SIHFW Rajasthan

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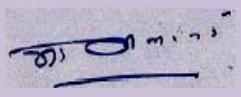
From the Director's Desk

Dear Readers,

Greetings from SIHFW!

The AAAs- ANM, ASHA and Anganwari Workers are three strong pillars of the State's health system under NHM for village/ local health services.

The AAAs, at the frontline, have a prime role in counselling and motivating community towards good health seeking behaviour. The AAA together form a team working in close coordination with each other. The coordination linkages and their specific role understanding have been described in the lead article of present issue of e-newsletter.



Information on Coordination and Communication links is being included in the newsletter to help readers supportively supervise AAAs in fields. We request you to observe functioning of the AAAs at the community level on following coordination and communication points and give them an immediate feedback. Kindly send us your relevant experiences.

The lead article shall also be helpful in formulating capacity building plans, supportive supervision tools and developing policy level recommendations, relevant to functioning of AAAs in the State.

We would solicit your feedback and suggestions.

Director

Inside:

Health and Social Days in May '14
International Labour Day May 1
International Red Cross Day May 8
International Nurses Day May 12
World No Tobacco Day May 31

AAAs: the Coordination Links

The AAAs - **A**NM (Auxiliary Nurse Midwife), **A**SHA –sahyogini (Accreditated Social Health Activist) and **A**WW (Anganwari worker) are the front line 'worriers' in the area of public health.

Each one of the AAAs are stands of the tripod which is the platform of health service delivery system. A close coordination and communication flow amongst them ensures good and quality service delivery specially in the areas with most difficult access.

The coordination of the AAAs stretches health service delivery beyond periphery of service delivery outlet specifically designed for the purpose and supported by resources (health facilities, Anganwari centres and MCHN day venues). The outreach of AAAs reaches homes of the masses, at the community level. This service delivery of AAAs includes care, check-ups, medication, counselling and awareness generation for the quantum of care for pregnant women, new born, infants, delivered mothers/ lactating mothers, adolescent girls, those married at an age earlier than 18 years and all community members for common or specific health problems such as Malaria, TB, Cold, Cough and Common fever and many more health conditions which required medical care.

All AAAs, are important links between the community and healthcare services and are expected to regularly coordinate with each other and various stakeholders, in order to ensure access and utilization of health care services by the masses.

ASHA's work consists mainly of five activities: Home visits, Community mobilization for MCHN day, Visits to health facility, Organising and Coordinating VHSNC activities and Maintain Records of service delivery and those who require the services.

The ANM provides services at the first level of the health system, which is the Sub-centre. But her main interaction with ASHA and Anganwari worker is through the MCHN Day.

Similarly, Anganwari worker is another local resident same as ASHA. She is incharge of the Anganwari centre which provides supplementary nutrition, Growth monitoring and Pre-school non-formal education.

For ASHA to be effective and to continuously improve her skills, ASHA needs support and mentoring while she works in the community. The support mainly comes from ANM, ASHA Facilitators and AWW. This is how the AAAs are expected to work together as a village health team.

ASHA and MCHN

- Common platform for people to access services
- Held at AWC
- Once every month

Who will attend

- Members of the PRI
- Women members of the community
- Pregnant women
- Women with children under two
- Adolescent girls
- General community members

Role of ANM

- Immunization-to pregnant women and children
- ANC care to pregnant women
- Counselling and contraceptive services to eligible couples
- Basic level curative care for minor illness with referral

What should ASHA do?

Make a list of the following-

- Pregnant women for ANC care and mothers needing PNC
- Infants who need their next dose of immunization
- Malnourished children
- TB patients who are on anti-TB drugs
- Those with fever who have not been able to see a doctor or need follow up
- Eligible couples who need contraceptive services or counselling
- Any others who need care by ANM

Ensure presence of the above

ASHA should consider including-

- In the list
- Individuals from families of new migrants
- Living in distant hamlets
- Vulnerable persons because of poverty or marginalized

Coordination with ANM and AWW

- Coordinate with ANM and AWW to know in advance which day the MCHN day is scheduled
- Location of MCHN day
- So as to inform those who need these services and the community, specially the VHSNC members

