MAKING PRIMARY HEATH CARE A REALITY

ANNUAL REPORT




AUGUST 2013 – JULY 2014

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Background

MYRADA[1] initiated a three year project in August 2012 with support from Sir Dorabji Trust and Allied Trusts, India, with the aim to develop sustainable interventions to improve quality and equal access to primary health care. The project is based in 136 villages across 8 PHCs (Primary Health Centre) in 4 districts of North Karnataka. These 4 districts, located in the northern most part of Karnataka, are part of the Hyderabad Karnataka region with features of low rainfall, high migration, high illiteracy and poor socio economic indicators. Health care is also very poor in this area. These districts are labelled as "high priority" by the National Rural Health Mission and have high levels of maternal, infant and child mortality and morbidity, diarrheal cases and inadequate health personnel and facilities in place.

Goal of project: *To improve quality and reach of primary health care through effective community based responses with the support of local institutions such as the VHSC, GP and ARS.*

Target group and Geographical area of intervention

The project is being implemented concurrently in 8 different locations across 4 districts: Bidar, Gulbarga, Yadgir and Bellary districts.

District	PHC name	No. of villages	Population	Gram Panchayats	VHSCs
Bidar	Bhatamabra	16	26361	3	14
	Dubulgundi	12	34985	3	10
Gulbarga	Arulagundagi	12	34430	3	9
	Jeratagi	16	25125	3	14
Yadgir	Nagnoor	12	25497	2	10
	Kakkera	39	31722	3	12
Bellary	Bennikalu	17	26425	4	8
	Alaburu	14	15650	3	6
	TOTAL	**138**	**220195**	**24**	**83**

Key strategies and activities

ACTIVITIES COMPLETED IN THE FIRST YEAR

During the first year, the following activities were completed:

a) Baseline assessment

[1]Mysore Resettlement and Development Agency (MYRADA) is a now a group of autonomous societies, companies and informal institutions sharing a common vision to promote livelihood strategies, local governance, management of natural resources, health and education favouring the rural poor in an inclusive, equitable and sustainable manner

A detailed baseline assessment was conducted over a period of 6 months. This exercise gave us a deep insight on the different unique problems facing the communities in these 138 villages. Some of the areas covered under this baseline were;

a) Profile of all the 138 villages
b) Nutritional status of children below 5 years
c) Knowledge, practice and coverage survey of pregnant women, mothers of under 2 years through a population cluster sample survey
d) Survey of prevalence of non-communicable diseases
e) Environmental sanitation maps for every village
f) Focus group discussions with community groups: gram panchayat, village health and sanitation committee, SHGs, school monitoring committees
g) FGDs with frontline workers and health staff
h) Assessment of the PHC, sub centre and anganwadis infrastructure and facilities.

b) Orientation of all stakeholders

The project teams in all 4 districts had orientation meetings with stakeholders form the health, women and child development, Panchayat raj, social welfare and rural development departments to explain the purpose of our study and decide how they could support our activities in the field

c) Goal setting workshops

The results of the baseline were shared with the local stakeholders in each PHC. Around 100 members of the community, health department and frontline staff attended these workshops. At the end of the presentation, they made a plan for their area.

d) Tracking of three target groups:

a. Children with malnutrition
b. High risk pregnant women
c. Persons with disability

This was decided during the goal setting workshops.

e) Capacity building of local communities and providers

This was initiated in the first year. Trainings were conducted for CBOs and frontline workers on the 8 elements of Primary Health Care.

Challenges faced during the first year

The most critical challenge was the delay in activities due to the ‘‘code of conduct’ put in place for State elections in March, April and May of 2013. The other challenge was the geographical distances between the PHCs. All these PHCs are in remote rural areas. It was a challenge to coordinate monitoring visits and supervise on a regular basis. Also, these distances led to over expenditure in the travel line with increasing costs of travel.

ACTIVITIES PLANNED IN THE 2ND YEAR

a) **Training of CBOs, private health care and non-allopathic practitioners** in providing basic health care services
b) **Identifying severe cases of malnutrition** and linking with nutrition programs in coordination with the Women and Child department.
c) **Providing mobile based health care services to remote locations** through locally identified and trained health care practitioners
d) **Introducing community based rehabilitation programs** through the frontline workers and PHC.
e) **Linkages to specific health schemes including health insurance schemes** for need based BPL and vulnerable individuals.
f) **Construction of appropriate drainage systems** with mechanisms in place to handle overflow,
g) **Providing access to safe drinking water** in anganwadi centres and schools.
h) Ensuring that all villages have a **basic first aid response mechanism** through trained ASHAs with basic drug kits.
i) **Planning a need based response for local endemic diseases** such as malaria, filaria etc.
j) **Ensuring that PHCs have the basic equipment in** place – adequate numbers and in working condition.

Field Interventions and Achievements of Second Year

1. Capacity building of local level institutions

Myrada's underlying philosophy in all its work is to work with communities and build local people's institutions to manage activities initiated through any project. The local level institutions relevant to a Primary Health Care project are the Gram Panchayat (GP), Village Health Sanitation Committee (VHSC), ArogyaRakshaSamiti (ARS), Self Help Groups (SHG) and School Development and Management Committee(SDMC) Several CBO trainings of GP, VHSC, SDMC and SHGs were conducted across the four districts.

The objectives of the training were:

- To understand the importance of each of the 8 elements of primary healthcare.
- To actively involve the GP and VHSC in the preparation of an action plan and take ownership in community monitoring.
- To involve the CBOs in the community based monitoring of the target groups- pregnant women, children and disabled persons.

Please find the CBO training manual as annexure 1 and VHSC training manual- governance

TABLE 1											
Sl. No	**CBO trainings & outputs**	**Gulbarga**		**Yadgir**		**Bidar**		**Bellary**		**Total**	
		Target	Ach	Target	Ach	Target	Ach	Target	Ach	Total	Ach
1.	GP training	06	06	05	05	05	05	07	06	23	22
2.	VHSC training-governance issues	18	18	12	12	24	24	14	14	68	68
3.	SHG trainings	112	104	141	141	252	210	324	258	829	713
4.	SDMC training	30	30	39	35	27	25	32	32	128	122
5.	ARS training	02	00	02	00	02	00	03	00	9	0
6.	**Total CBO training**	**168**	**158**	**199**	**193**	**310**	**264**	**380**	**310**	**1057**	**925**

issues as annexure 2.

Table 1: CBO trainings during the second year (2013-14) of the project.

A total of 168 trainings were conducted across 4 districts in the year covering 4 different groups. The only group that was resistant and not available for training was the Arogya Raksha Samiti.

The interactive training sessions provided the CBOs with knowledge on the importance of primary healthcare and their responsibility in achieving it at the community level.

