Internship training

At

CARE India, Bihar

Title of the study:

"Assessment of Village Health Nutrition Day(VHND) services in Nawada district"

by

Smita Wahane

Under the guidance of

Dr. Preetha G.S

Post Graduate Diploma in Hospital and Health Management

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Acknowledgement

Effective team work is essential to complete any project that includes a good guider and efficient team players. My dissertation work is also a result of such a team activity. So, I wanted to take this opportunity to thank every bits that supported me during this work.

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Also, I wish to thank Mr. Narendra Kumar Singh (Team lead) , who guided me during my work and Dr. Pawan Singh(District technical Officer - Facility) who as a colleague supported and helped.

Along with them I would also like to take this opportunity to thank all my Block managers and other office staff who helped me in collecting data and visiting the VHND sites.

Smita Wahane

ABBREVIATIONS:

ORGANIZATION PROFILE

CARE INTERNATIONAL

CARE international is a global confederation of 14 member organisations working together to end poverty in 2016. CARE worked in 94 countries around the world , implementing 962 poverty-fighting development and humanitarian aid projects , to reach more than 80 million people directly and 256 million people indirectly.

CARE is working in 95 countries around the world, supporting 890 poverty-fighting development and humanitarian aid projects to reach more than 65 million people.

CARE International is a global confederation of 14 National Members and one Affiliate Member with the common goal of fighting global poverty. Each CARE Member is an autonomous non–governmental organization and implements program, advocacy, fundraising and communications activities in its own country and in developing countries where CARE has programs.

At the beginning, there was a package: a CARE package, aimed to reduce hunger and show solidarity with the people of war-torn Europe.

At the end of World War II in 1945, twenty-two American charities, a mixture of civic, religious, cooperative and labor organizations got together to found CARE. Originally known as the *Cooperative for American Remittances to Europe*, it began to deliver millions of CARE packages across Europe. This was basically a small shipment of food and relief supplies to hungry recipients - with a huge impact on people's lives.

During the next three decades, CARE shifted its focus from helping Europe to delivering assistance in the developing world. It started programs in the areas of education, natural resources management, nutrition, water and sanitation, and healthcare in Southern Africa, South Asia and South America. Broadening the geographic focus and expanding beyond the original food distribution programs, CARE started to assist people affected by major emergencies – from famine in Ethiopia to hurricane recovery in Honduras.

Over the previous decades, Care has continuously developed its approach to reducing poverty. In 1945, CARE was established on the premise that poverty was mainly due to a lack of basic goods, services, and healthcare. As the organization grew, so did their understanding of poverty. CARE's scope widened to include the view that poverty is often caused by the absence of rights, opportunities and assets, largely due to social exclusion, marginalization, and discrimination. In the early 1990's, its work grew into what they call a 'rights based approach' to development.

In 1993, in an effort to reflect the wider scope of its programs, vision and impact, CARE changed the meaning of its acronym to *"Cooperative for Assistance and Relief Everywhere".* By 2007, it started focusing on women's empowerment realizing that women are the key: by empowering women entire families can be lifted out of poverty.

CORE VALUES :

CARE India works towards motivating and encouraging its staff to imbibe , internalise and demonstrate these defined core values of the organisation.

RESPECT – believing in and appreciating the dignity and potential of all human beings.

INTEGRITY- maintaining social , ethical , and organisational norms and adhering to the code of conduct.

COMMITMENT- Fulfilling organisational goals with full commitment towards our duties and responsibilities.

EXCELLENCE – Setting high performance standards and being accountable for and responsible towards our work.

VISSION AND MISSION :

VISION – “We seek a word of hope , tolerance and social justice , where poverty has been overcome and people live in dignity and security”

MISSION – “CARE India helps alleviate poverty and social exclusion by facilitating empowerment of women and girls from poor and marginalised communities.”

- **CARE INDIA**

CARE is a not- for profit organisation working in India for over 65 years , focusing on alleviating poverty and social injustice .

Organisation do this through well planned and comprehensive projects in health , education , livelihood and disaster preparedness and response .

Overall goal is the empowerment of women and girls from poor and marginalised communities leading to improvement in their lives and livelihoods.

CARE focuses on empowerment of women and girls because they are disproportionately affected by poverty and discrimination , and suffer abuse and violations in the realisation of their rights.

Also, experience shows that , when equipped with the proper resources , women have the power to help whole families and entire communities to overcome poverty , marginalisation and social injustice.

Please see below for the list of the 14 states:

Fig 1. CARE in India works across 14 states & 38 Projects, touching the lives of 37 million people (Headquarter in Delhi)

HISTORY OF CARE INDIA

CARE came to India in June 1946 when one of its co- founder , Lincoln Clark , signed the CARE Basic agreement in New Delhi at the office of Foreign Affairs. The agreement was limited to contribution of technical books and scientific equipment for universities and research institutes. In November 1949 , the first chief of mission , Melvin Johnson , arrived in India to establish operations. Subsequently on the invitation of the then president of India , he developed a CARE India food package that caused the re negotiation of the CARE agreement to include importation

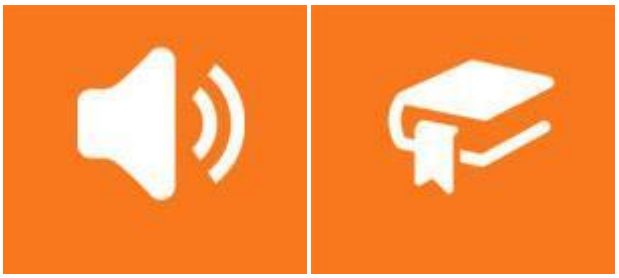
of food through Indo – CARE Agreement on 6th March 1950 . The CARE Office during 1950's in Delhi was a hutment (a long thin building) located in Janpath , Cannaught Place. CARE had three additional offices and ware houses in India located in Bombay , Madras and Calcutta.

The initial programmes those days included assistance to educational institutions, relief camps and assistance to hospitals in form of books, laboratory equipments, tools supplies etc. When the Mid-Day Meal (MDM - school lunch) program started in 1960, state offices were established and the staff in Delhi and state offices increased. Since 1960's CARE has been supporting government's school feeding programs. CARE has been providing nutritious food for the beneficiaries of Integrated Child Development Services (ICDS) on the request of GOI since 1982. CARE supported the Government's ICDS in the states of Andhra Pradesh, Bihar, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and West Bengal. As a part of support from USAID, CARE implemented a long term project named Integrated Nutrition and Health Project (INHP) from 1996 till 2010 and reached to about 1297 blocks in nine major states of India. Recognized worldwide for its contribution in disaster response and rehabilitation operations, CARE in India has supported the efforts of Government of India and individual state governments as and when major disasters occurred in the country. CARE has provided relief to several natural disasters since 1966 with Jammu and Kashmir floods 2014 and Hud Hud in Andhra Pradesh being the most recent. Some of the efforts include response to flood relief in West Bengal in 1979, cyclone in Andhra Pradhesh in 1977 and in 1996, and earthquake relief in Latur, Maharashtra in 1993, and Odisha super cyclone in 1999.

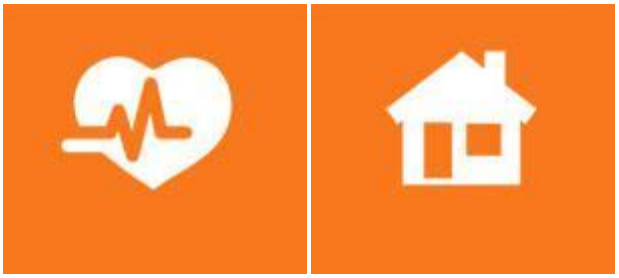
CARE India's current 'Programme' approach stems from a redrawn vision, under which, working with partners on projects has been overlapped with holistic, long term, deep impact "programmes".

