Madhya Pradesh (MP) State's Best Practice in Social Sector Delivery (Public Health), identified by Government of India's policy making Think-tank i.e. NITI (National Institution for Transforming India) Ayog

Gram Arogya Kendra

Presented at

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Gram Arogya Kendra (GAK)

'Health for All' Through Village-level Horizontal Convergence

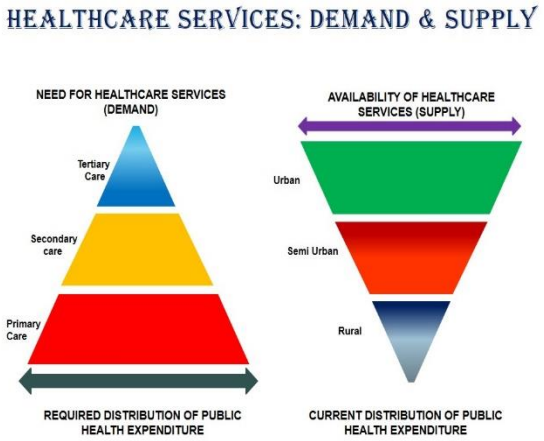
- *Dr. Sanjay Goyal, IAS*

Gram Arogya Kendra initiative was conceptualised and rolled out in the year 2011-12 by the then Collector Dr. Sanjay Goyal in Sehore district of Madhya Pradesh, which fortunately is also the home district and assembly constituency of Hon. Chief Minister and is part of Parliamentary constituency of Hon. Union Minister for External Affairs, Ms. Sushma Swaraj. The initiative was subsequently implemented all over the state of Madhya Pradesh. Principal Secretary, Health & Family Welfare, Mr. Pravir Krishn ensured its implementation to about 50,000 villages across the state.

Rationale

Most people generally confuse healthcare with medical Care which caters only to the tip of iceberg; but it is only one component restricted to Hospital based treatment aimed at reducing impact and damage from disease or illness. Apart from curative and rehabilitative services, the term health care also means preventive, promotive and early intervention services aimed at achieving positive health in comparison to mere absence of disease.

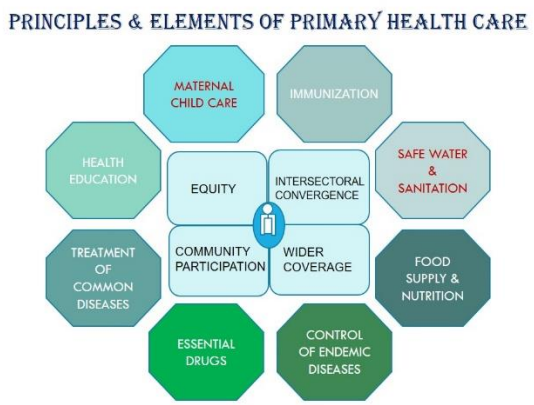
Majority of profit making private sector investments as well as substantial part of public health care expenditure flows into establishment of specialist and super-specialist level medical facilities. We shall strive to meet the demands of general population for basic, primary health care services, which not only prove to be the most cost-effective option but also reduces the burden on higher level facilities by decreasing the overall incidence and disease load.



Moreover, these essential health care services can easily be rendered by most field level health workers with appropriate minimum training under the supervision of a medical graduate.

Primary Health Care

Based upon principles of social equity, nation-wide coverage, inter-sectoral convergence as well as individual & community Involvement, it consists of at least 8 essential elements which integrate the preventive, promotive and curative services at the field level. Primary health care through health, hygiene and dietary education, immunization, early diagnosis & treatment, timely identification of high risk cases etc. helps in preventing any serious illness.

