Part I

INTERNSHIP REPORT

INTERNSHIP REPORT AT MINISTRY OF HEALTH AND FAMILY WELFARE

1.1 INTRODUCTION TO MINISTRY OF HEALTH AND FAMILY WELFARE:

The **Ministry of Health and Family Welfare** is the Indian government ministry charged with health policy in India. It is also responsible for all government programs relating to family planning in India.

The Minister of Health and Family Welfare is situated at Nirman Bhavan at Central Secretariat that holds a cabinet rank as a member of the Council of Ministers. The current minister is **Shri. Ghulam Nabi Azad**, who is assisted by a Minister of States for Health and Family Welfare, **Shri. Dinesh Trivedi** & **Shri. S. Gandhiselvan.**

The ministry is composed of three departments:

- Department of Health,
- Department of Family Welfare, and
- Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH).

DEPARTMENT OF HEALTH

The **Department of Health** deals with health care, including awareness campaigns, immunization campaigns, preventive medicine, and public health. Bodies under the administrative control of this department are:

- National AIDS Control Organization (NACO)
- 13 National Health Programmes
    - National AIDS Control Programme (AIDS)
    - National Cancer Control Programme (cancer)
    - National Filaria Control Programme (filariasis)

    - National Iodine Deficiency Disorders Control Programme (iodine deficiency)
    - National Leprosy Eradication Programme (leprosy)
    - National Mental Health Programme (mental health)
    - National Programme for Control of Blindness (blindness)
    - National Programme for Prevention and Control of Deafness (deafness)
    - National Tobacco Control Programme (tobacco control)
    - National Vector Borne Disease Control Programme (NVBDCP) (vector-born disease)
    - Pilot Programme on Prevention and Control of Diabetes, CVD and Stroke (diabetes, cardiovascular disease, stroke)
    - Revised National TB Control Programme (tuberculosis)
    - Universal Immunization Programme
- Medical Council of India
- Dental Council of India
- All India Institute of Speech and Hearing (AIISH), Mysore
- All India Institute of Physical Medicine and Rehabilitation (AIIPMR), Mumbai
- Hospital Services Consultancy Corporation Limited (HSCC)

DEPARTMENT OF FAMILY WELFARE

The **Department of Family Welfare** (**FW**) is responsible for aspects relating to family welfare, especially in reproductive health, maternal health, pediatrics, information, education and communications; cooperation with NGOs and international aid groups; and rural health services. The Department of Family Welfare is responsible for:

- 18 Population Research Centres (PRCs) at six universities and six other institutions across 17 states
- National Institute of Health and Family Welfare (NIHFW), South Delhi
- International Institute for Population Sciences (IIPS), Mumbai
- Central Drug Research Institute (CDRI), Lucknow
- Indian Council of Medical Research (ICMR), New Delhi - founded in 1991, it is one of the oldest medical research bodies in the world

DEPARTMENT OF AYUSH

The **Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy** (**AYUSH**) deals with ayurveda (Indian traditional medicine), and other yoga, naturopathy, unani, siddha, and homoeopathy, and other alternative medicine systems.

The department was established in March 1995 as the **Department of Indian Systems of Medicines and Homoeopathy** (**ISM&H**).The department is charged with upholding educational standards in the Indian Systems of Medicines and Homoeopathy colleges, strengthening research, promoting the cultivation of medicinal plants used, and working on Pharmacopoeia standards. Bodies under the control of the Department of AYUSH are:

- Various research councils
    - Central Council for Research in Ayurveda and Siddha (CCRAS)
    - Central Council for Research in Unani Medicine (CCRUM)
    - Central Council for Research in Homoeopathy (CCRH)
    - Central Council for Research in Yoga and Naturopathy (CCRYN)
- Several educational institutions:
    - National Institute of Ayurveda, Jaipur (NIA)
    - National Institute of Siddha, Chennai (NIS)
    - National Institute of Homoeopathy, Kolkata (NIH)
    - National Institute of Naturopathy, Pune (NIN)
    - National Institute of Unani Medicine, Bangalore (NIUM)
    - Institute of Post Graduate Teaching and Research in Ayurveda, Jamnagar,Gujarat (IPGTR)
    - Rashtriya Ayurveda Vidyapeeth, New Delhi (RAV)
    - Morarji Desai National Institute of Yoga, New Delhi (MDNIY)
- Indian Medicine Pharmaceutical Corporation Limited (IMPCL), Mohan, Uttaranchal (a public sector undertaking)
- Professional councils
    - Central Council of Homoeopathy (CCH)
    - Central Council of Indian Medicine (CCIM)

NATIONAL RURAL HEALTH MISSION:

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission in 2005 to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.

The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

VISION OF NRHM:

The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

• These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

• The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP.

• It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country.

• It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the Health & Sanitation Committee of the

Panchayat; strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); and integration of vertical Health & Family Welfare Programmes and Funds for optimal utilization of funds and infrastructure and strengthening delivery of primary healthcare.

• It seeks to revitalize local health traditions and mainstream AYUSH into the public health system.

• It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health.

• It seeks decentralization of programmes for district management of health.

• It seeks to address the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure.

• It shall define time-bound goals and report publicly on their progress.

• It seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

GOALS OF NRHM :

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life.

STRATEGIES

(a) Core Strategies:

• 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 an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).

• Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).

• Preparation and Implementation of an inter-sectoral 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, Block, and District levels.

• Technical Support to National, State and District Health Missions, 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 Resources for health.

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

• Promoting non-profit sector particularly in under served areas.

(b) Supplementary Strategies:

• Regulation of Private Sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost.

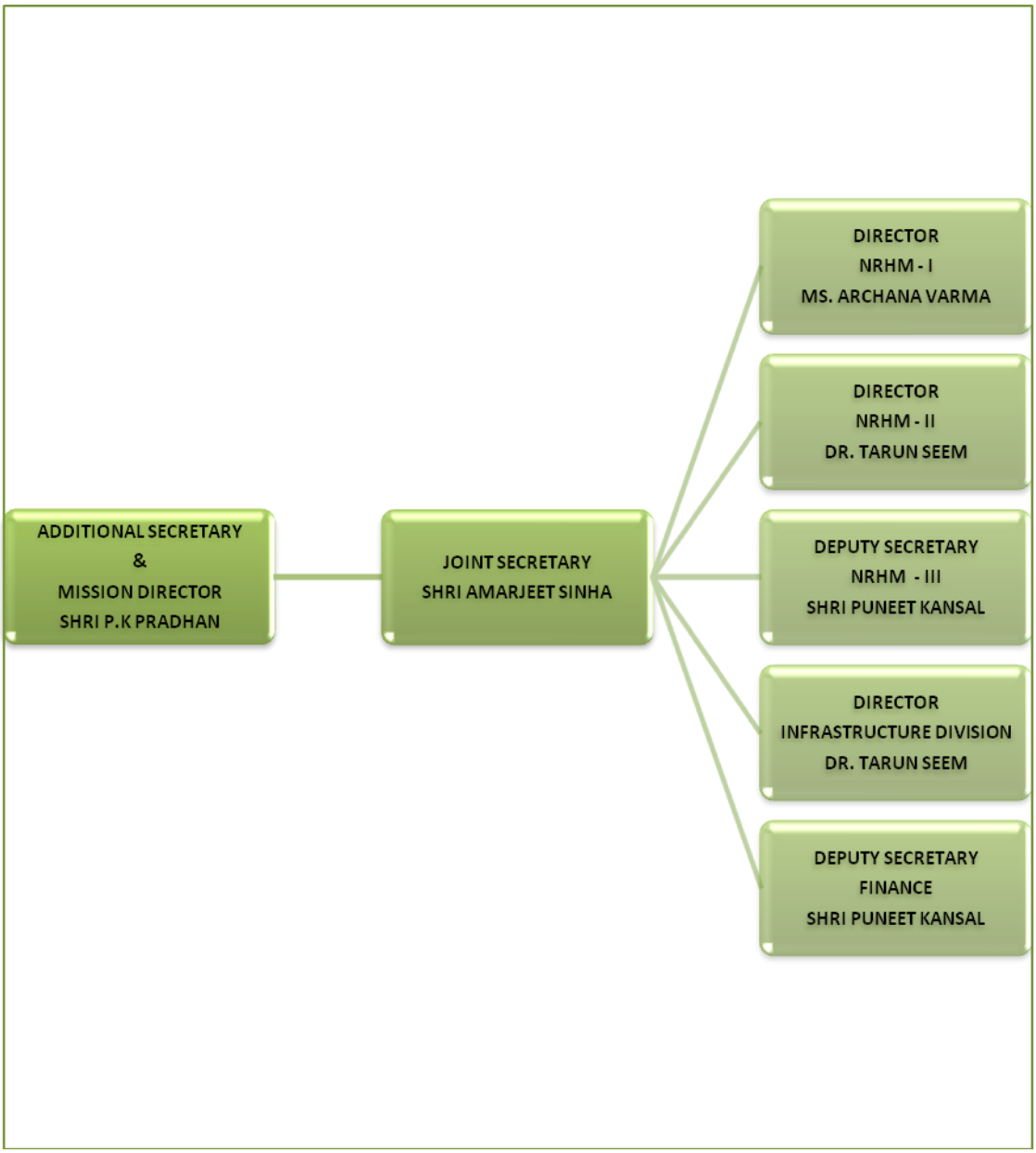
• Promotion of Public Private Partnerships for achieving public health goals.

