

**7th National Summit on Good and Replicable  
Practices and Innovations in Public Health Care  
Systems in India**

(Category: Health Programs)

**Comprehensive Primary Health  
Care in a Remote tribal block  
(Part of Pushprajgarh Health and Nutrition Initiative)**

National Health Mission, Madhya Pradesh in technical collaboration  
with Jan Swasthya Sahayog

**Comprehensive Primary Health Care**

Primary health care became a key term in India's health related planning right from independence. The term 'Primary Health Care' was introduced in India's health realm by Sir Joseph Bhore through the 'Health Survey and Development Committee' report published in 1946. The committee recommendations laid the foundation of a three tier health system with emphasis on building a network of peripheral health centres like Primary Health Centres to provide integrated promotive, preventive, curative and rehabilitative services to both rural and urban populations. Huge disparities still remain and access to healthcare in rural areas still remains a huge challenge. Pushprajgarh Health and Nutrition Initiative (PHNI) is a step towards reducing these health disparities and inequalities in Pushprajgarh block of Anuppur district, a remote and underserved part of the State of Madhya Pradesh.

Pushprajgarh Health and Nutrition Initiative (PHNI) is an Initiative started in the year of 2018. Program was initiated to improve the issues of high maternal and child mortality and malnourishment in children and adults. Major objectives of the program are to improve community's access to healthcare, to improve the quality of primary health care services and to improve the nutritional status of under-three children in the program area. PHNI is implemented under two heads namely Phulwari Program and Comprehensive Primary Health Care Program, out of which the later one is presented in this document.

### **Need of Intervention**

Primary healthcare is the first level of contact that individuals and communities have with the health system. Primary care responds to the broad health needs and the epidemiological priorities of the community. This implies that a primary care approach should also address underlying social and environmental determinants of poor health. The term 'comprehensive care' is used to refer to the full continuum of care, spanning both acute and chronic, all specialities and levels of care. In its role to ensure access to comprehensive health services, primary care acts as a hub to guide people through a health system ([WHO 2008](#)). The notion of equity and access is central to the primary health care model, ultimately aimed to ensure 'Health for all' ([Landscaping of Primary Healthcare in India](#), 2016).

In order to achieve the goal of health and well-being to all by 2030 as mentioned in National Health Policy 2017, it is important to cater to and strengthen health services in most deprived areas and set a model that could be replicable in other parts with necessary modifications according to the local needs. 'Comprehensive Primary Health Care' part of PHNI caters to 49,000 population residing in around 50 sq.km area of 75 villages of Karpa and Titahi-Jaithari sectors of Pushprajgarh block of Anuppur district. The surveys conducted by Jan Swasthya Sahayog (JSS) in early 2018 revealed following challenges

1. Healthcare infrastructure is not in good condition which leads to non-functional health facilities
2. Referral transport service is unreliable. It is very difficult for the local population to avail private health services as well, because the majority of the population is tribal population

involved in farming activities who cannot afford it. The quality of privately provided services is another challenge in the area.

3. Human resources at health facilities is not adequate

Thus, despite government schemes to encourage institutional care during pregnancy and childbirth, less than 30% deliveries are in public health facilities, and fewer than 40% get 2 or more ANC checks done. No wonder that maternal and perinatal mortality are high, often undocumented in these remote areas.

Thus, PHNI was initiated in these two sectors considering the dire need of accessible and quality primary health care in the given geographical areas.