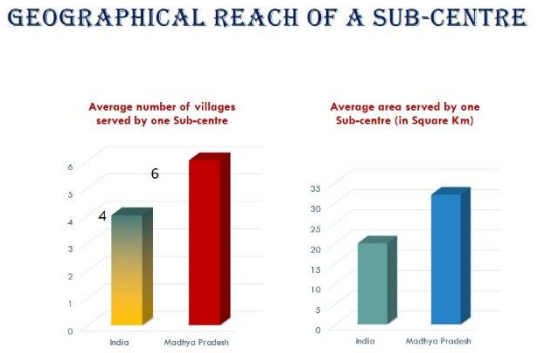


World Health Assembly in May 1977 resolved that main social target of governments as well as WHO in coming decades should be the attainment by all citizens of the world by year 2000 -- A level of health that will permit them to lead a socially and economically productive life-- which in year 1978 culminated in International objective of "Health for All" popularly called Alma-Ata declaration, named after the beautiful Kazakhstan city. It proclaimed Primary Health Care as key to achieve this goal. Keeping this in view, Govt. of India evolved a National Health Policy 1983-- based on Primary Health Care Approach.

Health Care delivery system in India

Based upon the recommendations of Srivastav Committee in 1975, Govt. of India launched 'Rural Health Scheme' in year 1977 -- A 3-Tier system of Health Care delivery in Rural Area. Amongst the 3-Tier system of Rural Public Health Care delivery in the country, sub-centre is the most peripheral outpost of health care delivery chain. Established for every 5000 population in general and for every 3000 persons in hilly, tribal and backward areas; It is manned by single or two ANMs & a Male Health Worker. Sub-centre provides all basic primary care services such as immunization, antenatal/ natal/ postnatal services, Counselling etc. apart from elementary drugs for minor ailments such as ARI, diarrhoea, fever, anaemia, worm infestation etc.

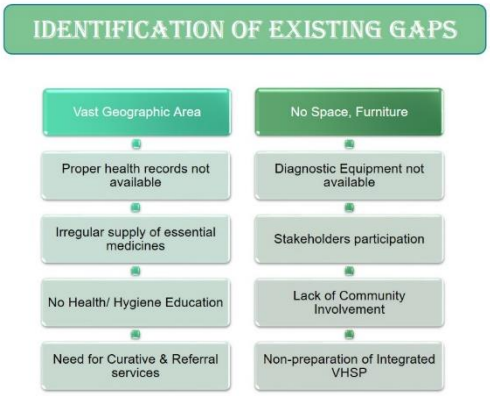
One sub centre covered an average of 4 villages spread over 20 square km in country; and average of 6 villages scattered across 32 sq km in sparsely populated state of MP; with some centres in interior forest and tribal areas having, nearest sub centre being more than 10 km on foot.



We realised that 'by incorporating the principles of Primary Health Care', almost all of these services can be easily made available at each & every village provided some space, basic equipment, minimum training and coordination can be ensured at that level. Together, in association with ICDS functionaries rendering supplementary nutrition, counselling, health & hygiene education, these can be efficiently delivered to all age groups.

Also a permanent organized health facility will facilitate convergence & coordination with panchyat, education and public health engineering staff for provision of safe drinking water, sanitation, solid & liquid Waste management, health & hygiene awareness; leading to preparation of a 'Joint Integrated Action Plan on Health' by facilitating regular interaction amongst all stakeholders through creation of permanent platform in the village itself.

Identification of existing gaps—



Before implementation of this plan, ANM & Male HW would go to every village once a month for monthly immunisation day with a vaccine carrier in hand and due list on a piece of paper. It was humanely not possible to take along the equipment required for even basic antenatal examination, mandatory requirement for monthly visit. Necessary equipment, for e.g. BP apparatus, hemo-globinometer, stethoscope or fetoscope or diagnostic kits were also not available.

In most of the villages it was being conducted at anganwadi centres; or in school campus; mostly without even having the necessary furniture or examination table; leave apart availability of private covered space. They will simply go and ask for a chair or two from them and complete their immunisation before rushing back to their sub centre or home. Large number of registers being maintained mainly at the sub-centre faraway, it was neither available for any use nor regularly updated.

Irregular demand, lack of proper storage and inventory records along with supply chain system to replenish the stock of either ASHA, AWW or depot holder was responsible for frequent unavailability of emergency basic medicines to most of the residents.

