7 years of National Rural Health Mission

(2005-2012)

Madhya Pradesh Experience

SHIVRAJ SINGH CHOUHAN
CHIEF MINISTER
MADHYA PRADESH

MESSAGE

We are committed to ensure that health care needs of the people, both curative and preventive must be met without compromising their financial security. This requires that all enabling actions are taken in a holistic manner to guarantee appropriate health care by choice, portability and continuity in an accountable and transparent manner. It calls for both augmented public health financing and an efficient mode of expenditure on health.

It is notable that the State's health budget which was 2.84% of the overall state budget in 2005-06 went up to 4% in 2011-12. More recently, the State Health Budget for 2012-13 at ₹ 2712.75 crores (against ₹ 2143.31 crores for the preceding year) marks an increase of 27% demonstrating our keen intent in this sector.

I am happy to learn that NRHM MP is bringing out a compendium of various papers, articles and lessons learnt as a mark of completion of 7 years of NRHM. I extend my best wishes.

(Shivraj Singh Chouhan)

Dr. Manohar Agnani
Mission Director, NRHM

Government of Madhya Pradesh
State Health Society
Bhopal

Seven Years of NRHM – Looking in Retrospect

At most of the times, it is a difficult job to write a preface. It is more so if one is personally involved. In such a situation it is not always possible to be entirely objective and some personal elements are bound to creep in. I seek your indulgence if any such thing occurs.

I have been associated with the concept of decentralized management of health care in Madhya Pradesh from its very inception. When DFID-supported project "Swasth Jeevan Sewa Guarantee Yojana" - Moving towards Decentralized Management of Health Care in Madhya Pradesh under Rajiv Gandhi Mission for Community Health - was being envisaged, I was one of the members of the core team in project planning and subsequently was responsible for implementation as well.

It was around the time that rural heath acquired a centre stage and a very ambitious National Rural Health Mission enriched with inputs from multiple fora was planned and launched with vigour and determination.

Since the launch of the National Rural Health Mission in the year 2005, the Department of Public Health and Family Welfare has been making concerted efforts for providing accessible, equitable, affordable, effective and quality health care to both the rural and the urban populations, especially the poor, women and children, with focus on the vulnerable populations and those living in remote/difficult locations. These efforts range from strengthening health care delivery services and generating demand for services through community involvement for increasing the utilization of services by the people from different strata of the society in the state. Our special focus has always been on ensuring social inclusion and equity. Several innovations, pilot interventions and collaborative initiatives have been taken up in the state during this period which proved to be successful.

This journey has been amazing with full of excitement, convergence, coordination and new lessons learnt. We could bring in many noteworthy positive changes in the state in terms of health indicators, infrastructure and service delivery since 2005. It was indeed gratifying that the state of Madhya Pradesh was adjudged winner of the second prize on 12th April, 2010 amongst the High Focus States (other than North Eastern States) on completion of 5 years by the Government of India. The distinction was conferred to the state for its improved performance across 4 criteria, namely, outcomes revealed by micro health indicators, physical capacity and delivery outcomes of rural health services, outcomes in

enhancement of human resources in health system and outcomes in the area of governance.

Moving along the directives of Maternal-New born-Child Health continuum of care approach significant reductions have been achieved in the Infant Mortality Rate (IMR) since the launch of NRHM in the state. State has recorded the highest fall in IMR in the country in 2010 with a five point fall which was also the largest single year fall in last decade for the state. The IMR of the state overall showed a 14 point fall from 76 in 2005 to 62 in 2010 as per the SRS reports. Institutional deliveries have increased from 29.7 % (NFHS 3) in 2005-06 to 81% in 2009 (CES). The proportion of pregnant women receiving 3 or more antenatal check-up has reached level of 60% in 2009 (CES), which stood at 34.2% during 2007-08. According to Sample Registration System, the MMR in the state was 335 maternal deaths on every 100,000 live births during 2004-06 which has been reduced to 310 as per the recent Annual Health Survey (AHS) 2010-11. As per NHFS-3 (2005-06), the state had the highest burden of Severe Acute Malnutrition (12.6%) among children in India which has been reduced to 8.3% in 2010 as per the recent survey conducted by National Institute of Nutrition, Hyderabad.

