

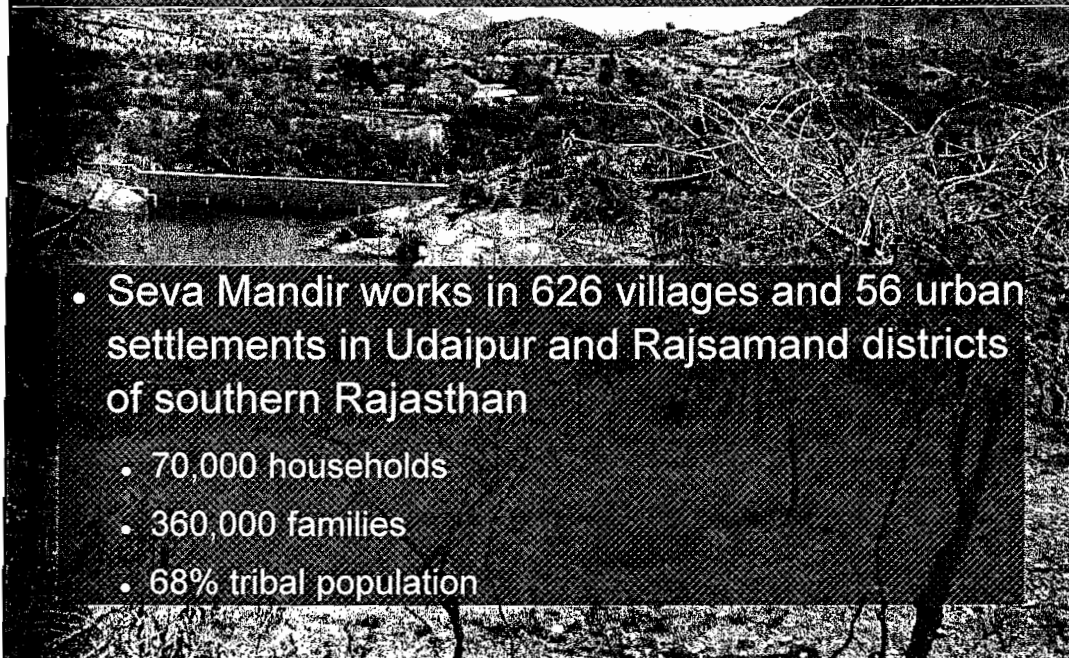
Seva Mandir



Planning Commission – Civil Society Window

29th October, 2009

Work Area



- Seva Mandir works in 626 villages and 56 urban settlements in Udaipur and Rajsamand districts of southern Rajasthan
 - 70,000 households
 - 360,000 families
 - 68% tribal population

Core domains



Livelihoods

- Natural Resource Development
- Alternative income generation activities

Capabilities

- Health
- Education
- Early childhood care and development
- Women's empowerment

Institutions

- Village Institutions
- Programme
- People's Management School

Development Communication

Today's Presentation –

Health Systems

Immunisation

Anaemia

Early Childhood Care



Health Context

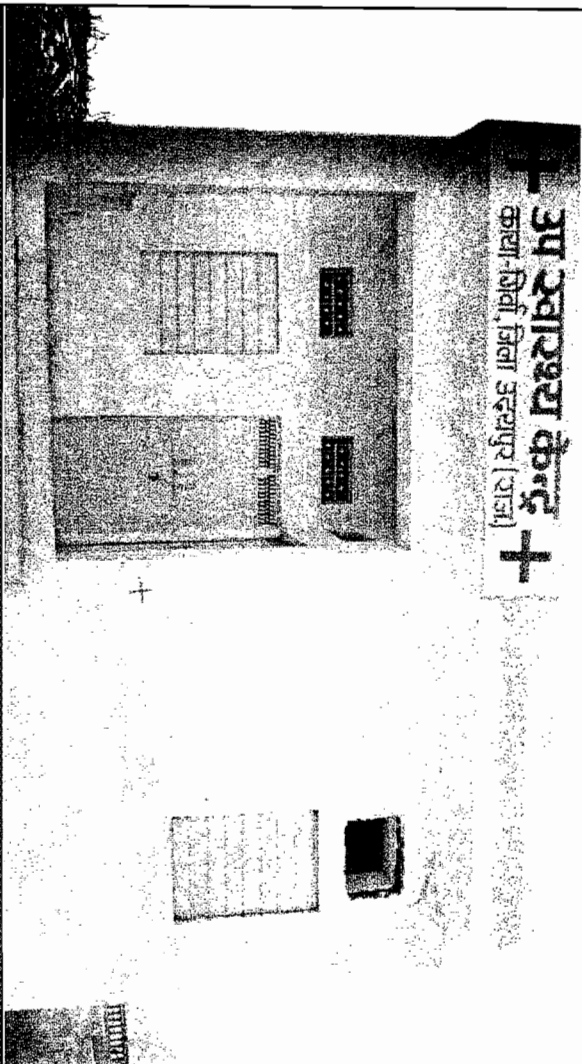
- **Status of the population** – average MPCC Rs 578, 56% women and 69.7% children anaemic, 88% women with BMI <21, 86.2% home deliveries, gap in services for safe abortion, very low rates of immunisation
- **Status of public health services** – physically available but high absenteeism (50-80% in sub-centres); corrupt and unresponsive
- **Status of private health services** – unregulated (practitioners often unqualified) and irrational care but providing higher client satisfaction, fast spreading
- **Expenditure and health seeking behaviour** – 10.65% of MPCC goes into health care, 50% of visits for health care to private facility, Rs 84 for each visit to private compared to Rs 7.1 for public



Seva Mandir's work on health

- Part of a broader effort based on community centred development processes... focus on:
 - **Maternal health** - (TBAs, immunisation, iron fortification, HIV/AIDS, use of vouchers, obstetric care insurance)
 - **Child health** - (immunisation, primary health care and referral)
 - **Adolescent health** - (reproductive and sexual health)
- Research collaborations with J-PAL and IFMR

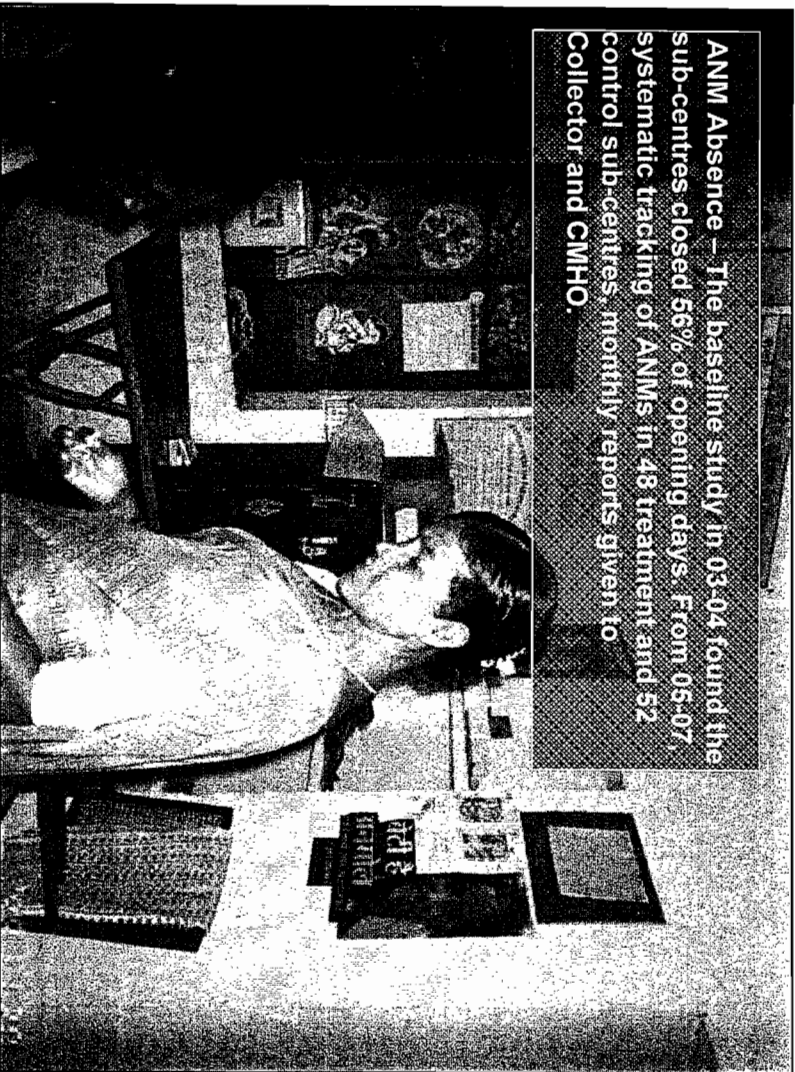
34 स्वास्थ्य केंद्र +
कला-बिर्वा, तिला अदवापुर (राजा)