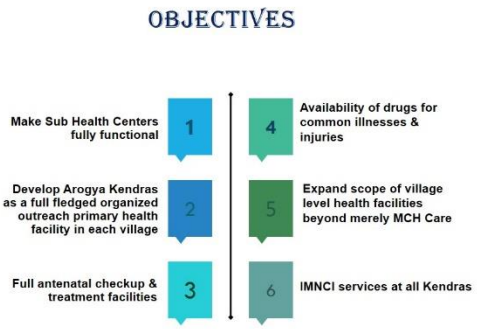
Need for coordination with ICDS and education was also necessary to impart health & hygiene education along with provision for regular child and adolescent health record; Joint effort of all stakeholders to detect and treat malnutrition and anaemia amongst them and better facilities, village level record maintenance, single point referral system was required.

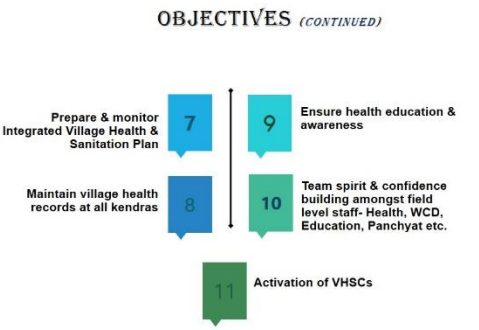
Coordination with panchayat and public health engineering department was necessary to ensure availability of safe drinking water and cleanliness, elimination of breeding places, proper disposal of liquid & solid waste including human excreta.

Forum for regular interaction with elected panchyat functionaries was required to prepare and follow Integrated Village Health & Sanitation Plan.

Objectives

So, our goal was to establish a single permanent centre where all these issues can be addressed and a platform for regular interaction where all health related activities concerning the village level community can be taken up.





Our first focus was identifying gaps in making existing sub health centres fully functional, before establishing Arogya Kendra as additional full-fledged primary health facility almost equivalent to sub centre guidelines; capable of providing Antenatal, IMNCI services and treatment for common injuries & illnesses.

Emphasis on team building amongst all stakeholders leading to development of integrated Village Health Plan after survey and identification of village specific problems.

Maintenance of health records of all families and individuals at village level itself was main objective and was necessary to ensure effective delivery and better planning.

Strategy

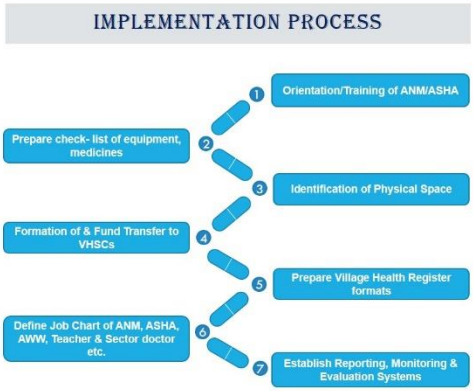
First and foremost task was to build capacity of all village level functionaries especially ASHA and Anganwadi workers. Standard treatment protocols and guidelines are of significant help. Functionalisation of VHSCs and guiding these to ensure availability of necessary space, infrastructure, equipment or instruments was an uphill task; but was carried out successfully; Credit goes to enthusiasm of village level health, ICDS and panchyat staff. Extension of medicine supply chain to village level through ANM/ Male HW was ensured.

Combining the efforts of different stakeholders, pooling of resources; and inculcating the sense of ownership & responsibility amongst them was most important component of the program.

Standard reporting and feedback proformas, MIS system as well as use of MCTS monitoring was done to monitor the progress of each and every centre.

Implementation Process

Orientation and training of all ANMs and ASHAs was done and panchyat secretaries functioning as Secretary of VHSCs were sensitised towards their duties. Coordination at both state and district level was necessary for any effective team building at lower level. 2011-12 was a phase when the issue of division of financial incentive for Jnani Suraksha Yojna between them was at its peak and some of them were not even on talking terms. Joint meeting and explanation of benefits to all; ANM, ASHA and AWW were quite helpful.