With the support of MYRADA-SDTT field staff, each **Gram Panchayat** prepared a **sanitation plan** for the villages in their catchment area.The sanitation plan included some mandatory sanitation activities like cleaning of drains, fogging, and bleaching of water tanks etc. The time line for each activity was decided. Many gram panchayats took up additional activities like construction of new drains, renovation of public toilets, clearing of blocked drains to improve the environmental sanitation conditions specific to their area.

Kadkol GP with their action plan, Aralagundagi PHC July 3, 2014

Likewise, **Village Health and Sanitation Committee** (**VHSC**) prepared a village health plan pertaining to the health conditions of their village. The village health plan focuses primarily on involving the VHSC members in the community monitoring of the three target groups (pregnant women, malnourished children and disabled persons).

The formats of both GP sanitation plan and village health plan are attached as annexure 3a and annexure 3b.

Village health plan wall painting- VHSC, Chintrapalli

TABLE 2											
Sl. No.	Indicators	Gulbarga		Yadgir		Bidar		Bellary		Total	
		Target	Ach	Target	Ach	Target	Ach	Target	Ach	Target	Ach
1.	Total number of village health plans prepared and being followed up	28	28	51	51	28	28	31	31	138	138
2.	Total number of GP sanitation plans prepared and being followed up	06	06	05	05	06	06	7	6	24	23
3.	Total number of villages with wall paintings done along with GP	28	28	51	35	28	28	31	31	138	122

Table 2 represents: CBO action plans

From the table above, it is evident that the teams were able to mobilise most GPs and VHSCs to prepare an action plan for their working area. It was very encouraging to see the active response from the Gram Panchayats who usually don't prioritise health as one their mandates. In 122 of the 138 villages, wall paintings on 3 important health messages were put up with equal contribution from the GPs.

2. Capacity building of health care providers

2a. Training of frontline workers

The community mainly depends on the health care providers at village and PHC level for itto receive primary health care services. The team conducted separate trainings for the frontline workers (ANMs, ASHAs and anganwadi workers) and the practicing doctors.

The frontline workers training emphasized on the following topics:

- To understand the importance of each element of PHC
- To understand the importance of Thayi card-regular updating and sharing information with pregnant woman/ mother.
- To understand how to treat & track SAM & moderate children through five steps of management
- To understand the importance of growth chart- grading, updating and sharing information with mother.

ANM/ASHA training – Kakkera, Nov, 25, 2013

Table 3 describes the number of frontline workers trained this year. A total of 565 frontline workers (from a total of 660) were trained on primary health care elements.

Table 3									
Sl. No	**Training**	**Gulbarga**		**Yadgir**		**Bidar**		**Bellary**	
		Target	Achievement	Target	Achievement	Target	Achievement	Target	Achievement
1.	ANMs & ASHAs trained in basics of primary healthcare	**56**	**41**	**56**	**51**	**55**	**55**	**52**	**52**
2	ASHAs	**50**	**35**	**48**	**42**	**44**	**44**	**41**	**40**
3	Anganwadi workers	**60**	**55**	**54**	**48**	**90**	**50**	**54**	**52**
	TOTAL	**166**	**131**	**158**	**141**	**189**	**149**	**147**	**144**

2b. Training of PHC level doctors

A one day doctor's training on "Updates in Medicine for Primary care Physicians" was conducted in Gulbarga. Dr. GD Ravindran, Professor of Medicine, St. John's Medical College, Bangalore was invited to be resource persons for this training. Some of the topics included management of common communicable and non-communicable diseases, depression, certain legal issues and rationale drug therapy were discussed. Doctors from both government and private facility had had an enriching experience and were motivated to practice the same.

Doctor's Training- May 26, 2014

There was very positive feedback form this training with a request for more of the same to be conducted.

Twenty two PHC medical officers attended this training from Yadgir and Gulbarga.

3. Tracking and treating Malnutrition

A total of 20,503 children below 5 years were identified across the 138 villages. Their weights were recorded and *815 of them were identified with severe malnutrition and 4182 as moderately malnourished.*

Myrada-SDTTproject staff, including all CRPs and ORWs was trained on 5 steps of nutrition management in Bidar from the staff who have been successfully implementing the Welthunger Hilfe supported nutrition project in Aurad Taluk. They learnt how to track children with malnutrition, do home based counselling of mothers and the importance a special nutrient supplement called My Nutrimix.

All the 4997 identified malnourished children were tracked under five steps of nutrition management for six months in collaboration with the VHSC members.

3a. Regular health check-up and monthly weighing of malnourished children.

The PHC doctors were encouraged to conduct monthly health check-up of malnourished children. With the constant help of frontline workers the mothers of malnourished children were motivated to take their children for regular monthly check-up. Several health camps were also conducted for specialist check-up of severe malnourished children and any children who had missed the previous health check-up.

3b. Regular micronutrient supplementation- vitamin A, B complex, IFA and albendazole.

As there was a shortage of B complex and IFA tablets in most PHCs, MYRADA-SDTT project had supported the cause by procuring the required quantity from Locost drugs, Vadodra Gujarat. The community resource persons monitor the consumption of the tablets and distribute the medically recommended dosage on a bimonthly basis. All the malnourished children and pregnant women are benefitting from the regular supply of essential drugs.

MYRADA has also procured albendazole and vitamin A from Vitamin Angels for all children below 5 years of age. A mass campaign for administrating Vitamin A and Albendazole will be organized in the coming months.

3c. Group discussions and home based diet counselling of SAM and moderately malnourished children's mothers.

Nutrition flip charts distributed to all health workers and anganwadi workers was used to emphasize on the practice of consuming balanced diet. A diet chart describing daily diet intake for pregnant women and malnourished children was put up in all households.

3d. Regular intake of supplementary nutrition from the anganwadi centres.

The anganwadi centres provide supplementary nutrition and take home ration to all children below 5 years of age. Different snack items under supplementary nutrition are being prepared as per the defined time table. Milk is also provided to all children but there is a shortage in supply of eggs.

Additionally, the mothers of malnourished children were trained on preparation of ready to use nutrition mix- My Nutrimix (see Annexure - for details)at home. The mothers are now preparing Mynutrimix powder and the children are consuming it as per the standard preparation and consumption guidelines.

3e. M**onthly weight checks and recording in the tracking register and growth chart.**

All 4997 children were weighed monthly and their weight recorded with other data in the tracking register of each CRP. The community resource persons weighed every malnourished child to track the increase or decrease in their weight for over 6 months. All the children below 5 years were weighed at the end of six months for the identification of any new malnourished children.

The list of malnourished children is shared with the VHSC members regularly. Every malnourished child has a growth chart put in the her home on the wall so that the parents can also track the progress of their child

Table 4 and 5 indicates the nutritional status of severely and moderately malnourished children respectively.