**Description of the Model**

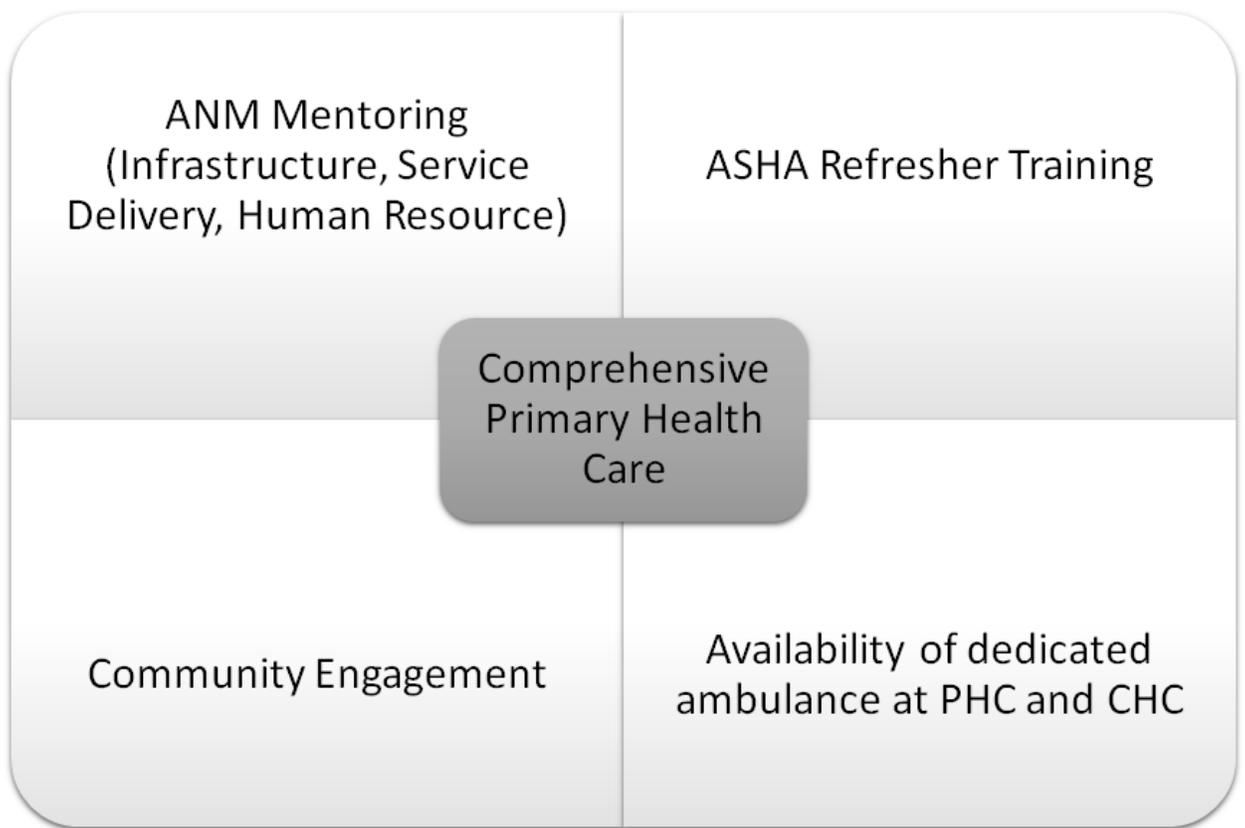


Figure 1. Components of 'Comprehensive Primary Health Care' intervention

**ANM Mentoring**

Baseline assessment surveys conducted by JSS in the project area revealed that the 14 health facilities i.e. 12 Sub Health Centres (SHCs), 1 Community Health Centre(CHC) and Primary Health Centre (PHC) need different kinds of inputs like significant infrastructural

improvement (including basics like water, electricity and septic tanks), human resource requirements, requirement of equipments and furniture, making medicine supply regular etc. Thus, although the name of this component is ‘ANM Mentoring’, this component is a package of **all end to end activities (the well known pillars being Staff, Space, Stuff and Systems)** which are needed to make SHC functional. **Infrastructural improvements include buildings for SHC, buildings for ANM residence, compound walls, availability of water, electricity connection and electrical fittings etc.** So, almost the initial year of implementation was utilized to fulfill infrastructural requirements of SHCs.

For effective functioning of SHCs it is necessary to have **adequate human resources appointed**. Thus, the next step in making SHCs functional was to get **two ANMs appointed in each SHC as per IPHS norms**. Along with government ANMs, **ANMs mentors** were appointed at each SHC for ‘supportive supervision and mentoring’. The SHCs where a number of ANMs were less than two or they were not living at SHC, ANM mentors also contributed for service delivery at SHC. **1 caretaker for each SHC** was also appointed for daily sanitation and maintenance. (Highlighting these two additional cadres to make the system function well – the ANM mentors and the Care taker.)

Village Health Sanitation and Nutrition Day (VHSND) are most important for ensuring health and well being in the villages. ANM provides a number of services including MCH services. **Training and hand-holding ANMs** in this process by the mentors helped to improve the quality of these services. ASHA refresher training also helped to improve people’s participation in VHSND.

### **ASHA Refresher Trainings**

ASHA is the community health worker who works on the ground and acts as a link between health service centers and community. Thus, it is important that ASHAs get quality training and they are equipped enough to carry out their responsibilities effectively. It was observed that induction training for ASHAs happens only once when ASHA is appointed. It is difficult for a village woman to grasp everything in one go, hence it was important to have refresher training for ASHAs. **These trainings were arranged once in a month and in the same sector where ASHA belongs so that she does not need to travel to the district for training.** The training was based on ASHA modules prepared for the induction training. ASHA Sahayoginis were also involved in these training sessions.

No explicit infrastructure was needed for these trainings as existing, unused **government infrastructures** were identified by the team and they were revived and utilized for these trainings.

### **Community Engagement**

There is no ‘One size fits all’ solution for delivering primary health care, involvement and ownership of the community is the common thread to ensure successful delivery (Kumar, 2017). Thus it is important to have constant engagement with the community to understand them and their problems. **Community meetings** arranged for various reasons was a great medium to get to know the community. ANM Mentors were a useful resource because they were living in the SHCs and interacting with people in OPDs, VHNDs. Community engagement is a crucial component to make intervention successful, but it is often ignored or given less importance.

### **Availability of Dedicated Ambulance at PHC & CHC**

The reach of 108 services is poor in areas with poor road connectivity and poor telephonic connectivity (centralised call log). People have difficulty reaching to the nearest PHC or CHC as well. Thus, availability of an additional ambulance at the PHC/CHC dedicated to that area was felt. This was outside the centralised 108 services. Most of the time ambulance of 108 service gets delayed and this delay could be fatal. Thus dedicated ambulance for PHC and CHC reduces the delays and makes timely referral possible.