• Mainstreaming AYUSH – revitalizing local health traditions.

• Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.

• Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

ORGANIZATIONAL STRUCTURE OF NRHM



1.2 TASKS PERFORMED DURING INTERNSHIP

At the time of joining i was involved in the NPCC meetings [National Programme Coordination Committee] where State wise NPCC meetings were held at the Committee hall of MOHFW chaired by Health Secretary, **Ms. Sujatha Rao**, Additional Secretary and Mission Director, **Mr. P.K Pradhan** and Joint Secretary, **Mr. Amarjeet Sinha**. This meeting was also mandatory for NRHM Directors, Deputy Secretaries, and Officials of all departments of MOHFW to attend. The Representatives from individual States (which constitutes the State's Principle Health Secretary, Mission Directors and Heads of other Departments of Health & Family Welfare of a State) give a presentation in front of MOHFW stating their last year's targets, their successful achievements and the goals they have targeted for the coming year and the coming next 5 years , the core strategies and innovations (like incentives for ASHA, PPP, Health Insurance) they would like to implement within a State to achieve the set targets, the budget they would require to implement such innovations and achieve the targeted goals.

As a Consultant we were required to note down the Minutes of Proceedings for NPCC Meetings and keep a close tab on the budget demanded by the State and its approval or rejection by the chaired members and noting the important discussions and decisions taking place in the meeting as well as help in organizing the meeting. The other routine job involves answering the Parliamentary Questions, studying the PIP's [Programme Implementation Planning] documents of various States, reviewing their Health Action Plans and collates the comments of various divisions of department of MOHFW on PIP and NHSRC [National Health Systems Resource Centre] on the Health Action Plans of State.

IN - DEPTH STUDY:

- Preparing the Records Of Proceedings (RoP's) for the States after the NPCC Meetings is indeed a unique and challenging task which requires the study of previous 5 years of ROP's of each State, focusing on their set targets for future and past and analyzing the progress they have made so far [with respect to every aspect], analyzing the budget allocated to States in past and its utilization and the budget demanded by them now, analyzing the targets they have achieved in comparison to other States with respect to all

the departments of Health and National Programmes and NRHM. (RoP of Puducherry 2010-11 is attached in the annexure 4.)

- We worked on the parliamentary questions such as: State wise amount approval by NPCC for EMRI to all the States and UTs in three consequetive years. (annexure 5)

1.3 BRIEF REPORT ON MANAGERIAL TASKS PERFORMED IN VARIOUS DEPARTMENTS / PROGRAMMES

The NPCC meetings involved us managing several aspects of management starting from managing the Documentation part to organizing and conducting the National level meetings. The File management is a big task of responsibility.

12th April, 2010 was celebrated as the day when NRHM completed its 5 years and the event was organized at Vigyan Bhavan. I was involved in managing the IT related work throughout the event. Further involved us in managing the event in various aspects. Rajasthan was awarded as the Best Performing State under NRHM. Event was attended by the National and State level Officials and other dignitaries' from other organisations.

Preparation of ROP's for every State requires us to be a team player and deliver the work under the restricted time guidelines and work under pressure, coordinating with Officials working in Ministry, State and NHSRC.

1.4 REFLECTIVE LEARNING DURING INTERNSHIP:

Understanding an Organizational Behaviour and culture is the biggest milestone if someone wants to excel in that Organisation. Previous professional experience with the private and Corporate Organisations is lot more different than what we have learnt in this Government Organisation. One Organisation with several Departments and thousands of employees working under its umbrella, dealing with their HR Issues and day to day administrative tasks is a remarkable thing to observe and this teaches that India is democratic Country.

Attending the National level meetings and hearing the State's targets and their achievements taught us how far National Programmes have reached and what potential they have to accomplish their set targets.

Coordination and sense of Belongingness is what keeps such a large organization keep going and achieve remarkable targets. Preparing of ROP's taught us how many factors and not one factor is responsible for the development of any Nation's Health.

PART II

DISSERTATION REPORT

On

“Innovations in healthcare sector changes, challenges and status of healthcare seeking behaviour of the community”

Chapter 1
Introduction

1.1 BACKGROUND

The challenge that we face—making health care affordable and conveniently accessible to most people—is not unique to health care. Almost every industry began with services and products that were so complicated and expensive to provide and consume that only people with a lot of skill and a lot of money could participate *(Christensen, Grossman and Hwang, 2009)*. The transformational force that has brought affordability and accessibility to other industries is innovation. Innovations in health and social services are also gaining prominence. Treating more people in their homes rather than in hospitals will be a major feature of future health services, enabled by telemedicine, remote monitoring devices and technology that improves patient-compliance with medicines.

The major drawback to encouraging innovation is that it drives up the cost of providing healthcare. Medical inflation has been running well ahead of all other sectors, even at a time of economic hardship. Reconciling the need to have an innovative healthcare sector while health ministers are battling to control spending will be a major challenge.

This feeds into the wider question of equality and access to innovative healthcare. The gap between those who struggle to have their basic health needs met and the developed world, where some patients have ready access to life-saving medication and state-of-the-art preventative technologies, is growing. Innovation is not just about technology—we especially need innovations in breaking through process and challenges that inhibit the adoption of new ideas. Patients, doctors, nurses, governments, communities, insurance companies, pharmaceutical companies all have vested interests (or incentives) that can actively prevent good ideas from being adopted. For example, patients want effective, inexpensive, and convenient care. Doctors want to help people but also earn a good living. Insurance companies want to limit the costs they are liable for. Governments want to make sure that healthcare is widely available. The categories above are great places to look for innovation, but you should feel free to "think outside the box" and propose solutions in other areas. *(Hill, Obando and Jensen, 2010)*

"Innovation": an intervention to address a specific problem through creative use of resources, often through public partnerships, often introduced on a pilot basis at the periphery level, with scope of scaling up.

The main objective of the National Rural Health Mission launched by the Government of India in the year 2005 is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

The design of RCH II /NRHM has fostered innovations across the country, resulting in an impressive range of innovative approaches being implemented to address identified needs /specific gaps in health services. Equity is a central consideration in all innovations with the majority being targeted BPL. With a view to improving the use of health care services by the poorest and the underserved populations, a number of innovations have been adopted by the States/Union Territories across various thematic areas.

RCH II and NRHM have offered the flexibility to states to design and implement local and context specific innovations, across a spectrum of health services, spanning a range of service delivery projects and programmes. The term "innovations" has been used very flexibly and covers new approaches as well as testing out known approaches in different contexts. Some innovations spanned several states, while many were state specific. The innovations are all being piloted in the context of substantial investments from national and state levels on improving the health infrastructure, strengthening health systems, promoting social mobilization and community participation, enabling decentralized health planning and implementation, incentivizing performance and quality to retain and attract human resources, and strengthening programme management and monitoring.

The innovations are categorized into themes that roughly follow those laid out in the National Programme Implementation Plan of RCH II and also in the Implementation Framework of the National Rural Health Mission. Nine major themes were identified that span major thematic areas of RCH II/NRHM. :

Table A: Category of innovations

Sl.No	*Category of innovation*
1.	**Safe Motherhood/Maternal Mortality Reduction** • **Innovations to promote safe motherhood and institutional delivery** • **Ambulance services and help lines for transport of obstetric emergencies** • **Strengthening Skills and Capacity of Providers**
2.	**Immunization and Infant and Young Child feeding**
3.	**Adolescent Reproductive and Sexual health**
4.	**Behavior Change Communication**
5.	**Mainstreaming gender issues into RCH II and NRHM**
6.	**Service Delivery for RCH**

7.	**Programme Management** • **Incentives to improve mobility, availability and attendance of staff** • **Incentives to improve performance and range of services** • **Alternatives to In service training for Improved Performance** • **Improving procurement and finance systems**
8.	**School health**
9.	**Urban health**

Interestingly most of these innovations are related to improving performance of the ongoing health programmes in the country and are intended to change the health seeking behavior of the beneficiaries. The provision of untied funds appeared to be an opportunity that all states have used. Quest for a better health is the ultimate objective of mankind for which they are striving to achieve from the time immemorial. Whether it is the primitive Stone Age or the age of the new Reproductive Child health programme/NRHM, mankind is striving to achieve this ultimate objective only. The integral relationship between family planning and the larger issues of reproductive health, education, status of women and development have recently pointed out as a major concern by Ministry of Health and Family Welfare. Knowledge of reproductive health and sexual attitudes and behaviour is important to family planning researchers, policy makers, health managers and service providers, because these underlie virtually all the conditions that these programmes address. However, little is known about the health seeking behaviour of the community.