Sl. No.	Indicators	Gulbarga	Yadgir	Bidar	Bellary	Total
1.	Total no. of children below 5 years age in October 2013[2]	5265	4679	3584	3886	**17414**
2.	Percentage of severe malnourished children below 5 years as of Oct-2013	2.67%	4.57%	4.26%	7.9%	**4.68%**
3.	Total no. of severe malnourished children followed up in 5 steps of nutrition management (Oct 2013 to March 2014)	141	214	153	307	**815**
4.	Total no. of severe malnourished children improved to moderate malnourished status	50	58	64	92	**264**
5.	Total no. of severe malnourished children improved to normal nutritional status	19	7	7	0	**33**
6.	Percentage of severe malnourished children with improved nutritional status (moderate and normal)	48.9%	30.3%	46.4%	29.9%	**36.4%**
7.	Total no. of children below 5 years age in July 2014	4141	7209	3156	3505	**18011**
8.	Total number of severe malnourished children in July 2014	178	286	128	288	**880**
9.	Percentage of severe malnourished children below 5 years as of July-2014	4.30%	3.96%	4.05%	8.21%	**4.8%**

[2] The line list prepared in October 2014 was incomplete in Gulbarga and Yadgir Districts.

TABLE 5						
Sl. No.	**Indicators**	**Gulbarga**	**Yadgir**	**Bidar**	**Bellary**	**Total**
1.	Percentage of moderate malnourished children below 5 years as of Oct-2013	22.8%	32.2%	17.3%	21.77 %	**24.01%**
2.	Total no. of moderate malnourished children followed up in 5 steps of nutrition management (Oct 2013 to March 2014)	1202	1511	623	846	**4182**
3.	Total no. of moderate malnourished children improved to normal nutritional status	340	260	254	86	**940**
4.	Percentage of moderate malnourished children improved to normal nutritional status	28.2%	17.2%	40.77%	10.1%	**22.47%**
5.	Total number of moderate malnourished children in July 2014	890	1136	865	593	**3484**
6.	Percentage of moderate malnourished children below 5 years as of July-2014	20.6%	15.7%	27.4%	16.9%	**19.3%**

Some of the important points to note from the table 4 and 5, in about 6 months of tracking, one third of the severe children improved to at least moderate if not normal status. However, a big concern, seen also in other programs, is that there are new children joining the severe group every year. Another weakness in our early data was that some of the children included were between 5 – 6 years**.** There has been an increase in the overall percentage of severe malnutrition over the year, with a 80% chunk of the new cases coming from only one PHC – Kakkera PHC in Yadgir district. This PHC also has issues of a relatively high prevalence of home deliveries, infant mortality and other poor MCH indicators.

There has been a small improvement in the percentage of moderate malnourished children over the 6 months of tracking.

Table below elicits the progress of nutritional status of severe and moderate malnourished children in Kakkera PHC.

Sl. No.	**Indicators**	**Kakkera**
1.	Total no. of children below 5 years age in October 2013	1681
2.	Percentage of severe malnourished children below 5 years as of Oct-2013	9.16%
3.	Total no. of severe malnourished children followed up in 5 steps of nutrition management (Oct 2013 to March 2014)	154
4.	Total no. of severe malnourished children improved to moderate malnourished status	49
5.	Total no. of severe malnourished children improved to normal nutritional status	4
6.	Percentage of severe malnourished children with improved nutritional status (moderate and normal)	34.4%
7.	Total no. of children below 5 years age in July 2014	4147
8.	Total number of severe malnourished children in July 2014	210

9.	Percentage of severe malnourished children below 5 years as of July-2014	5.06%

Sl. No.	Indicators	Kakkera
1.	Percentage of moderate malnourished children below 5 years as of Oct-2013	47.7%
2.	Total no. of moderate malnourished children followed up in 5 steps of nutrition management (Oct 2013 to March 2014)	802
3.	Total no. of moderate malnourished children improved to normal nutritional status	96
4.	Percentage of moderate malnourished children improved to normal nutritional status	11.97%
	Percentage of moderate malnourished children moved to severe malnourished nutritional status	15.4% (124)
5.	Total number of moderate malnourished children in July 2014	927
6.	Percentage of moderate malnourished children below 5 years as of July-2014	22.3%

3f Using the diet diversity score to determine quality of diet

Through another project, Myrada learnt how to use a scale to determine if the children are getting a balanced meal. Called the **diet diversity score**(see annexure 7), it measures how many different food groups are included in a typical diet of a child in a day. This scoring was done for a sample of the malnourished children who have been tracked over the past year.

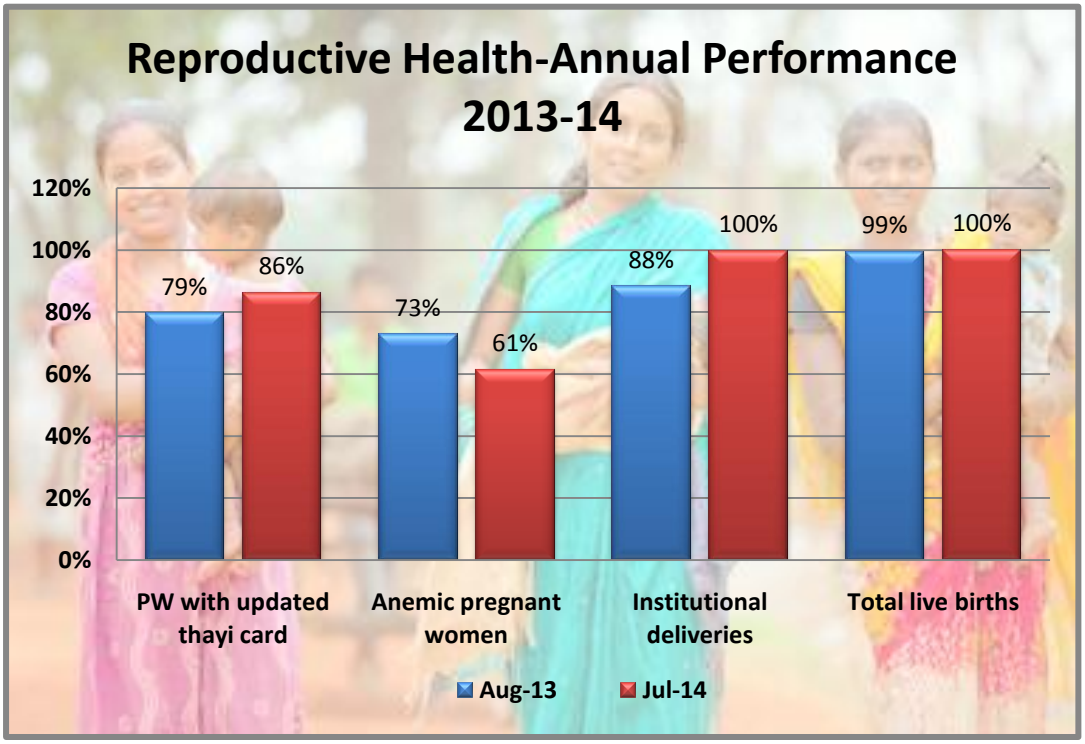
The score is on a total of 9. Any child who scores 5 or less has a poor diversity and is not getting an ideal balanced diet. To our surprise, we found that the average score for children with severe malnutrition was 5.54/9, and for those with moderate malnutrition, the score was 5.72/ 9. However, the diet diversity score in Bidar was way below the average expected (see Table 6 below). It is hoped that this is a consequence of the home based counselling given to all mothers. This will be repeated every 6 months to determine the change in eating behaviour of the children.

