MATERNAL AND CHILD HEALTH : MANAGEMENT ISSUES AT COMMUNITY, HEALTH POST AND DISTRICT LEVELS

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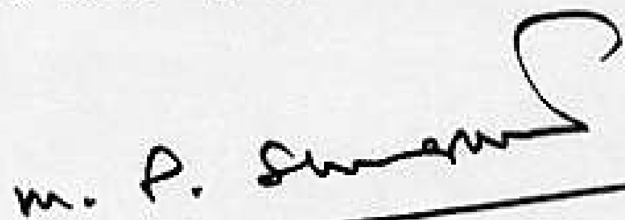
Message from the Honorable Minister of Health, Prof. Mathura Prasad Shrestha

One of the basic rights of all Nepali citizens is the right to health care. This is especially true for the mothers and children of our country who still face particularly high risks of morbidity and mortality. His Majesty's Government is strongly committed to health for all by the year 2000 and thus, cut the infant and maternal mortality rates by half. In order to achieve these goals and provide adequate and appropriate maternal and child health services to those in rural and remote areas of the country, effective and efficient management of health care services plays a crucial role. This paper has explored some of the management issues that affect the ability of the health managers at the community, health post and district levels to implement health services for mothers and children. This is a timely paper as our country focuses on the integration and decentralization of health care services and emphasizes maternal and child health. Though the Division of Nursing initially collected the data found in this paper for the National TBA Training Programme, the findings are relevant to all health programmes being implemented in our communities of rural Nepal.



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Prof. Mathura Prasad Shrestha
Minister of Health
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Appreciation must ultimately go to the health staff at health posts, District Public Health Offices and hospitals who took time to answer the questionnaire frankly in the hope that the findings will help to draw attention to the problems of providing maternal and child health to the women and children of rural Nepal.

Glossary

1. AHW - Auxiliary Health Worker
2. ANM - Auxiliary Nurse Midwife
3. ARI - Acute Respiratory Infection
4. CHV - Community Health Volunteer
5. DON - Division of Nursing
6. DPHO - District Public Health Office
7. EPI - Expanded Programme on Immunization
8. FP/MCH - Family Planning/Maternal and Child Health
9. HPIC - Health Post In-charge
10. Ilaka - A political division and service area for one health post
11. MCH - Maternal and Child Health
12. MCHW - Maternal and Child Health Worker
13. MOH - Ministry of Health
14. ORS - Oral rehydration Solution
15. PBHW - Panchayat Based Health Worker
16. PHN - Public Health Nurse
17. TA/DA - Travel Allowance/Daily Allowance
18. TBA - Traditional Birth Attendant
19. TT - Tetanus Toxoid
20. VHR - Village Health Records
21. VHW - Village Health Worker
22. Ward - Lowest policital division, can include several villages

FOREWORD

Nurses have been integrally involved in the provision of Maternal and Child Health services at all level of the health care system. Though many achievements have been made, there are still many problems that prevent the effective and efficient provision of MCH to the mothers and children in rural Nepal. It is with the intention to shed light on some management problems so that changes can be enforced and improvements made that this paper was written. With the current review and reorganization of the Ministry of Health, it is hoped that the findings and recommendations in this paper will be integrated in these new plans.

Mrs Bimala Maskey
Chief, Division of Nursing
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December 1990

MATERNAL AND CHILD HEALTH: MANAGEMENT ISSUES AT COMMUNITY, HEALTH POST AND DISTRICT LEVELS

Preface

On our visit to a district in a mountainous area of rural Nepal, Division of Nursing (DON) staff found no ANMs, no PHN, nor family planning assistant at the District Public Health Office. The District Health Office visited provides no maternal and child health services and although Traditional Birth Attendant (TBA) and Community Health Volunteer (CHV) training has been conducted, it was very difficult to communicate or meet with these grassroot workers due to the difficult terrain and severe weather. There was no on-site supervision of health post staff due to district staff shortages, nor was there equipment for MCH at either health post or District Public Health Office. During a visit to one of the more accessible health posts of that district, the health post staff informed us that no women visit the health post as there are no female health staff since the two ANMs posted in this health post are on deputation to a health post in the district centre. The only MCH activity provided at that health post was immunization for infants and children.

During an assessment trip to another district located in a hilly area, we found that though there is no PHN, there are ANMs at the District Office. However, these ANMs refuse to go out to health posts to supervise or conduct training. They do hold an MCH clinic at the district centre daily. Although this clinic seems well equipped, we found that growth monitoring and maternal records were not properly filled out, making patient follow-up vertually impossible. Although they have a postpartum clinic, this clinic provides only immunization for newborns 6 weeks or older and no assessment of mother's health. Both TBA and CHV training had been conducted, but interest of the Health Post In-charges in these programs and the volunteers varies and affected the quality of supervision and coordination. There was little consistency between health posts in management of MCH activities.

In the Terai, during an assessment visit, it was found that the District Public Health Officer (DPHO) had to manage programs for a population of 500,000 in 918 wards. Therefore, he was responsible for the training of 918 CHVs in 9 Ilaka health posts and ultimately 300 TBAs. The health posts in this district had to cover 100 wards. The health post in-charge was to supervise 2 ANMs, 2 AHWs, 12 VHWs, peons and other assistants, plus train and supervise 100 CHVs and 30 TBAs. However, he was often away at the central level to attend workshops, training of trainers, and meetings. Fortunately, this district has a Public Health Nurse (PHN) and Health Inspector to help the DPHO, though they claim to have insufficient funds for TA/DA to go for health post supervision.

These are a few of the scenarios we observed during trips to 16 districts over the past two years. Some health posts appeared well managed with enthusiastic staff. Most were seriously lacking effective management, sufficient staff, equipment and supplies to provide even basic MCH services resulting in low health worker morale, limited job satisfaction and ultimately poor quality work. The following paper gives a glimpse into the management of MCH services from district, health post and community perspectives.

1.0 INTRODUCTION

1.1 Purpose of Paper

The purpose of this paper is to examine management issues related to Ministry of Health Maternal and Child Health (MCH)[1] service delivery at district, health post and community levels. The paper aims to identify current management strengths and areas that require strengthening, as well as to raise management issues for future discussion. Specifically, the paper examines the following management areas that affect the provision of MCH service delivery:

1. Types and avilability of manpower providing maternal and child health services at district public health offices, health posts and communities;
2. Feasibility of job descriptions and workload realities;
3. Level of data collection existing at the field level to monitor and evaluate MCH services;
4. Scope of MCH services being provided;
5. Adequacy of equipment and supplies to carry out MCH services.

Data for this paper have come primarily from surveys and supervision field visits conducted by the Division of Nursing technical staff in 15 districts between November 1988 and August 1990, and from interviews with senior health planners and policy makers both inside and outside the Ministry of Health in 1990.

It is hoped that the findings presented in this paper will assist health planners and policy makers in evaluating the delivery of maternal and child health services at the field level and in developing viable solutions to existing management problems.

1.2 Background

According to the Ministry of Health, maternal and child health focuses on women during their childbearing years and children in the first five years of life.

The first formal program in Nepal started in 1964-65 when the country had only 9 health posts and 36 hospitals. It was at this time that the Institute of Medicine began to train Auxiliary Nurse Midwives to be stationed at health posts to carry out maternal and child health activities. Prior to the MCH program, emphasis in the health sector had been on the eradication of malaria and smallpox. After these two diseases were brought under control, the emphasis shifted to preventive activities and to the treatment of tuberculosis and leprosy. These initial programs were vertical in structure with each program having its own cadre of health workers.

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1 In this paper, Maternal and Child Health includes Family Planning/Child Spacing.

In 1972, the decision was taken to integrate the vertical programs at the health post level in a sample of districts. To manage and supervise maternal and child health activities in these districts, a Public Health Nurse was posted at the Public Health Office of these few integrated districts. This integration continues at the present time with all health posts currently either partially or fully integrated.

The 1980s has been a period of further refinement and redefining of maternal and child health. In 1984, a national workshop on Maternal and Child Health was held and a Strategy for Maternal and Child Health was developed. The Ministry has placed increasing emphasis upon outreach activities and training of female workers and volunteers in an effort to reach the goal of Health for All by the Year 2000. A number of workers and volunteers were created during this period including Panchayat Based Health Workers (PBHWs), Community Health Leaders, Village Health Workers (VHWs), Trained Traditional Birth Attendants (TBAs), Community Health Volunteers (CHVs) and Maternal and Child Health Workers (MCHWs). The latter four categories of workers and volunteers remain an integral part of the maternal and child health care delivery system. TBAs, CHVs and MCHWs are all local, rural women who are trained to provide MCH services within their own communities and strengthen health post MCH service provision.

Furthermore, in this last decade, research on the causes of maternal and child mortality and morbidity has been increased and attention given to identifying low-cost, high impact health interventions both globally and in Nepal. The use of Oral Rehydration, Vitamin A and Iodine therapies, identification and treatment of Acute Respiratory Infection, and emphasis on child spacing and temporary methods of birth control have been added to traditional maternal and child health strategies. National immunization activities and coverage targets were expanded to match international efforts to eliminate childhood diseases that lead to mortality and lifelong disabilities.

Efforts to increase the integration process and reduce vertical program approaches are being attempted. Currently, each of the 75 districts have a district public health office and nine Ilaka health posts (for a total of 75 public health offices and 675 Ilaka health posts nation-wide) with health manpower working in MCH activities at district, health post and community levels. Most recently, the FP/MCH and EPI vertical projects have been integrated into the Ministry of Health as separate Divisions indicating the government's further commitment to maternal and child health care. Thus, MCH in Nepal has grown from humble beginnings to a nation-wide multi-faceted program in only three decades.

1.3 Method of Data Gathering and Analysis

This paper deals primarily with the findings of three baseline surveys conducted by the Division of Nursing. The original purpose of these surveys was to collect information for district TBA training programs. Specifically, the Division needed to know where TBAs could make referrals within their own districts for antenatal and postnatal care, for high risk pregnancies, for complicated deliveries and for family planning and immunization. This information would be fed into the training program.

Survey questionnaires were developed by the Division of Nursing, and administered by Senior Public Health Nurses. Three questionnaires were used: 1) a health post survey, 2) a district public health office survey, and 3) a hospital survey. Data were collection on types and numbers of staff posts filled at the time of the survey, MCH equipment and supplies available, capacity to handle routine and high risk patients, as well as provision of routine maternal and child health services.

Surveys were conducted in October 1988 and January-February 1990. To date, data have been gathered from 15 DPHOs, 90 health posts and 11 hospitals in 15 districts. Nine of the 15 districts surveyed are located in the Central Region, three in the Western Region, two in the Mid-Western Region, and one in the Eastern Region. Annex A provides a list of the districts and hospitals surveyed. Plans are for the research to continue as the TBA training programs expands.

In addition to data from surveys, information on MCH activities and management issues was also gathered during district level trainings and supervisory field visits conducted by Division of Nursing technical staff within 34 districts during the last three years.

These data were analyzed for this report to provide a description of the management of MCH activities at the field level. Objectives of this analysis are:

a) To determine the availability of staff and volunteers to implement maternal and child health at district, health post and community levels;

b) To determine the types of maternal and child health services that are being offered;

c) To determine the availability of MCH-related equipment and supplies and examine the relationship between equipment/supply availability and provision of maternal and child health services;

d) To identify management problems to improve the consistency as well as the scope of maternal and child health services;

e) To determine whether the availability of the full complement of staff, equipment and supplies ensures the offering of MCH services;

f) To assess the level of supervision, reporting/recording, and monitoring for maternal and child health activities being implemented.