Improving Sub-Centre Reliability



ANM Absence – The baseline study in 03-04 found the sub-centres closed 56% of opening days. From 05-07, systematic tracking of ANMs in 48 treatment and 52 control sub-centres, monthly reports given to Collector and CMHO.



Monitoring Results *(Date and Time Stamping Machines)*

Average Attendance of the ANMs since the beginning of the program		
Category	Three Days Monitoring (Dec'05 – Mar'07)	Monday Monitoring (Mar'06 – Mar'07)
Presence (Including half days)	45%	45%
Absence	16%	11%
Exempted	20%	20%
Total	81%	76%
Note : Remaining % is associated with problem of machinery and leaves availed by the ANMs		

Monitoring Results *(Random Visits)*

Random Checks Performed (Mar'06 – Mar'07)		
Category	Treatment Subcentres	Control Subcentres
Total random checks performed	734	416
Average attendance of three days monitoring Subcentres	49%	31%
Average attendance of Monday monitoring Subcentres	41%	19%
Average number of patients found at the subcentres	40 patients / 100 visits	24 patients / 100 visits

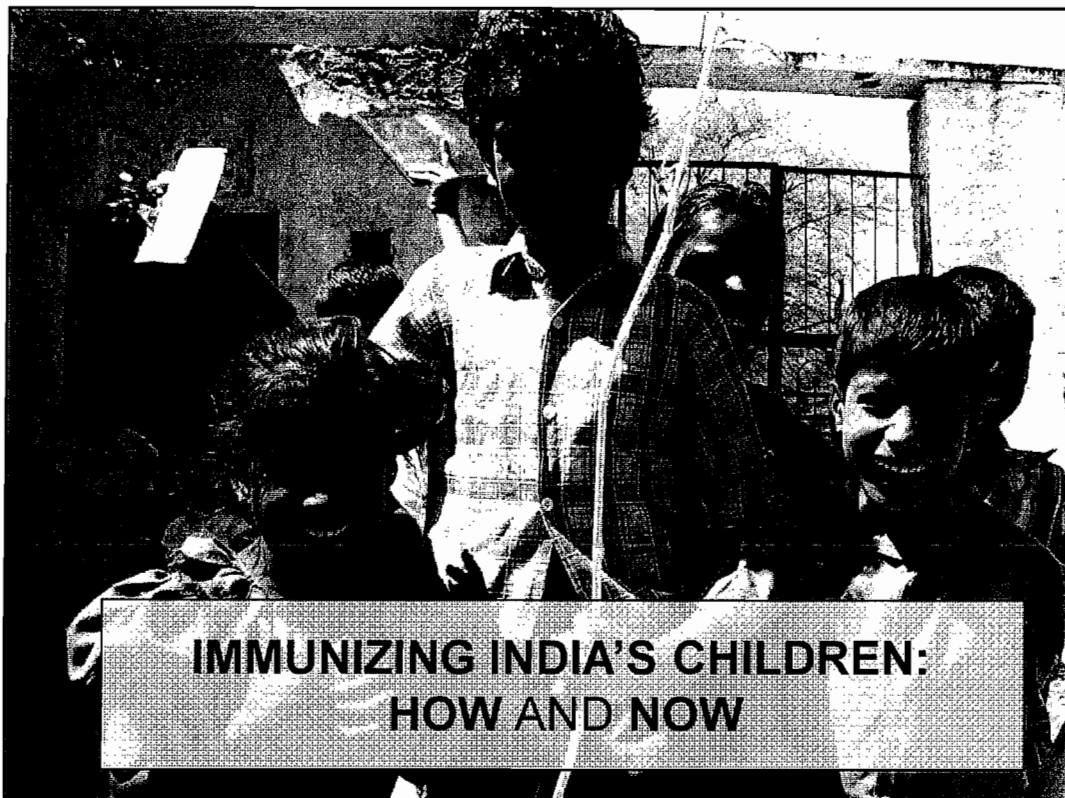
Conclusion

Absence has as much to do with dereliction as with contradictory expectations.

Monitoring system did not lead to any significant improvement in presence.

The system was not only indifferent to low presence but actively colluded in covering up.

Ensuring presence is an essential first step along with the competence, motivation and resources issues .

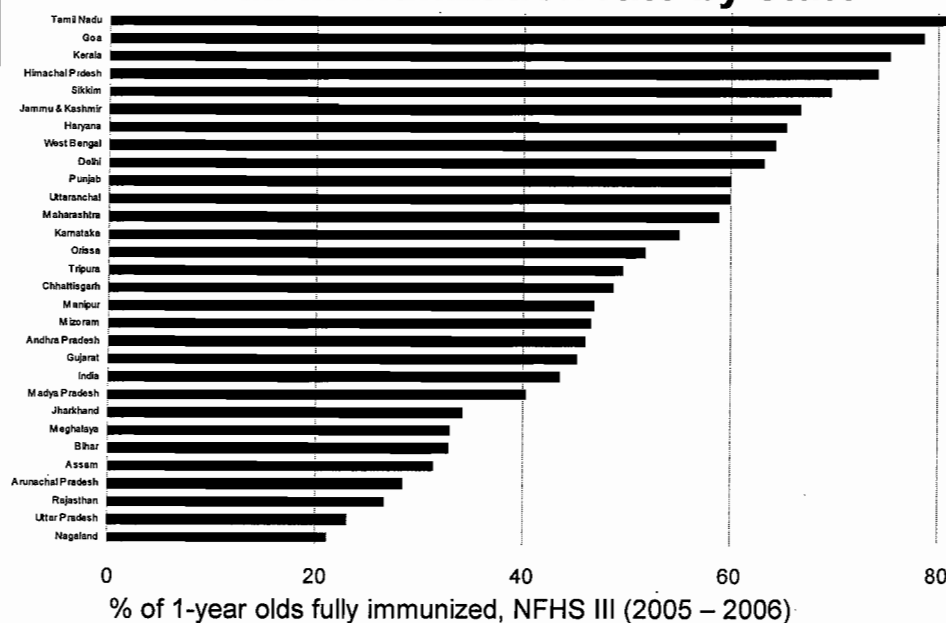


The Problem

- **Worldwide** 7,000 children die every day from vaccine-preventable diseases (2.5 million per year) (WHO 2006)
- **India** has among lowest immunization rates in the world
 - Only **43.5%** of 1 year-olds have
 - BCG, 3 DPT, 3 Polio, MMR (NFHS III, 2005-06)
 - Slow progress – **42.0%** in NFHS II (1998-99)
 - Rural areas are much worse