TABLE 6

Sl. No.	Indicators	Gulbarga	Yadgir	Bidar	Bellary	Total
1.	Total number of severe malnourished children surveyed	69	284	48	190	591
2.	Average diet score for severe malnourished children (maximum score = 9)	5.56	5.84	4.06	5.35	5.52
3.	Total number of moderate malnourished children surveyed	797	989	311	711	2808
4.	Average diet score for moderate malnourished children (maximum score = 9)	6.35	5.93	4.24	5.22	5.73

4. Follow up of pregnant women

The project aims at ensuring the basic health care services during and after pregnancy for safe delivery and a healthy child. Every month the health workers along with the VHSC members track approximately 2,000 pregnant women. A pregnant women register is maintained which records the basic services availed by the pregnant women like thayi card, health counselling, number of health check-up, haemoglobin and other tests , preparation for delivery, post natal and newborn health.



A special exercise was done to determine how many pregnant women had high risk pregnancies (see Annexure 8 - for High Risk score sheet). Out of a total of 1904 pregnant women administered the High risk scoring questionnaire, 1398 were found to have some high risk factor.

The most common high risk factors identified were:

- 84.4 % of high risk pregnant women were identified with a haemoglobin level below 11gm/ dl. Thus anaemia is identified as the most prevalent high risk factor during pregnancy.
- Underweight i.e., weight below 45 kgs.
- Poor socio-economic status such as unemployment, poverty etc.
- Perinatal loss during previous child birth
- Previous caesarean or instrumental deliveries.

Table 7 below represents the services availed by pregnant women as of July 2014.

TABLE 7						
Sl. No	Reproductive Health Indicators (as of July 2014)	Gulbarga	Yadgir	Bidar	Bellary	Total
1.	Total number of pregnant women	439	603	547	340	1929
2.	Total pregnant women with updated thayi card	387	554	459	259	1659
3.	Total pregnant women identified as high risk	296 (272 anaemic)	381 (343 anaemic)	440 (365 anaemic)	281 (201 anaemic)	1398
4.	Total anaemic pregnant women consuming 60 IFA tablets monthly	272	343	365	201	1181
5.	Total institutional deliveries between August 2013 to July 2014	686/687	948/981	732/737	610/610	2976/ 3015
6.	Total live births between August 2013 to July 2014	687	981	732	610	3010
7.	Total infant deaths between August 2013 to July 2014	0	6	5	0	11
8.	Total maternal deaths between August 2013 to July 2014	0	1	8	0	9

5. Community based rehabilitation programs

A total of 1897 disabled persons were identified, and as a first phase, were ensured disability certificates and pension. Altogether 265 disabled persons were checked for disabilities through 6 specialist disability assessment camps. Dr. Maya Therattil a specialist in physical medicine/ rehabilitation from St. John's Medical College assessed all the patients and suggested required treatments. The health workers were trained in physical therapy which and community based rehabilitation is being implemented by 23 village rehabilitation workers.

All the disabled were linked to getting a certificate from the government and to get pensions schemes. A total of 1749 (92.2%) got their certificates during this reporting period, and 1637 (86.3%) were linked to the pension scheme of the government.

Myrada made a serious effort to ensure that all disabled below 14 years were sent back into schools. Out of a total of 238 children with disabilities below 14 years, 200 are in school. The project also focuses on ensuring that every disabled child has access to primary education. A request letter for admission of disabled children in the academic session starting June 2014 along with the line list of 107 disabled children who were not admitted any school was submitted to Deputy Director- public instruction and BEO of respective districts and blocks. This was followed up diligently resulting in the admission of 101 disabled children.

For the older age group above 14 years, they were encouraged to either undergo a skills training or get linked to an income generation activity in order to improve their quality of life.

Also a total of 7 physically disabled persons received free wheel chairs and 2 persons received free walkers in Gulbarga district during a campaign organised by the MLA through the efforts of our CRPs. The teams were able to refer some of them for surgical interventions: 26 patients availed free eye surgeries and 2 persons received free spectacles in Gulbarga and Yadgir districts. 4 disabled children were diagnosed with deformity in leg/ foot and were referred to Basaveshwara hospital and Baroda Hospital Tirupati for surgery and rehabilitation. As the deformity was diagnosed early, all the 4 children have shown significant improvement. Three children with wasting in one or two legs were recommended homemade walkers for children. With daily practice and the support of the family members the three children are now able to walk on their own feet with or without any support. Similarly, in Bidar district 6 disabled persons have received hearing aid and 1 hearing impaired person was referred for surgery.

MYRADA in collaboration with I Create India conducted a four day Aspiring Entrepreneurs Workshop in Bellary district. Twenty five disabled persons groups from different villages had attended the workshop and at least 5 business plans are in the process of execution. From Gulbarga district 8 disabled persons have been selected for one month computer and beautician training starting in August, 2014. Many disabled persons have been linked to different livelihoods with the effort of health workers and village rehabilitation worker and financial support from gram panchayats.

Table 8 indicates the district wise achievement of disability interventions.