1.4 Limitations of Data

The Division of Nursing did not randomly select districts to be surveyed but rather surveyed those districts where TBA training was to be undertaken. Lack of a true random sample limits the usefulness of the data for making projections about the country as a whole. Furthermore, nine of the fifteen districts surveyed are in the Central Region, the most developed region in the nation. Therefore, the results may be biased toward more positive findings.

Not all health posts were personally visted by DON staff. Of the ninety health posts surveyed, 68 health posts were visited by DON staff and 22 questionnaires were filled in by interviewing ANMs or other health post staff from the health post during training at the district centre or from interviewing District Public Health Officers.

Data on services, equipment and supplies were collected by interviewing health post staff rather than the more accurate methods of observation and inventorying. Thus, the degree of reliability of the survey data on equipment and supplies is unknown and can only be verified by comparison with data from other sources.

Health posts that the nurses visited were well within a one-day walk of the nearest road. The fact that 68 of the 90 health posts surveyed were more easily accessible, gives further evidence that the data present a picture of manpower, service, equipment and supplies that is above average.

Surveys did not attempt to assess the effectiveness or management of specific programs such as EPI or Family Planning, but rather focused on the array of MCH activities being provided.

In spite of the limitations inherent in the data, these data do provide an up-to-date portrayal of staffing patterns, MCH services, equipment and supplies for maternal and child health among health posts, District Offices and hospitals surveyed.

2.0 MODEL OF MATERNAL AND CHILD HEALTH CARE SYSTEM

2.1 Components of MCH Program

The current (1990/91) Maternal and Child Health (MCH) Program in the Ministry of Health has six components:

1. Basic Natal Care
2. Family planning/child spacing
3. Maternal and Childhood immunizations
4. Control of diarrhoeal disease
5. Management of acute respiratory infection
6. Nutrition

2.2 MCH Care Delivery Infrastructure and Staff

Maternal and Child Health Care is delivered through the Ministry of Health (MOH) infrastructure. One cannot understand the management, supervision and monitoring of MCH programs without some knowledge of the MOH health care infrastructure. This infrastructure consists of five levels of management and implementation: Ministry (otherwise known as Central) level, Regional level, District level, Ilaka level and Community level. The following is a brief description of the structure for each level including MCH management responsibilities, MCH care facilities and MCH related job responsibilities of health workers.

1. Central Level

Although there is a Family Planning/Maternal and Child Health (FP/MCH) Division at the Ministry of Health which is responsible for the planning, administration and implementation of MCH programs nationally, the responsibility for the six individual components of MCH lie among a number of Divisions. For example, the Public Health Division manages projects for the control of diarrhoeal disease and treatment of acute respiratory infection and trains Community Health Volunteers to improve MCH practices, Nutrition Division is responsible for maternal and child nutrition, Expanded programme on immunization Division administers the national immunization program, and Division of Nursing trains MCH Workers and Traditional Birth Attendants in safe and healthy pregnancy and delivery and neonatal care. Most of the MCH programs found at the other levels are planned at and funded through the Central Level. As a result, planning at Ministry Divisions greatly influence community, health post, and district level MCH program implementation.

2. Regional Level

Recognizing the top-down approach to planning, the Ministry of Health has taken measures to decentralize and has established Regional Health Directorates in each of the five Development Regions. The Regional Health Directorate is headed by a Regional Health Director, usually a doctor, and supported by Regional Nurses and other administrative staff. This office coordinates, supervises and monitors health programs being implemented in each of the districts of their region. With regard to MCH, the Regional Public Health Nurses assist the District Public Health Nurses (PHN) to ensure a high standard of health care. They review family planning and MCH activities of the PHN at the district with a view to improve service. Ideally, the Regional Public Health Nurse provides guidance and supervision of the PHNs in efficient management of antenatal, postnatal and children's clinics at health posts and district MCH clinics in each district and advises PHNs for home visiting to identify family needs and prepare MCH care plans, follow-up of antenatal and postnatal cases and newborns. To ensure safe natal and child care practices, the Regional Nurse encourages PHNs to maintain close collaboration with TBAs and CHVs. The Regional Nurse ensures that records pertaining to MCH/FP volunteer activities are correctly maintained by PHNs. In actuality, only two of the five Regional Senior Public Health Nurse posts are filled.

3. District Level

Nepal is divided into 75 districts, and each district has a District Public Health Office and district hospital or health centre. This office administers the district public health program implemented through health posts, the majority of which deals with the six components of MCH, and often offers clinical MCH services at the district centre.

The District Public Health Office is managed by a District Public Health Officer who plans, manages, and supervises the implementation of health service delivery and health training programs throughout the district. Although planning is said to be decentralized, in reality, public health officers are sent targets and budgets for training and service delivery from central sources, and are left with the tedious job of juggling schedules and staff.

Ideally, this officer is assisted in MCH program management by a Public Health Nurse who oversees all MCH activities in the district and supervises health post staff to improve MCH services. The PHN provides, supervises and evaluates maternal and child health care including nutrition, health education, family planning, and school health. The major part of her responsibilities is to supervise and guide the Auxiliary Nurse Midwives (ANMs), TBAs and CHVs who are working out of the health posts and in communities. To date, only 12 of the 75 districts have posts for a Public Health Nurse. Ten of the 12 posts are currently filled. In districts without Public Health Nurses, ANMs work in the district health office fulfilling some of the PHN job responsibilities though there is no job description for ANMs working in the district public health offices. In addition to the Public Health Nurse, the district health office has an array of supervisors to look after specific programs such as family planning supervisor, EPI supervisor, and Malaria Supervisor, as well as administrative staff.

The district hospital staffed by ANMs, staff nurses, sisters and physicians provides secondary care for cases referred by health post staff or volunteers such as MCH complications and high risk cases. District hospitals usually conduct normal as well as complicated deliveries, and may provide other MCH services.

4. Health Post Level

Each district has nine Ilaka health posts which are the direct responsibility of the district public health office and a varying number of sub-health posts. Health posts provide preventive and curative primary health care, drug supply and outreach services utilizing paid staff and volunteers. Most of the MCH services reach the rural populace through health post activities.

A fully staffed health post has the following paid personnel to carry out primary health care activities, including MCH services:

One Health Post In-charge
Two Assistant Health Workers
Two Auxiliary Nurse Midwives
1-2 MCH Workers (new to program, not yet posted)
Seven to twelve Village Health Workers

The health post is managed by a health post in-charge who has a certificate in general medicine science which includes 2½ years of study in general sciences and math, general medicine, community health care, midwifery and gynecology, surgery and pharmacology. According to his job description, the health post in-charge (HPIC) administers, implements, supervises, monitors and keeps records of health programs including EPI, control and treatment of diarrhoeal disease, family planning, MCH, nutrition, health education, drug schemes, and a number of other programs outside the realm of MCH. The HPIC is responsible for holding an MCH clinic weekly for the care of mothers and children, plus separate clinics for immunization and family planning and outreach clinics which include MCH services. The HPIC supervises the work of ANMs, AHWs and VHWs to ensure that MCH and other primary health care activity targets are met. All health post reports are sent by the HPIC to the District Public Health Office.

The Auxiliary Nurse Midwife (ANM), after completing a 2-year program focusing on MCH and community health, provides, supervises, and evaluates MCH services including nutrition, health education, family planning, and school health through the health post. The ANM's major work responsibility is in the area of MCH and family planning, in particular basic natal care, management of normal deliveries, training and supervision of TBAs and CHVs, care of newborns, growth monitoring, prevention of the main causes of child mortality, and identification and management of clients for family planning. The ANM implements FP/MCH programs at the health post by holding clinics and making home visits. In addition to her work in FP/MCH, her job description states that the ANM is responsible for promoting of lactation, and immunization of mothers and children. Though the ANM is the main provider of MCH at the health post level, a recent survey of 51 districts in five regions by the Division of Nursing indicated that only 32% of the ANM posts have an ANM actively working and 50% of the health posts have no ANM.

MCH Workers are the newest addition to the MCH program cadre of workers with the initiation of training in 1990. The MCH Worker's job is to support the ANM, when present, and to carry out various activities of the MCH program alone, when no ANM is present. Chosen from their home communities, these literate women do not have to overcome the social and physical difficulties of being assigned to unfamiliar and often remote rural areas as ANMs often do. MCH Workers are provided a three month theoretical and practical training to prepare them to work in health posts providing MCH services. To date, no posts in Ilaka health posts for MCH Workers have been created, and though 564 have received a 3-month training, none are working.

5. The Community Level

MCH services are delivered at the community level through outreach services implemented from the health post along with services provided by trained local women.

Probably, the most important health post staff working at the community level is the Village Health Worker. The Village Health Worker (VHW) is a local person, usually a male, trained for 90 days in primary health care. The VHW is accountable to the HPIC but works within his own community (in approximately 9 wards) conducting household visits. He provides health education and motivation, some treatment and medicines and makes referrals when necessary. Most recently, VHWs have been trained in immunization and conduct immunization outreach clinics. Each month, the VHW is to visit homes in their own service area to provide immunizations including Tetanus Toxoid and child immunizations, motivate for family planning, identify and keep a record of pregnant women and all children under 5, motivate pregnant women to attend MCH clinic for antenatal care, give nutrition advice to pregnant women, and teach the importance of child spacing, ORT, lactation, using a trained delivery attendant and immunization. The VHW helps to make arrangements for either a trained TBA or health post staff to attend deliveries, refers for postpartum care and motivates for good postnatal nutrition. An important part of his work

is coordinating health education classes and trainings and assisting CHVs and trained TBAs with any problems. On a monthly basis, VHWs report to ANMs on MCH activities and the Health Post In-charge on all other activities. The VHW is the link between the health post and community and thus plays a critical role in MCH care delivery.

In 1990, the FP/MCH Division embarked on a new program to bring MCH to remote rural areas through Outreach MCH Clinics. This program is being introduced to 55 remote districts. The main objective of outreach clinics is to expand MCH service access for remote rural populations for whom long distance walking to reach a health post is not possible. The aim is to increase the ante/post natal visits to MCH clinics. Ideally, the outreach clinic is run by an ANM, with an AHW if the health post is fully staffed, and assisted by a peon to carry equipment. Services at the outreach clinic are mainly preventive including health education, temporary family planning method distribution, health check-ups for pregnant and postpartum women and for children under 5, follow-up of contraceptive users, family planning motivation and counselling, immunization sessions for mothers and children, ORS packet distribution, treatment for worm infestation and Acute Respiratory Infection (ARI) in children, treatment to children and mothers suffering from vitamin deficiency diseases, and provision of health education to mothers who visited the outreach clinic. The potential for success of this very impressive effort is severely hampered by the fact that half of the health posts are without even a single ANM.

To improve MCH practices in the community and increase use of health post and outreach MCH services, HMG is currently training two types of female volunteers: the Traditional Birth Attendant (TBA) and the Community Health Volunteer (CHV). National targets are set to train 12,000 TBAs (1 per 3 wards) and 36,000 CHVs (1 per ward) to meet the rural MCH service needs and to reduce maternal and child mortality and morbidity. TBAs are women already working in their communities providing basic natal care and are trained for 14 days by ANMs. They are taught safe methods of home delivery, and motivation for family planning/child spacing, immunization, lactation and good nutrition. Following training, TBAs are supervised by health post staff in bi-annual meetings and records on service delivery and mortality are collected. Since 90% of all deliveries in Nepal are at home, their role in improving maternal and child health and reducing mortality is significant. By the end of fiscal year 1990-91, 6,300 (about half of the targeted number) TBAs had been trained.

