



RMNCH+A Highlight Series

Improving RMNCH+A interventions: Block Monitoring in Lohardaga District, Jharkhand



“Supportive monitoring is always helpful. Instead of fault finding, it is fault rectifying. Improvement in quality of service delivery is only possible through monitoring and repeated monitoring.”

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The Government of India identifies the “block” as the primary unit for implementation and management of life-saving RMNCH+A interventions. The “Guidance Note for Block Monitoring Visits” advises state and district health officers and their development partners to systematically assess the health infrastructure, human resources, and quality and coverage of RMNCH+A information and services, with the goal of identifying and addressing bottlenecks in the local health system. Block monitoring is also promoted as an opportunity to assess community outreach, home-based interventions and client satisfaction. Jharkhand State has been proactive in undertaking block monitoring visits. This success story describes the block monitoring process and initial results in Lohardaga, one of Jharkhand’s 11 high priority districts (HPD).

Background

Government of India (GOI) co-convened the global Call to Action for Child Survival in 2012 with USAID, the Government of Ethiopia and UNICEF. Shortly thereafter, the Minister of Health hosted India’s own National Summit on the Call to Action to accelerate progress toward Millennium Development Goals 4 and 5 and the health goals of the 12th Five Year Plan. A new, comprehensive Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) Strategy was launched at the National Summit and is currently being rolled out in all 29 states and 184 high priority districts (HPDs). MCHIP, USAID’s flagship program for maternal, newborn and child survival is providing technical support to the MOHFW and six state governments for RMNCH+A roll out. A key component of the RMNCH+A strategy involves regular block monitoring visits to the high priority districts for supportive supervision, on-site mentoring and training and to encourage corrective action.

Objectives of Block Monitoring Visits

- 1) To assess the infrastructure, human resources, and provision of RMHCH+A services in facilities and communities
- 2) To assess both the quality and coverage RMNCH+A service delivery in the block,
- 3) To review progress of community outreach and home-based interventions.

Block Monitoring in Jharkhand State

As a first step in block monitoring, the Government of Jharkhand designated a senior official from the Department of Health & Family Welfare (DoHFW) as Team Leader and nodal officers for each of 11 HPDs. District Monitoring teams were then formed to include key district officials and development partner representatives. District teams visit one block each month in each HPD, along with resource persons from mentoring institutions that include medical colleges and NGOs.

The block monitoring team spends 3-5 days at each block, visiting all labor and delivery points including district hospitals and first referral units (FRUs), Primary Health Centres (PHC), Community Health Centres (CHC), and a sample of Sub-centres. The team also observes Village Health and Nutrition Days (VHND) and interacts with the community.

Block monitoring teams share key findings and recommendations with the facility heads and staff at the end of each day. An action plan is also prepared and shared with the Civil Surgeon/Chief Medical Officer. Findings and recommendations are also shared at regular district review meetings where corrective actions are discussed and earlier action plans are reviewed. Finally, key findings are shared at the state level and block performance is compared quarterly with the State Rural Health Mission Director, Director in Chief - Health Services, and Program Officers.

Results – A Case Study of Lohardaga District

In Lohardaga district, the District Hospital, four Community Health Centers (CHCs), four Primary Health Centers (PHCs), and 12 Health Sub-Centers (HSCs) have received block monitoring visits since June 2014. Two rounds of visits were conducted at the District Hospital and the four CHCs. This document highlights the changes that have been made by these five health facilities which serve the majority of patients across the district.

Improvement in Labor Rooms

GOI guidelines recommend that all Level 2 and Level 3 facilities have seven trays with equipment

and drugs available in the labor room. These trays include the delivery tray, episiotomy tray, baby tray, medicine tray, emergency drug tray, vacuum aspiration tray, and PPIUCD tray. Availability of trays at the five facilities improved over the course of the visits. Improved availability improves quality of services provided at these facilities.

Facility	Trays at first visit	Trays at follow-up visit
CHC Kuru	4	7
CHC Kisko	3	7
CHC Senha	2	6
CHC Bhandra	3	6
District Hospital	4	7

Each delivery tray requires scissors, artery forceps, sponge holding forceps, urinary catheter, bowl for antiseptic lotion, kidney tray, gauze pieces, cotton swabs, sanitary pads, and gloves. The number of required trays depends on the delivery load at the facilities. As per GOI guidelines in the Maternal and Newborn Health Toolkit, the delivery trays required in the facilities are: four at CHC Kuru, two each at CHC Kisko, Senha and Bhandra, and six in the District Hospital.

