



Best Practices in area of Tribal Health

PRESENTED IN NATIONAL WORKSHOP ON
TRIBAL HEALTH - SEARCH GADCHIROLI
OCTOBER 2015

MINISTRY OF HEALTH & FAMILY WELFARE

Best Practices in Area of Tribal Health

**PRESENTED IN NATIONAL WORKSHOP ON TRIBAL HEALTH -
SEARCH GADCHIROLI, OCTOBER 2015**

CONTENTS

S. No.	Particulars	Page No.
1	The Best Practices Presented	4
2	Rural Eye Care and Vision Centre run by L V Prasad Eye Institute Hyderabad	5
3	Fluorosis Mitigation through Nutrition Supplementation, Food Diversification and Safe Drinking Water in Tribal Areas of Madhya Pradesh	8
4	Malaria Control in Dindori District (Madhya Pradesh) – A Case Study	11
5	Control of Hyper – Endemic Malaria through Community Based Effort in Tribal districts of Southern Odisha	14
6	Preventing under - three child malnutrition through creches (Phulwari) in rural Bilaspur district of Chhattisgarh (Jan Swasthya Sahyog)	17
7	Fulwari Scheme: Community Managed Health and Nutrition Centres for under 3-year Children and mothers (Chhattisgarh)	20
8	Health Wednesday at Jashpur Chhattisgarh	22
9	Strengthening Community Action for Health under the National Health Mission (Population Foundation of India)	24
10	End Maternal Mortality Now - Nazdeek, Assam	26
11	Health Care Delivery Monitoring for Mother and Child in Tribal Area	28
12	Reaching the healthcare to unreached - Karuna Trust Karnataka	30
13	Strengthening of CEmONC unit through a unique PPP model at CHC Jabugam, Chhota Udepur District, Gujarat - Deepak Foundation and Government of Gujarat	33
14	Maternal And Newborn Survival Initiative(MANSI) in Jharkhand A Corporate Social Responsibility Initiative	35
15	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 By Shrey Desai, SEWA Rural	37

16	Bridge Training Program for AYUSH physicians in Allopathic Primary Care Delivery - IKP Trust & ICTPH	40
17	Training of tribal girls as ANM & GNM in two tribal predominant Districts of Chhattisgarh - Jan Swasthya Sahyog	42
18	Outsourcing of HR - Health Department, Chhattisgarh	44
19	Community Monitoring and action for women's health and malnutrition- Area Networking and Development Initiatives (ANANDI), Gujarat	46
20	Outreach Program through Mobile Medical Units - Shrimad Rajchandra Hospital, Dharampur, Gujarat	48
21	Sickle Cell Anemia screening in tribal population of Gujarat - Health & Family Welfare Department Gujarat	50
22	Enrolment and Rapid Risk Assessment (E&RRA)- Best Practices in Tribal Healthcare Shodhgram, Gadchiroli	52
23	Integrated Tribal Development Agency, Adilabad, Project AVVAL- 100% Institutional Deliveries Project	54
24	National Health Mission, Tamil Nadu: Birth Waiting Room. National Health Mission - Tamil Nadu	56

Introduction

Ministry of Health and Family Welfare, Govt. of India constituted an Expert Group on Tribal Health, in 2014. The Expert Group organized a national workshop on “the best practices in tribal health care” to bring together the best practices from across the country, as a beginning of the Expert Group’s search for solutions’, which was hosted by SEARCH, Gadchiroli from 11 to 13 October, 2015, at Shodhagram (SEARCH HQ) Gadchiroli, Maharashtra.

The workshop was aimed at sharing of the best practices and examining them to identify; a) the practices with the potential for scaling up, and b) learnings for the tribal health care policy in India. The 53 participants from all over India, selected from the government health care programs in states, the civil society and the academic/research organizations participated in the workshop. Twenty three nationally selected best practices were presented and discussed. The selected “Best Practices” were meant to demonstrate an effective method/approach or solution which would become a candidate for scaling up to solve some of the critical problems in tribal health care.

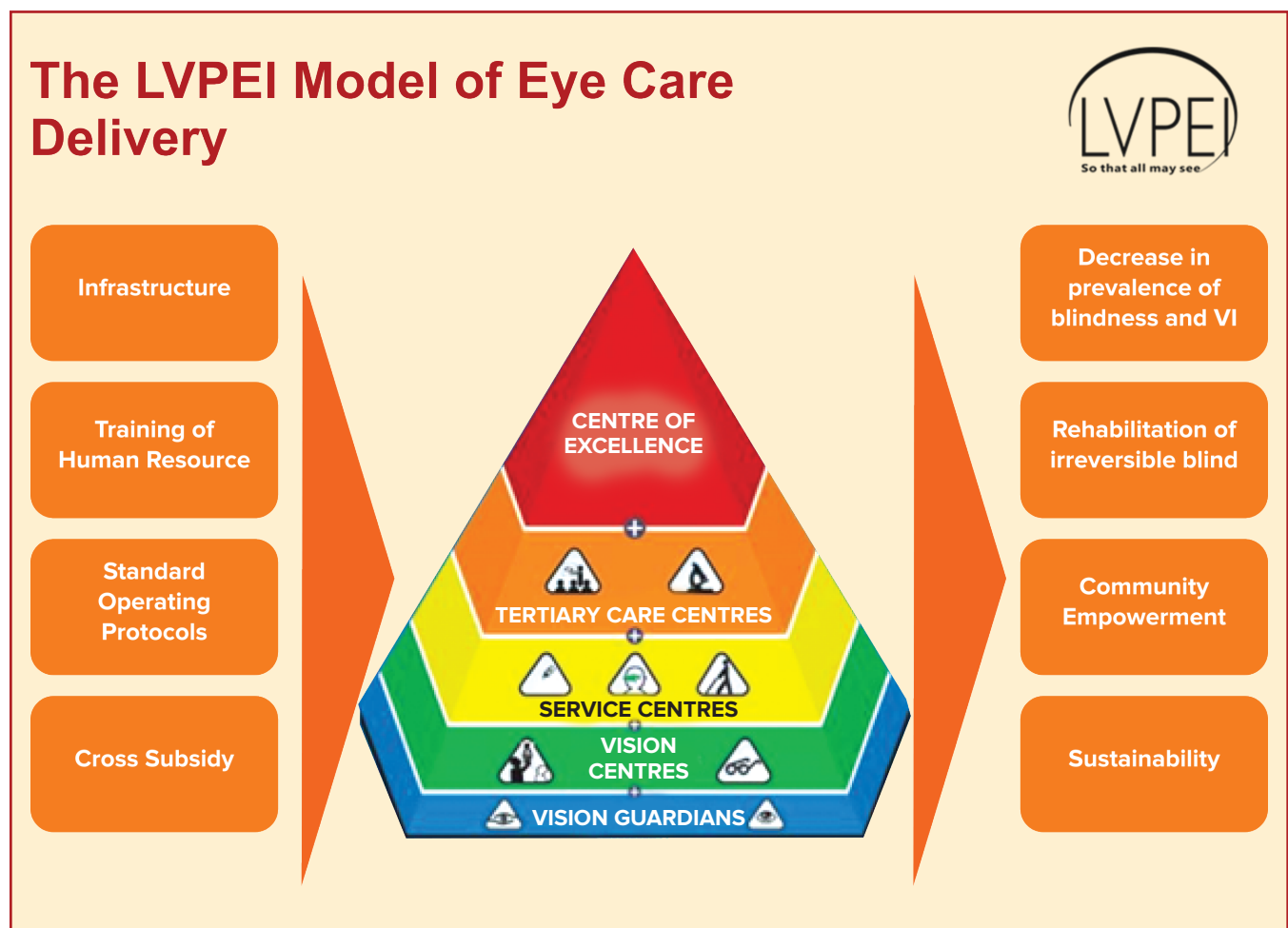
The parameters which were used to select the best practices were –

- 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) It demonstrates a distinct method or a component,
- 3) Demonstrated feasibility of implementation,
- 4) Proven impact,
- 5) Scalability.

Sl. No.	Organization	Best 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

Problem Statement

- Prevalence of Blindness (1.8 %)
- Visual Impairment (8.1%)
- High prevalence of both blindness (60%) and moderate visual impairment (87%) in rural areas. Cataract and uncorrected refractive errors were responsible for it.
- High barriers to utilization of eye care services: accessibility, affordability and availability
- Vision of majority of visually impaired and blind can be restored by a simple pair of glasses and cataract surgery
- High proportion of persons who could benefit from attending the outreach services do not participate in them



Programme Description

Creation of an Ideal Rural Eye Care Centre. Key components of programme -

- Infrastructure
- Training of Human Resource
- Building Standard Operating Protocols
- Cross Subsidy

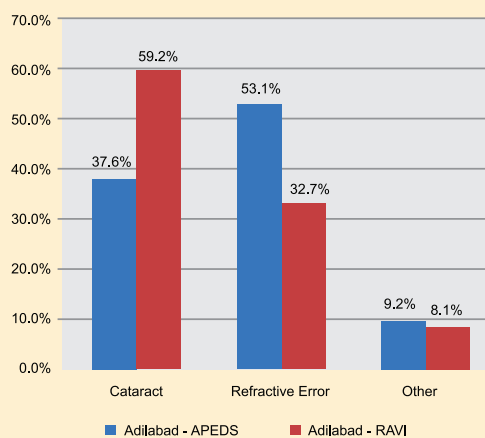
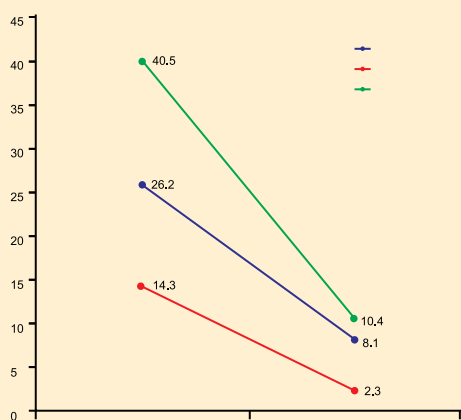
Core Activities of the Institute -

- Service Delivery
- Education
- Research
- Consultancy
- Advocacy

Programme Goal

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

Prevalence and Causes of Visual Impairment (above age of 40 years)



*APEDS: 1998-2000

*RAVI: 2014 (unpublished data)

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%

Key elements of Vision Centre – Permanent Primary Eye Care Facility for 50,000 population (500-600 sq. ft. area)

- Walk in free screening centre
- Runs 5.5 days / week
- Half day community visit every week
- Basic undilated eye examination and retinoscopy
- Provision of low cost spectacle
- Recruitment of local staff, their training at tertiary care centre

Programme Outcomes

- Decrease in prevalence of blindness and Visual Impairment (VI)
- Rehabilitation of irreversible blind people
- Community Empowerment
- Sustainability

Financial Implications

One time fixed cost of vision centre – Rs. 8 Lakh.

Average cost to patient – Rs. 178 + / - 48 (compared to Rs. 366 +/- 48 in nearby private clinics)

Scalability

Support provided by the organisation's tertiary care centre and the referral linkages are critical to the success of the programme. So the scalability of the interventions is closely linked to such support systems.

