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## Introduction to the organization

Action Research and Training for Health (ARTH) is a private, non-profit, research and training organization that was established by a group of professionals in 1997 with the intent to contribute to the improvement of health status among underprivileged communities in India. ARTH focuses on the health needs of marginalized rural and urban slum inhabitants, as well as on those of vulnerable groups like adolescents, women, migrants and unorganized labour. Its office is located in Udaipur and the field service and surveillance programme operates in two geographic clusters (total population about 60, 000) spread over three blocks of southern Rajasthan namely Kumbhalgarh in Rajsamand district, and Gogunda and Badgaon in Udaipur district. The southern part of Rajasthan was chosen as the intervention area because this area had the most adverse health indicators in the state. ARTH focuses its efforts towards the following areas of work. Service innovationTrainingResearchProgramme Support and AdvocacyThis case study will focus on the service innovation model that ARTH has adopted to carry out its field operations. In its own field area, ARTH has conducted nearly 4, 700 deliveries over the past 12 years and also attended to nearly 600 maternal emergencies that came at other times, such as during pregnancy, or with post-abortion or postpartum complications.

## Motivation/ background to innovating as an organization

After its inception, ARTH realised that in order to substantially improve health outcomes of the community of which it was a part, it was essential to begin some form of service delivery – and therefore, a service innovation model was adopted by the organization. ARTH then later branched into other areas of research, training and advocacy. It was essential for ARTH to demonstrate that some of its ideas that could form the base to generate evidence. ARTH started its work quietly by setting up a field and health service programme in ten villages and alongside started an enquiry on how health seeking behaviour of women in the region, especially for reproductive health issues worked. ARTH started working with a few tribal women in the community who began working as outreach workers. ARTH increased its scope of work from 10 to 18 villages, then reached 49 villages and set up two health centres. Dr Sharad Iyengar, the Chief Executive of ARTH, feels that innovating at the grassroots level forms the very core of ARTH’s philosophy. It needs to keep re-inventing itself in order to meet the needs of the community. ARTH does not believe in being a large scale service provider but instead, in demonstrating how innovations can be taken to scale within the Government or the private sector. ARTH continuously strives to make services available at a cheaper rate, more conveniently, and in a manner that empowers the user. Dr Iyengar believes that there is a role for NGOs to be innovative, to demonstrate, question and criticize. Policy makers should encourage this and learnings from them will then be available to the larger system.

## Selected innovations

## A. Nurse Midwife run health centre

ARTH’s first health centre was started in 1997 in one village in the Rajsamand district of southern Rajasthan, with one nurse mid-wife. At another location closer (25 km) to Udaipur, as part of a drought relief initiative, a second health centre was opened. It was at this point that ARTH realised that if it wished to provide delivery as a care service, it would have to be a 24x7 facility, and a 24x7 facility could never rely on the efforts of one professional. Therefore the number of staff had to be scaled up and a team set up. Thus the health centres have 2-3 nurse midwives at a time, all of whom are trained to provide a 24x7 service. ARTH now operates three health centres in these villages which cater to a population of about 60, 000. The health centres are mainly managed by trained nurse-midwives who reside near the health centre premises and are available around the clock. They are supported by specialist doctors who come in from Udaipur, once or twice a week to cater to specific problems of women and children. These health centres mainly provide the following services: 24x7 delivery services and management/ referral for maternal-newborn complicationsIntegrated Management of Neonatal and Childhood Illness (IMNCI) for children and primary health care by nurse-midwivesSafe abortion services (first trimester)Reversible methods of contraceptionGynaecological services, including infertility managementLaboratory facilities for basic pathological servicesThe nurse mid-wife run model is operated with the help of consultant gynaecologists as the nurses consult the doctors on the phone and accordingly take the decision about whether to refer a patient or not. In a study done of the two health centres it was found that from the years 2000 to 2008, 2, 771 women in labour and 202 women with maternal emergencies, who were not in labour, were attended by nurse-midwives. Of women in labour, 21 percent had a life-threatening complication or its antecedent condition and 16 percent were advised referral, of whom two-thirds complied. Compliance with referral was higher for maternal conditions than foetal conditions. Among the 202 women who came with complications antenatal, post-abortion or post-partum, referral was advised for 70 percent, of whom 72 percent complied. The referral system included counselling, arranging transport, accompanying women, facilitating admission and supporting inpatient care, and led to higher referral compliance rates. According to figure 1, it is evident how the number of women in labour coming to the ARTH health centres increased from 2000 to 2012. ARTH's health centres were accredited under the Janani Suraksha Yojana (JSY) in 2008. Figure 1: Delivery conducted by Nurse Mid-wives at ARTH from 2000-2011Source – Report provided by ARTH official sources

