

Better Planning of Work amongst Human Resources available in the Sub-Center Level

A NRHM Guideline:

I. PURPOSE OF THE GUIDELINES:

The NRHM has catalyzed and directly supported a substantial increase in human resources available in the sub-center and village level. More than 100,000 nurses and 900,000 ASHAs have been added on.

However there are concerns about clear allocation of work between them, so that there is synergy and increased outputs- and not fragmentation and wastage of this precious resource. In a poorly managed scenario, the second ANM which was expected to double the work output of the sub-center, becomes an assistant of the first, and the net output remains the same.

The Operational Guidelines and Training Module 6 of the ASHA have clearly explained the work allocation and scheduling of the ASHAs work. This guideline is on the work allocation of the ANM. The ANM is also synonymous with the term multipurpose worker female. Different states have renamed this functionary as village health nurse, junior public health nurse etc. This applies to them to.

This guideline also briefly covers the work schedule of the male multipurpose worker.

II. APPROACH TO MAKING GUIDELINES:- THE PRINCIPLES OF DESIGN:

While making these guidelines we are conscious of a high degree of variability between sub-centers. Broadly speaking the workload of the sub-center functionaries and ASHAs depends on the following six parameters- each of which acts independently of each other. These are:

- a) The number of staff posted there (one or two ANMs with or without one male worker),
- b) The geographic distribution or scatter of the habitations (from within 1 sq. km to over 30 sq. km),
- c) The population to be served (though ideally 3000 in tribal areas, and 5000 in the rest, it could in practice vary from 1000 to 10,000) and
- d) The total fertility rate(TFR) or crude birth rate(CBR) (a Total fertility rate of above 3 and CBR of above 30/1000 would mean above 150 children below one year of age and 150 pregnant women for a 5000 population, and a CBR of 20 or less would mean less than 100 children and an approximately equal number of pregnant women.
- e) The frequency with which midwifery services of the ANM (syn: skilled birth attendance) are sought/ available. (Could range from less than 1% of sub-

centers in most non high focus states, to as high as 30% of all sub-centers in some of the high focus districts within the high focus states)

- f) The high endemicity of malaria or kala-azar in that sub-center area. At API levels above 10, the work would be overwhelmed by malaria control activity. Below an API of two there would be very little work on this score.

Permutations and combinations between these variables, would lead to a very wide variety of contexts. We must also add in other disease burdens, especially NCDs that the current program design does not emphasize, but which is essential to address under the 12th Five year Plan.

Understanding these problems - the guidelines below categorizes all the sub-center activities into five activity categories:

- a) Ambulatory Out-patient Services at the sub-center.
- b) Services delivered in the Outreach Mode: Immunization Sessions/Village Health and Nutrition Day.
- c) Services delivered during home visits and visits to the community.
- d) Midwifery services- which are also most often the only in-patient services of the sub-center- though it could happen during a home visit.
- e) Maintaining records, planning her work, building her capacity.

(In addition to this one should include two days per month on school health – but ideally there is separate human resource deployed for the same. School health is not part of these guidelines- and can be seen in the RBSK guidelines).

These guidelines also indicates how work allocation between these five categories of work would vary based on the six context parameters, so that districts and states could adapt and issue these guidelines to suit their contexts- but at all times ensuring that the work of the ANMs, the male worker, the ASHA and the health worker of the *Anganwadi Worker* are all synergized and maximized.

We estimate that every week, 30 hours of each ANM or male MPWs time is spent on service delivery in one or other of the first four activity categories and another 10 to 14 hours on the 5th activity category- records, planning, meetings, inter habitation movement etc. Whereas for an ASHA it is 15 hours per week, all of it spent on contact with the community/ household- except on those days where she has to leave the village on escort functions or to attend training programs.

III. AMBULATORY OUTPATIENT SERVICES AT THE SUB CENTER:

Time Spent in Sub Center: Distribution within available staff:

If both ANMs are present, field visits are organized such that the sub center is open with at least one ANM present, on all 5 days of the week.

If one ANM is present, at least 2 days are marked as days when the ANM is present in the sub center.

It is desirable that on 2 other days, she is present for at least 2-3 hours in the morning before she goes for field visits. However this would not be possible if distance is considerable and 2 days at the sub center is all that would be available for her.