Problem Statement

Occurrence of unknown disease characterised by knock knee of all children <20 Years in a village (Tilaipani) of district Mandla. Differential diagnosis in initial phases – Sickle Cell Osteopathy, Endemic Ricket, Fluorosis. Cases found:

Village Tilaipani -

- Genuvalgum – 52% (below 20 years of age)
- Dental mottling – 74 %
- Fluorine in Water – 9.2 – 10.8 ppm

Village Hirapur -

- Genuvalgum – 6% (below 20 years of age)
- Dental mottling – 56 %
- Fluorine in Water – 0 to 13.5 ppm

Programme Goal

To correct the deformities and reduce the micronutrient deficiencies

Programme Description

Steps Recommended to state govt. and subsequently implemented in the villages were -

- Alternate water source

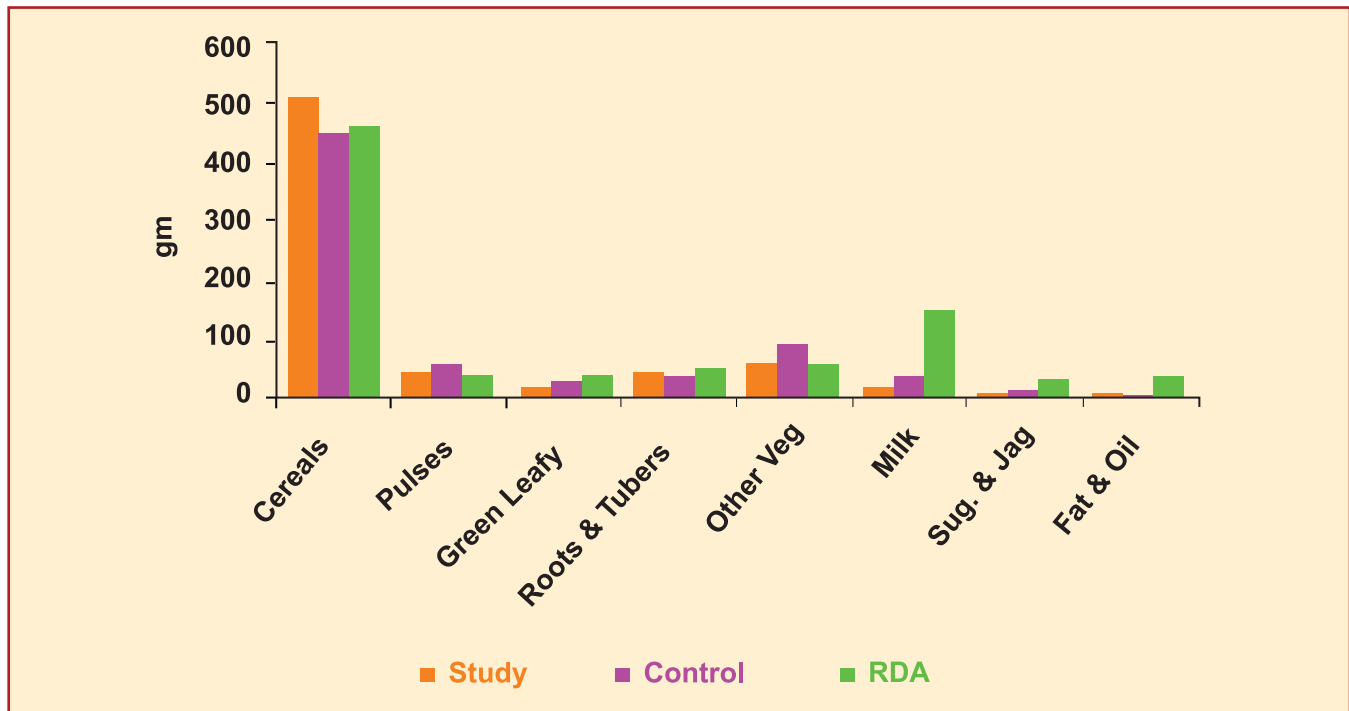
Problem: Rationale of selection

Village Hirapur (n=198)



- Genuvalgum - 6.3% (below 20 yrs)
- Dental mottling - 56%
- Water F- 0-13.5ppm

- Closure of all contaminated hand pumps
- Surgical shoes for children of < 10 years age
- Supplement Calcium, Vitamin C, D3, Iron
- Dietary Counselling and health education
- Initiating ICDS activities



Average consumption of foodstuffs gm/day in Mandla, Central India (1995) (n=48)



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



ICDS Activities in Affected villages

Dismantled hand-pumps

Programme Outcomes

Effect of intervention on Fluorosis in two villages of Mandla after 5 years of programme in Village Tilaipani -

Genuvalgum – 2.6 % (below 20 years age)

Dental mottling – 70 %

Fluorine in Water – <1 ppm

Urine Fluoride – 9.8% (baseline value was 41%)

Financial Implications

Cost of a subsequent intervention in District Seoni based on same model was Rs. 27 Lakh.

- Scalability - Same model was implemented by UNICEF in Dhar and Jhabua through NGOs in 2006-07. Independent evaluation showed similar results
- UNICEF included it in their internal learnings and subsequently trained 13 country teams on this model
- INREM foundation of TATA Trust worked in Jhabua with same model, and same results were seen.
- Concept was included in National Programme for Prevention and Control of Fluorosis (NPPCF)

Problem Statement

Malaria is among the major health problems for the area alongwith Tuberculosis, Viral Diseases, Filaria, Scabies, Diarrhea, HIV, Haemoglobinopathies, Malnutrition, Fluorosis, and Hypertension.

Malaria has a perennial transmission in the area. The dominant variant found in the area is Plasmodium Falciparum. P. Vivax is also found commonly, and P. Malariae is found as a rare occurrence. Two highly efficient vectors are, Anopheles culicifacies and Anopheles fluviatilis.

The risk factors that contribute to the high occurrence of Malaria in the area are, 37% geographical area being under forest, and inaccessible terrain. The main inhabitants of the area are Baiga tribes.

The district contributes to 12% of the burden of Malaria in the state, through it has only 1% population of the state. In 2009, its statistics related to Malaria were; SPR- 27%, Pf% 87%, Spleen Rate 47%, IPR (<1 Yr.) 40%, CPR (<5 Yr) 45%.

Programme Description

The goal of the programme is, a) To control Malaria in Baigachaak with an aim to accomplish Zero indigenous malaria transmission in Dindori district, so that it will not remain a major public health problem and will serve as a guide for Malaria Elimination programmes, b) Develop evidence based strategy for elimination of Malaria from highly endemic tribal areas of the state, and c) Strengthen existing health systems. The programme duration was 5 years.

The interventions of the programme included; a) Indoor residual spray (IRS) using Alphacypermethrin, b) Long lasting Insecticide Treated Nets (LLINs), c) Robust surveillance using RDT and ACT, d) Intensive IEC in collaboration with a Kolkata based NGO (funded by Ministry of Tribal Affairs - MOTA).

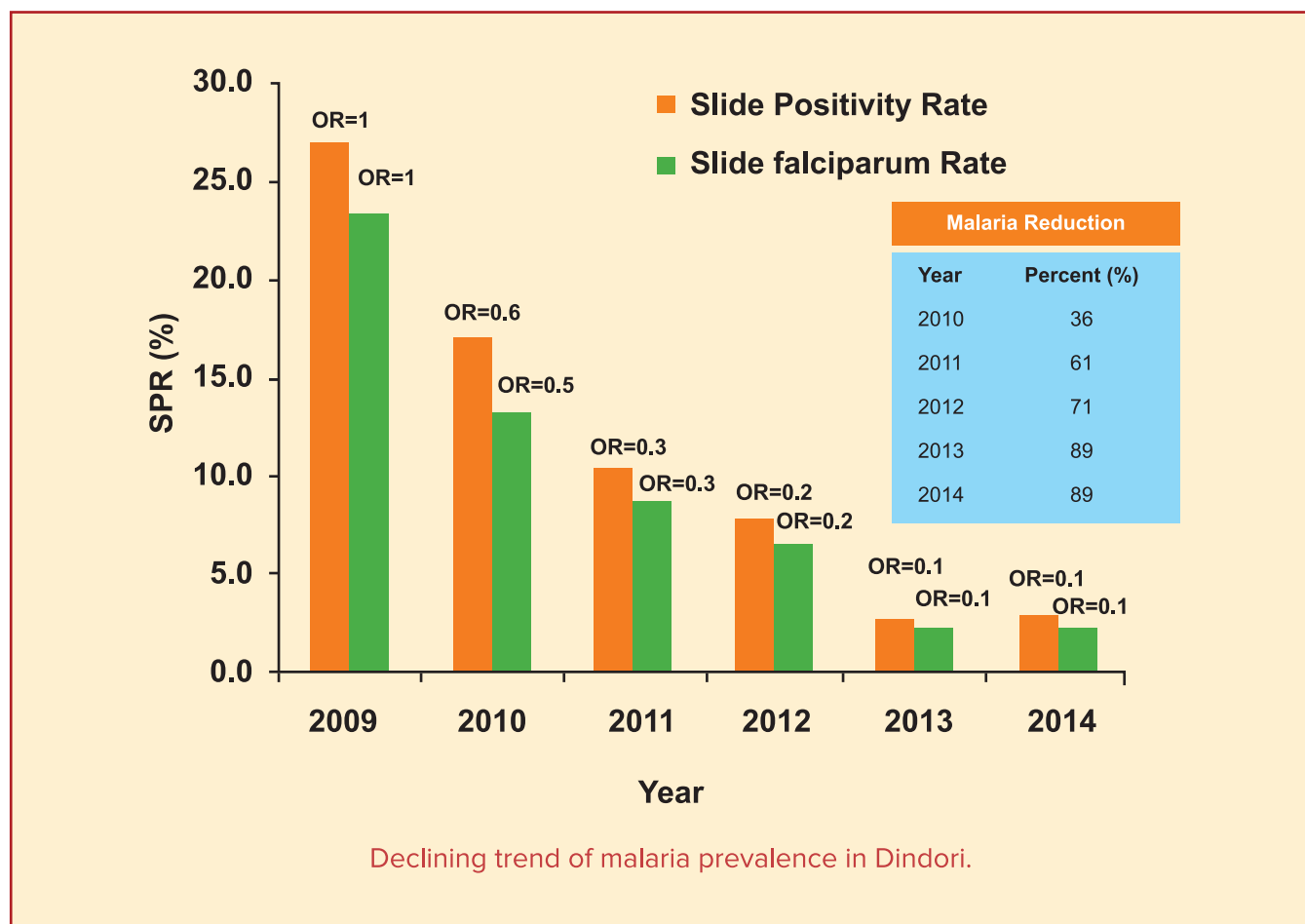
Training Workshops jointly with NGO-Bangla Natak Dot Com, Kolkata



Organized 36 Training Workshops with students (Total in the field)

- Trained on survey techniques
- Trained on theatre based methods
- Trained on tools of communication
- Saha KB. et 012015. IJ MR, 141 N., 576-583

Extensive Health Education was undertaken through IEC campaigns in the district under the intervention, focussing on Promotion of Preventive Measures, and generation of demand for health services. The IEC campaign engaged; 235 local school going children (class 8-12), 47 local unemployed youth as village facilitators, 3 block monitors, and 1 field coordinator. Total 42 schools were enrolled in the process. 36 Training Workshops were conducted in the district with students (total 84 days of workshop). The workshops focused on survey techniques, tools of communication, and theatre-based methods for conducting IEC in the community.



Programme Outcomes

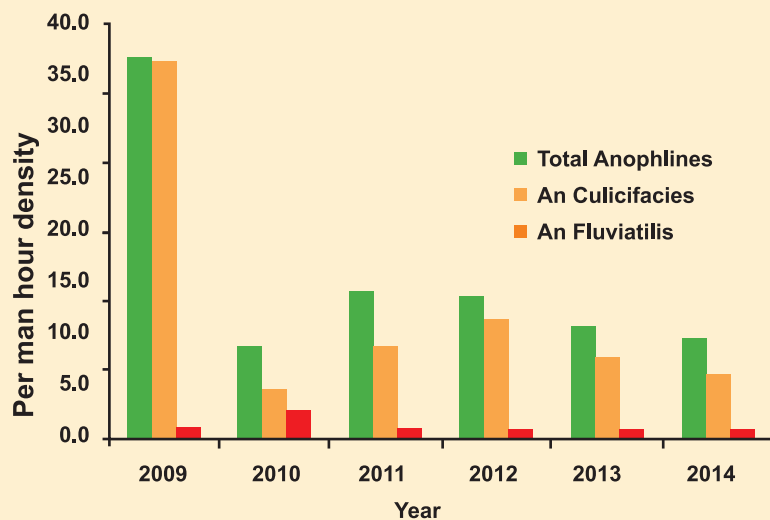
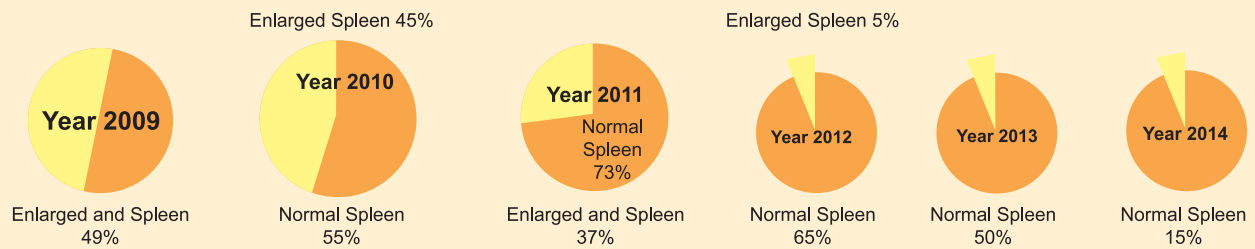
Major reduction in Malaria prevalence was recorded. From a level of 36% reduction in 2010, it went up to 89% in 2014.

Slide positivity rate came drastically – from 27% in 2009, it came down to about 4% in 2014. Similarly, Slide falciparum rate also came from 24% in 2009, to about 3% in 2014.

