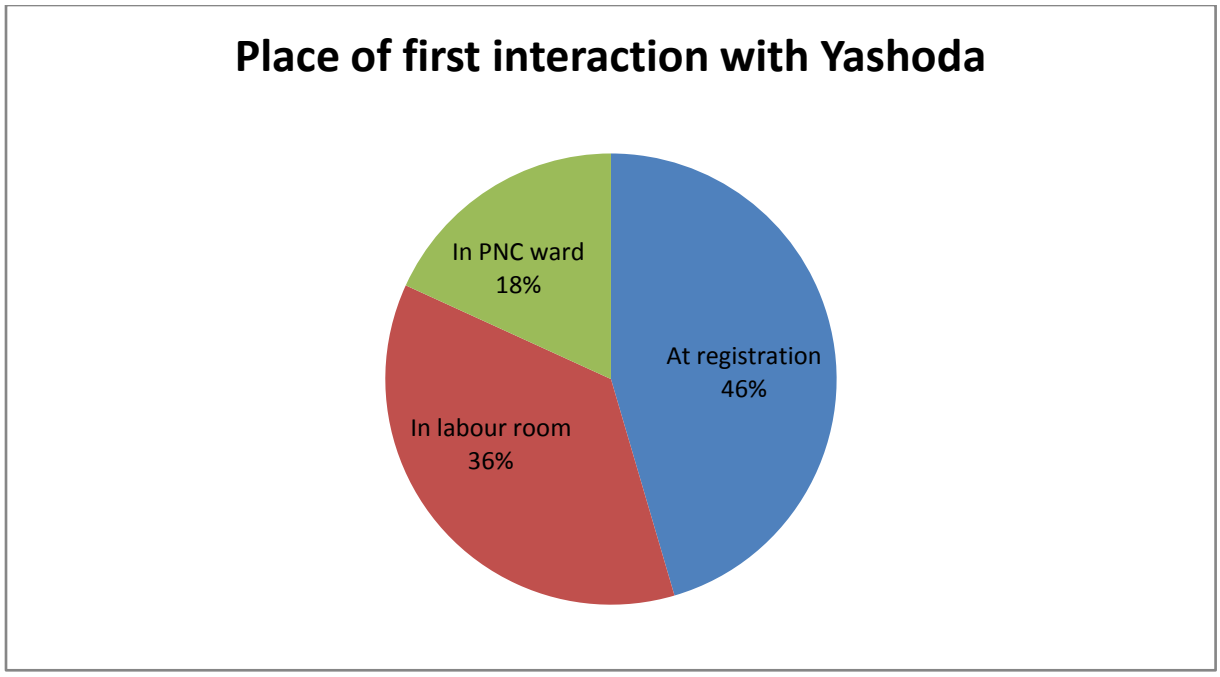


80% of respondents in Haryana reported receipt of three antenatal care (ANC) visits.