The Problem

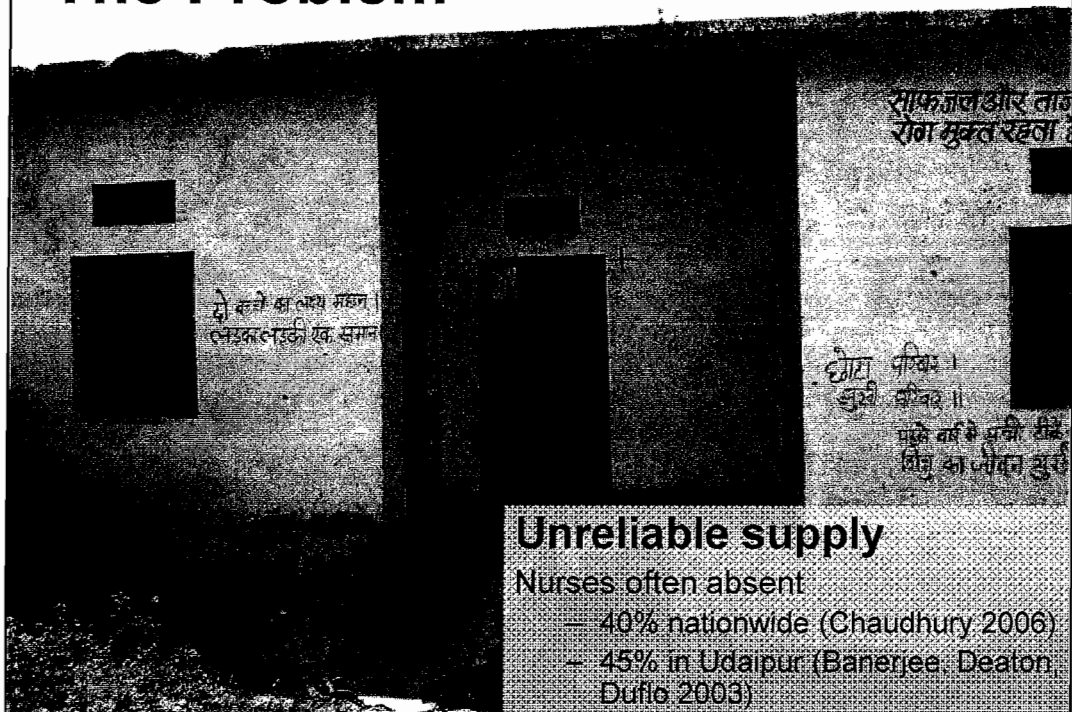
Full immunization rate by state

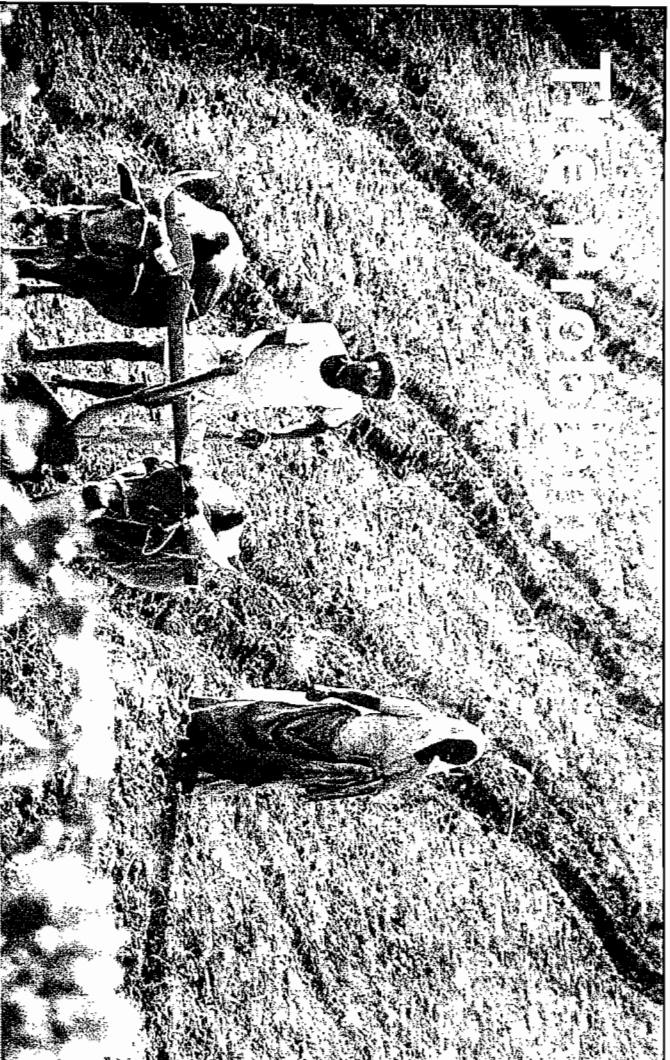


The Problem

- 95% have at least 1 vaccination (NFHS III)
- Half drop out before full immunization
- National progress has been painfully slow
 - Increase of only 1.5 percent in 7 years
- **Why?**

The Problem

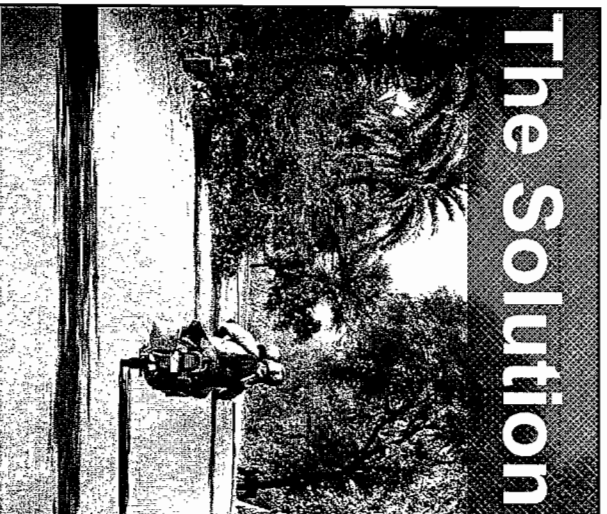




The Problem

Lack of parental demand

Distance, Opportunity cost of time, Painful, Can make child ill, Hard to see the benefits



The Solution



Ensure Reliable Supply

1. Mobile Vaccination
Teams

2. Monitored with Date &
Time Stamped Photos

The Solution



Increase Demand

- 1kg bag of daal for scheduled vaccination
- Thali set upon full immunization

Randomized Evaluation

Conducted by J-PAL – MIT based researchers

Baseline study – only 3% of children fully immunized (2004)

30 hamlets with regular, reliable camps

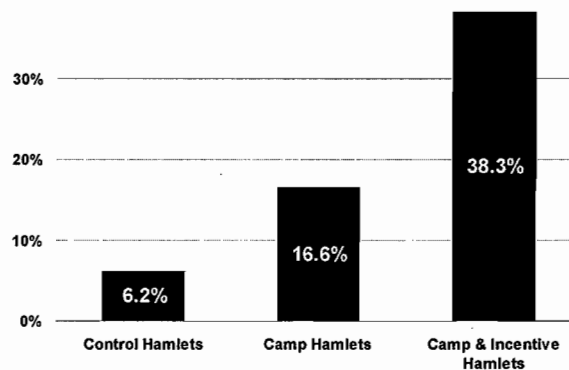
hamlets with same camps + parental incentives