The study comprises of two studies:

1. Study 1- Detailed review of "Community Mobilization for Improving Mother and Child Health through the Life Cycle Approach, Jharkhand"

2. Study 2- Qualitative study for assessing the health seeking behaviour of community, knowledge, practices and factors affecting the health of mother and child.

1.2 Literature review

After reviewing the related literature the following conclusions could be drawn:

1. Most studies have focused only on finding the utilization of Maternal and Child Health services and not on health seeking behaviour on the whole.
2. Not much effort had been made to understand the perception of health among women, their pattern of health seeking behaviour and its various determinants and
3. Although study at macro level is available but in the micro level not many study on assessing the health seeking behaviour of the community is available which can be used as a ready reference.
4. From the available literature it has been identified that suggests that women and children are more likely to seek health services for emergent and urgent needs than for non urgent/emergent or preventive ones, and potentially that women's needs are accorded lower priority by their families and themselves.

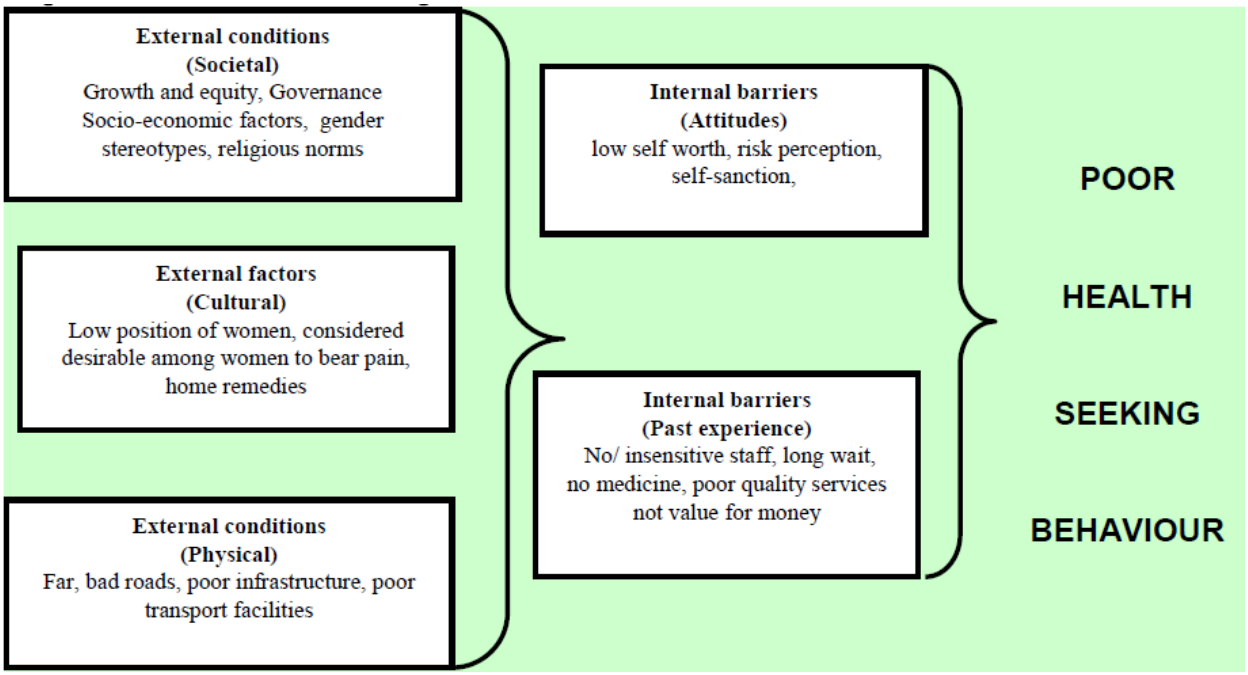


Figure 1: factors for poor health seeking behavior

Source: **http://www.healthpolicyinitiative.com**

5. Poor literacy and lack of awareness about services, schemes and entitlements; low status of women and lack of family support for women reinforcing low self worth; abject poverty that pushes health to a low priority; and prevalence of culturally influenced practices that may in certain situations be detrimental to health are among the crucial factors that determine the health-seeking behavior in the state. (Prasad. G, 2009)

6. Analysis of literature pertaining to uptake of reproductive and child health (RCH) services suggests that use of services is affected by the broader contextual factors in which women live, such as poverty and limited educational opportunities, as well as individual attitudes which, in turn, are shaped by past experience, community perceptions, and practical aspects. Delays in seeking appropriate care, difficulties in physically accessing services, and facing serious breakdowns in services at the facility level have been noted as the three crucial barriers that inhibit access to healthcare.

Several other deterrents, such as bad roads, the unreliability of finding the health provider, costs for transport, and wages foregone, make it cheaper for a villager to get some treatment from the local practitioner or "quack," who may have limited knowledge and skills in either modern or traditional medicine.

Therefore in order to fill these lacunae and bridge the existing gap a strong information base needs to be developed. Hence the present study was undertaken to understand the health seeking behaviour of the community and give strategic inputs for implementation of the health services under NRHM / RCH II in better way.

Chapter 2
Methodology

2.1 Objectives of the studies

- To identify the innovative approaches during the implementation of RCH II / NRHM.
- **Study 1:** To learn about the various health indicators and changes after the innovative approaches have been implemented in the selected study area (Community Mobilization for Improving Mother and Child Health through the Life Cycle Approach ,Jharkhand , an example)
- **Study 2:** To assess the health seeking behaviour of community for availing mother and child health services in district Deoghar of Jharkhand.

Specific objectives of the Study 2

1. To assess the level of knowledge and practices among community regarding:
    - Pregnancy related matters
    - Child Care
2. To assess the knowledge and practice among ANMs/ ASHAs on:
    - Antenatal, Natal and Post-natal Care
    - New-born care

2.2 Study Methodology:

Study 1

The innovation was subjected to a desk review. The range and spread of innovations is truly impressive. The limitation of the desk review is that documentation on processes and outcomes could not readily be accessed, even though they probably exist in some form or other.

1. Secondary data source

    Data source consist of documents available from variable sources such as-

    - Brief narratives extracted from state Project Implementation Plans (PIP) for fiscal years 06-07, 07-08, 08-09, 09-10 and 10-11
    - Power point presentations
    - Mid project reviews for selected innovation.

2. **Annexure 1** provides a list of the innovations classified by state. Some of the suggested innovations were excluded from the list because of the following reasons:
    a. Element of a state or national programme and not a new intervention or innovation, for, e.g. "National Family Planning Insurance Scheme",
    b. An activity rather than an intervention or innovation, for instance: "Mapping of difficult areas" in preparation for launching a project.
    c. Micro research studies
    d. Discontinued by the state

Study 2

The study of health seeking behavior supporting the innovative approach being implemented was done in the district of Deoghar, Jharkhand.

- ***Sample Size***

The study was conducted taking adequate sample (according to the availability) from four different villages. For the sake of convenience the entire target population is divided into the following categories.

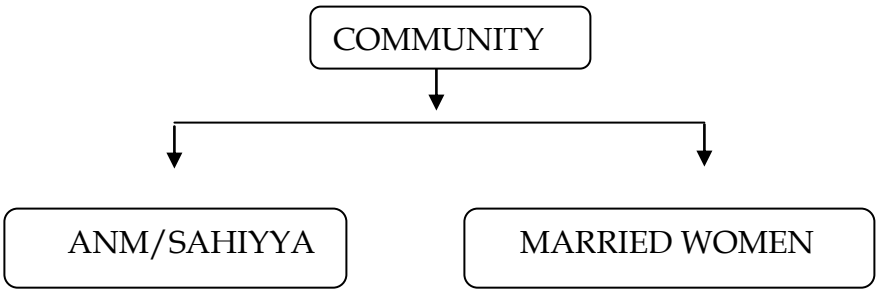


Figure 2. Target group

Primary data collection

Qualitative study was also conducted to assess the health seeking behavior and service utilization pattern of the people in the study area. Four villages were selected in the district of Deoghar .Focus Group discussion were conducted among the target groups which comprised of ANMs & Sahiyyas and Married Women.

