A Report on

"Rapid Assessment Study on Effect of Posting 2nd ANM at Sub Centers in Maharashtra"

Study Conducted by

Centre for Social Medicine

Pravara Institute of Medical Sciences – Deemed University

Loni- 413736, Ahmednagar, Maharashtra

Under the aegis of

State Health Systems Resource Centre (SHSRC),

Govt. of Maharashtra, Pune

Sponsored by

UNFPA Maharashtra, Mumbai

December 2013

A Report on

Rapid Assessment Study on Effect of Posting 2nd ANM at Sub centers in Maharashtra

Principal Investigator

Prof. K.V. Somasundaram
Director, Centre for Social Medicine
Pravara Institute of Medical Sciences – Deemed University, Loni

Co-investigator

Dr. Sunil Thitame
Asst. Professor,Centre for Social Medicine
Pravara Institute of Medical Sciences – Deemed University, Loni

Under the Guidance of

Dr. Uddhao Gawande
Executive Director,State Health Systems Resource Center, Pune

and

Dr. DayakrishanMangal,
UNFPA State Program Coordinator, Mumbai

Ms. AnujaGulati,
State Programme Officer, UNFPA, Mumbai.

December 2013

Rapid Assessment Study on Effect of Posting 2nd ANM at Sub centers in Maharashtra

C O N T E N T S

Particulars

Preface
Acknowledgements
List of Abbrevations
List of Tables
Executive Summary

Chapter 1: Introduction

1.1 Rationale of the Study
1.2 Broad objective of the study
1.3 Specific objectives of the study

Chapter 2: Study Design & Methodology

2.1 Study Design
2.2 Primary data
2.3 Secondary Data
2.4 Sample Size
2.5 Methodology of Selection of Sub Centers for Quantitative Survey
2.6 Methodology for Selection of Sub-centers for Qualitative Survey
2.7 Survey Instruments

Chapter 3: Job Characteristics of Survey Respondents

3.1 Length of Service of ANMs at SCs
3.2 Residence at Headquarters
3.3 Distance between workplace and residence
3.4 Clarity of Job assignment

Chapter 4: Performance of Sub-Centers with Single ANM and Two ANMs

4.1 Performance of Sub-centers with Single ANM
4.2 Performance of Two ANM SCs before &after appointment of2nd ANM.
4.3 Performance of Single ANM Vs Two ANM Sub-centres

Chapter 5: Analysis of the Jobs Performed by 1ST and 2ND ANM's

Chapter 6: Support to ASHA/AWW and SHG for planning VHND

Chapter 7: Perception of Community Members on the Performance of SCs

Chapter 8: Perception of Supervisory Staff on the performance of SCs

Chapter 9: Recommendations

PREFACE

In order to improve the basic health services in rural areas the NRHM has provided an additional nurse to perform clinical & outreach work on non-itinerary basis in each Sub-Centre, since one ANM has been found to be inadequate to handle the increased workload. The second ANM is expected to supplement and augment the services provided by the first ANM and they would complement each other.

Government of Maharashtra, following the norms of NRHM, appointed second ANM (approx. 6223 ANM's) on contract basis in all districts across the State. The Government of Maharashtra is keen to learn whether access to and quality of RCH services have improved in Sub-Centre areas where second ANM's are in position for more than 1 year. Department of Public Health, Government of Maharashtra in collaboration with UNFPA Maharashtra commissioned a rapid assessment study to understand the effect of posting second ANM at SCs.

Pravara Institute of Medical Sciences (PIMS) – Deemed University, Loni, Ahmednagar – one of the technical consultants with SHSRC, Pune, has been assigned the task of undertaking the study entitled *"Rapid Assessment study oneffect of posting second ANM at Sub Centers in Maharashtra".* The study has been carried out in 150 Sub-centres (75 single ANM & 75 two ANM SCs) randomly selected from 15 districts of Maharashtra during 2013-14.

Within the limitations of duration of the study for rapid assessments, the research team from PIMS-DU, Loni has done a meticulous job. We sincerely believe that the study findings will be useful for taking appropriate decisions on continuation and up scaling of the intervention in the State

Dr. Uddhao Gawande
Executive Director,
State Health Systems Resource Centre (SHSRC),
Govt. Maharashtra, Pune

ACKNOWLEDGEMENTS

Pravara Institute of Medical Sciences (PIMS) – DeemedUniversity, Loni is grateful to the State Health Systems Resource Centre (SHSRC), Pune for assigning the task of formulating and undertaking the study entitled "Rapid Assessment study on effect of posting second ANM at Sub Centers in Maharashtra". The study was conducted by Centre for Social Medicine in collaboration with College of Nursing of PIMS-DU, Loni.

The Research Team is grateful for the constant guidance and support received from Dr. UddhaoGawande, Executive Director, and Ms. KavitaShelar, Asst. Program Manager, SHSRC, Govt. of Maharashtra, Pune, Dr. Daya krishan Mangal, UNFPA State Program Coordinator and Miss AnujaGulati, State Programme Officer, UNFPA, Mumbai. The Research Team of PIMS appreciates and thanks the efforts of Dr. PrakashDhoke, Dr. Abhijit Khanvilkar, and Dr. RajuJotkar for their valuable suggestions on the draft report of the Study.

The Research Team expresses it deep sense of gratitude to ShriRajendra E. VikhePatil, CEO, PIMS and Dr. S.D. Dalvi, Vice Chancellor, PIMS-DU for their strong support and encouragement for undertaking the Study. Thanks are due to Dr. PrathibhaChandekar, Principal, College of Nursing, PIMS-DU for sparing the faculty for undertaking the field level study.

The Research Team is grateful to the support extended by all the ANM's of Sub-Centers, ANM Supervisors/Medical Officers, ASHAs, AWWs, PRI members of the selected villages who have participated in the IDI & FGDs in Maharashtra.

The Research Team of PIMS believes that the observations and recommendations of the study will help State Health Department for taking considered decisions for effective functioning of the Sub-centers where two ANMs are in position in Maharashtra.

Dr. Sunil Thitame
Co-Investigator
Asst. Professor, CSM

Prof. K. V. Somasundaram
Principal Investigator
Director, Centre for Social Medicine (CSM)

LIST OF ABBREVIATIONS

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
ARI	Acute Respiratory Infection
AWW	Aanganwadi Worker
CSM	Centre for Social Medicine
FP	Family Planning
GoM	Government of Maharashtra
HQ	Headquarters
IYCF	Infant and Young Child Feeding
JSY	JananiSurakshaYojana
JSSK	JananiSishuSurakshaKaryakram
JSSY	JananiSishuSurakshaYojana
MCH	Maternal and Child Health
MCTS	Mother Child Tracking System
MO	Medical Officer of Health
MPHW(F)	Multi-purpose Health Worker (Female)
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PIMS	Pravara Institute of Medical Sciences
PNC	Post Natal Care
PRI	Panchyati Raj Institution
RCH	Reproductive Child Health
RGABY	Rajiv Gandhi ArogyaBhimaYojana
RTI	Reproductive Tract Infections
SBA	Skilled Birth Attendant
SC	Sub-Centre
SHG	Self-Help Group
STI	Sexually Transmitted Infections
SHSRC	State Health Systems Resource Centre
TT	Tetanus Toxide

UNFPA	United Nations Population Fund
VD	Venereal Diseases
VHND	Village Health and Nutrition Day
VHNSC	Village Health, Nutrition and Sanitation Committee

List of Tables

Table 2.1: Sample Districts Selected for Quantitative and Qualitative Survey

Table 2.2: Detail of the Sample Sub-centers Selected for Quantitative Survey

Table 2.3: The Summary of Sample Size of SCs to be surveyed in the State

Table 2.4: Detail of the Sample Sub centers Selected for Qualitative Survey

Table 4.1: Performance of Single ANM Sub-Centre (2011-12 & 2012-13)

Table 4.2: Performance of Two ANM SC Before & After Appt. of 2nd ANM

Table 4.3: Performances of Single ANM & Two ANM SC

Table5.1: Different jobs performed by the 1st and 2nd ANM at Sub center under study (%)

Table 6.1: Frequency of meeting of ANM with ASHA/AWW

Table 6.2: Place of Meeting of ANM with AWW/ASHA

Table 6.3: Role of ANM in organization of VHNSCs reported by ASHA/AWW

Table 6.4: Areas of Improvement in Functioning of VHNSC after appointment of 2nd ANM

Table 6.5: Satisfaction of ASHA/AWW with the work of ANM

Table 6.6: Areas of Improvement after appointment of 2nd ANM

Table 6.7: Reach SCs Services after appointment of 2nd ANM

Table 7.1: Satisfaction of the community with the services of ANM

Table 7.2: Reasons for dis-satisfaction with the services provided by SC ANM

Table 7.3: Need for additional services from the ANM at Single ANM SC

Table 7.4: Satisfaction of people after appointment of 2nd ANM at two ANM SC

Table 7.5: Reasons for satisfaction of the people by two ANM SC

Table 7.6: Formulation of VHNSC in Village

Table 7.7: Role of ANM in VHNSC

Table 7.8: Improvement in Functioning of VHNSC after appointment of 2nd ANM

Table 7.9: Areas of improvement in functioning of VHNSC after appointment of 2nd ANM.

Table 7.10: Areas of improvement in functioning of SC after appointment of 2nd ANM

Table 8.1: Opinion of Supervisory Staff on overall functioning of SC

Table 8.2: Opinion of Supervisory Staff on Performance of the SC

Table 8.3: Changes occurred after appointment of 2nd ANM

Table 8.4: Areas of Improvement in performance after appointment of 2nd ANM

EXECUTIVE SUMARY

Introduction

In order to improve the basic health services in the rural areas and recognizing the implications of additional responsibility on the performance of the ANM, the NRHM has made provision for an additional ANM (second ANM) to perform clinical work on non-itinerary basis in each Sub-Centre, since one ANM was believed to be inadequate to handle the increased workload. The second ANM is expected to supplement and augment the services provided by the first ANM and they would complement each other. In order to check the impact of posting 2nd ANM at sub center, the study was undertaken with the broad objective "To find out the effect of increasing Human Resources (HR) at SC level on access and quality of RH services"

Study Design and Methodology

The study was case control, retrospective study with primary and secondary data collected from the ANM and Sub center as well as the community member's and the supervisors of the ANM's. The sub centers with single ANM and two ANMs were sampled randomly. The was collected for two reference periods i.e. for last two preceding years for single ANM and before and after appointment of 2nd ANM for Sub-Centre with two ANMs. The base for selection of districts was the performance of the districts in terms of the percent institutional deliveries in three categories i.e. better, average and poor performing districts.