As CARE India moves ahead, their key programming approaches will include social analysis and action, gender transformative value chain approaches, leadership and life skills strengthening, building capacities and leadership roles at multiple levels, advocacy on national and international platforms and facilitating links and dialogues between public, private and civil society.

FOUR MAIN FUNCTIONAL AREAS:



Disaster Preparedness Education



Health Livelihood

- **CARE INDIA INITIATIVES IN HEALTHCARE**

Delivering healthcare to over a billion people is a very complex challenge. CARE India works in close collaboration with State and Central Government and other partner organizations to secure accessible and quality maternal and child healthcare among marginalized communities. It works towards identifying the root causes of healthcare challenges, provides innovative solutions, and helps implement secure and quality healthcare services in India. CARE India believes that a healthy mother and a healthy baby is the route to a productive and a developed nation. Hence, CARE has specially focused upon providing comprehensive solutions to address public health problems. CARE India promotes essential new born care and immunization, reducing malnutrition, preventing infant and maternal deaths and protecting those affected by or susceptible

to HIV/ AIDS and TB. CARE works closely with its partners to achieve good health care for everyone.

CARE India projects in Health care:

- Axshya project.
- Madhya Pradesh nutrition project.
- Bihar technical support programme.
- Strengthening the Integrated Child Development Services (ICDS) Programme.
- ICDS System Strengthening and Nutrition Improvement Project.(ISSNIP)
- Strengthening Health and Nutritional strategies in community Platforms.
- Improving Maternal health through engaging Family and Community.
- Ensuring New Born survival by engaging community and Facility interventions.
- Village Health Nutrition and Sanitation Day (VHSND).
- BRIDDHI.
- Family Health Initiative in Bihar (FHI).

- Treatment adherence and follow up of MDR TB patients in West Bengal.

NUTRITIONAL TECHNICAL SUPPORT UNIT

For CARE India, the N-TSU project offers the opportunity to provide long term support to the Bihar state government's Integrated Child Development Services (ICDS) scheme. The ICDS scheme attempts to harness human, institutional and financial resources to do more, with high quality and with increased precision and efficiency. The goal of N-TSU is to achieve greater impact on the overall development of children in the state by addressing under-nutrition, especially focusing on Young Child Feeding practices, mainly through giving vigorous Home visits by the various stakeholders to the households of beneficiaries.

Recognizing that the Ministry of Women and Child Development alone cannot meet the needs of all children, CARE India is assisting the government to undertake convergence with other ministries and departments. CARE India is drawing from its field-tested, proven approaches to systematically create an enabling policy environment for ICDS, build trust across sectors, document models and promote convergence. Besides this, CARE India is facilitating training and capacity building of government functionaries, promoting safe drinking water, hygiene and sanitation at the household and community levels, promoting wheat fortification carrying BCC intervention, undertaking community mobilization and participatory governance. Finally, CARE India is responsible for working with block and district level ICDS personnel to improve their capabilities in data-driven management – using information to make evidence-based decisions to iteratively strengthen programs and improve outcomes.

Through monthly convergence meetings, N-TSU plans to re- establish the importance of convergence and coordination amongst the different government departments and other stake holders that contribute in reduction of malnutrition.

KEY LEARNINGS

- Care as a developing partner has been given many key responsibilities and implementation of various program activities at the ground level.
- Supportive supervision is the major component of care that helps in providing handholding as well as incremental learning support to front line workers.
- Laisoning with the health and ICDS department alongwith other development partners , helps to improve effective deliverance of services to the beneficiaries.
- Major data findings shared by CML team of care is taken as evident findings and are considered further for decision making effecting the major health outcomes.
- Care team in the district also works intensively to improve quality in terms of services , processes.
- Sharing of the data being collected by district team with the partners is one of the focused area.
- Work profiles of government officials, i.e. DPOs, CDPOs and LSs in the Department of Social Work, Government of Bihar, is heavily loaded with add-on responsibilities like election duties, land issue resolutions, etc; which often results in a compromise with their actual job-specific work.
- The functioning state of AWCs is miserable, with unmaintained dust-filled registers, unreadable IEC on walls, no electricity and an acute shortage of space for the conduction of AWC functions, especially on VHSNDs.
- AWCs are equipped with Nutritional and Health education kits and materials, to be used by the FLWs on VHSNDs for educating women; but they are mostly unaware of the proper message to be communicated or the way to deliver it.
- There is a severe shortage of home visits by the FLWs, and this result in an improper knowledge of women on topics like exclusive breast feeding, complimentary feeding, family planning and birth preparedness.
- There are huge gaps in the logistics or supplies of the essential materials like registers, growth charts, IFA tablets, THR, etc at the AWCs, which majorly affect their day to day functioning.
- A lot of meetings like ANM Tuesday meetings, HSC meetings, Sector meetings, DRG meetings, BRG meetings, etc are a part of general operations of the various

stakeholders of health, but their regular conduction is a matter of question and a major challenge for the development partners like CARE.

PROJECT REPORT

Title of the study**: ""Assessment of Village Health Nutrition Day (VHND)Services at selected sites in Nawada district"**

Background of the study

Village Health and Nutrition day**(VHND)** is a major initiative under the National Rural Health Mission (NRHM) to improve access to Maternal , Newborn , child health and nutrition (MNCHN) services at the village level.

Across , the country VHND is intended to occur in every village once a month(preferably on Wednesday and for those villages that have been left out , on any other day of the same month) usually at the anganwadi centre (AWC) or other suitable location. The AWC is identified as the hub for service provision in the RCH -II , NRHM , and also as a platform for intersectoral convergence. VHND is also to be seen as a platform for interfacing between the community and the health system.

On the appointed day ASHA'S , AWW will mobilise the villagers , especially women and children , to assemble at the nearest AWC .the VHNC comprising the ASHA, ANM , AWW and PRI representatives ,if fully involved in organising the event , can bring about dramatic changes in the way that people perceive health and health care practices.

SERVICES TO BE PROVIDED :

- All pregnant women are to be registered , the registered pregnant women are to be given ANC services and any drop out pregnant women eligible for ANC are to be tracked and services are to be provided to them.

- All eligible children below one year are to be given vaccines against six vaccine preventable diseases. All drop out children who do not receive vaccines as per the scheduled doses are to be vaccinated . vitamin A solution is to be administered to the children.

- All the children are to be weighted , with the weight being plotted on a card and managed appropriately in order to combat malnutrition.

- Anti – TB drug are to be given to the patients of TB.

- All the eligible couples are to be given condoms and OCP's as per their choices and referrals are to be made for other contraceptive services.

- Supplementary nutrition to be provided to underweight children.

ISSUES TO BE DISCUSSED WITH THE COMMUNITY :

- Danger signs during pregnancy.

- Importance of institutional delivery and where to go for delivery.

- Importance of seeking post natal care.
- Counselling on ENBC.
- Registration for JSY.
- Counselling for better nutrition.
- Exclusive breastfeeding.
- Complementary feeding.
- Care during diarrhoea and home management.
- Care during acute respiratory infections.
- Prevention of malaria, TB , and other communicable diseases.
- Importance of safe drinking water.
- Prevention of HIV/AIDS and STI'S.
- Personal hygiene.
- Household sanitation.
- Education of children.
- Disaster management.