Major reductions were also recorded in % of enlarged spleen. From a level of 49% people with enlarged spleen in 2009, it came down to 5% in 2014.

Yearwise man hour density of Malaria vectors also came down from the level of 37 of Total Anophlines in 2009, to 8 in 2014. Sporozoite rates also came down. For *An. Culicifacies* it changed from 1.2 in 2009 to 0 in 2014, and for *An. fluviatilis* it changed from 0.5 in 2009 to 0 in 2014.

Spleen Rate



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

Financial Implications

This intervention was supported by MOTA funds. NGO was engaged for its implementation.

Scalability

The scalability of the intervention is linked to the factors that contributed to its success and those factors that hindered it. Unwillingness of the staff to work, and limitations of mobile network, and the public transport in the area were faced as challenges. Strengthening and capacity building of the frontline workers (ASHA, ANM/AWW), and organization of sensitization camps at public places were found to be positive factors in the intervention.

The conditions necessary for the successful implementation of the interventions were recorded as; Robust surveillance, Prompt diagnosis, and treatment, Increase in ground level health worker, scaling up of LLINs, RDTs & ACTs, Need based IEC / BCC, Intersectoral coordination, and supply chain management.

Problem Statement

Malaria incidence in India accounted for 76% of cases in South East Asia region. In India, 80% of cases come from the 22% population in high transmission, tribal, hilly and inaccessible areas. Of these, Odisha, reported 26% of Malaria cases and 85% of *Pf* cases.

Odisha is particularly endemic for *Falciparum* malaria. Surveys done in from 2001 to 2010 showed a Child Parasite Rate of 38.2% (of the 21845 children screened, 8340 were found Malaria positive in 5 districts).

The most vulnerable groups for severe malaria are children (under 5 years age group), and pregnant women, especially Primi-gravidae. The region also ranks highly in the state for Child Malnutrition and Child Mortality. Insights from the years of community health work in the region showed that, reduction of Childhood malaria will significantly reduce Child Malnutrition and Child Mortality, besides other improvements in their quality of life.

It has also been recorded that Malaria, is a major killer in tribal parts of Odisha, and causes morbidities among tribals, especially children. *Anopheles Fluvialis* is the common vector which breeds in flowing water, making it difficult to control. Inaccessible areas are the most vulnerable, with high mortality and suffering to people. Malaria also contributes to socio-economic distress in these endemic areas.

Programme Description

In the initial phase of the programme, active screening of children was conducted through 50 camps, between June to Dec 2010. Through this screening, 59% of children in under 5 age group, were found positive for Malaria. The prevalence rates were found highest in remote hill villages. Seven small hilly villages had 100% positivity among children.

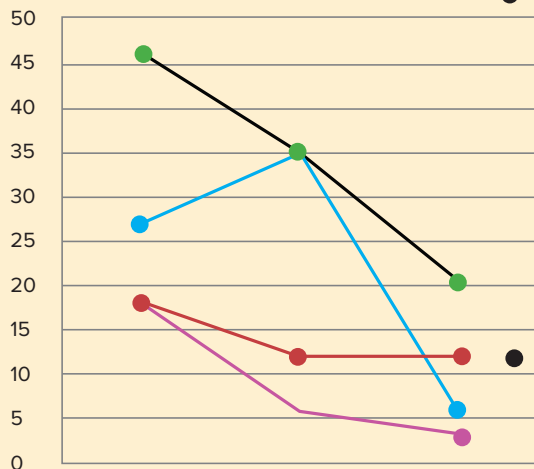
The program aimed at reduction of Point Prevalence of Malaria by 25% (as assessed by blood tests in children under 5 years), and reduction of Fever Deaths by 25% (as reported in household surveys or

Some decline in total fever cases



Fig 3: Decline in Total Fever Cases (All)

Fever deaths declined



- 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.

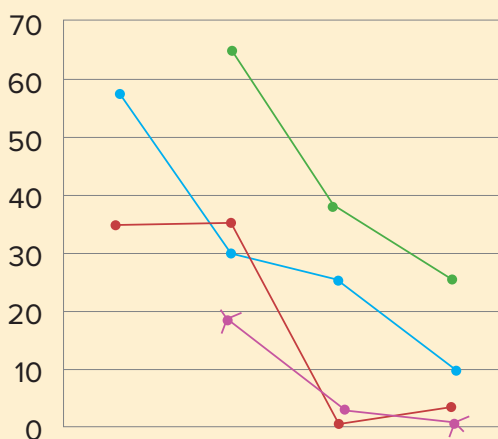
	Y2011	Y2012	Y2013
DAPTA	27	35	6
FARR*	18	12	12
MITRA	46	35	20
SWATI	19	6	3

Fig. 4: Fewer Deaths in Project Areas

community- based MIS). The interventions set out to establish '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 facilitation of access to the tools needed for the same'.

The intervention focused on a few key strategies and implemented a no. of activities under each. The first strategy focussed on Education for Empowerment, the second one was – Saving Lives, Decreasing Suffering and reducing Parasite Load, the third strategy was – Reduction of Vector Density, fourth strategy

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.

	2000	2001	2002	2003
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

Fig. 5: U5 parasitaemia (%)

was focused on Behavioural Change and use of Personal Protection Measures, and the fifth strategy was aimed at 'Organisational Capacity Building, Monitoring and Evaluation for Measuring & Sustaining Change'.

The education campaign included knowledge on Malaria (what is Malaria, how it spreads, what to do after infection, and preventive measures) and facilities available for malaria control. The second strategy focused on encouraging use of government services, provision of presumptive CQ-SP through volunteers, and CQ-SP, or blood test with RDT and treatment with ACT by staff, as well as the referral support for severe cases. The interventions also focused on camps for active screening, for under 5 children, and antenatal mothers. Efforts for vector control included, awareness building for breeding site reduction, weekly dry days, and IRS, and promoting Larvivorous Fish. Training and capacity building of the health workers and FLWs (ASHA & AWWs), and VHSNCs – the community organization called GKS in the state, was conducted extensively. Simple community-based management information systems on select health indicators were also set up. The programme was implemented with five collaborating NGOs, with each covering 50 villages.

Programme Outcomes

In the programme intervention (implemented by the NGO) which had pre-dominantly tribal and dalit communities, Malaria Parasite Rate in children, in under 5 age group, came down from 59% in 2010, to 16% in 2014, the under 5 mortality rate (per 1000 live births), reduced from 295 to 93, and Fever Death Rate (per 1000 population), reduced from 7.1 to 1.8. Similarly, major reductions in key parameters were seen in intervention areas of other four NGOs.

Financial Implications

The project cost was estimated to be Rs. 235/ person/year, which translated to total cost of Rs. 23.5 Lakh per year for coverage of a population of 10,000 (which includes HR, transport, materials etc.).

Scalability

The intervention was based on the Community Based Malaria control programme, that was implemented in that area, by one of the collaborating NGOs since last 19 years. This NGO also conducted training for many other NGOs and civil society networks between 1996 to 2009.

This intervention has also been implemented and scaled up in 630 villages of 4 districts of Odisha, between 2010 to 2015, by Tata Trust Partners Network.

In 2015, Health and family Welfare Dept. of Govt. of Odisha, and NVBDCP programme launched a programme to upscale this intervention in 8 districts.



Project Activities in Community

Problem Statement

- One third of the children are underweight, which means they go to bed hungry every night
- High Malnutrition is prevalent in this age group
- Long term effects are, reduced learning ability and work capacity, leading to poverty trap
- No one to feed these children frequently. They can't eat themselves.
- Where food is offered, portion size is small.
- Illnesses leads further to poor eating – it leads to malnutrition which leads to further illnesses
- Extreme poverty and low purchasing capacity of parents further aggravates it

Some key Malnutrition data (India's Rapid Survey for Children 2013-14)

Category	India	Chhattisgarh
Stunted	38.8	43
Severely Stunted	17.4	16.4
Wasted	15	12.9
Severely Wasted	4.6	2.4
Under weight	29.4	33.9
Severely underweight	9.5	9.9

Programme Description

Fulwaris, Hamlet based creches were established

- A Caretaker is selected by village community
- One per ten children (2 workers for 13-20 children)
- Several creches in a large village
- Opens 8 AM to 4 PM.
- Health Care by Village Health Worker
- Basic Training in child nutrition or health is given to Phulwari workers
- 83 creches in 38 villages – 1066 children
- Food Supplementation at Fulwari centre – Sattu daily – cereal – pulse – oilseed mix 60 gm / child / day



Hand washing



Adding oil to food



A younger child being fed



Older children feed themselves

- Khichdi daily – rice / daal mix (5:1) 125 gm rice
- Eggs thrice a week
- Oil supplementation – 10 ml / child /day
- > 900 K Cal + 22 gm protein / day

Also provision for:

- Iron supplementation – daily
- Albendazole twice an year
- Toys for cognitive learning
- Growth monitoring every month
- Early Child Education

Caretaker : Child ratio - to be not more than 1: 8-10

Programme Outcomes

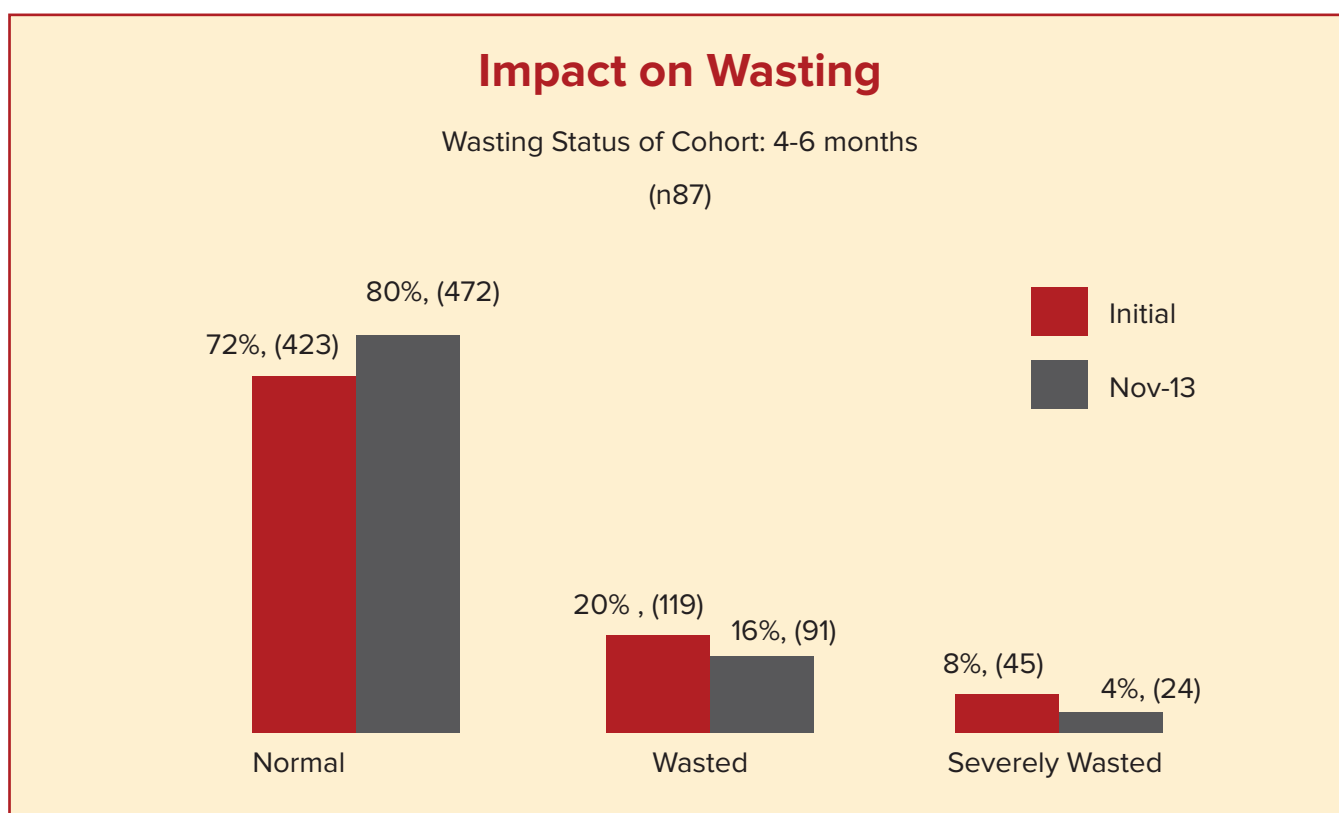
- Positive community response
- Children now eat more even at home
- Children wash hands regularly, even at home before meal

- Older siblings going back to school
- Improvement in Nutritional Status
- Long term effect of Malnutrition on height has not shown any change. Stunting persists.
- Weight for age and weight for height have significantly improved (Status monitored using WHO Anthro Software)

Financial Implications

Cost is Rs. 27.68 / child / day for food. Wages – Rs. 3000 per month for supervision, logistics, and medicines.

