

Assessment of “Quality of VHND Sessions” of
District Faizabad in Uttar Pradesh

By

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*Dissertation submitted for the partial fulfillment of the
MBA Hospital and Health Management*

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TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Priya Bhat** student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at India Health Action Trust (IHAT) from February 16' to April 16'.

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

The Internship is in fulfillment of the course requirements.

I wish him all success in all his future endeavors.



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The certificate is awarded to

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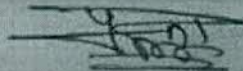
She has successfully completed her Project on
Assessment of quality of VHND sessions in District Faizabad, U.P

From 22-2-2016 to 10-5-2016

INDIA HEALTH ACTION TRUST, LUCKNOW

She comes across as a committed, sincere & diligent person who has a
Strong drive and zeal for learning

We wish her all the best for future endeavors.



Mr. Jairam Pathak
State Community Specialist
Barabanki Zone

THE IIMMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled ' A Study to assess the Quality of VHND Sessions in 4 blocks of District Faizabad, U.P. and submitted by Dr. Priya Bhat Enrollment No. **0191** under the supervision of **President Dr. S.D Gupta** for award of MBA Hospital and Health Management of the Institute carried out during the period from **22nd February 2016** to **10th 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.



Dr. Priya Bhat

Signature

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s.no	contents	Page no.
1.	Acknowledgement	2
2.	Abstract	7
3.	contents	
4.	List of graphs	
5.	List of abbreviations	6
	Dissertation	
1.0	INTRODUCTION	8-9
2.0	LITERATURE REVIEW	9-10
3.0	RATIONALE	10
3.1	RESEARCH QUESTION	11
3.2	OBJECTIVE	11
3.3	METHODOLOGY	11
4.0	RESULT	13-27
5.0	DISCUSSION	27-28
6.0	CONCLUSION	28-29

S.no.	Title of the graph	Page no.
1	percent distribution of place of VHND	13
2	percent distribution of ASHAs and AWWs	14
3	percent distribution of toilets, waiting area and privacy for ANC	14
4	percent distribution of logistics	15
5	percent distribution of weighing machines	16
6	percent distribution of due list preparation	16
7	percent distribution of ANM information	17
8	percent distribution of VHNDs as per micro plan at various sites	17
9	percent of ASHAs present	18
10	percent of AWWs present	18
11	percent distribution of toilets at various sites	19
12	percent distribution of adequate waiting space at different sites	19
13	percent distribution of privacy for ANC at various sites	20
14	percent availability of MCP cards	20
15	percent availability of BP apparatus	21
16	percent availability of haemoglobin meter strips	21
17	percent availability of urisix at various sites	22
18	Availability of weighing machine (adult)	22
19	Availability of weighing machine (child)	23
20	percent distribution of RI due list at various sites	23
21	percent distribution of ANC due list	24
22	percent distribution of PNC due list	24
23	percent distribution of Nutrition due list	25
24	percent distribution of FP due list	25
25	percent distribution of review of birth plan by ANM at different sessions	26
26	percent distribution of line listing of HRPs at various sites	26

List of Abbreviations

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCG	Bacillus Chalmette Guerin
BMO	Block Medical Officer
CDPO	Child Development Project Officer
CRP	Community Resource Person
DOTS	Directly Observed Treatment Short course
Hb	Haemoglobin
HRP	High Risk Pregnancy
IFA	Iron and Folic Acid
IUCD	Intra Uterine Contraceptive Device
MCH	Maternal and Child Health
NRHM	National Rural Health Mission
NSV	No Scalpel Vasectomy
NUHM	National Urban Health Mission
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
PNC	Post Natal Care
PRI	Panchayati Raj Institution
RBSK	Rashtriya Bal Swasthya Karyakram
SAM	Severely Acute Malnourished
TT	Tetanus toxoid
TSU	Technical Support Unit
UIP	Universal Immunisation Program
VHND	Village Health and Nutrition Day

VHSC	Village Health and Sanitation Committee
VVM	Vaccine Vial Monitor
WIFS	Weekly Iron Folic Acid Programme

Abstract:

Village Health and Nutrition Day, introduced by National Rural Health Mission is an initiative to improve maternal, new born, child health and nutrition in rural areas. All over India VHNDs are held once in a month in every village at the Anganwadi centre.