Services at the Sub Center:

In the sub center, those seeking her health care services come to meet her and they could be from any of the following category:

- a) Those who missed attending the immunization outreach services or VHND and therefore could not avail of the services offered there (ANC registration & check-up, immunization, blood & urine tests, IFA tablets, access to contraceptives etc.)
- b) Those with common ailments – fever, cough, diarrhea, RTI/STI& others – for which she provides first contact care
- c) Any acute fever for which blood smear/RD test must be done, and anti-malarial given or referral made as indicated
- d) Any patient with chronic illness coming to meet her to collect their monthly free drugs / follow-up visit. (Including TB, HIV, leprosy, and if included in package- hypertension, diabetes, epilepsy, asthma etc. In all such cases, drugs have been initiated at a higher level- and this is only a provisioning and follow-up function.)
- e) Those coming for special family planning needs – e.g. emergency contraceptives, pregnancy tests, IUD insertion, etc.
- f) Those referred to see her by the ASHA (could be for any of the reasons cited earlier)

It is estimated that in a population of 5000, the weekly load of patients would be about 30-50. This is with the understanding that ASHAs are also taking care of some part of the caseload during their home visits, VHNDs are also managing some part of it and the nearby PHCs are functional. If any of this is defective, then out patient attendance could be more.

Special “Day Clinics” can enhance attendance for ambulatory outpatient services. Each of these could be held once a week:

- a) Adolescent wellness clinic/session
- b) Family counseling clinic
- c) Chronic illness clinic

If there are two ANMs, the work of these three clinics should be divided amongst them, with one ANM being responsible for one or two of these clinics. This facilitated

skill building. The male worker should be attending to males in the adolescent and family counseling clinic and attending to the chronic illness clinic.

In sub-centers of high work loads- either due to high fertility, or high requirements on midwifery services, this is the only occasion to attend to these chronic illness services- and those who do not come to the sub-center could get missed out. In low case-load areas, we must ask for home visits to follow up those with chronic illness, who missed collecting their medication or failed to come for follow up. Similarly in sub-centers with high dispersion of habitations, and only one ANM, the clinics may have to be clustered and held within three half-day sessions- giving more time for home visits. On the other hand where the full complement of staff is there it could be spread out over three days, with good home visit follow ups as required.

IV. ACTIVITIES DURING IMMUNIZATION OUTREACH SESSIONS / VHND:

Distribution of work amongst two Sub-center Staff:

The responsibility of attending the VHNDs is divided between the two ANMs except for those, which are held in the sub-center building itself when both could be present. The main work of the MPW is in vaccine delivery to the immunization session and attendance there.

Some states have separated immunization outreach sessions from VHNDs – reserving the later for all outreach activities other than immunization, especially focusing on health education

In other states, given the number of immunization delivery sites (outreach sites required), these are the same as VHNDs

Services available at VHND

In any immunization outreach session / VHND, the following activities must be scheduled:

- a) Routine immunization
- b) Antenatal care (all components)
- c) Postnatal care (all components)
- d) Issue of IFA tablets to adolescent girls
- e) Delivery of condoms or pills
- f) Counseling on family planning
- g) Treatment of patients with any minor illness, who come to seek her services
- h) *Follow-up visit for any chronic illness who come to seek care (in remote and inaccessible areas, in areas of low case load of children for immunization)

- i) Making blood slides/doing RD tests on any patient with fever and giving treatment if required.
- j) Counseling on nutrition, especially for pregnant women and children

Note: Most immunization sessions/VHNDs are held in an *Anganwadi Center*. And this has the following advantages:

- a) *Anganwadi Worker* also use the same platform to provide take-home ration to children below 2 years of age
- b) *Anganwadi Worker* could refer and ensure that sick children or any other condition requiring ANM's services are encouraged to attend the session
- c) *Anganwadi Center* could store some of the supplies or material that ANM needs, thus saving the ANM having to carry it each time

Clarifying ASHA's role in VHND:

The ASHA is expected to participate in every immunization session/VHND and her role is as follows:

- a) Mobilize and ensure that children requiring immunization as per schedule are present
- b) Pregnant women requiring ANC/PNC are present
- c) Any minor illness or chronic illness requiring to meet the ANM are present
- d) Any eligible couple who
 - i. Has an unmet need but the ASHA has been unable to convert to an unmet demand for services
 - ii. Those on contraceptives with side-effects
 - iii. Those requiring change of contraceptives or initiate on oral pills
 - iv. Women requiring other services or those who need to discuss such options
- e) While ANM is busy with immunization, ASHA could take the opportunity for health education and counseling work.

Time spent on Immunization Outreach Sessions/VHNDs:

In a population of approximately 5000, we expect 100 infants in non-high focus states and 150-200 in high-focus states, with an equal number of pregnancies. This translates to 60 children per month for immunization and 15 children per immunization session in non-high focus states. In high focus states, there would be around 100 children per month and 25 children per immunization session.

Where hamlets are scattered or population is larger than 5000, one would need 2 immunization sessions per week and it desirable to have 2 ANMs. In others, one session per week is adequate, and it is quite possible for one ANM to manage.

