

Performance Improvement Input			
Performance Improvement Community Level Health and Nutrition Functionaries			
BACKGROUND INFORMATION			
Project Name:	Provision of Essential Maternal & Child Health Services in Tribal Areas		
Lead Agency/ Agencies	Action Research and Training for Health (ARTH)		
Intervention Area/ Scale of Intervention	The intervention is implemented through two ANM run health facilities, and covering a population of around 50,000 across 45 villages in three blocks - one in Rajasmand and two in Udaipur		
Primary & Secondary Target Group	Primary Target Group: tribal women of reproductive age in South Rajasthan and children (0-5 years) Secondary Target Group: All men and elderly women of tribal communities in south Rajasthan		
Profile of the Primary Community Level Health & Nutrition Functionary	Nurse Midwives (NMs) are women from Kerala or Rajasthan, with basic training in nursing (ANM or GNM). Their earlier experience was very limited, like bed-making, ward duties and administration of medicines, IV and IM injections under doctor's instructions. Some of them were married, husband either worked in area around or were given employment by ARTH as male attendant (who escorted the NM for field visits). They were selected through advertisement and interview by ARTH		
Purpose of the Intervention	Key Strategies	Key Components/ Activities	Program Outcomes of the Intervention
<p>Improvement of maternal-neonatal health and survival</p> <ul style="list-style-type: none"> <li>- to establish the effectiveness of trained NMs in providing safe motherhood and neonatal health services</li> <li>- to increase utilization of such services in rural blocks of Rajasthan</li> <li>- to enhance the contributions made to safe motherhood by panchayats and men in the family</li> </ul>	<ol style="list-style-type: none"> <li>1. Provision of five pillars of safe motherhood services (family planning, safe abortion, ANC&amp;PNC, skilled attendance at birth and emergency obstetric care)</li> <li>2. Engaging professional nurse-midwives as free standing practitioners for delivering maternal and related RCH services at low costs to clients</li> <li>3. Dovetailing community level educational activities and additional MCH services with existing RCH services</li> </ol>	<ol style="list-style-type: none"> <li>1. Practical hands-on clinical and counseling training in a range of RCH issues incl. first aid for obstetric emergencies, reversible contraception and neonatal and child care</li> <li>2. Use of standard guidelines and protocols adapted to Rajasthan setting</li> <li>3. Pairing of nurse-midwives at a health centre, guaranteeing 24x7 services and reducing the feeling of isolation</li> <li>4. Providing mobility to nurse midwives by placing a health worker-cum-driver with motorcycle in the health centre</li> <li>5. Subsidies to poor women and children who need referral to district hospital</li> <li>6. Arrangement for assisted referral</li> <li>7. Mobilization of men and panchayats to take greater responsibility for maternal health care</li> <li>8. Support from doctors, who visit NM clinics 1-2 times every week</li> <li>9. Regular supply of drugs and consumables</li> <li>10. An escort to accompany nurse-midwives for home visits, and for referrals in the night</li> </ol>	<ol style="list-style-type: none"> <li>1. Increase in uptake of institutional delivery in the area (from 12% in 1999 to 38% in 2005), esp. among socially and economically marginalized (from 3% in 1999 to 13.8% in 2005)</li> <li>2. Nurse midwife conducted delivery increased from 1.6 per cent in 1999 to 20.7 per cent in 2005</li> <li>3. Stillbirth rate of 28.9 and NNMR of 37 per 1000 live births respectively, way below the established averages of 30.9-32 stillbirths and 49 per 1000 livebirths (for Rajasthan)</li> <li>4. Increase in health services uptake among tribals: ANC - 18 per cent in 1999 to 73.9 per cent in 2005, TT - 45 per cent in 1999 to 70 per cent in 2005 IFA - 40 per cent in 1999 to 71 per cent in 2005</li> </ol>
<p>Source of Information</p> <ol style="list-style-type: none"> <li>1. PROD Website, PROD No. 176</li> <li>2. Nurse Midwives for Maternal Health, Experience in Southern Rajasthan, ARTH, 2005</li> <li>3. Nurse Midwives for Maternal Health, Experience in Southern Rajasthan, ARTH, 2006 (Hindi)</li> </ol>			
PERFORMANCE OUTPUTS (COMMUNITY LEVEL HEALTH & NUTRITION FUNCTIONARY)			