The present study focuses on identifying the loopholes in the functioning of VHND through interaction with the staff and site observation at the VHND site and use of these observations and findings to make suggestions for a better delivery of services on VHND site. The findings can be used for improving the quality of services at the VHND site.

Total number of VHND sites assessed were 92. Out of 92 sessions, only 80 sessions were Held as per micro plan. Out of total sessions, only 16.3 percent were held in AWCs, 26 Percent held in sub centres, schools and PRIs and 57 percent sessions held at someone's residence.

Around all the sessions observed percentage of ASHAs and AWWs present was 94 percent and 92 percent respectively. On an average, only 24 percent VHNDs had toilet facility available. Sixty percent VHNDs held at AWCs had toilet facility whereas only 36 percent of VHNDs held at someone's residence had toilets available which is very less as most of the VHNDs were held at someone's residence i.e. 57 percent.

Privacy for ANC was around 80 percent and 92 percent at AWCs and government institutions respectively and only 60 percent at someone's residence.

On an average availability of MCP cards was around 85 percent. Availability of BP apparatus was around 89 percent. Around 93 percent and 95 percent of VHNDs had availability of haemoglobin meter and uristix. Slightly less number of logistics was found when VHNDs were conducted at someone's residence.

Availability of adult weighing machine was around 92 percent overall.

Availability of child weighing machines in VHNDs constituted around 62 percent. Only 50 percent of VHNDs held at government institutions had the weighing machine available.

Due list prepared for nutrition services were only 53 percent in AWCs, 75 percent in schools and PRIs and 66 percent at someone's residence.

On an average, only 79 percent of birth planning prepared by ASHA was reviewed by ANM and around only 69 percent was reviewed by ANM when VHNDs were conducted at someone's residence and 92 percent VHNDs held at Government institutions where such where ANMs reviewed the birth planning prepared by ASHA.

1.0: Introduction:

India has more hungry masses than any part of the world. The IFPRI 2010 Global Hunger Index scores national levels of hunger as “alarming” and India being at the lowest score than many sub Saharan African countries. The percentage of underweight children who are under 3 years of age is still hovering under 50%. More than 75% of the people live in households with per capita calorie consumption less than the daily minimum requirements. (5)

Nutritional interventions are carried out under various government programmes like the Integrated Child Development Services (ICDS) programme, the Midday Meal Scheme (MMS), the Total Sanitation Campaign (TSC), and some activities within National Rural Health Mission (NRHM). About 54% of all under-5 deaths are due to malnutrition. Majority of childhood deaths in India are due to stunting, wasting and intrauterine growth restriction-low birth weight. The major cause of malnutrition among women and children is due to low nutritional and social status.(2)

Village Health and Nutrition Day, introduced by National Rural Health Mission is an initiative to improve maternal, new born, child health and nutrition in rural areas. All over India VHNDs are held once in a month in every village at the Anganwadi centre. VHNDs are held on a predetermined time, place and day. VHNDs provide health and nutritional services along with counselling on nutrition, contraception, family planning, complete immunisation, sanitation and hygiene. Anganwadi workers (AWWs) and Accredited Social Health Activists (ASHAs) bring the villagers to the Anganwadi centre with the help of Panchayati Raj Institutional members. The task of Auxiliary Nurse Midwife (ANMs) is to provide ante-natal care and immunisations. AWWs monitor growth of children and refer children with severe malnutrition to the nearest public health facility. Apart from it, supplementary nutrition is also provided. All the three frontline members (ANM, ASHA, and AWW) are important for the proper functioning of VHND.(1)

Anganwadi centre is the main hub to carry out the services provided on VHND. VHND acts as a platform to bring under privileged community closer to the health system. On VHND, Villagers get basic health services and health education. Masses are encouraged to a more preventive and promotive approach to health care. The main motive of VHND is to provide healthcare at the doorstep so that people don't have to waste their time and money on travel. If the associated health personnel keenly participate and involve in the successful functioning and organising of VHND, can change the people's approach towards healthcare drastically.

