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Every family in targeted high-malaria villages received Long Lasting Insecticidal Nets (LLIN) to protect themselves

NET GAIN FOR ORISSA

Orissa

Malaria is a major health problem in Orissa. 1.5 million malaria cases are reported annually in India and a quarter of these are from Orissa. Malaria morbidity and mortality is the maximum where health services are the weakest. The most vulnerable to malaria are children under five, pregnant women, and marginalized communities.

An important new method available today for protection from malaria is the use of Long Lasting Insecticidal Nets, 'LLIN', made of fibrous materials treated with insecticides. The Government of India's National Vector Borne Disease Control Programme (VBDCP) purchased 2.3 million nets of which 1.2 million were given to Orissa due to the scale of the problem in the state and the commitment of the Health Department to fight the disease. To tackle the large number of malaria cases in Orissa, the VBDCP aims to better manage the disease

by using Rapid Diagnosis Kits (RDK) to detect infection within 24 hours, treating malaria cases with Artemisinin-based Combination Therapy (ACT), and controlling the spread of the disease through indoor sprays and LLINs.

80% of LLINs have successfully been distributed to target villages between Feb – Mar 2010. However, the real test of success is whether every family provided with an LLIN sleeps under it every night. Local folk, interpersonal communication, and mass media messages are being used to not only highlight the benefit of LLINs but also to address issues such as using the nets in confined spaces. Often messages about additional benefits of LLINs, such as for avoiding hair lice and reducing household bugs, convinces people to use the nets.

Gaon Kalyan Samities (GKS: Village Health and Sanitation Committees) are responsible for distributing LLINs in villages. More than half of the ASHAs in the state have been trained on using the RDKs and are the frontline workers diagnosing malaria with the kits, giving ACT to treat those with the disease, and giving the nets to every household. Pregnant women are given priority with the nets being distributed to them free of cost, while a token amount of Rs. 5-10 is collected from the rest of the beneficiaries. Charges are also waived for the poorest households. Money collected is deposited in the GKS account and can later be used for other health activities.

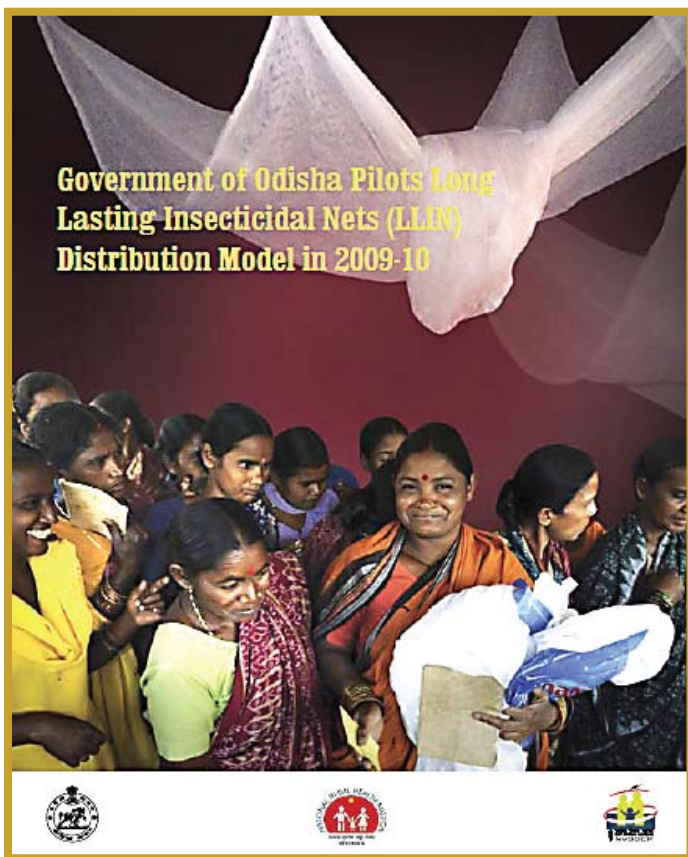
The state government has also launched the 'Mo Mosari' (My Mosquito Net) scheme in which LLINs will be provided to pregnant women in all high endemic districts. LLIN distribution will begin in the poorest districts of Kalahandi, Bolangir and Koraput (KBK). Each LLIN given to a pregnant woman will protect her during pregnancy and her newborn child for 3-4 years. LLINs will also be given to students in tribal school hostels and to communities in affected areas.