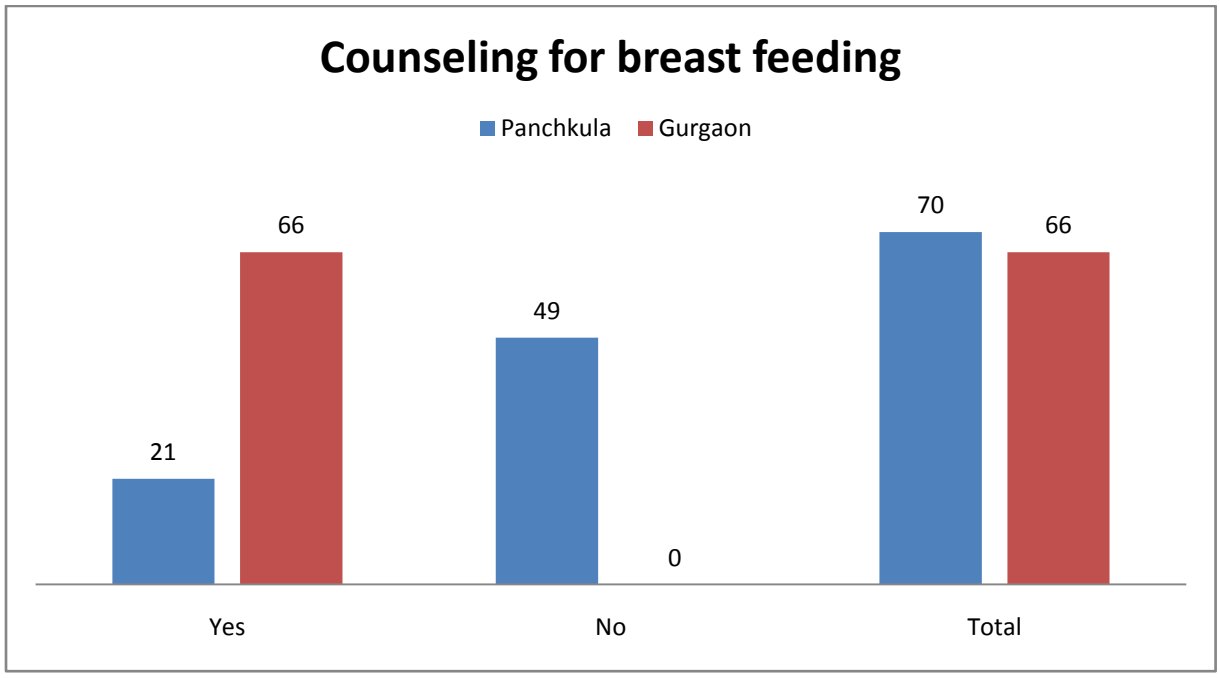


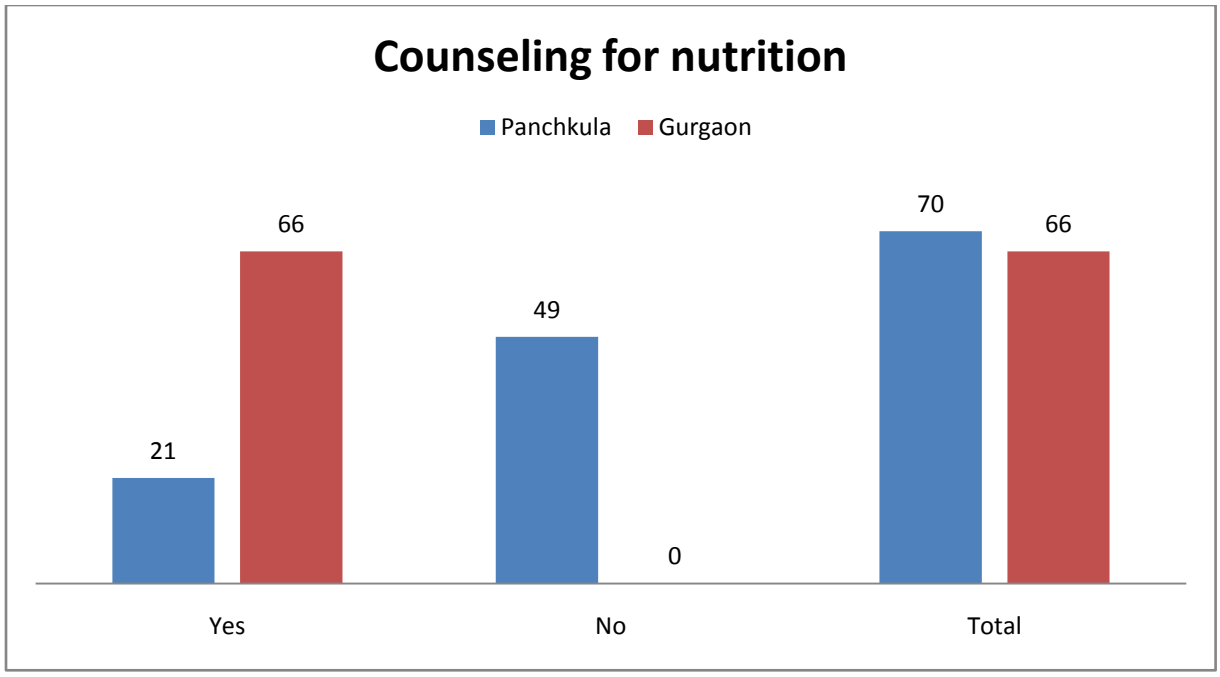


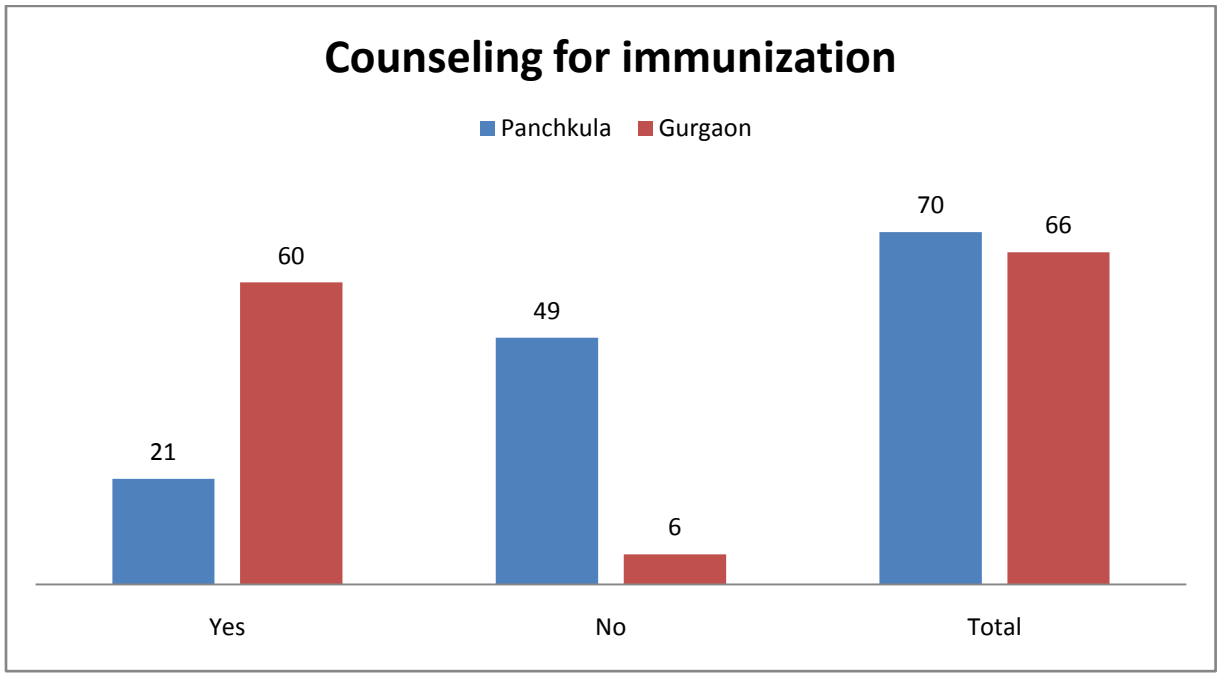
Sex ratio was 846 female newborns for 1000 male in 0-6 year age group for Haryana (as per 2011 census). However, no discrimination by gender was reported for length of stay in facility, initiation of breastfeeding, immunization at the facility and referral.



The survey findings showed that the maximum interaction of mothers with Yashodas happened during registration 46% reported being attended by Yashoda during registration. Very little interaction took place in PNC ward and during discharge from facilities.




Counseling for nutrition
Panchkula
Gurgaon
21
66
49
0
70
66
Yes
No
Total


Counseling for immunization
Panchkula
Gurgaon
21
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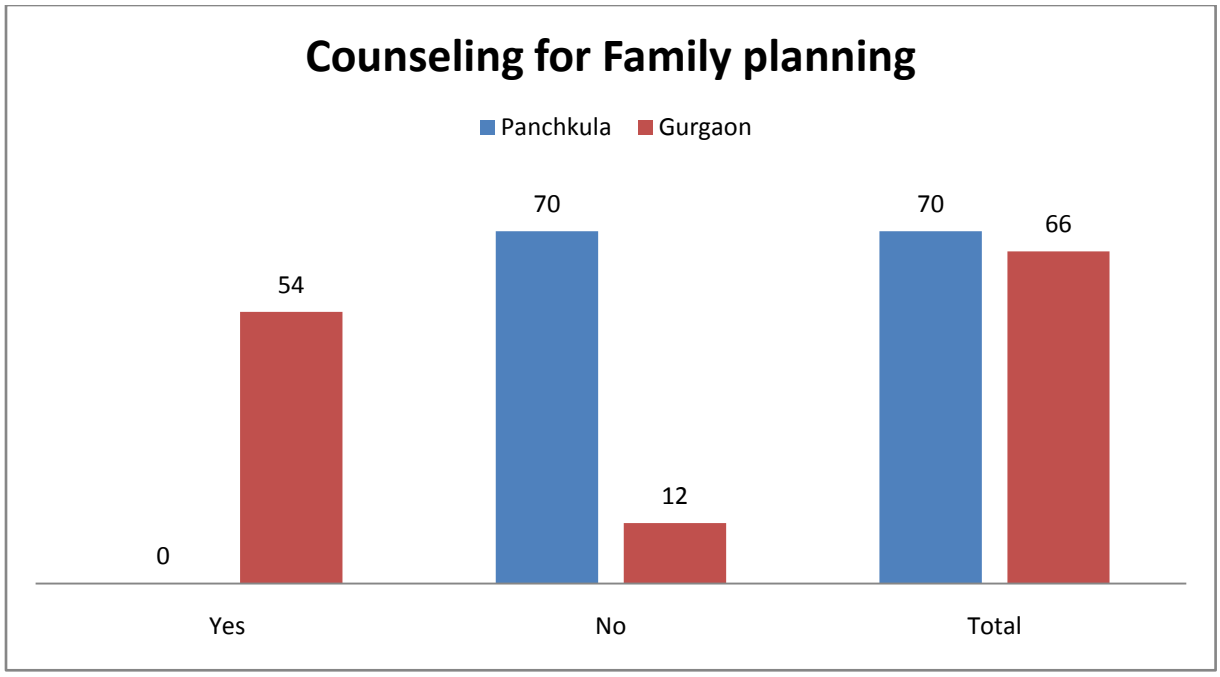


The study showed that a higher proportion of mothers in the intervention districts reported receiving counseling on immunization, breastfeeding, family planning and nutrition than those in control districts.

Some of the neonatal care indicators (initiation of breast feeding and immunization), were reported by more than 90% of mothers in both intervention and control districts and thus did not show significant differences between the districts. This perhaps reflects the impact of the National Rural Health Mission program in all districts of these states. However, the benefit of Yashoda program was most evident for initiation of breastfeeding among women.

Thus, the study found that Yashodas at the DH provided significant support to mothers and newborns during the postnatal period at the facilities-- mothers/families felt that the presence of Yashodas was beneficial to them and that they were more comfortable within the hospital environment in the presence of Yashoda than without a Yashoda. The support in terms of counseling, facilitating postnatal checks and support for initiation of breast feeding among women who had a caesarian section were evident and resulted in significantly higher levels of these outcomes.