Study Tools

The various tools used for the study were as follows:

a) In-depth Interview- of the Sahiyyas and ANM.

b) Focus Group Discussion- with different target groups.

c) Observations- during the field visits and survey work.

- ***Target Groups***

1. Married women

   Married women in the survey represent those women in the village with marital duration less than 5 years – they can be daughters or daughter-in-laws of the home.

2. In-depth interview of Sahiyyas/ ANMs

   Practising in the village both trained and untrained.

Chapter 3
Results and findings

3.1 Findings:

1. NRHM's mandate is to bring about "architectural correction and make public health services equitable, affordable and effective". The RCH II programme focuses on addressing the poorest and underserved populations within a framework of substantial degree of flexibility, decentralized management, and enhanced accountability for results. These parameters have resulted in the states piloting innovations across the major RCH II and NRHM themes.

2. Several state governments are using state level funds to pilot new innovations based on need and context. In addition there is likely to be a plethora of innovations, many of them demonstrating a strong evidence base, that have been implemented by NGO[1].

3. Some innovations were state specific while some are spanned several states. The innovations are all being piloted in the context of substantial investments from national and state levels on improving the health infrastructure, strengthening health systems, promoting social mobilization and community participation, enabling decentralized health planning and implementation, incentivizing performance and quality to retain and attract human resources, and strengthening programme management and monitoring.
4. The study specific findings are depicted along with the details of the study.

STUDY 1

Detailed analysis of

“Community Mobilization for Improving Mother and Child Health through the Life Cycle Approach”

3.2 Community Mobilization for Improving Mother and Child Health through the Life Cycle Approach

Table 3.2: Details of project

Title	Community mobilization for Improving mother and child health through the life cycle approach
State	Jharkhand
Geographic area of coverage	• Silli and Angara blocks of Ranchi District; • Churchu block of Hazaribagh District; • Sadar block of Gumla District. The project serves as a learning site for the state government and has put on ground a rigorous research design and data collection system to track progress on a number of maternal and child health outcomes, including primary, community-based birth weight data.
Target population	• Primary target group : Women of reproductive age, newborns, infants, and children • Secondary target group :Community, mothers-in –law and husbands
Population covered	3.7 lakh
Project life	2003-2008 (ongoing)
Agencies involved	**Lead agencies:** • Department of Health & Family Welfare • CINI (Child In Need Institute) In the first year of the VHC & Sahiyya program of GoJH, CINI was involved in the development of operational guidelines for the Sahiyya program and providing capacity building to NGOs who were helping the GoJH to implement the program. (CINI served as a lead NGO

	• KGVK (Krishi Gram Vikas Kendra) • NBKJ (Nav Bharat Jagriti Kendra) • LGSS (an NGO) • Department of Health & Family Welfare **Other key agencies (partners)** • ICICI Bank- Social Initiative Group • Population foundation of India (PFI) • SDTT (an NGO)

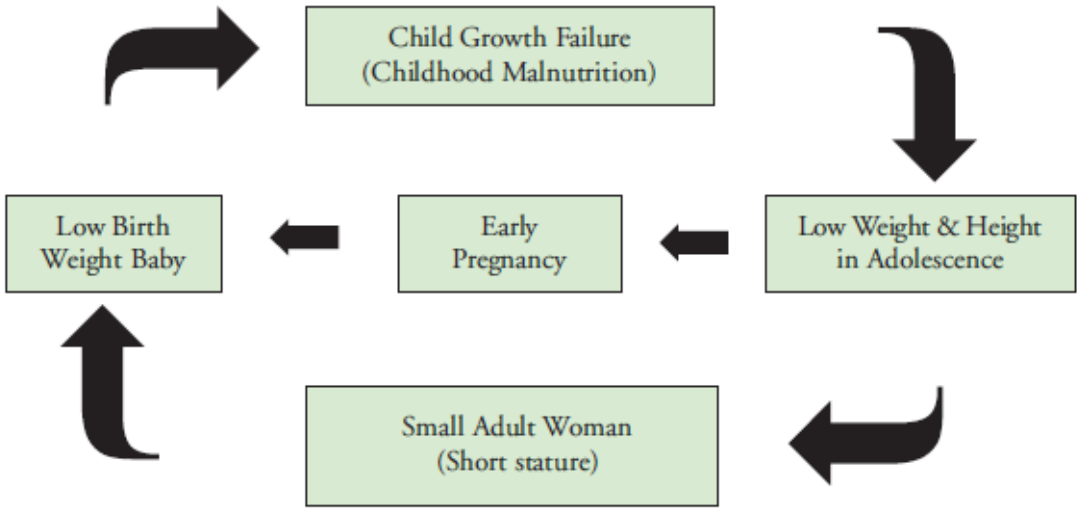
Why focus on Low Birth Weight?

Low birth weight (LBW) and childhood malnutrition continue to be major public health problems in India. Out of 26 million infants born in India each year, 7.8 million are born with low birth weight, accounting for about 40 percent of the global burden (*Low Birth weight: Country, regional and global estimate, 2004).* LBW contributes to neonatal and childhood morbidity and mortality, impedes growth and development during childhood, and has been linked to adult disease like diabetes and coronary heart disease *(Yasmin, 2001, Barker 1998; Gillespie, Haddad, 2003).* Reduction of LBW is therefore critical to improving infant and child morbidity and mortality, as well as raising productivity and lifetime private earnings, and also reducing private and public health care expenditures throughout the lifecycle.

Aims

Low birth weight (LBW) and childhood malnutrition continue to be major public health problems in India. It is well recognized that maternal and child health services as well as a range of behavioral factors need to work synergistically to break the intergenerational cycle of malnutrition and improve these key indicators which determine long term prosperity and productivity of a nation. The project aim to improve maternal and infant health outcomes.

Figure 3. INTERGENERATIONAL CYCLE OF LOW BIRTH WEIGHT AND MALNUTRITION



Objectives:

The objectives of the project were to:

1. Community empowerment
2. To facilitate access to and delivery of effective healthcare.
3. To ensure availability and access to preventive curative services
4. To identify health needs of the community
5. To generate awareness on health issues

Strategies:

Two complementary sets of interventions are used in the project:

1. *Community level behavioral interventions* –

   The community based interventions include a hamlet level female community health volunteer (Sahiyyas), who is selected and supported by Village Health Committees (VHCs), comprising of community representatives. The quality and type of training is the most crucial determinant of a CHW's effectiveness in serving her community's health needs. Towards this end, the project has developed three rounds of training which introduce, in a phased manner, new knowledge regarding maternal and child health, public health services, behaviour change communication, and communicable diseases. Further, in-service training is provided by trainers visiting the villages and working with the Sahiyyas to constantly reinforce learnings. The project has also conceptualized and created a supportive structure for the Sahiyya at different levels, comprising of the Master

Trainer and the Village Health Committee at the village level, the Supervisor at the cluster level and the Coordinator at the block level. These cadres of personnel support the training of the Sahiyya, provide ongoing support, and supervise and evaluate her work. Equipped with this training, support structure and the 'cohort register' that records details about each case, the Sahiyya plays a primarily preventive and promotive role focusing on changing dietary practices, reducing workload during pregnancy, availing antenatal care from health facilities, promoting appropriate child feeding and caring practices, and building awareness about health and nutrition issues in her hamlet. Together, the VHCs and the Sahiyyas act as agents of community mobilization by facilitating behaviour change for better maternal and child health practices, preventive and promotive case management in the area of maternal and infant health, building ownership and initiating action on community health issues, and facilitating linking of communities with health services.

2. *Interventions to ensure provision of mandated public health services –*

At the service delivery level, the focus is on bridging existing gaps in mandated public health care delivery by ensuring regular supplies of essential drugs, provider capacity building which involves orientation and training of public health functionaries, renovation/ construction of sub-centre facilities, ensuring availability of emergency obstetric care through equipped health facilities, and ensuring provision of medical services in remote and inaccessible areas. The sustainability of any CHW programme is intrinsically linked to the support it receives from the public health system. As one of the central roles of the Sahiyya is to act as a link between the public health system and the community, the project has undertaken various initiatives of training, sensitization and orientation for public health personnel such as Auxiliary Nurse Midwives (ANMs), Medical Officers and Anganwadi Workers (AWWs) to support and facilitate the Sahiyya and her work. The monthly cluster meetings with participation of Sahiyyas, Master Trainers, Supervisors, VHC members, ANMs and AWWs illustrate the principles of supportive supervision, the problem solving approach, collective participation of the community, linkages with the public health system, and synergies between the health and nutrition systems at decentralized levels.