To ensure use of the nets, a Behaviour Change Communication plan has been developed to communicate messages to target groups. A campaign promoting the use and maintenance of LLINs, called 'Nidhi Mousa to Masari Ne' (Uncle Nidhi You take the Net), will also be launched. Furthermore, the Orissa Technical and Management Support Team (TMST) worked with the Vector Borne Disease Control Programme and the Department of Health to produce a brochure on distribution of LLINs in the state which will serve as a useful guide to other state governments. This was shared at a national meeting to mark five years of the National Rural Health Mission.

DFID: a partnership to fight malaria

DFID's financial support to the government of Orissa and technical assistance through the Orissa TMST is playing an important role in several aspects concerning the LLINs, including:

- ⇒ Helped develop the LLIN distribution strategy
- ⇒ Provides innovative ideas for Behaviour Change Communication
- ⇒ Supports documenting processes and lessons learnt
- ⇒ Provides procurement support to purchase additional nets for pregnant women
- ⇒ Works with the Department of Health to procure LLINs for the 'Mo Mosari' scheme
- ⇒ Monitors coverage and use of LLINs as well as diagnosis and treatment of malaria through Lot Quality Assurance Sampling (LQAS) which provides reliable estimates using small sample sizes. This will help local managers improve programme performance.



The Orissa TAST supported the publication of a brochure capturing the process, challenges, and achievements of distributing Long-Lasting Insecticidal Nets in the state. This brochure is available on the cross-TAST website at www.indiahealthtast.org

There will remain a long-term need for LLINs, but rapid coverage of the worst-affected population now, together with early diagnosis and prompt treatment of malaria, has the potential to greatly reduce the burden of malaria in the state. ❖



Gao Kalyan Samities, or Village Health and Sanitation Committees, are responsible for distributing Long-Lasting Insecticidal Nets to communities in Orissa

BREAKING BARRIERS FOR WOMEN VICTIMS OF VIOLENCE

Bihar

Most boys and girls in Bihar grow up seeing their mothers face physical and sexual violence at home. When the boys get married, chances are they will replicate the same violent behavior towards their wives, and in all probability violence is something the girls have been taught to accept. Bihar has the highest rates of domestic violence in India with almost 60% of married women living with physical and sexual abuse at home. The state has

taken some measures to address the issue but several hurdles remain.

In an effort to bring together individuals and groups that can play a vital role in overcoming these hurdles, the Women's Development Corporation held a state-level consultation analysing steps taken by the Government and NGOs to provide safety nets to women facing violence. The consultation was held with support from DFID's SWASTH (Sector Wide Approach to Strengthening Health) programme and the Bihar TAST.



Managing Director of the Women's Development Corporation, Dr. N. Vijaylakshmi, addressing a state-level consultation in Bihar on violence against women

The consultation brought forth some of the challenges of tackling violence against women. Many women do not seek assistance or report cases for fear of the 'shame' it will bring on the family. And in Bihar, a state that has the highest number of women facing physical, spousal, and sexual violence, that's a lot of women who chose to remain silent.

Help lines, short-stay homes, a state women's commission, and self-help groups are some initiatives taken by the government to reach out to women victims of violence, however much more needs to be done. Even law enforcing bodies such as the police often harbor stereotypes about women who face violence and look to blame the women themselves for their situation. This further discourages women from taking legal action and seeking justice. Working with the police, the judiciary, and communities to change mindsets is important to ensure gender equity.

Some action points resulting from the consultation were—

- ⇒ Improving access of women, especially from marginalized communities, to the formal justice system
- ⇒ Reforming state policies and practices
- ⇒ Working with communities to tackle violence against women
- ⇒ Increasing the number of women participating in decision-making forums
- ⇒ Establishing shelters for women
- ⇒ Providing counseling, health services, legal aid, and livelihood support



The police often discriminate against women victims of domestic violence. There is a need to work with law enforcing bodies and the judiciary to be sensitive to such cases.