For quantitative data, 150 sub centers (75 with Single ANM and 75 with two ANM's) were randomly selected from 15 districts of Maharashtra to assess the performance of the sub centers and to the effect of posting 2nd ANM. For qualitative data 30 sub centers (15 with single ANM and 15 with two ANM's) were randomly selected from three districts i.e. Nashik, Gadchiroli and Gondia of Maharashtra. The qualitative study also includes the health workers (49ASHA & 59 AWW, 1 each from same and farthest village of the SC), community members (60 PRI & 56 SHG -1 each from same & farthest village of the SC) and 30 supervisory staff of the Sub centers under study.

Performance of Two ANM Sub-centres before and after Appointment of 2nd ANM

The performance of Sub-Centres in Maharashtra with two ANMs in place has been studied for two periods – before appointment and after appointment of 2nd ANM. The performance has been studied following selective 12 important parameters, especially covering the four major reproductive and child health services like (i) ANC and PNC, (ii) Natal Care, (iii) Child care and (iv) Family Planning.

A reasonably good increase of 6-8% in the Antenatal services coverage rates has been registered after appointment of 2nd ANM in the 150 Sub-centres surveyed. The rate of antenatal registration has increased from 91.92%to 98.84% – a rise of 7.53%.A better increase rate of 8.4% was observed in 3 ANC check-ups from 86.55% to 93.88%. The rate of increase of 6.61% in 4 ANC checkups from 83.01% to 88.50% has helped in realizing the objective of placing 2nd ANM. The coverage immunization through TT injection during ANC has increased from 89.35% to 94.90% - an increase of 6.21%. A marginal increase of 3.3% was noticed in postnatal care visits from 86.81% to 89.70%.

A very impressive performance – an increase of 26% was noticed in deliveries conducted at Sub-center level which took its rate from 42.90% to 54.10% after appointment of 2nd ANM. Another change that was noticed in deliveries assisted at home has also increased from 13.46% to 18.80%, up by 40%. Overall the natal care has improved institutionally and on domestic front after appointment of 2nd ANM.

A marginal increase of 3.37% in child (12-23 Months) immunization from 90.58% to 93.90% was observed. This also can be attributed to the fact that the SC ANMs rapport with AWW and ASHA has improved after appointment of 2nd ANM.

Overall there was a marginal increase in family planning services – both temporary and permanent methods were noticed during the reference period. Utilization of temporary contraceptive methods especially Copper T insertions has increased by 13.1%, distribution of Pills increased by 8.52%, and condom distribution by 4.39%. The utilization of permanent method – sterilization has increased by 5.04%.

Performance of Single ANM Vs. Two ANM Sub-centres

The comparative performance of Sub-Centres with Single ANM and Two ANMs has been studied in selective 12 important parameters covering the four major reproductive and child health services like (i) ANC and PNC, (ii) Natal Care, (iii)

Child care and (iv) Family Planning. The results however have shown that Sub-centres with two ANMs have certainly fared better compared to single ANM in all the 12 parameters, spread over in four broad areas of service.

One of the quality indicators for antenatal care i.e., completeness of ANC check-up with 3 and 4 visits has made a marked change of over +8% in single and two ANM SCs. Besides, the rate of antenatal registration has also peaked to 98.84% in two ANM SCs compared to 92.84% in single ANM SC – a change of 6.5%. The coverage immunization through TT injection during ANC has also made a positive change from 90% to 95%. A marginal increase of 5.34% was noticed in postnatal care visits. Both Sub Centre deliveries and home deliveries assisted by ANM have shown a positive change to a tune of 18% and 22% respectively.

A marginal positive change of 4.45% in child (12-23 Months) immunization from 89.90% to 93.90% was observed. This also can be attributed to the fact that the SC ANMs rapport with AWW and ASHA has improved after appointment of 2nd ANM.

Overall there was a marginal increase in family planning services – both temporary and permanent methods were noticed during the reference period. Utilization of temporary contraceptive methods especially Copper T insertions has increased by 11.87%, distribution of Pills increased by 6.68%, and condom distribution by 5.75%. The utilization of permanent method – sterilization has increased by almost 7%.

Jobs performed by 1st And 2nd \ANM's

Most of the administrative jobs were performed by 1st ANM in both single ANM and Two ANM Sub centers, which is as per the prescribed job chart. Nearly 80 % of ANMs at "single ANM SCs" are monitoring CHG/ASHA and 100 % of 1st ANMs at two ANM SCs are doing this job, which perhaps due to the support of second ANM. Almost all the financial transactions (100 %) of two ANM SC are handled by the first ANM; however in 6.7% cases the second ANM is also dealing the financial transactions. This may be due to lack of clarity in job description or as per the instructions of 1st ANM, in some SCs.

The ANC check up by the first ANM at home was found increased (53.3 % to 73.3%); however, only 40 % of second ANM were involved in ANC check-up at

home. Major improvement was observed in the conduction of delivery at SCs. Only 73.3 % 1st ANM at "single ANM SC" are conducting deliveries at SC; while 100 % of both the ANM's at "two ANM SC" are conducting deliveries at SC. Only 20 % ANMs at "single ANM SC" are conducting deliveries at home, however at "two ANM SC", as many as, 60 % of 1st ANM and 26.7 % of 2nd ANM are conducting deliveries at home. There is an increase in VHND celebrations after appointment of 2nd ANM. While 80 % of ANMs from "single ANM SC" were attending VHND, this was increased up to 93.3% after appointment of 2nd ANM in "two ANM SC"

Improvement in Supportive Services to ASHA'S & AWW'S

ANMs rapport with farthest villages of SC has greatly improved in two ANM SCs (88.9%) compared to Single ANM SC (10.7%). The reach of 2nd ANM at AWW was 55.6 %, while it was 18.5 % for single ANM SC and 26.9 % for Two ANM SC.

The farthest village has been benefited in terms of getting technical support in VHNSC by the ANM at two ANM SC (60.7%) as compared to single ANM SC (40.7%). The ASHA & AWW were of the opinion that the SC ANMs presence has improved the functioning of the VHNSC after the appointment of second ANM both in the SC villages and farthest villages.

The satisfaction levels of ASHA and AWW with the work of ANM are relatively more in two ANM SC (92% in SC Village & 85% in farthest village) compared to Single ANM SC (74% in SC Village & 75% in farthest village).

The ASHA & AWW of both SC village & farthest village were of the opinion that availability of ANM at SC, Home visits by ANM has improved by the appointment of 2nd ANM in the SC. The services of SC like ANC/PNC care, Patient care, deliveries, family planning etc. are reaching the farthest villages also as in the SC villages after appointment of 2nd ANM.

Satisfaction of Community on the Services of the SCs with Single & Two ANMs

After the appointment of 2nd ANM the satisfaction levels of community members of farthest village has increased by nearly 10%. The reasons attributed for their dis-satisfaction include unavailability of ANM most of the times in 43.3% members of SC village and 17.9 % of farthest village of Single ANM SC. However, in case of two ANM SC 20 % of farthest village members were not happy compared

to that of 35.7% of SC village. The second most common reason for dissatisfaction was that the ANM do not stay in the village.

Over 96% and 90% members of SC village and farthest village respectively were satisfied with the services and availability of second ANM. The community members however have expressed that the ANMs of two ANM SC compared to single ANM SC are giving priority to administrative roles rather than technical roles pertaining to VHNSC. This is a surprising observation contrarily to the expectations that the ANMs of two ANM SC will be able to devote their time for technical support to VHNSC.

However, majority of the community members (82% of SC village & 77% of Farthest village) have agreed that there was an improvement in functioning of VHNSC after the appointment of 2nd ANM at SC. There was a marked improvement in planning, organization, availability, and participation of regular VHNSC meetings and extending technical support by the ANM in both SC villages and the farthest villages.

As per the revelation of community member, services of the SC like ANC/PNC care, Patient care, deliveries, family planning, immunization etc. are equally reaching the farthest villages as in the SC villages after appointment of 2nd ANM. It is important to note that services like deliveries by SC nurse, decrease of communicable diseases, and increased utilization of govt. schemes have reached the farthest villages of SC after the appointment of 2nd ANM.

Perception of Supervisory Staff on functioning of SC with Single & Two ANMs

As many as 80% of supervisory staff of Two ANMs SC have opined that the functioning was good compared to 47% in Single ANM SC. Over 87% supervisors of Two ANM SC opined that the performance of SC was good in terms of targets fixed for quality and quantity of services provided to the public in comparison to that of 73% in Single ANM SC.

Over 93% supervisors felt that changes have occurred in maternal and child health care (ANC, PNC and immunization) and in home visits, followed by 87% felt that in registration of vital events, 80% in achieving targets, general patient care, organizing VHNSC, and administrative work like reporting. Over 2/3rd of supervisors felt that satisfaction levels among people have improved.Family planning,

immunization and spreading the benefits of government schemes (JSY etc.) were the areas improved by the appointment of 2nd ANM according to 87%of supervisors. However, over 73% felt that improvement was observed in institutional deliveries, organizing VHND/VHNSC, control of communicable diseases and vital registration.

CHAPTER 1

INTRODUCTION

The National Rural Health Mission (NRHM) was launched throughout the country in April 2005 by the Government of India, to provide accessible, affordable and accountable healthcare to rural population. Over the decades, the Government has concentrated on providing basic health infrastructure to the vast majority of our rural population through the Sub-Centers. Sub-Centre is the most peripheral and first contact point between the Primary Health Care System and the Community. Each Sub Centre is required to be staffed by one Auxiliary Nurse Midwife (ANM), Multipurpose Health Worker (Male & Female).

1.1 Rationale of the Study

In order to improve the basic health services in the rural areas and recognizing the implications of additional responsibility on the performance of the ANM, the NRHM has made provision for an additional ANM (second ANM) to perform clinical work on non-itinerary basis in each Sub-Centre, since one ANM was believed to be inadequate to handle the increased workload. Women, who are residing in one of the villages under the jurisdiction of the SC, are appointed as Additional ANMs on a contract basis. Is it a necessary condition for appointment of second ANM?