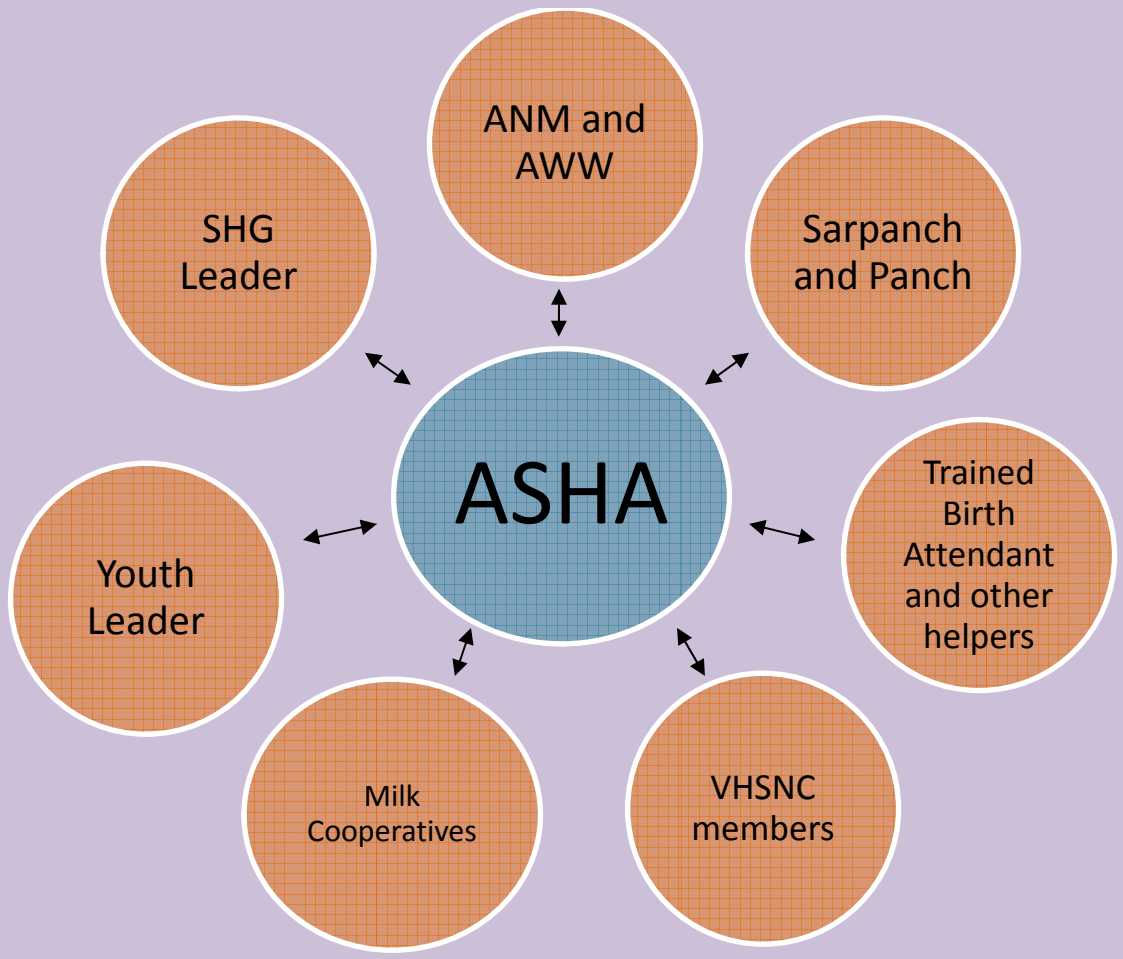
Coordination Linkages
The AAAs need to coordinate with various health functionaries for:

- Obtaining and updating information on decisions taken at the PHC or at the Integrated Child Development Officers' level on schemes and programmes related to health service provision
- Sharing concerns regarding the access to health care and nutrition services at the village level
- Planning health activities to get optimum outcome like-a health camp at the village level or organise MCHN
- Ensuring timely referrals for pregnant women and sick children when needed