Coverage Expansion	Deepening of Services	Quality of Services	Reliability of Services
<p>1. Both clinics shows annual increase in footfalls. Combined uptake went up from 7951 in 2004-05 to 11017 in 2006-07.</p> <p>2. Around 7% of clients for deliver and obstetric emergency were from non-project area</p> <p>3. The services provision to SC/ST population has increased (over 4 fold in 6 years). Each NM-run-centre covers 25,000 population, 8 times that covered by ANM-run-sub-centres.</p>	<p>The NM run clinic started providing 24 hr delivery since 1999. Added basic lab services, IMNCI services, DMPA were added later.</p>	<p>Of the women accessing delivery through trained professionals, nearly 68% of SC/ST women and 48% of general women got services from ARTH's NMs</p> <p>Improvement in case management. Referral of delivery fell from 22.6% in 2000-01 (14 of 62 cases) to 9.38% (55 of 586 cases). No maternal deaths. Still birth rate (28.9 per 1000 live births) lower than community based studies (30.9-32 per 1000 live births. NNMR is 37 per 1000 live births</p> <p>Infection Prevention Protocols are in place. NM provide ANC, delivery and PNC services. Follow-up PNC care happens through home visits</p>	<p>NMs are available 24x7. Counselling linkages with specialists (over phone and through visits to clinic). Referral linkages for complicated delivery and obstetric emergency to District Hospital. NM accompanies the referral to the hospital. A social worker employed by the project facilitates smooth service to the district hospital</p> <p>In 2006, 85.6% of those referred to district hospital, stated the referral as essential. 68.5% were satisfied with referral and 81.7% indicated that the behaviour of the hospital staff towards them as good</p>

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#### PERFORMANCE IMPROVEMENT INPUTS (COMMUNITY LEVEL HEALTH & NUTRITION FUNCTIONARY)

INPUT COMPONENTS	EXPERIENCE
<p>Input 1: Clear Job Expectations</p> <p>Does the CLHNF have clearly written job responsibilities? Is it clearly demarcated from functions of other health workers? Is it flexible? Has it been modified to include emerging issues? Does the CLHNF know his/her responsibilities? How was it communicated to him/her? How is the CLHNF's work divided between on-field activities, in-facility activities, surveillance and record-keeping and reporting?</p>	<p>ARTH has a training manual for nurse-midwives, where her job responsibilities are listed. Nurse Midwife is informed of her responsibilities during training, through official circular and one-to-one interaction with medical supervisors and managers</p> <p>The available document do not have information on:</p> <p><i>1. How is the CLHNF's work divided between on-field activities, in-facility activities, surveillance and record-keeping and reporting??</i></p> <p><i>2. How is NM's JR different from an AWW (when they do monthly field clinics at AWC), clinic attendants and health worker-cum-escort?</i></p>