74 control hamlets



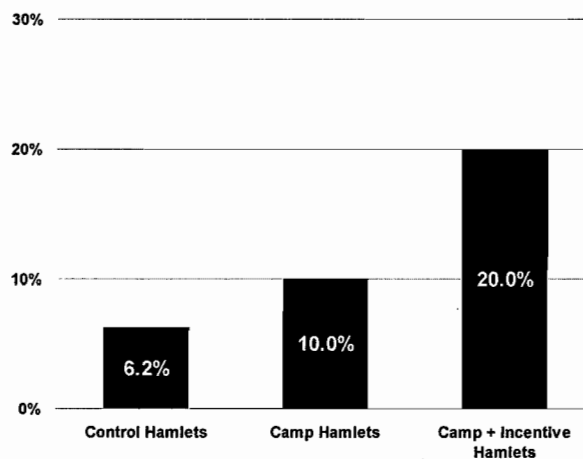
Results: Immunization Rates

A large increase after only 20 months
Percentage of 1-year olds fully immunized (2006-07)



Results: Geographical

Impact on other hamlets within 6km
Percentage of 1-year olds fully immunized (2006-07)



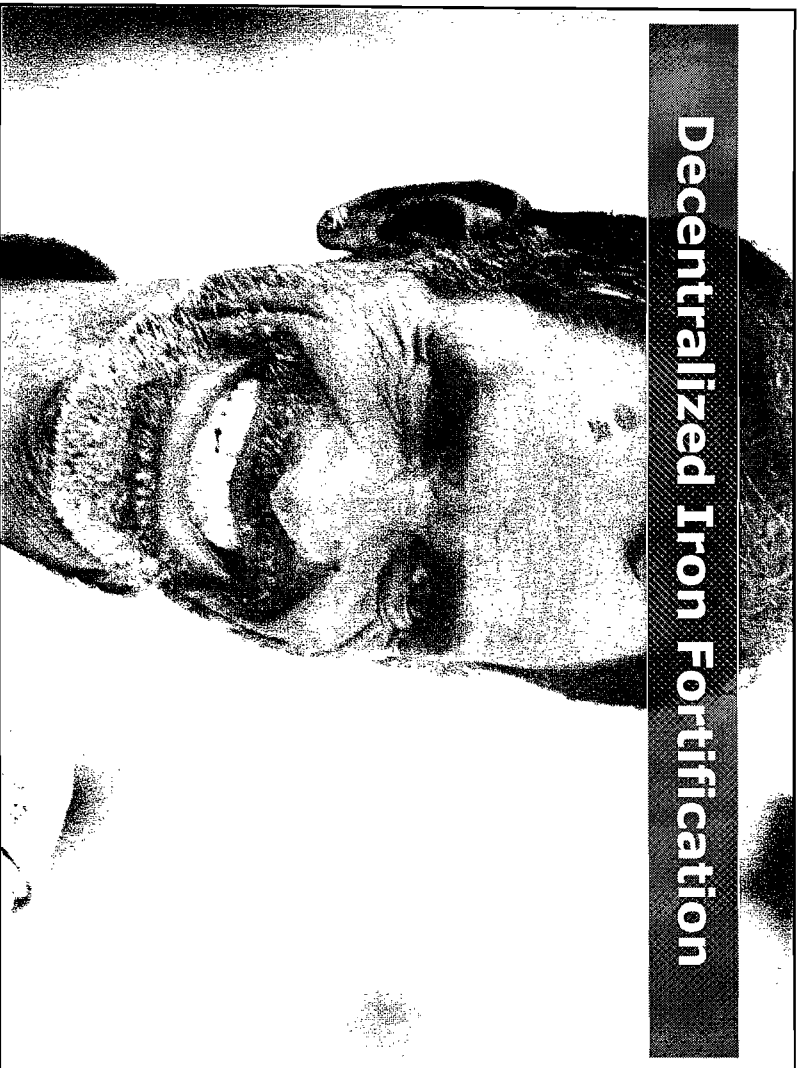
Results in Context

- In **7 years** – National immunization rate only rose from **42.0%** to **43.5%**
- In **20 months** – Udaipur immunization rate increased from **6.2%** to **38.3%**
- Encouraged more parents to keep coming back for **full immunization** course

The Model: Essential Elements

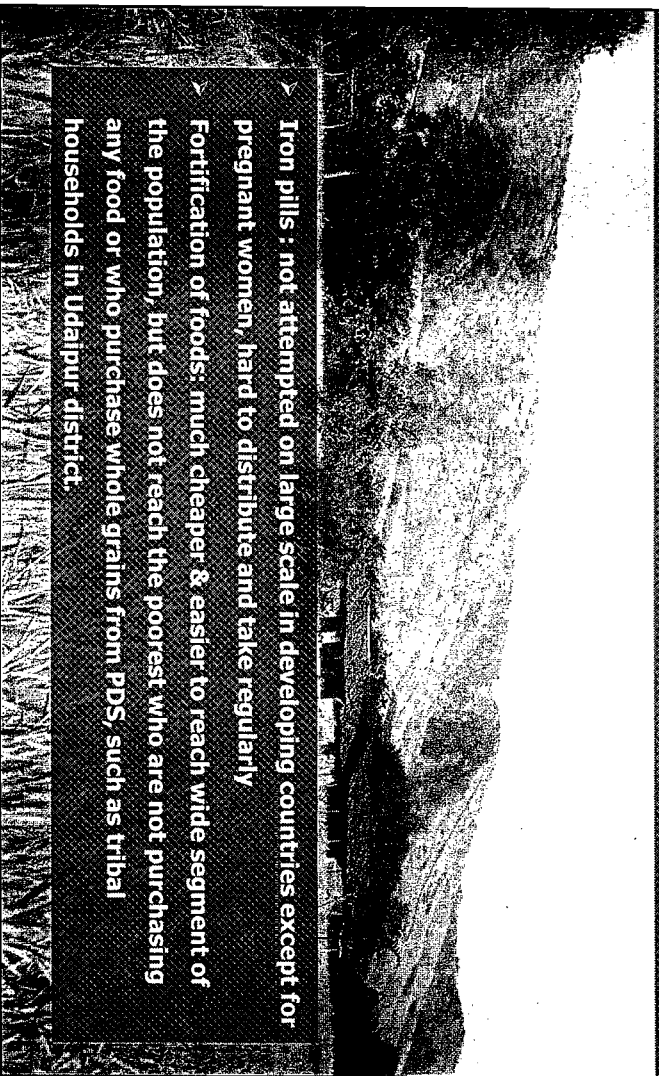
- Camps must be **predictable & reliable**
 - Camera monitoring tied to payment works
 - Terms of contract must be **enforced**
 - Implementation and monitoring must be **separate**
- Incentives encourage parents to do the necessary 5 trips to fully immunize their children

Decentralized Iron Fortification

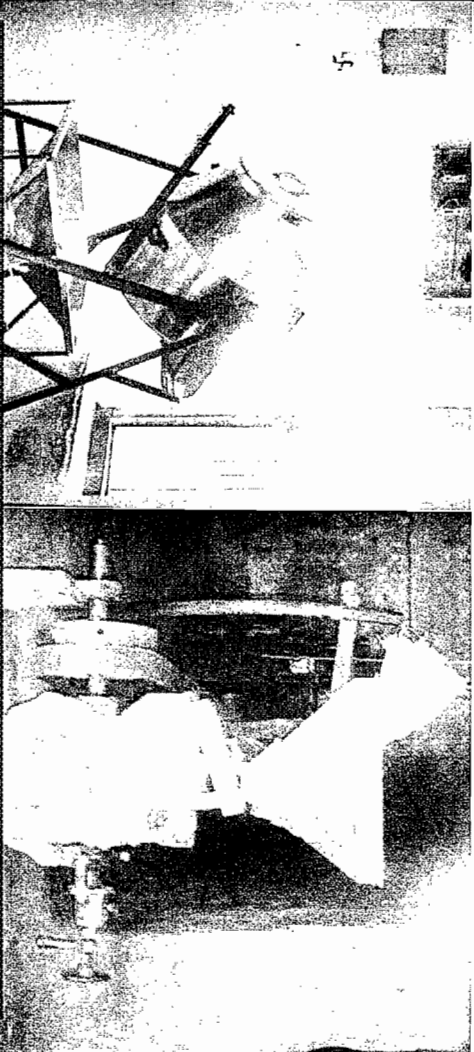


Addressing Anemia - Current Practices

- > Iron pills : not attempted on large scale in developing countries except for pregnant women, hard to distribute and take regularly
- > Fortification of foods: much cheaper & easier to reach wide segment of the population, but does not reach the poorest who are not purchasing any food or who purchase whole grains from PDS, such as tribal households in Udaipur district.