Requirements for organising VHND:

- ASHA.
- AWW.
- PRI member.
- Helper of AWW.
- Staff to come from outside the village – ANM's , Male MPW (If available) , ASHA facilitators (if available).

Instruments , Equipments and Furniture :

- Weighing scale – adult , child.
- Examination table.
- Bad screen or curtain.
- Haemoglobin meters , kits for urine examination.
- Gloves.
- Slides.
- Stethoscope and blood pressure instrument.
- Measuring tape.
- Foetoscope.
- Vaccine carrier with ice -packs.

If these items are not available , their provision could be arranged by using the untied fund of Rs. 10,000 /- available with the ANM or with the VHSC.
These items should be kept under the safe custody of the ANM / AWW/ ASHA as the case may be.

Supplies:

- Supplies such as vaccines IFA tablets , Vitamin A , Condoms , OCP's , ECP's, ORS.
- Anti- helminthic drug.
- Chloroquin.
- Anti – TB drugs.
- Paracetamol.
- Stains for fixing BF.
- AD syringes in sufficient quantity.
- IEC materials for communication and counselling.

Outcomes of VHND services :

The organisation of the Village Health And Nutrition Day on a regular basis as per the guidelines will result in the achievement of the following outcomes :

Hundred percent coverage with preventive and promotive intervention , especially for pregnant women , children , and adolescents.

Preventive and promotive coverage for the National Disease control Programmes.

Increased awareness about the determinants of health such as Nutrition , Sanitation , and timely care , etc

Improved knowledge about the services offered under the various Nutritional Health Programmes.

Greater emphasis on the community’s role in making the health system responsive to the health needs of the community and in demanding and ensuring accountability.

Literature Review:

- The organisation of village health nutrition day occurs on a fixed day , place and time through convergent actions by the departments of health and the department of women and child development. The health workers often lack clarity in understanding their role at these session sites due to inadequate dissemination of guidelines for the conduction of outreach sessions.(1)

- In the 1978 Alma Ata declaration focused on the importance of primary Health Care and the critical role played by the Community Health workers (CHW) to link communities to the health system. Their have been innumerable experience throughout the word with programmes ranging from large scale national programmes to the community based initiatives. The use of the community members to render certain basic health services to their communities is a concept that has existed for at least 50 years.

- The data reflects that the VHND sessions are being organized as per the immunization session roaster of the villages and the services related to immunization are only being provided rather than providing all basic health services. (3)

- According to a rapid assessment on VHND was carried out by UNICEF in 2011 indicate that VHNDs are conducted on a designated day; however discussions and feedback from the community and functionaries show that quality of interaction during VHND sessions is not up to the mark.

  This has an impact on the participation of the community in VHND. Quality entails a number of aspects –
  a) involvement of the organizers (frontline workers from health, ICDS, panchayat functionaries and involvement of community institutions),
  b) common understanding amongst all stakeholders about how VHND is to be organized and services that are to be offered,
  c) pre-service mobilization and post service follow up, d) publicity and preparation for the VHND and e) instruments and required equipment for VHND
  f) motivation amongst FLWs due to over worked schedules
  g) information shared during sessions etc. (4)

- Village Health Nutrition Day is a priority intervention under the National Rural Health Mission (NRHM), Government of India which emerged from attempts to increase coverage of basic health and nutrition services in rural areas as a part of outreach activity not served by health facilities.

  The focus of Village Health Nutrition Programm is Inter-sectorial convergence between Health and Nutrition activities NRHM of the Ministry of health and family Welfare,

Government of India. The ASHAs, Angan Wadi Workers, Auxiliary Nurse Midwives and the Panchayati Raj Institute members work as a team to ensure that services are provided on the VHND. The case can be used to discuss the challenges in convergence between various government departments in planning the services to be offered on the VHND, generating demand for the services through IEC/counseling and actually providing services on the VHND. (5)

Rationale:

A very few studies has been done on VHND services in Bihar.
VHND were not been organised regularly and when they were conducted , it primarily offered only routine immunisation and supplementary nutrition instead of full package of services.
Also , the presence of all three front line workers i.e ANM , ASHA , AWW is not supervised.
This study is an attempt to know that whether the sites require system strengthening for the effective service deliverance.

Statement of Problem:

- System strengthening leads to program implementation and improvement in the quality of services.
- Delivery of services at the session site and its utilisation by the benificiaries.

General Objective :

To assess the Organisation and delivery of services during Village Health Nutrition Day at 24 sites in Nawada District.

Specific objectives:

-To assess the availability of Infrastructure , Drugs , Equipments , for conducting Village Health Nutrition Day.

- To Review the delivery of different services during Village Health Nutrition Day.

Methodology:
Study Design and Methods:

Type of the study : Descriptive cross sectional study design.

Location of the study : 24 Villages of 12 HSC of Nawada District.

Study duration: The duration of study is for 3 months (February 2018 to April 2018)

Study Respondent: The respondent for the following study included ANM , AWW and ASHA at the VHND session site.

Sample method: Among 12 HSC, 24 villages conducting VHND sessions has been selected by simple random sampling.

Sample size: A sample size of 24 villages was taken. VHND is held on Wednesday and Friday of every week. Thus, in a time period of 3 month, 24 VHND sites had been visited.

Data collection technique: Prepared structured questionnaire was distributed among the present FLW'S of selected session sites during VHND Day.

Data collection tool: Structured Questionnaire.

Data analysis: The data obtained from the study have been edited , and organized as per the requirement of the study. The data analysis was done in MS Excel, tables and graphs are used to show the results as per the need.

FINDINGS :

Services being provided at the Village Health and Nutrition Day site :

Figure 1 : Providing ANC services at the VHND site is the main service provision. Below figure shows that out of 28 pregnant women at 24 VHND site , all were registered for ANC but only 20 received the ANC services

N= 24 VHND session sites .