The second ANM is expected to supplement and augment the services provided by the first ANM and they would complement each other. In some states, however, in the absence of clear and specific guidelines of the role and responsibility of the second ANM at present, each SC is following its own operating procedure and job allocation. For effective implementation of the programs, it is desirable that the two ANMs work in such a way that together, they actually enhance the quality, effectiveness and coverage of the health programs in the area. This calls for a high degree of co-ordination and understanding between the two.

Maharashtra has till date appointed 6223 ANM's on contract as second ANM in all districts across the State. The State is keen to learn whether access to and quality of RCH services have improved in SC areas where second ANM's are in position for more than I year. Department of Public Health, GOM has requested UNFPAState

office to commission a rapid assessment to study effect of posting second ANM at SCs. UNFPA provided funds under AWP with SHSRC to undertake this study.

In this context, the SHSRC, Pune, Maharashtra with the help of Pravara Institute of Medical Sciences - Deemed University, Loni, Ahmednagar has undertaken the project on "Rapid Assessment study on effect of posting second ANM at Sub Centers in Maharashtra" during *November to December 2013*.

1.2- Broad objective of the study:

To find out the effect of increasing Human Resources (HR) at SC level on access and quality of RH services.

1.3- Specific objectives of the study:

1. To assess Utilization of RCH services at SC before and after the intervention.
2. To assess how VHNDs are conducted and utilization of different services at VHNDs.
3. To study change over time on proportion of fully immunized children (12-23 months), early registration of pregnancy, SC delivery or SBA, institutional delivery, postnatal visits, newborn care, unmet need for spacing contraceptives, registration of births and other vital events, uptake to State Govt. schemes such as MC'I'S, JSY, JSSK referral transport, free medicines and RGRBY.
4. Improved support to ASHA's & AWW's and SHG's for village level planning and effective functioning of VHND and other community level processes.
5. Change in community perception regarding RCH and other health services provided by the SCs.
6. To identify impelling &impending factors for effective functioning of 2^{nd}ANM.

The study has examined separately SCs served by one ANM and those served by two ANMs to understand the functioning mechanism currently in operation and identify strengths and weaknesses.

CHAPTER 2

STUDY DESIGN & METHODOLOGY

2.1 Study Design: The study design is a case-control, retrospective. The two ANM SCs were treated as cases, while Single ANM SCs were treated as controls. The research setting was both institutional and community based. Primary and secondary data were collection from the selective SCs.

2.2 Primary data: Primary data was collected from both quantitative and qualitative surveys. The quantitative survey was carried out by employing a pre-tested structured interview schedule addressed to ANMs in Single ANM SCs and Two ANM SCs. The qualitative survey was carried out through a semi-structured IDI schedule addressed to peripheral health workers (ASHA, AWW), members of PRI, women SHGs, MOs, Nurse Supervisors.

2.3 Secondary Data: Secondary data was collected in a prescribed format from the selected Single ANM and Two ANM Sub-centers.

2.4 Sample Size:

Quantitative Survey:

Randomly Selected Districts	No of Single ANM SCs	No. of TWO ANM SCs	Total SCs Selected
15	75	75	150

Qualitative Survey:

Sr. No	Type of Sample	Sample Size	Details of samples
1	Districts	3	Gondia, Nashik, Gadchiroli
2	Sub-Centers	30	15 Single & 15 Two ANM SC
3	ANMs	45	15 Single & 30 Two ANM SC
4	ASHA & AWW	108	59 AWW & 49 ASHA – 1 from same village & 1 from farthest village
5	Members of PRI & SHG	116	60 PRI & 56 SHG - 1 from same village & 1 from farthest village

6	MOs & Supervisor	Nurse	30	One each Single & Two ANM SC

2.5 Methodology of Selection of Sub Centers for Quantitative Survey

A multistage stratified random sampling technology was adopted. In the first stage all districts in Maharashtra were classified into three categories poor, average and better performing districts based on % institutional deliveries (decided in consultation with Public Health department, GOM) (Table 2.1). In the second stage, 15 districts- 11 from Better, 2 from Average & 2 from Poor performing district strata's, were selected randomly. In Third stage PHCs were randomly selected from the districts. In the fourth stage Sub-centres were selected from the PHC. Table 2.1 show the sampling methodology adopted as well as the randomly selected sample districts for quantitative and qualitative study.

Table 2.1: Sample Districts Selected for Quantitative and Qualitative Survey

% Institutional Deliveries	Performance Grade	No. of Districts	Name of District (% Inst. Deliveries)	Random Sample for Quantitative Survey	Random Sample for Qualitative Survey
91 – 100	Better	27	Kolhapur (100), Sindhudurg (100) Sangli (99), Nagpur (99), Wardha (99), Gondia (99), Mumbai (99), Ratnagiri (98), Satara (98), Latur (98), Akola (98), Bhandara (98), Pune (97), Solapur (97), Osmanabad (97), Yavatmal (97), Nanded (96), Chandrapur (96), Aurangabad (95), Jalna (95), Hingoli (95), Washim (95), Thane (94), Ahmednagar (94) Parbhini (92), Beed (92), Amarawati (91)	Gondia, Sindhudurg, Solapur, Yavatmal, Satara,Sangli, Ahmednagar, Thane, Ratnagiri, Amarawati, Akola	Gondia
81 - 90	Average	5	Jalgaon (90),Buldana (89), Dhule (88), Raigad (87),Nashik (86)	Nashik, Dhule	Nashik
80 & Below	Poor	2	Gadchiroli (80) Nandurbar (54)	Gadchiroli, Nandurbar	Gadchiroli
Total		34			

Table 2.2-Detail of the Sample Sub-centers Selected for Quantitative Survey

District	Name of Block	Name of PHC	Name of Sub - Center
1. Akola	Akola	Kapashi	Chandur(Kapashi)
			GogregaonKhurd
	Akot	Sawara	Punda
			Ruikhed
	BarshiTakali	Dhaba	Kinkhed
			Lohagad
	Murtizapur	Dhotra (Shinde)	Kanzara
			NimbhaDhotra
	Telhara	Danapur	Gadegaon
			Ghodegaon
2. Amravati	Achalpur	DhamangaonGadhi	Dhamangaon
			Belkheda
	Chandur Rly	AamalaVish.	AmlaVishweshwar
			Bagghi
	Chikhaldara	Semadoh	Raipur
			Boratyakheda
	Dharni	Sadrabadi	Titamba (IPHS)
			Dhodra
	Warud	Rajura Bazaar	Haturna
			Pawani
3. Nandurbar	Taloda	Borad	Mod
			Kharvad
	Akkalkuwa	British Ankushvihir	Kakarpada
			Khatawani
	Nandurbar	Dhekwad	Songir
			Khamgaon
	Navapur	Pratappur	Raypur
			Vadkalambi
	Dhadhagaon	Talai	Padali
			Mundalvad
4. Dhule	Dhule	Kusumba	Kusumba
			Lonkhedi
	Shindkheda	Dhamane	Amalthe
			Chilane
	Shirpur	Sangavi	Kalamsare
			Karvand
	Dhule	Boris	Boris
			Burzad
	Sakri	ChadawelKorde	ChadwelPakhrun
			ChhadwelKarde
5. Ratnagiri	Mandangad	Panderi	Adkhal
			Nargoli
	Dapoli	Asood	Gimhavane
			Harne
	Chiplun	Furus	Durgewadi
			Kutare

	Ratnagiri	Kotawade	Kasarveli
			Gawadeaambere
	Lanja	Shiposhi	Wadghaon
			Talwade
6. Thane	Wada	Gohra	Kharivali
			Khutal
	Talasari	Udhawa	Kodad
			Kurze
	Murbad	Kishor	Kishor
			Asole
	Bhiwandi	Kon	Sai Colony
			Naikwadi
	Dahanu	Dhundalwadi	Bahare
			Gangangaon(IPHS)
7. Ahmednagar	Sangamner	Jawalebaleshwar	PimpalgoanMatha
			Sawargoan Tal
	Parner	Palve	Narayangavhan
			Ralegansiddhi
	Karjat	Baradgaon	Dhalwade
			Khed
	Rahata	Astgaon	PimpriNirmal
			Ekrukhe
	Shrigonda	Kolgaon	Suregaon
			Bhangaon
8. Sangali	K.Mahankal	Agalgaon	Agalgaon
			Ghatnandre
	Kadegaon	Khearadewangi	Nevari (Kadegaon)
			BhikwadiKhu.
	Walava	Bavachi	MArdwadi
			Nagav
	Shirala	KokrudPhc	SC Kudaiwadi
			SC Bilashi
	Jath	Walsang	Jath 1
			SC Nigadi
9. Satara	Wai	Bhuinj	Kikali
			Chindhawali
	Mahableshwar	Taldeo	Parut
			Kumbhroshi 1
	Jawali	Kudal	Dapawadi
			Valuth
	Phaltan	Rajale	Widani
			Somthali
	Man	Mardi	Dahivadi
			Panchwad
10. Sindhudurga	Kankavli	Kasarde	Vagheri
			Talere
	Vaibhavwadi	Umbarde	Umbarde
			Kolpe
	Sawantwadi	Sangeli	Kalmbist
			Kariwade

	Kudal	Kadawal	Kupavde
			Sonvde
	Dodamarg	SateliBhedshi	Shirange
			Usap
11. Solapur	Karmala	Warkute	Hiware
			Gaundre
	Mangalwedha	Marwade	Marwade
			Bhalavani
	Akkalkot	Dudhani	Dudhani
			Boroti
	Madha	Upalai Bu	Chincholi
			Kumbhej
	Sangola	Nazare	Ajnale
			Balavadi
12. Yawatmal	Ner	Manikwada	Manikwada
			Vatphali
	Darwha	Bori Arab	Ladkhed
			Kamathwada
	Arni	Loni	Sawanga
			Tiwri
	Kalamb	Sawargaon	Mankapur
			Kotha
	Ghatanji	Bhambora	Kurha
			Belora 1
13. Gadchiroli	Korchi	Kotgul	Kotgul
			Kosmi No. 2
	Kurkheda	Deolgaon	Yerkadi
			Deolgaon
	Armori	Vairagad	Arsoda
			Saigaon
	Gadchiroli	Bodali	Gadchiroli No-1
			Chandala
	Charmoshi	Kunghada	Pavimuranda
			Navergaon
14. Nashik	Niphad	Naitale	Gajarwadi
			Kundewadi
	Dindori	Kochargaon	Vilwandi
			Ravalgaon
	Nashik	Shinde	Rahuri
			Palse
	Igatpuri	Dhamangaon	Shenit
			Kawadadara
	Nandgaon	Pimparkhed	Bangaon Bk.
			Pokhari
15. Gondia	Tirora	Mundikota	Kesalwada
			Ghogera
	Gondia	Kati	Rajegaon
			Banthar
	Amgaon	Kalimati	Nansari
			Girola

Deori	Kakodi	Mispiri Kadikasa

2.6 Methodology for Selection of Sub-centers for Qualitative Survey

Five SCs from each selected district were drawn randomly from both groups i.e. with 2nd ANM and without 2nd ANM. As a whole the study was carried out in 30 SCs - 10 from each selected districts of Maharashtra.