TABLE 8

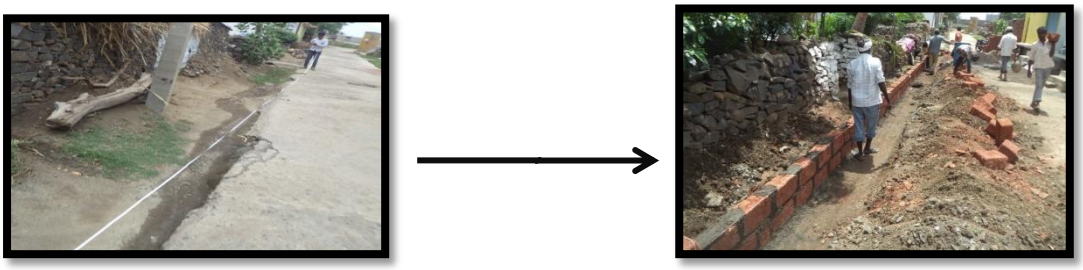
Sl. No.	**Indicators**	**Gulbarga**	**Yadgir**	**Bidar**	**Bellary**	**Total**
1.	Total no. Of disabled persons	398	473	521	505	1897
2.	Total no. Of received disability certificates	365	438	518	428	1749
3.	Total no. Receiving pension	334	384	508	411	1637
4.	Total disabled children (6-14 years) linked to schools	48	24	23	6	101
5.	Total disabled adults trained in livelihoods	0	0	0	25	33
6.	Total no. disabled persons Linked to job schemes	47	48	0	6	101
7.	Total no. Health check-up done	75	145	45	0	265
8.	Total no. Of Village Rehabilitation Workers (VRWs)	6	5	6	6	23

6. Environmental Sanitation and Safe Drinking Water

The gram panchayats were actively involved in maintaining the environmental sanitation of their respective villages and ensuring safe water supply. A village sanitation plan was prepared along with every gram panchayat that focuses on regular activities like sweeping, cleaning of drainage, bleaching of water tanks etc. The time line for each activity was decided. At least one gram panchayats in every PHCtook up special sanitation activities and agreed to provide financial or labour support in its implementation.

The special sanitation work completed in each PHC area as of July 2014 is:

- Arulagundagi and Jeratagi PHCs- drainage cleaning and clearing of blockages- 10 villages; clearing of community garbage in 2 villages
- Kakkera and Nagnoor PHCs- drainage cleaning and clearing of blockages- 12 villages; clearing of community garbage in 5 villages
- PHC Nagnoor- Roof top rainwater harvesting in Kirdahalli Thanda village- established in 4 households
- PHC Dubalgundi- Renovation of 2 public toilets for women in Dubalgundi village (detailed report in case study section)
- PHC Bhatambara- Drainage construction in Bhatamabara village, Juntanagar- length of 23 metres
- PHC Alaburu- Drainage construction inMasariNelkudri - length of 15 metres
- PHC Bennikallu- Drainage construction in Kallaliand Kallali Thanda villages- length of 15 metres



<u>Tippy Tap Initiative</u>

Over 1000 children die every day in India from diarrhoea; fortunately half of them can be saved through simple practice of hand washing with soap. With the motto of saving lives and water tippytap.org has come up with simple technique of hand washing that requires readily available everyday items.

MYRADA under SDTT-MPHC project had committed to providing special hand washing facility in 172 schools and 229 anganwadi centres in all the four districts. After regular orientation of gram panchayat on importance of safe water supply, currently 91 schools and 123 anganwadi centres are benefitting from tippy tap established through SDTT-MPHC project.

Table 9 describes district wise sanitation and safe water supply activities and achievements.

Table 9

Sl. No.	Sanitation activities	Gulbarga		Yadgir		Bidar		Bellary		Total	
		Tar	Ach	Tar	Ach	Tar	Ach	Tar	Ach	Tar	Ach
1.	Total no. Of villages	28		51		28		31			138
2.	Total villages monthly sweeping done	**28**	**28**	**51**	**51**	**28**	**28**	**31**	**31**	**138**	**138**
3.	Total monthly bleaching of water tanks & wells done	**64**	**64**	**36**	**36**	**61**	**61**	**58**	**58**	**219**	**219**
4.	Total water sources testing completed-schools & AWC	**94**	**89**	**105**	**105**	**113**	**113**	**94**	**94**	**406**	**401**
5.	Total water sources safe for drinking-schools & AWC	**89**	**88**	**105**	**105**	**113**	**113**	**94**	**94**	**401**	**400**
6.	Total number schools with special hand washing	**31**	**31**	**45**	**43**	**56**	**56**	**40**	**40**	**172**	**170**
7.	Total number of AWCs with special handwashing	**60**	**42**	**60**	**53**	**57**	**57**	**52**	**52**	**229**	**204**
8.	Total villages with fogging completed	**28**	**0**	**51**	**43**	**28**	**0**	**31**	**31**	**138**	**74**

7. Follow up on Immunization

The CRPs, along with the VHSC members, spread awareness about the importance of immunization in preventing childhood illnesses. Also the frontline workers were encouraged to maintain a regular record of all the vaccinations in the immunization card of each child. Total of 20,503 children less than 5 years of age were monitored for full immunization (up to measles).

Table 9 represents district wise achievement of immunization as of July 2014.

TABLE 10

Sl. No.	**Indicators**	**Gulbarga**	**Yadgir**	**Bidar**	**Bellary**	**Total/ Average**
1.	Total number of children less than 5 years of age	4141	7209	3156	3505	**18011**
2.	Percentage of children fully immunized till measles (1-5 years)	71.5%	67.5%	92.5%	100%	**80.6%**
3.	Total number of children administered Vitamin A (6-59 months)	100%	97.3%	95.6%	95%	**97.1%**

The lowest immunization coverage is in Kakkera PHC of Yadgir district.

8. General Activities

8a. Health Camps

Health check-up camps were organised with specialist doctors, mainly focusing on the health of pregnant women, mothers and children below 5 years of age. Total of 41 health camps were conducted across 8 PHCs in the four districts. Special disability assessment camp was conducted under which check up was done for 265 cases. Two days skin specialist camp was organized with the support of Dr. Preethy Harrison and Dr. Rohini Mathias from St. John's Medical College. Total of 160 patients had attended the health camp from 19 arsenic affected villages in ShorapurTaluq.

8b. Basic first aid response mechanism

A training of trainers in basic first aid mechanism was conducted in each district in collaboration with St. John's Ambulance, Gulbarga and St. John's Medical College, Bangalore. A total of 17 first-aid trainings were done in all 8 PHCs under which total **of 660 first-aid volunteers were trained and provided with a first aid kit and booklet**. First aid kits were distributed to every school, anganwadi and gram panchayat. Currently, there are 2-5 first aid volunteers in every village and as of July 2014,they have rendered services to 5916 villagers.

8c. Linkage of BPL families to Health insurance schemes.

A line list of 23,113 BPL families not linked to any health insurance schemes was prepared in the four districts. The health workers along with gram panchayat and VHSC members are spreading awareness about the importance of health insurance. With the support of taluq and district health officers are working towards linking most of them to government health schemes of their choice.

Table 10 describes district wise achievements under general activities

Table 11						
Sl. No.	**Activities**	**Gulbarga**	**Yadgir**	**Bidar**	**Bellary**	**Total**
1.	Total number of health camps conducted	8	15	4	14	**41**
2.	Total number of persons provided with first aid service	1525	1761	970	1660	**5916**
3.	Total number of BPL families linked to health insurance schemes[3]	1927/7819 (24.6%)	1540/6734 (22.8%)	387/2460 (15.7%)	285/6100 (4.6%)	**4139/23113 (17.9%)**

8d. Ensuring that PHCs have the basic equipment in place

Total of 8 PHCs were scored to assess the availability of basic infrastructure and services. The PHC check-list as suggested by NRHM guidelines stipulates the availability of minimum 36 basic services in each PHC. The missing facilities in each PHC was consolidated and shared with the Mission Director, NRHM ,Govt of Karnataka.Currently, every PHC has seen an addition of 2-3 services but the score still remains very low in some PHCs like Aralagundagi and Nagnoor.