<p><b>Input 2: Building Knowledge &amp; Skills</b>  (Was the knowledge and skill building process designed to match job responsibilities? How was the training done - the strategy, the methodology, spacing between trainings, duration and venue? What was the training content? What was the profile of the trainers? How were they trained and oriented to train CLHNFs? How was the training monitored? Any accreditation process? Any training module, any facilitator's manual?)</p>	<ol style="list-style-type: none"> <li>1. ARTH has a set of guidelines in English and Hindi for training nurse-midwives, and is adapted from international and national evidence based guidelines and modules</li> <li>2. The curriculum design addresses safe motherhood issues and public health aspects of maternal health and clinical skills, laboratory skills, management skills, counselling and communication skills</li> <li>3. Classroom training (2 days per week x 8 weeks) at ARTH office. Clinical training for out-patient services at ARTH clinics, delivery services training at ARTH clinics and CHC (2 days per week x 4 weeks), neonatal care training at Medical College hospital and a private lab for lab skills (2 days)</li> <li>4. Trainers include ARTH doctors, pediatricians and gynecologists. Two NMs of ARTH were promoted as trainers.</li> <li>5. Methodology included hands-on training, classroom training, case reviews, verbal autopsy and mentoring during day-to-day clinic management</li> <li>6. NMs had already undergone an accredited training program (18 months - 3 years)</li> </ol>
<p><b>Input 3: Motivation and Incentives</b>  &gt; Were CLHNFs paid workers or volunteers? How were they paid - fixed monthly pays, performance based incentives, sales returns, etc.? What was the amount? How was their work financially rewarded?  &gt; Any mechanism for non-financial rewards? What was the career-growth chart (promotions, etc.)?  &gt; Was there any mechanism for recognition and awards? How was the community involved in recognizing and rewarding the CLHNF?  &gt; Any other information of how the CLHNF's were kept motivated?</p>	<p>NMs are paid staff of ARTH ( monthly salary range: 5300 - 7530)  Most of the NMs are trained Junior Public Health Nurse from Kerala. The project employs their spouse as co-workers to reduce distraction of shifting to a more urban area  ARTH has a strong anti-harrassment policy, which is applied strictly and swiftly. This facilitates a cordial working relationship between female and male staff, incl. at times when they have to travel at night for attending emergencies. ARTH facilitates regular knowledge building and exposure to NMs. Two of the NMs were even promoted as trainers  NMs are consulted on management and operational issues related to the clinics, which keeps them involved</p> <p><b>Challenge:</b> The disadvantage is of losing both the workers in case one of the couple either quits or is suspended from work. <i>Current set of documents do not give much information on this aspect. Will need more information from the lead organization on this</i></p>
<p><b>Input 4: Supervision and Enabling Structure</b>  (How was CLHNF provided back-up referral support? How were the CLHNFs mentored and provided supportive supervision?    What was the supervisory structure? What was the profile of the supervisors immediately above the CLHNF? How was CLHNFs-supervisor ratio? How were the CLHNFs reporting their work (format, frequency, etc.)? Was the reporting format long and complex, or short and simple? Is there any evidence of optimization? What was the community's role in supervision and monitoring? How was the feedback provided to CLHNF on his/ her performance (format, frequency, etc.)? Any use of technology?</p>	<p><b>Referral:</b> Each centre was linked to the Medical College Hospital for referral support. ARTH doctors were available 24x7 for telephonic consultation. Pre-negotiated transportation with transporters from the village. ARTH co-funded transport through Referral Transport Fund for those cannot afford to pay. ARTH has guidelines for RTF. NM has discretion on its use</p> <p><b>Supervision:</b> Doctors (ped, gyne) from ARTH supervised the NM. ARTH also had health mgmt graduates to supervise the clinic mgmt. The NM-Supervisor ratio is 5:2. The NMs were informed of their performance during monthly staff meetings. Gaps in performance are addressed through regular in-house trainings</p> <p><b>Reporting:</b> The NMs maintained records through separate registers for Clinic Intake, Field Clinic, Drugs and Consumables (Main Stock, OT Stock and OPD stock), Contraceptive Users, etc. The NM reported performance and management issues to ARTH office once a month through a 4 page summary reporting sheet. Information was cross-checked during routine monitoring visit of doctors/ managers</p> <p><b>Technology:</b> Clinic have telephone, doctors and social worker have mobile phones, both clinic have computer</p>

<p>Input 5: Medical Supplies and Material Support (Did CLHNFs have any kit or medical supplies package? Were there products for sale? What are its contents? How was the resupplies done?)</p> <p>What were the non-medical materials in the supply? What was the effectiveness of the materials? How were the materials made socially and culturally consistent to the community?)</p>	<p>NMs maintain reorder levels for all drugs and supplies. As supplies touch reorder level, they are requisitioned through ARTH. Drugs are purchased centrally to get quantity discounts from suppliers. Stocks are sent within 3-5 days of order. All drugs and supplies are dispensed through sale, unless they are consumables for OT procedures.</p> <p><i>The current set of documents do not give information on supply of education materials, its use and effectiveness</i></p>	
<p>Comment of the Reviewer: There are some points of deviation in ARTH model which positions it slightly differently from the public health systems. The NM run centres coverage is almost that of a PHC and the services are provided by Nurse Midwives (some are ANM - 18 months Diploma holders and others are GNMs - a three years degree holder). This experience is built on the leadership provided by Drs. Iyengar, once again underscoring the role of able leaders in making a programme successful.</p>		
<p>Sources of Information</p> <ol style="list-style-type: none"> <li>1. PROD Website, PROD No. 176</li> <li>2. Nurse Midwives for Maternal Health, Experience in Southern Rajasthan, ARTH, 2005</li> <li>3. Nurse Midwives for Maternal Health, Experience in Southern Rajasthan, ARTH, 2006 (Hindi)</li> </ol>	<p>Date of Review</p> <p>24 Dec 2007</p>	<p>Reviewer's Name</p> <p>K G Venkateswaran</p>