Table 2.3-The Summary of Sample Size of SCs to be surveyed in the State

Randomly Selected District as per performance category	No of SCs selected from without 2nd ANM group	No. of SCs selected with 2nd ANM group	Total No. of SCs selected
District 1 (Better)	5	5	10
District 2 (Average)	5	5	10
District 3 (Poor)	5	5	10
Total sample SCs	15	15	30

Table 2.4-Detail of the Sample Sub centers Selected for Qualitative Survey

District	**Name of Block**	**Name of PHC**	**Name of Sub-center**
Gadchiroli	Korchi	Kotgul	Kotgul Kosmi No. 2
	Kurkheda	Deolgaon	Yerkadi Deolgaon
	Armori	Vairagad	Arsoda Saigaon
	Gadchiroli	Bodali	Gadchiroli No-1 Chandala
	Charmoshi	Kunghada	Pavimuranda Navergaon
Nashik	Niphad	Naitale	Gajarwadi Kundewadi
	Dindori	Kochargaon	Vilwandi Ravalgaon
	Nashik	Shinde	Rahuri Palse
	Igatpuri	Dhamangaon	Shenit Kawadadara
	Nandgaon	Pimparkhed	Bangaon Bk. Pokhari
Gondia	Tirora	Mundikota	Kesalwada

		Ghogera
Gondia	Kati	Rajegaon
		Banthar
Amgaon	Kalimati	Nansari
		Girola
Deori	Kakodi	Mispiri
		Kadikasa
ArjuniMorgaon	Korambhitola	Arjuni 2
		Wadegaon 1

2.7 Survey Instruments

The following five sets of data collection tools were designed and pre-tested for both quantitative and qualitative field study.

Tool No.	Type of Survey Instrument	Respondent	Number Canvassed
1	Sub Centre Performance Assessment Schedule	I/CANM & SC Registers	150 (75 of 1 ANM SC &75 of 2 ANM SC)
2	ANM Interview Schedule	Single ANM & Two ANMs as the case may be	45 (15 Single ANM SC & 30 Two ANM SC) (Nashik, Gadchiroli, Gondia)
3.	IDI Schedule of Community Health Worker	AWW and ASHA	120 (60 AWW & 60 ASHA)
4.	IDI Schedule of Community Representative	Member of PRI and SHG	120 (60 PRI & 60 SHG)
5.	IDI Schedule of Supervisory Staff	Medical Officer of respective PHC	30

All necessary and relevant information as per the study criteria mentioned above was collected from I/C ANM and/or Registers/Reports available at 150 SCs for each year since the launch of intervention to study the performance, through a specially designed *"Sub Centre Performance Assessment Schedule" (Tool 1).*An effort was made to compare performance within each group before and after posting of 2nd ANM using HIM's data.

The effect of posting second ANM was assessed on the study criteria enlisted above by comparing that performance of between two groups of SCs by collecting information from ANMs of the selected 30 SC through a specially designed *"ANM*

*Interview Schedule"(Tool 2).*Community perspective and the perceptions of village level functions e.g. AWW, ASHA, member of PRI, and SHG's was gathered through IDI's (Tool 3 & 4). Two representatives of AWWs, ASHAs, PRI members & SHG members (1 from SC village & 1 from farthest of SC village) was selected from each of the 30 SCs.IDIs were also conducted with the supervisory staff (MO PHC) of the concerned SC's to understand factors that have contributed to effectiveness of the intervention (Tool 5).

Chapter 3

Job Characteristics of Survey Respondents

This chapter highlights the findings of the study with respect to some important job related characteristics of the respondents (ANMs/MOs) like length of service, staying at HQ, distance between work place and residence, clarity in job description who was interviewed in present study.

Job Characteristics of ANMs

3.1- Length of Service of ANMs

Single ANM SC: Theaverage length of service of the ANM's of 3 districts was 3.96 years, ranging from 3.38 years for Nasik to 4.8 years for Gondia.

Two ANM SC: Theaverage length of service of the 1st ANM was 5.8 years, ranging from 3.4 years for Nasik and 8.8 years for Gondia. The average length of service of 2nd ANM was 3.83 years ranging from 3.6 years for Gondia to 4 years for Gadchiroli.

3.2-Residence of ANM @ SC Headquarters

Single ANM SC: By rule, the ANM is supposed to stay at the HQ. But it was found that one in every three ANMs stay of single ANM SCs was staying away from the HQ in the Study area. Nearly 67% ANMs at Nasik, 20% ANMs each at Gadchiroli and Gondia were staying away from the HQs.

Two ANM SC: By rule, the 1st ANM should stay at the HQ. But it was found that on an average nearly 16% 1st ANMs of Two ANM SC stay away from HQ, while 20% of 1st ANMs stayed away in Nasik and Gondia districts. Over 40% of 2nd ANM was staying away from HQ, which was recorded as 60 % at Nasik, 40% at Gondia and 20 % at Gadchiroli.

3.3-Distance between place of work and residence of ANMs

Single ANM SC: The distance between "Place of Stay" and "Place of Work" of ANM at Nasik district ranges from 8 KMs to 45 KMs with an average of 26 KMs. However, it was 1 km for Gadchiroli and Gondia districts.

Two ANM SC: The average distance of place of stay & work of 1st ANMs SC was 1 KM while it was nearly 5 Kms for 2nd ANM.

3.4-Clarity of Job description in ANMs

Single ANM SC: Nearly67 % of ANM's from the study area reported that they did not receive any written job chart.

Two ANM SC: Nearly47 % of 1st ANMs from the study area reported that they did not receive any clear written jobs assigned to her.Only 13.33 % 2nd ANMs reported that they have received the job chart. No 2nd ANM in Nasik district reported that she has received the job chart.

Job Characteristics of Supervisory Staff

3.5- Length of Service of Supervisory Staff

Single ANM SC: The years of experience at PHC ranged from less than 2 yr. (13.33%) to maximum (6.66%) 28 yr. The respondent who worked five year and less were (53.33%), from five year to ten year were (26.66%) and above 10 yrs. Work experience at same PHC were three (20.00%) respondents.

Two ANM SC: The length of work in the same PHC forthe supervisory staff was varied from 1 yr. to 28 yr. The respondents who had completed less than five year were 40 % and who had five years to ten years' experience were 40 % and 20 % were with more than 20 %.

3.6 -Distance of SC with the PHC

Single ANM SC: There were 8 SC (53.33%) within 10 km distance. Five SC (33.33%) were within 10 to 20 km and two SC (13.33%) were having more than 20 km distance from PHC.

Two ANM SC: The distance of SC from PHC was less than 5 km for four (26.67 %) and 5 to 10 km for 6 (40%) and above 10 km for 5 (33.33%). Over 60 % ANM were covering less than 5 villages, 33.33 % ANM's were covering villages between 5-10 and 6.67 % ANM's were covering villages more than 10.

CHAPTER 4

Performance of Sub-centres with Single & Two ANMs

The Sub-center is the fundamental public health unit in rural areas of India, each serving on an average a population of about 5000. This section presents the findings of the survey regarding performance of the sub centers with and without 2nd ANM for two reference periods based on the responses of the ANM who is in-charge of the Sub-center. The information obtained has been recorded in the semi structured questionnaire. It would be relevant to emphasize that the information thus obtained relates only to the selected Sub-Centers. As mentioned earlier, in the methodology, 75 Sample Sub-Centers were with single ANM and 75 with two ANMs in 15 districts were selected for the study. For single ANM sub center the reference period was two proceeding years' i.e.2011-2012 & 2012-2013. For sub center with two ANM the reference period was before & after appointment of 2nd ANM.

4.1 Performance of Sub-centers with Single ANM

The performance of Sub-Centres in Maharashtra with single ANM in two reference periods has been studies as controls to understand the benefits accrued by appointing 2nd ANM at Sub-center level. The performance has been studied following selective 12 important parameters, especially covering the four major reproductive and child health services like (i) ANC and PNC, (ii) Natal Care, (iii) Child care and (iv) Family Planning.

4.1.1 Antenatal & Postnatal Care:

A marginal increase of 2% in coverage rates of Antenatal services has been observed from 2011-12 to 2012-13. The rate of antenatal registration has increased from 90.63% to 92.84% – a rise of 2.4%. A similar quantum (2.4%) of increase was observed in complete 3 ANC check-ups from 85.02% to 87.10%. However, the rate of 4 ANC checkups has increased by less than 2% from 80.15% to 81.63%. The coverage immunization through TT injection during ANC has increased from 88.62% to 90.14% - an increase of 1.7%. A nominal increase of less than 1% was noticed from 84.42% to 85.15% in postnatal care.

4.1.2 Natal Care – Deliveries

A major jump in deliveries conducted at Sub-center level has been noticed which took its rate from 37.48% in 2011-12 to 45.79% in 2012-13 – an increase of 22.2%. Understandably, it has resulted in decline in deliveries conducted at home from 10.39% to 8.48%, down by 18.4%. How much is this decline explains the demand for 2nd ANM has to be further studied.

4.1.3 Child Care

A marginal increase in child (12-23 Months) immunization from 87.60% to 89.90% was observed.