CHVs are local women who are trained for 24 days and supervised by health post staff. The CHV is the front-line worker in the overall MOH service delivery strategy. Working with the VHW and health post staff, the CHV is expected to promote the utilization of available health services (immunization, family planning, ORT, nutrition, first aid, antenatal care) at the health post and mobile clinics and the adoption of preventive health practices. CHVs provide monthly reports to VHWs. As of July 1990, 14,000 CHVs had been trained.

Official job descriptions of District Public Health Nurse, Health Post In-charge, Assistant Health Worker, Auxiliary Nurse Midwife, MCH Worker, Village Health Worker, Community Health Volunteer and the responsibilities of trained TBAs are attached in Annex C. Annex D also provides a summary and comparison of these job descriptions, including management, supervision and reporting roles of staff and volunteers.

In this section, we have briefly outlined the model of the MCH care delivery system managed through the Ministry of Health. In the following section, we will review the baseline survey findings conducted by the Division of Nursing to draw a portrait of the MCH service delivery scenario as it actually functions. It should be noted that at the time these surveys were carried out, TBAs had not received training and CHVs had only recently been trained and thus an anaysis of the impact of volunteers on MCH is not attempted.

3.0 FINDINGS ON THE IMPLEMENTATION OF THE MATERNAL AND CHILD HEALTH PROGRAM: THE FIELD EXPERIENCE

What follows is a summary of the main findings of the three surveys conducted by the Division of Nursing. Findings include availability of manpower, equipment, supplies and recording systems in health posts, District Public Health Offices and hospitals and investigates how the level of availability relates to the provision of MCH services. The tables mentioned in the text are found in Annex B.

3.1 Health Post Survey Findings

The availability of appropriate manpower is essential to providing basic MCH services. The survey indicates that the majority of health posts are not fully staffed. Of the 90 health posts surveyed, the vast majority of staff posts were filled for HPIC, AHW, and VHW positions (Table 1). However, 42% of ANM posts were vacant and 39 health posts had no ANM indicating a high proportion of health posts without female health manpower. As ANMs are the most critical and appropriately qualified personnel for carrying out the MCH program at the health post, the quality and level of MCH care services have to be reviewed carefully even where data suggest services do exist. Findings indicate that even in these well supported districts, significant deficiencies in staffing remain.

For the manpower that do exist, job descriptions are often outdated and job expectations unrealistic (see Annex C for Job Descriptions). New tasks are added to old job descriptions without eliminating out of date tasks, thereby increasing workloads rather than refining and re-prioritizing work expectations. This is particularly true for the VHW who is to cover populations ranging from 2,700 to 12,000 over varying distances and terrain to provide house to house preventive and curative services, distribute medicine and contraceptives, hold immunization camps and manage the logistics of a cold chain, plus supervise Community Health Workers and collect vital statistics. Health Post In-charges are supposed to supervise 15 staff and anywhere from 36 to 108 CHVs and 15-30 TBAs, in addition to managing clinics and any new programs, providing health care, and lab services, managing a drug scheme, treating leprosy, TB, malaria cases and attending meetings at the district centre. Often, in addition to service provision, health post staff are involved in either receiving training or giving training. Annex D summarizes and compares work tasks for six health post staff and volunteers. From this chart, it can be seen that some job descriptions are so old (i.e., the VHW job description) that small pox is still mentioned though it has already been eradicated and immunizations are no longer given. Often tasks performed or expected are not included in job descriptions or tasks supervisors are intended to supervise are not included in job descriptions - for example, the ANM job description does not include running an MCH program though the HPIC is supposed to supervise the work of ANMs running the program. Work expectations within job descriptions among the varied but inter-related staff and volunteer positions are neither coordinated nor inter-linked in a consistent manner, weakening the potential for a successful team effort in health service delivery.

During discussions with TBAs and CHVs, we found dissatisfaction in the apparent conflict of roles and inequality in training allowance and monetary benefits. Several CHVs stated that it was their job to do antenatal care, motivation for immunization and family planning and not the job of TBAs who were to only conduct deliveries in their opinion. TBAs, on the other hand, were distraught at getting less training allowance and no other financial allowances. Interestingly, many CHVs asked for TBA training and some already began doing deliveries following instructions in their manual. There was little coordination of the two programs at any level, and more often than not there was competition for trainers and training time. The only coordination found was that in several districts, trained TBAs were selected as CHVs.

Many health posts lack the necessary equipment for carrying out MCH activities (Table 2). While most health posts do have blood pressure cuffs, stethoscopes, needle and thread for suturing, scissors, and fuel for a sterilizer, unfortunately far fewer have sterilizers, baby or adult scales, height measuring tapes, suction tubes, albumin/sugar urine tests, delivery room or table, or haemoglobin tests. Thus in a majority of health posts, it would be impossible to do growth monitoring, normal deliveries, and test for protein in the urine and for anemia. Without a sterilizer, one must wonder at the ability of staff to maintain aseptic technique.

At the time of the survey, health posts were fairly well stocked with supplies required for MCH care delivery (Table 3). These findings should be viewed cautiously as the HMG drug scheme is known to provide sufficient supplies for only a portion of the year. The data are also limited in that health posts were not asked the amount of supplies available or existence of a drug scheme. When the survey was conducted, the majority of health posts had oral contraceptives, condoms, depo-provera, iron tablets, folic acid tablets, vitamin A, vitamin D, B complex, local anesthesia and gauze. Calcium tablets were not available in most health posts.

However, if we analyse the data on the basis of individual health post availability of essential supplies, we draw a slightly different picture. Nine essential/basic MCH supplies were selected to indicate the completeness of health post supply availability: oral contraceptives, condoms, iron tablets, folic acid tablets, Vitamin A, Vitamin D, gauze, and local anesthesia. It was found that only 28 of the 90 health posts had all these essential supplies needed to carry out MCH activities. The lack of a full array of supplies may be one reason why MCH services are not fully carried out.

The data points to the fact that temporary contraceptives were widely available at the health post level at the time of the study. Thus, it appears that the availability of contraceptive supply may not be a major obstacle to family planning acceptance.

The data on availability of MCH services at the health post indicate that family planning and immunization activities are strongest (Table 4). Almost all health posts offered family planning and immunization clinics. Three-quarters of the health posts provide an antenatal clinic but far fewer offer normal delivery or portpartum care. Nutrition counselling is said to be available in two-thirds of the health posts even in those health posts that lack equipment for growth monitoring. The weakest component of MCH services appears to be in the availability of care for delivery complications though both health post in-charges and ANMs have been educated in management of minor obstetrical complications. There appears to be little emphasis on postnatal home visits though one-half of infant deaths occur within the first month of life. Postnatal clinics are targeted at the 6-week old, apparently for the survivors, and do not provide care to the mother. Although successful child spacing is dependent on timely postpartum contraception, no efforts are made to either educate or motivate mothers to accept family planning during the postpartum visit. Apparently, the postpartum clinic consists mainly of infant immunization.

MCH services are genrally provided through a series of separate clinics such as immunization clinic, family planning clinic, antenatal clinic, MCH clinic and postnatal clinic, all usually held on different days. A pregnant woman who comes to attend an antenatal clinic may have to return another day to receive a TT immunization. The scope of services provided at these various clinics are not clear and may vary from health post to health post. An MCH clinic may

refer to an under 5 clinic or to an antenatal clinic and a postnatal clinic may offer only immunizations for newborns. Therefore it is difficult to analyze the data without a better understanding of specific services provided during clinics. The data do suggest that there is little consistency in the types and scope of services provided within clinics. As a result of this analysis, the Division of Nursing has redesigned its surveys to collect information on specific services provided at each clinic. Data on scope of clinical services for 8 districts will be available in early 1991.

The relationship between the presence of an ANM and the types of MCH services offered was analysed. Of the 90 health posts, 50 health posts had at least one ANM and 39 had no ANM present at the time of the study. We compared services offered at health posts with and without an ANM present (Table 5). The findings indicate that there appears to be little difference or correlation in the scope of MCH services provided between health posts with or without ANMs. The proportion of health posts offering newborn immunizations, deliveries, episiotomies, postnatal home visits is slightly, but not significantly, higher where there are ANMs, all other MCH services are offered at the same level regardless of the presence of an ANM. One of the most puzzeling findings is that the same proportion of health posts without ANMs (74%) are offering antenatal clinics as those with ANMs (78%). Similar were findings on postpartum clinics (46% with ANMs, 44% without ANMs) and family planning clinics (88% and 90%). Even for the treatment of delivery complications such as hemorrhage, retained placenta, breech and prolonged labour, there is no distinction between health posts with or without ANMs in the availability of these services.

As the survey questionnaire did not ask health post personnel to define exactly what care was provided during clinics, there is a need to question the quality and level of MCH care being provided in general and especially where there are no ANMs. It is clear from our understanding of Nepali culture and from our field experiences that male health staff are neither doing palpation nor auscultation on pregnant women. Division of Nursing staff visiting health posts during supervision trips have found that antenatal clinics often consist of administering Tetanus Toxoid and are void of any physical assessment.

The quality of antenatal care also comes into question by a look at equipment available at the health post. Only six of the 90 health posts had all five of the most basic equipment items necessary for an antenatal physical assessment (blood pressure cuff, stethoscope, fetoscope, adult scale, and albumin urine test). Thus, of the 68 health posts claiming to offer antenatal clinics, 62 are doing so without the most basic equipment and 29 without the availability of an ANM.

The survey also did not address the question of coverage so that although clinics exist, we have no idea of how many women and children are covered. It could be that in clinics with ANMs there are a higher number of women attending than in clinics without ANMs. Further investigation is certainly required.

Whether or not MCH services are offered, and which ones are offered may be determined to a great extent by the District Public Health Officer, district MCH program funding, and by the Health Post In-charge, rather than by the presence of an ANM. This impression is derived from looking at MCH services per district. In some districts, the program was quite strong in every health post, whether or not they had ANMs in their health posts, and in other districts the program was weak, regardless of the presence of ANMs. This finding suggest that ANMs in some areas are not given the responsibility to carry out MCH work.

It also appears that many MCH services are being carried out by personnel other than the ANM (though the scope and quality of services are unknown). Thus, the absence of an ANM does not mean that the MCH program at the health post is weak (at least it may appear strong on paper), nor does her presence ensure that the program will appear strong. ANMs have no decision-making power when it comes to MCH program implementation and follow the plans set down to her from her supervisor, the Health Post In-charge.

In order to monitor and evaluate the effectiveness, quality and impact of the MCH activities, accurate record keeping of services and vital events are essential. The survey found that of the 90 health posts, 31 have some type of family roster, 20 keep a pregnancy roster, and 21 maintain a nutrition roster (Table 6). Considering the high level of VHW manpower available and the fact that record keeping is a major part of the VHW's job description, the proportion of health posts maintaining records on targeted service population is low.

Availability of health post service records is equally discouraging (Table 7). During visits to health posts, Division of Nursing staff have found that many health posts are without maternal health record cards and that growth monitoring cards are either sorely lacking or not filled out properly, making identification of high risk cases, ability to conduct nutrition counselling, and provision of follow-up for mothers and children impossible. Health posts on the whole are not keeping records, and consequently are not able to monitor or evaluate their activities, nor supervise staff effectively.