Key components and activities:

1. The committee was formed through facilitators, who were paid NGO staff and who interacted with the community and built rapport with them. These facilitators were trained for this work and mobilized the community to form the VHC.
2. The VHC was supposed to have representation from all tolas (hamlets). The community elected three office bearers - President, Secretary and Treasurer (Treasurer had to be a female).
3. The VHCs developed mechanisms to monitor quality of health services (e.g., monitoring tools, reports for use by Sahiyyas)
4. VHCs develop monthly or six monthly health plans.
5. Selections of health worker “Sahaaiya” is done by and from the community by the VHC.Sahiyyas are responsible to the VHCs and are expected to attend the VHC

meetings. The ANM and other health functionaries along with representatives from the tolas are invited to attend (optional)

6. VHC meetings are used to identify local health problems at community level and also to monitor progress of the plans and Sahaaiya performance.
7. The NGOs provided training to the Sahaaiya (21 day program, as per GoJH curriculum).
8. The VHC plans often included health awareness programs and health camps.
9. A number of Village health committees got together to form a federation to mobilize more Govt resources and to form a stronger pressure group for better implementation of the Govt health schemes.
10. The VHCs raised funds from voluntary contributions in cash or in kind from households in the village, which were used for emergency health needs or collective community initiatives.

Outcomes:

- Institutional deliveries increased from 10% at baseline to 16% at midterm.
- Breastfeeding within one hour of birth went from 11% at baseline to 13% at midterm.
- The baseline and mid-term review did not focus on the VHC processes or their operationalisation.
- The critical outcome measures of the project include low birth weight, infant mortality rate, childhood malnutrition, maternal and neonatal care practices, dietary habits of adolescent girls and pregnant women, and infant feeding practices. The project critically examines the processes through which change in such practices occur in the community and the role of community agents and health systems in bringing about this change. It also documents and analyses the processes of capacity building and engagement of the Sahiyyas and the VHCs with the public health system.

Lessons learnt:

- Since its inception the project has been able to inform state policies and programmes, and contribute to sectoral knowledge in some critical areas, such as the selection and training of CHWs in rural and tribal contexts and with low levels of literacy; the role of VHCs as community based support structures for CHWs; the creation of a community-based information system and problem-solving mechanism through the introduction of a simple pictorial cohort register and cluster-level meetings; and the synergies and dynamics between CHWs, VHCs, and local health and ICDS functionaries in altering the quality of service delivery and its utilisation. These learnings have been especially valuable for the Sahiyya Programme in Jharkhand (which aims to introduce hamlet-level CHWs in the state), as well as for the Accredited Social Health Activist (ASHA) Programme in the current context of the National Rural Health Mission.

- Successfully establishing a VHC is a long and formal process. It takes time to gain acceptance and generate community participation and ownership and there are complex local and political issues that may need to be addressed. The evidence shows that it is important to have gender sensitive leadership of the VHC to enhance outcomes. There

are challenges, but the VHC can improve the functioning of the Government service delivery at Primary Health Centers and Community Health Centers. There is a gap in outcome level data on functioning of the Village Health and Sanitation Committees, which will need further examination.

- The Jharkhand initiative builds on the "*Sahaaiya*" (now part of the NRHM ASHA scheme) and the NRHM Village Health and Sanitation Committee formation. To support this qualitative study have been conducted on the health seeking behavior of the beneficiaries and providers.

Study 2

QUALITATIVE STUDY FOR ASSESSING THE HEALTH SEEKING BEHAVIOUR OF COMMUNITY

3.3 QUALITATIVE STUDY FOR ASSESSING THE HEALTH SEEKING BEHAVIOUR OF COMMUNITY

Introduction:

A qualitative study was undertaken to assess the health characteristics of the women, their health seeking behaviour in the villages and also to assess the level of knowledge of the Sahaaiya/ANMs working in the community, both trained and untrained.

Data analysis

a. Married women Focus Group Discussion

There were in all 40 participants in the 4 Focus Group Discussion conducted. Majority of the married women were in age group of 19-25 years. The major findings of the study were as sited below:

Pregnancy Complications

Regarding pregnancy related advice among the newly married women, ANM (38%) and Sahiyya (37%) play an important role but interestingly a number of them also visits local dais (25%) for pregnancy related advice. For those who visited Sahiyya/ANM during pregnancy to seek advice, questions were asked on the advice given by Sahiyya/ANM. The most common response given was regarding restrain from taking heavy weights (50%) followed by nutrition advice (25%) and refers to hospital for check-ups (25%). Only about 40% of the newly married women know of women suffering from pregnancy. *Refer Table 3.3.4.1*

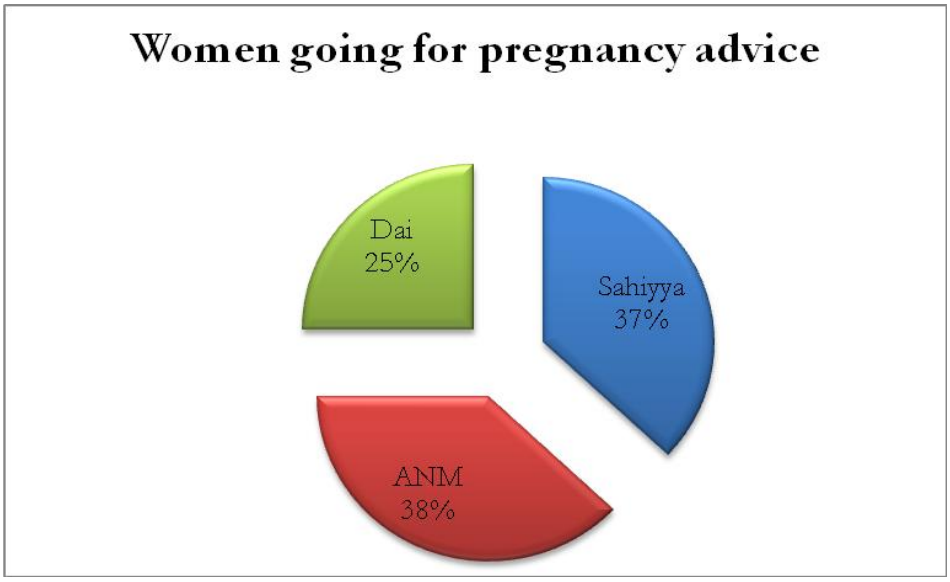


Figure 3.3.4.1 (a)

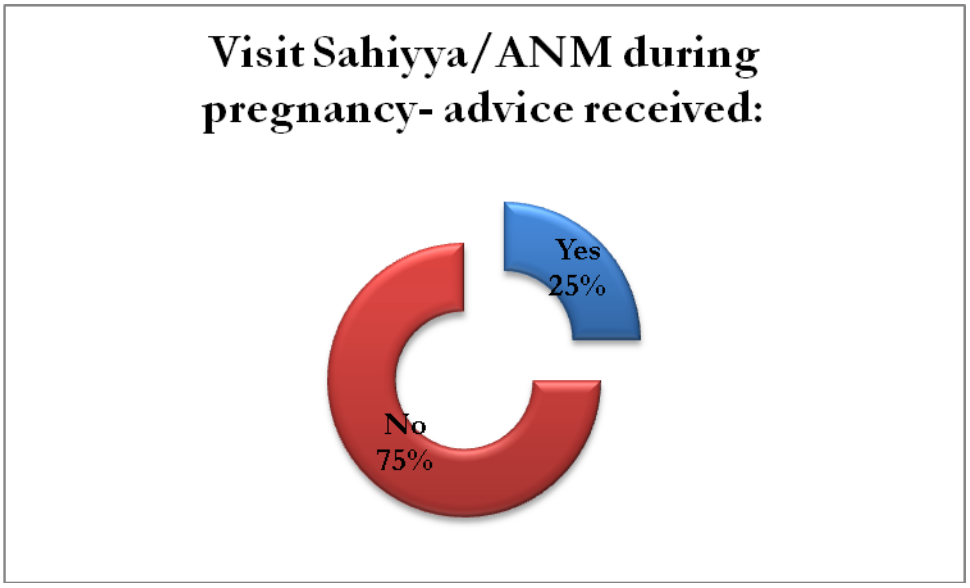


Figure 3.3.4.1 (b)