Our thrust on developing State and District Programme Implementation Plan (PIP) based on focused activities woven around the identified gaps at the delivery points has been a notable feature of planning process. The Government of India recently commended the Maternal Health component of State PIP for 2012-13 as a 'reference plan' and called upon other states to draw upon the Maternal Health PIP of the state of MP.

I am happy to report that the state has utilized the application of Mother and Child Tracking System (MCTS) with significant pace and 98% of health facilities are currently uploading data in the software. Major successes have been achieved in strengthening the monitoring and evaluation system and processes in terms of timely and complete reporting, increased use of data for annual planning, and development of e-health bulletin. Improved funds flow and strict monitoring has resulted in increased utilization of sanctioned budget under RCH, NRHM, and Immunization in the state. Against the approved budget of Rs. 733.62 Crores in years 2010-11, the state has recorded utilization of funds to the tune of Rs. 659.31 Crores (89.87%).

Some of the innovative interventions which have registered notable success and have been scaled up substantially include Sick Newborn Care Units, Nutrition Rehabilitation Centres, Janani Express Scheme linked to call centre for monitoring utilization by clients, 24 x7 deliveries at Sub Health Centres in remote areas, Model Maternity Wings, communitization of NRHM, strengthening of Village Health and Nutrition Days and empowerment of adolescents and youth through life skills approach.

In order to strengthen the maternal and child health services we have fully operationalised 78 facilities as CEmONC (level 3) and 494 facilities as BEmONC (level 2 MCH) centers. We made significant efforts for improving the availability of blood in the health facilities. Currently, we have fully functional 45 Blood Banks and 53 Blood Storage Units in the state. For further improving the maternal health services, we have planned to establish model maternity wings in all 50 district hospitals. We are also making conscious efforts to review maternal deaths through facility based as well as community based approaches and using this data to further improve quality of services to avert maternal deaths.

For addressing the survival of sick newborns, we have fully operationalised 36 SNCUs in the state with more than 80,000 newborns treated in these units in last four years and adequate HR availability has been ensured with 3.39 doctors per unit and 10.15 staff nurses per unit on an average. To extend continuum of care back to community follow up system and tracking of new born after discharge from SNCU using online monitoring software developed by UNICEF has been initiated in five districts and by the end of 2012 would be scaled up across the state.

At the community level, huge cadre of Accredited Social Health Activists (ASHAs) has been developed and currently 52,694 ASHA are working in 52,117 villages in the state. The ASHAs, endowed with knowledge on public health and roles in linking community with the service providers, are proving to be worthy social capital to reckon with. Similarly Mentoring Groups for Community Action (MGCA) have been constituted at state, district and block levels for strengthening community participation and monitoring mechanisms.

We have taken steps to strengthen our capacity building capabilities by adding 3 new ANM Training Centers in Anuppur, Dindori and Umaria districts, whilst adding 2 colleges of B.Sc. Nursing at Jabalpur and Ujjain. Likewise, we have also instituted 1 year Diploma Course in Public Health Management in collaboration with Public Health Foundation of India and at present, second batch course is in progress. These measures will have far reaching impetus on capacity building of health functionaries.

We are conscious of our constraints and challenges and we are taking holistic and keen efforts for addressing them. Still, there is significant scope for improvement in the quality of services being rendered. High MMR, IMR and TFR are the most challenging issues for the state. Lack of skilled human resources, suboptimal access to quality EMOC services, deficient quality public health infrastructure and facilities continue to be the key bottlenecks.

Coincident with the completion of seven years of NRHM this year, we have composed a compendium to share our experiences, achievements and lessons learnt during the journey of NRHM which commenced on 12th April, 2005. It

includes a series of papers written by those persons who have been closely associated with planning, implementation and monitoring of NRHM interventions in the state. These papers critically analyse the situation and document the processes, strategies, experiences, lessons learnt and achievements of various interventions and initiatives.