### **Human Resources**

Human resources are the persons with skill and consistent approach to managing the most valuable responsibilities of any establishment - engaged individually and collectively for the achievement of objectives. To fulfill the objectives of community health programs under Pushprajgarh Nutrition and Health Program, we mainly needed 18 human resources detailed below:

<b>Human Resource</b>	<b>Number</b>
Community Doctor	1
Health Program Lead	1
ANM Mentor Facilitator	1
ASHA Trainer cum Mentor	3
ANM Mentors	12
<b>Total</b>	<b>18</b>

Along with project staff facilitating the operations, at a SHC, 2 ANMs, and 1 caretaker is essential for effective functioning of SHC.

## **Capacity building strategies**

### **ANM Mentors**

ANM Mentors are rigorously trained at JSS, Ganiyari. They also attend 'Dakshata' training which is 3 days long technical update cum skills standardization training for improved MNH care during institutional training. They are also trained in communication and mentoring skills. After they have themselves worked as ANMs in the field, and shown promise, 6-7 ANMs can be mentored by one ANM mentor.

### **Government ANM Staff**

As ANM mentors work with government ANM staff, ANM mentors try to improve skills of government ANMs through 'supportive supervision and mentoring'. All ANMs undergo a 2 week residential refresher training at the hospital and community program of JSS Ganiyari. This also includes Dakshata training on Labour Room activities.

### **ASHA Refresher Training**

ASHA trainers of JSS impart ASHA refresher training as mentioned earlier. Topics of training include maternal and child health, use of malaria detection kit, water and home based water treatment, detection of high risk pregnant women, etc.

## **Evidence of Effectiveness**

S.No.	Detail	2018-19	2019-20
1	Functionality of SHC (out of 12)	4	10
2	Functionality of Delivery point at SHC (>35 deliveries per year)	1	3
3	No. of deliveries in SHCs (Prior to 2018 only occasional delivery)	114	173
4	No. of deliveries in 1 PHC & 1 CHC	NA	267
5	OPD patients seen at SHCs	NA	16930
6	OPD patients seen at 1 PHC and 1 CHC	NA	13300
7	No. of Ambulance with 1 PHC and 1 CHC	0	2

8	No. of Functional Gram Arogya Kendras in 75 villages	28	73
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Outcomes are more difficult to quantify but better data entry and management can help achieve this.

### **Cost**

Financial support is provided by National Health Mission (MP) and District Mineral Fund (DMF) Anuppur.

Details of the Cost incurred:

S.No.	Major Heads	Annual budget	3 Years budget	Remarks
1	HR cost (salaries and mobility)	5,139,720	15,419,160	
2	Training Cost	2,244,000	6,732,000	
3	Infrastructure development	6,000,000		One time cost
4	Ambulance Cost	4,900,000	3,900,000	Ambulance(one time), driver and fuel
5	Other Costs	14,000	42,000	
6	Contingency	530,000	1,590,000	
	Total*	13,927,720	23,783,160	

\*The values have been rounded off to the nearest major figure. According to the population, annual per person cost comes around 285 rupees.

### **Lessons learnt:**

1. Quality improvement is possible, when the other basic requirements (infrastructure, equipment, residential facilities, adequate HR) are met.
2. Ensuring quality of training is essential. This is possible by limiting batch size, provide residential facility to trainees, training center which are nearby (especially for recurring trainings)

3. Real change happens when trainers hand-hold their trainees during their actual work. This also gives trainers an actual understanding of the challenges faced by their trainees. Thus, training and mentoring programs should be clubbed together. Thus, it is better to have small training institutions near the work areas, rather than large institutions situated far away. Training of trainers may be done more centrally, and these trainers should be paid a respectable remuneration for good quality training to happen. Training centre expenses can often be cut down by liasoning with the local administration (Zila Panchayat)
4. Every PHC/CHC should have its own ambulance with provision for driver and fuel. This is in addition to 108 services. This dual system is a must for remote areas with poor road and telephonic connectivity.
5. Positive engagement with community and local political leaders is essential to understand what is relevant for them.
6. Availability of a caretaker at the SHC helps in its care and maintenance.
7. Close coordination with the local administration through the Collector and CEO ZP, helps take positive steps as big strides.

### **Potential for Scale**

It is evident from the outcomes and impacts of the intervention that the intervention is feasible and impacting as well. This intervention is successful in remote and loosely connected sectors of a tribal populous block, this proves the workability of this intervention in most difficult circumstances. Important aspect of the intervention is that the intervention does not demand any explicit infrastructure, rather existing infrastructure of the government health system is revived and utilized to its fullest. The feature like successful implementation in difficult circumstances and no need of explicit infrastructure of the intervention makes it scalable and replicable in other parts of state and India.

### **Partners involved in implementation**

Government health facilities, their staff and officials from other departments like PWD, electricity, water etc. other than the health department are partners in the implementation. Jan Swasthya Sahayog have provided all necessary facilitation and technical support for the implementation.

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