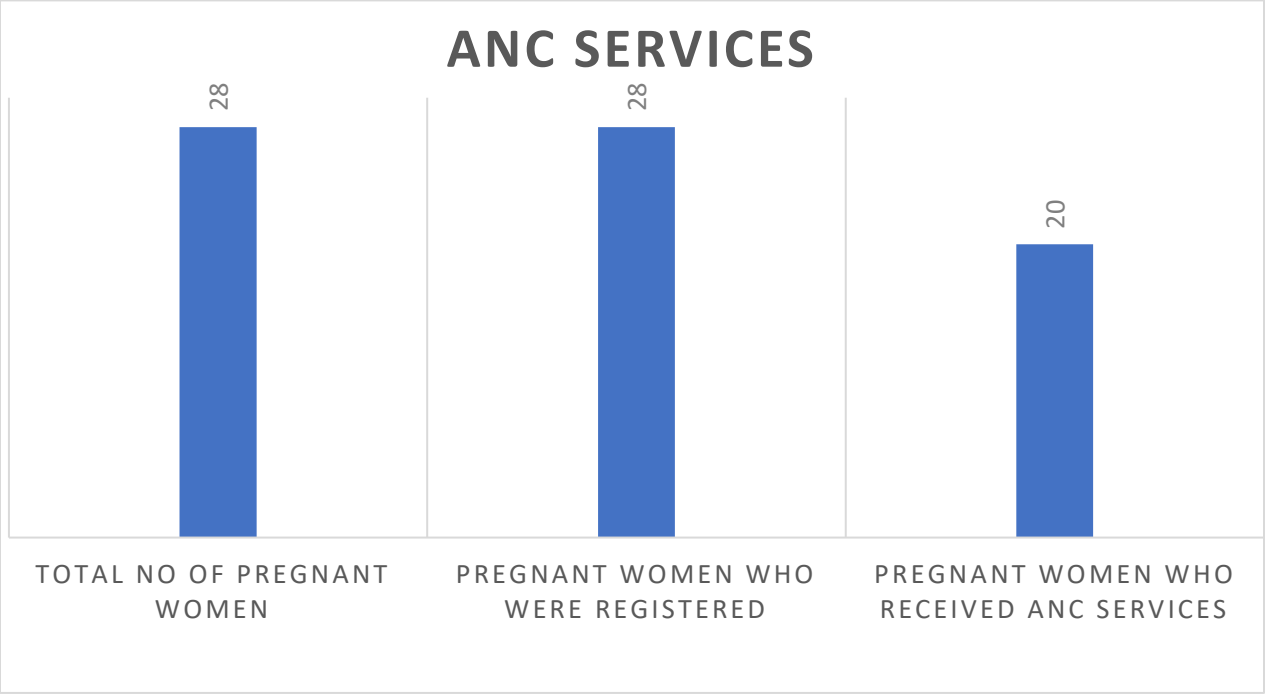
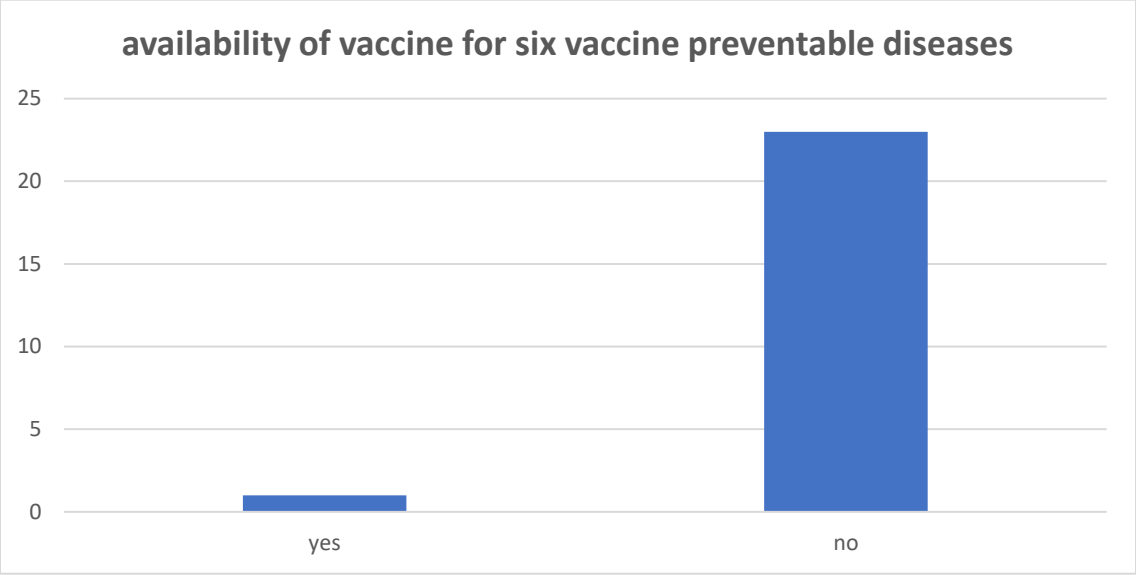


Figure 2: **SHORTAGE OF VACCINES FOR THE SIX VACCINE PREVENTABLE DISEASES**.

As per the guidelines developed for Village Health Nutrition Day conduction , one of the service provison includes , that all the children below one year of age need to be vaccinated against six vaccine preventable diseases.

Hence , the below figure will help to access any shortage of vaccine at the VHND session sites among the selected sample of the villages.

N= 24 VHND session sites .



Out of 24 VHND sites , only 1 site had the shortage of vaccine rest 23 sites were having vaccines.

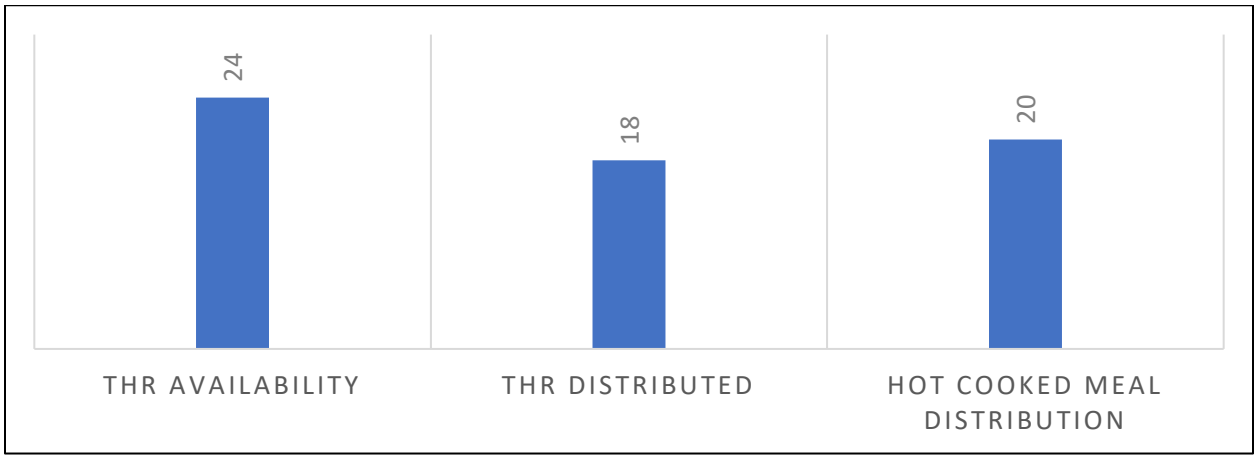
Figure 3 :

Take home ration is provided to the pregnant women in which among 24 VHND THR was available at all the sites but the distribution was done only at 18 of these sites.

And at 20 sites hot cooked meal was been distributed to the children , for fulfilling the nutritional aspect of the programme.

N= 24 VHND session sites .

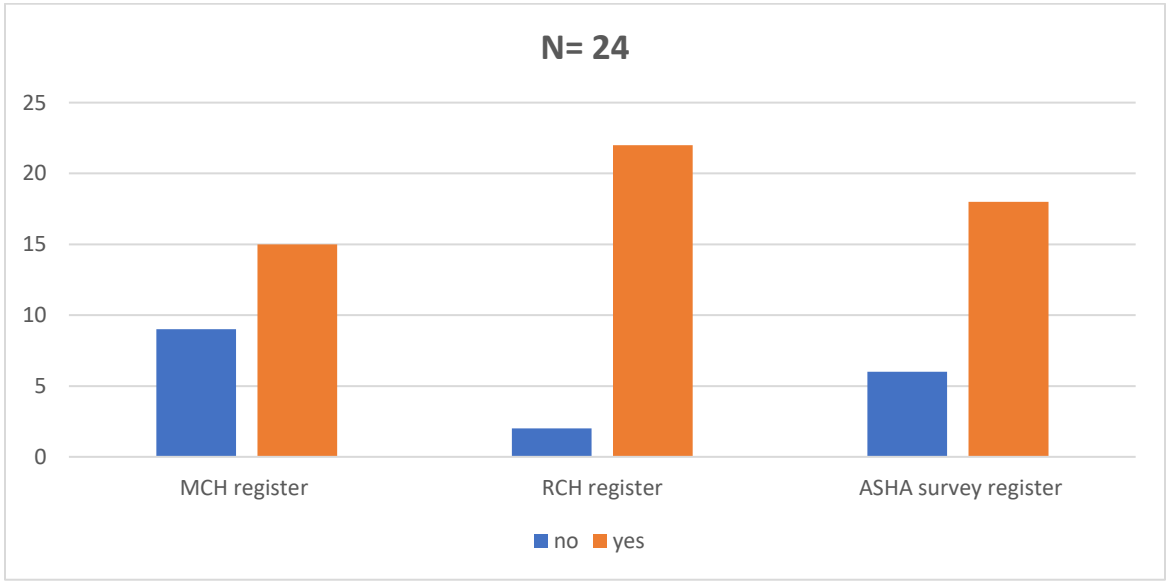
TAKE HOME RATION AND PREPARATION OF HOT COOKED MEAL FOR CHILDREN AT THE VHND SESSION SITES :