4.1.4 Family Planning

Overall there was a marginal increase in family planning services – both temporary and permanent methods were noticed during the reference period. While utilization of temporary contraceptive methods has increased by 3.4% in terms of distribution of Pills, by 4.8% in Copper T insertions, by 1.1% in condom distribution, the permanent method – sterilization has increased by 7.3%.

Table 4.1 Performance of Single ANM Sub-Centre (2011-12 & 2012-13)

Sr. No	Indicator	Single ANM SC		
		2011-12	2012-13	% Change
1	ANC Registration (%)	90.63	92.84	+ 2.4
2	ANC 3 Checkups (%)	85.02	87.10	+ 2.4
3	ANC 4 Checkups (%)	80.15	81.63	+ 1.8
4	TT Injection during ANC (%)	88.62	90.14	+ 1.7
5	Sub-Centre Delivery (%)	37.48	45.79	+ 22.2
6	Deliveries Conducted at Home	10.39	08.48	- 18.4
7	PNC Visits (%)	84.42	85.15	+ 0.9
8	Immunization of Children (12-23 Months) (%)	87.60	89.90	+ 2.6
9	Distribution of Contraceptive pills (%)	77.70	80.33	+ 3.4
10	Copper T Insertion (%)	61.26	64.18	+ 4.8
11	Condom Distribution (%)	79.63	80.47	+ 1.1
12	Family Planning Operation (%)	75.10	80.60	+ 7.3

4.2 Performance of Two ANM SCs before &after appointment of2nd ANM

The performance of Sub-Centres in Maharashtra with two ANMs in place has been studied for two periods – before appointment and after appointment of 2nd ANM. The performance has been studied following selective 12 important parameters, especially covering the four major reproductive and child health services like (i) ANC and PNC, (ii) Natal Care, (iii) Child care and (iv) Family Planning.

4.2.1 Antenatal & Postnatal Care:

A reasonably good increase of 6-8% in the Antenatal services coverage rates has been registered after appointment of 2nd ANM in the 150 Sub-centres surveyed. The rate of antenatal registration has increased from 91.92%to 98.84% – a rise of 7.53%.A better increase rate of 8.4% was observed in 3 ANC check-ups from 86.55% to 93.88%. The rate of increase of 6.61% in 4 ANC checkups from 83.01% to 88.50% has helped in realizing the objective of placing 2nd ANM. The coverage immunization through TT injection during ANC has increased from 89.35% to 94.90% - an increase of 6.21%. A marginal increase of 3.3% was noticed in postnatal care visits from 86.81% to 89.70%.

4.2.2 Natal Care – Deliveries

A very impressive performance – an increase of 26% was noticed in deliveries conducted at Sub-center level which took its rate from 42.90% to 54.10% after appointment of 2nd ANM. Another change that was noticed in deliveries assisted at home has also increased from 13.46% to 18.80%, up by 40%. Overall the natal care has improved institutionally and on domestic front after appointment of 2nd ANM.

4.2.3 Child Care

A marginal increase of 3.37% in child (12-23 Months) immunization from 90.58% to 93.90% was observed. This also can be attributed to the fact that the SC ANMs rapport with AWW and ASHA has improved after appointment of 2nd ANM.

4.2.4 Family Planning

Overall there was a marginal increase in family planning services – both temporary and permanent methods were noticed during the reference period. Utilization of temporary contraceptive methods especially Copper T insertions has

increased by 13.1%, distribution of Pills increased by 8.52%, and condom distribution by 4.39%. The utilization of permanent method – sterilization has increased by 5.04%.

Table 4.2 Performance of Two ANM SC Before & After Appt. of 2nd ANM

Sr. No	Indicator	Two ANM Sub Centre		
		Before Appointment of 2nd ANM	After Appointment of 2nd ANM	% Change
1	ANC Registration (%)	91.92	98.84	+ 7.53
2	ANC 3 Checkups (%)	86.55	93.88	+ 8.47
3	ANC 4 Checkups (%)	83.01	88.50	+ 6.61
4	TT Injection during ANC (%)	89.35	94.90	+ 6.21
5	Sub-Centre Delivery (%)	42.90	54.10	+ 26.11
6	Deliveries Conducted at Home (%)	13.46	18.80	+ 39.67
7	PNC Visits (%)	86.81	89.70	+ 3.33
8	Immunization of Children (12-23 Months) (%)	90.58	93.90	+ 3.67
9	Distribution of Contraceptive pills (%)	78.97	85.70	+ 8.52
10	Copper T Insertion (%)	63.47	71.80	+ 13.12
11	Condom Distribution (%)	81.52	85.10	+ 4.39
12	Family Planning Operation (%)	82.06	86.20	+ 5.04

4.3 Performance of Single ANM Vs. Two ANM Sub-centres

The comparative performance of Sub-Centres with Single ANM and Two ANMs has been studied in selective 12 important parameters covering the four major reproductive and child health services like (i) ANC and PNC, (ii) Natal Care, (iii) Child care and (iv) Family Planning. The results however have shown that Sub-centres with two ANMs have certainly fared better compared to single ANM in all the 12 parameters, spread over in four broad areas of service.

4.3.1 Antenatal & Postnatal Care:

One of the quality indicators for antenatal care i.e., completeness of ANC check-up with 3 and 4 visits has made a marked change of over +8% in single and two ANM SCs. Besides, the rate of antenatal registration has also peaked to 98.84% in two ANM SCs compared to 92.84% in single ANM SC – a change of 6.5%. The

coverage immunization through TT injection during ANC has also made a positive change from 90% to 95%. A marginal increase of 5.34% was noticed in postnatal care visits.

4.3.2 Natal Care – Deliveries

Both Sub Centre deliveries and home deliveries assisted by ANM have shown a positive change to a tune of 18% and 22% respectively.

4.3.3 Child Care

A marginal positive change of 4.45% in child (12-23 Months) immunization from 89.90% to 93.90% was observed. This also can be attributed to the fact that the SC ANMs rapport with AWW and ASHA has improved after appointment of 2nd ANM.

4.3.4 Family Planning

Overall there was a marginal increase in family planning services – both temporary and permanent methods were noticed during the reference period. Utilization of temporary contraceptive methods especially Copper T insertions has increased by 11.87%, distribution of Pills increased by 6.68%, and condom distribution by 5.75%. The utilization of permanent method – sterilization has increased by almost 7%.

Table 4.3 Performances of Single ANM & Two ANM SC

Sr. No	Indicator	Single ANM	Two ANM SC	% Change
1	ANC Registration (%)	92.84	98.84	+ 6.46
2	ANC 3 Checkups (%)	87.10	93.88	+ 7.78
3	ANC 4 Checkups (%)	81.63	88.50	+ 8.42
4	TT Injection during ANC (%)	90.14	94.90	+5.28
5	Sub-Centre Delivery (%)	45.79	54.10	+18.15
6	Deliveries Conducted at Home	08.48	18.80	+21.70
7	PNC Visits (%)	85.15	89.70	+5.34
8	Immunization of Children (12-23 Months) (%)	89.90	93.90	+4.45
9	Distribution of Contraceptive pills (%)	80.33	85.70	+6.68
10	Copper T Insertion (%)	64.18	71.80	+11.87
11	Condom Distribution (%)	80.47	85.10	+5.75
12	Family Planning Operation (%)	80.60	86.20	+6.95

Chapter 5

ANALYSIS OF THE JOBS PERFORMED BY 1ST AND 2ND ANM's

Besides providing clinical services, the ANMs perform various other activities at the Sub-Centre. Some of the main activities, mostly those pertaining to the Sub-Centre activities, were listed out and the ANMS were asked to report theactivities which they are performing. Based on the response of the ANMs each activity is presented in Table 5.1

Table 5.1 Different jobs performed by the 1st and 2nd ANM at Sub center under study (%)

Sr. No.	Jobs	Single ANM SC	Two ANM SC	
		1st ANM (%)	1st ANM (%)	2nd ANM (%)
1	Monitoring the work of 2nd ANM, CHG, ASHA	80.0	100.0	93.3
2	General administration of the SC	100.0	100.0	86.7
3	Submission of reports/returns to Health Supervisor	100.0	100.0	100.0
4	Financial Management of SC	93.3	100.0	6.7
5	Maintenance of Stock Ledger of FW material/articles	100.0	100.0	53.3
6	ANC registration	100.0	100.0	100.0
7	ANC check-ups (1st, 2nd and 3rd at SC and 4th at home)	100.0	100.0	100.0
8	ANC Checkup (At Home)	53.3	73.3	40.0
9	Routine immunization of Pregnant women (TT)	100.0	100.0	100.0
10	Routine Immunization of infant & children	100.0	100.0	100.0
11	Conducting Deliveries at SC	73.3	100.0	100.0
12	Conducting Deliveries at Home	20.0	60.0	26.7
13	Post natal care visits	100.0	93.3	100.0
14	New Born Care Visits	100.0	93.3	100.0
15	Routine immunization of 12-23 months children	93.3	93.3	93.3

16	Vit A distribution to children below 5 years age	100.0	93.3	100.0
17	Registration of Malnourished Children	100.0	93.3	100.0
18	Treatment/referral of Malnourished children	93.3	93.3	100.0
19	Treatment of diarrhea cases in children	100.0	93.3	100.0
20	Treatment of ARI cases in children	86.7	93.3	93.3
21	Providing services Infant and Young Child Feeding (IYCF)	80.0	60.0	73.3
22	Detection and treatment of STI/RTI cases	53.3	93.3	46.7
23	Counseling of eligible women for Family Planning	100.0	93.3	93.3
24	Distribution of Oral Contraceptive Pills	86.7	80.0	73.3
25	Cu. T insertion	93.3	93.3	80.0
26	Distribution of Condoms	93.3	80.0	86.7
27	Counseling of eligible couples for spacing	100.0	80.0	93.3
28	Family planning	93.3	86.7	93.3
29	No. of beneficiaries of JSY Scheme	80.0	86.7	66.7
30	No. of beneficiaries of JSSK Scheme	73.3	86.7	66.7
31	No. of beneficiaries availed Referral Transport facility	80.0	86.7	40.0
32	No. of AFP, AEFI cases & Measles cases reported	46.7	53.3	53.3
33	No. of beneficiaries of RGRBY	26.7	46.7	40.0
34	No. of VHNDs celebrated in the community/SC	80.0	60.0	93.3
35	No. of entries and updates of ECR	46.7	66.7	46.7
36	Registered Deaths	86.7	86.7	73.3
37	Registered Births	93.3	86.7	73.3
38	Registered Maternal Deaths	60.0	73.3	66.7
39	Registered Infant Deaths	60.0	73.3	60.0
40	Registered Still Births / IUDs	53.3	73.3	66.7
41	Registered Marriages	66.7	80.0	60.0
42	Other	26.7	60.0	53.3

It is seen from table 5.1 that, there is a difference in the jobs performed by the first and second ANM at the sub center. It is obvious that all the jobs at single ANM SC will be performed by the first ANM, but at two ANM SC, major difference observed in the work performance of both the ANM is that most of the administrative jobs are performed by 1st ANM.Following are some impressions of the job performance by first and second ANM at both types of sub centers.

