**Internship Training**

at

**Indian Health Action Trust (U.P. Technical Support Unit)**

on

**"A Study on Gap Analysis of Village Health and Nutrition Day in Kannauj District"**

by

**Dr. Ankit Sharma (PT)**

Enroll No. PG/14/009

Under the guidance of

**Dr. Anandhi Ramachandran**

Post Graduate Diploma in Hospital and Health Management

2014-16


**International Institute of Health Management Research New Delhi**

# (Completion of Dissertation from Indian Health Action Trust )

The certificate is awarded to

**Dr. Ankit Sharma (PT)**

In recognition of having successfully completed his
Internship in the field of

**Public Health on Nutrition Domain**

and has successfully completed his
Project on

**"A Study on Gap Analysis of Village Health and Nutrition Day in Kannauj District"**

**22nd Feb 2016 to 17th May 2016**

**Indian Health Action Trust (U.P. Technical Support Unit)**

He comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning

We wish him all the best for future endeavours

**Training & Development**

**Zonal Head-Human Resources**

**TO WHOMSOEVER IT MAY CONCERN**

This is to certify that **Dr. Ankit Sharma (PT)** student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at **Indian Health Action Trust (U.P. Technical Support Unit)** from 22nd Feb 2016 to 17th May 2016.

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfilment of the course requirements.

I wish him all success in all his future endeavours.

Dr. A.K. Agarwal
Dean, Academics and Student Affairs
IIHMR, New Delhi

Dr. Anandhi Ramachandran
Associate Professor
IIHMR, New Delhi

INDIA HEALTH ACTION TRUST

17th May 2016

## DISSERTATION COMPLETION CERTIFICATE

This is to certify that **Dr Ankit Sharma** has undergone 3 months training in **Indian Health Action Trust (Uttar Pradesh Technical Support Unit)** from **22nd Feb 2016** to **17th May 2016**. During this period, he has worked in Kannauj District as District Nutrition Specialist in Public Health domain and was mentored by Mr Mithilesh Pathak (Zonal Community Specialist).

He has shown keen interest in understanding the work culture of IHAT (U.P. TSU), learn various managerial and administrative skills which can effectively implement all the health related programmes, overall benefit of the community, and has successfully completed his training with the organisation.

We wish him good luck for his future assignments.

**For Indian Health Action Trust**

**Mr Nikit Srivastava**
**Zonal Admin Associate**
**(Zonal Head Human Resource)**

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## CERTIFICATE OF APPROVAL

The following dissertation titled **"A Study on Gap Analysis of Village Health and Nutrition Day in Kannauj District"** at **"Indian Health Action Trust (U.P. Technical Support Unit)"** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

| Name | Signature |
| --- | --- |
| Dr. Nishita Bele | |
| Dr. Oommen John | |
| Dr. Anandhi Ramachandran | |

## CERTIFICATE FROM DISSERTATION ADVISORY COMMITTEE

This is to certify that **Dr. Ankit Sharma (PT),** a graduate student of the Post- Graduate Diploma in Health and Hospital Management has worked under our guidance and supervision. He is submitting this dissertation titled **"A Study on Gap Analysis of Village Health and Nutrition Day in Kannauj District"** at **"Indian Health Action Trust (U.P. Technical Support Unit)"** in partial fulfilment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Dr. Anandhi Ramachandran
Associate Professor
IIHMR, New Delhi

Mr. Mithilesh Pathak
Zonal Community Specialist
Indian Health Action Trust

# INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH
# NEW DELHI

## CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"A Study on Gap Analysis of Village Health and Nutrition Day in Kannauj District"** submitted by **Dr Ankit Sharma (PT)** Enrollment No. PG/14/009 under the supervision of **Mr Mithlesh Pathak** for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 22nd Feb 2016 to 17th May 2016 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Signature

## FEEDBACK FORM

**Name of the Student:** Dr Ankit Sharma (PT)

**Dissertation Organisation:** "Indian Health Action Trust (U.P. Technical Support Unit)"

**Area of Dissertation:** Identifying existing gaps on Village Health Nutrition Day.

**Attendance:** 100% (Full)

**Objectives achieved:** Understand the work culture of IHAT (U.P. TSU), learn various managerial and administrative skills which can effectively implement all the health related programmes, overall benefit of the community. Identify existing gaps in, service delivery quality and implementation of health programs in the district and to propose probable solutions to them.

**Deliverables:** Mentoring of CRPs, counselling of beneficiaries at different VHND sites, supporting front line workers (ANGANWADI, ANM and ASHA) and also understanding their issues and solving challenges faced during field visits.

**Strengths:** Ankit is highly motivated, shows high initiative, he is extremely diligent, he has a curious and inquisitive mind, he is highly conscientious and he has a great sense of humour.

**Suggestions for Improvement:** He requires guidance in this public health domain because he is new for that, so that he can develop great skills because he is capable to grasp the knowledge. I believe experience allows one to gain clarity of thought and practice on that. I am sure Ankit will strengthen these skills, in time and with practice.

Mr Mithlesh Pathak

Zonal Community Specialist

Indian Health Action Trust

**Date:** 17th May 2016

**Place:** Kannauj

## ACKNOWLEDGEMENT

The success and final outcome of this project required a lot of guidance and assistance from many people and I am fortunate to have got this all along the completion of my project work. Whatever I have done is only due to such guidance and assistance and I would not forget to thank them.

I start by expressing my sincere gratitude to **Dr Manish Kumar (Director- Nutrition Project), Mrs Mansi Shekhar (State Nutrition Specialist), Mr Mahesh Lingappa Doddamane (State Specialist)** and **Mrs Mirnalini Dixit (HR Head)** who gave me the opportunity to do the project work in Indian Health Action Trust, U.P. and I am also thankful to all the staff for providing me the support and guidance which made me complete the project on time.

I would also like to thank our **Dr. A.K. Khokhar, Director, IIHMR New Delhi, Dr A.K. Aggarwal, Dean, IIHMR New Delhi** and my Mentor **Dr Anandhi Ramachandran, Associate Professor, IIHMR New Delhi** without whom the project would have been a distant reality.

I owe my profound gratitude to my Guide **Mr Mithilesh Pathak (Zonal Community Specialist)** who guided throughout in the project work, by providing the necessary information.

I take this opportunity to acknowledge the services provided by the library staff, lab staff and everyone who collaborated in producing this work.

I also wish to thank specially to my **Kannauj UP TSU Team (Mr Mithun, Mr Sammaan, Mr Ajay and Mr Ved)** and my friend **Mr Biswajit Patra** and **Dr Deeksha Tiwari** and my family members and well-wishers who has always been supportive in successful completion of my project.

# DEDICATION

MY

PROJECT

IS

DEDICATED TO

MY SISTER (HARSHITA)

MY PARENTS

MY TEACHERS

&

MY FRIENDS

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| | | | |
|---|---|---|---|
| **AAA** | Anganwadi ASHA ANM | **AG** | Adolescent Girls |
| **AIDS** | AcquiredImmunodeficiency Syndrome | **ANC** | Anti Natal Care |
| **ANC** | Ante Natal Check-up | **AWC** | Angan Wadi Centre |
| **ANM** | Auxiliary Nurse Midwife | **AYUSH** | Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa Rigpa and Homeopathy |
| **ASHA** | Accredited Social Health Activist | **AWW** | Angan Wadi Worker |
| **BCC** | Behaviour Change Communication | **CHC** | Community Health Center |
| **DPMU** | District Programme Management Unit | **DHH** | District Health Hospital |
| **DPT** | Diphtheria Pertussis and Tetanus | **ECP** | Emergency Contraceptive Pills |
| **GOI** | Government of India | **GoUP** | Government of Uttar Pradesh |
| **HBPNC** | Home Based Post Natal Care | **HPD** | High Priority Districts |
| **HIV** | Human Immunodeficiency Virus | **IEC** | Information, Education and Communication |
| **IHAT** | Indian Health Action Trust | **IFA** | Iron Folic Acid |
| **IMR** | Infant Mortality Rate | **JSSK** | Janani Shishu Surakhsha Karyakram |
| **JSY** | Janani Suraksha Yojna | **LBW** | Low Birth Weight |
| **LHV** | Lady Health Visitor | **MCH** | Mother and Child Health |
| **MCHN** | Mother Child Health Nutrition Day | **MDG** | Millennium Development Goals |
| **MoHFW** | Ministry of Health and Family Welfare | **NGO** | Non-Governmental Organization |
| **NHM** | National Health Mission | **NRC** | Nutrition Rehabilitation Centre |
| **NRHM** | National Rural Health Mission | **NUHM** | National Urban Health Mission |
| **OCP** | Oral Contraceptive Pills | **OPV** | Oral Polio Vaccine |
| **ORS** | Oral Re-hydration Sallt | **PHC** | Primary Health Center |
| **PRI** | Panchayati Raj Institutions | **RKS** | Rogi Kalyan Samiti |
| **RMNCH+A** | Reproductive Maternal Newborn Child Health + Adolescent Health | **RTI** | Reproductive Tract Infection |
| **SAM** | Severe Acute Malnutrition | **SC** | Sub Center |
| **SAARC** | South Asian Association for Regional Cooperation | **SHSRC** | State Health Systems Resource Center |

| | | | |
|---|---|---|---|
| **SIHFW** | State Institute of Health and Family Welfare | **STD** | Sexually Transmitted Diseases |
| **STI** | Sexual Tract Infection | **TFR** | Total Fertility Rate |
| **TT** | Tetanus Toxoid | **TSU** | Technical Support Unit |
| **UoM** | University of Manitoba | **UP TSU** | Uttar Pradesh Technical Support Unit |
| **VHND** | Village Health and Nutrition Day | **VHSND** | Village Health Sanitation and Nutrition Day |
| **VHSNC** | Village Health Sanitation & Nutrition Committee | **WHO** | World Health Organization |

## LIST OF ANNEXTURE

# CHAPTER 1

# INTERNSHIP REPORT

## 1.1 Introduction

Internship is a part of the second year program, where we have to observed and learn the work culture of organization. Also it will be necessary to participate in various department/activities so we could orient our self with different departments that gives us first hand exposure.

Internship is the process, through which we can understood process of work and there after be able to involve on decision making.

I was appointed as District Nutrition Specialist at Kannauj in Uttar Pradesh by Indian Health Action Trust (IHAT) to provide technical support to district ICDS and health officials in holding field visits, monitoring of all nutritional activities in district and other pertaining to strengthening of ICDS.

### 1.1.1 Objectives of Internship

a) To understand the work culture of IHAT( UP TSU)

b) The next objective of internship was to learn various managerial and administrative skills which can effectively implement all the health related programmes, overall benefit of the community.

c) To identify existing gaps in, service delivery equality, data collection, analysis and implementation of health programs in the district and to propose probable solutions to them.

### 1.1.2 The key responsibilities undertaken were :

a) Delivery of quality and effective trainings and meetings to be conducted under the project.

b) Provide technical support to district ICDS and health officials in holding field visits, supportive supervision of VHNDs and other tasks pertaining to strengthening of VHNDs.

c) Work in close with training teams at different levels in order to identify the support and resources they need for strengthening training mechanisms.

d) Regularity and quality of monthly meetings and other project related activities.

e) Develop close working relationships with all project participants and stakeholder at various levels to establish a shared vision of the project objectives and envisaged outputs.

f) Facilitate compiling of the data on trainings, review meetings and VHND assessments and quality monitoring.

## 1.2 Demographic Profile

a) In 2011, Kannauj had population of 1656616 of which male and female were 881776 and 774840 respectively. In 2001 census, Kannauj had a population of 1388923 of which males were 744170 and remaining 644753 were females.

b) There was change of 19.27 percent in the population compared to population as per 2001. In the previous census of India 2001, Kannauj District recorded increase of 20.16 percent to its population compared to 1991.

c) Average literacy rate of Kannauj District in 2011 were 77.70 compared to 61.88 of 2001. If things are looked out at gender wise, male and female literacy were 80.91 and 63.33 respectively. For 2001 census, same figures stood at 72.76 and 61.88 in Kannauj District. Total literate in Kannauj District were 1192763.

d) With regards to Sex Ratio in Kannauj, it stood at 879 per 1000 male compared to 2001 census figure of 866. The average national sex ratio in India is 943 as per latest reports of census 2011 Directorate. In 2011 census, child sex ratio is 898 girls per 1000 boys compared to figure of 912 girls per 1000 boys of 2001 census data.

## 1.3 Main Activities in Public Health

a) Community empowerment for health and health security.

b) Adolescents and children for better health.

c) Community AIDS awareness programme.

d) Capacity building programme for FLW.

e) Economic Empowerment and livelihood issues.

f) Universalization of quality education

g) Create Health Awareness

## 1.4 Organizational Profile

### 1.4.1 About Uttar Pradesh Technical Support Unit (UP TSU)

Established by the University of Manitoba and the **India Health Action Trust (IHAT)** with support of the Bill and Melinda Gates Foundation, **UP TSU** was created to support GoUP in enhancing its capacity to plan and implement RMNCH+A programs with increased efficiency, effectiveness and equity, in line with the Memorandum of Cooperation signed between the Foundation and GoUP in December 2012.

We are a **consortium** of global health organizations who work together to **support GoUP** and **NHM** in improving the lives of **women, children and their communities** by improving state's planning and execution capacity to enhance the efficiency, effectiveness and equity in health and development.