Techno managerial support

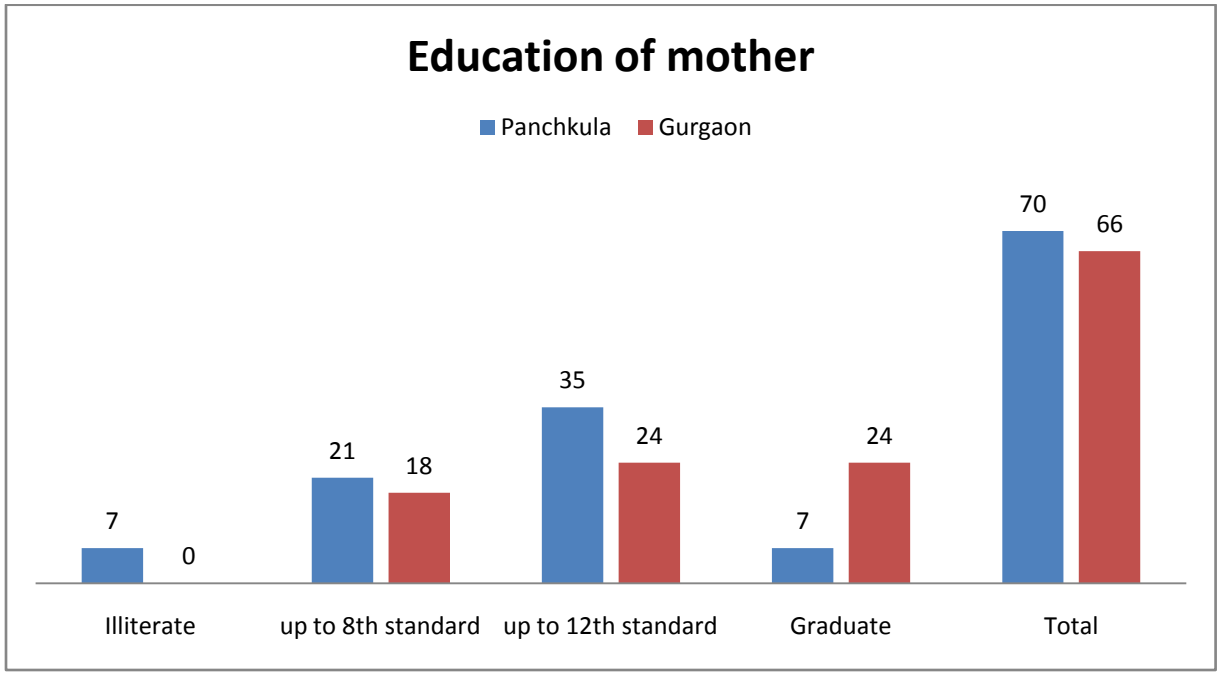
The techno managerial support envisaged by NIPI of coordinating and providing technical support for all maternal and child health issues in the districts. The Norway - India Partnership Initiative (NIPI) is an outcome of a commitment by the Prime Ministers of Norway and India to reduce child mortality and improve child health with a view to attaining the Millennium Development Goal (MDG) 4 by 2015.

Demographic, socio-economic profile & pregnancy history

Demographic and socio-economic characteristics of the respondents provide useful insight into the factors which influence population health, reproductive behaviors and some aspects of utilization of health facilities. This section describes the household and respondent characteristics of the sample, including background information on the current birth of the respondents. As mentioned earlier, the survey covered a total of 136 women, 66 in intervention and 70 in control districts respectively.

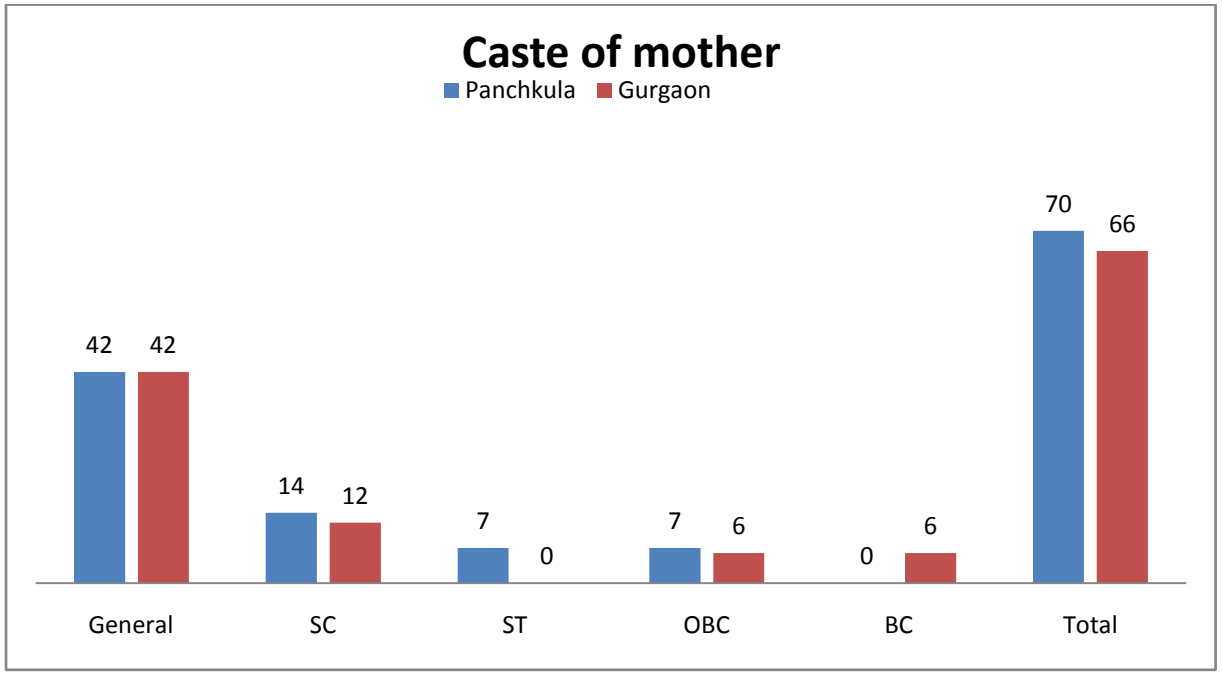
Demographic & social characteristics

Age structure: The age of the respondents ranged from 18 years to 40 years, with the median age being 23 years in Intervention group and 24 in Control group.



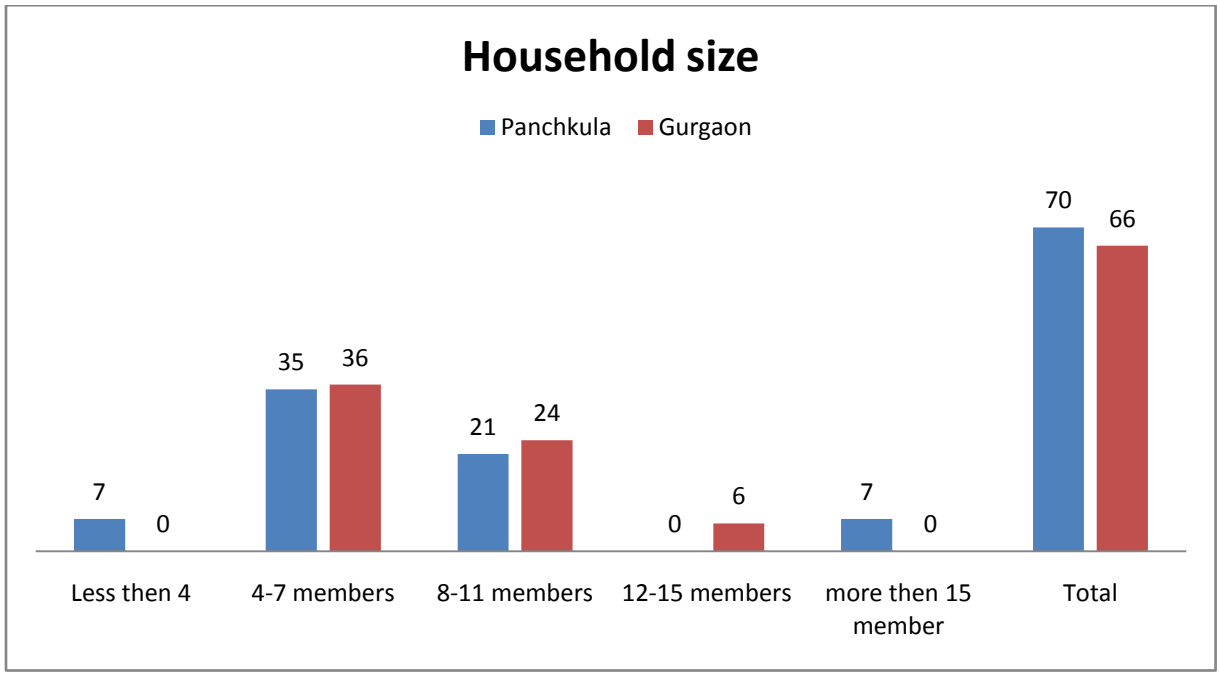
Education levels: Respondents on the whole had low levels of education. 5 percent respondents had no formal education while 29 percent had only basic education between first to eighth grades. Women in Panchkula had much lower levels of education. Women in Gurgaon had comparatively higher level of education, with about 36 percent women educated above basic level. Women on the whole were slightly better educated in intervention areas as compared to control areas.