Information about the availability of registers and records will help to understand that the FLW'S are keeping a proper record of the pregnant women , ANC check up availed by pregnant women ,drop out women for ANC check up , line listing for immunisation of the children , drop out children and their tracking.

Figure 4: Availability of registers and records at the selected VHND site.

N= 24 VHND session sites .



MCH register- 9 session sites does not have MCH register while 15 sites had the register.

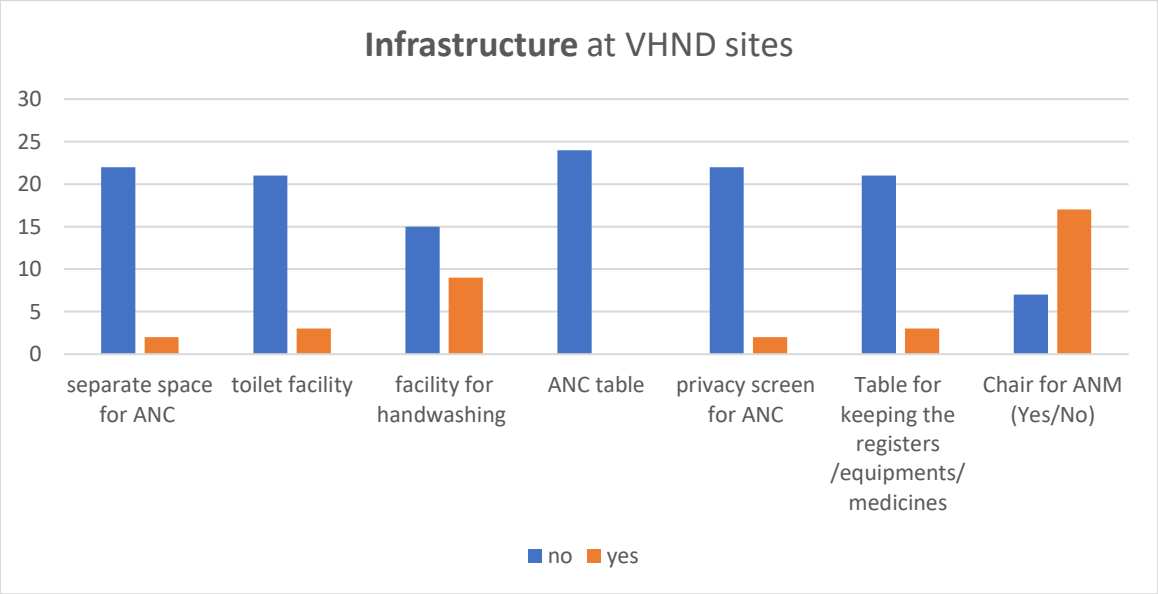
RCH register – 2 session sites was not having RCH register while rest 22 sites had RCH register.

ASHA survey register- 6 session sites were not having ASHA survey register rest 18 sites had the register.

Important requirement for conduction of Village Health Nutrition day , to improve accessibility can be assessed by the infrastructure available at that session site.

N= 24 VHND session sites .

Figure 5:



Separate space for ANC-22 sites don't have separate space for ANC and only 2 sites had the space.

Toilet facility – 21 sites don't have toilet facility and only 3 sites had the toilets.

Facility for hand washing – 15 sites don't have hand washing facility and only 9 sites had the facility for hand washing.

Privacy screen for ANC- Only 2 sites had the privacy screen and rest 22 sites don't have any privacy screen.

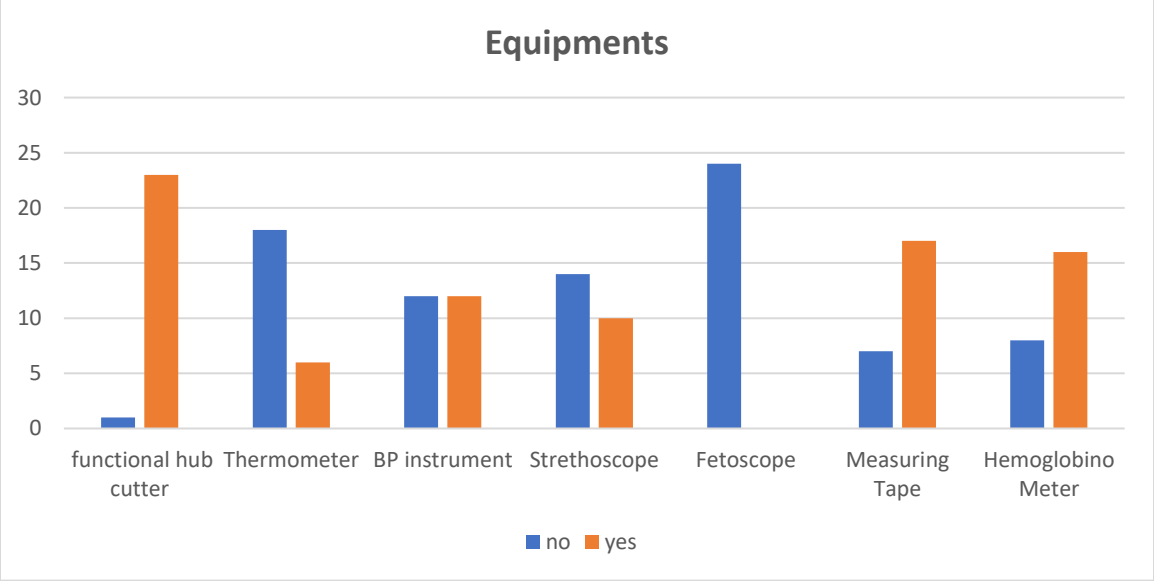
Table for keeping register- 21 sites don't have tables for keeping registers or equipments while only 3 sites had the table.

Chairs for ANM – 7 sites don't have the chairs for ANM while rest 17 sites had chairs for them.

At VHND session site , according to guidelines the equipments that are needed to be available are hub cutter , thermometer , B.P instrument , stethoscope , fetoscope , measuring tape , and hemoglobinometer. If these items are not available their provison could be arranged by using the iuntied fund of Rs. 10,000 available with the ANM or with the VHSC.

N= 24 VHND session sites .

Figure 6:



Functional hub cutter – at 23 session sites the hub cutter was functional and at only 1 it was non functional.

Thermometer – at 18 session sites thermometer was not available and rest 6 sites had thermometer.

