National Workshop on
Best Practices in Tribal Health Care

Organized by

The Ministry of Health and Family Welfare,
Government of India

Hosted by

SEARCH, Gadchiroli

Report of the National Workshop on Best Practices in Tribal Health Care

Edited by

Dr. Abhay Bang

With Assistance from

Dr. Priyamadhaba Behera

SEARCH, Gadchiroli

(January, 2016)

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Foreword

How to improve health care for the tribal people? What are the potential innovations and solutions? Are they evidence-based and effective? Can they be scaled up?

The national workshop on the Best Practices in Tribal Health Care was organized by the Ministry of Health and Family Welfare, Government of India to provide the inputs to the Expert Group on Tribal Health for finding answers to the above questions. Twenty three nationally selected best practices were presented and discussed. This document is a record of the workshop.

This probably was the first such attempt in India. The Expert Group on Tribal Health is grateful to the Ministry of Health and Family Welfare, Govt. of India for organising this workshop, to the National Health System Resource Centre, New Delhi for facilitating the organisation and to SEARCH (Society for Education, Action and Research in Community Health), Gadchiroli for hosting the workshop. The 85 best practices nominated, 25 selected and 23 presented – all deserve thanks.

A special thanks are due to the reporting team of SEARCH – Dr. Priyamadhaba Behera, Ms. Ruth Tryphosa, Mr. Satish Babu and Mr. Ranjan Pandhare whose painstaking efforts of recording, transcribing and editing have made this report possible.

The report will be a valuable input to the Expert Group, but will also serve as a unique document useful to others interested in the health of the tribal people in India.

Gadchiroli   Dr. Abhay Bang
10th January 2016   MD, MPH, D.Sc. D. Lit
                                                                         Chairman, Expert Group on Tribal Health
                                                                                                Director, SEARCH

1. Background

Concept

Ministry of Health and Family Welfare, Govt. of India has constituted an Expert Group on Tribal Health. The Expert Group had decided to organize a national workshop on 'the best practices in tribal health care' with the aim to bring together the best practices, share and examine them to identify the practices which offer the potential for scaling up or the learnings for the tribal health care policy in India.

The 53 participants were from all over India, selected from the government health care programs in states, the civil society and the academic/research organizations.

The 'Best Practice' was meant to demonstrate and effective method/approach or solution which would become a candidate for scaling up to solve some of the critical problems in tribal health care. The features essential to be called a best practice were -

1) A specific important problem is addressed. The problem may be a disease, a health indicator (IMR, MMR etc) or a barrier to providing health care in tribal areas (human resource, outreach, community participation, health education, community based care, secondary care, transport, acceptance by the tribal people, coverage, monitoring, financing, etc).
2) A distinct method or a component.
3) Demonstrated feasibility of implementation.
4) Proven impact.
5) Scalability.

The nominations/applications were invited and a selection group selected the appropriate best practices for the workshop. Invitation letter and Best Practice Nomination Form are attached in Annexure I & Annexure II respectively.

The workshop was organized by the MOH&FW and hosted by SEARCH, Gadchiroli.

Date: October 11th to 13th, 2015

Location: Shodhagram (SEARCH HQ) Gadchiroli, Maharashtra (200 km from Nagpur)

2. Objective

This workshop is the beginning of the Expert Group's search for solutions. The purpose is to share, examine and find potential solutions which can be/should be delivered on large scale

3. Selection

Selection committee

1. Dr. Abhay Bang (Chairman)
2. Mr. Manoj Jhalani (MOH&FW, GOI)
3. Dr. Neeru Singh (ICMR)

We received very enthusiastic response with 85 entries. The 5 criteria for selection were

1) A specific important problem is addressed.
2) A distinct method or a component.
3) Demonstrated feasibility of implementation.
4) Proven impact.
5) Scalability.

It was very challenging to select only 25 best practices out of the 85. Selection procedure had two stage review. National Health Systems Resource Centre (NHSRC) did the initial screening, and the three member expert group made the final choice. Twenty three best practices were presented in this workshop. The Expert Group, the Ministry of Health, NHSRC and Society of Education, Action and Research in Community Health (SEARCH) have joined hands to make this happen.

4. Workshop Proceedings

List of participants

(The list of participants is attached in Annexure III)

Programme/Time table

(The detail of program and time table is attached in Annexure IV)

Presentations

S.N.	Organization	Practice
1	L V Prasad Eye Institute, Telangana	Eye care
2	National Institute for Research in Tribal Health, Jabalpur	Fluorosis
3	National Institute for Research in Tribal Health, Jabalpur	Malaria Control
4	MITRA, Christian Hospital, Bissamcuttack, Odisha	Malaria control
5	Jan Swasthya Sahyog, Chhattisgarh	Phulwari - creches for malnutrition
6	Government of Chhattisgarh	Fulwari, Scaling up
7	Health Department, Jashpur, Government of Chhattisgarh	Swasthya Lika Jagruti (Health Wednesday)
8	Population Foundation of India, National Health Mission	Community Based Monitoring
9	Nazdeek, Assam	Community reporting of deaths
10	National Health Mission, Palakkad, Kerala	Software-based monitoring Janani – Jatak
11	Karuna Trust, Karnataka	Operationalising PHCs by PPP

12	Deepak Foundation and Health Department, Gujarat	CEmONC by PPP
13	Tata Steel	MANSI - HBNC through ASHAs
14	SEWA Rural, Gujarat	ImTecho
15	IKP Centre For Technologies in Public Health (ICTPH), Tamil Nadu	Bridge Training for AYUSH doctors
16	Jan Swasthya Sahyog, Chhattisgarh	ANN/GNM Training
17	Health Department, Chhattisgarh	HR Outsourcing
18	Area Networking and Development Initiatives (ANANDI), Gujarat	Women's empowerment
19	Shrimad Rajchandra Hospital, Dharampur, Gujarat	Mobile unit
20	Health and Family Welfare Department, Gujarat	Sickle cell
21	Sugha Vazhvu Healthcare, Tamil Nadu	Enrollment and Rapid Risk Assessment
22	Integrated Tribal Development Agency, Adilabad	Increasing Institutional Deliveries
23	National Health Mission, Tamil Nadu	Birth waiting room

Two organizations selected for presentation were absent, namely by Suraksha, Odisha on 'Malaria control' and SERP, Andhra Pradesh on 'Nutrition for mothers and children'.

In addition the HBNC model of SEARCH was presented along with demonstration by trained community health worker.

The workshop proceedings are attached in Annexure V.

5. Evaluation

Assessment of 23 best practices

All participants of workshop were given chance to evaluate all 23 practices presented in this workshop through a structured score sheet. The score sheet is attached in Annexure VI.

Analysis of assessment score

For score sheet, the individual presentations were analysed with the score A to D in each of the 5 domains and presented in tabular form.

Participants' score to the presentations

(This does not necessarily mean the final verdict of the workshop)

Sr No.	Name	Mean score (maximum=4)
1	MITRA, Christian Hospital, Bissamcuttack, Odisha (Malaria Control)	3.62
2	Karuna Trust, Karnataka (Operationalizing PHCs by PPP)	3.46
3	Jan Swasthya Sahyog, Chhattisgarh (ANN/GNM Training)	3.42
4	Tata Steel (Mansi - HBNC through ASHAs)	3.42
5	National Health Mission, Palakkad, Kerala (Software-based monitoring Jatak and Janani)	3.32
6	National Institute for Research in Tribal Health, Jabalpur (Fluorosis)	3.31
7	SEWA Rural, Gujarat (ImTeCHO)	3.27
8	National Institute for Research in Tribal Health, Jabalpur (Malaria Control)	3.26
9	Deepak Foundation and Health Department, Gujarat (CEmONC by PPP)	3.25
10	Government of Chhattisgarh (Fulwari - Scaling Up)	3.21
11	Area Networking and Development Initiatives (ANANDI), Gujarat (Women's empowerment)	3.1
12	Population Foundation of India (Community Based Monitoring)	3.08
13	Jan Swasthya Sahyog, Chhattisgarh (Phulwari – crèches for malnutrition)	3.06
14	IKP Centre For Technologies in Public Health (ICTPH), Tamil Nadu (Bridge Training for AYUSH doctors)	3.03
15	Health Department, Chhattisgarh (HR Outsourcing)	3.01
16	Shrimad Rajchandra Hospital, Dharampur, Gujarat (Mobile Unit)	2.88

17	Nazdeek, Assam (Community reporting of deaths)	2.84
18	L V Prasad Eye Institute, Telangana (Eye Care)	2.8
19	Health and Family Welfare Department, Gujarat (Sickle Cell)	2.76
20	Sugha Vazhvu Healthcare, Tamil Nadu (Enrollment and Rapid Risk Assessment)	2.76
21	Integrated Tribal Development Agency, Adilabad (Increasing Institutional. Deliveries)	2.74
22	National Health Mission, Tamil Nadu (Birth waiting room)	2.5
23	Health Department, Jashpur, Government of Chhattisgarh (Swasthya Lika Jagruti - Health Wednesday)	2.37

Feedback on the workshop

All participants provided their feedback about workshop in a structured format. The feedback form is attached in Annexure VII.

The detail of feedback analysis is presented in the next page.

S. No.	Domain	Total (n=36)					Percentage (%)				
		Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
1	The selection process	9	19	7	0	0	25	52.8	19.4	0	0
2	The topics of the various practices presented	15	20	2	0	0	41.7	55.6	5.6	0	0
3	The quality of the best practices presented	5	24	7	0	0	13.9	66.7	19.4	0	0
4	Your learning on tribal health care	18	16	1	0	0	50	44.4	2.8	0	0
5	Did this workshop offer potential solutions for tribal health care on scale?	8	21	6	0	0	22.2	58.3	16.7	0	0
6	How would you feel about meeting periodically on the topic of tribal health?	22	9	1	0	0	61.1	25	2.8	0	0
7	Environment in Shodhagram	30	5	0	0	0	83.3	13.9	0	0	0
8	Food	26	8	1	0	0	72.2	22.2	2.8	0	0
9	Accommodation	22	10	1	1	0	61.1	27.8	2.8	2.8	0
	Total	155	132	26	1	0	47.8	40.7	8	0.3	0

Analysis of feedback form of National Workshop on Best Practices in Tribal Health Care (11th to 13th October 2015)

Thirty six participants provided feedback about workshop. All feedback form are entered in excel sheet along with comments and suggestions. Analysis was done on the basis of 1-5 score (very satisfied, satisfied, neutral, dissatisfied and very dissatisfied). **Nearly half of the participants (47.8%) were very satisfied and 40.7% participants were satisfied and 8% participants were neutral in the feedback for workshop.** Detail results are attached. The comments and suggestions are summarized in a separate word document.

Feedback: Comments, suggestions & grievances

General Comments:

1. Very Good Workshop. Everything is good (4 persons)
2. Please open up this forum for more interested individuals and may be, a 'learning (hands on) session' on 'Evidence-based study' on health practices.
3. More case studies exclusively on tribal health should have been invited. Few presentations were not projecting their exclusive work on tribal health.
4. The simplicity of being and depth of purpose and conviction that I see in the work and existence these last three days has left a deep impact.

Salient Features

   a. Shodhagram
   b. Emphasis on post presentation discussions.
   c. Emphasis on generating evidence + minimizing duplication. Thinking about the big picture + thinking about the real impact we intend to create.
   d. SEARCH team.

   The content conversation + community provided great food for thought professional + personally.

5. Health system particularly the PHC and District head quarters should be more people centric rather than PHC and hospital centric. Tribal people still fear to get across health staff.
6. Very good exposure to learn from so many kinds of organizations working at different levels and ends for same problem.
7. Make it more periodic.
8. It is good to know about other organizations work, especially on different health issues. Along with the interaction with all the representatives.
9. Learned a lot. Got improved and recharged again. Hope we continue to meet once again.
10. Many best practices presentation are proof of concept state which needs further testing in terms of outcome assessment to provide evidence based for scale up. Research recommendations should emerge from the ideas presented that need to be tested on priority base to improved tribal health.

11. Fantastic boot camp for ideas! Hopefully many can take back learning and replicate them in their areas. I for one, are going back energized and enthused and with a (very important) perspective of where our own work falls in the larger national scheme of things. Fantastic discussions on what I do believe public health is constantly gapping with.

12. Inspiring environment reenergized to work for tribal health and issues.

13. Selected presentations and giving opportunity to much related ones to give detail presentation on success stories as well the failures. It is a unique idea of demonstrating best practices to improve tribal health. This group itself is a community to understand and interact with each other for a common goal.

14. Express my sincere thanks all committee members on Tribal health Care and especially chairperson. Dr. A. Bang for organizing this types of workshop. It my very learning atmosphere for me. Liked the environment and campus very much due its tribal natural touch.

15. This workshop was definitely inspiring on one issue and there was very much superior discussion along with indicating solution a problems.

16. It is a visionary exercise for extentification of need based comprehensive and innovative solution for health of tribal people

17. The best practices presented are best practices for the presenter but got an idea that it should be statistically significant also. Most of the best practice for one area is the best practice for the issue pertaining to that area and so the solutions an also very specific. The alternatively one successful as they were made specific for the area. So whenever scaled up the comments and suggest of the original should be taken.

18. ----- And progress a presentations. Summary of learning's and adaptations. Would be good to ---- medical institutions on how empathy needs to be build in our curriculum.

19. The objective of workshop/expert committee to understand tribal health status and health care status. The latter is one at the determinants of first. The best ------ ------ the solutions attempted and find the way toward in   improving tribal health status. The --------- side ----- ---- to be in minority. The cross-cutting concerns like phone/internet/connectivity may get top priority when dreamt in tribal health.

20. Excellent learning opportunity

21. The idea of ----- equal time for discussion after presentation was very good. Discussion helped more in many ----- expert views, ------

22. These practices are to be documented, printed and widely circulated (not just as a tech. report of the ministry). Further implementation and ----- of ------ practices are to be taken up by the ministry/state with ------ -------- may be in bit larger area.

23. A good start. Going forward this effort should be continued suggest sub categories of theme are made, so that submission of practices can be made under those. Secondly there has to be a guideline given for an idea/strategy to become part of best/good practices. Kindly a pilot and a policy, there has to be a phase to debate strategies before scaling up.

24. Very rich discussion re some long standing policy issues. But need much more specific process oriented information on best practices not clear what makes a best practice.

Other specific suggestion/ grievance for further improvement:

1. Please share the individual comments (video) that could be shared with the actual decision makers in proper precision.

2. The organizer/host could have informed the participants about non availability of all mobile network/internet in the venue campus. Otherwise we would have prepared ourself with BSNL sim etc.

3. As a society we have come to take certain things for granted. While this unit the best way to be. This is so. So a disclaimer on non-availability of all phone reception will be helpful

4. I believe connectivity was an issue, but it worked to the advantage as peer interaction was effective. Else everyone would have been ---- with there ----- and other -----

5.
   a) Today there appears to be too much expectations of work from the ASHA worker with little rewards
   b) There is a need of entire medical system staff to outreach the tribal people in villager.
   c) There is a tremendous needs of collaboration and support to each other between the Govt. Hospital , NGO and private organizations
   d) Education on tribal on Health through commitment, dedication, interest, love and affection will provide a solution for very good health services and success

6. Scale it to include more participants. Make it issue based for intensive study. Document all sources and attempt to institutionalize.

7. The workshop venue should be in a more convenient place with respect to the direct connectivity to trains or Flights since people are coming from all over the country and keeping mind busy

schedule of every one. This would be very much helpful. Also Air India flights doesn't conduct everywhere and doesn't have a good flight frequency. So the reimbursement shouldn't have to be limited to air Indian flights.

8. There should be periodic meeting to share new ideas to asses/ examine outcome of already presentation ideas. The criteria for scoring may be modified to include more options.

9. Do believe there were lopsided amounts of time/discussion spent on different practices. But probably due to time management could be improved upon becomes we might be missing one on discussing/debating important issues of public health, could have been a session for scientific data collection and presentation.

10. Impact evaluation capacities in partner organizations working in tribal health required. NHSRC/SEARCH/MoTA/ MoHFW can contribute.

11. Involving community and interacting with them during these meeting will be helpful

12. To prepare actionable perspectives and action plan for tribal health care, regional level consultation with participation of local NGOs, local tribal leaders etc may be organized.
    a) In future, the venue for workshop should be same –Shodhagram if repeated
    b) It may be better to involve officials from MOTA
    c) While shortlisting innovations, the activities should not have possibility of overlapping with ongoing NHM activities in tribal health.

13. The best practices of Maharashtra could not find place in this workshop which could have triggered more discussion.

14. Except "IEC for Malaria" and "Ethics tool of hospital" the demand side practices were not included or received. Front door management of health facility begins in tribal in comfort zone is a major factor. I believe. So is true in NCDs.

15. Accommodation for govt. official @ Gadchiroli district HQ was not managed properly. Government guest house was very dirty without basic facility of tap water, fan, shifting to local hotel was little better for ----- stay.

16. Groups of tribal people (not NGOs working on them) or source community level groups (like -----) ------ have been involved. Perspectives of tribal people is to be taken into consideration.

17. This kind of workshop to be organized at different place. Also place the field visits to such organizations to learn more about best practices.

18. Some strategies selected but they are still too early to find space in good practices. Eg. Shrimad Rajchandra. This space was good for debating certain strategies even if they are not of the level of best practice discussion forum. Some evaluation is important for selection in best practice. A forum or platform should be created for discussion/brainstorming health. Medical anthropologists should be involved. Tribal should be part of this.

19. Need to relook at some of the criteria for ratting innovations eg. It may be addressing an limp problem, but is it sufficiently/directly addressing it. Also most practices here have been tried by multiple agencies. What makes this one a best practice not clear word "best practice needs to be re-examined.

    a) Work with ICMR on generating evidence
    b) Training to identify and document processes
    c) Consider and take forward some policy debates with evidence generation
    d) Need to study and document tribal health practices to learn and build on and also to identify certain practices that may be causing problems. Reverse / two way knowledge sharing. Tribal best practices can solve problems of non-tribal.

6. News reports

The news reports related to "National Workshop on "Best Practices in Tribal Health Care" are summarized below. The detail of the news reports are attached in Annexure VIII.

Media	Web link
1. inbministry blogspot	http://inbministry.blogspot.in/2015/10/national-workshop-on-best-practices-in.html
2. United News of India (October 15, 2015)	http://www.uniindia.com/national-workshop-on-best-practices-in-tribal-health-care-held-in-gadchiroli/india/news/236903.html
3. The Hindu (November 29, 2015)	http://www.thehindu.com/opinion/op-ed/taking-health-care-to-tribal-heartland/article7927736.ece
4. Times of India (October 10, 2015)	http://timesofindia.indiatimes.com/city/nagpur/Bangs-to-hold-natl-workshop-on-tribal-health-at-Gadchiroli/articleshow/49294556.cms
5. The Economic Times (October 13, 2015)	http://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/indian-council-of-medical-research-dg-calls-for-new-researches-on-tribal-health/articleshow/49335311.cms
6. India Today (October 13, 2015)	http://indiatoday.intoday.in/story/icmr-dg-calls-for-new-researches-on-tribal-health/1/497373.html
7. The Economic Times (October 13, 2015)	http://health.economictimes.indiatimes.com/news/industry/punjab-to-spend-more-than-rs-419-crore-to-boost-medical-research/49673110
8. Business Standard (October 15, 2015)	http://www.business-standard.com/article/government-press-release/national-workshop-on-best-practices-in-tribal-health-care-held-115101500348_1.html
9. Report Odisha (October 15, 2015)	http://reportodisha.com/national-workshop-on-tribal-health-care-held/
10. ICMR website	http://icmr.nic.in/icmrnews/National%20Workshop%20on%20Be

	st%20Practices%20in%20Tribal%20Health%20Care.pdf
11. Press Information Bureau Government of India Ministry of Health and Family Welfare (October 15, 2015)	http://pib.nic.in/newsite/PrintRelease.aspx?relid=128746
12. Dailyexcelsior (October 16, 2015)	http://www.dailyexcelsior.com/expert-group-on-tribal-health-to-submit-report-by-year-end/
13. India Today (October 15, 2015)	http://indiatoday.intoday.in/story/expert-group-on-tribal-health-to-submit-report-by-year-end/1/499402.html
14. The Economic Times (October 15, 2015)	http://economictimes.indiatimes.com/articleshow/49380203.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

Annexure I

Invitation letter

Subject: National Workshop on the Best Practices in Tribal Health Care.

Ministry of Health and Family Welfare, Govt. of India has constituted an Expert Group on Tribal Health. The Ministry will be conducting a national workshop on "the best practices in tribal health care," at SEARCH Headquarters, Gadchiroli. The goal is to compile, share, examine and identify the best practices which offer the potential for scaling up or the learnings for the tribal health care policy in India.

Hon. Shri J.P. Nadda, Minister of Health and Family Welfare, Govt. of India, will inaugurate the workshop.

For this cause, we request you to pass this invitation on to the potential grantees that can provide the example of "best practice" in tribal health care. Out of the many applications, a three membered committee will select 40 participants to attend the workshop.

Accordingly, please find the attached concept note, detailing the essential features of what a best practice is, and a Nomination form.

Please note that the deadline for final submission is 15th September, 2015 and the workshop will be held from 11 to 13th October, 2015.

Nomination forms should be sent to search.gad@gmail.com. We will be honoured by your contributions.

Thanks and regards,

Dr. Abhay Bang
Chairman,
Expert Group on Tribal Health,
Ministry of Health and Family Welfare.

Attachments:

1. Concept Note on the Workshop

2. Nomination form

<u>Annexure II</u>

<u>The nomination/description form</u>

1. Name of the organization : _____

2. Head/ contact person :_____

3. Address : _____

4. E-mail : _____   Phone : _____

5. State : _____

6. Working in tribal population since _____

7. Which 'Best Practice' do you wish to share?

   _____

   _____

8. The specific problem addressed by the Best Practice?

   _____

   _____

9. Goal of the Best Practice?

   _____

   _____

10. Content/Process of the Best Practice?

    _____

    _____

    _____

11. What is new or different in this practice?

    _____

    _____

12. Tribal Population size?

    _____

13. Feasibility of delivery and acceptance by tribal people?

_____

_____

14. Evidence of the impact?

_____

_____

_____

15. Limitations, difficulties?

_____

_____

16. How and how much can it be scaled up?

_____

_____

Annexure III

List of participants

National Workshop on Best Practices in Tribal Health Care

Shodhagram, SEARCH, Gadchiroli

11th – 13th October 2015

Sr. No.	Name of Person	Organization / Designation
1.	Dr. Soumya Swaminathan	DG ICMR & Secretary Health Research
2.	Smt. Limatula Yaden	Director, NHM GOI
3.	Dr. Abhay Bang	Committee Chairman & DIRECTOR OF SEARCH
4.	Prof. H. Beck	Committee Member
5.	Dr Neeru Singh	Committee Member
6.	Dr. Yogesh Jain	Committee Member
7.	Dr. A. C. Dhariwal	Committee Member
8.	Dr. H. Sudharshan	Committee Member
9.	Ms. Neidonuo Angami	Committee Member
10.	Dr. Satish Kumar	NHSRC
11.	Dr. Padam Khanna	NHSRC
12.	Mr. Venkatesh Roddwar	NHSRC
13.	Mr. Manoj Kumar	NHSRC
14.	Mr. Arvind Poswal	Ass. Sec MOH, GOI
15.	Ms. Shruti Ojha	Ass. Sec MOH GOI
16.	Mr. R. K. Lakhani	Consultant, MOHFW
17.	Mr. Nikhil Utture	Consultant, MOHFW
18.	Dr. Krushna Vijaykumar	Consultant, MOHFW

	Sirmanwar	
19.	Dr. Tapas Chakma	NIRTH, Jabalpur
20.	Dr. K. B. Saha	NIRTH, Jabalpur
21.	Dr. Amol	LV Prasad Eye Institute, Hyderabad
22.	Mr. Bejoy Daniel	Sugha Vazhu Health Care, Tamilnadu
23.	Dr. Akash K. Lal	DF, Vadodara
24.	Mr. Hemant Kispotta	Nazdeek, Assam
25.	Shri Gaurij Hood	Shrimad Rajchandra Hospital, Dharampur
26.	Mr. Bipin Rawat	TSRDS, Jharkhand
27.	Mr. Anup Sarma	Nazdik, Karuna Trust
28.	Mr. R. K. Ananth Krishnan	ITDA, Adilabad
29.	Dr. Prabhakar Reddy	ITDA, Adilabad
30.	Dr. B. V. Babu	ICMR, New Delhi
31.	Dr. Akhilesh Tripathi	Deputy Director, NHM, Chattisgarh
32.	Dr. Satish Tajne	State Programme Manager,NHM, Chattisgarh
33.	Ms.Innaciammal	JSS, Bilaspur
34.	Mr. Anil Barme	JSS, Bilaspur
35.	Dr. Reeta Rasaily	Scientist F ICMR
36.	Dr. Nandini Srivastava	DF, Vadodara
37.	Ms. Aparna Manoharan	ICTPH, Tamil Nadu
38.	Dr. Shrey Desai	SEWA Rural, Gujrat
39.	Ms. Pradeepa Dube	ANANDI, Gujrat
40.	Ms. Hema Priyadarshini	Health and WCD Dept. of Chattisgarh
41.	Ms. Gunjan Veda	Consultant
42.	Ms. Jayeeta Chowdhury	TATA Trusts Mumbai
43.	Dr. Ajay Mishra	Advisory Group on Community Action (AGCA)
44.	Dr. John Cherian Oommen	MITRA, Odisha
45.	Dr. Sreehari M	DPM, NHM, Palakkad, Kerala

46.	Mr. Santosh Nayak	NHM, Odisha
47.	Dr. Adaif K. Pradhan	SPM, NHM, Odisha
48.	Abhay J. Dixit	NHM, Maharashtra
49.	Anil Naxine	NHM, Maharashtra
50.	Dr. Raju M. Jotkar	NHM, Maharashtra
51.	Mr. Dipesh Dave	MOH; Gujarat
52.	Dr. Dinkar Raval	MOH; Gujarat
53.	Dr. M. Senthilkumar	Deputy Director (Trng); NHM Tamil Nadu

Annexure IV

Programme Time-Table

Ministry of health and Family Welfare

Government of India

National Workshop on Best Practices in Tribal Health Care

Shodhagram, Gadchiroli

October 11th – 13th, 2015

11th October (Sunday)	Topic	Session Chair	Venue/Person
10.00 – 11.00	Registration		Mahesh Deshmukh, team
Session 1	**Inaugural session**	Dr. Abhay Bang, (Chairman, Expert Committee on Tribal Health)	Patanjali Bhavan
11.00 – 11.15	Welcome and purpose of the workshop		Dr. Abhay Bang Dr. Limatula Yaden, (Director, NHM Govt. of India)
11.15 – 11.30	Self-introduction		Participants
11.30 – 11.50	Inauguration and inaugural speech		Dr. Soumya Swaminathan (Secretary, Health Research and D.G., ICMR)
11.50 – 12.15	Tea break		
Session 2			
12.15 – 13.15	**Specific health problems** 1. L V Prasad Eye Institute, Telangana - *Eye care* 2. National Institute for Research in Tribal Health,	Dr. Limatula Yaden (Director, NHM Govt. of India)	Patanjali Bhavan

	Jabalpu - *Fluorosis*		
13.15 – 14.00	Lunch		
Session 3			
14.00 –15.30	**Malaria** 3. National Institute for Research in Tribal Health, Jabalpu – *Malaria Control* 4. Suraksha (Odisha) – *Malaria Control** 5. Health and Family Welfare Department, Gujarat – *Sickle Cell*	Dr. A. C.Dhariwal (Director, NVBDCP Govt. of India)	Patanjali Bhavan
15.30 – 15.50	Tea break		
15.50 – 17.50	**Malnutrition** *6.* Jan Swasthya Sahyog, Chhattisgarh – *Phulwari - creches for malnutrition* 7. Govt. Chhattisgarh – *Fulwari Scaling up* 8. SERP, (A.P.) – *Nutrition for mothers and children** 9. Health Dept, Jashpur, Govt. Chhattisgarh – *Swasthya Lika Jagruti (Health Wednesday)*	Dr. Reeta Rasaily (Mission Director, Maharashtra	Patanjali Bhavan
17.50 – 20.00	Free time		
20.00 – 21.00	Dinner		

* These two presentations were absent.

12th October (Monday)	Topic	Session Chair	Venue/Person
6.30 – 6.45	Tea		
6.45 – 7.30	Shrama-yoga (Environmental Service)		
7.30-8.30	Breakfast		
Session 4			
9.00 – 10.30	**Monitoring** 10. Population Foundation of India, National Health Mission – *Community Based Monitoring* 11. Nazdeek, Assam – *Community reporting of deaths* 12. National Health Mission, Palakkad, Kerala – *Software based monitoring Jatak and Janani*	Dr. Sudarshan (Karuna Trust)	Patanjali Bhavan
10.30 – 10.50	Tea-break		
10.50 – 11.50	**Public Private partnership** 13. Karuna Trust, Karnataka – *Operationalising PHCs* 14. Deepak Foundation and Health Dept, Gujarat – *CEmONC by PPP*	Mrs. Angami (Member, Expert Committee)	Patanjali Bhavan
12.00 – 13.30	Shodhagram, SEARCH, and HBNC		SEARCH Team
13.30 – 14.30	Lunch		

Session 5	Topic	Session Chair	Venue/Person
14.30 – 15.30	**HBNC and ASHA** 15. Tata Steel – *Mansi - HBNC through ASHAs* 16. SEWA Rural, Gujarat – *ImTeCHO*	Dr. Neeru Singh (Director, NIRTH)	Patanjali Bhavan
15.30 – 15.50	Tea break		
15.50 – 17.50	**Human Resource** *17.* IKP Centre For Technologies in Public Health (ICTPH), Tamil Nadu – *Bridge Training for AYUSH* 18. Jan Swasthya Sahyog, Chhattisgarh – *ANM/GNM Training* 19. Health Dept., Chhattisgarh – *HR Outsourcing* 20. Area Networking and Development Initiatives (ANANDI), Gujarat – *Women's empowerment*	Prof. H. Beck (TISS)	Patanjali Bhavan
17.50 – 18.45	Free time		
18.45 -19.00	Community Prayer		Pimpal Bhavan
19.00 – 19.15	NHSRC – *Innovation Portal*		
20.00 – 21.00	Dinner		

13th October (Tuesday)	Topic	Session Chair	Venue/Person
6.30 – 7.00	Tea		
8.00 – 8.45	Breakfast		
Session 6			
9.00 – 10.30	**Other issues** 21. Shrimad Rajchandra Hospital, Dharampur, Gujarat – *Mobile unit* 22. MITRA, Christian Hospital, Bissamcuttack – *Malaria Control* 23. Sugha Vazhvu Healthcare, Tamil Nadu – *Enrollment and Rapid Risk Assessment*	Dr. Yogesh Jain (JSS, Ganiyari)	Patanjali Bhavan
10.30 – 11.00	Tea break		
11.00 – 12.00	**Maternal Health** 24. Integrated Tribal Development Agency, Adilabad – *Increasing Institutional Deliveries* 25. National Health Mission , Tamil Nadu – *Birth waiting room*	Dr. Satish Kumar (NHSRC)	Patanjali Bhavan
Session 7			
12.00 – 13.00	Conclusions	Dr. Abhay Bang	Patanjali Bhavan
13.00 – 13.30	Feedback and Travel forms		
13.30 – 14.30	Lunch		
14.30	Return journey		

Annexure V

Workshop Proceedings

Admission

We have attempted to capture the proceedings under three heads – the presentations (PPT), discussion (Q and A) and the Chairpersons' comments. The PPTs are as provided by the presenters – original or the revised version. The discussion, unfortunately was incompletely recorded because often the participants spoke without the mike. Hence, many a question-answers have been left out. The comments of the session chair person and the Committee Chairperson have been more or less completely recorded. Moreover, while transcribing, we often experienced difficulties in deciphering the recorded spoken word. Hence some errors or omissions might have occurred. If the concerned persons notice such errors/omissions, please inform us the corrections. We will be more than happy to incorporate such corrections.

SEARCH team

Introductory Session

Dr. Abhay Bang
Chairman of the Expert Group on Tribal Health

Friends, welcome to SEARCH. Welcome to Gadchiroli.

Ten crore (hundred million) tribal people live in India, a fact we often are not even aware of. It is not necessary to tell the group assembled here that tribal people are the worst affected people – health, development, human rights and politically . It took almost 65 years after independence for government to appreciate that there may be a need to look at tribal health as an independent major public health priority. Government of India needs to be complimented that the Ministry of Health and Family Welfare and the Ministry of Tribal affairs jointly constituted this expert group on tribal health.

Our planning of rural health care – the NRHM and NHM – it seems has assumed that tribal people are no different from others. Everything planned for rural India should apply to the tribal areas albeit with a little different population ratio. All of us who have been working with tribal people in India know that tribal people are different culturally, tribal people are different socially and tribal people are different environmentally – their terrain, geography and climate are different. Tribal people are different economically – their means of production are different than in the other parts of India. And finally, though only a little bit, they are different genetically also. The differences are important because they all reflect on the health status and health care. But in spite of these huge differences some how we missed viewing health as a product of these differences. We often kept on lamenting that the doctors' posts are vacant, nurses posts are vacant, diarrhoea morbidity is high, child mortality is high, malaria is high, malnutrition is high, but we never thought that we need to look at these as a special situation which needs a special treatment.

In 2013, these two ministries together constituted this expert group. The TOR of this expert group – I am summarizing – is to review the present state of tribal health and health care in the states and the country, and to prepare a road map for the future – a tribal health plan and a framework of the district health plan for tribal areas ;a plan of tribal health care which is appropriate to the needs of tribal people, appropriate to the geographical conditions,

appropriate to the culture, social situation of tribal people; in short, to develop an appropriate alternative health care plan for tribal population.

This expert group started almost from a scratch. We found that there was practically no compiled data about the health status of or health care for the tribal people in India. We were very surprised that the Sample Registration System of India, which monitors a population of 7.2 million, was unable to tell us what the IMR in tribal areas was. This is just an example. Various ministries couldn't tell how much money is spent on health care in tribal areas because nobody kept the data. This committee faced enormous challenge of a complete lack of available data. So it took longer than what we had envisaged. Various subgroups were constituted – one subgroup on the demographic details, mortality rates and life expectancy of tribal population is being coordinated by the International Institute of Population Sciences; another group on nutrition was coordinated by the scientists from the NIN, Hyderabad, the subgroup on morbidities and disease pattern in tribal population was coordinated by the National Institute of Tribal Health Research (ICMR) Jabalpur – Dr. Neeru Singh chaired that group, the subgroup on Malaria was led by Dr. A.C. Dhariwal – Chief of the National Vector Born Disease Control Programme, the subgroup on tribal health culture was led by Prof. Beck. We constituted 3 subgroups on health services in tribal area. Health services in the tribal areas in the states, in the north east; and one group on the financial allocation and utilisation for tribal health. NHSRC coordinated these groups. The last group is on Human Resources: needs and the alternatives for tribal areas of India. Prof Dileep Mavlankar is chairing this group. Based on the work of these 8 sub groups we now have a fairly comprehensive picture of what is the health status and the state of health care in tribal areas. Probably for the first time in the country such situational analysis is now available at the national level.

With this workshop the expert group's work enters the phase II. This phase could be termed as 'the search of solutions'. The purpose of this workshop on the Best Practices in Tribal Health is to share, examine and find the potential solutions which can be or should be delivered on a large scale for tribal people in India.

The picture of tribal health painted in the media and in various health forums is bleak; everything is bad, as if nothing is happening. We were surprised, pleasantly surprised, when we received nearly 85 nominations of best practices in tribal health. It gave us hard time to select 25 best practices from these 85. We used certain selection criteria. A best practice

should have addressed a specific and important health priority in tribal health, it does not mean a rare and unique problem, but it must be a problem which causes sufficient amount of morbidly and mortality or disability to tribal population. The best practice should have a distinct method or a distinct component to be considered a best practice. It should have demonstrated the feasibility of implementation in the field and should have produced a proven impact in the form of reduction in the original problem; and finally, it should be scalable. The best practice could be in a public sector programme, in a social sector programme, or in a private sector programme. A three member expert group finally selected 25. We could not resist the temptation to include the 26th one; so it became 26 best practices. Your practices are going to provide the expert group and the ministry some of the missing pieces in the form of the potential solutions. Each of your practice is not going to solve the complete problem. We don't aim, we don't dream that the entire problem will be solved in one go, but your practices when shared, examined, and evaluated here, hopefully many of these would be found suitable for further scaling up.

The expert group on tribal health, the ministry of health and family welfare, the NHSRC and SEARCH have joined hands to make this workshop happen. I again welcome all of you here, in Shodhagram, in Gadchiroli.

Ms. Limatula : NHM Director

Hon. Chief Guest Dr. Soumya and Chairperson Dr. Abhay Bang. On behalf of the ministry, I would like to welcome all the participants. We did not expect these many and anyway I must tell that this has been possible only because of the active participation of Dr. Abhay Bang, in a short while. We could sit together and bring everyone around. So, a big thank you to Abhay Bang. As all of us are aware that we don't have many tribal specific programme from NHM, specific vertical programmes for any segment of population or even disease control programmes, we are working towards convergence. The beauty of NRHM is that it has given so much flexibility. The NRHM has been encouraging states to come up with specific recommendations to address the regular and local needs. We are also aware of the interstate, intrastate, intraregional and intra-district relations and the health needs of the areas. NRHM encourages states to come up with innovations that will solve local issues and then see if these can be scaled up and replicated in other states as well. Apart from that we are still learning and in fact this is one of the first such workshop that has been organized, and god willing, this will continue. Then it will not only facilitate cross learning across states it will

also give the ministry inputs from expert committee recommendations and I think the future will be brighter.

The Inauguration speech

Dr. Soumya Swaminathan
Director General, ICMR and Secretary, Health Research

It's a great honour and I am privileged to be here today with all of you here and particularly what is a legendary place now in public health, SEARCH in Gadchiroli. I don't need to tell, but what Dr. Abhay Bang has done is unique and notable. Many people who have worked in remote and tribal areas were missionaries. He has worked out lot of the key issues which were studied very systematically and published in journals which are now being read by people all over the world. This has really helped to change policies not only nationally but also globally in the way of child health and community, and also women's health issues by Dr. Rani Bang. This actually shows us that not only is this a very simple and basic setting and surrounding but also comes with commitment to meet that background and the interest to ask the right questions and to find out the resources to do this type of work. I think this is very important and needs to be scaled up.

Policies should be based on good research evidence, which perhaps in the past has not happened. Policies have been made where a group of people or so called experts sitting around a table and come to some kind of consensus. Policies should be based on evidence and once the policy is made and implemented there needs to be periodic assessment and impact assessment. Very often what happens is that we become defensive about both things and a certain policy implemented becomes counterproductive. While questioning issues there is always a fear that a programme can be delinked and people will be blamed. I think that culture has to change. We have to be more open and transparent about why we do things and how we do things. There should be a firm foundation of these things.

I remember from my own experience very long ago, when HIV testing had not been introduced in TB Programme. TB Programme itself had been revised and the RNTCP was young. Programme Managers felt that bringing HIV testing at that stage could actually deviate both, and stigma would be associated with HIV than TB, and if the word spread people would stop approaching government programme. So, very quickly we undertook some

action research in 2 districts, one in Karnataka and one in Tamil Nadu where HIV testing was offered and we found that HIV testing was very much acceptable, feasible and no negative impact on TB Programme. In fact many more people were identified with HIV. We found out that we could reduce morbidity, particularly mortality thus contributing to the starting of TB treatment and anti TB treatment. That gave us confidence and over the next couple of years they scaled up the HIV testing quite rapidly all over the country. There are many issues that confront health policy makers. There are many issues and questions which come up – what will happen, its adverse effects, cost effectiveness of approach A versus approach B. Cost becomes a very important consideration.

Part of the research in our country is based out of the apex institutions and research organizations. Majority of the research output comes out a few a handful of Medical colleges – apex ones, and ICMR institutes. There is very little public health research being done especially in medical colleges. Past one and half days I have been touching many of these institutes and my colleagues here are experienced and many of them are coming from rural background. I know some of them here are coming from NGOs working in rural areas and been engaged with them in research, so definitely I think there needs to be much more collaborations between government and NGOs as well as some private sector partnerships.

In the department of health research and the ICMR we have something called `Tribal Health Research Forum' essentially for ICMR institutes to meet couple of times in a year and talk about issues and research that are going on in tribal welfare. We have one institute focused on tribal health but many other institutes around the country who are working in some aspect or other in tribal health issues. We meet once or twice a year or sometimes even more, so we want to now expand and include NGOs working on tribal health issues and learn from each other. We should be able to plan studies together through multicentric network studies mainly to have common protocols and common measurements, which have been done collectively from different parts of the country. We can also learn about local issues in different settings and scale up.

In this context I think it is important to mention the importance of qualitative research and social behavioural research in tribal areas. They are unique and I think one can extrapolate within tribal area that a particular strategy would work across country for all tribals, based on their practices, customs, beliefs, their myths and their health seeking behaviour which are going to be very different between North-East, central India, southern

Nilgiris and the Western Ghats. In this we need to be context specific and flexibility needs to be given not only to state level but also down to district level. We often don't pay heed to this in our national programmes. We have very fixed regime. Flexibility is necessary in our national programmes. To scale it up it has to be decentralised to district level and I think then we will have better outcomes for many of our national programmes viz., malaria control, TB control, vector borne diseases and so on. The vectors that breed are different in the different districts so what is true in Kerala is not true in Assam. And, while planning from Delhi we often are not aware of these conditions and the importance of including anthrolopologists, sociologists and health economist in the studies. This will add a lot of value and we should not miss the opportunity. The tribal way of life is changing just like everything else is changing in India by urbanization, globalization, environmental degradation and ecological changes. Their livelihood patterns, food habits, their diet, their health seeking behaviour and everything are changing. We are in a state of transition.

In tribal areas some of their practices are actually not good for health. If you look at the rates of NCDs which are coming out from some of the surveys in tribal areas, it is quite frightening. Especially within increase in their secular trend how do we prevent this increase of NCDs? Otherwise our hospitals are going to be overwhelmed with complication of these NCDs like CVD, stroke, diabetes. So timely and sustainable primary prevention and secondary prevention studies need to be carried out on a large level at the field or community level.

Being the need of the hour, this workshop I hope is going to identify solutions, as Dr. Abhay mentioned, and list out the problems we have faced. We need to focus on solutions and put forward the best practices and take some of them to scale up. So the next step I think is to select some of these programmes on malaria, TB, nutrition now launched by Government of India. Sickle cell screening programme is not happening in little states and in tribal populations, at the moment. The initial part would be to train technicians, people who will conduct this mass screening whether it is in Adivasi schools or it is at community level. So we are going to have lakhs of people who will know the sickle cell status very soon in the coming years. What are we offering to these people? Should we test and screen these people only if we have some solutions? We have found out sickle cell disease may be a symptomatic case, but what are we going to offer them? We don't have a very good answer. I think very urgently we again need to have few projects looking at solutions and strategies as to what is

going to be the mechanism by which after scaling up we could offer something to reduce mortality and morbidity and what type of counselling services are going to be offered.

We provide in Ashram schools, perhaps in PHCs, CHCs which may be easily available otherwise. I am worried there may a negative incidence like stigma etc. I don't know these are things which may come up. We need to think about that. I was discussing with team yesterday about Alcohol and Tobacco use which is also very high in many tribal areas which in turn leads to cancers and risk factors of course like NCDs so those are very tough things to handle as it implies change in behaviour, especially when they belong to cultural and social customs. By introducing different kinds of sustainable approach, and may be communication...people here may be can add some advice on how we can have strategies to for behaviour change. ICMR and DHR has several schemes for bio medical research capacity. Enhancement of these schemes are in infancy. They have partnered with Department of Health Services. There is lot of scope but one of the things we could encourage is the cross talk between people who are predominantly city based serving in medical colleges who might have some interest and inclination to do some rural work in research. We could try to bring those people and work with NGOs for 1-3 years by offering them sabbatical kind of pay or fellowship. They will bring their skills to the NGO and will gain experience. Not everybody is interested but I am sure there will people. Similarly, we could offer training programmes for young staff working in NGOs, to come to ICMR institutes and then train them in Research and Statistics and so on.

As for tribal youth, a lot of them study up to class 10th and are very literate, but they don't have many opportunities in what I have seen and they have to migrate or they have to go for manual labour, which they don't want to do after studying. Many of them are frustrated, jobless and so on. Recently I met an old woman in Kollam district of Kerala on the banks of the Periyar river. I got to learn that the tribals move in and out and live in their settlements. They are allowed some entry in the forest. She was sitting by the lake to fish from early morning and didn't get a single fish. I met her at 1 pm and she said she was going back. She said that since last 2 weeks she is coming to this huge Periyar river but didn't get anything. She had to walk back 10 kms to tribal settlements. She has 2 daughters and when asked she told me that they got educated in tribal schools up to 10th class but what is the use, both of them got married now and along with their husbands and they do manual labourer. She struggled a lot to educate her daughters up to 10th class but it's really of no use as they

are still dependent on labour work. There are opportunities to use these people and there are many of you also. I can see that here, in a tribal hospital run by tribal people is very successful, by training lab technicians, para-medical workers. They have immense intelligence. We have not utilized their services. I am just thinking how can we use them in research studies? We can empower them and employ them as field research workers and change them as community health workers. They could collect the research data from the villages and I am sure that many of them could be trained to operate tablets or mobile phones and use them in the data collection. One should build their skills and provide vocational opportunities to these young people. There's absolutely no point in educating them up to Class 10th and abandon them. I think there may be opportunities we need to explore and use them particularly for teacher training and para-medical training and we will also be able to partly solve the problem of not having people on to work in tribal areas. I don't want to take much more time but I just want to reiterate the commitment at least from DHR and ICMR. I hope that the expert committee will come up with best practices for scalability and time line and we with NHSRC and NHM will work together. DHR objective should be to help synthesize the things and try to generate evidence where it does not exist and identify the gaps.

So I thank you very much for the hospitality and I look forward to continue the collaboration.

Thank you.

S.N.	Organization	Practice	Page number
1	L V Prasad Eye Institute, Telangana	Eye care	43
2	National Institute for Research in Tribal Health, Jabalpur	Fluorosis	58
3	National Institute for Research in Tribal Health, Jabalpur	Malaria Control	75
4	MITRA, Christian Hospital, Bissamcuttack, Odisha	Malaria control	89
5	Jan Swasthya Sahyog, Chhattisgarh	Phulwari - creches for malnutrition	106
6	Government of Chhattisgarh	Fulwari, Scaling up	125
7	Health Department, Jashpur, Government of Chhattisgarh	Swasthya Lika Jagruti (Health Wednesday)	140
8	Population Foundation of India, National Health Mission	Community Based Monitoring	161
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10	National Health Mission, Palakkad, Kerala	Software-based monitoring Janani - Jatak	186
11	Karuna Trust, Karnataka	Operationalising PHCs by PPP	208
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16	Jan Swasthya Sahyog, Chhattisgarh	ANN/GNM Training	303
17	Health Department, Chhattisgarh	HR Outsourcing	317
18	Area Networking and Development Initiatives (ANANDI), Gujarat	Women's empowerment	325
19	Shrimad Rajchandra Hospital, Dharampur, Gujarat	Mobile unit	337

20	Health and Family Welfare Department, Gujarat	Sickle cell	361
21	Sugha Vazhvu Healthcare, Tamil Nadu	Enrollment and Rapid Risk Assessment	376
22	Integrated Tribal Development Agency, Adilabad	Increasing Institutional Deliveries	387
23	National Health Mission, Tamil Nadu	Birth waiting room	405
24	Society for Education Action and Research in Community Health, Gadchiroli	Home-based Newborn Care	421

1
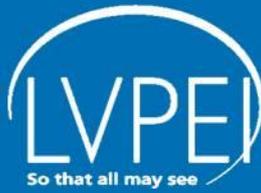
Vision Centre Model

Amol Sonawane

Gullapalli Pratibha Rao
International Centre for Advancement of Rural Eye Care
L V Prasad Eye Institute

Areas of Work
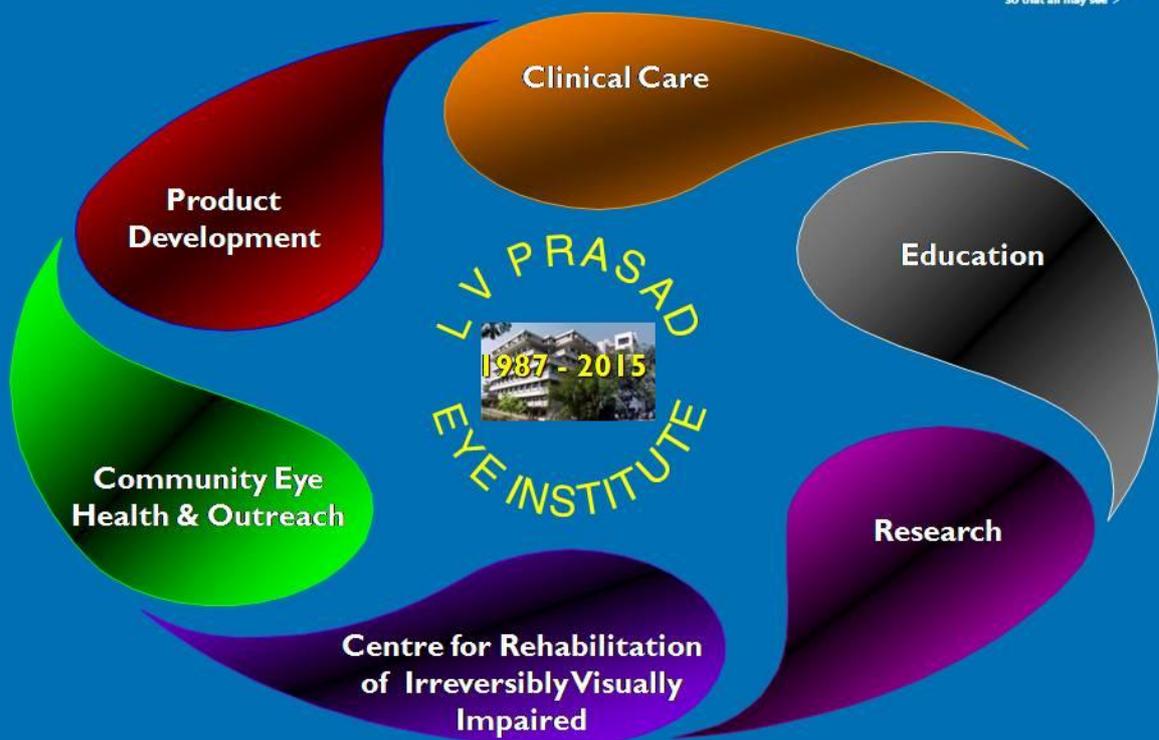
The LVPEI Model of Eye Care Delivery

Infrastructure

Training of Human Resource

Standard Operating Protocols

Cross Subsidy

CENTRE OF EXCELLENCE

TERTIARY CARE CENTRES

SERVICE CENTRES

VISION CENTRES

VISION GUARDIANS

Decrease in prevalence of blindness and VI

Rehabilitation of irreversible blind

Community Empowerment

Sustainability

GPR ICARE - Core activities

G P R

I C A R E

Service Delivery

Education

Research

Consultancy

Advocacy
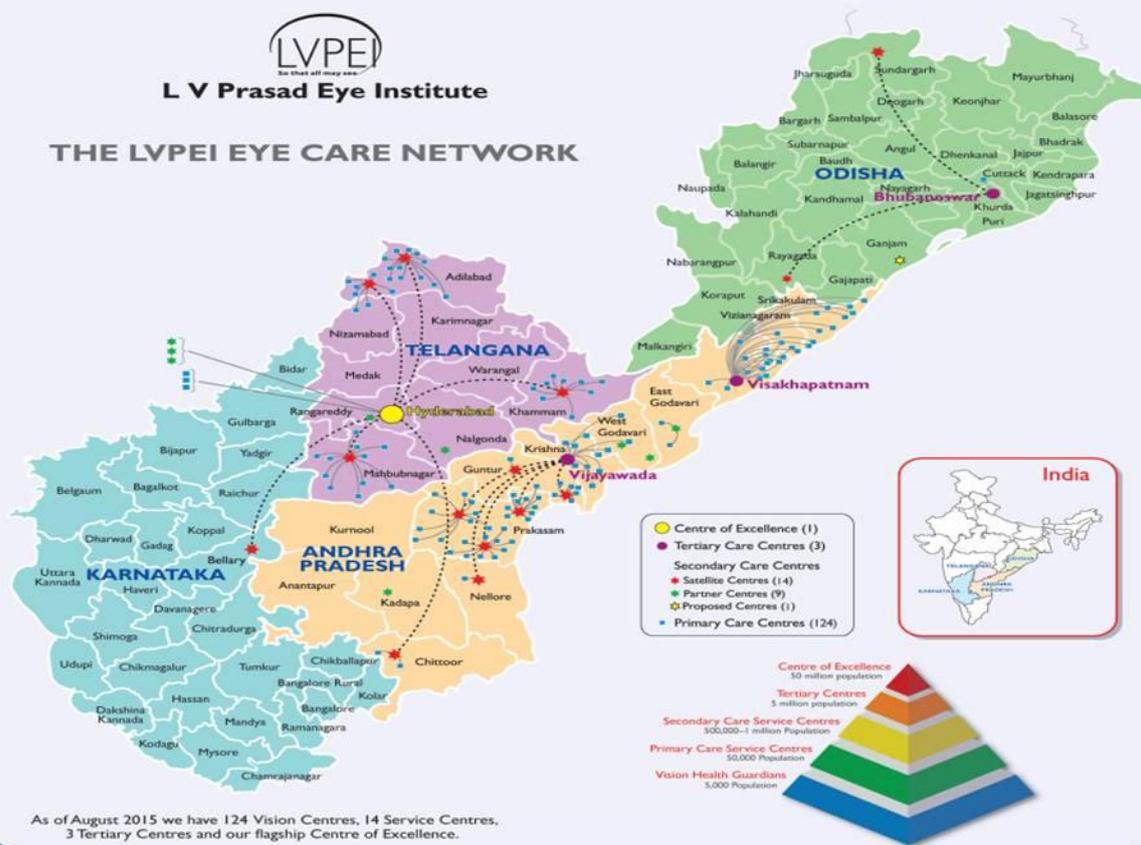
Problem Statement

- Prevalence of blindness: 1.8% (1)

- Visual impairment 8.1% (1)

- Both blindness and moderate visual impairment was higher in rural areas (1)

- Cataract and uncorrected refractive errors were responsible of 60.3% blindness and 87.5% moderate visual impairment.(1)

- Barriers of utilization of eye care services : accessibility, affordability and availability (2 – 4)

Problem Statement

- A simple pair of glasses and cataract surgery can restore vision of majority of visually impaired and blind

- High proportion of persons who could benefit from attending the outreach services do not participate in eye care camp (5)

Goal

- Vision Centre Model aims to eliminate avoidable blindness and visual impairment by providing affordable and quality eye care to rural populations.

Vision Centre concept

- Permanent Primary Eye Care facility for 50,000 population (500 – 600 sq.ft area)

- Free walk-in screening centre

- Operates five and half days a week

- Half day a week of community visits

- Basic undilated eye examination, including retinoscopy

- Provision of spectacle at low cost

Vision Centre

➤ Human Resource

- One year trained Vision Technician
- Higher Secondary education
- Locally recruited and trained at LVPEI Bausch & Lomb School of Optometry and at tertiary centres

➤ Functions

- *Refraction and dispensing of spectacles*

- *Recognition of eye conditions causing VI*

- *Referral services, for non correctable causes of VI*

Equipment

Infrastructure	Activity
Vision Drum and near vision chart	Vision Assessment
Streak Retinoscope and Trail set	Refraction
Slit Lamp	Anterior Segment Examinations
Applanation Tonometer	Intraoccular Pressure measurement
Direct Ophthalmoscope	Optic disc and retinal examination
Spectacle frames	Dispensing of spectacles
Lensometer	Determining power of current spectacles

Cost of Vision Centre Project

Furniture	Rs. 150,000
Equipment	Rs. 400,000
Renovation	Rs. 150,000
Training	Rs. 100,000
One Time Fixed Cost	Rs. 800,000

Adilabad District, Telangana

Total population : 2,737,738

Scheduled Tribes : 17%
(Gonds, Lambada, Kolam, Koyas and Pardans)

Total Blocks: 52

No. of Blocks having LVPEI Vision Centres : 16

Time line of Opening of Vision Centres in Adilabad District
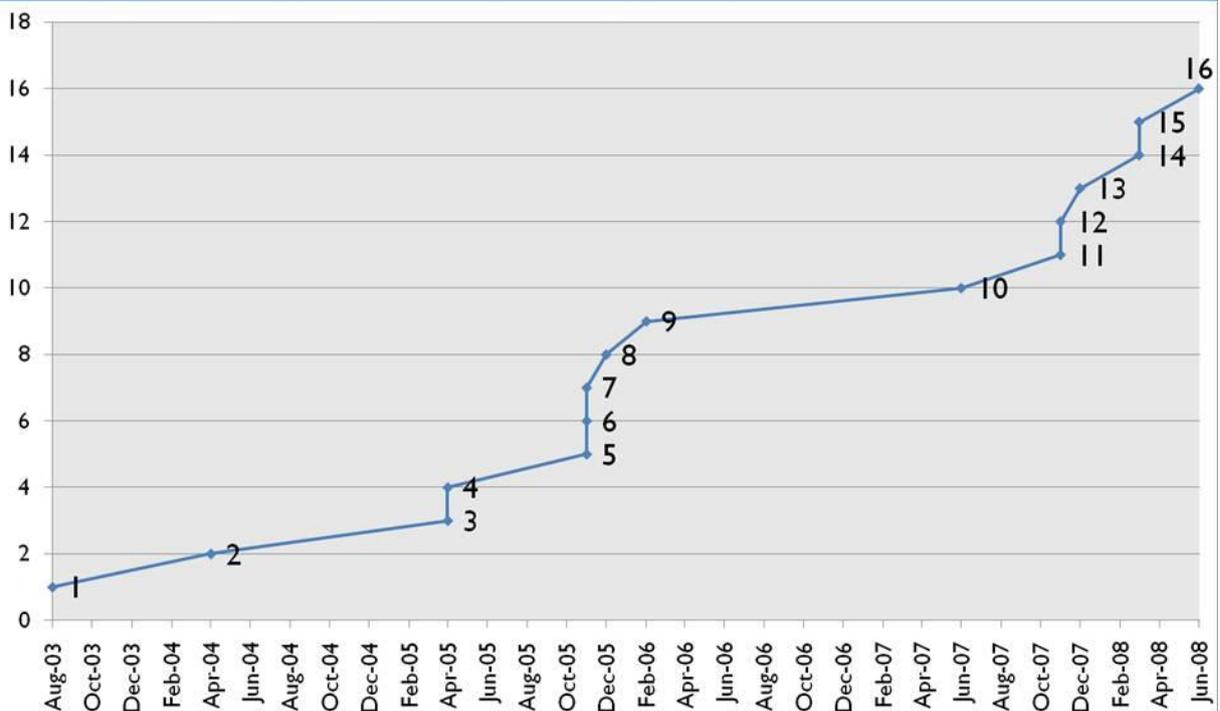
Performance of Centre

16 centres established between August 2003 to june 2008

Indicator	Performance
No. of people examined (OP)	300,583
No. of glasses prescribed	105,477 (35% of total OP)
No. of glasses dispensed	92,134 (31% of total OP)
No. Of people referred to higher level	59,770 (20% of total OP)

*Spectacle Conversion rate: 87%
*Total OP without Visual Impairment: 45%

Prevalence and Causes of Visual Impairment (above age of 40 years)
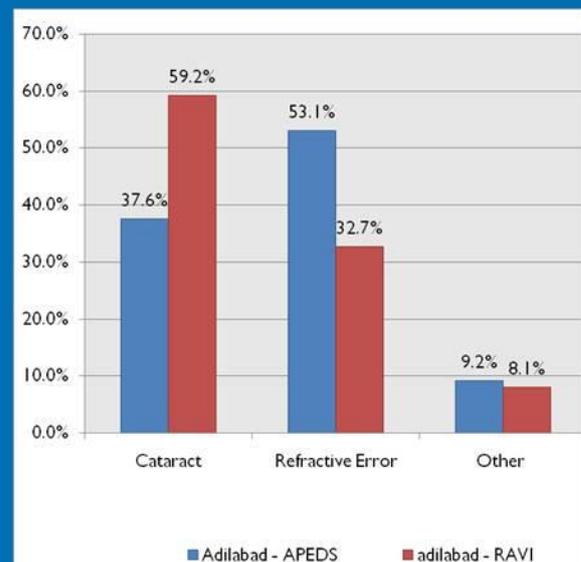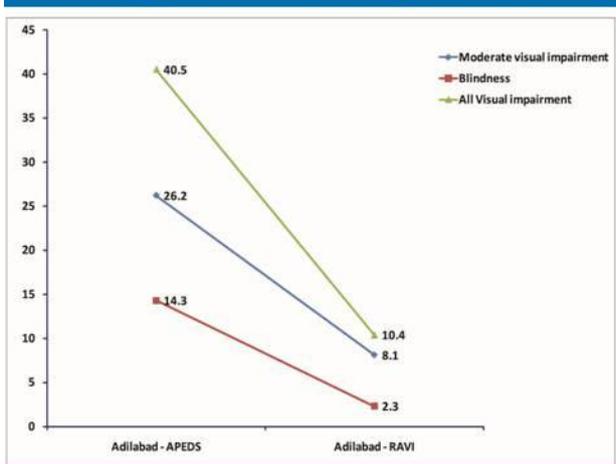
*APEDS : 1998 – 2000
*RAVI: 2014 (unpublished data)

51

Cost Saving to Community

- Cost (both direct and indirect) to patient to access eye care

	Vision Centre	Nearest town based clinic
Mean Cost to patient	Rs. 178 +/- 48.3	Rs. 366.2 +/- 48.2

*t test P value <0.001 (6)

Limitations

- Neither surgical nor medical care is provided at vision centre

- Those who need medical or surgical care, need to travel to secondary level eye care facility (within 50 – 60 Km)

- Difficulty in recruitment

Critical Factors for Vision Centre

LVPEI
So that all may see

- Training of Vision Technician

- Supply of Spectacle

- Referral Linkages

- Strong Monitoring System

- Community Ownership

Conclusion

LVPEI
So that all may see

- Decrease in Visual impairment shows effectiveness of model

- Large number of people (45% of total OP) without visual impairment walking in to VC to get eyes screen shows increased awareness about eye health

- High spectacle conversion rate shows acceptance of services

- Any organization with capacity to impart training and provide secondary and tertiary level care to referred patients can replicate the model

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6. Vilas K, Rao GN, Holden B, Krishnaiah S, Bhattachrya S, Srinivas M and Khanna R, et al. An estimate of patient cost and benefit of the new primary eye care model utilization through vision centres in Andhra Pradesh. India. Asia- Pacific journal of Public Health. 2010 May, 22(4): 426:435

Thank you!
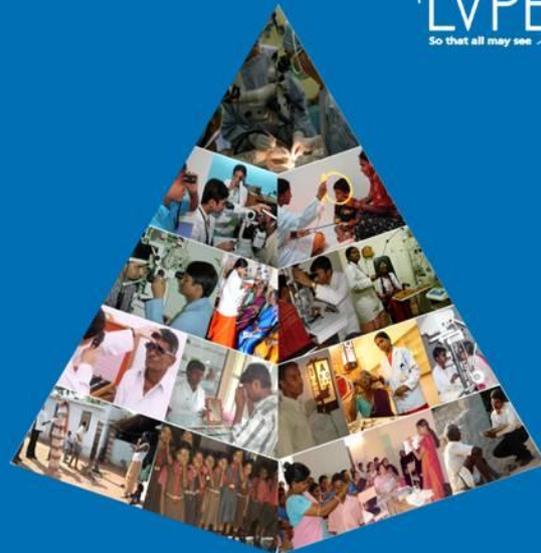
LV Prasad Eye Institute

www.lvpei.org

Excellence • Equity • Efficiency

Questions and answers

Q: Do you provide any emergency eye care in this model?

A: Because technicians are just one year trained, they refer patients immediately to the secondary centre and if required the technician also accompanies the patient to the secondary centre. The secondary centre administrators and doctors are informed over the phone and they are ready to attend to the patient.

Q: Have you involved children in this project?

A: It is a free walk in centre for everybody; let it be a boy or girl or 100 years man. For study, we have selected people above 40 years.

Q: In the study population, what proportion of the population is tribal?

A: More than 50% are tribal. Twenty nine thousand five hundred (29,500) are tribal out of 57,800 people.

Q: *Dr. Sudarshan:* We also learnt something from this vision centres. Now the problem is who will maintain them and how do you integrate it. Vertical programme is not cost effective. It has to be integrated into primary health care. Your focus is again only on spectacles…this is a business model, but I am interested in primary health care. What can ASHAs and ANMs do? Primary eye care has to be integrated into primary health care.

A: In response to what is said, the spectacles are not only to make money; spectacles also will restore the vision of those visually impaired. If we see the cost recovery of the entire network of 124 centres, our cost recovery was 74% so we are at a loss but still we try to do it because we want to serve the people.

Q: *Dr. Sudarshan:* Can you share the information on the proportion of referrals turned into the secondary and tertiary centre?

A: The referral conversion rate is around 40%. If somebody is having conjunctivitis, walks into our vision centre, vision technicians cannot prescribe and dispense medicines. They refer him to secondary centre which is in the distance of 40 to 60 kms from the vision centre. So instead of travelling a distance of 40 to 60 kms, patients go to a pharmacy or to go to a RMP

in the village or nearby village and they get the medicine. That is why, the referrals conversion is less than 60%. But, for binding conditions like Cataract and Glaucoma the referrals conversion is high, because we do ensure that they come to secondary centre.

Q: What is the cost of your spectacles?

A: The minimum frame costs Rs 80 and the lens cost is Rs 40. So, Minimum cost is Rs 120 and maximum cost can go up to Rs 2000 depending quality of frame and power of lens.

<u>Chairpersons' questions and comments</u>

<u>Ms. Limatula</u>

Thank you for the short presentation. Actually what we saw in the presentation is the utilization of Human Resource. Because of shortage of HR in tribal areas what most people do is rush to train some HR. I think that is also a very short way of addressing a problem. When you train, I think that is more sustainable. Another way as Dr. Sudarshan said that is to integrate in primary health care and I think that is the approach. My only concern was, I think the National Blindness Control Programme is reduced only to cataract. I wanted to know why organizations are not able to leverage NHM for the Blindness Control Programme for other eye problems beyond cataract.

A: That is why when there is a camp generally people are scared. In vision centre, we also have the equipments to identify anterior segment abnormalities, diagnose glaucoma etc like Slit lamp. We also have direct options to see and regulate optical needs. So, ours is quite comprehensive and appropriate at every level. So the comprehensive care is not focused only on cataract as such.

<u>Dr. Abhay Bang</u>

Thank you Dr. Amol. I must congratulate you and the LV Prasad Institute for having tried a new angle. There are several beauties of your model. There is a large coverage. You have trained XII Std passed. There is no shortage of XII passed youth in India. I don't know why you said that you are finding difficult to get recruits for training but there must be some other reason. The number of equipments used pose some limitations. Similarly, as Dr. Sudarshan commented, this model is not part of primary health centre, so there is a limitation. At the same time one would say that some of the services that primary health care system is

not able to provide at present, can be supplemented by outside system – that is one potential solution. So I see several strengths in your model.

I found two major limitations. We did not get an idea (except Ref 4 in your presentation) that why a camp approach or a mobile eye clinic approach is not more appropriate to this stationery model. You are largely providing refractive error correction, which is not an emergency. If any population gets services once in 3 months or once in 6 months that should suffice for refractive error correction. So, why should you invest in one stationery approach which merely covers 20,000 population. Will it not be more convenient for the old people in the villages that this service periodically comes to their own village? I am not convinced, that based on your data, stationery model for refractive corrections is better model than camp approach or a mobile approach.

Secondly, we are not looking only for patient treatment; we are looking for the impact on the problem at the population level. You showed us patient related data from the vision centre, but the impact data from the whole district. We would have loved to see the impact in these villages of vision centre. You say that you have treated 26,000 patients which means almost half of the population catered by the vision centre. There remains a question about the impact at the population level because of mixing the two levels of data – coverage data from the centre but the impact data from the district.

There are several strengths as mentioned. It will be wonderful to see how this model would work in primary health centre. I will repeat that not every solution has to be at the primary health centre system; there could be primary solutions outside the primary centres. We also look forward at some stage to see the data of impact and how this model could function in a primary health centre.