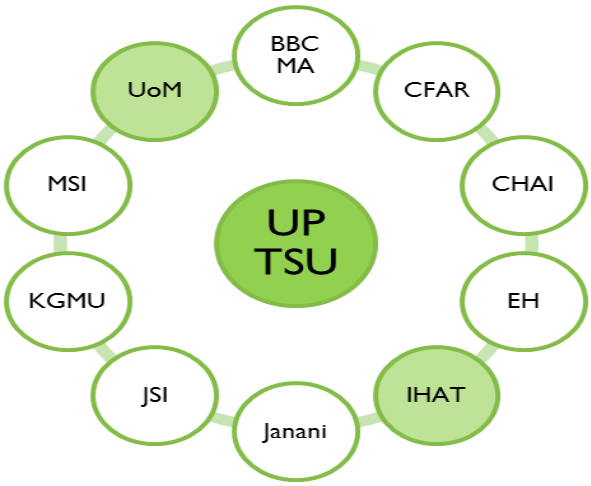



Figure 1 Partners of UP TSU(IHAT)

**University of Manitoba (UoM) – Role of Academic institution in public health**

- Established in June 2008
  - Faculty of Medicine (Health Sciences), Department of Community Health Sciences in collaboration with Medical Microbiology
- Consolidate:
  - Research
  - Global public health programs and services
  - Education and knowledge translation

→
- Improve Health
- Reduce Inequities

**UoM: Strategic Leadership and Global Networking**

- Technical support with national and state programs:

- ❖ National HIV programs
    - Nigeria, Pakistan, India, Kenya
- ❖ Maternal, neonatal and child health
    - Health Departments and National Health Mission – Uttar Pradesh and Karnataka, India
    - Rural Kenya

- Global HIV "Program Science" network

## About India Health Action Trust (IHAT)

- IHAT was established in 2003 to improve public health in India and abroad
- Supported by UoM's Centre for Global Public Health to extend Karnataka Health Promotion Trust's success
- IHAT and UM have successfully designed and implemented several large, complex HIV/AIDS projects in Rajasthan and Karnataka
- Extensive experience in building the capacity of NGOs and other civil society organizations
- Developed advocacy programs from the grassroots to the senior political level through media advocacy workshops, large-scale police sensitization programs, and the establishment of crisis response programs

**IHAT** currently provides technical support to State AIDS Prevention and Control Societies and to NACO in designing and implementing evidence based HIV prevention and care programmes. IHAT also implements HIV prevention and care programmes in the State of Rajasthan to gain implementation experience. These implementation experiences enrich the technical support that IHAT provides in the country and outside.

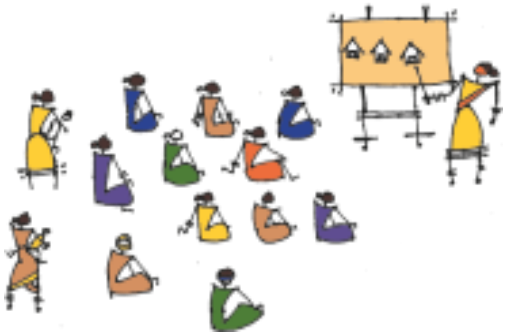
**IHAT provides technical support through various mechanisms.**

- At the National level, IHAT has been involved in Data Triangulation Project under the leadership of NACO. In this project, IHAT was primarily responsible for HIV data triangulation in the states of Karnataka and Maharashtra and provided technical support

to Indian Institute of Public Health (IIPH), Hyderabad, and Andhra Pradesh. The project was undertaken to enhance evidence-based programming and policy in dealing with the HIV epidemic. The project was initially implemented in selected states as a pilot. Learning's from these pilots have guided NACO to scale up the process in other states and encouraged an environment of evidence based planning.

- Additionally in Karnataka, IHAT has continued to extend technical assistance to Karnataka State AIDS Prevention Society through the Technical Support Unit (TSU) to support the scale up of quality Targeted Interventions(TIs) in the State and help it achieve the goals and objectives of NACP III.

**IHAT** in collaboration with UoM and SIHFW initiated the State Training Resource Centre which was successful in ensuring standardized and high quality training of TIs as per NACP III operational guidelines. Besides this, IHAT, along with Centre for Global Health, University of Manitoba provided technical support to South Asian Association for Regional Cooperation (SAARC) countries like Bhutan and Sri Lanka to help them initiate and scale up the HIV prevention programmes.



**India Health Action Trust (IHAT)** is a registered secular trust working on public health issues focusing on HIV and AIDS in different states of India. Established in December 2003, IHAT envisions impacting the public health policy and programmes in the country through the application of programme science.

## 1.4.2 Area of Work

**Project planning, appraisal, implementation, monitoring and evaluation :**

IHAT and UoM have successfully designed and implemented several large, multifaceted HIV/AIDS projects in Rajasthan and Karnataka and provided evidence of our skills in project planning, implementation and evaluation. Specifics include:

•Providing technical assistance in design, scale up and implementation of targeted intervention projects working with female sex workers, MSMs, injecting drug users, migrants and long distance truckers.

•Analysing sentinel surveillance data and other indicators, and collaboration with RSACS and KSAPS to re-prioritize HIV programmes and services.

•Development and evaluation of innovative district-wide, programme models in Rajasthan and Karnataka that have demonstrated how integrating an outreach model with improved services can substantially increase the utilization of VCT and HIV care services.

•Design and implementation of state-wide capacity building systems for HIV counsellors and health care providers. The supportive supervision system for counsellors is seen as a model for enduring capacity building and also for quality improvement of counselling services.

Development of a comprehensive strategy for rapidly scaling up targeted interventions by defining macro and micro level coverage needs. This has involved developing innovative methods for geographic mapping to define macro level coverage needs, and community-friendly tools to assist sex workers and outreach workers to engage in micro-planning of outreach and service delivery.

Establishment of an integrated monitoring and evaluation system for targeted interventions for sex workers, that measures achievement from the field level to the state level. Innovative tools have been developed to empower illiterate peer educators to track their work and measure their achievements in outreach, education and mobilization of sex workers to services.

**Capacity building of NGOs/CSOs**

IHAT and UoM have extensive experience in building the capacity of NGOs and other civil society organizations (CSOs), especially in the context of targeted interventions. Evidence includes:

- Building networks of NGOs and CBOs in Rajasthan. Our team has worked with large grassroots NGOs in 7 districts of Rajasthan to build networks that provide integrated prevention programmes for high-risk and vulnerable groups, including FSWs, MSM, IDUs, truckers and high-risk migrants. Through building and supporting these networks, a cohesive district-level programme was developed wherein NGOs and CBOs worked in synergy. One result of this process was the establishment of the first FSW CBO in Rajasthan.
- Currently, IHAT professionals are also contributing significantly towards training in TIs for the state through ToTs supported by Rajasthan SACS. In Karnataka, we support a wide range of NGOs and CBOs through formal capacity building and mentoring. The projects involve more than 1,300 peer educators, many of them illiterate. Majority of them have developed the capacity for micro planning, outreach, behaviour change communication and programme monitoring.
- We also support several CBOs of female sex workers to implement targeted interventions, including one that is reaching more than 4,000 FSWs in northern Karnataka.

### 1.4.3 Policy analysis, advocacy and communication

We have worked closely with RSACS and KSAPS to develop advocacy programmes that are effective at different levels, ranging from the grassroots, to the senior political level. We have a well-defined advocacy strategy for marginalized groups that includes three main elements:

- Reducing stigma and discrimination;
- Reducing violence and responding effectively to violence;
- Improving access to social entitlements.

To achieve these objectives, we have developed strategies such as media advocacy workshops, large-scale police sensitization programmes and the establishment of crisis response programmes in each district.

For communication, we have employed unique strategies, such as a systematic awareness and education programmes with RSACS at all major fairs and festivals and the use of folk media to mobilize rural populations. We emphasised dialogue-based interpersonal communication techniques with sex workers and MSM.

### 1.4.4 Managing inter-disciplinary teams on complex projects

An assessment of our key personnel reveals that our team brings together strengths from multiple disciplines, including epidemiology and public health, social sciences, demography, medicine and communications. This has allowed us to successfully manage complex projects. This process of engaging multi-disciplinary teams is a hallmark of our approach

### 1.4.5 UP TSU focus areas for RMNCH+A interventions

### High Priority Districts (HPDs) divided into 5 zones

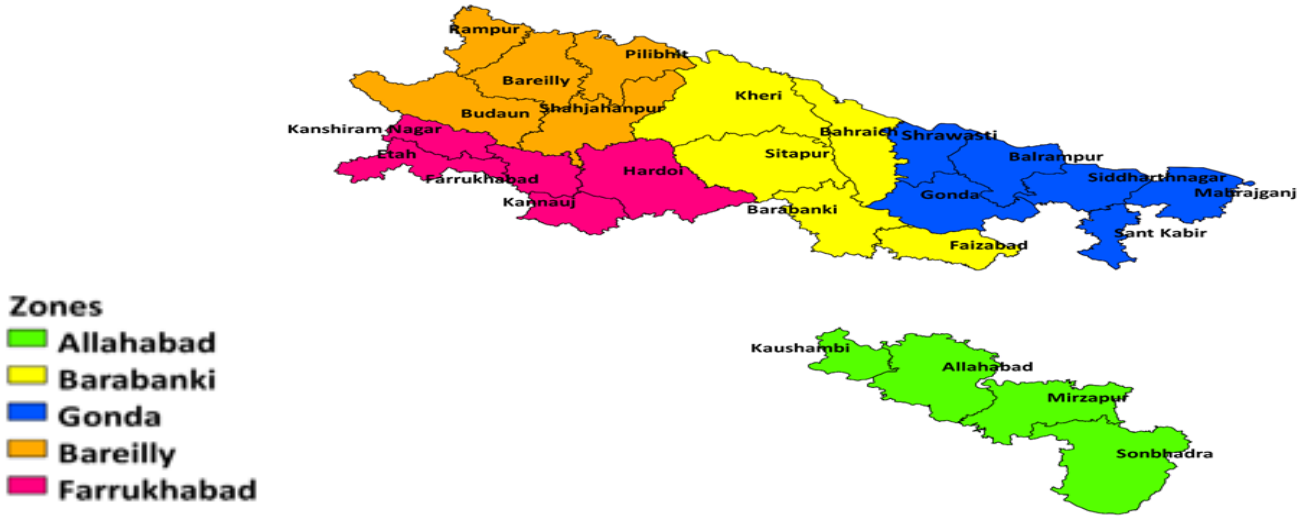
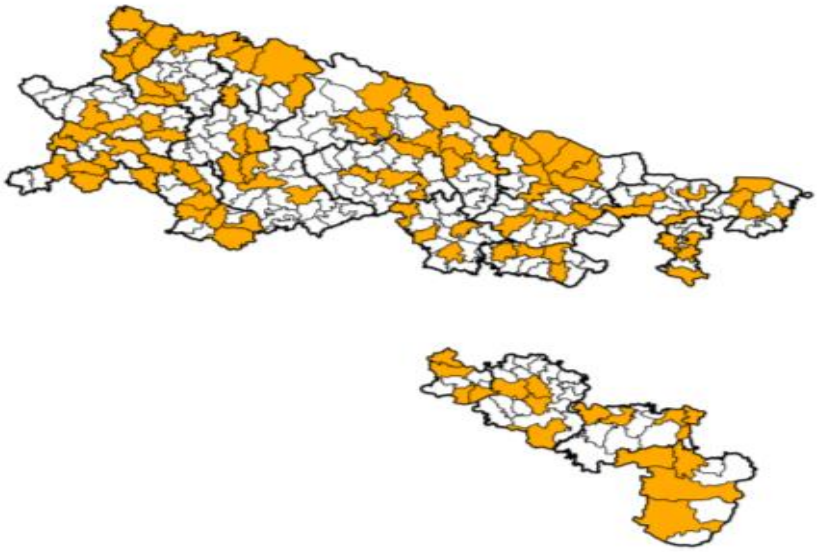



Figure 2 Five zones of HPDs of UP

State population: **200 million**
HPD population: **69 million**
100 Block population: **31 million**
Expected annual number of deliveries
in 100 Blocks**: ~1 million**

### 1.4.6 UP TSU support across all 25 districts of Uttar Pradesh



Specific support systems rolled out in 100 blocks (4 blocks per district) for demonstration (2 with high and other 2 with lower proportion of institutional deliveries) and support the GoUP to diffuse/replicate/adapt beyond the 100 Blocks.

### 1.4.7 UP TSU Framework

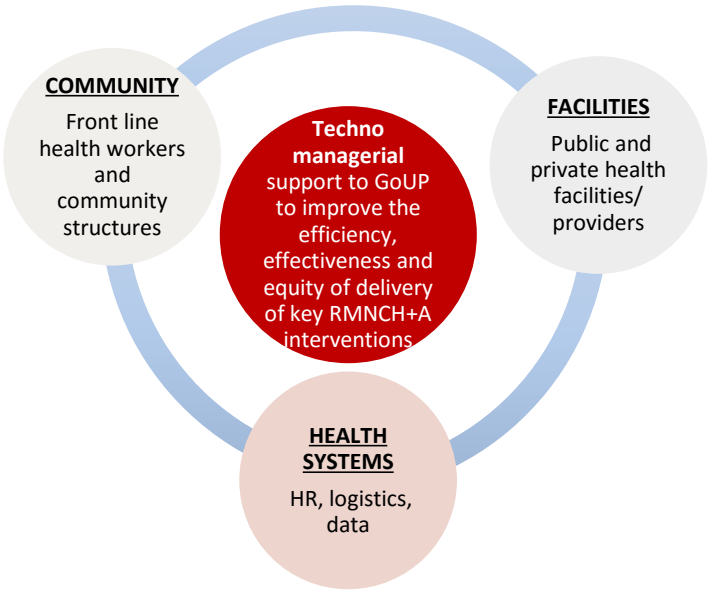



Figure 3 The TSU leverages three platforms to support the government at scale

### 1.4.8 UP TSU Objectives

- Support GoUP in improving the quality and quantity of frontline worker interactions at the community level and within households to drive the priority RMNCH+A behaviours.
- Support GoUP in improving the quality of RMNCH+A services at facilities.
- Support GoUP in improving strategies and systems and systems required to deliver improved frontline workers capabilities and service delivery at primary care facilities.
- Support GoUP in improving its capacity to fund, contract, regulate, mandate private providers.
- Support GoUP in improving the scale and quality of community accountability mechanisms.