Table 11 describes the basic services status between 2013 and 2014.

TABLE 11 Basic facilities score (max. score=36)					
Sl. No	**District**	**PHC**	**Sept 2013**	**July 2014**	**New facilities introduced**
1.	Gulbarga	Aralagundagi	**20**	**22**	Treatment of children suffering from diarrhea with severe dehydration. Health educator available
2.		Jeratagi	31	31	
3.	Yadgir	Nagnoor	**23**	**24**	Treatment of children suffering from diarrhea with severe dehydration. Low birth-weight babies treated Internal examination and treatment for gynecological conditions Medical Officer available/appointed
4.		Kakkera	33	34	Facility for abortion- Medical Termination of Pregnancy (MTP)
5.	Bidar	Bhatambara	27	29	Anti-rabies vaccine available Urine examination of pregnant women done at PHC
6.		Dubalgundi	33	34	Minor surgeries started in the PHC
7.	Bellary	Alaburu	25	26	Medical Officer available/appointed
8.		Bennikallu	27	28	Part time attendant (female) available

[3]THE Govt. of Karnataka put the RSBY scheme on hold for several months.

Some of the common facilities not available in PHCs:

1. Telephone line
2. Health educator
3. Facilities for cataract surgery, minor surgeries
4. Facilities for tubectomy and vasectomy
5. Internal examination and treatment for gynaecological conditions and disorders like leucorrhoea, and menstrual disturbance
6. Facility for abortion- Medical Termination of Pregnancy (MTP)
7. Treatment for children with pneumonia

8e. Health Education

Group discussions with pregnant, mothers, disabled persons and school children, were conducted on pre-decided topics related to mother and child health, personal hygiene, environmental sanitation and safe drinking water.In the last 4 months Village Health and Nutrition Day was also conducted as per NRHM guidelines and with the support of VHSC members. VHND was used as a platform to conduct group discussions, showcase nutritious food in a balanced diet plate, My Nutrimix demonstration and monitoring weight and growth of malnourished children and pregnant women.

Table 12 indicates number of group discussions (GD) and VHND conducted.

Table 12

Sl. No.	**Activities**	**Gulbarga**	**Yadgir**	**Bidar**	**Bellary**	**Total**
1.	Total no. of sessions with pregnant women	385	468	288	82	**1223**
2.	Total no. of GDs with mothers	538	513	313	129	**1493**
3.	Total no. of VHND s conducted	37	43	22	14	**116**

9. Staff trainings and review meetings

9a. Staff Trainings

Continuous improvement ofthe knowledge of SDTT-MPHC staff is an important part of the project. The following trainings and workshops were conducted between August 2013and July 2014.

- **First- aid training (training of trainers)-** 3 trainings were done in Gulbarga, Bidar and Bellary in collaboration with St. John's Ambulance, Gulbarga and St. John's Medical College, Bangalore. All the project district staff and few members identified as field trainers from other projects were trained.

- **Treat and track malnourished children (Nutrition management training) -** 2 day (29-10-2014 to 30-10-2014) training program in Bidar was conducted for all the field staff on how to treat and track malnourished children. Special exposure visit was arranged with the self help group of Wadagaon village that is manufacturing the My Nutrimix product under DWHH nutrition project.
- **Zone wise microplanning workshop-** 2 day (18-03-2014 to 19-03-2014) microplanning workshop was conducted at Shahpur, Yadgir. The field staff from Gulbarga, Yadgir and Bidar was trained on planning day wise field visit and field level monitoring of the three target groups in each zone. Similar, workshop was conducted in Bellary for the field staff on 24-03-2014.

9b. Review Meetings- District and Head Office

The progress of the project is reviewed on a monthly basis at district level and an all district review meeting is conducted once in every two months. During the review meetings the monthly progress of every ORW is reviewed and they then prepare the action plan for the next month. The following table describes the total number of review meetings conducted.

Sl. No.	Review meetings	Gulbarga	Yadgir	Bidar	Bellary	H/O	Total
1.	Monthly review meetings	12	12	12	12	N/A	48
2.	SDTT-MPHC central meeting	1	1	1	0	3	6

9c. Donor Field Visits

Mr. Govind Madhav, the then Program Officer at Sir Dorabji Tata Trust had visited three districts between August 2013 to July 2014. He had visited the Bellary district (21-08-2013) and field staff along with Dr. Maya Mascarenhas and reviewed the progress of initial field activities. He had suggested streamlining of the action plan which was duly accepted in all future plans. His second visit to Yadgir district was on 11-03-2014, during that time he had visited the Nagnoor Gram panchayat and some arsenic affected villages. In order to make the field level monitoring more effective he had suggested zone wise planning and monitoring with the assistance of ASHA in every zone. Also, he had visited Jeratagi PHC in Gulbarga district on 13-03-2014. He was impressed with the field and documentation work in the area and had suggested to improve the work in every PHC to that level.

SDTT-MPHC Project Staff- Head Office & Field

The current SDTT-MPHC project staff includes of the following at the designated posts and locations.

Program Officer		Dr. Maya Mascarenhas		Bangalore	
Central Coordinator		Dr. Priyamvada Kumar		Bangalore	
M & E assistant		B.C. Reddy		Yadgir	
Accounts		Ashok		Yadgir	
District	**ORW**	**CRPs**	**District**	**ORW**	**CRPs**
Bidar	Nagaraj	Kavita	**Yadgir**	Devappa	Anwar Pasha
		Parvati			BapuGowda
		Sri Devi			Manjula
	Ladle Saab	Rekha		Basavaraj	Amaresh
		Rajappa			Renuka
		Mahananda			Viresh
Gulbarga	Rayappa	Sudha	**Bellary**	Tejaswi	Sruthi.V
		Parwathi			Uchhagemma
		Mahantamma			M.D. Maheshwari
	Ananda	Renuka			Maruthi
		Soubaghya		Nagaraju.O	Manjappa. B
		Laxmi			Bhagya

CASE STUDIES – Myrada Primary Health and Sanitation Project North Karnataka – 138 villages

Case Study 1:

TACKLING THE ARSENIC PROBLEM IN KIRDAHALLI THANDA, YADGIR DISTRICT

Kirdahalli Thanda, a remote little thanda (settlement) in SurpurTaluq of Yadgir district, threw up a very curious problem during the baseline assessment done in 2012. At least 70 of the 105 households had someone with either a skin problem or a chronic disease. Already 17 persons had died in the past 2 years.