The main focus of VHND is on maternal health, child health, family planning, prevention of sexually transmitted infections, sanitation and hygiene, prevention and control of communicable diseases and health promotion and nutrition.

2.0: Review of Literature:

1. Fighting Maternal and Child Malnutrition: Analysing the political and institutional determinants of delivering a national multisectoral response in six countries:

The study proposes a four pillar nutrition governance framework: InterSectoral cooperation across stakeholders, vertical coordination within the government and the financing mechanisms for nutrition policymaking and implementation. A fourth dimension, common to all, is the extent to which countries are committed to developing accurate indicators of nutrition and required budgets, that are validated by a wide array of stakeholders and the extent to which the data is effectively used to monitor progress. Good quality data can also help civil society groups to advocate for more focused and sustained government interventions. The report identifies knowledge gaps, and which institutional arrangements and political dynamics are more likely to advance government efforts in reducing maternal and child under nutrition. (3)

2. Aga Khan University, Karachi, Pakistan (Prof Z A Bhutto PhD, B A Haider MD); Centre for Health and Population Research, Dhaka, Bangladesh:

Reviewed interventions that affect maternal and child under nutrition and nutrition-related outcomes. These interventions included promotion of breastfeeding; strategies to promote complementary feeding, with or without provision of food supplements; micronutrient interventions; general supportive strategies to improve family and community nutrition; and reduction of disease burden (promotion of hand washing and strategies to reduce the burden of malaria in pregnancy).

Management of severe acute malnutrition according to WHO guidelines reduced the case-fatality rate by 55% (risk ratio 0.45, 0.32–0.62), and recent studies suggest that newer commodities, such as ready-to-use therapeutic foods, can be used to manage severe acute malnutrition in community settings. Effective micronutrient interventions for pregnant women included supplementation with iron folate (which increased haemoglobin at term by 12 g/L, 2.93–21.07) and micronutrients (which reduced the risk of low birth weight at term by 16% (relative risk 0.84, 0.74–0.95). Recommended micronutrient interventions for children included strategies for supplementation of vitamin A (in the neonatal period and late infancy), preventive zinc supplements, and iron supplements for children in areas where malaria is not endemic, and universal promotion of iodised salt. (4)

3.0: Rationale for study:

In the current scenario, in India, maternal and child malnutrition is persistently on a higher scale. Expectants usually have low Body Mass Index (BMI) due to severe malnutrition resulting in low birth weight babies, still births and children under 5 years of age are stunted, wasted and severely underweight and anaemic. Malnutrition is a problem of concern in poor and low income countries mainly due to the low socioeconomic status of people.

Poverty is the main cause of malnutrition and women, adolescent girls and children under five are its major victims. Malnutrition weakens the immune system and makes the person susceptible to various infections. Under privileged population usually have inadequate access to food, maternal and child health care practices, healthcare services and lack proper sanitation

The period of pregnancy in mother and the first two years of life of a child that is from conception till child's second birthday, lack of good nutrition and healthy growth practices can be quite fatal. Underweight and malnourished mothers have a serious threat during pregnancy due to anaemia, folic acid deficiency, vitamin A deficiency and iodine deficiency. Also underweight, wasted and stunted are more prone to death from pneumonia, measles, diarrhoea and other infectious diseases. Also incomplete immunisation in children and infants makes the poor more vulnerable to serious life threatening conditions. Lack of ante-natal care in remote in the remote areas can increase the chances of complications during labour and sometimes even lead to death of both mother and the new born.