### 1.4.9 Strategy for technical support

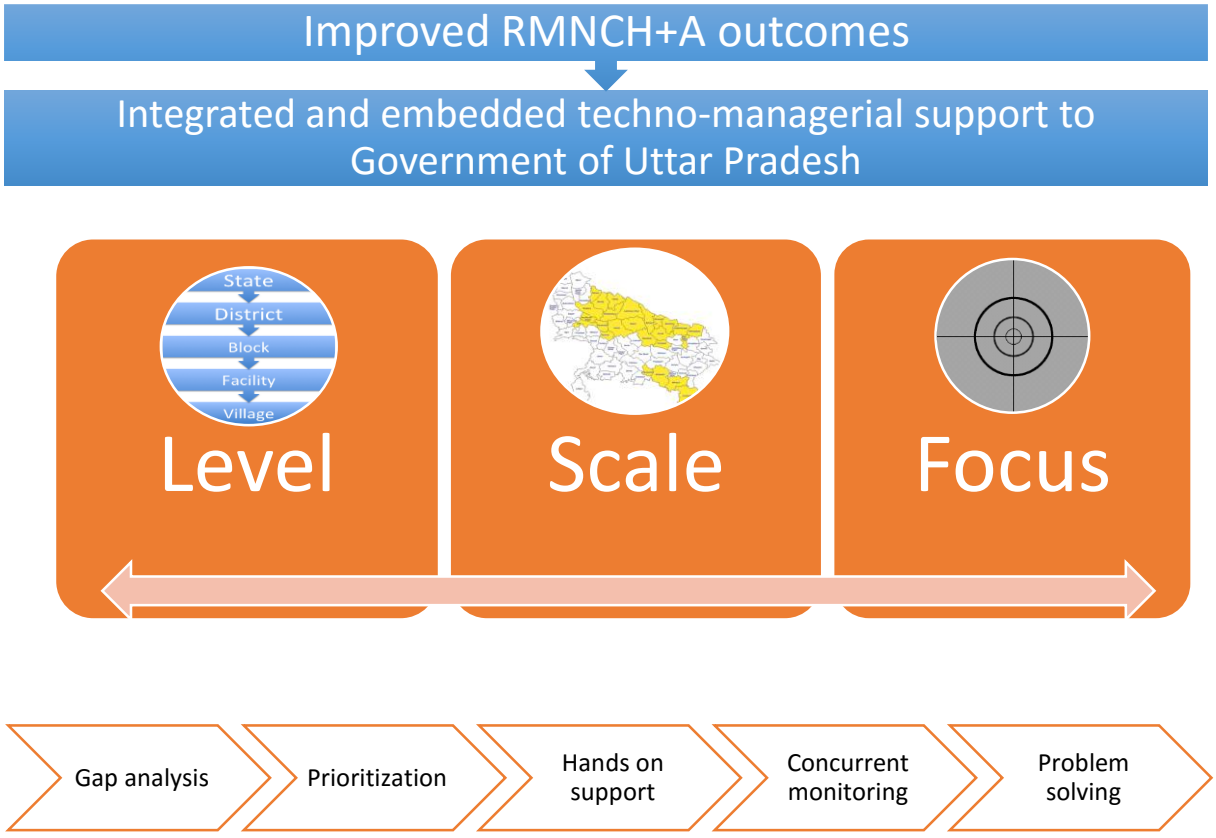



Figure 4 Strategy for Technical Support by UP TSU

### 1.4.10 Integrated Support

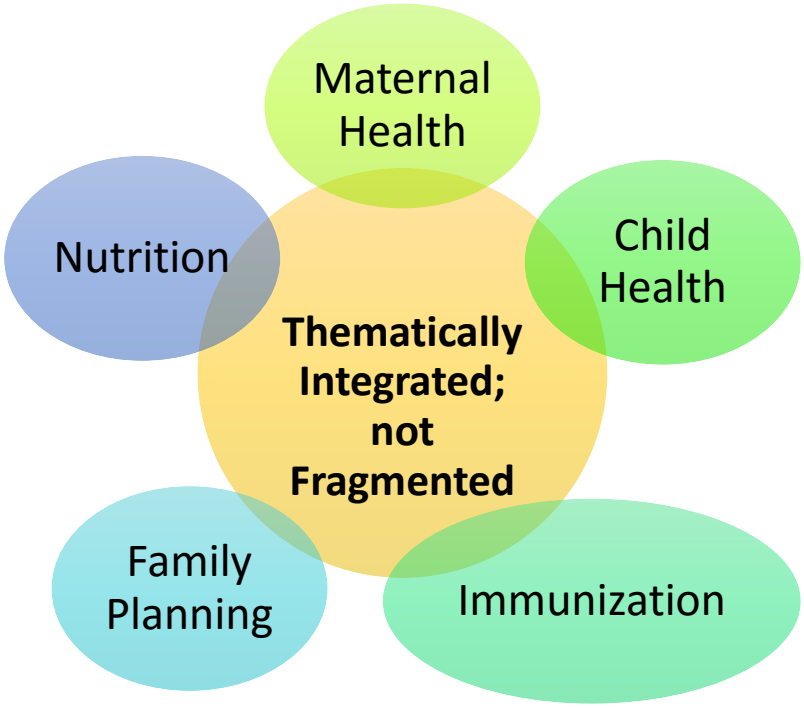
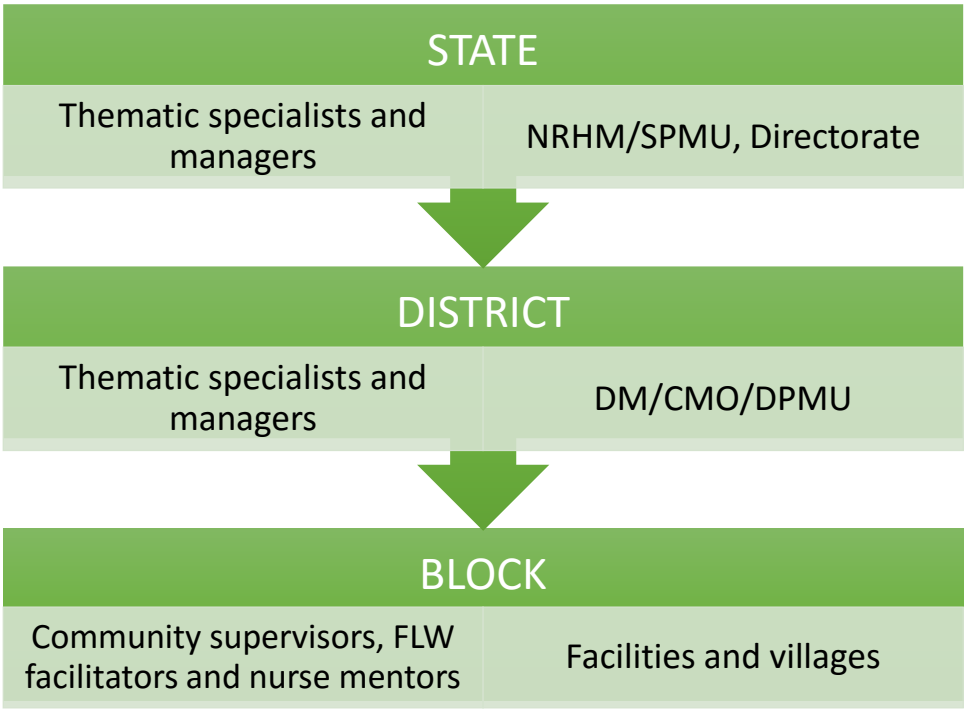