B.P Instrument – at 12 sites B.P instrument was available and at 12 sites it was not available.

Stethoscope – at 14 sites stethoscope was not available and at 10 sites it was available.

Fetoscope – at all the 24 sites fetoscope was not available.

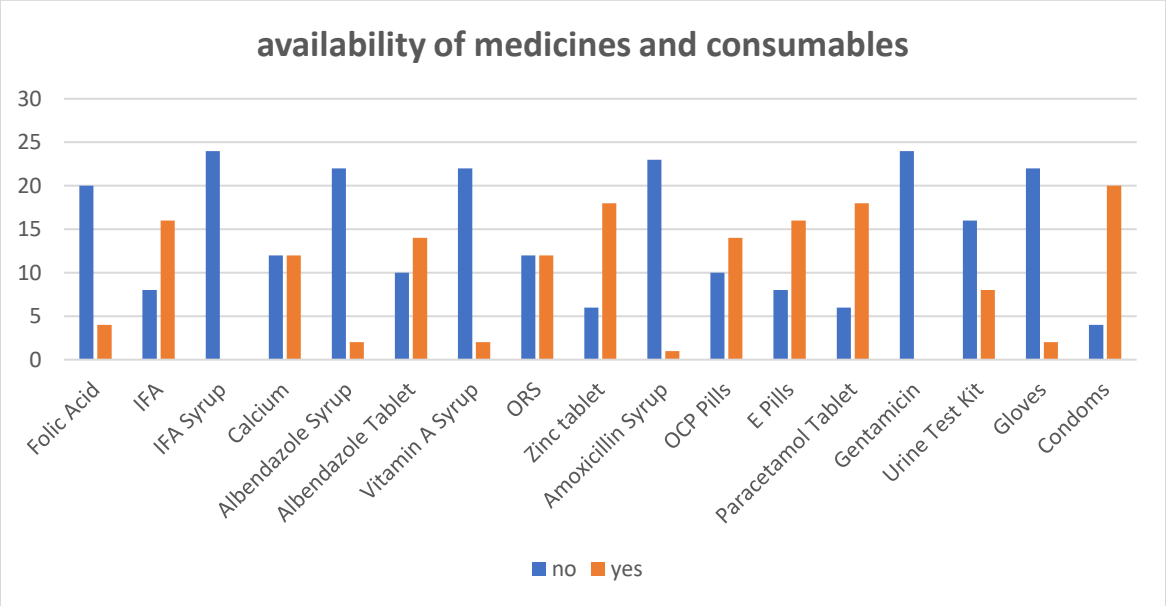
Measuring tape – at 7 sites measuring tape was not available while at 17 sites it was available.

Hemoglobino meter – at 8 sites hemoglobino meter was not available and at 16 sites it was available.

Medicines are required to be given to the benificiaries availaing the services during VHND and the consumables will ensure the quality of the services.

N= 24 VHND session sites .

Figure 6 :



Folic acid : at 20 sites folic acid was not available and at only 4 sites it was available.

IFA : at 8 session sites it was not available and at 16 sites it was available.

IFA syrup – at all 24 sites it was not awailable.

Calcium – at 12 sites calcium was not available and was available at 12 sites.

Albendazole syrup – was available only at 2 sites and at rest 22 sites it was not available.

Albendazole tablet – at 10 sites albendazole tablet was not available rest at 14 sites it was available.

Vitamin A syrup – at 22 sites it was not available and at 2 sites only it was available.

ORS – at 12 sites ORS was available and at 12 sites it was not available.

Zinc tablet – at 6 sites it was not available and rest at 18 sites it was available.

Amoxicillin syrup – at 22 sites amoxicillin syrup was not available and at only 2 sites it was available.

OCP Pills – at 10 sites OCP pills were not available and rest at 14 sites it was available.

E- Pills – at 8 sites E pills was not available and at 16 sites it was available.

Paracetamol – at 6 sites paracetamol was not available and at 18 sites it was available.

Gentamycin – It was not available at all 24 sites.

Urine test kit – Kit was not available at 16 sites and was available only at 8 sites.

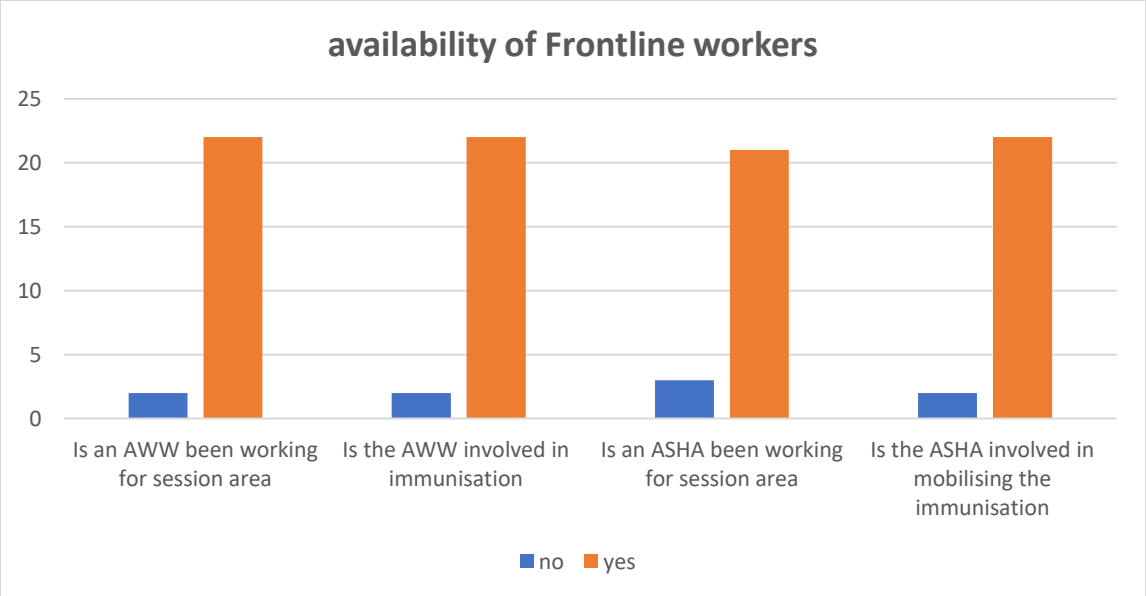
Gloves – at 22 sites it was not available and only at 2 sites it was available.

Condoms – was available at 20 sites and at 4 sites it was not available.

Availability of FLW's at the VHND session sites is necessary to provide the needed services to the beneficiaries. In absence of these FLW's villagers will be reluctant to attend the monthly VHND.

N= 24 VHND session sites .