Improper sanitation and hygiene practices in villages again make people vulnerable to health risks mostly affecting women and children. Though health systems provide good facilities, for proper delivery of services on VHND, all the frontline workers need to be skilled and efficient so that they can contribute effectively towards the health of masses.

The present study focuses on identifying the loopholes in the functioning of VHND through interaction with the staff and site observation at the VHND site and use of these observations and findings to make suggestions for a better delivery of services on VHND site. The findings can be used for improving the quality of services at the VHND site.

3.1: Research Question:

What is the quality of health services being delivered at VHND session sites?

3.2: Objective:

- To quantify the availability of logistics in the VHND
- To assess the effectiveness of service delivery at VHND sessions.

3.3: Methodology:

Study Design: cross sectional Descriptive study

Study Location: purposively selected 4 TSU blocks from district Faizabad (where IHAT is going to start the project Nutrition), Uttar Pradesh.

Sampling: sampling Random sampling (where India Health Action Trust is going to implement Nutrition project)

Sample size: 4 Technical Support Unit blocks were selected. Each block is divided into 3 – 4 clusters. 8 villages were selected randomly from each cluster to observe the VHND session

Total no. of clusters = 13

No. of villages from each cluster = 8

Total no. of VHND sites = 104

Sample size = 104

Non response rate = 12 (due to trainings conducted by IHAT)

Study Duration: 3 months (22nd February to 10th May)

Data Collection Tool: VHND Assessment Tool

Method of data collection: The methodology adopted was:

1. Participant observation
2. Site observation.

3.3.1: Methodology of VHND Assessment

S.no	Methods	Purpose
1.	Observation of VHNDs	• To observe the status of infrastructure and its environment • To observe the quality of service delivery. • To observe active participation of beneficiary, service provider and community members.
2.	Review of records	• To document quantitative information on availability of equipment, medicines and service delivery.
3.	Recording of Information	• To document information and observations for data analysis and report preparation

Table 2. Sample Size of the Assessment

Coverage	numbers
District	1
Block	4
Cluster	13
VHND sessions	92

3.3.2: Methodology of data collection

Data collection was done by the individual as well as the Community Resource Persons who were initially oriented on how to collect the data. CRPs are the community level team introduced by TSU to provide Hand Holding support to the Frontline workers.

3.4: Statistical Treatment:

Assessment tool was checked for completeness and correction and data was entered in MS excel for further analysis and graphical presentations.

3.5: Ethical Considerations:

Informed consent was taken before starting the assessment. If anyone disagreed to become part of data collection process they were not forced by any means. Confidentiality was ensured to all participants.

4.0: Results:

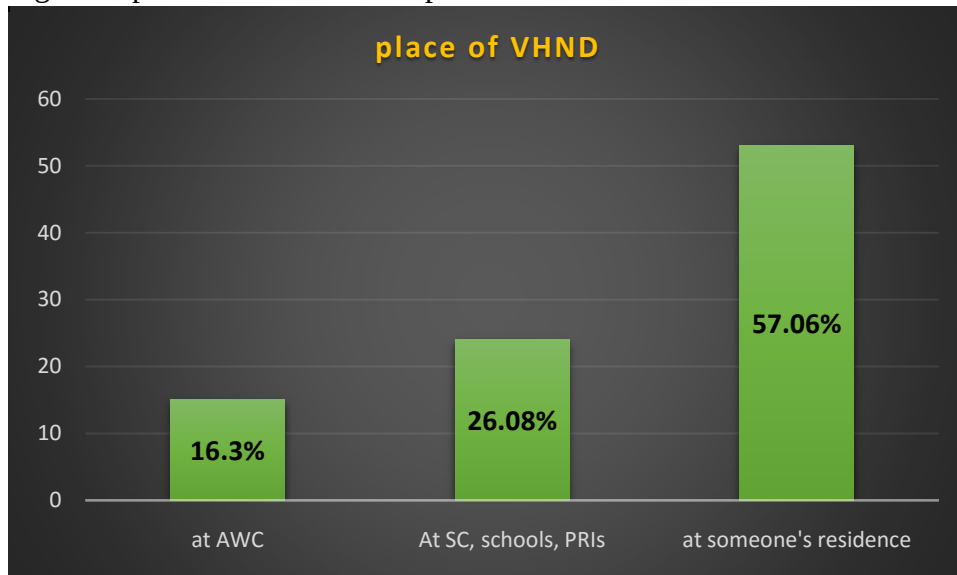
Background characteristics:

A total of 92 VHND sites were assessed in 4 blocks of district Faizabad, Uttar Pradesh. Out of 92 VHNDs, 80 VHNDs were held as per micro plan.

4.1: Parameters of Assessment

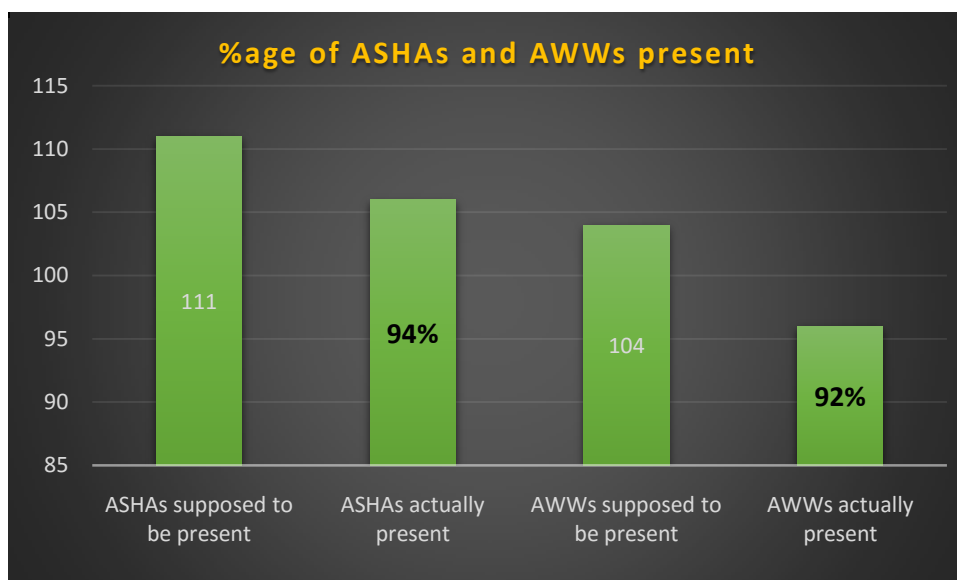
4.1.1: Place of VHND: out of 92 VHNDs assessed, 16.3 percent VHNDs were held at Anganwadi centres, 26.08 percent VHNDs were organised at Sub centres, Schools and Panchayati Raj Institutions and a majority of them, i.e. 57.6 percent were held at someone's residence.

Figure 1: percent distribution of place of VHND



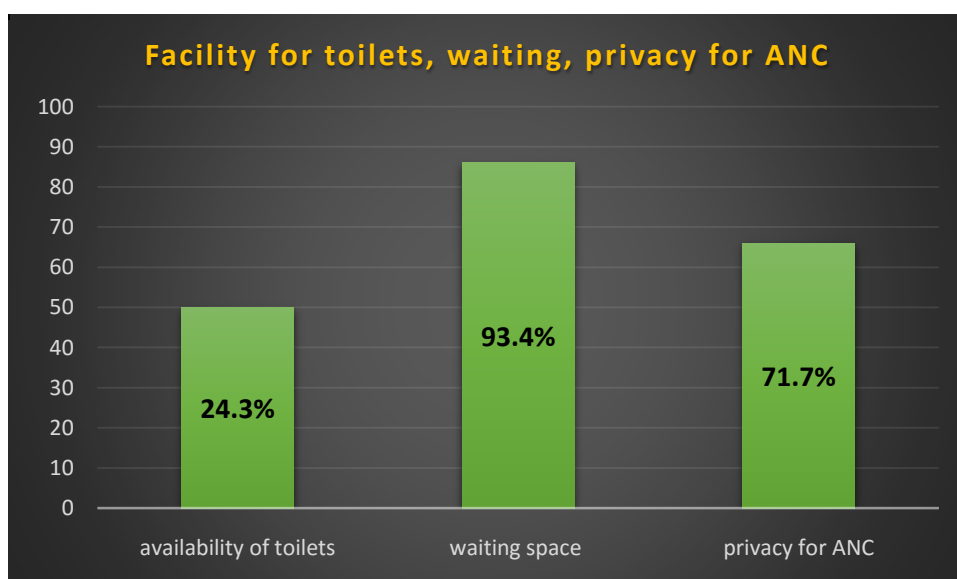
4.1.2: Presence of ASHAs and AWWs: Out of 111 ASHAs, 106 were present. Around 94 percent ASHAs were present. Out of 104 Anganwadi workers, 96 were present at the sessions. Percentage of AWWs present was 92 percent.