Figure 5 Integrated Support by UP TSU

### 1.4.11 Integration across all levels



## 1.4.12 UP TSU Organogram

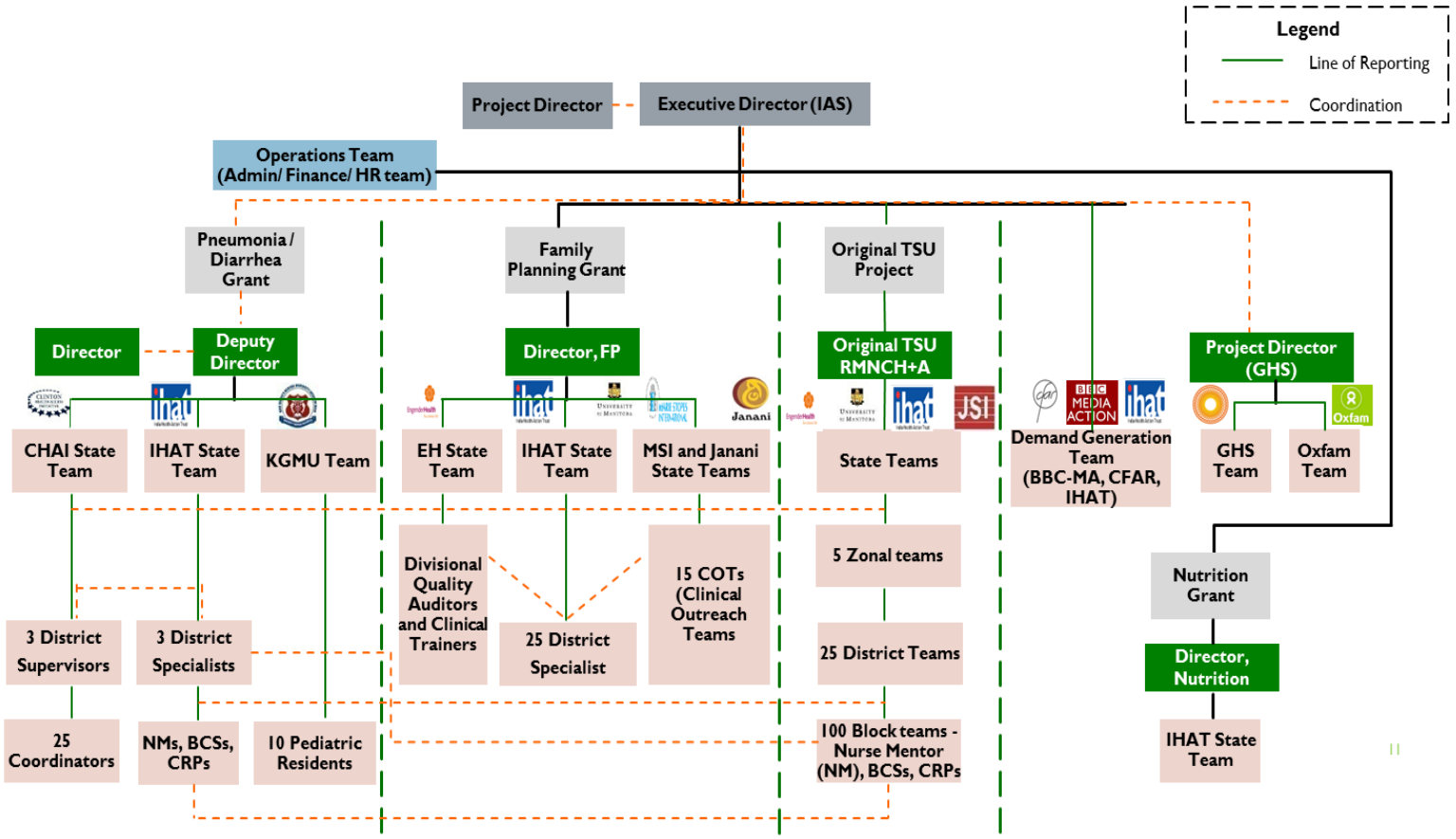



Figure 6 Organogram of UP TSU

### 1.4.13 Co-located support teams at different levels

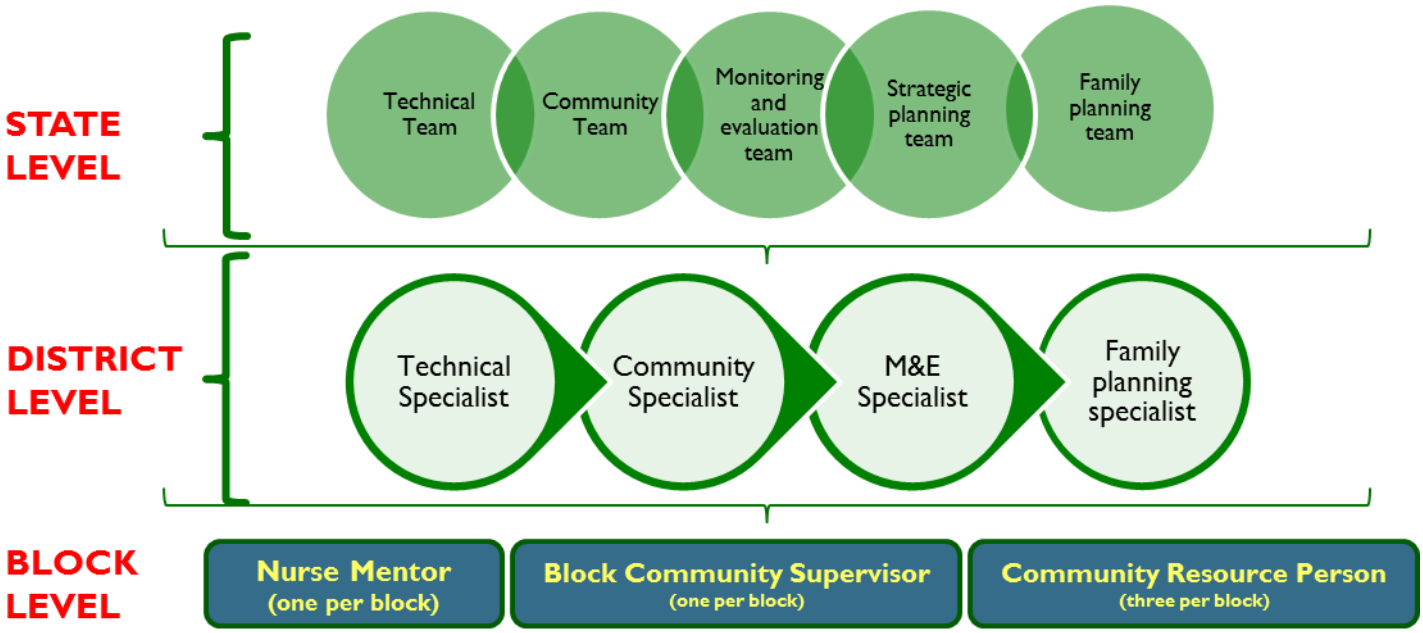



Figure 7 Hierrarche at different levels

### 1.4.14 TSU's engagement with Government

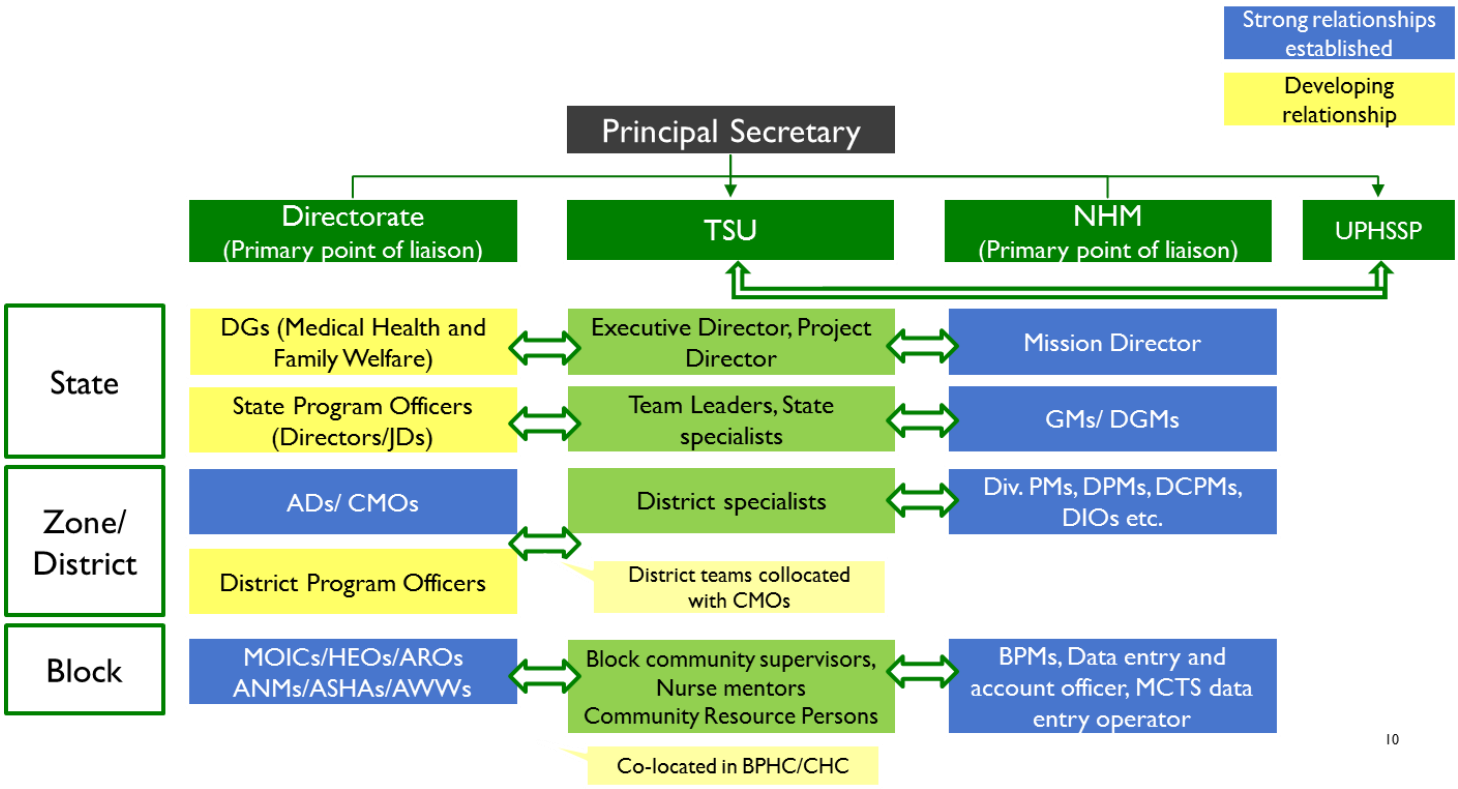



Figure 8 Egagement of TSU with Government

### 1.4.15 Priorities at different Community platforms

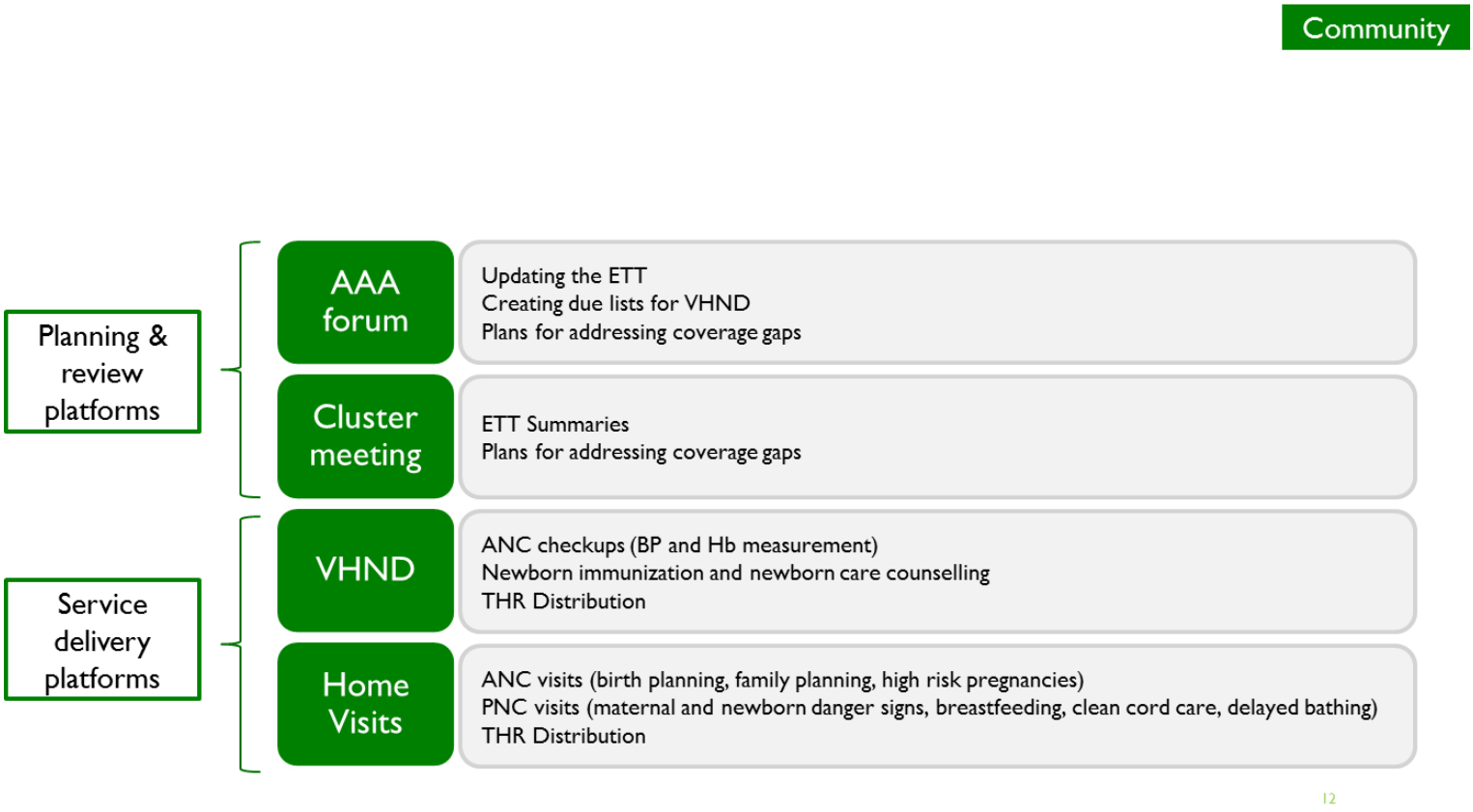



Figure 9 Priorities at different Community platforms

# CHAPTER 2

# A STUDY ON GAP ANALYSIS OF VILLAGE HEALTH AND NUTRITION DAY IN KANNAUJ DISTRICT

## 2.1 Abstract

**Background:**

Village Health and Nutrition Day (VHND) is a community-based health service package delivered on a fixed day approach. Services like early registration of pregnancy, regular antenatal care and postnatal care, growth monitoring and referral of sick children, discussion of health topics to generate awareness, and convergence between health and ICDS, are delivered every month at VHND at the Anganwadi Centre. This study explores the awareness, perception and practice of service providers, and beneficiaries, regarding VHND.

**Aim:**

The study aimed to identify the gaps in the services provided in the VHND sessions and to assess availability of health, nutrition and sanitation services, required instruments/equipment and medicines at VHND sites with client satisfaction from the VHND services.

**Materials and Methods:**

A cross-sectional study was conducted in districts of Kannauj at Uttar Pradesh involving 20 villages in four TSU blocks using multistage stratified sampling using predesigned pretested observation checklists (quantitative data). All the concerned frontline workers and beneficiaries were interviewed (qualitative data) to understand the gap in services and remediation.

**Results:**

Of the 20 VHNDs observed, only at 4 VHND sites electricity was available, total 15 sites where toilet facility was not available out of which only 11% toilet had running water facility. There was a major gap in privacy for ANC which was limited to only 18 %. The availability of Weighing Machine (Infant) is only 5%. The availability of vaccines BCG was present at only 20 %. The frontline workers do not have proper skills to deliver the services. Services relate to immunization are in focus and other services are kept aside.

**Conclusion:**

It is very clearly evident from the results that the services available at VHNDs is very poor and needs immediate attention. The infrastructure is very poor and mostly sites do not have basic facilities like electricity, toilet, and drinking water. Counselling is rarely done. The drugs and

equipment's are not sufficiently available at many VHND sites and if available then the utilization is very poor. The frontline workers do not have proper skills to deliver the services. Services relate to immunization are in focus and other services are kept aside. Overall there is a huge gap in the service delivery at VHNDs sites falls under poor performing zone (red zone), few of them falls under satisfactory performing category and no one fall under the good performing category

## 2.2 Introduction

Government of India launched a program known as Village Health Sanitation and Nutrition Day under this umbrella program was covering all maternal health services including services as well as health education to both age group Adolescent & Pregnant women's.

A proper Anti Natal Care, Intra Natal Care, Post Natal Care, Proper delay management, vaccination, Nutrition supplementation and management on a single platform which was lacking, these all services was coming under various programme because of that a complete of all services to needy women was lacking which was effecting the overall progress of RCH program in country. Village Health and Nutrition Days (VHNDs) are a major initiative under the National Rural Health Mission (NRHM) to improve access to maternal, new-born, child health and nutrition (MNCHN) services at the village level. Across the country, VHNDs are intended to occur in every village level. Village Health and Nutrition Day (VHND), "Mamata Diwas", a concept for interdepartmental convergence having desirable health outcomes of children below five years, is being introduced in the State of Orissa by the Department of Health and Family Welfare. This would provide the first point of contact for essential primary health care and would work as the common platform for convergence amongst service providers of Health, ICDS and the community. Strategically, trainings would be given at State, regional district and sector level to various categories of functionaries. Under the programme, the primary clients are pregnant women, lactating mothers, children below five years and adolescent girls. Basic components of primary healthcare services, including early registration, deworming, counselling on early breastfeeding, identification and referral of high risk cases of children and pregnant women, as well as basic ANC and PNC care will be provided at community level in order to address the essential requirements of pregnancy, delivery, referral, childhood illnesses and adolescent health. The programme would be organized for once a

month in every Anganwadi Centre on a fixed day basis (either Tuesday or Friday) with joint efforts of ANM, AWW and ASHA. On an average, there are six to eight AWCs under the operational jurisdiction of one Sub Centre and thus there would be about eight fixed days in a month per Sub Centre. There should be an advanced fixation of the day with all AWCs for the entire month, so that the service providers and the community are aware of it much in advance.

**2.2.1 Service Package for VHND-** A proper VHND provides following services,

Maternal Health-

Early registration of pregnancies, Focuses ANC, Referral for women with signs of complications during pregnancy and those needing emergency, Referral for safe abortion to approved MTP canters, Counselling on: Education of girls, age at marriage, care during pregnancy, danger signs during pregnancy, birth preparedness, importance of nutrition, institutional delivery, identification of referral transport, availability of funds under the JSSK for referral transport, post-natal care, breastfeeding and complimentary feeding, care of new-born, contraception.

Child Health-

Infants up to 1 year: Registration of new births, counselling for care of new-borns and feeding, complete routine immunization, immunization for dropout children, first dose of vitamin A along with measles vaccine, weighing.

Children aged 1-3 years: Booster dose of DPT/OPV, second to fifth dose of vitamin A, table IFA-(small) to children with clinical anaemia, weighing, provision of supplementary food for grades of mild malnutrition and referral cases for severe malnutrition.

All children below 5 years: Tracking & vaccination of missed children by ASHA and AWW, case management of those suffering from diarrhoea and acute respiratory infections, counselling to all mothers on home management and where to go in even of complications, organising ORS depots at the session site, counselling on nutrition supplementation and balance diet.

Family Planning-

Information on use of contraceptives, Distribution- provision of contraceptive counselling and provision of non-clinic contraceptives such as condoms and OCPs, information on

compensation for loss of wages resulting from sterilization and insurance scheme for family planning.

Reproductive Tract Infections and Sexually Transmitted Infection-

Counselling on prevention of RTIs and STIs, including HIV/AIDS, and referral of cases for diagnosis and treatment, counselling for premenopausal and postmenopausal problems, communication on causation, transmission and prevention of HIV/AIDS and distribution of condoms for dual protection, referral for VCTC and PPTCT services to the appropriate institutions.

Sanitation-

Identification of households for the construction of sanitary latrines, guidance on where to go and who to approach for availing of subsidy for those eligible to get the same under the total sanitation campaign, avoidance breeding sites of mosquitoes.

Communicable Diseases-

Group communication activities for raising awareness about signs and symptoms of leprosy, suspected cases and referrals, awareness generation about symptoms of TB, provision of anti-TB drugs to patients.

Gender-

Communication activities for prevention of pre-natal sex selection, illegality of prenatal sex selection & special alert for one daughter families, communication on the prevention of violence against women, domestic violence act,2006, age at marriage, especially the importance of raising the age at marriage for girls.

# CHAPTER 3

# REVIEW OF LITERATURE

## 3.1 Review Of Literature-

- The 1978 Alma Ata declaration of highlighted the importance of Primary Health Care and critical role played by Community Health Workers (CHW) to link communities to the health system. The use of community members to render certain basic health services to their communities is a concept that has existed for the last 50 years. There have been innumerate experiences throughout the world with programme ranging from large scale, national programmes to community based initiatives.