## B. PNC check-ups at home

It is usually observed that when a woman has been discharged after delivery of her baby, she is at her most vulnerable. She can suffer disabling consequences and the newborn is at risk of death. ARTH felt that it is imperative to reach women after delivery, i. e., in the post- natal period as most families do not consider this as an important phase for a woman. There are traditional, cultural, and even health reasons, why a woman and her newborn are not too mobile at that stage, and so ARTH devised the postnatal care (PNC) model where nurse-midwives visited every single mother irrespective of her place of delivery. ARTH began its postnatal services where nearly every woman from the 49 villages covered is visited by a nurse midwife from the health centres. The nurses are provided with a checklist and make up to three visits after delivery to check for maternal and neonatal complications. During the 3. 5 year period between January 2007 and June 2010, 4, 521 births were reported to the nurse midwives (90% of expected births in the community based on expected birth rates) and the nurses provided early postpartum visits to these women at their homes, with the first visit being at 2-3 days after delivery. There was gradual improvement in promptness of reporting births. After a scheme to provide cash incentives to women delivering in government institutions was instituted in 2006, there has been a major shift in place of delivery from home to institutions. More than three fourths of deliveries were by skilled birth attendants. More than 94 percent of women whose deliveries were reported received a postnatal visit by nurse midwives. Over time it was ensured that the visit occurred as early as possible. An improvement was seen in timeliness of visits over the years.

## Activities carried out by nurse-midwives during postpartum visits

## Mother

## Newborn

## Detailed structured questionnaire, including that for postpartum depression and maternal morbidities

## Enquiry about problems using a structured checklist

## Examination:

## General examination including temperature, pulse, BP and respiratory rate

## Haemoglobin test for anaemia

## Breast and abdominal examinations

## Perineal and pelvic examination. if any complaint related to these areas

## Examination:

## Physical examination including temperature, respiratory rate

## Weight

## Observation for local infections in eyes, umbilicus

## Examination for sepsis

## Counselling and information on :

## Diet and work

## Danger signs and where to go for care

## Counselling and information of mother on :

## Breastfeeding

## Bathing, keeping the baby warm

## Danger signs

## Medications as per the condition

## Referral support

## Medications as per the condition

## Referral support

## Innovations in the Home based PNC model

To carry out the home based PNC visits successfully, there had to be a system of communication whereby ARTH would be informed of deliveries in the area. Thus a system of pregnancy tracking was developed. The system was able to pick up more than 90% of all births in the area. The system using key informants, volunteers and even family members was used whereby, using telephone or other communication means, the nurse midwives were informed of women who had very recently delivered in the area. The challenge is to reach these women within the first couple of days after delivery as there is no point going to a woman's house 10 or 15 days after she has delivered. To overcome this challenge, a small incentive of giving Rs 50 for reporting births was used if the birth was reported within 24 hours. A nurse midwife was to visit these women and she would go on a motor cycle and was provided with a chauffeur who would drive her to the locations in order to save time and increase efficiency and productivity. The nurse is provided with a kit with basic diagnostic materials, including some educational material. Table 19. B. 1 Service package during PNC period offered by ARTH

## C. Access to reproductive health at village level

Especially in the rural areas, women have little control over their fertility and reproductive health and, besides, are subject to both physical and social mobility constraints. They are unable to travel freely due to lack of low-cost transportation, and there are concerns of personal security and social stigma. The health system’s emphasis on female sterilization leaves a high unmet need for reversible contraception among women who wish to delay but not completely prevent the next pregnancy. Women who are adolescents, who have no children, who wish to space their children, who fear the death of a child, or who have unstable marital relationships (and might be concerned that they may eventually have to remarry), may wish to maintain their fertility potential. While emergency contraception (EC) has become available over-the-counter in cities, women in rural areas yet do not have access to EC. ARTH strongly believed that there is no reason why such a technology should be restricted to the cities, and rural women should also have information about and access to EC as a critical step in gaining control of their own fertility. Again, pregnancy tests have traditionally been available only from specialists or graduate doctors, and may cost as much as up to Rs. 100 in the cities. Due to these conditions, women who are uncertain of their pregnancy status often seek pregnancy tests late and then resort to seeking abortions from untrained providers. Since June 2007, ARTH has introduced village level pregnancy advisory services through an initiative called " gaon pas" or gpas, whereby village volunteers (Accredited Social Health Activists [ASHAs] and Village Health Workers VHWs]) have been trained to provide awareness of and access to contraceptives, including emergency contraceptives and pregnancy tests. This intervention was started almost a year before the Nischay programme was launched by the National Rural Health Mission (NRHM). In essence, ARTH is utilizing the potential of village volunteers (ASHAs and VHWs) to increase awareness of, and access to, reproductive health services to enable women to better manage their own fertility. Uptake of EC was initially slow and increased after about a year and a half. Most EC users were young women with 60 percent being in the age group of 15 to 24 years. Nearly 17 percent were unmarried/single. About three fourths of users took EC pills from the health worker in advance, i. e., before unprotected intercourse. Most women took EC either because they forgot to take their contraceptive, had stopped it, used contraceptives irregularly or stayed with the husband only occasionally.