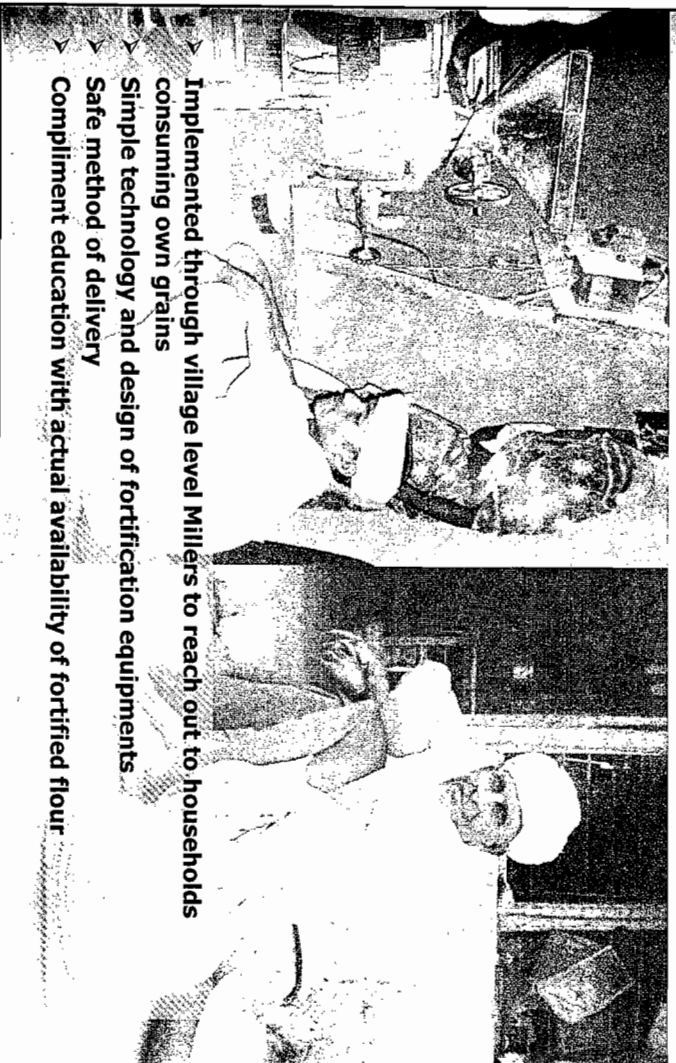


A Feasible And Innovative Option - Decentralized Flour Fortification



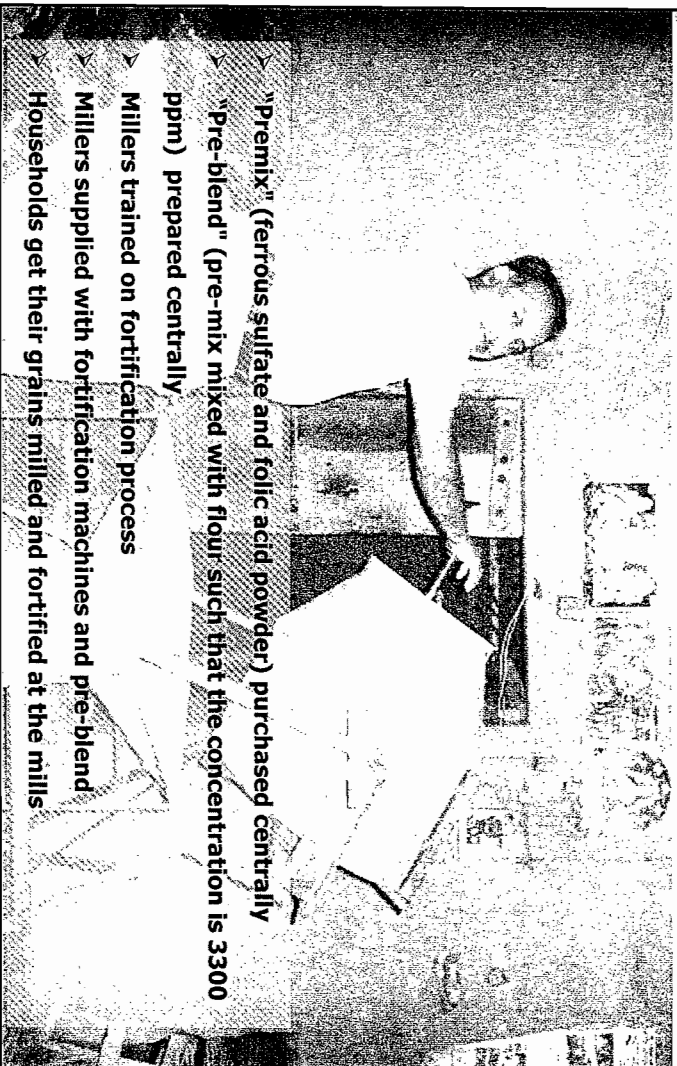
- 76% of households in our work area never purchase flour and go to a local miller to get their grain milled.
- Community Iron Fortification - The only solution for these households

Decentralized Flour Fortification - An Innovation -



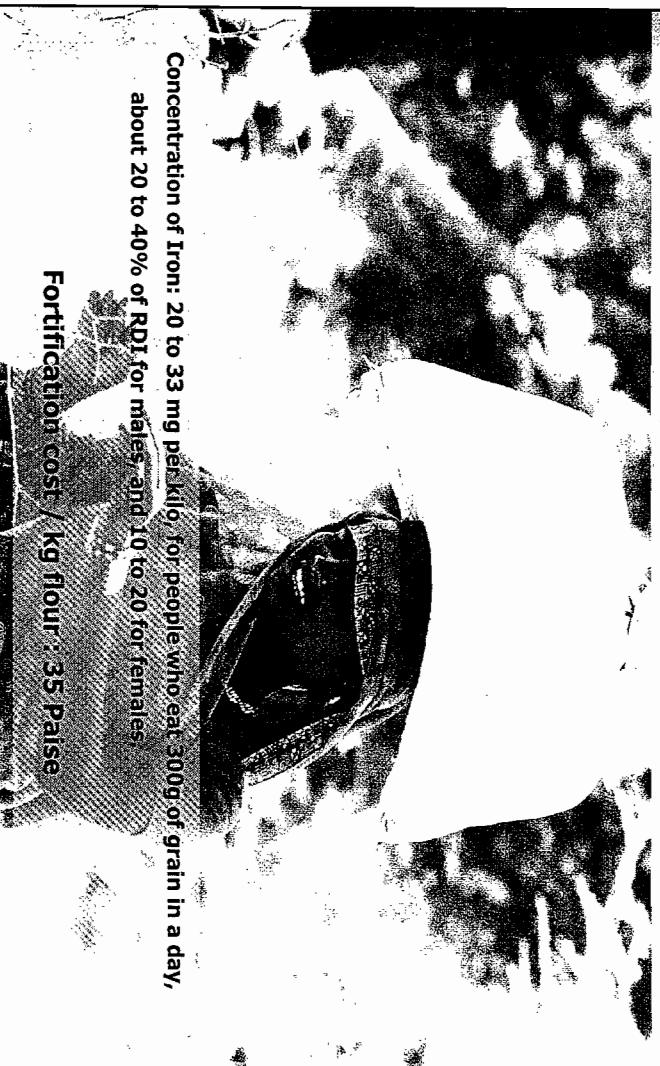
- Implemented through village level Millers to reach out to households consuming own grains
- Simple technology and design of fortification equipments
- Safe method of delivery
- Compliment education with actual availability of fortified flour