Religion and Caste status: Hinduism was the dominant religion among the respondents, which is reflective of the religious composition of the overall population.



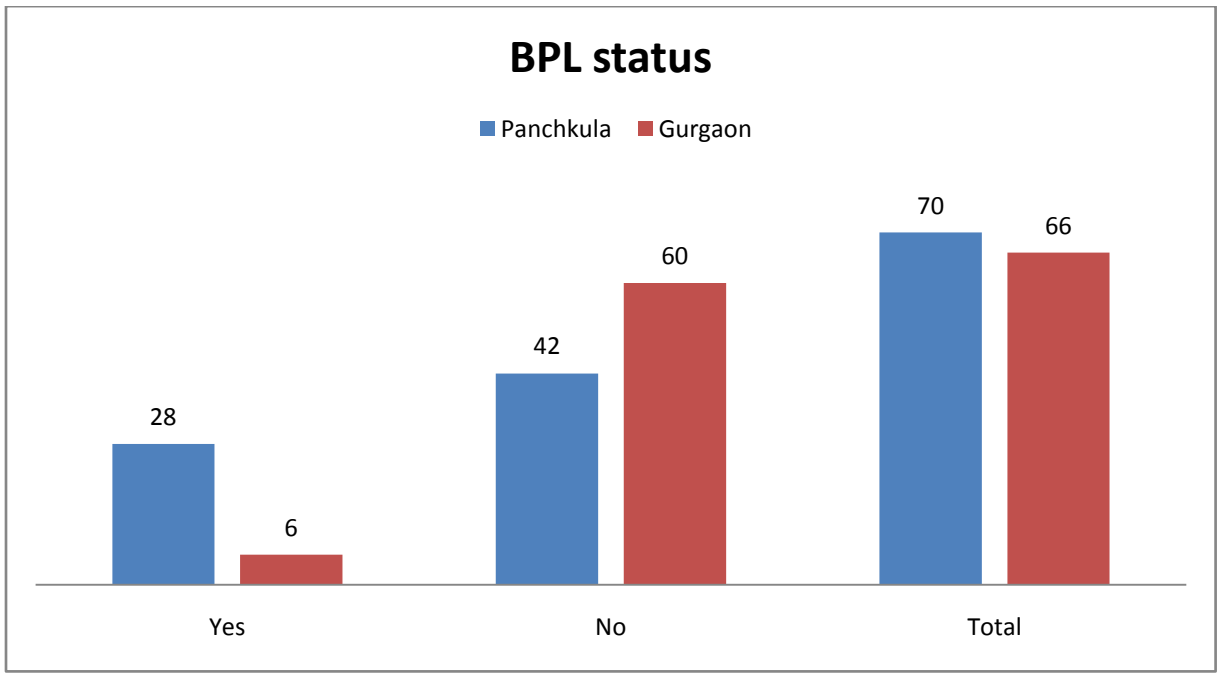
In terms of caste status proportions were similar in the intervention and control areas in both the states.

Household size:



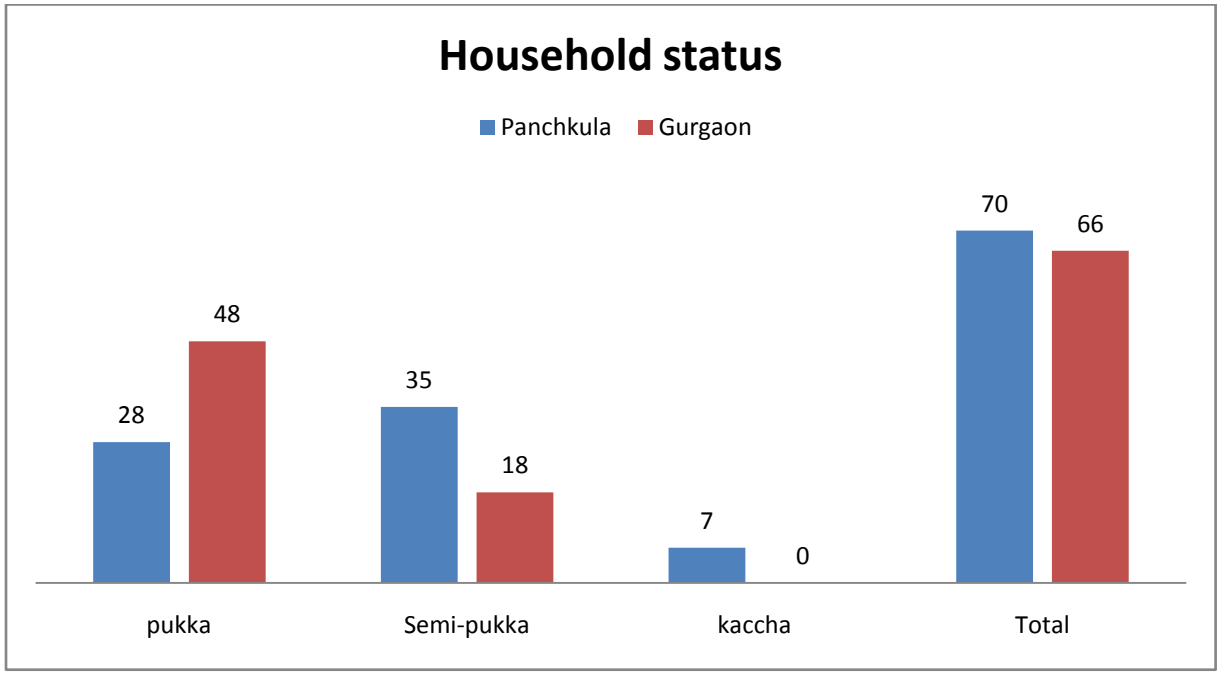
The household size of the respondents varied from 2 to 17 members, with majority (52 percent) ranging between 4-7 members.

Below Poverty Line (BPL) status:



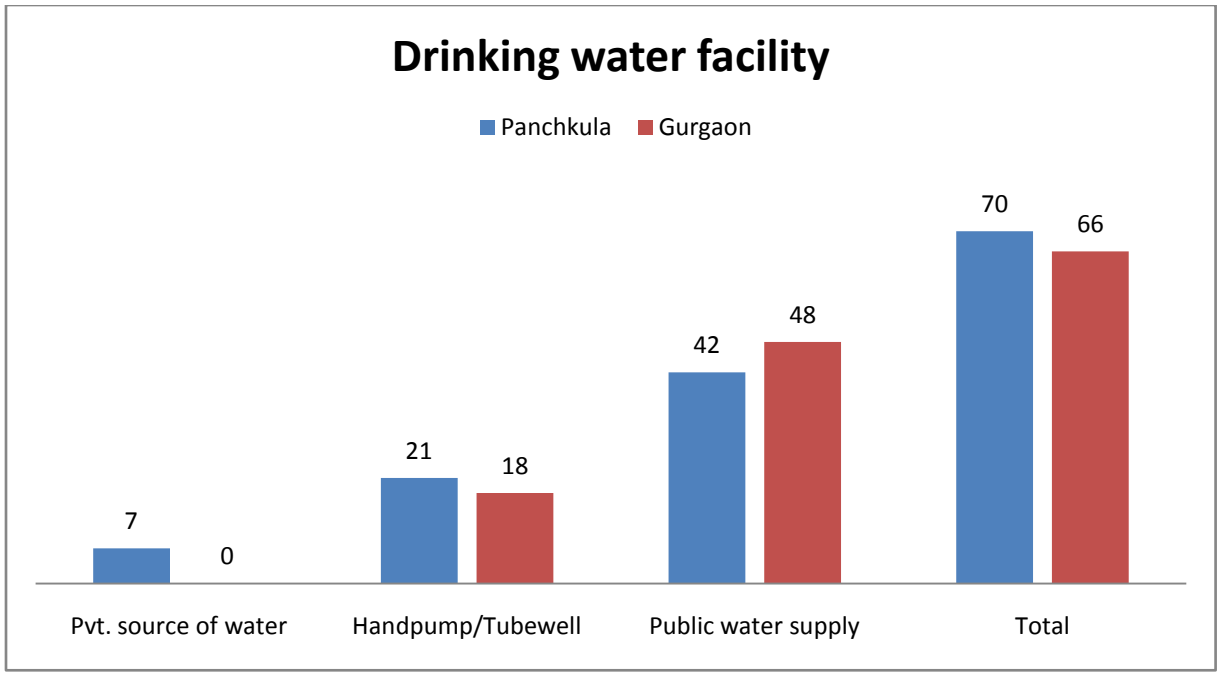
Possession of a 'Below Poverty Line' card in poor households enables them to access various social benefits and welfare entitlements. Among the respondents, one fourth had a BPL card