Antenatal Care

Government hospital is considered to be the most preferred place for delivery. But when asked about the frequency of Tetanus Toxoid injection, it was quite evident that a sense of misconception or lack of proper information exists among the community. Regarding the period of antenatal visit it was found interestingly that a majority of the women consider that it should be done every month (45%) although the practise level for the same is very low as per national survey results. *Table: 3 .3.4.2*

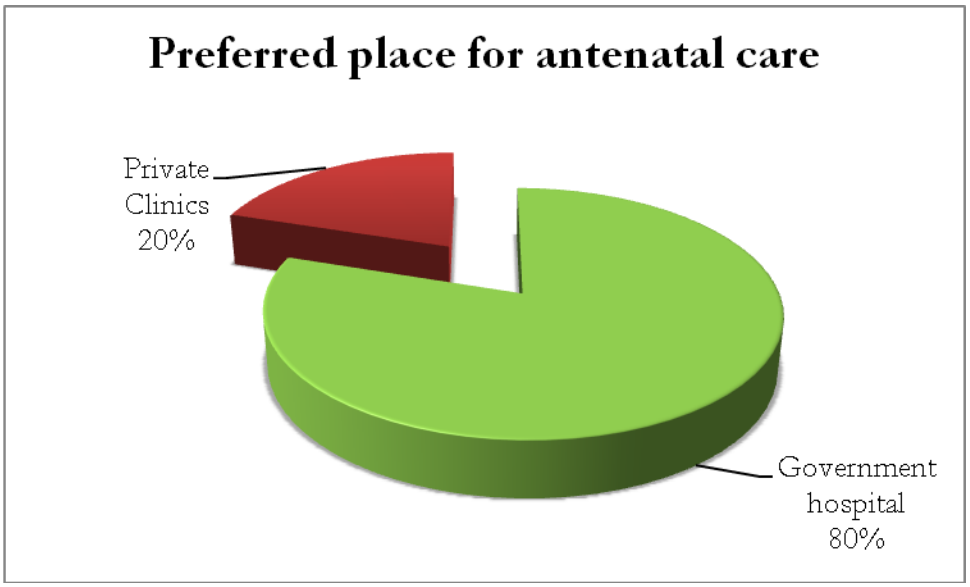


Figure 3.3.4.2 (a)

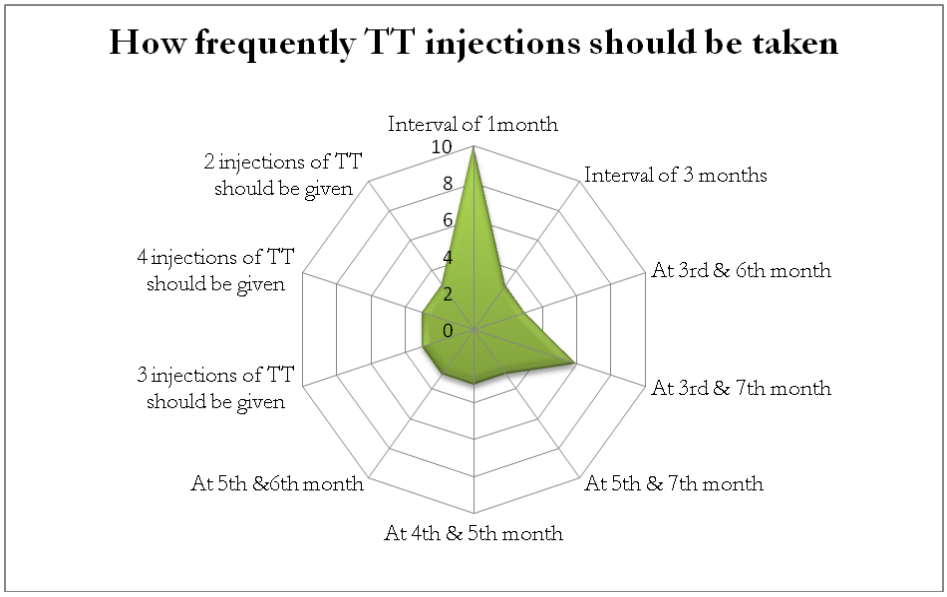


Figure 3.3.4.2 (b)

Delivery and Puerperium

Regarding preparation for child almost 62% don't know what precautions should be taken during delivery. With mere 25% telling about restrain from taking heavy weights. It is notable that a major information gap exists regarding such issues among the community. Almost none of them were aware of any proper care during delivery. House is considered as the most common place of delivery (63%) but a majority of them do consider hospital as the best place of delivery (70%). *Refer Table 3.3.4.3*

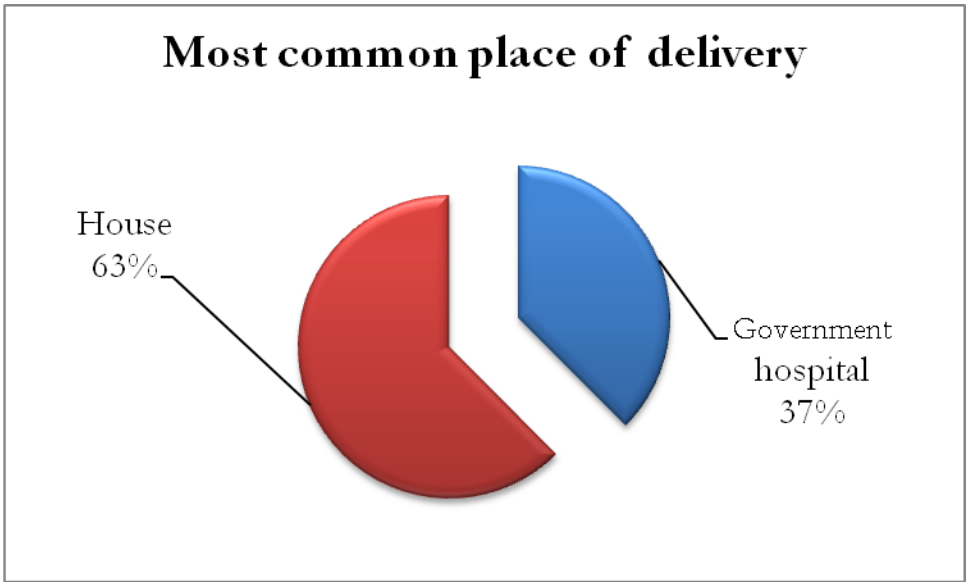


Figure 3.3.4.3 (a)

Child Birth

A majority of the women refer to caesarean complications (38%) followed by excessive bleeding and backache (13%) as the other problems during child-birth. But it seems that after childbirth complications were not recognised as a problem in the community. That's why knowledge regarding the same is also very low (67%). And among those referring to such problems fever, excessive bleeding (33%) are quoted by the respondents. *Refer Table: 3.3.4.4*