2

Fluorosis Mitigation through Nutrition supplementation, food diversification and Safe drinking water in Tribal areas of Madhya Pradesh

Dr Tapas Chakma
Scientist 'F' & Deputy Director (Senior Grade)
tapas_chakma@rediffmail.com
National Institute For Research in Tribal Health

Tribes
Mandla   : Gond, Baiga
Dhar   : Bhil, Bhilala
Jhabua   : Bhil, Bhilala

Study Area
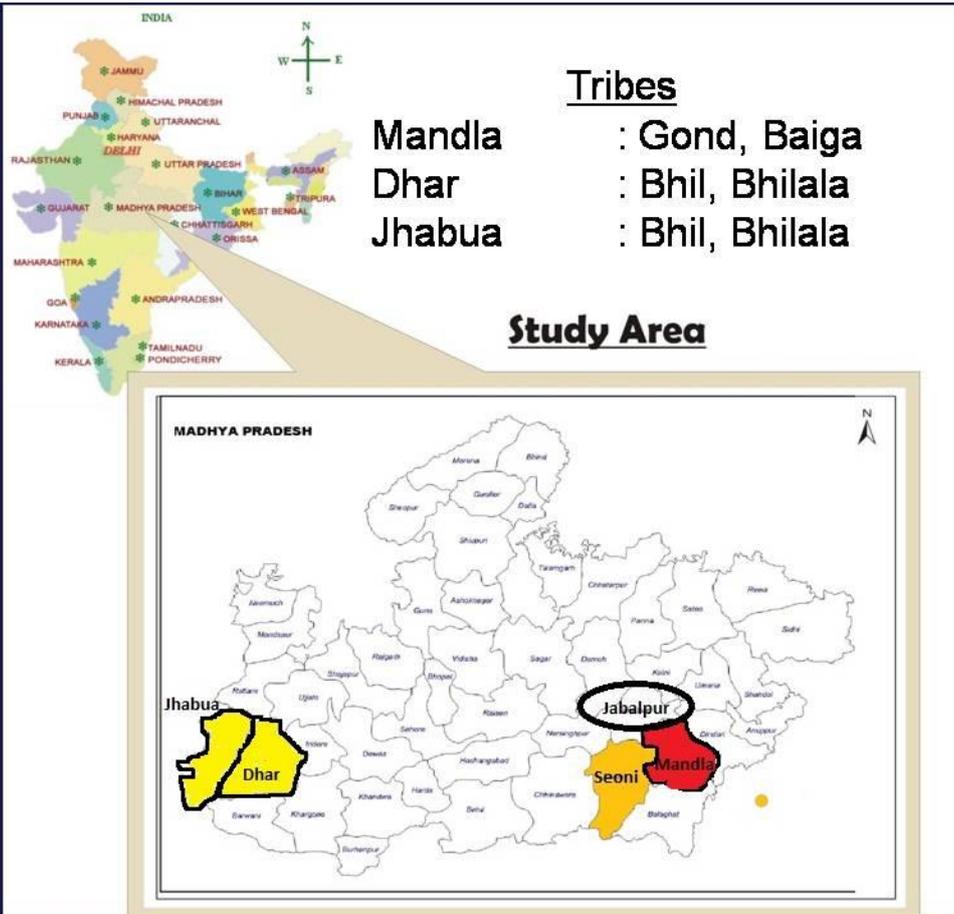
Organizations Major work

- Multidisciplinary research Institute dedicated to Tribal health
  - Vector Biology, Entomology, Community Medicine, Epidemiology, Microbiology, Genetics, Virology, Social Science
- Major Thrust areas:
  - Vector Borne disease: Malaria, Filaria, Dengue
  - Fluorosis and Nutritional deficiency disorders
  - Hemoglobinopathies: Sickle cell Disease, Thalassemia
  - Tuberculosis: Intermediate referral lab
  - Viral diseases: State referral lab
    - H1N1, Influenza, HIV, HBV, HBC, HBE, Dengue, Chkunguniya, Rota virus, RSV, Rubella, Mumps, Measles, Herpes Virus

Problem: Rationale of selection

1995, May Request from District Collector to investigate the unknown disease characterised by knock knee of all the children <20 years in village Tilaipani, pain in the lower limbs

Differential diagnosis: Sickle cell Osteopathy, Endemic Ricket, Fluorosis

Village Tilaipani (n=152)

- Genuvalgum - 51.7% (below 20 yrs)
- Dental mottling -74.4%
- Water F^- 9.2 -10.8 ppm

Problem: Rationale of selection

Village Hirapur (n=198)

- Genuvalgum - 6.3% (below 20 yrs)
- Dental mottling - 56%
- Water F^- 0-13.5ppm
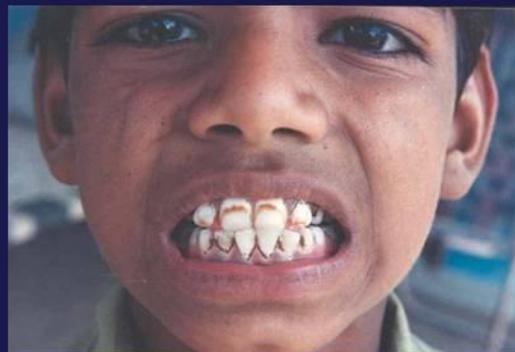
Average consumption of foodstuffs gm/day in Mandla, Central India (1995) (n=48)
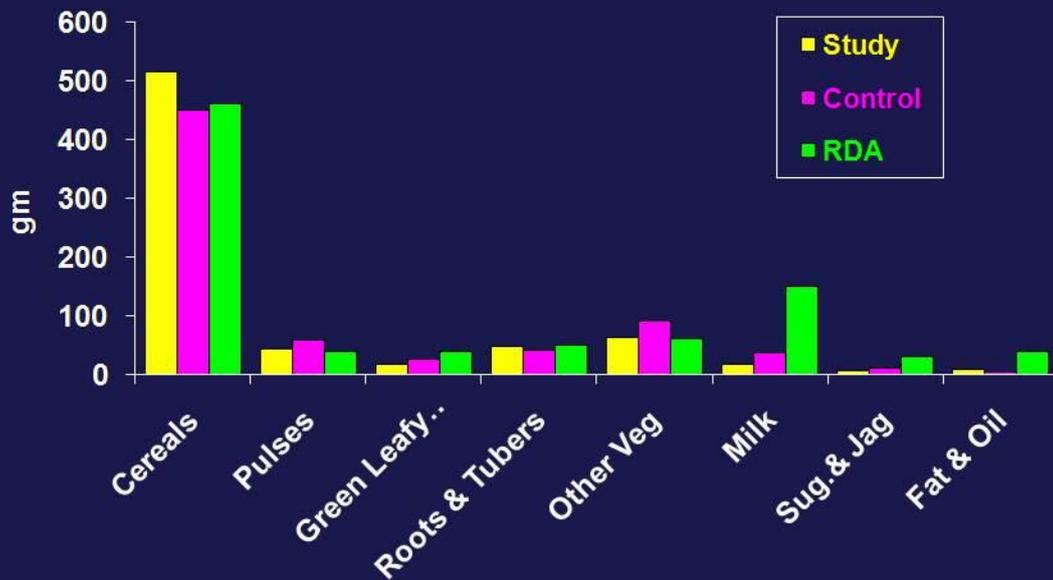
Average nutrient intake per day in Mandla, Central India (1995) (n=48)
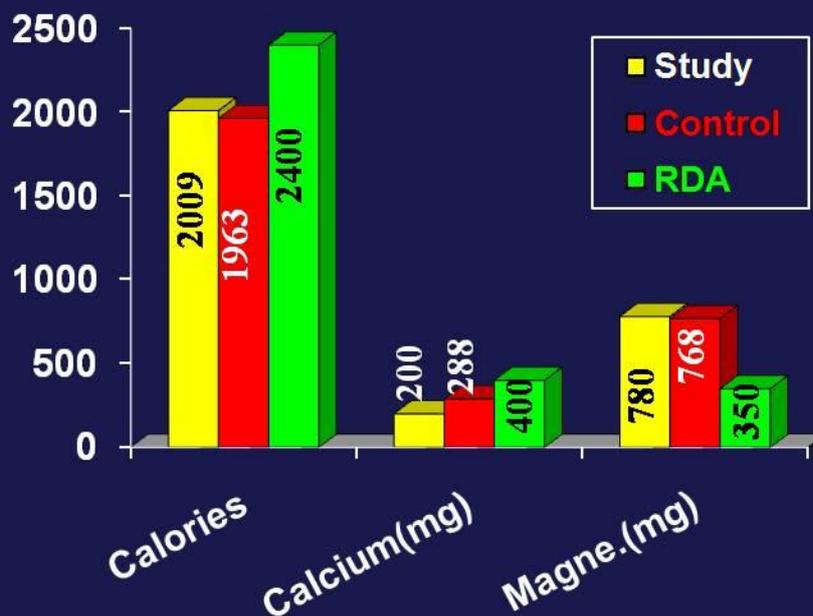
Mean Micronutrient intake of Fluorosis affected Patients (n=17) in Mandla, Central India, 1995
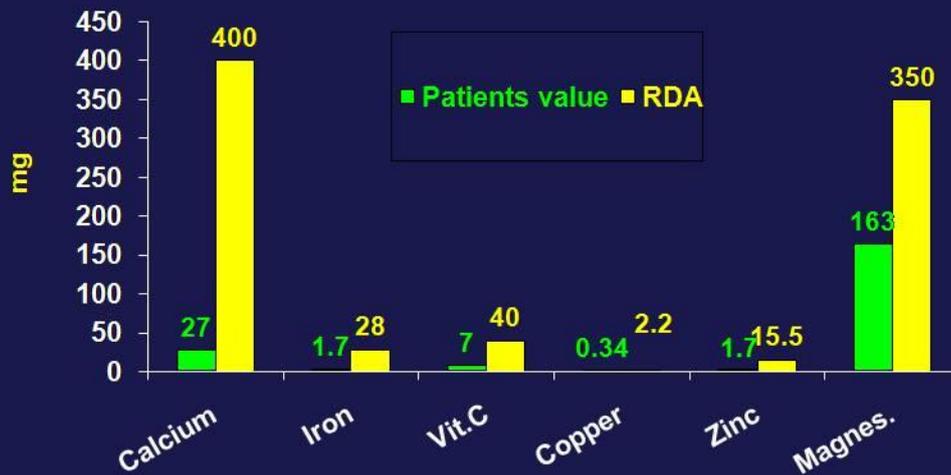
Goal: How to correct the deformities and reduce the micronutrient deficiencies

Recommendations given to Govt. of Madhya Pradesh in 1996

- Alternative water source
- Close all contaminated hand pumps
- <10 Years Children Surgical shoe
- Supplement Calcium, Vitamin C, D_3, Iron
- Dietary Counseling and Health education
- Initiate ICDS activities

Alternative water supply in affected villages of Mandla, 2004-05
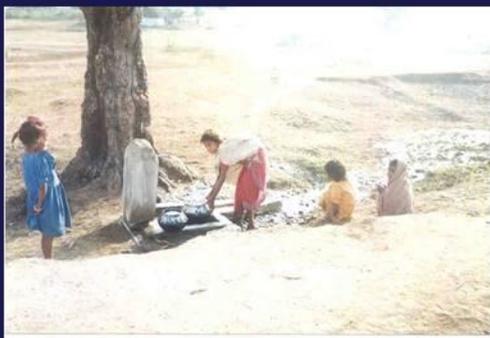
ICDS Activities in Affected villages

Dismantled hand-pumps

IEC Campaign
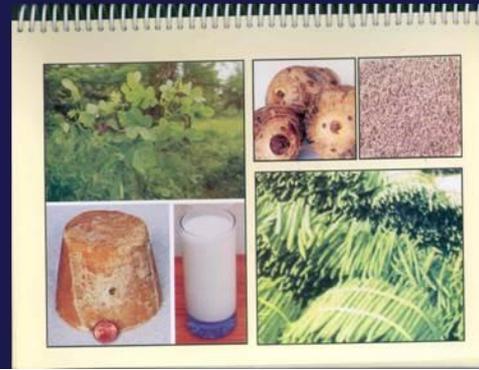
Average Nutrient intake of fluorosis affected villages at baseline and post-intervention (n=48)
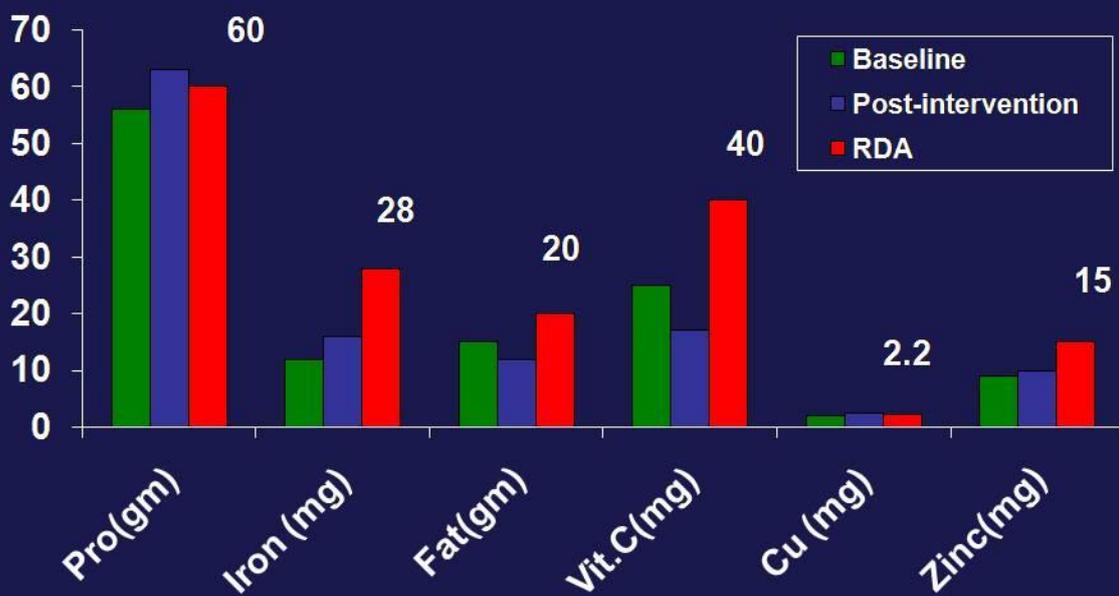
Average Nutrient intake of fluorosis affected villages at baseline and post-intervention (n=48)
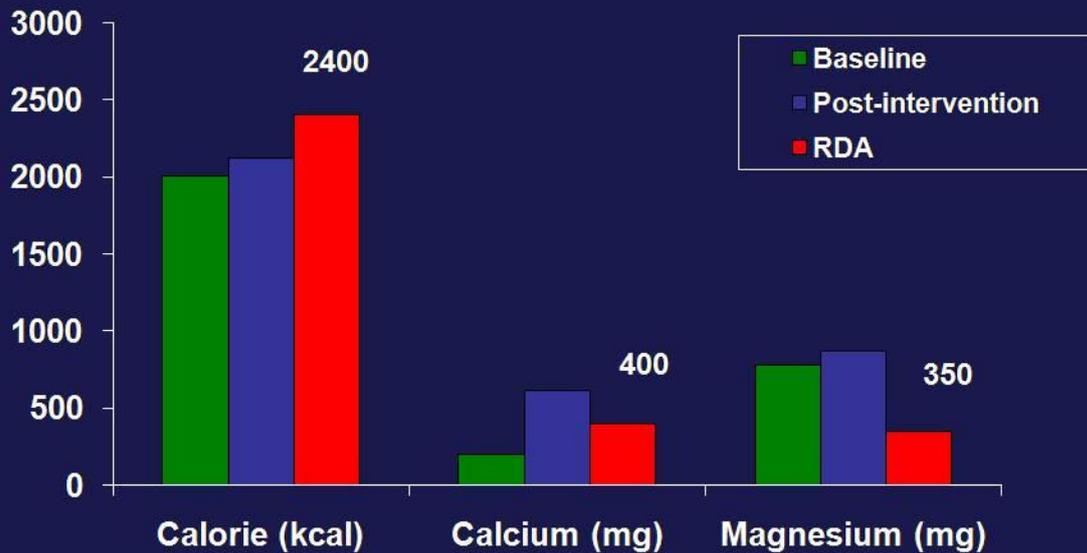
Average foodstuff intake of fluorosis affected villages at baseline and post-intervention (n=48)
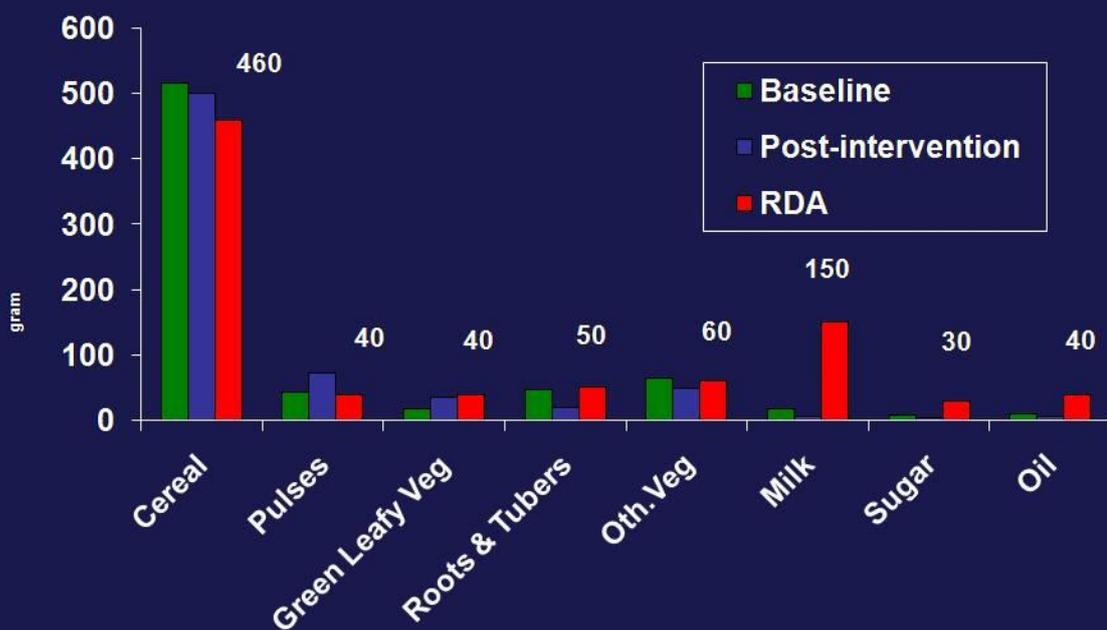
English: Fetid Casia; Botanical Name: Cassia Tora.

Nutritive value
- Calcium   -520mg/100gm wet leaves
                 -3200mg/100gm dry leaves
- Vitamin C   -82mg/100gm wet leaves
- Iron   -12.4mg/100gm wet leaves

Source:
"Nutritive value of Indian Foods"
National Institute of Nutrition (ICMR)
Hyderabad. India

Chakod Bhaji (Casia Tora)

Effect of intervention on fluorosis in two village of Mandla after 5 year intervention

Health complaints	Baseline	Post-intervention	t- test; df,
Genu valgum (<20 Yrs)	51.2%	2.6%	6.96; 162
Dental Mottling (<20 Yrs)	74.4%	70%	
Water Fluoride (ppm)	9.2-10.8	<1	
Urine fluoride (>2ppm)	40.8%	9.8%	

Impact of nutritional intervention on clinical parameters of Knock Knee

1995

2003

Baseline

Post- Intervention

Impact of nutritional intervention on clinical parameters of Knock Knee
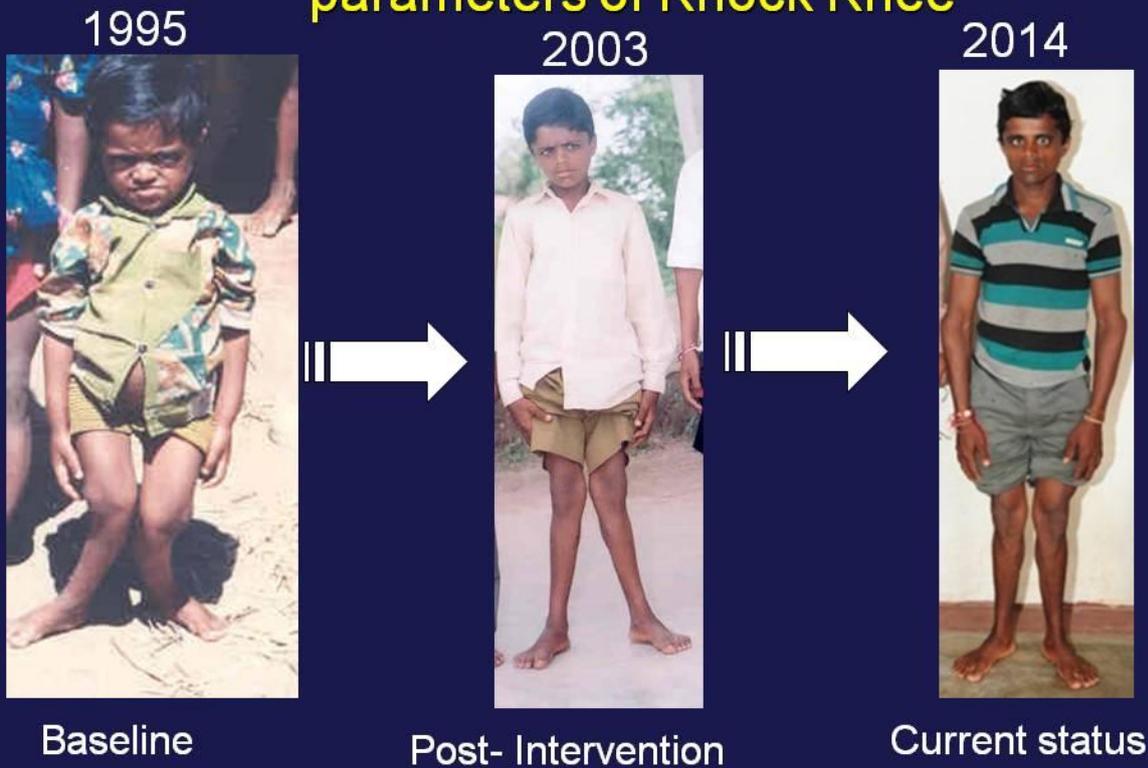
1995

2003

Baseline

Post- Intervention

67

Impact of nutritional intervention on clinical parameters of Knock Knee

1995   2003   2014

Baseline   Post- Intervention   Current status

Impact of nutritional intervention on clinical and radiological parameters of Knock Knee

1995   2003   2014

Baseline   Post- Intervention   Current Status
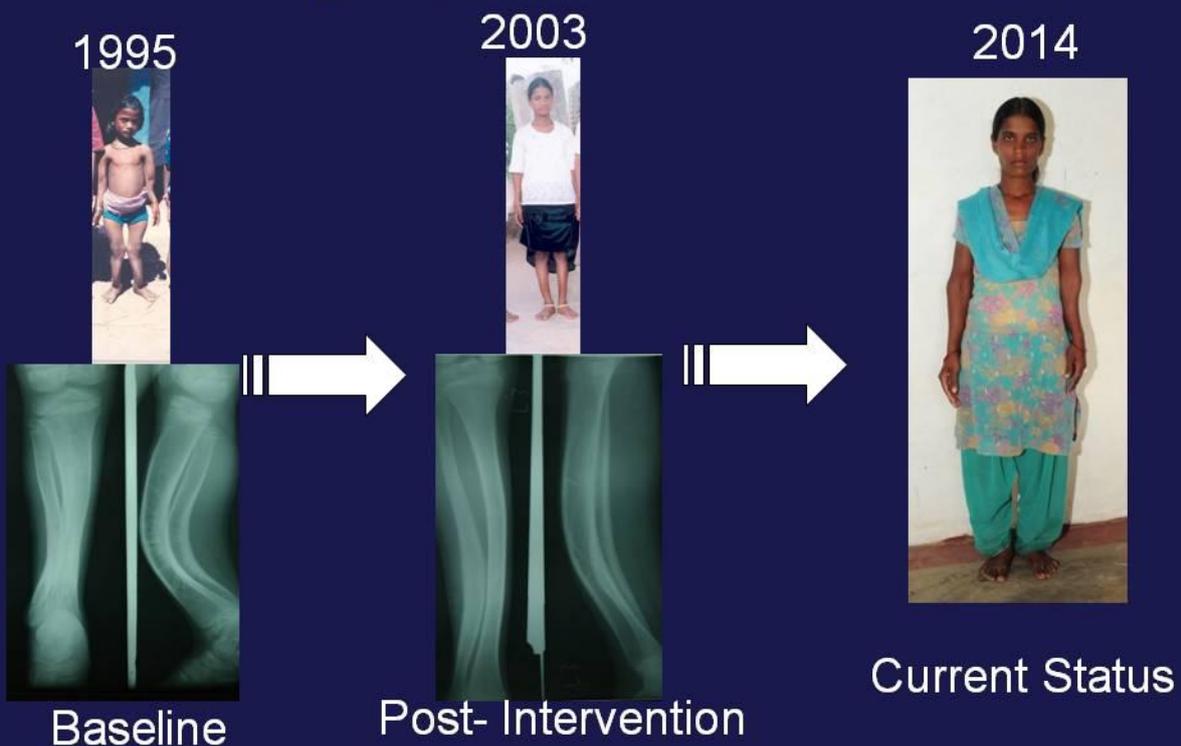
Impact of nutritional intervention on clinical and radiological parameters of genuvarum

1995   1995   2014

Current Status

Baseline   Post- Intervention
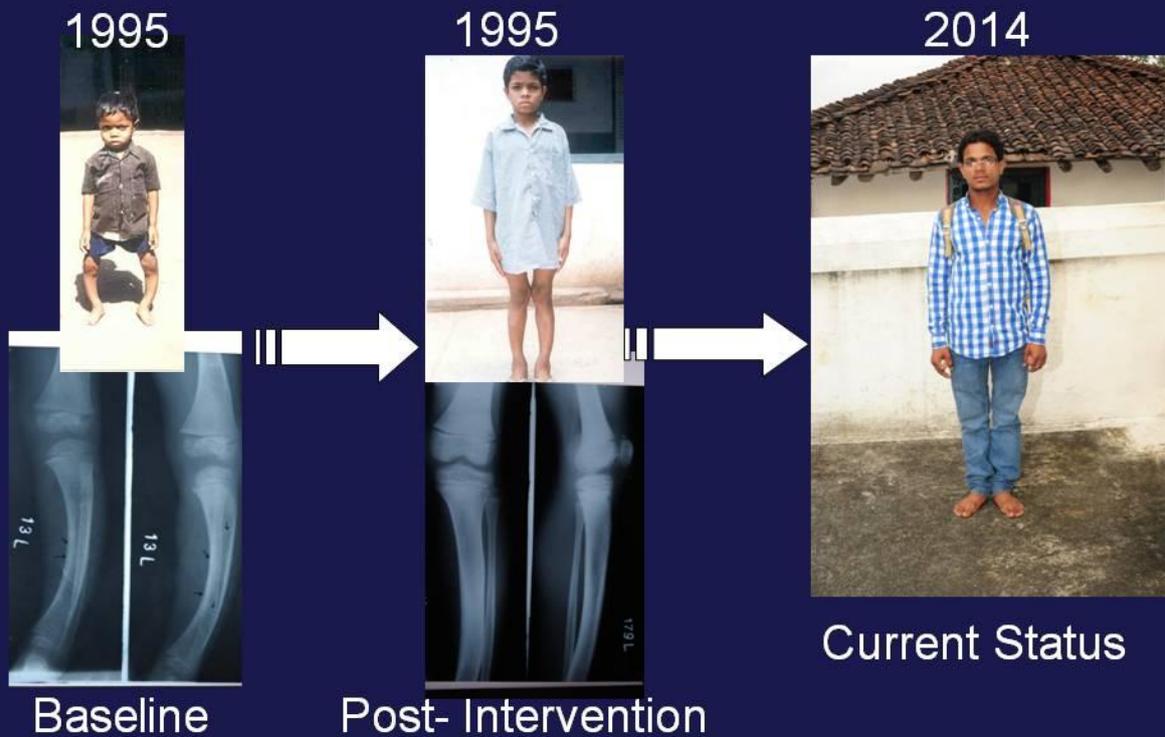
Effect of intervention on fluorosis in Seoni after 2 year intervention

	Pre intervention		Post Intervention		% +/-	P value
	No. Exam.	No. (%)	No. Exam.	No. (%)		
Dental Fluorosis	5437	1032 (18.9)	5037	898 (17.8)	–13.0	>0.05
Genu valgum	5437	509 (9.3)	5037	343 (6.8)	–32.6	<0.001
Skeletal Fluorosis	5437	184 (3.4)	5037	122 (2.4)	–33.7	<0.01
Non skeletal Fluorosis	5437	909 (16.7)	5037	313 (6.2)	–65.6	<0.0001
Other Symptoms	5437	596 (11)	5037	116(2.3)	–80.5	<0.0001

Reversal of Skeletal fluorosis (Touching chin with chest)

A lady with stiff Neck, unable to touch chest with chin before intervention

Same lady with stiff Neck, able to touch chest with chin after intervention

Cost: Seoni study was ~ 27 lacs

Scale up

- Unicef implemented the same model in Dhar and Jhabua through different NGO in 2006-07
- Independent evaluation revealed similar results
- Included in UNICEF international learning exchange programme in 2007,08 and 13 country participants were trained
- INREM Foundation of TATA TRUST working in Jhabua with same intervention model and has reported similar result
- Concept included in National Programme for Prevention and Control Fluorosis (NPPCF) but Need Strengthening of NPPCF

Limitation

- Lack of inter departmental coordination e.g.
  - Health
  - PHED
  - Women and Child Development
- Cassia tora leaves not available through out the year
- Not available in the market
- Lack of knowledge about fluorosis by all sections
- No fluorosis diagnostic facility in district hospitals or even Medical Colleges

Thank you

Questions and answers

Q: *Question not clearly recorded*

A: Sir, it is something which is difficult to reply why they have said that. They are public health engineering people. Later on it was found that they have not tested the water. Let me tell you, it has gone to the high court under public interest litigation and they have accepted and given in writing that they have not tested for fluoride, assumed that area is free of fluoride.

Q: *Dr. Satish:* What about the use of domestic filters in fluorosis? How we can set up water testing in National programme?

A: Domestic filter, extensively used in Rajasthan, has to be recharged in every 3 months which is a major limitation of this. It produces huge amount of sludge which is full of sodium chloride where do we throw it? If we throw it in the soil, that soil is gone. We cannot grow anything in that soil and moreover if it leaches to water. There is a huge draw back.

Q: *Dr. Sudarshan:* Thank you for the presentation, I was also involved in the 2 districts. There is a wonderful programme. There are kits used by gram panchayat and VHSCs to test for fluoride. I am doing that in 2 districts - early diagnosis, alternate sources of water, mapping. There is pressure on the panchayat *raj* system to provide alternative sources now. You, yourself want to do the intervention. If I were you, I would have brought the Government into real action, after finding out the important lacunae in the health system and the rural panchayat *raj* system. PHE does all the chemical testing but never shared with the health department and the health department does all the bacteriological contamination studies but never looks at chemical contamination. These systems convergence are meant to happen at every PHC level. Now we know, because we have a map of all the testing done and are a part of the district. Convergence between the 2 departments is crucial. Moreover, you yourself are doing the intervention and then scaling up will be an issue.

A: Thank you, sir. I did not do the interventions. They were done by the different NGOs. I was only a technical expert there and giving the training on water. What you said is absolutely correct, sir, and it is felt. There is no coordination between 2 departments. In Mandala, I got excellent cooperation because of public interest litigation only.

Chairpersons' questions and comments

Ms. Limatula

What about your Gujarat experience?

A: That's what I said, that this was scaled up by the Indian Foundation, in Jhabua. It is still working. They are at technically different levels. Traditionally, I did not modify or change anything from what traditional tribals are doing. NGOs did various modification of leaves at ANAND, Gujarat, after transporting leaves from Jhabua during monsoon. They powdered it which can then be used as a vegetable or a *ladoo or* as a different regime.

Dr Abhay Bang

My feeling is that this is a beautiful investigative story which could go into the medical curriculum for young doctors. My hearty congratulations!

I have 3 observations. One, we did not get any data on how prevalent is flurosis in the tribal population. One would have loved to know how large this problem is for the tribals in Madhya Pradesh as a whole or the country as a whole – is it a priority, or is it only a local issue. Although this is an important problem, like leprosy, TB etc, it may be a general problem which affects tribal people as well. One would need some evidence as to how widespread is this in tribal people.

Secondly, you used two packages of intervention to give recommendations to the M.P. Government; and then there is this *Cassia tora*. The main value addition you have made in scientific knowledge is the *Cassia tora.* It is a wonderful analysis that you have made. Those of you who have not seen this plant, if you walk outside the gate of Shodhagram, on the either side of the road you will see ample of *Cassia Tora* plants. In this area it is called *Tarota*. Tapas has proposed us a logic for its application to solve a problem. Tapas, instead of mixing the results in this way, to me it seems that *Cassia tora* is more at the pilot stage and needs good field trial. How much of a value addition *Cassia tora* makes to the management of flurosis at the population level? You may have already done that and in a short time could not have presented. We would like to know, subsequently, later on. It's a beautiful approach but it lacks evidence on how much value addition was made by the *Cassia tora.* I am happy

that the M.P. Government or UNICEF are promoting it. It should continue further with an evidence based approach which will be worthwhile.

One more apprehension – there is a tendency to believe that Indian traditions and Indian plants have   solutions to everything. One has to be very specific. It's *Cassia tora* on flurosis. Generalising that all Indian plants are of great medicinal values might be unscientific. Be careful.

3

Malaria Control in Dindori District, Madhya Pradesh – a case study

Dr. Neeru Singh

National Institute for Research in Tribal Health (ICMR), Jabalpur

ICMR 's Research Institutes/Centres/Units

★ ICMR's INSTITUTES
★ ICMR's REGIONAL MEDICAL RESEARCH CENTRES
★ ICMR'S UNITS
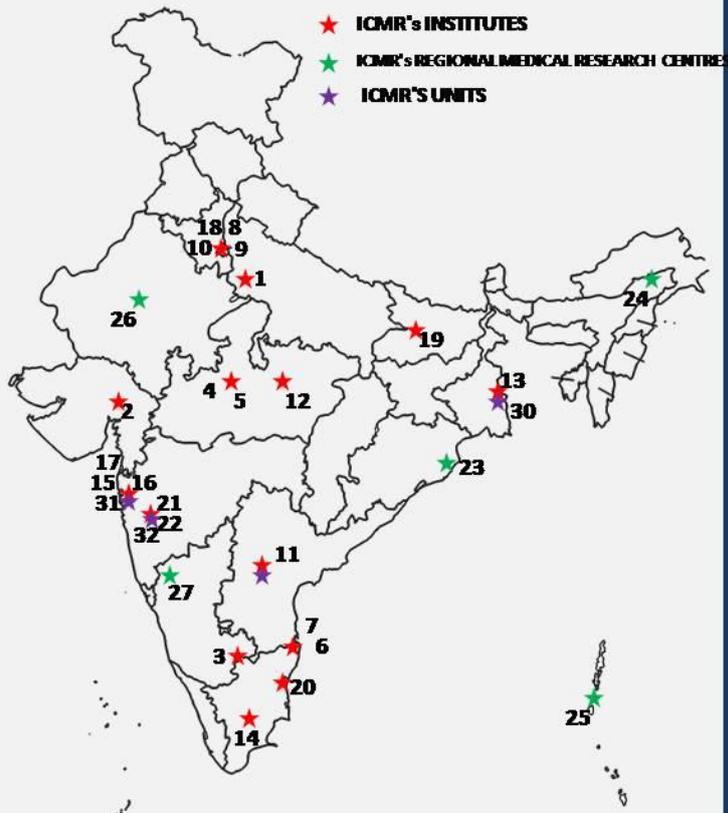
S. No.	Inst. Name
1	Jalma, Agra
2	NIOH, Ahmedabad
3	NCDIR, Bangalore
4	BHMRC, Bhopal
5	NIREH, Bhopal
6	NIRT, Chennai
7	NIE, Chennai
8	NIMR, Delhi
9	NIP, Delhi
10	NIMS, Delhi
11	NIN, Hyderabad
12	NIRTH, Jabalpur
13	NICED, Kolkata
14	CRME, Madurai
15	NIRRH, Mumbai
16	NIIh, Mumbai
17	ERC, Mumbai
18	ICPO, Noida
19	RMRIMS, Patna
20	VCRC, Pondicherry
21	NIV, Pune
22	NARI, Pune
23	RMRC, Bhubaneswar
24	RMRC, Dibrugarh
25	RMRC, Port Blair
26	DMRC, Jodhpur
27	RMRC, Belgaum
28	FDTRC, Hyderabad
29	NCLS, Hyderabad
30	Icmr Virus Unit, Kolkata
31	Genetic Research Centre, Mumbai
32	Microbial Containment Complex, Pune

Major Health Problems

Communicable Diseases
❖ Malaria
❖ Tuberculosis (IRL)
❖ Viral Diseases (ARL)
❖ Filaria
❖ Scabies
❖ Diarrhea
❖ HIV (SRL)

Non Communicable Diseases
❖ Haemoglobinopathies
❖ Malnutrition
❖ Fluorosis
❖ Hypertension

Major tribal groups (MP & CG)
✓ Bhil
✓ Gond
✓ Kol
✓ Korku
✓ Sahariya
✓ Baiga
✓ Bharia
✓ Panika
✓ Kawar
✓ Oraon
✓ Halba
✓ Bhattra
✓ Korwa
✓ Bharia Bhumia

Major Studies

➢ Micro mapping of G6PD deficiency– 8 States

➢ Establishment of Prenatal Diagnosis of ß Thalassemia Syndromes and Sickle Cell Disorders – 4 States

➢ Newborn Screening for Sickle Cell Disease – 3 States

➢ Estimate the burden of TB among the tribal population and develop an innovative health system model to strengthen TB control in the tribal areas - NIRTH (M.P. & C.G.).

➢ Endline household survey to assess the Impact of LLINs in MP & CG

➢ National Hospital Based Rotavirus Surveillance Network –NIRTH & Medical College, Jabalpur.

➢ State intervention model for Malaria funded by NRHM.

➢ Recognized for filariasis training SVBDCP/ NVBDCP.

✓ Provided H1N1 pdm09 diagnosis to entire state; 28% cases are from tribal areas.

✓ Collaboration with the Medical Colleges of MP & CG

Problem

Perennial malaria transmission

Plasmodium falciparum **dominant.**

P. vivax **common &** *P. malariae* **rare.**

Two highly efficient vectors

A
B
C
D
E

Anopheles culicifacies

Anopheles fluviatilis

S
T
U

Breeding sites

Risk Factors

37% geographical area under forest. Inaccessible terrain.
Inhabitants are primitive tribe **"Baigas"**

Goal

➤ To control malaria in Baigachak with an aim to accomplish Zero indigenous malaria transmission in Dindori district, so that it will not be a major public health problem and serve as a guide for a program of malaria elimination.

➤ Develop evidence-based strategy for elimination of malaria from highly endemic tribal areas of the state.

➤ Strengthen existing health systems.

➤ Duration 5 Years.

Baigachak
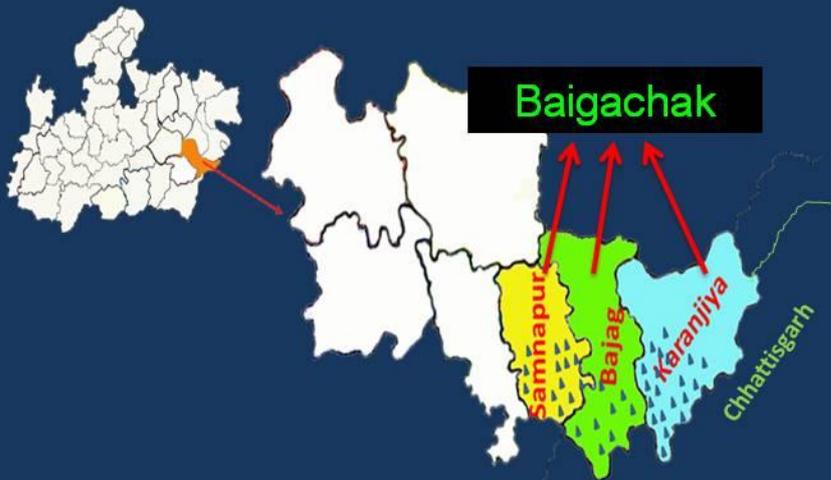
Population of Dindori District (Census 2011):- 704524

Number of Villages:- 52

Bajag:- 9, Karanjiya:- 25, Samnapur:- 18

Baiga Population:- 31900

Intervention Measures

Indoor residual spray (IRS) using Alphacypermethrin

Long lasting Insecticide Treated Nets (LLINs)

Robust surveillance using RDT and ACT.

Intensive IEC in collaboration with a Kolkata based NGO. (Funded by MoTA)

Prompt diagnosis & treatment

IEC on Malaria in Baigachak of Dindori district

Funded by: Dept of Tribal Welfare, Govt of MP

Promote preventive aspects ← **Health Education** → **Generate demand for health services**

➢ 235 local school going children (class 8th -12)

➢ 47 local unemployed youths as village facilitators

➢ 3 block monitors

➢ 1 field coordinator

➢ 42 schools enrolled

Saha KB. *et al* 2015. IJMR, 141 (5), 576-583

Training Workshops jointly with NGO-Bangla Natak Dot Com, Kolkata

Organized 36 Training Workshops with students

(Total 84 days workshop in the field)

Trained on survey techniques

Trained on tools of communication

Trained on theatre based methods

Saha KB. *et al* 2015. IJMR, 141 (5), 576-583

Baseline problem level

Contributes **12%** malaria in state.

Population **1%** of state population.

Baigachak (CHCs Karanjia, Bajag & Samnapur)

In 2009-		
	SPR	27%
	Pf%	87%
	Spleen Rate	47%
	IPR (<1 Yr)	40%
	CPR (<5 Yr)	45%

Govt health services: 14%

Malaria/ASHA worker: 5%

Traditional village healer: 52%

Declining trend of malaria prevalence in Dindori.

Malaria Reduction	
Year	Percent (%)
2010	36
2011	61
2012	71
2013	89
2014	89

Spleen Rate

Year 2009
Enlarged spleen 49%
Normal spleen 51%

Year 2010
Enlarged spleen 45%
Normal spleen 55%

Year 2011
Enlarged spleen 27%
Normal spleen 73%

Year 2012
Enlarged spleen 5%
Normal spleen 95%

Year 2013
Enlarged spleen 5%
Normal spleen 95%

Year 2014
Enlarged spleen 5%
Normal spleen 95%
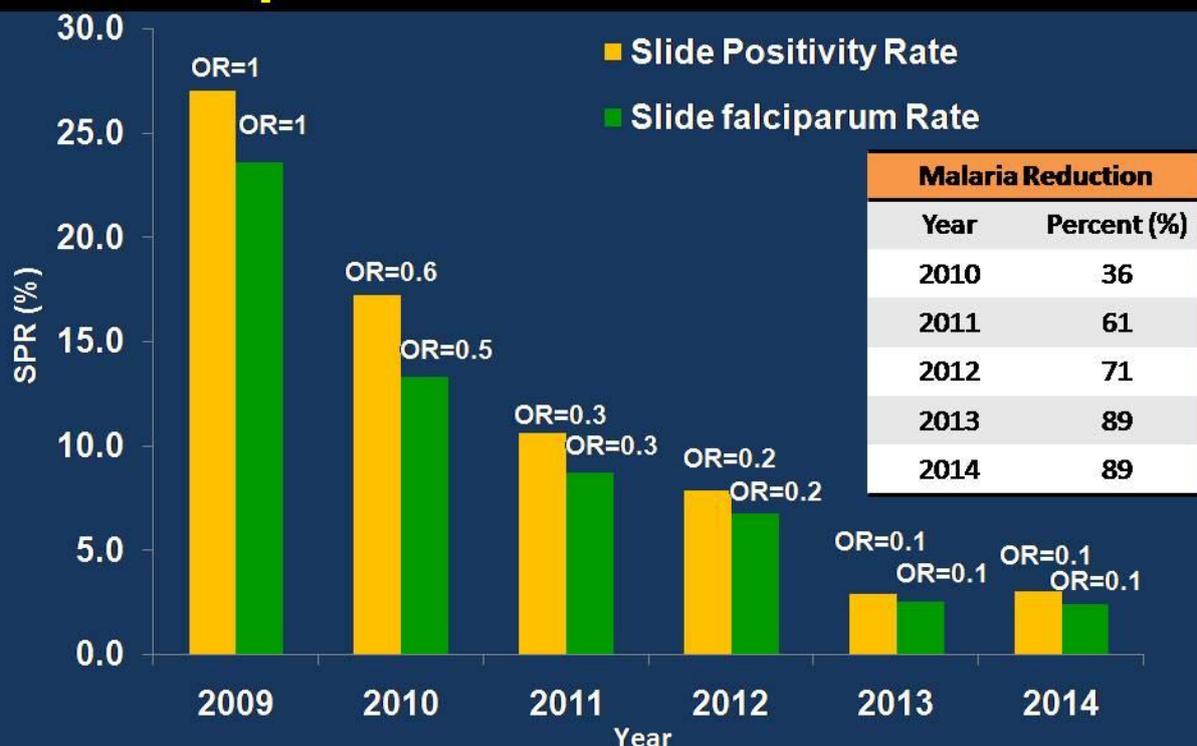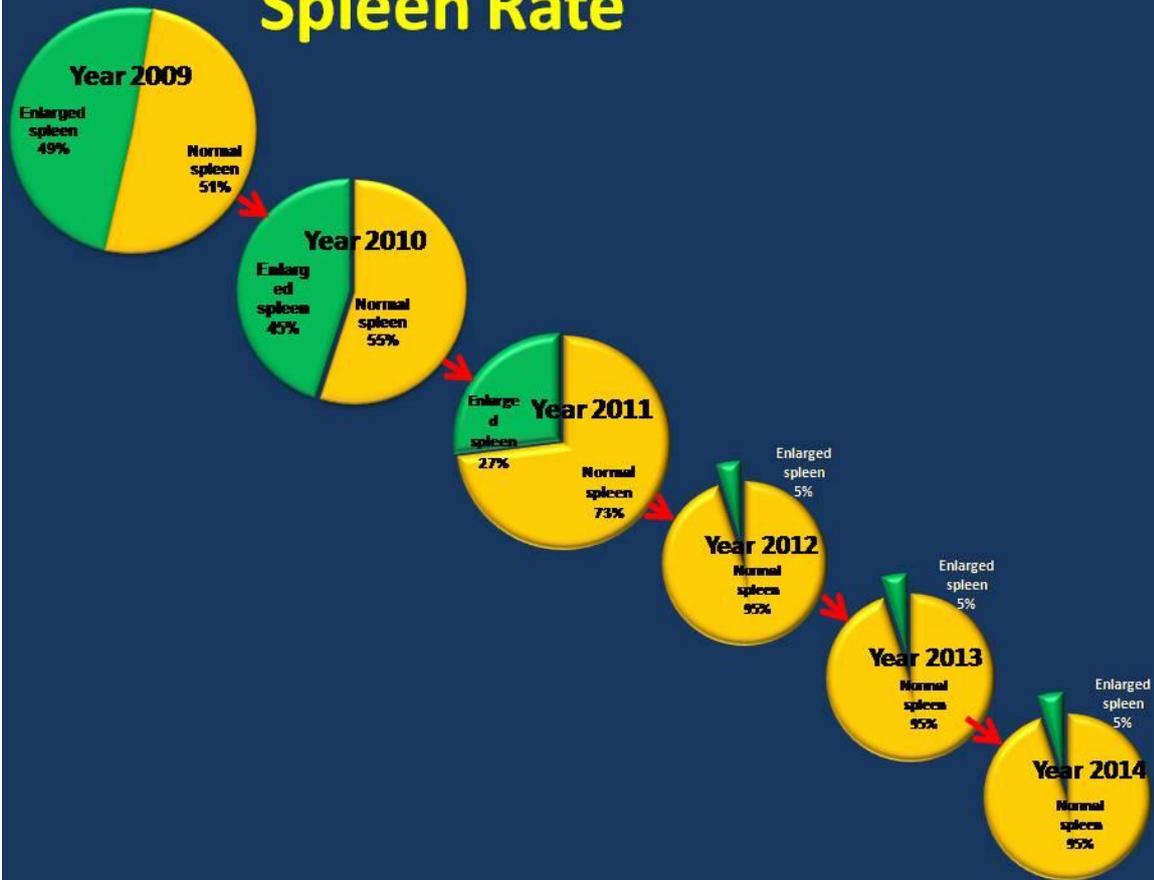
Year wise man hour density of malaria vectors

Legend: ■ Total Anophlines ■ An. culicifacies ■ An. fluviatilis

Y-axis: Per man hour density (0.0 – 40.0)
X-axis: Year (2009, 2010, 2011, 2012, 2013, 2014)
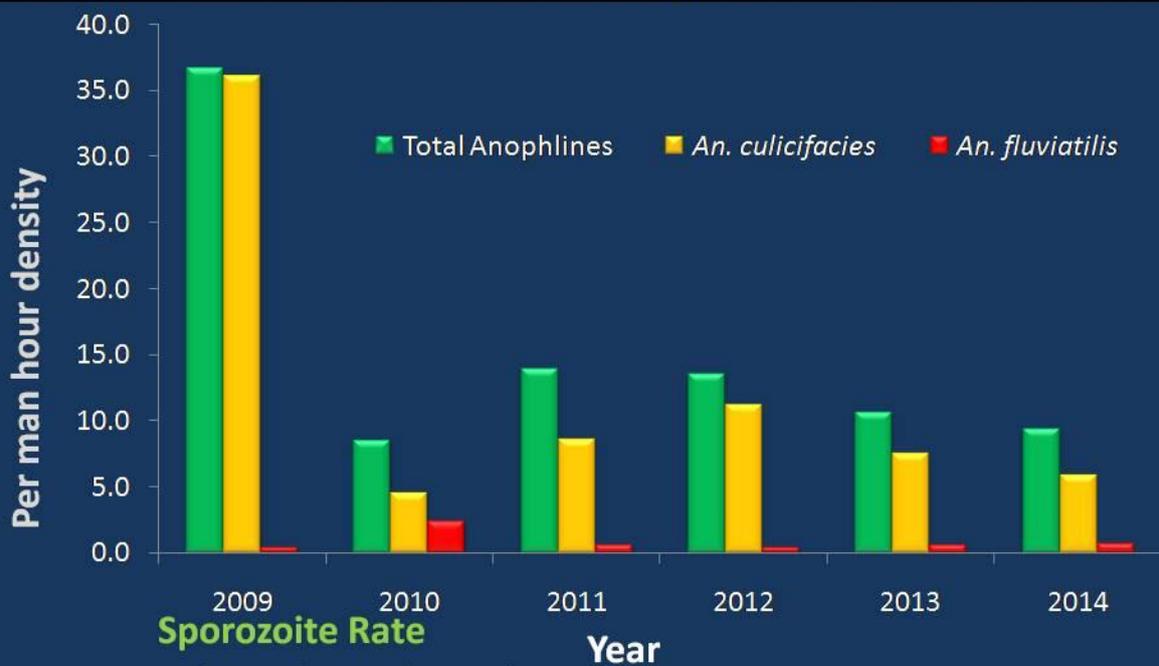
Sporozoite Rate

	2009	2012	2013	2014
An. culicifacies	1.2	0.4	0.0	0.0
An. fluviatilis	0.5	0.0	0.0	0.0

Improvement in awareness to malaria (2011 to 2014)

Utilized health services
Govt. health services: 15 - 42%
Malaria/ASHA worker: 10 - 15%
Private doctors: 17% to34%
Traditional healer: 29 – 5%

Limitation/Challenges

➢ Unwillingness of staff to work.

➢ Limited mobile network.

➢ Limited Public transport.

➢Strengthening of ASHA/ANM/AWW.

➢Organizing sensitization camps at public places.

Condition necessary for Successful Implementation

1. Robust surveillance

2. Prompt diagnosis and treatment

3. Increase in ground level health worker

4. Scale up LLINs, RDTs & ACTs

5. Need based IEC/BCC

6. Inter-sectoral coordination

7. Supply chain management

Malaria Control in Two Districts of MP
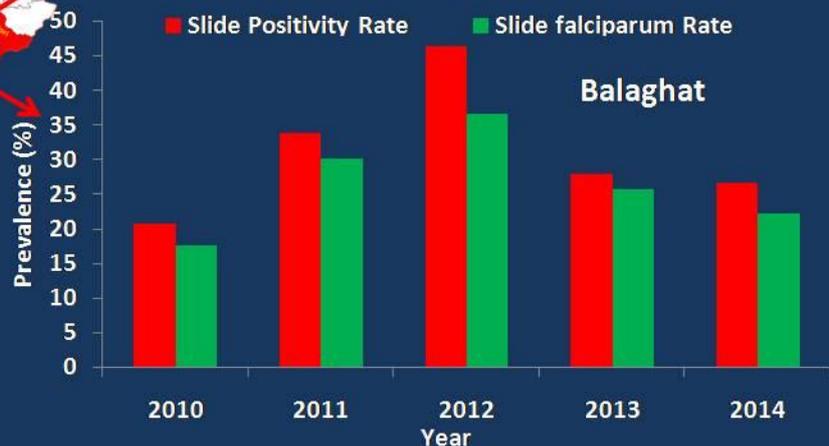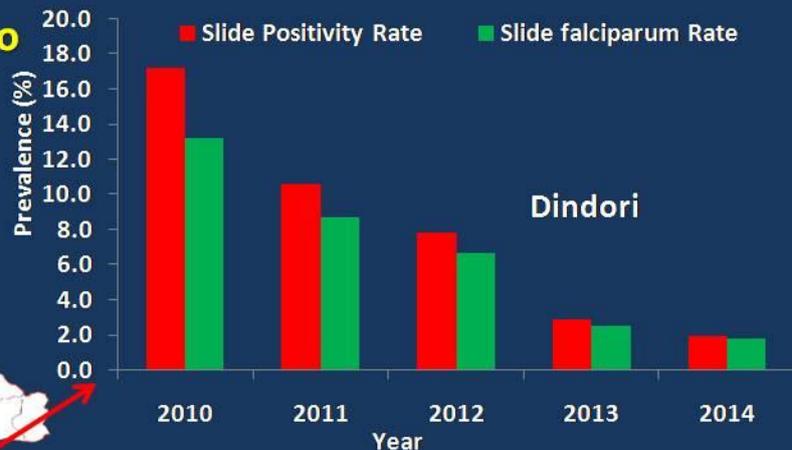
Way Forward

PROPOSAL FOR ELIMINATION OF MALARIA STARTING WITH EIGHT DISTRICTS OF JABALPUR DIVISION, MADHYA PRADESH.
A PUBLIC-PRIVATE-PARTNERSHIP (PPP) PROPOSAL
BY
THE SUN PHARMACEUTICAL INDUSTRIES LIMITED (SPIL)

Collaborating Organizations

Key Government Nodal Collaborating Agencies:

- Ministry of Health and Family Welfare (MoHFW), Government of India
  1. National Institute for Research in Tribal Health (NIRTH), Indian Council for Medical Research (ICMR), Department of Health Research (DHR), MoHFW.
  2. National Vector Borne Disease Control Program (NVBDCP), National Health Mission, Department of Health and Family Welfare (DoHFW), Ministry of Health and Family Welfare (MoHFW).
- Government of Madhya Pradesh.
- Ministry of Tribal Affairs, Government of India.

Thank you...

Questions and answers

Q: *Dr. Sudarshan:* I am not clear, when you said that the programme was a state malaria programme and you were part of that, and your contribution was IEC. Even bed nets were a part of that programme. Your intervention is an IEC component which you brought from West Bengal and did a good job, and the outcomes is because of the IEC. If you make a conscious effort to make the district health system provide the services in that district, in order to improve there should be some indicators. I would like to know if you got those indicators to consciously measure the efforts of the health system.

A: Sir, the entire thing is done by the state government, only and we were acting as facilitators. Also, the long lasting bed nets were distributed because of the data that was provided by Rajsekhar. The earlier drug was replaced because of the systematic data provided by us. Our limitation is that we cannot not change the state government. If they are willing we can provide. Unfortunately they were not able to provide the long lasting bed nets to another district and we could not get the results. That is intensive IEC, funded by others. So we have our limitation and we accept that but this is the model we proposed that it is working in that area.

A: *Dr. Saha:* Actually, the IEC part which was done in collaboration with banglanatak.com, a Kolkata based NGO who helped us in designing the tools for communication, for which we were not expert. Jointly we designed what was needed and generated everything from the local area. We did not import anything from outside so even the pamphlets and slogans are generated within the community. So we developed a strategy and they helped in designing based on our strategy.

Q: *Dr. Sudarshan:* Did you involve Village Health and Sanitation Committee (VHSNC) there?

A: No, we had our own local youth who were involved.

Chairpersons' questions and comments

Dr. Abhay Bang

We must congratulate you and your team and the health system for wonderful approach and the research. I wish this is done everywhere. It would probably provide some

significant solution to malaria problem. What did you do additionally? One is the use of LLIN. Several areas have used LLIN and still results are not as wonderful as you have. You have solid evidence of the impact. I find that you have 2 inputs in addition to LLIN and RDK etc. One is the demand generation which you have outsourced. I don't know how but you have managed to mobilize the health system, something which everybody knows is extremely difficult. What did you do that the same health system in Dindori district started delivering, which otherwise it fails to deliver? That needs to be elaborated. In a way that is also outsourced because you are not a part of the district system. So both demand generation is outsourced, and facilitating the health system is also outsourced. Does it gives us a message that for anything good to happen in tribal areas you need to bring in other agencies apart from the health department? So without bringing outside agencies the health department by itself probably would not have done it. What did you do? Please share the magic.

A: Sir, I think I did not come across clearly. bangalanatak.com, spent only 84 days in the field. Persuasion of the school children and for them to tell their parents about the do's and don'ts about malaria. After the initiation they left and were not persistently present there. Afterwards the whole thing was done by Dr. Saha of the NIRTH. It was after one year that I personally went there and my role was mostly that of a facilitator. We constantly asked them, not only at the level of MO but also at the level of Joint Director about the intensity of malaria. I was simply showing the data about malaria incidence and when high infant mortality rate, and that worked very well.

And unfortunately in the other villages also I was showing data but somehow instead the effect was not long lasting. We could not introduce LLIN there.

Dr Abhay Bang

I don't think there is anything wrong in outsourcing a specialized role. If the local health system does not have that capacity, taking help from another agency whether it is from Calcutta or elsewhere is not wrong. I don't think it undermines the success of this project. It only tells us the conditionality. For good health education, IEC and demand generation, you need special inputs more than what is available currently with the District Health System. That one input was provided whether for the 84 days or more. The point is that it is important and necessary for making the malaria control programme successful that the demand is generated.

Secondly, why is it not happening today in every district? Obviously, your institution's involvement was a critical addition. You and Dr. Saha facilitated the state and district departments to focus on malaria and got it done. Left to themselves what will happen?

So, I see three new inputs in your practice.
(i) Technical inputs in the form of LLIN, ACT, RDK etc.
(ii) Intensive demand generation with the help of a competent agency and sustained by your team.
(iii) External facilitator, a technical managerial team, the NIRTH which successfully mobilized the health system. These three ingredients are necessary for making this approach a success.

A: Sir, technical mobilization is very much essential. Besides whatever is mentioned in IRS, ACT, etc there has to be regular monitoring. You are also showing regular feedback that there is a decline from this year; that was another obligation. Sir, in this IEC for the first time we mobilized the students and we tried that they should be the agents of change. When they go back home after being trained by us and NGO our message will be disseminated to their parents.

4

Sharing Ideas for Tribal Health Care
Gadchiroli, October 2015

Control of Hyper-Endemic Malaria
Through Community-Based Effort
in Tribal Districts of Southern Odisha

MITRA, Christian Hospital, Bissamcuttack
&
9 NGO's in the Malaria Partners Network in Odisha
&
Tata Trusts, Mumbai

Our Context
Odisha – KBK + Districts - Predominantly Tribal
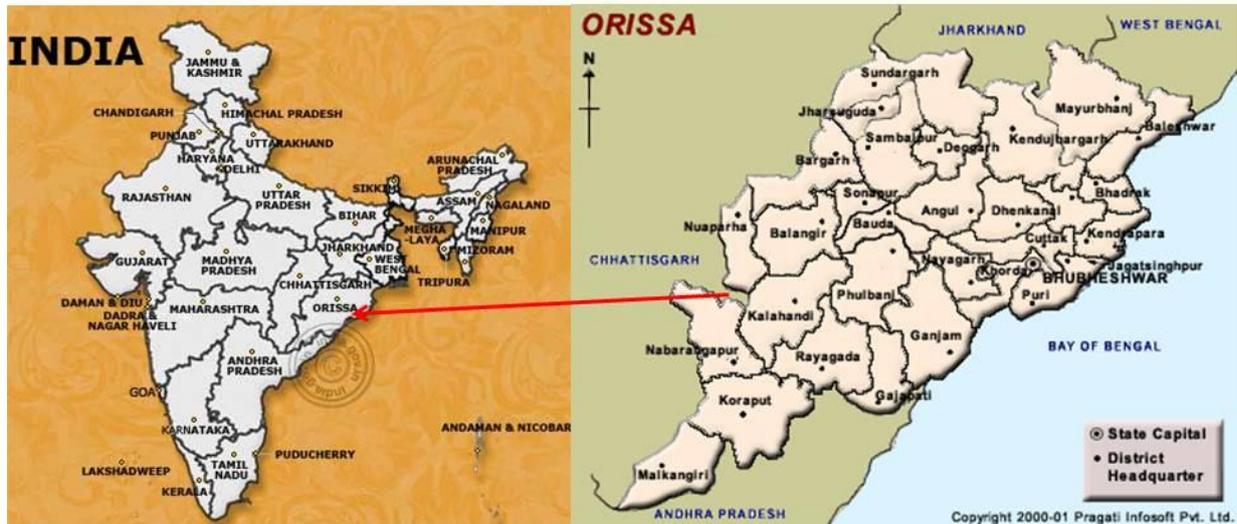
Malaria, Maternal Deaths, Maoism & Multi-Nationals

➢ Malaria incidence in India accounted for 76% of cases in South East Asia region
➢ 80% of reported in India is confined to 22% of population in high transmission, tribal, hilly inaccessible areas
➢ Odisha – 26% reported Malaria cases & 85% *Pf* cases

Source: World Malaria report, NVBDCP

Introduction to MITRA

Health Care	Training in Health	Children's Education

Madsen's Institute for Tribal and Rural Advancement (MITRA)

- MITRA project across 53 villages in Bissam Cuttack & Chandrapur blocks
- MITRA Training & Resource Unit
- MITRA Residential School, Kachapaju (MRSK)

- Mobile clinics
- Malaria malnutrition camps
- Child nutrition program
- Adding Quality to Education
- School Health Program
- Milla Kahini Basa (Playschool for under 5)
- Ageing with Dignity
- Sickle Cell Anemia Support

Christian Hospital, Bissamcuttack: 61 years history; only 200 bedded Hospital in 200 km radius

Christian Hospital, Bissamcuttack today...

16 acre campus; 300 staff;
120 nursing students; 1500 school children...
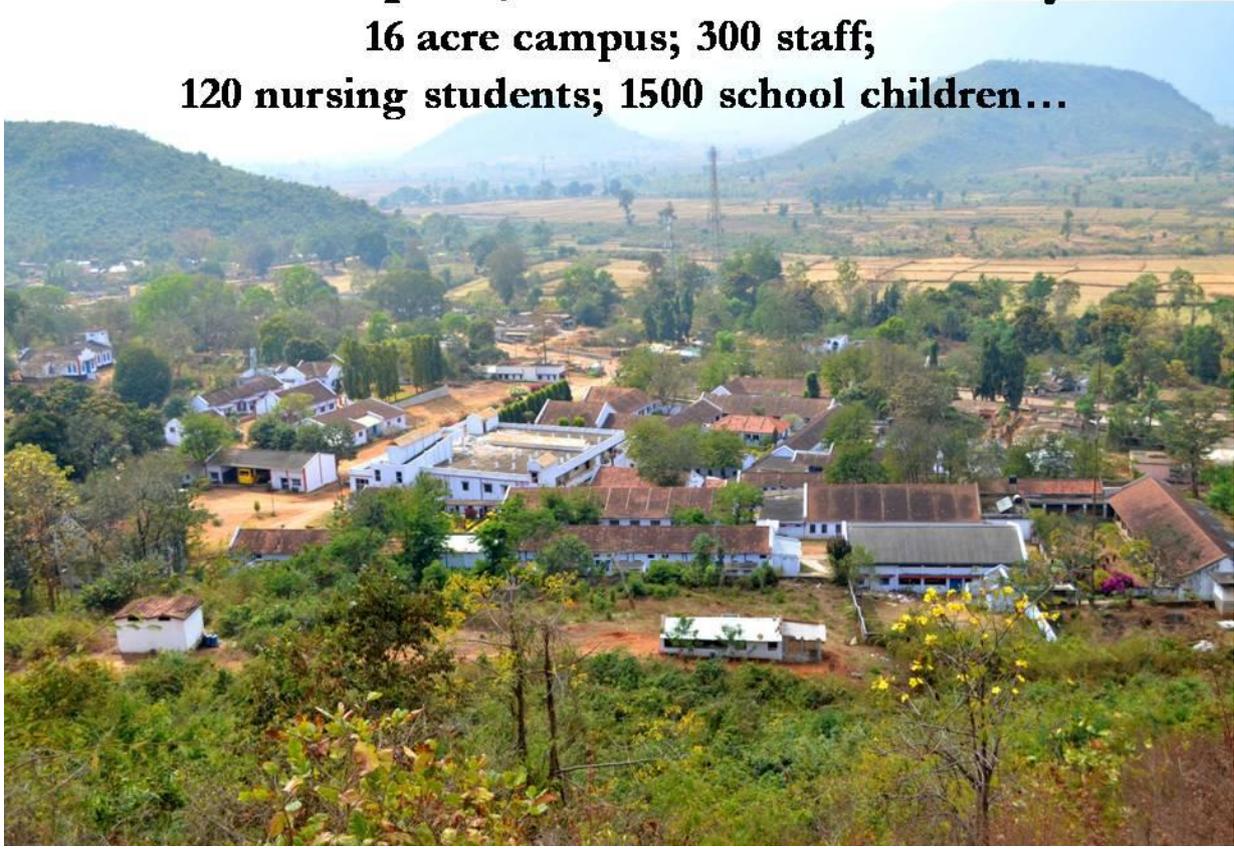
Introducing the Partners

The Technical Lead	• MITRA - Christian Hospital, Bissamcuttack, Odisha
The Implementing Partners	• 10 grass-roots NGO's in 4 districts • MITRA, DAPTA, FARR, SWATI, CCD, CARD, JKP, PRAVA, SACAL, SURAKSHA
The Facilitating Partner	• Tata Trusts, Mumbai
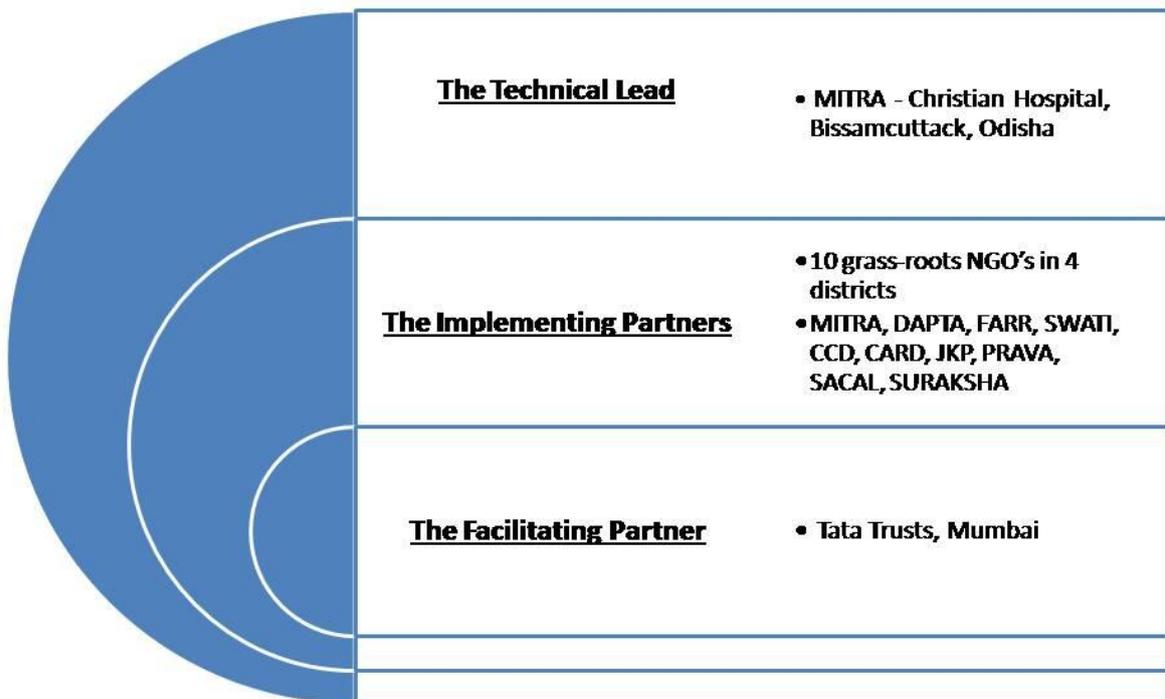
The Tata Trusts Malaria Control Partners Network, Odisha
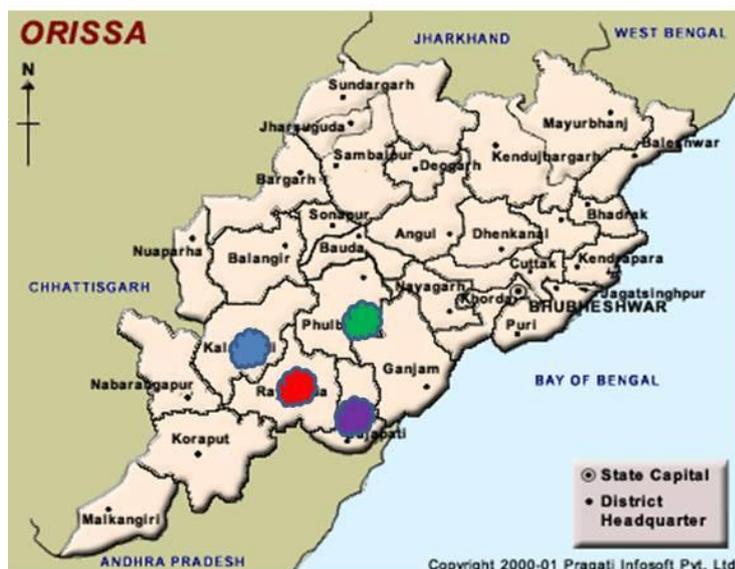
Partner	District	Villages
🔴 MITRA	- Rayagada	- 50
🔵 DAPTA	- Kalahandi	- 90
🔵 FARR	- Kalahandi	- 90
🟢 SWATI	- Kondhamal	- 100
🟣 CCD	- Gajapati	- 50
🟣 CARD	- Gajapati	- 50
🟣 JKP	- Gajapati	- 50
🟣 PRAVA	- Gajapati	- 50
SACAL	- Gajapati	- 50

Population Covered 151445 in 630 villages 12 blocks in 4 districts

Problem Rationale

South Odisha is Hyper-Endemic for Falciparum Malaria
Surveys done 2001-2010 showed a **Child Parasite Rate of 38.2%** **8,340 MP Positive of 21,845 children** actively screened, with or without fever, in 5 districts.   Source: Prem Plan, MITRA, Tata Trusts

The most vulnerable groups for Severe Malaria are Children (Under-5 years of age) and Pregnant Women especially Primi-gravidae

The region also ranks highly in the State for Child Malnutrition and Child Mortality

Insights from many years of community health work in this region - reduction of Childhood Malaria will significantly reduce Child Malnutrition and Child Mortality, besides other aspects of quality of life of children.

Problem Statement

• Malaria is a major killer in tribal parts of Orissa and causes morbidities among tribal, especially children.

• *Anopheles Fluviatilis* is the common vector which breeds in flowing water, making it difficult to control the vector.

• Inaccessible areas are the most vulnerable and with high mortality and suffering.

• Malaria goes beyond being a parasitological problem and ends up as socio-economic distress factor in these endemic areas.

Goal

The Dream
That Our People Will Be Free From The Physical, Mental, Social And Economic Burden Of Malaria

Philosophy
A People-Centred, Scientifically-Sound, Locally-Relevant Malaria Control Strategy, that aims to Empower Individuals and Communities with the Knowledge, Skills and Motivation Needed to Protect Themselves From and to Control Malaria, and includes Facilitation of Access to the Tools Needed for the same.

The Objectives:
In a period of 3 years
1. Reduce Point Prevalence of Malaria by 25 % (as assessed by blood tests in children under 5 years)

2. Reduce Fever Deaths by 25% (as reported in household surveys or community-based MIS)

Content: Details of Best Practice

"Towards a People's Movement Against Malaria"

Malariological Focus Areas:

▶ Reduction in Parasite Density

▶ Reduction in Vector Density

▶ Increase in Utilisation of Personal Protection Measures through Empowerment & Behavioural Change

Project Strategies (Generic Strategy – adapted locally)

▶ Strategy 1: Education for Empowerment

▶ Strategy 2: Saving Lives, Decreasing Suffering and Reducing Parasite Load

▶ Strategy 3: Reduction of Vector Density

▶ Strategy 4: Behavioural Change and use of Personal Protection Measures

▶ Strategy 5: Organisational Capacity Building, Monitoring and Evaluation for Measuring & Sustaining Change

Content: Details of Best Practice

Education For Empowerment Vision

Vision: Malaria Education Campaign will empower people with

• Knowledge on malaria & facilities available for Malaria Control –
4 Question Format
1. What is Malaria?
2. How does it spread?
3. What should I do if I get it?
4. What can I do so as not to get it ?

• Skills: Breeding Reduction, Personal protection with MN and Repellants, Referral Skills

• Motivation on Prevention & Early Treatment

• Process: Multiple Methods, Multiple Audiences

Content: Details of Best Practice

Saving Lives & Decreasing Suffering through Early Diagnosis, Treatment and Referral Services

Level 1: Encourage utilisation of Government services

Level 2: Volunteers may provide Presumptive CQ-SP

Level 3: Staff may provide Presumptive CQ-SP or Blood Test with RDT & Treatment with ACT

Level 4: Referral Support for Severe Malaria

Content: Details of Best Practice

Saving Lives & Decreasing Suffering through Early Diagnosis, Treatment and Referral Services

Top: Positive cases are treated.
Right: Weight checkup of children is also done to assess malnutrition cases, if any.

Mal-Mal Camps: Active Screening and Treatment of Under-5's

- Malaria—Malnutrition Education

- Check-up for Under 5's with Weights and Blood Tests (Malaria Microscopy / RDT)

- Additional RDT optional for Antenatal Mothers or Fever Cases

- Mosquito Net and Neem Oil Sales with Net Re-dip Counter

- Report back to village with results and treat all Malaria-Positive children as per guidelines (ACT for PF; CQ for Pv / Pm)

Content: Details of Best Practice

Reduction of Vector Density

- Primary Vector in South Orissa: An. Fluviatilis (breeds in slowly flowing water)

- Secondary Vector : An. culicifacies (breeds in stagnant water)

- Approach: Create Awareness on Breeding Site Reduction; Weekly Dry Day

- Facilitate NVBDCP inputs: IRS, Larvivorous Fish

Content: Details of Best Practice

Behavioural Change and Personal Protection Measures
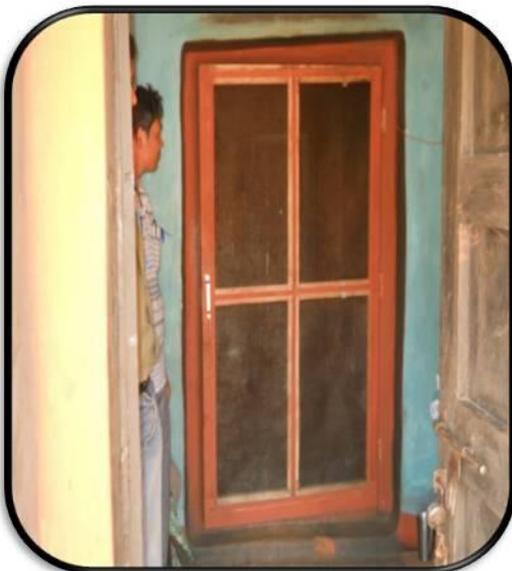
- Providing Access to and Promoting Use of Neem Based Repellants
- Promoting, Providing and Advocating Medicated Mosquito Nets
    - Advocacy for use of MMN
    - Facilitating Access to and use of LLIN from NVBDCP
    - Providing ITMN to fill gaps in provision

- The DAPTA Innovation: Exploring Innovative Mosquito Proofing of Tribal Houses
    - Can we reduce mosquito entry ?
    - Can we lobby for getting this into IAY house designs?

Content: Details of Best Practice

Organisation, Monitoring & Evaluation: Measuring & Sustaining Change

• Insider Perspective and focusing on building local capacity in the community that will be present even after the project ends

• Training and Capacity Building of the Organsiation's leadership, Team on Malaria & in Community Health

• Building capacities of GKS, ASHA, AWW
• Establishing systems of supervision and monitoring

• Setting up a simple Community Based Management Information System on relevant health status indicators.

Content: Delivery System Cluster In-charges

Human Resource Planning

Tailormade & Decentralised Training process

Programme Review & Dissem.

Service Delivery

Course Correction

Supply

Monitoring, MIS, Handholding

Linking with Public Health System

Prog. Coord.

Field Coord./MIS staff

Malaria Resource Persons

Village: CHWs, Volunteers, ASHAs
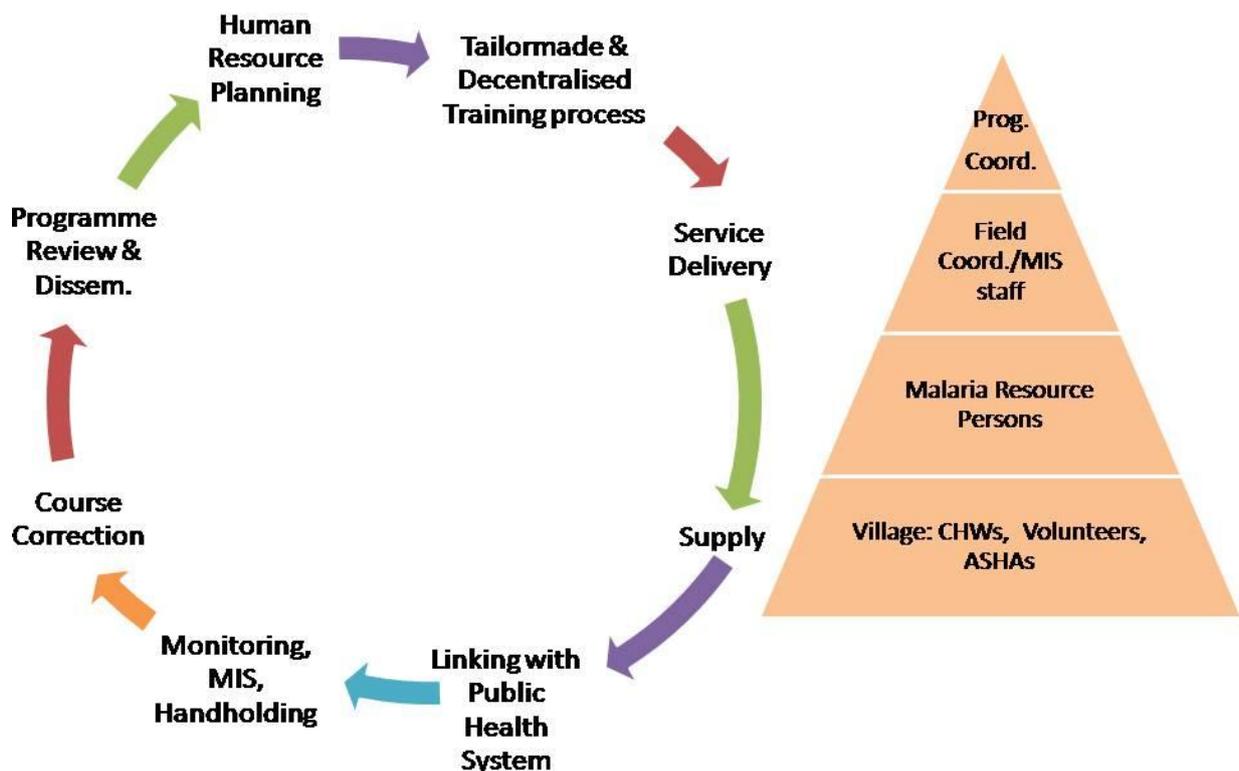
Results: Baseline - Point Prevalence of Malaria Parasitemia in Children U5 Years (CPR) Surveys done by NGOs in South in Orissa

YEAR	ORGANISATION	DISTRICT	No. of Villages Surveyed	No. of Children (< 5 yrs) Tested	No. of Children Positive	Percentage Positive for Malaria
2001	Prem Plan & 16 Partner NGOs	Gajapati	1000	15,676	5613	35.8%
2004	Mitra	Rayagada	5	169	99	58.6%
2010	Mitra	Rayagada	50	1245	730	58.6%
2010	DAPTA	Kalahandi	30	829	512	61.7%
2010	FARR	Kalahandi	30	882	293	33.2%
2010	PARIVARTAN	Malkangiri	30	888	476	53.6%
2010	PUSPAC	Malkangiri	30	716	276	38.5%
2010	SDS	Malkangiri	30	658	145	22.0%
2010	SWATI	Kondhamal	40	782	196	25.0%
2001-10	TOTAL		1245	21,845	8340	38.2%

Results: Active Screening of Children in 50 Mal-Mal Camps of Mitra, Bissamcuttack (Round 1: June – December 2010)

Indicator	Frequency
No. of Under-5 Children in 50 project villages	1375
No. of Children examined and tested	1245 (91.5 %)
No. of Children who tested positive for Malaria	730 (59 %)

59% of children under the age of 5 were positive for malaria with or without fever.

Of the 730 children who tested positive, only 8% had Fever ; the other 92% were Afebrile But Positive.

The point prevalence of malaria shows the following patterns:
- The prevalence rate increases with age between 0 and 5 years
- There is no gender variation in prevalence rates
- The prevalence rates are highest in remote hill villages, and relatively lower in plain area villages.
- There were 7 villages with 100% positivity – every child in the village was positive. These were mostly small villages in the hill area.

Result: MITRA-Evidence of Change 50 villages; 12,700 population predominantly Adivasi and Dalit communities

Indicator	1995 baseline	2010	2011	2012	2013	2014
Malaria Parasitemia Rate in Children under 5 years (%)	-	58.6%	33.1%	27.1%	11.5%	15.9%
Under 5 mortality Rate (per 1000 live births	295.3	138.7	106.0	103.8	86.8	92.7
Fever Death Rate (per 1000 popln)	7.1	3.8	2.9	1.6	0.9	1.8
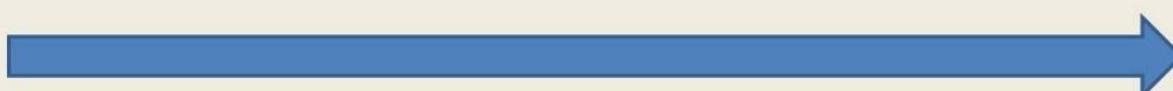
Overall Trends from the Partner Network

Orgn	Villages Covered	Populn	Years	Reduction in Child Parasite Rate (% Pos in < 5 yrs)	Reduction in Fever Death Rate (per 1000 pop)
MITRA Rayagada	50	12,700	2010 – 2013	54% (58.6 to 27.1)	58 % (3.8 to 1.6)
DAPTA Kalahandi	90	14,700	2011 – 2014	59% (65.8 – 26.9)	55.6% (2.7 – 1.2)
FARR Kalahandi	90	26,204	2012 – 2014	46% (8.3 – 4.5)	Increased (0.2 – 0.4)
SWATI Kondhamal	100	30,208	2011 – 2014	99% (18 - 0.05)	86% (0.7 – 0.1)
CCD + 5 Gajapati	300	67,633	2012 - 2015	73% (22.0 – 6.0)	85% (1.3 – 0.2)

Costing

Approx. Project Cost Estimates

Rs 235 / person / year x project population x 3 yrs

(or Rs 23.5 lakhs x 3 yrs for a 10,000 popln coverage)

(including HR, transport, materials etc)

Up-Scale-able?

1996 : Mitra, Bissamcuttack began working on Community Based Malaria Control in the area. The approach has evolved over the last 19 years.