- Sessions like VHND are organized, in the village at a fixed day, place and time through convergent actions by the departments of health and the department of women and child development. Due to inadequate dissemination of guideline for conducting the outreach sessions, health workers' often locked clarity in understanding their role.

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

- In India VHND is a priority intervention under the National Rural Health Mission (NRHM), Government of India which are emerged from attempts to increase coverage of basic health and nutrition services in rural areas not served by health facilities.

- According to a rapid 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 functions show that quality of interaction during VHND sessions is not up to the mark. This has an impact on the participation on the community in VHND. Quality entails a number of aspects- 1)involvement of the organizations(frontline workers from health , ICDS, panchayat functionaries and involvement of community institutions), 2) common understanding among all stakeholders about how VHND is to be organised and services that are to be offered,3) pre-service mobilization and post service follow up, 4)publicity and preparation for the VHND and 5)instruments and required equipment for VHND, 6)motivation amongst FLWs due to over worked schedules) information's during sessions.

- Inter-sectorial convergence between Health and Nutrition activities is the focus of the Village Health Nutrition Day (VHND) program under NRHM of the Ministry of health and family welfare, Government of India. The ASHAs, Anganwadi Workers, Auxiliary Nurse Midwives and the Panchayati Raj Institute members, work as a team to ensure that services are provided by

VHND. The case can be used to discuss the challenges in convergence between various government departments in planning the services tom be offered on the VHND, generation demand for the services through IEC/counselling and actually providing services on the VHND.

# CHAPTER 4

# RESEARCH METHODOLOGY

## 4.1 Research Methodology

**4.1.1 STUDY TYPE :** The study will be conducted at four blocks of Kannauj district (Uttar Pradesh) with a sample size of 20 respondents through a cross sectional survey.

**4.1.2 STUDY PERIOD :** 3 month

**4.1.3 STUDY RESPONDENTS :** The respondents for the following are front line workers (ANM, ASHA and AWW) at the various VHND site.

**4.1.4 SAMPLE METHOD :** The method followed for the study would be simple random sampling. From every PHC area, 2 sub centres will be selected and 4 VHND sessions will be selected from each sub centre area. The sample will be decided from the micro plan available at block. Simple random sampling method will be applied for selecting the VHND sites from the micro plan.

**4.1.5 SAMPLE SIZE :**A sample size of 20 will be taken. VHND is conducted on Wednesday and Saturday of every week. If 1 VHND site are visited every Wednesday and 1 sites every Saturday, 8 VHND sites can be assessed in a month. In a time period of 3 months, 24 VHND sites can be visited. Leaving public holidays aside a sample size of 20 can be taken.

**4.1.6 DATA COLLECTION TECHNIQUE :** Face to face interview and direct observation.

**4.1.7 DATA COLLECTION TOOL :** Structured Questionnaire

## 4.2 Research Question-

- What are the gaps at the Village Health Nutrition Day services at village level?

# CHAPTER 5

# RATIONALE

## 5.1 Rationale

Village Health and Nutrition Day is an initiative taken under NRHM, with a prime motto to deliver basic health services to the last person in the community. The data shows that health service provision has fairly improved but the aim of the program is yet to be achieved. The current study is aimed at understanding the gaps, barriers and challenges that are existing in service delivery at VHNDs at a Kannauj block in Kannauj district of UP.

# CHAPTER 6

# OBJECTIVES

## 6.1 General Objective

- To identify the gaps in the services provided in the VHND sessions and to assess availability of health, nutrition and sanitation services, required instruments/equipment and medicines at VHND sites with client satisfaction from the VHND services.

## 6.2 Specific Objectives

- To identify the facilities available at VHND sites.
- To find out the presence of frontline workers.
- To understand the counselling services available at VHND sites.
- To get the status of availability of food and THR at the VHND sites.
- To identify the availability of equipment's and there utilization status at the VHND sites
- To find out the availability of drugs at VHND sites
- To check the status of availability of vaccines at VHND sites
- To understand the data collection & maintenance of the data at VHND sites

# CHAPTER 7

# NEED OF THE STUDY

## 7.1 Scope of the Study :

Facilities available at VHND sites, Presence of frontline workers, Counselling services available at VHND sites, availability of food and THR at the VHND site, availability of equipment's at the VHND sites, utilization of equipment's, availability of drugs at VHND sites, availability of vaccines at VHND sites, availability of records and registers at VHND sites.

## 7.2 Use of the study :

After the study based on the lessons learned recommendations and way forward will be suggested for improving the quality of the the service by supportive supervision at VHND sessions, capacity building of frontline workers, strengthening monitoring and motivate the workers to perform better by introducing an award for best VHND site.

# CHAPTER 8

# DATA ANALYSIS

A sample of 20 VHNDs is selected for data collection.

Sample represents the whole population.

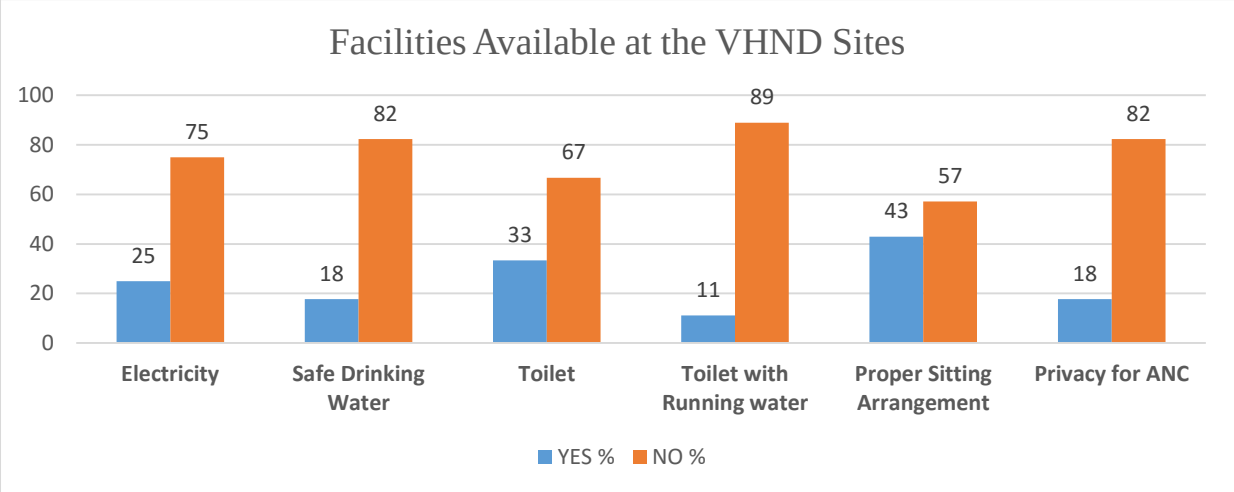
The data is collected in a structured questionnaire format.

Data is analysed through MS excel. After analysing the data of 20 VHND sites throughout four TSU blocks of Kannauj district the major findings are clubbed under various heads are presented as below:

**Table 8.1 Facilities Available at VHND Sites**

| SL No | Facilities Available at the VHND Sites | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| a. | Electricity | 4 | 16 | 25 | 75 |
| b. | Safe Drinking Water | 3 | 17 | 18 | 82 |
| c. | Toilet | 5 | 15 | 33 | 67 |
| d. | Toilet with Running water | 2 | 18 | 11 | 89 |
| e. | Proper Sitting Arrangement | 6 | 14 | 43 | 57 |
| f. | Privacy for ANC | 3 | 17 | 18 | 82 |

**Figure 8.1 Bar Graph showing the percentage of various facilities available at VHND sites**

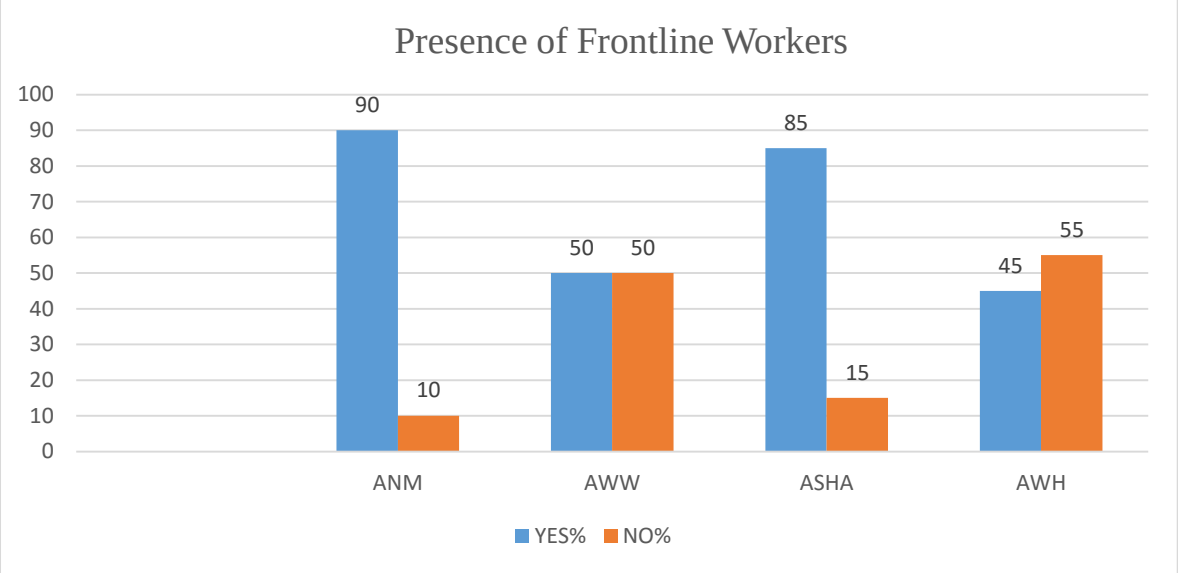



Here table 8.1 is presenting the availability of facilities at the VHND sites. Out of 20 VHND sites only at 4 VHND sites electricity was available. There was all total 15 sites where toilet facility was not available out of which only 11 percent toilet had running water facility. Safe drinking was available only at 3 sites. There was a major gap in privacy for ANC which was limited to only 18 percent of the VHND sites visited.

**Table 8.2 Presence of Frontline Workers**

| SL NO. | Presence of Frontline Workers | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| a. | ANM | 18 | 2 | 90 | 10 |
| b. | AWW | 10 | 10 | 50 | 50 |
| c. | ASHA | 17 | 3 | 85 | 15 |
| d. | AWH | 9 | 11 | 45 | 55 |

**Figure 8.2 Bar Graph showing the percentage of presence of Frontline Workers at VHND sites**

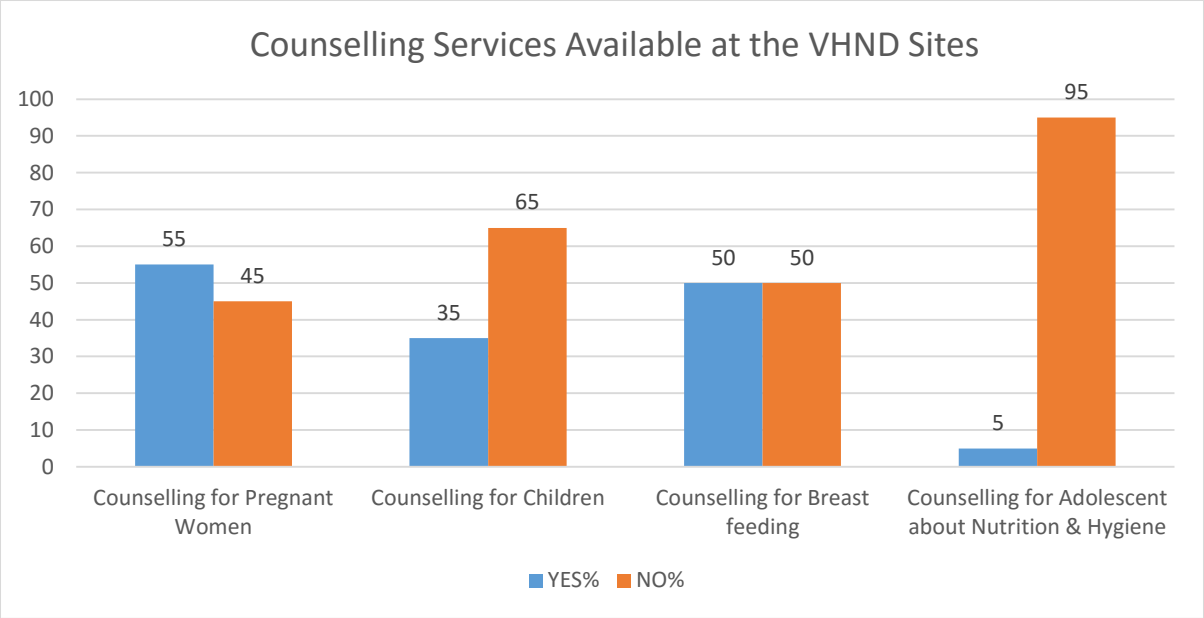



The above table and figure shows the presence of frontline workers (ANM, AWW, AWH, and ASHA). Within all 20 VHND sites the presence of ANM was 90 percent, AWW presence was 50 percent. On the other hand in 85 percent sites ASHA was present and only in 45 percent VHND sites AWH were present.