- While 80 % of ANMs at "single ANM sub centres" are performing the job of monitoring CHG and ASHA, almost 100 % of 1st ANMs and 93% of 2nd ANMs of"two ANM sub centres" are doing this job. This observation reveals that monitoring of ASHA and CHG has been improved in "two ANM Sub-centres".Due to availability of 2nd ANM first ANM can concentrate more on the monitoring of the health workers.
- As many as 86.7 % of 2nd ANM's reported that they are also involved in general administration of the sub centres, which is otherwise an exclusive job of 1st ANM.
- The financial management at Sub-centres has been done by the 1st ANM at "two ANM sub-centres" as well as "single ANM Sub-centres". However, a minor 6.7 % of 2ndANMshave reported that they are also involved in this job.
- As many as 53.3 % of 2nd ANM are involved in maintenances of stock ledger, however, 100 % first ANM at both the sub centres are involved in stock ledger maintenance.

The above jobs which are administrative in nature are to be performed by the 1st ANM only. However, the 2nd ANM is also involved these activities. This may be happening either due to lack of clarity in job description or the 1st ANM is transferring her responsibilities deliberately to 2nd ANM.

- Both the ANMs are completely involved in the ANC registration and check-ups at SC. However, only 53.3 % 1st ANM at single ANM sub centres are involved in ANC check-up at home, this was found increased up to 73.3 % by first ANAM at two ANM sub center. Only 40 % 2nd ANM are involved in ANC check-up at home. Hence, there is no significant improvement in ANC check-up at home after appointment of 2nd ANM.
- All (100 %) 1st and 2nd ANMs are involved in immunization of pregnant women and children.

- Major improvement was observed in the conduction of delivery at sub center. Only 73.3 % 1st ANM at "single ANM sub center" are conducting deliveries at Sub center; while 100 % of both the ANM's at "two ANM sub centres" are conducting deliveries at sub center.
- Only 20 % ANMs at "single ANM sub center" are conducting deliveries at home, however at "two ANM sub center", as many as, 60 % of 1st ANM and 26.7 % of 2nd ANM are conducting deliveries at home.
- PNC visits and new borne care visits were attended by 100 % first ANM at "single ANM sub center". In "two ANM sub center", this was shared by the 1st ANM (93.3 %) and 2nd ANM (100%)
- Routine immunization of 12-23 month children's are performed by 93.3 % ANM's at both types of sub centres. There is no improvement in this activity with addition of 2nd ANM.
- There is an increase in VHND celebrations after appointment of 2nd ANM. While 80 % of ANMs from "single ANM sub center" were attending VHND, this was increased up to 93.3% after appointment of 2nd ANM in "two ANM Sub Centres"

The major impression of this chapter is that, appointment of 2nd ANM have defiantly helped the sub centers/ANM's to improve the number of cases they are attending in some important areas like monitoring the work of CHG, ASHA, ANC Check-up (At Home), Conducting Deliveries at SC, Conducting Deliveries at Home, Treatment/referral of Malnourished children etc. However it was also reflected that, even though the total performance of two ANM sub center is increased, work performance of the 1st ANM at two ANM sub center has been deteriorated in some areas as compare to the 1st ANM of single ANM sub center. This may be due to the fact that 1st ANM at two ANM sub center is mostly relaying on the 2nd ANM for most of the jobs.

Chapter 6

Improvement in the supportive services to ASHA's & AWW's

In Planning VHND

One of the key components of NRHM is to provide a trained female community health activist - ASHA for every 1000 population in villages. ASHA is expected to create health awareness and thereby mobilize the local community to participate in local health planning and increased utilization of the available public health services at PHC, SC and Aanganwadi Center. ASHA is expected to work in tandem with AWW – another village level functionary under ICDS Scheme to support the SC ANM. Hence, the performance of SC in delivering the services to the needy public, especially women and children depends on the rapport the SC ANMs with the ASHA & AWW.

Hence, in order to assess how the appointment of second ANM has helped in improving the rapport with ASHA & AWW, we have carried out an analysis of the data in terms of "single ANM" and "two ANM" SCs as well as ANMs reach to the "farthest village" compared to the SC village.

A total of 49 ASHAs (12 from SC village and 13 from farthest village to SC with single ANM and 12 each for SC village and farthest village to SC with two ANM) and 59 AWWs (15 each from SC village and farthest village to SC and 14 for SC village and 15 for farthest village of SC with two ANM) were interviewed to assess how they are engaged with SC ANM. Three SC villages and 2 farthest villages to SC were not appointed any ASHA.

Awareness about appointment & timings of availability of ANM

While assessing the awareness levels of AWW & ASHA about the appointment and availability 2nd ANM at SC, 100% respondents from SC Village reported that they were aware of the appointment, while only 89% respondents from the "farthest village to SC" have reported that they were aware of the appointment.

Frequency of meeting of ANM with ASHA/AWW

Frequency of meeting of ANM with ASHA/AWW was considered as one of the important parameters which determine the rapport of ANM with the health workers. The survey has revealed that, the ANMs meet ASHA/AWW quite frequently

(Less than a Week) in the two ANM SCs (85.8%) compared to Single ANM SC (74.1%). However, the most important finding is that the ANMs rapport with farthest villages of SC has greatly improved in two ANM SCs (88.9%) compared to Single ANM SC (10.7%). Besides, the meeting of ANMs with ASHA/AWW became more systematic following specific timings in Two ANM SC compared to Single ANM SC for farthest villages.

Table 6.1: Frequency of meeting of ANM with ASHA/AWW

Frequency of meeting	Single ANM SC				Two ANM SC							
					Before appointment of 2nd ANM				After appointment of 2nd ANM			
	SC Village (N=27)		Farthest Village (N=28)		SC Village (N=27)		Farthest Village (N=27)		SC Village (N=28)		Farthest Village (N=27)	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Daily/alternative day	14	51.9	2	7.1	17	65.4	7	25.9	12	42.9	7	25.9
Weekly	6	22.2	1	3.6	9	34.6	15	55.6	12	42.9	17	63.0
More than a week	7	25.9	1	3.6	1	3.8	5	18.5	2	7.1	3	11.1
No specific time	0	0.0	24	85.7	0	0.0	0	0.0	2	7.1	0	0.0

Obviously the SC is the preferred place of meeting for single ANM (70.4%) and two ANM (61.5%) SCs, followed by Aanganwadi Centre (18.5% and 26.9% respectively). However, the preferred place for meeting ASHAs in farthest villages for both Single ANM (53.6%) and two ANM SC (55.6%) is Anganwadi Centre.

Table 6.2: Place of Meeting of ANM with AWW/ASHA

Place of Meeting	Single ANM SC				Two ANM SC			
	SC Village (N=27)		Farthest Village (N=28)		SC Village (N=26)		Farthest Village (N=27)	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
At AWW	5	18.5	15	53.6	7	26.9	15	55.6
At SC	19	70.4	18	64.3	16	61.5	9	33.3
At home	1	3.7	3	10.7	1	3.8	3	11.1
Elsewhere	2	7.4	2	7.1	1	3.8	6	22.2

It is seen from table 6.3 that, ANM's at both the sub centers are engaged more in the administrative role as compare to technical role. However for farthest village at

two ANM sub center, similarity was reported in performing both administrative and technical role by the ANM. Most important thing associated with VHNSC is that, 2nd ANM is delivering more technical role in the farthest village (60.7%) as compare to single ANM (40.7 %)

Table 6.3 Role of ANM in organization of VHNSCs reported by ASHA/AWW

Role of ANM in VHND (Multiple response)	Single ANM SC				Two ANM SC			
	SC Village (N=26)		Farthest Village (N=27)		SC Village (N=27)		Farthest Village (N=28	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Adm. Role (*Secretary /Member/Accounting*)	24	92.3	25	92.6	25	92.6	17	60.7
Technical Role (*Planning/help in Org. VHND/health talk)*	13	50.0	11	40.7	12	44.4	17	60.7
Other	3	11.5	3	11.1	1	3.7	7	25.0

The ASHA & AWW were of the opinion that the SC ANMs presence has improved the functioning of the VHNSC after the appointment of second ANM both in the SC villages and farthest villages. Table 6.4 reveals that the there is a marked improvement in planning, organizing and participation of regular meetings in both SC villages and farthest villages.

Table 6.4 Areas of Improvement in Functioning of VHNSC after appointment of 2nd ANM

Areas of Improvement	SC Village (N=27)		Farthest Village (N=27)	
	Freq.	%	Freq.	%
VHNSC meetings are conducted regularly	22	81.5	25	92.6
ANM is available for VHNSC meeting	10	37.0	13	48.1
ANM helps in planning of the village	1	3.7	4	14.8
Health of villagers has improved	10	37.0	8	29.6
Sanitation of village has improved	10	37.0	11	40.7
Nutritional level of villagers has improved	9	33.3	18	66.7
ANM provides technical support	14	51.9	18	66.7
Other	0	0.0	9	33.3

The satisfaction levels of ASHA and AWW with the work of ANM are relatively more in two ANM SC (92% in SC Village & 85% in farthest village) compared to Single ANM SC (74% in SC Village & 75% in farthest village).