1996 – 2009 : Many NGO's and Civil Society networks have undergone training from Mitra to undertake locally adapted initiatives based on this approach in Odisha, Chattisgarh, Jharkhand and the North Eastern states.

2010 – 2015 ; The Tata Trust Partner Network in Odisha ran this initiative in 630 villages of 4 districts.

2015 : Govt of Odisha (H &FW Dept) and NVBDCP, Odisha are launching Project Daman, which drew on inputs from the Mitra & Tata Trust work, and includes the idea of Active Screening and Treatment Camps for inaccessible areas of 8 districts.

Lessons Learnt & Shared

1. Malaria Parasitemia is far more prevalent than system data indicates.

2. 92% of the Malaria Parasitemia is children is afebrile; if Fever is the only indicator for testing, then these are missed.

3. The effects of Malaria Parasitemia in Children are far more than just Fever – it is linked to Faltering Growth and Malnutrition and Child Mortality (All Cause) (and probably Anemia, School Performance and other indicators of Quality of Life).

4. Active Screening & Treatment Camps for Under-5 Children and Pregnant Women during Malaria Season can help clear parasitemia and save lives.
   - They actively detect parasitemia and clear it, giving increased heath, growth potential and child survival .
   - They also provide an objective indicator of malaria village-wise (Child Parasite Rate or Point Prevalence of Malaria Parasitemia in Children Under 5), that can be tracked annually.

5. Malaria Control Strategies need to be tailor-made for the specific epidemiological situation – including Parasite Factors, Vector Factors and Community Factors. A local and focal strategy that is do-able by ordinary people can actually decrease malaria significantly.

6. Most of the highly endemic areas for Malaria in India have a combination of P.falciparum predominance and An. Fluviatilis as the vector. Personal Protection Measures become key interventions.

7. Engagement of GKS, ASHA, AWW added momentum to the programme.

Limitations

- The strategies addressed local realities. Therefore the replication of the strategy will depend on local malaria epidemiology.

- MIS data entry by NGO partners, there may be errors/biases.

- This Initiative was not designed for any research purpose. It was developed and implemented with the main aim of saving lives of tribals and reducing their sufferings using a techno-social approach.

Idea Sharing for Community Malariology

a. Designing Community Based Strategies based on local epidemiology of Malaria and perspective of the affected community.

b. Education for Empowerment of tribal addressing 4 key questions.

c. Annual Active Screening & Treatment Camps to reduce blood parasite and prevent transmission (that can double as Child Health Camps and Mal-Mal Camps)

d. Access to Early Diagnosis and Complete Treatment at village-level 24x7.

e. Access to and Motivation for use of Personal Protection Measures against nocturnal mosquito bites, especially

   - Use of locally available Repellants at sunset

   - Medicated Mosquito Nets (LLIN / ITMN)

   - IMPROOF (Innovative Mosquito Proofing of houses)

f. Use of Population-Based Indicators such as Child Parasite Rate for measurement of malaria endemicity and control in high burden areas.

Conclusion

Is this practice effective in reducing the problem?

- Yes. Technically sound and socially relevant. Demonstrated results in programme area using multiple strategies.

Is it feasible to deliver and acceptable to tribal people?

- Yes. Strategy has worked. Training and supportive supervision essential. Tribal people become part of mobilisation and service delivery thereby making it acceptable.

Is it scalable? By whom?

- Yes, GoO has designed DAMaN programme for high endemic inaccessible areas in Odisha with the component of biannual mass screenings along with other strategies. It is yet to be rolled out.

Thank You

Fever deaths declined

Fig 4: Fever Deaths in Project Areas

N of deaths	Y2011	Y2012	Y2013
DAPTA	27	35	6
FARR*	18	12	12
MITRA	46	35	20
SWATI	19	6	3
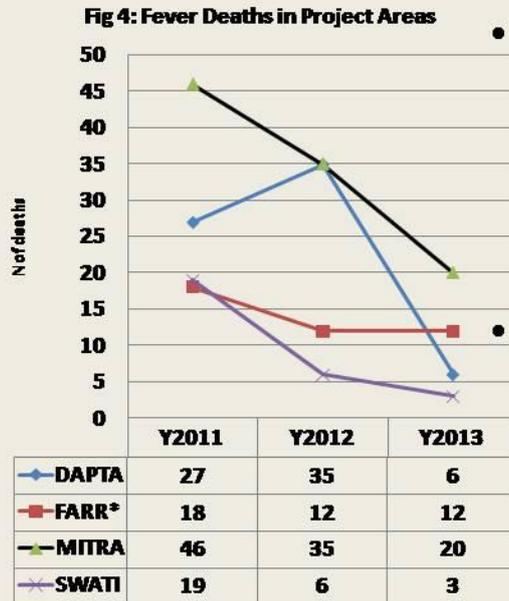
- Fever deaths are difficult to establish except in hospital admission or by verbal autopsy.

- Govt data usually underestimates Malaria-deaths, often talks only about cerebral malaria deaths.

Some decline in total fever cases

Fig3: Decline in Total Fever Cases (All)

fever cases	Y2011	Y2012	Y2013
FARR(26000 in Y12 & 13)	1636	4863	3944
DAPTA (18000)	2508	3172	1508
SWATI(27000)	5106	4904	4680
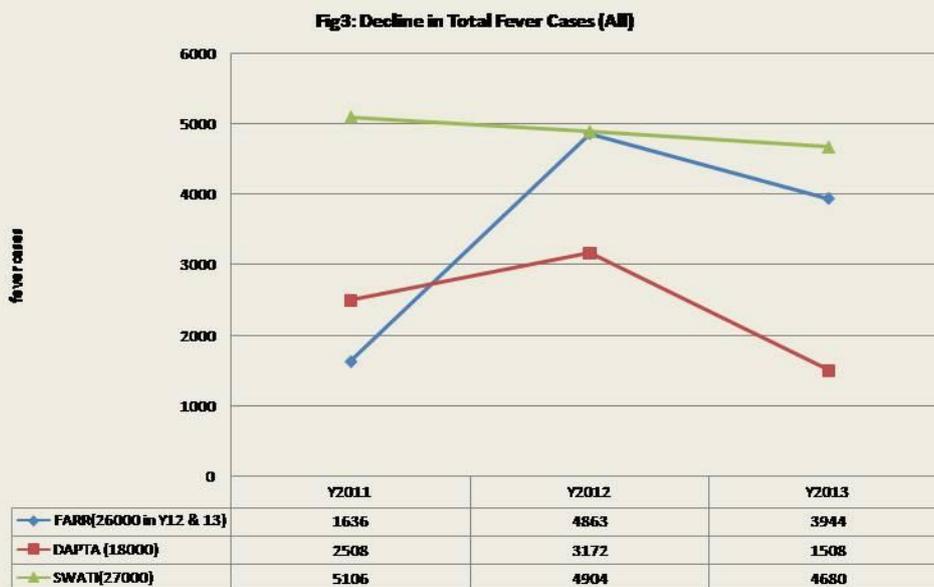
Decline in % of U5 children with Malaria-parasite in blood

- A major success of the program
- Mal-Mal camps, with personal protection (Nets + BCC) effective.

Fig5: U5 parasitaemia(%)
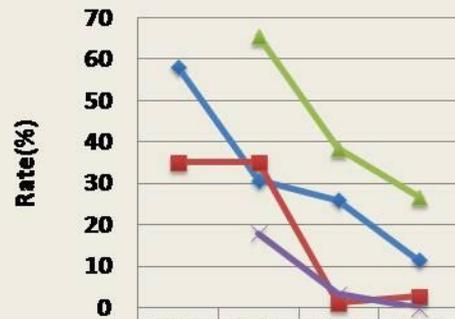
	2010	2011	2012	2013
MITRA	58.3	30.8	26.1	11.5
FARR	35.2	35.2	1.3	2.7
DAPTA		65.8	38.6	26.91
SWATI		18	3.4	0.06

Questions and answers

Q: *Dr. Neeru Singh:* Do you have data on *fluviatilis* species? *Fuviatilis* is a very efficient vector. Mostly, *fluviatilis* is an outdoor vector. It is responsible for outdoor transmission. So, the methods that work beautifully with the *A. culicifacies* may not work with *fluviatilis.*

A: Research centre, ICMR which is in Kolhapur has primary data. We don't have access to primary data.

Chairpersons' questions and comments

Dr. Abhay Bang

I can imagine that the area must be very difficult where the under-five mortality rate, as you report, is 285/1000 live birth. Exceptionally bad area to have such a high under five mortality rate, and I can well imagine that malaria would probably be one of the most important cause of death in that area. I will not go into technicality of the intervention, but the intervention appears to be quite comprehensive. It has worked well with the people and the effect, we were told, is very profound.

We did not have the opportunity to understand or he did not have the opportunity to explain in details about their measurement system. If the service intervention was provided to children then how those children were selected, etc. These are all more details which need to be understood. So, I think this project, is worth taking seriously and to be studied more seriously. About scalability, you are attempting even scalability through various NGOs and as you mentioned, I hope Orissa government is also taking it and scaling it up on higher level. And, so, several of the process details and several of the measurement details, too warrant much detailed description and examination.

5

Preventing under-three child malnutrition through crèches (Phulwari) in rural Bilaspur district, Chhattisgarh

Jan Swasthya Sahyog, Chhattisgarh

- By
Anil Bamne
Field coordinator

1

Location
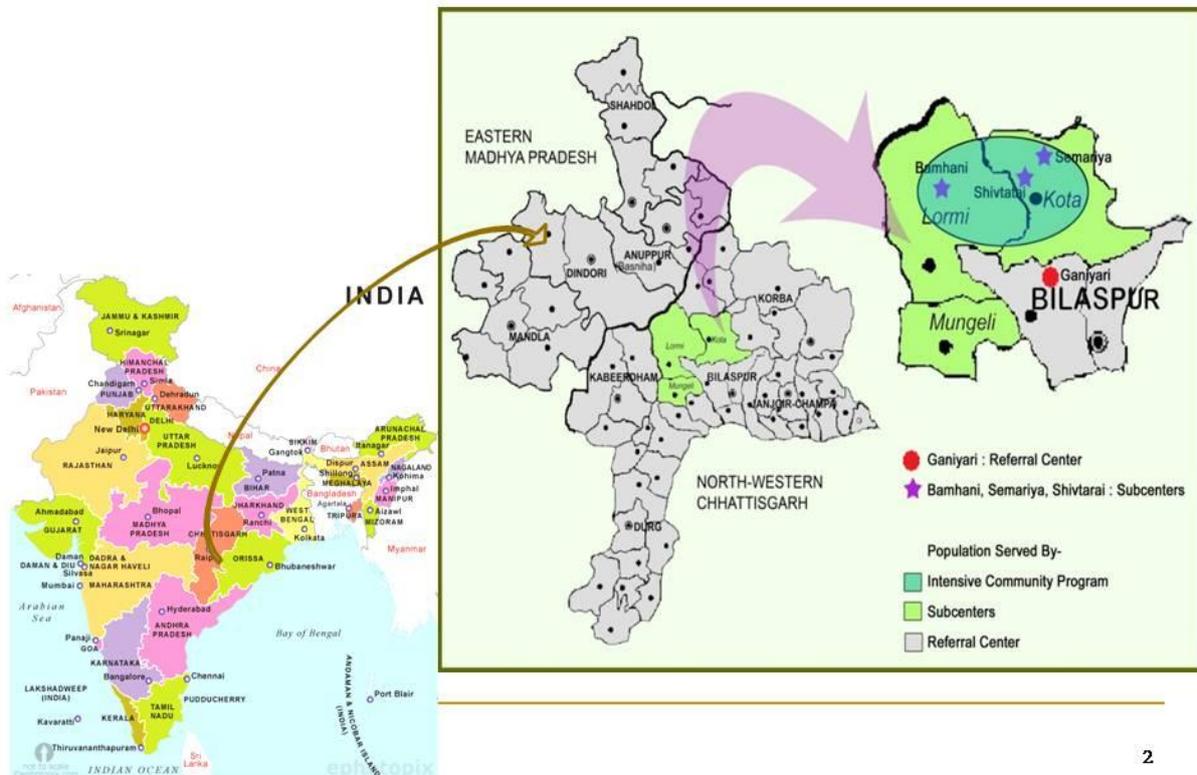
Jan Swasthya Sahyog
(People's Health Support Group)

- Jan Swasthya Sahyog (JSS) is a non-profit organization providing both preventive and curative services for the past 15 years to people from the tribal and rural areas of Bilaspur.

- We run a community health program and a hospital with three rural health centres.

- Hospital team includes specialists in Medicine, Paediatrics, Public health, Gynaecology, Surgery, ENT, Ayurvedic Medicine and Microbiology. Many members of the team were trained at the All-India Institute of Medical Sciences, New Delhi.

- Community program has a team of 3 program coordinator, 7 Field coordinator, 8 senior health worker, 104 village health worker, 80 Dai, Phulwari worker, 110

Problem statement

- When we say one third of the children are underweight, we mean that one third children go to bed hungry every night.

	Stunted	Severely stunted	Wasted	Severely wasted	Under weight	Severely underweight
India	38.8	17.4	15	4.6	29.4	9.5
CG	43	16.4	12.9	2.4	33.9	9.9
	India's Rapid Survey for Children 2013-14 (India)					4

Why focus on under 3years?

- UNICEF suggests once child turns six months appropriate and complementary feeding should be introduced to provide infants with critical nutrients and protection against deadly diseases
- High malnutrition rate in this age group.
- Long-term effects: reduces learning ability and work capacity – ensuring the person is forever in a poverty trap.

5

Contd…

- No one to feed them frequently, food that they can eat.
- Cannot feed themselves.
- Where food is offered, portion size is small
- Illness – poor eating – malnutrition – more illness
- Extreme poverty, lack of purchasing capacity of parents

Sibling care

What has been tried so far?

- Health education – limited impact
- Take home rations – dilution at family level
- Kitchen gardens – limited impact
- Improve overall economic status?
- Nutrition Rehab Centres – addresses SAM, not others.

What extra care does an under-3 child need that an older child does not require?

- Picked up and dropped at the centre
- Different food needs – consistency, variety
- Have to be given food – cannot take it themselves
- Some need to be fed
- Cleaned up after toilet
- Active children need to be in a "safe" place
- More individual attention to learning needs

8

Objectives

- To provide a safe, secure and stimulating environment for young children 6 months to 3 years of age when their parents are out at work.
- To demonstrate to mothers that older infants (beyond 6 months) can consume and digest food other than breast milk, and that they thrive on it.
- To prevent malnutrition among this age group and where children are malnourished, to improve their nutritional status.
- To help older siblings who have dropped out of school for the care of the younger child, to return to school.
- To allow parents to go out for work and increase their income that accrues out of it.

9

The Experience

Jan Swasthya Sahyog
&
Action against Malnutrition

Phulwaris or hamlet based creches

- Caretaker selected by village community
- One per ten children. (two workers for 13-20 children)
- Several creches in a large village
- Open 8 am – 4 pm
- Health care by Village Health Worker (VHW)
- Basic training in child nutrition or health is given to Phulwari workers
- 83 creches at JSS (in 38 villages), 1066 children

Food supplementation at Phulwari

- Sattu daily – cereal-pulse-oilseed mix 60 gm/ child / day
- Khitchdi daily – rice / daal mix (5:1) 125 gm rice.
- Eggs thrice a week
- Oil supplementation – 10 ml / child / day

> **900KCals + 22 gm protein / day**

12

Hand washing

Adding oil to food

13

A younger child being fed

Older children feed themselves

Time to sleep…

15

Caretaker : Child ratio for young children

- Not more than 1: 8-10, exhausting work
- Current anganwadi for 1000 population will need 6-7 additional workers to provide for under-3 care !

- Not only create the demand for women workers

- But support the need for all children whose mothers work

Also provide for

- Iron supplementation – daily
- Albendazole twice a year
- Toys for cognitive learning
- Growth monitoring every month
- Early child education

What has been the impact?

- Positive community response, more in the poorer villages
- Children have started eating more, even at home
- Children insist on hand washing with soap before eating food at home
- Older siblings going back to school
- Improvement in nutritional status
- Long term effect of malnutrition on height has not shown any change. Stunting persists.
- However, weight for age (underweight children), and weight for height (wasting, or sign of acute malnutrition) have significantly improved.

(Status monitored using WHO Anthro software)

18

Weight for age, all children
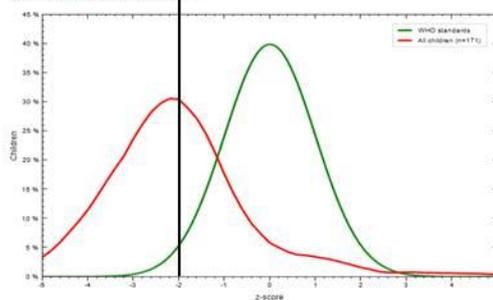
2009

56% underweight
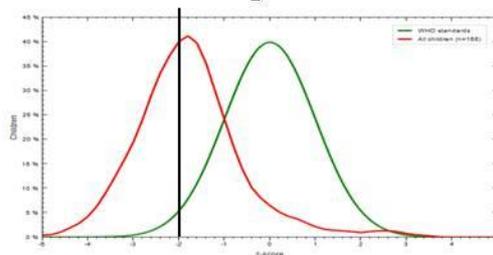
2011

44% underweight

Weight for height, all children
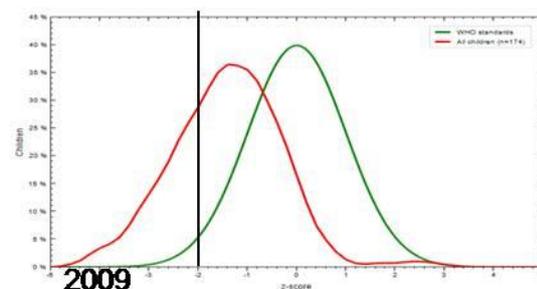
2009

26% wasted
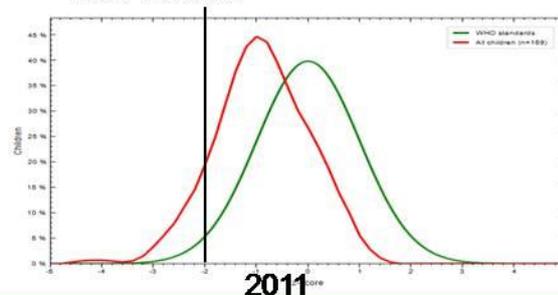
2011

10% wasted

19

Impact on Wasting

Wasting Status of Cohort: 4-6 months (n=587)

Normal — Initial: 72%, (423); Nov-13: 80%, (472)
Wasted — Initial: 20%, (119); Nov-13: 16%, (91)
Severely Wasted — Initial: 8%, (45); Nov-13: 4%, (24)
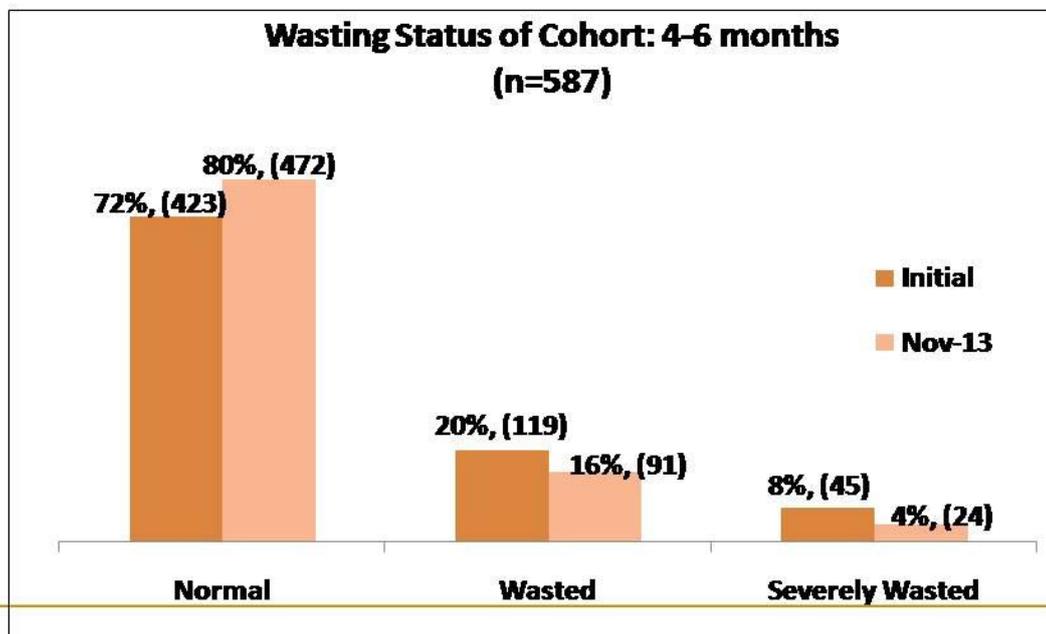
20

Change in Average z-score (Weight for Age)

2008; 2009; 2010; 2011; 2012; 2013 — Mean z score
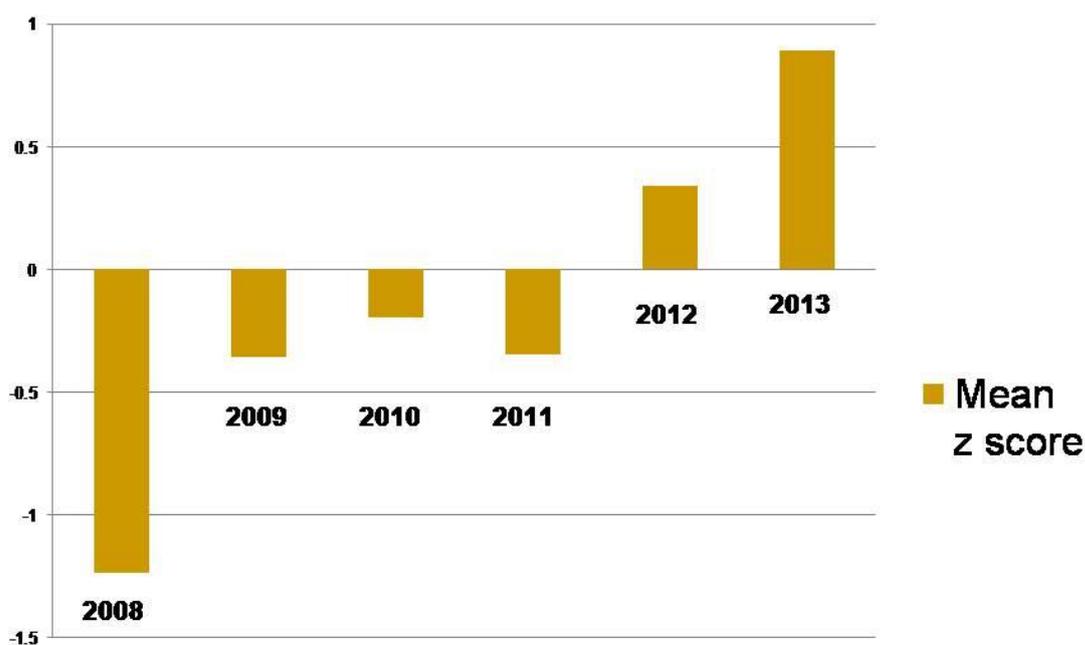
21

Coverage of creche program

- Cost Rs. 27.68 / child / day for food, wages Rs 3000 per month supervision, logistics, medicines (JSS)

- November 2012, PHRN (Public Health Resource Network) launched148 creches at AAM, 1552 children

- Madhya Pradesh & Chhattisgarh launched Anganwadi-cum-creches (in 5% AGWs) on pilot basis. JSS is providing technical support and training

- Replicated in Bihar, Orissa & Jharkhand by NGOs

Creches For Under 3:
Non -Negotiables

- Community needs based and not thrust from above

- 8 hours a day, to be run by trained crèche nutrition workers from the same hamlet, 26 days a month.

- Child caretaker ratio of not more than 10:1. Caretakers should be regular paid.

- Food - at least three large feeds, a minimum of 75% calories.

Creches For Under 3:
Non- Negotiables

- Iron supplement daily and bi-annual deworming
- Early child education essential
- Child safe environment, safe drinking water and mosquito proof interiors
- Community monitoring and debate should be inbuilt in the plan.
- Growth and illness monitoring are essential

Scaling up?

- At present, in India there is provision of creches under National Rajiv Gandhi Crèche Scheme: Generous budget allocation for food and honorarium
- NREGS: provision for wages to be paid for a crèche worker
- The crèches could be run in collaboration with ICDS, tribal department, NREGS and National Rajiv Gandhi Crèche Scheme.

Thank you

26

The creche kitchens

Count your eggs…….

Hand washing

Adding oil to food

28

A younger child being fed

Older children feed themselves

Time to sleep…

30

Thank you
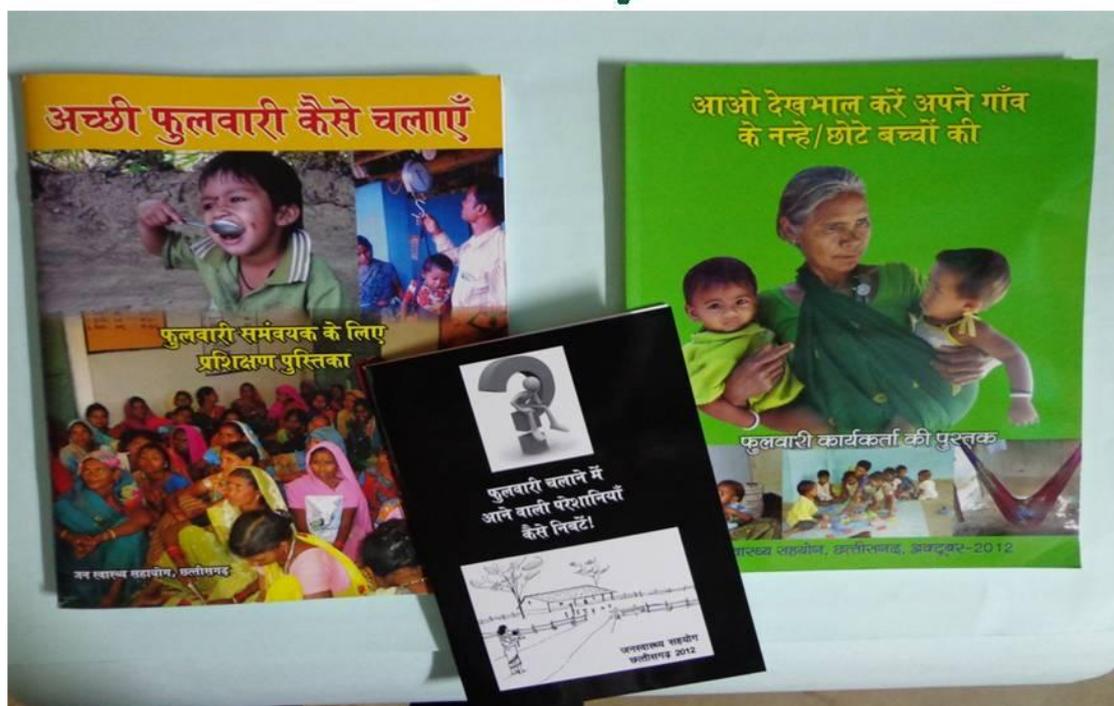
31

Questions and answers

Q: From our observation. Rajiv Gandhi National Crèche Scheme does not work in 50% cases. Can we integrate these services into ICDS services? Shifting the target age may also be crucial as we all are aware about importance of 0-3 years.

A: Yes. There are hardly any children who go to Anganwadis who are less than 3 years of age. And usually by three years you have lost the game.

Q: *Dr. Satish:* Community based volunteering for care. Can it done for other areas?

A: This is a primary need for working parents. They have to earn their livelihood, they have to be away, leave the child where they can get food and need a safe and secure place.
The second thing what we require is an intersectional coordination if it is possible. The ladies can come from villages. The food can be gotten from the woman child department. And a safe place could be provided by the panchayat. This is possible technically, all under the aegis, or say coordinated by the Ministry of Tribal affairs, but provided by these three departments. Or it should be a stand-alone project, as a commitment towards all tribal children.

Chairpersons' questions and comments

Dr. Abhay Bang

The importance of the "under 3 year old" has been emphasized for almost more than a decade. This practice has very correctly identified a crucial group and tried to address it by way of an intensive intervention. Very encouraging to see the results. However, to me the talk of scaling this up is a little premature. I have only broadly understood the process. There are several questions.

One question is about the supplementation of 900 cal/day/child. This is as you said 75% of the total calorie requirement of a child. Child is spending 16 hours at home and 8 hours in the crèche. I was surprised that mothers are saying that child is eating more at home after eating 900 calories. How can the child eat more at home? But, are you really aiming to supplement 900 calories a day?

What about the breast feeding for those 8 hours? There are now large number of studies coming up regarding maternal deprivation – we should say parental deprivation in the younger child has serious psychological, social and intellectual consequences. So when a child is deprived of its mother or family member's contact for those 8 hours, what will be its consequences?

I have three other major concerns.

One is, that your outcome data is before- after. Without a control group, we do not know what is happening in the entire population. It is claimed at the national level, that during the same period malnutrition is reducing. PDS scheme in Chhattisgarh is claimed to be very active. So, there have been multiple interventions occurring. As a scientist I would really ask for a controlled trial.

Secondly, always look for a population based data. The effect on malnutrition that you showed, is it about the entire child population in that area, where your Phulwaris are working, or is it only in the children who are attending Phulwaris? If it is only for children attending Phulwaris, the impact is good and the team should be congratulated, but that doesn't necessarily answer the question of malnutrition in the tribal population as a whole. Data on those who received the service is not enough, we need a denominator based, population based data as to what happened to the nutritional status on the whole child population in these villages to draw a conclusion.

The third question is about the cost. I think for any large scale government programme this might be considered a prohibitive cost. It is nearly, Rs 28 per day per child including the salary etc. It would be good to have a comparison with the ICDS. How much of food are you providing and its cost. However, I feel if you need 6-8 workers per village of 1,000 population, the scaling up cost is going to become a major hindrance.

There are several objectives of your practice, what about them? What is the effect on child's education? Are the elder children getting free from being tied down due to younger siblings care? Increase in parental income? It will be useful to know the multiple outcomes of this practice, as originally aimed, apart from the nutritional data that you've mentioned.

These under 3 children as we all know often fall sick. When they fall sick, they are irritable, difficult to handle. They will have diarrhoea, fever or vomiting. So, how much can a

woman hired by the programme take care of a sick child and how much can parents feel confident in sending or depositing their sick children with a third party?

I was wondering about the Ashramshala's tribal children, above the 6 years of age. The experience in Maharashtra is that the children are treated miserably. When some other agency takes charge of tribal children, the food and healthcare are terrible. In just one Gadchiroli district, in the last 5 years, 33 tribal children have died in Ashramshalas. In the age group their mortality rates are expected to be very low.

One outcome that you showed is definitely the health outcome – malnutrition status. But, all the activities you described don't belong to the health department. They are from the ICDS, Women and Child department's or some other department's domain. Thus there is a health outcome but the activity is not related to the health department. So which department will own it, is the question you have legitimately raised. Which department will spend the money?

The Phulwari is a sensitive and delicate programme. Less than 3 year old child being taken care of by hired workers. Here the beauty is that she's coming from the same village so it is more likely that there will be a community acquaintance, but that could also create other problems of enmity, caste or village groupings.

I think, this is a potential intervention and the age group is very crucial, very rightly identified, that's where the intervention should be. But, is crèche the only or the best concept? Who will run this with the same degree of sensitivity and commitment and care? Are we sure of the population based impact on the nutritional status of this intervention? Is this a cost effective intervention?

6

Fulwari Scheme
Community Managed Health and Nutrition Centres
for Under-3 year children and mothers

Chhattisgarh

October 2015

Issues in health and nutrition

- Inadequate access of families to food items esp. high quality or protective foods (e.g. protein from animal sources).

- Lack of adequate time for child feeding and care

- Recurrent infections

- Inadequate reach of Health Workers to children under-3 years age

- Gaps in feeding and care of pregnant and lactating women leading to poor maternal nutrition status and also low birth weight

- Gaps in household level production of diverse foods

- ICDS resources more focused on 3-6 year olds and no centre-based spot feeding or care for under-3 age children or pregnant/lactating women

- Situation is worse in tribal areas

Interventions needed

- Health
- Feeding
- Care

The Fulwari Intervention

- Fulwari – A Community managed Health and Nutrition Centre

- The key features of Fulwari Initiative are:

    a) Focus on feeding and care of under-3 year children, pregnant and lactating women

    b) Prevent infections in children, ensure early detection and cure

    b) Organise daycare through habitation based collective of mothers

    c) Promote household /community level production of diverse foods

Fulwari Design

- No paid worker for working in the Fulwari

- 2 Mothers volunteer each day to run the Fulwari and take care of children

- Fulwari is managed and run by group of mothers

- All decisions with respect to Fulwari taken by this group

- Group also manages the funds made available to them through Panchayats for food and other items in Fulwari

Fulwari Design

- Fulwaris initiated at habitation level in tribal blocks

- Habitations with higher levels of poverty prioritized in initial short listing of habitations

- No population norm for selecting habitations, each Fulwari covers 5-20 children depending on habitation size

- Demand based, a series of Community meetings done, Fulwari sanctioned based on Community Resolutions demanding Fulwari, which are ratified by Panchayat

Functioning of Fulwari

- Fulwari centre opens for 6-7 hours, depending upon timings of mothers work.

- Fulwari runs on all days including holidays.

- Fulwari run from space voluntarily given by a community member

- Each Fulwari given a grant of around Rs.4000 for utensils, bed nets, toys etc.

- At least three hot cooked meals provided to children and two meals to pregnant women.

- Eggs (atleast per child per week), Oil, vegetables emphasized in menu which gets finalized by the group of mothers.

Functioning of Fulwari

- Women and Child development department runs Fulwari scheme through Zila Panchayats who in turn involve Gram Panchayats

- Community Health Workers (Mitanins) and their support structure play the key role in Community mobilization, health linkage, problem solving and capacity building for Fulwaris.

- Rs. 6 per child per day provided for food (by Gram Panchayat)

- Rs. 15 per pregnant women per day provided to Fulwaris for food.

- Mothers/women volunteering to work in Fulwari also get food for that day.

- Ready to Eat powder available from Anganwadis also fed in Fulwari as one breakfast

Functioning of Fulwari

- Zila Panchayat provides grant for the food component and basic set-up through Gram Panchayats. An average budget of Rs.50,000 per Fulwari allocated by State Government

- Fund Flow: ZP to Gram Panchayat to Mothers' group running Fulwari.

- All expenditure done directly by Mothers' group.

- Most food items purchased locally

- Fulwari thus used as a base for promoting kitchen gardens, poultry etc in the families

Functioning of Fulwari

- Day care centres also function as demonstration for feeding and care related behaviors like – use of eggs, oil, vegetables in diet, frequent feeding, hand washing, handling of drinking water, use of bed-nets etc.

- Mothers group meets twice a month and this meeting provides Mitanin an opportunity for giving them nutrition and health education.

- Children monitored for pneumonia, diarrhea, fever (malaria) and any cases detected given the required advice/treatment/referral by Mitanin.

- Weighing of children done each month and grade (weight for age) communicated to mothers along with required counseling by Mitanin.

- Community based management of Severely malnourished children happens in Fulwari.

- Input to Fulwaris on Child Development i.e. Psycho-social stimulation aspects in collaboration with UNICEF

Fulwari Volunteer Duty Charts

दिनवार ड्यूटी

सोमवार - शान्ति, अंजू
मंगलवार - बालमति, गीता
बुधवार - सरिता, पार्वति
गुरुवार - क्रिस्टीना, प्रमिला
शुक्रवार - सुमन, अमृता
शनिवार - मिना, पुष्पा
रविवार - सुरजमुनी, प्रमिला

दिनवार ड्यूटी की सूची
टोंगरी पारा, ग्रा.पं. करौली, वि.ख. लुण्ड्रा

क्र.	दिन	ड्यूटी देने वालों का नाम
1	सोमवार	इन्दकुँवर, श्यामपति
2	मंगलवार	समेतो, गंगोत्री
3	बुधवार	गुलाबी, फुलमनी
4	गुरुवार	हिरामनी, बैंगिन
5	शुक्रवार	मालती, तीजो
6	शनिवार	मुदियारो, फुलवंती
7	रविवार	राजकुमारी, श्यामपति

Coverage

- Fulwari Initiative started as an innovation in Surguja district
- Hon'ble CM announced Fulwari scheme for all tribal blocks on 26 January 2013
- Successful roll-out of replication completed in 2013-14 in all 85 tribal blocks through Panchayats in 2013-14
- 2850 Fulwaris set-up across 85 blocks in 19 districts – covering total of 36,000 children and 16,000 pregnant / lactating women
- State Budget allocation in 2015-16 – Rs.30 Crore, number of Fulwaris to be expanded to 6,000 in tribal areas.

Benefits

- High Acceptability – Despite requiring voluntary effort from mothers – in 92% of the Fulwaris mothers continued to be willing to contribute their time, communities willing to give space
- Practices related to hygiene and feeding improved
- Mothers by participation in activities of Fulwari learnt more about preventing infections and child feeding
- It made it easier for Mitanin, Anganwadi worker and ANM to reach young children and pregnant women. Linkage with health likely to reduce infections, improve access to treatment without delay, reduce mortality
- It has helped in reducing the episodes of illnesses (diarrhea, malaria, ARI) and also seems to have reduced child deaths as sick children get identified faster.
- Better weight gain by pregnant women and improvement in birth-weights

Benefits

- Growth monitoring improved
- Mothers were able to be free from child care for 6 days a week as childcare was provided in Fulwari
- Household level production of vegetables etc. increased
- Panchayats started getting involved in Nutrition and Health
- It strengthens social image of Panchayats
- Fulwari brought the community together around the issue of improving child nutrition
- Fulwari 's collective ownership by mothers and their control over funds minimised chances of pilferage

Documentation and Research

- Detailed **Baseline Survey** through UNICEF support and by External agency for Surguja and then for Chhattisgarh
- **Rapid assessment** of the Impact was done by the team of experts from Pt. J.N.M. Medical College, Raipur (C.G.) & Pt.Ravishankar Shukla University, Raipur (C.G.) – early August 2013
- **Surguja Interim Assessment Survey** after one year of Baseline survey -through UNICEF support and by External agency February 2014
- **Chhattisgarh – Interim Assessment Survey** 2015 by SHRC
- External documentation done by CIPS Hyderabad
- External evaluation study conducted by hiring Expert on orders of Panchayat department

Impact on Health and Nutrition

- Baseline: Underweight 29%, Severe-underweight 16%

  Second Round Survey: Underweight 24%, Severe-underweight 10%

  24% reduction in overall under-weight rate

  38% reduction in severe under-weight rate
- Chhattisgarh Interim Assessment Cohort Study shows that 64% of severely-underweight children enrolled in Fulwari, were able to come out of severe-underweight category
- The Low Birth Weight incidence has come down from 25.5% to 13.9% for newborn born to pregnant women enrolled in Fulwari.

Recognition

- Fulwari Initiative recently got Prime Minister Award for excellence in public administration
- Ministry of Health and Family Welfare GoI selected Fulwari as a Best Practice in 2015.
- Institute of Tropical Medicine (Antwerp) has included 'Impact of Fulwari on improving Maternal Nutrition and IUGR ' in its Colloquium 2015
- Nutrition Coalition (New Delhi) invited Fulwari Initiative to be presented in the **South Asia Conference** on Policies and Practices to Improve Nutrition Security 30-31 July 2014
- **Centre for Innovation in Public Systems** (an autonomous body promoted by GoI) chose Fulwari Initiative to be presented as a leading innovation in country on their Foundation Day in Hyderabad on 14th May 2014

Recognition

- International Food Policy Research Institute **(IFPRI)** has chosen Fulwari Initiative and Documented its implementation as a promising strategy for strengthening community action on Nutrition. Presented in International Conference 30th October 2014
- A research article (Dasgupta et al) in **Indian Pediatrics Journal** has referred to Fulwari Initiative as a key hope for community management of malnutrition.
- Fulwari Intiative was invited and presented at Swasth Swachh Bharat – at New Delhi – A national seminar on Convergence organised Centre for Policy Research on 15th January 2015
- Fulwari Initiative has been selected by UNICEF as a leading innovation for tribal nutrition and was presented at the **Conclave on Tribal Nutrition**, Bhubaneswar on 16th January 2015
- Fulwari included at Asian Congress of Nutrition, Yokohama, Japan May 2015

Challenges

- Sustaining departmental involvement and designing their role in a programme built on multi-sector convergence and community ownership
- Improving fund-flow to Fulwaris by reducing delays and bottle-necks.

Replication

- Replicated across 19 districts of Chhattisgarh. The state government has made it a state scheme in 2013-14.
- 2850 Fulwaris are operational, covering all 85 tribal blocks of the state with enrollment of around 35000 children and 16000 pregnant/lactating women. The state government has increased the allocation to Rs.30 Crores in year 2015-16 to allow expansion into 6000 Fulwaris.
- The initiative is needed for any area with a problem of malnutrition and poverty.
- Allowing substantial autonomy to mothers groups in decision-making regarding Fulwari is essential.
- Further it needs an active support structure like Mitanin CHW programme to facilitate community based processes.

Chairpersons' questions and comments

Dr. Yogesh

Community participation in an NGO setting is a difficult task. There are models of success but when you look at community participation through Government system, it is a very difficult task. It's a holy grail of so many things. You are describing it as success here. Can you show some more data about the involvement of panchayat & VHSCs - how many VHSCs, panchayat *raj*, grampanchayat you might have approached to involve in this programme, how many consented etc.?

A: We do agree that it is somehow successful. When the task was given to me, I too was doubtful in the beginning of the programme on community based approach, but SHRC helped us in doing so. Mitanis have helped us in sorting out these issues, we have trained mitanis in community mobilization and through that mitani structure we are able to conceptualize and implement in a government setting. So we needed a very committed team at the district level and during implementation at grassroot level. As for scalability, we will need to identify such NGOs which are doing this work and can collaborate with them.

Dr. Yogesh

How is your experience about the volunteerism at the grassroot level? Our experience is not so good.

A: Once we started paying, they agreed. We are giving them incentive.

Dr.Yogesh

Are they Anganwadi workers?

A: No, they are not Anganwadi workers. We have a parallel, well established anganwadi structure. But, additionally to look after the less than 3 year old children in anganwadi would incur the cost of HR, recruitment, infrastructure etc. which is much more than what we are spending on nutrition.

Dr. Abhay Bang

Everyone agrees that child malnutrition is a very serious issue in tribal population. 0 to 3 year is a very crucial age and you have very correctly hit this target group. These are innovative methods of how to reach out and provide those children with necessary nutrition. Now, my concerns.

I still find that the evidence is selective. We all have a tendency to pick up the success part, but that doesn't give us the entire picture. How many villages? How many under 3 children were there in the selected population? How many fulwaris have been opened? How many children attended those fulwaris? How many children were left out? What is the change in nutritional status in the whole under three population, a question I have also asked the JSS? Is the change in nutrition that you are reporting for the entire population or only for those attending the fulwaris?

Any public health intervention has to always focus on what is our denominator. We all have a tendency only to talk about the numerator. So, please tell us your denominator – your population based denominators, and out of that how many received the care? What is the impact on the total population denominator? Looking at the quality of evidence, my apprehension is that currently the evidence is weak. I am only talking about the evidence right in front of us. Is it completely convincing? I say it looks hopeful. It may open a new, a possible approach. However, probably the same people who have done the study need to present more complete data or if they have not collected, may design and collect it.

My second concern is cost. I was just calculating the cost based on what both of you (you and the JSS) mentioned. By using your approach, you said, Rs 30 crore budgeted for 6000 fulwaris. To extrapolate, at the all India level, we shall need about Rs 3500 crore to provide fulwaris to all tribal hamlets and villages using your approach. Using the JSS approach, where they are employing women and paying them money, we shall need about Rs 6000 crore.

There seems to be a debate about whether to pay or not to pay and whether can the communities manage such initiative collectively. In the tribal societies, when they build their houses, what do they do? Until very recently the whole village would unite and construct a house for the new family. When they go for rice transplantation, until recently the practice was I will come to your field and help you and you come to my field and help me. Mutual help or exchange of labour or barter of labour is very common in tribal society. Looking after

children by sharing the responsibility by way of a rotational approach could work only in a tribal society. Who should handle this work? Are these women doing it voluntarily? The issues are valid which need to be further explored.

Under the PESA Act, tribal hamlet gramsabhas have several social sector responsibilities. So, instead of some department doing it, can a tribal hamlet gramsabha do it? They have a tradition of doing this. If they find it acceptable they will do it. If they don't do it, it would mean that probably this approach does not work on a voluntary basis. The issue probably is best suited for an organization platform such as the SHGs or the tribal gramsabhas.

I will show you how sometimes data becomes questionable. You said the LBW proportion reduced from 27% to 14%. What does it mean? WHO statistics for India (2015) says that 13% babies in India are born preterm, and I presume that most of the preterm babies are underweight. If your low birth weight has come down to 14% it means actually only preterm babies are underweight and the IUGR has completely disappeared. It is impossible. So we need to examine all these data much more vigorously. The processes need to be standardized and tested. Since we are looking for a scalable intervention, please examine the evidence and imagine what will happen if this approach is magnified a thousand times?

Another issue is should mother be paid to take care of her own children? Partly this is an ideology issue. Various political ideologies answer this differently. In socialism it is assumed that every child is a social responsibility and so it is partly the government's responsibility to sponsor it. In Scandinavian countries, the mothers might be paid to take care of their own children. This kind of debate has been going on – should the mothers be paid up or should the village women be paid for taking care of their children, or should the mother be given maternity leave to take care of her own child. I don't think we can resolve these here.

Let me propose an alternative. I have not tried it. Somebody can try. Can we have a model where mothers can stay at home, because baby needs mother's stimulation, care, warmth and love. A child who does not receive maternal contact will psychologically become handicapped. So mother has to stay but she has to earn money as well. If we give mother a work like spinning on *charakha* women can work from home, earn money and at the same time take care of her baby. So instead of externalizing child care to either hired service or to

shared services, can we really provide opportunities for mothers where economically they will be productive at home and can still take care of their children?

A: *By a participant:* It is already happening in Bastar. Bastar is in NRHM intensive resource block where all the women have been mobilized to government centre. In every village all the women are members of the SHG group and they are part of the village organization. Now, UNICEF is trying an approach income based on combating malnutrition programme.

Dr. Abhay Bang

It is a SHG. What I am proposing is home based ability for a mother that she should take care of her child. Yogesh said one year but I say 2 years because children are of a vulnerable and very sensitive age. Child needs mother's contact and mother's protection and attention. We do have potential solutions in both these ideas. Congratulations and thank you very much.

7

"There are people in the world so hungry, that God cannot appear to them except in the form of food."

— Mahatma Gandhi

Health Wednesday @ Jashpur Chhattisgarh

Jashpur district in Chhattisgarh
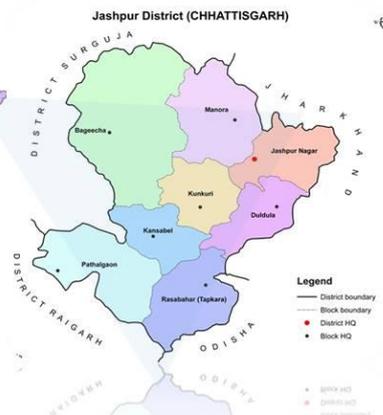
| Blocks: 8 | Area: 645741 hectares | Population: 851669 | Literacy Rate : 82% | Sex Ratio : 1000: 1005 |

ST Population: 530378 (2011 census) – 62.28% of the district

Total number of severe under-weight children: 7171(including tribal and non-tribal)

Local Tribe: Pahari Korwa, Birhor, Oraon and more

As per census conducted by Chhattisgarh Govt. in 2002 for the Korwa population:

Development Block	No. of villages	No. of families	Total Population		
			Male	Female	Total
Manora	12	143	299	325	624
Bagicha	76	2326	5101	5127	10228
Total	88	2469	5400	5452	10852

Brief History

U5MR reduced 16% (2011-13)
[Source: Annual Health Survey, GoI]

Health Wednesday @ 43 CHCs &PHCs
[Coverage: all 8 blocks of Jashpur]

'Health Wednesday' project launched
[By: District Administration of Jashpur under the Health Department in convergence with DWCD. To: Combat under-five mal-nutrition related death]

Jashpur - one of the highest incidences of under-five mortality rates
[Source: Annual Health Survey , GoI]

Rationale of selecting the problem (Why?)

Situation: According to Annual Health Survey 2011-12, the IMR at Jashpur was one of the highest in Chhattisgarh at 64 and U5MR was at 100.

Focus: SAM Children who are at the immediate risk of under-five mortality.

Precise Problem Statement

As per protocols:

Children with Severe Acute Malnutrition with medical complications are to be admitted in Nutritional Rehabilitation Centres (NRCs).

Severe Acute Malnutrition without medical complication to be managed through community based program

But, in reality:

Even non-SAM children and SAM children without medical complications were being admitted to NRCs. (The required number of beds are huge but availability is limited.)

Specialised care in NRCs was a challenge (feeding protocol training was needed.)

DO APPETITE TEST

Direct admission to Phase 2 in NRC: Pass appetite test and no complication

Antibiotics , micronutrients & management of medical complication

Direct admission to Phase 1 if Fail appetite test or complication

Phase 2 treatment in NRC using F100/TF/mixed DIET based on protein and calories recommended in IAP 2006

Fails **appetite test** or develops medical complications

Loss of appetite and increase in edema

Phase 1 In-patient treatment F 75

Return of appetite and reduction of edema

Transition Phase In-patient treatment F100/TF

Good appetite: no edema

Good appetite: no edema

DISCHARGE to Follow up by AWW (SFP)

FOUR FOLLOW UP AT 15 DAYS INTERVAL AT NRC

F-75 FEEDS

- Milk 300ml
- Sugar 10gms
- Powdered puffed rice 35gms
- Vegetable oil 20ml
- Water to make up to 1000ml
- Energy 75 Kcal/100ml
- Protein 0.9gm/100ml

F-100 FEEDS

- Milk 900ml
- Sugar 75gms
- Vegetable oil 20gms
- Water to make total vol1000ml
- Energy100 Kcal/100ml
- Protein 2.9 gm/ 100ml

1. Stabilization Phase:

- Children with SAM without an adequate appetite and/or a major medical complication are stabilized in an in-patient facility.

- This phase usually lasts for 1–2 days.

- The feeding formula used during this phase is Starter diet which promotes recovery of normal metabolic function and nutrition-electrolytic balance.

- All children must be carefully monitored for signs of overfeeding or over hydration in this phase.

2. Transition Phase:

This phase is the subsequent part of the stabilization phase and usually lasts for 2-3 days.

The transition phase is intended to ensure that the child is clinically stable and can tolerate an increased\ energy and protein intake. The child moves to the Transition Phase from

Stabilization Phase when there is:
At least the beginning of loss of oedema
AND
Return of appetite
AND
No nasogastric tube, infusions, no severe medical problems
AND
Is alert and active

Contd.

The ONLY difference in management of the child in transition phase is the change in type of diet.

There is gradual transition from Starter diet to Catch up diet (F 100).

The quantity of Catch up diet (F100) given is equal to the quantity of Starter diet given in stabilization Phase.

Rehabilitation Phase: Once children with SAM have recovered their appetite and received treatment for medical complications they enter

3. Rehabilitation Phase

The aim is to promote rapid weight gain, stimulate emotional and physical development and prepare the child for normal feeding at home.

The child progresses from Transition Phase to Rehabilitation Phase when:

S/he has reasonable appetite; finishes > 90% of the feed that is given, without a significant pause.

Major reduction or loss of oedema

No other medical problem

Monitoring Weight Gain

- Good weight gain- 10 g/kg/day or more

- Moderate weight gain-5 to 10g/kg/day

- Poor weight gain-less than 5 g/kg/day

GOAL

0 death due to Malnutrition

The specific problem addressed by Health Wednesday at Jashpur, Chhattisgarh is to reduce U5MR (84) and IMR (56) through accurate screening of SAM children with medical complications by Medical Officers for NRC referral and by providing regular and appropriate medical assistance and counselling to other malnourished children and mothers.

What happens @ Health Wednesday

Mobilisation

AWW @ Village

Mitanin @ Hamlet

Medical Officer/AMO/ RMA @ PHC & CHC
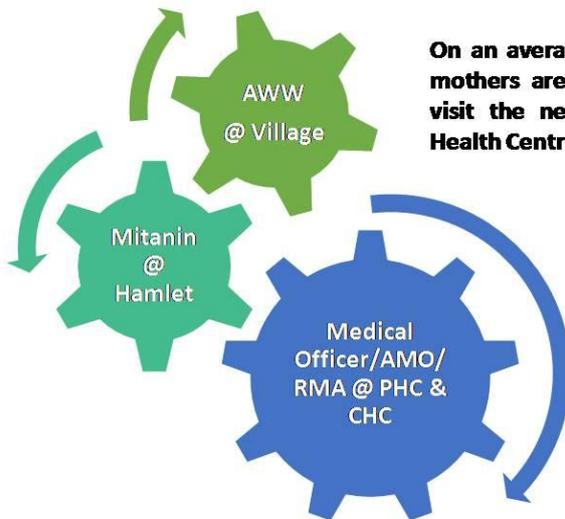
On an average, about 800-1000 malnourished children and their mothers are mobilised by Anganwadi Workers and Mitanins to visit the nearest Community Health Centre (CHC) or Primary Health Centre (PHC) every Wednesday.

Free Health Check-up

Mother's Health → Child's Health → Community Health → Free Health Check-up & Free Medicines → Monthly follow up → Mother's Health
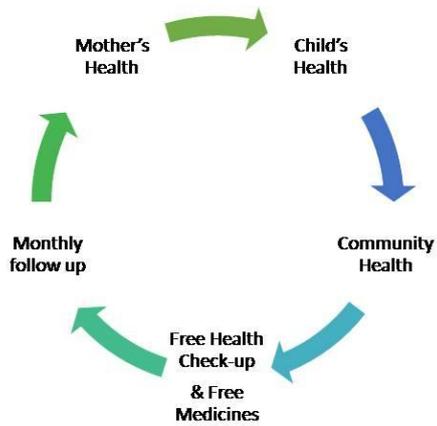
Free Health Check-up is provided by the Medical Officer (MO), Rural Medical Assistant (RMA) or Ayurvedic Medical Officer (AMO) at 8 CHCs and 35 PHCs across the district.

Free Medicines

Mother's Health → Child's Health → Community Health → Free Health Check-up & Free Medicines → Monthly follow up → Mother's Health
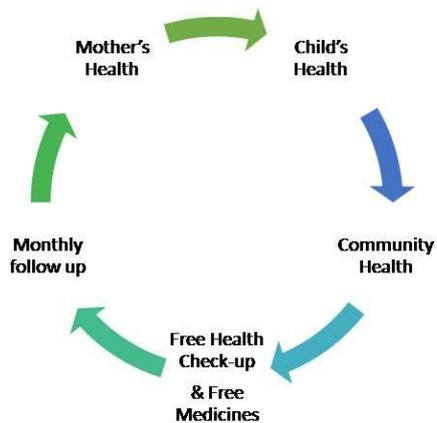
Free medicines are provided to the child and mother in case of any identified illness apart from providing vitamin/ iron/ folic acid/ calcium supplementation using funds from Mukhya Mantri Bal Sandarbh Yojana. .

Standardized Medicines and supplements are pre-purchased by the concerned CDPO and made available to the CHC/PHC in advance.

Nutritious Meal

Healthy Child
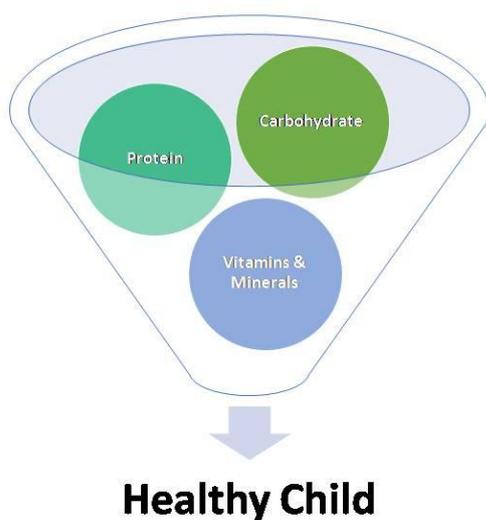
Nutritious meal, ideally 2 eggs, 1 glass of milk, peanut cake, banana and hot cooked meal worth Rs 40/- is provided to both the mother and the child, using funds from the concerned Jeevan Deep Samiti.

Screening of SAM children

Day	Total	Red	Yellow	Green
19th August	956	414	410	132
26th August	1219	447	546	203
2nd September	797	342	355	100
9th September	1135	492	503	140
16th September	1236	539	571	126
23rd September	814	406	350	56
30th September	621	290	256	75
7th October	614	347	214	53
Total	7392	3277	3205	885
Percentage	100%	44.33%	43.36%	11.97%
Average	924	410	401	111

From mid of August 2015, MUAC tape has been recommended for identification of SAM children. On an average, around 811 severe and moderate malnourished children are identified every week. Out of which, 400 children fall into SAM category.

NRC Referral
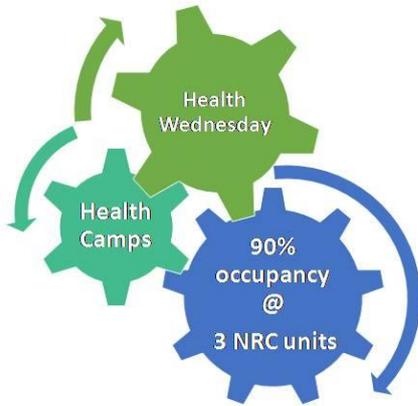
Severely Acute Mal-nourished (SAM) Children are referred to NRC units located at 3 places in Jashpur – Pathalgaon, Bagicha and Jashpur. They are transported using funds from Bal Sandarbh Yojana (DWCD).

At NRC units, the child and mother are given about 15 days of intensive care until the child's nutritional status reaches normal using NRHM funds.

Monitoring

The Health Wednesday Monitoring Team comprises CMHO, DPO, OIC Health, BMOs, DPM, BPMs, BEEs, BAAs, CDPOs and DWCDOs who cover all 43 centres every week. A fixed visit chart has been made and followed.

Health Wenesday Jashpur Visit Chart

S.no	Name of Block	Name of Health Facility	Officer's Name			
			1th Week 19.08.2015	2nd Week 26.08.2015	3rd Week 02.09.2015	4th Week 09.09.2015
1	Lodam	CHC Lodam	OIC Health	BPM	BMO	BMO
2		PHC Paiku	CDPO Lodam	CDPO Jashpur	BEE	BPM
3		PHC Gholeng	CDPO Lodam	CDPO Jashpur	BEE	BEE
4		PHC Arra	OIC Health	BPM	BMO	BEE
5	Manora	CHC Manora	BMO	BAA	BMO	OIC Health
6		PHC Ghughra	CDPO Manora	CDPO Aasta	BEE	CDPO Manora
7		PHC Aslha	BEE	BMO	CDPO Aasta	BEE
8		PHC Somkyari	CDPO Manora	CDPO Aasta	BEE	CDPO Manora
9	Duldula	CHC duldula	BMO	BEE	CDPO Duldula	DWCDO
10		PHC Kastura	BPM	BEE	CDPO Duldula	DWCDO
11	Kunkuri	CHC Kunkuri	BMO	BAA	DPM	BMO
12		PHC Narayanpur	CDPO Kunkuri	BEE	CDPO Keradih	BEE
13		PHC Ranpur	CDPO Kunkuri	BEE	CDPO Keradih	BEE
14	Kansabel	CHC Kansabel	DPM	BMO	BAA	BMO
15		PHC Bagia	DPM	CDPO Kansabel	CDPO Dokra	BEE
16		PHC Dokda	DPM	CDPO Kansabel	CDPO Dokra	BEE
17	Pharsabahar	CHC Pharsabahar	DWCDO	BMO	BEE	BPM
18		PHC Bhagora	DWCDO	BPM	BMO	CDPO Pharsabahar
19		PHC Bhelwa	BPM	BPM	BMO	CDPO Tapkara
20		PHC Tapkara	BEE	CDPO Pharsabahar	CDPO Tapkara	BEE
21		PHC Kersai	BEE	CDPO Pharsabahar	CDPO Tapkara	BEE
22	Bagicha	CHC Bagicha	DPO	BMO	BPM	CMHO
23		PHC Jhikki	CDPO Bagicha	CDPO Sanna	BEE	BPM
24		PHC Kurrog	CDPO Bagicha	CDPO Sanna	BEE	BPM
25		PHC Maini	BEE	BMO	CDPO Bagicha	CDPO Sanna
26		PHC Kalia	DPO	BEE	BPM	CMHO
27		PHC Sanna	BPM	BEE	CDPO Sanna	CDPO Bagicha
28		PHC Chichli	CDPO Sanna	CDPO Bagicha	BPM	BEE
29		PHC Champa	CDPO Sanna	BEE	CDPO Sanna	CDPO Bagicha
30		PHC Pandrapath	BPM	BEE	CDPO Bagicha	CDPO Sanna
31		PHC Sulesa	BEE	BPM	CDPO Bagicha	CDPO Sanna
32	Pathalgaon	CHC Pathalgoan	CMHO	BMO	DPO	BMO
33		PHC Tamta	CDPO Pathalgaon	CDPO Bagbahar	BEE	Dr. Basant
34		PHC Sekharpur	BEE	Dr. Basant	CDPO Bagbahar	CDPO Pathalgaon
35		PHC Surungpani	BMO	BEE	CDPO Pathalgaon	CDPO Bagbahar
36		PHC Ludeg	CDPO Bagbahar	CDPO Pathalgaon	Dr. Basant	BEE
37		PHC Kukargaon	BEE	Dr. Basant	CDPO Bagbahar	CDPO Pathalgaon
38		PHC Kotba	BMO	BEE	CDPO Pathalgaon	CDPO Bagbahar
39		PHC Kilkila	CDPO Pathalgaon	CDPO Bagbahar	BEE	BMO
40		PHC Bagbahar	CDPO Bagbahar	CDPO Pathalgaon	Dr. Basant	BEE

Fool-proof Monitoring

An online monitoring application for photo-based fool-proof monitoring the health status of children visiting the 43 health centres during Health Wednesday programme has been developed and is at the roll out stage.

In the mean-while

Off-line Monitoring: A Whatsapp group on Health Wednesday was formed to enable all stakeholders to be on the same page. Every Wednesday, the MOs would share their status report. The group being moderated by the District Collector, CMHO and DPO, WCD paves way for better implementation on ground.

RBSK SAM tour: In order to further reach out to children who could not visit the health centres during Health Wednesdays, 8 mobile teams of RBSK doctors were asked to cover all 411 gram panchayats of Jashpur between May & June 2015. The RBSK team identified over 640 SAM children and provided them with medical assistance.

S. No	Block Name	No. /Block	Hospital	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Jan	Total
1			District Hospital	86	280	189	191	161	73	54	70	332	99	48	1493
2			PHC Ginabg	0	50	82	35	83	47	97	119	165	114	57	849
3	Jashpur	628	PHC Arra	33	59	157	39	64	68	69	64	62	49	23	678
4			CHC Ludwa	35	130	153	69	191	65	115	186	163	176	79	1192
5			PHC Pinba	29	39	170	60	113	122	80	132	119	164	126	1145
6			CHC Manora	0	45	267	55	81	6	39	108	119	36	17	764
7	Manora	905	PHC Saalguri	40	143	94	349	36	19	94	112	59	192	0	1042
8			PHC Bimgidra	15	46	194	87	191	54	29	48	191	50	0	725
9			PHC Asta	0	87	182	17	196	55	0	42	146	42	0	677
10			CHC Bassarki	76	278	280	119	161	70	79	129	348	182	32	1594
11	Kansabel	619	PHC Dalobi	5	81	152	35	52	79	60	0	64	120	65	713
12			PHC Bagia	10	24	47	28	17	18	18	0	33	5	20	220
13			CHC Bimbari	30	248	198	157	187	104	118	62	153	152	36	1365
14	Kunkuri	630	PHC Birmyepur	12	280	292	187	86	42	49	48	175	247	51	1469
15			PHC Baspur	0	53	115	216	184	116	193	120	156	78	25	1166
16	Duldula	472	CHC Dabbbla	0	105	141	83	120	174	25	28	188	285	112	1261
17			PHC Bastara	0	29	173	64	68	0	16	53	81	91	38	613
18			CHC Pharsabahar	13	141	172	75	81	67	76	78	106	68	34	911
19			PHC Bingara	22	96	293	115	83	82	53	191	93	88	29	965
20	Pharsabahar	720	PHC Birkoon	3	119	143	107	62	134	22	185	129	73	8	905
21			PHC Tiplara	0	106	229	151	174	80	64	122	140	176	123	1356
22			PHC Berrai	0	82	286	183	212	156	115	184	155	202	102	1677
23			CHC Pathalgaon	212	245	122	82	84	66	88	72	35	136	88	1230
24			PHC Hitola	4	115	60	36	70	39	17	29	25	52	25	472
25			PHC Barimage	0	82	71	86	47	28	68	55	40	58	23	565
26			PHC Bagimbar	23	188	293	170	127	100	75	23	57	56	28	1050
27	Pathalgaon	1276	PHC Tiaola	0	157	126	61	64	60	34	21	54	75	2	654
28			PHC Lodg	0	93	76	86	203	63	78	85	66	51	11	818
29			PHC Shrikimpur	0	111	62	11	73	23	25	54	30	34	10	433
30			PHC Suruggand	16	46	88	30	57	7	13	15	2	17	25	316
31			PHC Batio	2	179	71	80	69	9	37	18	14	76	36	598
32			CHC Bagicha	0	191	144	60	29	6	35	114	170	160	60	969
33			PHC Barryg	0	70	60	24	68	36	37	64	52	179	57	647
34	Bagicha	637	PHC Idaiai	0	22	113	5	24	49	51	34	79	44	60	481
35			PHC Bakbi	0	61	53	22	19	24	70	48	56	33	21	407
36			PHC Balo	0	84	337	75	74	63	72	63	97	108	24	797
37			PHC Sanna	0	116	152	72	47	44	149	41	38	60	45	764
38			PHC Chichi	0	56	187	78	60	35	67	37	25	32	24	513
39	Sanna	1208	PHC Cheega	0	181	81	56	46	46	38	31	63	42	36	620
40			PHC Pankhapath	0	76	74	34	31	29	31	25	33	33	39	405
41			PHC Saleska	0	4	148	41	26	14	14	6	12	12	28	305
	Total	**7095**		**672**	**4598**	**5792**	**3427**	**3471**	**2372**	**2374**	**2666**	**4017**	**3768**	**1667**	**34824**

Results @ Health Wednesday

Results in Mobilisation

Manora	905											
Kansabel	619											
Kunkuri	630											
Dukdula	472											
Pharsabahar	720											
Pathalgaon	1276											
Bagicha	637											
Sanna	1208											
Total	7095	672	4598	5792	3427	3471	2372	2374	2666	4017	3768	1667	34824

Average: 3165 children per month in 2014-15

Average: 3696 children per month in 2015-16

90% of these children belong to Severe or Medium malnourished category

NRC: Results in Bed Occupancy & Recovery Rate

Yearly progress at NRC Jashpur (2013-15)

	2013	2014	2015
Bed occupancy rate	56.67%	74.17%	76.25%
Recovery rate	36.03%	49.44%	77.05%

NRC: Maximum reach out to tribal population

Year	Male	Female	ST	SC	OBC	General
2013	44.12%	55.88%	63.97%	9.56%	25.74%	0.74%
2014	44.38%	55.62%	71.35%	2.81%	25.84%	0.56%
2015	39.34%	60.66%	57.38%	4.92%	34.43%	3.28%
Overall	43.47%	56.53%	66.40%	5.60%	27.20%	1.07%

Divisional Level Workshop on Malnutrition

In order to strengthen the treatment provided at the NRC and to fill the gaps in identification and treatment of malnourished children, a divisional level workshop on Malnutrition was held on 15th March 2015 at Jashpur. It greatly helped improve the efficiency of treatment to be provided at NRC. Post which, there has been a significant rise in the recovery rate of SAM children from about 36% in 2013 (unacceptable level) to about 77% at NRC Jashpur.

The Story of Lav Kumar

On Admission

Name: Lav Kumar
Age: 1 year
Sex: Male
Mother's Name: Late Gangi Bai
Father's Name: Ramesh
Name of Care Giver: Jhhalo
Caste: Routia
Local Add: Bada Banai
Block /District: Lodam/Jashpur C.G.
Date of Admission: 3/05/2012
On Admission:

Wt.	--	4.8kg
Length	--	65 cm.
MUAC	--	8 cm.

Progress of Lav Kumar's health @ NRC

Progress of Lav Kumar's health @ NRC

Weight on Admission: 4.8 Kg.

Weight on Discharge: 5.55 kg.

Weight on Follow-up: 6.150 kg.

Progress of Lav Kumar's health after 2 years

"Poverty is a very complicated issue, but feeding a child is not."
— Jeff Bridges

Thank you

Questions and answers

Q: Who will be looking at the data part, did you give anyone the responsibility? Also, are you developing your own application?

A: It will be the PHC's responsibility for data collection, this data collection will have information like height, weight etc.

Q: *Dr. Abhay Bang:* What is the proposed Best Practice in this?

A: Best Practice is building a culture like every, Wednesday morning let's go to a hospital. The best part is the mobilization. This Wednesday culture is the best practice just like VHND on every Tuesday, Health awareness on every Wednesday, because it enables to give focus and attention to the actual group who needs their attention as simple as that.

Q: Why did you adopt separate mechanism to find out the SAM? That gives contrasting figures.

A: What I am saying is that not all children are brought, so whoever the Anganwadi workers suspect as malnourished are brought and the medical officer categorises them. The categorization of the suspected malnourished children is not done by the anganwadi but it is done by the medical officer.

Chairpersons' questions and comments

Dr. Abhay Bang

I have got a few comments on this best practice. One, I am equally confused as Tapas Chakma, about the data given by them, because I don't know your population denominator. How many under 5 are there in your district, how many of them were malnourished, how many are engaged in the Wednesday clinic?

A: Out of the 20,000 children in the area, 7095 of them are identified as severe underweight by the ICDS and out of them 900 children are visiting the Wednesday clinic.

Dr. Abhay Bang

So approximately 10%...so the coverage of every week is 10%.

We also did not get the good impact data, some of the data was from the NRC. Again, I am repeatedly reiterating that the data on the treated patients alone is very fallacious. All physicians like to quote it. All programme people like to quote it. But, that does not tell you the entire story. The hidden iceberg is those who never come to you. We are talking about policies and programme for the entire tribal population. We are not talking about the patients who visit our facilities. We should always insist upon impact data at the population level, district level or whatever level. One would like to know from you, in addition to the success rate in NRC, what is the impact on the children in a district, or block you covered.

Next question is, is this strategy child centred or doctor centred? Should we be asking thousands of such children to be brought miles away to a PHC where the doctor may or may not be present? And then again go to the referral centre to NRC? I think this arrangement is not really keeping a malnourished child at the centre. This is more like keeping the convenience of the supplier at the centre, a doctor in this case. We all know that in the tribal areas there are no proper transportation facilities; mother has to go for a full day's labour, etc. Can we use information technology tools so that child does not have to physically go to the health centre? Can doctor have telemedicine kind of view on the mobile phones? These trips to medical centres or doctors can be reduced and will save lot of time and suffering for the children.

From all the three presentations that we heard on the malnutrition, each of these seem to be saying that ICDS is not useful. In the ICDS model the anganwadi worker the supervisor and the PHC MO are supposed to detect a child with malnutrition in the village. We have made a new best practice which works the other way round, where doctor will not go to the children but the children will come to the doctor. But, what about the ICDS, which is our main programme? I read in the newspaper that India is spending Rs 30,000 crore on ICDS and mid-day meal programme. So if we leave the main programme which we have and we do additional interventions there is a risk of duplication and in paradigm the ICDS remain uncorrected.

8

Strengthening Community Action for Health under the National Health Mission

Population Foundation of India

Secretariat

Advisory Group on Community Action (AGCA)

National Health Mission

Accountability Framework under the NHM

- — Three pronged assessment
  - external surveys and
  - routine program monitoring
  - **community based monitoring**

- — Communitization of health institutions
  - Prominent display of information on funds received, medicines in stock, health right entitlements

- — Public reports on health at the State and district levels to report progress to the community

Advisory Group on Community Action (AGCA)

- Group of civil society experts constituted by the MoHFW in 2005 with Population Foundation of India (PFI) as the Secretariat
- *Mandate :*
  - Advise on developing community partnership and ownership for the Mission
  - Provide feedback based on ground realities to inform policy decisions – community monitoring , Common Review Mission (CRM) and fact finding missions
  - Develop models on community action and recommend for further adoption/extension to national and state governments

Coverage

Pilot phase (2007-2009)
9 States 36 districts 1620 villages

Scaling Up (2015)
Implementation in progress in 19 States

Problem statement

- Availability, accessibility and quality of services provided through the public health system are key issues, especially in tribal areas

- Community Action for Health enables the community representatives to interact, monitor and provide feedback to service providers to improve delivery of health services

Process

1. Education and awareness generation:
- Community awareness on health entitlements
- Training of VHSNC and RKS
- Display of citizen's charter and service guarantees

2. Monitoring and information sharing
- Collection of information on community experiences of health services
- Compilation and sharing village and facility report cards
- Regular meetings of Monitoring and Planning Committees at block district and state levels to discuss on issues and gaps

3. Public dialogue
- Periodic public dialogue (Jan Samwaad) – Engagement with providers based on community evidence

4. Follow up action to resolve issues and gaps- including incorporation into the District and State Programme Implementation Plans (PIPs)

Process flow
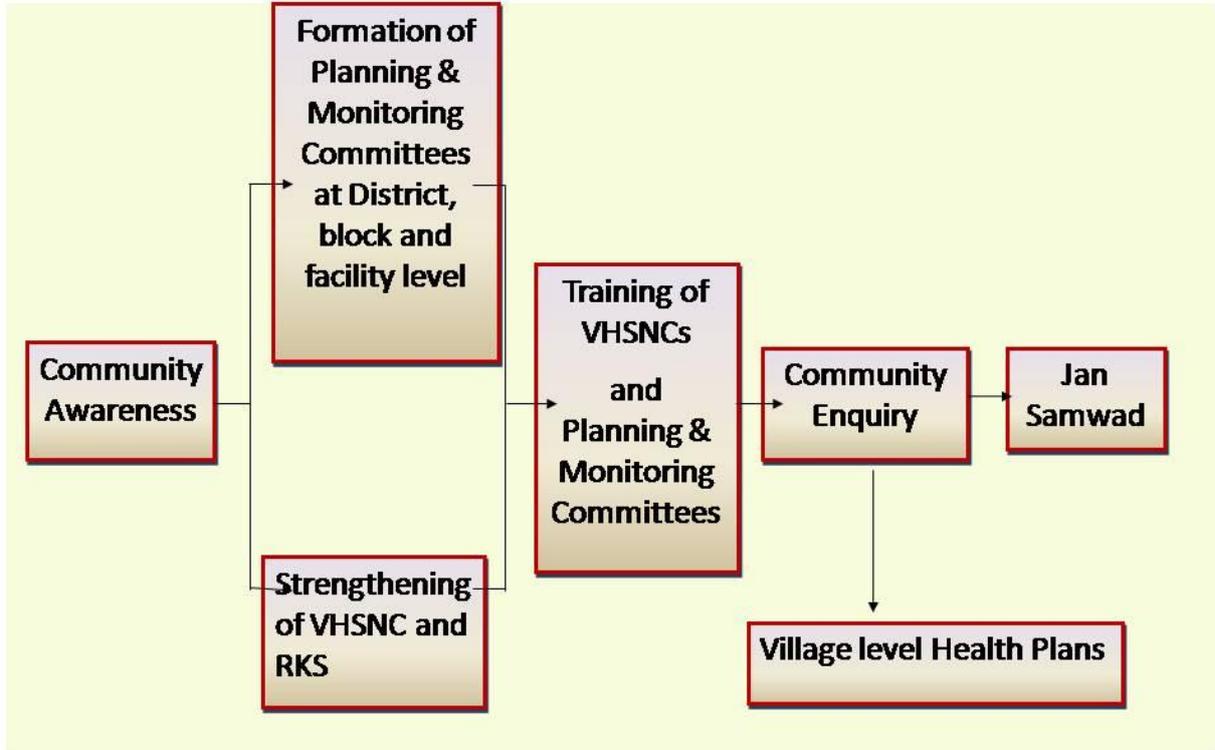
Change in Health Services
in a PHC area - Maharashtra

Key outcomes

Five Tangible Benefits:

1. Construction work completed

2. Improvements in status of delivery of health services

3. Enhanced trust and improved interaction

4. Community based inputs in planning and action

5. Reduction in out of pocket expenditure

---

1. Construction work completed

Story of change - Maharashtra

- In Jamshet village (Palghar district) construction of a sub-center was incomplete for over two years

- VHSNC members discussed the issue in a series of Gram Sabha meetings and in Block monitoring committee meetings

- A large group of community members went to the sub-centre initiated construction through 'Shramdaan'.