Coordination Matrix of AAAs

Activity	ANM	ASHA	AWW
Home visits	• Priority to families where ASHA having difficulty in motivating for changing health seeking behaviour • Non-users of MCHN day • Home-base services for post-partum mothers, sick newborn and children who need referral but are not able to go	• Health education • Care in illness • Priority to households with pregnant women, newborn, postnatal mother, children under two, a households with malnourished family member/s • Maintain her drug and equipment kit	• Nutrition counselling • Supportive role on childhood illness
MCHN Day	**Service Provider** to deliver- • Immunization • Antenatal care • Identification of complications • Family Planning Services	**Social mobilisation** for • Women and children to utilize services at MCHN • Marginalised groups • Enabling access to health care and entitlements (through motivation and counselling)	**Anganwari Centre is the venue** AWW provides – • Support • Take Home Rations to pregnant, lactating mothers and children under three. On usual days other than MCHN keeps a track of malnutrition under five years on monthly basis and provides nutrition and counselling
VHSNC	**Support to ASHA** • In convening meeting • Village health planning • Rolling out of plans	Convener of the activities- meetings, preparation of Village Health Plans	**Support ASHA** • In convening meeting • Village health planning • Rolling out of plans
Escort or mobilisation services	• Ensuring provision of good quality services • Assist community to avail JSY benefits • Encourage and recognize ASHA (when delivered at her facility)	**Voluntary Escort** • As per requirement and feasibility • Can be done for delivery • Mobilize community for institutional delivery	
Record maintenance	Maintain tracking register and record of service delivery for services given to pregnant women and children below two years of age	• **Drug stock card** • Diary for individual work record • Register to assist and organise her own work • Identification of beneficiaries who need services through these records	Maintain tracking register for record of service delivery to- • pregnant and lactating mothers • children, • weight children and five years of age • Growth charts

Coordination Cycle of AAAs



List of Services to be provided on MCHN Day

Maternal health

- Early registration of pregnancies.
- Focused ANC
  - Complete history of the current and previous pregnancy and any medical/surgical problem in the past
  - Weight, BP, Blood test for Hb, urine and abdominal examination
  - 100 IFA tablets and TT
  - Counselling on nutritious diet and proper rest
  - Identification of High Risk Pregnancy
  - Danger signs during pregnancy.
  - Referral, if needed and counselling for precautions
  - Birth preparedness
  - Institutional delivery.

- Referral for safe abortion to approved MTP centres.
- Counselling on Care during pregnancy.
- Importance of nutrition.
- Identification of referral transport.
- Availability of funds under the JSY for referral transport.
- Post-natal care.
- Breastfeeding and complementary feeding.
- Organizing group discussions on maternal deaths, if any, that have occurred during the previous month in order to identify and analyse the possible causes.

Child Health (Infants to 5 years)

- Registration of new births.
- Counselling for care of newborns and feeding.
- Complete routine immunization.
- First dose of Vitamin A along with measles vaccine.
- Growth monitoring.
- Table IFA – (small) to children with clinical anaemia.
- Provision of supplementary food for grades of mild malnutrition and referral for cases of severe malnutrition
- Tracking and vaccination of missed children by ASHA and AWW and Immunization for dropout children.
- Case management of those suffering from diarrhoea and Acute Respiratory infections.
- Counselling to all mothers on home management and where to go in event of complications.
- Organizing ORS depots at the session site.
- Counselling on nutrition supplementation and balanced diet.
- Counselling on and management of worm infestations.

Family Planning

- Information on use of contraceptives.
- Distribution – provision of contraceptive counseling and provision of non-clinic contraceptives such as condoms and OCPs.
- Information on compensation for loss of wages resulting from sterilization and insurance scheme for family planning.