3.2 Findings of the District Public Health Office Survey

The survey shows that the district public health offices do not have a full complement of staff to manage district-wide MCH programs effectively (Table 8). Though all districts have a Chief Public Health Officer, only six had a Public Health Nurse (PHN). It should be recognized that the districts surveyed have one half of the PHN posts for the country and thus are not representative of the national picture. Only 16% of the districts throughout Nepal have a PHN post. As the PHN post is responsible for the provision, supervision and evaluation of the MCH program in a district, there remains a wide gap in district manpower, in particular female technical/administrative manpower that is capable of managing a comprehensive MCH program.

Of the 15 DPHOs surveyed, eleven had an ANM. Districts with no PHN post are attempting to fill some of the PHN work responsibilities using ANMs. ANMs have no management training and have at least five years less education in comparison to the PHN. All but two of the 15 DPHOs had either a Public Health Nurse or an ANM. Curiously, one of the DPHOs that had neither an ANM nor a PHN offers a number of MCH services. Again, this finding leads us to question the scope and quality of care being provided in clinics.

Most DPHOs offer a number of MCH services (Table 9). All but one of 14 districts that provided information on services available through the DPHO offer family planning, eleven offer antenatal clinics, postpartum clinics and immunization services. The survey indicates that the DPHOs are weak in providing ORT and nutrition counselling, while mobile clinics and home delivery services were virtually unavailable at the time of this survey.

Two districts in particular provide few of the MCH service components. One offered no MCH services possibly owing to the fact that there was neither an ANM, PHN nor EPI assistant at the time of the survey. Another only offered family planning though there was an ANM and EPI assistant. Neither provided supervision for health post staff by district staff.

Although one District Public Health Office does not itself offer MCH clinic services, they do provide mobile clinics and coordinate with the SCF/UK MCH clinic located within the district centre. Thus, they rightly felt offering another clinic would only duplicate service. This district has a full array of manpower, including a Public Health Officer, PHN, ANM, FP/MCH assistant and EPI assistant, who provide mobile clinics, supervision and training for health post staff and manage the district program.

Two-thirds of the DPHOs surveyed kept no records of the total number of deliveries, the number of maternal deaths, or the number of neonatal deaths in their districts (Table 10). Of the three DPHOs, who did keep records on the number of deliveries, one kept records only on hospital deliveries, two kept records on hospital and ANM deliveries. No DPHO had records on the total number of deliveries for their district. This low level of record-keeping at the district level is related to the lack of records at the health post and community levels and leaves the district office without any means of monitoring the program on a regular basis and limits attempts to decentralize planning and to supervise health post staff.

3.3 Hospital Survey Findings

In all, eleven hospitals were surveyed: one mission hospital, two zonal hospitals, and eight district hospitals. Although there are no formal posts for ANMs in hospitals and ANMs are not trained to work in hospitals, this survey indicates that ANMs are the most commonly found staff working in hospitals. ANMs are usually filling posts meant for staff nurses. There was at least one physician found in each hospital, although not all hospitals had a hospital director and few had a Nurse In-charge. Therefore, although there appears to be at least minimal staff to provide routine natal care and other MCH services, staff to manage hospital services is lacking (Table 11).

District hospitals were understaffed for emergency maternal and neonatal care having neither surgeons, Ob-Gyns nor anesthesiologists.

Hospitals appear to be able to provide routine MCH care, however hospital facilities to handle complicated MCH cases were limited (Table 12). Of the eleven hospitals surveyed, 9 had operating theatre, only three had a blood bank and two had incubators. Though most could handle routine MCH care and simple perinatal complications, few could do caesarians or blood transfusions though most had operating theatres (Table 13). Most of the district hospitals surveyed handled less than 40 deliveries a month, though 2 larger hospitals handled over 60 per month. Hospitals have on the average 4-5 beds in total in one ward for labour, high risk cases, gynecology cases and postpartum recovery, often patients in the busier hospitals are found to be on mattresses on the floor. The number of women going to hospitals is said to be increasing, though capacity for patients remains constant.

With the lack of incubators, low birth weight and premature newborns might best be cared for at home with advice from health post staff knowledgable of the "kangaroo" technique or from trained TBAs who are taught how to care for "small" babies.

Although nine of the eleven hospitals had operating theatres, shortage of surgical staff, lack of anesthesia and poor condition of the theatre are reasons why only three or four of the hospitals offered caesarian deliveries, tubal ligations, IUD insertions, or laproscopies.

In summary, it appears that District hospitals are not equipped or staffed to handle serious complications and thus must be questioned as referral source for complicated MCH cases, especially those that may require some surgery or blood transfusion, until major improvements are made.

4.0 CONCLUSIONS

There is no doubt that a great deal has been accomplished in the area of Maternal and Child Health service delivery over the last three decades in Nepal. Stringent efforts have been made to get the much needed information and care to the rural areas. Mortality of infants, for example, has been declining, though, not as quickly has planners have hoped, and health service infrastructures have been created.

This paper indicates that much of the current constraints to improving health service delivery to mothers and children are management oriented and require critical review from a management perspective. Attention to management matters such as staff time management, clinic management, service scope and flow, job descriptions and workloads, linkages in chain of job descriptions, coordination and integration of trainings, cash flow timing and accounting system uniformity, and laws to protect the safety and rights of employees, especially women, could make vast improvements in the efficiency and thus the quality of services provided.

The infrastructure is in place, it is now time to make functional refinements, to fine tune the system, to reduce the frustrations of service providers, and make the system work for the mothers and children living in rural areas.

The final section of this paper outlines a number of management issues and points for discussion which have arisen from the findings. Some possible recommendations have been included and can be used as discussion springboards. These points have been highlighted to stimulate critical thinking and to encourage the reader to focus on the importance of management to attaining the goal of health for all for mothers and children by the year 2000.

5.0 ISSUES AND POINTS FOR DISCUSSION

ISSUES/POINTS FOR DISCUSSION	RECOMMENDATIONS
1. The Maternal and Child Health Macro Coordination	
1.1 Fragmentation of MCH The concept of "Maternal and Child Health (MCH)" is not viewed as an integrated package of six components. The term "MCH" is used inconsistently, and rarely refers to immunization or family planning. It appears that MCH most often refers to basic natal care at the level of implementation. As a result of this decomposition of MCH, MCH services are also fragmented and disintegrated at all levels.	a) Re-define MCH so that it fits operational realities. b) Integrate all components of MCH at least at clinics and in the community.
1.2 Unequal Resource Allocation for Various Components of MCH The pouring in of funds for specific MCH actities, diminishes the flow of resources into other MCH activities. There are large resource allocations for EPI and Family Planning and relatively little for Nutrition, Basic Natal Care, Control of Diarrhoeal Disease and ARI. Thus at community, health post and district levels there are high levels of activities for EPI and FP and little attention given to other areas.	a) Increase allocation of resources for other areas of MCH. Set policies that services must be provided in an integrated manner, so that family planning cannot be provided without postpartum care of mothers and growth monitoring for example.
2. MCH Management	
2.1 Clinic and Staff Time Management MCH activities are organized in a series of weekly clinics often scheduled for a few hours on different days resulting in poor staff time management, time wastage, and leaving little time for mobile clinics and community outreach, home visits, supervision, and follow-up. Services provided in these separate clinics are also fragmented and require patients to return on several occasions.	a) Review any existing clinic guidelines and develop a handbook or series of booklets for MCH clinic management. b) Organize clinics so that they provide the full array of MCH services one or two times per week and use remaining time to schedule other activities.
2.2 Scope of Services The scope of services to be provided in clinics is not specified and thus the scope of services varies from place to place for the different types of clinics. There are no written operational guidelines or task guidelines.	a) Include operational and task guidelines in clinic management handbook.

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ISSUES/POINTS FOR DISCUSSION	RECOMMENDATIONS
3. Coordination of Research and Implementation	
3.1 Nepal-Specific vs. Global Health Intervention There is an emphasis on global interventions rather than seeking Nepal-specific interventions. For example, though one-half of infant deaths are neonatal deaths, no emphasis has been given to neonatal care, prevention of hypothermia, prevention and treatment of neonatal asphyxiation. Only TBAs are encouraged to do postpartum home visits within the first 24 hours following delivery, on the 4th and 7th days. Little attention is given to the underlying causes of most childhood illnesses such as control of diarrhoeal disease in particular, improving personal hygiene, nutritional status and community sanitation.	a) Increase the use of and access to research on causes of infant and maternal mortality in Nepal to develop Nepal-specific interventions. Publish a health research review periodical which emphasizes applied health research. Require researchers to give talks at the Ministry of Health on research findings. Involve researchers in the development of health intervention proposals related to the topic of their study.
3.2 Poor Coordination at Central level Results in Poor Time Management at Implementation Levels Since programme planning is not coordinated at the Central level, health manpower spend much time attending meetings, workshops, and trainings for each separate program. Often the same people learn the same material in several trainings. Time to travel to and attend these meetings takes away from time to provide services, staff supervision, and follow-up activities.	a) Organize meetings on a yearly basis for Divisions working in the area of MCH to coordinate trainings and schedules and attempt to integrate workshops. b) There should be a central schedule of all activities that includes which districts and staff will be involved. c) Utilize regions to advise of all trainings and to assist in coordinating them or combining as appropriate.
4. Female Health Providers and Managers	
4.1 Lack of Female Health Service Providers and Managers Though MCH activities (including family planning and EPI) are priorities in MOH, it is disheartening to find so few female managers, i.e., Health Posts In-charge and DPHOs. While male health workers gain benefits from working in remote areas in terms of promotional opportunities, it is not surprising that female health workers (PHNs and ANMs) refuse to work in remote areas as they do not have the same types of benefits, facilities and opportunities.	a) Increase benefits, particularly housing and career ladders, for those women who go to work in remote areas. Develop career opportunities for female health workers. b) Nurses and other female health professional should be encouraged to apply to management posts such as Health Post In-charge and DPHOs.

ISSUES/POINTS FOR DISCUSSION	RECOMMENDATIONS
	c) Initiate MCH Worker program to assure other women health workers in health post. d) Consider rules and/or sensitization training for male supervisors concerning the proper treatment of female workers.
4.2 Training of Local Women is a Good Strategy Rather than sending persons from towns in rural areas, the training of locally available manpower appears to be more efficient and practical.	a) Persons in areas in need of health manpower should be given special consideration in health program admissions at the Institute of Medicine (IOM). Targets for remote area admission should be set by IOM. b) Appointments should consider weighing heavily the placement of graduates in their home districts.
4.3 Job Descriptions and Workload Feasibility Require Evaluation and Up-dating First of all, there is no central source to distribute job descriptions. Job descriptions are often out of date, for example the ANM job description was last revised in 1983. Rather than revising job descriptions as work responsibilities change, the new tasks are often just added to the old job description increasing workload. The VHW, in particular, has an enormous job that grows with the addition of each new program and as populations increase in his service area.	a) Workshops need to be organized to review all job descriptions on an annual or bi-annual basis and to revise work responsibilities as programs change. Tasks should be prioritized so that no one worker has a work overload. b) With populations increasing, the number of VHWs needs to be re-calculated. Some VHWs are covering a population of 12,000.
4.4 Health Service Facilities Have Inadequate Equipment and Insufficient Supplies Health Workers in health posts, health centres, clinics and hospitals are put in a difficult position of being responsible for health care without the most basic of equipment and supplies. Feeling frustrated with their work, they often leave, asking to be deputed or re-assigned.	a) Drug schemes should be given priority. b) The handbook for clinic management should include a list of the most necessary equipment and supplies. Equipment inappropriate for remote areas should not be included and there should be an emphasis on local procurement of equipment so that they can be easily replaced. Storage facilities and proper treatment of equipment should be taught.