The compendium also has papers which suggest the road map on some important areas which require specific attention. Having fully realized the importance of addressing young fertility for reducing TFR, the state has taken initiatives to prepare a technical approach paper in consultation with International Institute of Population Sciences, Mumbai which explains the road map to faster fertility decline in MP. Similarly the paper titled "Need for community based management of SAM children in MP" explains the necessity of management of estimated 85% of SAM children without medical complications by adopting a low cost solution at community level, provided appropriate medical nutrition therapy is locally produced and made available. The Paper on "Road Map for an effective and integrated referral transport system for the state of MP" argues for the need of developing an integrated response for emergencies through a Central Emergency Response Centre. Under this, it is envisioned that all existing referral transport systems, both public and private, be coordinated through a centralized response system. It is expected that this integrated approach will benefit in terms of improving access, quality of services including improved response time and also in bringing down the cost.

Of course the road ahead is very long and formidable indeed! However, having taken the initial steps with resolve and expectancy, we are now poised to bring about transformational improvements in terms of health outcomes for the people of our state. I may mention that the papers included in the compendium may have evoked need for the readers to seek more of information as we wanted to accommodate all papers in the compendium and the contributors had limitations on word count. Should the readers require more detailed information, I would encourage them to contact the primary authors (first named ones in case of joint authorships) for full papers or other details.

I extend my earnest gratitude to all the authors and co-authors of these papers for their intellectual contribution. I hope that the papers presented in this compendium will be interesting and useful for policy makers, programme managers and other concerned stakeholders in Madhya Pradesh as well as in other states.

The inspiring support and guidance of the Government of India has always been a major enabling source for forward actions to the State NRHM. I am grateful to all officials of the GoI, for extending keen support and providing valuable inputs to state NRHM through successive seven years of planning and implementation.

I extend my sincere gratitude to our Hon'ble Chief Minister, Health Ministers, Minister of State for Health, all Chief Secretaries, Principal Secretaries, Secretaries, Health Commissioners, and Mission Directors of NRHM, who have officiated under NRHM and provided leadership to the state. I also extend my sincere thanks to the senior officials of MPSACS, department of Medical Education, Women and Child Development, Atal Bihari Vajpayee Bal Arogya Evam Poshan Mission, Commissioner, Food Safety/Controllers Food and Drugs, department of AYUSH and faculties of medical colleges of the state, who during the last 7 years have provided their dynamic support without which these significant achievements would not have been possible.

I would also like to express my deep sense of appreciation for all my colleagues, directors, joint directors, deputy directors, CMHOs, civil surgeons, faculty members of training institutions, health care providers, MGCA members and NRHM colleagues for their untiring efforts in joining the pursuit of NRHM agenda with dedication and commitment.

I am also grateful to Divisional Commissioners, District Collectors and members of District Health Societies for their thoughtful support and attention to the public health issues and actions. I also wish to extend my heartfelt thanks to all the development partners including UNICEF, UNFPA, NIPI,MI, JICA, DFID, Public Health Foundation of India, ASCI, IPAS, amongst others who have been associated and provided technical support over the last 7 years in the NRHM journey.

I am happy to present this compendium to you.

(Dr. Manohar Agnani)

*Deputy Director, Health Service MP
** Sr. Advisor, IPAS India
*** State Programme Officer, IPAS MP
**** Sr. Programme Co-ordinator, IPAS MP

Reducing Maternal Mortality in Madhya Pradesh by Improved Access to Comprehensive Abortion Care Services: Learning of last Five years

Dr. Bhushan Shrivastava* , Dr. Sushanta K. Banerjee**, Dr. Jyoti Benawri***, Kamal Saratkar****

ABSTRACT

Nearly 40 years after the enactment of the Medical Termination of Pregnancy Act of 1971, unsafe abortion remains a critical attribute of maternal mortality. Keeping this point in mind and further to support MDG-5 (reducing MMR) the state of Madhya Pradesh with technical support of Ipas-India introduced a comprehensive abortion care (CAC) model in 2007.