Care and Counselling for

- RTI/STI
- Sanitation
- Communicable diseases
- Counselling on Education of girls, Age at marriage and Gender Issues
- AYUSH services
- Health promotion-tobacco, Healthy lifestyle

Key IPC (Inter Personal Communication) Skills required by AAAs

1. When frontline workers have to meet family members/house visit, they should always greet and explain the purpose or intention of visit.
2. AAAs should learn and practice maintaining eye contact with the community, with confidence but in polite language, full of respect for everyone.
3. Talk to the point so that wastage of time can be avoided. Use of technical terminologies and extra load of difficult words should be avoided.
4. Use simple and local language words. Keep your pronunciation clear.
5. Talk with honesty and straightforwardly.
6. Be understanding to circumstances and motions of community members.
7. Be a good listener. This will help you understand people better. While talking to community members ask for doubts or queries, if any. If yes, clarify in simple language.
8. Praise community members for raising queries and never return without a word of acknowledgement, gratefulness or appreciation.

Points AAAs should keep in mind for Communication Amongst Each Other and Stakeholders

1. Give due respect to all stakeholders, either from the community level or service providers level
2. While exchanging information with stakeholders ensure that you have all the data and evidential documents with you.
3. Never put information causally. This has to be presented with clearly expressed expectations from the staff/stakeholders, changes required and to be continued in future.
4. Be polite in discussions. Do not express unnecessary worries and blame each other.

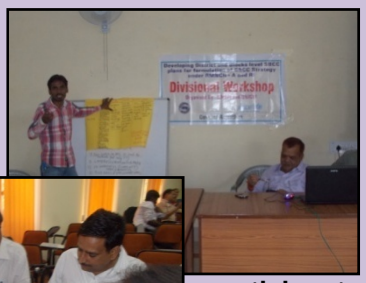
Social and Behaviour Change Communication (SBCC) activities to be done for better implementation of MCHN Days

- Care in pregnancy, including nutrition, importance of antenatal care and danger sign recognition
- Planning for safe deliveries and postnatal care
- Exclusive breastfeeding and the importance of appropriate complimentary feeding
- Immunization: the schedule and the importance of adhering
- Importance of safe drinking water, hygiene and sanitation, and discussion on what actions can be taken locally to improve the situation
- Delaying the age at marriage, postponing the first pregnancy and the need for spacing
- Adolescent health awareness, including nutrition, retention in school till high/higher secondary level, anaemia correction, menstrual hygiene and responsible sexual behaviour
- Prevention of Malaria, TB and other communicable diseases
- Awareness on prevention and seeking care for RTI/STI and HIV/AIDS
- Prevention of tobacco use and alcoholism

Trainings, Workshops and Meetings

Divisional Workshops for development of SBCC plans for 10 HPDs

It was decided in collaboration with DPs to organize divisional level workshops on IEC/SBCC for RMNCH+A and Routine Immunization and engage district level stakeholders in the finalization of operational plans. The 10 HPDs are divided in four zones-Bharatpur, Jodhpur, Kota and Udaipur. With this objective, **one-day divisional level workshops** were organised at Jodhpur, Udaipur and Jaipur (for Bharatpur and Kota zone HPDs), on 11th, 12th and 15th April, 2014 respectively. The workshops were organised under partnership and collaboration of SIHFW UNICEF. The workshops were held under chairmanship of Dr. M.L. Jain, Director SIHFW and Ms. Girija Devi, Communication for Development Specialist, UNICEF.



There were totally **124 participants from the 10 HPDs** including Jalore, Jaisalmer and Barmer (41), Dungarpur, Banswara, Rajasamand and Udaipur (52), Dholpur, Karauli and Bundi (31).

The participants were a mix of district level managers, block facilitators and frontline workers- 3 AAAs (ASHA) Anganwadi worker and ANM) . The comprised of CMHO/RCHO/Divisional Coordinator, District IEC Coordinator, District ASHA Coordinator, and Focused District Coordinator of development partners, BCMOs, ASHA Supervisors, ASHA facilitators, ANM, ASHA and Anganwari workers.

Representatives from the Development Partners –UNICEF, UNFPA, NIPI, EARTH including Ms. Girija Devi, Dr. Anil Agrawal, Mr Sunil Thomas, Ms Vaedehi, Ms Shibumi, Mr Vinod, Ms Akansha were also present.

The sample draft plans were developed keeping in mind the performance of the district and blocks as per the dashboard monitorable indicators. These district and block plans will be further detailed out, reviewed and compiled for state action plans by the core group at SIFHW with concerted nodal officials of the department.