- Scalability - In Nov. 2012, the programme was scaled up – through an NGO (Public Health Resource Network - PHRN) - 148 creches established with 1552 children
- Madhya Pradesh and Chhattisgarh, launched Anganwadi cum creches (in 5% AWCs) on pilot basis. Being replicated in Bihar, Orissa & Jharkhand by NGOs.



Problem Statement

Key challenges identified were, Inadequate access of quality food items among families, poor maternal nutrition, lack of time for child feeding, recurrent infection, the inadequate reach of health workers to under 3 years children, ICDS resources more focused on 3-6 years old.

Programme Description

Fulwari intervention is a community-managed health and nutrition center. Focused on feeding and care of under 3-year-old children, pregnant and lactating women. It aims to prevent infections in children, ensure early detection and cure; by organized daycare through habitation based collective of mothers, promoting household / community level production of diverse foods.

No paid worker for working in Fulwari, it is managed and run by the group of mothers and 2 mothers volunteer each day to run the Fulwari and take care of children. All decisions regarding the Fulwari are taken by the group. Group manages funds that are made available for running the centres from Panchayats. Each Fulwari covers 5-20 children depending on habitation size. It runs on all days, 6-7 every day hours depending on timings of working mothers, at a space provided voluntarily.

Programme Outcomes

Fulwari is highly accepted in the community and among mothers, Hygiene and feeding practices improved, it made it easier for ANM and Anganwadi workers to reach out to pregnant women and young children, it helped in reducing the episodes of illness and child mortality, which led to weight gain by pregnant women and improvement in birth weights. Growth monitoring also improved also improved in the community.

Chhattisgarh Interim Assessment Cohort Study shows that 64% of severely underweight children enrolled in Fulwari, were able to come out of the severely underweight category. The low birth weight incidence has come down from 25.5% to 13.9% for newborn to pregnant women enrolled in Fulwari. The second round Survey reported a 24% and 38% reduction in the overall and severe underweight rate respectively.

Financial Implications

An average budget of Rs. 50,000 per Fulwari is allocated by State Government. Rs. 6 per child per day and Rs. 15 per pregnant woman per day for food were provided by Gram Panchayat and Fulwaris respectively. The state government increased allocation to Rs. 30 Crores in the year 2015-16 to allow expansion into 6000 Fulwaris.

Scalability

It was replicated across 19 districts of Chhattisgarh and became a state scheme in 2013-14. A total of 2850 Fulwaris are operational presently, covering 85 tribal blocks of the state with an enrolment of around 35000 children and 16000 pregnant/lactating women,

Fulwari Volunteer Duty Charts

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

दिनवार ड्युटी की सूची	
टोंगरी पारा, गा.पं. करौली, वि.स. लुधड़ा	
क्र. दिव	ड्युटी देनेवालों का नाम
1 सोमवार	इन्दकुंवर, श्यामपति
2 मंगलवार	समेता, गगोत्री
3 बुधवार	गुलाबी, फुलमती
4 गुरुवार	हिरामती, बैंगन
5 शुक्रवार	मालती, तीजो
6 शनिवार	मुटियारो, फुलवंती
7 रविवार	राजकुमारी, श्यामपति

Problem Statement

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. As per the protocol, Children with Severe Acute Malnutrition (SAM) with medical complications need to be admitted to Nutritional Rehabilitation Centres (NRCs) and without medical complications to be managed through a community-based program. However, in reality, non-SAM and SAM children without medical complications were being admitted to NRCs. The required number of beds is huge but availability is limited. Specialized care in NRCs was a challenge and feeding protocol training was needed.

Programme Description

The defined problem was addressed by Health Wednesday at Jashpur through accurate screening of SAM children with medical complications by medical officers (MO) for NRC referral and by providing regular and appropriate medical assistance and counseling to other malnourished children and mothers. Under the program **Mobilization of malnourished** children and their mothers were mobilized to CHC/PHC; **Free Health Checkup** was provided by MO/Rural Medical Officer (RWA)/ Ayurvedic MO at 8CHCs and 35 PHC across the district; **Free Medicines** were provided to the child and mothers in case of any identified illness apart from providing Vitamin/iron/folic acid/ calcium supplementation using funds from Mukhya Mantri Bal Sandarbh Yojna, **Nutritional meal**, ideally, 2 eggs, 2 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** from mid of Aug 2015, MUAC tape has been recommended for identification of SAM children. On average around 811 severe and moderately malnourished children are identified every week. Out of which, 400 children fall into the SAM category; **NRC Referral**-SAM children are referred to NRC units located at 3 places in 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 NHRM funds; **Monitoring** was done by the monitoring team that comprises CMHO, DPO, OIC Health, BMOs, DPM, BPMs, BEEs, BAAs, CDPOs and DECDOs who cover all 43 centers every week were done.

Programme Outcomes

- Average 3165 and 3696 children per month in 2014-15 and 2015-16 were mobilized, 90% of these children belong to the severe or medium malnourished category. NRC bed occupancy rate has been increased from 56.67 in 2013, followed by 74.17% and 76.24% in 2014 and 2015 respectively. NRC recovery rate from 36.02% in 2013 was increased to 49.44% and 77.05 % in 2014 and 2015 respectively. The overall NRC maximum reach out to tribal population was an increase for both male (43.47%) and female (56.53%), and social categories i.e. SC (66.40%), SC (5.60%), OBC (27.20%), and General (1.07%).

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



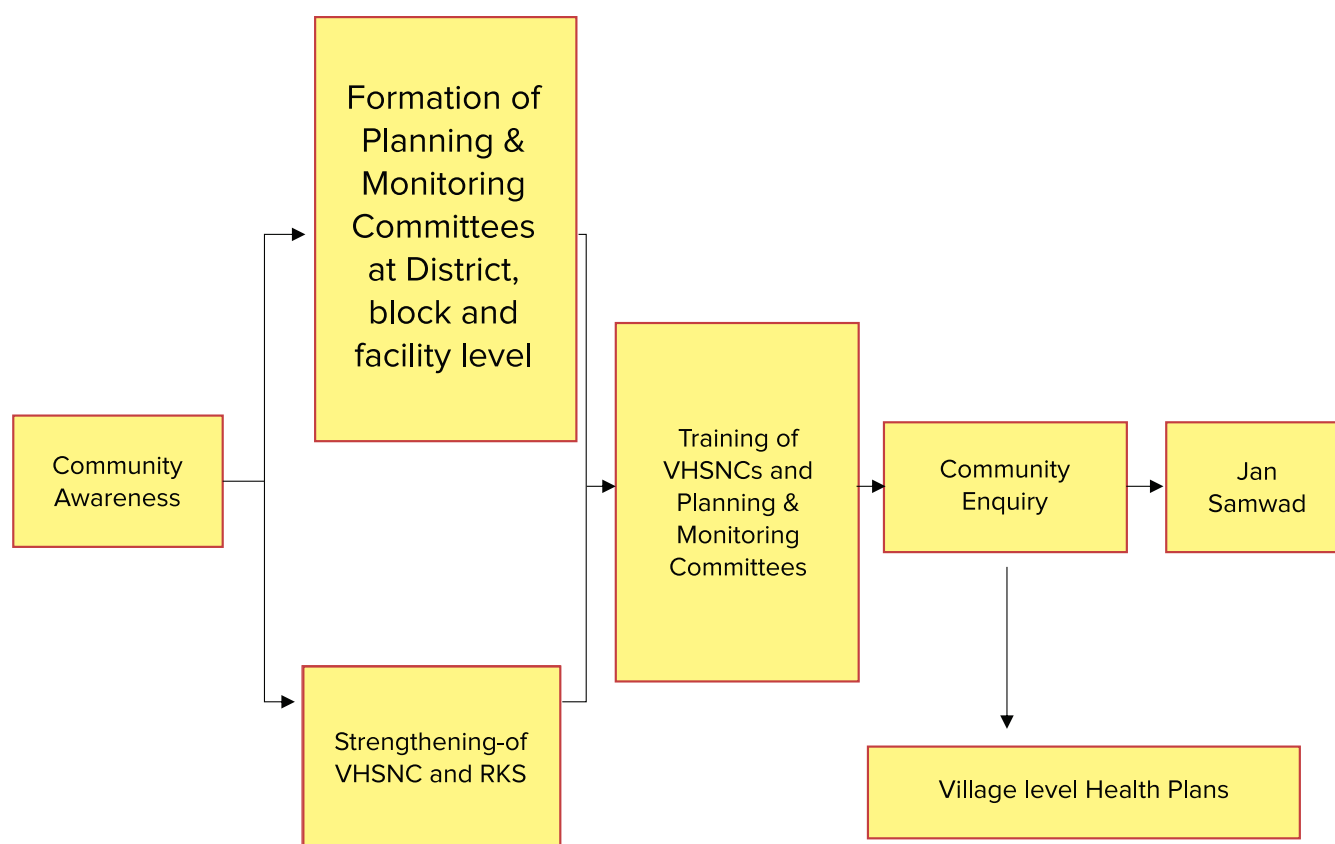
Strengthening Community Action for Health under the National Health Mission (Population Foundation of India)

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 the delivery of health services.

Programme Description

Process flow



Programme Outcomes

The construction of the Sub centre building was complete through “Shramdaan”, later support came from the district authorities. Performance of the health services improved in Rajasthan, and maternal health services improved in Bihar (5 districts). Enhanced trust and improved interaction between provider and community- improvement in service delivery (ANC, PNC, Immunization), the responsiveness of provider

to community needs, Improved provider attitude and behavior. 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. Reduction in out-of-pocket expenditure.

Financial Implications

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

Scalability

Technical support was provided by the Advisory Group on Community Action (AGCA) for scaling up community action. It includes Develop/adapt manual, tools, communication materials; Building the capacity of state nodal officers and implementation organizations; Facilitating state-level visioning and planning exercises, including the development of State PIPs; Regular mentoring and guidance to states on programme implementation; Undertake programme implementation reviews.



Activities at Community Level

Problem Statement

India has one of the highest maternal mortality rates in the world, and Assam leads the country with the highest maternal mortality ratio of 328 deaths per 100,000 live births (against India's 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 mortalities 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.

Programme Description

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. The 40 women volunteer in Balipura and Dhekiajuli block, 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. It covers more than 30 types of violations under NHM and the Plantation Labor Act. The Project team in Tezpur verifies the reports by phone calls. Verified information is uploaded and mapped on a website and publicly available. Cases reported are addressed at the local level through the filing of complaints or litigation and advocacy with local health authorities.

Programme Outcomes

Community members gained rights awareness and confidence and skills to address violations. More than 70 cases were collected, and a report was 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 complaints at the Block level led to improved access to maternal and infant health services. Data will also be used for litigation.

Reports were received about the lack of food rations in Anganwadi Centres in the Block from Oct 2014 to April 2015. Total 4 complaints were 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).

Complaints filed on a range of health and nutrition issues arising in tea garden hospitals and local food distribution shops, resulted from Sapoi teas estate (1000 workers)- new ASHA appointed; Panbari tea estate (1517 workers)- new doctor appointed; Tinkhurria teas estate- APL cardholders (about 150) received food rations; Dhekiajuli CHC- Complaint was filed about undue payments asked for pregnancy registrations. Now pregnant women are not charged money anymore; Other 5 complaints are currently pending against CHC, PDS shops, and tea garden hospitals.