Figure 2: percent distribution of ASHAs and AWWs



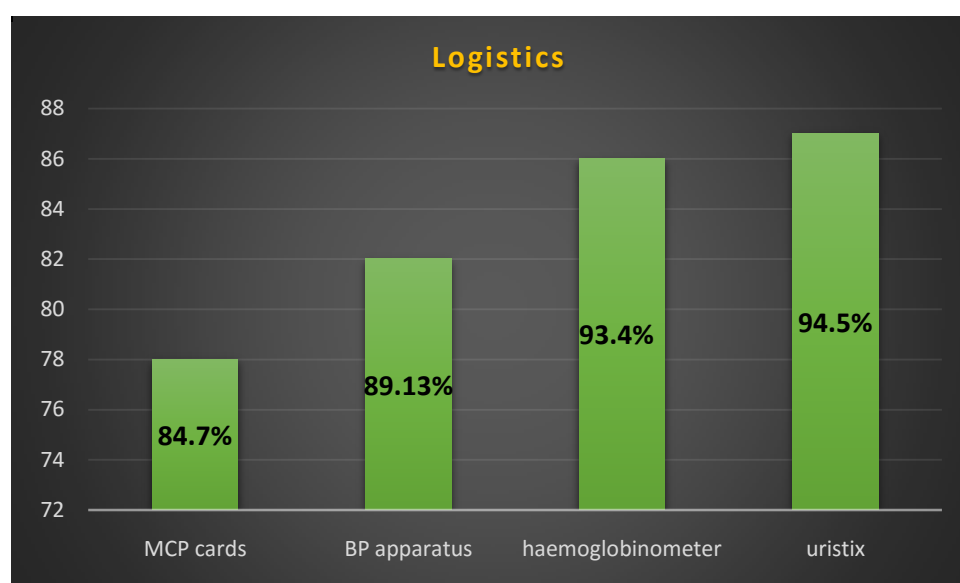
4.1.3: Availability of toilets, waiting area and privacy for ANC: out of 92 VHNDs attended, only 24 percent had toilet facility. Ninety three percent had adequate space for waiting for beneficiaries and around 72 percent had privacy for Ante natal check-up