- Support later came from the district authorities

- The sub-center building is fully functional

2. Performance of health services improves - Rajasthan

District Chittorgarh

First Round: September 2008

Second Round: October 2009

Poor
Average
Good

District Udaipur

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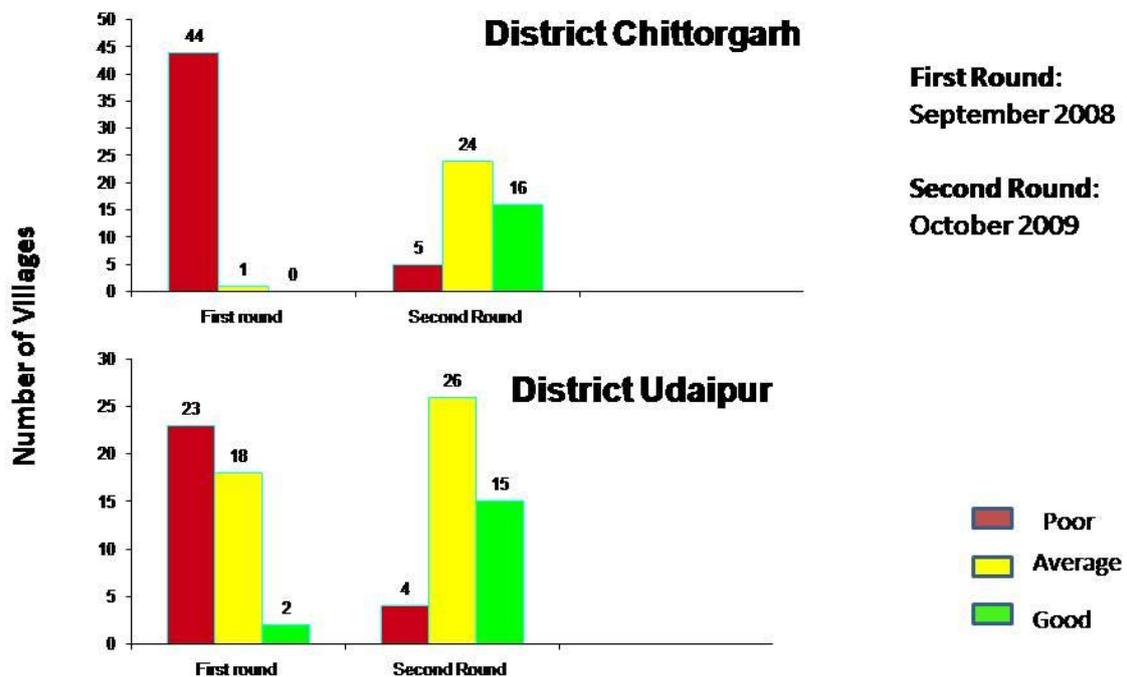
2. Performance of maternal health services improves – Bihar (5 districts)

Poor
Average
Good

Number of villages = 300
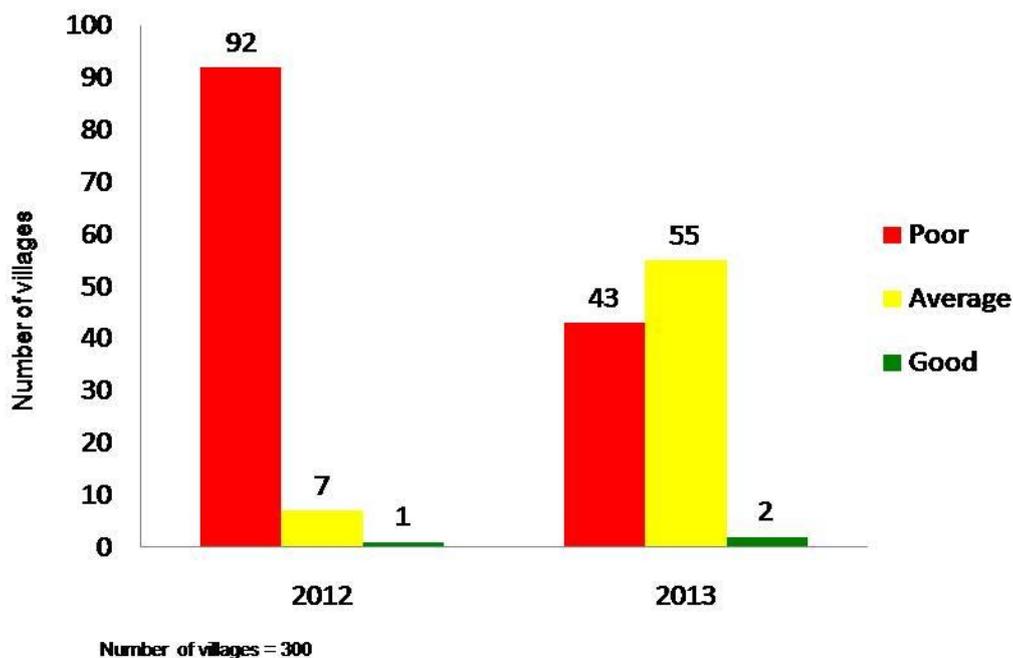
.......Key outcomes

3. Enhanced trust and improved interaction between provider and community
    - Improvement in service delivery - ANC, PNC, immunization
    - Responsiveness of provider to community needs
    - Improved provider attitude and behavior
4. Community based inputs in planning and action
    - Appropriate planning and utilization of untied funds at VHSC, PHC and CHC
    - Active involvement of PRI members in planning and functioning of health facilities

........Key outcomes

5. Reduction in out of pocket expenditure
    - Reduced demands for informal payments
    - Timely and full payments of Janani Surksha Yojana incentives
    - Significant reduction on outside prescription

Key outcomes

Community Action for Health programme in Bihar Outcome clip.wmv

Positive Changes

- **Community support for health providers:**
  - In Badapada PHC in Mayurbhanj district (Odisha) the process helped Panchayat members to understand the key local health issues and identify steps to improve upon weak areas.
  - They even lobbied for better facilities for doctors and hospital staff like provision of quarters, drinking water and sanitation facilities

- **Community contributions:**
  - In Mopungchuket village of Mokokchung district (Nagaland), the community raised Rs 40,000 for repairing the sub-health centre.
  - The Chairman of the Village Health Committee (VHC) visits sub-health centre twice a week to review delivery of health services

Positive Changes

- **Access to Below Poverty Line (BPL) cards for access to health entitlements:**
  - Baigas (primitive tribal group) in Chhindwara district, Madhya Pradesh, did not have access to BPL cards and therefore denied access to Deen Dayal Antodaya Upchar Yojana Cards (which provides treatment coverage of Rs 20,000 annually for each family)
  - Issue was discussed during community enquiry process and this resulted in the distribution of BPL and health cards by the district administration.

- ***Improvement of services in PHCs and Sub- Health Centres***
  - There were non-availability of staff and medicines in health facilities of Darbha block of Bastar district (Chhattisgarh).
  - VHSNC members shared the issue at a block level meeting resulted in improvement of services in the health facilities along with other local services such as cleaning of areas around the boring wells.

Challenges and Pre-requisites for Scaling Up

1. Simplification of the model without losing effectiveness
2. Develop state capacities for implementation
3. Strengthen existing structures: Accredited Social Health Activist (ASHA), Village Health Sanitation and Nutrition Committees (VHSNC) and Panchayati Raj Institutions (PRI)
4. Introduce grievance redressal mechanisms
5. Ensure adequacy and sustainability of funding
6. Promote ownership at all levels

Support for scaling up community action

Technical support provided by the AGCA include:

i. **Develop/adapt** manuals, tools, communication materials

ii. **Build capacities** of state nodal officers and implementation organizations

iii. Facilitate **state level visioning and planning exercises,** including development of State PIPs

iv. Regular **mentoring and guidance** to states on programme implementation

v. Undertake **programme implementation reviews**

The MoHFW has approved plans for 18 states (State PIP, 2015-16) and amount of Rupees 24.69 Crores has been allocated

Thank You

Please visit our website for more details
www.nrhmcommunityaction.org

Questions and answers

Q: Are you able to make village health plan in those VHSNC? If yes, are you able to integrate this in district health plan?

A: *Dr. Sudarshan on behalf of the presenter:* I think community processors are done irrationally overnight without thinking their capacities. In one year you can't show results. It may be in 10 years if the VHSCs really take more responsibilities in planning, action and monitoring, but it is worth investing on that and there are no shortcuts. We have done village health plans, for every village, simple plans and again these are not micro plans. I don't want people to do detailed micro-plans as they are not experts. This is our village and we will plan for our village. We are responsible for our health. They prioritize their problems and use them and at the end of the day or 2 they will come up with the village health plan. They prioritize their investment and what they will do with the Rs. 10,000, what are their priorities, what action they can do as individuals and family members and as a community and all these will be added in that plan. So, village health plan will ultimately lead to the district health plan. Along with NHRC we are planning in 3 districts to show bottom up planning , need-based plus all other micro-planning at various levels etc., that's not been done as you've said.

Q: What will happen when NGO will be withdrawn after 5 year? What about sustainability?

A: *Dr. Sudarshan on behalf of the presenter:* The whole implementation of this community planning and community action, for health. I feel 'planning' is the right word, as I don't want to use the word monitoring, because that is planning too. It is also action, because we don't want just policies.

Action and monitoring the services are now 2 methodologies in Maharashtra. The NGO which is very active took the whole responsibility and other states NGOs did not. But, in Karnataka the NGOs were in the pilot phase and later on it was implemented by state itself, and the state took over. We had a proactive Health Secretary where he said that on pilot let's do the TOT for the entire state and he made a circular. Of course he diluted the whole process. We have learnt lessons from that, when we scale up so fast. The model is not just for the NGOs. The agency also agrees in principle. It's a state implementation. Meghalaya for example is doing excellent and in Nagaland, the community processors are very good but they may not be following the same community action.

Q: What are the factors and technicalities which could make it work in certain places?

A: *Dr. Sudarshan on behalf of the presenter:* That's why the NGOs are working. The fund flow is important. For example, in Karnataka we got Rs 8 crores. The mission director got changed, the principal secretary got changed and their priorities are now different and the Rs 8 crores are lying unutilized for the last 6 months. Privatization is an important component and thanks to the NRHM in every meeting the secretary, joint secretary and everyone is talking about it, so they are forced to include it in the PIP plan and in the PIP approvals. You can see this initiative and that this is approved. All the initiatives are happening by the state. Programme itself has to be watched by the state and we don't want to push it through NGOs alone. Although Maharashtra state model is different. We can't get NGOs everywhere in the state and secondly it may not accept those NGOs. So, state ownership is very important, institutional memory of privatization and principal secretary and mission director changes also very important and we are looking at those factors also.

Community action for health is such an important topic and such a wide spread impact of so many things. The health system its worth working for 2 to 5 to 10 years to see the results. We also work with PHCs in our area, and frankly we are not very successful honestly what we are seeing from our experience and what we are hearing is 2 things. Firstly, whole intervention still needs more formative work and more understanding about the best practices of the community action for health. I think we have not yet found the right combinations of various things in this intervention. To make it work in an area it may take few years. Secondly, more in terms of the impact assessment, it needs more robust in design, measurement and supplementation.

The focus should be on VHSNs as they are very weak all over the country and they need to strengthen. For example, in Himachal Pradesh, which also has tribal districts, from 2011, the mission director was very much interested in getting the process. He took up a village case and brought the villagers into the system so. The whole process went from village to district etc. and all of it went into the state plan. It was a year long process, which actually went through the system. Himachal has very few NGOs which are working with the system, so they are also part of the system and most of the villages are in the system. That happened and the PIP came for the Central Government's Approval, and routine money was approved, and that disheartened the whole system of spirit. We are talking of the disheartening of the NGOs who are partners who work at down-level. Even that which was initiated may not have been

totally invited by the system and again the process has started. I think we need to reflect on this and how we could integrate NGOs in the system.

Chairpersons' questions and comments

Dr. Abhay Bang

What you are trying to address is a huge problem of democracy. Becoming responsive to the people's needs and desires is a crucial issue. It is largely political issue. Though that should not deter us it is a crucial but a very ambitious issue. Actually you are dealing with the issue of transfer of power. Today the state machinery has the power to plan and manage health care. You are trying to bring it to the people's level. I much appreciate what Dr. Sudarshan initially stated about the need to add planning and action. Only monitoring without involvement of people in the process of planning and action is inadequate. So, monitoring may become a sterile process at the mercy of the officers.

I requested you to revisit the problem statement because if the problem statement is vague and descriptive, the outcome also will be vague and descriptive, it will be difficult to evaluate. I wish you would make the problem statement little more specific and more concrete. Break down the big problem in to small doable, measurable, narrow problem statements. From this you can identify the crucial indicators, action and outcome. It's a very ambitious project and I am worried by its sweep.

For outcome evaluation, in how many villages have you tracked the health care by way of community based monitoring? I am sure you can't do that in the all villages of your states but only in some villages. Please, give us the complete picture with appropriate flow diagram. Please give us the data on a few doable and measurable outcomes.

Secondly, who will measure the results? The health department data suffers from the problem of under-reporting of failures. The same person provides the service and the same person also reports the outcome. It's a natural human tendency to hide the failure. Whoever measures the outcome, if possible, should be independent.

My expectation is that this approach of community monitoring might work better in tribal areas, because the size of the tribal villages is small. They have a tradition for a community meeting for any issue and take a decision. Under the PESA the tribal Gramsabhas

have power to control all social sector and health programmes. It will be a different experience and also different processes, worth describing and knowing.

How to translate the community needs from the village to the district and the state level is a missing link. Those who create district, state, or the national plan may or may not heed all those voices coming from the community. Communities are very wise in expressing their priorities and these priorities are often very crucial which we missed in our target setting in our national programme.

Demand generation is very useful. Immunization will definitely increase if the people are involved in the immunization planning. Grievance redressal also may be very useful. Many of your processes have potential for the use of Information Technology in the collection of data on the need, grievance redressal, community monitoring etc.

Dr. Sudarshan

Taking it positively, the indicators need not be an outcome if you have empowered the villages and we have made the state own this programme. If today Gilani comes and attends all these meetings, asking how this kind of privatization programme is going on at Central Government level, I feel that it is a success for this whole initiative. The PHC Medical Officers were threatened by the community people in the beginning, but now own it up. There are many successes, we don't put it in the reductionist researchers' point of view, and we know the results but need to work on it.

9

END MATERNAL MORTALITY NOW

Nazdeek

Contents

"*Whose faces are behind the numbers? What were their stories? What were their dreams? They left behind children and families. They also left behind clues as to why their lives ended so early*"

-Anonymous

Context

- The Adivasi community of Assam, who are also known as Tea tribe are the descendants of tribal people who were brought by the British colonial planters as bonded laborers from the Chhota Nagpur Plateau region.

- These people were brought into Assam during 1860-90s for the purpose of being employed in the tea gardens industry as laborers.

- Over the years they haves pread out and reside in various districts of Assam. The total population of the community is estimated to be around 6 millions or about 20 percent of total population of Assam.

- They generally use Nagpuri or Sadri as a common language among themselves along with use of other tribal dialects like Santhali, Kurukh and Mundari.
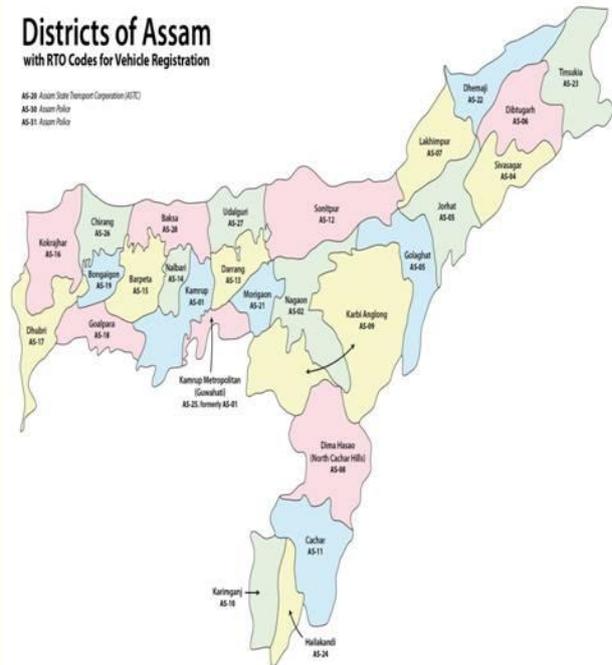
Area supported by the project

Nazdeek – Bringing Justice Closer

- Nazdeek is a capacity building organization with a mission to bring access to justice closer to marginalized communities and individuals and a role to Bridge gaps between communities/activists and lawyers/judicial system.

- **Core focus:**
  - Socio-economic rights: right to health, food and housing
  - Accountability of Governments and private entities
  - Access to justice through existing judicial and non-judicial remedies

- **Nazdeek partners with grassroots organizations and communities to:**
  - increase legal capacity of activists and lawyers
  - build community legal networks

      Through
  - Training programs
  - Filing of litigation and complaints
  - Legal advising and support
  - Connecting with lawyers and external resources
  - Developing and implementing advocacy and litigation strategies

Problem statement

- India has one of the highest maternal mortality rates in the world.

- Assam leads the country with the highest maternal mortality ratio of 328 deaths per 100,000 live births (against country MMR of 178)

- The infant mortality rate (IMR) is 54 which is far above the national IMR of 40.

- Based on national and international obligations, the Central and state government have enacted policies and programs to curb maternal and infant mortality rates, such as the National health Mission (NHM).

- However, due to insufficient budget allocation, weak implementation of policies and poor monitoring and oversight, none of these programs are successful.

- These human rights violations are particularly prevalent for women hailing from Adivasi communities who live and work in the tea gardens of Assam.

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Gap between healthcare providers and patients

- Factors such as lack of awareness over rights and entitlements, corruption, lack of services and poor quality of treatment available in public and private hospitals are the main causes behind such gaps.

- Tea gardens hospitals receive funding under NHM to provide basic health services, but funding is often diverted due to lack of monitoring from the State

- In tea gardens, additional factor contributing to high rates of maternal and infant death is the failure to ensure access to non-medical services such as food rations under the PDS system etc.

- Poor infrastructure and services further delay access to health facilities.

"End MM Now" Project Goals

A partnership between 3 NGOs, namely Nazdeek (Delhi), Pajhra (Tezpur) and ICAAD (NY, USA)

- Document and Map gaps in the delivery of maternal and infant health services

- Build a platform for communities to report health rights violations

- Raise awareness on the government schemes and how to avail of them

Contents

- 40 women volunteers in Balipara and Dhekiajuli Blocks, Sonitpur District, Assam.

- Project volunteers attended a series of training sessions on issues of maternal and infant health and rights and entitlements under the NHM.

- Volunteers identify health rights violations occurring in their areas and report them by SMS using a list of codes

- List of codes covers more than 30 types of violations under NHM and the Plantation Labor Act (for example lack of doctor, bribes, no availability of blood etc.).

- Project team in Tezpur verifies the reports by phone calls

- Verified information is uploaded and mapped on a website and publicly avaialble (endmmnow.org)

- Cases reported are addressed at local level through filing of complaints or litigation and advocacy with local health authorities.

fppt.com

Training
Participants living in tea garden areas learn about instances of lack of access to government health services for pregnant and lactating women.

Reporting
Trainees are then provided with a SMS compatible mobile device and codified system covering a range of maternal health issues. Trainees use their SMS mobile devices to text in violations including undue payments, denial of JSY benefits, or non-availability of guaranteed services.

Verifying
All reports are verified by local staff by phone or through on the ground fact-finding.

Mapping
Verified reports are uploaded to the website, endmmnow.org, to be analyzed for advocacy purposes.

Sharing and Advocating
Data collected and analyzed can be used, for example, to inform local health authorities about gaps in the current healthcare infrastructure to ensure problems are addressed.

Most commonly reported issues

Bar chart with y-axis ranging from 0 to 35. Categories along the x-axis (in descending order of value):
- Payment/Bribery (~32)
- Lack of medical care (~19)
- Multiple hospital referrals (~18)
- Ambulance unavailability (~17)
- Women not receiving JSY payments (~11)
- Difficulties with blood transfusion (~4)
- Women not receiving nutritional supplements (~2)
- Discrimination based on ethnic status (~2)
- Unavailability of food rations (~2)

The stories untold... unheard...

S was taken to Sapoi TE hospital on the morning of July 13th 2014, as she went into labor. It was her first child. She was taken in an ambulance from Sapoi TE to Tezpur Kanaklata Hospital, as she needed blood. She was told to find a man from her village to donate blood so she could get the blood she needed in exchange, which her family managed to do. Having received blood, a nurse and doctor examined her, and said it wasn't time for her to deliver yet. By evening she had still not delivered, and although she was too weak to push out the baby, a Cesarean section was not offered. During the evening S was given an injection by a nurse. The family do not know what the injection was for, but they were told it was to "warm her body." Within 10 minutes of the injection, she died at the hospital. The hospital gave the family 1000 rupees and sent them away in an ambulance. The cause of death is written in English on a discharge certificate as "cardiac respiratory failure," but neither her family nor the ASHA are aware of this being the cause of death.

Sister in law of patient S

Results

- Community members gained rights awareness + confidence and skills to address violations

- More than 70 cases collected, and a report produced and submitted to District level authorities.

- Establishment of periodic Grievance Redressal Forums where women volunteers raise cases reported with Block level health authorities.

- Data used for filing of complaints at Block level and led to improved access to maternal and infant health services.

- Data will also be used for litigation (Guwahati High Court).

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Results in Balipara block

- Reports received about lack of food rations in Anganwadi Centres in the Block from Oct 2014 to April 2015

- 4 complaints filed with local Anganwadi Centres to address the issue

In April 2015, 527 Anganwadi Centres in the Block received food grains and began providing rations to more than 27,000 beneficiaries (women and children)

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Result in Dhekiajuli Block

Complaints filed on a range of health and nutrition issues arising in tea garden hospitals and local food distribution shops, resulted in:

- Sapoi tea estate (1000 workers) – new ASHA appointed

- Panbari tea estate (1517 workers) – new doctor appointed

- Tinkhurria tea estate – APL card holders (about 150) received food rations

- Dhekiajuli CHC – complaint was filed about undue payments asked for pregnancy registration. Now pregnant women are not charged money anymore.

- Other 5 complaints are currently pending against CHC, PDS shops and tea garden hospitals.

THANK YOU

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Questions and answers

Q: *Dr. Satish:* Why are the district level officers not able to see this?

A: *Jo humari jagah hai chote se gaav mein. Waha bhi* hospital *hai. Waha bhi hum gaye the, aur saamne doctors the. Waha jo* medical *ka* condition *hai, bahut buri tarah se rakha hai aise dekha gaya. Matlab charo oar itna ganda tha. Kuch bhi safai ka kaam nai hota hai. Iska koi benefits nai milta hai, koi* kits *nahi milte hai,* HIV kits *nai hai. Har cheez mein* problems *hai. Bahut saari kami hai. Toh jaake hum log jab baat kiye, "Un logo se safai humko* available *nai hone ke vajah se sab ko* available facility *nai de pata hu," aise bol rahe the.*

Q: *Dr. Sanjay*: *You are working there for how many years?* You are taking foreign funding and blaming Government system. How is the Government's reaction there?

A: *We are working for last 2 years. Itna Government ka support nai hai. Aur ek cheez ye hai ki logo mein…ki log bahar nikal ke nai aa rahe hai…nikal aana pasand nai karte hai. Jo* marginalised *female hai, unke liye bahar nikal aana bahut mushkil hota hai. Matlab darte bhi hai. Aake apni problem ko bataye ya apne job ki appati hai jatye – wo nai karte.*

Q: (*Question recorded unclearly*)

A: We have Government Hospitals in very bad condition there. 50% of our PHC and CHCs are in very bad conditions.

Chairperson questions and comments

Dr. Abhay Bang

    Ek sawal mai jankari ke liye poochna chahata hu. Hum neurology *mein jo padhte hai, ek* afferent loop *hota hai. Jaankari* end organ *se upar jaati hai. Ye jo aapka jaankari bhejhna hai* SMS dwara wah afferent loop *hai…sensory loop hai. Baad mein woh* gray matter *mein* process *hona padta hai aur baad mein acion ka* motor loop *hota hai. Toh aapka* mainly information gathering *wala* arm *hai. Uske liye* technology *ki* power *bahut achhi istmaal ki hai.*

    Lekin kyunki yahan kafi Governement Officers *hai* States *se, aisi jab shikayat, ya* information*, kahi koi* gap *reh gayi* service *mein, wo* information *agar logon se ya* NGO *se ati hai toh* what happens in the Government Head Quarter?

10

DR SREEHARI, DPM,NHM, PALAKKAD

Health Care Delivery Monitoring for Mother and Child in Tribal Areas

JANANI – JATAK: A Mother-Child-Centric Approach

National Workshop on Best Practices in TRIBAL HEALTH CARE
SHODHGRAM, Gadchiroli, October 11th – 13th, 2015

ATTAPPADY

Largest Tribal Block in the state Kerala
IRULA,
KURUMBA,
MUTHUWA

Location of Palakkad, Kerala
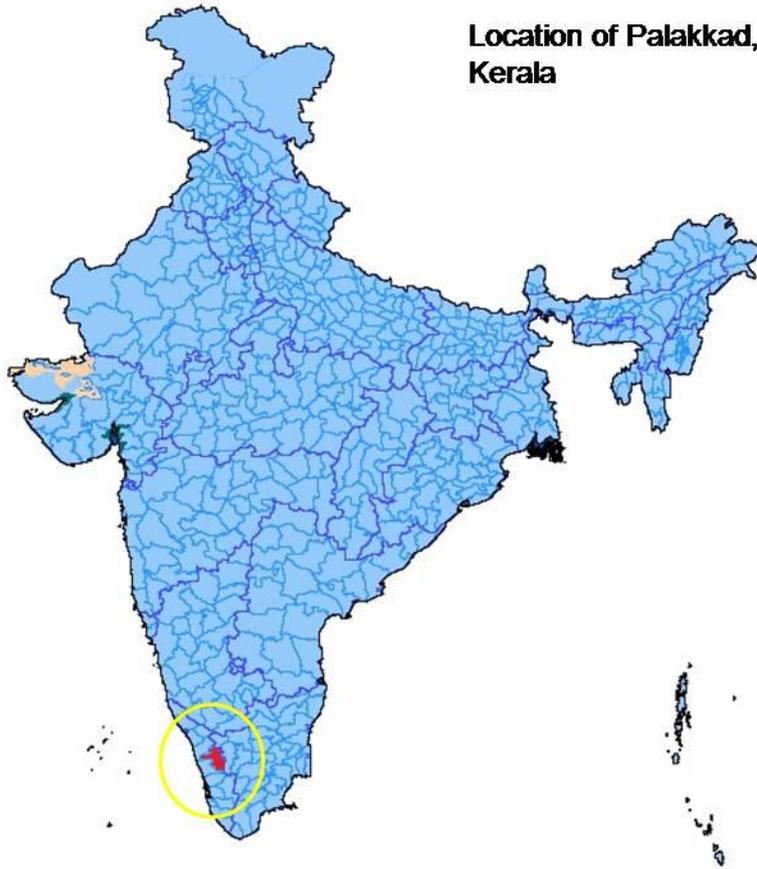
Command area map showing Grama Panchayaths

Layer Search Query Nutritional Status Distance Buffer Refresh Zoom Extent

Layer

- Satellite Image
- Contour
- ☑ GP
- Village
- Tribal Habitation
- Child
- AWC
- PHC
- Sub Centre
- State Highway
- Road
- Water Body

Display

Pudur GP

Sholayur GP

Agali GP

Powered By Whizmap™

Demography

Panchayath wise population

Panchayath	Total population	female	male	Under 5 children	Baseline data completed	Growth Monitoring updated
Agali	34941(10919)	17548	17393	2704	2731	2279
Pudur	12170(8131)	6107	6063	1104	1179	1044
Sholayoor	17207(8577)	8628	8579	1199	1182	938
TOTAL	64318(27627)	32283	32035	5007	5092	4261

WHY ATTAPPADY ?

Infant deaths in Attappady in 2013 - 36 (30) out of 1016 deliveries. (ALLEGED FIGURES 54 & HIGHER)

It is shocking to see in Kerala –a state with superb achievements in human development, people's planning, governance, and female literacy, an alarming rate of malnutrition deaths of tribal infants/children in Attappady

➢ KERALA MODEL OF HEALTH SYSTEM DEVELOPMENT
➢ IMR – 12 (RURAL 13)
➢ NEONATAL MORTALITY – 6
➢ UNDER 5 MORTALITY - 12
➢ MMR - 56
➢ LITERACY – 94.04% (Male-96.1%,Female 92.1%)
➢ ONLY CONTRIBUTES TO 1% OF UNDER 5 MALNUTRITION IN INDIA.

Infant deaths in 2014   -   18 (14) out of 986 deliveries.

Infant death in this year till date 11 (10) out of 516 deliveries.

Analysis of Death of Children

➢ 36 deaths have been captured under Janani out of whom 28 are STs and 26 are LBW babies.
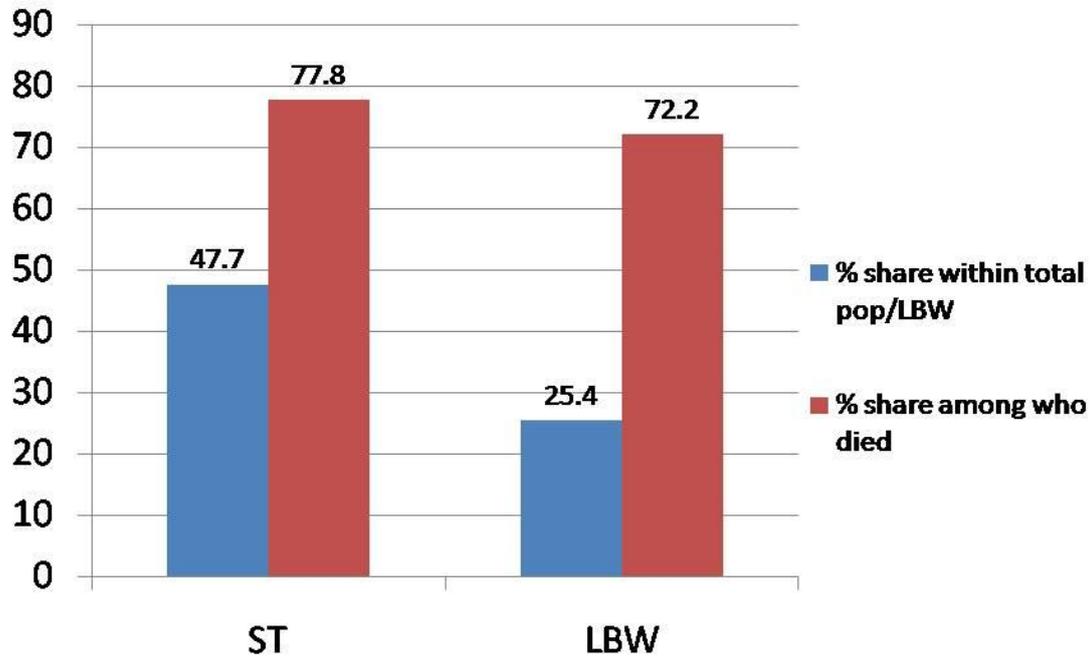
Why IMR at Attappady was high ?

The various reasons owing to infant deaths in Attappady considered were as follows :-

DIRECT CAUSES	UNDERLYING CAUSES
•Low birth weight/ Extremely LBW •Prematurity •Sepsis •Congenital Anomalies	•Teen marriages •Maternal under nutrition •Poor diet patterns among Tribal •Pockets left out for service delivery •Poor interdepartmental co-ordination. •Poor health seeking behavior. •Poor monitoring of service delivery.

Is there a co-relation ?

Two GPs of Attappady have **2nd** and **3rd** highest percentage of Scheduled Tribe population and **2nd** and **4th** lowest female literacy rate within 1011 GPs of Kerala (as per Census 2011).

Set Goal:- Improve the service delivery for better child nutrition and survival through monitoring of pregnant women and children.

•Knowing **nutritional status** of every child on real time basis....using mobile telephony and GIS technology.

Challenge was to expose malnutrition for focused curative and preventive care & Ensure service delivery to pregnant women and under five children....

• After exposure of malnutrition, taking appropriate measures...

•Ensuring early registration to all PW, ensure that designated services are provided in time to all....

•For those who are already in critical stage...
     •Getting **SOS** from every sick child & other emergencies....
     •Taking appropriate action....

➢ The initiative was launched in January 2014 for improving child survival and child nutrition

➢ The strategy was to (i) track each child and expecting mother, (ii) monitor and analyse the services delivered using ICT applications, (iii) guide the field workers everyday to ensure better delivery of services and (iv) focus on the exceptions who needs special attention and failures of service delivery

➢ Two ICT based systems with GIS backbone have been developed – 'Janani' to capture maternal services for safe delivery & to watch on LBW babies and 'Jatak' to monitor growth of every child in all three nutrition parameters; namely wasting, underweight and stunting

➢ Children below 5 years were surveyed by the JPHN & the AWW to capture weight and height/length to create the baseline of children already born & to ascertain their nutrition status .

Evidence Based Analysis & Decision Support

➢ Capturing all evidences to ensure proper maternal care during pregnancy for reducing incidence of LBW & Pre-term babies and services to children from PNC and up to 5 years & monitoring growth

➢ Personal health records which are captured progressively in 110 data fields for PW (viz. Wt, BP, Hg, Albumin/Sugar, past delivery details etc.) and 63 data fields for newborn (birth weight, initiation of breast feeding, immunization etc) and growth of children are to be captured electronically for this purpose

➢ Health data is captured by JPHN using Android run mobile phone on a real-time basis. The voice data is transcribed and fed in to the server for analysis. The GIS captures the location and the person for whom any service is due/ has failed or who is facing any health risk for ensuring delivery of due services/mitigating the risks/failures

➢ Various analyses are displayed in the websites and exception reports are notified to the person concerned for immediate action.

➢ The system helps to improve monitoring, supervision and management

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Actions after exposure….

❑ The children notified as SAM are to be rechecked for infections, height/weight every 15 days by health worker in AWC.

❑The children notified as MAM are to be rechecked for weight /height every one month at respective Anganwadi center.

❑ Protocol are finalized by the district Health/ICDS team for initiating action for malnourished children and the same are embedded into 'Jatak' system.

❑Using the existing baseline data(Jatak software) and human resources a new programme for SAM/MAM has been launched called C-MAM program with the support of UNICEF.

❑Community level therapeutic Diet plan is prepared for each MAM child and these children are being fed 6 times daily till they achieve their median weight.

❑All identified pregnant females with signs of malnutrition were given extra feed through community kitchen, the group of JPHN, AWW,TP,NRLM Health Volunteers are entrusted for ensuring follow up and safe delivery.

Mobile Telephony
And
Geographic Information
System

ICT based systems with GIS backbone – **Mobile** based application to capture '**Real Time**' data of each child/PW for initiating immediate action for child survival...

Janani to capture maternal services for safe delivery and to watch on LBW babies and Jatak to monitor growth of every child in all three nutrition parameters; namely wasting, underweight and stunting.

The principal purpose of Jatak is to bring to notice that a child as soon as she/he enters into the arena of 'malnutrition'

Jatak Software Process

Web Server

Outcome reporting

Jatak Software screens and highlights underweight/wasted/stunted children as per WHO protocol

Feedback

Feedback to MO and other upper-tiers

Location information (lat-long), weight, length/height, Date of Birth and picture of the child

growth monitoring through NRC module of Jatak software

Follow-up protocol

Data

Frontline Workers

Admission to NRC / initiating Home based care etc.

Flow - Janani

Voice Data Transcription

Data storing and processing Web Server

Feedback to frontline workers

Voice Recording (along with beneficiary picture and lat-long information)

Service delivery point

Service delivery point

Service delivery point

Mobile Notification on due services for ANMs

Every Morning, Janani provides a 'work plan' to ANM for next three days in her mobile phone.
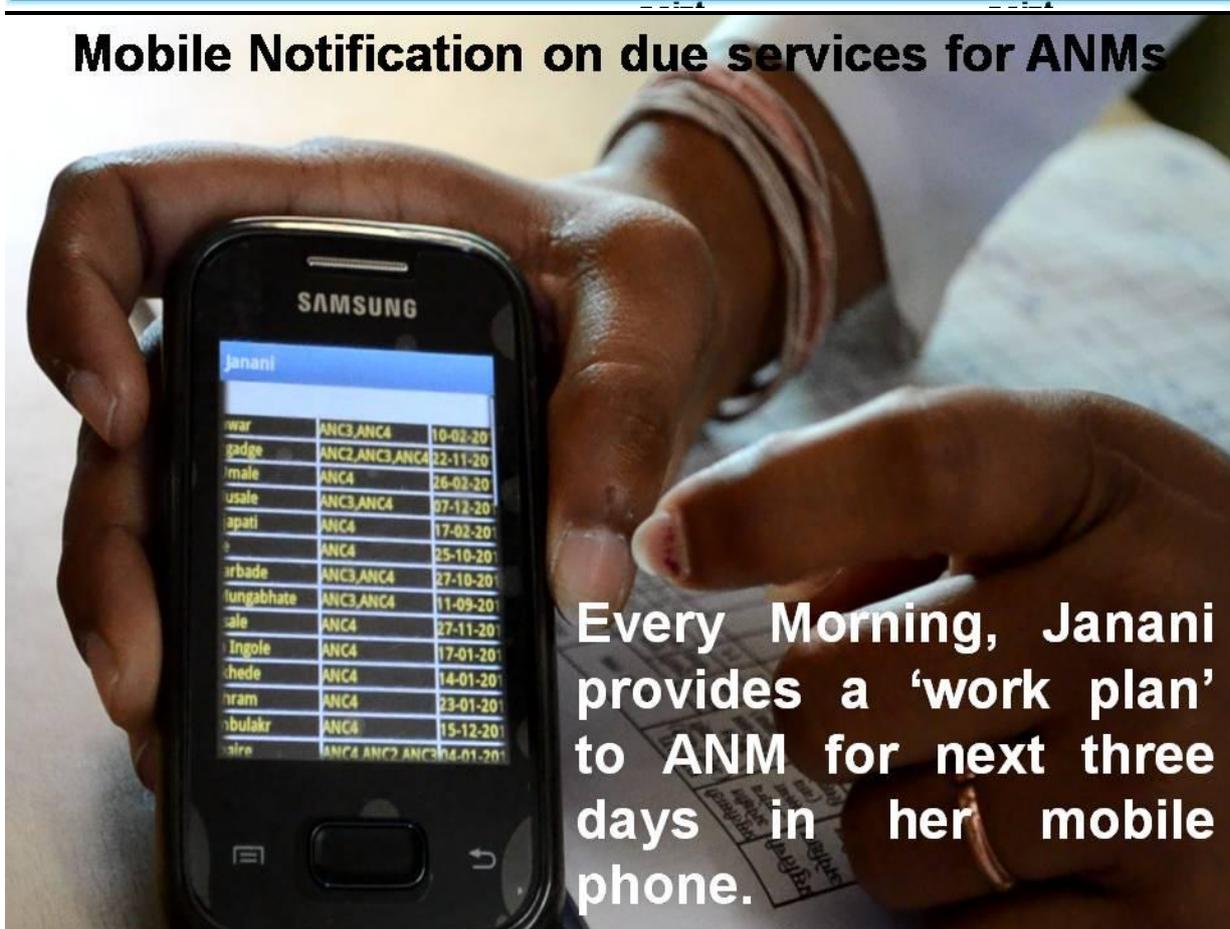
The online system

Janani: Viewing each Pregnant Women

Dynamic Locator for Action Plan (D-LAP)
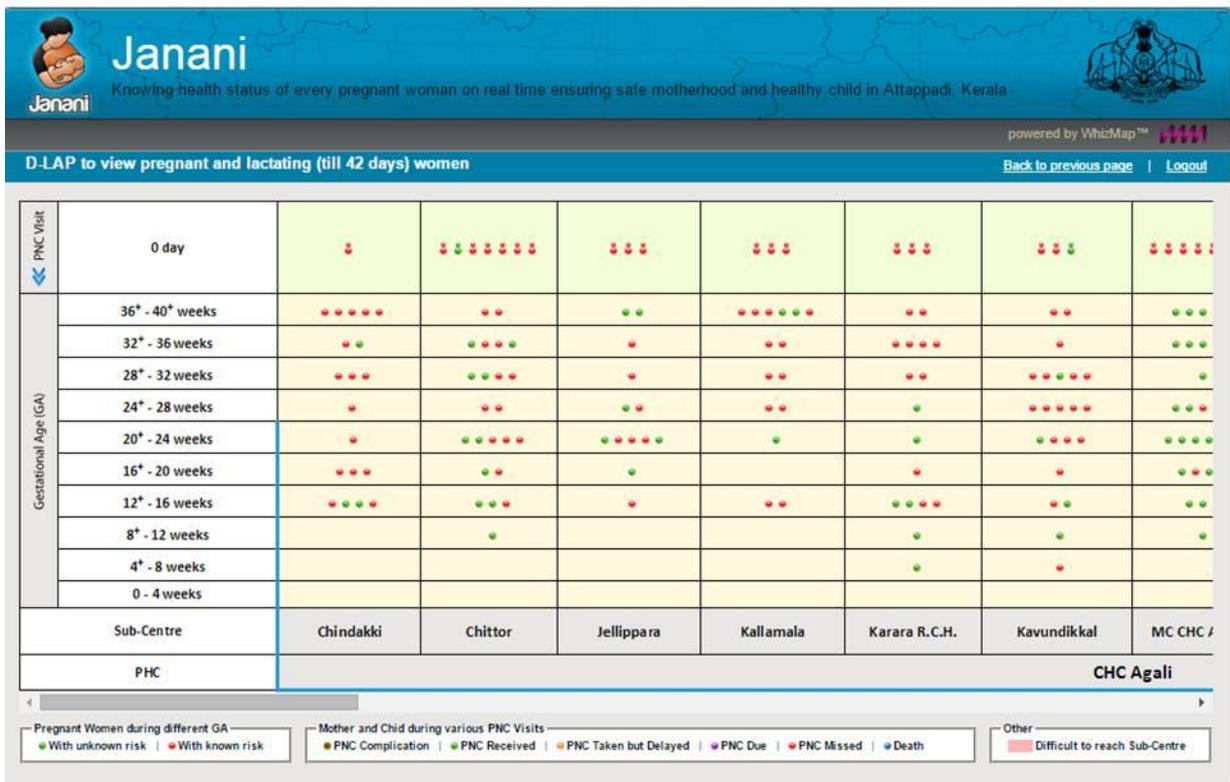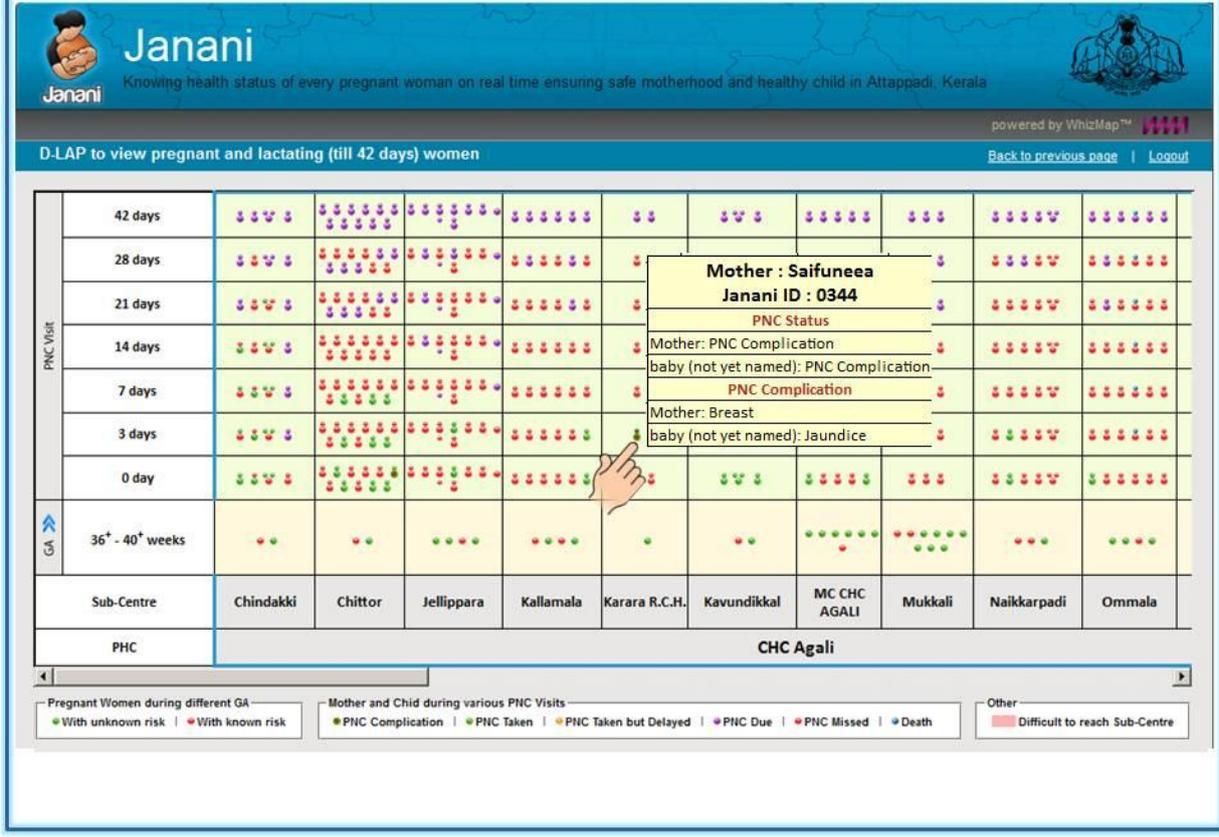
Picture Gallery of registered mothers

Customized online reports

Jatak.. (Nutritional Status viewer)

The system automatically screens and highlights Overweight/ Normal/MAM/SAM children...

Clicking on a particular child, the system generates her/his picture, related information and Growth Chart as per WHO standard...

The details of all children of an Anganwadi Centre can also be viewed

Jatak..

Viewing Community Growth Chart of an Anganwadi Centre...

Child Report

Date: 02/01/2015

Name: Sharmila
Jatak ID: 5364
Gender: Female
Name of Mother: Sundari
Child Janani ID: Not available
Sub Centre: Kadampara
AWC: Thoova

Age (as on date): 11 months   Birth Weight (kg): 2.72

MUAC (mm):   Grade:

Nutritional Status

Weight-for-Age:		Wasting:		Stunting:	
Status:	MUW	Status:	Normal	Status:	MCM
As on:	18/12/2014	As on:	18/12/2014	As on:	18/12/2014
Weight (kg):	6.4	Weight (kg):	6.4	Height (cm):	67.2
		Height (cm):	67.2		

WHO Growth Chart (Weight-for-Age):

Child Report

Date: 02/01/2015

Name: Balakrishnan
Jatak ID: 5370
Gender: Male
Name of Mother: Veeramma
Child Janani ID: Not available
Sub Centre: Kadampara
AWC: South Kadampara

Age (as on date): 8 months   Birth Weight (kg): 2.65

MUAC (mm):   Grade:

Nutritional Status

Weight-for-Age:		Wasting:		Stunting:	
Status:	SUW	Status:	SAM	Status:	SCM
As on:	14/12/2014	As on:	14/12/2014	As on:	14/12/2014
Weight (kg):	3.6	Weight (kg):	3.6	Height (cm):	57.9
		Height (cm):	57.9		

WHO Growth Chart (Weight-for-Age):

Command area map showing location of each child
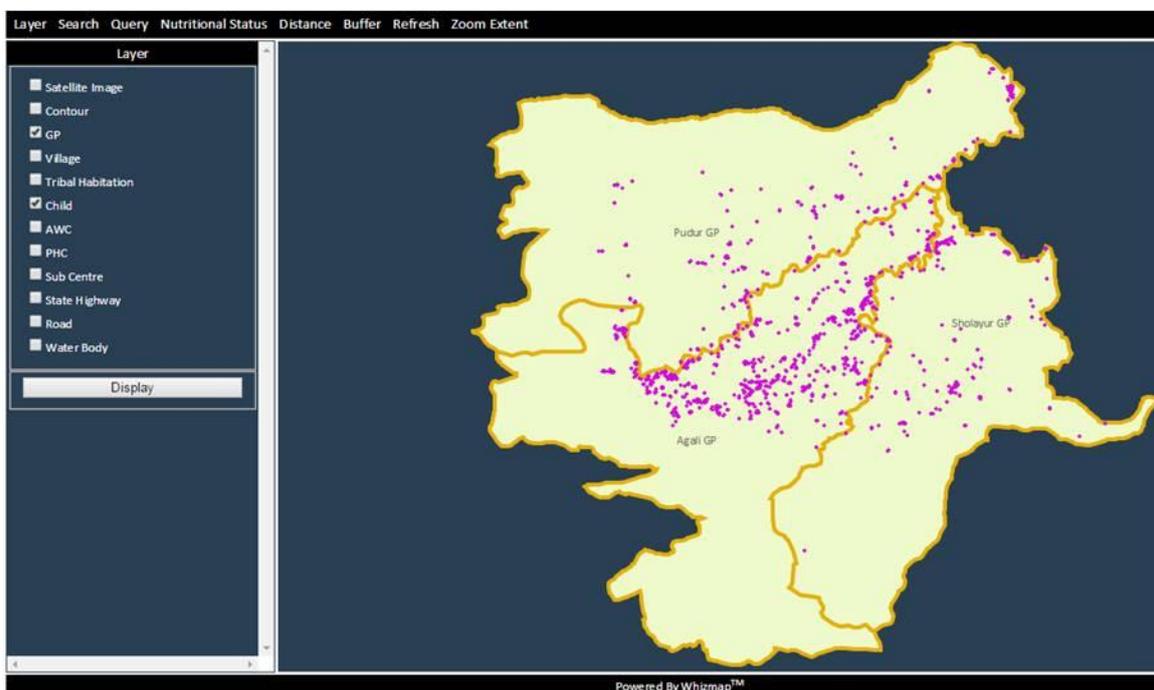
Nutritional Status of each child (weight for age)
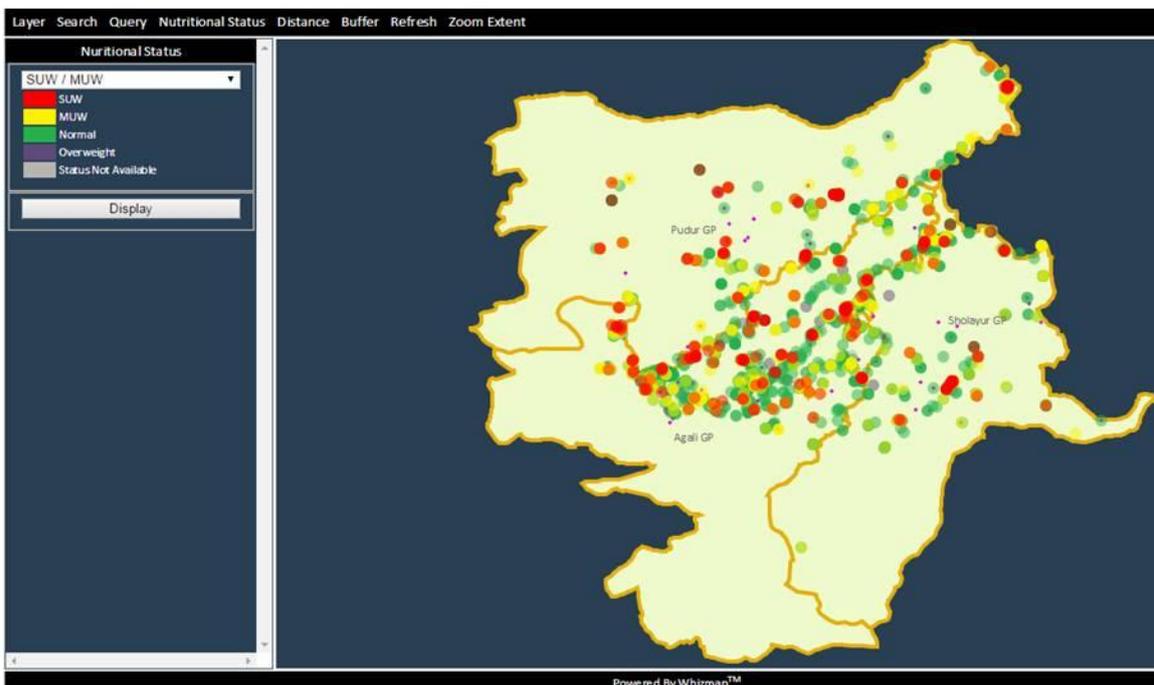
Nutritional Status of each child (weight for length/height) Wasting
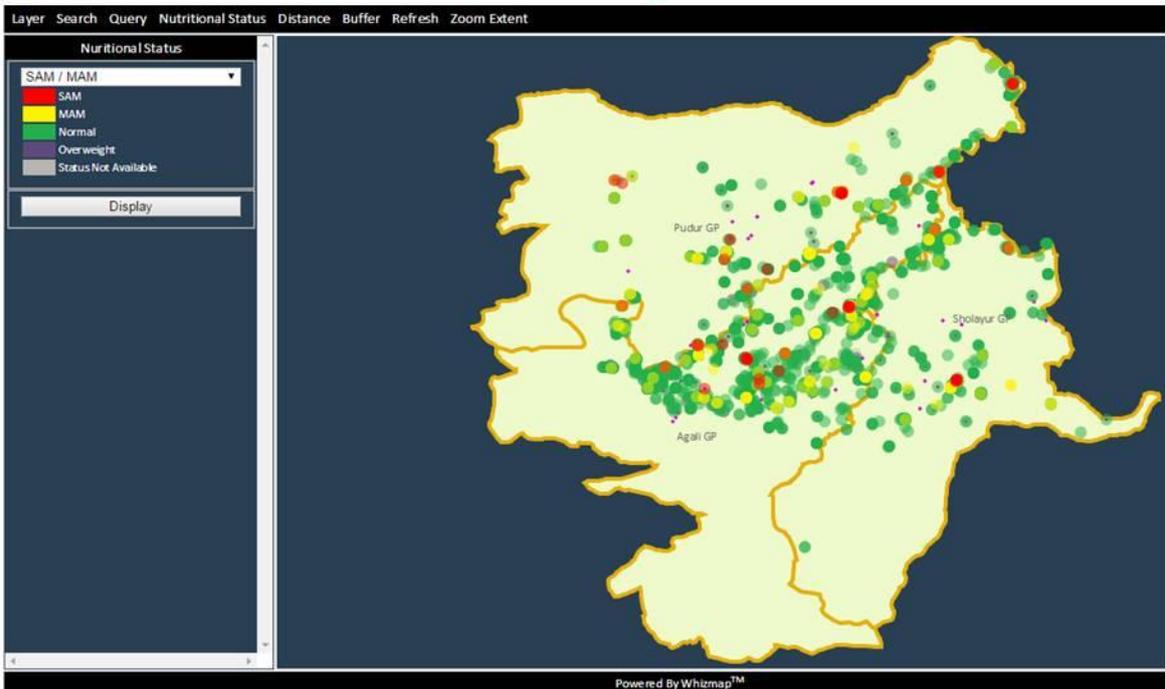
Nutritional Status of each child (length/height for age) Stunting
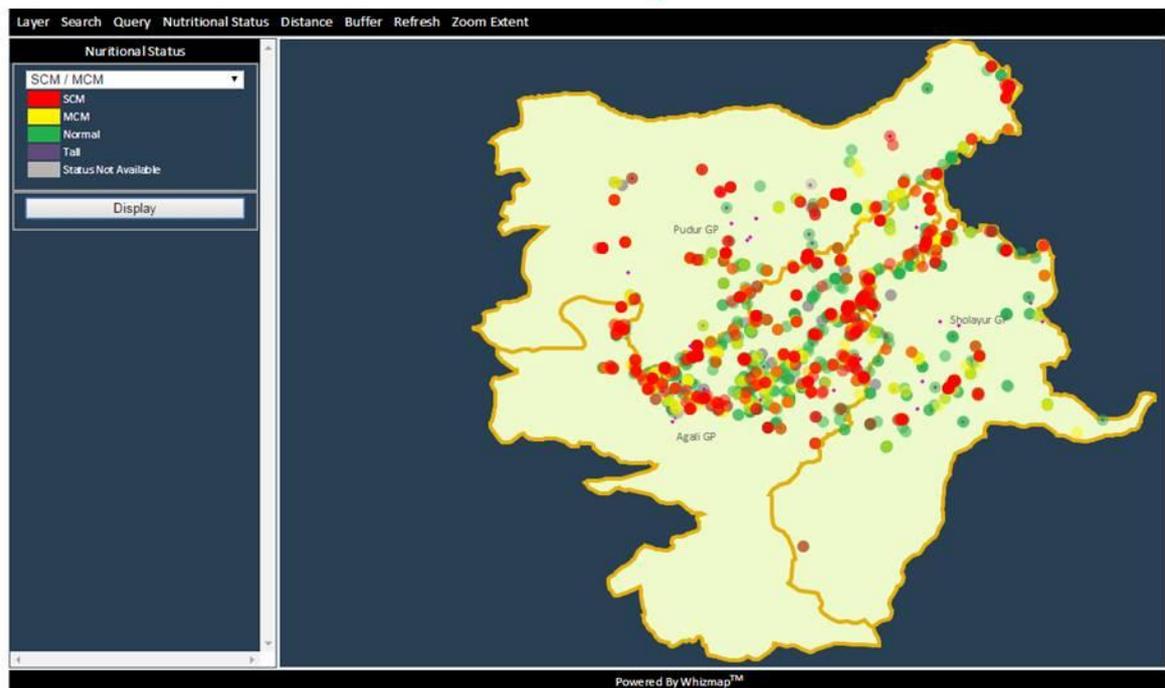
3 or more ANC services received (No. of preg. women)
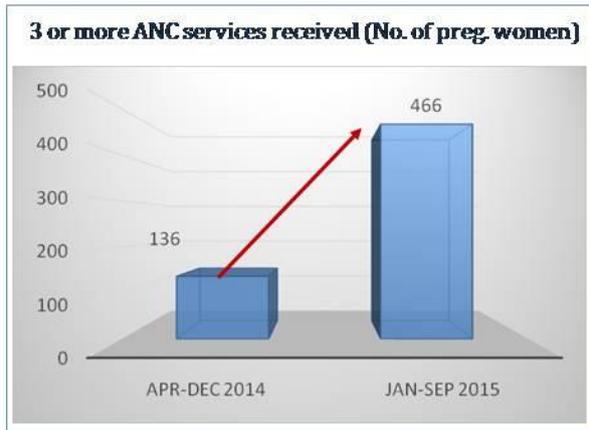
Time-Period	Mid-Apr to Dec 2014 (8.5 months)	Jan to mid-Sep 2015 (8.5 months)
ANC service taken (3 or more)	136	466

1 or more PNC services received (No. of preg. women)

Time-Period	Mid-Apr to Dec 2014 (8.5 months)	Jan to mid-Sep 2015 (8.5 months)
PNC service received (1 or more)	163	388
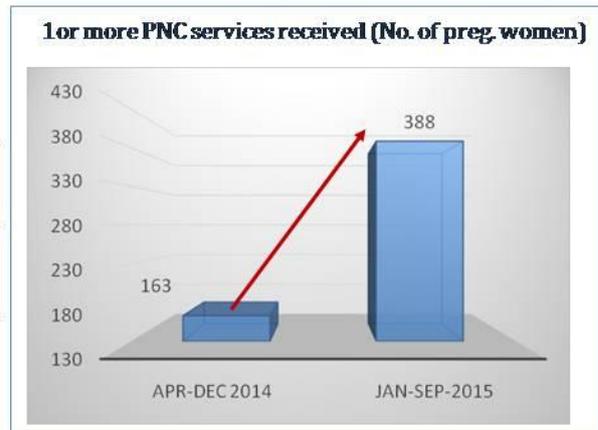
No. of child death (U-5 yrs.)
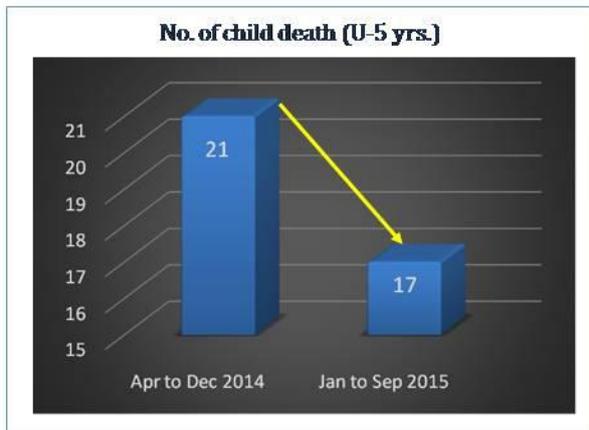
Time-Period	Mid-Apr to Dec 2014 (8.5 months)	Jan to mid-Sep 2015 (8.5 months)
No. of child death (U-5 yrs.)	21	17

There were 47 Infant deaths in 2013 the number is gradually decreasing

Time-Period	Mid-Apr to Dec 2014 (8.5 months)	Jan to mid-Sep 2015 (8.5 months)
No. of infant death	12	8

No. of Infant Death
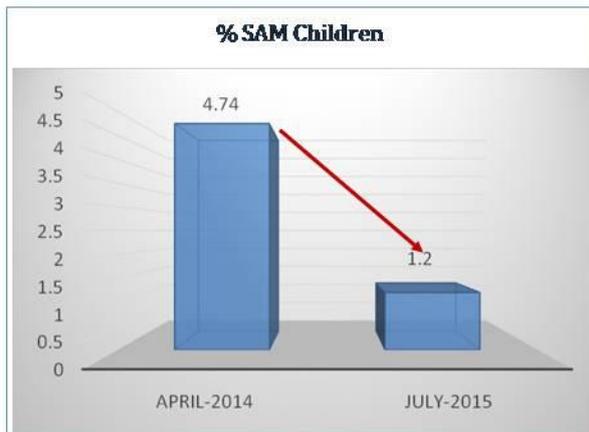
% SAM Children

Time-Period	Surveyed Children (U-5 yrs.)	SAM	% SAM
April-2014	3836	182	4.74
July-2015	4160	50	1.20

Time-Period	Surveyed Children (U-5 yrs.)	SUW	% SUW
April-2014	3836	559	14.57
July-2015	4160	384	9.23

% SUW Children

THE HINDU

- However,......... The success of the Government tribal specialty hospital in Kottathara is noteworthy. Following **the 47 infant deaths in 2013**, the hospital was renovated; a special newborn care unit (SNCU) was set up. Seventeen doctors, including specialists, were posted; of which 12 are available regularly in tribal mobile clinics. On an average, 20 monthly field medical camps are being organised in primitive tribal areas, thus making micronutrients supply, **systematic antenatal care** and field level public health activities accessible.

- **Home delivery reduced in Attapadi drastically; in March, 2015, there was none.** Nutritional rehabilitation centres have been started at Agali, Sholayur and Pudur for the **children suffering from Severe Acute Malnutrition; this brought down the SAM numbers from 299 in April, 2013, to 64 in April, 2015.**

❖ It is started using as a *regular monitoring tool for malnutrition tracking and management* by Health, Tribal and Social Justice Departments.

❖ The State/District/Block level officers receive notification on Nutritional Status of children, high risk pregnancies, LBW children and timely alerts on different Health parameters.

❖ Services due/missed can be tracked and corrective measures taken at different levels.

Uptake for Sustainability and Replication

It is made part of the existing system for service delivery reporting, monitoring at all levels. Based on the feed back from different stakeholders updating and customization is done on a regular basis.

❖ Piloted in tribal areas in Wayanad, Government has decided to expand the program to the complete Wayanad district this year.

❖ Current and future schemes and programmes implementing through various agencies are linked with this system. Availing of Govt. schemes by pregnant women (Eg. JSSK, JSY, IGMSY, Tribal Insurance, Janani Janma Raksha schemes) can be ensured.

❖ NRC – C MAM programme linked to JATAK.

Challenges

- Ownership by Departments.
- Regular data collection.
- Poor mobile connectivity in few pockets.
- Convergence at different level.

Winning - the war against **malnutrition...**

For more information, please contact
Dr Sreehari.M, DPM, NHM, Palakkad.
drsreeharim@gmail.com
Tel: 9539191910

Akila Radhakrishnan
Planning, Monitoring and Evaluation
Specialist
aradhakrishnan@unicef.org
Tel: 044-42891111

Mr. Kamal Pal, Riddhi Foundation,
Kolkata.
kamalpal@riddhi.org

Questions and answers

Q: What is the cost of developing software?

A: Software has already been developed. It is not the first time in the Attappadi and Palankad. It is used in Maharashtra, Nasik, some areas of Jharkhand and Tripura. However, we need to have some sort of customisation at different levels, like who needs to send the information, who all should get it back etc.

Q: *Dr. Sudarshan*: You said, these outcomes are not due to software but because of improving of the health system. Your title should also say it. If we glorify these tools everyone thinks that it's the tools that brought the result, but, for us the improvement of health system due to this is also very important. Secondly, Kerala is known for decentralization but you are again depending on ANMs. The health department is implementing it, though convergence is good to a certain extent, but there are limitations. The VHCs are not involved; the panchayats were not involved; they didn't take the responsibility; why is it so?

A: With regard to the panchayat, all the three are tribal panchayat. We tried a lot to empower the panchayat and the members but since were unable to convince them. They were not even accepting the SAM children in that area because to them all the children looked similar. We had community forms for feedback and data. For data we technology workers who would send the information back to the community. The tribal community was also getting the information, and not just the health department. SHGs are formed in Errnakulam. So, these SHGs are working on the SAM children.

Chairpersons' questions and comments

Dr. Abhay Bang

Congratulations for a very innovative people-centric programme.

Next, this and the earlier examples of Nazdeek and the community based monitoring that we heard, these demonstrate the potential of the powerful combination when people and technology join hands and we see transfer of power or empowerment

To me it's a black box as to what happens in that government office. Information comes but unless somebody acts on that information, that information alone is of no use. Now, if there is one good sensitized government officer something is going to happen. It's a good pilot project. Though, right now I am not commenting on your outcome figures because your absolute numbers are very small. Like, 12 deaths becoming 8 deaths, I don't know how much significance to give to that. But, what happens in the black box of that government system? How do they process information and translate it into effective corrective action that might be the bottle-neck. People will not lag behind in adopting technology. Even in tribal villages now youth and women are using mobile phones for technology. Technology is not the bottle neck; people are not bottle neck; if at all there will be a bottle neck it will be us, the decision makers. So, probably, for whoever works in this field, the next challenge will be how to sensitize those decision makers who do not take any corrective actions. Does somebody monitor them? And what incentives to correct – positive incentives, negative incentives? That might be the another crucial factor in making all this possible.

11

Innovations in Primary Health Care

"Reaching the Health Care to Unreached"

by
Dr.H.Sudarshan
Secretary VGKK & Karuna Trust

Former Chairman, Task Force on Health & Vigilance
Director, Karnataka Lokayuktha
&
Anup Sarmah
Coordinator NE

Vivekananda Girijana Kalyana Kendra

VISION

A self reliant and empowered Tribal society rooted in its culture & tradition, living in harmony with Nature.

MISSION

Sustainable development of Tribal People through rights based approaches to Health, Education, Livelihood security and Biodiversity conservation.

B.R Hills
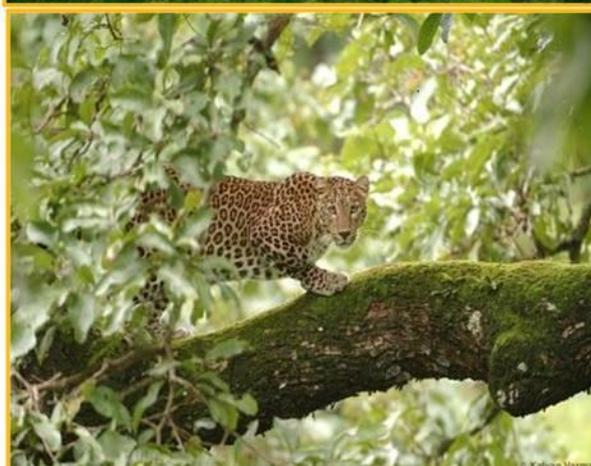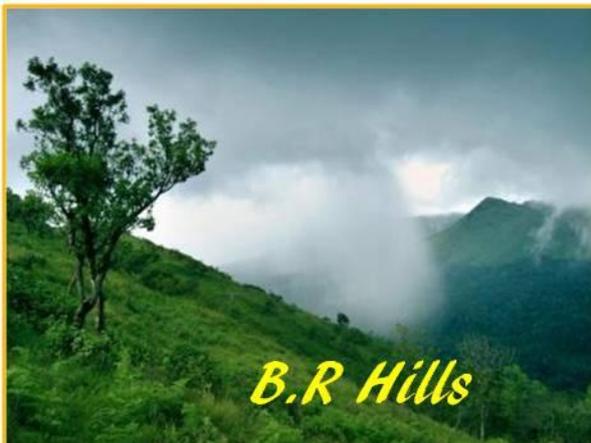
Soliga Tribal people

- Children of Bamboo
- Veddoid Group of Aborginals-
  Pre-dravidian or early Dravidians
- Shifting Cultivation. Food
  gathering and hunting
- Lived in hormony with Nature
  – Nature worshipers

Tribal Culture

- Living in Harmony with Nature Vs Alienation from Nature

- No distinction between Secular & Sacred

- Take what you need for basic needs and give back to Nature.

- Present moment is most important than the past or future.

- Integration of Head & Heart, Feminine & Masculine

Evolution of Tribal Development

- Started **Curative Health Services- (1979-80)**

- Whooping Cough epidemic – initiated **Community Health**

- "I had no pills for poverty" - Land rights issue – **Community Development**

- Conservation of Biodiversity and Livelihood of tribal people – **Sustainable Development**

Megalithic (800 BC) Burial Sites- B R Hills

Basic Principles of Tribal Development

- Living with the people – understanding their strengths – Traditional Knowledge

- Humility to learn from people

- Build on the strengths

- Respect Diversity and no need to bring them to so called "National Main stream"

Tribal Health Care

- Comprehensive Primary Health Care: Preventive, Promotive, Curative and Rehabilitative Health Care

- Understanding Traditional Health and integrating/building on it.

- Empowering people to manage their health

Tribal Education

- Started with 6 children in a hut-1981

- 4 of them have done Post Graduation

- Jadyea has done MSc in Agriculture
  & completing his PhD- Asst Professor
  in Forestry College-President of VGKK

- 2 MSWs & 1 MSc in Botany

Karuna Trust

- Started in 1986 in Veerappan's area in Karnataka

- Response to high prevalence of Leprosy in Yelandur- 21.4/1000 in 1987 to 0.2/1000 in 2005

- Extended to Naxalite & Insurgency prone areas, remote, hilly tribal areas of NE

- Hilly, difficult, interior, inaccessible, no or less road, no electricity, no internet, no telephone

- Proposed and took over the responsibility to manage a PHC Gumballi in Yelandur taluk in 1996. This marked the beginning of a public-private partnership in running PHCs in India.

- Serving 1.5 million population in India, 1600+ health professionals
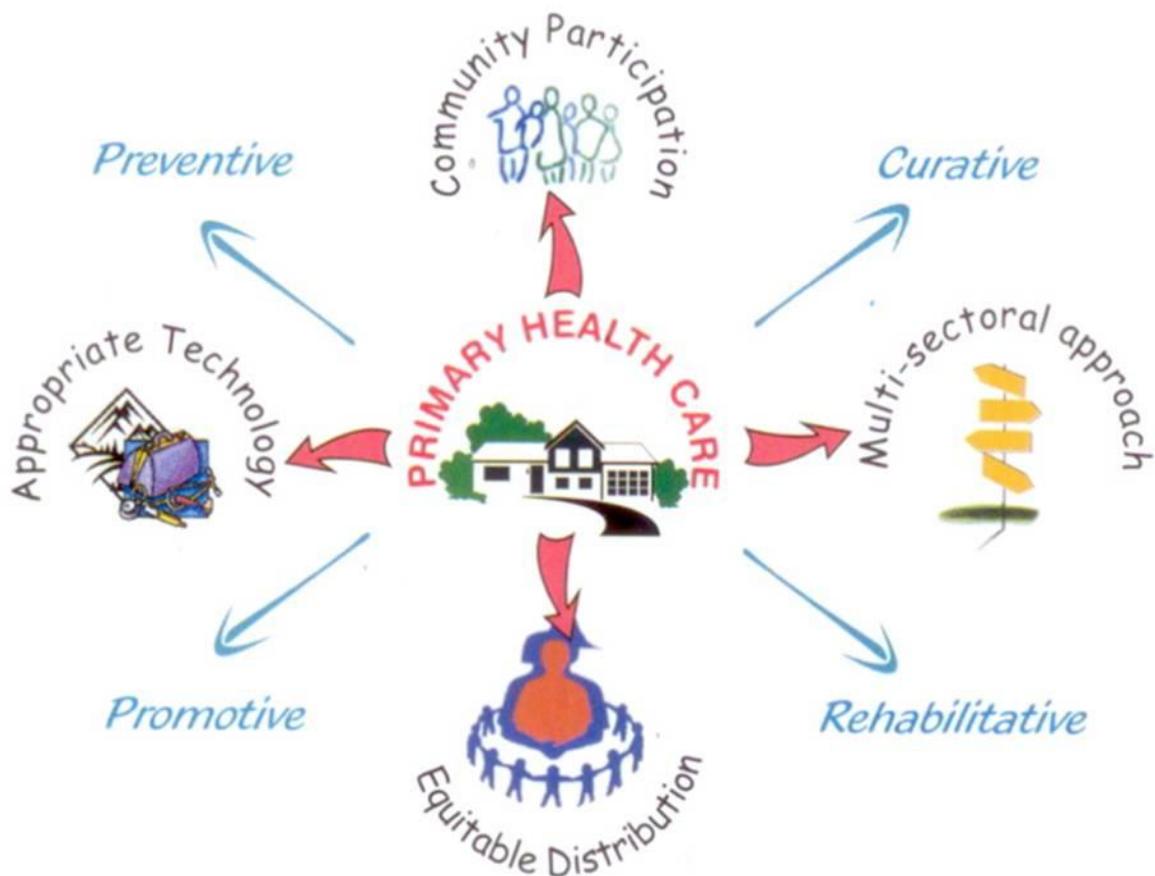
Comprehensive Primary Health Care

- Rights based empowerment of people for managing their health – Right to Health, Reproductive rights.
- Community based Preventive, Promotive, Curative and Rehabilitative services
- Mother & Child Health, All National Health programs and specific local problems.
- Addressing all other determinants of health – Safe water, Sanitation, Nutrition, Livelihood etc

Public Private Partnership (PPP)

- Public – Government

- Private – For Profit Private Sector & Not for Profit Sector (NGOs, VOs)

- **Privatisation:** Partnership with Not for Private Sector is not Privatization

- **Partnership:** It is not being "Contractors" for implementation of Government Programs. Partnership in Policy formulation, planning Implementation, Monitoring, evaluation, Training & Research.

Details of the Karuna Trust's PPP model

Key Actors

- National Govt.- approval of PIP & Budget

- State Govt.- MoU, fund, guidelines, logistics, vaccines, review

- Karuna Trust- Implementation, management as per IPHS

- PRI(Panchayat)- local support, guidance, community mobilization

- 3 tier monitoring system-
    NGO (Coordinator, supervisor, MO)
    Local governance (PRI),
    District officials and State Govt.