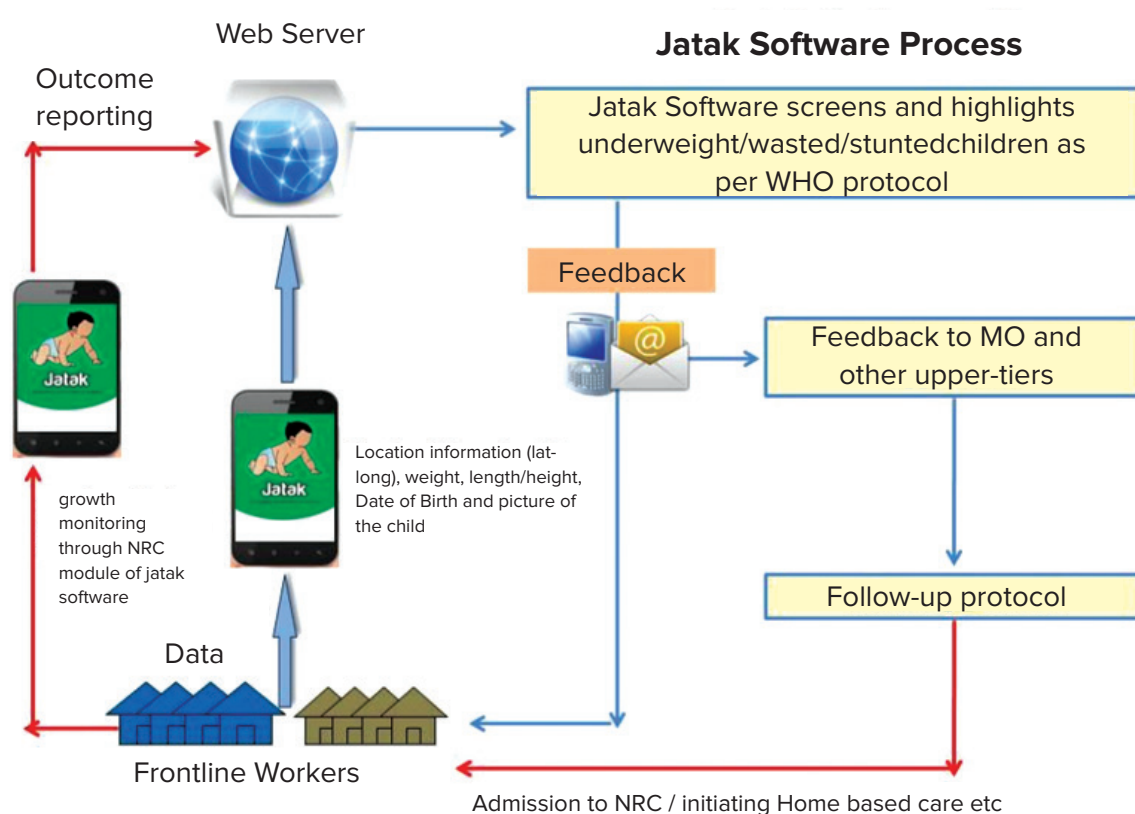


Problem Statement

Infant deaths in Attappady in 2013 -36 (30) out of 1016 deliveries. It was 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. The direct causes of infant deaths in Attappady were low birth weight/ extremely LBW, prematurity, Sepsis, Congenital Anomalies. Underlying causes were 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.

Programme Description

The initiative was launched in January 2014 for improving child survival and child nutrition. Knowing the nutritional status of every child on a real-time basis, using mobile telephony and GIS technology. Challenge was to expose malnutrition for focused curative and preventive care and Ensure services delivery to pregnant women and under-five children. After exposure to malnutrition, take appropriate measures. Ensuring early registration to all PW, ensure that designated services are provided in time to all. For those who are already in the critical stage of getting SOS from every sick child and other emergencies, Take appropriate action.



Programme Outcomes


Mobile notification on due services for ANMs. Dynamic locator for an action plan (D-LAP), ANC services in Mid-April to Dec 2014 was 136 and from Jan to mid-Sep 2015 it is 466, Number of child death decreased from 17 in Mid Apr to Dec 2014 to 17 in Jan to mid-Sep 2015. The number of Infant death reduced from 12 in Mid Apr to Dec 2014 to 8 in Jan to Mid-Sep 2015. The percentage of SAM children reduced from 4.74% in April 2014 to 1.2 % in July 2015. The percentage of SUW reduced from 14.57% in April 2014 to 9.23% in July 2015.

Scalability

It is made part of the existing system for service delivery reporting, monitoring at all levels. Based on the feedback from different stakeholders updating and customization are done regularly. 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 implemented through various agencies are linked with this system. Availing of govt Schemes by pregnant women can be ensured. NRC – C MAM programme linked to JATAK.

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

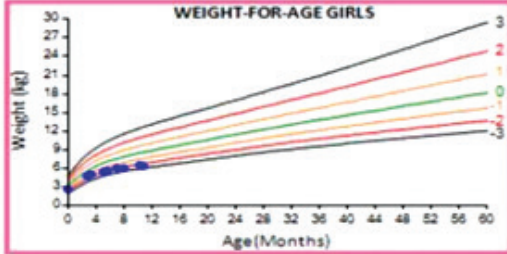


Age (as on date): 11 months **Birth Weight (kg):** 2.72

MUAC (mm): **Grade:**

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

WHO Growth Chart (Weight-for-Age):



Problem statement

The motto is to reach and provide healthcare to unreached tribal population. The 50% of the PHCs provide comprehensive community health care. North-East have difficult to reach population, without electricity, communication, education, interior, inaccessible areas, devoid of healthcare facilities provided by the government. Such areas, Karuna Trust build partnerships with the state government and build up public health system.

Program Description

Provides Comprehensive Primary health care including MCH, NHPs and other endemic diseases along with addressing other determinants of health, by understanding the traditional culture and empowering to manage themselves. A partnership formation (Public-Private partnership) with Central, state government, NGOs and Local self-government for the effective implementation of the services.

Program outcome- Sustainable development of tribal people through right based approaches to health, education, livelihood security and biodiversity conservation. KT manages the non-functioning/non-profit PHCs and now they have become Community hubs through community participation process.

Changes brought by Karuna Trust in NE

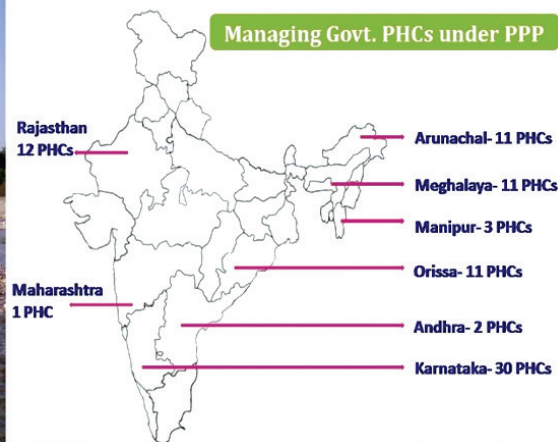
Baseline (2006)	Present (2015)
Non/poor functional PFIC	Functional at 24x7 pattern & bas per IPHS
Non functional SC	Functional
Inadequate drugs, equipment	Adequate, 120+ varieties of essential drugs
No lab facility	All essential lab tests are done
No IPD, OPD almost nil	6-12 beds with diet facility, 2 MOs
Full immunization (0-1 yr) <30%	No staff staying Staff stay in PHC/SC 24X7
ANC coverage (<40%)	72% achievement, 90% coverage in 60% PHCs 91% coverage (2014-2015)
No institutional delivery at PI IC/SC	47% ID in PI IC, 35% in SCs

Financial implications

Allocation of budget through PIP from Central government.

Scalability

With the support of community, NGO, central and state governments, such models can be adopted anywhere implied. Adequate Staff including medical doctors, equipment, drugs and timely grants will fetch such success stories ahead.





Some Glimpses from Health Facilities

Problem statement

High maternal & infant Mortality in Tribal areas of Vadodara District was 452 per 1 lakh and 55 per 100 live births respectively. It is mainly due to the unavailability of quality maternal and child health services in the tribal areas.

Program Description

Under the Safe Motherhood and Child Survival project-PPP project, few interventions have been implemented as CEmONC. Such as capacity building of front-line health workers, web-enabled computerised management system, infrastructures etc. Reviews on key health indicators periodically, efficient partnership with GOG and concerned Local self-government were ensured to provide all components under the CEmONC. PPP envisaged wide scope of helpdesks at district hospitals, backward linkages of healthcare facilities through ASHA, free ambulance, waiting rooms, drop-back services (khilkhilahat), Mamta Ghar-mother waiting home, Post-partum counselling and follow-up, ICTC, Kangaroo mother care, ARSH clinic. Also made possible in free of cost for poor communities, accessibility within 40 km radius for tribal poor, periodic health camps at community level. Nearly 9 lakh population belongs to 6 tribal blocks were been utilised these services.

Program outcome

MMR declined from 452 to 263 per 1 lakh population (41.8% reduction). The number of OPDs steeply increased from 3312 to 35602 during 2006 to 2015. Community became more aware about child health and the health utilisation increased from 8% to 30% by 2015. High risk deliveries have also been reduced from 40% to 28% due to effective antenatal services. Results showed an increase in institutional births showing increased accessibility for health care services and proper coverage in ANC IEC activities. Other major & minor surgeries have been performed appropriately to increase the quality of life. A broad estimation of annual savings among those who sought services from the CEmONC were Rs. 27,810,620 per year.

Financial implications

From Central and State government

Scalability

CEmONC through PPP can achieve better health indicators to attain the SDG. The engagement in the model for nearly a decade has helped in setting systems and procedures that could be utilised 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 Organisation to achieve the goals of MDGs and SDGs.

Facilities













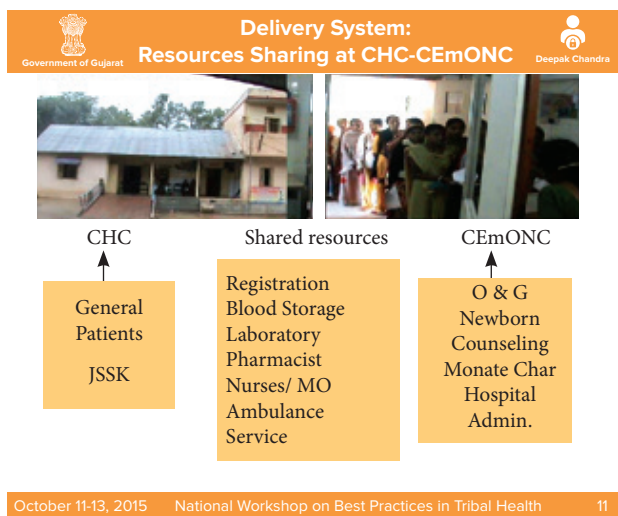

October 11-13, 2016 National Workshop on Best Practices in Tribal Health 10

Major and Minor Surgeries






Type of Surgeries	2010-11	2011-12	2012-13	2013-14	2014-15	Total
VH	180	208	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
Certical Encirciage	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

October 11-13, 2015 National Workshop on Best Practices in Tribal Health 22



Major and Minor Surgeries

Broad Estimate of Annual Savings among those who Sought services from the CeMNC Average Saving per Year : Rs. 27,810,620

Services	2012-13	2013-14	2014-15
1 OPDs	11,55,990	15,96,370	16,37,000
2 Delivery	2,3720,000	2,48,54,000	2,19,61,600
3 Govt. Surgeries	31,11,000	29,47,750	24,41,750
Total	2,79,86,990	2,93,58,120	2,60,46,750

October 11-13, 2015 National Workshop on Best Practices in Tribal Health 23

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 Pneumonia, Asphyxia/prolonged delivery.

Program Description

Project goal is to reduce neonatal and infant mortality on 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 mode and strengthen the public health system. The project area divided into zones and each field coordinator made responsible for the work under the area. Training of Sahiyas, ToT at SEARCH, Monitored handholding and supervision. Infrastructure and Health resources made available by SEARCH following the govt. guidelines. MIS by SEARCH to monitor and guide the coordinators daily, weekly, monthly, quarterly, annually.

Program outcome

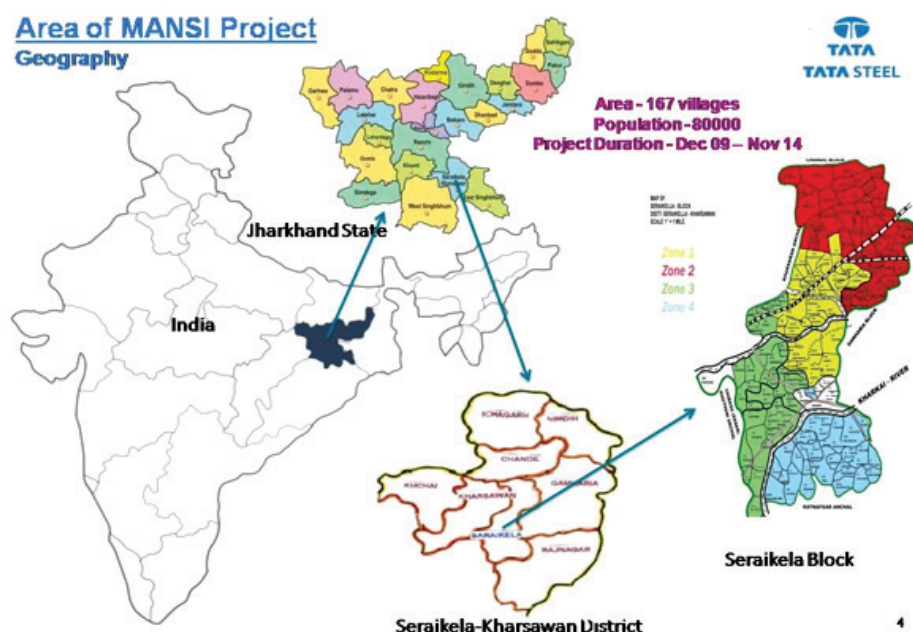
Few sample case studies managed by the Sahiyas are noted such as Low Birth Weight and Hypothermis, Pneumonia, Sepsis, etc. Both Infant mortality rate and Nonatal Mortality rate has been reduced drastically by 46% and 39% respectively by the intervention from 2011 to 2014.