ISSUES/POINTS FOR DISCUSSION	RECOMMENDATIONS
5. Data Collection, Monitoring and Recording	
5.1 Monitoring/Recording Should not Focus Solely on Numbers By focusing on numerical targets, the scope of services is neglected. The number of women attending MCH clinics tells nothing of the types of services she received, how often she received services and gives little focus to the quality of services provided.	a) Monitoring tools should include scope of services provided for those attending clinics, and the number of visits per woman and child.
5.2 Data Collection Systems Need Revamping and Simplification Data collection to monitor programs, supervise staff, plan and evaluate is desperately needed. A new simplified system that integrates all health post or clinic activities into one form should be developed. Staff are often bogged down with stacks of forms from each of the individual programs.	a) Hold an inter-Divisional workshop to develop data collection tools to be used at community, health post, and district levels. b) Set policies as to when forms should be distributed and collected. c) Train managers on how to fill out forms and use the data to improve services.
5.3 Vital Statistics Must be Collected on a Regular Basis At the time of the survey, health posts were collecting data only on births and deaths related to health posts services. There are no general statistics for the overall service area. Births attended by ANMs (only 3%) or conducted in hospitals (5%) are the only birth statistics collected. How can plans for family planning, immunizations, growth monitoring, postpartum clinics, antenatal care be made and evaluations carried out without number of births.	a) Develop easy to use vital statistics forms for VHWs and continue to encourage TBAs and CHVs to inform VHWs of any births or deaths they are aware of.

ISSUES/POINTS FOR DISCUSSION	RECOMMENDATIONS
4.4 <u>Even Where There are ANMs, They May Not be Providing Midwifery Services</u> ANMs have been found to be conducting only 3% of the deliveries in the rural areas. This study has found that the presence of an ANM does not improve the scope of MCH services found largely because ANMs are not given the authority to carry out services for which they have been trained. They remain at the mercy of their male supervisors. Without female supervisors to support them, they have no way to change the system.	a) Public Health Nurses are needed in the district health offices to plan MCH programmes and supervise/support ANMs in health posts. b) Guidelines for ANM work should be made clear and basic natal care/midwifery services should have targets. c) Male supervisors should be provided sensitivity training on how to supervise female workers and on the rights of female workers. d) Rules to protect female employees should be made with an easy system for females to bring infringements to authorities.

ANNEX A:

DISTRICTS, HEALTH POSTS AND HOSPITALS SURVEYED, 1988-1990

NAME OF DISTRICT	# OF H.P.s	HOSPITALS SURVEYED
Central Region		
Mohattari	9	Jaleshwor Hospital
Kavre	7	Shur Memorial Hospital
Sarlahi	7	Sarlahi Hospital
Rasuwa	5	
Dhading	5	
Nuwakot	5	
Bara	5	Kalaiya District Hospital
Sindhuli	4	
Dhanusha	4	Janakpur Zonal Hospital
Sub-total:	51	
Western Region		
Lamjung	9	Lamjung Hospital
Palpa	6	Palpa Hospital
Rupandehi	5	Bhim Hospital
Sub-total:	20	
Mid-Western Region		
Banke	9	Bheri Hospital
Surkhet	5	Surkhet Hospital
Sub-total:	14	
Eastern Region		
Ilam	5	Ilam Hospital
Sub-total:	5	
TOTAL:	90 H.P.s	11 Hospitals

ANNEX B:

TABULATED FINDINGS OF THE DIVISION OF NURSING SURVEY

Table 1.: Staffing Patterns of 90 Health Posts

STAFF/VOLUNTEERS	# Posts	# Posts Filled	% Posts Filled
Village Health Worker	356	346	97
Health Post In-Charge	87	83	95
Assistant Health Worker	162	133	82
Assistant Nurse-Midwife	144	83	58
CHL/CHV*	1068	938	88
TBAs*	1350	0	-

* Number trained at the time of the survey. The training is on-going. This survey was conducted prior to TBA training. There are now a total of 1350 TBAs trained.

Table 2: Equipment in 88 Health Posts

EQUIPMENT	# HPs Equipped	% HPs Equipped
Blood Pressure Cuff	84	95
Stethoscope	82	93
Needle and Thread	81	92
Scissors	75	85
Fuel for Sterilizer	71	81
Sterilizer	56	64
Baby Scale	41	47
Fetoscope	33	38
Scale for Adults	32	36
Height Tape	20	23
Albumin/Sugar Urine Test	9	10
Delivery Room	12	14
Delivery Table	11	13
Suction Tube	7	8
Haemoglobin Test	7	8

(* Data from two health posts were not available)

Table 3: Supplies in 88 Health Posts

SUPPLIES	# HPs with Stock	% HPs with Stock
Oral Contraceptives	85	97
Condoms	83	94
Iron Tablets	80	91
Local Anesthesia	80	91
Gauze	78	89
Folic Acid Tablets	64	73
B Complex	62	70
Depo Provera	60	68
Vitamin A	60	68
Vitamin D	50	57
Calcium Tablets	17	19

(* Data not available for two health posts).

Table 4: MCH Services of 89 Health Posts

SERVICES	# Offering	% Offering
FP Clinic	80	90
TT Immunization	80	90
Newborn Immunization	78	88
Referral System	78	88
Antenatal Clinic	68	76
Nutrition Counselling	55	62
Hemorrhage Treatment	52	58
Normal Deliveries	41	46
Postpartum Clinic	39	44
Postnatal Home Visits	21	24
Episiotomy	21	24
Labour Induction	19	21
Complicated Delivery:		
Retained Placenta	35	39
Breech	20	22
Prolonged Labour	19	21
Septic Infection	17	19
Neonatal Tetanus	17	19

(* Data not available from one health post).

Table 5: Relation Between ANM Presence and Services Offered

MCH/FP SERVICE	50 HPs with ANM #	and % Offering	39 HPs without ANM #	and % Offering
Newborn Immunization	48	96	33	85
Referral System	45	90	33	85
FP Clinic	44	88	35	90
TT Immunizations	44	88	36	92
Antenatal Clinic	39	78	29	74
Nutrition Counselling	36	72	20	51
Haemorrhage Treatment	30	60	23	59
Postpartum Clinic	23	46	17	44
Normal Deliveries	28	56	13	33
Episiotomy	15	30	6	15
Postnatal Home Visits	14	28	7	18
Labour Induction	8	16	11	28
Complicated Delivery Management:				
Retained Placenta	22	44	14	38
Breech	12	24	8	21
Prolonged Labour	12	24	8	21
Septic Infection	10	20	7	18
Neonatal Tetanus	10	20	7	18

(* No data available for one health post).

Table 6: Health Post Target Area Data Collection

DATA COLLECTION SYSTEM	% HEALTH POSTS KEEPING
Family Roster	30
Pregnancy Roster	22
Nutrition Roster	23

Table 7: Health Post Record-Keeping

ACTIVITY	% Health Posts Keeping Records
# of currently pregnant women coming to health post	17
# of deliveries in past 12 months	13
# of postpartum clinic visits in the past 12 months	8
# of home visits in the past 12 months	7

Table 8: Staffing Patterns in 15 District Public Health Offices

STAFF PRESENT	# OF DPHOs
Chief Public Health Officer	15
ANM	11
Assistant Health Educator	11
EPI Assistant	11
Health Assistant	10
Public Health Nurse	6
FP/MCH Assistant	8
Assistant Health Worker	3

Table 9: MCH/FP Services Offered at 14 DPHOs

SERVICES OFFERED	# OF DPHOs
FP Camps/Clinics	13
Antenatal Care	11
Postpartum Care	11
EPI Programme	11
ORT	8
Nutrition Counselling	6
Home Deliveries	2
Mobile Clinics	1

Table 10: MCH District Level Data Collection

MCH DATA	# DPHOs that kept Records (N = 14)
# of currently pregnant women	10
# of deliveries	3
# of deliveries in hospitals	3
# of deliveries by ANMs	2
# of maternal deaths	1
# of neonatal deaths	1

Table 11: Staffing Patterns in Eleven Hospitals Surveyed

STAFF	# of Hospitals with One or More Posts Filled
ANMs	11
Other Physicians	11
Staff Nurses	10
Hospital Director	7
Senior Medical Officer	7
Sisters	4
Anesthesiologists	3
matron or Nurse In-Charge	2
Ob-Gyns	2
Surgeons	2

Table 12: Hospital Handling of High Risk and Complicated Cases in Eleven Hospitals Surveyed

COMPLICATIONS	# Hospitals Handling
Anemia	10
Threatened Abortion	10
Septic Infection	10
Neonatal Jaundice	10
Low Birth Weight Newborns	10
AP/IP/PP Hemorrhage	9
Toxemia	9
Cord Infection	9
Cord Bleeding	9
Neonatal Tetanus	9
Premature Infants	9

Table 13: MCH Services in Eleven Hospitals Surveyed

SERVICES	# Hospitals Offering
Normal Delivery	11
Postpartum Care	11
TT Immunization	11
Antenatal Care	10
Forceps Delivery	9
Repair of Perineal Laceration	9
X-Ray	9
D&C for Incomplete Abortions	9
Depo Provera	9
Oxygen	9
Labour Induction	9
Vasectomy	8
Suction for Asphyxia in Newborns	7
Vaccum Delivery	5
Blood Cross and Match	5
Caesarean Delivery	4
Anesthesia	4
Blood Transfusion	4
Fetal Craniotomy	4
Tubal Ligation	4
IUD Insertions	4
Laproscopy	3
Sonagram/Ultrasound	1

Table 14: Maternity Patient Load and Beds in Eleven Hospitals Surveyed

	# OF HOSPITALS
Average number of deliveries per month:	
0	1
1-20	5
21-40	3
41-60	0
More than 60	2
# of Labour/Recovery Beds:	
1-4	5
5-8	3
9-12	2
data not available	1
# of Women in Labour/Recovery at time of Survey:	
1-2	3
3-4	1
5-6	2
Data not available	5
# of Delivery Tables:	
1-2	9
3-4	2
# of Deliveries being Performed at Time of Survey:	
0	1
1-3	6
Data not available	4

ANNEX C: JOB DESCRIPTIONS

JOB DESCRIPTION FOR SENIOR DISTRICT PUBLIC HEALTH NURSE

HIS MAJESTY'S GOVERNMENT
MINISTRY OF HEALTH
DIVISION OF NURSING

The Public Health Nurse is responsible for:

Management and Administration

1. Identifying nursing needs at the district/health post level.
2. Planning and coordinating all public health nursing activities with district level staff through the District Health Officer in the district.
3. Assisting and implementation and management of the MCH activities in the district to ensure a high standard of health care.
4. Coordinating the activities of ANMs/MCHWs at the health post with those of the health post staff and CHVs, through the Health Post In-charge and VHWs.
5. Surveying the health post area prior to the placement of a new ANM at the health post with a view to:
   - inform the local leaders of her pending arrival;
   - ensuring the availability of suitable living quarters;
   - discussion with family members of the chosen household regarding the ANM's welfare and particularly her safety;
   - orientation of ANM at District Office regarding her job function and duties and to familiarize her with the district and to meet the district staff;
   - introduction to the health post staff and orientation to the health post area and the local leaders.
6. Providing guidance to the ANMs/MCHWs regarding the maintenance of equipment and instruments, sterilization techniques.
7. Formulating and carrying out a supervisory plan to ensure that all health posts in the district area are visited for guidance.
8. Reviewing the family planning and maternal and child health activities of the ANM/MCH Worker at the health post with the Health Post In-charge with a view to improve services.