Table 6.5Satisfaction of ASHA/AWW with the work of ANM

Satisfaction	Single ANM SC				Two ANM SC			
	SC Village (N=27)		Farthest Village (N=28)		SC Village (N=26)		Farthest Village (N=27)	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Satisfied	20	74.1	21	75.0	24	92.3	23	85.2
Not Satisfied	5	18.5	4	14.3	2	7.7	4	14.8
Don't Know	2	7.4	3	10.7	0	0.0	0	0.0
Total	27	100.0	28	100.0	26	100.0	27	100.0

The ASHA & AWW of both SC village & farthest village were of the opinion that availability of ANM at SC, Home visits by ANM has improved by the appointment of 2nd ANM in the SC (Table 6.6)

Table 6.6 Areas of Improvement after appointment of 2nd ANM

Areas of Improvement	SC Village (N=26)		Farthest Village (N=27)	
	Freq.	%	Freq.	%
ANM is always available at SC	17	65.4	16	59.3
Patients can be sent at any time in day	9	34.6	13	48.1
Home visits are increased	13	50.0	14	51.9

Various services of the SC like ANC/PNC care, Patient care, deliveries, family planning etc. are reaching the farthest villages also as in the SC villages after appointment of 2nd ANM, as per the revelations of the ASHA and AWWs (Table 6.7). It is important to note that services like deliveries by SC nurse, VHNDs, decrease of communicable diseases, increased utilization of govt. schemes have reached the farthest villages of SC after the appointment of 2nd ANM.

Table 6.7 Reach SCs services after appointment of 2nd ANM

Areas of Improvement of SC (multiple response)	SC Village (N=26)		Farthest Village (N=27)	
	Freq.	%	Freq.	%
ANC Care	22	84.6	22	81.5
PNC Care	17	65.4	16	59.3

General Patient Care	8	30.8	8	29.6
Deliveries by SC ANM	12	46.2	19	70.4
Family planning	7	26.9	9	33.3
Immunization	24	92.3	20	74.1
VHND	3	11.5	4	14.8
Decrease in communicable diseases	8	30.8	10	37.0
Increased utilization of other schemes of Govt.	2	7.7	4	14.8
Other	3	11.5	2	7.4

Chapter 7

Perception and Satisfaction Levels of community on the services of SCs with single and two ANMs

A total of 116 community members (60 from PRIs & 56 from Women SHGs) representing the village community were interviewed to understand the perceptions and satisfactory levels of the services being provided by the single and two ANM SC. Further, an equal number of representatives were selected from SC village and the farthest village to SC to understand the reach of services to distant villages, which is one of main objective of appointing a 2nd ANM.

As many as 96% of respondents who belong to SC village and 90% of respondents who are from farthest village were aware that a 2nd ANM has been posted in their SC area. However, 86% respondents of SC village and 80% respondents of farthest village have felt that there is no difference in their job responsibilities. According to them, they both have the similar responsibilities to perform.

Majority of the respondents (80% of SC village & 67.9 % of farthest village) had agreed that the villagers are satisfied by the services of the Single ANM SC. While, 76.7% of farthest village and 64.3 % of same village of two ANM SC community members were satisfied. It means that due to the appointment of 2nd ANM the satisfaction levels of community members of farthest village has increased by nearly 10% (table 7.1). However, relatively more number (32%) of community members belong to SC village of two ANM SC were not satisfied compared to 20% of similar group from Single ANM SC.

Table 7.1 Satisfaction of the community with the services of ANM

	Single ANM				Two ANM			
	SC Village (N=30)		Farthest Village (N=28)		SC Village (N=28)		Farthest Village (N=30)	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Satisfied	24	80.0	19	67.9	18	64.3	23	76.7
Not Satisfied	6	20.0	8	28.6	9	32.1	6	20.0
Don't Know	0	0.0	1	3.6	1	3.6	1	3.3
Total	30	100.0	28	100.0	28	100.0	30	100.0

The reasons attributed for their dis-satisfaction include unavailability of ANM most of the times in 43.3% members of SC village and 17.9 % of farthest village of Single ANM SC. However, in case of two ANM SC 20 % of farthest village members was not happy compared to that of 35.7% of SC village. The second most common reason for dissatisfaction was that the ANM do not stay in the village.

Table 7.2 Reasons for dis-satisfaction with the services provided by SC ANM

Reason for dissatisfaction	Single ANM SC				Two ANM SC			
	SC Village (N=30)		Farthest Village (N=28)		SC Village (N=28)		Farthest Village (N=30)	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Unavailable most of the time	13	43.3	5	17.9	10	35.7	6	20.0
Stays in another village	8	26.7	1	3.6	4	14.3	4	13.3
Doesn't attend any patient	2	6.7	2	7.1	2	7.1	0	0.0
Always busy	0	0.0	0	0.0	7	25.0	1	3.3
Other	0	0.0	2	7.1	6	21.4	1	3.3

ANC, immunization services and home visits are the priority needs of the community members of both SC village and the farthest village to SC (Table 7.3)

Table 7.3 Need for additional services from the ANM at Single ANM SC

	SC Village (N=28)		Farthest Village (N=30)	
	Freq.	%	Freq.	%
Home visits	15	50.0	10	35.7
General Patient Care	8	26.7	10	35.7
ANC	18	60.0	14	50.0
PNC	6	20.0	6	21.4
Immunization	15	50.0	11	39.3
Health Awareness	2	6.7	3	10.7
VHNSC	0	0.0	2	7.1

Over 96% and 90% members of SC village and farthest village respectively were satisfied with the appointment of 2nd ANM (Table 7.4). The major reason for the satisfaction of the members of both SC village and farthest village is that ANM attends all the patients, followed by her availability at SC (Table 7.5)

Table 7.4Satisfaction of people after appointment of 2nd ANM at two ANM SC

	SC Village (N=28)		Farthest Village (N=30)	
	Freq.	%	Freq.	%
Yes	27	96.4	27	90.0
No	0	0.0	0	0.0
Don't Know	1	3.6	3	10.0
Total	28	100.0	30	100.0

Table 7.5 Reasons for satisfaction of the people by two ANM SC

	SC Village (N=28)		Farthest Village (N=30)	
	Freq.	%	Freq.	%
ANM is always available at SC	19	67.9	11	36.7
ANM stays in same village	11	39.3	4	13.3
ANM attends all patient's	14	50.0	23	76.7
Other	0	0.0	0	0.0

As much as 90% of SC village members of both single ANM and two ANM SCs have formed the VHNSC in the villages, while nearly 85% in farthest villages it was formed (Table 7.6).

Table 7.6 Formulation of VHNSC in Village

	Single ANM SC				Two ANM SC			
	SC Village (N=30)		Farthest Village (N=28)		SC Village (N=28)		Farthest Village (N=30)	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Yes	27	90.0	24	85.7	27	90.0	25	83.3
Know	2	6.7	2	7.1	0	0.0	5	16.7
Don't Know	1	3.3	2	7.1	1	3.6	0	0.0
Total	30	100.0	28	100.0	28	100.0	30	100.0

The community members, however have expressed that the ANMs of two ANM SC compared to single ANM SC are giving priority to administrative roles (*Secretary/ Member/Accounts matters*) rather than technical roles *(Village Planning/help in conducting meeting /health talk)* pertaining to VHNSC.This is a surprising observation contrarily to the expectations that the ANMs of two ANM SC will be able to devote their time for technical support to VHNSC.

Table 7.7: Role of ANM in VHNSC

	Single ANM SC				Two ANM SC			
	SC Village (N=30)		Farthest Village (N=28)		SC Village (N=28)		Farthest Village (N=30)	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Adm. Role (*Secretary/ Member/Accounts matters*)	16	53.3	14	50.0	17	60.7	18	60.0
Technical Role *(Village Planning/help in conducting meeting /health talk)*	13	43.3	7	25.0	6	21.4	7	23.3
Other	3	10.0	3	10.7	5	17.9	3	10.0

However, majority of the community members (82% of SC village & 77% of farthest village) have agreed that there was an improvement in functioning of VHNSC after the appointment of 2nd ANM at SC (Table 7.8).

Table 7.8 Improvement in Functioning of VHNSC after appointment of 2nd ANM

	SC Village (N=28)		Farthest Village (N=30)	
	Freq.	%	Freq.	%
Yes	23	82.1	23	76.7
No	2	7.1	2	6.7
Don't Know	3	10.7	5	16.7
Total	28	100.0	30	100.0

Majority of the Community members were of the opinion that the ANMs presence has improved the functioning of the VHNSC after the appointment of second ANM both in the SC villages and in the farthest villages. Table 7.9 reveals that the there was a marked improvement in planning, organization, availability, and participation of regular VHNSC meetings and extending technical support by the ANM in both SC villages and the farthest villages. Due to which some of community members of both SC village and farthest village felt that there was an improvement in sanitation and nutritional level of the village (Table 7.9)

Table 7.9 Areas of improvement in functioning of VHNSC after appointment of 2nd ANM

	SC Village (N=28)		Farthest Village (N=30)	
	Freq.	%	Freq.	%
Meetings are held regularly	13	46.4	16	53.3
Meetings are conducted regular	9	32.1	6	20.0
She is available for meeting	4	14.3	3	10.0
She helps in planning of the village	1	3.6	0	0.0
Health of the village is improved	6	21.4	5	16.7
Sanitation of the village is improved	9	32.1	12	40.0
Nutritional level of the village is improved	13	46.4	21	70.0
She provides technical support	18	64.3	19	63.3
Other	9	32.1	8	26.7

Various services of the SC like ANC/PNC care, Patient care, deliveries, family planning, immunization etc. are equally reaching the farthest villages as in the SC villages after appointment of 2nd ANM, as per the revelations of community members (Table 7.10). It is important to note that services like deliveries by SC nurse, decrease of communicable diseases, and increased utilization of govt. schemes have reached the farthest villages of SC after the appointment of 2nd ANM (Table7.10)

Table 7.10 Areas of improvement in functioning of SC after appointment of 2nd ANM

	SC Village (N=28)		Farthest Village (N=30)	
	Freq.	%	Freq.	%
ANC care	26	92.9	27	90.0
PNC Care	16	57.1	17	56.7
General patient care	12	42.9	12	40.0
Increase in sub center deliveries	14	50.0	9	30.0
Family planning	8	28.6	14	46.7
Immunization improved	26	92.9	23	76.7
Village health nutrition day	2	7.1	5	16.7
Decrease in communicable diseases	2	7.1	3	10.0
Implementation of other government schemes	5	17.9	6	20.0

CHAPTER 8

Perception of Medical Officers & Nurse Supervisors on functioning of SC withSingle ANM & Two ANMs

Functioning of the SC has been judged in terms of ANMs stay at HQ, timings of opening of SC and presence of ANM at SC, availability of ANM for public, regularity of the clinics, meetings etc. As many as 80% of supervisory staff of Two ANMs SC have opined that the functioning was good compared to 47% in Single ANM SC. Nearly 40% of the supervisory staff of single ANM SC opined that the functioning was poor or very poor (Table 8.1).