Financial implications

Planning of MANSI project in Jharkand via partnership of AIF (part funding, coordination, development sector expertise), TATA steel (ground knowledge of communities, local resources committee of workforce, project implementation), SEARCH (technical know-how consultancy), Government of Jharkhand (Administrative supports, permissions).

Scalability

The PPP has planned to envisage the programme or initiative to Odisha district inspite of many challenges like illiteracy, reduced man power, material etc.



Project Implementation

Training of frontline health workers - Sahiyas (part of Government health walker system at village level): adopted system of Training of Trainers at SEARCH -enable systemic capacity to furtherpass 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



Project Monitoring and Supervision

Frequency	Tool	Level	Type of Data
Checklist	Supervision format	MNHMs Zonal Cconfnators (Zcs)	Knowledge & skills of Sahiyas Availability of nexsource muderial
Weekly	Community Meetings Review Meetings	MNHMs Zonal Cconfnators (Zcs) Field Coordinator (FG)	Knowledge and Attitude of community on MCH Supply status, high risk birth & pregnant women
Monthly	Monthly Progress Repeat Case Studies Monthly accomplishment and action plans Review Meeting	MNHMs Zcs Fcs Monitoring & Evaluation Officer (M&EC)	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



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

By Shrey Desai, SEWA Rural

Problem statement

Low coverage and quality of selected community based MNCH interventions to be delivered or facilitated by ASHAs and PHC staffs due to inadequate training/ poor skills of ASHAs, insufficient motivation, inadequate support, supervision, irregular payment of incentives.

Program Description

ImTeCHO is an initiative by SEWA Rural in partnership with Dept of Health, Govt. of Gujarat to improve coverage of proven MNCH interventions, improving performance of ASHAs and PHC staff, ensuring effective support, supervision and motivation. Its components include web interface at PHC level to provide timely and accurate information for better support to ASHA. Support given as morbidity detection and management, scheduling tasks, BCC through video clips, web-based incentives, supply management tools, assist them to manage sensitive cases, daily alerts, supervision, HR management, HMIS etc.

Program outcome

The make use of the initiative by ASHA were high and the task completion rate sustained as the login rate of ASHA. Medical officer utilised the portal effectively. Comparatively high number of Antenatal registration visits, IFA intake, delivery rates, Exclusive breast feeding, ASHAs visits to home for PNC, checking height and weight, any illness in the field data have registered in the portal.

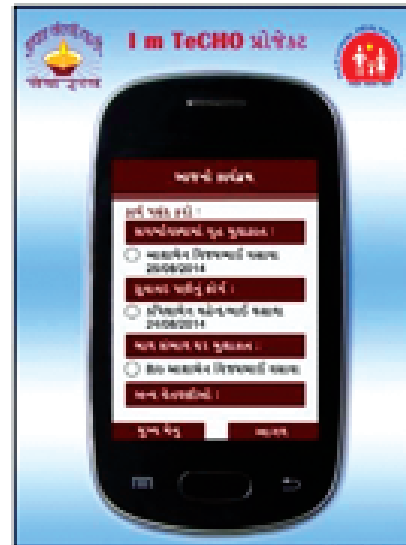
Financial implications

Financial/HR support by State departments of health, GoG, LSG, Argusoft India Lts, JAmsetji Tata Trust, Mumbai, ICMR Newdelhi, Mac Arthur Foundation

Scalability

Formal implementation research through Randomised Control Trial covering 22 PHCs in tribal area. Gradula 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 along with integrating other health programs.

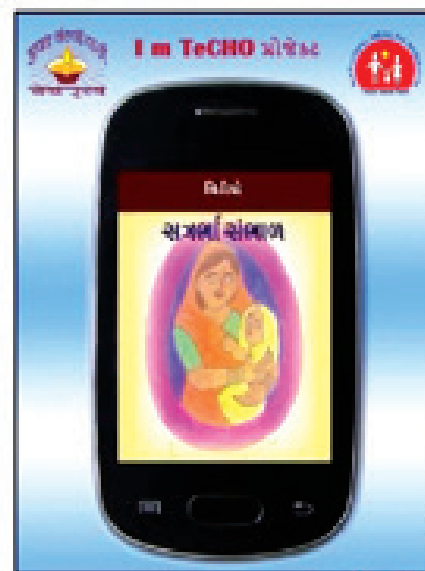
Main Menu and Schedule Alerts for ASHA



Tasks at VHNSD



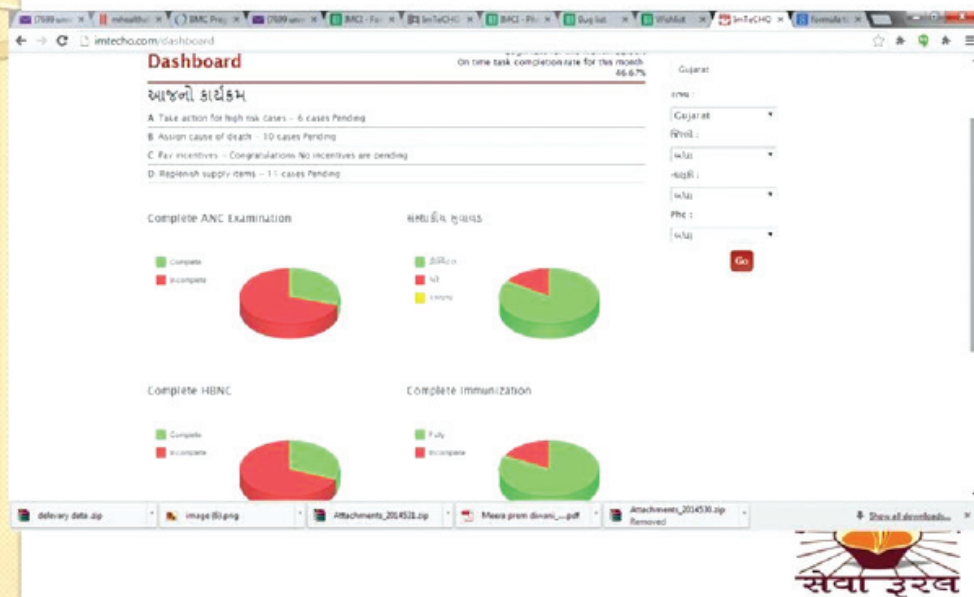
Inbuilt Videos for Awareness



Automatic Diagnosis, Risk Screening and Treatment Protocol



Supervision and Support made Easy and Effective at PHC Level



Problem statement

The Indian health care HR challenge is the unavailability of physicians for the needy people, Reduced accessibility 26% presence vs 70% requirement in rural India.

Program Description

Capacity building strategy using AYUSH physicians trained through Bridge Training Program, in the use of evidence-based protocols to deliver quality, primary healthcare to inaccessible populations. ICTPH AYUSH training strategy implemented for physicians in SughaVazhvu network. SughaVazhvu physician training program conducted for licensed Ayurveda, Siddha, homeopathy practitioners by MBBS physicians, M.Pharm graduates and nurse trainers. They had 2 months tcontact classes and practical training with module-wise written examinations and test. It focused on pharmacology, protocols, interventions, practical skill enhancement, technology, patient care.

Program outcome

ICTPH AYUSH training strategy implemented for physicians in SughaVazhvu network for primary care delivery in rural Thanjavur, staandardised treatment guidelines and workflows, HMIS, Chronic disease management. 34 AYUSH physicians trained in protocol driven primary care delivery: served 7 catchment areas, 70000 primary care patient visits, CHD screening for over 6000 adults, cervical cancer screening for over 2000 individuals, School health activities, community camps etc

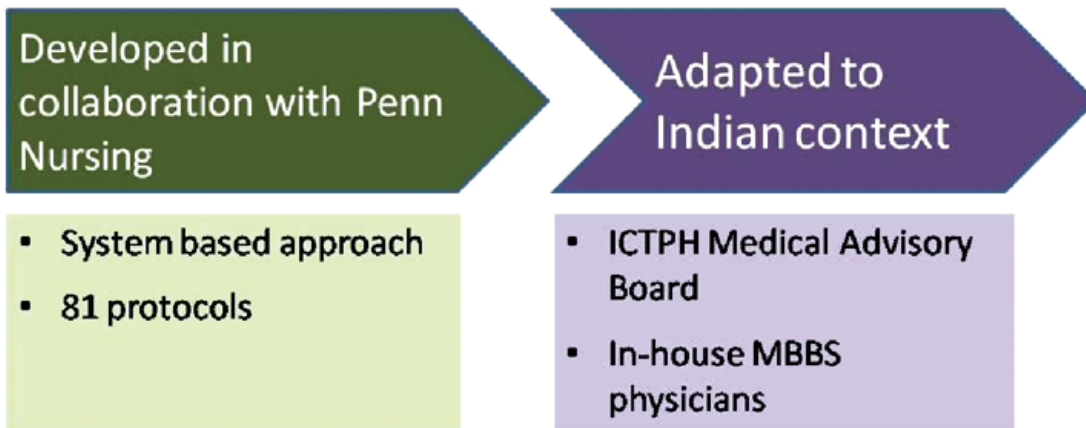
Financial implications

By Sughavazhvu Healthcare.

Scalability

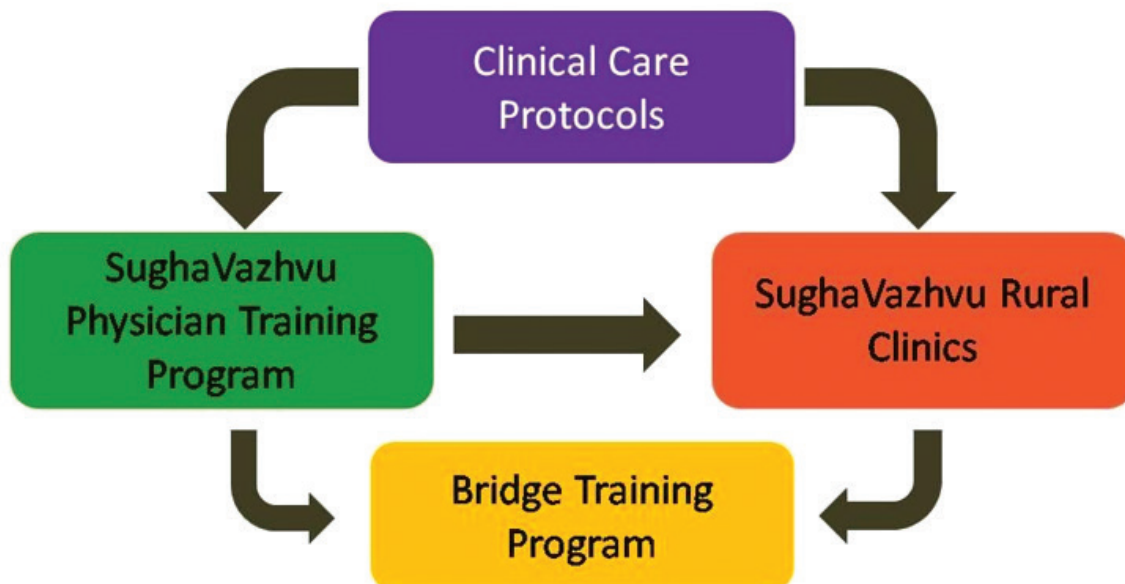
IKP(Innovation,Knowledge,Progress)-BTP(Bridge Training Program) through Sughavazhvu clinics for enhancing healthcare of the needy. Recommendation for curriculum development and validation.

ICTPH Primary Care Protocols



Conditions include acute ailments, upper respiratory tract infections, gastro-intestinal conditions (diarrhea, acidity), urological conditions, chronic conditions

Evolution of the BTP



Problem Statement

Bilaspur district has a population of 26 lakhs out of which 12 lakhs belong to the tribal population. The region has poor access to healthcare facilities and many nurses, paramedics (Lab tech, OT tech, Pharmacists) and doctors are not willing to work in these areas. There is also an existing cultural and language barrier where tribal patients access healthcare.