DFID's SWASTH programme, that supports the above interventions, will play an important role in developing and implementing a strategy to address violence against women. DFID recognizes that in order to reach its goal of improving health and nutrition in Bihar, violence against women is an issue that needs proper attention and steps have to be put in place to ensure the women are safe in their homes and in their communities. ❖

EDITORIAL



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Strengthened Systems = Better Services

The underlying factor for sustainable health sector reforms is system improvements. This is why all the health budget support programmes of DFID (which TAST is supporting) are essentially sector reform and systems strengthening ones. These are a shift from the earlier regime of 'projects' based interventions which though quicker with their implementation and results, usually fizzled out soon after the project was completed. Health systems strengthening, on the other hand, are slow, painful and often iterative but once through are invariably owned and sustained by the government. The technical assistance challenge is to accelerate the pace of systems development, help governments demonstrate tangible results to fuel the reform process, and build individual and institutional capacities for the long-run. There is a need for these programs to demonstrate a clear impact and verifiable results.

William Hsiao's control 'knobs' (2000) is a useful way to look at the health sector as a network of systems. Hsiao suggests that the major focus of health sector reform efforts should be to establish, set, or adjust these control knobs of financing, payment, organization, regulation, and consumer behavior in order to influence better health service delivery. The Health sector reform programmes which TAST are supporting also have similar systems reform agenda. Some of the key reforms are in strategic planning, organizational development, human resource management, procurement and financial management which together will help improve health services.

A workshop on health procurement reforms was organized in March 2010 by the Empowered Procurement Wing (EPW) of the Ministry of Health, Government of India. All 5 DFID supported states were invited and experts from Management Science for Health (MSH) presented their assessment of the state's procurement system. The workshop was useful in bringing together professionals and practitioners in order to have a common understanding of procurement reforms, a shared vision for the possibilities and greater awareness of challenges ahead. Such workshops are very useful in consolidating learning and should be encouraged for all major health system areas.

DFID has approved the Bihar health sector reform programme – Sector Wide Approach to Strengthening Health (SWASTH) recently with a budget of GBP 145 million. This will be one of the largest and most integrated health programme of DFID where it will be working with 3 departments simultaneously. The Bihar TAST team is all geared up to take on the challenge of implementation and to improve services through sector reforms in one of the poorest states of India.

There has also been an enhancement of the support to the Orissa government for Health Sector reforms by DFID. The original budget of GBP 50 million has been increased to GBP 100 million. Within this funds for DWCD increased from GBP 5 m to 38 m. The Madhya Pradesh support has increased from GBP 60 m to 120 m up to 2015. The Orissa and MP TAST teams will be happy to support the government in optimal utilization of these additional funds. This is another example of the increased DFID commitment to the health sector reforms in these states.

On another note though, two states – West Bengal and Andhra Pradesh – are completing their DFID sector support programmes in June 2010. The TASTs of these two states have provided tremendous support to the government which has been appreciated in several forums. We would like to thank them for running through these programmes successfully which blazed a trail for other TASTs to follow. ❖

A DAY IN THE LIFE OF AN ANGANWADI WORKER

By Barsa Ray, Interim
Communication Specialist,
Madhya Pradesh

Being seven months pregnant does not deter Anjali Yadav from work. The extra income from collecting wood and forest products will go a long way in feeding her family, even though it jeopardises her and her soon-to-be-born baby.

The anganwadi centre (AWC: village-level nursery) and its caretaker Leela Rawat, are both blessings for women like Anjali who don't have access to modern amenities. They can safely leave their children under 5 years of age here when they go to work.

Leela has been an anganwadi worker in Ari village of Madhya Pradesh for fifteen years. She is responsible for delivering nutrition and health services to pregnant and lactating mothers and to children up to six years of age. Some of the services she provides are health check-ups, immunisation, identification and referral of complicated pregnancies or severely malnourished children to higher health institutions, providing non-formal pre-school education, and giving nutrition and health education.

The anganwadi centre opens at 9am and after the anganwadi helper has cleaned the premises she fetches pre-school children from their homes. Leela oversees the serving of breakfast which consists of *lapsi* (broken wheat dessert) and *dalia* (porridge) or *halwa* (sweet semolina). She then teaches the children the alphabet, counting, and how to identify objects around them.

On a fixed day every week, mothers with

children in pre-school or with children below 3 years of age come to the anganwadi centre to have them weighed and immunized. "Weighing is important to monitor physical development. Some of the children don't turn up at the centre on weighing days even though their mothers have been informed. But I cover them by the end of the week in my home visits. If a child's weight isn't increasing I counsel the mother", says Leela as she emphasizes the importance of healthy weight for a healthy child.