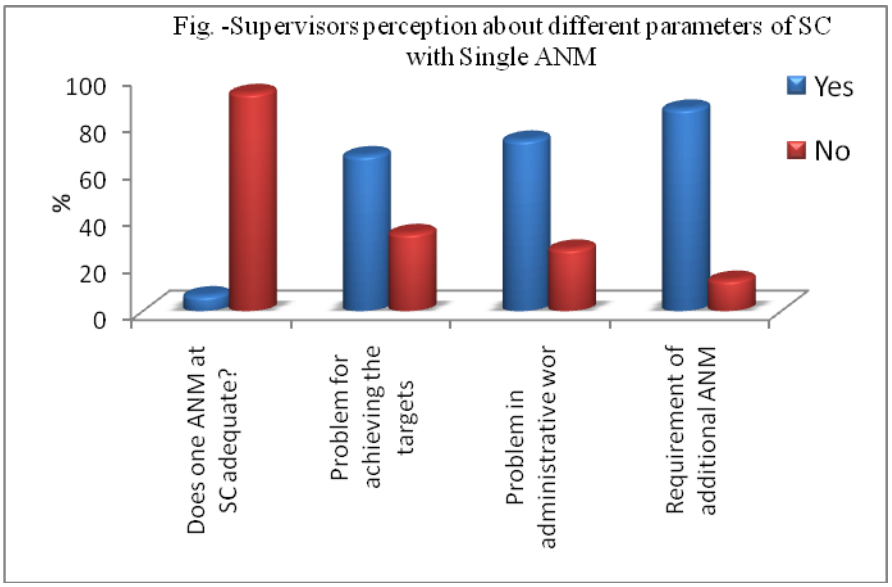
Table 8.1 Opinion of Supervisory Staff on overall functioning of SC

Opinion of MO/Supervisor Nurse	Single ANM SC		Two ANM SC	
	Freq.	%	Freq.	%
Very Good	2	13.33	3	20.00
Good	7	46.67	12	80.00
Average	5	33.33	0	0.00
Poor	1	6.67	0	0.00
Very Poor	0	0.00	0	0.00
Total	15	100	15	100

Performance of the SC has been judged in terms of achievement of targets fixed for quality and quantity of services being provided to the public. Relatively more number of supervisors (87%) of TWO ANM SC has opined that the performance was good compared to that of 73% in the case of Single ANM SC (Table 8.2).

Table 8.2 Opinion of Supervisory Staff on Performance of the SC

Opinion of MO/Supervisor Nurse	Single ANM SC		Two ANM SC	
	Freq.	%	Freq.	%
Very Good	1	6.67	1	6.67
Good	11	73.33	13	86.67
Average	2	13.33	1	6.67
Poor	1	6.67	0	0.00
Very Poor	0	0.00	0	0.00
Total	15	100	15	100



The perception of supervisors in changes that have occurred in various administrative, functional and technical aspects of SCs after appointment of 2nd ANM has been assessed. Maximum number of supervisors i.e., 93% was of the opinion that changes have occurred in maternal and child health care (ANC, PNC and immunization) and in home visits, followed by 87% in registration of vital events, 80% in achieving targets, general patient care, organizing VHNSC, and administrative work like reporting. Over 2/3rd i.e., 67% of supervisors felt that changes have occurred in satisfaction levels among people.

Table 8.3 Changes occurred after appointment of 2nd ANM

Changes occurred in	Freq.	Percent
Satisfaction levels of people	10	66.67
Targets achieved	12	80.00
ANC/PNC/Immunization	14	93.33
General patient care	12	80.00
Home visits	14	93.33
Functioning of VHNSC	12	80.00
Vital Registration	13	86.67
Administrative work like reporting	12	80.00
Others	6	40.00

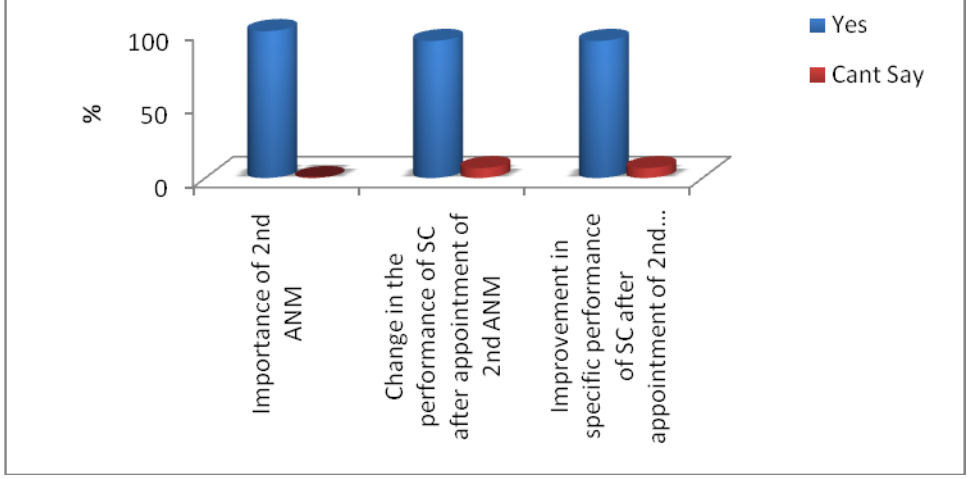
Family planning, immunization and spreading the benefits of government schemes (JSY etc.) were the areas improved by the appointment of 2nd ANM according to 87% of supervisors. However, over 73% felt that improvement has taken

place in institutional deliveries, organizing VHND/VHNSC, control of communicable diseases and vital registration.

Table 8.4 Areas of Improvement in performance after appointment of 2nd ANM

Areas of performance	Freq.	%
ANC & PNC	9	60.00
General OPD	8	53.33
Institutional Delivery	11	73.33
Family Planning	13	86.67
Immunization	13	86.67
VHND/VHNSC	11	73.33
Communicable disease control	11	73.33
Vital Registration	11	73.33
Govt Scheme Benefit (JSY etc.)	13	86.67
Other	1	6.67

Fig. -Supervisors perception about different parameters of SC with two ANM



CHAPTER 9

Impelling and Impending Factors Observed by the Team which can Influence the Performance of the SC's

IMPELLING FACTORS

1. Appointment of 2nd ANM have improved the performance of the SC in the areas which (i) ANC and PNC, (ii) Natal Care, (iii) Child care and (iv) Family Planning. Besides, the pace of growth of performance is much high in two ANM SC compared to single ANM.
2. Availability of 2nd ANM's at the SC improved the % of total activities attended by the ANM's as compared to the single ANM SC.
3. Reach of two ANM SC to the farthest village has been improved after appointment of 2nd ANM.
4. Availability of ANM for the health workers like ASHA and AWW has improved after appointment of 2nd ANM.
5. There is marked improvement in the functioning of the VHNSC in the villages after appointment of 2nd ANM.
6. Satisfaction level of the general community has been improved after appointment of 2nd ANM.

IMPEDING FACTORS

1. Absence of clear cut job chart for 1st and 2nd ANM is creating confusion in the functioning of the SC.
2. It is reported that, some ANM stay away from the HQ which affects the functioning of the SC, this can be prevented.
3. There was no improvement in the SC infrastructure to accommodate the 2nd ANM and the increased patients.
4. Improper location of SCs in the catchment area. Some SCs are located very near to urban areas and some SCs are not centrally located from the catchment area villages. In both the cases, the rate of utilization of services by the community is on the lower side.
5. 2nd ANMs were treated as contractual ANM's, not given much importance by the 1st ANM and the supervisory staff.

6. It was also reported that, sometimes the supervisory staff uses 2nd ANM as a reliever ANM for the regular ANM at PHCs when they were on leave. This also affects the major objective of appointment of 2nd ANM.
7. It was found that, 1st ANM at two ANM sub centres were relying on the 2nd ANM for the some administrative responsibilities which they were not supposed to do.

CHAPTER 10
RECOMMONDETATIONS

1. The government should complete the appointment of 2nd ANM in all SCs and further strengthen the Scheme, as the study had observed a marked improvement in all performance indicators in "T*wo ANMs SC*" before and after appointment of 2nd ANM and also compared with "S*ingle ANM SC*".

2. As over one third of SC ANM's, more in the case of remote SC, stay away from the HQ, government should ensure that, at least one ANM stay 24/7 at HQ's. Appropriate action be taken on the ANM who is a defaulter.

3. An orientation training of the job description along with written job charts to 1st and 2nd ANMs should be conducted at Taluka level in the presence of their Supervisory Staff, so that all the three can perform their jobs in tandem and achieve the common objective.

4. As improper location of SCs in the catchment area has been one of the impending factor for delivering health services by the ANMs and also availing the facilities by the Public, some alternative mechanism like **Gram Arogya Banks/Village Health Posts,**to be developed with adequate infrastructure & supplies in some suitable & distant villages, where the 2nd ANM should be made available 24/7.

5. Position of infrastructure like electricity, proper building, equipment's and supplies, medicines and vehicle (transportation) at the SCs be upgraded to maintain and improve the demand for services and satisfactory levels of community members due to the appointment of 2nd ANM.

6. The existing vacancies of ANM's (1st or 2nd ANM) at SC level be filled on priority. Besides, nursing staff position at "PHC level" be improved so that the ongoing frequent practice of shifting of SC ANM by MOs, where two ANMs were in position can be avoided.

7. Some newly appointed 2nd ANM's have not undergone the SBA training. Hence, SBA training should be imparted to all 2nd ANM's.

8. Periodic counseling of the 1st ANM be done by the Supervisory Staff to accept and accommodate the 2nd ANM. This will iron out unnecessary mistrust and non-cooperation attitude between the two ANM's and enhance the performance of SC and cliental satisfaction.

9. Some 2nd ANM's lack technical & counseling skills which are essential for service delivery. Hence it is recommended to plan appropriate training program for all of them at Taluka/district level.