PPP – the process

- Advocacy with respective state government
- Expression of interest / direct application
- Identification of PHCs – poorly performed, remote area
- Dialogue with community and PRI members
- Applying to ZP/ state, sharing draft MoU
- Finalizing MoU, budget formulation
- Office order from DHS/MD
- Formal takeover of the PHC from DMO/CMHO
- Withdrawal of govt. staff , KT appoints its own staff
- Recruitment and induction training
- Govt. provides 90% fund to run the centre, KT contributes remaining 10% (varies from state to state)
- Reporting as per the HMIS- report to block /dist/state

Managing Govt. PHCs under PPP

Rajasthan 12 PHCs

Maharashtra 1 PHC

Arunachal- 11 PHCs

Meghalaya- 11 PHCs

Manipur- 3 PHCs

Orissa- 11 PHCs

Andhra- 2 PHCs

Karnataka- 30 PHCs
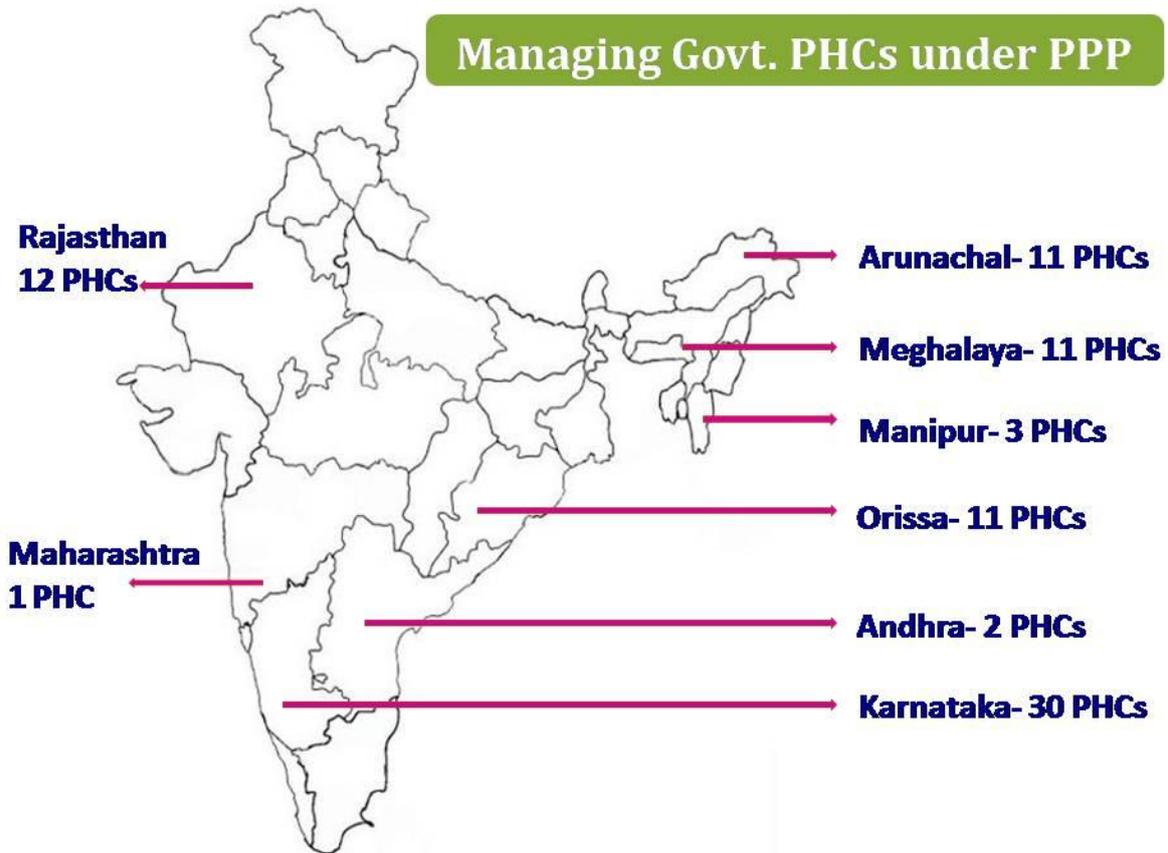
Models/Options for PPP

- Model I : KT directly implementing

- Model II : Partnership with local NGO & Government.

- Model III: KT playing the role of facilitator and partnership between local NGO and Govt.

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Features of PHCs run by Karuna Trust

- The MO, Staff Nurse, ANM, Pharmacist & LT stay in PHC HQ
- ANMs and Male Health Worker stay at the Sub-center HQ
- Services in 24 X 7 pattern, all services are free of cost
- 6-12 Beds inpatient facility with DIET
- 24 hrs labour Room & Essential Obstetrics facility.
- Minor OT facility. 24 hrs Ambulance facility.
- Essential Laboratory tests & Essential medicines free of cost
- Total responsibility of population, name based tracking system
- Mainstreaming traditional medicine & vision centre in PHC
- Implementation of National Programs including NHM
- Management of Sub-Centre attached to PHC.
- Adequate manpower to achieve the target as per IPHS
- Innovations-

Quality in Primary Health Care

- NABH Accreditation for Gumballi PHC – First PHC to get it other than Gujarat State.
- Standard Operating Procedures (SOPs)
- 4 PHCs and the FRU accreditation in process.

National Accreditation Board for Hospitals & Healthcare Providers

Certificate of Accreditation

Primary Health Centre (PHC)
Karuna Trust, Gumballi
Taluk– Yalandur
District – Chamaraja Nagar, Karnataka
India

has been assessed and found to comply with

NABH

accreditation requirements for

Primary/Community Health Centre

Innovations in ICT

- Telemedicine

- Logistimo – drug logistics – cell phone

- Sensors for monitoring Cold Chain system in ILR

- Drone for delivering emergency drugs

- Empowering Health workers with Tablets and android phone – Dtree, EMC2

- To integrate traditional medicines into PHC
- To make a rapid assessment and validation of sound local practices.
- To develop a cadre of Arogya mitras to cater to the preventive, promotive and curative needs of the community
- To advocate for policy on mainstreaming the traditional medicine into official primary health care system.

Mainstreaming Eye care in to PHC

- Community Eye Care – Village blindness registry – VHSC & RKS
- Training MO & PHC staff, ANM, MHWs, ASHAs in Community based eye care.
- Vision Centers in every PHC – Ophthalmic Assistant PMOA and Optician – Vision testing and optical dispensing at PHC

Mainstreaming Communication Disorders in to Primary Health Care

- Collaboration with All India Institute of Speech and Hearing (AIISH).
- Prevention, Early detection, Aids and appliances and Surgical correction.
- Pilot in Gumballi PHC, Akkihebbal and Hullali PHCs
- Scaling up to all the PHCs in Yelandur (5PHCs), K R Pet (21 PHCs) and Nanjangud (20 PHCs)Talukas.

Community Health Insurance- T.Narasipur Model

- NGO & Government Collaboration
- Three Levels:
- Community Herbal Gardens - for common ailments
- SHGs - Micro-credit for out-patient care
- Pre-paid Insurance for Inpatient care - Hospitalization

Community Planning & Monitoring

- Pilot of NRHM in 9 States
- Karuna Trust -Nodel Agency for Karnataka
- Implemented in 4 Districts in partnership with local NGOs
- 49 PHCs & 562 Villages covered
- VHSC & RKS capacity building
- Village Health Plan and Report cards

Community Participation

Management of FRU- Santhemaranahally CHC

- CHC building at cost of 1.5 Crores but FRU not functional – only two doctors.
- Thayi Bhagya Scheme (Chiranjeevi Scheme)
- Partnership with FOGSI
- Rs.2250/- per delivery
- 2118 deliveries and 311 C-sections done during 20 months.

F.R.U Santemaranahalli

We are closely working with

Arunachal
Adi, Apatani
Galo, Nyshi, Miji
Idu, Khamti,
Nocte, Tutsa,
Wangcho, Tagin
Monpa, Tutsa
Miju, Monpa,
Digaru, Tangsa,
Singpho, Memba,

Assam
Mishing, Boro
Tea tribes, Karbi

Meghalaya
Khasi, Garo, Jaintia,
Bhoi, Lalung

Manipur
Naga, Kuki,
Paite, Vaiphei,
Thadoru, Zou

Karnataka
Soliga, Jenu
Kuruba, Betta
kuruba, Yeravas,

Andaman & Nicobar:
Great Andamanese,
Jarwas, Schompens,
Onges, Sentinels

Andhra Pradesh
Adilabad – Gonds,
Kolams
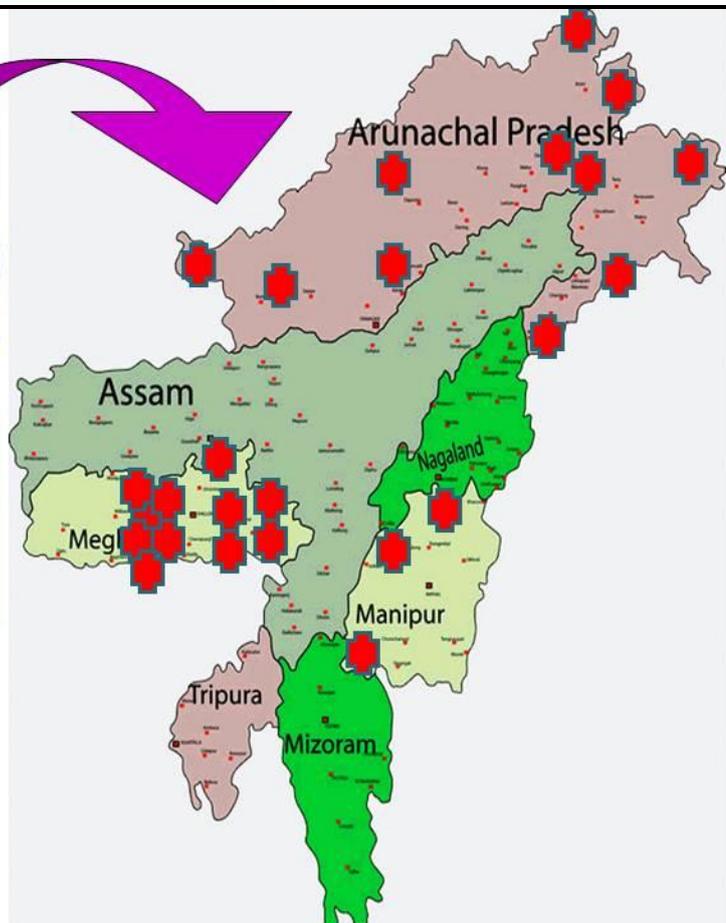
Coverage area (100% tribal population)

Categories	Arunachal Pradesh	Meghalaya	Manipur *	Total
No of PHCs	11	11	3	25
Project started	2005	2009	2011	-
Population	65600	97300	41500	204400
No of villages	408	279	105	792
No of Districts	9	4	3	16
Status	Ongoing	Ongoing	Completed	

NB: We have started 3 health centres in Manipur with Dept of Hills & Tribal Development from Oct 2015

Problem Statement

- Non functional health centres in rural/ remote areas
- Poor utilization of public health centres
- No staff staying in PHCs, high mortality rate (IMR>60)
- Geographic barriers- No access to health centres

Name of PHC	Distance from KT office km	Travel hours
Tuting	670	30
Walong	923	27
Etalin	850	25
Lumla	550	22
Impa	230	15 km walk
Sub Centre Lada- 2 days walk from PHC		
Sub Centre Singa- 3 days walk from PHC		

Thingpuikhul PHC is 290 kms from Imphal, need to travel by 4 hours in river boat and then walk for 2 hours

Distribution of villages- Arunachal Pradesh

Fully Motorable (174), 43%

Partial motorable/ partial trekking (73), 18%

Fully Trekking (161), 39%
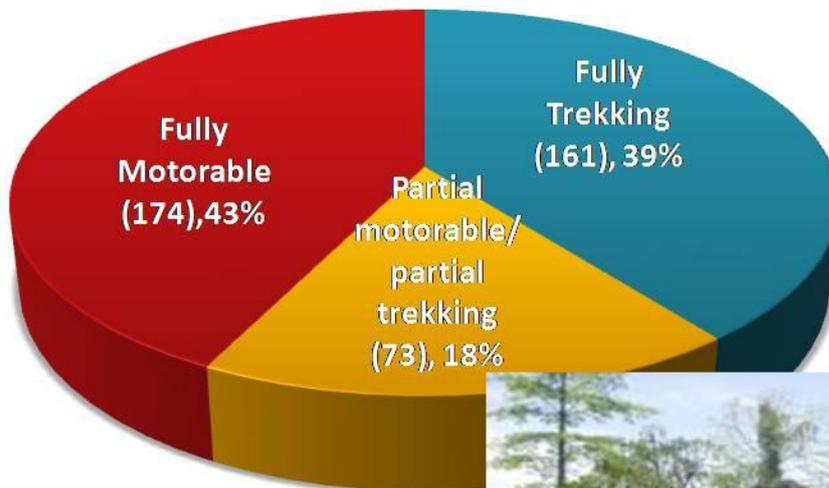
ANM nurse crossing the river Lohit for vaccination

Etalin PHC road
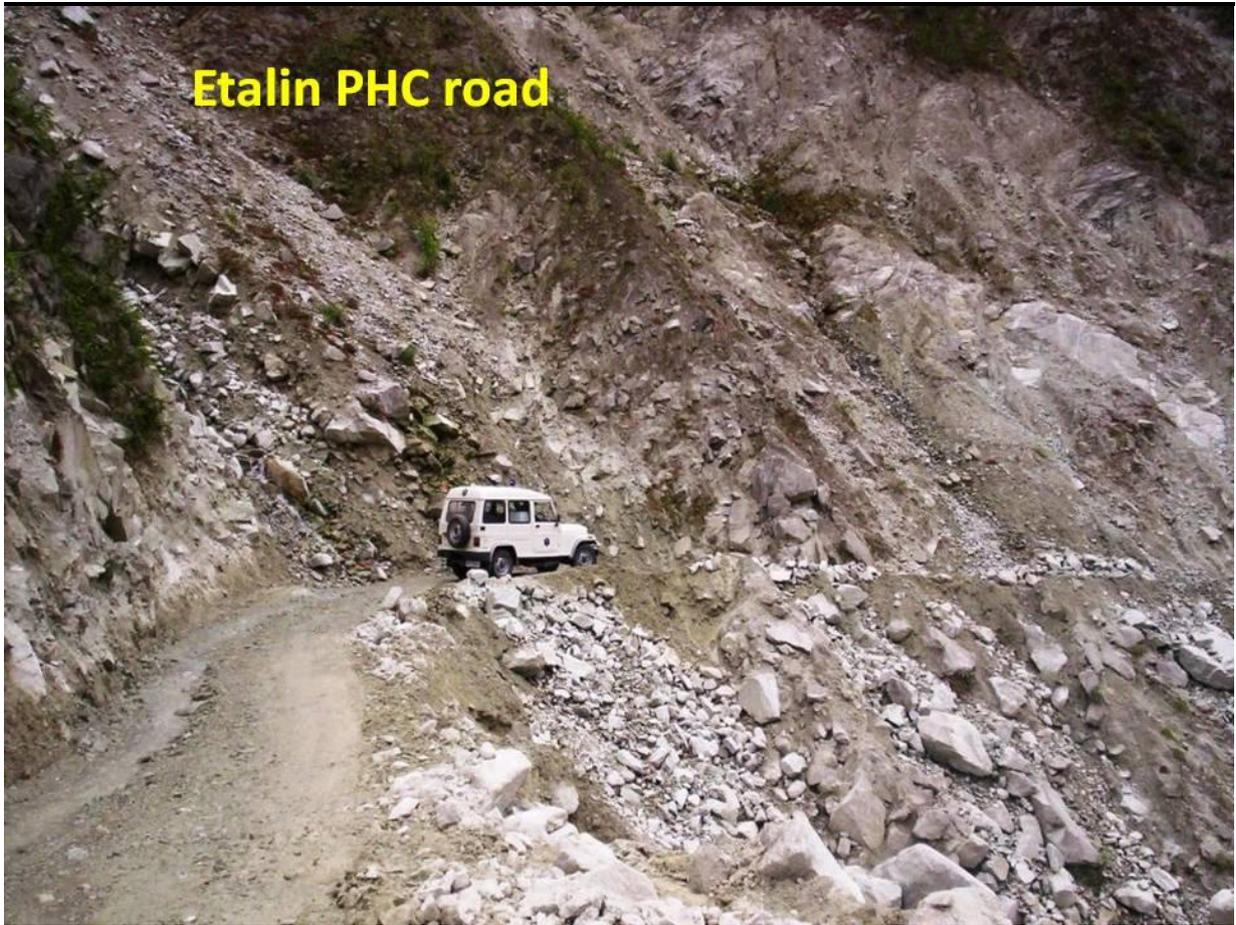
Anpum PHC road, opens for 4 months

Poor Access to health care:

- Inadequate infrastructure
- Poor Quality of construction work
- Medical staff not staying in remote areas
- NO specialist in majority of CHCs
- Inadequate equipment & drugs
- Non functional PHCs & SCs

Goal of the Best Practice

- Strengthen the Public Health centres located in remote & inaccessible areas
- Develop a replicable model of comprehensive primary health care system
- Make a model PHC in the district which others can follow
- Implement innovations in the field of primary health care for the improvement of health issues of indigenous communities

Changes brought by Karuna Trust in NE

Baseline (2006)	Present (2015)
Non/poor functional PHC	Functional at 24X7 pattern & bas per IPHS
Non functional SC	Functional
Inadequate drugs, equipment	Adequate, 120+ verities of essential drugs
No lab facility	All essential lab tests are done
No IPD, OPD almost nil	6-12 beds with diet facility, 2 MOs
No staff staying	Staff stay in PHC/SC 24X7
Full immunization (0-1 yr) <30%	72% achievement, 90% coverage in 60% PHCs
ANC coverage (<40%)	91% coverage (2014-2015)
No institutional delivery at PHC/SC	47% ID in PHC, 35% in SCs

Tousem PHC, Manipur

Luxury inpatient beds, Mawlong PHC

Infant mortality rate of Gumballi PHC from 1996 to 2010

New Population added

MMR

National Average: 254
Karuna Trust PHC's: 81
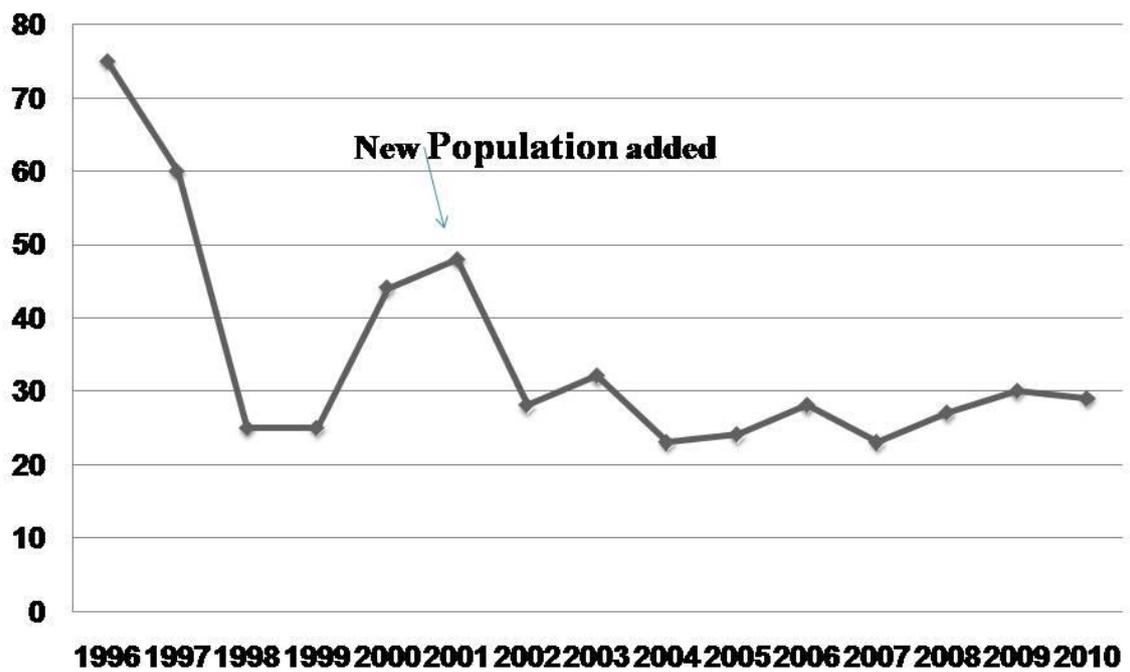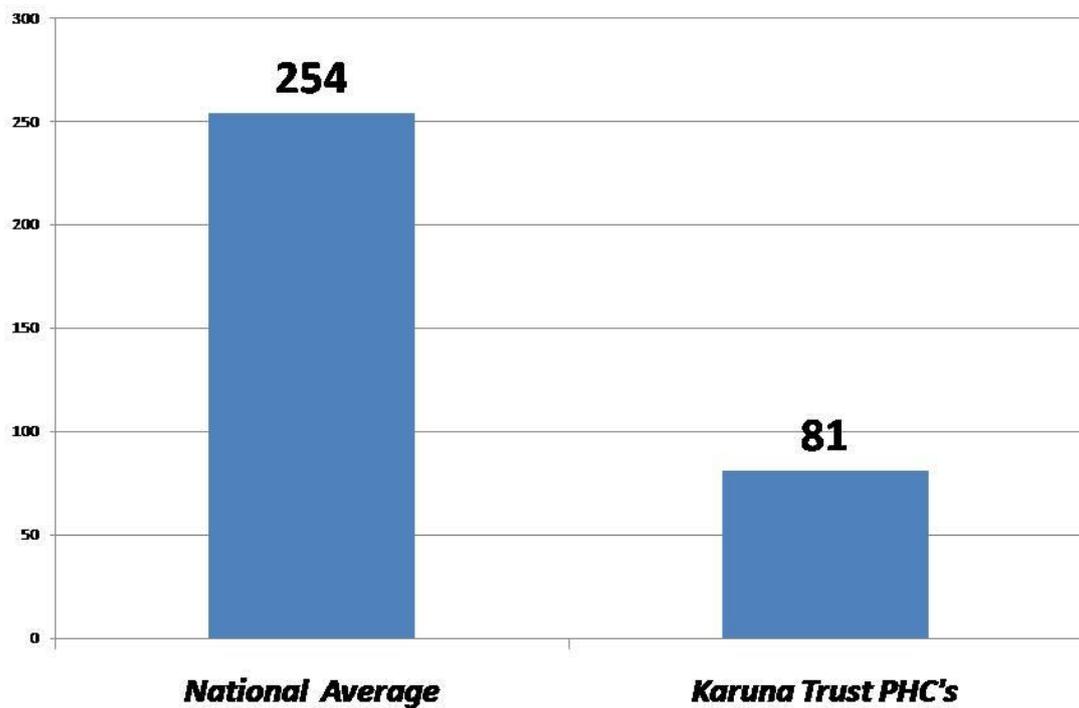
HBNC by ANMs- No of home visits (Arunachal)

ANMs house visits

Year	Visits
2008-09	14930
2009-10	17495
2010-11	36081
2011-12	51158
2012-13	47495
2013-14	60135
2014-15	69753

Delivery 1070 in 2014–15

VHNDs (Arunachal)

Bar chart titled "VHNDs" showing VHNDs (Arunachal) by year:
- 2006-07: 0
- 2007-08: 43
- 2008-09: 353
- 2009-10: 695
- 2010-11: 1375
- 2011-12: 1935
- 2012-13: 1947
- 2013-14: 1908
- 2014-15: 2184

Malaria Positive cases (Arunachal)

Bar chart showing Malaria Positive cases (Arunachal) by year:
- 2006-07: 3206
- 2007-08: 3688
- 2008-09: 3160
- 2009-10: 2456
- 2010-11: 1822
- 2011-12: 1572
- 2012-13: 1097
- 2013-14: 628
- 2014-15: 663

Emergency medical service in PHCs

Student Health Volunteers

SHV- 322 nos
Peer educators- 533

Spread health messages-
Malaria, adolescent etc.

Papa Mama Class

310 camps in 2015-2016

Counseling Eligible couples
on FP, safe motherhood,
child care, etc

Promoting Institutional Deliveries

Started in 2015

Improvement in Key health indicators

Indicators	CES,09	DLHS 4	KT PHCs in NE
ANC registration	69%	61.6%	91%
ANC < 12 weeks	27%	34.8%	69%
3 ANC visits	50%	43.8%	74%
100 IFA tablets	NA	17.4%	71%
Home delivery	30%	48.5%	37%
Institutional delivery	70%	49.5%	63%
Institutional Delivery at PHC	6%	NA	47%
Institutional Delivery at SC	4%	NA	35%
Home delivery by SBA	2%	3.1%	74%
PNC within 48 hrs (IDs)	NA	45.2%	72%
PNC within 2- 10 days	48%	48.8%	89%
Full Immunization(0-1 yr)	24.8%	49.2%	72%

Constraints & suggestions

- Shortage of MBBS doctors- community preference to Allopathic doctors and high staff attrition rate

- Long delay in releasing the Grants, 5-6 months, Inadequate supply of drugs, equipments & infrastructure

- Corruption at State/Dist/Block level in procurement & constructions

- 10% contribution from NGOs- there should be 100% grant

- Lack of physical security for staff – underground militants in some PHCs.

- Lack of security among NGO staff regarding their future in the PHC in terms of permanency of their appointment (unlike NHM staff)

- Unrealistic expectations- community, public leaders and officials (cardiac surgery, orthopedics, etc.)

- Govt should give service benefit (for PG) to the MBBS doctors if they work in NGO run PHCs.

- Govt can depute MBBS doctors in NGO run PHCs to overcome this problem. MBBS doctors prefer appointment from NHM, but not from NGOs.

- Hard area allowances to Medical & paramedical staff who stay in remote PHCs/SCs

Conclusion

The main problem was the non functioning of remote PHCs. Karuna Trust's non for profit comprehensive PPP model could show the result in those non functioning PHCs by making them functional at 24X7 pattern.

KT is managing only the non functioning/non performing PHCs. All of them have now become not only a curative health centre- they have become a community Hub where community come & discuss all the developmental Issues.

Through the community participation process, we have made the model in such a way that it is acceptable to the local communities.

This model is a replicable one. We have scaled up this model from Karnataka to Arunachal, then in Meghalaya, Manipur, Orissa and now started in Rajasthan.

Non for profit organization with zeal to serve the indigenous community can only work in those remote areas.

Journey continues……

Questions and answers

Q: Are we trying to say that by introducing privatization, we are setting an example that the government is not able to handle? And, by private I mean non-profit.

A: *Dr. Sudarshan:* Our motto is to reach the unreached. The challenge is to see if the government is able to manage. Let's be clear that 50% of the PHCs are doing very well and we have solid foundation of comprehensive community health care. Government of India has accepted Alma Ata Declaration. We are implementing that programme. North East is difficult where they are, but in Karnataka, Tamil Nadu and Gujarat it's fairly good now. PHCs are functioning well. So the areas where the government is unable to function due to various reasons, we build partnerships with them and help them to build up public health system.

We have not taken over a PHC. It has happened in Manipur PHCs, that whenever the government says we are ready to take over, we hand them over. It has happened in 3 to 4 PHCs but majority in MOU have asked us to continue. Also, I would like to say that there are good people in the government, when we talked about Arshad. The chief minister said that we could continue and today, we established the brand of Karuna Trust. We have not paid a single paise bribe and we get the government grants. Overall Karuna Trust receives 75% funds from the government and partly from other programmes also included in it. It's 90% in the PHCs and we have not paid a single paise bribe. We take the health infrastructure i.e. land, building and equipment, and the human resources are given a choice to continue in this one deputation and if they are not willing to continue with us, they are sent or transferred to the vacant positions and we again recruit the staff.

One more point I would like to add here is that, in Arunachal Pradesh, district level review meeting was organized in our PHC. All the district officials, doctors and all the para-medical staff came to review with CMHO and they reviewed the entire district's performance. They prepared the District Performance Report. So, it's learning for them also, as we have made some innovations, in their PHC.

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Strengthening of CEmONC unit through a unique PPP model at CHC Jabugam, Chhota Udepur District, Gujarat

Deepak Foundation & Government of Gujarat

About Deepak Foundation

Objectives

❖ **Promoting practices for safe motherhood and child survival**

❖ **Making available health and pre-school education services**

❖ **Ensuring sustainable livelihood for under-privileged and marginalized communities**

❖ **Providing effective disaster relief and rehabilitation services**

Location of Best Practice: Chhota Udepur District, Gujarat
(Erstwhile Tribal Blocks of Vadodara District)

Main Tribes : Rathwas, Bhil, Bhilala, Kolis, Naiks

Problem and Problem Statement

Deepak Foundation

Problem:

High Maternal & Infant Mortality in Tribal Areas of Vadodara District

MMR: 452 per 100000 LB; IMR: 55 per 1000 LB

(Baseline Survey, 2005)

Problem Statement:

High rates of Maternal and Infant Mortality due to unavailability of quality maternal and child health services in the tribal areas

Goals: Safe Motherhood and Child Survival Project-PPP Project (2005-2011)

❖ ⬆ **Institutional deliveries to >80%**

❖ ⬇ **MMR to < 100 /100,000 live births**

❖ ⬇ **IMR to < 30 /1,000 live births**

In line with
MDGs: IMR - 2/3rds, MMR -75%,
NRHM : IMR<30, MMR<100,
Guj. State Pop. Policy : IMR<16, MMR <100

CEmONC: Part of Package of Intervention of SMCS Project

Deepak Foundation

Behavior Change Communication

Emergency Transport Facility

Strengthening govt. health facilities

Capacity Building of Frontline Health Functionaries

Web-enabled Computerized Management System

Structures for Community Monitoring & Decentralized Health Plan

Process of Strengthening CEmONC

- Facility Gap Assessment and Planning

- MOU with DOHFW, GOG

- Infrastructure Development as CEmONC (Pre-existing upgraded PHC)

- Human Resource Deployment & Skills Building

- Stakeholder Sensitization & Engagement – Grassroots connect with help of Village Level Health Volunteers (ASHA), Village Health Committees, community gatekeepers

- Complete control over Operations & Management – local liaison with Govt. Superintendent, BHO

- Review of Performance Indicators– Monthly (DF) and Quarterly (GOG) – COH, RDD, CDHO, BHO, Civil Surgeon

Services Offered at CEMONC (24X7)

Comprehensive care providing broad spectrum of preventive, promotive and curative services

- Round the clock emergencies addressed by trained obstetrician & staff nurses
- Planned and emergency surgeries
- Paediatric care, newborn stabilization
- Blood storage (with CHC) & Blood transfusion
- Laboratory and imaging services (A shared resource with CHC)
- Iron sucrose administration for severely anaemic women

Services Offered at CEMONC (24X7)

Deepak Foundation

Coordinated with other care providers:

Forward linkages with Help Desk at District Hospital (another PPP initiative with H&FWD catering to maternal and child health referrals)

Backward linkages with peripheral health facilities through ASHAs

Free ambulance, waiting facility for relatives / attendants, drop back services (*Khilkhilahat*)

Mamta Ghar – Birth waiting home (A H&FWD, GoG initiative)

Services Offered

Deepak Foundation

People centric services:

Post-partum counselling and follow-up

Integrated Counselling and Testing facilities for HIV with GSACS

Kangaroo Mother Care (KMC) corner, Adolescent Reproductive and Sexual Health (ARSH) clinic

Accessible to poor communities:

Free of cost services

Available within the radius of 40 km for tribal poor

Periodic health camps at community level

Gynec Care

OT

Counselling

Pediatric Care

Laboratory & Pharmacy

Khilkhilahat Services

Delivery System:
Resource Sharing at CHC-CEmONC

Government of Gujarat

Deepak Foundation

CHC

CEmONC

Shared resources

General Patients

JSSK

**Registration
Blood Storage
Laboratory
Pharmacist
Nurses/ MO
Ambulance
Service**

**O & G
Newborn
Counseling
Mamta Ghar
Hospital
Admin.**

Post	Sanctioned in MoU (2015-17)	In-position
Gynaecologist	2	2
Pediatrician	1	0
Medical Officer	2	3
Nurses (OT & Staff nurses)	17	14
Hospital Administrator	1	1
MIS Officer	1	1
Accounts & Admn. Officer	1	1
Pharmacist	2	1
LabTech	3	4
F.P. Counsellor	1	2
Computer Operator	1	3
Support Staff	12	14
Driver	2	2
Total Staff	46	48

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Coverage Area

Deepak Foundation

Blocks	2013-14	2014-15
Chhota udepur	83	16
Sankheda	57	19
Naswadi	28	9
Pavi jetpur	26	17
Madhya Pradesh	19	3
Kawant	18	6
Panchmahal	10	5

Nearly 9 Lakh pop.
6 Tribal Blocks

Panchmahal

Jambughoda (5)
18 Km

Pavi Jetpur (17)
18 Km

Chhota udepur (16)
Km

Alirajpur (3)
92 Km

Madhya Pradesh

CH=CHC Jetpur
25 Km

Sankheda (19)

54 Km

Kawant (6)

32 Km

Naswadi (9)

Results : Type of Cases

Deepak Foundation

Legend: ANC — PNC — Gynaec — Pediatric cases

Data points (ANC, blue): 1666, 3039, 6993, 9122, 12974, 13916, 14971, 16866, 17062

Data points (PNC, red): 127, 268, 757, 894, 1639, 1907, 1903, 1890, 1540

Data points (Gynaec, green): 1919, 1583, 3428, 5472, 7058, 7119, 6344, 6304, 6250

Data points (Pediatric cases, purple): 924, 1089, 1614, 949, 716, 1902, 9079, 10750

Years: 2006-07, 2007-08, 2008-09, 2009-10, 2010-11, 2011-12, 2012-13, 2013-14, 2014-15

Results: No. of OPDs

Deepak Foundation

3312 · 5814 · 12267 · 17102 · 22620 · 23658 · 25233 · 34139 · 35602

SMCS Project ended

In-house Pediatrician

2006-07 2007-08 2008-09 2009-10 2010-11 2011-12 2012-13 2013-14 2014-15

Results: Type of Cases

Deepak Foundation

2012-13 N=25233
Pediatric cases (8%)
Gynec (25%)
ANC (59%)
PNC (8%)

2013-14 N=34139
Pediatric cases (27%)
Gynec (18%)
ANC (49%)
PNC (6%)

2014-15 N=35602
Pediatrics cases (30%)
Gynec (18%)
ANC (48%)
PNC (4%)
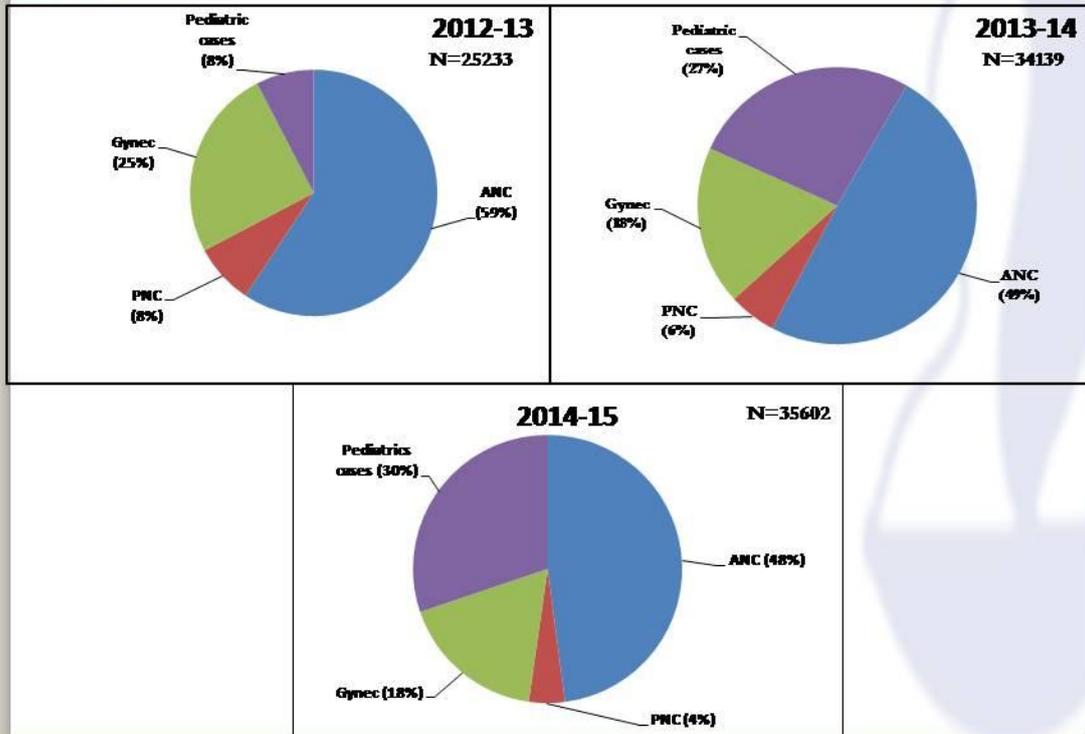
Blood Transfusions
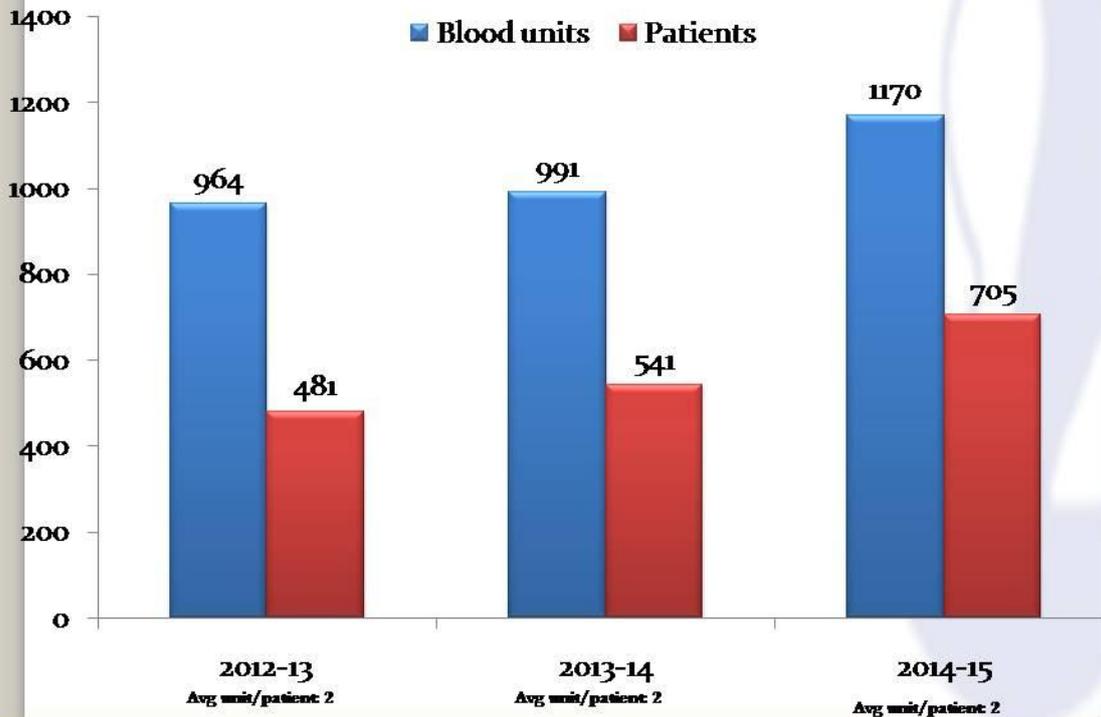
Results: % High Risk Deliveries
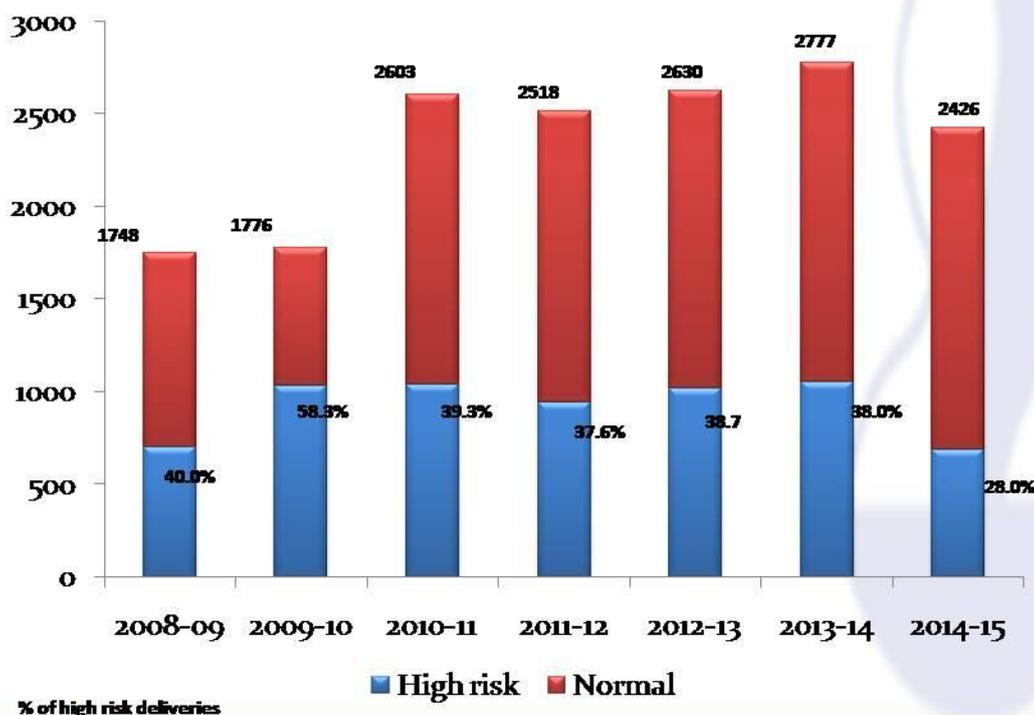
% of C- sections

	201	666	1748	1776	2603	2518	2630	2777	2426
C-Section	0	4.4	5.9	6.6	8.6	11.8	11.2	10.9	11.4
Normal	100	95.6	94.1	93.4	91.4	88.2	88.8	89.1	88.6
	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15

■ Normal ■ C-Section

Deliveries Conducted

No. of deliveries by CHCs in Chhota Udepur (2014-15)

CHCs in Blocks	Deliveries
Chhota Udepur	1067
Zoz (Chhota Udepur)	278
Sankheda	106
Golagamdi (Sankheda)	0
Naswadi	517
Pavi Jetpur	37
Kawant	926
	2426
Jabugam (Pavi Jetpur)	(45%)
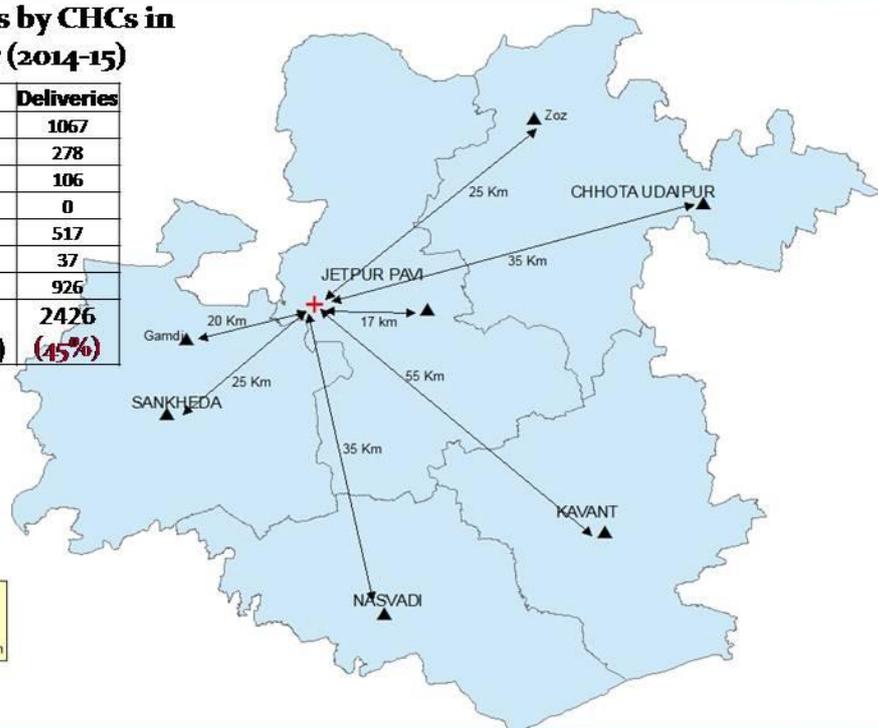
Legend
▲ CHC (8)
✚ CEmONC, Jabugam

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Major and Minor Surgeries

Type of Surgeries	2010–11	2011–12	2012–13	2013–14	2014–15	Total
VH	180	205	145	104	57	691
TL	11	53	118	161	107	450
D & E	45	73	33	37	25	213
MTP		7	22	44	39	112
TAH	50	14	8	10	6	88
Cervical Encirclage	13	4	5	8	4	34
D & C	1	0	13	8		22
Cervical Tears. Sutured	4	0			4	8
Myomectomy	0	2	0		2	4
NDVH	1	0	2			3
Resuturing	1	0	0	0	0	1
Other	2	11	17	12	11	53
Total	308	369	363	384	255	1679

Impact

Broad Estimate of Annual Savings among those who sought services from the CEmONC
Average Saving per Year : Rs. 27,810,620

	Services	Amount Saved (Rs)		
		2012-13	2013-14	2014–15
1	OPDs	11,55,990	15,96,370	16,37,000
2	Delivery	237,20,000	248,54,000	219,68,000
3	Gynec. Surgeries	31,11,000	29,47,750	24,41,750
	Total	279,86,990	293,98,120	260,46,750

Calculation made based on average cost in Chhota Udepur district amongst Private doctors

Impact

Deepak Foundation

Maternal Mortality Ratio Declined
(100,000 live births)

4 Tribal Blocks

Maternal deaths reported=266 (2006-11)

41.8 % decreased

452 → 263

Total Live Births=77,677 (2006-11)

2006-07   2010-11
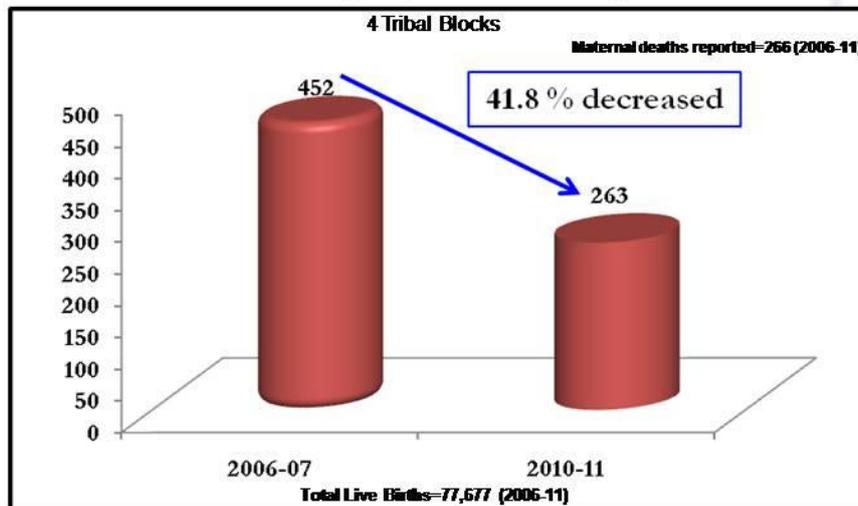
Population based measurements as part of MIS
No formal Impact Evaluation conducted
Post SMCS project – Lack of linkage with ASHAs and verification of
IMR and MMR data not feasible

Limitations

Deepak Foundation

- Inadequate staff at existing 4 BEmOC centres leading to unnecessary referral and high drainage of normal cases to CEmONC. Overstretching results in space constraints and expected quality of care
- Effective utilization of RKS funds
- Inability to strengthen paediatric services due to high turnover
- High level of nutritional anaemia in the area affecting the expected impact
- Stringent guidelines affecting availability of blood at storage units
- Poor basic services and facilities for relatives such as canteen, waiting shed and drinking water, toilets etc.
- Unavailability of residential facilities for staff of PPP models and non-eligibility of receiving performance incentives from government

Critical Conditions for Success

- Mutual trust and respect between govt.'s middle level functionaries and CSOs
- Effective leadership at both institutions towards shared goals
- Monthly meetings at facilities to establish linkages with grassroots health functionaries to strengthen postpartum care
- Consistent and quality services following Standard Operating Procedures
- Strong results framework with effective and transparent HMIS and measurement of data
- Monthly dissemination of performance indicators to stakeholders & opportunities for skills building of hospital staff
- Maintenance of systems for hygiene & sanitation
- Continuous engagement of partners
- Engagement of private sector in operation and maintenance of the facility
- Introduction of pay for performance system for staff by private sector
- Regular contact with frontline grassroots functionaries

Conclusion

- CEmONC is one of a unique and innovative PPP model that not only achieves the goals of Universal health Coverage but also has a ripple effect in improving utilization of government health services.
- The engagement in the model for nearly a decade has helped in setting systems and procedures that could be utilized for quick and assured results and hence it can be easily replicated in other tribal areas.
- The model also provides opportunity for shared resources and partnerships between government, corporate partners and engagement of Civil Society Organization to achieve the goals of MDGs and SDGs.

Thank You!!

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Questions and answers

Q: *Dr. Yogesh:* In how many CHCs of entire Gujarat do you have emergencies being done? In how many FRUs of Gujarat would you have emergencies and everything done?

A: Around 69 out of 100. What we have done is we have reinvented the process. We had earlier designated 61 centres as FRU, now we are in the process of revaluing the entire FRU process. And, we have mapped the FRU, within the 50kms or 60kms of travel distance, looking at the conditions and 1 hour travelling. Now we have come down to 101 FRUs. And there, we have started up the place. Plus, we have got a society called Gujarat Social Development Society. All this receives the CSR of the other public sector units of Gujarat government. And, there we have flexibility of paying high salary market rate to gynaecologist and paediatrician. And you will be surprised that we have 7-8 gynaecologist and paediatrician for tribal areas where they are being paid, 1.2-1.5 lakhs. We placed gynaecologist, paediatrician, and anaesthetist. In the last 5 months there the delivery rate has gone from 40 to 100.

Chairpersons' questions and comments

Dr. Abhay Bang

We just now heard two successful examples of Public Private Partnership. I have had the misfortune of being a partner, 30 years ago, of probably the first Public Private Partnership model in the health sector in India, which miserably failed. In 1986, we started with the Government of Maharashtra, a PPP partnership in Gadchiroli. Didn't work. However, we now have better processes and better understanding. SEWA Rural and Karuna Trust are two successful examples. Especially what they did in North East is simply amazing.

Regarding this practice of Deepak Foundation and Gujarat Government – there are several reasons maybe that some of these partnerships, though they are still very few, are successful.

One, what was the political and administrative support mechanism? Without that nothing would happen. I do not know how each one of you managed.

Secondly, there has to be a clear cut policy, between the state and the NGO or whosoever is the other partner. There has to be a principle of parity. Otherwise the power is very unequally distributed, between the state and the partner.

Third, it is the leadership on both sides – their personalities, their values, and their principles enormously matter. That's why such examples still remain rare examples. Both the leaders, from Government side and from civil society side, should be really sincere, mature and oriented towards certain values. That's very essential.

Fourth, there should be a very clear cut understanding of goal. Both of them should share the same goals. If there is a hidden agenda then there are going to be serious problems and often there are hidden agendas.

Then obviously, in the successes of all these projects there might have been a lot of processes which they didn't have time to describe in great details. But, it is those processes, and the values and principles behind those, succeed. It's not an easy model. It's not such a quick shot, *ki ek* antibiotic *de diya aur* pneumonia *thik ho gaya.* It's a complex difficult model, especially this is value and process oriented model that must be paid attention to. Monitoring, management and finances can be difficult. I was part of some committee of Government of India. They were shaping policy on NGOs. Government was not able to get medical officers in PHC, so they said that, those PHCs where we don't get medical officers the NGO should take it up. But, our PHC medical officer would get Rs 40,000 salary. NGO PHC medical officer will get just Rs 25,000. So, it's a funny that when it comes out to giving the role to NGOs the financial norms change. Financial parity is essential.

Now, I have two questions or doubts about this model. It seems what we are seeing are the examples that either institutionally or functionally, Government system seems to be inadequate in delivering the services in some settings, and so, they are outsourcing the work. But in this PPP model where are the "people"? This is partnership usually between the Government and NGO. Usually people are not represented in this. Can we add the 4th P in this? "PPPP" model. Public People Private Partnership. We talk of community based monitoring. We would be probably in the best position, to involve people in this partnership. All the benefits that we saw of community based monitoring, knowing the need, the demand generation, all those should be brought into this by bringing in the People in the partnership. Secondly, this model is especially tried in tribal areas. It is a good example that things can happen and can be made to work. But, usually tribal people are powerless, in the current

administrative political structure. Opportunistic individuals or organisations grab such institutions. This happened in Maharashtra in the case of the educational institutions and the Ashramshalas. Many of these NGOs are not NGOs like Karuna Trust, or SEWA Rural or Deepak Foundation. So these kind of NGOs can hijack the whole institution, Government budget and agenda, and can lead to a miserable situation. And, the people will have no opportunity to defend themselves, because politically they don't stand anywhere.

Next question, this model again will be very easily applicable to the CSR. And, the coming years there will be partnerships between Government and the Corporate sector, but will the goals match? Will there be community accountability? So, with the CSR money, I am sure the corporate sector will join the PPP model. Maybe even with good intention, but some of them may have hidden agenda as well. So, we need to take care that there is a clarity in values, goal and accountability. There is definitely potential to this model. But then it also depends on, as I said, Leadership, the principles and values and the processes.

Dr. Yogesh

In Chhattisgarh there have been 2 unsuccessful PPP attempts. One was outsourcing of laboratories, of all the PHCs, CHCs and district hospitals. They would in fact request for proposals and send to everyone. One was able to prevent that from happening, because it was done on a very unfair contract basis. And the other was running Mobile Medical Units in South Chattisgarh, which also failed miserably.

Can we develop better guidelines for PPP? What are the things that should not happen when PPP is planned? If such a document is also prepared we would know what is the wrong and the right thing to do, and that would make it strong.

Dr. Abhay Bang

The 3 NGOs who did it successfully, together if they can join hands and prepare one such draft document it will be very useful because you have done something which has succeeded. You also know what the pitfalls are.

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Jamsetji Nusserwanji Tata

Bipin Rawat
Corporate Social Responsibility
Tata Steel

Maternal And Newborn Survival Initiative

Operational Areas
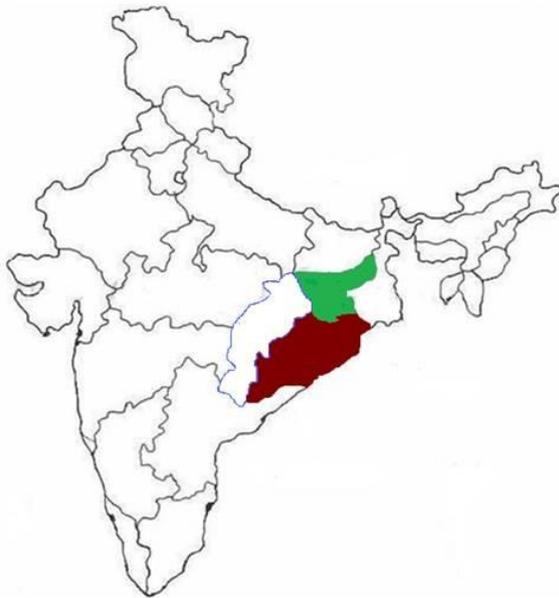
Jharkhand	
Steel Works	Jamshedpur, East Singhbhum
Collieries	Jharia, Dhanbad West Bokaro, Ramgarh
Iron Ore Mines	Noamundi, West Singhbhum
Odisha	
Iron Ore and Manganese Mines	Joda, Keonjhar Malda, Sundergarh
Chromite Mines	Sukinda, Jajpur
Ferro Chrome Plant	Bamnipal, Keonjhar
Green Field Plants	Kalinganagar, Jajpur Gopalpur, Ganjam
Dolomite Quarry	Gomardih, Sundergarh

Corporate Social Responsibility
TATA STEEL

Create a Favourable Social Environment to Enable Business

Delivery Arms

Impacting a million lives by improving the socio-economic status of the community

Engaging Communities

Disaster Relief · Education · Ethnicity · Livelihood · Health · Sports · HDI · Environment

Improving Quality of life

Infrastructure Development

1. Corporate Social Responsibility
   - Tata Steel Rural Development Society (TSRDS)
   - Tribal Cultural Society (TCS)
   - Tata Steel Family Initiatives Foundation (TSFIF)
   - Tata Steel Skill Development Society (TSSDS)
   - Urban Services
2. Medical Services
3. Sports Department
4. Tata Steel Adventure Foundation
5. Jamshedpur Utilities and Service Company (JUSCO)
6. Other Societies (Ardeshir Dalal Memorial Hospital, Blood Bank, Kantilal Gandhi Memorial Hospital, etc)
7. Tata Relief Committee

Area of MANSI Project
Geography

Area - 167 villages
Population - 80000
Project Duration - Dec 09 – Nov 14

Jharkhand State

India

Zone 1
Zone 2
Zone 3
Zone 4

Seraikela Block

Seraikela-Kharsawan District
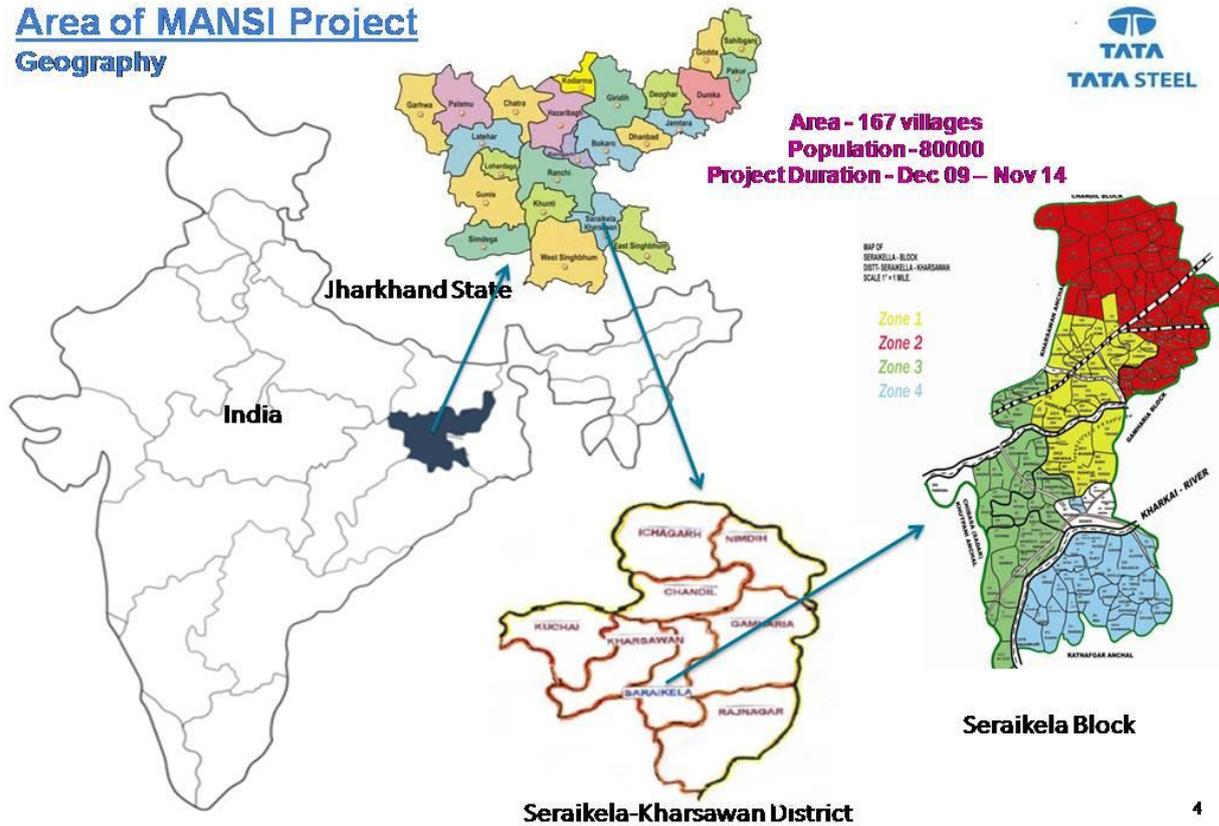
Local Tribes

- Total Population of Seraikela Block: 80000 (approx.)

- Total population of scheduled tribes in Seraikela block: 40000 (around 50% ST population: Source: Census 2011)

- Main Tribes: Santhal, Ho, Oraon, Munda, Bhumij

Inception of MANSI Project in Jharkhand

TATA
TATA STEEL

- Tata Steel and American India Foundation (AIF) collaborated for pilot project in Seraikela
- Initial findings of secondary data from the project MIS shows 390 child births from July – December 2010
- 24 deaths recorded – 23 neonate deaths (first 28 days of life) or 96%

Causes of Neonatal Deaths

Cause	No. of deaths	Cumulative %
Weak due to LBW/PT	7	30%
Pneumonia/Infection	6	57%
Asphyxia/Prolonged delivery	6	83%
Birth deformity	2	91%
Unknown	2	100%

☐ No. of Deaths
▲ Cumulative %
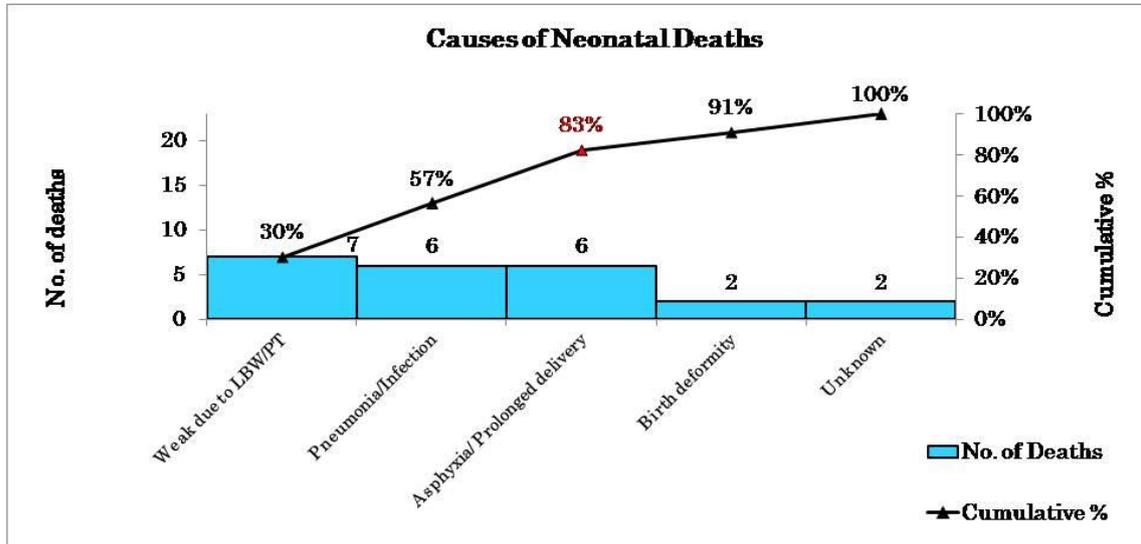
6

Inception of MANSI Project in Jharkhand
Root Causes

TATA
TATA STEEL

LBW/PT*

Lack of quality Ante Natal Check-up (ANC)

Lack of awareness about care during pregnancy

Poor maternal health

Poor infrastructure for treatment

Untrained service provider at village level

Delivery by untrained Traditional Birth Attendant (TBA)

Less institutional delivery

Neonatal death

Pneumonia/ Infection*

Asphyxia/Prolonged delivery*
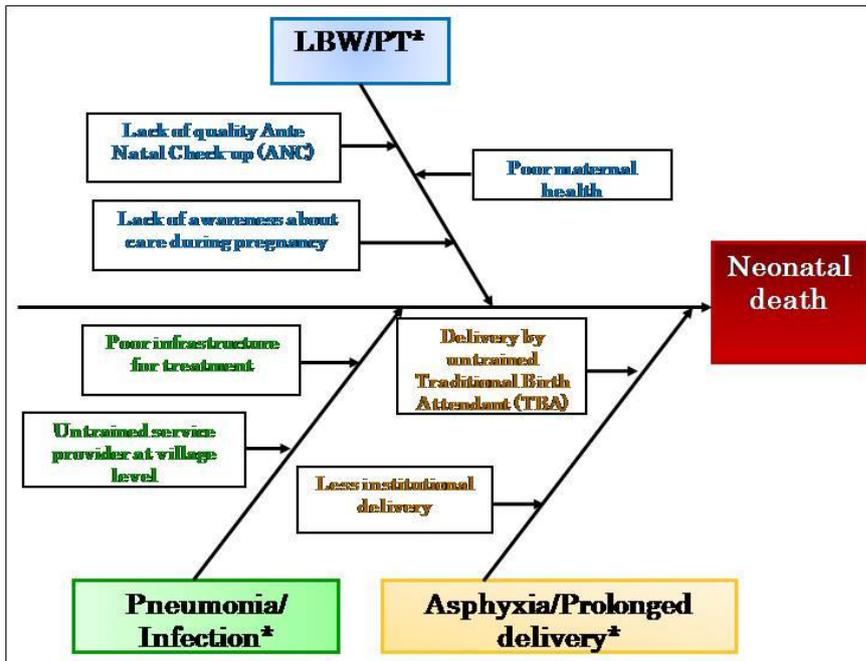
Problem Statement

High number of deaths of newborn babies within the first month of life occurs during pre-birth, delivery and post-birth stages, most of which are preventable deaths.

*Source: Lawn, Joy E., Simon Cousens and Jelka Zupan, '4 million neonatal deaths; When? Where? Why?', The Lancet, vol. 365, no. 9462, 5 March 2005, p. 895.

7

Planning for MANSI Project in Jharkhand
Partnership

Part Funding, Co-ordination, Development Sector Expertise

Ground Knowledge of Communities, Local Resources, Committed Workforce, Project Implementation

Technical Know-how, Consultancy

Administrative Support, Permissions

Project Goal: To reduce neonatal and infant mortality in Seraikela block of Jharkhand by facilitating improved implementation of Home Based Newborn Care (HBNC) through the existing govt health machinery at village level (Sahiyas) in a Public Private Partnership (PPP) mode and strengthen the public health system

8

Project Manpower Structure

- Tata Steel personnel
- AIF personnel
- Project MANSI personnel
- ZC – Zonal Coordinator
- MNHM – Maternal and Newborn Health Mobilizer
- M&E – Monitoring and Evaluation
- Sahiya – Village volunteer (otherwise called ASHA in other states)

Zone 1 - ZC	Zone 2 - ZC	Zone 3 - ZC	Zone 4 - ZC
MNHM - 5	MNHM -4	MNHM - 5	MNHM - 5
Villages – 38	Villages – 46	Villages – 46	Villages – 37
Sahiya - 61	Sahiya - 46	Sahiya - 47	Sahiya -43

9

Project Implementation

Training of frontline health workers – Sahiyas (part of Government health worker system at village level): adopted system of Training of Trainers at SEARCH – enable systemic capacity to further pass on training

Closely monitored handholding and supervision

Equipment, medicine and resource material: as per SEARCH package following the government guidelines

Management Information System: paper based tracking and management – following same as SEARCH

10

Project Monitoring and Supervision

Frequency	Tool	Level	Type of Data
Daily	Checklist Supervision format	MNHMs Zonal Coordinators (ZCs)	Knowledge & skills of Sahiyyas Availability of resource material
Weekly	Community Meetings Review Meetings	MNHMs ZCs Field Coordinator (FC)	Knowledge and Attitude of community on MCH Supply status, high risk birth & pregnant women cases
Monthly	Monthly Progress Report Case Studies Monthly accomplishment and action plans Review Meeting	MNHMs ZCs FCs Monitoring & Evaluation Officer (M&EO)	Birth and Death details High Risk Cases Supply Status Major daily and weekly issues
Quarterly	Quarterly Progress Report	ME&O Project Manager Senior Management	Birth and Death details High Risk Cases Supply Status Project Activities Major monthly Issues
Annual	Annual Progress Report Vital Rate Survey	ME&O Project Manager Senior Management Partners (AIF, SEARCH, Govt of Jharkhand)	Birth and Death details High Risk Cases Supply Status Project Activities Major quarterly issue Analysis of vital rates

11

Tribal traditions and beliefs w.r.t mother and child health

TATA STEEL

Mother
- Less food during pregnancy
- No fish and egg during pregnancy
- Husband conducts delivery
- Use of coin for cord cutting

Newborn & infant
- Bathing immediately after birth
- No proper clothing
- Untouchability
- Dark room without ventilation

Superstitions
- Goat's milk instead of mother's milk
- use of three-face hot iron wire
- Goat faeces or dirt from the *khatiya* on the umbilicus
- *Birds or goat sacrifices* in case of neonatal and infant illness

- Delivery Complications
- Weak baby
- Undernourished women
- Infection
- Hypothermia

Sample Case Studies

TATA STEEL

Name of Sahiya	Category	Case managed	Name of Beneficiary	Category	Village
Priyanka Purty	ST	Low Birth Weight (2 kg) & Hypothermia	Sonam Purty	ST	Bundu
Surmi Purty	ST	Sepsis	Naguri Hembrom	ST	Jhilingburu
Surmi Purty	ST	Pneumonia	Laxmi Purty	ST	Jhilingburu
Sushma Gope	ST	Sepsis	Minir Gope	ST	Hathimara
Sumitra Soren	ST	Low Birth Weight (1 kg)	Kandri Soren	ST	Charakpathar
Jamuna Dango	ST	Hypothermia	Yashoa Gope	ST	Patahesal

Achievements
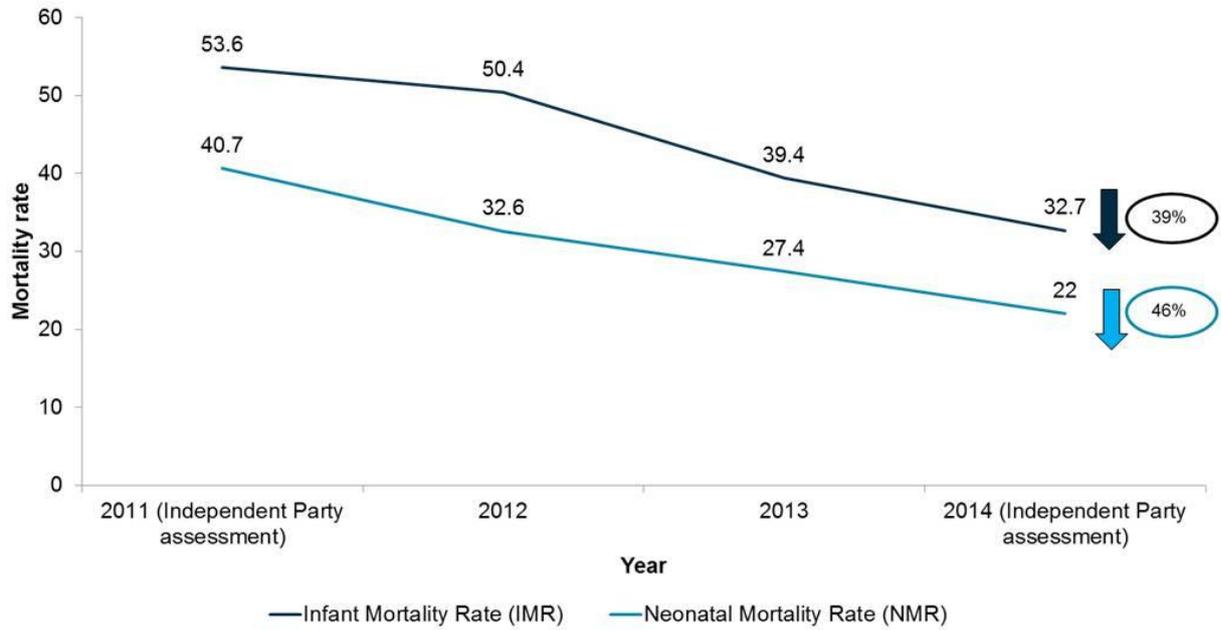
Project Cost

Total project cost	2,70,00,000
Total Birth (5 and 1/2 years)	9000
Cost per birth (Rs)	3000

New Horizon for MANSI Project in Jharkhand
Scale up in Jharkhand

Graduating in Jharkhand to higher level of intervention with new inputs in terms of technology and different level of implementation and monitoring

Entire Seraikela Kharswan district for a district level pilot
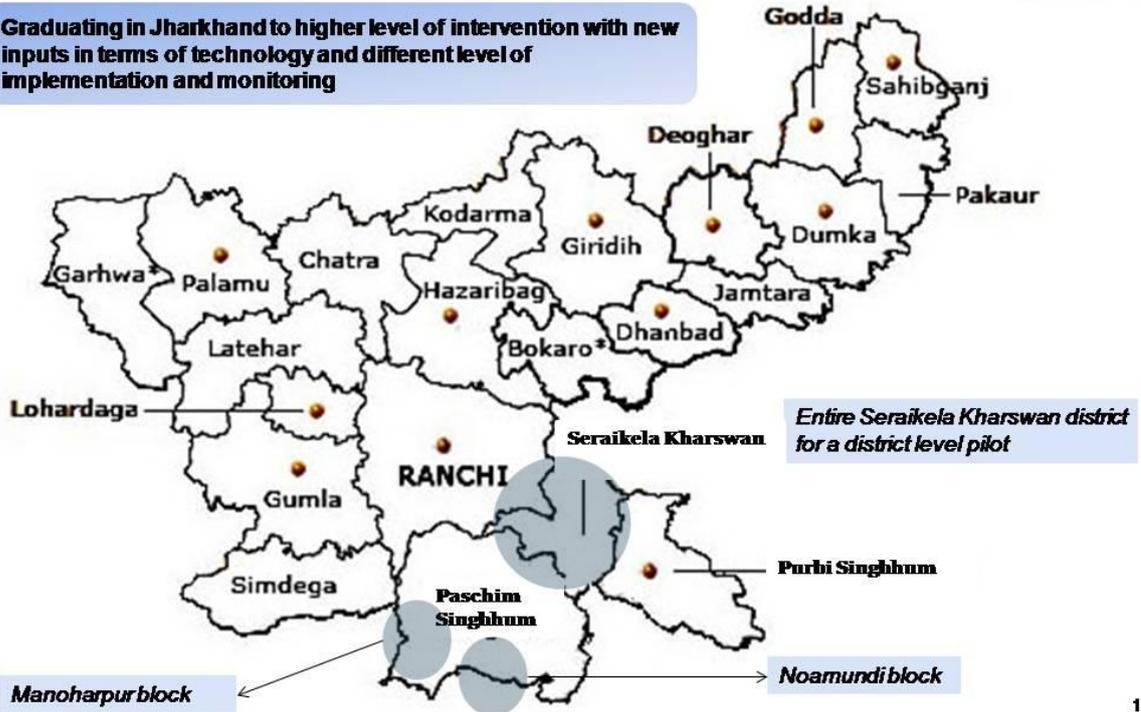
16

MANSI Project in Odisha
Geography

17

Semi-literate or even illiterate Sahiyas

Challenges in the supplies of equipment, medicines, consumables and other resource materials

Building relationships with various parts of changing government machinery at the Seraikela block and district levels

TATA
TATA STEEL

Thank You

Questions and answers

Q: *Dr. Rita:* Who did the supervision part of it?

A: This is the project management tree. Right down you will see the Zonal Coordinator. Those all were a part of our project team.

Q: Did you try to involve ANM?

A: Yes, our committee meetings, cluster meetings and the review meetings on project monitoring and supervision on a daily basis and on a weekly basis, would take place in the ground between ANMs and the Anganwadi *sewikas*. During surveys we did cross check between the *sewikas'* data and the ANM data as well.

A: *Dr. Abhay Bang*: In the ASHA programme, the ASHAs are to be supervised by the ASHA facilitator. Unfortunately, in Jharkhand, the decision to appoint ASHA facilitators and in turn their appointment was delayed. So, when MANSI project started they had to introduce their own field supervisors, called the MNHM. Later on, as a part of the NRHM, "*sahiya-saathin*", as they called the ASHA facilitators, were introduced. Then they became the supervisors of ASHAs.

Q: ASHAs and *Sahiya*'s are the same?

A: Yes.

Q: The incentives were paid by the Government?

A: Yes.

Q: For all the activities?

A: Yes.

Chairpersons' questions and comments

Dr. Abhay Bang

TSRDS has not paid a single paisa incentive money to ASHA. Actually, *Sahiya* started getting HBNC incentive from NRHM quite late, maybe in 2014. So, initial 3 years

they provided HBNCC service without getting any money. I would give, for this good coordination with the Government, credit partly to the TSRDS senior officers who had really mastered that art of relationship in a very sound way without any financial transaction or bribes. They had developed very good relationships with the leadership both at the district level and state level. Secondly, the NRHM Director, Aradhna Patnaik, a very dynamic young woman, came all the way here, saw the original SEARCH model and was absolutely convinced that she wanted to do this in Jharkhand. She gave them all possible support. With the Mission Director's support, the message gradually goes to the district also. I would give credit to these two, the State level leadership and the district level TSRDS leadership.

The Government already had the ASHA programme going on, and the MANSI project came in as a supplement. But the system needed additional supplements in the form of man power, technical support and some financial support; not directly to *sahiya* but in other forms. While replicating, obviously this additional support should be minimized. So it's a management challenge. Next challenge is obviously how to further do it on a larger scale.