ASHA ToT Training at Gadhchiroli, Maharastra

State level Trainers team of Round 2 of ASHA module 6&7 was developed for strengthening of ASHA capacity building interventions in the state. State Institute of Health and Family Welfare, Rajasthan has prime responsibility of implementing and coordinating all trainings related to ASHA Programme.

Under guidance of Dr. M.L Jain, Director SIHFW and in consultation of NHSRC, New Delhi, the trainings are being implemented in Rajasthan.

The ToT was organised at National level Training Centre-Gadhchiroli, Maharastra during 24 March to 9 the April 2014. Ten participants have received this training in this batch. Participants from SIHFW included Mr Hemant Yadav and Mr Ezaz Khan.

Supportive Supervision and Mentoring visits

Teams of SIHFW Staff, Focused District Coordinators ad UNICEF consultants visited Jalore and Barmer district during 21 to 23 April, 2014. This was an activity of Block Monitoring. The activity was done in guidance of Dr M.L. Jain, Director, SIHFW.

Team for Barmer district included Dr Mamta Chauhan, Dr Richa Chaturvedy and Mr Aseem Malawatat (SIHFW) and Mr Vinod, Mr Shashank (UNICEF)

Teams of Jalore district comprised of Dr Vishal Singh, Ms Archana and Ms Aditi (SIHFW) and Dr Apoorva Chaturvedi and Dr Pallavi and Mr Indrapal (UNICEF).

The teams visited Sub-centres, Primary health Centres, Community health centres and District Hospitals. The activity included interactions and feedbacks from community (service users).

The identified gaps were then de-briefed in presence of CMHO and other district stakeholders, under chairmanship of Dr. M.L. Jain, Director SIHFW, at District Headquarters.Dr Sanjeev Gupta of UNICEF also participated in the de-briefing session at Barmer and Jalore.

Workshop on Delivery Points

A workshop on orientation of the MO I/Cs, Labor room I/Cs, BPMs, LHVs & ANMs of various delivery points (DH/SDH/CHC/PHC/SC) of Dholpur District was organised on 11th – 12th April 2014 at Seminar hall of Zila Parishad, Dholpur.

The objectives of the workshop were to assess the working of the delivery points and discussion on the points of improvement during the workshop and to improve the quality of services provided in the labor room. The workshop was also a platform to review of the health status with focus on maternal health & child health of the district with state health officials, including Dr.J.P.Singhal, Director RCH, DM&HS, Jaipur, Dr. R.P.Jain, PD Maternal Health & Immunization, DM&HS, Jaipur and Dr Girish Dwivedi, Project Director Child Health, DM&HS, Jaipur.

Resource Persons from Development Partners included Dr. S.P.Yadav,SSPO, NIPI, Dr. Sushila Saharan, Consultant – MH (RMNCH+A) UNFPA, Dr. Sanjeev Gupta, Consultant – Child Health, UNICEF.

From the district, CM&HO, RCHO, BCMOs, Labour room in-charges, Staff Nurses/ ANM Delivery points & DPM, BPM, BAF with other health officials were present. Mr. Sunil Thomas, State Programme coordinator, UNFPA & Mr. Rajesh Pachori, Divisional Family Planning Coordinator, UNFPA were the key resource persons to facilitate the workshop, which was coordinated by Dr Rajni Singh of SIHFW with logistics support from Mr Syoji.

Orientation Workshop of Trainers for training of Female Medical Officers

An orientation workshop of trainers was held on 4 April 2014 at SIHFW. Dr. M. L.Jain, Director SIHFW and Shri Neeraj K Pawan, AMD, Director IEC co-chaired the workshop with a key note address.

The workshop envisaged orientation of the female doctors towards improving maternal health, skill strengthening training of female Medical Officers working at PHCs/CHCs for conducting normal deliveries, identification of complicated deliveries, its management and timely referral. There was a consensus that Female Medical Officers shall be trained at the Medical Colleges. The orientation was done for Master Trainers from Medical Colleges.