Outcome and experience of this model highlighted the success story, operational and programmatic challenges to scale up the access to safe abortion services at all levels of public health facilities. Some important outcomes of the project include Iinstitutional capacity building of the state to implement sustainable CAC training model, shifting the state focus to improve the access to CAC at primary level facilities, post-training mentoring and monitoring to improve the quality of services, piloting a behavior change communication (BCC) model to improve the community awareness.

The journey of last five years has paved the pathways of a sustainable model and helped identifying operational challenges to improve the maternal health scenario in the state. This paper advocates for enhancing the base of CAC trained providers and restricting the misuse of medical abortion by ensuring availability at public sector facilities.

I. Background

Recognizing the preventable nature of maternal mortality and morbidity related to unsafe abortion, the Indian parliament passed the Medical Termination of Pregnancy Act (MTP Act) in 1971. Although the liberal law permits a woman to seek abortion services for many indications, but unfortunately, it has not led to a sufficient reduction in unsafe abortion or related maternal mortality and morbidity. Even 40 years after passage of the MTP Act, as many as 8-10% of maternal deaths and a large proportion of maternal morbidity are due to complications of unsafe abortions.

Keeping these points in mind and further to support the Millennium Development Goal (MDG-5) of reducing the MMR the state Madhya Pradesh with technical support of Ipas-India introduced a comprehensive abortion care (CAC) model in early 2007. The broad goal of this initiative was to ensure access to safe abortion services, especially in the public sector, through a model that focuses on strengthening training systems and improving service delivery in primary health care settings.

II. CAC Intervention: Scope, Implementation and Rollout

1. The CAC program was initiated in Madhya Pradesh in early 2007. The major components of the project included:

2. strengthening institutional capacities of training CAC providers in safe and updated technologies;

3. training and certification of MBBS doctors and training of gynaecologist to enable them to offer legal and safe abortion services;

4. post-training monitoring and mentoring of trained providers to ensure post-training service provision;

5. piloting communication interventions to create awareness in the community on availability of abortion services in the public sector; and

6. strengthening district level committees (DLCs) to improve the legal service access at private sector.

7. Strengthening Institutional Capacity of CAC Training

As a routine protocol, a detailed training site assessment was carried out in all potential district hospitals and medical colleges of the state with the objective of upgrading them as MTP training centre. The assessment used five evaluation criteria, namely, i) MTP case load, ii) staff availability, iii) facility infrastructure, iv) training exposure and v) interest and/or motivation of staff toward MTP training. The site assessment also attempted to capture existing operational barriers to be addressed in future training of medical doctors. Based on the results of the training site assessment, a total of 14 district hospitals and medical college hospitals were approved as CAC training centres. As a lead technical support agency, Ipas conducted 15 training of trainers (TOTs) workshops and created a pool of 104 master trainers.

2. Training of Medical Doctors and Orientation of Nursing Staff

The training and orientation needs of CAC providers differed across categories of gynecologists , MBBS and Nursing staff; thus, cadre specific training curricula was developed for each category. A six day training curriculum was prepared for post graduates in Obstetrics & gynecology whereas a 12 day curriculum was developed for the MBBS doctors. As nursing staff are not allowed to provide MTPs a separate curriculum was developed to orient them on the legal aspects, infection management, and post-abortion contraception. The "Team training" (doctor and nursing staff together) approach helps in clearly understanding of each other's roles, responsibilities and easier operationalization of post-training service provision.

The training methodology was of participative nature -'Hands-on Approach'. The topics include abortion scenario, MTP Act, reproductive rights, infection prevention, current first and second trimester abortion technologies, complications and their management, post abortion care and counseling, contraceptive services and community linkages and team work.

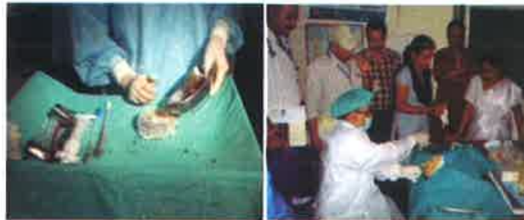

Fig. 2 Hands on live cases (left) & Coaching on Pelvic Model (right)

To facilitate trainees initiating CAC services at their worksites immediately after completion of training, training manuals, skill checklists, manual vacuum aspiration (MVA Plus) kit with cannulae, site signage and posters of MVA procedure and instrument processing, facility log-books for recording MTP cases and demographic backgrounds of women requesting abortion services, consent forms and CDs on MVA and medical abortion were provided to trainees.