MANSI was not conceived and implemented as a field trial. For any government department to have unserved control area would have been difficult, ethically and politically. So MANSI was a before-after study. It is a limitation for assessing the true effect of the interventions. But, one strength is that all the data on the NMR and IMR are of the entire area. And, it is not one time fluke. We can see that throughout the 4 years an uneven but continuous decline in the rates. Over the period of 4 years their NMR and IMR have declined annually by nearly 6 points. MANSI is a good example of when a government agency, a technical agency and a corporate agency collaborate. The Government has large outreach and expanse reaching out practically to every village which no one has. The corporate sector has local commitments, financial strength and management structure. The strength of these two may be complementary as we see in this project. However, keep in mind the other things which ought to match for a successful partnership – the values, goals, culture and the leadership.

14

Use of Mobile Phone Technology for Empowering ASHAs and PHC staff to Improve MNCH Services in tribal areas of Gujarat: A joint initiative of SEWA Rural and Department of Health and Family Welfare

Shrey Desai, MD, MPH

SEWA Rural

SEWA Rural A Voluntary Service Organisation
Providing Medical, Public health and Educational Services

Districts of Gujarat

Rural, Poor and Tribal (Vasava/Bhil tribe) Community of Bharuch and Naramda Dists. in South Gujarat, India where inadequate public health facility exists

SEWA Rural, Jhagadia

About SEWA Rural

A Voluntary Development Organization
Established in 1980 (Completing Three and half Decades)

- Inspiration: Swami Vivekananda and Gandhiji
- 150 bed hospital
- Comprehensive eye care program
- Health training center
- Skill development center
- Women development and empowerment activities
- Community outreach projects

Increasing health service utilization by ST population at SEWA Rural

Scheduled tribes patients
Non Scheduled tribe patient
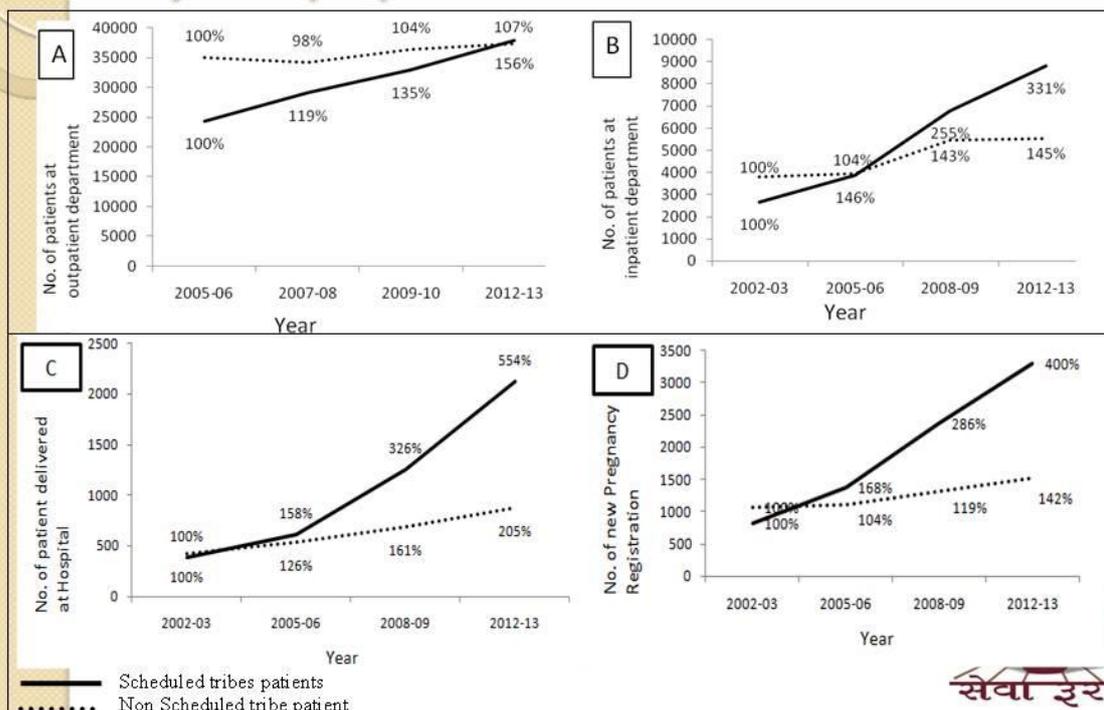
Reduction in MMR, NMR. Creation of cataract free tribal blocks

MMR in Jhagadia block (Population: 175,000)

Bar chart values:
- 2002-04: 544
- 2004-06: 227
- 2006-08: 241
- 2008-10: 153
- 2010-2012: 188
- 2012-2015: 64
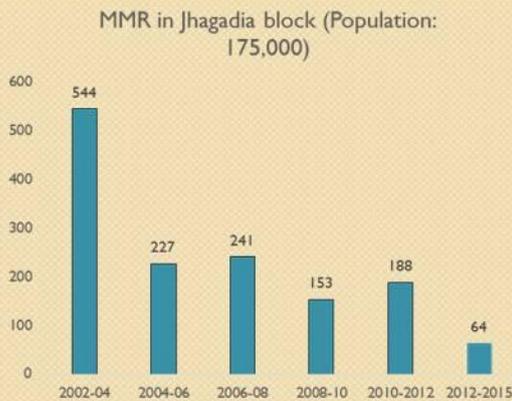
Research, advocacy and replication

Changing epidemiology of maternal mortality in rural India: time to reset strategies for MDG-5

Pankaj Shah[1], Shobha Shah[1], Raman V. Kutty[2] and Dhiren Modi[1]

1 Community Health Department, SEWA-Rural, Jhagadia, India
2 Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram, India

Abstract

OBJECTIVE To understand changes in epidemiology of maternal mortality in rural India in the context of increasing institutional deliveries and implementation of community-based interventions that can inform policies to reach MDG-5.

METHODS This study is a secondary analysis of prospectively collected community-based data of every pregnancy and its outcomes from 2002 to 2011 in a rural, tribal area of Gujarat, India as part of safe-motherhood programme implemented by voluntary organisation, SEWA Rural. The programme consisted of community-based interventions supported by a first referral unit, and

Softer impact: inspiration to peers, preserve ethical values and development of employees

---

Best practice: Intervention "ImTeCHO"
(Innovative mobile-phone Technology for Community Health Operations)

Initiative is in Partnership with Dept. Health, Govt. of Gujarat

"ImTeCHO is a platform based on mobile phone technology...

- to improve coverage of proven MNCH interventions......
- through improving performance of ASHAs and PHC staff......
- by ensuring effective support supervision and motivation....

Problem statement

Low coverage and quality of selected community based MNCH interventions to be delivered or facilitated by ASHAs and PHC staff (e.g: full ANC, SBA, HBNC, EBF, Initiation of CF, care seeking for pneumonia, diarrhea)

Ref: (1) Columbia University. Improving the performance of Accredited Social Health Activists in India. Working papers series, Mumbai, 2011

(2) National Health Systems Resource Centre (NHSRC) and National Rural Health Mission (NRHM). ASHA- Which way forward?, 2 New Delhi, 2011

Reasons are:

- Inadequate training/poor skills of ASHAs
- Insufficient motivation
- Inadequate Support, Supervision
- Irregular payment of incentives

ImTeCHO: Conceptual framework, hypothesis and goal

ImTeCHO (Input)

⬇

Better support, motivation, supervision to ASHAs and PHC staff(Output)

⬇

Better performance (output)

⬇

Increase in coverage of proven promotive and curative interventions (outcome)

⬇

Better health outcomes (Impact)

Continuum of care
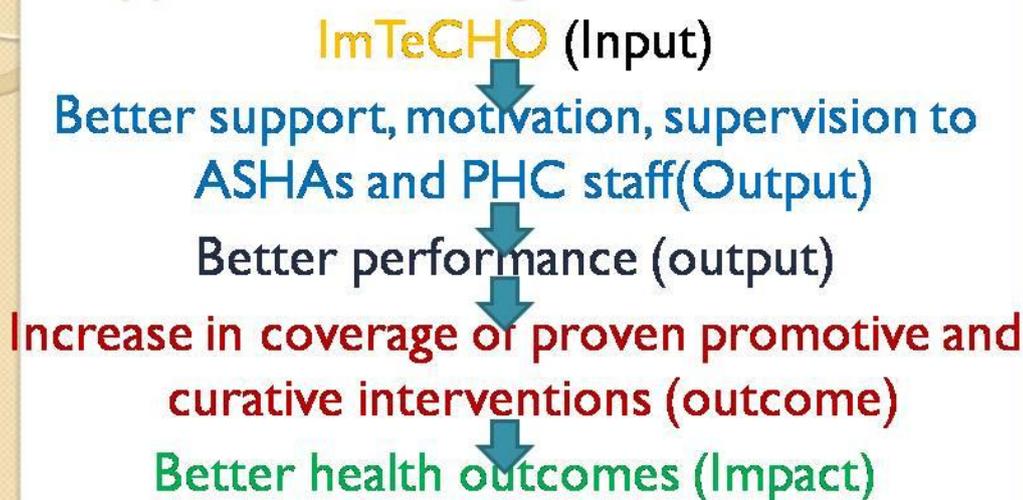
Ref: Dhiren Modi, Ravi Gopalan, Shobha Shah, Sethuraman Venkatraman, Gayatri Desai, Shrey Desai and Pankaj Shah. Development and formative evaluation of an innovative mHealth intervention for improving coverage of community- based maternal, newborn and child health services in rural areas of India. Glob Health Action 2015, 8: 26769.

"ImTeCHO"
(3 COMPONENTS)

Mobile phone as job aid to....

ASHAs for ensuring her routine MCH services

Mobile phone as a job aid to.....

ASHAs/FHWs/ Helpline for better morbidity management

Web interface at...

PHC level to provide timely and accurate information for better Support to ASHAs

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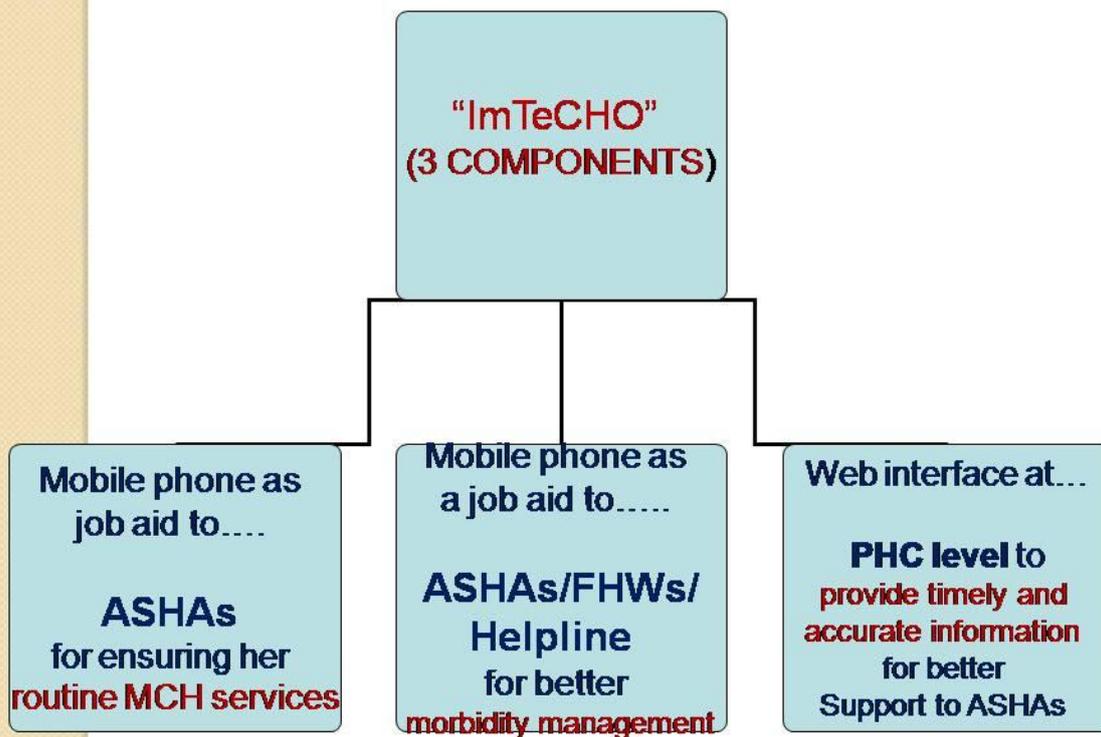
Intervention "ImTeCHO" = I am support

Supports ASHAs towards better
- Morbidity detection and management
- Scheduling tasks
- Health education (BCC) through video clips

Support PHC staff and higher level staff towards better
- Providing support and motivation to ASHAs (web based incentives and supply management tools etc)
- Support in Managing Critical Cases (Daily Alerts)
- Supervision and HR management (online performance reports)
- Reporting & HMIS

Support/Value creation for all involved in ASHA program

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Main Menu and Schedule Alerts for ASHA
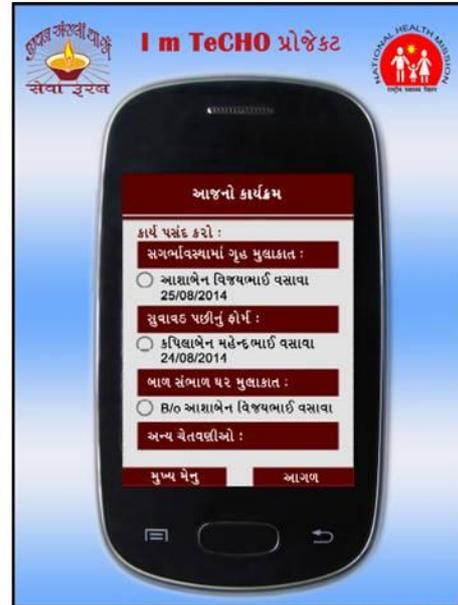
Tasks at VHNSD

Inbuilt Videos for Awareness
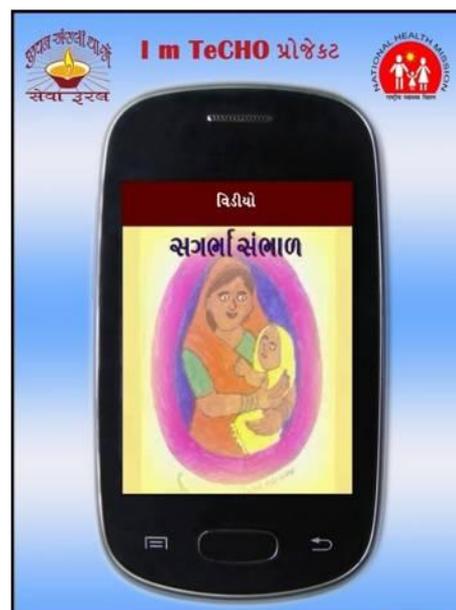
Automatic Diagnosis, Risk Screening and Treatment Protocol

Supervision and Support made Easy and Effective at PHC Level
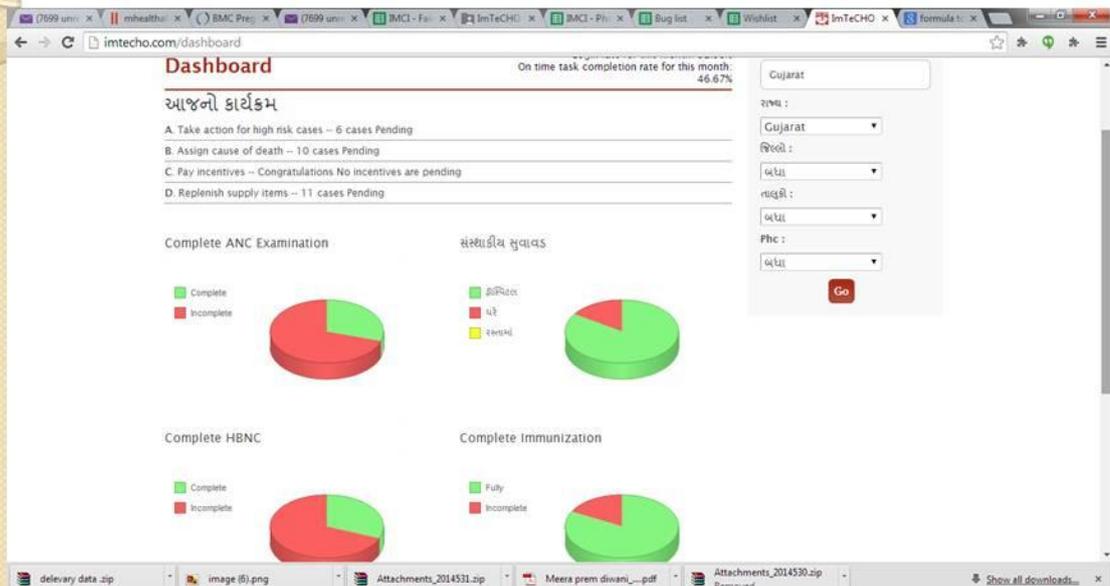
Implementation steps/delivery

- Training preparation/Checklists/Change management
- Training (3+4 days)
- On the job Mentoring & Certification (2-3 weeks remotely)
- Registration of all existing cases
- Ongoing technology support and adherence to intervention
- Well tested delivery model
- Adaptable in any language

GUJARAT DISTRICT MAP

Operational since May, 2013 Gradually Expanding in Bharuch, Valsad and Narmada districts, Gujarat (High Priority Blocks). 36,000 beneficiaries. 86,000 m-transactions.

May 2013

September 2014

March 2014 & Feb 2015
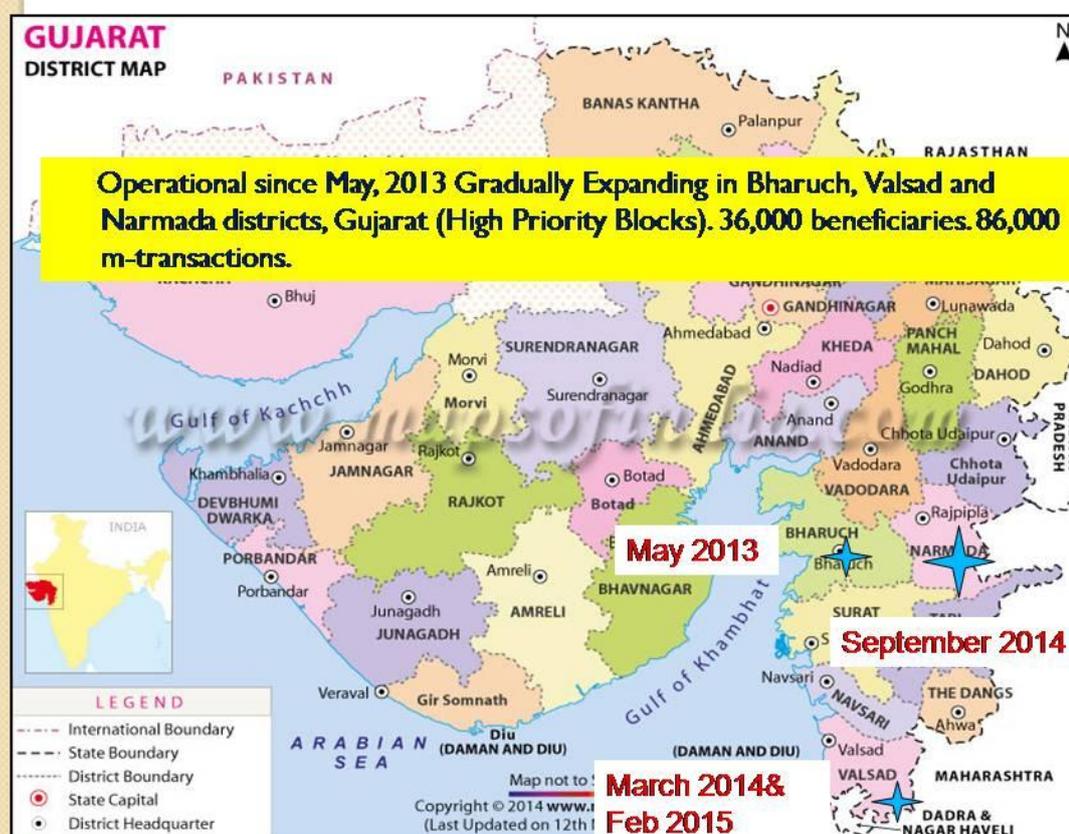
Formative evaluations

- Mixed methodology
- Used MRC's (UK) guidelines for step wise evaluation of complex intervention *
- Goal: (1) Assess acceptability, feasibility and usefulness of ImTeCHO (over all and component wise) among ASHAs (2) Identify barriers for delivery of intervention

Background: A new cadre of village-based frontline health workers, called Accredited Social Health Activists (ASHAs), was created in India. However, coverage of selected community-based maternal, newborn and child health (MNCH) services remains low.
Objective: This article describes the process of development and formative evaluation of a complex mHealth intervention (ImTeCHO) to increase the coverage of proven MNCH services in rural India by improving the performance of ASHAs.

Login Rate & Task Completion Rate of ASHAS (N=50)
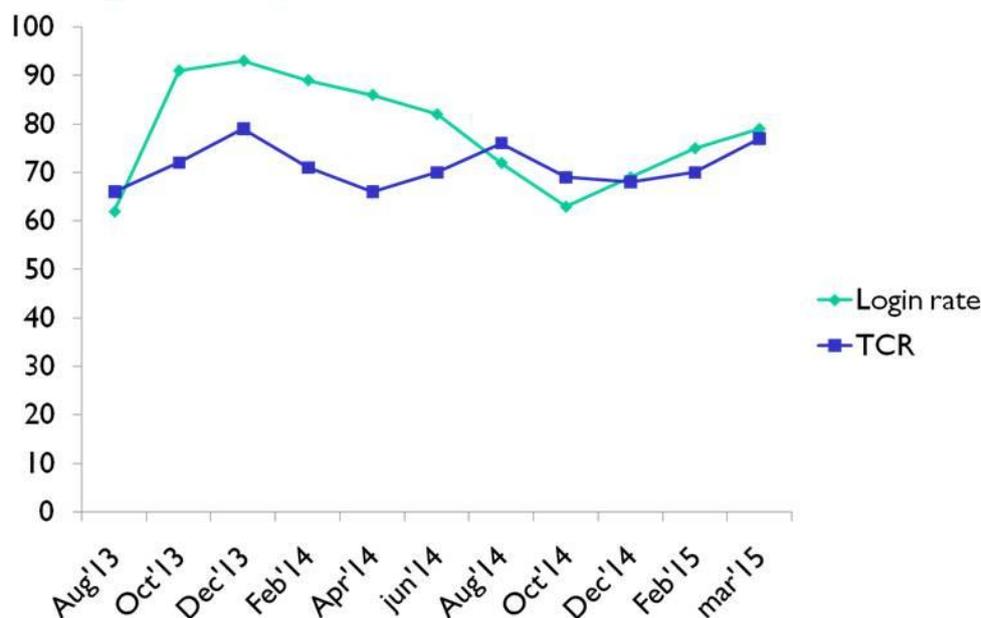
Medical officer login Rate and Task Completion Rate

ImTeCHO Login rate of Medical officers (n=2)
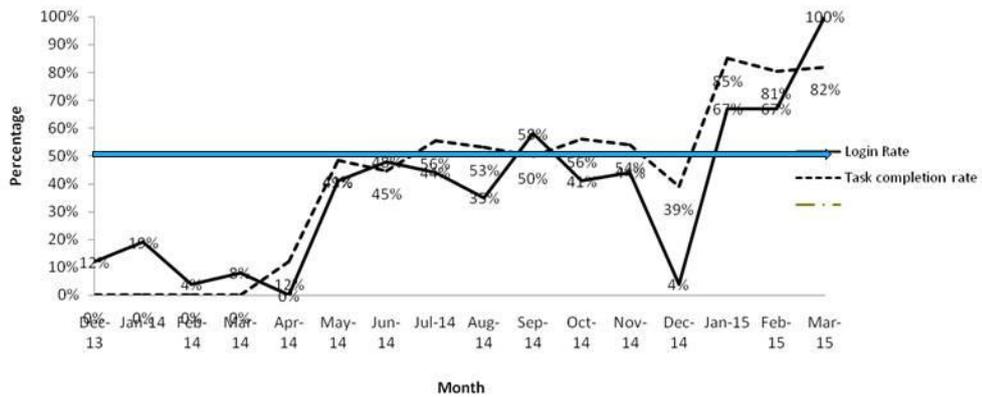
During Antenatal period (%)

During Delivery (%)

Legend: ImTeCHO, N=50 (green) | Control, N=49 (blue)

Category	ImTeCHO	Control
Institutional Delivery rate	78	71
ASHA visit within 24 hrs of delivery	84	69
Early Initiation of breast feeding	90	73
Satisfactory early newborn care	60	48

During PNC (%)

Legend: ImTeCHO, N=50 (green) | Control, N=49 (blue)

Category	ImTeCHO	Control
Asha visited at home within 24 hrs of reaching home	60	32
At least 2 home visits by Asha within first week of delivery	82	46
At least 5 home visit by asha within first month of delivery	40	2
Satisfactory PNC Counselling by ASHA	44	2
Checked Temprature	70	4
Checked Weight	92	34

Child 6 to 9 Months

Morbidities, Sought help from asha in (%)
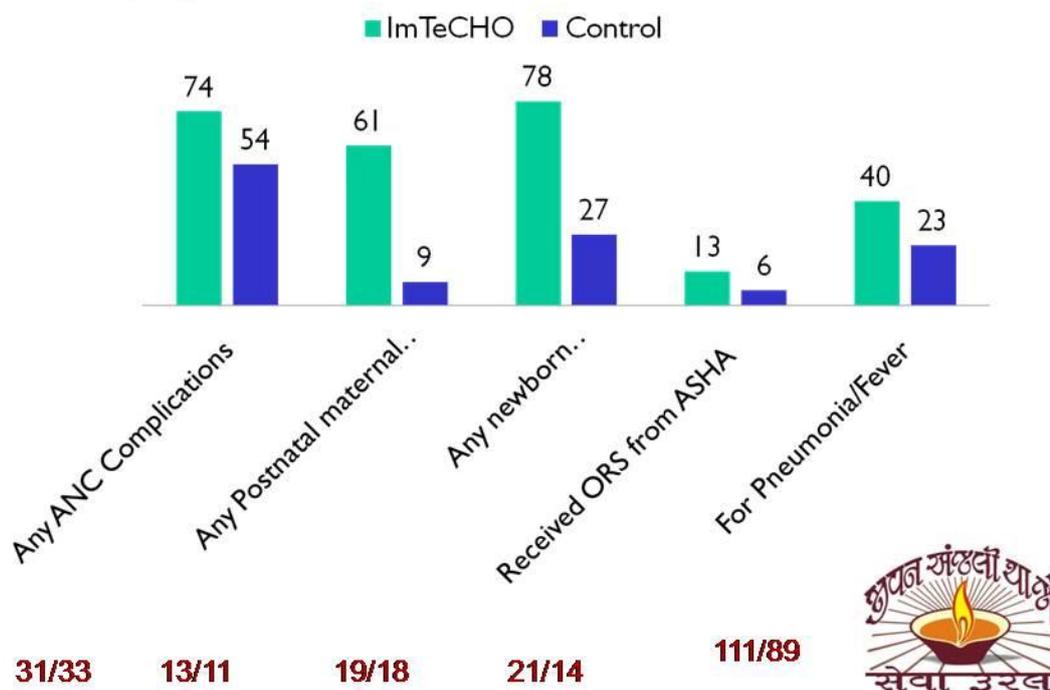
Future Scope of ImTeCHO

- Formal Implementation Research through Randomised Control Trial Covering 22 PHCs in Tribal area
- Gradual Expansion of this experiment of ImTeCHO to cover
  - Narmada and Bharuch Districts
  - Future Potential to Upscale in other High Priority Blocks in Gujarat
  - Support other NGOs interested in introducing Mobile Phone Technology
- Integrate other Health Programmes (FP, Malaria, TB, sickle cell, Chronic Diseases, etc..) on same Platform

Challenges

- Keeping Pace with Updations in ASHA Programme and Ensuring Appropriate Modifications in Software
- Change management and understand limitations of technology
- Resource intensive

Acknowledgements

- State Department of Health, Govt. of Gujarat
- Local Health Staff at PHC level and Health Officials at Block and Dist. Level
- Argusoft India Lts at Gandhinagar
- Jamsetji Tata Trust, Mumbai
- ICMR, New Delhi / WHO, Geneva
- Mac Arthur Foundation (USA)

THANKS FOR THIS OPPORTUNITY…..

Contact:
Shrey Desai
Cell: 09429109050
Email: sdesai1977@yahoo.com
Web: www.imtecho.com
www.sewarural.org

Watch ImTeCHO demo video:
https://www.youtube.com/watch?v=MBTL5d6BXbA

Questions and answers

Q: For the randomised control trial what's the primary outcome?

A: So, what is that one indicator which shows effect throughout the continuum of care – prenatal, intra-natal, and post-natal. So, studying literature we found something called as CCI – "Composite Coverage Index" – which is now used by 15-20 people. It gives a component indicator which looks into antenatal, intranatal period, 1 indicator in postnatal and few indicators in the 2 years of age or 5 years of age. These are vaccination rates, home based visitations, birth attendants, coverage, and so forth. They actually also add family planning into it, which is not spoken here. So, we consulted certain experts – the Biostatistician head, Dr. Pandey from AIIMS. We devised composite coverage index and got a modified ASHA centric composite coverage index. And we have validated that this is a SEWA Rural production totally. But, this is the primary indicator which is an index throughout the continuum of care. So, that is our primary indicator. One more primary indicator is the proportion of newborns visited at least 2 times at home, within 1st week of delivery. So, these are the two primary indicators.

Q: Why didn't you take IMR as primary outcome?

A: Looking at our data and at the situation in Gujarat, we thought that if we want to make 'mortality' in samples-wise it would be just huge and will not be manageable by us.

Q: *Dr. Abhay Bang:* Haven't you scaled it up to 22 PHCs?

A: At that level it was not coming out to be effective although we are measuring mortality. There are very good chances that there will be definite improvement but the power may or may not show the significance. This is again done more in the spirit of the implementation of research.

Q: Although the ultimate will be to reduce the IMR, it might take some time, I think two years, is a short time. So, you might not achieve IMR reduction in that time but the coverage would be good.

Q: What happens when ASHA sends information? What about training of ASHA for technology and how do you address the attrition of ASHA? How do you ensure the services delivered, rather than collecting information?

A: Medical Officer is supposed to do three things as soon as he/she gets a message:

Number 1 – contact the ANM and ASHA of that area, and tell them something serious is going on, and to do something if the medical officer cannot visit himself or herself

Number 2 – follow-up on that.

Number 3 – when the medical officer visits the next time, he/she has the list of all the high risk cases now in the mobile phone. So, rather than just doing blinded visits, just maybe focus on the high risk cases.

Number 4 – which is happening quite well actually. Monthly the medical officer gets information on the web interface, looks at the list and questions ANMs and ASHAs about the patients. And, once the action taken is completed there is a feature on web interface to be checked out.

Now, we have instances where the medical officer falsify the task and say the task is completed. We do not go after that, because as we've said our role is very well defined. We hope to take this up to a scale where SEWA Rural does not have any presence. But, there are certain limitations. The second thing is, ASHA's role is just to report and then the medical officer has to go into the village and do one more autopsy. When the medical officer gets into the web interface and there is a drop down, where he has to select one or more causes of death and then enter it. So, the cause of death is not ASHA's job. Cause of death assignment is medical officer's job. So, even though the Government may or may not inform us we get to know that there is something going on. We call up the particular ASHA and investigate. If she says she's no more working. We contact the PHC medical officer. If a new ASHA is recruited we again have to give that person training. So, that is how we manage the attrition part.

With regard to training, I don't know if we have found the best practice many of the ASHAs have been trained for PHC. The quality of training is a big concern. So, we do give them a three day quick refresher training, which does not substitute the original training, with the limited resources and the scope and nature of the work. We give a four day training for the mobile. But, what is important is that we do look at the outcome of training. So, at the end of mentoring period (1 month) we call them, we get the ASHAs back and along with government stuff we take their exam – repetition exam. We assess certain important things

like measuring weight, taking temperature etc. We cannot do justice for everything but important 5-6 points are checked and the certification will be accordingly provided.

As for how can we ensure that the service is being provided and even when data entry is not done. We do many things for that. During training, we emphasize that the purpose of this project is to provide service and not data entry. Mobile phone actually helps to do your job better. We make them realize it. ASHAs do understand at the end of seven days, that this does help me to provide services. Secondly, the ASHAs have to take a photograph of the '*Mamta* card' or the 'MCH card' from the mother, to ensure that she did visit the mother.

Thirdly, what we do is that technology helps you to count the duration of the visit. So, the detailed time between entering the form, exiting it and sending via GPRS, by the AHA, is recorded. We analyse if justice has been given, because it should at least it take 10-15 mins.

Number four, the best thing is GPRS. But, is it best for us to make ASHA accountable and not make other people accountable? I don't know. We can debate about it, but our heart said that is getting too far and too much. So, even though technological answer is GPRS, because of ideological regions we have covered it.

Chairperson's questions and comments

Dr. Neeru Singh

I just have one question. Do you think this kind of project is possible to adopt in a very primitive kind of situation, say in a tribal area of Jharkhand or a tribal area of Chhattisgarh?

A: That answer will be given only when it happens. We will not only look at acceptability or feasibility of health workers but also the beneficiaries who are the tribal wheel.

Dr. Abhay Bang

If we take an overview in the field of tribal health our search is for

1. How to provide services to tribal areas
2. How to empower the people
3. How to reduce the health problems, let's say infant mortality

In some practices presented here, like Home Based Newborn Care, these three questions are addressed, the ASHA is empowered to perform certain tasks that earlier were considered to be the domain of neonatologists or paediatrician. Similarly, in this project, the ImTecho, we saw how technology can further empower ASHA and the primary healthcare system, and make things happen which otherwise probably wouldn't have happened. Thus, the use of community health worker, use of technology for empowering the worker, (we saw earlier in the example from Kerala, how technology can be used in reporting of mother and child.) Then we also heard from Assam from Nazdeek, how community based reporting can reduce the violation or   adverse events. There's a continuity in all these presentations.

One of the key questions in tribal healthcare is how we provide care in the remote, inaccessible tribal village. That's a human resource question. Probably ASHA emerges as a very potential and powerful answer. But the barrier is…our mental barrier, "How can ASHA do all those difficult tasks?" We are getting evidence here. ASHA can do all those things, which we thought earlier that only doctors can do. The experts sitting in Delhi haven't yet let ASHA do what she can competently do. Asphyxia management, Sepsis management, Injection gentamycin, "No" they say. 1 crore *log har roz apne aapko insulin injection lagate hai*. Ordinary, untrained people. *Woh* safely *hota hai. Lekin hum ASHA ko nahi lagane denge*. So, these are all our mental barriers which probably we carry from the past; from our professional backgrounds. Doctors are the ultimate gods but gods don't want to get to tribal areas. What do you do? So, ASHA offers an enormous hope. Enable ASHA by way of training, by way of management support, by way of technological support – all these are potential answers to the original question, 'How to reach out to tribal areas?'

I feel very encouraged today that many of the presentations from morning till now have added very significant pieces of evidence to our search, of 'How can services be provided in the tribal areas?' 'How can people and community health worker be empowered to perform complex task?' 'How can management be performed in a better fashion?' This session and the earlier sessions, attempted answers to the questions which the expert group on tribal health, and all of us as a community, are trying to search for. We are receiving some glimpses of the answers. Thank you very much and all the best.

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IKP CENTRE FOR TECHNOLOGIES IN PUBLIC HEALTH (ICTPH)

BRIDGE TRAINING PROGRAM (IKP-BTP) FOR AYUSH PHYSICIANS IN ALLOPATHIC PRIMARY CARE DELIVERY

Best Practices in Tribal Healthcare
Shodhgram, Gadchiroli
October 11 - 13, 2015

IKP Trust & ICTPH
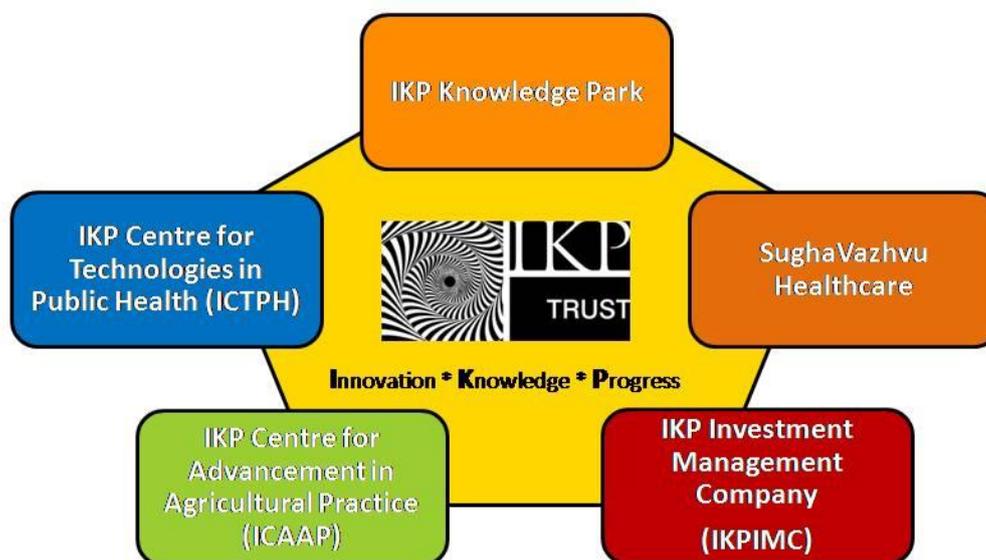
Leveraging advances in science and technology, especially healthcare and life sciences, for the progress of the society

IKP Centre for Technologies in Public Health (ICTPH)

ICTPH aims to improve health conditions for populations in India, by designing, developing and delivering healthcare solutions geared to work towards creating "disease-free communities"

- Think-Do Tank
- Incorporation: 2007
- Primary healthcare (systems design)
- Implementation Partner: SughaVazhvu Healthcare

ICTPH – Primary Healthcare Focus

Primary care at ICTPH

- Human resource and Capacity building strategy
- Adherence to evidence based care (through 81 clinical protocols)
- Robust technology support through IKP-TechPrima (cloud-based HMIS)
- Strong public / community health approach
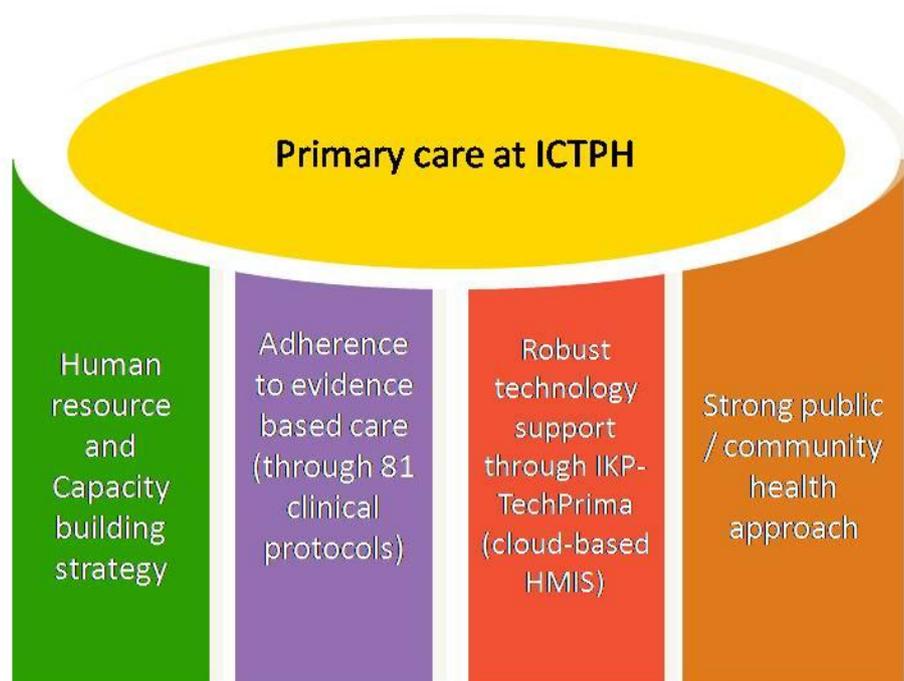
BTP – Meeting challenges in primary care delivery

The Indian healthcare HR challenge
- Availability (physician : patient < 1:1000)
- Accessibility (26% presence Vs 70% requirement in rural India)

The Indian healthcare HR Opportunity
- Availability (untapped pool of physicians trained in alternate medical systems (AYUSH)
- Accessibility (significant presence in semi-urban and rural India)
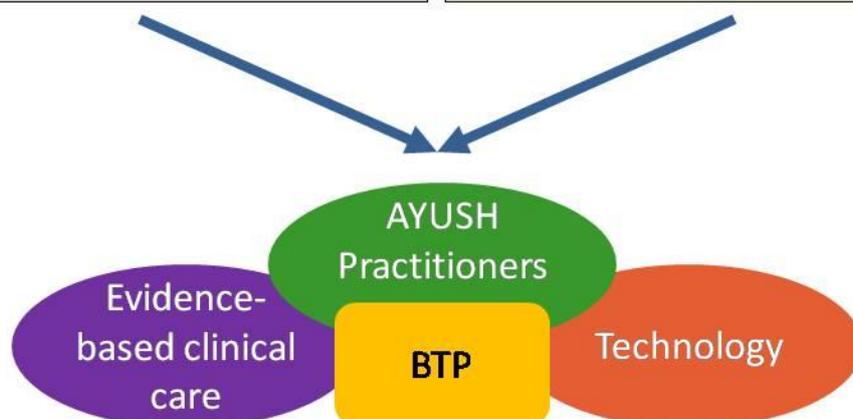
AYUSH Practitioners

Evidence-based clinical care

BTP

Technology

Bridge Training Program (IKP-BTP) for AYUSH physicians in allopathic primary care delivery

AYUSH Practitioners

Evidence-based clinical care

BTP

Technology

Capacity building strategy using AYUSH physicians trained in the use of evidence-based protocols to deliver quality, primary healthcare to inaccessible populations.

Penn Nursing Science
Care to change the world.
UNIVERSITY of PENNSYLVANIA
SCHOOL of NURSING

▶ **Initial program planning and development**

ICTPH AYUSH Training Strategy (Implemented for physicians in SughaVazhvu network)

- ▪ Primary Care Delivery in rural Thanjavur
- ▪ AYUSH trained physician & Health worker
- ▪ Standardized treatment guidelines & workflows
- ▪ Health Management Information Systems
- ▪ Chronic disease management – Pre-payment model

Evolution of the BTP

Clinical Care Protocols

SughaVazhvu Physician Training Program

SughaVazhvu Rural Clinics

Bridge Training Program
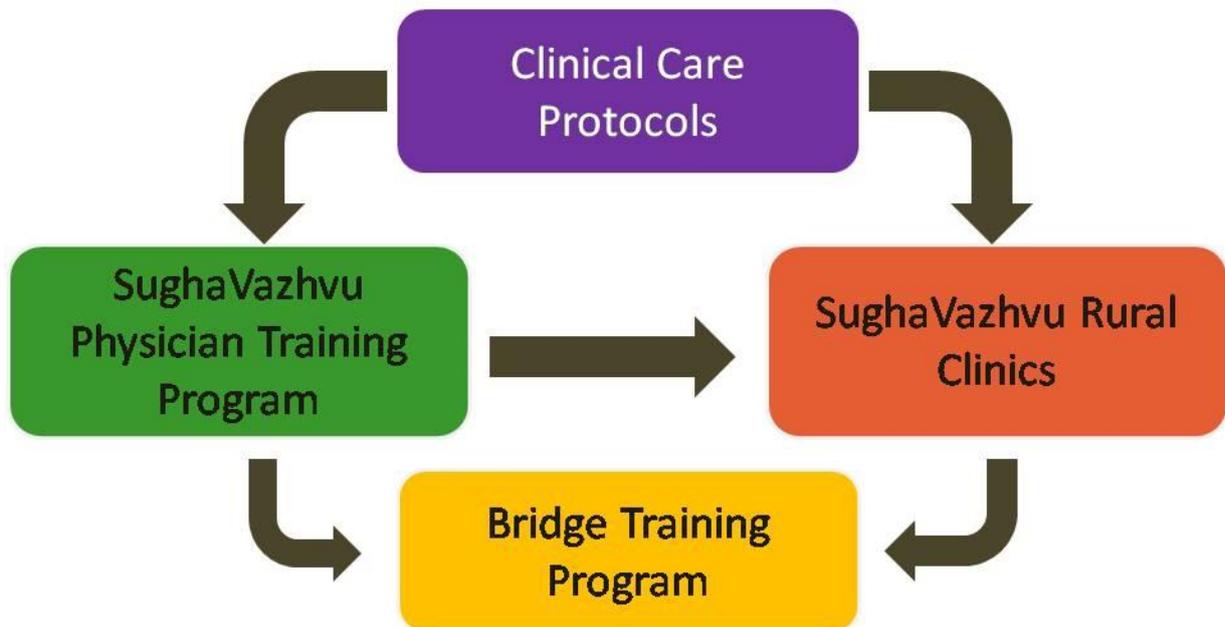
ICTPH Primary Care Protocols

Developed in collaboration with Penn Nursing

- System based approach
- 81 protocols

Adapted to Indian context

- ICTPH Medical Advisory Board
- In-house MBBS physicians
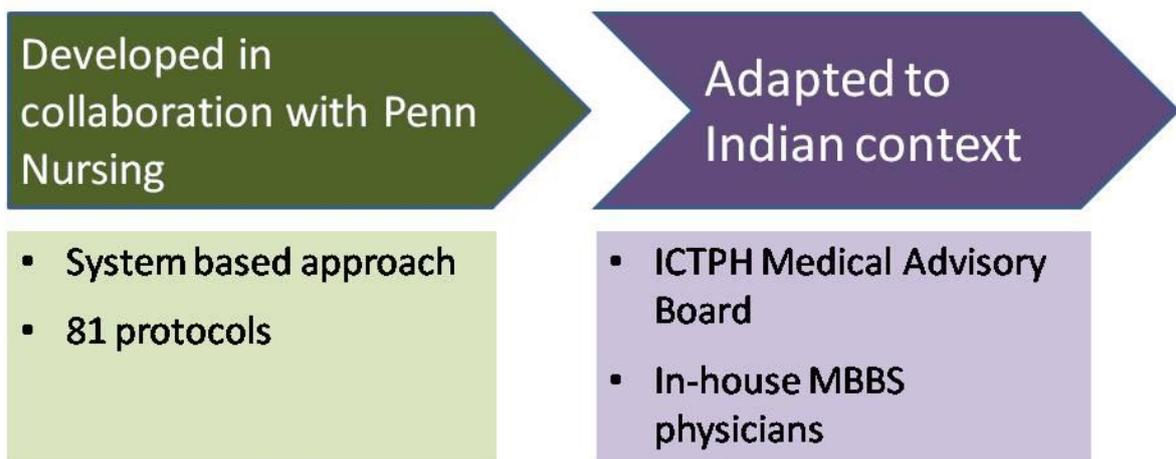
Conditions include acute ailments, upper respiratory tract infections, gastro-intestinal conditions (diarrhea, acidity), urological conditions, chronic conditions

SughaVazhvu Physician Training Program

Training Program	• SughaVazhvu physician training course focused on pharmacology, protocols, interventions, practical skill enhancement, technology, patient care • Combines training with a general induction program & soft skills training
Trainees	• Licensed licensed Ayurveda, Siddha and Homeopathy practitioners (BAMS, BSMS, BHMS) • 34 physicians trained till date
Trainers	• MBBS physicians, M. Pharm graduates (for pharmacology) and nurse trainers (for specific clinical skills)
Duration	• 2 months classroom training PLUS onsite practical training
Assessment	• Module-wise written examinations and tests

ICTPH – Primary Healthcare Effort

- HR Capacity building through BTP
- Clinical Protocols
- IKP-TechPrima (HMIS)
- Public / community health approach

- **34 AYUSH physicians trained in protocol driven primary care delivery**
  - ✓ Served 7 catchments (Total population: 75,000)
  - ✓ 70,000 primary care patient visits
  - ✓ Provided cardiovascular risk screening for over 6,000 adults
  - ✓ Cervical cancer screening for over 2000 individuals
  - ✓ Touched over 10,000 students through school health activities
  - ✓ Conducted over 300 community camps
  - ✓ Actively managing chronic care for over 150 individuals

Limitations in Tribal Health Context

Environmental Factors

- The current legal framework indicates that prescription of allopathic medications by AYUSH practitioners is up to individual State Governments.

Local Availability of Resources

- Availability of local AYUSH physicians in some tribal areas who can be trained.

Comprehensiveness of Current Training Program

- Current field-tested version of the training program focuses on acute primary care areas as well as chronic disease management.
- Other areas such maternal health, mental health and will need to be customized based on area of delivery.

Bridge Training Program – Way Forward

BTP for SughaVazhvu Physician Training ➤➤➤➤ **Bridge Training Program for a wider audience (IKP-BTP)**

Enhancement of the curriculum to cover most common conditions

▶ Curriculum development and validation

Thank you

Gadchiroli, 2015

Questions and answers

Q: Do people avail services of the AYUSH doctors who have been trained in few skills? Does it create an inferior category of doctors?

A: *Input by Dr. Abhay Bang*: Look the choice in a tribal area is not between a PHC with MBBS doctor versus a PHC with AYUSH doctor; but it is between a vacant PHC versus a PHC with AYUSH doctor. The choice of AYUSH versus MBBS is only on paper. Now second question is, even nurses are not allowed to practice, so there is a need to change the current rules and law in every situation. It's not only in relation to AYUSH that you need to change. Change will be required for any policy where you want to engage a non MBBS person who performs certain functions. Third question is – are they inferior? There was a study published, by Dr. Krishna from the PHFI, in which they compared, an MBBS doctor, an AYUSH doctor and some trained health-workers on common type of illnesses. Who followed the guidelines and the protocol? Trained health workers performed the best. Now, will you call it inferior? We are not interested in their ability to diagnose the rare illnesses found in the Harrison's textbook. Tribal people need care for the common health problems as the first priority. The choice is between – no treatment, versus traditional tribal healer, versus a bridge trained AYUSH practitioner. That will be the choice in reality.

Now, to whom will the tribal patients go? We do not know. But they may not even go to an MBBS doctor. I don't think tribal people will care so much for an MBBS degree. They will certainly care for the availability, sensitivity, cultural friendliness, and the quality of treatment. Engaging and training non-MBBS is not necessarily inferior for managing the common conditions if a protocol or the treatment guidelines are taught to them plus if there is a monitoring.

Q: What about training BDS doctor in place AYUSH practioner?

A: There is the same problem in getting BDS trained doctors as with MBBS physicians. The other alternative is we did think about a nurse practitioner model but we came up with the same set of limitations. Ultimately, we want to create a more comprehensive system. The reason we chose AYUSH was because, surprisingly if you look at their training they have the same length of training as an MBBS doctor physician. A lot of them during their internships do go to allopathic centres to practice, because they want to learn. And, incidentally they're all taught a bit of allopathy in their curriculum.

Q: When you are developing this training curriculum have you incorporated their practices which are good and will be useful for comprehensive primary care? Have you given a thought? And, second thing is they were saying 7 lakh AYUSH doctors are available, MBBS doctors are not available. Imagine, after 5 or 10 years, if the MBBS doctors are available and the Government makes schemes so that they come to the area, what about those AYUSH doctors? Have you given it a thought? Basically, we need doctors for 25,000 PHCs; every year nearly same number of doctors are coming out. Someday private market will be saturated and they may come to practice in tribal PHCs. What will you do then?

A: *Input by Dr. Abhay Bang:* There are several gaps in healthcare system including the lack of job satisfaction, availability of drugs, why doctors do not want to go there etc. These need to improve as well. Just changing a person's degree is not going to help by itself. Both things will have to happen simultaneously. The experience in Maharashtra is that MBBS doctors do not prefer to go to the PHCs and Government is able to find AYUSH doctor to be sent to PHCs in tribal area. It speaks something about market forces and choices. Then, yes, Ayurvedic doctors and maybe just because of the force of the market are willing to go. But then, if suppose Government decides that yes, we will give them bridge training and post them there, there could be some bond arrangement. Like, they have to work for at least 5 years, and then they will be free ready to go elsewhere. Something, which is suitable to both the sides – that may work.

Q: *Input by Dr. Padam:* In am going to talk little different. I met some MBBS doctors who are posted in the tribal area of Bastar, and they shared their difficulty to handle most of the critical cases because the tribals say, "If you are a doctor, I want you to treat my person and my person should come back healthy. If something happens to my person you're nowhere." So, there's a threat! So, these doctors said, that yeah they do go, they do take care of patiets but with a caution. So, that's also a condition. I am posing certain conditions in front of you. Second condition, is there were a bunch of AYUSH doctors who were managing PHCs, who were managing deliveries, who were literally running the PHCs and all kind of case works, and interestingly they were administering only AYUSH medicines. They asked us, "*Aap humein training kyu nai dete ho? Aap humko baaki skills ke training kyu nai dete ho?*" If we are managing and there is no MBBS doctor available to do the PHC work and all that, why are they paid less? We are asked to work extra hours, we are asked to take a look at the case reports and not paid. Why? Why are we not being treated on par? Third is, we are discussing

a lot of about AYUSH and AYUSH capacities, now we have to keep in mind how to combat the form of scientificity of each pathy. Unless and until there is an education programme to understand the other pathys, it is not right to comment on them.

Q: Why do AYUSH practitioners need to be bridge-trained? Why can't the AYUSH doctors practice AYUSH system?

Chairpersons' questions and comments

Dr. Abhay Bang

There is an organisation in Jharkhand, which has continuously advocated for allowing the tribal traditional medicine in Jharkhand, to become a part of primary health care. And, their argument is AYUSH OPDs in Jharkhand are not utilized by tribals, because for tribal people AYUSH is as foreign or alien. I am not supporting them, but my point is, that in tribal areas it's not necessary that they would accept AYUSH, because even AYUSH would be something new or alien for them.

Prof. Beck

Dr. Abhay is saying, a tribal population relying on the traditional healers is very much prevalent, for reasons of poverty. And these people are always available at your door step for no charge of any kind. So, the doubt and fear of approaching to the medical centres is still a fear that needs has to be broken. So, I think I would appreciate an organisation training the people who will be available to attend at least some of the basic requirements.

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TRAINING OF TRIBAL GIRLS
as ANM & GNM in
Two Tribal Predominant Districts of Chhattisgarh

Jan Swasthya Sahyog, Ganiyari,
Bilaspur (CG)
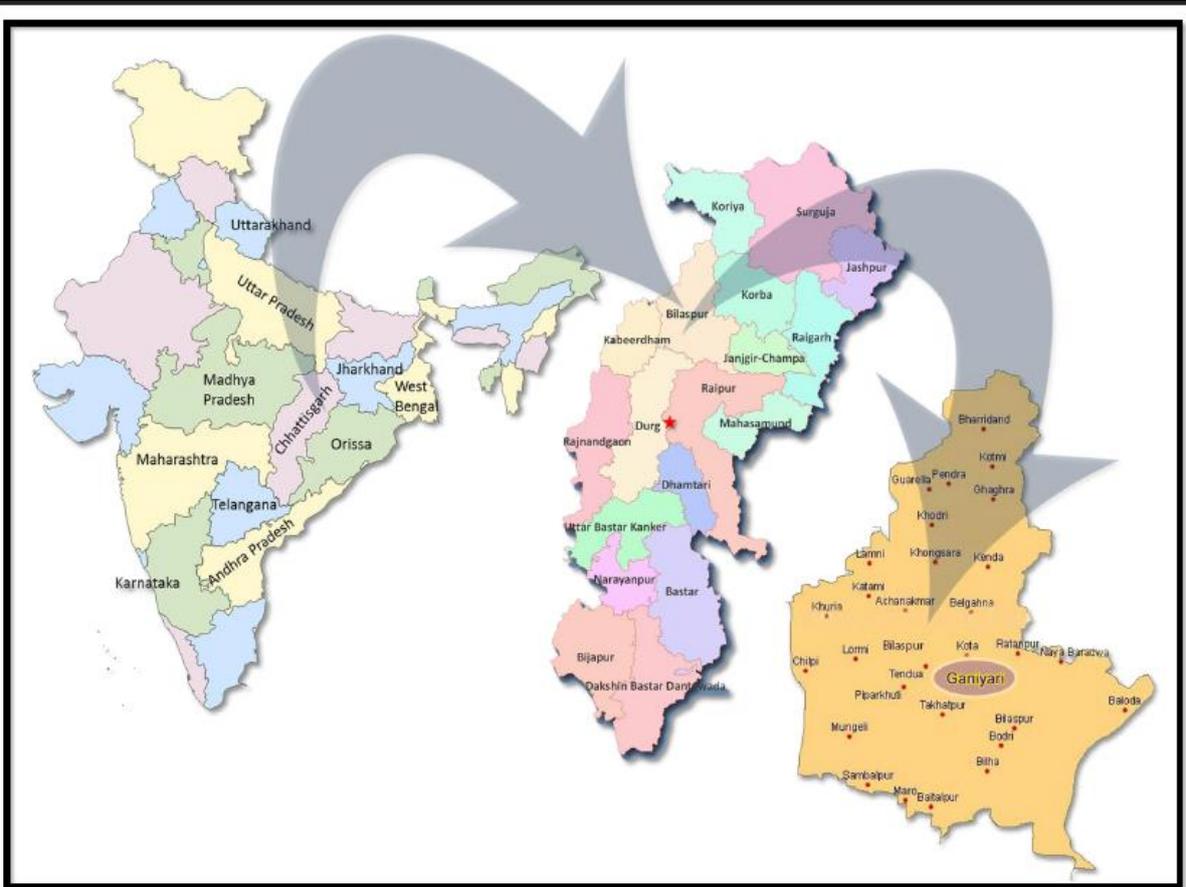
Local Tribes in the area

- Gond
- Baiga
- Birhor
- Uraon
- Kol

Jan Swasthya Sahyog

▸ Clinical services at Ganiyari and the other two tiers

▸ The Community programme

▸ Developing Training materials and running training programmes

▸ Asking the right questions and careful documentation

▸ Appropriate Technology development

▸ Advocacy

-Problems-

- There are scarce healthcare providers like Doctor, Nurse, or Health workers etc. in villages especially in tribal areas like forest and forest fringe villages and even in rural hospitals.

Problem statement

▸ Poor access to Health care facilities

▸ Cultural and language barriers even where tribal patients access health care

▸ Most nurses and paramedics (Lab tech, OT tech., Pharmacists) of course medics (Doctors) are not willing to work in these area because they want to be in big cities or go abroad.

▸ **How does Health care reach the rural folks especially the tribal people with Empathy?**

Goal

▸ To prepare a large cadre of tribal girls as ANM/GNM to serve in their own community and their hospitals

Contents

We started Nursing School in 2010. with full support of The Tribal Welfare Department of the Government of Chhattisgarh.

It is recognized by Indian Nursing Council, State Nursing Council and the health department of C.G. we are permitted to have 25 candidates each per year for the ANM and GNM courses.

All of the candidates are either Tribal or Dalit girls whose families are living below the Poverty line.

▸ Our process starts from village level like spreading information by visiting community, family and tribal girls hostels etc.

▸ Our selection process not only takes merit into account but also social background, social sensitivity, awareness about problems which rural and tribal people face.

▸ These are brought out during the interviews
- Marks 12th
- Written test (MCQ/Short answer)
- Interview

Trainees are exposed to all Tiers of our programme structure

The JSS Programme Structure

Tier 1 — Referral Center
2500 Villages / 15 Lacs (Approx) Population
Tribals - 32% / PVTG - 2.4%

Tier 2 — 3 - Sub-Centers
225 Villages / 1.35 Lacs Population
Tribals - 64% / PVTG - 17%

Tier 3 — 110 Village Health Workers for Forest & Forest Fringe Villages
54 Villages / 32000 Population
Tribals - 67% / PVTG - 19%
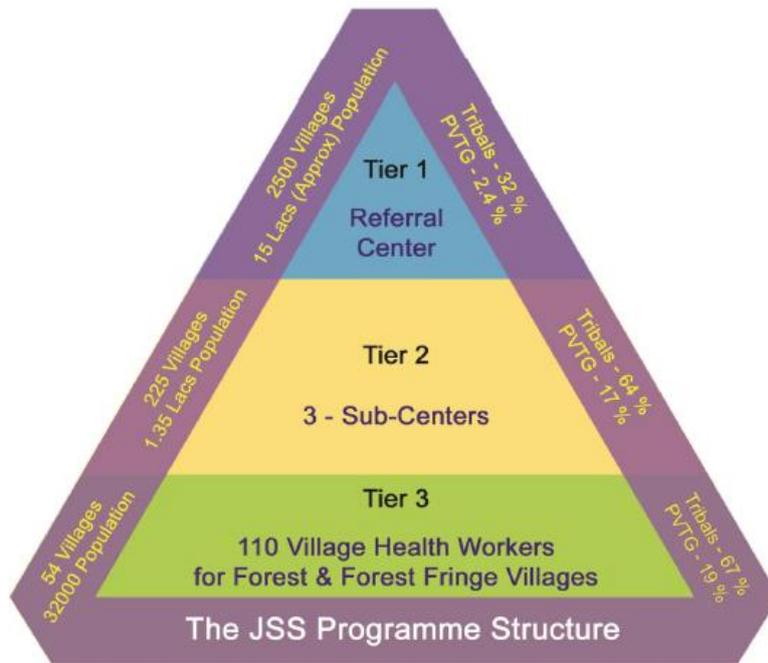
▸ **Bilaspur District with 26 lacs population has a tribal population of 12 lacs**.

▸ We have also been training Mid-level workers (Senior health workers) from 10 organizations across the country working in community health, they are trained to handle common emergencies and work as Physician Extenders in situation where doctors are unlikely to go in to rural areas.

Results

▸ We have applied for financial support for training programmes and to build hostel for tribal girls.

▸ We have made budget for training programme

▪ ANM Rs. 60000/- per year/ per student ▪ GNM Rs. 70000/- per year/ per student.	Inclusive of board, lodge, tuition, books, uniform, stationary, salaries, transport, health, exam fee etc.

▸ Admissions are made at Zero cost to the students.

▸ As part of the grant from the TWD, we have received funds for hostel construction to now accommodate 150 students.

▸ Training programme started in 2010 and so far two batches of ANMs passed out with 100% result and 90% students have been awarded distinctions.

▸ Besides they continue their learning for another year as interns giving them an opportunity to enhance their skills in various specialties like pediatric, emergency, new born care, obstetric and community health.

▸ Among these girl 60% have been posted in Govt. sector in sub centre, PHC & CHC. 30%   are working in voluntary sector and 10% in private sector.

▸ The   acceptance   of   these   Nurses   in   the Community, their immediate rapport with patients, sans any cultural or language barriers, is one of the most impressive achievements.

▸ Respect for their elders and traditions

Limitations

▸ One cannot ensure that they will continue to work in rural areas, but the likelihood is high, given their background, assessment before the course and available opportunities.

▸ In the absence of doctors in the rural community especially in backward and tribal areas there is a need to train and equip these nurses further as "Nurse Practitioners" who can independently provide primary care and contribute significantly as Nurse anesthetist, Advanced midwives etc. in a secondary care set up.

Conditions necessary to Implement

1. Who can provide this training?
- Those health care institutions working in rural and tribal areas:
- Governmental- CHCs, District Hospitals with their attached Nursing Schools.
- NGO or Non Profit hospitals with Nursing schools.

▸ 2. Political will and support of the Tribal Welfare department

Conclusion

▸ This programme creates a cadre of primary care providers from rural/ tribal communities who are well trained & motivated to serve these populations.

▸ The need for such skilled manpower is high and can be met through local resources

▸ Their acceptability and resonance with community is excellent

Questions and answers

Q: In Gujarat, ANM are there but they are not going where they were supposed to, they are not doing what they are supposed to. Also, implementation is more of a problem rather than shortage of ANM.

A: ANM is not needed in Chhattisgarh also, with the exception for the tribal girls who have the advantage of reservation. Otherwise, ANM post is saturated. As, this school is only for tribal girls, it will go on. Otherwise there is no option for ANMs in private sector. As Nursing Council says this is not nursing at all. This is only for NGO and government sector.

A: *Input by Dr. Yogesh:* I think this model has an advantage. Tribal affairs ministry should be encouraged and allow groups that are working in health in tribal areas to start nursing schools. They should relax the essential criteria of at least 12th standard pass. So that selections could be done and so that we have nurses, in both, hospitals and the community. GNM for hospitals and ANMs for community.

Chairpersons' questions and comments

Prof. Beck

Over the time we have been portraying that people are not available. Doctors are not willing to go. So, new option that remains for immediate availability of manpower is the tribal themselves.

Dr. Abhay Bang

First, we must congratulate the JSS, for the kind of situation that they are working in and that they have been able to start and run this kind of ANM/GNM training school. And, one would agree that this kind of well trained nursing career is very much needed in tribal areas.

Now, though I love this idea that tribal should be selected and trained to serve in tribal areas but what I do not know is if it will really happen? Dr. Sanga here is from Jharkhand. During my visit to Madhya Pradesh and Jharkhand with Dr. Neeru Singh, a medical officer was accompanying us. During our travel I asked both of them, "If we give tribal boys or girls training as doctors will that solve the problem of lack of doctors," and both of them said, "Is

there a guarantee?" And their comment matches my experience. Whatever little that I have seen, the very process of medical education is extremely detribalising. It builds a culture; it builds different aspirations of going away from the tribal area. Not that all tribal doctors go away from tribal areas. Do we have any mechanism to ensure that they will go in to work in the tribal area? Or will there be an issue of human rights – why should only a tribal doctor go to tribal areas? Does it solve the problem?

So, Yogesh, it will be very interesting to look at your experience and from elsewhere that when tribals are trained as doctors or as nurses, what is their propensity to go and work in the tribal areas ?

So, I would request that you should go further. Just opening an ANM training school in tribal area doesn't guarantee several things that we were discussing. So, there must be several elements in your programme – qualitative elements, which would encourage those nurses to work better in tribal areas. Otherwise, usually most of the ANM training schools are really training the tribal youth to go to the urban area for jobs. That's how their orientation is. So, do emphasise on those other aspects so that ultimately they do end up in tribal area.

Input Dr. John Oomman: Our School of nursing started in '78 – ANM training – and GNM training in '96. We take girls only from Orissa for Orissa. I find most people trained by us want to stay in the state. They want to work with Government in their own districts. Only when they don't get that option they go with the other options. Like you said, all education can alienate you from your roots, school as well. Second point is, there is no guarantee that a tribal schooled will stay in a tribal area. If you try to force that, it is like clipping wings to ensure they can't move. I would argue that all training should aim for situational excellence – this is the best we can do in the space – and social relevance, and balance between those two. So, that you are trying to bring in the ethos, 'come back and serve your own people' but they should have the potential to work in an ICU of Delhi as well.

While there is no guarantee that everybody stays back, if you take 10 people from 10 communities train them all equally, who is more likely to serve in a tribal area? It will be the tribal person. There is no guarantee that the tribal people will come back; there is no guarantee that anybody will come back, but there is a possibility and probability. It has to be in comparison to somebody from another community who has the right to go back.

The last point, this is related to the previous discussion – (I'm so sorry I nearly joined at the end of the road) – the discussion being AYUSH being the answer to the gap in healthcare of the country, I'd suggest that nurses could be that key. Nurses are trained in the allopathic system. Doctors have very little understanding of what nurses are about or nursing curriculum. By and large, most doctors probably think that nurses are supposed to come behind them and wash their hands for them. The general nursing curriculum is not very different from the MBBS curriculum. There are many subjects in general nursing curriculum that don't exist in MBBS curriculum. They have ethics, communication, they have research, they have pedagogy and health economics, in their curriculum. And, therefore, I suggest that that is a root fitting in as the healthcare divide. The problem is that we all have a caste system in healthcare if you're a doctor, AYUSH, A, B, C, D, E, F, G – you're OK; you're a nurse, you belong to a different category. That's where the problem lies. They probably can help us with rural healthcare. And, honestly there is a huge quality problem in nursing training, right now. So, if they are trained well and when experienced they have your option of being our answer to actual healthcare issues where MBBS don't go.

We are trying to come up with an idea of "Advance Training in Nursing" which is suggested to the Indian Nursing Council. This, combined with the previous discussion is really an option if we are chasing down for Primary Healthcare Centre.

Input Dr. Neeru Singh: What is the objective of providing this nursing training to tribal girls? Ultimately, they are human beings and it is their right, whether they want to serve in a tribal area or not, just like any other human being. So, it is actually a very good view. For empowering the tribal girls let them decide where they want to leave or stay to serve their own community or something different.

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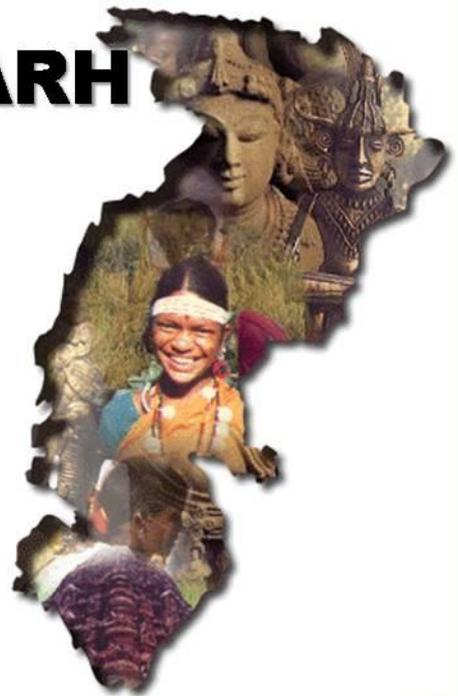
GOAL

- Ensuring availability of health human resources to improve health care services in tribal areas.

HR ISSUES IN CHHATTISGARH

- The dearth of health human resource is very critical in the districts of Bastar division and Surguja division as compared to Bilaspur and Raipur.
- Moreover the problem has been many folded in Bastar division due to LWE activities in those districts.
- 90% Specialist positions, 60% Medical Officer and 66% Staff Nurses positions remains vacant in Bastar division
- In Surguja division 88% Specialists, 51% of medical officer 62% Staff Nurses remains vacant.
- Several recruitment drives have been conducted by Health Department from time to time and even walk-in-interviews have been conducted without much result.

REASON FOR POOR AVAILABILITY OF HR

- Less no of MBBS and PG seats in medical colleges
- Lack of availability of qualified nurses from these two division
- Strict reservation policy- due to non availability of ST candidates these post were laying vacant for long.
- Lack of lucrative packages or amenities for working in difficult areas.
- Schemes like (Chhattisgarh Rural Medical Corps) CRMC, did not attract nurses and doctors to work in tribal and difficult areas.

OUTSOURCING OF HR

- Looking at this critical issues of HR unavailability, decision was taken to adapt HR out sourcing through agencies.
- Hiring of service through HR agency is an unique model, where employee remain employee of the agency but works in the health facilities.
- It reduces liabilities, increase flexibility to re-deploy & ensure effective management,
- Easy and simple head hunting process by the HR agencies, enable them to motivate to work in the difficult areas.

PROCESSES

- Expression of interest were called from the HR agencies to provide staff nurses and doctors in 2 tribal dominated divisions.
- 6 HR agencies were empanelled out of which 4 are working
- Attractive packages are prepared including CRMC incentives (hardness differential incentives).
- Developed a reception centre at state HQ to facilitate information regarding salary packages & facility wise vacancies.
- Moreover it provides information on accommodation & means of travel.
- Reviewing the status of facility wise vacancies every 3 months and providing requirement to HR agencies

EVIDENCE OF THE IMPACT (SN RECRUITMENT)

Division	Districts	Sanctioned	In Position	Vacant (1/02/2015)	Engaged Through Out Sourcing	Vacant (31/08/2015)
Surguja	Jashpur	173	65	108	95	13
	Surguja	151	91	60	58	2
	Koriya	118	54	64	58	6
	Balarampur	99	14	85	85	0
	Surajpur	113	34	79	66	13
Bastar	Bijapur	73	22	51	51	0
	Narayanpur	57	22	35	35	0
	Jagdalpur	105	74	31	31	0
	Dantewada	78	24	54	54	0
	Kanker	147	65	82	82	0
	Sukma	60	18	42	42	0
	Kondagaon	106	40	66	66	0
Total		1280	523	757	723	34

BENEFITS

- Through the out sourcing model as on now 723 SN and 16 doctors have been deployed which improved health human resources availability
- Ultimately resulted in increased service delivery.
- Easy and simple head hunting process by the HR agencies to identify motivate personals from various part of country to work in the difficult areas

COSTING

- The financial burden is as similar as regular set up but morbidity & mortality count higher than the cost on this HR.

CHALLENGES

- Acceptance of male nurses at PHC level
- Induction of out sourced nursing staff to ensure quality services
- Being centralised payment, ensuring timely salary payment of out sourced HR

THANK YOU

Dr. AKhilesh Tripathi
Dy Director
Dept. Of Health & Family Welfare

Questions and answers

Q: How the HR agencies are able to do something which the government can't?

A: By eliminating reservation. In Government, you have to put up an advertisement with reservation.

Q: By Dr. Abhay Bang *Iske kuch* advantage *to saaf dikhai dete hai, lekin kitne der ke liye pata nahi, kyuki abhi bahut taaza taaza anubhav ho raha hai. Lamba arse ke liye woh log tikenge-nahi tikenge abhi batana mushkil hai. Lekin mujhe ek sawaal pareshan kar raha hai. Aap* Government *ke bheetar do varna vyavastha* create *kar rahe hai. Ek hain,* permanent Government employee, *kya woh waise hi rahenge? Aur ye* contractual *vyavastha. Sawal ye lagega ki jo* permanent *wale hai, unka kya?*

NRHM *mein aur is mein farak ye hai, ki* NRHM *mein kam se kam* Government contract *karti thi, ab toh* contract *karne ki* agency *bhi* outsource *kar di. Is mein gambhir* issue *hai* equality *ka,* parity *ka…aur aapka* management *ka tatva kya hai. kyuki agar is* argument *ko aage le jaenge toh koi kal aapko puchega ki IAS ko kab outsource karne wale hai?*

A: *Aapne jo baat ki hai, uske bare mein ullekh kiya tha, ki us pure darmyaan mein chappan log jo hai us mein se 20 log chod ke gaye hai. 20 log jo chodke gaye hai woh under pressure the, ya unko woh jaga jam nahi rahi thi, aur chattis log aise hai ki unko* better opportunity *mili thi. Usko dekhte hue lagta hai ki aise* scheme *ki* sustainability *rahegi aur* service *rahega. Raha sawal* manage *karneka, toh* manage *toh karna padega kyuki ye humare liye behat naya hai toh us mein lagatar lage hue hai aur koi rasta zaroor niklega.*

Q: Dr. Padam: *Mere dimag mein thoda alag* question *hai. Ek* question *hai jo appke paas 16* doctor *hi aaye abhi tak, wohi 16 continue kar rahe hai, ya koi bhi 16 continue kar rahe hai?*

A: *Nai nai. 16* continue *kar rahe hai. Mai unhi ka* figure *de raha hu.*

Q: Dr. Padam: *Isiliye kyuki* doctor *ke saat* patient *ka ek rishta banta hai aur usi* centre *mein log jaate hai jaha pe unko vishwaas hota hai. Agar doctor* change *ho jaye toh nai jaenge. Apne ghar se 10 km ho, toh bhi jaane ko tayar honge. Dekho* continuity *of the same* doctor *ye bahut zaroori baat hai.*

Q: Dr. Abhay Bang: Akhilesh *ji. Aapka* impression *kya hai – waha ke* services *mein koi* improvement *hui hai kya?*

A: *Haan. Mai kuch* centres visit *karke aaya hu. Humare* social services *mein jo* state officer *hai wo bhi gaye the.* Everybody has said, *ki* improvement is there. *Ab uski* study *jo hai…apne* services *ka* data *nikal ke rakhenge woh. Pehla toh ye hai ki* OPD and IPD load *kitna badha hai, aur dussra ki* delivery *kitni thi – ye humara* prime focus *hai – aur* delivery service *mein kitna farak padha hai inke* employment *ke baad se.*

Chairpersons' questions and comments

Dr. Abhay Bang

Akhilesh *ji, aapke samarthan mein mai aur kuch sabot juthane wala hu. Aur, mai fir se keh du mere lihaaz mein toh aapaki practice bahut bahut taaji cheej hai. Thoda bahut samay parakhna padega. Toh koi bhi nishkarsh nikalna bahut* premature *hoga. Lekin ye sirf* health service centres *ka nahi hai,* Maharashta *mein ek* Gaikwaad *naam ke aadmi hain. Unhone ek* agency *kholi yeh kehke ki, "Hum* service *denge.* Housekeeping *wala jitna* role *hai hum karenge," kyuki sabhi* companies *mein aaj kal saaf safai karne ke liye kisike paas fursat hai. Unka kaam badhte badhte, aaj* Rashtrapati Bhavan *aur* Parliament *ka bhi pura saaf-safai unko* outsource *kar diya gaya hai. Toh ye toh sarkar ki* philosophy *dikh rahi hai. Woh sahi ya galat hai iski charcha mai abhi nahi karna chahuga. Uspar kafi vyacharik bhumika ke anusar tay hoga ki aap kya bhumika lete hai. Toh aur koi chalae, hum sirf* contractual relationship *rakhenge.*

Human service programme *mein ye kitna lagu pad sakta hai, nahi pad sakta hai?* Human service programme *ko sirf* salary *ke roop mein* standardise *nahi kar sakte. Uska* behaviour, *uski* quality of diagnosis *kaisi hai, kaise* assess *karenge? Toh, kaafi* problems *toh is mein ayenge. Lekin, fir bhi ek* interesting *prayog hai, aur aaj ke sarkar ki jo bhi 20-25 saalo se chalti* ideology *hai, uske anusar kar rahe hai. Isiliye aap koi zamane ki baat ke khilaaf nai baat kar rahe hai. Toh, fir bhi iska fayada tribal logo ko kitna milta hai, kya aadivasi ilaako ki* health service *isse sudhari jaayegi? Agar sudharti hai toh ye* case *zyada strong hoti hai. Agar nahi hoti hai, toh fir toh dono oar se gaye. Toh isiliye isko aur bhi thoda…kaafi bareekhi se parakhna chahiye, ki iska parinaam kya aata hai. Lekin ye bada* interesting *prayog hai .* Double edged sword *hai, ye mujhe zaaroor chinta hai. Lekin har prayog mein* double edged risk *toh hoti hi hai.*

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Community monitoring and action for women's health and malnutrition

anandi આનંદી

AREA NETWORKING AND DEVELOPMENT INITIATIVES

About ANANDI

❖ Started working in 1995

❖ Feminist Collective

❖ Combining the Empowerment and Livelihood Approach

❖ Key strategy – Organising women's collectives

❖ Approach towards sustainability – Investing in women's leadership and partnership with women's collectives

ANANDI's Area of Work
State: Gujarat
Districts: Dahod, Panchmahaal, Morbi and Bhavnagar

The **context** for the community monitoring program for **maternal health** (2012 – present)

❖ Districts: Dahod and Panchmahaal
❖ Taluka: Devgad-Baria and Goghambha
❖ 25 villages, 4 PHCs
❖ Total population = 35,588
❖ Located in a dense tribal belt, with approximately 80% of the population being tribal
❖ Tribes indigenous to these areas = Nayaks and Rathwas

The Problem:

❖ Lack of access, reliability, and quality of ante-natal and post-natal services at the PHC.