Decentralized Flour Fortification – How it Works



- "Premix" (ferrous sulfate and folic acid powder) purchased centrally
- "Pre-blend" (pre-mix mixed with flour such that the concentration is 3300 ppm) prepared centrally
- Millers trained on fortification process
- Millers supplied with fortification machines and pre-blend
- Households get their grains milled and fortified at the mills

Cost of fortification



Concentration of Iron: 20 to 33 mg per kilo, for people who eat 300g of grain in a day, about 20 to 40% of RDI for males, and 10 to 20 for females

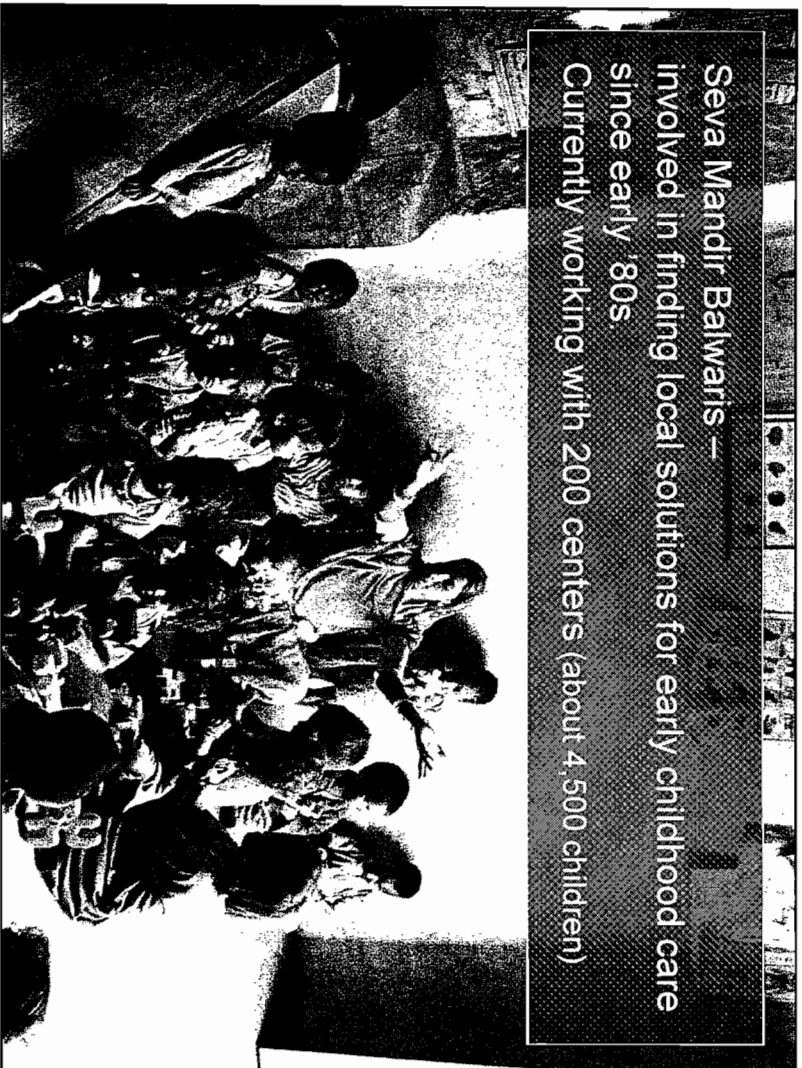
Fortification cost / kg flour : 35 Paise



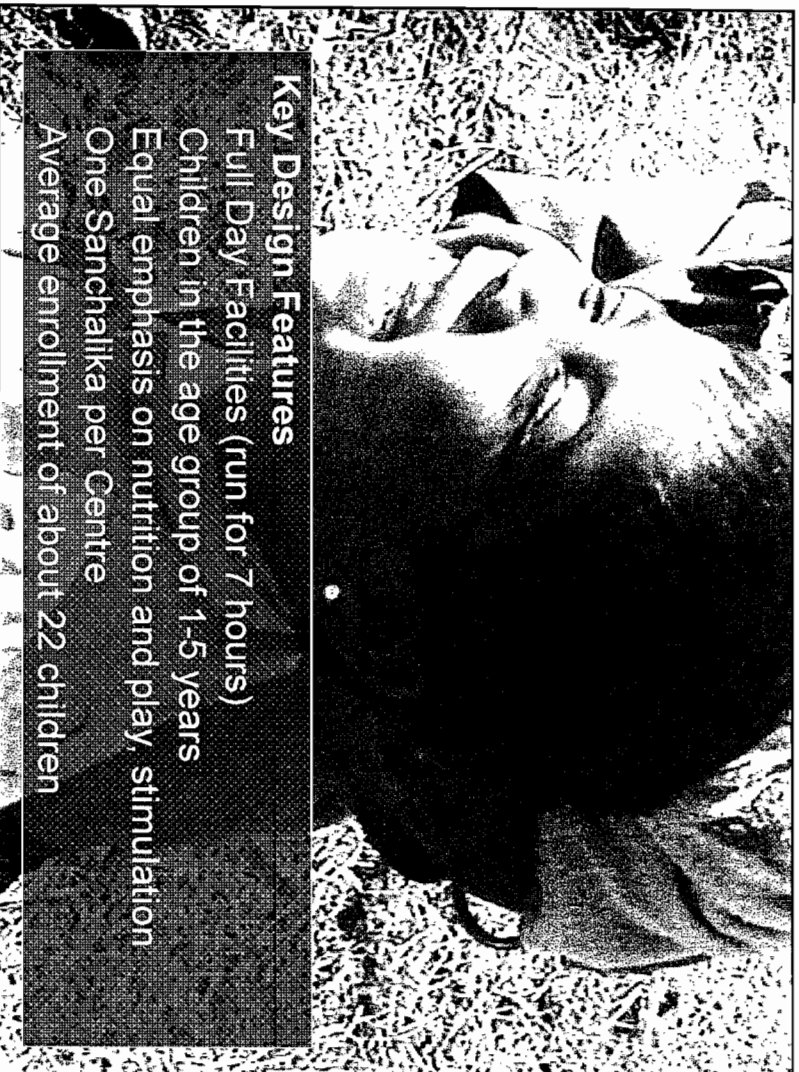
Anaemia – Objective was to find a decentralised solution; tried flour fortification at local mill level; 68 treatment and 74 control hamlets; midline results show haemoglobin increase of 0.65g/dl.