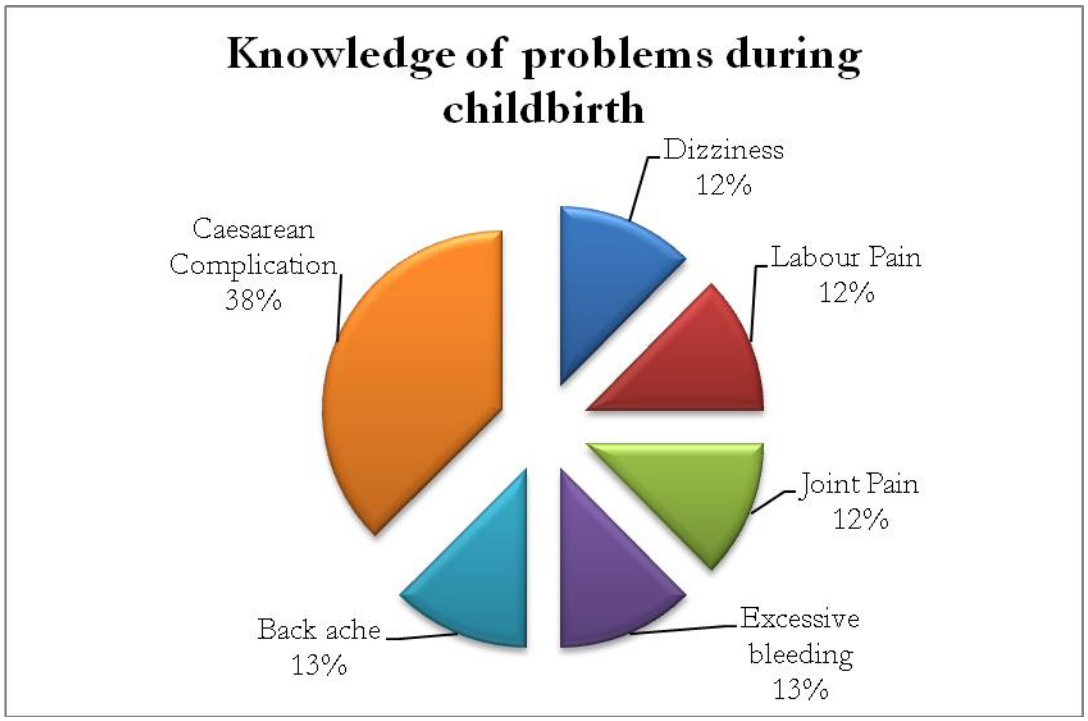


Figure *3.3.4.4 (a)*

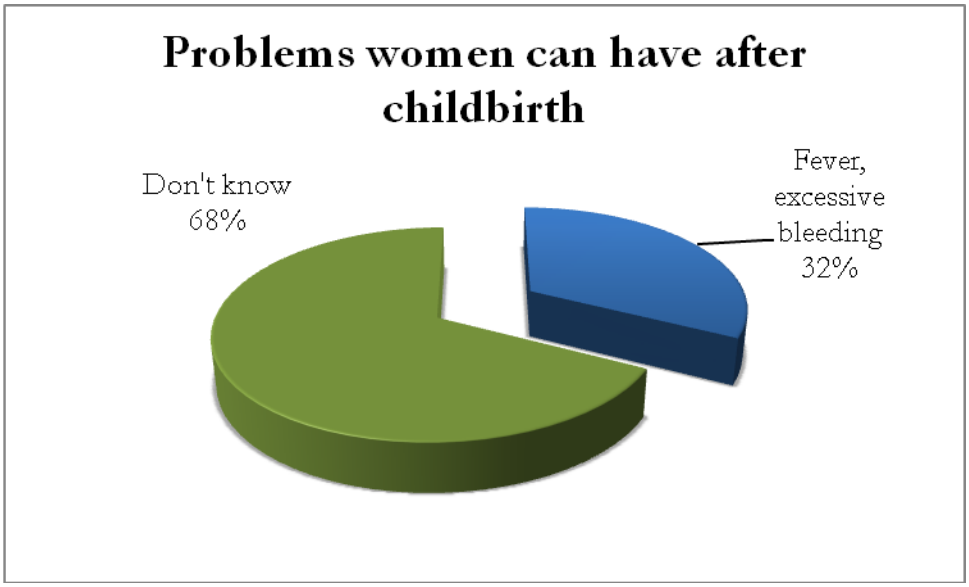


Figure *3.3.4.4 (b)*

b. In-depth Interview of Sahiyyas/ANM

There were in all 10 in-depth interviews of Sahiyyas which consists of both trained and untrained ones. Out of the total interviewed 60% were trained and rest 40% were untrained. The major findings of the study were as sited below:

Antenatal Care

Regarding advice on care during pregnancy, the major items mentioned were regarding safe delivery (50%), nutritional advice (10%) and TT injection (20%). But knowledge level regarding scientific methods like taking B.P and care of health is low (0%). Regarding problems which women may suffer during pregnancy, the major mentioning were regarding swelling of hands and feet (20%), dizziness (20%) and bleeding (20%). The interesting part is that knowledge level among them regarding the major problems faced by women is quite good and this might be due to the gradual practise followed by them throughout the year around. Refer: Table 3.3.4.5

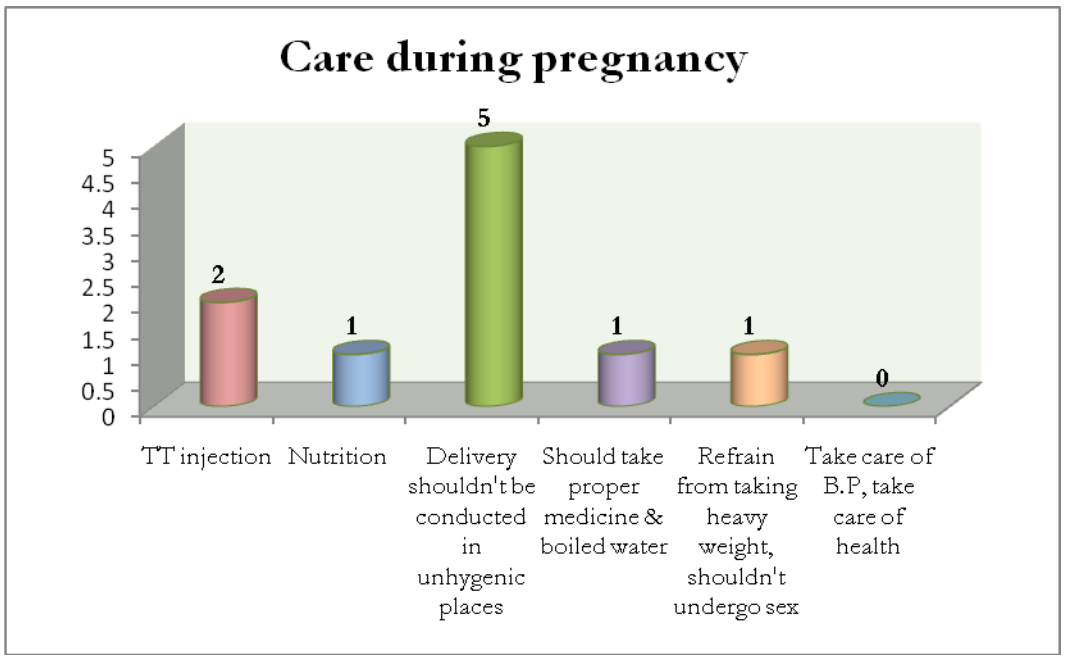


Figure 3.3.4.5

Natal Care

When asked about knowledge regarding 5 cleans of delivery it was found interestingly that majority of them irrespective of whether trained or untrained don't remember all the 5 Cs. Majority of them sited Clean hands(20%), Clean blades(10%), Clean place(20%), clean soap(10%), clean thread (10%) as the 5 cleans. But quite a number of them identifies wearing of gloves (10%), folding sleeves of blouse (0%), clean gauze (10%) and child shouldn't be put on bare floor (10%) as the cleans of delivery. Regarding danger signs of delivery, excessive bleeding (30%) is the major danger sign amongst them besides this 20 % reported that they are unaware of any kind of danger sign of pregnancy . *Refer Table: 3.3.4.6*



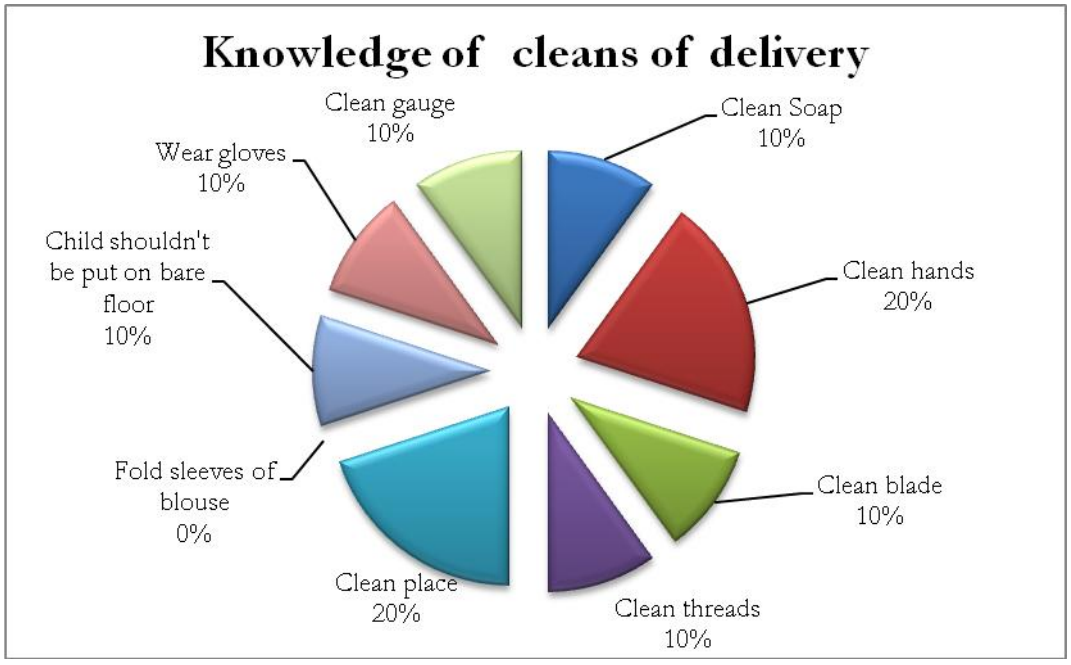

Knowledge of cleans of delivery
Clean gauge 10%
Clean Soap 10%
Wear gloves 10%
Child shouldn't be put on bare floor 10%
Clean hands 20%
Fold sleeves of blouse 0%
Clean blade 10%
Clean place 20%
Clean threads 10%