**Table 8.3: Counselling Services Available at the VHND Sites**

| SL NO | Counselling Services Available at the VHND Sites | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| a. | Counselling for Pregnant Women | 11 | 9 | 55 | 45 |
| b. | Counselling for Children | 7 | 13 | 35 | 65 |
| c. | Counselling for Breast feeding | 10 | 10 | 50 | 50 |
| d. | Counselling for Adolescent about Nutrition & Hygiene | 1 | 19 | 5 | 95 |

**Figure 8.3: Bar Graph showing that percentage of Counselling Services available at VHND sites**



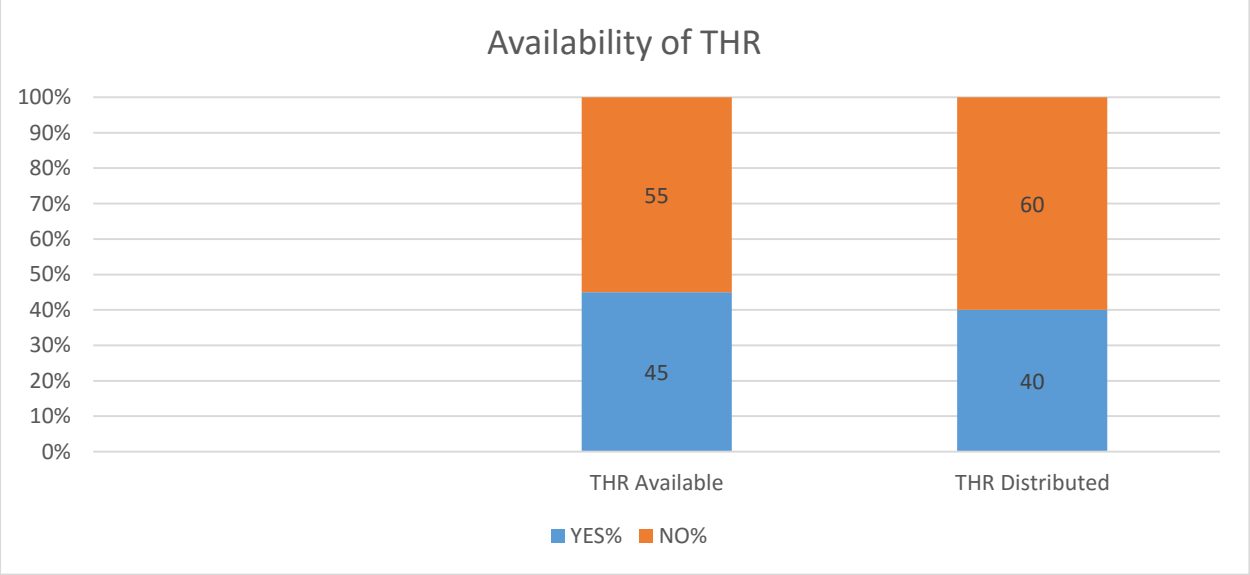

The above table and figure shows the counselling services provided at the VHND sites. Out of the 20 VHND sites visited, counselling services for pregnant woman, children and breast feeding were provided at only around half of those sites (55 percent, 35 percent and 50 percent

respectively). Counselling services to adolescents about nutrition and hygiene was rarely provided at the VHND sites (5 percent). This was a major concern.

**Table 8.4: Availability of THR at the VHND Sites**

| SL NO | Availability of THR | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| a. | THR Available | 9 | 11 | 45 | 55 |
| b. | THR Distributed | 8 | 12 | 40 | 60 |

**Figure 8.4: A Bar Graph showing that the availability of THR at the VHND Sites**

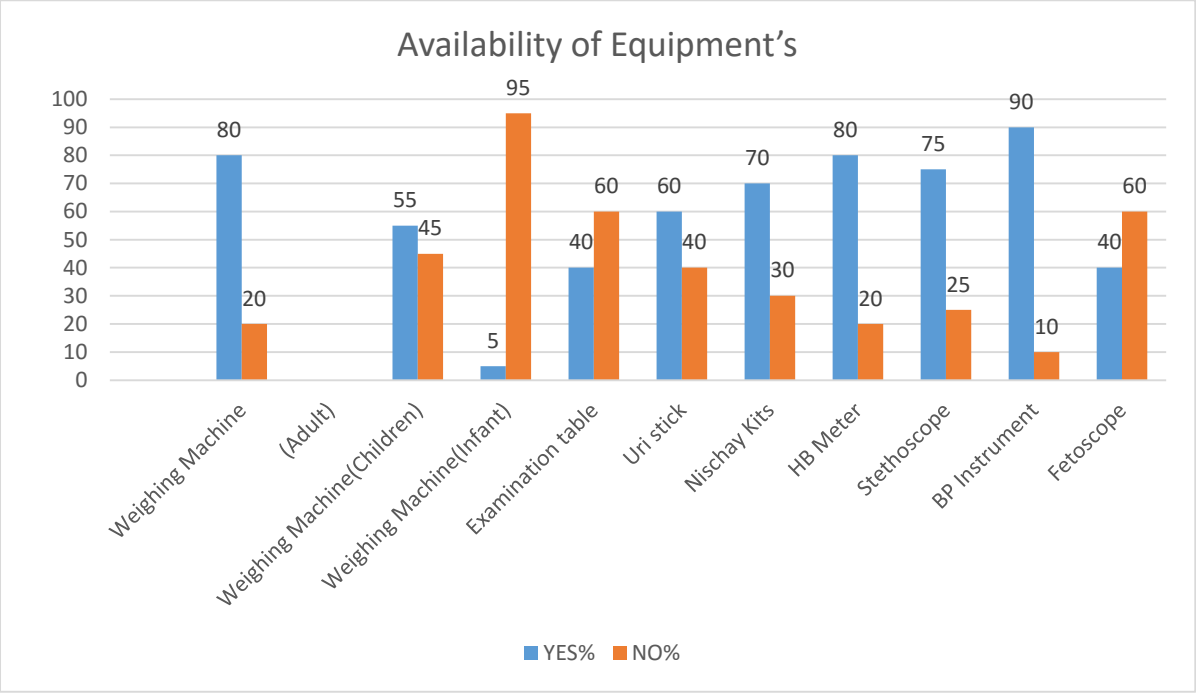



The above table and figure shows the availability of THR at the VHND site. Among the 20 VHND sites visited, THR was not available at 55 percent and not distributed at 60 percent of these VHND sites. THR is a step taken to full fill the nutritional need of the community and hence it is identified as a major gap at the VHND sites as nutrition is a major component of the program.

**Table 8.5: Availability of Equipment's at VHND sites**

| SL NO | Availability of Equipment's | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| a. | Weighing Machine (Adult) | 16 | 4 | 80 | 20 |
| b. | Weighing Machine(Children) | 11 | 9 | 55 | 45 |
| c. | Weighing Machine(Infant) | 1 | 19 | 5 | 95 |
| d. | Examination table | 8 | 12 | 5 | 95 |
| e. | Uri stick | 12 | 8 | 40 | 60 |
| f. | Nischay Kits | 14 | 6 | 60 | 40 |
| g. | HB Meter | 16 | 4 | 70 | 30 |
| h. | Stethoscope | 15 | 5 | 80 | 20 |
| i. | BP Instrument | 18 | 2 | 75 | 25 |
| j. | Fetoscope | 8 | 12 | 90 | 10 |

**Figure 8.5: Bar Graph showing that the percentage of availability of Equipment's at VHND sites**



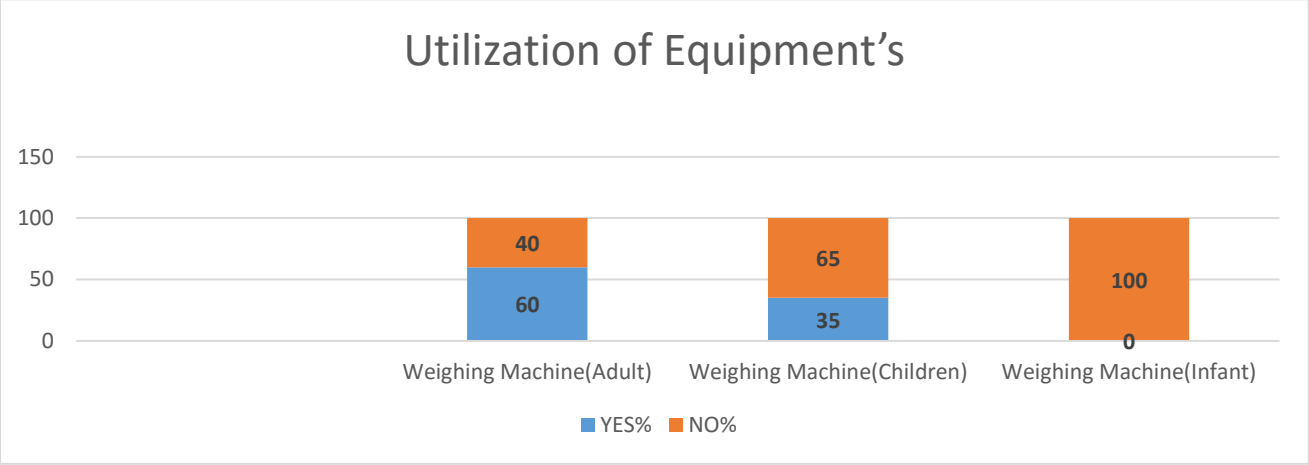

The above table and figure shows the availability of equipment's which are supposed to be present in sufficient quantity at various VHND sites as per the guidelines. The weighing machine for adult, children and infant were present at 80, 55 and 5 percent of the VHND sites visited. The other equipment's like examination table, Uri stick, nischay kits, HB meter were present at 40, 60, 70 and 80 percent at VHND sites. On the other hand stethoscope, BP instrument and fetoscope present at 75, 90 and 40 percent sites.

**Table 8.6: Utilization of Equipment's at VHND sites**

| SL NO | Availability of Equipment's | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| a. | Weighing Machine(Adult) | 12 | 8 | 60 | 40 |
| b. | Weighing Machine(Children) | 7 | 13 | 35 | 65 |
| c. | Weighing Machine(Infant) | 0 | 20 | 0 | 100 |
| d. | Examination table | 2 | 18 | 10 | 90 |
| e. | Uri stick | 6 | 14 | 30 | 70 |
| f. | Nischay Kits | 7 | 13 | 35 | 65 |
| g. | HB Meter | 13 | 7 | 80 | 20 |
| h. | Stethoscope | 9 | 11 | 70 | 30 |
| i. | BP Instrument | 15 | 5 | 0 | 100 |
| j. | Fetoscope | 1 | 19 | 10 | 90 |

Although there were sites where many equipment's are present but rarely in use for different reasons like lack training to use the equipment, unwillingness to use the instrument or maybe they had fear of damaging the equipment, resistance from the community on using the equipment's etc.

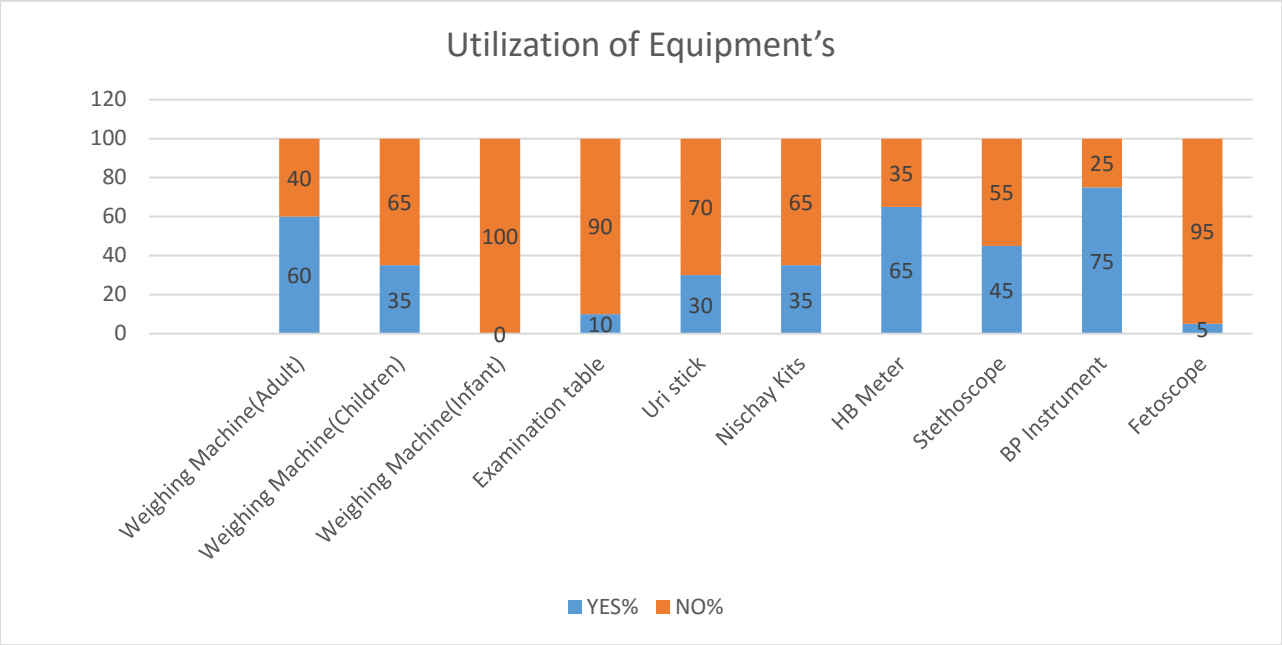
**Figure 8.6. Bar Graph showing that the percentage of utilization of weighing machine at VHND sites**




The above figure shows the availability and usage of the weighing machines at VHND sites. Among 80 percent of available adult weighing machines only 60 percent are actually being used. Similarly, among 55 percent of available children weighing machines only 35 percent were in used whereas among 5 percent of infant weighing machines none are being used.

For better understanding a comparison of equipment's present and equipment's used at the VHND sites has been done.

**Figure 8.7. Bar Graph showing that the percentage of utilization of Equipment's at VHND sites**




Above figure shows the availability and usage of equipment's like stethoscope, BP instrument and fetoscope at VHND sites. Among 80 percent sites where stethoscope was available but only at 45 percent sites were using it serve the purpose. There were 75 percent sites where BP instrument was available but utilization was in 75 percent sites. Fetoscope utilization was seen only 5 percent sites. From figure 6 and 7 is clearly evident that there is a huge gap in availability and utilization of the equipment's at the VHND sessions.