Early Childhood Care



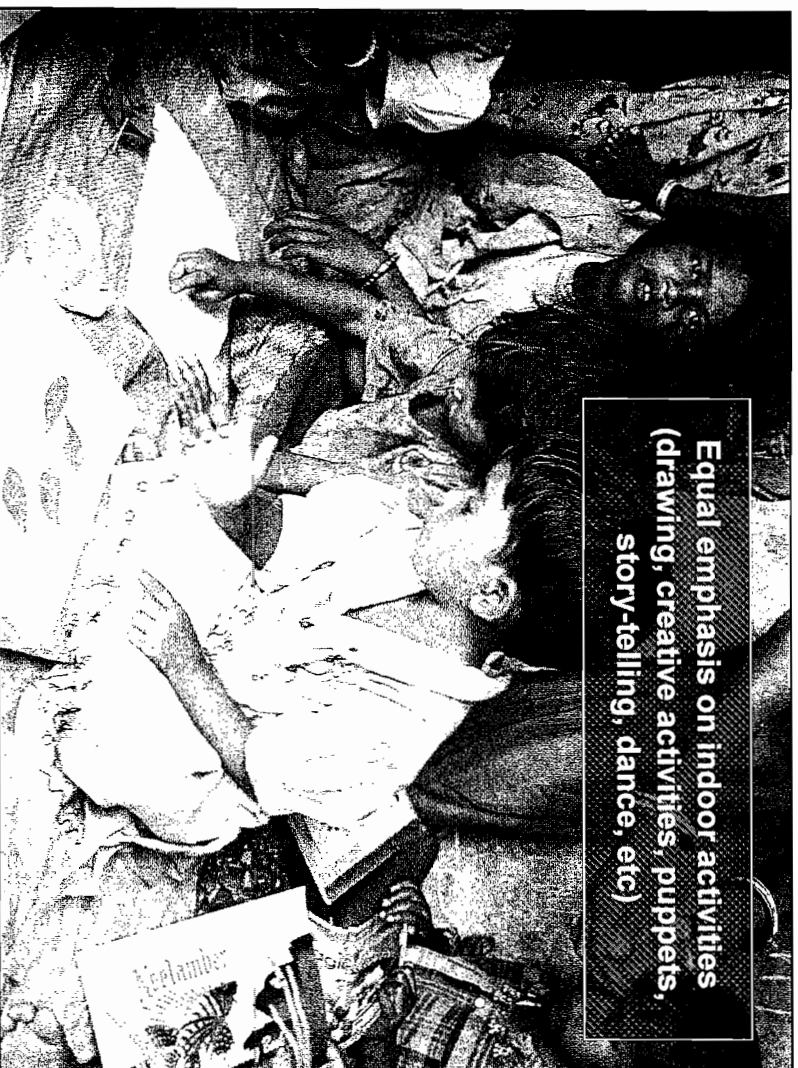
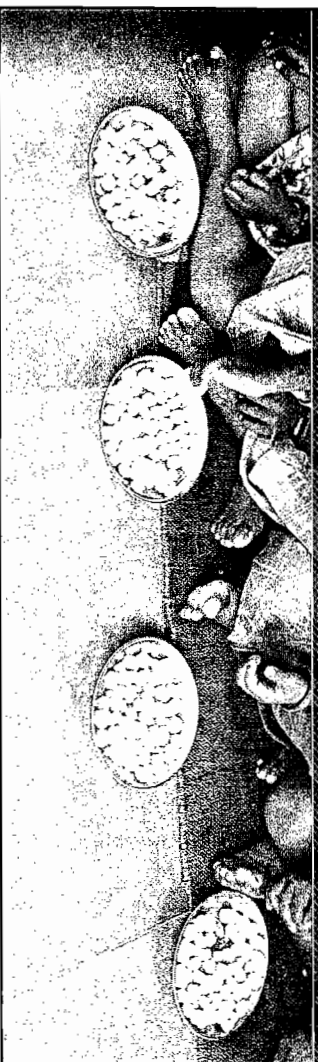
Seva Mandir Balwaris –
involved in finding local solutions for early childhood care
since early '80s.
Currently working with 200 centers (about 4,500 children)



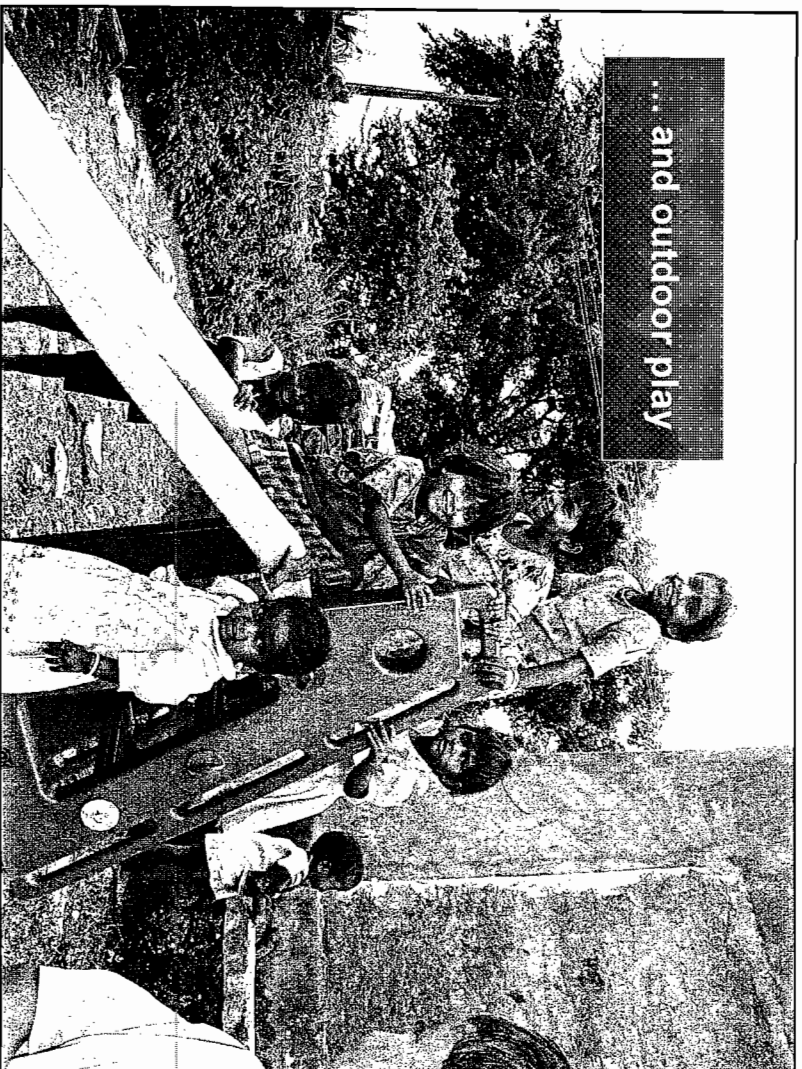
Key Design Features
Full Day Facilities (run for 7 hours)
Children in the age group of 1-5 years
Equal emphasis on nutrition and play, stimulation
One Sanchalka per Centre
Average enrollment of about 22 children



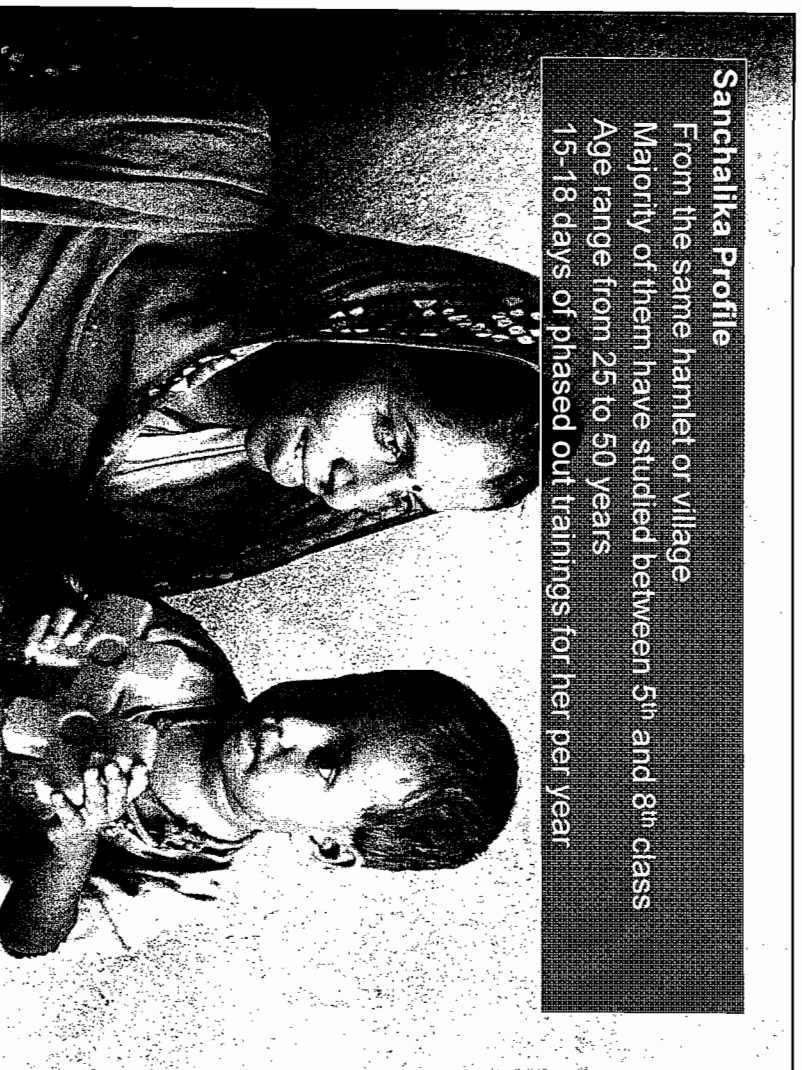
**One hot cooked meal and one ready to eat fortified snack everyday
Micronutrient supplements and medicines provided at Centre**