Figure 7:



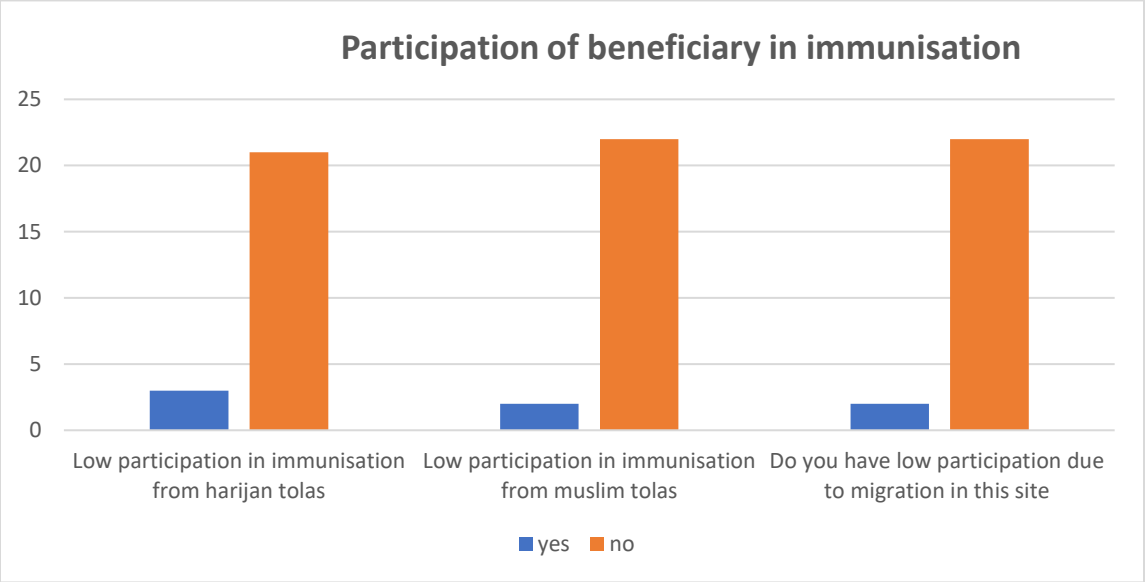
AWW – only at 2 sites AWW was not appointed rest at all 22 sites AWW were available and at these 22 sites AWW were involved in immunisation.

ASHA – at 3 sites ASHA was not appointed and at 21 sites ASHA was appointed . Whereas at 22 sites ASHA was involved in mobilisation for immunisation and at 1 site ASHA was not involved in mobilisation.

Since our objective is to assess the service utilisation , hence the following figures will be helpful to find out the participation of beneficiary in VHND activity and some factors that affects the utilisation by them.

N= 24 VHND session sites .

Figure 8 :



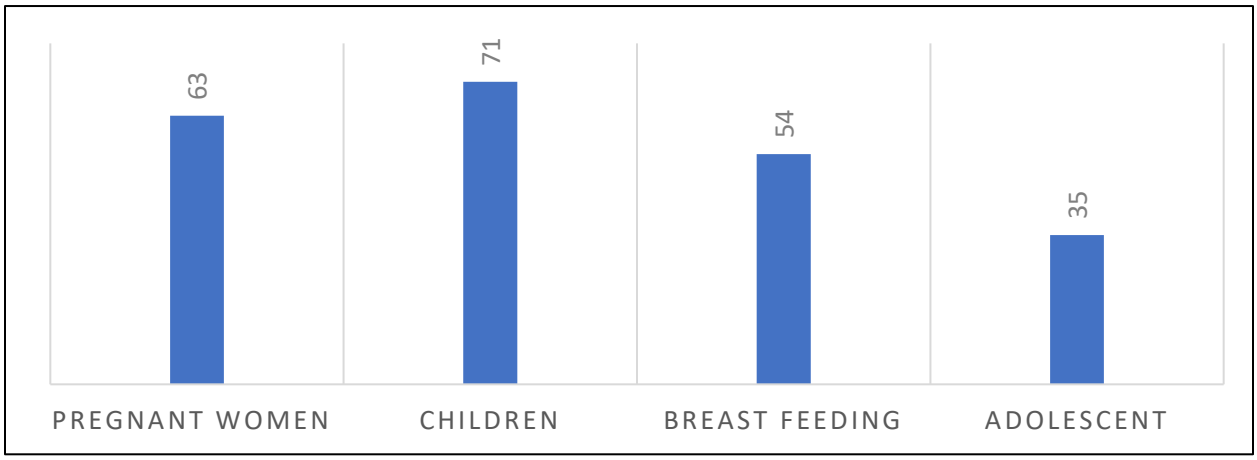
Harijan tolas – from 3 session sites their was low participation in immunisation from harijan tolas and at rest 21 sites they were participating in immunisation.

Muslim tolas – only from 2 session sites participation was not done from muslim tola , in immunisation and from rest 22 sites people from muslim tolas were participating.

Low participation due to migration – This factors was prevalent only in 2 sites rest at 22 sites their was no hinderance due to migration.

Figure 9 :Councelling to the beneficiaries by the FLW's:

N= 24 VHND session sites .



Pregnant women: at all the 24 sites 63 % pregnant women were receiving necessary councelling.

Children : coucelling was given to 71% of the mothers of the children who received immunisation , about exclusive breast feeding , supplementary nutrition , diarrhoea management etc…

Breast feeding : about 54% mothers were given information regarding the frequency of breast feeding , early initiation of breast feeding , .

Adolescent : only about 35 % councelling was provided among the 24 session sites to the adolescents and it was also only through the IEC materials.

Figure 10 : Services utilized by villages and population of village:

N= 24 VHND session sites .

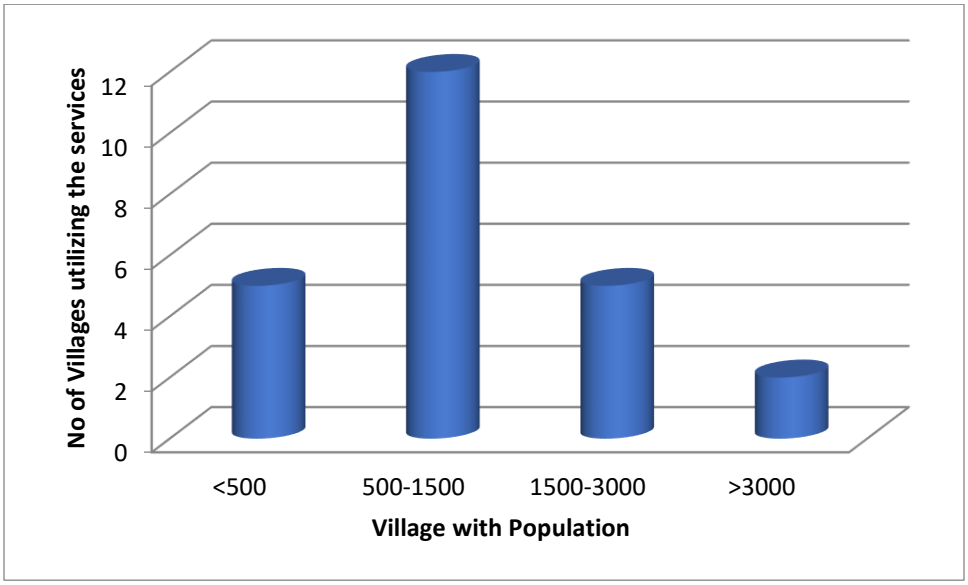


Fig determines that out of 24 villages, nine villages with range of 500 to 1000 population utilizing 50 percentage of services and as size of population of villages increasing lesser the services is been utilized. Inspite of less population with range of 500 services utilized by five villages is 21 percent only. Proper Microplanning of VHND which will increase utilization of services.

Figure 11: Percentage of education level of literates in 24 villages using the services

N= 24 VHND session sites .