**Table 8.7: Availability of Drugs at VHND Sites**

| SL NO | Availability of Drugs | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| a. | OCP | 7 | 13 | 35 | 65 |
| b. | Condoms | 12 | 8 | 60 | 40 |
| c. | IFA for Adults | 16 | 4 | 80 | 20 |
| d. | IFA for Children | 10 | 10 | 50 | 50 |
| e. | Iron Syrups | 17 | 3 | 85 | 15 |
| f. | ORS | 18 | 2 | 90 | 10 |
| g. | Zinc Tab | 16 | 4 | 80 | 20 |
| h. | VIT A TAB | 14 | 6 | 70 | 30 |
| i. | Cloroquine | 13 | 7 | 65 | 35 |
| j. | Albendazole | 15 | 5 | 75 | 25 |
| k. | Paracetamol | 18 | 2 | 90 | 10 |
| l. | Calcium Citrate | 15 | 5 | 75 | 25 |

| | | | | | |
|---|---|---|---|---|---|
| m. | Methylcobalamin | 3 | 17 | 15 | 85 |
| n. | Cloroquine IE Ointment | 6 | 14 | 30 | 70 |
| o. | Cotton Bandage | 8 | 12 | 40 | 60 |
| p. | Cotton Swab | 14 | 6 | 70 | 30 |

**Figure 8.8: Bar Graph showing that the percentage of availability of Drugs at VHND Sites**

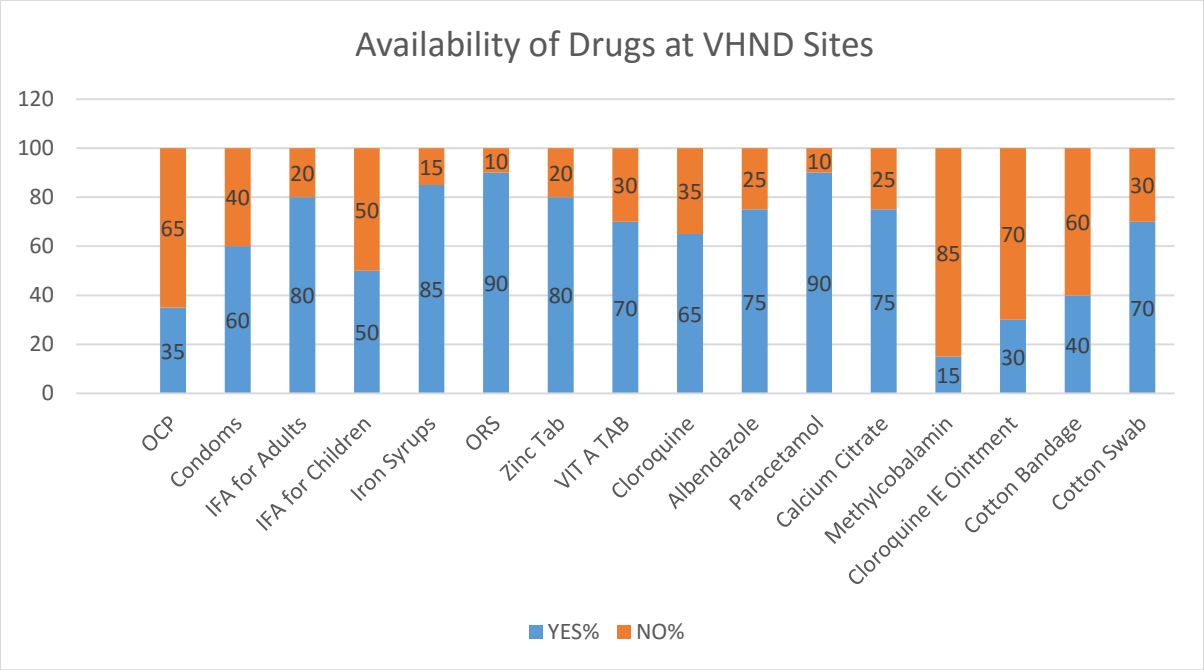
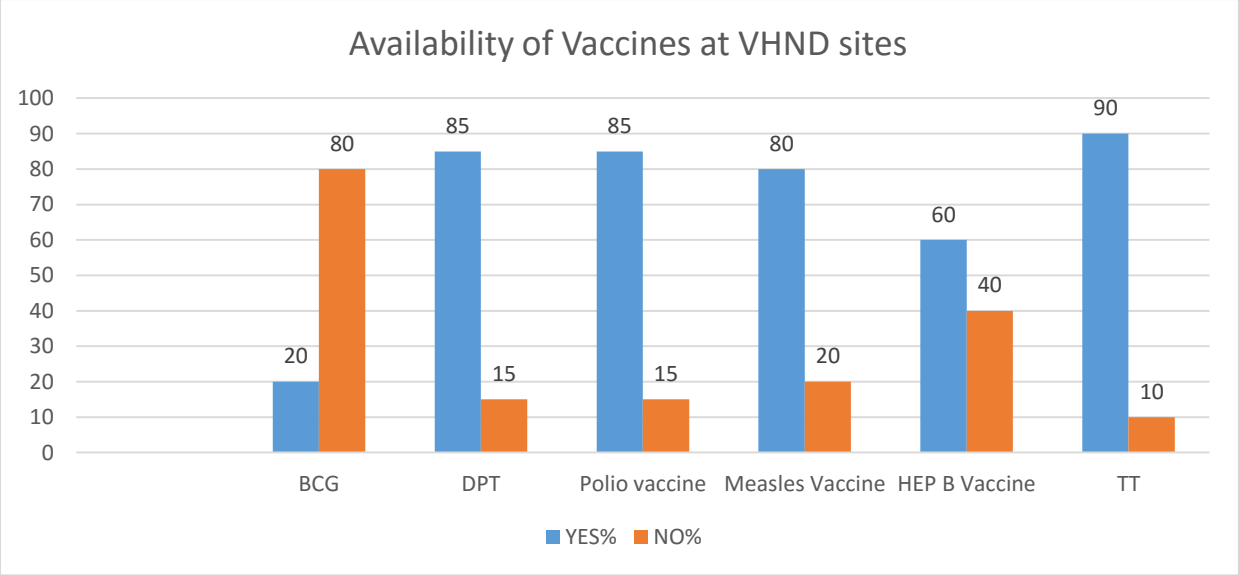


**Table 8.8: Availability of Vaccines at VHND Sites**

| SL NO | Availability of Vaccines | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| a. | BCG | 3 | 17 | 20 | 80 |
| b. | DPT | 17 | 3 | 85 | 15 |
| c. | Polio vaccine | 17 | 3 | 85 | 15 |
| d. | Measles Vaccine | 16 | 4 | 80 | 20 |
| e. | HEP B Vaccine | 12 | 8 | 60 | 40 |
| f. | TT | 18 | 2 | 90 | 10 |

The above table shows the availability of drugs at the VHND sites. A huge gap seen in the availability of drugs at many VHND sites. There were few sites where were scarce in quantity. ORS and paracetamol were present at 90 percent of the sites in sufficient quantity.

**Figure 8.9: Bar Graph showing that the percentage of availability of Vaccines at VHND Sites**

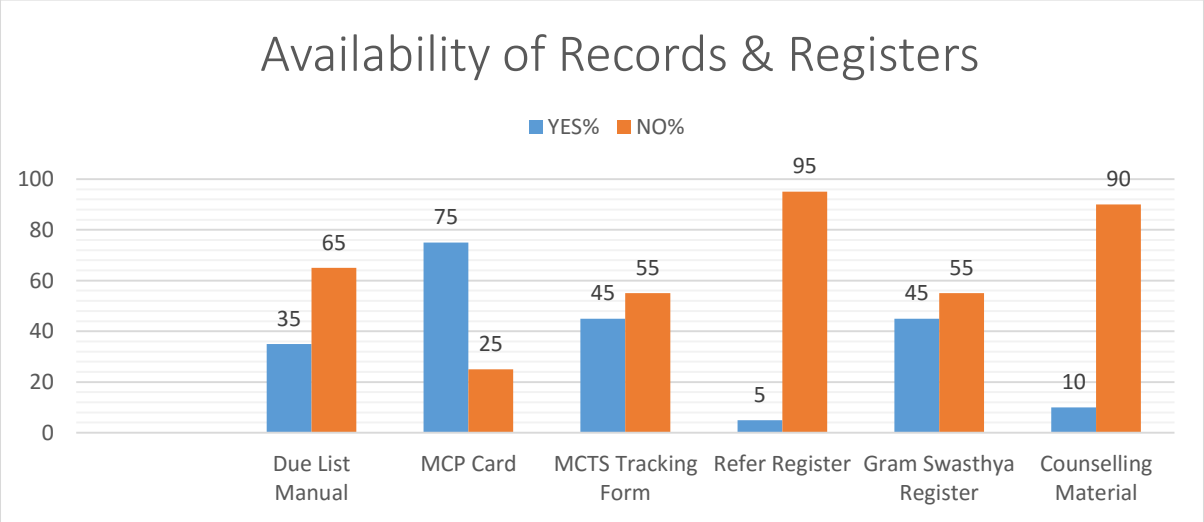



The above table and figure shows the availability of vaccines at the VHND sites. BCG was present at only at 20 percent of the sites visited. The reason of such less number of BCG was because of very few beneficiary at VHND. DPT, Polio and TT were present at almost all the sites the percent was 85, 85 and 90 accordingly. Measles was present at 80 percent of the sites and Hep B vaccine was present at 60 percent of the sites.

**Table 8.9: Availability of Records & Registers**

| SL NO | Availability of Records & Registers | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| a. | Due List Manual | 7 | 13 | 35 | 65 |
| b. | MCP Card | 15 | 5 | 75 | 25 |
| c. | MCTS Tracking Form | 9 | 11 | 45 | 55 |
| d. | Refer Register | 1 | 19 | 5 | 95 |
| e. | Gram Swasthya Register | 9 | 11 | 45 | 55 |
| f. | Counselling Material | 2 | 18 | 10 | 90 |

**Figure 8.10: Bar Graph showing that the percentage of availability of Records & Registers at VHND sites**

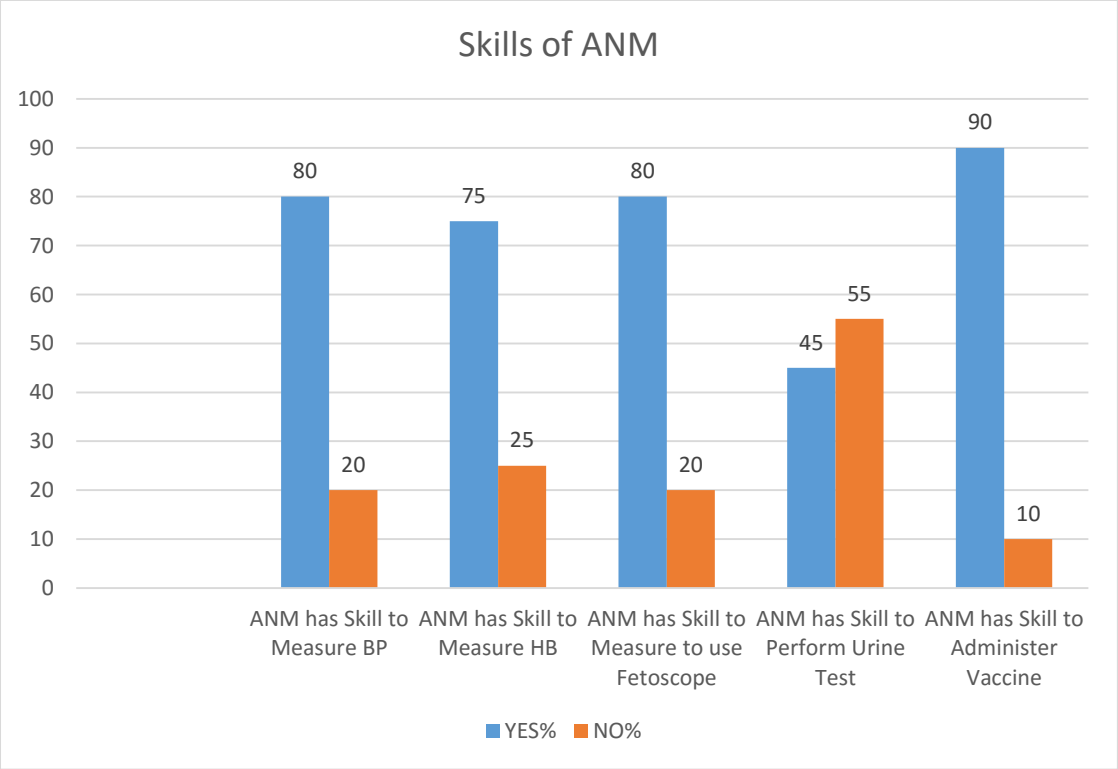



The above table and figure shows that the availability of records and registers. Due list was available at 35 percent of the sites. MCP card. MCTS training form and Gram swasthya register were available at 75, 45 percent of the sites respectively. Refer register and counselling material was rarely available at the VHND sites visited.

**Table 8.10: Skills of ANM**

| SL NO | Skills of ANM | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| a. | ANM has Skill to Measure BP | 16 | 4 | 80 | 20 |
| b. | ANM has Skill to Measure HB | 15 | 5 | 75 | 25 |
| c. | ANM has Skill to Measure to use Fetoscope | 16 | 4 | 80 | 20 |
| d. | ANM has Skill to Perform Urine Test | 9 | 11 | 45 | 55 |
| e. | ANM has Skill to Administer Vaccine | 18 | 2 | 90 | 10 |

**Figure 8.11: Bar Graph showing that the skills of ANM at VHND sites**



The previous page table and figure shows the skills of ANM to deliver services at VHNDs, 20 percent of the sites visited had ANM who do not know how to measure BP, 25 percent had ANM who do not know the proper way of HB estimation, 20 percent ANM who do not know how to use a fetoscope and only 45 percent ANM know that how to perform urine test. 10 percent had ANM who were not aware of the way to administer vaccine. There seems to a huge gap here as the service provider should possess all the important skill in order to improve the quality of service.

## SCORE CARD OF VHNDs

To measure the performance of VHNDs, it was assured by a checklist and mapped on this scale.