Supervision

MCH/Family Planning

1. Providing district guidance and supervision of the ANMs/MCHWs in efficient running of antenatal, postnatal and children's clinics at the health post and OPD clinics.
2. Assisting the ANM/MCHW to maintain a registry of priority families, high risk mothers and children.
3. Assisting ANMs/MCHWs to utilize available resources within the reach of the community and family.

4. Guiding and supervising the ANMs in the provision of immunization of newborn in the home, BCG, Polio and DPT for children attending the MCH clinic.
5. Guiding and supervising the delivery of family planning services by the ANM/MCHW at the MCH clinics and during home visiting.

MCHWs/TBA/FCHVs/MGs

1. To assist in identification, training and supervision of MCHWs, TBAs, FCHVs and MGs.
2. Maintain close collaboration with TBAs, FCHVs, Mothers Group through ANM/MCHW and monitoring their activities.

Training and Health Education

1. Identifying training needs of ANMs/MCHWs and TBAs and FCHVs.
2. Planning and conducting continuing education programmes for ANMs/MCHWs/TBAs/FCHVs.
3. Emphasizing and ensuring the need for holding education sessions pertaining to maternal, infant and child health and ensuring that ANMs/MCHWs are adequately prepared to fulfill this function.

Recording and Reporting

1. Guiding the ANM/MCHW regarding referrals to be made to hospitals through the health posts.
2. Ensuring that records pertaining to MCH/FP/TBA/FCHV/MG activities are correctly maintained by ANMs/MCHWs and promptly submitted to the health Post In-charge.

JOB DESCRIPTION FOR DISTRICT PUBLIC HEALTH NURSE

The Public Health Nurse is responsible for:

Management and Administration

1. Identifying nursing needs at the district level.
2. Planning public health nursing activities in the district.
3. Coordinating all public health nursing activities in the district.
4. Assisting the implementation and management of the MCH activities in the district to ensure a high standard of health care.
5. Coordinating the activities of ANMs at the health post with those of the health post staff through the Health Post In-charge.
6. Surveying the health post area prior to the placement of a new ANM at the health post with view to:
   - inform the local leaders of her pending arrival;
   - ensuring the availability of suitable living quarters;
   - discussion with family members of the chosen household regarding the ANM's welfare and particularly her safety;
   - orientation of ANM at District Office regarding her job function, duties and to familiarize her with the district and to meet the district staff;
   - introduction to the health post staff and orientation to the health post area and the local leaders.
7. Coordinating with the district level staff through the Health Inspector.
8. Providing guidance to the ANMs regarding the maintenance of equipment and instruments, sterilization techniques.
9. Managing the health post team in cleaning, inceneration, and waste disposal and water supply.
10. Formulating and carrying out a supervisory plan to ensure that all health posts in the district are visited for guidance, supervision and evaluation of missing activities.
11. Reviewing the family planning and maternal and child health activities of the ANM at the health post with the Health Post In-charge with a view to an improved service.

Supervision

MCH

1. Providing district guidance and supervision of the ANMs in efficient running of antenatal, postnatal, and children's clinics at the health post and OPD clinics.
2. Assisting the ANM to maintain a registry of priority families, high risk mothers and children.

3. Providing missing care to families, mothers and children beyond the capability of the ANMs.
4. Assisting ANMs to utilize available resources within the reach of community and family.
5. Conducting deliveries at the health post where inadequate facilities exist and in the home.
6. Home visiting in order to identify familiy needs and prepare MCH care plans, follow-up of antenatal and postnatal cases and newborns.
7. Providing and supervising the ANMs in the provision of immunization of newborn in the home, BCG, and DPT for children attending the MCH clinics.
8. Guiding and supervising the ANMs in the provision of immunization of newborn in the home, BCG, and DPT for children attending the MCH clinics.

Traditional Birth Attendants

1. Maintaining close collaboration with TBA.
2. Monitoring their activities to ensure safe practise.
3. Providing formal and informal teaching to help them improve practise.

Family Planning

1. Guiding and supervising the delivery of family planning services by the ANMs at the MCH clinics and during home visiting.

Training and Health Education

1. Identifying training needs of ANMs.
2. Recommending training programmes for ANMs.
3. Planning training programmes for ANMs.
4. Conducting training programmes for ANMs.
5. Participating in the continuing education programmes for ANMs.
6. Emphasizing the need for holding health education sessions pertaining to maternal, infant and child health and ensures that ANMs are adequately prepared to fulfill this function.
7. Ensuring that the health education sessions are relevant and specific subjects are achieved during MCH clinics and home visiting rounds.
   - stressing nutrition education particularly the feeding of children between the age of six months and five years and the 12 points for the health of the child;
   - prevention of diarrhoea and redydration therapy in the treatment of diarrhoea and dysentery.

Recording and Reporting

1. Guiding the ANM regarding the referrals to be made to hospitals through the health posts.

2. Ensuring that records pertaining to MCH/FP/TBA activities are correctly maintained by ANMs and promptly submitted to the Health Post In-charge.

Inter and Intra-Sectoral Linkages

1. Informing other health workers about nursing activities.
2. Maintaining a two-way communication with the district hospital.
3. Establishing relationship and keeping contact with panchayat and community leaders, voluntary and government agencies and other agencies in order to obtain their cooperation in the efficient and effective delivery of health care services.
4. Maintaining a registry or directory of available resources and making them accessible to ANMs.

JOB DESCRIPTION FOR HEALTH POST IN-CHARGE

Designation: Health Post In-Charge

Status : Non Gazetted First Class (Technical)

Health Post In-charge under the DPHO, is responsible for curative, preventive and management of the health programmes in the health post area.

1. He has to work all the concerned being Health Post In-charge (sic).
   a) To manage efficiently daily work in the health post.
   b) To confirm all drugs, equipment and other materials are in proper place, good condition and kept in proper way.
   c) To arrange to run clinic in health post.

2. To render general clinical service.
   a) To render first aid service.
   b) To manage to send to hospitals if cases incurable in health post.

3. To prepare area profile:
   a) To prepare area profile according to village health register and other information.
   b) To produce map of the health post coverage area.
   c) To plan and implement health programmes in the health post area according to area profile and map.

4. <u>Treatment and control of communicable diseases:</u>
   a) Malaria:
      - To arrange to send blood slides with form of suspected malaria patients collected to the lab for test.
      - To treat patients under guess treatment whose blood has been collected for lab test.
      - To follow-up regularly for one year the malaria patients who have been diagnosed of and under treatment.
      - To plan and implement the programme to find out malaria disease in the area.
      - To find out whether all malaria patients are registered, properly classified and done in time by verification.
      - To implement the programme of spraying insecticide in the health post area and to supervise.
      - To seek community participation in anti malarial campaign.

b) Tuberculosis:

- To make cough slide of suspected TB patients.
- To arrange to send the collected cough slides to lab for test.
- To render regular treatment for patients diagnosed for TB.
- To inform the patients the probable reaction of drugs, to treat the reactions of drugs, and to motivate to patients to undergo regular treatment.
- To manage to do defaulter tracing.
- To cure, treat properly by identifying drug resistant and if necessary to arrange to send to higher level.
- To try to change the people accept positively for the tuberculosis through health education.
- To use different measures to identify the patients of this disease in the health post area.
- To give training course to the staff if necessary.

c) Leprosy:

- To diagnoze suspected leprosy patients in the health post.
- To take smear of skin of suspected leprosy patients.
- To send the collected slides with forms to lab for test.
- To treat the diagnosed patients according to directions.
- To inform the patients of probable drug reaction and advise to undergo the regular treatment.
- To manage to refer to the higher level for the patients who are identified as severe cases.
- To change people's negative attitude towards the disease through health education.
- To seek the community participation in identifying and regular treatment of leprosy patients.
- To train staff as necessary.
- To manage defaulter tracing.

5. Control of Epidemic at health post level:

- To manage campaigns for controlling epidemic with the help of governmental, non-governmental offices, institutions and agencies in the area.
- To seek help from sub-health post within the area if necessary.
- To inform Public Health Office about the epidemic.

6. Immunization Programme:

- To implement programmes of immunization actively in the health post area.
- To demand for necessary vaccines and manpower to run immunization programme.
- To manage cold chain properly.
- To spread widely the necessity and importance of immunization.
- To check whether the immunization programmes are held according to health post and village Ilaka at scheduled timetable.
- To check whether the progress is made according to the programme's objectives and coverage within health post area.
- To supervise the work done by AHW, ANM and VHW in immunization programme and upgrade the quality of service rendered in immunization.

7. Diarrhoea:

- To study the prevalence of diarrhoeal disease in the health post area.
- To give oral rehydration solution treatment to the patients with diarrhoea.
- To refer the severe case patients to hospital nearby.
- To check whether Jeevan Jal packets are enough in health post.
- To teach village mothers/visitors of the health post area to make Nun Chini Pani for home treatment by demonstrating.
- To give health education to all on the effects of dehydration from diarrhoea.
- To seek community participation in the campaign of health education for the prevention and control of diarrhoeal disease.

8. Family Planning:

- To motivate the couples of reproductive age about the contraception in health post area.
- To avail the temporary contraceptives to the interested couples.
- To make arrangement for sterilization for the interested couples who have two or more than two children.
- To identify and treat the side effects of contraceptives and to refer if severe case prevails.
- To run programmes for family planning camp for the motivated couples in the health post area by contacting public health office.
- To run family planning camps successfully by obtaining community participation and cooperation.

9. Mother and Child Service:

- To run MCH clinic once a week in the health post.
- To render MCH service by managing outreach clinic in the village development committees within the health post area.
- To examine children and mothers, to advise as necessary and to perform medical treatment in MCH clinic.
- To supervise the MCH programme run by ANM, AHW and village health worker.

10. Nutrition:

- To treat and advise appropriately to the malnourished children in the health post area.
- To give health education to mothers and other people on nutritious food.
- To motivate the mothers to feed litho or Sarbottam Pitho, Jaulo, Ligooms, green vegetables in enough quantity.
- To identify malnutrition in health post area, to establish the system of measurement of arm circumference and weighing scales wherever possible.
- to spread the idea of importance of kitchen garden in every household.

11. Environmental Hygiene:

- To keep clean the health post boundary area to demonstrate as a model.
- To give health education on environmental and personal hygiene.
- To build safe latrine in the health post and use and demonstrate as model.
- To encourage every household to dispose dirty water and disposals in a ditch and building of latrine.

12. Control of Blindness Programme:

- To plan and implement to identify the blindness problem in health post area.
- To treat blindness.
- To manage to refer severe cases.
- To seek methods for controlling blindness in the MCH clinic.

13. Control of Leprosy:

- To give health education on leprosy.
- To contribute in the control of leprosy with active participation.

14. Health Education:

- To run health education programme in the health post area for:

  = incoming patients;
  = community people;
  = school health education;
  = feast & festivals

- To develop and produce educational materials from local resources as possible.
- To run special health education programme at the times of epidemic.
- To seek community participation and help to succeed the health education programmes.

15. Laboratory Service:

- To manage laboratory service in health post.
- To check the quality of laboratory service in health post.

16. <u>Mental Disease</u>:
    - To identify patients suffering from mental disease.
    - To refer the patients who cannot be cured at health post to the concerned place.

17. <u>Drug Scheme</u>:
    - To manage supply of drugs according to directions where drug scheme applies in the health post.
    - To initiate actively and seek community participation to succeed run the drug scheme programme.