On further exploration, we found that the underlying cause for the suffering of the residents of this village was the high level of arsenic in the ground water. This was a result of the flooding of a nearby closed gold mine, releasing arsenic based toxins into the ground water.

Like the many other villagers, Thipanna, son of Champulal residing in K. Thanda for more than 40 years was also drinking the unsafe arsenic water, and, as a consequence is affected with skin disease. He has been suffering from this problem for 12 years. He also told us that his mother had expired 3 years back due to skin cancer. Thipanna's family includes of five members.

During a special skin camp conducted in this area in collaboration with dermatologists from St. John's Medical College, Myrada ensured that Thipanna and others like him were checked. A total of 160 persons attended the skin camp. Thipanna was diagnosed with leucomelanosis on the trunk and back. This is a pre-cancerous skin problem, and if left untreated, may lead to skin cancer. Based on the specialist's advice, he was provided with plenty of free Whitefield ointment from the project. After 2-3 months, Thipanna has reported relief from skin itching and lightening of the skin lesions. Diagnosed and treated with some topical medicine.

In addition, Myrada has convinced the PHC medical officer and the ArogyaRakhsaSamiti to indent and purchase from their special fund, extra doses of Whitfield's ointment for these persons. Another 18 persons were referred to tertiary hospital for more advance skin problems some of them already having skin cancer. They were all linked to the Vajpayee Arogyashree Insurance scheme to defray the costs.

Thipanna- Reduced skin lesions on palm after 6 months treatment, August 13, 2014

Skin Camp K. Thanda- Dr. Rohini screening a patient, K. Thanda 16-11-2013

As a preventive measure towards Thipanna and the many hundreds like him from the 19 affected villages in this area. Myrada has conducted village wise campaigns on the importance of drinking only arsenic free water. In around 8 villages, the government has installed water filtration plants and charge Rs. 4/- for a 20 litre can. This water must be used for drinking and cooling purposes.

Two other measures taken up for prevention by Myrada are

a) **Pilot**ing the use of arsenic free home based filters providing arsenic free water at the home level using a filter with 1 litre capacity. This has been developed by Tata Consultancy Services R & D division. Their team came and demonstrated this to the villages, and currently a pilot is going on using 10 filters with volunteers. Tests for arsenic levels done before and after filtration have shown that they work effectively. If this is accepted by the community, it can be scaled up.

TCS Mr. Shankar Kausley demonstrating arsenic filter – Kiredalli Thanda, July13, 2014

b) Long term measures to provide an alternate source of water through rain water harvesting has been tried in 4 houses. The 2000 litres tank attached to this system in each house provides water to an additional 4 houses. Demonstration tests to show that the rain water was free from arsenic were done to convince the villages. As of now, 12 households are using arsenic free rain water for daily consumption through these units.

Thippana's daughter drinking water from the Rain Water harvesting system: July 30, 2014

Thipanna and other villagers in K. Thanda have shown a good support to all SDTT-MYRADA interventions and intend to support further. They have also expressed a need for a visiting skin specialist doctor at PHC level. MYRADA plans to scale up its interventions and meet the community needs to alleviate the sufferings of the people in K. Thanda and other affected villages. Myrada advocated with the Health Department to get special funds to address this problem, which they did through a supplementary PIP in October 2013. Myrada was also selected to conduct training for their frontline workers. However, the local DHO used up the funds for some other purposes and this training could not be done through this. SDTT funds were finally used to conduct the training in our working area only. To date, the

department has not conducted any specialist camps though they had received approval for the same.

Case Study 2:

MAKING OF AN ENTREPRENEUR OUT OF A DEPENDENT VISUALLY IMPAIRED PERSON, BELLARY DISTRICT

Pakiraswamy, a 22 year old youth from Ulavathi village, Bellary, was born with impaired vision in his left eye. With much difficulty he had completed his matriculation and had plans to work and support his parents. But, owing to his bad eye, he could not earn a steady income and was mostly dependent on his family. Pakiraswamy had a will to improve his means of livelihood and not just remain as a marginal construction labourer. Upon hearing about the special workshop organised by Myrada SDTT project, he immediately enrolled himself for it.

A total of 25 differently abled persons attended the four day (02-07-2014 to 05-07-2014) entrepreneurship workshop conducted by SDTT-MYRADA in collaboration with I-Create. The objective of the workshop was to change the mind sets of the disabled persons towards their entrepreneurship capabilities and develop pragmatic business plans. Apart from several team activities focusing on developing entrepreneurship skills, successful entrepreneurs from disadvantaged groups were invited to speak about their personalexperiences. Pakiraswamy actively participated and says he found it very encouraging and informative. All participants had prepared business plans which were judged by the local bank manager, PragathiGrameen Bank, H. Bommanahalli. Mr. Pakiraswamy had also prepared an elaborate plan which he intended to put into action after reaching his village.

Aspiring Entrepreneurship Workshop, Danapur Training Centre, Bellary 02-07-2014 to 05-07-2014

Pakiraswamy receiving AEW completion certificate

Myrada field staff, led by outreach worker Nagaraju, provided constant support to Pakiraswamy and other participants to prepare a more feasible business plan. With their help, he submitted an application to SC/ST Corporation on 19.07.2014 (under GoK scheme) for financial support to take up income generation programme (petty business). The idea of establishing own petty shop was discussed with the family members and all members expressed their co-operation. The family members expected ST/SC Corporation to give financial support of Rs One lakh (60% as grant and 40% as loan) to establish own business. But the corporation informed that the money will be provided only after the approval of the

application. The family members arranged a capital of Rs. 20,000/- to invest in the business. Pakiraswamy procured all the necessary items after doing a quick survey of the village demands from a nearby town and on 1st of August, 2014 successfully opened a kirana shop near to his home.

His shop started with a great response from the villagers bringing him an average daily income of Rs 400. It is a dream-come-true for Pakiraswamy who always wanted to be independent and sense the pride of supporting his parents. He is very enthusiastic to further improvise his shop after getting additional support from the SC/ST Corporation. Pakiraswamy says "the topics taught during the workshop at training centre are coming to use in his business and has expressed thanks to Myrada and SDTT project for all the motivation and guidance that made an entrepreneur out of a blind person".

Pakiraswamy's Kirana Shop in Ulavathi Village

As many as 5 disabled persons in Bellary have applied for SC/ST corporation scheme and are now in the process of executing their business plans. Other disabled persons are also finalising their business plans with constant support from I Create and SDTT-MYRADA project. Myrada plans to conduct many more such trainings in Bellary and other SDTT project districts.