Household characteristics



House type and cooking space: More than half of the respondents lived in pucca houses, 39 percent in semi-pucca and a few in kaccha houses.

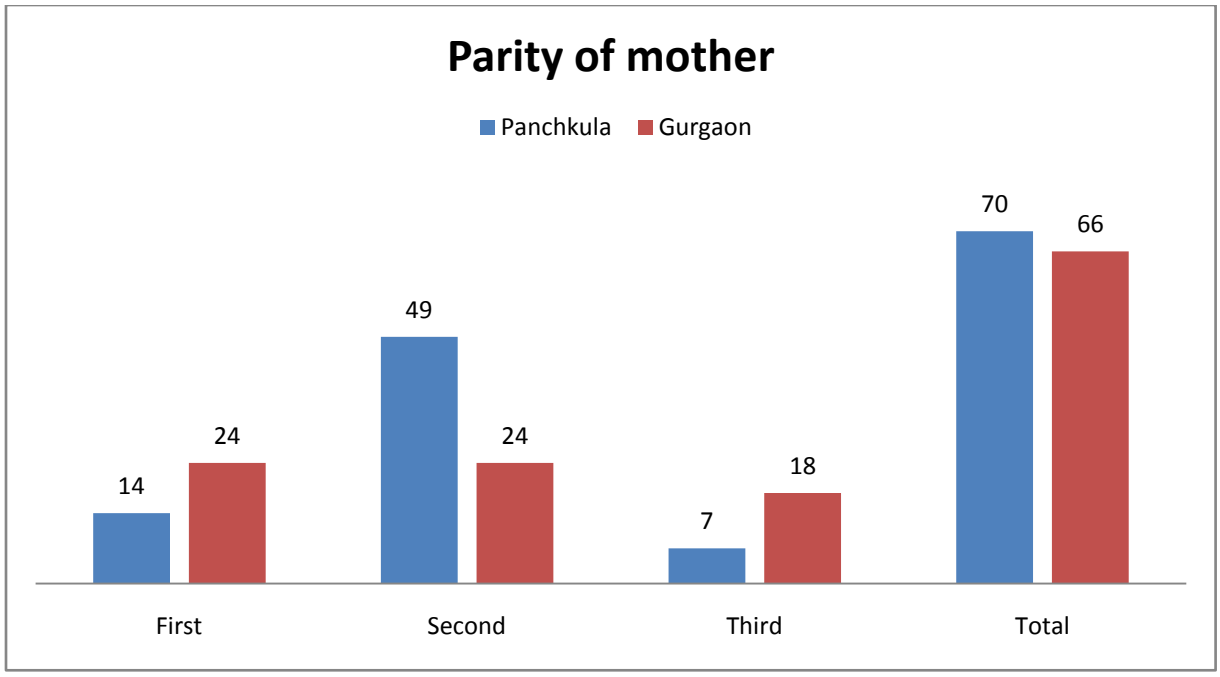
Drinking water and electricity:



About 66 percent of the total households were dependent on public source of water, either tap, hand pump or tube well. About 100 percent of the houses had electricity connections, the proportions being similar across intervention and control areas in both states.

Reproductive history of respondents

Some information on the parity of the respondents and details about their current birth was collected to understand their pregnancy history and maternal care seeking behavior. This helps explain many aspects of their overall reproductive behavior, perceptions on care and their choice of place of delivery.



Parity: Information on parity included the current birth of the respondents. The median parity level of the respondents was two**,** while about 28 percent had a parity of one.