Availability of room space for Arogya Kendra was first requirement. Wherever possible a separate room lying vacant in old panchyat building, school or anganwadi was identified;

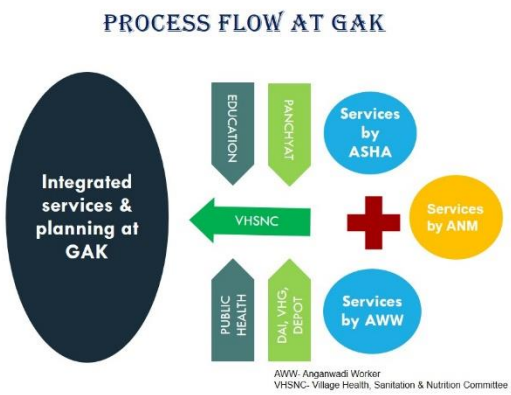
otherwise it was located within the existing anganwadi centre which was already functioning as monthly Vaccination site. Funds transferred to VHSC, made use of for making necessary infrastructure available. At places funds from panchyats were used for necessary repairs of the building. Some of the instruments and all the medicines were made available from PHCs. To ensure proper monitoring. Specified tasks were assigned to Sector, Block & District level medical officers. Slight changes were also made to job charts of ANM, ASHA and AWW, apart from clearly defining the role of school teacher and Panchyat secretary.

Anganwadi Cum Gram Arogya Kendra

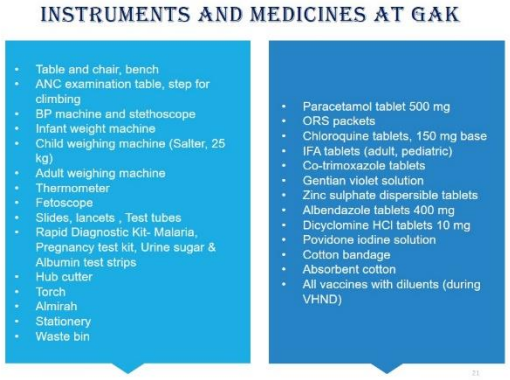
Later when district initiative was replicated all over the state, department of women and child development, facilitated with convergence by issuing an official order for setting up of a Anganwadi Cum Arogya Kendra in every village where ANM & ASHA can provide services and also conduct meeting for e.g. Coordination or VHSC meeting; do counselling sessions of Mothers or Adolescent girls, physical examination etc. after one pm when Anganwadi building is free.

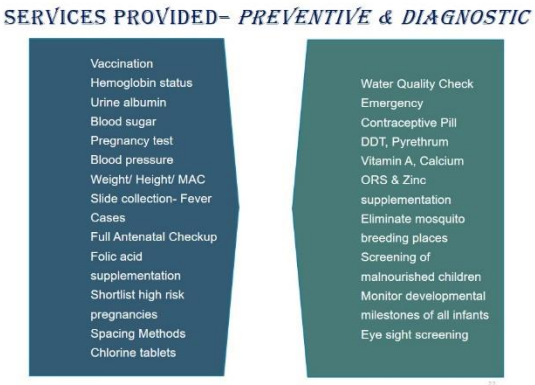
Flow of Services

As a model for horizontal convergence; Services provided by health functionaries get supplemented by efforts of other related department determining the social, educational & environmental dimensions under spectrum of health care intervention; different from medical intervention alone.



On vertical integration, it was ensured that wherever possible, ANM and Male HW visit at least every week or every fortnight; with sector doctor or RBSK/ AYUSH doctor at least every week. For this orientation of AYUSH doctors was also done at district level and they were of considerable help. Now ANM and Male HW was forced to stay in the village for whole of the day and providing full range of services; which also gave first hand training to assistant workers I.e. ASHA, AWW or Dai or VHG or Depot holder.





IEC funds from NRHM, ICDS scheme, Total Sanitation Campaign were used to depict health awareness messages and list out the facilities available at each Kendra.