Leela Rawat, an anganwadi worker in Madhya Pradesh, reviews a weight card of a child to monitor proper growth and nutrition

There are many malnourished children in the 1.5 - 2 year age group in Leela's village. Often children become malnourished when their working mothers take the children with them to their workplace. By the time the children are old enough to attend pre-school, they are already considerably underweight and malnourished.

Leela is passionate about advocating for good health practices and spends a lot of time talking to mothers to ensure their children are healthy. As Leela points out, "Although a child's health is the mother's responsibility, in many cases the care she gives her baby is inadequate, especially for those not attending the anganwadi centre. I talk to the mothers at monthly meetings and at other social functions. I have referred three severely malnourished children this month to the Nutrition Rehabilitation Centre." These rehabilitation centres are part of a new initiative of the state government to tackle the 7% increase reported between 1998-99 and 2005-06 in underweight children below three years of age.

In the fifteen years that Leela has been an anganwadi worker, there have been a number of positive changes such as increased awareness about women's and child health. Many more women get antenatal check-ups and immunisations for themselves and their children. Malnourishment, however, continues to be a challenge.

Another difficulty Leela faces is the distribution of Take Home Rations, nutritious food for pregnant and lactating women and their young children. At times there isn't enough to

be given to all beneficiaries and food meant for children under five years of age is often shared by other family members.

Despite these obstacles, Leela enjoys the trust her community puts in her on account of her long services in the village. "People come to me at all hours with their problems. I feel very satisfied when I am able to save lives through my services or by referring cases to better health centres. I want everyone in my village to work towards a healthier future for themselves and for their children." ❖



Children at an anganwadi center, or village-level nursery, eating nutritious food. They are at lower risk of being malnourished than children who don't come to the centre.

MAPPING THE WAY FORWARD FOR EMERGENCY OBSTETRIC CARE

Madhya Pradesh

Complications associated with pregnancies are not always predictable. Links between pregnancy-related care and maternal mortality are well recognized. National programmes and plans have stressed the need for making essential and emergency obstetric care widely available.

In Madhya Pradesh, maternal mortality remains high - 335 per 1000 live births (RGI2004-06). Reducing child mortality and improving maternal health are major goals for the Department of Public Health and Family Welfare. A priority area is ensuring access to quality Emergency Obstetric Care. The state aims to ensure that pregnant women will be able to access Basic Emergency obstetric Care within 1 hour from their homes and Comprehensive Emergency obstetric Care within 4 hours from where they live.

The MP TAST has been working closely with the state government to start up centres offering basic and comprehensive obstetric services. The TAST has now stepped up its efforts towards tracking the effectiveness of Basic Emergency Obstetric and Neonatal Care (BEmONC) and Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) facilities in the state. MP aims to have 120 CEmONC centres, or First Referral Units offering comprehensive obstetric services, by 2009-2010. 83 are already functioning. BEmONC services will be available in 600 centres. Approximately 400 such facilities are currently up and running. Steps are being taken to ensure adequate infrastructure, medicines, equipment, and trained staff are available at these centres, especially at the First Referral Units offering comprehensive emergency obstetric care services.

Though there has been significant progress in setting up such centres in MP, more focus is needed to offer quality maternal and new born health care to meet increasing demands by communities. While several centres are being set up to provide these services, it is also important to track how they are run and whether they meet the requirements of those benefitting from the facilities.



The MP TAST, working with the state health department, is monitoring basic and comprehensive emergency obstetric and neonatal care centres in 10 districts of MP



A healthy mother and child after receiving emergency obstetric and neonatal care in a health institution in Madhya Pradesh

The MP TAST, working closely with the Department of Public Health and Family Welfare, has taken a lead in monitoring the efficiency and effectiveness of the centres in ten underserved districts of the state. Through field visits, the MP TAST has given regular feedback to the Department on good practices and how BEmONC and CEmONC facilities can be enhanced. It has also jointly developed a checklist to assess how the centres are operating. The checklist looks at performance indicators, Government of India and state guidelines for service provision, internationally and nationally accepted functions of the centres, status of infrastructure, equipment, and medicines, availability of trained personnel, and adherence to standards and protocols. As a result of the TAST inputs, the Department has alerted district health authorities, such as in Tikamgarh district, to take steps to improve service delivery.