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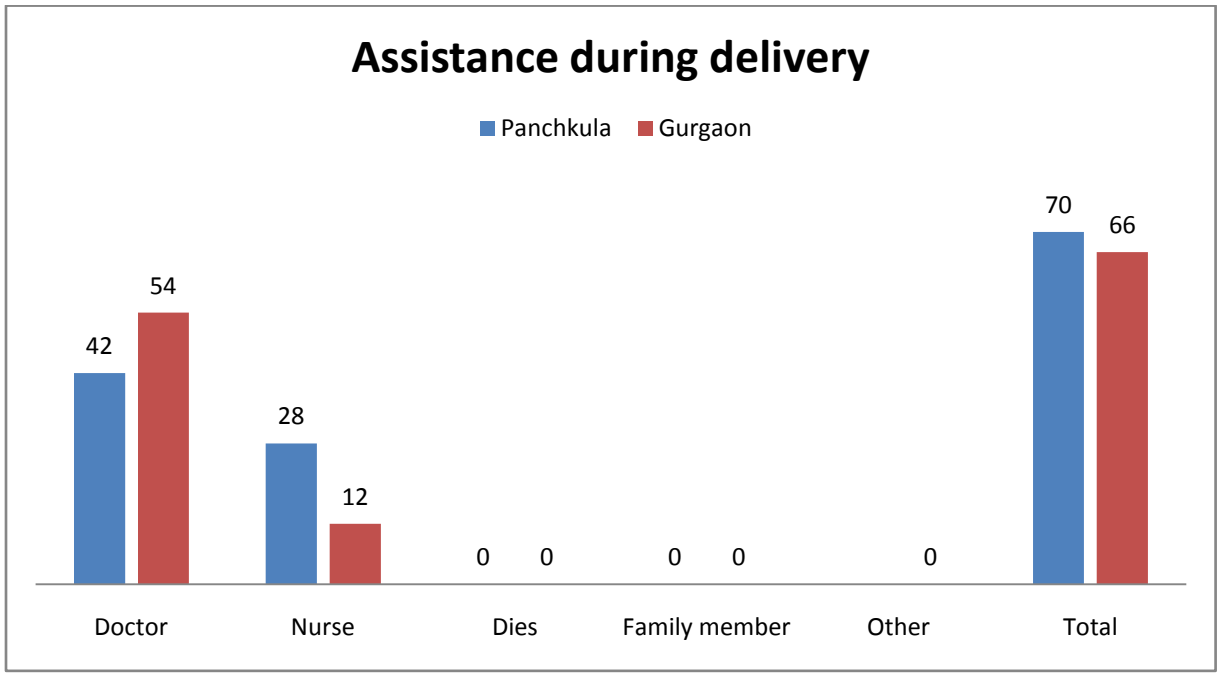
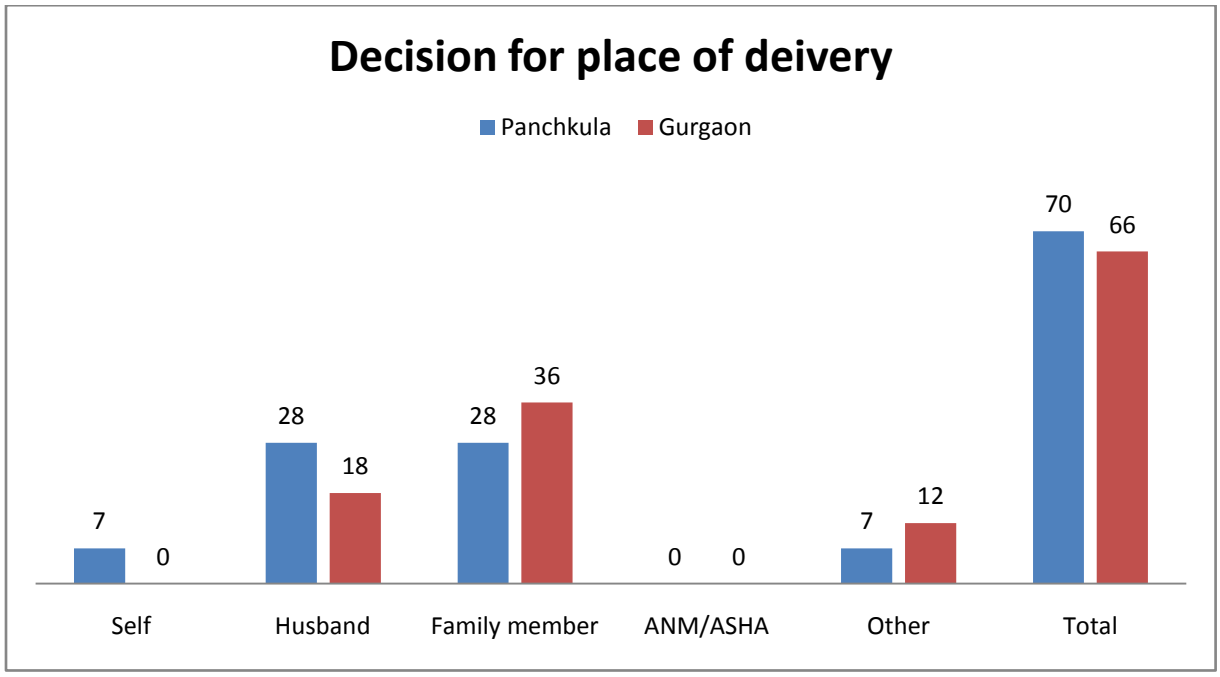
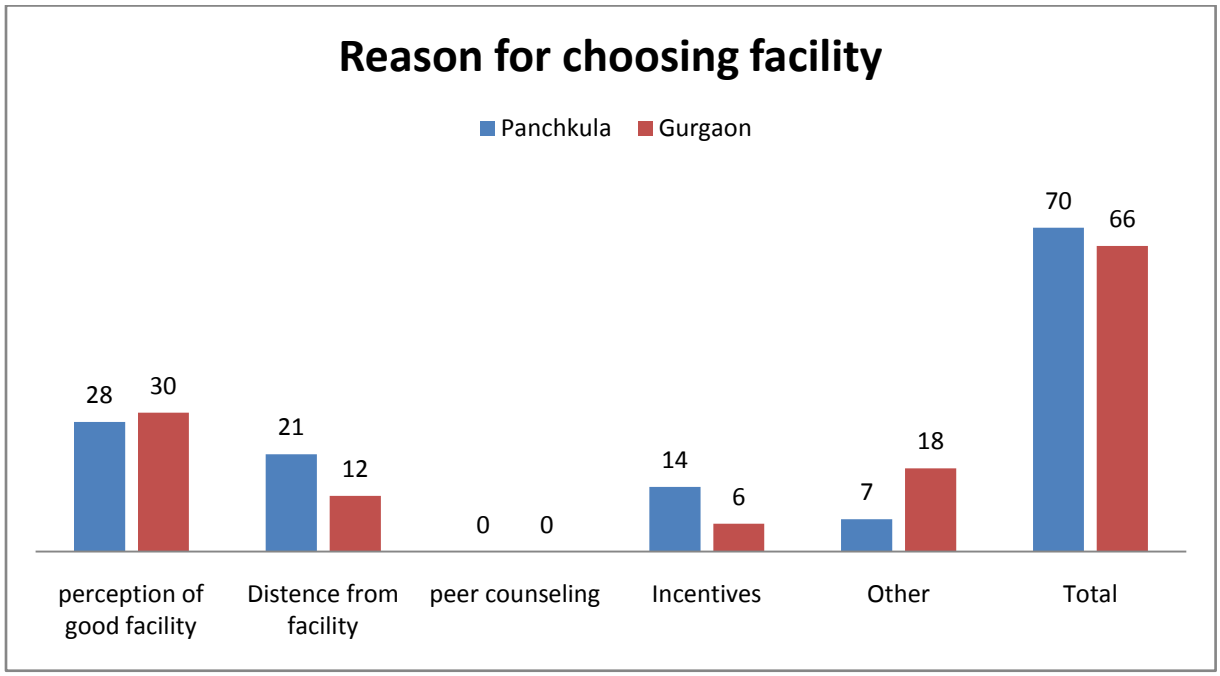


About three fourths (**70 percent**) of the deliveries were conducted by doctors. This was the pattern in both intervention and control areas.

Decision on place of delivery:



The majority of respondents reported self/husband/family members as the major influencers of decision regarding place of delivery, followed by doctors (14percent). The actual decision was also taken largely by self/husband/family members, as reported by 86 percent respondents.



Perception of good facility was the main reason for choosing DH as a place of delivery.

Gender

Gender is a key social factor influencing newborn care in the patriarchal social setup of northern India. Haryana in particular is among the states in India with low child sex ratios and practice of female feticide, indicating discrimination against the girl child.

To see the effect of gender on newborn care, four key indicators – length of stay in facility, initiation of breastfeeding, immunization at the facility and referral – were analyzed by sex of the newborn.

No significant differences were found in these outcomes by gender**.**

Pre delivery and Delivery experience

The first responsibility listed in the operational guideline for Yashodas states that she is responsible for "welcoming the pregnant woman heartily (in the facility) and make sure that she relaxes, and reassure that she is in a safe place and among people, who care for her." Considering registration as the first point of contact for the pregnant women and her family members in the health facility it is important for the Yashoda to interact with them at this point.

Yashodas do not seem to have a significant influence on reported receipt of physical examinations prior to delivery, the event perhaps more influenced by type of delivery and presence of any complications.

The presence of ASHAs at registration provides an excellent opportunity for Yashodas to interact with them and take over the mother's care from ASHA to themselves (through sharing of the ANC card information) at the facility. Similarly, at discharge, Yashodas could provide similar information about the mother to the ASHAs to continue care through postnatal visits at home.

Experience in the postnatal ward

An important element of the Yashoda program is to provide additional support and important information on maternal and newborn care during their postnatal period at the facility. As of current practices, Yashoda spends 43 percent of her time in the PNC wards with mothers and newborn. Of the time spent in PNC ward, 60 percent of her time is devoted to counseling mothers on issues of breast feeding, immunization, family planning, identification of danged signs, hygiene etc (Yashoda IDIs). In the control districts, nurses and ASHAs (who sometimes accompany mothers) undertook counseling; however this was not a routine task.

The Length of stay at the facility therefore impacts the level of Yashoda exposure and the associated benefits. Although it is important to note that, LOS is influenced by a variety of factors ranging from type of delivery, to health system issues to influence of family members.
In terms of benefits related to Yashoda program, the community survey showed that a significantly higher proportion of respondents who delivered at facilities where Yashodas were present reported having received counseling on a variety of maternal and newborn care issues when compared to respondents who delivered at facilities where Yashodas were not present. The proportion of mothers who reported receipt of counseling messages however, varied across the topics (exclusive breast feeding, family planning, immunization, nutrition, identification of danger signs and cleanliness/hygiene).

Some of the neonatal care indicators (provision of food/water at the PNC ward, initiation of breast feeding and immunization), did not always show significant differences between the intervention and control districts.