Program Description

The goal of the program was to prepare a large cadre of tribal girls as ANM/GNM to serve in their own community and their hospitals.

JSS started a Nursing school in 2010 with support of the tribal welfare department of Govt of Chhattisgarh recognized by Indian Nursing Council, State Nursing Council, and the health department of Chhattisgarh. They were permitted to have 25 candidates each per year for the ANM and GNM courses. Selected candidates belonged to the families below poverty line and were either tribal or Dalit girls. The process started at village level by spreading information by visiting community, family and tribal girl's hostels etc. Selection process took into account a) Merit of the candidate b) Social background c) Social sensitivity d) Awareness about problems with rural and tribal people. These trainees were exposed to all Tiers of the programme structure

Program Outcome

With financial aid they were able to build hostels for tribal girls. Training programme started in 2010 and so far, two batches of ANMs have graduated with 100% result and 90% students have been awarded distinctions. As interns these girls enhanced their skills in various specialities like emergency, new born care, obstetric and community health. Among these girls, 60% have been posted in Govt. sector in sub centre, PHC &CHC. 30% are working in voluntary sector and 10% in private sector.

Financial Implications

Admissions were made at zero cost to the students. As part of the grant from the TWD, they received funds for hostel construction to accommodate 150 students. A budget has also been drafted for training program.

▪ ANM Rs. 60000/- per year/ per student	Inclusive of board, lodge, tuition, books, uniform, stationary, salaries, transport, health, exam fee etc.
▪ GNM Rs. 70000/- per year/ per student.	

Scalability

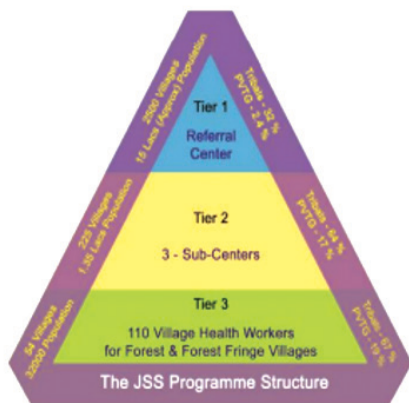
JSS was successful in training Mid-level workers (Senior health workers) from 10 organizations across the country working in community health for handling common emergencies. These health workers are trained to handle common emergencies in rural areas.

Local Tribes in the area

- ▶ Gond
- ▶ Baiga
- ▶ Birhor
- ▶ Uraon
- ▶ Kol



Trainees are exposed to all Tiers of our programme structure



Problem Statement

Scarcity of human resources in the districts of Bastar division and Surguja division as compared to Bilaspur and Raipur.

Bastar division: 90% specialist positions, 60% Medical officer and 66% staff nurse's positions remain vacant in Bastar division

Surguja Division: 88% Specialists, 51% medical officers, 62% Staff Nurses remain vacant

Program Description

The goal of the program is a) to ensure availability of human health resources to improve healthcare services in tribal areas b) to overcome the issues of HR unavailability, decision was taken to adapt HR outsourcing through agencies c) to Hire service through HR agency, where employee remain employee of the agency but works in health facilities d) to Reduce liabilities, increase flexibility to re-deploy & ensure effective management e) to enable them to motivate to work in difficult areas by making the head-hunting process easy and simple.

Program Outcome

Through the out-sourcing model as on now 723 Staff nurses and 16 doctors have been deployed which improved human health resources availability that ultimately resulted in increased service delivery. This made head-hunting process easy and simple by the HR agencies to identify motivated personals from various part of country to work in the difficult areas.

Financial Implications

The financial burden is similar to the regular set up.

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
	Balrampur	99	14	85	0	
	Surajpur	113	34	79	66	13
Baste	Bijapur	73	22	35	51	0
	Narayanpur	57	22	35	35	0
	Jagdalpur	105	74	31	31	0
	Dantewada	78	24	54	54	0
	Kanler	147	45	02	32	0
	Sukma	60	111	42	42	0
	Kondagaon	106	40	6.5	66	
Total		1280	523	757	723	34

Problem Statement

Lack of access, reliability and quality of ante-natal and post-natal services at the PHC with major indicators such as blood pressure, blood test (for sickle cell anaemia), weight and haemoglobin count not being regularly monitored. Widespread misconceptions linked to breast feeding and weaning food in the community as well as maternal deaths going under-reported has been a major issue which is a result of lack of awareness in the community. Another problem which is faced by the community is lack of technical knowledge and skills related to healthcare and nutrition support.

Program Description

The goal of the program is to improve maternal health and child survival in tribal areas b) to engage the community-especially women- in understanding, resolving, and monitoring specific health interventions to improve health outcomes and c) 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.

Program setting: women in their 8th month of pregnancy were included and Same women 10 days after their delivery. There were two phases for assessing the reach of PNC and ANC and every 3 months, a compiled report card is put together from the findings collected and then shared with doctors at PHC, their staff and the community

Program Outcomes

Outcomes between 2012 and 2015 respectively

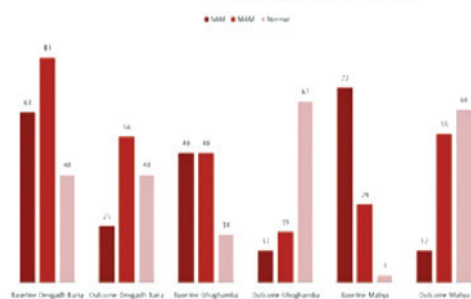
Impact on ANC Parameters	2012	2015
Pregnancy Registration	25%	75%
Weight of the mothers	2%	51%
Sickle cell anemia assessment	0%	50%
Abdominal test	4%	31%
Blood pressure monitored	4%	53%
Hemoglobin reported	4%	41%
Calcium supplement	3%	36%
Identified high risk mother	18%	76%

Scalability

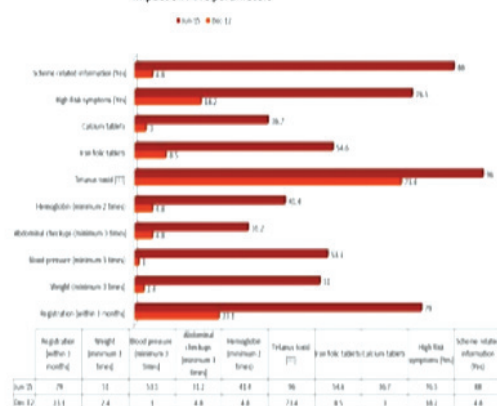
The strategy relies on a model which does not need more medical doctors. Strong emphasis on education of the community and women about rational health practices and Integrating ideas into pre-existing systems to increase effectiveness.

Bal Poshan Shikshan Kendra Outcomes

Maliya, Ghoghamba, Devgadhi Baria



Impact on ANC parameters



Sharing of Community Report Card back with community



With Village Panchayat Members



Problem Statement

Primary healthcare for the tribals has availability, accessibility, affordability and quality concerns. Successful linkage of primary healthcare with secondary and tertiary healthcare for tribals and early intervention and rehabilitation is possible through outreach services

Program Description

Goal of the program is a) to reach out to the unwell, underprivileged tribal people who are unable to reach even a nearby health center b) Provide at their doorsteps, easily accessible primary level medical care of highest possible quality c) to provide comprehensive primary healthcare (preventive, promotive, curative and rehabilitative) through outreach and linkage component for secondary and tertiary care.

Program Setting- Dharampur and Kaprada districts of Gujarat

Major tribes- Warli, Kunkna, Dhodiya Patels(99% of total population is tribal with 55% literates)

Features of the SRRHP MOBILE MEDICAL UNIT

- SRRHP vans operate as per a fixed route plan, on daily basis throughout the week from Monday to Saturday
- More than 65 outreach centers 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 referrals to those in need
- Every patient is given follow up cards to ensure compliance
- Timings of outreach are 9 AM-4PM (suitable to the local tribals)

Program Outcomes

They have managed to treat a greater number of patients over the years, from treating 7816 patients in 2004-05 to 108351 patients in 2013-14. Through the outreach program no of patients treated increased from 44223 in 2009-10 to 81830 patients in 2014-15 with no of patients referred from Outreach to SRH that increased from 409 in 2004-06 to 5135 in 2014-15.

Government schemes implemented at SRH

- Bal Sakha Yojana
- Sarva shiksha Abhiyan
- ADIP (Assistance to disabled persons) Scheme

Financial Implications

Rising cost of running the program can be a constraint

Scalability

To ensure long term and sustained benefits on health of tribal community through promotive, preventive, curative and rehabilitative approach which can be easily replicated by any organization. An SOP has been laid down to facilitate this process with sustained and combined efforts that have brought about change in health indicators of the area.

Shrimad Rajchandra Rural Health Project
Geographical Areas Covered



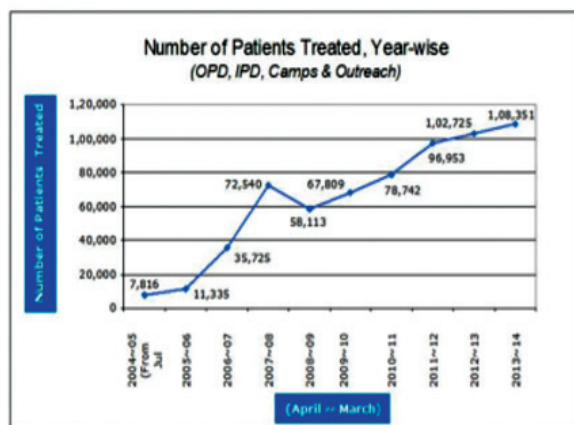
**TOTAL POPULATION
OF THE AREA – 4.5
LACS
(2011 CENSUS)**

Our Outreach Programme covers, roughly, the area within the thick hand-drawn boundary

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



Numbers of Patients Treated



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)

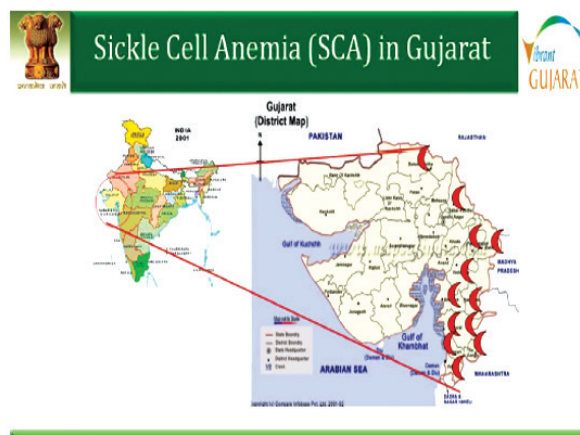


Problem Statement

Disease specific in medically underserved population belonging to lower socio-economic class living in remote areas affects 14.8% population of Gujarat. No Cure of the disease is available and prevention is the only feasible solution which also includes improper treatment as a result of misdiagnosis of Iron-deficiency Anemia.

Program Description

Goal of the program is a) to screen entire tribal population by 2015 along with treatment and counseling to ensure prevention of deaths from Sickle Cell Crisis b) Reducing Burden of sickle cell disease and increasing productivity, longevity and quality of life c) to provide counseling for preventing transmission of disease to next generation.



