A Revolutionary Concept for RCH II and NRHM in Maharashtra

Background

In 1985, IHMP introduced the concept of monthly surveillance and micro-planning for the MCH and Immunization programmes, which was replicated all over Maharashtra. In 1996, the Institute was commissioned by the World Bank and GoI for designing the Information Education and Communication component of the RCH - I programme. Based on this experience IHMP has adapted 5 innovations for effective implementation of RCH II under the National Rural Health Mission (NRHM), in Maharashtra.

5 Innovations in Health Care Delivery

The following 5 innovations have been successfully tested in Maharashtra for:

1. All eligible couples under the RCH II programme in one block (7 PHCs),
2. Maternal and neonatal health in the slums of 7 municipal corporation areas
3. Reproductive health of young eligible couples in 5 backward districts.

What are the 5 Innovations?

1. **Monthly Surveillance** – Is a process of assessing reproductive health needs of eligible couples on a monthly basis. One ASHA is appointed for every 1000 population or 200 households. The ASHA visits 10 households a day, covering 200 households in 20 days to identify the health and information needs of young married women on a monthly basis. They are provided with a simple tool that enables them to collect this information.

2. **Micro-planning** – Data collected by the ASHAs on the specific health and information needs of each woman, forms the basis of micro-planning. ASHAs prepare a list of women with details of their reproductive health needs. They hand over the list to the ANMs every month. Examples of health needs are: need for pregnancy confirmation, ANC registration and care, contraceptives, hospital delivery, RTI treatment, etc.

3. **Behaviour Change Communication (BCC)** - A new paradigm in behavior change communication has been developed by Institute of Health Management, Pachod. During monthly household visits the AHSAs use simple algorithms to assess the information needs of each client and make a behavioural diagnosis. ASHAs provide need specific BCC and counseling based on behavioural diagnosis. For example –
   - ASHA visits a household where marriage of an adolescent girl is being considered. She tells them about the risks involved in early marriage and first birth and counsels them to delay her marriage till 18 years of age.

4. **Active linkage of clients with the ANM and other health providers** – The ASHAs inform all the women identified during surveillance about the date and time when the

ANM will hold the village clinic. On the stipulated date she takes all her clients to the ANM. She also accompanies women with danger signs to referral facilities.

5. **Community Based Monitoring** – At the end of each month the ASHA convenes a Village Health, Nutrition, Water Supply and Sanitation Committee meeting. During the meeting the ASHA submits the list of eligible couples, in need of services. The ANM submits the list of eligible couples to whom she has provided services or referral advice. By comparing the health needs assessed by ASHA and the health needs addressed by the ANM, the VHSC monitors the health delivery system on a monthly basis.

The Potential of ASHAs: Effective implementation of the 5 innovations is dependant primarily on the ASHA. 45,000 ASHAs have been trained in Maharashtra. The introduction of these 5 innovations could bring about a revolution in health care delivery in the State.

What outcome can be expected after 18 to 24 months of intervention?

- Significant increase in contraceptive use by 40 percent points
- Delay in age at first birth by 1 year
- Increase in interval between 2 births by 4 – 6 months
- Early antenatal registration increase by 30 – 40 percent
- Increase in use of minimum antenatal care by 40 %
- Increase in institutional deliveries by 10 percent points
- Increase in use of post natal care services by 60 percent points
- Increase in treatment for reproductive tract infections – by 20 percent points
- Increase in pregnant women testing for HIV by 50 percent points
- Reduction in prevalence of Low Birth Weight babies (LBW) by 5 – 10 %
- Reduction in prevalence of antenatal, delivery and postnatal complications
- Several maternal and new born deaths averted

What can a District Administrator do?

1. Arrange for orientation of the District Society and health staff – no additional cost
2. Include training of ASHAs for the 5 systems in the scheduled 6 module training (1 day out of each training module of 4 days duration) No additional cost
3. Depute NRHM and PHC staff for training in 5 innovations – (3 days training).
4. Introduce the surveillance register for ASHAs – Cost Rs. 300 per ASHA
5. Introduce the New Paradigm in Need specific BCC – Cost Rs. 400 per BCC kit.
6. Ensure that health delivery matches the rapid increase in demand for services
7. Introduce the protocol for Community based monitoring by VHSCs
8. Review the innovations on a monthly basis at the district level