Time spent on ANM going to ILR site to get vaccines and again go back to deposit unused vaccines should be completely eliminated by deploying the male worker or other alternate vaccine delivery system. This is particularly important where the vaccine has to be collected or deposited the previous or next day, which could compromise the vaccine quality. In such sites MPW (M) or alternate vaccine delivery system must be used.

V. ACTIVITIES DURING COMMUNITY / HOME VISITS:

Distribution of work between sub-center staff:

If there is only one ANM and one immunization outreach session/VHND per week, then there are 2 days of sub center work and only 2 days available for community visits.

However, where the sub center is located in a large village or population is not dispersed, the ANM can open the sub center for 2 to 3 hours in the mornings and then make home visits in the afternoon session, which makes 4 days of home visits or 12-15 hours of home visits.

If on the other end, there are 2 ANMs, then 4 full days can be devoted to community visits per week i.e. 30 hours of home visits are available other than sub center being open on all 5 days of the week

In addition each ASHA makes about 12 to 15 hours of home visits per week and since we expect 5 ASHAs in a population of 5000, we should add another 60 to 75 hours of home visits.

Given an approximate number of 1000 to 1200 households and about 30 minutes taken for each household visit, 500 to 600 hours is needed for all households to be visited once. So even at peak availability of about current human resources we would provide only 100 hours per week of home visit, which would mean only one visit per household will take place in 6 weeks. This is why it is essential to both strategize the visits and make it a team effort.

It is important to strategize the visits so that households most at risk are visited most. Otherwise, what public health science calls the problem of "*inverse care law*" will apply – "*The availability of good medical care tends to vary inversely with the need for it in the population served*". Also it is essential to take a team approach- where the ASHAs, the two ANMs and the male worker, and the *anganwadi worker* are part of a singular team- who synergizes their movements for a maximum outcome. This is not to be confused with duplication of work- and multiple levels of attentions are part of planning for service delivery. However, if not synergized, it could become duplication of effort and wastage of human resources.

Prioritizing Households for Home Visits:

All households are divided between the two ANMs- as evenly as possible, with some adjustment for distances. No household should be without an assigned ANM and an ASHA.

Home visits are essential- and we indicate below how this could be planned. Adapt this table to your needs. (*Anganwadi Worker* roles are indicated in the ASHA column and have been also elaborated in box):

With the help of the ASHA, it is imperative to identify the households where visits have to be prioritized:

ASHA	ANM /MPW (M) (MPW (M), wherever available will focus on Non-RCH activities, allowing ANM to focus on RCH activities- but both act as a team)
At least 4 visits to every pregnant women at home- especially during the last month	Pregnant women who did not attend their regular ANC's in the VHND, especially if they are in their 9th month of pregnancy
6 visits after delivery for every case of institutional deliveries and 7 visits for every case of home delivery	Post partum mothers who need home based services- either as indicated by the ASHA after a home visit, or if ASHA is not there, because they failed to attend VHND
Every children who needs immunization, for mobilization	Children who missed their immunization sessions
6 visits for every case of institutional deliveries and 7 visits for every case of home delivery Counseling for malnourished children. (this work is shared with <i>anganwadi worker</i> , with latter being more accountable for the same)	Sick new born and children who need referral but are unable to go, as indicated by ASHA. Malnourished children beyond grade III who did not go for the medical reference.
Visits every household with eligible couple	Families with whom ASHA is having difficulty in motivating for changing health-seeking behaviors, adopting family planning methods and who did not come to VHND..
Identify and refer patients with chronic illnesses. Preventive counseling with respect to tobacco control, diet and exercise, especially to adolescents	Patients having chronic illnesses, who have not reported for follow-up at the sub center or VHND
Identify fever cases, makes blood slides, conducts RD tests and refers positive	Prioritizing visits in areas where Fever Treatment Depots/ASHAs have not

cases. If not having	been deployed
	Collecting blood smears or performs RDTs from suspected malaria cases during domiciliary visits and maintains records. Providing treatment to positive cases
Identifies seriously ill cases and refers them PHC or higher centers for immediate treatment and if necessary accompany them	Where ASHAs have failed, advise/counsel seriously ill cases to go to higher centers or provide possible home based care
Assist ANM & MPW (M) in distribution of LL Bed Nets, Sprays & insecticide treatment of community-owned bed nets	Distribution LL Bed Nets; facilitate and ensure quality spray in households and insecticide treatment of community-owned bed nets
Reporting child births and any deaths	Verbal autopsy/ or at least preliminary inquiry into any maternal or child death.

What emerges from the above list is that if there is an ASHA, we could identify and make lists of those who have missed out on VHND/sub-center services, and prioritize her visits accordingly. If ASHA is not active and synergized, looking at the number of households and time available with even ANMs it would obviously difficult, if not impossible for ANM to reach all the 600 plus households in her area!!