At the first visit, delivery trays did not match the delivery load and, where available, did not have all the required commodities. Follow-up led to improvement in the overall availability of the delivery trays as well as their contents:

Facility	Delivery Trays: First Visit	Delivery Trays: Follow-Up Visit
CHC Kuru	2 sets (partial)	2 sets (all items) 1 set (partial)
CHC Kisko	2 sets (partial)	2 sets (all items)
CHC Senha	2 sets (partial)	1 set (all items) 1 set (partial)
CHC Bhandra	2 set (partial)	1 set (all items) 1 set (partial)
District Hospital	3 sets (partial)	3 sets (all items) 2 sets (partial)

At the first visit it was observed that labor rooms in the five facilities were not storing oxytocin, which is administered to prevent the primary cause of maternal death – postpartum hemorrhage – in a refrigerator in the labor room as per national guidelines. Refrigeration is necessary to guarantee the effectiveness and potency of oxytocin. By the second visit, three of the facilities were storing oxytocin in a refrigerator

in the labor room and two others had it in a nearby room due to space limitations.



Improvements in Service Delivery

Elbow taps for infection prevention were found installed in only two facilities at the first visit. At the subsequent visit, all five facilities had elbow taps installed. The availability of PPIUCD forceps also increased as per guidelines resulting in higher PPIUCD insertion rates in the three months following the visits. While the overall insertion rate was 11% from April 2013 to March 2014, it increased to 20% from March-May 2014.

Facility	PPIUCD Forceps: First Visit	PPIUCD Forceps: Follow-up Visit
CHC Kuru	2	3
CHC Kisko	1	2
CHC Senha	1	2
CHC Bhandra	1	2
District Hospital	2	4

All facilities had functional newborn care corners (NBCC) in their labor rooms, however, the neonatal bag and mask was missing at the District Hospital at first visit. A bag and mask was available at the second visit. Operation theatres in CHC Kuru and the District Hospital did not have functional NBCCs. Funds have been proposed in the annual District Health Action Plan (DHAP) for establishing NBCCs in these two sites.

System Improvements

Various actions were initiated to address gaps identified through block monitoring visits across the district. Three CHCs shifted to new buildings and the construction of the district hospital is in process (to be operational in late 2014). The construction of two PHCs and five sub-centers has

been budgeted for in the state's Program Implementation Plan (PIP) 2014-15. Moreover, the District Collector advocated with the electric supply department for electrical connection in three new CHC buildings and solar lights have been proposed and budgeted for in the state PIP to electrify remote sub-centers. To address the availability and quality of health information, block data managers were recruited and oriented to data management using the Mother and Child Tracking System (MCTS) and follow up of defaulters and other critical cases.



Well established labor room: CHC Kisko

Block monitoring visits provided an opportunity to orient Accredited Social Health Activists (ASHAs) on reporting maternal and infant deaths and to ensure the availability of pregnancy test kits. Availability of essential commodities such as iron, folic acid tablets, zinc, oral rehydration solution, Vitamin K, and misoprostol is being prioritized during the visits to prevent stock-outs.

Community Health Centre Senha initiated recruitment for vacant positions and trained existing staff nurses on Essential Newborn Care and Resuscitation (Navjaat Shishu Surakha Karyakram, or NSSK) and other priority public health programs. Line listing of severely anemic pregnant women and referrals to the district hospital for treatment were also initiated, and free referral transport and free meals, previously not available under Janani Shishu Suraksha Karyakram (JSSK), were implemented for the first time. Information, education, and communication (IEC) materials are displayed at the health center and the Mother and Child Health register is being regularly updated.

At Sub-Centre Ekaguri, RMNCH+A essential commodities that were not available during the first block visit are now available, as is a new haemoglobinometer and haemoglobin testing during antenatal care. Color-coded bins for waste segregation and infection prevention have been purchased from the sub-center united fund and wall paintings now inform beneficiaries about fixed day service for IUCD insertion. Provision has been made in the District Health Action Plan for purchase of a radiant warmer for the newborn care corner.

Budgetary provision was also made in the District Health Action Plan for construction of a placenta pit in the new CHC building at CHC Kisko to prevent contamination of the community from biowaste.



Recognizing Improvements

A cross learning visit was organized by the district in June 2014 for block officials to witness the functioning of CHC Kisko, where block monitoring has led to significant improvements in RMNCH+A services. The Additional Director, Health Services, Govt. of Jharkhand and the District Civil Surgeon recently visited the facility and recommended that CHC Kisko be designated as a model CHC.

Conclusion

In Lohardaga District, block monitoring is leading to improvements in the availability of key RMNCH+A commodities and equipment, as well as infection prevention measures that will have a positive impact on the quality of services.

Government of Jharkhand has taken proactive measures to institutionalize block monitoring with the involvement of health officials at the state, district, and block levels, as well as members of the State RMNCH+A Unit and medical colleges.

Block monitoring visits identify gaps and inspire the development of plans to address the gaps and build the skills of staff. Repeat visits help to regularly follow-up on corrective actions and assess improvements. The block monitoring process increases the accountability of service providers leading to improvement in the quality of RMNCH+A services.

Block monitoring should be institutionalized across all districts to revitalize health systems and processes to improve quality and coverage of health services.

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