## Emergency contraception

ARTH introduced the emergency contraceptive pill in 2006 in the community through village volunteers. The product had been around for quite some years before that and is extremely safe. The challenge was on how to promote the use of emergency contraception. ARTH, through its surveys and community interactions, understood that there were three scenarios for the use of emergency contraception. Firstly, about 40-50 percent of couples in the area are long distance couples as men have migrated to a city in search of work, and the women remain behind in the village. The men make sporadic visits, often sudden, as they do not know when they will get leave from their work. On such occasions the wife is not using any form of contraception and such visits result in unwanted pregnancies. Such unwanted pregnancies are in greater number after festivals or at certain times of the year. ARTH therefore positioned emergency contraception as something that could be used by a woman if her husband visited her without prior planning. A second scenario is the social custom prevalent in the area where boys and girls are married off young but the girls have not yet started cohabiting with their husbands (which usually occurs after a ceremony of ‘ Gauna’). Before they begin living together there are instances of young, enthusiastic husbands visiting the wife's village, and notwithstanding reservations by her parents, they meet the young girl who is the wife when she is out fetching water or firewood, or looking after the cattle, and they might have sex and that might result in an unwanted pregnancy. More often the young girl is invited by in-laws’ family at the time of any major function in their household and is expected to help in the work for 3-4 days. This also provides an opportunity for newly married (and yet without the social sanction of " gauna") to meet. This pregnancy which has occurred before the official co-habitation phase often creates social embarrassment. ARTH has tried providing access to emergency contraceptive pill either before the co-habitation phase, or soon after, in the early months after the marriage. The third scenario is where a woman at any stage faces sexual coercion and would need to use emergency contraception. Unfortunately, given the sensitivity of the situation, it has been very difficult to monitor as to whether the pill actually has been used. ARTH’s volunteers have provided the emergency pills to several women and adolescents in such situations. . However, doubtless, the emergency contraceptive pill has worked as there are anecdotal examples. Profile of pregnancy test users: During the three year intervention period (June 07 to May 10) ASHAs and VHWs conducted nearly 3, 000 pregnancy tests in the villages and counselled and helped women in seeking services as per their individual needs. The uptake of pregnancy tests was fairly quick. After the first six months, it picked up to an average level of 50-60 tests per month and then further increased to about 100-120 a month. The intervention was successful in reaching the underprivileged and adolescents. Most women who received pregnancy test services at village level belonged to scheduled castes or tribes. Nearly 40 percent were in the 15 to 24 year age group and 70 percent had either no child or one or two children.

## The introduction and country wide scale up of Copper-T 380A (The 10 year Copper-T)

The 1991 census for the area where ARTH started work revealed a female literacy rate among tribals of 0. 2 percent. There has been a big change since then. The ARTH surveys are showing that the fertility rate has come down to 2. 4 which is quite remarkable. The fact remains that the ability of women to make their own decisions about when they will have children, when they will get married, about sexual activity and consequences of that sexual activity is still not where it should be in rural Rajasthan. It was observed that family planning was in the form of a directive rather than providing an option and working towards a behaviour change model. In this pursuit, the needs of younger women, adolescents, people who may not have completed a family, couples who may have lost a child or are worried about whether the children will survive, tend to be ignored. Reproductive right is all about enabling people to make decisions and changing decisions. ARTH through its work in health centres started expanding choices in terms of reversible methods of contraception. In 1999, the 10 Year Copper T was introduced. This is a Copper T device, which if hygienically provided to the woman, could help her avoid a pregnancy for ten years. And the logic is that a woman who did not want to have a child for 10 years was unlikely to want one in the 11th or 12th year. Subsequent research showed that this device worked for more than 12 years. It was positioned as an alternative to female sterilization, and yet with the advantage of removal, instantly, whenever required by the woman. To ARTH, it appeared like a fixed deposit which had the liquidity of a current account. This method grew in success and we provided it at a nominal rate of 50-75 rupees per device. Local government officials took note of this achievement as they saw it as something that is affecting the achievement of sterilization numbers. The Government (District, State and Central) actually helped ARTH to scale up the Copper T intervention to four blocks of Udaipur district and this was documented. This was noticed by a Joint Secretary in the Government of India, who on making inquiries, found that the country had the capacity to manufacture this device, and in 2004 the whole country switched to the 10 Year Copper T. However, while the type of copper-T in the government program has changed, there has not been adequate attention to providing the reproductive choice to women. Oral contraceptive pills (OCPs) were the most preferred form of contraception, though we do not know that once initiated, how many of these women continued to use OCPs