❖ Major indicators – blood pressure, blood test (for sickle cell anaemia), weight and haemoglobin count – not being regularly monitored.

❖ Maternal deaths going under-reported.

❖ Widespread misconceptions linked to breast feeding and weaning food in the community.

❖ Lack of awareness about all of the above in the wider community

❖ A mysticism around the 'technical' knowledge and skills related to health care and nutrition support.

Goal

❖ To improve maternal health and child survival in tribal areas.

❖ To engage the community – especially women – in understanding, resolving, and monitoring specific health interventions to improve health outcomes.

❖ To empower the community to seek specific interventions from the ICDS and the Health Department towards maternal and child health and to increase accountability of these governmental institutions.

Who do we study?

❖ Women who are in their 8th (penultimate) month of pregnancy

❖ The same women, 10 days after their delivery

❖ The two are phases where it becomes easiest to assess the reach of the PNC and ANC

❖ Every three months, a compiled report card is put together from the findings collected through several tools

❖ This report card is then shared with the doctors at the PHC, their staff, and the community at large

❖ A plan is then put together to address the gaps in the previous report card

Participatory tools for community monitoring and awareness on maternal and child health
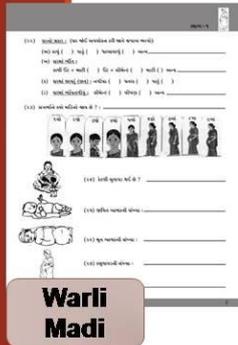
Warli Madi
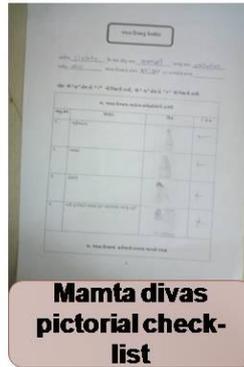
Mamta divas pictorial check-list

Report Card

Mamta Toran (banner)

Sharing of Community Report Card back with community

With Village Panchayat Members

Dialogues with the health system

The Role of Women:

❖ 'Bhaneli – Ganeli' : Pairing women- one educated, one wise – to act as a team of community animators, that gets involved at the PHC during monthly meetings and contribute to planning processes.

❖ Several training inputs provided to community animators - including filling data collection tools, reporting and investigating maternal deaths, the role of ASHA workers during Mamta Divas, etc.

❖ Dais – midwives – an important component of the community animators. Though de-recognized by the government and blamed for the large number of home deliveries, they are a vital source of information, and help successfully bridge the gap between the villagers and the often intimidating health infrastructure.

Outcomes between 2012 and 2015

Pregnancy registration
23% / 79%

Weight
2% / 51%

Sickle Cell anemia assessment
0 % / 50%

Abdominal test
4 %/ 31 %

Conti..

Blood Pressure
4 % / 53%

Hemoglobin
4 % / 41%

Calcium supplement
3% / 36%

Identifying high risk mother
18% / 76%

Impact on ANC parameters

■ Jun-15 ■ Dec-12

- Scheme related information (Yes): 88 / 4.8
- High Risk symptoms (Yes): 76.5 / 18.2
- Calcium tablets: 36.7 / 3
- Iron folic tablets: 54.6 / 8.5
- Tetanus toxid (TT): 96 / 73.4
- Hemoglobin (minimum 2 times): 41.4 / 4.8
- Abdominal checkups (minimum 3 times): 31.2 / 4.8
- Blood pressure (minimum 3 times): 53.1 / 1
- Weight (minimum 3 times): 51 / 2.4
- Registration (within 3 months): 79 / 23.1

	Registration (within 3 months)	Weight (minimum 3 times)	Blood pressure (minimum 3 times)	Abdominal checkups (minimum 3 times)	Hemoglobin (minimum 2 times)	Tetanus toxid (TT)	Iron folic tablets	Calcium tablets	High Risk symptoms (Yes)	Scheme related information (Yes)
Jun-15	79	51	53.1	31.2	41.4	96	54.6	36.7	76.5	88
Dec-12	23.1	2.4	1	4.8	4.8	73.4	8.5	3	18.2	4.8

Baseline Survey of Malnourishment among under-5 children (February 2013)

Taluka	Total Villages	Total Population	Children under 5	Sample Size	SAM Children	MAM Children	Healthy Children	Migrants	Children without birth certificates
Baria	8	13209	1168	803 (69)	183 (23)	203 (25)	232 (29)	22 (3)	163 (20)
Gogambha	5	12292	1206	681 (56)	90 (13)	128 (19)	175 (26)	107 (16)	181 (26)
Total	13	25501	2374	1484	273	331	407	129	344

Bal Poshan and Shiksha Kendra

Digital weighing scale for growth monitoring

Mapping on growth chart

Hygiene education and demonstration

Collective responsibility of cooking & feeding children

Health Camp

Mobilizing children to go to AWCs

Supplementary Nutrition to mothers of SAM and MAM children and lactating mothers

Sharing of Growth Report

For Anganwadis

For Families

Bal Poshan Shikshan Kendra Outcomes

Maliya, Ghoghamba, Devgadh Baria

■ SAM ■ MAM ■ Normal

	SAM	MAM	Normal
Baseline Devgadh Baria	63	83	40
Outcome Devgadh Baria	21	54	40
Baseline Ghoghamba	48	48	18
Outcome Ghoghamba	12	19	67
Baseline Maliya	72	29	3
Outcome Maliya	12	55	64
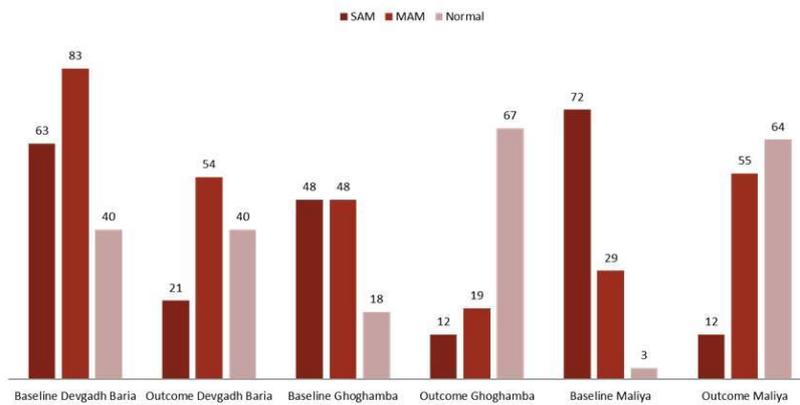
Limitations

❖ Currently a limited amount of impact data available – more comprehensive review under process

❖ No 'convergence at the top' when it comes to planning – all departments/programs in the Government have their independent delivery systems that run without convergence right from planning to implementation to monitoring

Conclusion

❖ This strategy relies on a model that does not need more medical doctors

❖ There is a strong emphasis on education of the community and especially women about rational health practices

❖ Therefore, improved maternal health and child survival become "an aspiration", not a casualty to live with

❖ Possible to absorb some of these ideas into the pre-existing systems to increase effectiveness – even the limited changes argue for more of an investment in community awareness

Questions and answers

Q: Dr. Abhay Bang: *Ek jagrut mahila sangathan ki iske liye zaroorat hai. Aise jagrut mahila sangathan ko kaha kaha mauka mil sakta hai…toh shayad jaha jaha* SHG group *ki sangathan hai waha shayad ye mauka mil sakta hai.*

A: *Ye jo sangathan bana hai woh pehele* SHG group *tha lekin* SHG group cluster labour *ka hota hai. Us mein se kuch* leaders *tayar bhi hai kyuki* ANANDI *ka jo kaam hai is area mein wo 20 saal se chal raha hai. Aur sangathan ka 18 saal ho gaya hai. Toh in* leaders *ko tayar karne mein pura 9 saal gaya hai.*

Chairpersons' questions and comments

Prof. Beck

Jaise jaise duniya badal rahi hai, gaon mein industries *aa rahe hai aur jo* tribal communities *mein samudaaein thi woh ghatt rahi hai. Nahi toh* naturally, *unke beech mein jo* unity *hai woh ek dusre ke saat rah kar bhi takat ka anubhav karte hai.*

Fir bhi autron ko kaafi neeche dekhte hai. Par asliyat mein dekha jaye toh pariwar ko sambhalna hota hai, bachha ko badhana, jadatar mahilao ko karna padta hai. Toh aap log jo kaam kar rahe hai, unko summon *karke, unke* systemic process implications *dekhke,* awareness *badhane ki koshish kar rai hai woh bahut hi mahatwapurn hai. Kyuki jab unmein woh dhyaan aa jaegi woh khudhki rakhsha kar paenge. Toh bahut hi* important *hai ye.* Thank you so much.

Dr. Abhay Bang

Mai is practice *ki khas takat jo dekhta hu woh ye hai ki adivasi jaise* marginalised community *hai,* political voice *unko nahi hai, aur un mein aurto ko aur bhi nahi hai. Toh aurto ko swastha sewaein thik se mile iske liye is mein* voice *milta hai. Ek oar toh gyaan bhi milta hai aur dusri oar* voice *bhi milta hai.* Action *ke liye* guidance *bhi milta hai. Toh* tribal community *ki aurto ko* political voice *mil pana* health *ke liye aur* healthcare *ke liye, ye mujhe uski khas takat lagi. Aapne jo uske parinam batae woh parniam ko toh mai abhi pura nahi* assess *kar paya hu, lekin aapki process mujhe bahut akarshik lagi. Thank you very much.*

19

REACHING THE UNREACHED ....

AUM SHRI PARAM KRUPALU DEVAY NAMAHA
AUM SHRI SADGURU DEVAY NAMAHA
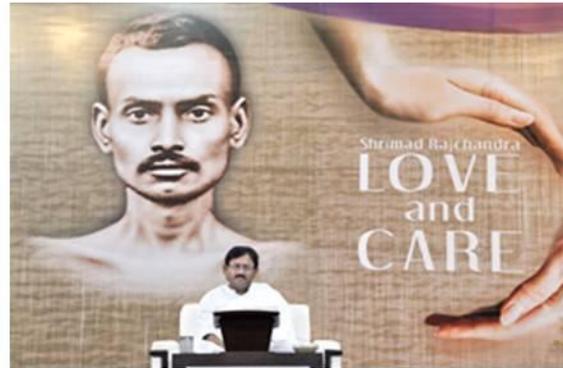
Shrimad Rajchandra Rural Health Project
(OUTREACH PROGRAM through MOBILE MEDICAL UNITS)

Health Care
Educational Care
Child Care
Woman Care
Tribal Care

Community Care
Humanitarian Care
Animal Care
Environmental Care
Emergency Relief Care

LOVE and CARE

A unique 10 fold benevolent programme

Where are we working ?
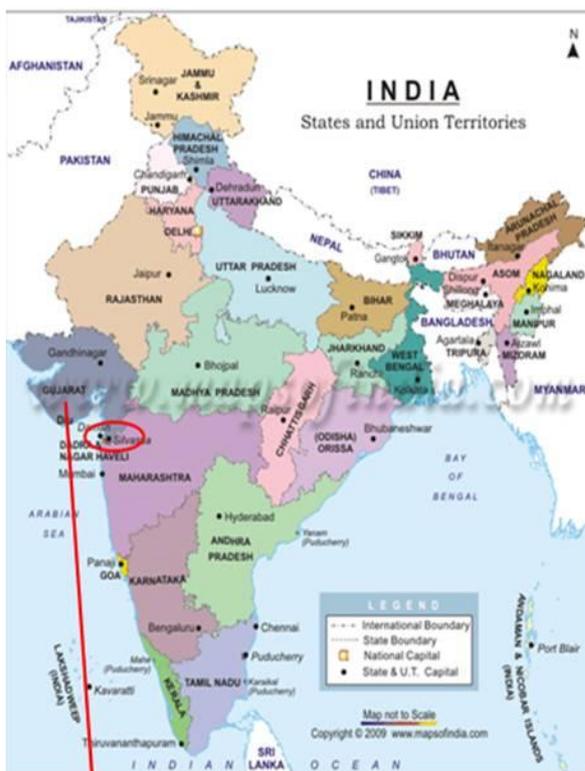
Shrimad Rajchandra Rural Health Project

Geographical Areas Covered

TOTAL POPULATION OF THE AREA – 4.5 LACS (2011 CENSUS)

Our Outreach Programme covers, roughly, the area within the thick hand-drawn boundary

COMMON AILMENTS

RATIONALE

- PRIMARY HEALTHCARE FOR THE TRIBALS HAS AVAILABILITY/ACCESSIBILITY/AFFORDABILITY/QUALITY CONCERNS

- SUCCESSFUL LINKAGE OF PRIMARY HEALTHCARE WITH SECONDARY AND TERTIARY HEALTHCARE FOR THE TRIBALS IS AN IMPORTANT ISSUE

- EARLY INTERVENTION AND REHABILITATION IS POSSIBLE THROUGH OUTREACH SERVICES

WHAT ARE OUR OBJECTIVES ?

- TO REACH OUT TO THE UNWELL ,UNDERPRIVILEGED TRIBAL PEOPLE WHO ARE UNABLE TO REACH EVEN A NEARBY HEALTH CENTRE

- PROVIDE AT THEIR DOORSTEPS, EASILY ACCESSIBLE PRIMARY LEVEL MEDICAL CARE OF HIGHEST POSSIBLE QUALITY

- TO PROVIDE COMPREHENSIVE PRIMARY HEALTHCARE (PREVENTIVE,PROMOTIVE,CURATIVE AND REHABILITATIVE)THROUGH OUTREACH AND LINKAGE COMPONENT FOR SECONDARY AND TERTIARY CARE

FROM AUGUST 2005, 2 SEPARATE MEDICAL VANS EACH STAFFED BY A DOCTOR, A PARAMEDIC, DATA ENTRY OPERATOR AND DRIVER AND CARRYING A DIVERSE RANGE OF MORE THAN 100 CAREFULLY SELECTED MEDICINES, TRAVEL INTO REMOTE TRIBAL VILLAGES

MOBILE MEDICAL UNIT IN ACTION AT THE DOORSTEPS OF TRIBALS

SRRHP MOBILE MEDICAL UNIT SERVICES

- THESE TWO VANS OPERATE AS PER A FIXED ROUTE PLAN, ON A DAILY BASIS, THROUGHOUT THE WEEK, FROM MONDAY TO SATURDAY.

- MORE THAN 65 OUTREACH CENTRES CAREFULLY SELECTED WHERE NO HEALTH FACILITIES ARE AVAILABLE ARE VISITED, ONCE A WEEK ON A 'FIXED-DAY-FIXED-TIME' BASIS

- EACH DOCTOR EXAMINES ON AN AVERAGE 100-120 PATIENTS PER DAY AND PROVIDES THEM FREE OF COST SERVICES INCLUDING MEDICINES,IMPARTS HEALTH EDUCATION MESSAGES AND PROVIDES REFRALS TO THOSE IN NEED

- EVERY PATIENT IS GIVEN FOLLOW UP CARDS TO ENSURE COMPLIANCE

- TIMINGS OF OUTREACH ARE 9AM-4PM (SUITABLE TO THE LOCAL TRIBALS)

SALIENT FEATURES OF SRRHP MOBILE MEDICAL UNIT

- LINKAGES WITH VILLAGE LEVEL HEALTH WORKERS LIKE ASHA, ANM,AWW AND FROM OTHER NGOS STRENGTHEN OUR SERVICE DELIVERY

- OUTREACH PATIENTS RECEIVE A MOST COMPREHENSIVE RANGE OF SERVICES, RIGHT FROM PRIMARY TO SECONDARY TO TERTIARY LEVEL CARE AND ALL TREATMENT IS PROVIDED WITHOUT DILUTING SCIENCE

- THE PROGRAMME IS VERY ROBUST. EACH VILLAGE COVERED BY THE PROGRAMME IS VISITED, WITHOUT FAIL, ON THE FIXED DAY OF THE WEEK, AT THE FIXED TIME

- BOTH THE DOCTORS IN THE TWO VANS ARE SENIOR GENERAL PRACTITIONERS AND THEIR ROUTES ARE ALSO FIXED TO ENSURE PATIENT'S FAITH,COMPLIANCE AND FOLLOW-UP

Number of Patients Treated, Year-wise
(OPD, IPD, Camps & Outreach)

Number of Patients Treated

7,816	
11,335	
35,725	
72,540	
58,113	
67,809	
78,742	
96,953	
1,02,725	
1,08,351	

2004~05 (From Jul) · 2005~06 · 2006~07 · 2007~08 · 2008~09 · 2009~10 · 2010~11 · 2011~12 · 2012~13 · 2013~14
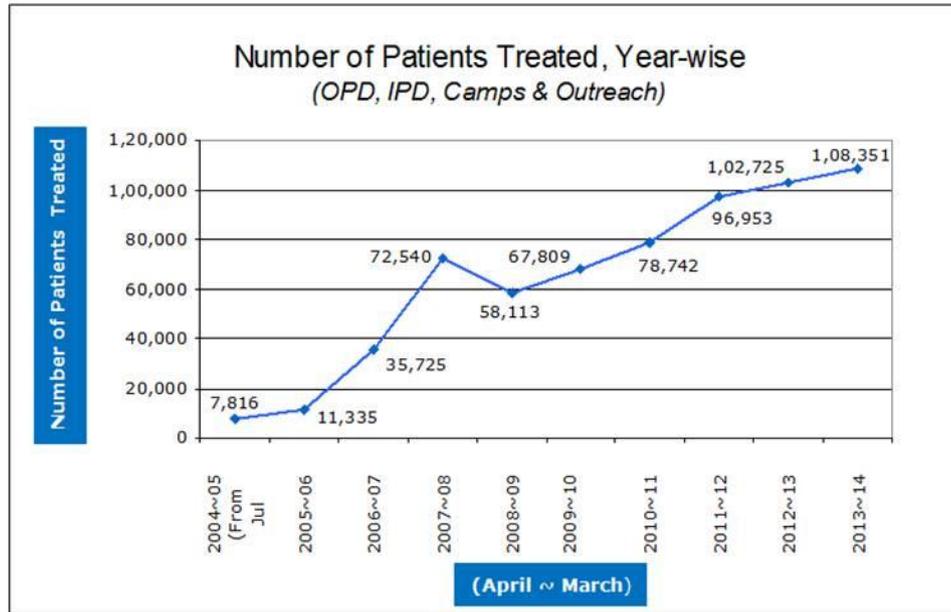
(April ~ March)

Total No. of Patients Treated: **6,40,109**

Shrimad Rajchandra Love and Care
Mobile Medical Clinics for Community Outreach Services

Outreach Patient Throughput – Year-Wise – (April ~ March)

Total No. of Patients Treated in the Outreach

Patient Count - Year-Wise

Year	Patients
2009 - 10	44,223
2010 - 11	53,603
2011 - 12	62,763
2012 - 13	69,524
2013 - 14	73,546
2014 - 15	81,830

Financial Year (April~March)

Shrimad Rajchandra Love and Care

Patients Referred from Outreach to SRH For Further Treatment
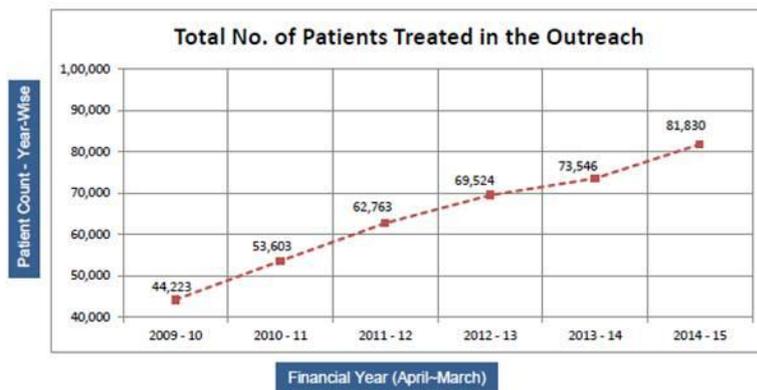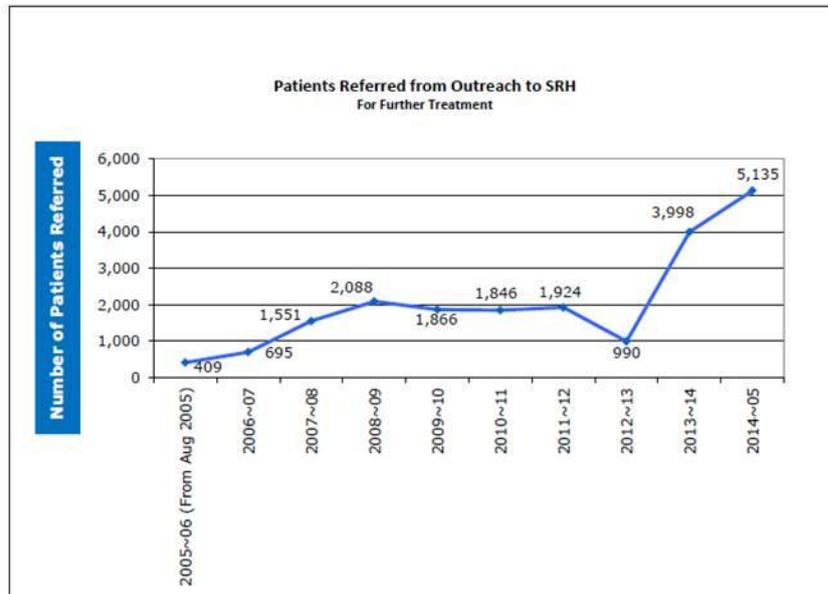
PRIMARY HEALTHCARE TO TERTIARY HEALTHCARE through OUTREACH

SPREADING HAPPINESS AND SMILES

CHINTABHAI GETS NEW LIFE !!!

PAINLESS HUGE LUMP IN RIGHT SIDE OF ABDOMEN OF CHINTABHAI MAHLA

(NOTICED BY OUTREACH DOCTOR IN one of OUTREACH CENTRE – SADADVERA)

RENAL CANCER BEING OPERATED AT SRH

RESECTED TUMOR WEIGHING MORE THAN 6 KG
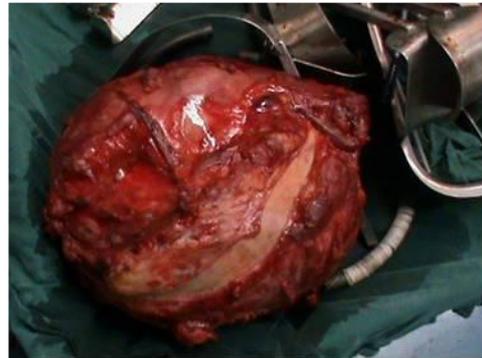
BACK TO WORK AFTER SURGERY

Chintabhai after a major surgery

OUTREACH MEDICAL HEALTH CHECKUP CAMPS

A CHILD WITH MENINGOCELE SCREENED FROM ONE OF THE OUTREACH CAMPS

NEONATAL INTENSIVE CARE UNIT

Baby of Ramila Patel(2 day old child) – Successfully operated for "Tracheaoesophageal Fistula" at SRH

SHRIMAD RAJCHANDRA VIKLANG CENTRE

Before   After

CLUB FOOT SUCCESSFULLY TREATED AT SRVC

JOURNEY FROM EARLY INTERVENTION TO
DISTRICT EARLY INTERVENTION CENTRE

To
Sri Abhay Jasani,
President and Managing
Trustee
SRIMAD RAJCHANDRA
Mission Hospital

Professor Dr. Arun K. Singh;
National Advisor,
Rashtriya Bal Swastya Karyakram
Ministry of Health & Family Welfare
Government of India
1st October 2014

Respected Sri Abhay Jasani ji,

Thank you for your Invitation. As a part of my visit, I have penned down some of my observation.

I visited Shrimad Rajchandra Hospital, Dharampur in South Gujarat on 17th September 2014 as a "National Advisor for Child Health Screening and Management" as was communicated by one of our colleagues in the ministry, that there is a trustee hospital in south Gujarat in which the Hospital authorities are running an "Early Intervention Center" very similar to the guidelines of the Ministry of Health, Govt. of India. We also recalled a meeting in which the RBSK team was invited on 16th August 2013 at Gandhinagar, Gujarat from the Commissionerate of Health, Government of Gujarat, regarding understanding

My comments: Both as a **Professor of Neonatology**, as an innovator of concept of "Sick New Born Care Unit", "Rural Human milk Bank", "alternative labor room concept" in this country and as a *National Advisor of Child Health, RBSK program, Government of India.*

Firstly I must congratulate the commendable work being done in a tribal belt in South Gujarat with out diluting Science. The quality and the difficult situations in which it is being implemented can be easily be put as one of the best example of transnational research in the country. Both the Sick New born care Unit, which takes *care of survival,* and "early intervention Center" (" EIC") that takes care *"beyond survival"* linked to the SNCU is of an excellent quality and Innovative at your hospital and also with the potential to reach international standards.

To the best of my knowledge such a model would be not only the first in Gujarat but also the only one when compared to the other states of the country. Let us not confuse the concept of disability center, they are plenty in the country, but they work with the concept that one avails the services only when one is disabled so that he/she does not become handicapped. (Prevents disability from becoming handicapped) EIC works on preventing and minimizing disability by approaching proactively children who are at risk of disability and intervening during the critical period so that there is a chance of reversal and prevent/minimize disability (Prevents at risk children from becoming disabled)

SHRIMAD RAJCHANDRA DISTRICT EARLY INTERVENTION CENTRE

Learning Disability

Attention Deficit Disorder

Cerebral Palsy

Chest and Facial Physiotherapy in the NICU

ADOLESCENT GIRLS HEALTH EDUCATION THROUGH SCHOOL OUTREACH PROGRAM

HEALTH EDUCATION THROUGH SCHOOL OUTREACH

GLIMPSES OF SCHOOL HEALTH CHECKUP OUTREACH CAMPS

GLIMPSES OF THE MAMTA DIWAS OUTREACH PROGRAM

THE JOY OF GIVING !!

LETTERS FROM THE GOVT.OF GUJARAT

No:FW/RCH/CH/Letter to Shrimad Rajchandra Hospital
Date : 21/10/2013
Commissionerate of Health, Medical Services and Medical Education (HS),
Block No:5, Dr. Jivraj Mehta Bhavan,
Gandhinagar GUJARAT, INDIA – 382010.
079- 23253311   079 – 23253304
Email- nbdholakia@rediffmail.com

Dr. N. B. Dholakia
Additional Director [FW]

Dear Shri Jasani,

You must be aware that as per the Millennium Development Goal, Gujarat has to achieve an Infant Mortality Rate of 29 to be achieved by 2015. It is of immense pleasure for me to inform you that Gujarat has been successful in decreasing the IMR from 41 to 38 (as per SRS 2012). This means we have achieved an approximate 7.3 % decline in our IMR in one year.

I appreciate your organization's support which has been critical in this achievement. The Government of Gujarat is hopeful to continue this mutually rewarding association.

Best wishes,

Additional Director (FW)

To,

Shri Abhay Jasani,
President
Shrimad Rajchandra Mission
Dharampur, Valsad Gujarat

No:FW/RCH/CH/Letter to Shrimad Rajchandra Hospital
Date : 21/10/2013
Commissionerate of Health, Medical Services and Medical Education (HS),
Block No:5, Dr. Jivraj Mehta Bhavan,
Gandhinagar GUJARAT, INDIA – 382010.
079- 23253311   079 – 23253304
E-mail: nbdholakia@rediffmail.com

Dr. N. B. Dholakia
Additional Director [FW]

Dear Shri Jasani,

Gujarat has achieved a decline of 7.3% in Infant Mortality Rate (IMR) from 2011 to 2012. The State now has an IMR of 38.

I must share with you that during the National Best Practices Summit held in July 2013, the Public Private Partnership model of Gujarat were well appreciated by various policy makers from all over the country, present at the summit.

Also, the PPP model of Jambugam and your organization and Government of Gujarat was well appreciated. A team from National Health Systems Resource Centre (NHSRC) New Delhi also visited Gujarat to study the different PPP models running in our State and gave us a very strong positive feedback.

I congratulate your organization for a successful association with the Government of Gujarat, which has brought applauds to the State from all over the country.

Best wishes,

Additional Director (FW)

To,

Shri Abhay Jasani,
President
Shrimad Rajchandra Mission
Dharampur, Valsad Gujarat

ANOTHER ACKNOWLEDGEMENT

Shrimad Rajchandra Sarvamangal Trust
Attn. of Mr. Abhay Jasani, President
10-B, East Wing
Bombay Market Apts.
78 Tardeo Road
Mumbai 400034
INDIA

Küsnacht, 23 March 2015

Dear Ladies and Gentlemen

I am writing you as Chairman of the Board of Laguna and Tibetania Foundation which have both supported the activities and the development of the Shrimad Rajchandra Hospital in the past.

Tibetania and Laguna Foundation have examined a great number of charitable activities in Asia and Africa which have the aim to improve the life quality of poor segments of the population in a sustainable way. The Board has come to the conclusion that Shrimad Rajchandra Hospital is a show piece of a well-planned and well administrated charitable project. It is particularly impressive that the activities are lead by local persons with practical management experience and that this team is guided by the spirit of love and care for the poor.

This unique concept has impressed me deeply when I had the privilege of visiting the facilities of Shrimad Rajchandra Hospital a couple of years ago. We hope that the support and the success of the project serves as an example for similar activities in other poor areas of India. The Board of the Tibetania and the Laguna Foundation wishes that your spiritual community will be able to continue activities of humanitarian nature in the years to come.

Sincerely yours

Jürg Plattner

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Sincerely yours

Jürg Plattner

VISIT AND APPRECIATION BY PROMINENET GUESTS-
MR CHARLES IRION FROM PROJECT CURE ,USA

GOVERNMENT HEALTH SCHEMES IMPLEMENTED AT
SHRIMAD RAJCHANDRA HOSPITAL

• Bal Sakha Yojana (BSY)

• SARVA SHIKSHA ABHIYAN

• ADIP(ASSISTANCE TO DISABLED PERSONS)SCHEME

Shrimad Rajchandra Hospital, Dharampur

Shrimad Rajchandra Rural Health Project
Mobile Medical Clinics for Tribal Community Outreach Services

Operating Expenses Budgeted for F.Y. 2015 ~ 16

(Cumulatively, for all 3 Outreach Wings put together)

Sr. No.	Expense Head	Expenses (In Rs. Lakhs) Budgeted for F. Y. 2015 - 16	Remarks
1)	Staff Salaries	38.00	For totally 14 persons including Consultant (Community Medicine), Medical Staff (x3), Outreach Manager, Drivers, Compounders and Helpers
2)	Vehicle Charges	8.00	Fuel Costs, Maintenance Charges etc. for totally three Outreach Vehicles
3)	Medicines and Treatment Charges	50.00	Medicines for 70,000 patients treated in the Outreach and Medicines and Treatment Charges for patients referred from the Outreach to the OPD and IPD Departments of Shrimad Rajchandra Hospital
4)	Miscellaneous Expenses	9.00	Printing of Outreach Stationery and conducting of Outreach Camps including Health Awareness Programmes
	Total of 1) ... 4)	105.00	

SCALABILITY AND LIMITATIONS

- BOON FOR THOSE DEPRIVED TRIBAL AND POOR PEOPLE WHO DON'T HAVE ACCESS TO BASIC PRIMARY AND QUALITY HEALTHCARE

- THROUGH PROMOTIVE, PREVENTIVE AND CURATIVE AND REHABILITATIVE APPROACH WE HOPE TO ENSURE LONG TERM AND SUSTAINED BENEFITS ON HEALTH OF TRIBAL COMMUNITY

- CO-OPERATION AND LIASION WITH GOVERNMENT HEALTH SYSTEM AND OTHER NGOS STRENGTHENS THE EFFORTS AND AVOIDS DUPLICATION

- IT CAN BE EASILY REPLICATED BY ANY ORGANIZATION. TO FACILITATE THIS PROCESS, A SOP HAS BEEN LAID DOWN IN A COMPREHENSIVE DOCUMENT WHICH RUNS INTO 50 PAGES.

- SUSTAINED AND COMBINED EFFORTS HAS BROUGHT ABOUT CHANGE IN HEALTH INDICATORS OF THE AREA AS EVIDENT FROM STATISTICS (REDUCTION IN IMR TO 38)

- RISING COST OF RUNNING THE PROGRAM CAN BE A CONSTRAINT

Questions and answers

Q: What is the number of villages that you cover once a month and the distance from your hospital? And another questions is, you said there's a doctor, is there a scope of counsellor there?

A: We are covering 45 villages .We are running two outreach centres. The radius which we are covering is around 60kms. So our farthest centre is 60 km from our tertiary. There is no counsellor. Basically we have trained our Medical Officer and our dispenser. They also give health messages.

Q: You are saying that you are providing comprehensive primary care. Are you performing any basic diagnostic test taking into consideration that NCD is a problem. Secondly, what is the cost per patient?

A: Doctor has to monitor blood pressure of each and every patient. So at least once if the patient comes blood pressure gets checked. We also have glucometer with the doctors to screen for diabetes. We have got the primary drugs for diabetes and hypertension also. For the second question, the overall cost including the inpatient comes up to roughly Rs 100-150 per patient. Patients are given free of cost treatment and medication in the hospital.

Chairpersons' questions and comments

Dr. Abhay Bang

Religiously or spiritually motivated charitable organizations like this can provide secondary and tertiary care well which government often finds difficult. So, maybe that vacuum can be partly filled by collaboration between government and these charitable organizations who are able to mobilize high quality specialist care by voluntary motivated doctors. Congratulations for doing that!

It looks to me like the apex care without the base. You have a 10 bedded NICU, as you have shown. What is the newborn care in the villages? In the absence of new born care in the village to build 10 bedded NICU is apex without base. As much as possible the care must be moved towards the community.

MMU is an excellent idea to provide outreach. NRHM has already done it. At one time it was 400 MMUs and now it is 1400 MMUs. Of course several of the operations of MMUs can be continued to be improved and some of the lessons might be there in your model.

Next, what is your outcome? Providing comprehensive primary care with primary, secondary, tertiary and rehabilitation is a broad vision. But within that probably one needs to define the outcome otherwise number of patients becomes the goal which should not be the goal. So I share your joy that large number of patients are coming to your hospital but that cannot be the impact that you're working for. So, that's a good service data but find out what is the expected outcome that you're working for. What is the expected impact. You need to monitor where do you want to reach and not how much diesel did you consume.

A: Actually the presentation is in the form of a story. We first started with a hospital, then there was a need of a camp, then there was a need of an outreach, then because we had to refer the neonates to Varsad we now have an NICU.

<u>Dr. Abhay Bang</u>

That's very fine. But, tertiary care without primary care, that's the problem I can notice in the model. Not only in your hospital health care model but also in the rehabilitation model. But, that's not the model of healthcare that we would like to have. Apex without base. And so I would like to suggest that you need to reexamine. What you're doing is very useful but what you're missing out is also very vital.

20

Sickle Cell Anemia Screening
in Tribal population of Gujarat

Health & Family Welfare Department
GUJARAT

Freedom
from
Agony

Sickle Cell Anemia (SCA) in Gujarat
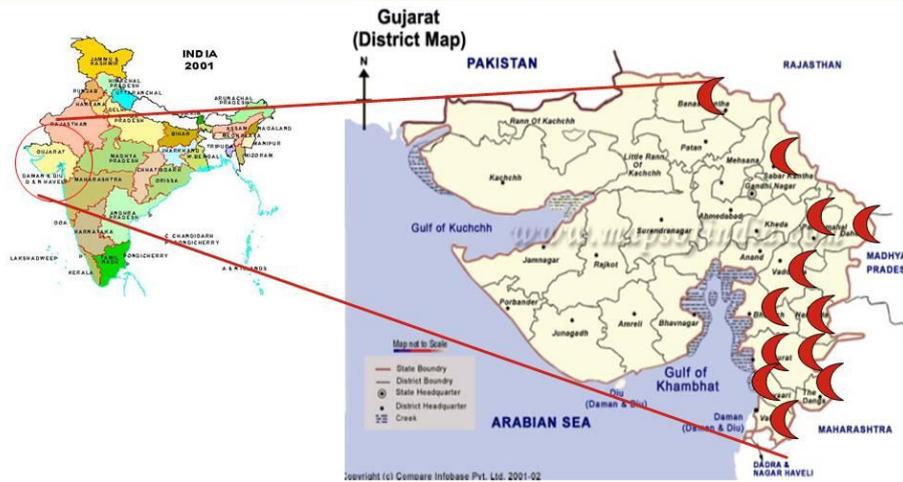
Rationale
of selecting Sickle Cell Anemia Screening

- Genetic blood disorder-mainly seen among tribal
- Prevalent in all 14 tribal districts of Gujarat.
- Sickle Cell gene HbS prevalence is 5 to 34 %- in different tribal groups –while prevalence of disease may be 0.5-2%.(ICMR 2002)
- 20% of SCD children die within first 2 years of life.
- Further, 10% expire before age of 14
- Most of the people suffering from SCD die before 50.
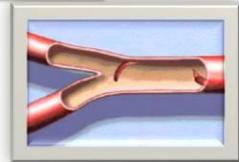
Precise Problem Statement

- Disease specific in medically underserved population belonging to lower socio-economic class living in remote areas, difficult terrain.

- Affects 14.8% population of Gujarat (Tribal population is 8.6% in India)

- No cure of the disease. Prevention is the only feasible solution.

- Often misdiagnosed as Iron Deficiency Anemia leading to improper treatment.

Goal of the Best Practice

Screening of entire tribal population by 2015 along   with treatment and counseling to ensure Prevention of deaths from Sickle Cell Crisis.

Reducing burden of Sickle Cell Disease, and thereby increasing **productivity, longevity and quality of life** among tribal through Screening throughout the life stages, Early Diagnosis, Prompt Treatment and Counseling for preventing transmission of disease to next generation.

2006	• Program started in 5 districts of South Gujarat on PPP basis
2008	• Extended to remaining 7 tribal districts of Gujarat
2011	• Gujarat Sickle Cell Anemia Control Society formed to integrate efforts by different departments
2012	• Screening outsourced to qualified, competent & dedicated competitive agencies
2015	• Prenatal diagnosis for Sickle Cell Anaemia

Details of best practice

- Autonomous Society with governing body under the Chairmanship of Hon. Health Minister and Executive Committee under PS (PH & FW) was formed to expedite implementation of program. And to provide participative framework for all stakeholders- MLAs, PRIs, Professional Bodies etc

- Outsourcing of district wise screening work to up scale the Sickle Cell Anemia screening in tribal. Ensures Accessibility, Equity, Transparency, Flexibility, Autonomy for Time –bound implementation.

- **Active screening** in Mission Mode as **Flagship Scheme of the State** is effective and assured tool to reach underserved Tribal Population to know the SCA Burden and timely interventions.

Delivery System
Institutions involved in the program

Sr. No.	Institutions	Year 2006-07	Year 2015
1	Medical Colleges	1	6
2	General Hospitals	3	11
3	PHCs	44	381
4	CHCs	29	69
5	NGO/ Private Agencies	1	7
	Total	**78**	**450**

Delivery System
Facilities made available

Sr. No.	Facilities available	Year 2006-07	Year 2015
1	Facilities for Primary Screening for Sickle Cell (DTT) test, Counseling and Treatment	78	450
2	HPLC based Hb Variant system for quantitative estimation of different hemoglobin	2	9
3	HPLC based Variant-NBS system for New Born Screening for SCA from heel prick	0	6
4	Molecular Lab for Pre-natal Diagnosis and Genetic Counseling Centers	0	2

Early diagnosis through
- Antenatal Screening
- Adolescent Screening
- Mass Screening on mission mode
- Newborn Screening
- Prenatal Diagnosis

Prevention through
- Marriage Counseling
- Genetic Counseling
- Building Community Awareness

Reduction in crisis & in mortality through
- Supportive treatment
- Regular follow up and counseling
- Life saving drug like Hydroxyurea
- Pneumococcal vaccination
- Advanced tertiary care centers

Regular Training and capacity building of
- Health care providers & ASHA
- VHSNC (Gram Sanjeevani Samitis) members & Teachers
- Providing program manual

Sickle Cell Card

Normal   **Sickle Cell Trait**   **Sickle Cell Disease**

Year wise Screening of Tribal Population for SCA
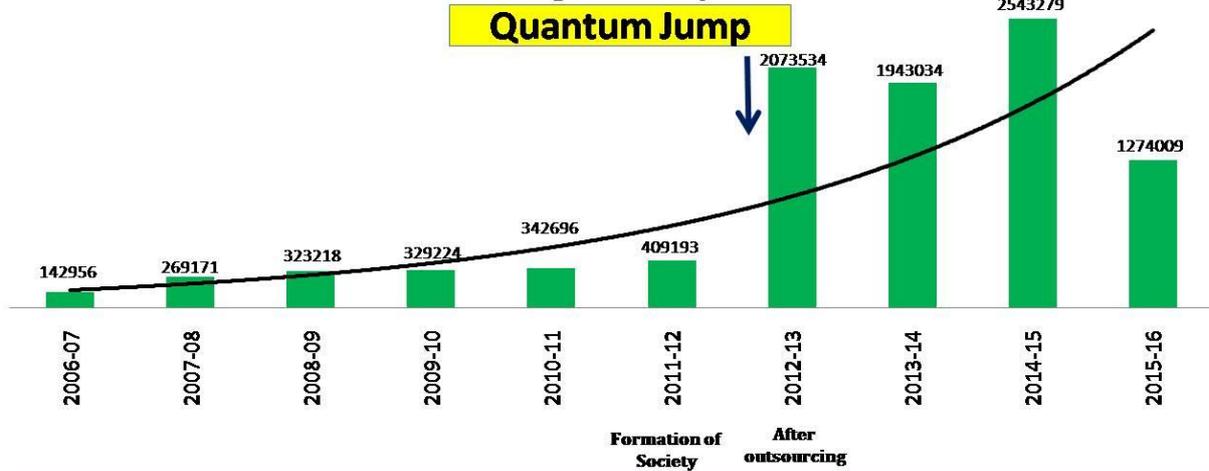
Quantum Jump

Year	Value
2006-07	142956
2007-08	269171
2008-09	323218
2009-10	329224
2010-11	342696
2011-12	409193
2012-13	2073534
2013-14	1943034
2014-15	2543279
2015-16	1274009

Formation of Society   After outsourcing

- 87% of tribal population (80.6 lacs) screened.

- Of which 7,66,954 (7.9%) are Sickle Cell Trait while 29,309 (0.31%) are diagnosed with Sickle Cell Disease.

- Regular Counseling at doorsteps of beneficiaries.

- Daily Folic Acid supplementation to all SCD patient to prevent anemia.

- Life-saving Hydroxyurea therapy to needy SCD patients

- 16,000 persons with SCD protected with Pneumococcal Vaccine

- Free blood transfusion to more than 1,900 patients in last year.

- More than 32,000 Antenatal screening, and 9,000 Newborn screening during year.

- More than 145 Prenatal diagnosis, 5 MTP during the year.

- Knowledge Sharing, Technical support by National and International experts (ICMR & SCDIO)

- Web Based Application - for Data collection and online tracking

- Application of modern techniques and research in the field situations - **Stem Cell Research,** etc.

Sickle Cell Screening Camp at Village Level

SCD Follow up Camp at Village Level & Counseling

- Though the program initially started with NGO participation, it has been now been integrated with the General Health Services through training and capacity building of the government service providers.

- Program approach gives wider reach and long term focus.

- Demand generation from the community due to their sensitization and awareness building.

- Training and capacity building of private service providers.

- Mass support to the program.

- Scientific approach along with dedicated team can reduce disease burden and provide medical relief to patients despite limitations of medical science.

Recognition

लोक प्रशासन में उत्कृष्टता के लिए प्रधानमंत्री पुरस्कार
वर्ष 2009–10 के लिए
स्वास्थ्य, चिकित्सा सेवाएं एवं चिकित्सा शिक्षा आयुक्तालय, गुजरात
को
उनकी उत्कृष्ट पहल
'सिकल सेल ऐनिमिया कन्ट्रोल प्रोग्राम, गुजरात सरकार'
के लिए प्रदान किया गया

PRIME MINISTER'S AWARD
for Excellence in Public Administration
for the year 2009-10
presented to
Commissionerate Health, Medical Services
& Medical Education, Gujarat
for its outstanding initiative
'Sickle Cell Anemia Control Program,
Government of Gujarat'

नई दिल्ली   डॉ. मनमोहन सिंह
दिनांक : 21 अप्रैल 2011   भारत के प्रधानमंत्री
New Delhi   DR. MANMOHAN SINGH
Date : 21 April 2011   Prime Minister of India

PM Award
for
Excellence in
Public
Administration

Limitations

- Resource intensive campaign

- Initial resistance in community for screening

- Accessibilities of services

- Migration of SCD patients resulting in irregular follow up

Conditions necessary for successful implementation

- Strong political commitment with flexibility in implementation through autonomous society to garnish Inter departmental convergence along with participation from Local Self government, PRI, Non – Governmental Organizations and Professional Bodies along with community awareness and participation needed to augment ongoing activities of program.
- Capacity building of field workers e.g. ASHA, Anganwadi Workers, Paramedics and Medics.
- Resource intensive campaign

- Non-tribal population Screening to know Sickle Cell gene prevalence.

- Research on Stem Cell Therapy for the treatment of SCD patients

- ?? National Sickle Cell Anemia Program-

- More than 100 million tribal of which 10 lacs may have Sickle Cell Disease.

- Most of tribal belt is endemic for Malaria

- Universal guideline for disease.

- Convergence between departments of Government and dedicated NGOs.

SCA requires Priority Attention....!
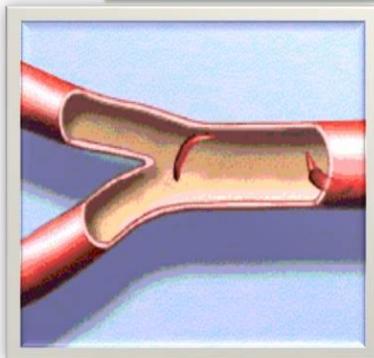
Our Indian Sicklers

Born with Pain , Live with Pain

&

Die with Pain.

They hardly Complain

Not So Anymore in Gujarat

Thanks...

Questions and answers

Q: *Dr.Yogesh*: What is the budget allotted for Sickle Cell Programme?

A: We are supported by NHM. We are getting Rs 9 crores from state but there is no limitation to budget. It is not a constraint for this project.

Q: *Dr. Sudarshan:* You have suggested that it can be integrated with the RBSY in tribal areas, if I understand correctly this is a state wide programme which screens the entire community. It is for 2 purposes (1) for medical relief from sickle cell disease and (2) prevent sickle cell from happening. For medical relief I would have been relieved if you had shown data about number of deaths or about complications of sickle cell that you see along the trends for the next few years but you have talked about your screening percentage. You haven't shown here how many of them use Hydroxyurea. Screening to reduce the occurring of sickle cell disease, your data should show the prevalence of sickle cell.

A: What I would like to mention here is that it was initially a modest programme by the NGO to screen and to create awareness on sickle cell anaemia among the tribal people, by the medical fraternity and to sensitize the government. So initially we scaled up and the first target we had was to screen the entire population. It is early to say how much we have succeeded in preventing sickle cell because we are still learning from other partners and still setting up for the first time to complete tribal screening by 2015.

Q: *Dr. Sudarshan* It is really exciting that a government agency could take it up. Yours is a model for the best practice for the state and other states should copy from this. Karnataka is struggling.

There are certain screenings you have done well and management is also important. But you are jumping into pre natal diagnosis be very cautious its double edged weapon. With five places involved what is the cost for prenatal diagnosis and why should you do this? People are surviving in spite of any intervention for 50 years. I don't know if it's ethical at this stage to jump into prenatal diagnosis. Maybe private sector is pushing into all this so that they can use ultrasound as a weapon and that comes with complications. I would cautiously say that invest more on the treatment of the patient than on prenatal diagnosis.

A: *Dr.John Oomman* I want to say that if this entire screening programme is a huge project, a huge amount of money will be invested. Our objective is to prevent incidence of sickle cell disease for future generations. For example In Italy it took 10 years to break out one percent prevalence of sickle cell disease. If we are doing the screening what is the purpose of doing this on such a large scale, and that if we are not even following it up with IEC programme. Another problem is that if you do marriage counselling, I would like to know if you have not studied social stigmatization. There is human discrimination among the girls who carry this and they are not getting married. Be very cautious about your purpose of such a huge screening, at such huge amount of investment. This has to be followed by IEC.

A: IEC is the second most important thing we are looking into for patients with sickle cell disease.

Q: *Dr. Sudarshan:* I think screening is not needed because we cannot do genetic counselling and prevent it. Sickle cell disease is in itself a problem; we don't need cards for the sickle cell and marriage counselling. For the last 35 years I am doing this and we have not succeeded and it's impossible. So, what I would suggest is that if screening is needed to detect sickle cell disease, give them Folic Acid and manage the sickle cell crisis if you want to manage that disease.

Chairpersons' questions and comments

Dr. Abhay Bang

I began our research work in Gadchiroli 30 years ago with the problem of sickle cell disease. After conducting a district sample survey and assessing the prevalence of sickle cell trait to be 15%, when the government didn't do anything we went back to the tribal leaders. They cockily looked at us and asked, "Who told you that this is our problem? It's your problem. You came, asked for the blood and we gave. Beyond that we don't have anything to do with this." The story raises a question for us, the scientists, interventionists, public health activists, is this a real priority? Do we have the data? We have data about prevalence. Sickle cell was first detected in Nagpur, in 1950, and ever since large amount of surveys have been conducted only to find about the prevalence. The questions that need answers are what is the morbidity load, the mortality load, the reduced life expectancy due to sickle cell in India, the disability, daily wage loss, the productivity loss etc. At least I am not aware of any data

portraying these. And, we have suddenly jumped on to a National Intervention Programme. I am a student of this for the past 30 years. It's a very evidence-less policy.

You screen everybody. My first question is why do you screen everybody when actually the only time you can do a preventive intervention is either before or immediately after marriage? For the others, you can treat only if they have symptoms. If you are to include marriage counselling then I will say screen only below 25 years, forget the older adults. As of now, you are not even carrying out marriage counselling. Why you are then screening? Those who are symptomatic should get the care. Several of the persons with the S-S show no symptoms. I have seen a 65 year old person from Gond tribe. He happened to be in our random sample and was found to be an S-S. We repeated the tests thrice because we couldn't believe that a 65 year old was surviving without a single symptom of sickle cell. Point here is, that probably many of them are asymptomatic or mild symptomatic. So, it is those with severe symptoms that definitely deserve treatment. Why do you have to screen everybody?

What is needed is to sensitise medical care centres, the PHCs and CHCs, for whoever came with symptoms suggestive of the sickle do the test. So we need to increase the index of the suspicion and diagnostic facilities at the PHCs, all public health care facilities or even private facility. Investigate those who go repeatedly to health care facility, instead of starting from the whole population denominator, since you're anyway going to do provide care only to the symptomatic. I really don't understand the strategy of the whole programme for doing mass screening first, as we don't have any quantitative evidence of the disease burden, mortality burden, cost burden etc.

Next, is this the priority of the tribal people? Prevalence as 13%, or 20% or 30% does not mean it's a public health priority as it has to cause severe morbidity, mortality, disability or something, but we don't have the data, and you have made it a priority. Actually, there is a wonderful opportunity now as you have 29,000 cases detected. If you spend all your money in a cohort study you will get an answer for the first time in India on the Indian sickle disease. How much life expectancy has been reduced by this disease? There could be severe manifestations in a subgroup, and mild or no manifestations in the other sub-group. Actually, the programme might be needed only to address the severe clinical manifestations. To me, the whole strategy needs to be thought about again.

Secondly, I do not know if we have really assessed - has the marriage counselling prevented the inter-marriages among the carriers? I don't know if anyone in India has studied, whether health counselling has prevented marriages. Several of you say that it does not work. It needs more evidence.

Also, what is the cost effectiveness? The cost spent to detect one Sickle cell case? Otherwise, you will be creating stigma, diverting money, time and resource from more priority problems like TB, iron deficiency anaemia etc. The iron deficiency anaemia prevalence is much more than this. You have forgotten it. You run to address the problem having only 0.3% prevalence. This is a classic example of how programmes and policies are made without evidence. Sorry to have to be so severely critical. I have personally blundered 30 years ago. You are repeating it.

21

SughaVazhvu
Healthcare

Enrolment and Rapid Risk Assessment (E&RRA)

Best Practices in Tribal Healthcare
Shodhgram, Gadchiroli
October 11 - 13, 2015

Dr Bejoy Daniel

IKP Trust and SughaVazhvu

HEALTH is HAPPINESS

IKP Knowledge Park

IKP Centre for Technologies in Public Health (ICTPH)

SughaVazhvu Healthcare

Innovation * Knowledge * Progress

IKP Centre for Advancement in Agricultural Practice (ICAAP)

IKP Investment Management Company (IKPIMC)
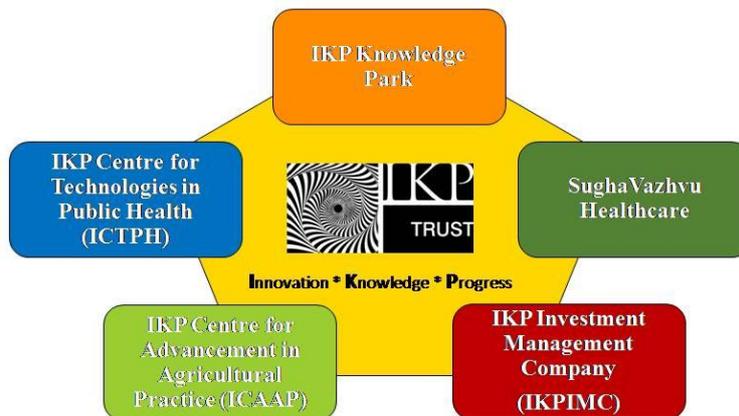
Rural Primary Health Care

➢ In Thanjavur, in and surrounding the Orthanadu Block
➢ Serving 7 catchments
➢ Serving a Population of approx. 75,000 individuals

RMHC

COMMUNITY ENGAGEMENT

RURAL DIAGNOSTICS

RISK SCREENING

SUBSCRIPTION-BASED DISEASE MANAGEMENT

RURAL PRIMARY HEALTHCARE NETWORK

TECHNOLOGY

CLINICAL PROTOCOLS

HUMAN RESOURCE
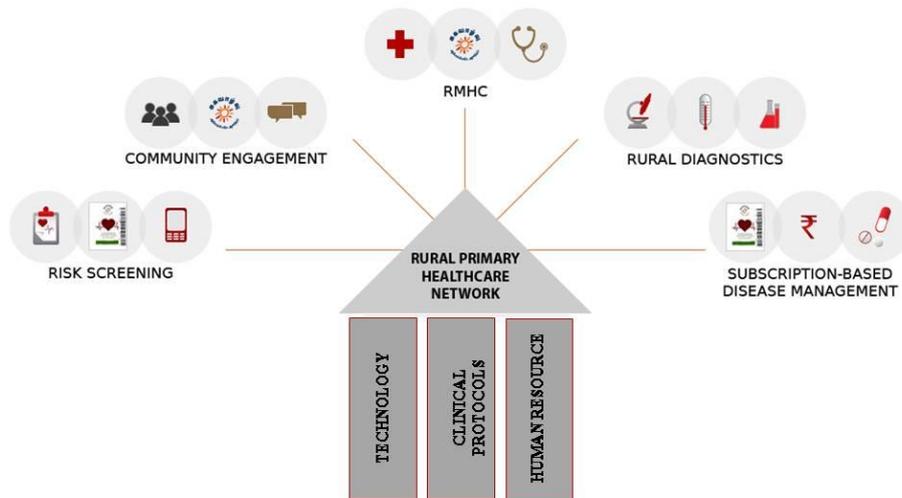
The Challenges

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62

Research indicates that 62 percent of deaths in LMICs occur due to NCDs.

Source: WHO estimates, 2008

48

Cardiovascular Diseases (CVDs) contribute to approximately 48% of all NCD-related deaths.

Source: WHO estimates, 2008

80

LMICs like India are disproportionately affected by CVDs, with ~80% of all CVD-related deaths occurring in these countries

Source: WHO report, 2011

• **Severe and growing chronic disease burden in India**
- ➢ **Diabetes and hypertension** are major public health challenges and key risk factors for cardiovascular diseases.
- ➢ India, which is fast on its way to becoming **the diabetic capital of the world, had over 60 million diabetic population** according to a 2011 estimate.

• **Debilitating impact on patients' conditions**
- ➢ A World Bank paper in 2010 indicates that assuming all caregivers and sick individuals above the age of 15 years were productive, yielded an **annual income loss of around INR 300 billion due to CVDs and hypertension.**

• **Exacerbation of the problem in rural areas due to lack of awareness and lack of care access**

Early identification and managed care of chronic conditions can enhance health outcomes and reduce OOP expenses, especially in tribal and rural areas. This is the problem the E&RRA best practice seeks to accomplish.
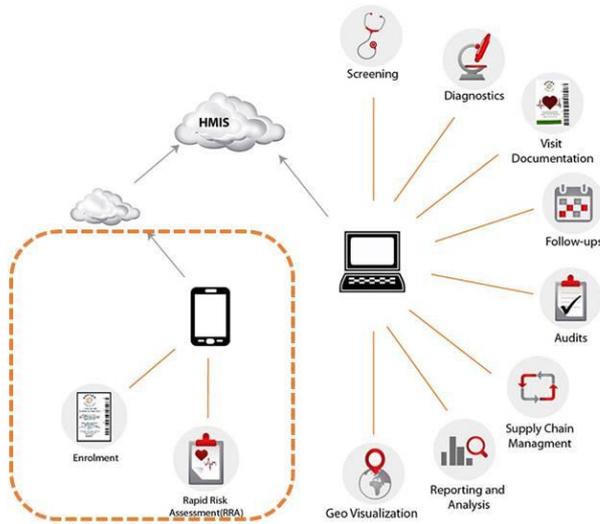
- **Enrol all residents of a community into the community level primary care clinic**
  - At household level
  - Including basic demographic data
  - Family health history of all members of the household

- **Conduct a rapid-risk assessment (RRA) exercise**
  - Provides an immediate and on-the-spot risk score of an individual
  - Indicating vulnerability to a chronic disease (presently hypertension, hyperlipidemia and diabetes).
  - The assessment can either be stratified (say, as low-medium-high risk) or binary (risk / no-risk).

This enables identification of high-risk individuals who can be diagnosed for confirmation.

Enrollment Exercise

HEALTH is HAPPINESS

Enrol all residents of a community into the community level primary care clinic

- A health extension worker (HEW), typically from the community being served, visits all households in the community
- Enrolls all residents with the help of an internet-enabled mobile communications device that can take in all the enrollment data and sync with the community HMIS (health management information system).
- The enrollment data includes basic demographic data and family health history of all residents of the community.
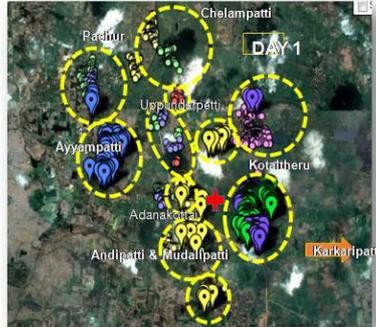
Enrollment of residents of a community into the community level primary care clinic

➢ A health extension worker (HEW), typically also geo tags the household in terms of latitude and longitude geo cordinates
➢ With the geo tag, the HMIS is able to plot the distribution of enrolled population and their vicinity to the health care center
➢ The geo coordinates can be used to color code various population, street wise and village wise

Enrollment residents of a community visiting the centre

➢ The household ID helps identify the individual at a household level and village level
➢ Every visit is documented and can be viewed, such as
  ➢ The Visit details
  ➢ The Diagnostic visit details
  ➢ Previous visits details

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Our risk screening tool is based on the WHO Steps guidelines and risk is calculate based on six non-invasive risk parameters

➢ Body Mass Index (BMI)
➢ Waist Hip Ratio (WHR)
➢ Tobacco consumption
➢ Personal history
➢ Age
➢ Blood pressure reading

Community Health Mapping

HEALTH is HAPPINESS

Disease Surveillance Map

Representative map of the enrolled population ( ) in a catchment served by one of our clinics ( ) showing the population diagnosed with a chronic disease ( ) in the year 2013 at our clinic.
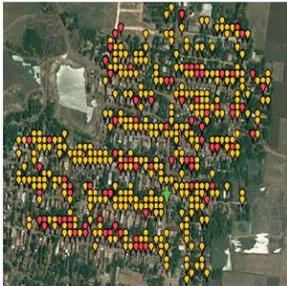
Risk Factor Screening Map

Representative mapping of a community based, android phone enabled risk screening exercise identifying individuals at low risk ( ), medium risk ( ) & high risk ( ) for cardiovascular diseases.

Variations in RRA

(1) RRA can be a part of population enrolment activity during initial clinic set-up in one catchment, or as an individual intervention to assess CVD risk in the area and as part of offering chronic disease management services.

(2) RRA can be done to drive diagnostic samples for individuals identified as "at Risk". This tough is a low cost procedure can result in low patient turn over. Another alternative to the same approach is to club RRA with a Strip test to ensure a more focused group that can be pushed for diagnostic sampling. However clubbing RRA with strip tests might be a more expensive alternative.

(3) The RRA can be used to identify risk in a binary methodology, wherein the presence of an risk factor would categories the patient as "at Risk". An alternative to this approach would be the stratified method. In this form of RRA, each factor would carry a certain weightage and hence would enable in classifying the patients as – Low, Medium and High Risk categories.

In the SughaVazhvu context, the RRA has been administered in three different scenarios:

(1) As part of population enrolment activity during initial clinic set-up in one catchment

(2) As an individual intervention to assess CVD risk in the area in another catchment

(3) Across the network as part of offering chronic disease management services.

➤ The first two RRA exercises covered groups of more than 3,000 individuals, in both cases.

➤ The approximate percentage of "at-risk-for-CVD" population was respectively 57% and 68%, as determined by persons with two or more risk factors for CVD.

➤ A segment of these "at risk" individuals availed confirmatory diagnostic testing; over 50% of those were confirmed for diabetes, hypertension or hyperlipidemia, which are strong predictors for heart attacks and strokes

Limitations in Practice (if in Tribal Area)

- **Training:**
  - ➤ The HEWs who conduct E&RRA must be well-trained not only in using the mobile device but also in eliciting information from residents of the community and entering it.
  - ➤ Any cracks in accuracy or shortcuts in obtaining complete information can severely compromise potential benefit.
- **Connectivity**: The impact of the exercise will be significantly reduced if the mobile device is not connected to the internet while the E&RRA is being administered in the field.
- **Behavioural / cultural aspects of the community**: It could sometimes create barriers in conducting successful E&RRA. It will be important to overcome these barriers through engagement of key opinion leaders, outreach, collaboration with local NGOs and government.
- **Effectiveness**: E&RRA exercise is only a first step in providing managed primary care to a community (with special focus on chronic care management). If it has to be effective, it has to be backed by :
  - *(a) completing the diagnostic cycle by following up RRA with confirmative diagnostic tests*
  - *(b) provision of managed care to confirmed chronic disease patients. Unless these two are also accomplished, the overall impact of RRA will be limited.*

HEALTH is
HAPPINESS

Based on SughaVazhvu's experience:
- E&RRA for a 3000 person / 600 household community is approximately a 120 person-day activity.
- While it is desirable to complete this as a one-time set-up activity (say, over a 3-month period), depending on the availability of trained HEWs, it could also be executed at a slower pace.
- Practically, this activity could be completed even by a single HEW, even if takes longer.
- For a typical community of 600 households and 3,000 population, a one-time E&RRA exercise will cost approximately Rs. 50,000.

To that extent, E&RRA is a fairly scalable activity at the level of a community. As long as the underlying primary care clinic model is scalable, E&RRA activity in the catchment area of each clinic is also scalable

Thank you

Gadchiroli,
2015

Questions and answers

Q: Are e-prescriptions legal?

A: No it's not legal. Tele-prescriptions in India are not legal yet, either.

Q: Are you doing biometrics for the enrolled patients?

A: No, we can't do the biometrics.

Chairpersons' questions and comments

Dr. Abhay Bang:

Question can be asked as to why this best practice was invited into the workshop, when the area of operation is not tribal and some of you might also feel that the problems they have been working on are not the priority problems of the tribal's yet. Actually, 2 practices of this organisation were selected and the main reason being, though their area is not tribal, the problems and approaches used are very relevant to tribal populations. This organisation is one of the first few that started working on chronic non-communicable diseases, and that is why it is selected as a best practice. The work is being done in the state and in an area where the other problems are relatively over and these problems emerge as priority. If you look at the National Nutrition Monitoring Bureau, a report on Tribal Health, from 9 states was studied and they found that 24% of tribal adults have hypertension. Hypertension and diabetes is gradually increasing. Tobacco and alcohol are great problems of tribal people. Non-communicable diseases are already knocking on their doors as well. So, health care community which works on the health problems of the tribal people must take into consideration these problems.

They have made wonderful use of technology and creatively. We need to start building models today, so that tomorrow when connectivity is available it can be used. They have used pre-payment model which might not be applicable in tribal areas. The question will be raised whether it is fair to ask for pre-payment in tribal population. So some of the aspects of their model are very relevant to the situation of Tamil Nadu where they operate. But the

problems on which they are working, their approach, the risk detection, the use of IT and the use of manpower etc are the aspects in their approach relevant to us.

At this moment it will be too premature to conclude. I am just quoting their own write-up. Sugha Vazhvu NCD project has been launched recently and overall impact has not been claimed to be recorded. They are very forthright about it. So far only a total of 388 adults have enrolled for the package, out of which 151 have renewed and currently 84 patients have active subscriptions. So it is too early. This approach is being piloted and tested. We wish them well so that this may help other people to think creatively and take some of the elements of their approach.