Some of these indicators like initiation of breast feeding, use of supplementary feed, keeping the baby warm perhaps could improve further with more consistent efforts by Yashoda. The involvement of Yashodas in assisting mothers with immunization of newborns was reflected in higher proportion of mothers reporting provision of BCG and OPV in the interventions areas.
In Haryana, education and number of ANC visits were the other significant factors influencing counseling and practice indicators in PNC.

"Yashoda has told her the right way of breast feeding & about the family planning methods also. Yashoda kept asking if she is having any problem."
Similarly, more than 95 percent of the respondents who had a C-section delivery reported that their C-section scar was checked and that their dressings were changed compared to 83 percent and 72 percent in the control districts for the same indicators.

The observation studies of Yashodas in DH documented that several of the roles prescribed to them were being fulfilled. In addition to defined roles of counseling and support, Yashodas also performed simple tasks that humanize the atmosphere in the health facility and maintain decorum in the ward.

One mother was feeling shy about feeding her baby as this was her first child, at this the Yashoda said "do not feel shy, feed the child without covering him, look…. now the child is having milk properly, every drop of the mother's milk is precious". The child started crying again. Then, the Yashoda took him in her lap and told the mother "put some clothes on the child… now-a-days, it is cold here". Then she (Yashoda) helped the mother in clothing the child…"

One Yashoda was giving advice to a family member*:* "do not comb hair inside the room, don't wear shoes inside the room, and don't sit on the patient's bed, please come one after the other to see the patient" (Observation)

The study found that mothers/families felt that the presence of Yashodas was beneficial to them in several ways. In general, mothers reported being more comfortable within the hospital environment in the presence of Yashoda. It was pointed out that "….even people from high socioeconomic status don't want to stay in (an exclusive) cabin because there are no Yashoda services in the cabin ". Mothers who had visited the hospital for their previous delivery prior to the Yashoda intervention felt that the wards were much cleaner now.

Summary

The profile of Yashoda (in terms of age and educational status) at the two study districts matched the NIPI guidelines. Many belonged to economically and socially vulnerable groups. Yashoda's training seemed to orient them more as a nurse's aide than a mother's aide in the facility.

In relation to the role and support provided by Yashoda, the study found that mothers/families felt that the presence of Yashodas was beneficial to them in several ways. In general mothers reported that they were more comfortable within the hospital environment in the presence of Yashoda rather than without a Yashoda.

The community survey found that decision regarding place of delivery was made mostly by self/husband/family members. Nurses conducted more than 75 percent of the deliveries. The length of stay at the facility impacted the level of Yashoda exposure and the associated benefits. Although it is important to note that, LOS is influenced by a variety of factors ranging from type of delivery, to health system issues to influence of family members.

A significantly higher proportion of respondents who delivered at facilities where Yashodas were present reported having received counseling on a variety of maternal and newborn care issues when compared to respondents who delivered at facilities where Yashodas were not present. Mothers from DH received significantly higher levels of counseling compared to mothers who delivered at CHCs (correlates to proportion who reported exposure to Yashoda).

The impact of presence of Yashoda was most apparent for mothers who had a c-section in terms of practice indicators like initiation of breastfeeding within 5 hours.

CHAPTER: 4. DISCUSSION

The Yashoda Program – Operational Aspects

Yashoda Profile

NIPI defines Yashodas as "volunteer support workers who are paid a performance-linked incentive, working in shifts, placed at the DHs and some Community Health Centers". The objective of the program is to enhance a joint ownership for care coordination at the facility with 'Yashoda' as part of the larger system, where the pregnant women feels welcome as she enters the facility and leaves with her newborn baby with a feeling of being cared for and looked after. The value addition that the Yashoda program brings is the demand generation of services for care of the newborn and improved accountability at the facility level..

Remuneration

In Haryana, payment to Yashodas depend on the number of deliveries in the hospital (an incentive of ` 100 is paid per delivery conducted in the hospital; the total amount of remuneration given to the Yashoda is calculated on the basis of total deliveries that happened within one month and divided equally among the Yashodas.). During Feb-Apr 2012 (when the survey was

being conducted), Yashodas in Haryana reported that they received an average income of about ` 400 per month.

Capacity building

The NIPI guideline has a holistic approach towards capacity building which is not only limited to training but encompasses the following:

Training

Support systems and supervision

Simple formats and reports

Assessment and feedback processes

Clarity on the reporting and monitoring processes

Learning, sharing and career growth opportunity

Recognition and rewards

A review of the training material and flip charts used by Yashoda's in Haryana was done.

Booklet on role of Yashoda – This booklet is a simple and comprehensive manual to guide Yashoda on her role and functions in the facility. In the beginning, it explains to Yashoda the rationale behind her nomenclature and her expected role as 'a sympathetic friend, assistant and counselor' to women coming to the facility for delivery. Her functions include ensuring a conducive/comfortable environment before delivery, assisting in the labour room and counseling in the PNC ward. It also contains tips on efficient utilization of work hours and effective teamwork with other staff members and fellow Yashodas. While the format of the manual is simple, the language is technical in many places and may not be easily understandable.

Flip charts for Yashoda to aid counseling of mothers and family members on postnatal & newborn care – The flip chart is to be used while counseling mothers on postnatal and newborn care. This is well illustrated, with effective guidance to enable Yashodas to use them as effective instruments in educating the women. However, some illustrations contain English sub-heads, which need to be translated to Hindi.

Important observations from the review are as follows:

Content: On the whole the manuals and flip chart for Yashodas are comprehensive and cover all essential elements of birth preparation, postnatal care, newborn care including breastfeeding,

care of postnatal mothers, identification and care of high-risk newborns, and other relevant issues like immunization and hygiene.

Format: Pictorial depictions have been extensively used in all material and are helpful in easy comprehension. Explaining situations through simple stories is also helpful. However, at places the language is complicated and not necessarily conversational. This may be difficult to comprehend for women who are generally not educated above the eighth grade, that too in rural settings. Some captions are in English and therefore not useful for Yashodas.

Branding / Identity: An attempt has been made to depict the Yashodas' distinct identity in the illustrations in all manuals and flip charts. Yashodas are shown with pink aprons and a tiny caption 'Yashoda' printed somewhere on the figure, which is often in English. The mode of identification needs to be made starker and also the distinct roles of nurses and Yashodas need to be more clearly illustrated, for the understanding of community members as well.

Role of Yashoda as 'sympathetic friend': Several aspects of Yashoda's role in comforting the mother are illustrated in the manual, such as making her comfortable, assisting her with toilet/drinking water, occasionally massaging her back, holding her hand and comforting her during delivery. However, at the same time, she is expected to closely watch the nurses and learn from them the various clinical tasks related to delivery care. This would naturally create an expectation among nurses and also a realization among Yashodas that they need to assist nurses in their tasks. Eventually this could erode her role and identity as a mother's companion and assistant, and not a nurses' aide.

It is important to suitably highlight her role as mother's aide, possibly illustrating the importance of emotional support in ensuring a satisfactory delivery experience and her crucial role in ensuring the same. At the same time, less emphasis must be paid to the need for Yashoda to learn all clinical delivery-related tasks from nurses and other hospital staff. This would help her and the staff to understand and appreciate her role and create her unique identity in the facility.

The Yashodas found the training sessions helpful in defining their role clarity and dispensing their duties.

"After attending the trainings, we know what our exact work is. Why we are appointed as Yashoda." "We learned a lot about mother and child care". "through these training we got knowledge about family planning , immunization, breast feeding, diet of the mother, how to

receive a mother and child after delivery, how to maintain hygiene within the hospital , what are the problems that a mother face after delivery etc." (IDI)

However some Yashodas stated that many of them did not perceive themselves to be well-informed to handle questions from the mother/family during counseling especially regarding complications. "We want more information about mother and child's complication. How do we know immediately that the mother is having a complication?" (IDI, Yashoda,Mewatl). Majority of the Yashodas recommended refresher trainings to upgrade their skills. "If we have trainings every six months then it will be good" (IDI, Yashoda).