18. <u>Community Health Volunteer Programme</u>:
    - To check whether CHV programme is being run smoothly and efficiently in the area.
    - To help run CHV training with the coordination with Public Health Office.
    - To run "Drop Out" training if necessary.
    - To utilize community participation and cooperation to effectively run the CHV programme.

19. <u>TBA Programme (Sudeni)</u>:
    - To check whether TBA programme is running smoothly in health post area.
    - To run TBA training and assist in the training programme.

20. <u>Ayurved Service</u>:
    - To render ayurved services apart from other curative treatment.

21. <u>Rehabilitation Service</u>:
    - To identify patients to keep in the rehabilitation centre.
    - To manage referral to Public Health Office for patients who want to obtain rehabilitation service.

22. <u>Administration</u>:
    - To manage day to day administration of health post.
      = staff
      = accounts
      = distribution

23. <u>Supervision</u>:
    - To supervise all the programmes being run at scheduled time within health post area.
    - To improve the programmes which show feedback.

24. <u>Recording and Reporting</u>

    - Record all the programmes being held in health post area.
    - Report to the Public Health Office within stipulated time.

25. To prepare analytically monthly, biomonthly and quarterly progress reports of the programmes being held in the health post with evaluation to the Public Health Office.

26. To send regularly the evaluated results of the reports to the implementing unit and higher level and to displace in the health post.

27. <u>Staff Meeting</u>:

    To arrange to hold monthly staff meeting for analysing the progress and improvement of programme in the health post.

JOB DESCRIPTION FOR AUXILIARY HEALTH WORKER

Auxiliary Health Worker has to work following programmes under Health Post In-charge.

Communicable Diseases

1. Regular treatment and follow-up for patients who are diagnozed of Leprosy, Tuberculosis and malaria.
2. Send cough of suspected tuberculosis and take smear of skin of suspected leprosy to the district health lab.
3. To implement methods for preventing from and control of communicable disease.
4. Work as assistant to Health Post In-charge in preventing, cure and treatment of disease where there is epidemic.

Hygiene

1. To assist in running programme on cleanliness (hygiene).

EPI

1. To assist in the immunization programme.

Supervision

1. To go for supervision of Village Health Worker at least 10 days of a month according to supervision timetable.

Training

1. To assist in all trainings run in health post.

In Relation to Community Leader

1. To motivate community members to cooperate and participate actively in the programmes of health post.

Camps

1. To assist in health post level family planning camp on vasectomy, tubectomy, IUD and other health camps.

Health Education

1. To assist in programmes of related health education activities in health post and locality.

Health Test Centre

1. To assist in mobile health test centres.
2. To assist in buying, storing and management of drugs, equipment and other necessary materials.

Accounting and Reporting

1. To assist in accounting and sending monthly reports to District Public Health Office.

School Health Programme

1. To assist in school health programme.

JOB DESCRIPTION FOR AUXILIARY NURSE MIDWIFE

Responsibilities and Activities

Maternal and Child Health/Family Planning:

1. Early diagnosis of pregnancy and screening for risk cases.
2. Health education during pregnancy.
3. Basic antenatal care.
4. Detection and management of pregnancy complications.
5. Management of normal delivery and detection of complications and referral as appropriate.
6. Identification, training and supervision of sudeni and assistance in complicated cases.
7. Management of risk cases in labour and complicated cases.
8. Management of newborn after delivery.
9. Basic care of newborn and mother during postpartum period.
10. Basic child care monitoring of growth and development, screening for risk cases, management of diseases or maldevelopment.
11. Prevention of main causes of child mortality.
12. Detection and management of social and family problems affecting child health.
13. Information on benefits of family planning method and services available.
14. Identification and management of client for family planning.

Promotion of Food Supply and Proper Nutrition:

1. Promotion of food supply.
2. Promotion of nutrition and prevention of protein energy malnutrition (PEM) in children.
3. Treatment and prevention of nutritional anaemias in pregnant women.
4. Treatment and prevention of xerophthalmia in children.
5. Promotion and protection of nutrition in pregnant and lactating women.

Immunization of Women and Children:

1. Motivation to women and young children for immunization.
2. Motivation/education of pregnant women, mothers and other family members.
3. Immunization of pregnant women and children.
4. Provision of vaccine.

Health Education - Education Concerning Prevailing Health Problems and the Methods of Preventing and Controlling Them:

1. Health promotions.
2. Prevention of disease and maintenance of health.
3. Education to deal with disease.

Prevention and Control of Locally Epidemic Diseases:

1. Early recognition of suspected malaria cases, appropriate treatment and referral.
2. Preventive Treatment to high risk groups of population, expectant mothers, children 0-4 years, and adults in communities of high economic importance.

Prevention and Control of Hypertension:

1. Early detection and diagnosis.
2. Identification of "at risk" subjects.
3. Detection of patients, initial management, drug treatment and needs and follow-up and prevention of complications.
4. Treatment of emergencies and management of complications.

Appropriate Treatment of Common Diseases:

1. Diagnosis of diarrhoeal diseases and other common diseases and provision of appropriate treatment.
2. Prevention of diarrhoeal and other common diseases.
3. Management of diarrhoeal diseases and other outbreaks in coordination with other health post team members.

Appropriate Treatment of Common Injuries:

1. Treatment of cuts.
2. Treatment of burns and scalds.
3. Treatment of poisoning and snake bites.

Safe Water Supply and Sanitation:

1. Promotion of personal and community hygiene.
2. Supply of drinking water.
3. Excreta disposal.
4. Protection of water sources and surveillance of drinking water quality.
5. Linkages with other related sectors. (This refers to activities and tasks that positively affect programmes of other sectors, e.g., in agriculture, housing, while being part of an environmental health programme).

School Health:

1. Health education in school with cooperation of teacher.
2. School sanitation (education).
3. Screening - vision, hearing, dental, growth and development of school children.
4. Referring students for medical care.
5. Immunization of children for school age.
6. Guideline for teachers on prevention, care and follow-up of children with illness, injury, and problems of behaviours.

JOB DESCRIPTION FOR MCH WORKER (1989)

The MCH Worker:

1. Recognizes symptoms of pregnancy, takes a history and conducts antenatal exams.
2. Identifies high risk factors and refers to hospital or other referral source.
3. Teaches mother about spacing/family planning.
4. Refers for tetanus immunization.
5. Keeps records on activities provided for each woman.
6. Detects malnutrition of complicating diseases and refers to Health Post In-charge or Auxiliary Nurse Midwife.
7. Visits mother and checks for infections and gives treatment or refers to hospitals as appropriate.
8. Arranges and motivates mother for immunization of newborn.
9. Keeps records on the weight and growth of child.
10. Motivates family planning and refers to ANMs, Health Post In-charge, family planning as available.
11. Recognizes illness and provides simple treatment and refers as necessary.

The MCH Workers works with TBA to:

1. Arrange appropriate place for delivery.
2. Manage labour of normal deliveries in a safe manner.
3. Cut cord in a safe manner.
4. Identify premature low birth weight newborns and advises mother in care.
5. Refer complicated deliveries, if not possible, conducts according to resources available (including manual removal of placenta when necessary).
6. Teach mother about the benefits of and how to breast feed.

Volunteer Supervision - The MCH Worker:

1. Supervises TBAs.
2. Assists TBAs in recording services and send TBA service reports to District.
3. Assists in TBA training.
4. Maintains contact with trained TBAs.
5. Supervises Trained TBAs either by meetings held at health post or by supervisory visits.

Clinic Management - The MCH Worker:

1. Sets up/manages MCH clinics at health posts, i.e., antenatal, well-baby, family planning.
2. Keeps up to date records of MCH services and of individual clients.
3. Keeps equipment in good and sanitary condition.
4. Orders and maintains supplies and medicine for clinic.
5. Motivates mother to attend clinics.
6. Provides health education to mother during clinics.

JOB DESCRIPTION FOR VILLAGE HEALTH WORKER *

I. General Field Activities

1. Checks his visiting bag to be sure that all the supplies needed, including the correct village health records (VHRs) are taken before making the daily round.
2. Follows the prescribed routine of activities for each house visit.
3. Records all particulars in the VHR.
4. Updates the stencil at each house visit.
5. Visits every house in the area once a month and tries to contact as many family members as possible.

II. Enumeration and Updating of Household Information

Finds out whether there have been any births, deaths, marriages or settlers (not visitors) or new houses constructed since his last visit and records the information in the VHR.

III. Malaria

1. Determines if anyone in the household or any visitor has a fever or has had a fever since his last visit.
2. Takes blood and prepares slides according to prescibed procedure of anyone who has a fever or has had a fever.
3. Gives presumptive treatment as prescribed.
4. Takes blood slides from all positive malaria cases for 12 consecutive months; if there is refusal, reports to AHW.

IV. Smallpox

1. Determined if anyone in the household or any visitor has a rash.
2. If a rash with illness is detected, examines it.
3. Reports all rashes with illness immediately to the health post.
4. Vaccinates and revaccinates according to the prescribed schedule on the annual basis.

V. Hansen's Disease

1. Observes for apparent signs of Hansen's disease during interaction with people in the house and encourages anyone with signs of the disease to visit the health post for check-up.
2. Checks on his non-surveillance (reporting days) whether the referred case has attended the health post for check-up; if not, encourages the suspected case again to go to the health post.
3. If a person is diagnosed as having the disease, encourages the person to take the prescribed treatment regularly.
4. Visits the diagnozed case every month to check whether the prescribed treatment is being continued; if not, reports to the AHW.
5. Reminds the case about when to return to the health post for follow-up.

VI. Other Diseases

1. Encourages any person complaining of other illnesses to go to the health post for check-up and treatment.

2. Reports any severe case of diarrhoea or vomitting with diarrhoea to the Health Post In-charge.

3. Reports any illness in unusual numbers to the Health Post In-charge.

VII. MCH

1. In the MCH's field area (home visiting area), furnishes names and addresses of the ANM of:
   - sick children, especially those not getting enough food, and diarrhoea cases.
   - newborns.
   - pregnant women (to report once during the period of pregnancy).

2. In all areas, finds out sick children:
   - if the sickness is due to diarrhoea, explains and shows making of special water mixtures (salt-sugar-water) and encourages the mothers to give food to the sick children.
   - even if the sickness is not due to diarrhoea, encourages the mother to give more food and water frequently.
   - refers the sick children to be taken by the mother to the health post for check-up and treatment.

3. If any child has visible thin ribs, thin arms, arms and pot belly, face like an old person, encourages the mother to give more food and mixed foods frequently; refers the child to be taken by the mother to the health post for check-up and treatment.

4. If any child has a puffy pale look, swelling of the legs or entire body, dull to light coloured hair, and no energy, encourages the mother to give more food and mixed foods frequently; refers the child to be taken by the mother to the health post for check-up and treatment.

5. Encourages all pregnant women to attend the antenatal clinics.

6. Encourages all mothers to have their children immunized and stresses the 12 points for the "Health of the Child".

VII. Family Planning

1. Identifies all the eligible couples and motivates them to use either temporary or permanent contraceptive methods.

2. Refers those couples eligible and willing for permanent contraceptive methods (sterilization) or loop-insertion to the district or zonal hospital.

3. If no contra-indications are apparent, explains the exact use of the pill to those desiring to use pills and provides the couples with two cycles of pills initially.

4. When contra-indications for using the pill are apparent, encourages the women to go to the health post for counselling and evaluation.