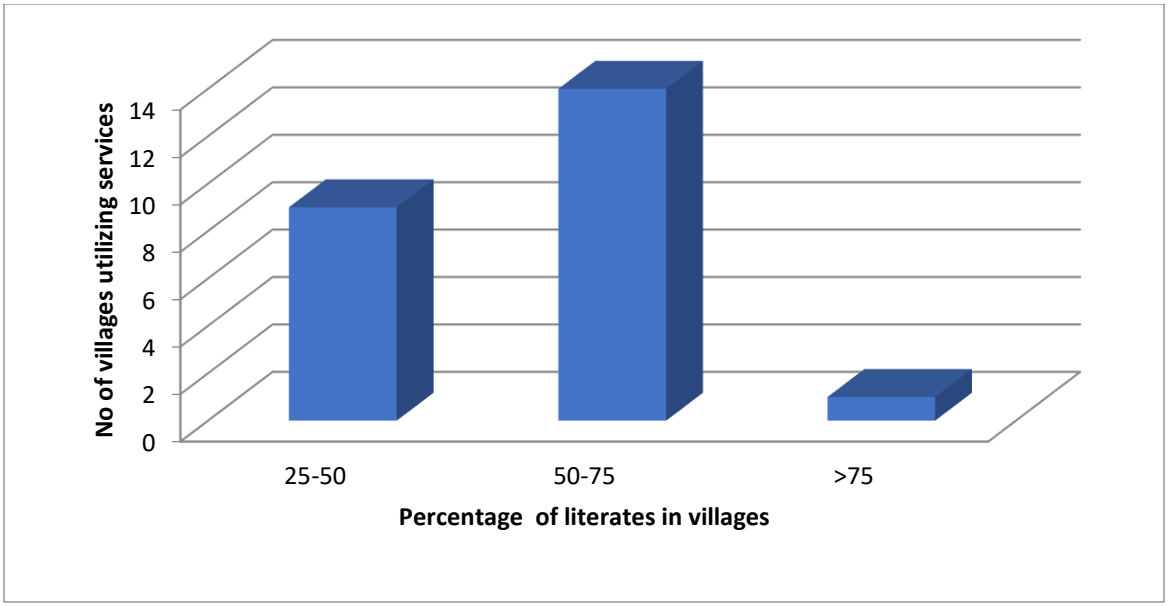


Fig explaines about 50 -75 percent of literates out of 24 villages 14 are using the services (i.e) 59 percent and as the percentage of literacy increases the services utlizing by literates are decresing and from the range of 25 -50 percent the servies utilized by literates are 38 percent.

Recommendations :

- ANC services provided at the VHND sites need to be strengthen in terms of Facility available at the sites (privacy screen , ANC table , separate space for ANC , toilet and hand washing facility , B.P instrument , hemoglobinometer , fetoscope , measuring tape.

- Immunisation during VHND session is carried out regularly , but ensuring quality services need to be focused for strengthening this aspect.

- Proper and Timely monitoring of VHND is required by MO I/C and BPM's of the respective blocks.
- FLW's were available at the 90% of all the VHND sites but their participation in each aspect of VHND service should be equal.

- Counselling sessions are needed to be given importance during VHND sessions.

- Proper counselling for the family planning services are needed to be done during VHND sessions to the pregnant women.

- Proper record keeping can only be ensured if registers are made available at the session sites. These records helps to maintain a check on the drop outs and their tracking and hence this activity will strengthen the program reach.

- All beneficiaries should be involved during discussions at the VHND session sites. The communication should be two ways.

- Availability of medicines should be ensured at the VHND session sites . the availability of medicines and consummables will help in quality service deliverance

Conclusion-

- It was noted that none of the VHND site was providing all the stipulated services , though immunization was provided mostly.
- Anganwadi centers were lacking availability of various essential instruments and equipments.
- So , regular orientation of village functionaries for ensuring all the VHND services with the availability of required logistic as recommended.

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- Study on Documentation of motivation, attitudes and capacities of front line workers towards counselling during VHND in Odisha by Unicef Consultant for 12 weeks.)(4)
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- *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4408710/* Availability of Village Health and Nutrition Day services in Uttarakhand, India.
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ANNEXURE : QUESTIONNAIRE FORMAT:

SESSION WISE FORMAT

Details
Name of Village
Name of the Session site
Frequency of RI in this site (1. Monthly, Quarterly, 3. IMI site)
Population of the session area
Total live births in 2017
Do you have an AWC in session area (Yes/No)
If yes, Write AWC Code.
Do you conduct Immunisation at AWC (Yes/No)
Is the AWW involved in immunisation (Yes/No)
Is an ASHA been working for session area (Yes/No)
Is the ASHA involved in mobilising the immunisation (Yes/No)
How many harijan tolas adjoining session area (Number)
From how many of these tolas do you have problems getting children for immunization?
How many Muslim tola adjoining session area (Number)
From how many of these tolas do you have problems getting children for immunization?
Do you have low participation due to migration in this site (Yes/No)
Is this tola listed as a polio HRA? (Yes/No)
Is there a tola identified as a Hard to Reach Area in this session area? (Yes/No)
Number of brick kilns in this tola
Were measles cases reported in this area in last one year? (Yes/No)
Were pertussis cases reported in this area in last one year? (Yes/No)
What is the distance between the VHSND session site and the house that located farthest from this site? (time taken to walk in minutes)
Number of hamlet/wards within the session area which are too far (or otherwise inaccessible) from session site
How many additional sessions are needed for this area?
Do you have separate MCH register for this site? (Yes/No)
Do you have separate RCH register for this site? (Yes/No)

Do you have separate ASHA survey register for this site? (Yes/No)
When was the last head-count survey done by ASHA?
When was the last head-count survey done by you?
Do you have separate due list register for this site (Yes/No)

Who brought the vaccine carrier to the session site in last month (Courier/ANM/Other)
Do you have any problem with vaccine delivery system for this site? (Yes/No)
Facilities for Arogya Diwas
Does the site have separate space for ANC (Yes/No)
Does the site have toilet facility (Yes/No)
Does the site have facility for handwashing (Yes/No)
Does the site have an ANC table (Yes/No)
Does the site have a privacy screen for ANC (Yes/No)
Table for keeping the registers /equipments/ medicines (Yes/No)
Chair for ANM (Yes/No)
Chairs/stools for mothers? (Yes/No)
Functional Adult weighing machine? (Yes/No)
Functional Child weighing machine (Yes/No)
Functional Salter scale (Yes/No)
MUAC Tape (Adult) (Yes/No)
MUAC Tape Children) (Yes/No)

QUESTIONNAIRE FOR HSC WISE DATA COLLECTION:

Name of Block:_____
Information
Name of ANM 1:
Name of ANM 2:
When do you add the name of the new born to your register: 1. As soon I come to know about the birth 2. When the baby is brought to me for the first vaccine
Was there any shortage of vaccine in last three months
If yes, specify the vaccine
BCG
OPV
DPT
Pent
Measles
Was there any shortage of any of Syringes in the past 3 months?
Was there any shortage of any of Needles in the past 3 months?
Equipments available and functional
Do you have a functional hub cutter
Thermometer
BP instrument
Strethoscope
Fetoscope
Measuring Tape
Hub Cutter
Hemoglobino Meter
Medicines, Consumables
Folic Acid
IFA
IFA Syrup
Calcium
Albendazole Syrup
Albendazole Tablet
Vitamin A Syrup
ORS

Zinc tablet
Amoxicillin Syrup
OCP Pills
E Pills
Paracetamol Tablet
Gentamicin
Urine Test Kit
Gloves
Condoms
VHSNC is being formed in this village? (Yes/No)
If formed, VHSNC account is opened? (Yes/No)
Whether the latest VHSNC's President/secretaries names are updated? (Yes/No)
Fund available with VHSNC on 31st January 2018

PICTURE RELATED TO CONDUCTION OF VHND SESSION AT THE VHND SITES