Figure *3.3.4.6*

Post-natal Care

Regarding giving of colostrum feeding, 90% of them responded positively, reason given was that it gives strength to the child. On the period of complete breastfeeding, majority of them were of the view that 9 months (40%) is the ideal period followed by 1 year (30%) and 6 months (20%) which shows the existence of myths within the study community. On advice given to the mother after delivery, the major responses were towards proper nutritional advice (30%), colostrum feeding and exclusive breastfeeding for 4 months (20%) and bring the mother for regular check-ups (40%). Majority of them responded that they give immunization advice for children (80%). Almost one-third of the responded that they don't promote spacing (30%) with 70% of them saying that they use to promote spacing, but this result may be biased towards the positive side given the village environment. *Refer Table: 3.3.4.7*

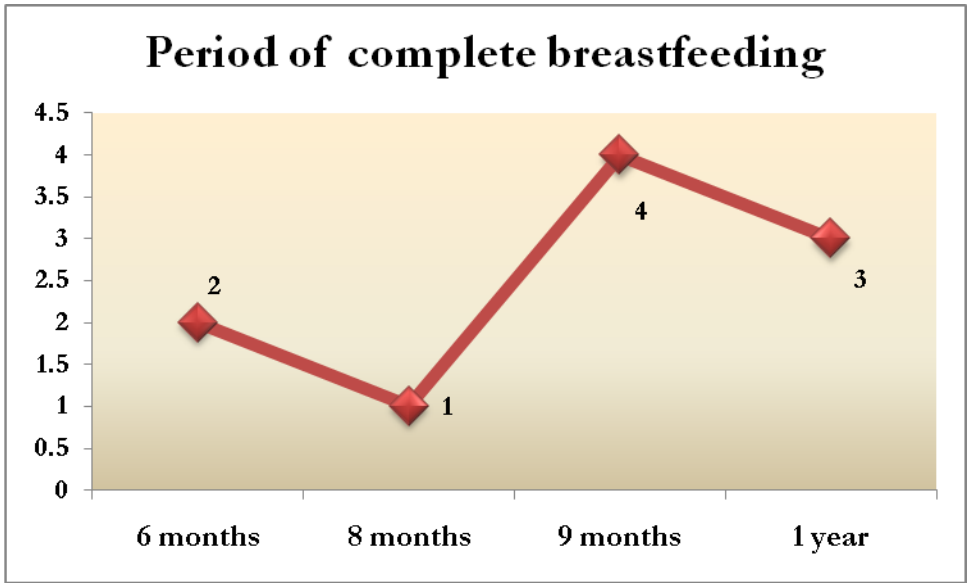


Figure *3.3.4.7*

New-born Care and Care after Pregnancy

Regarding care of a new-born child majority of responded that cleaning of mouth, cleaning eyes of the child and covering the body (30%) as the ways to take of a new born child. High fever (20%) and dizziness (20%) are identified as the other major problem a mother may face after delivery. *Refer Table: 3.3.4.8*

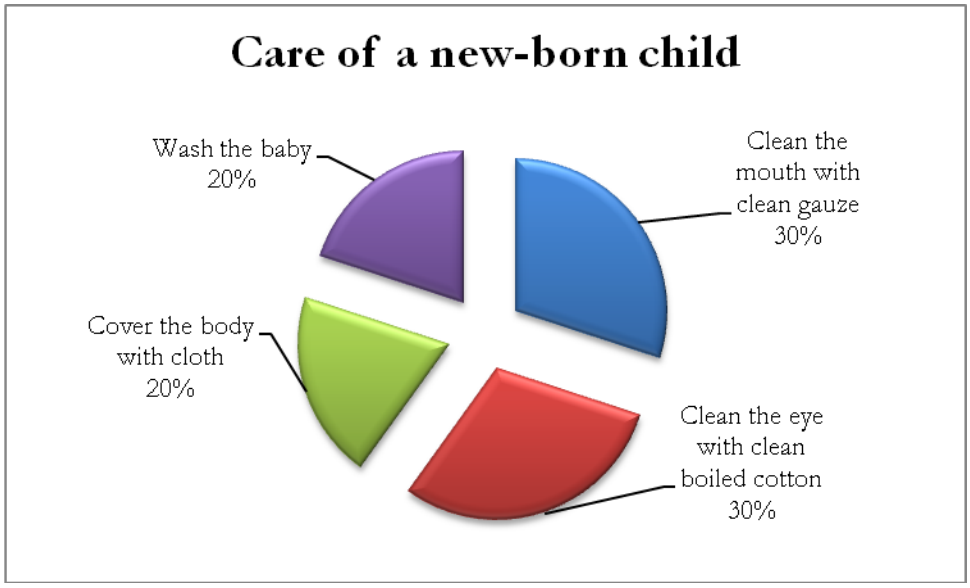


Figure 3.3.4.8



Chapter 4
Conclusions

The trend of piloting new initiatives and state led design of need and context specific innovations is path breaking. The context for piloting innovations has of course been set by the flexible framework set by RCH II and NRHM. Varying performance by states in overall health programme management, and the limitations of inadequate human resources, governance issues, and the lack of attention to good process documentation and effective systems for monitoring and follow up are limitations to enabling scaling up of these innovations even where they prove to be successful.

The current study analyzes the level of knowledge, attitude and practices of these target groups and also the knowledge level of Sahiyyas/ANMs as they do continue to be a prime source of information on pregnancy related matters so they were the most easily accessible persons. The study report highlights the salient features of the health seeking behaviour of the community on various indicators. The study does not provide any rates and ratios.

References

1. Christensen, C.M, Grossman, J.H, and Hwang, J (2009) *The Innovator's Prescription: A Disruptive Solution for Health Care*, London, McGraw-Hill.

2. Hill D, Obando P and Jensen G, (2010) *Healthcare innovation: The cost killer?*

3. Govt of Jharkhand (2006), *Sahaaiya Guidelines* by the Dept of H&FW

4. India (December 2006), *Study Protocol*, Krishi Gram Vikas Kendra, ICICI Bank and Child in Need Institute

5. India (December 2006*), Baseline Survey Summary Report*, Ranchi Low Birth Weight Project, Krishi Gram Vikas Kendra, ICICI Bank and Child In Need Institute

6. Krishi Gram Vikas Kendra, Child In Need Institute and Social Initiatives Group-ICICI Bank (October 2006), *Ranchi Low Birth Weight Project: Baseline Survey Summary Report*.

7. Prasad. G. 2009. "Urban Health in Uttar Pradesh: Challenges and Opportunities." Available at http://uhrc.in/downloads/Presentations/Gajraj_Prasad.pdf

8. Chirmulay, D. 1997. "Factors Affecting Health Seeking and Utilization of Curative Health Care." Draft Report. Pune: BAIF Development Research Foundation. Available at http://www.cehat.org/publications/rhr4.html#4

9. Aggarwal, O.P., Kumar, R., Gupta, A., et al. 1997. "Utilization of Antenatal Care Services in Periurban Area of East Delhi." Indian Journal of Community Medicine 22 (1): 29–32. Available at http://www.cehat.org/publications/rhr4.html#1

10. Chirmulay D. 1997. Factors Affecting Health Seeking and Utilization of Curative Health Care. Pune: BAIF Development and Research Foundation. Available at: http://www.cehat.org/publications/rhr4.html

8. State PIPs from year 2006- 2010

9. Websites:

- http://hetv.org/pdf/ranchi-lbwprotocol.pdf
- http://www.cbhihsprod. nic.in/prin.asp?SF=27&KI=18&OT=1
- http://hetv.org/resources/nutrition.htm
- http://www.indianngos.com/issue/population/corporates/index.htm

- http://www.blonnet.com/bline/2003/07/05/stories/2003070500150500.htm
- http://mohfw.nic.in/NRHM/Documents/dfid_directory_of_innovations_march.pdf
- http://www.healthpolicyinitiative.com

8. Presentation on Strengthening NGOs Capacity to Improve Maternal and Child Health though a Life Cycle Approach, CINI, December 2006