5. Explains how to use the condom to those men desiring to use condom and provides fifteen condoms initially.

6. Explains to the couples how to get a resupply of either condoms or contraceptive pills.

7. On monthly visits:

   - encourages continuation of the contraceptive method accepted.
   - determines if contraceptives are being used correctly.
   - provides relief for minor side-effects due to the pill and refers those with major side-effects to the health post.
   - resupplies couples with needed contraceptives.
   - continues motivation for those not yet accepting one of the family planning methods.

IX. Health Education - General

1. Uses both individual and group communication methods during house visits.

2. Attempts to motivate people with regard to improved health behaviour by following, whenever possible, the four simple rules of motivation.

3. Establishes good interpersonal relations with people in the community.

Health Education Regarding Specific Activities

1. Provides individuals and families with correct messages concerning each of the health activities.

2. Answers questions about the various health activities with correct information.

3. Works in cooperation with other health post staff in solving special health problems.

X. When Working at the Health Post on Non-Surveillance (Reporting) Days

1. Records all the prescribed information on his areas in the VHRs.
2. Prepares all the required forms and reports as prescribed.
3. Obtains instructions from the Health Post In-charge, AHW and ANM about all referrals made by him to the health post and about follow-ups needed pertaining to family planning, positive malaria cases and newly diagnosed cases of tuberculosis and leprosy.

*English translation taken from Policies, Plans and People by Judith Justice, 1986. A more recent job description was not available at the Public Health Division, Ministry of Health.

JOB DESCRIPTION OF COMMUNITY HEALTH VOLUNTEER (1989)

The CHV is the front-line worker in the overall Ministry of Health delivery strategy. Working with the VHW and health post staff, the CHV is expected to promote the utilization of available health services (i.e., immunization, family planning, etc.) and the adoption of preventive health practises. The CHV informs and activates the community while also stimulating and communicating community demand for services. In this way, the CHV complements the efforts of the health staff, especially the VHW, in delivering primary health services to the community.

The specific tasks assigned to the CHV are:

Diarrhoea Disease Control

1. Teach and help mothers treat diarrhoea in the home with ORT (fluids including breast milk, ORS, food).
2. Recognize the signs of severe dehydration, dysentary and other complications and refer cases to the health post or hospital.
3. Teach mothers how to prevent diarrhoea through improved hygiene.
4. Arrange for and make ORS packets available to the community.
5. Organize campaigns for community participation in control of diarrhoeal diseases (hand washing), latrine construction, cleaning of water sources, etc.).

Family Planning

1. Identify the eligible couples in the Ward.
2. Motivate for/inform about family planning and about contraceptive methods.
3. Distribute condoms.
4. Refer couples interested in oral contraceptives to the VHW. Those CHVs demonstrating competency in identifying contra-indications and counselling pill acceptors will also be given responsibility for initial distribution.
5. Follow-up and resupply pill acceptors.
6. Refer acceptors to the health post and district hospital for other contraceptive methods and for other than inicidental side-effects and complications.

Immunization

1. Inform mothers about the importance of immunization and the dates and location of immunization clinics.
2. Explain immunization schedules and the importance of completing immunizations.
3. Identify children and women who need immunization and facilitate their attendance at immunization clinics.
4. Help during immunization clinics in their area.

Nutrition

1. Teach mothers about the importance of breastfeeding up to 2 years and the proper introduction and types of weaning foods.
2. Identify malnourished children using ACM (or in some areas, using scales and growth charts).

3. Teach mothers about nutritious food and the importance of a mixed diet for children: demonstrate how to prepare mixed foods such as litho, sarbottam pitho, etc.
4. Teach mothers about the importance of their diet, especially during pregnancy and lactation.

Pregnancy

1. Inform the VHW about all births and deaths in the Ward, especially child and maternal deaths.
2. Identify pregnant women in the Ward and advise them about personal care during pregnancy, preparation for delivery and preparation for infant care, and refer high risk women.
3. Advise mothers with newborns about the care of the infant and the need for immunization.
4. Accompany the VHW on visits to families where deaths have occurred to investigate the cause of death and determine follow-up action with the family to protect the health of other children. (The VHW will be responsible for investigating all deaths and submitting a "Lay Mortality Report" Form, one for each death).
5. Discuss the causes of infant and child deaths and how such deaths can be prevented in the mothers' groups.

First Aid

Provide elementary first aid services upon request.

Reporting

Report the above activities through the VHW to the health post. (Literate CHVs will record activities on the CHV register. Non-literate CHVs will discuss the service they provided during the month with the VHW). VHWs will be responsible for compiling and submitting reports of CHV activity to the health post.

Note: CHVs will gradually undertake other health activities, especially ARI, with training from the health post, as they become more competent in the above.

RESPONSIBILITIES OF THE TRADITIONAL BIRTH ATTENDANT (1989)

The Traditional Birth Attendant is a private practitioner. She receives no income from the government. Her work should be compensated by the families she serves. Therefore, she has no job description. The following is a list of responsibilities that TBAs are able to perform following training. The community needs to provide encouragement and incentives. The Traditional Birth Attendant:

MCH/FP

1. Recognizes the symptoms of pregnancy, takes a history and conducts antenatal exams.
2. Identifies high risk factors and refers to Auxiliary Nurse Midwives.
3. Arranges for appropriate place for delivery.
4. Teaches pregnant mothers about required nutrition.
5. Teaches mother about child spacing and family planning.
6. Teaches mother about good hygienic practises.
7. Refers all pregnant women for tetanus immunization.
8. Keeps records on services provided to each woman.
9. Detects malnutrition and complicating diseases and refers to Health Post In-charge or Auxiliary Nurse Midwife.
10. Manages labour of normal deliveries in a safe manner and attends to the newborn.
11. Refers complicated deliveries; if not possible, conducts according to resources available (including manual removal of placenta when necessary).
12. Teaches mother to breast feed.
13. Cuts cord in safe manner.
14. Visits mother and checks for infections, and gives treatment as appropriate.
15. Motivates for immunization of infants.
16. Refers children to health post for weight and growth monitoring.
17. Teaches mother how to provide good food for the child.
18. Motivates for family planning and refers to Auxiliary Nurse Midwives.
19. Recognizes illness and provides simple treatment or refers as necessary.

Nutrition

1. Teaches women about breastfeeding and encourages women to breastfeed a minimum of 2 years, introducing supplementary cereals at 4 months and weaning foods at six months.
2. Teaches mother how to prepare good food for the infant.
3. Motivates mother to be aware of growth and weight of children.
4. Identifies malnourished children and refers to Auxiliary Nurse Midwife or Public Health Nurse supervisor.
5. Teaches mother about increase in food intake and food quality during pregnancy and following delivery.
6. Teaches oral rehydration techniques and when and how to administer oral rehydration therapy.

Safe Water Supply and Sanitation

1. Teaches the community the relationship between unhygienic practices at home and ill-health.
2. Practises good personal hygiene in her work.
3. Discourages indiscrimate defaecation.
4. When in homes, encourages hygienic practices.
5. Keeps area of work clean with proper disposal of waste materials.
6. Boils cord cutting materials and maintains sterile technique throughout delivery.

ANNEX D: SUMMARY AND COMPARISON OF FIELD LEVEL JOB DESCRIPTIONS

General Field Activities	HPIC	ANM	MCHW	VHW	CHV	TBA
Cultivates good relations with the community		+		+		
Visits every house in area once a month				+		
Collects birth/death statistics				+	+	
Provides general curative care	+	+				
Shares in management of health post	+	+				
Provides in-service training of staff in MCH/FP		+				
Conducts household visits to families needing special MCH care		+				
Searches for pregnant women		+		+	+	+
Searches for newborns needing postnatal care		+		+		
Receives instructions from health post in patient follow-up				+		
Provides first aid treatment in homes and refers to HPI			+		+	
Provides simple medicines				+	+	
Maternal/Child Health						
Identifies pregnant women and high risk cases		+	+		+	+
Gives antenatal care		+	+			+
Manages pregnancy complications		+				
Refers high risk pregnancies to ANM or closes referral point			+			+

Maternal/Child Health ... cont.	HPIC	ANM	MCHW	VHW	CHV	TBA
Encourages attendance at antenatal clinic				+		
Arranges good place for delivery						+
Teaches safe delivery practises		+				
Teaches antenatal nutrition	+		+		+	+
Refers for tetanus immunization			+		+	+
Detects malnutrition and refers			+	+	+	+
Detects sick children and refers			+	+		+
Teaches prevention of childhood diseases			+			
Conducts home deliveries and attends to newborn		+	+			+
Assists TBAs in complicated deliveries		+				
Refers complicated deliveries			+			+
Teaches breastfeeding			+		+	+
Gives postnatal care		+	+			+
Implements immunization programme	+					
Motivates for childhood immunization			+	+	+	+
Provides immunizations		+		+		
Manages Cold Chain	+					
Refers children for height/weight monitoring				+		+
Teaches childhood nutrition	+	+		+	+	+
Malnutrition surveillance				+	+	+
Treats malnourished children	+					
Tuberculosis surveillance among children	+			+		
Teaches ORS	+	+	+	+	+	+
Study prevelance of diarrhoeal disease in health post area	+					
Encourages attendance at health post well-baby clinic		+				
Update Road to health care		+				
Identifies total family needs for MCH and makes plan for family		+				
Teaches 12 points for "Health for Child"		+		+		
Helps establish ward vaccination clinic and assists in work					+	
Helps health workers to maintain cold chain					+	
Holds MCH clinics in health post and in mobile outreach clinics	+	+	+			
Supervises MCH Programme	+					

Family Planning	HPIC	ANM	MCHW	VHW	CHV	TBA
Motivates couples to accept family planning	+	+	+	+	+	+
Makes home visits to pill and loop acceptors		+				
Refers couples for sterilization				+		+
Explains use of pills and provides two initial cycles				+		
Refers women with contra-indications to pills to health post				+		
Explains use of condom and provides 15 condoms initially				+		
Explains to couples how to resupply condoms and pills				+		
Encourages continued use of contraceptives				+	+	
Determines if contraceptives being used correctly				+		
Treat side effects of contraceptives	+					
Runs family planning camps	+					
Refers major side-effects to health post				+	+	
Resupplies couples with contraceptives				+	+	
Distribute pills and condoms					+	
Assists in establishing vasectomy camps as needed					+	
Water Supply and Sanitation						
Gives hygiene education	+	+			+	+
Malaria						
Plans and implements programmes	+					
Send blood smears to lab	+					
Takes monthly blood smears on infected persons				+		
Takes history on fevers				+		
Gives treatment	+			+		
Helps community prevent malaria by encouraging mosquito nets, filling ditches, planting saplings, spraying insecticide, etc.	+					

	HPIC	ANM	MCHW	VHW	CHV	TBA
Small Pox						
General surveillance and referral to HPI				+		
Vaccinates and revaccinates patients in an annual basis				+		
Hansen's Disease						
General surveillance and referral to HPI				+		
Oversees compliance of patients to medical treatment				+		
Diagnoses patients	+					
Takes skin smear	+					
Treat diagnosed patients	+					
Change negative attitudes through health education	+					
Other Diseases						
Makes general surveillance and referrals		+		+		
Reports possible epidemics to HPI				+		
Surveillance for TBA and for compliance for treatment					+	
Diagnosis and Treatment of TB patients	+					
Health Education						
Conducts health education sessions in clinic	+	+	+			
Conducts health education sessions during home visits				+	+	+
Develops and produces health education materials	+					
Reporting						
Keeps records on services provided to each woman						+
Keeps health post records	+	+				
Keeps records of MCH activities at health post and community	+	+	+			