**Equal emphasis on indoor activities
(drawing, creative activities, puppets,
story-telling, dance, etc)**



... and outdoor play



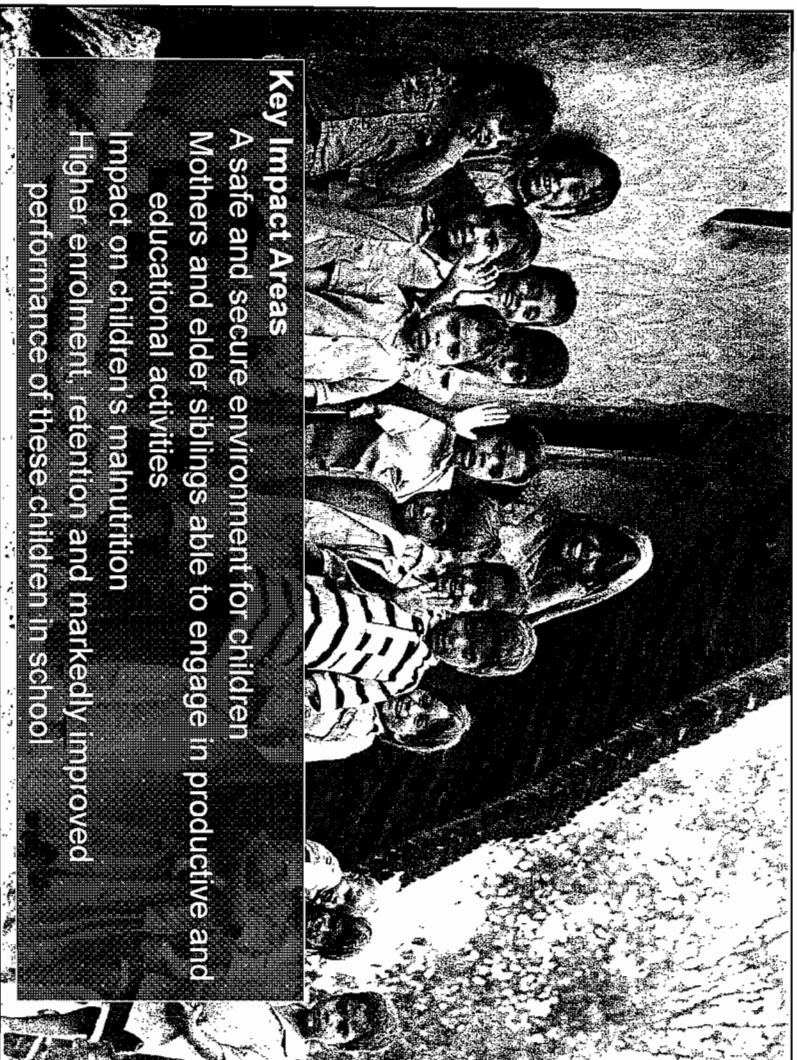
Sanchalika Profile

From the same hamlet or village

Majority of them have studied between 5th and 8th class

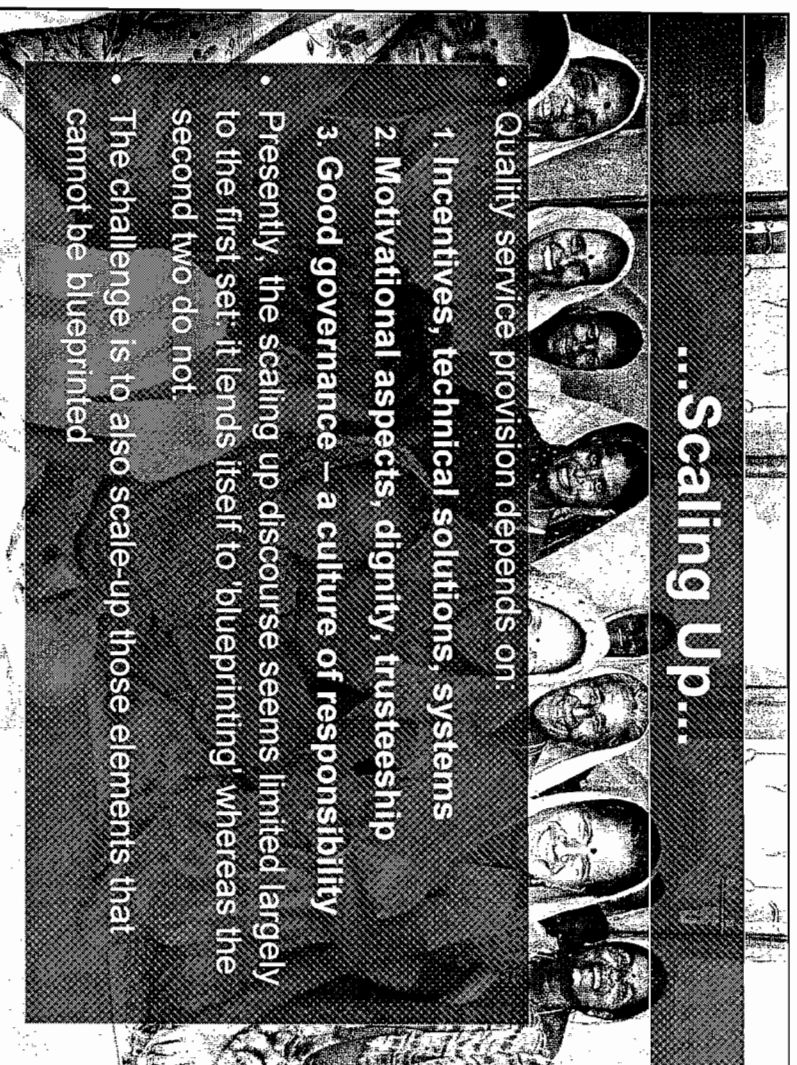
Age range from 25 to 50 years

15-18 days of phased out trainings for her per year



Key Impact Areas

A safe and secure environment for children
Mothers and elder siblings able to engage in productive and educational activities
Impact on children's malnutrition
Higher enrolment, retention and markedly improved performance of these children in school



...Scaling Up...

- Quality service provision depends on:
 1. Incentives, technical solutions, systems
 2. Motivational aspects, dignity, trusteeship
 3. Good governance – a culture of responsibility
- Presently, the scaling up discourse seems limited largely to the first set: it lends itself to 'blueprinting' whereas the second two do not.
- The challenge is to also scale-up those elements that cannot be blueprinted