Such monitoring and feedback is essential across the wide spectrum of health services. It is also essential for those in the health system, as a result of the monitoring and feedback, to put into practice steps that bring positive changes to maternal and new born health in the state. ❖

CLOSING THE GAP BETWEEN ASHAs

Orissa

It's not easy to underestimate the important role of ASHA's, or Accredited Social Health Activists, in local communities. From being the first port of call for those with health needs to being an activist for proper health, nutrition, and sanitation, the ASHA is a vital link between communities and the health system. However, in Orissa, ASHA's from the poorest regions find themselves lagging behind those from better-off parts of the state.

In an assessment commissioned by the Orissa Technical and Management Support Team (TMST) carried out on behalf of the Department of Health and Family Welfare, ASHA's from Orissa's KBK region, a group of 8 poorest districts from the Koraput-Balangir-Kalahandi area, were found to be slightly better aware of their rights and incentives (such as for male sterilization and blood sample collection). However they were less educated and paid less than ASHA's from non-KBK districts. The monthly entitled income, which is the income an ASHA earns for activities in a given time frame, in this case from May-Sept 2009, was 25% less than in non-KBK areas.

The table below brings to light some obvious differences in income for ASHA's from poor and well-off regions:

	Potential Income (per month)	Earned Income (per month)	Income Received (per month)
KBK	Rs. 1800	Rs. 954	Rs. 721
Non-KBK	Rs. 1800	Rs. 1273	Rs. 1048

Not only is there a disparity in income, but ASHAs are often paid in bulk for several months work. There are no written statements for the payment which means they are unable to verify whether or not the amount they have received is correct. No systems are in place to enable the ASHA to seek assistance and reimbursement if there are errors in payment.

Furthermore, incentives for ASHAs are centred more on events rather than on actual ground work, e.g. an ASHA will get an incentive for participating in immunization day activities but not for attending to children and pregnant women. 70% of the total income of ASHAs is earned through the Janani Suraksha Yojana scheme (JSY, Safe Motherhood Scheme) by bringing pregnant women to proper health institutions for their deliveries. They receive Rs. 600 per delivery, including Rs. 250 for transportation, however there are no incentives for extending their services to ante and post natal periods.

The assessment recommends expanding the scope of incentives to include services over and above bringing women to hospitals for their deliveries. Some additional incentives could include having the ASHAs play a greater role as community mobilisers and provide services such as minor first aid. ASHAs also need further training to enhance their skills to boost their confidence and be more effective.

Ensuring that ASHAs are well trained, receive fair wages, and have proper incentives is a step towards better health for whom ASHAs are a ray of hope. ❖



ASHA's from the poorest districts of Orissa are often not well educated, are not aware of incentives, and are paid less than ASHAs from better-off districts

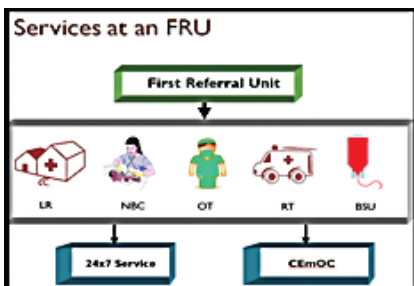


ASHAs that are well trained, well paid, and have proper incentives can greatly contribute to meeting the health needs of communities

INNOVATIVE SOFTWARE HELPS TRACK FIRST REFERRAL UNIT PERFORMANCE

West Bengal

Maternal mortality in India continues to remain unacceptably high. Historical evidence at the global level shows that it is possible to bring down maternal mortality effectively if a package of obstetric services is provided within reach of communities and families.



Services available at an FRU

In West Bengal, the government aims to bring down maternal mortality to 100 from 141. In an effort to save more lives during pregnancy and child birth, the Department of Health and Family Welfare aims to improve access to health institutions and increase access to quality emergency obstetric care through First Referral Units (FRUs). FRUs are district or sub-district health care facilities where obstetricians, gynecologists, anesthetists, and pediatricians are available and where there are facilities for cesarean sections and blood transfusions. The FRU's are required to provide services 24x7 as well as comprehensive emergency obstetric care to local communities.