CASE STUDY 3:

ENSURING FUNCTIONAL PUBLIC TOILETS FOR WOMEN IN DUBALGUNDI, BIDAR

Dubalgundi, a village in Bidar, with a population of 11909 and 1706 households, is head quarter to the Gram Panchayat, Primary Health centre and many banks. Despite such development, 80% of people go for open defecation from past many years. Many families in the village are well to do, but have not constructed toilets in the households due to myths and misconceptions.

In the absence of toilets, women, children and old people are the most affected ones. They have no privacy and have to wait either for dawn or dusk although with the threat of stray dogs, pigs, snakes etc. in the dark. They are also ridiculed by road commuters. The practice of waiting for appropriate time to go out for defecation have led to problems such as constipation, stomach pain and other gastric problems. It is especially cumbersome for women during any illness, diarrhoea, menstruation, pregnancy and post-delivery.

Dubalgundi village has four public toilets in the village that are built by the Gram Panchayat. When the team asked the women why they did not use the public toilets, most responded that there was no water supply in the toilets. Lack of water supply and improper maintenance rendered the public toilets unfit for further usage. Also, the public toilets were roofless which caused difficulty for women during rainy as well in summer season.

Public toilet ward no.3- before renovation

Discussion with Gram Panchayat
Dubulgundi, June 13, 2014

Myrada, with the support of SDTT, is working in the village for the past one and half years to improve primary health care in the region. Improving environmental sanitation and safe water supply is an important component of primary health care and program commitment.
The team had a detailed discussion with gram panchayat chairman Mrs.Padmavati and other members to make a detailed action plan. After careful need based assessment, Myrada agreed to install Galvanised Iron sheets and water tank in two public toilets in ward no. 1 and ward no. 3. As per the agreed terms MYRADA signed an MOU with the gram panchayat for maintenance of public toilets and support for the regular water supply. The gram panchayat and Myrada prepared a budget estimate, purchased the necessary material and installed the

G.I sheets and water tank. The total expenditure for renovation of two public toilets amounted to Rs. **50000**. Myrada paid for the materials (GI Sheets and water tank) while the labour was supported by the Gram Panchayat.

Labourers fixing of GI sheet - July 26, 2014

Public toilet ward no.3- after renovation- Aug,13, 2014

Currently 185 and 250 women in ward no.1 and ward no. 3 respectively are enjoying the benefits of clean and hygienic public toilets near to their homes. The women say they feel safer now and are utilizing the toilets at any hour of the day without any inhibitions. The intervention has brought shade during summer, protection during rain and regular water supply in the toilets. The community members especially women and young girls have expressed their gratitude towards Myrada.

This move has increased the awareness among community and the gram panchayat. They now show a willingness to construct many more such public toilets in the best interests of the community. MYRADA plans to replicate this intervention in other districts under SDTT project wherever there is a need.

Successes and Challenges

The implementation phase of the project was faced with several challenges but the project had worked its way through many of them. Some of the common challenges faced were:

- **Motivating the CBOs for active participation in the trainings and plan preparations**. Village health and sanitation committees were especially difficult to involve as many were non-functional or non-existent. The district project staff assisted the government health staff to establish new and functional VHSCs.
- There was lack of awareness on the importance of health check-up of severe and malnourished among the parents and frontline workers. **Mobilizing the community** for regular monthly health check-up of malnourished children was mammoth task but now it is a developing practice.
- In some PHC villages the thayi/ mother card of pregnant women was retained with the Auxiliary Nurse Midwife (ANM). MYRADA worked at community level by spreading awareness about importance of retaining thayi card with the mother. Later, it also brought up this issue with district officials and recommended changes. Now, every pregnant woman has her thayi card and also keeps a track of her health through it.
- A major challenge in the beginning of nutrition management intervention was the **documentation of tracking of nutritional progress of malnourished children**. All the staff are trained and retrained to improve their understanding of the tracking system. A standard format for tracking of every child has been provided through printed tracking registers. Every child is also given an unique identification number to prevent any repetition or misreporting.
- **Turnover of CRPs**: This has been a big challenge through the project. CRPs, which have been trained, have left for higher studies or other jobs. New recruits are difficult to find and train.

Successes

- Conducting CBO trainings was difficult but MYRADA through SDTT project has conducted several trainings of gram panchayat, VHSC, SDMC and SHGs.
- Nutrition management is an essential component of the project and MYRADA has made some improvement in the nutritional status of the children in all target districts.
- Under SDTT-MPHC project many disabled persons have received health check-up through the constant support of St. John's Medical College. Many disabled persons have been trained in entrepreneurship program; they are now making a living through their experience.
- All pregnant women now have thayi card and track their health status during the pregnancy. There is significant reduction in the prevalence of anemia among pregnant women in all districts.
- The CBOs have shown an increased responsiveness towards improving the environmental sanitation conditions in their respective areas.
- With the training of local first aid volunteers a systematic first-aid response is in place in every village.

Plans for Next Year

The second year of the project has seen the initiation of several interventions targeted mainly towards improving nutritional status of children, reproductive health indicators, disability health status and environmental sanitation and safe water supply. All the interventions are now being implemented in a systematicmanner without the initial glitches. In the 3rd year of the project implementation the existing interventions will be continued with greater focus on CBO involvement in community monitoring.

- Intensifying the existing interventions to meet the goals as was set by the community in the beginning of the project.
    - Tracking of malnourished children
    - Regular health camps
    - Environmental sanitation activities
    - Provision of safe drinking water
    - Community based rehabilitation activities
    - Promoting health insurance for the poor
    - Planning mobile health camps in collaboration with Indian Medical Association district branches.
    - Providing first aid services through the cadre of first aid volunteers.

- Involving the self help groups in community based monitoring of the three target groups.
- Intensifying the involvement of gram panchayats in improving the environmental sanitation and safe water supply indicators.
- Conducting more livelihood trainings for the disabled persons and linking them to livelihoods.
- Conduct trainings for government and private doctors in paediatrics and dermatology in collaboration with the respective departments of St. John's Medical College, Bangalore.
- Ensuring the availability of basic infrastructure in all the 8 PHCs with special focus on the poor performing PHCs.

Conclusion

This project has been an extremely important project for Myrada to venture into. The partnership with Sir Dorabji Tata Trust & Allied Trusts, has provided us with an opportunity to restore basic health services in North Karnataka although there is much to be done in this area.

We are very grateful to SDTT for their continuous and positive support through the year, and look forward to another year of successful implementation.

Annexures

1. CBO training manual
2. MYRADA-VHSC training manual
3. Village health plan
4. Gram Panchayat Sanitation Plan
5. Nutrition tracking format
6. My Nutrimix
7. Diet Diversity Score sheet
8. High risk pregnancy score sheet
9. PHC report card
10. Primary health care eight elements poster
11. Seasonal calendar
12. Eight elements flip chart