"In trainings we get to learn new things and clear our doubts. These trainings should happen more often" (IDI, Yashoda, Anugul).

Some of the Yashodas especially the more educated also suggested the need for more paramedical training (nurse's aide rather than mother's aide).

Supervision and mentoring

As per the NIPI guideline the overall supervision is provided by the medical superintendent identified by the Civil Surgeon/PMO in the DHs as the case may be in each state. The District Programme Managers will assist the Medical Superintendent in discharging/coordinating all Yashoda related functions and day to day operations.

Yashodas are supervised and supported by the Yashoda Supervisor. It has been suggested that the Yashoda Supervisor will be from the nursing stream, preferably a retired nurse/ANM/LHV; because of their understanding of the functioning of the health system and can begin to support the Yashodas.

It has been observed that the above cadres have been fulfilling their supervisory duties. The supervisors also provide a strong support system for Yashodas within the hospital setup and ensure that Yashodas are used for appropriate tasks. Some examples:

"The Yashoda Supervisor, after coming to Hospital, on duty, takes a round and marks attendance of the Yashodas. She visits the labor room every half an hour and keeps a watch on the Yashoda" (Observation)

The supportive supervision role is also demonstrated effectively by the supervisors:

"Supervisor didi tells us how we can counsel the mother better and shows us by talking to the mothers" (IDI, Yashoda)

"The supervisor didi supervises our work personally. She interacts with mothers and asks them what information they have received from the Yashoda. She suggests us in which way we can do our work better." (IDI, Yashoda)

In Haryana, the Yashodas were appointed before the supervisors and hence their role in handholding mothers seems to be limited. It may be wise to appoint Yashoda supervisor before the Yashodas and hence played an important role in fitting Yashodas into the hospital environment.

Operational guidelines for Yashoda and their implementation in Haryana Parameters

Parameters	**NIPI guidelines**	Haryana
Place of work and number of Yashodas	Places where delivery load is high. Adequate number of Yashodas should be recruited including reserves to cover absence due to leave and sickness.	4, 8 & 12 Yashodas were recruited according to the delivery lode at District Hospital
Working hours	8 hourly shifts and their leave is a local arrangement	8 hourly shifts -- leave sanctioned by supervisor. Yashodas get a day off after completing three shifts consecutively.
Recruitment process	As it locally suits, involve some stakeholders from the health system and some district authorities	Under the direction of the DHS, recruitment occurs under a committee comprising of the Civil Surgeon, DPM and Principal Medical Officer (PMO).
Orientation and training	At least 5 days training for familiarizing Yashodas with the hospital environment and	Five days training given to all Yashodas.

	focusing on counseling	
Supervision and mentoring	Supervisory cadres to be appointed, who will hand-hold Yashodas in the hospitals, mentor them and ensure availability of Yashodas at all times, etc.	In Hrayana, Yashoda coordinating body fulfills this role. This body consist of Civil Surgeon, DIO, PMO, DPM, LHV or Yashoda Supervisor
Payment system	Yashoda received performance based incentives.	In Haryana, an incentive of Rs. 100 is paid to Yashodas per delivery conducted in the hospital. There is no fixed salary, total amount of remuneration given to the Yashoda is calculated on the basis of total deliveries that happened within one month and divided equally among the Yashodas.

According to NIPI guidelines, monthly load of deliveries serve the basis for calculation of Yashoda requirements. All DHs were considered for implementation of the Yashoda program. Yashodas are expected to attend to 5-6 mother-child per day during any 8 hr shift. The study observations however indicated that Yashodas placed at DHs in few districts were not being efficiently utilized as envisaged. This was especially true for facilities that reported less than 4 deliveries a day and had a full time nurse available at the facility. In addition, the lack of supportive supervision for Yashodas at DHs contributed to the lack of clarity in their roles.

The Yashoda program – Health provider & Community perspectives

Health provider's perspective and interaction

The role of Yashodas seems to be generally well understood, however, there is a thrust for the Yashodas to become a nurse's aide rather than her envisaged role as a mother's aide. The Yashoda Operational Guide 2010 mentions "While Yashoda fills a critical gap for counseling the mother on newborn care and coordinate services within the maternity ward, Yashoda is NOT a substitute for the nurses."

From the point of view of the hospital staff, the most important role played by Yashodas is in reducing the work burden of nurses (in caring for mothers):

"..After coming of Yashodas at the hospital, we have got much help from Yashoda, because, now we do not to worry about mothers as Yashodas take care of the mothers…" (IDI, Staff nurse).

Observations recorded instances where Yashodas were being used for clinical support:

"The Yashoda told us that she is well acquainted with giving injections and drips. On asking her, "Do you help nurse in all this," she replied hesitatingly, "I help the nurse, and while helping, I gradually learnt all these, with the help of the nurse".

In general, the importance of the counseling and psychological support roles of Yashodas is not completely acknowledged by other health staff, they see Yashoda or would like to see them as nurse's aide rather than a mother's aide.

"Some Yashodas are not well-trained, they cannot give injection nor do dressing. Other than counseling they should know some more things. Previously what the sisters were doing…it is no longer sufficient now since the number of deliveries have increased. So someone should help them…" (IDI, Doctor)." Further, the Yashoda said that nurse asked her to learn all this…" (Observation). Doctors also felt that in an environment where clinical staff was not adequate, it would be very useful if the Yashodas were trained to assist in simple para-clinical tasks. Many Yashodas also expressed a wish to learn simple clinical skills. About the Yashodas, it has been said: "…skill upgrading is required …training for dressing, change of saline, danger signals of pregnancy and PNC…other than counseling, they should know about some more things" (IDI, Doctor).

The contact between doctors and Yashodas is limited and in general, their relationship is cordial. The most interesting relationship is the one between Yashodas and nurses. Before the arrival of Yashodas, nurses were the main caretakers of hospital wards. Thus, while nurses recognized the advantages of Yashodas, there was also an underlying tension between the two cadres in some

places. The tension seemed to have eased with time "In the beginning, when Yashodas joined the hospital, hospital staff troubled them a lot, but, at present there is better co-operation", (FGD, Yashoda).

"We do not have much interaction with the Doctors and the Nurses, because, they understand that we are not permanent government staff and hence give us less importance." "The behavior of the nurses have improved, however the behavior of class IV employees is so-so – neither so good nor so bad." (IDI, Yashoda)

"Overall the relation with nurses is good…they are cooperative, but at times they under estimate us. Staff nurses feel they are more educated." (IDI, Yashoda)

In Haryana the color of apron provided to Yashodas is beige colour. The appropriate branding and identity of Yashodas are important; therefore a distinct uniform with specific office space and appropriate positioning within health system is important.

The staff in the health facility generally regarded the non-clinical training of Yashodas as a limitation. There is also concern that Yashodas affectionate behavior towards mothers is only "beginner's enthusiasm" and would not last over time.

CHAPTER: 5. CONCLUSIN & RECOMMENDATION

There is need for Yashoda's role as a mother's aide to be made specific and keep her identity distinct from that of nurse's aide. This may require, more appropriate branding of identity both at the facility and at the community level.

Role of Yashoda as sympathetic friend and mother's aide needs to be strengthened in her training vis-à-vis her current perception as a nurse's aide.

Weak supervision of Yashoda's has serious implications of discharge of duties by them, and therefore needs to be strengthened.

The presence of ASHAs at registration provides an excellent opportunity for Yashodas to interact with them and take over the mother's care from ASHA to themselves (through sharing of the ANC card information) at the facility. Similarly, at discharge, Yashodas could provide

similar information about the mother to the ASHAs to continue care through postnatal visits at home.

Although the presence of Yashoda has improved the level of care, there is an immense scope of improvement in postnatal care. Some of these indicators like counseling on danger signs, facilitation of PNC checks, and use of supplementary feed could receive further focus and attention. Customized, field based, and frequent training should be considered.

The assessment thus showed that the Yashoda program in Haryana has resulted in significant improvements in knowledge and practice of important maternal and new born indicators. These could have an impact on both maternal and neonatal outcomes.

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