9 medical college hospitals and 61 other health facilities function as FRUs in West Bengal. The state aims to have 64 more centres that will be easily accessible to expectant mothers. Apart from having these referral units up and running, the government is keen to monitor the performance of the FRUs and their services. A study conducted by the West Bengal TAST about the FRUs highlighted the fact that setting up referral units has many dimensions to it and it takes time, there needs to be regular tracking of how it is being run and progress made, and that simply setting up the units does not ensure that the way they function and the services being offered are satisfactory. A system needed to be in place to closely keep a track of how the FRUs were being run, that services were of good quality, and that proper qualified staff were doing their job well.

The state health department engaged the West Bengal TAST to devise a monitoring tool for the FRUs. Using the support of a software developing agency,

the TAST developed a simple and user-friendly on line reporting software with unique logins for each FRU, automated reporting, and quick analysis. The software was field tested in 2009 and based on encouraging results, was rolled out in 29 phase one FRUs.

The software was an immediate success allowing health professionals to easily key in performance figures for each month which the state could see in real time. The TAST then developed further reporting formats and even initiated a mobile sms facility for monitoring the FRUs. The software has been extended to 20 phase 2 FRUs and similar software is even being considered for all facilities in the state.

Some of the highlights of the software are –

- ▶ It is built with web programming technology allowing simultaneous login by facility, district, and state officials
- ▶ It is user-friendly with inbuilt validations for totals, variations between number of deliveries and births (such as twins or triplets). An FRU can enter their monthly performance in minutes.
- ▶ The software provides quarterly reporting and updated data such as availability of infrastructure and human resources.
- ▶ It confirms, through sms, when a report is submitted by an FRU. The sms is sent simultaneously to the FRU Superintendent as well as to the state nodal officer. The sms facility is also used for urgent communication to all FRUs.
- ▶ It has inbuilt reports that analyse performance by a health facility, block, district or state. Graphs are auto-generated showing trends and highlighting areas of low performance.
- ▶ The software enables health facilities to enter comments and suggestions for improving performance where a response can be posted by district or state officials.
- ▶ Three best performing health facilities are sent a congratulatory sms every month.

The software is being regularly used since June 2009 and the FRU reporting website has been linked to website of the Department of Health and Family Welfare (www.wbhealth.gov.in) under the 'Interactive Reporting System' tab.

This innovative software is another step towards better health systems in West Bengal. ❖



A delivery taking place in an FRU

The user-friendly software to track the performance of FRUs in West Bengal is a step towards better health performance by the state

GEARING UP FOR HEALTH INSURANCE FOR POOREST COMMUNITIES

Orissa

For people living below the poverty line, an illness not only represents a permanent threat to their income earning capacity, in many cases it could result in the family falling into a debt trap. When the need to get the treatment arises for poor families they often ignore it because of lack of resources, fearing wage loss, or wait till the last moment when it's too late.

To address this, the Government of India launched the Rashtriya Swasthya Bima Yojana, or RSBY, a scheme that provides health insurance to families below the poverty line who require hospitalization.

The Orissa TAST organised an exposure visit of state officials to Kerala and Gujarat on how RSBY is being implemented in these states. As a result of the visit, an action plan was formed and government orders will be issued for forming various sub-committees to manage funds, ensure availability of health infrastructure in public hospitals, and empanel private hospitals for the smooth implementation of RSBY across the state.

Covering families under an insurance scheme like RSBY which provides better health services almost at no cost is a great step forward in addressing health concerns of communities. Orissa has moved forward rapidly in designing strategies to adapt RSBY.

The Department of Health and Family Welfare plays the key role of providing services to meet the demands of RSBY. A state-level committee with officials from the Department and members of the Orissa TAST has been formed to support the scheme.



State officials visit Gujarat to see how the Rashtriya Swasthya Bima Yojana, a health insurance scheme for those below the poverty line, is being implemented in the state

The Rashtriya Swasthya Bima Yojana (RSBY) was launched by Ministry of Labour and Employment, Government of India, to provide health insurance coverage for Below Poverty Line (BPL) families. The objective of RSBY is to provide protection to BPL households from financial liabilities arising out of health problems that involve hospitalization. Beneficiaries under RSBY are entitled to coverage of up to Rs. 30,000 for most diseases requiring hospitalization. Pre-existing conditions are covered from day one and there is no age limit. Coverage extends to five members of the family. Beneficiaries need to pay only Rs. 30 as registration fees while the Central and State Government pays the premium to the insurer selected by the State Government through competitive bidding. ❖

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