Figure 3: percent distribution of toilets, waiting area and privacy for ANC



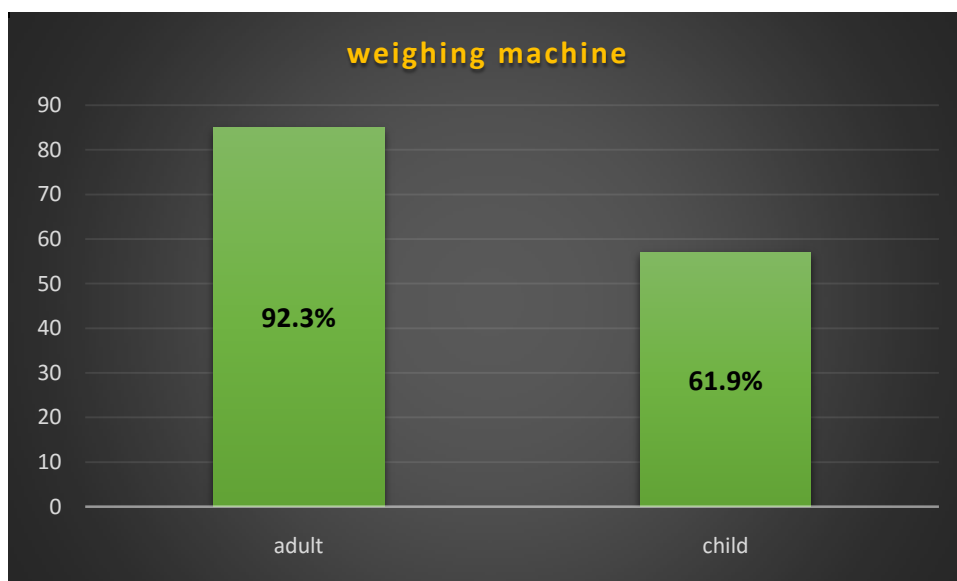
4.1.4: Availability of logistics: out of 92 VHNDs assessed, only 85 percent sessions had MCP cards available, 89 percent sessions had BP apparatus available. Ninety three percent sessions had haemoglobin meter strips available and uristix strips were available in almost 95 percent sessions.

Figure 4: percent distribution of logistics



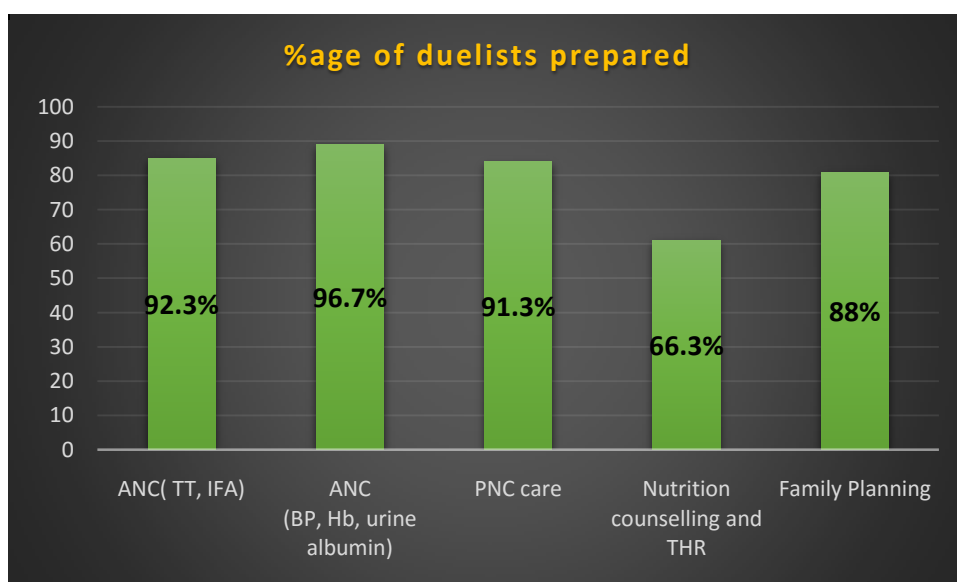
4.1.5: Availability of weighing machines: out of 92 VHNDs held, 92 percent of them had availability of adult weighing machines whereas only 62 percent of VHNDs had child weighing machines available.