Contents of Best Practice

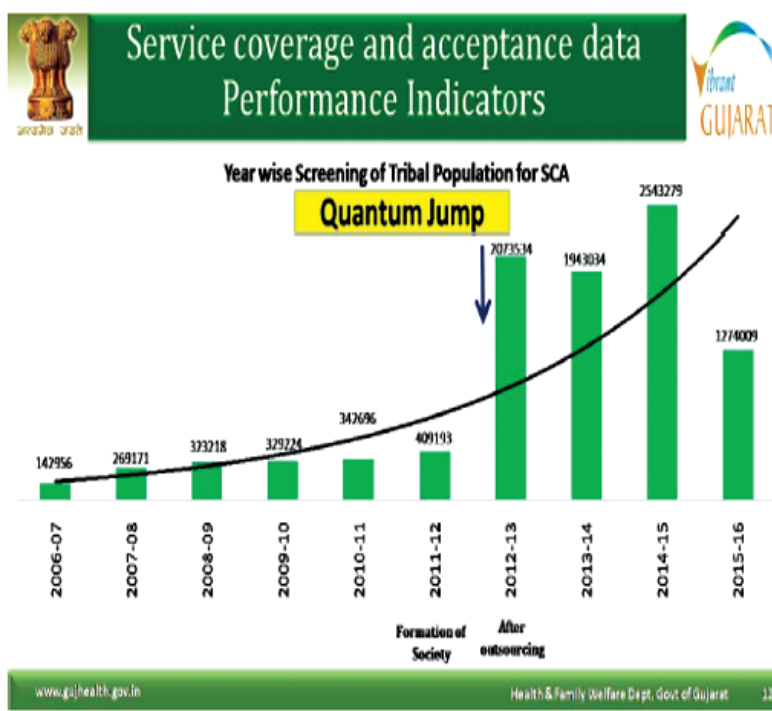
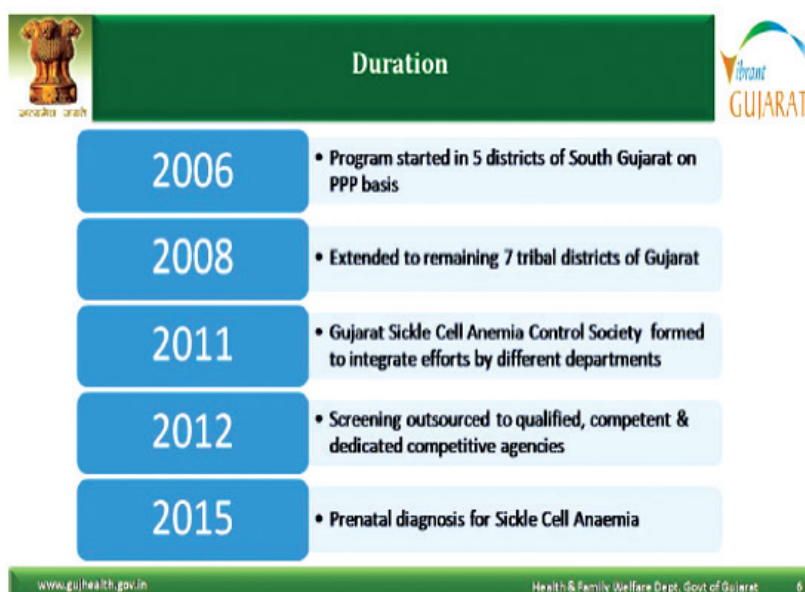
Early diagnosis through <ul style="list-style-type: none"> • Antenatal screening • Adolescent screening • Mass screening on mission mode • New born screening • Prenatal Diagnosis 	Prevention through <ul style="list-style-type: none"> • Marriage counseling • Genetic counseling • Building Community Awareness
Reduction in crisis and in mortality through <ul style="list-style-type: none"> • Supportive treatment • Regular follow up and counseling • Lifesaving drug like Hydroxyurea • Pneumococcal vaccination • Advanced tertiary care centers 	Regular training and capacity building of <ul style="list-style-type: none"> • Healthcare providers and ASHA • VHSNC (Gram Sanjeevani Samitis) • Members and teachers • Providing program manual • 87% of tribal population (80.6 lacs) screened • 16000 persons with SCD protected with pneumococcal vaccine • Free blood transfusion to more than 1900 patients • More than 3200 antenatal screening and 9000 newborn screening • More than 145 Prenatal diagnosis, 5 MTP during the year

Program Outcomes

now about 87% of tribal population (80.6 lacs) have been screened with 16000 persons with SCD protected with pneumococcal vaccine. Free blood transfusion to more than 1900 patients have been provided and more than 3200 antenatal screening, 9000 newborn screening, more than 145 Prenatal diagnosis, 5 MTP during the year have been done so far.

Financial Implications

Resource intensive campaign



Problem Statement

Severe and growing chronic disease burden in India where Diabetes and hypertension are major public health challenges in India. India is on its way to becoming the diabetic capital of the world and had over 60 million diabetic population (2011 estimate). The other issue is the debilitating impact on patients' conditions and exacerbation of the problem in rural areas due to lack of awareness and lack of care access.

Programme Description

Goal of the programme is

a) to enroll all residents of a community into the community level primary care clinic and conduct a rapid risk assessment (RRA) exercise.

b) Enroll all residents of a community into the community level primary care clinic

- A health extension worker (HEW), visits all households in the community
- Enrolls all residents through internet enabled mobile communications device and sync with HMIS
- Enrollment data includes demographic data and family health history of all residents of the community

c) Enrollment of residents of a community into the community level primary care clinic

- A health extension worker (HEW) geo tags the household in terms of latitude and longitude geo coordinates
- With geo tag, the HMIS is able to plot the distribution of enrolled population and their vicinity to the healthcare centre
- Geo coordinates can be used to color code various population, street wise and village wise

d) Enrollment of 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: visit details, diagnostic visit details and previous visit details

e) Rapid Risk Assessment

The screening tool is based on the WHO steps guidelines and risk is calculated based on six non-invasive risk parameters

- Body mass index
- Waist hip ratio
- Tobacco consumption
- Personal history
- Age
- Blood Pressure

In Sugha Vazhvu 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

Focus Area

Thanjavur, in and surrounding Orthanadu Block, Serving 7 catchments and a population of approximately 75000 individuals

Program Outcomes

The first two RRA exercises covered groups of more than 3000 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.

Financial Implications

For a typical community of 600 households and 3000 population, a one time E&RRA exercise will cost approximately Rs 50,000

Scalability

E&RRA for a 3000 person/600 household community is approximately a 120 person-day activity. E&RRA is a fairly scalable activity at the level of community. It is also scalable at the catchment area of each clinic as long as primary care clinic model is scalable



Problem Statement

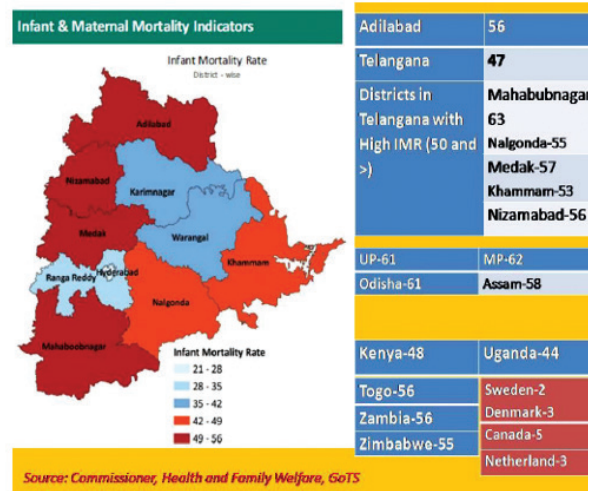
High cases of mortalities b) Low rate of accessing maternal services c) Malnutrition d) Home deliveries e) Cultural inhibitions f) Economic reasons g) Poor service Delivery h) Terrain -Interior places

Program Description

The objectives of the program are a) tracking expectant mothers with EDD b) Reducing home deliveries to Zero in the tribal Mandals and c) Enhance Maternal Services to tribal population of Adilabad

Description:

- Tracking EDDs
- Collect data of expectant mothers for each mandal from PHC
- Calls to families before due date
- ANMs, AWWs at village level



WORKFLOW



Program Outcomes

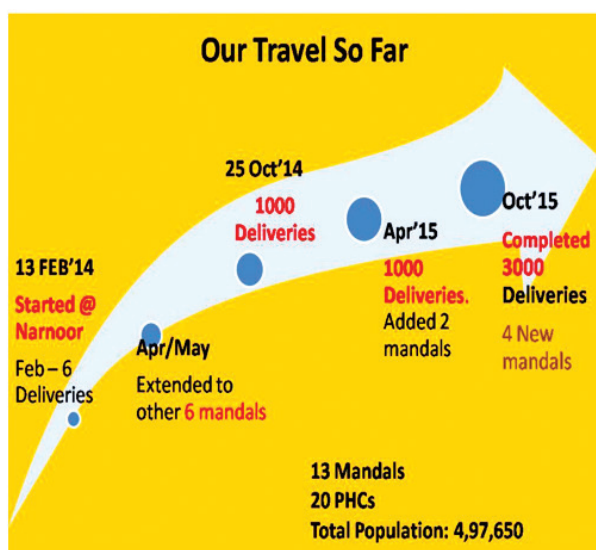
They have been able to cover 13 Mandals, 20 PHCs with a total population of 4,97,650 and have been able to complete 3000 deliveries from Feb 2014- oct 2015. The IMR cases have come down to 20 cases since the beginning of the program and MMR has been recorded at 2 for every 1000 cases with on 86 c-sections per 1000 deliveries.

Financial Implications

Health Expenditure- 3.8% of GDP and Indirect economic benefits- organized families

Scalability

At village level and at Mandals the ANMs, ASHAs, medical officer and supervisors can track expectant mothers in the area. Integrating call centres to connect them with the Project officers, DMHO and ADMHO



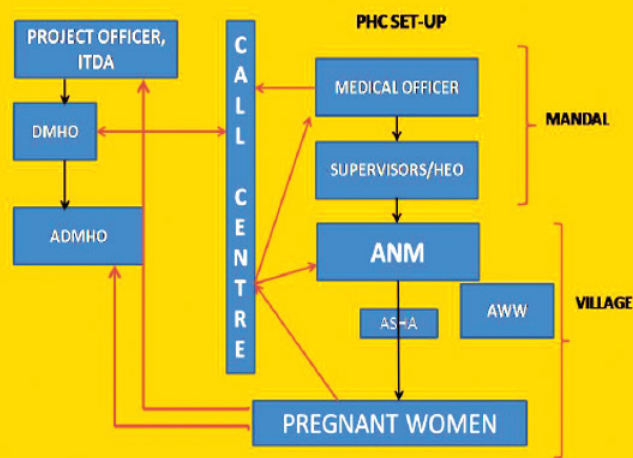
RESULTS

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		

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	Lalasingh	Bortalguda	Bortalguda	22	ST	G1	8.5	45	24-17-2015	10-10-2015	7659835371
Devapur	Pawar Anguri	Bharath	Bortalguda	Bortalguda	23	ST	G1	9	48	15-11-2015	10-10-2015	7382664643
Devapur	Wagnare Godavari	Goutham	Jairanguda	Jairanguda	35	ST	G5	8.6	58	17-01-2015	10-10-2015	8331049378
Devapur	Madavi Ambubai	Kanna	Iemlaguda	Iemlaguda	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	9492006654

SYSTEM SET-UP AND SCALING



Problem Statement

Due to sporadic and distant geographical areas of tribal inhabitation the pregnant mother finds it difficult to attend the medical facilities during labor and this leads to more home deliveries with a tribal population in 800 villages of 70 PHC catchment areas

Rationale for 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

Programme Description

To promote institutional deliveries among the tribal population thereby ensuring safety for the mother and child

National Health Mission-Tamil Nadu

NHM helped in providing funds for the establishment of Birth waiting rooms (BWR)

The Directorate of Public Health and preventive medicine is the implementing Department of this initiative

Programme Outcomes

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.

The community health nurse of that particular block is supervising the functioning of BWR and will be paid Rs 500/- as honorarium

BWR have the facility for cooking food

Provided with 3 supportive staff for round the clock care and services

Pregnant women are brought well in time for their deliveries and monitored during the entire process of pre labor and labor and the home deliveries have been reduced between 2013 to 2016

Financial Implications

BWR COST

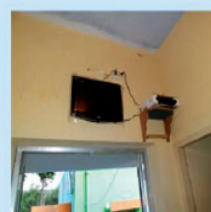
Total Cost: Approx. Rs 15 lakhs per unit	
Non-recurring cost per unit: Rs 12.5 lakhs unit	
Civil works	Rs 10 lakhs
Furniture, utensils and electrical appliances	Rs 2.5 lakhs
Recurring cost-Rs 1.80 lakhs per annum	
Contingency	Rs 30,000 per annum
Electricity Charges	Rs 30,000 Per annum
Honorarium to the 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

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%)	8. Ariyalur(1.4%)
2. Dharmapuri(4.2%)	9. Tiruvallur(1.3%)
3. T.V.Malai(3.7%)	10. Krishnagiri(1.2%)
4. Salem(3.4%)	11. Kancheepuram(1.03%)
5. Namakkal(3.3%)	12. Erode(0.97%)
6. Villupuram(2.2%)	13. Coimbatore(0.82%)
7. Vellore(1.9%)	14. Trichy(0.67%)

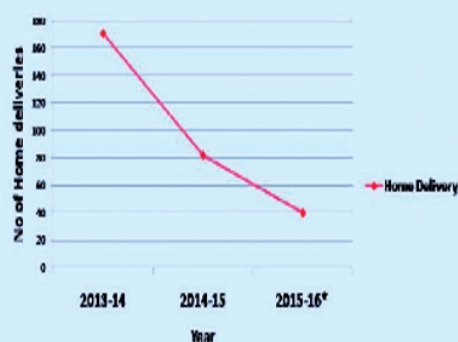
Birth Waiting Rooms- Interior view



Birth waiting rooms (contd)



Birth Waiting Room -Impact



NOTES



NATIONAL HEALTH SYSTEMS RESOURCE CENTRE