22

PROJECT AVVAL

24x7 INTEGRATED CALL CENTRE AND AMBULANCE SERVICES

100 % INSTITUTIONAL DELIVERIES PROJECT

INTEGRATED TRIBAL DEVELOPMENT AGENCY (ITDA), UTNOOR

Tribal Context and ITDA

Major Tribal Groups

- Gond, Kolam, Naikpod, Thoti, Pardhan, Lambada
- 18% of total population

Integrated Tribal Development Agency (ITDA)

- Nodal agency for Tribal Welfare in Adilabad
- Education, Health, Infrastructure, Drinking Water, Irrigation, Livelihoods
- Works spans in 44 mandals

Infant & Maternal Mortality Indicators

Infant Mortality Rate
District - wise

Infant Mortality Rate
- 21 - 28
- 28 - 35
- 35 - 42
- 42 - 49
- 49 - 56
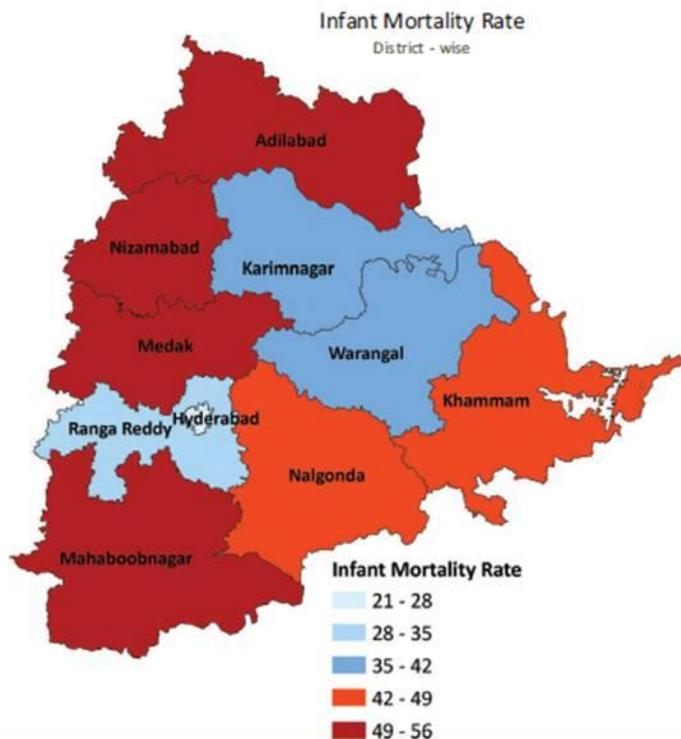
Adilabad	56
Telangana	**47**
Districts in Telangana with High IMR (50 and >)	Mahabubnagar-63 Nalgonda-55
	Medak-57 Khammam-53 Nizamabad-56

UP-61	MP-62
Odisha-61	Assam-58

Kenya-48	Uganda-44
Togo-56	Sweden-2 Denmark-3
Zambia-56	
Zimbabwe-55	Canada-5 Netherland-3

Source: Commissioner, Health and Family Welfare, GoTS

ADILABAD DIST.MA
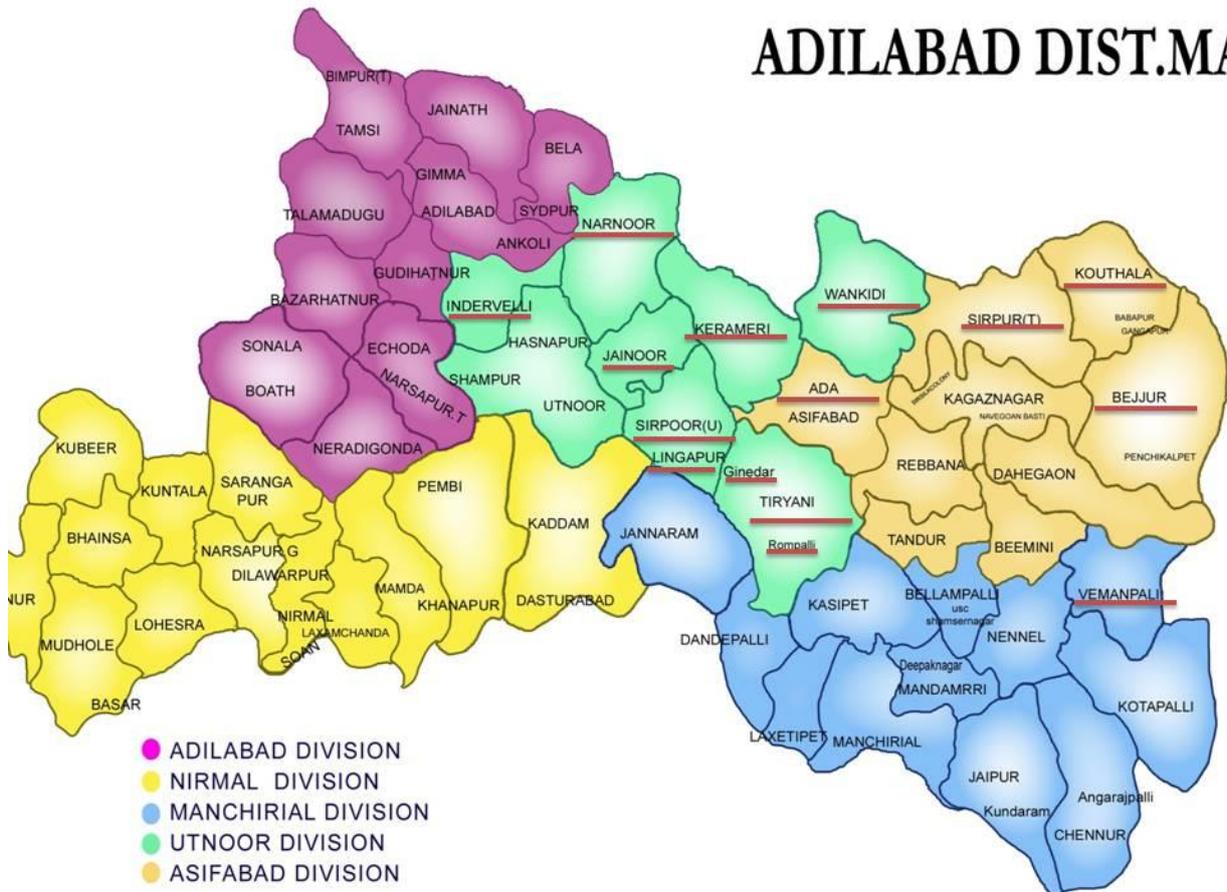
Problem – High Cases of Mortalities

- Why Mortalities?
- Low rates of accessing maternal services
- Malnutrition
- **Home Deliveries**
- Cultural Inhibitions

- Economic Reasons – Rs.2000-3000 / Rs.30000
- Terrain – Interior Places_Long Distances
- Poor Service Delivery

VISION

- REDUCE HOME DELIVERIES IN ADILABAD DISTRICT **TO ZERO**

- **TRACK ALL CASES OF PREGNANCY**

- FACILITATE FOR **100% INSTITUTIONAL DELIVERY** AS A MEANS TO REDUCE IMR <10 IN 3 YEARS

OBJECTIVES

1. TRACKING EXPECTANT MOTHERS WITH EDD
2. REDUCING **HOME DELIVERIES TO ZERO** IN THE TRIBAL MANDALS

- Enhance Maternal Servies to tribal populace of Adilabad

24x7 CALL CENTRE SERVICES

1800-4255-226
08731-274200

What Are we doing?
STEP 1 : TRACKING EDDs

1
- COLLECT DATA OF EXPECTANT MOTHERS FOR EACH MANDAL FROM PHC

2
- CALLS TO FAMILIES BEFORE DUE DATE
- ANMs, AWWs AT VILLAGE LEVEL

WORKFLOW

|::24x7CALL CENTRE AND AMBULANCE SERVICES- WORK FLOW ::|

1. Tracking EDDs
2. Call from Family
Call Centre
Message Alerts
Ambulance Driver
ANM — Med. Officer — ADMHO — PO, ITDA
For Pick-Up
3. Admit in Hospital
HOSPITAL
SAFE MOTHER - HEALTHY CHILD
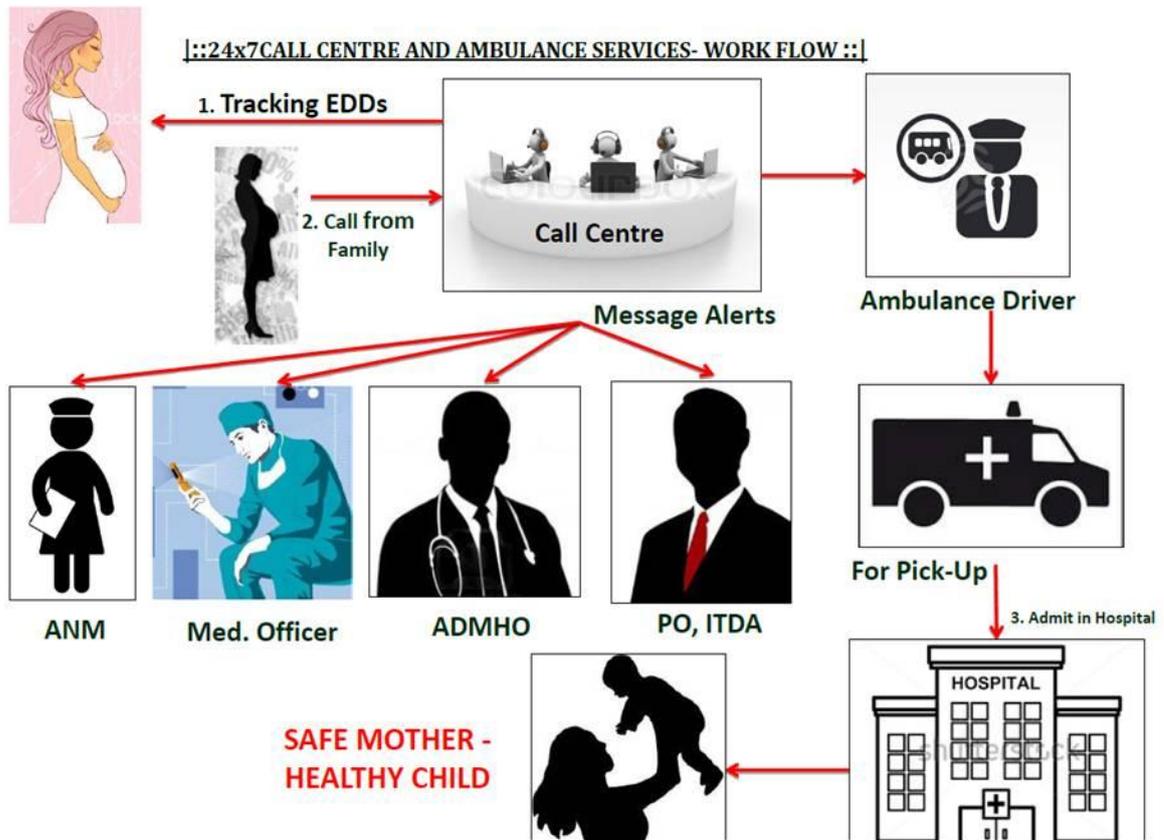
www.callcenter.itdautnoor.com/admin

Mandal	No. Of Cases			Delivery in PHC		Baby Gender		Baby Condition				Baby Weight	
	No.Of Cases Registered	No. Of Cases Updated	No. of Cases Not Updated	Normal	Cesarean	Male	Female	Normal	Abnormal	Baby Complicated	Still Birth	Below 2.5 Kgs	Above 2.5 Kgs
Jainoor	98	97	1	68	5	33	34	64	2	4	2	18	50
Narnoor	333	328	5	233	26	123	108	218	11	26	4	40	193
Sirpur-U	190	188	2	146	5	72	73	138	5	10	3	45	101
Kerameri	259	256	3	205	14	99	105	197	6	16	5	47	161
Asifabad	259	254	5	181	34	96	91	179	5	12	3	38	149
Wankidi	227	225	2	201	12	104	101	192	8	10	5	43	162
Thamsi	195	194	1	176	6	82	93	165	5	6	6	22	154
Sirpur-T	51	49	2	33	11	20	16	33	1	2	0	9	25
Koutala	60	59	1	31	18	20	12	32	0	1	1	10	23
Total :	3033	3009	24	1274	131	649	633	1218	43	87	29	272	1018

ALL ABSTRACT REPORT

Our Travel So Far

13 FEB'14

Started @ Narnoor

Feb – 6 Deliveries

Apr/May

Extended to other 6 mandals

25 Oct'14

1000 Deliveries

Apr'15

1000 Deliveries.

Added 2 mandals

Oct'15

Completed 3000 Deliveries

4 New mandals

13 Mandals
20 PHCs
Total Population: 4,97,650

RESULTS

Mandal	Total Home Del.		Avg. No. of Home Del. / Month	
	2013	Project Period Feb'14– Feb'15	2013	Project Period Feb'14– Feb'15
Narnoor	138	47	12	4
Jainoor	210	87	18	7
Sirpur-U	146	89	12	7
Kerameri	401	170	33	14
Wankidi	354	174	30	15
Asifabad	395	208	33	17
Tamsi	124	16	10	1
Total	1768	791		

Mandal	% Home Del. / Month		% decrease in Home Del./Month
	2013	Project Period	
Narnoor	25	12	13
Jainoor	32	11	21
Sirpur-U	48	27	21
Kerameri	59	18.3	40.7
Wankidi	49	22	27
Asifabad	36	17	19
Tamsi	35	4	31

STRENGTHENING PHCs

PHC	Total PHC Del.		Avg. No. of Del. At PHC/month	
	2013	Project Period Feb'14–Feb'15	2013	Project Period Feb'14–Feb'15
Narnoor	115	151	10	13
Jainoor	190	263	16	22
Sirpur-U	66	110	6	9
Kerameri	97	232	8	19
Wankidi	172	268	14	22
Asifabad	318	0	0	0
Tamsi	41	195	3	16
Total	778	1219		

Delivery Status : Feb –Sep'2015

S.No.	PHC	TOT DEL	% PHC	% OG	% PVT	% HOME
1	Gadiguda	131	41.2	50.4	0.8	7.6
2	Jhari	150	19.3	62.7	2.7	15.3
3	Narnoor	231	34.2	48.5	16.0	1.3
4	Sirpur-U	166	37.3	37.3	1.2	24.1
5	Lingapur	92	8.7	63.0	14.1	14.1
6	Jainoor	312	30.1	53.5	9.6	6.7
7	Kerameri	383	27.7	48.6	9.1	14.6
8	Ada	555	0.2	35.3	48.3	16.2
9	Wankidi	398	35.4	18.3	27.1	19.1
10	Indravelly	397	26.4	35.0	26.4	12.1
11	Pittabongaram	339	2.7	47.5	26.3	23.6
12	Thiryani	128	46.9	20.3	20.3	12.5
13	Ginnedhari	75	13.3	36.0	13.3	37.3
14	Rompally	44	11.4	47.7	4.5	36.4
15	Koutala	316	20.3	22.2	28.2	29.4
16	Babapur	219	0.0	20.5	41.6	37.9
17	Bejjur	261	36.4	0.4	20.7	42.5
18	Lonavelly	326	0.0	24.8	58.6	16.6
19	Vemanpally	142	9.2	16.9	52.1	21.8
20	Bheempur	218	51.4	37.2	7.8	3.7
	Total	4883	21.4	34.6	25.5	18.4

CHALLENGES

- Deciphering Exact Expected Date of Delivery
- High Risk Pregnancies – Anaemia, Malnourishment – Still Births
- Multiple depts. of health – Institutional Challenges
- *Cultural inhibitions*

REVISED EDD TRACKING

State : Andhra Pradesh   District : Adilabad District (1)   HealthBlock : A

HealthFacility : Ada (1992)   HealthSubFacility : ALL

Total Pregnant Women :120

EDD Month :SEPTEMBER-
Report Type:ANMwise

Mother ID	Aadhaar No.	EID No.	Name / Husband Name	Address	Phone No. /LMP Date	Category /Economic Status	EDD	Bank Name /Branch Name	Account No
ANM ID:91117		**ANM Phone:9440049976**		**ANM Name : Shankaramma**				**HealthFacility : Ada**	
280101501811200123	368638678148		Madavi Nirmala/ Donu	Koutaguda	9440049976/ 25/11/2012	ST/ BPL	01/09/2013	STATE BANK OF HYDERABAD/ SBH JANKAPUR	62291978905
280101501811300006			Koulkhar Savitha/ Shankar	Babapur	9440049976/ 08/12/2012	Others/ BPL	14/09/2013	/	
280101501811200126	425614450092		Koulkhar Sunitha/ Thirupathi	Ankusapur	9440049976/ 29/11/2012	Others/ BPL	05/09/2013	STATE BANK OF HYDERABAD/ SBH ADA	62285082385
280101501811200133	988590138236		Mengre Sravantha/ Thirupathi	Babapur	9440049976/ 11/12/2012	Others/ BPL	17/09/2013	DECCAN GRAMEENA BANK/ Deccan Grameena Bank Asifabad	79008263363
280101501811300005			Koulkhar Savitha/ N	Babapur	9440049976/ 06/12/2012	Others/ BPL	12/09/2013	/	

TRACKING 7TH MONTH AND HIGH RISK PREGNANCIES

Name of the Sub Centre	Name of the ANC	Husband's Name	Address	AWC Name	Age	Caste	Gravida	HB	Weight (kg)	L.M.P	EDD	Mobile Number
Devapur	Jadhav Rajitha	Srinivas	Jankapur	Jankapur	26	ST	G2	9.5	48	01-02-2015	10-09-2015	7660070984
Devapur	Jadhav Archana	Chandra shekar	Thumma-guda	Thumma-guda	26	ST	G2	10	52	01-02-2015	10-09-2015	8096111894
Devapur	Pawar Devika	Lalsingh	Borlalguda	Borlalguda	22	ST	G1	8.5	45	17-1-2015	24-10-2015	7659835371
Devapur	Pawar Anguri	Bharath	Borlalguda	Borlalguda	23	ST	G1	9	48	15-1-2015	22-10-2015	7382664643
Devapur	Wagmare Godavari	Goutham	Jairamguda	Jairamguda	35	ST	G5	8.6	58	17-01-2015	24-10-2015	8331049378
Devapur	Madavi Ambubai	Kanna	Temlaguda	Temlaguda	35	ST	G6	6	40	15-12-2014	22-9-2015	9705369619
Devapur	Jadhav Sheshikala	Raju	Jankapur	Jankapur	26	ST	G3	8.6	48	01-01-2015	10-08-2015	9492006054

New Services - Ultra-Sound Scanning Services

- Organising camps for ANCs for Sonology
- Problems of EDD and other complications

IMR – MMR Cases RECORDED

- IMR: 20
- MMR: 2

*For First 1000 Deliveries

No. of C-Sections : 86/1000

- Following up each case uptil delivery
- Continous Real time Monitoring till drop-back
  – Whatsapp and Mobile Phones

Mechanism to promote institutional deliveries among tribal women of Adilabad shows considerable success

IT'S NEVER BEEN SO GOOD

S. Harpal Singh

Pregnant women in the agency area of Adilabad now have good reason to be happy about. A specialised initiative to improve institutional deliveries has not only resulted in better access to hospitals but also succeeded in significant reduction of infant and maternal mortality rates (IMR and MMR) among tribal people of nine mandals in the district.

The initiative was launched in February to eventually cover the mandals of Narnoor, Jainoor, Sirpur (U), Kerameri, Wankidi, Asifabad, Tamsi, Sirpur (T) and Kutala under a centralised mechanism to track each and every case of pregnancy aimed, among other things, to facilitate transport of pregnant women to hospitals.

A 24x7 call centre at the ITDA sends SMS alerts to everyone concerned – including the ITDA Project Officer, the Additional District Medical and Health Officer in Agency, the ANM and even the driver of the ambulance on the time of the delivery in a given case.

The ITDA has purchased six vehicles used exclusively for the purpose in the mandals in question. The facilitation has drastically reduced home deliveries from 1,768 in 2013 to 322

> In the last six months since the initiative was launched, the IMR has come down by over half to 20, and the MMR is just 2 in the mandals where the initiative has been taken up
>
> **R.K. ANANTHA KRISHNAN,**
> PRIME MINISTER'S RURAL DEVELOPMENT FELLOW WITH THE ITDA

so far, said R.K. Anantha Krishnan, Prime Minister's Rural Development Fellow with the ITDA, who is also the nodal person looking after implementation of the programme.

Adilabad district has one of the highest rates of IMR at 56 (deaths per 1,000) against the State's average of 47 and country's average of 41. The MMR rate of 222 (deaths per 1 lakh population) is also among the highest in the State and the country.

"In the last six months since the initiative was launched, the IMR has come down by over half to 20, and the MMR is just 2 in the mandals where the initiative has been taken up," Mr. Krishnan reveals. "Against the 681 institutional deliveries in these mandals recorded last year, we have already achieved 1,018 during the eight months in question," he adds to underscore the success of the specialised initiative.

The programme has also helped the ITDA tackle the perilous problem of anaemia, the haemoglobin percentage being less than 8 in a majority of pregnant tribal women. "The help of Integrated Child Development Services (ICDS) is enlisted to provide proper food to weak mothers through the tracking system in operation," Mr. Krishnan says.

WHAT DOES IT DO?

TRACKS THROUGH A CENTRALISED MECHANISM EACH CASE OF PREGNANCY IN NINE MANDALS OF THE DISTRICT

Facilitates the transport of pregnant women to hospitals

24x7 call centre at the Integrated Tribal Development Agency sends SMS alerts to the driver of the ambulance and the officials concerned

1. ITDA Project Officer
2. Additional District Medical and Health Officer
3. Auxiliary Nurse Midwife (ANM)

DELIVERIES AT HOME
1,768	in 2013
322	in 2014 (so far)

INSTITUTIONAL DELIVERIES
681	in 2013
1,018	in 2014 (so far)

VIS-A-VIS

INFANT MORTALITY RATE PER 1,000 PEOPLE
ADILABAD	TELANGANA	INDIA
56	47	41

MATERNAL MORTALITY RATE PER 1,000 PEOPLE
ADILABAD	TELANGANA	INDIA
222	138	178

Kumra Mothubai, a Gond woman of Ragapur village in Sirpur (U) mandal with her infant girl, the 1,000th baby delivered under a specialised initiative for promoting institutional deliveries in the tribal mandals.
— Photo: S. Harpal Singh

SYSTEM SET-UP AND SCALING
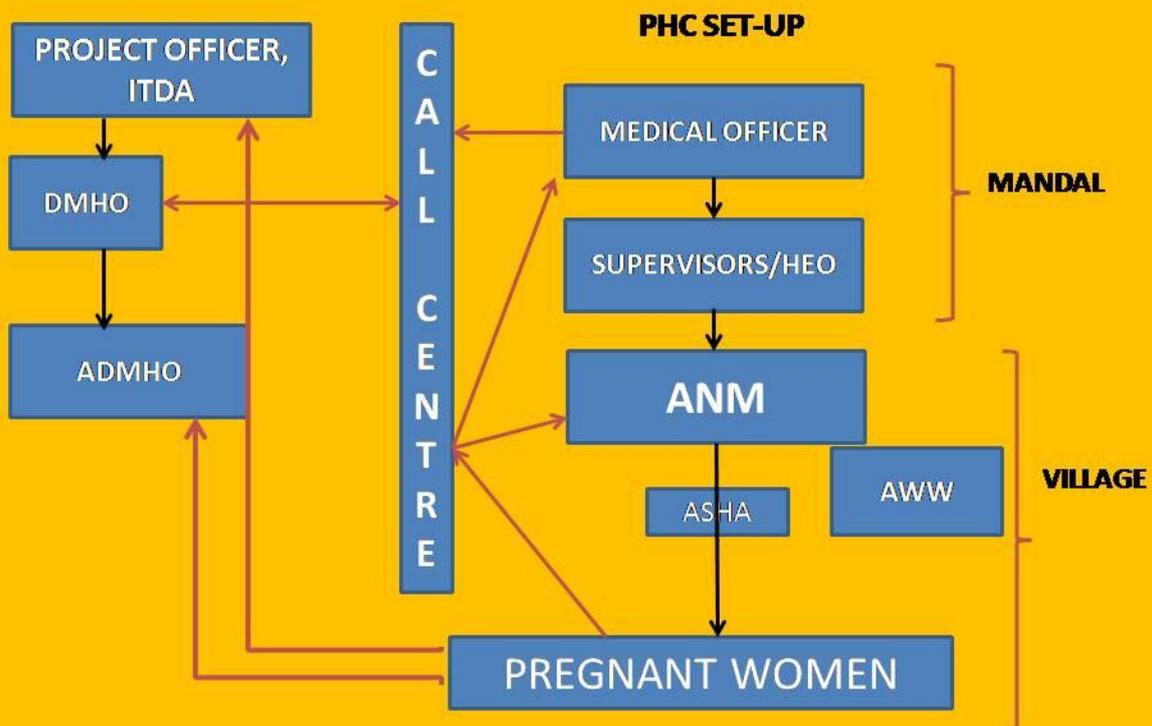
CONCLUSION

- INSTITUTIONAL DELIVERIES IS ONE INTERVENTION – HAS SIGNIFICANT IMPACT ON REDUCING MORTALITIES
- IT IS ESSENTIAL GOVT. TRACKS EVERY CASE OF PREGNANCY
- HEALTH EXPENDITURE – 3.8% OF GDP
- INDIRECT ECONOMIC BENEFITS – ORGANISED FAMILIES

THANK YOU

Questions and answers

Q: *Dr. Tapas Chakma:* I have serious doubt about the evidences that you have shown. The ultimate goal is whether it is reducing the MMR and the IMR. Data is very poor. How far are your calculations of IMR or MMR based on your hospital deliveries, justifiable? You have to change the indicators. Secondly, as for the geographical area which you have shown, this practice can work only where the vehicle can reach. What about the areas which are inaccessible, where the vehicle cannot reach, like the tribals living in the hill top? How far could you expect a full term mother to walk down? What will be the time taken by the vehicle to reach a particular place? What about those inaccessible areas?

A: Agreed sir. Fortunately, Adilabad has a good coverage of roads. Ninety percent of the villages have good road communication. We do go to the point till where road is available. Family members bring the cases to that point, say 1-1.5 km.

Q: *Dr. Tapas Chakma:* What is the coverage with the telephone?

A: It's the same with telephone as well. 90% of the area has connectivity. This will work only in areas with connectivity.

Q: *By Dr. Rita:* There is serious doubt in terms of scalability – like setting up a separate system for this and another call centre, the cost of running etc. As it is, under the programme conditions I think we envisage that the ASHAs are meant to be there with the guidelines on how to identify pregnant woman, to identify high risk cases, to inform ANM and then the service flows from that point onwards. I don't see much of benefit in the outcome.

A: We are creating 2 call centres. There is a real time information being disseminated. For example an ASHA can call on behalf of the pregnant women, as well.

Q: *Dr. Rita:* I know but then with regard to man power you will need somebody 24*7.

A: We pay Rs 7,500 to each operator. Three operators will come up to Rs 22,500.

Q: *Input by Dr. John C. Oomman* People want quality of care; people want respect; people want to know that they are not looked down on when they come to a labour room. Labour rooms can be very inviting. So, I have a suggestion - the headquarter Ashram, council for headquarter ashram, every healthcare facility catering to tribal health, should have one

woman from that community who's available to actually bridge that cultural gap. I think it's a supplier side issue. It's not a demand side issue.

Chairperson questions and comments

Dr. Satish

Fantastic! You're providing ambulance services and addressing type 2 delays, which occurs while transporting the patient from home to hospital. But, also the service provider delay (hospital delay) needs to be taken care as well.

My second concern is, that you are only contacting women only two weeks prior to her delivery. So, it's good to be focused in an intervention but let us have a little broader perspective. Some of them can be detected in their earliest stage of pregnancy. Also ensure that all of them can take care. Observation is that 15% of the pregnancies will land up with complication and will need specialist intervention. But, the only problem is, how are we going to detect these complications before hand? Let's have them in a physical setting where we are in a better position and have better availability with emergencies. Having said that, I also fully agree with the observation that hospitals are not in a position to cater with increased number of institutional deliveries.

Dr. Abhay Bang

I'll not get into what I've already spoken about. My reservations are about promoting institutional delivery. But, keeping those aside, you have made a very interesting effort to bridge the gap and improve the institutional delivery. I have 2 comments.

One, you should restate your goal, because your goal of reducing IMR less than 10 and your strategy of 100% institutional delivery don't necessarily match. IMR will not get less than 10 merely by 100% institutional delivery. Even 110% institution delivery will not reduce IMR to less than 10. So, you probably need to remove that mismatch between your goal and your strategy.

Second, did you try to ask and understand what are the issues of the proportion of women delivering at home and not going for institutional delivery?

A: Sir, they have economic reasons. For every 35-40 km we have a PHC. Even in tribal areas each PHC has doctors, 3 staff nurses, all necessary equipments, baby warmers and everything. The supply side is good.

Dr. Abhay Bang

If that is so, it is great that you're asking them first, "Why don't you come?" That has to be the starting point before offering any solution. Otherwise, we solve our problems not their problems, because we don't know their problems. And the kind of barriers that you mentioned, some of your strategy and solution do remove those barriers. Quality of care at the institution is an issue. Being sensitive to the women especially tribal women is an issue. These are all supply side issue. For example (from another field), right to education. Now we have made it compulsory for every child to go for 8 years of schooling. What sort of education are we offering there? It's our moral and political responsibility that what we offer in those schools has to be of good quality and has to be relevant to the child's need. Similarly, on healthcare side, if we promote certain things like the institutional delivery or 48 hours stay post-delivery in the institution then the quality has to be much better.

Dr. Chakma has rightly said, that your data is all numerator based data and you need population based data, so your aims will be better valid.

In spite of all those efforts of institution delivery, maybe 5 to 10 to 15 % of deliveries would still continue to occur in the community. So, at least have a component of empowering the community and the whoever conducts deliveries in the community, whether it is *dai* or an older women, or even the woman herself (in some of the Gond communities in Gadchiroli, the woman conducts her own delivery). So, give at least a few hours of information and knowledge on basic things . So, don't completely forget empowering community with knowledge and skills, and transfer an entire onus as well as power only to the institution. Accept this that few women will always deliver at home. Also, add a component, especially now with ASHA and with ANMs, something can always be provided within a community.

So, a very good effort and, with your data becoming more population based, we will have even more solid evidence as to its impact on the NMR and IMR. The MMR is going to be difficult, because MMR will need huge population.

23

National Workshop on Best practices in Tribal health

Birth Waiting Room

Dr.M.Senthilkumar
Deputy Director (Training)
National Health Mission - Tamil Nadu

Tamil Nadu

Tribal Population in the State

- Tribal : 1.1% of the total population (Census 2011)

- About 8 lakhs tribal people are living in TN

- The top 14 districts with % of tribal population

  1. Nilgiris (4.5%)
  2. Dharmapuri(4.2%)
  3. T.V.Malai(3.7%)
  4. Salem(3.4%)
  5. Namakkal(3.3%)
  6. Villupuram(2.2%)
  7. Vellore(1.9%)

  8. Ariyalur(1.4%)
  9. Tiruvallur(1.3%)
  10. Krishnagiri(1.2%)
  11. Kancheepuram(1.03%)
  12. Erode(0.97%)
  13. Coimbatore(0.82%)
  14. Trichy(0.67%)

Local Tribes of Tamil Nadu

- Irular
- Toda
- Kurumbas
- Konda
- Kattunayakan

National Health Mission – Tamil Nadu

- To achieve the objectives of NHM, the State Health Mission was constituted and the State Health Society is functioning under the Mission Director
- Birth waiting Rooms (BWR) were established with NHM funds
- The Directorate of Public Health and Preventive Medicine is the implementing Department for this initiative

Rationale of Selecting the Problem

- Tamil Nadu has achieved > 99% of Institutional delivery

- In tribal areas the home delivery is to the extent of 0.5%

- In order to reduce it further Birth waiting rooms are established

Problem Statement

- Due to sporadic and distant geographical areas of tribal inhabitation the pregnant mother find it difficult to attend the medical facilities during labour and this leads to more home deliveries

- Tribal population in 800 Villages of 70 PHC catchment areas

Goal

- The goal of the BWR is to promote Institutional deliveries among the tribal population thereby ensuring safety to the mother and child

Government Orders

ABSTRACT

State Rural Health Mission - State Health Society - Establishment of Birth Waiting Room in 15 PHCs - Appointment of Sanitary Workers and sanction of honorarium to the Community Health Nurse - Orders issued.

Health and Family Welfare (EAP II / 2) Department

G.O. (Ms) No.275

Dated : 3.9.2009.
Thiruvalluvar Aandu – 2040
Aavani - 18

Read:

1. G.O. Ms. No.432, Health and Family Welfare, dated 26.12.2008.
2. From the Mission Director, State Health Society, Letter No.3855 / PS / SHS / 2009, dated 21.7.2009.

ORDER:

The Government in the G.O. first read above, permitted the Mission Director, State Health Society to construct Birth Waiting Room in the two Primary Health Centres one each in Dharmapuri and Krishnagiri Districts.

2. The Mission Director, State Health Society, in the letter second read above, has stated that the Government of India has approved in the PIP of State Health Society - Tamil Nadu for 2009-10 to establish Birth Waiting Room in 15 Tribal area Primary Health Centres at the rate of Rs.15 lakhs per unit at a total cost of Rs.225/- lakhs. It is proposed to establish Birth Waiting Room (BWR) in the 15 BEmONC Primary Health Centres / upgraded Primary Health Centres in the foothill areas of 15 tribal areas. Pregnant mothers in remote and inaccessible hilly and forest terrain will be encouraged to come to the Birth Resorts well in appropriate time prior to delivery. All facilities will be provided for stay in the Birth Waiting Rooms. Normal deliveries can be conducted in the Primary Health Centre where Birth Waiting Room is located. Mothers who require caesarean will be transported to CEmONC hospitals within 20-30 minutes travel time using the available facilities.

3. It is proposed to establish Birth Waiting Room in 15 Primary Health Centres located in tribal area at the cost of Rs.225/- lakhs as detailed below:

Birth Waiting Rooms in Tribal areas

Sl. No	Name of the HUD	Name of the BEmONC /Upgraded PHCs
1	Namakkal	Powerkadu
2	Salem	Valavanthi
3	Salem	Karumanthurai
4	Vellore	Odagathur
5	Tirupathur	Athanavur
6	Trichy	Top Sengatupatti
7	Kalakurichi	Kariyalur
8	Thiruvannamalai	Jamnamarathur
9	Dindigul	Kosakurichi
10	Palani	K.Keeranur
11	Nagercoil	Petchiparai
12	Coimbatore	Valparai
13	Thiruppur	Erisinampatti
14	Nilgiris	Ayyankolli
15	Erode	Thalavadi
16	Dharmapuri	Theerthamalai (Pilot in 2009-10)
17	Krishnagiri	Anchetty (Pilot in 2009-10)

Birth Waiting Rooms -Details

- Birth waiting rooms/Birth Resorts are residential facilities where pregnant women from remote areas can wait before giving birth rather than at a hospital or health centre

Top Sengattupatti, Trichy

Birth waiting room (contd)

- The term pregnant mothers at tribal areas are brought well in appropriate time prior to delivery (usually 7-10 days before her EDD) and monitored during entire process of pre-labour and labour

Birth waiting room (contd)

- BWR have the facility for cooking food
- Provided with 3 supportive staff for round the clock care and services

Valavanthi PHC, Salem

Furniture, utensils and Electricals

- Steel Cots for AN mother
- Sponge Mattress-Foam
- Cotton Bed sheets and Pillow cover
- Pillows
- Waste Disposal buckets, mugs etc
- Wooden bench (couch) for Attender
- Foot stool
- Window Screen
- Bed side Screen S.S
- Chairs(Plastic)
- Bed Side Steel Table S.S
- Wheel Chair S.S. (Cycle Wheel, Godrej Patten)
- Stretcher Trolley – Four Wheel S.S. Top 18G with One Set of Spare Wheel
- Bp apparatus, Thermometer
- TV / DVD accessories, and torch light 3 cell etc
- Weighing Scale-Adult (digital)
- Geyser-water heater
- Reverse Osmosis Water purifier System
- Room Heater
- Inverter- Power Back up

Birth waiting room (contd)

- The pregnant women along with her attender is provided Rs.80/day each during the entire period of their stay in antenatal and postnatal period

Birth waiting room (contd)

- Normal deliveries can be conducted in the same PHC where the BWR are located

- Mothers who require Caesarean section will be transported to the nearest CEmONC centre using the 108 ambulance service

Birth Waiting Rooms -Supervision

- The Community Health Nurse of that particular block is supervising the functioning of BWR and she will be paid Rs.500/- as honorarium

- The Medical officer who provides medical and technical assistance will be the overall in-charge

- The Deputy Director of Health Services(DDHS) & Maternal and Child Health Officers (MCHO) are the district level supervisors

Birth waiting rooms (contd)

Top Sengattupatti, Trichy

Anchetty, Krishnagiri

Kariyalur, Kallakurichi

Birth Waiting Rooms- Interior view

Anchetty

Valavanthi

BWR- Performance

Year	No. of beneficiaries
2013-14	1628
2014-15	3026
2015-16 (upto Aug 2015)	1201

Source : SBHI Data from DPH & PM

Birth Waiting Room -Impact

Source : www.nrhm-mis.nic.in HMIS data of 17 BWR PHCs

BWR-Cost

Total Cost : Approx. 15 Lakhs per Unit	
Non recurring cost per unit – Rs. 12.5 lakhs per unit	
Civil works	Rs. 10 lakhs
Furniture, utensils and electrical appliances	Rs. 2.5 lakhs
Recurring cost – Rs. 1.80 lakhs per annum	
Contingency	Rs. 30,000 per annum
Electricity charges	Rs. 30,000 per annum
Honorarium to the CHN and Sanitary worker	Rs. 24,000 per annum
Transport/POL for transport of mothers	Rs. 96,000 per annum
Diet Charges	Rs. 80 per mother and Rs. 80 for attender.

Challenges

- Some resistance amongst the elders of the family

- Extensive IEC

- Constant motivation

Thank you

Website : www.nrhmtn.gov.in & E mail : srhm.tn @nic.in

Questions and answers

Q: *Dr Abhay Bang:* How many birth waiting rooms are there?

A: 17

Q: *Dr Abhay Bang:* In order to know the utilization rate, can you give the bed occupancy rate?

A: Around 50%.

Q: What about the manpower to this Birth Waiting Room. What is the recurring cost per user?

A: Three support staffs are provided to the Birth Waiting Room and they are provided with honorarium of Rs 500 per month and some of them who have completed 7 years are getting Rs 1500 as honorarium. Incentives provided are Rs 80 for the mother and Rs 80 for the attendant who is allowed to stay for 10 days along with the mother.

Q: Is it supported by the Tamil Nadu Government?

A: No, it is supported by National Health Mission, Directorate of Public Health, Delhi.

Q: The community Health Nurse whom you have mentioned, is she from the community? What is the reimbursement process to pay her honorarium?

A: She is the extension of the government worker actually. She works in the PHC, and extends her services on honorarium basis apart from her regular salary.

Q: In Gujarat, we have mamatha blocks, having the same concept. In spite of our best efforts, people were reluctant to come. Do you put any additional effort to make them come to Birth Waiting Room?

A: Lot of efforts are being put into bringing them. Mainly, IEC is used to create awareness.

Chairpersons' questions and comments

Dr. Abhay Bang

Thanks Dr. Senthil Kumar for this presentation. Few decades ago, we used to say, what Kerala does today, India will do tomorrow, but now gradually we have to include 'What Tamil Nadu does today, India will do it tomorrow.' So I will be a little critical about your approach. My first question is, which Dr. Chakma has very directly asked, "Will they come?" and what if "They don't come?" As you state the problem, in the *Janani Suraksha Yojana* for institutional delivery is they could come only for 6 hours, but will they come for 8 to 15 days with a attendant? In a tribal society where delivery is a part of the natural life, the big question remains, "Will they come?"

We have some evidence on "Do they come?" I have your data; each centre is being used by 45 women per year in 17 centres, amounting to total 3,400 women delivering. Each centre has got 6 rooms, so each room is used on an average by 7 and half women in the whole year. Do they come? I would say based on your room occupancy that it's very low. Seven women occupying a room in the whole year is giving one room per women for 50 days. That is very low occupancy.

What is the cost? Again, your recurring cost would work out to be Rs. 1.8 lakhs per centre. It comes to be, your recurring cost is Rs. 4,000 per woman to stay there. In addition to that a woman with an attendant bears their own cost, which is not included here. So, the question arising here is why medical-ise the delivery to such an extreme high degree? I was wondering, who asked for the list of fancy gadgets that are kept in your Birth Waiting Room? Tribals? Are we chasing false goals?

My last argument is the link between the problem of home delivery and maternal mortality. What is your intended impact? Home delivery is merely a surrogate problem of maternal mortality. The link between the place of delivery and maternal mortality is poor. The evidence that the institutional delivery alone reduces maternal mortality is poor. The access to emergency obstetric care reduces maternal mortality and not the institutional delivery per se. Institutional delivery is a different matter and access to emergency obstetric care is a different matter. So, why are we making so much effort for pushing every woman to institutional delivery when its link with reducing MMR is not very much clearly established? Our goal should be to reduce MMR. Home delivery or institutional delivery has a remote link with that, but we have gradually replaced maternal mortality with the institutional delivery as our goal which might be a false goal.

Are we following and chasing some wrong goal which has displaced some valid needs of the tribal people and the rural people and introduced some professional goal in its place? This is for you to think.

The national policies will remain as they are but I will, of course, examine your programme on the basis of evidence. It will be great if you go to your 8,00,000 tribals and the 17 centres, and calculate how much MMR came down because of Institutional Delivery. So, show us the hard evidence that it reduced maternal mortality.

Further, what is the cost effectiveness? With the same amount of money you might be able to save many tribal lives. Just make Anti Snake Venom available.

For the sake of the tribals of Tamil Nadu, please ask them if they want to spend 8 to 15 days there? I have found only one place and that is Ladakh, where I was told that women will go to Leh for delivery a 10 to 15 days earlier, because, it is impossible to travel in Ladakh. Access to EOMC is difficult in Ladakh and Leh is the only place. A sizable proportion of the women go to Leh and stay with their relatives. That's very exceptional. Whereas I am not sure if the tribal women from other tribal villages would like to go to the waiting room for a long period of time, to avoid that 0.5% risk of MMR.

I am not very sure whether this will be a good approach, trying to move tribal women out of their natural situation. Probably, train ANMs to conduct normal delivery, then you will need very small proportion of deliveries to occur in the institutions. I am sorry that I was really critical but I find that it's difficult to reduce the problem of maternal mortality. Home delivery is not a problem. Maternal mortality is definitely a problem. Does your practice solve maternal mortality? So please examine that. We don't have the evidence and you have the opportunity of collecting the evidence, because you have 8,00,000 tribal people in Tamil Nadu. Please collect the evidence.

24. Presentation by SEARCH

Home based Newborn Care (HBNC)

Dr. Anand Bang

Society for Education, Action and Research in Community Health (SEARCH), Gadchiroli

SEARCH Program Area

Total : 134 village
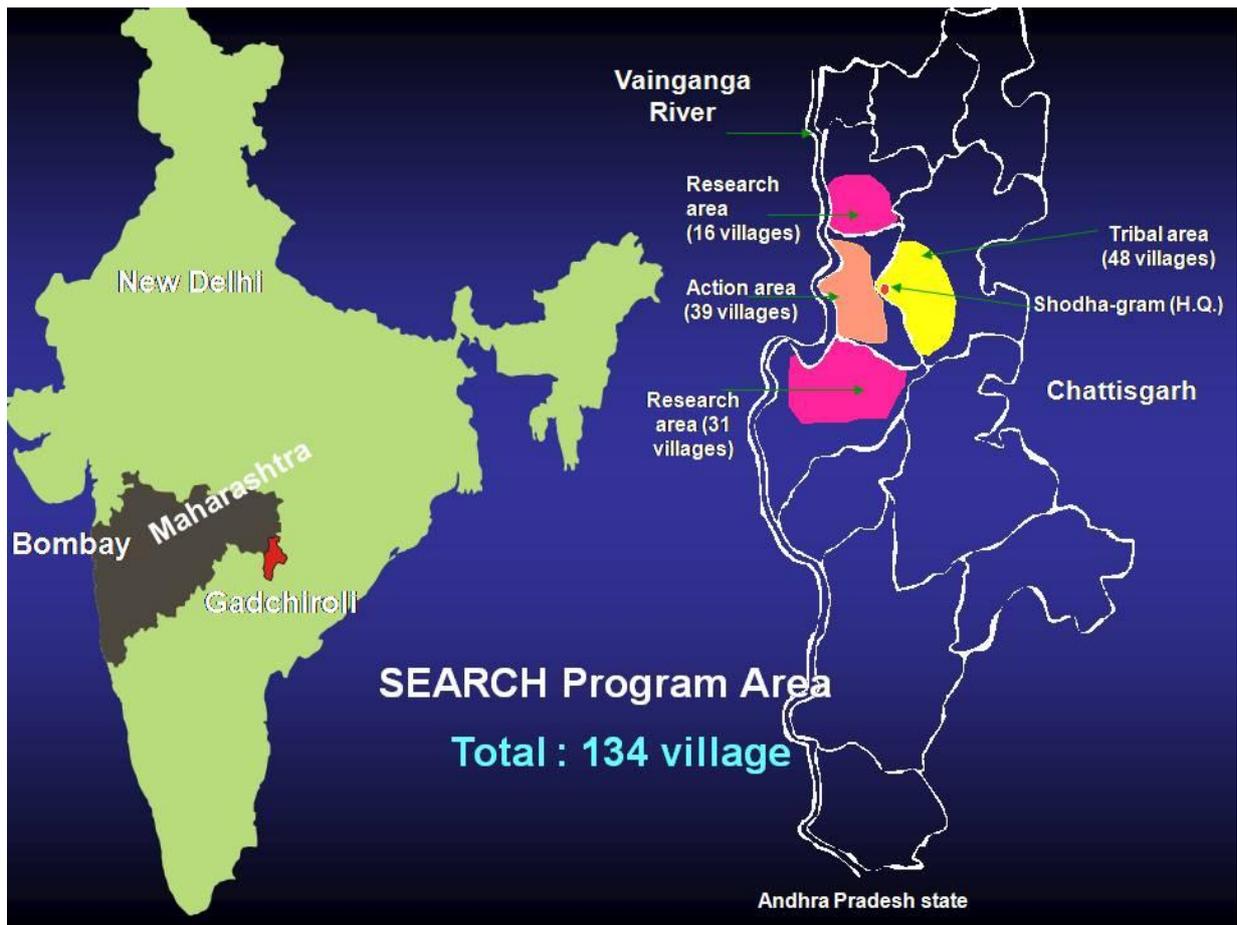
Overall Work of SEARCH

1) Hospital serving 1500 villages.
2) Community based maternal, newborn and child health & primary care program serving 134 tribal and rural villages.
3) Tribal health care program - Mobile Medical Unit & Community based care through CHW.
4) Rural health care research in 88 villages.
5) Training of youth and women in life skill education
6) Prevention and deaddiction program for tobacco and alcohol.
7) Training of NGOs in child survival, tobacco & alcohol prevention & youth organization.
8) Training of officers from different State Governments in HBNC.
9) Shaping State, National and Global Health policies through evidence based advocacy.

The Problem

- **27 Million births**

- **572,000 are born dead** (SBR - 22 per 1000 births)

- **748,000 die in first month** (NMR – 28 per 1000 live births)

- **Inequitable progress** (Rural/ Urban / Tribal, Male/ Female, Rich/ Poor, Interstate and Intrastate variations)

Data Source – NMR : SRS 2013, Still Births : Lancet 2011

Home-Based Newborn Care

Goal : To reduce neonatal mortality by developing a low-cost, home-based model of primary newborn care by using the human potential in villages.

	1993 – 95 Baseline	1995 – 96 Observation	1996 – 98 Interventions	1998 – 03 Continuation of interventions
Control area 47 villages Population: 42,617	Vital Statistics Collection			
Intervention area 39 villages Population: 39,312	Vital Statistics Collection			
		Observational studies: - Neonatal morbidities - Cause of death	Interventions and Measurements	

Interventions & Delivery System

- Health education for behavior change & care seeking
- Attending delivery
- Care of baby at birth
- Regular home visits and support in newborn care
- Monitor the newborns
- Management of NB sicknesses
    - Birth asphyxia
    - LBW / Preterm
    - Sepsis / Pneumonia
    - Breast feeding problems
    - Hypothermia
- Meticulous Record keeping
- Training – Modular, Step Ladder, Field practice under supervision
- Supervision
- Supplies
- Performance based remuneration

SEARCH, Gadchiroli

COVERAGE AND COMMUNITY ACCEPTANCE OF HBNC

Year	% Neonates	% Adequacy of coverage on 15 indicators.	% Referred
1995-96	75	37.9	0.5
'96-97	85	58.4	0.6
'97-98	93	81.3	0.4

SEARCH, Gadchiroli, INDIA

Neonatal mortality rate (1993 to 2003) (intervention and control area)

Neonatal mortality rate

| | 1993-95 Baseline | 1995-96 Training & visiting | 1996-97 Interventions | 1997-98 Full Interventions | 1998-01 | 2001-03 |

Continuation of care

70 % reeducation in the NMR

SEARCH, Gadchiroli

427

The Infant Mortality Rate in Gadchiroli (1988 – 2007)
39 intervention villages
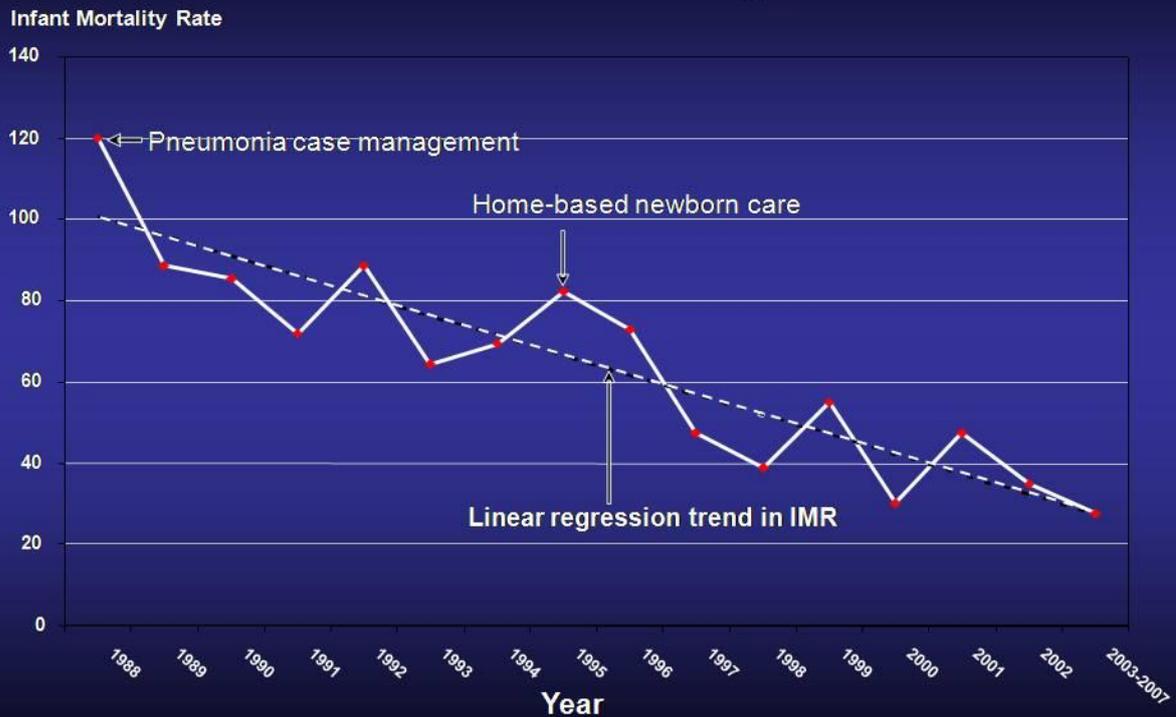
62 % reeducation in the IMR

SEARCH, Gadchiroli

Effect of home-based newborn care on case fatality
(1995-96 Vs 1996-03)
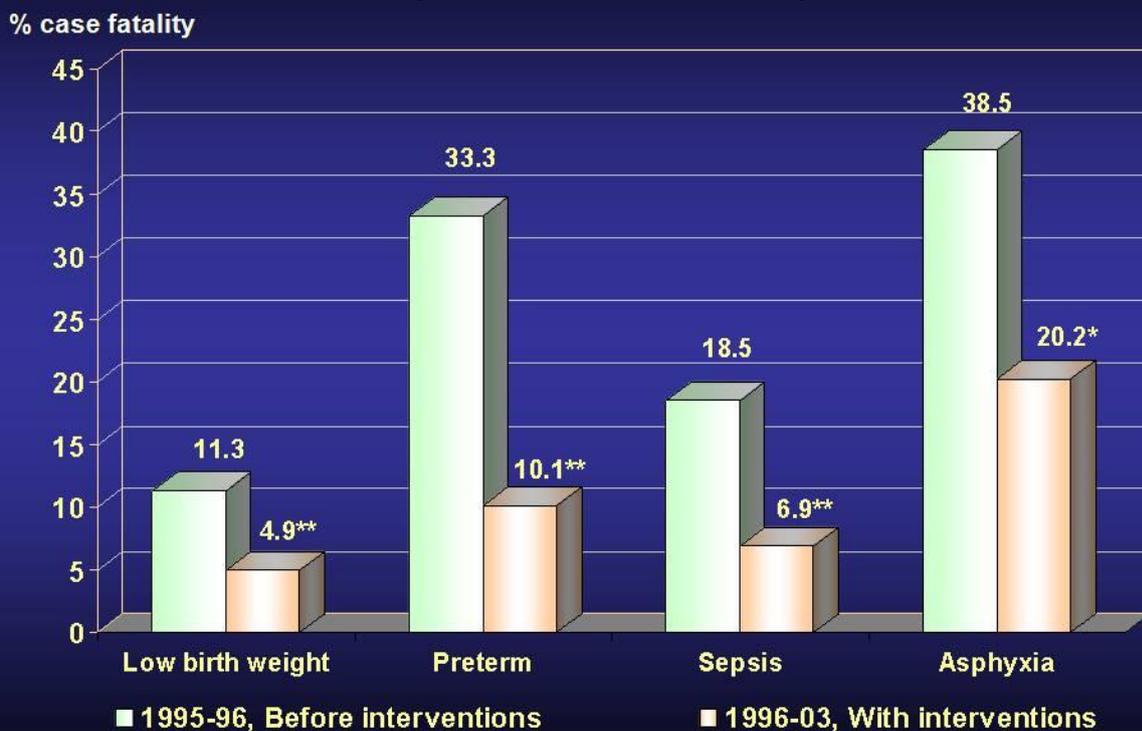
SEARCH, Gadchiroli

** p < 0.005, * p < 0.07

Cost-Effectiveness
Home Based Neonatal Care
vis-a-vis
Child Survival Interventions*

Interventions	Cost per DALY saved ($)
Home-based neonatal care	7
Zinc fortification	14
Zinc supplementation of children	47
Case management of pneumonia in children	86
Oral rehyderation therapy	194
Vitamin A fortification	237
Vitamin A supplementation of children	2137
Growth monitoring and supplementary food to undernourshed infants	8235

* WHO CHOICE Project : Cost-effectiveness in SouthEast Asia at 95% coverage , 2000

Scaling Up

- 11th & 12th Five Year Plan

- Module 6 & 7 of GoI

- Partnership with UNICEF Africa

- Joint statement by WHO, UNICEF, US-AID and Save the Children (2009); Supported by Johns Hopkins University and Gates Foundation - Endorsement of home visiting neonates and management of sick neonates at home by trained worker if referral is not possible.

HBMNC Scaling up

★ SEARCH, Gadchiroli
● ANKUR Project in Mahatashtra
○ ICMR Study: Government of India, five states.
▲▲ 23 States in India
◎ Other Countries
✴ State ASHA training centers

Africa
4 countries

SEARCH, Gadchiroli
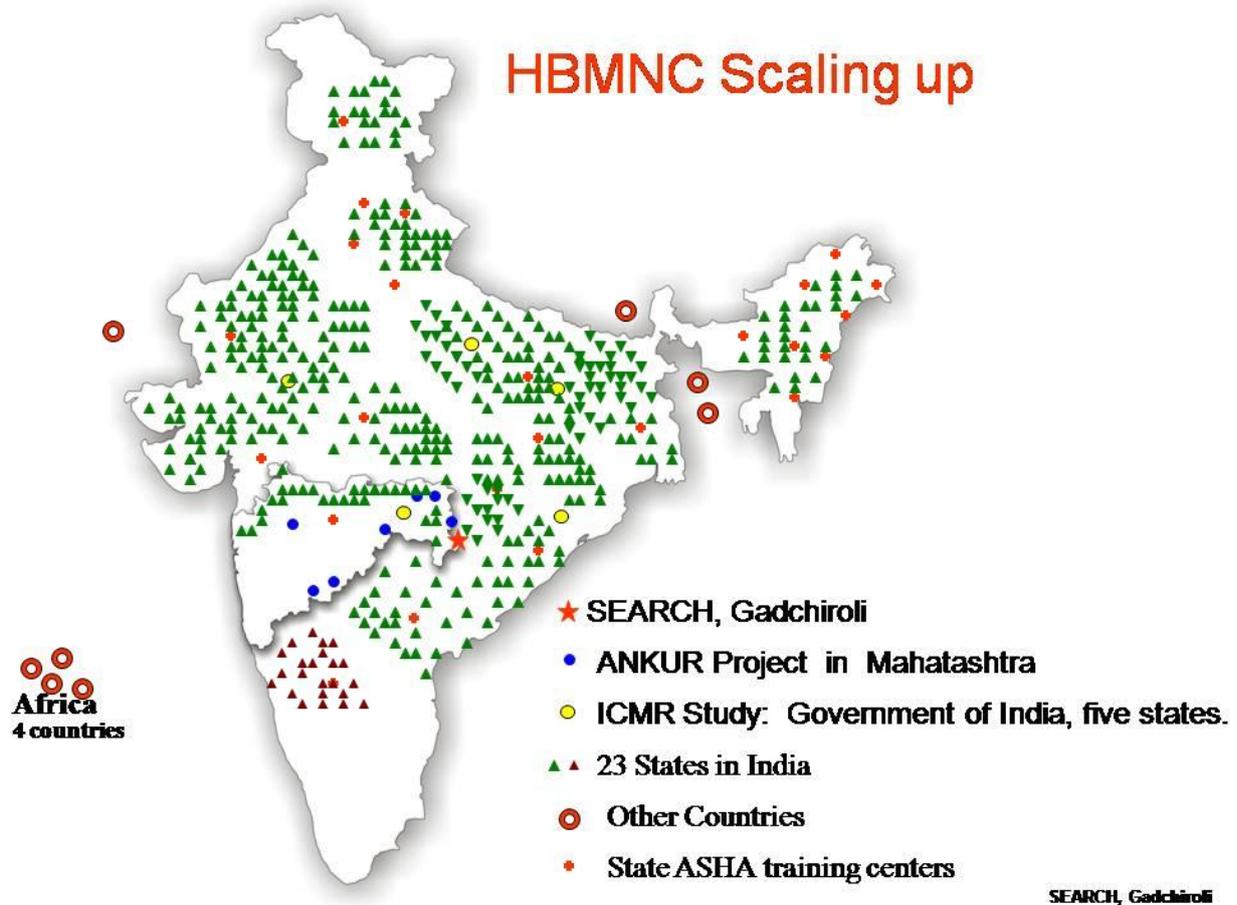
Limitations

1) Political and administrative will

2) State level program management

3) Demand generation and community participation

4) ASHA training system - Number, quality, participatory method, imparting values & attitudes

5) Field supervision and monitoring

6) Supplies

7) Incentives streamlining

Annexure VI

Assessment form with score sheet

Dear participant,

       Your assessment of the best practices presented in this workshop will be an important input to the Expert Group on Tribal Health. Please give score to each practice on the sheet attached.

The criteria

1) The problem addressed is an important health priority for tribal health.

   [To assess the importance of the problem, Ask your self –

   - Is the problem of high frequency – incidence or prevalence or uncommon ?
   - Does the problem cause severe loss – mortality, morbidity, disability, cost ?]

2) The practice presented will be acceptable to the tribal people.

   [Assuming that IEC will be conducted]

3) The practice is feasible to deliver on scale (a district) in a tribal area.

   [Either by government, or private or social sector]

4) The practice is backed by good evidence of sufficient reduction (impact) in the problem at the population level [not merely in the treated patients]

5) It will be cost-effective or financially feasible approach to reduce the problem.

   [consider the cost of delivering this approach to a block or district or state, and the number of lives or suffering saved.]

The score is to be given on each criteria on the following scale

        A   =   Strongly agree

        B   =   Mildly agree

        C   =   Mildly disagree

        D   =   Strongly disagree

Score sheet								
S.N.	**Organization**	**Practice**	**Criteria (Write A or B or C or D for each of the five criteria)**					**Comments**
			1	2	3	4	5	
1	L V Prasad Eye Institute, Telangana	Eye care						
2	National Institute for Research in Tribal Health, Jabalpur	Fluorosis						
3	National Institute for Research in Tribal Health, Jabalpur	Malaria Control						
4	MITRA, Christian Hospital Bissamcuttack, Odisha (Malaria Control)	Malaria control						
5	Jan Swasthya Sahyog, Chhattisgarh	Phulwari - creches for malnutrition						
6	Government of Chhattisgarh	Fulwari, Scaling up						
7	Health Department, Jashpur, Government of Chhattisgarh	Swasthya Lika Jagruti (Health Wednesday)						
8	Population Foundation of India	Community Based Monitoring						
9	Nazdeek, Assam	Community reporting of deaths						
10	National Health Mission, Palakkad, Kerala	Software-based monitoring Jatak and Janani						
11	Karuna Trust, Karnataka	Operationalising PHCs by PPP						
12	Deepak Foundation and Health Department, Gujarat	CEmONC by PPP						
13	Tata Steel	Mansi - HBNC through						

		ASHAs						
14	SEWA Rural, Gujarat	ImTeCHO						
15	IKP Centre For Technologies in Public Health (ICTPH), Tamil Nadu	Bridge Training for AYUSH doctors						
16	Jan Swasthya Sahyog, Chhattisgarh	ANN/GNM Training						
17	Health Department, Chhattisgarh	HR Outsourcing						
18	Area Networking and Development Initiatives (ANANDI), Gujarat	Women's empowerment						
19	Shrimad Rajchandra Hospital, Dharampur, Gujarat	Mobile unit						
20	Health and Family Welfare Department, Gujarat	Sickle cell						
21	Sugha Vazhvu Healthcare, Tamil Nadu	Enrollment and Rapid Risk Assessment						
22	Integrated Tribal Development Agency, Adilabad	Increasing Institutional. Deliveries						
23	National Health Mission, Tamil Nadu	Birth waiting room						
Additional comments on any practice (give the serial number, and comment.)								

Annexure VII

Feedback form

Mark ✓

S. No.	Domain	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied
1	The selection process					
2	The topics of the various practices presented					
3	The quality of the best practices presented					
4	Your learning on tribal health care					
5	Did this workshop offer potential solutions for tribal health care on scale?					
6	How would you feel about meeting periodically on the topic of tribal health?					
7	Environment in Shodha-gram					
8	Food					
9	Accommodation					

10. General comments

_____

_____

_____

11. Other specific suggestion/ grievance for further improvement

_____

_____

_____

_____   _____

         Name   Signature

Thank you for your participation.

News Reports

1. **inbministry blogspot**

National Workshop on Best Practices in Tribal Health Care Held

A three-day National Workshop on Best Practices in Tribal Health Care was organized by the Ministry of Health and Family Welfare recently in at Shodhagram, Gadchiroli, a tribal district of Maharashtra. The workshop held to identify possible solutions to address the healthcare needs of India's 100 million tribal population was inaugurated by the Dr. Soumya Swaminathan, Secretary, Department of Health Research and Director General, Indian Council for Medical Research (ICMR).

In her inaugural address Dr. Swaminathan noted, "This workshop marks an important step towards integrating evidence from the field into policy making for tribal healthcare. It also presents a unique opportunity for government departments, ICMR and voluntary agencies to share experiences and learn from each other."

The workshop saw over 50 representatives from 23 organizations in academia, government and civil society present programs that they have been running to address problems ranging from malaria and maternal mortality to fluorosis and human resource constraints. Selected entries included a web-based application developed by SEWA Rural, PPP model run by the Karuna Trust in Arunachal Pradesh, Malaria control strategy by MITRA in Orissa, Phulwaris for children by the Jan Swasthya Sahyog in Bilaspur, human resources outsourcing by the Government of Chhatisgarh and a weed that can assist in fluorosis management by the National Institute for Research in Tribal Health, Jabalpur. SEARCH demonstrated the Home-based Newborn Care approach including a live demonstration of how ordinary village women, trained as health workers, save newborn lives. This model has been adopted by the National Health Mission and scaled up nationally through nearly 9 lakh ASHAs.

The practices were selected from the 85 entries received by the Expert Group on Tribal Health. "These practices represent not just potential solutions for the health related problems

that plague tribal communities, they also offer a ray of hope in an area that is normally seen as dark and dismal. They show us that work is being done to make healthcare accessible to tribal communities," Dr. Abhay Bang, Chairperson of the Expert Group, noted in his concluding remarks.

The Expert Group on Tribal Health was constituted jointly by the Ministry of Health and Family Welfare (MoHFW) and the Ministry of Tribal Affairs (MOTA) in October 2013 to review the existing situation of health in tribal areas, suggest interventions, formulate strategic guidelines for states and develop a national framework to improve healthcare services among the tribal population. It includes representatives from the central government, various state governments, research organizations and the civil society. The Expert Group has conducted visits to various states to review the existing situation and has, for the first time, compiled health data for tribal people at the national level. It is expected to complete its report and recommendations by the end of this year.

The workshop was hosted by the Society for Education, Action and Research in Community Health (SEARCH).

Website: http://inbministry.blogspot.in/2015/10/national-workshop-on-best-practices-in.html

United News of India

Oct 15 2015 4:03PM

National workshop on best practices in tribal health care held in Gadchiroli

New Delhi, Oct 15 (UNI) More than 50 representatives from 24 organisations attended a three-day national workshop on 'Best Practices in Tribal Health Care' where programmes to address problems relating to tribals ranging from malaria to maternal mortality and fluorosis were presented.

A web-based application developed by SEWA Rural, PPP model run by the Karuna Trust in Arunachal Pradesh, malaria control strategy by MITRA in Odisha, Phulwaris for children by the Jan Swasthya Sahyog in Bilaspur, human resources outsourcing by the Chhattisgarh government and a weed that can assist in fluorosis management by the National Institute for Research in Tribal Health, Jabalpur were among the selected entries at the workshop. The workshop was organised by the Health and Family Welfare Ministry recently in at Shodhagram, Gadchiroli, a tribal district of Maharashtra.

Website: http://www.uniindia.com/national-workshop-on-best-practices-in-tribal-health-care-held-in-gadchiroli/india/news/236903.html

THE 🦁🐘 HINDU

Updated: November 29, 2015 03:45 IST

Taking health care to tribal heartland

New Delhi travelled to tribal heartland. The expert group offers hope; an opportunity to ensure that the tribals have a say in policies that are framed for them.

Earlier this month, a motley group of 50 academicians, government officials and activists gathered at Shodhagram village in Maharashtra's Gadchiroli district.

This is an area known for malaria, malnutrition and Maoists, not necessarily in that order. Everyone left technology behind (mobile phones and gadgets) to ensure that there were no distractions to the flow of conversation over three uninterrupted days. It was to talk about an 'x' number of India's 100 million tribal population.

The Health Ministry had decided to hold the workshop on "Best Practices in Tribal Health" in tribal heartland; on a campus surrounded by lush forests and designed as a Gond village. Instead of tribals going to New Delhi, New Delhi had come to the tribals.

What led to this meeting was another first: the government's recognition of the differential and unique health needs of tribal communities. In October 2013, the Ministry of Health and Family Welfare and the Ministry of Tribal Affairs's expert group was to frame a national policy on tribal health, given the unique sociocultural realities of these communities.
Its chairperson, Dr. Abhay Bang, who along with his wife, Dr. Rani Bang, has, for almost three decades, led community based action and research for and on the health of India's neonates and tribal people.

Seeking scaleable solutions

As a result, we now have access to multidimensional, national level data; data that has not only been missing from our statistical databases but also from our consciousness. The results will be presented along with the group's report at the end of this year.

The three days were fruitful. The group identified 26 areas that have the potential to break some of the biggest barriers to tribal health. Some are malaria, malnutrition, maternal and child mortality and fluorosis.

"In 1995, the district collector of Mandla contacted the National Institute for Research in Tribal Health (NIRTH) at Jabalpur. In Tilaipani village, all the children had knock-knees and severe pain. They had fluorosis," said Dr. Tapas Chakma, senior scientist with NIRTH. His team then focused on a commonly grown weed, rich in calcium, iron and vitamin C that could help mitigate fluorosis.

Dr. Sudarshan from the Karuna Trust showed how publicprivate partnerships with northeast Indian governments have taken health to the hinterlands. The Chhattisgarh government highlighted its outsourcing human resource recruitment, while doctors from Jan Swasthya Sahyog, Bilaspur, pushed for community run crèches to fight malnutrition. Village women trained by the Society For Education, Action and Research in Community Health demonstrated how they treated sepsis and used ambubags to save newborn children.

Policy priorities

Each of the practices offered a ray of hope for a population that has long been relegated to the peripheries of India's development story.

Now some key policy issues that could determine the state of tribal health in India. For instance, is outsourcing the answer to providing quality care in tribal areas? Is volunteerism in health services sustainable? Can Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homoepathy doctors or nurses fulfill the human resource gap created by lack of doctors in tribal areas? Most importantly, what are the priorities for tribal health and who determines them?

Dr. Soumya Swaminathan, Director General of the Indian Council of Medical Research (ICMR) called for greater collaboration between academia, civil society and government to conduct multicentric evidence studies. "It is important to include anthropologists, sociologists and economists in health research," she said, while asking for a sharing of ideas and evidence in tackling the sickle cell disease.

Sickle cell disease is an inherited condition where the hemoglobin in red blood cells is abnormal and may block the passage of oxygen, resulting in severe pain and gradual damage

to vital organs. It can only be prevented, not cured. According to ICMR, the sickle cell gene is widely prevalent among some tribal groups, with a prevalence rate of 140 per cent.

"We have launched a screening programme in 18 States. This will enable us to know the problem. But what of the solution? At the end of the programme, lakhs of people would know that they carry the disease or the gene for it," she said.

"What recourse will we offer them?" Dr. Swaminathan asked. She laid stress on the need for projects that reduce morbidity and mortality among sickle cell carriers.

Evidence from Gujarat, which initiated sickle cell screening in 2006, shows that premarital counseling to prevent transmission does not work. It also presents itself as an ethical conundrum. The State needs to ensure that carriers, particularly girls, do not face discrimination.

Perhaps the Bangs's experience of sickle cell testing best frames the policy question. "When we started work in Gadchiroli in 1986, we detected sickle cell disease and tried to discuss the way forward with the tribals. They laughed and said, "Who told you this is our problem?" For them, malaria and child mortality are much bigger issues as most sickle carriers lead normal lives."

So, who determined that sickle cell screening is a priority in tribal health? Did someone study the impact of sickle cell on the life and productivity of tribals?

This takes us back to the main question. Do our policies address the priorities of tribals or do they set priorities for them? Unfortunately, it has been the latter. But this time New Delhi travelled to tribal heartland. The expert group offers hope; an opportunity to ensure that the tribals have a say in policies that are framed for them.

Will we let it move forward? Only time will tell.

(Gunjan Veda is a former policymaker and coauthor of Beautiful Country: Stories from Another India.)

Website: http://www.thehindu.com/opinion/op-ed/taking-health-care-to-tribal-heartland/article7927736.ece

THE TIMES OF INDIA

Nagpur TNN | Oct 10, 2015, 03.34AM IST

Bangs to hold nat'l workshop on tribal health at Gadchiroli

NAGPUR: Around 100 million tribal people in India are easy targets of diseases and death as poverty keeps them lagging in critical public health indicators. Bearing this in mind, Union ministry of health and family welfare is conducting a national workshop on 'The Best Practices in Tribal Health Care' from October 11 to 13 to be hosted by SEARCH, Gadchiroli.

With the aim to reviewing the present health and health care situation and to suggest alternatives for redesigning health care in tribal areas and preparing the tribal health care plan, the ministry had constituted an expert committee on tribal health under Dr Abhay Bang of SEARCH, Gadchiroli.

The committee has, for the first time, compiled data on the birth and death rates, main diseases and the barriers to health care in tribal areas at the national level. The committee visited several states to observe the situation and discuss problems with the representatives of tribal people, civil society and the government officers.

In the next phase, the expert committee is exploring potential solutions. For that purpose 25 best practices have been selected from organizations working with tribals, academics and research organizations, civil society, government health programmes in states, and various innovations and schemes for tribal health. These practices will be presented, analysed, evaluated and selected for recommending on national scale.

Dr Soumya Swaminathan, secretary (health research) and director general of Indian Council of Medical Research, will be inaugurating the workshop on Sunday at Shodhagram, headquarter of SEARCH in Gadchiroli.

Website: http://timesofindia.indiatimes.com/city/nagpur/Bangs-to-hold-natl-workshop-on-tribal-health-at-Gadchiroli/articleshow/49294556.cms

5. **The Economic Times**

THE ECONOMIC TIMES

Healthcare By PTI | 13 Oct, 2015, 01.45PM IST

Indian Council of Medical Research DG calls for new researches on tribal health
GADCHIROLI: Indian Council of Medical Research (ICMR) Director General Dr Soumya Swaminathan has expressed the need for conducting new researches on tribal health.

"There is a need for coming together of institutes like ICMR, other government agencies and voluntary organisations working in the field of tribal health and learning the experiences from each other," Swaminathan said after inaugurating a national workshop on 'The Best Practices in Tribal Health Care' at SEARCH NGO's premises here recently.

The living standard of the tribals is changing fast, and hence non-communicable diseases are also increasing among them, she noted.

A research programme will be taken up by the research wing of the government to chalk out programmes and policies for tribal health, said Swaminathan, who is also the Secretary, Department of Health Research (Ministry of Health & Family Welfare).

This is the first national workshop on tribal health in the last 60 years of Independence and organised in the tribal district, she stated.

National Rural Health Mission (NRHM) Director Limatula Yaden and Dr Abhay Bang, Chairman of the government's expert group on tribal health, were present on the occasion. Doctors and health researchers from different parts of the country participated in the three-day workshop which is concluding today.

Website: http://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/indian-council-of-medical-research-dg-calls-for-new-researches-on-tribal-health/articleshow/49335311.cms

ICMR DG calls for new researches on tribal health

Gadchiroli, Oct 13 (PTI) Indian Council of Medical Research (ICMR) Director General Dr Soumya Swaminathan has expressed the need for conducting new researches on tribal health. "There is a need for coming together of institutes like ICMR, other government agencies and voluntary organisations working in the field of tribal health and learning the experiences from each other," Swaminathan said after inaugurating a national workshop on The Best Practices in Tribal Health Care at SEARCH NGOs premises here recently.

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Website: http://indiatoday.intoday.in/story/icmr-dg-calls-for-new-researches-on-tribal-health/1/497373.html

7. ICMR DG calls for new researches on tribal health

PTI | 13 October 2015, 3:49 PM IST

Indian Council of Medical Research (ICMR) Director General Dr Soumya Swaminathan has expressed the need for conducting new researches on tribal health.

Gadchiroli, Oct 13: Indian Council of Medical Research (ICMR) Director General Dr Soumya Swaminathan has expressed the need for conducting new researches on tribal health. "There is a need for coming together of institutes like ICMR, other government agencies and voluntary organisations working in the field of tribal health and learning the experiences from each other," Swaminathan said after inaugurating a national workshop on 'The Best Practices in Tribal Health Care' at SEARCH NGO's premises here recently.

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Website: http://health.economictimes.indiatimes.com/news/industry/punjab-to-spend-more-than-rs-419-crore-to-boost-medical-research/49673110

Business Standard

Delhi October 15, 2015

National Workshop on Best Practices in Tribal Health Care Held

A three-day National Workshop on Best Practices in Tribal Health Care was organized by the [Ministry of Health and Family Welfare](#) recently in at Shodhagram, Gadchiroli, a tribal district of Maharashtra. The workshop held to identify possible solutions to address the healthcare needs of Indias 100 million tribal population was inaugurated by the Dr. Soumya Swaminathan, Secretary, Department of Health Research and Director General, Indian Council for Medical Research (ICMR).

In her inaugural address Dr. Swaminathan noted, This workshop marks an important step towards integrating evidence from the field into policy making for tribal healthcare. It also presents a unique opportunity for government departments, ICMR and voluntary agencies to share experiences and learn from each other.

The workshop saw over 50 representatives from 24 organizations in academia, government and civil society present programs that they have been running to address problems ranging from malaria and maternal mortality to fluorosis and human resource constraints. Selected entries included a web-based application developed by SEWA Rural, PPP model run by the Karuna Trust in Arunachal Pradesh, Malaria control strategy by MITRA in Orissa, Phulwaris for children by the Jan Swasthya Sahyog in Bilaspur, human resources outsourcing by the Government of Chhatisgarh and a weed that can assist in fluorosis management by the National Institute for Research in Tribal Health, Jabalpur. SEARCH demonstrated the Home-based Newborn Care approach including a live demonstration of how ordinary village women, trained as health workers, save newborn lives. This model has been adopted by the National Health Mission and scaled up nationally through nearly 9 lakh ASHAs. The practices were selected from the 85 entries received by the Expert Group on Tribal Health. These practices represent not just potential solutions for the health related problems that plague tribal communities, they also offer a ray of hope in an area that is normally seen as dark and dismal. They show us that work is being done to make healthcare accessible to

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The workshop was hosted by the Society for Education, Action and Research in Community Health (SEARCH).

Website: http://www.business-standard.com/article/government-press-release/national-workshop-on-best-practices-in-tribal-health-care-held-115101500348_1.html

9. Report Odisha

National Workshop on Tribal Health Care held

Mumbai, Oct 15: A three-day National Workshop on Best Practices in Tribal Health Care was organized by the Ministry of Health and Family Welfare recently in at Shodhagram, Gadchiroli, a tribal district of Maharashtra.

The workshop was held to identify possible solutions to address the healthcare needs of India's 100 million tribal population was inaugurated by Soumya Swaminathan, Secretary, Department of Health Research and Director General, Indian Council for Medical Research (ICMR).

In her inaugural address Swaminathan noted, "This workshop marks an important step towards integrating evidence from the field into policy making for tribal healthcare. It also presents a unique opportunity for government departments, ICMR and voluntary agencies to share experiences and learn from each other."

Over 50 representatives from 24 organizations in academia, government and civil society participated in the programme to discuss the issues ranging from malaria and maternal mortality to fluorosis and human resource constraints.

The workshop was hosted by the Society for Education, Action and Research in Community Health (SEARCH).

Website: http://reportodisha.com/national-workshop-on-tribal-health-care-held/

10. On ICMR website:

National Workshop on Best Practices in Tribal Health Care sponsored by Ministry of Health & Family Welfare, Govt. of India was held at Society for Education, Action and Research in Community Health (SEARCH), Shodhagram, Gadchiroli, Maharashtra from 11th – 13th Oct. 2015. Dr. Soumya Swaminathan, Secretary, Department of Health Research & Director-General, ICMR, Chief Guest, inaugurated the programme. The workshop was organized by Dr. Abhay Bang, Director, SEARCH and Chairperson, Expert Committee on Tribal Health. Twenty Six best nominations for best practices by various Academic, Governmental institutions and NGOs for improving tribal health were selected for its presentation in the workshop. Scientists from ICMR, Hqrs who were present on the occasion includes Dr. Reeta Rasaily, Scientist 'E' – RHN Division, Dr. Bontha Veerraju Babu, Scientist 'F' – HSR Division. A team of Scientists from NIRTH, Jabalpur including Dr. Neeru Singh, Director, Dr. Tapas Chakma, Scientist 'F' and Dr. K.B. Saha, Scientist 'E' presented their studies on best practices. The meeting ended with a positive note.

Website:http://icmr.nic.in/icmrnews/National%20Workshop%20on%20Best%20Practices%20in%20Tribal%20Health%20Care.pdf

Press Information Bureau Government of India Ministry of Health and Family Welfare

15-October-2015 10:42 IST

National Workshop on Best Practices in Tribal Health Care Held

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In her inaugural address Dr. Swaminathan noted, "This workshop marks an important step towards integrating evidence from the field into policy making for tribal healthcare. It also presents a unique opportunity for government departments, ICMR and voluntary agencies to share experiences and learn from each other."

The workshop saw over 50 representatives from 24 organizations in academia, government and civil society present programs that they have been running to address problems ranging from malaria and maternal mortality to fluorosis and human resource constraints. Selected entries included a web-based application developed by SEWA Rural, PPP model run by the Karuna Trust in Arunachal Pradesh, Malaria control strategy by MITRA in Orissa, Phulwaris for children by the Jan Swasthya Sahyog in Bilaspur, human resources outsourcing by the Government of Chhatisgarh and a weed that can assist in fluorosis management by the National Institute for Research in Tribal Health, Jabalpur. SEARCH demonstrated the Home-based Newborn Care approach including a live demonstration of how ordinary village women, trained as health workers, save newborn lives. This model has been adopted by the National Health Mission and scaled up nationally through nearly 9 lakh ASHAs. The practices were selected from the 85 entries received by the Expert Group on Tribal Health. "These practices represent not just potential solutions for the health related problems that plague tribal communities, they also offer a ray of hope in an area that is normally seen as dark and dismal. They show us that work is being done to make healthcare accessible to

tribal communities," Dr. Abhay Bang, Chairperson of the Expert Group, noted in his concluding remarks.

The Expert Group on Tribal Health was constituted jointly by the Ministry of Health and Family Welfare (MoHFW) and the Ministry of Tribal Affairs (MOTA) in October 2013 to review the existing situation of health in tribal areas, suggest interventions, formulate strategic guidelines for states and develop a national framework to improve healthcare services among the tribal population. It includes representatives from the central government, various state governments, research organizations and the civil society. The Expert Group has conducted visits to various states to review the existing situation and has, for the first time, compiled health data for tribal people at the national level. It is expected to complete its report and recommendations by the end of this year.

The workshop was hosted by the Society for Education, Action and Research in Community Health (SEARCH).

Website: http://pib.nic.in/newsite/PrintRelease.aspx?relid=128746

Posted on 16/10/2015 by Dailyexcelsior

Expert group on tribal health to submit report by year end

NEW DELHI, Oct 15: An expert group constituted to review health situation and formulate guidelines to improve services among tribal population has compiled health data at the national level and is expected to submit its report by this year end, the Government said today.

The expert group on tribal health was constituted jointly by the Health Ministry and Tribal Affairs Ministry in 2013 to review the existing health situation in tribal areas, suggest interventions, formulate strategic guidelines for states and develop a national framework to improve healthcare services among the tribal population.

"The expert group has conducted visits to various states to review the existing situation and has for the first time, compiled health data for tribal people at the national level. It is expected to complete its report and recommendations by the end of this year," a Union Health Ministry statement said.

The group includes representatives from the Central Government, State Governments, research organizations and the civil society.

The statement said that the Ministry also organised a three-day national workshop on best practices in tribal health care at Shodhagram, Gadchiroli, a tribal district of Maharashtra recently to identify possible solutions to address the healthcare needs of India's 100 million tribal population.

The workshop saw over 50 representatives from 24 organizations present programmes that they have been running to address problems ranging from malaria and maternal mortality to fluorosis and human resource constraints.

Selected entries included a web-based application developed by SEWA Rural, PPP model run by the Karuna Trust in Arunachal Pradesh, malaria control strategy by MITRA in Orissa, Phulwaris for children by the Jan Swasthya Sahyog in Bilaspur and others.

The practices were selected from the 85 entries received by the expert group on tribal health. "These practices represent not just potential solutions for the health related problems that plague tribal communities they also offer a ray of hope in an area that is normally seen as dark and dismal.

"They show us that work is being done to make healthcare accessible to tribal communities," said Abhay Bang, Expert Group Chairperson.

During the workshop, Society for Education, Action and Research in Community Health (SEARCH) also demonstrated the home-based newborn care approach including a live demonstration of how ordinary village women trained as health workers can save newborn lives.

This model has been adopted by the National Health Mission (NHM) and scaled up nationally through nearly 9 lakh ASHAs.
Earlier the workshop was inaugurated by the Soumya Swaminathan, Director General, Indian Council for Medical Research (ICMR).

"This workshop marks an important step towards integrating evidence from the field into policy making for tribal healthcare.

"It also presents a unique opportunity for government departments, ICMR and voluntary agencies to share experiences and learn from each other," he said. (PTI)

Website: http://www.dailyexcelsior.com/expert-group-on-tribal-health-to-submit-report-by-year-end/

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Website: http://indiatoday.intoday.in/story/expert-group-on-tribal-health-to-submit-report-by-year-end/1/499402.html

THE ECONOMIC TIMES

Politics and Nation

By PTI | 15 Oct, 2015, 03.25PM IST

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Website:

http://economictimes.indiatimes.com/articleshow/49380203.cms?utm_source=contentofintere st&utm_medium=text&utm_campaign=cppst