Monitoring/ Visits done by SIHFW personnel

Sno	Name	Place/District	Activity/Training
1	Dr M.L. Jain	Jalore and Barmer	Block monitoring under Supportive supervision and Mentoring Visits
2	Dr Vishal, Archana and Aditi	Jalore	
3	Dr Mamta, Dr Richa and Mr Aseem	Barmer	
4	Mr. Mohit Dhonkeriya	Kaman-bharatpur	HBNC+ monitoring on 21-22 by
5	Mr Anil Sharma	Tonk and Sawaimadhopur	ASHA monitoring and Hand-holding

Celebrations!

Birthdays of Dr Bhumika Talwar, Dr. Richa Chaturvedy, Ms Reena Miglani and Ms Archana Saxena were celebrated together in month of April, 2014, at SIHFW.

Visitors & Training Feedbacks

- Neatness at SIHFW was liked most
- Teaching faculty solved all queries
- A very nice organization and very helpful people

Source: Visitor Book and Training feedbacks

Health News

Global

WHO's first global report on antibiotic resistance reveals serious, worldwide threat to public health

New WHO report provides the most comprehensive picture of antibiotic resistance to date, with data from 114 countries

A new report by WHO–its first to look at antimicrobial resistance, including antibiotic resistance, globally–reveals that this serious threat is no longer a prediction for the future, it is happening right now in every region of the world and has the potential to affect anyone, of any age, in any country. Antibiotic resistance–when bacteria change so antibiotics no longer work in people who need them to treat infections–is now a major threat to public health.

"Without urgent, coordinated action by many stakeholders, the world is headed for a post-antibiotic era, in which common infections and minor injuries which have been treatable for decades can once again kill," says Dr Keiji Fukuda, WHO's Assistant Director-General for Health Security. "Effective antibiotics have been one of the pillars allowing us to live longer, live healthier, and benefit from modern medicine. Unless we take significant actions to improve efforts to prevent infections and also change how we produce, prescribe and use antibiotics, the world will lose more and more of these global public health goods and the implications will be devastating."

Key findings from the report include:

- Resistance to the treatment of last resort for life-threatening infections caused by a common intestinal bacteria, *Klebsiella pneumoniae*–carbapenem antibiotics–has spread to all regions of the world. *K. pneumoniae* is a major cause of hospital-acquired infections such as pneumonia, bloodstream infections, infections in newborns and intensive-care unit patients. In some countries, because of resistance, carbapenem antibiotics would not work in more than half of people treated for *K. pneumoniae* infections.
- Resistance to one of the most widely used antibacterial medicines for the treatment of urinary tract infections caused by E. coli–fluoroquinolones–is very widespread. In the 1980s, when these drugs were first introduced, resistance was virtually zero. Today, there are countries in many parts of the world where this treatment is now ineffective in more than half of patients.
- Treatment failure to the last resort of treatment for gonorrhoea–third generation cephalosporins–has been confirmed in Austria, Australia, Canada, France, Japan, Norway, Slovenia, South Africa, Sweden and the United Kingdom. More than 1 million people are infected with gonorrhoea around the world every day.
- Antibiotic resistance causes people to be sick for longer and increases the risk of death. For example, people with MRSA (methicillin-resistant *Staphylococcus aureus*) are estimated to be 64% more likely to die than people with a non-resistant form of the infection. Resistance also increases the cost of health care with lengthier stays in hospital and more intensive care required.

Source: WHO/mediacentre/30 April, 14

Low cholesterol slows HIV progression

"A fascinating aspect of the AIDS epidemic is that a small percentage of HIV-1-infected persons maintain a relatively normal number of CD4 T cells (Th cells) and low viral load for many years without receiving antiviral therapy," said Giovanna Rappocciolo from University of Pittsburgh.

Knowing how these individuals naturally control their HIV-1 infection and prevent the virus from progressively destroying their Th cells could be critically important to developing effective therapeutic and prevention strategies for HIV-1/AIDS, she added.

When HIV enters the body, it is typically picked up by immune system cells, called antigen-presenting cells (APCs), including dendritic cells and B lymphocytes.

Those cells then transport the virus to lymph nodes where the APCs pass it to other immune system cells, including Th cells, via a process known as trans infection.