Less than 60%- Poor performance (Red Zone)

60%-80%- Satisfactory performance (Yellow zone)

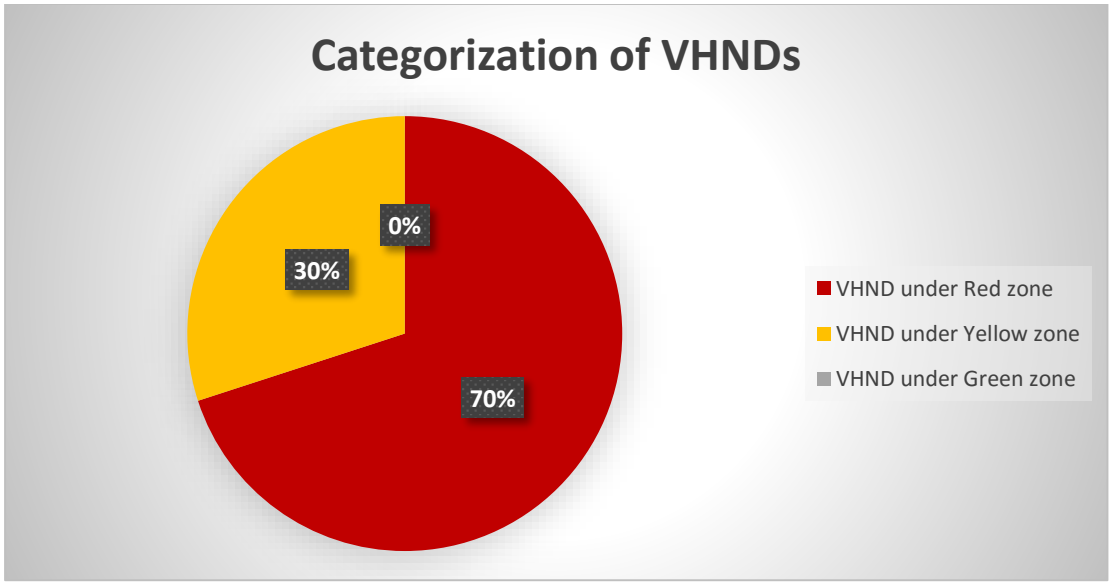
More than 80%- Good performance (Green zone)

**Table 8.11: Performance on the basis of colour coding**

| Categorization of VHNDs | In whole no | In percentage |
|---|---|---|
| Total VHNDs | 20 | 100% |
| VHND under Red zone | 14 | 70 |
| VHND under Yellow zone | 6 | 30 |
| VHND under Green zone | 0 | 0 |

It was observed that out of 20 VHND sites assured during the study, most of them fell under red zone 70 percent, a few under Yellow zone 30 percent and none under the Green zone.

**Figure 8.12 : A pie chart showing the performance of the VHND sites based on the colour coding.**



# CHAPTER 9

# DISCUSSION

## DISCUSSION

The objective of the study was to observe and find out the gaps in the service delivery at VHNDs in Kannauj district and compare some parameters with VHND guidelines. Study type is cross sectional study and total 20 VHND sites data was collected. The sampling method was simple random sampling from 1 PHC area 4 Sub Centers was taken 2 VHND sessions was selected from each sub center area. The sample was decided from the micro plan available at block. Simple random sampling method applied for selecting the VHND sites from the micro plan. Data collection technique was direct observation. Data collection tool was structured questionnaire and data analysis done in MS Excel.

Out of 20 VHND sites only at 4 VHND sites electricity was available. There was all total 15 sites where toilet facility was not available out of which only 11 percent toilet had running water facility. Safe drinking was available only at 3 sites. There was a major gap in privacy for ANC which was limited to only 18 percent of the VHND sites visited.

Within all 20 VHND sites the presence of ANM was 90 percent, AWW presence was 50 percent. On the other hand in 85 percent sites ASHA was present and only in 45 percent VHND sites AWH were present.

Counselling services for pregnant woman, children and breast feeding were provided at only around half of those sites (55 percent, 35 percent and 50 percent respectively). Counselling services to adolescents about nutrition and hygiene was rarely provided at the VHND sites (5 percent). This was a major concern.

The weighing machine for adult, children and infant were present at 80, 55 and 5 percent of the VHND sites visited. The other equipment's like examination table, Uri stick, nischay kits, HB meter were present at 40, 60, 70 and 80 percent at VHND sites. On the other hand stethoscope, BP instrument and fetoscope present at 75, 90 and 40 percent sites.

Although there were sites where many equipment's are present but rarely in use for different reasons like lack training to use the equipment, unwillingness to use the instrument or maybe they had fear of damaging the equipment, resistance from the community on using the equipment's etc.

Among 80 percent sites where stethoscope was available but only at 45 percent sites were using it serve the purpose. There were 75 percent sites where BP instrument was available but utilization was in 75 percent sites. Fetoscope utilization was seen only 5 percent sites. From figure 6 and 7 is clearly evident that there is a huge gap in availability and utilization of the equipment's at the VHND sessions.

The reason of such less number of BCG was because of very few beneficiary at VHND. DPT, Polio and TT were present at almost all the sites the percent was 85, 85 and 90 accordingly. Measles was present at 80 percent of the sites and Hep B vaccine was present at 60 percent of the sites. VHNDs, 20 percent of the sites visited had ANM who do not know how to measure BP, 25 percent had ANM who do not know the proper way of HB estimation, 20 percent ANM who do not know how to use a fetoscope and only 45 percent ANM know that how to perform urine test. 10 percent had ANM who were not aware of the way to administer vaccine. There

seems to a huge gap here as the service provider should possess all the important skill in order to improve the quality of service.

# CHAPTER 10

# CONCLUSION AND RECOMMENDATIONS

# CONCLUSION & RECOMMENDATIONS

It is very clearly evident from the results that the services available at VHNDs is very poor and needs immediate attention. The infrastructure is very poor and almost 90 percent of sites do not have basic facilities like electricity, toilet, and drinking water. Counselling is rarely done. The drugs and equipment's are not sufficiently available at many VHND sites and if available then the utilization is very poor. The frontline workers do not have proper skills to deliver the services. Services relate to immunization are in focus and other services are kept aside. Overall there is a huge gap in the service delivery at VHNDs as 70 percent of the VHND sites fall under poor performing zone (red zone), 30 percent fall under satisfactory performing category and zero percent fall under the good performing category. There is a need to fill the gaps present at the VHND sites and for the following steps need to be taken:

- Supportive supervision and on the spot training at VHND sessions.
- Capacity building of frontline workers and frequent training of the same.
- Proper planning and implementation of VHNDs.
- Strengthening monitoring and supervision of VHNDs.
- Community awareness and proper IEC should also be done to encourage health seeking behaviour among the masses.
- Mobile VHND concept.
- Motivate the workers to perform better by introducing an award for the best VHND site (Model VHND)
- AAA meeting platform should be properly utilize, it will help to develop the coordination between ASHA, Anganwadi worker and ANM. So main moto behind VHND will be fulfilled.

The three of us always follow a list (of mothers and children needing services) in advance. We also inform people in advance. We ensure that there is supplementary nutrition, a weighing scale, growth scale, growth charts, immunizations, are available."

**ANM Focus Group Discussion**

"We (AWWs), along with ANMs, weight children and prepare growth charts. Growth charts are kept at the AWC. The Anganwadi Helper informs the beneficiaries about the VHND sessions and reminds them to come on time."

**AWW, Focus Group Discussion**

"The ANM does health check-ups of those present and carries out immunizations. The AWW, mainly gives supplementary nutrition and counsels mothers of malnourished children. The ASHA sees who has come to the VHND and who has not. She matches names (of mothers) in her register with that of the AWWs."

## 10.1 Challenges and Lessons Learned

**Systems strengthening leads to programme Improvements at scale:**

It is important to strengthen multiple systems to achieve improvements in VHNDs. Efforts focused on frontline workers to the guidelines and their roles, strengthening supervision, using a structured checklist to monitor VHNDs, using data for programmatic decision-making and ensuring platforms for convergence. All of these aspects collectively will contribute to increase the coverage and quality of VHNDs.

**Inter-departmental convergence at various levels:**

Convergence meetings institutionalized at the block and district level have proved a very effective mechanism is addressing gaps in VHND services. Joint problems-solving is improving the quality of VHND. Visible improvements at the field level have encouraged government officials to continue with these convergence meetings on a regular basis.

**Supporting frontline workers is critical for ensuring VHNDs are reaching the community with needed services:**

Support frontline workers to knew their roles and responsibilities during VHND and received the support they needed from supervisors to perform these functions. Supervisory support from ICDS supervisors and ANMs helped AWWs and ASHAs to appreciate the importance of their roles and helped them with problem-solving and motivation. Supervisory visits contributed to improved performance of frontline workers, who are motivated by the fact that someone cares about their performance.

This study is to attempt to find out the effectiveness of factors for strengthening on important to strengthen multiple systems to achieve improvements in VHNDs. Effectiveness on frontline workers.

# CHAPTER 11

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# ANNEX A

# CONSENT FORM

# CONSENT FORM

**Invitation to participate**

We would like to invite you to participate in a research study on

**"A Study on Gap Analysis of Village Health and Nutrition Day in Kannauj District (UP)".**

**Basis of subject selection**

FLWs and Beneficiaries who are willing to answer the questions are invited to participate.

**Purpose of the study**

This Study was to evaluate the gap of the VHND services at village level in Kannauj District.

**Potential risks and discomfort-** NO

**Financial Obligation-**

No costing will be charged for participation in the research study.

**Assurance of confidentiality**

Any information obtained in connection with the study will be held in strict confidence. Any information obtained in this study may be published in appropriate journals or at any professional meetings with masked identity i.e. individual indication will be strictly confidential.

**Withdrawal from the study**

Participation is voluntary. If you decide to participate you are free to withdraw your consent and discontinue participation at any time in the study.

**Offer to answer questions**

If you have any questions, please do not hesitate to ask.

You are voluntarily making a decision whether you want or do not want to participate in this research study. Your signature certifies that you have decided you can participate, having read & understood the information presented.

Your signature also certifies that you have had an adequate opportunity to discuss this study with the investigator.

Signature of participant: _____ Date: _____

In my judgment the FLWs and beneficiaries will be voluntarily and knowingly giving the informed consent and possess the legal capacity to give informed consent to participate in this research study.

Signature of Investigator: _____Date:_____

Address: UP TECHNICAL SUPPORT UNIT, CMO OFFICE, VINOD DIXIT CHC MAKRAND NAGAR, KANNAUJ (U.P) - 209726

Contact no - 7565008363

# ANNEX B

# ASSESSMENT FORM

**CONFIDENTIAL**
(For study purpose only)

# IIHMR DELHI

## Assessment and Rapid Survey

## **VHND Questionnaire**

STATE_____

DISTRICT_____

THESIL/TALUKA/BLOCK_____

VILLAGE_____

NAME OF THE INVESTIGATOR
……

SIGNATURE OF THE INVESTIGATOR

Interview

DATE | MONTH | YEAR | DAY

TIME

Start of interview:-……

End of Interview:----------

1. Facilities Available at the VHND Sites

| SL No | Facilities Available at the VHND Sites | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| 1. | Electricity | | | | |
| 2. | Safe Drinking Water | | | | |
| 3. | Toilet | | | | |
| 4. | Toilet with Running water | | | | |
| 5. | Proper Sitting Arrangement | | | | |
| 6. | Privacy for ANC | | | | |

2. Presence of Frontline Workers

| SL NO | Presence of Frontline Workers | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| 1. | ANM | | | | |
| 2. | AWW | | | | |
| 3. | ASHA | | | | |
| 4. | AWH | | | | |

3. Counselling Services Available at the VHND Sites

| SL NO | Counselling Services Available at the VHND Sites | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| 1. | Counselling for Pregnant Women | | | | |
| 2. | Counselling for Children | | | | |
| 3. | Counselling for Breast feeding | | | | |
| 4. | Counselling for Adolescent about Nutrition & Hygiene | | | | |

4. Availability of THR

| SL NO | Availability of THR | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| 1. | THR Available | | | | |
| 2. | THR Distributed | | | | |

5. Availability of Equipment's

| SL NO | Availability of Equipment's | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| 1. | Weighing Machine (Adult) | | | | |
| 2. | Weighing Machine(Children) | | | | |
| 3. | Weighing Machine(Infant) | | | | |
| 4. | Examination table | | | | |
| 5. | Uri stick | | | | |
| 6. | Nischay Kits | | | | |
| 7. | HB Meter | | | | |
| 8. | Stethoscope | | | | |
| 9. | BP Instrument | | | | |
| 10. | Fetoscope | | | | |

6. Utilization of Equipment's

| SL NO | Availability of Equipment's | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| 1. | Weighing Machine(Adult) | | | | |
| 2. | Weighing Machine(Children) | | | | |
| 3. | Weighing Machine(Infant) | | | | |
| 4. | Examination table | | | | |
| 5. | Uri stick | | | | |
| 6. | Nischay Kits | | | | |
| 7. | HB Meter | | | | |
| 8. | Stethoscope | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 9. | BP Instrument | | | | |
| 10. | Fetoscope | | | | |

7. Availability of Drugs at VHND Sites

| SL NO | Availability of Drugs | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| 1. | OCP | | | | |
| 2. | Condoms | | | | |
| 3. | IFA for Adults | | | | |
| 4. | IFA for Children | | | | |
| 5. | Iron Syrups | | | | |
| 6. | ORS | | | | |
| 7. | Zinc Tab | | | | |
| 8. | VIT A TAB | | | | |
| 9. | Cloroquine | | | | |
| 10. | Albendazole | | | | |
| 11. | Paracetamol | | | | |
| 12. | Calcium Citrate | | | | |
| 13. | Methalogemathocyn | | | | |
| 14. | Cloroquine IE Ointment | | | | |
| 15. | Cotton Bandage | | | | |
| 16. | Cotton Swab | | | | |

8. Availability of Vaccines at VHND sites

| SL NO | Availability of Vaccines | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| 1. | BCG | | | | |
| 2. | DPT | | | | |
| 3. | Polio vaccine | | | | |
| 4. | Measles Vaccine | | | | |
| 5. | HEP B Vaccine | | | | |
| 6. | TT | | | | |

9. Availability of Records & Registers

| SL NO | Availability of Records & Registers | YES | NO | YES% | NO% |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| 1. | Due List Manual | | | | |
| 2. | MCP Card | | | | |
| 3. | MCTS Tracking Form | | | | |
| 4. | Refer Register | | | | |
| 5. | Gram Swasthya Register | | | | |
| 6. | Counselling Material | | | | |

10. Skills of ANM

| SL NO | Skills of ANM | YES | NO | YES% | NO% |
|---|---|---|---|---|---|
| 1. | ANM has Skill to Measure BP | | | | |
| 2. | ANM has Skill to Measure HB | | | | |
| 3. | ANM has Skill to Measure to use Fetoscope | | | | |
| 4. | ANM has Skill to Perform Urine Test | | | | |
| 5. | ANM has Skill to Administer Vaccine | | | | |