Project Evaluation

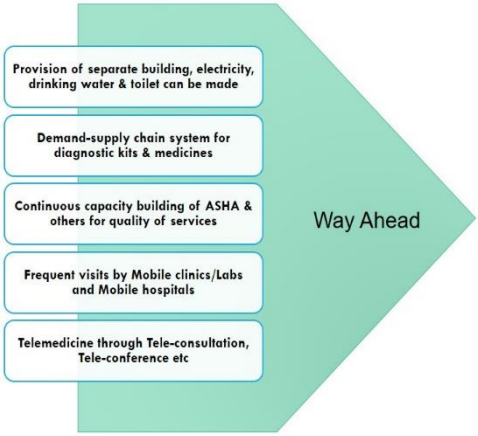
Relevance of intervention is judged from the purpose and facilities it intend to provide and the need for those services. It aimed to provide the basic health needs of the population by decreasing the social and geographical barriers.

It is quite feasible, provided ASHA workers and VHSC members are well oriented and regularly trained. It required no special building and extra financial/ human/ material resources.

In terms of cost effectiveness; Cost of establishing and buying the necessary equipment etc was Rs 10-20,000/- max and can be easily met from the annual fund provided to VHSCs by NHM. It is easily replicable across the country too, wherever ASHA or equivalent level worker is available.

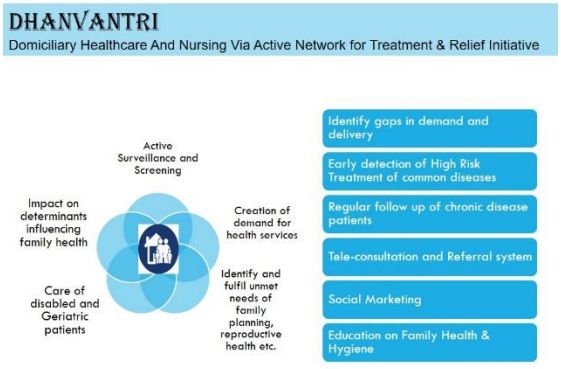
In terms of Impact- It also increased the facilities available for children and pregnant & lactating mothers at Anganwadi by providing furniture, drinking water or electricity.

In a study conducted by MP TAST Supported by DFID from April 2014, till the end of March 2015, 1020 GAKs have been assessed. Grading of the functional status of the GAKs based on assessment checklist with a total of 57 parameters, subgrouped into four areas. Based on this 29% Kendra got into Category A, 56% into Category B and 15% were placed in C Category.



DHANVANTRI

Domiciliary Healthcare And Nursing Via Active Network for Treatment & Relief Initiative



A step forward to Gram Arogya Kendra is the next initiative started by Dr. Sanjay Goyal in district Gwalior, focussing on the concept of proactive screening detecting high risk cases, missed cases and, diseased for prevention and early intervention, providing health services to all the family members in their home itself. Each ASHA worker will cover every family at least once a year and take full family history in detail in a designed format. Follow up of each identified cases shall also be done every month

along with delivery of prescribed medicines for them. Use of CUG and 3G Mobile for tele-consultation of patient with doctor and subsequent consultation appointment or elective surgery, if necessary is the heart and soul of this project. All these services are to be provided free of cost as economic impact of early detection and promotion of health seeking behaviour itself will lead to increase in efficiency & productivity of the workforce. She will deliver sanitary napkins, contraceptives etc at home through social marketing. Counselling on family health issues as well as providing health and hygiene education will be one of the main objectives of the home visit. Health visitor will also talk to reluctant females in home environment and identify unmet needs of family planning and obstetric or gynaecological and menstrual care services. Cornerstone of this intervention is identification of gaps in demand and delivery of essential services for e.g. Immunisation, Antenatal/ Postnatal Care, Adolescent & Child Nutrition. Domiciliary care of geriatric and disabled members of family is important component.

Recommendation

We shall aim to establish a fully equipped and functional separate GAK or Village level Health Centre at every village or at least at every panchyat headquarter of country in next five year plan for improved access and better delivery of integrated essential health care services.