## Challenges faced

When ARTH started its operations from one village, the people were initially sceptical of their work. There was a certain element of suspicion and questioning and it took nearly three to four years before there was a sense of comfort with ARTH. ARTH also faced a challenge while training the village health volunteers as most tribal women were illiterate. Many pictorial aids and hands on training were used to train village volunteers. During the initial years, it was also difficult to recruit nurse midwives who were willing to stay in the field area to provide 24x7 services. Managing the 24x7 ARTH health centres was not easy. It is difficult to retain nurse-midwives at the health centre for night shifts and especially during holiday and festival season. The organization has tried to work around this challenge and ensured that the nurses have their residential quarters next to the health centres, so in times of emergency they are available. It was observed that the community questioned ARTH’s operations and were curious about their work. However, the work done by the organization helped ARTH gain the trust of the community. Today, ARTH’s reputation in the community allows them to bring in innovative approaches in the provision of health services. All this ARTH does while staying within the limits of the law. As Dr Sharad Iyengar puts it " we went about our job of providing care". With this zeal and enthusiasm, ARTH has not just been successfully working in rural communities in Udaipur, but providing innovative ideas for the rest of the developing world to learn. ARTH concedes that innovation is triggered by a sense of restlessness or dissatisfaction with the current state of things. Innovation has resulted from the effort to change and improve the maternal health environment. ARTH has gone through a cycle of testing innovations and successfully scaling them up in their field activities.

## Discussion

ARTH has been able to scale up its activities by influencing policy at the national level. For instance, the 10 year IUD has been incorporated by the Government of India. ARTH has also been able to scale up some of its work by training health workers/ officers/ medical officers from Rajasthan and across India on various training courses on maternal and child health. The dissemination of ARTHs work has been mainly through scientific publications and advocacy at state and national level. ARTH as an organization is seen as an engine which is driving innovations in maternal and child health. There have been a variety of forces affecting the innovative efforts of ARTH as illustrated in Figure 3. Funders, beneficiaries, market players, policy environment have all contributed towards ARTH being able to continuously innovate. Figure 3 - Forces affecting innovative efforts of ARTHFactors such as other competitive players in the market providing similar services (perhaps for a profit), funding opportunities available, policy regulations, technological interventions, clients who visit ARTH’s service delivery centre and ARTH’s own accountability towards the community it is serving can either help or hinder innovation. In the case of ARTH's innovative engine, these forces have helped ARTH to continue to innovate in the area of maternal and child health (MCH) and reproductive and child health (RCH). ARTH has adopted the client focussed approach where innovations in MCH and RCH have been made more acceptable, of better quality and more affordable. The health centre model, PNC services and RCH services offered by ARTH have changed the way the clients of these services in the villages of Rajsamand and Udaipur access and use health care. Without these services, the villagers would have to go to quacks or very expensive private providers. Going to the Government hospitals was not an option for many. ARTH has provided a more convenient, effective and less expensive treatment option for many. As catalytic innovators, ARTH has been able to meet needs of the communities which are not served at all. ARTH has been able to bring new benefits to most people in the area in which it has been working and has emerged as a strong player from within the established set of players in the area. As a catalytic player, ARTH has demonstrated the following five qualities as shown in Figure 4. ARTH has been able to meet a need of the community which was previously not being addressed; its nurse mid-wife-led health centre model offering services which were previously not easily accessible to people among other catalytic changes. Many existing players feel that the ARTH model is not profitable and thus cease to be competitors to ARTH. The existing competitors rely on the profit model to be able to run their establishment whereas ARTH depends on grants etc. from donors for services to be given to people. This way to generate capital is unattractive to the incumbent competitors. Figure 3: Attributes of ARTH[1]

## Way ahead

As ARTH has already demonstrated its successes and disseminated its findings in a scientific way, going forward, technological innovations seems to be a route for ARTH to adopt. Using technology based health solutions in the field for improving health coverage and health outcomes might prove beneficial for ARTHs growth and impact. Piloting and testing some field based health technologies with the community and scaling them up will provide robust evidence for the use of phone and information technology based interventions. For scaling up beyond rural southern Rajasthan, introduction of newer technology and collaborating with external partners will help ARTH in spreading the reach of its service delivery model.

## Disclaimer

This case study was prepared by the XXX in collaboration with Action Research and Training for Health (ARTH). The case is developed solely for academic purposes. Cases are not intended to serve as endorsements, sources of primary data, or illustrations of effective or ineffective management of innovations documented. There is an accompanying film with the printed case. We are grateful to the John D. and Catherine T. MacArthur Foundation for supporting preparation of this case and the film.