As on December 2011, a total of 948 medical doctors (357 obstetrician-gynecologist and 591 MBBS doctors) from 544 different health facilities across the state successfully completed CAC training.

As recorded in table 1, at the initiation, the CAC initiative was strategically focused in urban area with CAC providers at secondary and tertiary level hospitals. With learning evidence of piloting CAC model at urban areas, the effort has gradually been shifted to the periphery (PHCs & CHCs) for benefiting rural women. As recorded in table 1, in 2007 around 40% (54 of 138) of activated sites were from district, sub-district and medical colleges. The same proportion declined to just 18% in 2011. In total, around 82% sites activated for providing CAC services at primary sector facilities.

Table 1: Cumulative numbers of public sector facilities with at least one CAC trained providers, Madhya Pradesh 2007-2011

Year	Primary facilities	Secondary & Tertiary facilities	Total facilities
2007	84	54	138
2008	188	73	261
2009	290	84	374
2010	374	95	469
2011	444	100	544

3. Post Training Follow-up of visits and contacts

The concept of post-training follow-up was introduced in 2008 as a part of the CAC training program. The objective of the follow-up contacts was to assess the translation of training efforts into service delivery, identifying the reasons for non-provision of services and steps to correct them. According to these follow-up visits around three-fifth of trained providers provided CAC services after the training.

It was observed that many trained provider hesitated to initiate the CAC services because of lack of clinical confidence. With little clinical support most of them started providing services.

Transfer of medical doctors to another site/non-clinical site, lack of equipment (MVA), infrastructure, and essentials drugs at the transferred sites were some other important reasons for non performance

4. Quality of Service Provision

Efforts were also made to visit the CAC activated sites to evaluate the quality of CAC services. Based on the facility assessment (table 2) around 71% public sector sites with a CAC trained provider reported providing CAC services. Around 78% women received MTP services with recommended techniques (MVA, EVA & MMA) while 87% women received post-abortion contraceptives. The important reasons for not providing services were lack of community awareness about the availability of CAC services followed by transfer of trained service providers.

Table 2: Service provision and quality of service provisions, Madhya Pradesh 2011

Performance Indicators	N	%
% of site offered CAC services	96	71%
% of women received 1st trimester MTP with appropriate technology	3338	78%
% of women received contraception after MTP procedure	4071	87%
Source: Facility Survey Ipas 2011		

5. Piloting Community Awareness Campaign in selected blocks

To address low levels of community awareness on the legal aspects and available sources of safe abortion integrated community awareness campaign in selected blocks of Betul & Jhabua districts was piloted with a series of communication activities, including wall signs, site signage, orientation of community intermediaries (ANMs, AWWs, MPWs & ASHAs) and Nukkad Nataks (street drama) through professional training of local youths. Results of pre- and post-intervention community surveys are awaited

Fig. 3 IPC (community); IPC (health intermediaries); Street Drama

III. Challenges

Although the initiative has been successful in establishing a CAC model, following programmatic challenges are yet to be resolved for scaling-up CAC intervention in the state of MP.

- Creating access to reach women of all geographical regions
- Reluctance of Medical Doctors for MTP training
- Strengthen the reporting of MTP cases . Providers often do not count medical abortion cases as MTP with a presumption that MTPs are always surgical.
- Sustained access to essential equipment like MVA and cannulae.
- Management of incomplete or post-abortion complications

Conclusions

This collaborative initiative demonstrated that improving accessibility to comprehensive abortion care services, particularly at rural areas is possible provided the above mentioned challenges are dealt with through strategic actions. Ensuring quality of CAC services will go a long way towards improving maternal health by expanding service access with appropriate technology further in rural areas.