HIV then uses Th cells as its main site of replication.

"It is through replication in the Th cells that levels of HIV increase and overwhelm the immune system," she noted.

In the study Rappocciolo and her colleagues compared the ability of APCs from non-progessors, progressors and uninfected control subjects to trans infect T cells.

They found that while the cells from progressors and control subjects were highly effective at mediating trans infection, those from nonprogressors lacked the ability.

The researchers took a closer look and discovered that the APCs from nonprogressors had low levels of cholesterol, even though the patients had regular levels of cholesterol in their blood.

This defect in cholesterol metabolism is not a direct consequence of virus infection.

Rather, it is likely present as an inherited trait in a low percentage of individuals.

"Understanding how this works could be an important clue in developing new approaches to prevent progression of HIV infection," Rappocciolo said. Source: TOI, 29 April, 2014

Pregnant women with high BP at risk

Researchers have said that pregnant women with chronic hypertension (high blood pressure) are highly likely to suffer from adverse pregnancy outcomes such as preterm delivery, low birth weight and neonatal death.

Chronic hypertension complicates between 1-5 per cent of pregnancies, and the problem may be increasing because of changes in the antenatal population.

Researchers from King's College London carried out a study to assess the strength of evidence linking chronic hypertension with poor pregnancy outcomes. They combined data from studies from 55 studies done in 25 countries.

The researchers looked at the following outcomes: preterm delivery (delivery before 37 weeks' gestation); low birth weight (below 2500g); perinatal death (fetal death after 20 weeks' gestation including stillbirth and neonatal death up to one month) and admission to neonatal intensive care or special care baby units.

The relative risk of pre-eclampsia (a condition in pregnancy characterised by high blood pressure) in women with chronic hypertension was on average nearly eight times higher than pre-eclampsia in non-hypertensive women. All adverse neonatal outcomes were at least twice as likely to occur, compared with the general population.

The researchers conclude that "chronic hypertension is associated with a high incidence of adverse pregnancy outcomes compared with a general population".

The study has been published in the *British Medical* journal. Source: ANI, 24 April, 2014

India

Stress number one lifestyle risk among Indian employees'

Stress is the number one lifestyle risk factor among Indian workers, ranking above physical inactivity and obesity, according to a survey conducted by professional services company Towers Watson.

Major causes of stress, according to the surveyed employees in India, include unclear or conflicting job expectations (40 percent), inadequate staffing and lack of support, uneven workload or performance in group (38 percent) and lack of work/life balance (38 percent).

In Asia Pacific, the top contributors were inadequate staffing, low pay (or low increase in pay) and lack of work/life balance.

Globally, inadequate staffing is common as the single most important contributor to work-related stress, according to Towers Watson's Global Benefit Attitudes Survey that polled 22,347 global workers out of which 7,094 workers are in Asia Pacific (2006 workers from India).

The survey highlights that the main sources of stress for employees across the globe are tied to their experience at the workplace.

While Indian employers lead their regional counterparts in developing strategies to manage work-related stress, only 38 percent identified improving the emotional and mental health of employees (i.e. lessening the stress and anxiety) as a top priority of their health and productivity programmes. "This signals a vast scope for improvement in strategic initiatives aimed at tackling stress among Indian employees," Towers Watson said in the survey report.

Globally, the causes of poor health are remarkably similar; however, the tools, abilities and resources needed to address these vary greatly across regions.

"Nonetheless, multiple issues related to stress are driving the need for a greater organisational commitment that extends beyond employees' physical and mental health; one that encompasses the work environment, culture and interpersonal relationships that connect employees to the mission and goals of the organization," it said. Source: TOI, 24 April 2014

Rajasthan- Key health Indicators

Sno	Indicator	value	Source
1	Sex Ratio	926 (Females per 1000 males)	SRS 2011 and Census: 2011(Rajasthan)
2	CBR	25.9	SRS 2011 and Census: 2011(Rajasthan)
3	CDR	6.6	SRS-11
4	IMR	49	SRS –Bulletin Sep 2013
5	MMR	208	AHS 2012-13
6	TFR	2.9	NRHM-India

We solicit your feedback:

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