VI. MIDWIFERY SERVICES AT THE SUB CENTER

Most sub centers today are no longer offering midwifery services. One of the major reasons for this is the improved roadways and transportation services. And with the availability of referral transport and drop-back facilities, it has become easier for the pregnant woman to go to the PHC or higher centers, where there is a health team available with a higher quality of assured services.

However, in about 10% of sub centers (range from less than 5% to 30% in some areas), ANM services for safe delivery are still sought after and indeed essential to save lives. In such areas, it is essential to keep the sub center at the level of preparedness to conduct institutional deliveries, even if the frequency is low. This is because access to health is more assured and because supply support and even emergency referral is more readily available in sub centers.

However, there are areas where the pregnant woman cannot come even to the sub center and in such places it is essential that the ANM go for safe delivery at home. In all such areas it is mandatory to post 2 ANMs and in sub centers where

deliveries are more than 20 per month, there is also provision to position a staff nurse.

When a pregnant woman is in labor, whether at the sub center or at home, it is mandatory for one of the ANM to be with her, until at least 4 hours after the 3rd stage of labor is completed.

The other tasks of the ANM are to be adjusted so as to prioritize these services.

VIII. MAINTAINING RECORDS – SYNONYMOUS WITH “ORGANIZING A POPULATION BASED APPROACH TO CARE”

In addition, to all the above work, register entries and housekeeping work would be about 1 hour/day, with Saturdays devoted to catch up on registers; data entry; report preparation and review meetings.

The main purpose of records should be to improve the quality of care provided to service users and to measure and plan for service needs and health outcomes in the population. The use of records to monitor her work, should flow from this priority- rather than dictate the design of registers and their use.

This implies first and foremost that the sub-center functionaries have a common list of all households in their service area with their family members. Then households are distributed amongst them

Ideally every sub-center should have a folder for every family under her care. This should be ideally in a digitized form but even a manual register with two pages dedicated to every family will also suffice for the time being. They should maintain this register with help of the ASHA and must have detailed records e.g. name-based list of children who require immunization etc.

This folder should have:

- a) MCH card for all mothers and children
- b) Simple card/register to line-list all the health events
- c) Separate card for anyone on a TB/HIV/Leprosy/Kala-azar treatment protocol.
- d) Separate card for anyone attending the special clinics – adolescent wellness, family planning, chronic illness etc. or being followed up at home for any chronic illness.

The MPW (M) in sub centers where they are posted will maintain records related to all non-RCH activities- items 2, 3 and part of 4 above.

There should be a set of population-based indicators for each sub center, which should be computed annually and quarterly and displayed.

IX. NOTE ON THE MALE MULTI-PURPOSE HEALTH WORKER:

It is estimated that the male multi-purpose health worker is present in less than half of all the sub-centers. This of course has to change, and we need such a worker in all sub-centers.

The work of the male MPW has been listed in each section above, and therefore there should be a clear picture. The important part is that except for ANC, PNC, and some elements of family planning the male worker is a part of every activity- and the female worker also helps in all. However the accountability of the male worker is to ensure that all the acute disease care and chronic illness follow up – including of chronic communicable disease like Tuberculosis, leprosy and HIV is followed up.

X: MONITORING AND SUPPORTIVE SUPERVISION:

What should be done?

Every ANM/sub-center should be visited at least once a month by one of the supervisory team from the PHC and block level- and they should spend the whole day, working with the team. This is on the job training and supportive supervision.

There is a review meeting at PHC level one day every week, usually the Saturday- and once a month, this same meeting could be held at the block level.

The sub-center would submit a consolidated work report, which has all service delivery data – once a month. This report could be on paper, or if she has the skills and equipment, in a digital format- the latter obviously being preferred. Disease surveillance however could ask for more frequent reports.

Facility level data should be carefully converted into indicators, it's meaning interpreted and feedback provided to the sub-center.

What should not be done in the name of monitoring?

- a) Call the ANM to the block or PHC and keep her sitting there for entering all the data into the computer. This often takes multiple visits and days and robs the population of her services.
- b) Ask for frequency of reporting at more than once per month. More frequent reporting is not seen as a desirable- and creates a notion of surveillance, which is resented without adding anything to the quality of supervision. Seldom do supervisors who are making field visits have the time or ability to process and respond to data flowing more frequently.
- c) Fail to provide a feed- back on reports.
- d) Fail to provide skill development inputs and encouragement during field visits and meetings.
- e) Threaten or admonish service providers reporting child and maternal deaths truthfully. However if careful non-threatening inquiry shows willful neglect, or actions in bad faith, or even non reporting/ hiding of deaths in their service area, that of course must be actionable.