Figure 5: percent distribution of weighing machines



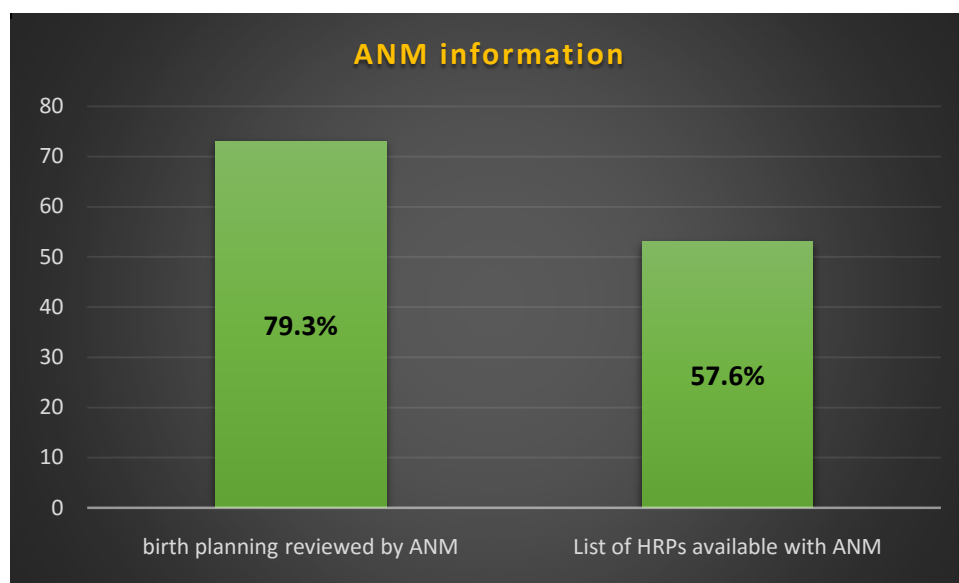
4.1.6: Preparation of due lists: due lists prepared for TT, IFA and BP, Hb, urine albumin and PNC care was 92 percent, 97 percent and 91 percent respectively. However due list prepared for nutrition counselling and Take Home Ration is only 66 percent. Also only 88 percent sessions had the availability of due list for Family Planning services.

Figure 6: percent distribution of due list preparation



4.1.7: ANM information: seventy nine percent sessions were such where ANMs reviewed the birth planning prepared by ASHA and only 58 percent VHNDs were such where list of High Risk Pregnancies was available with the ANM.

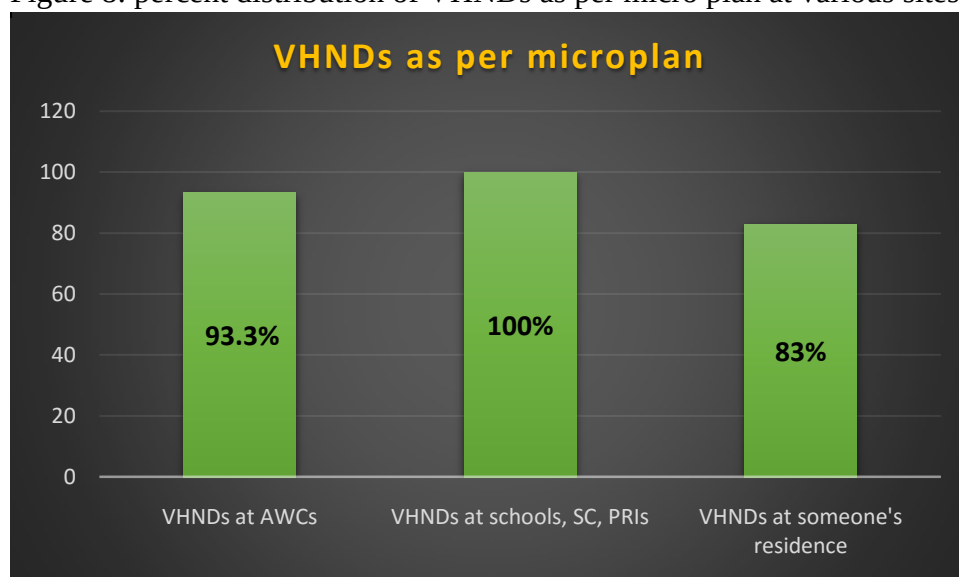
Figure 7: percent distribution of ANM information



4.2: Comparison of VHND sessions at AWCs; SC, schools, PRIs; someone's residence

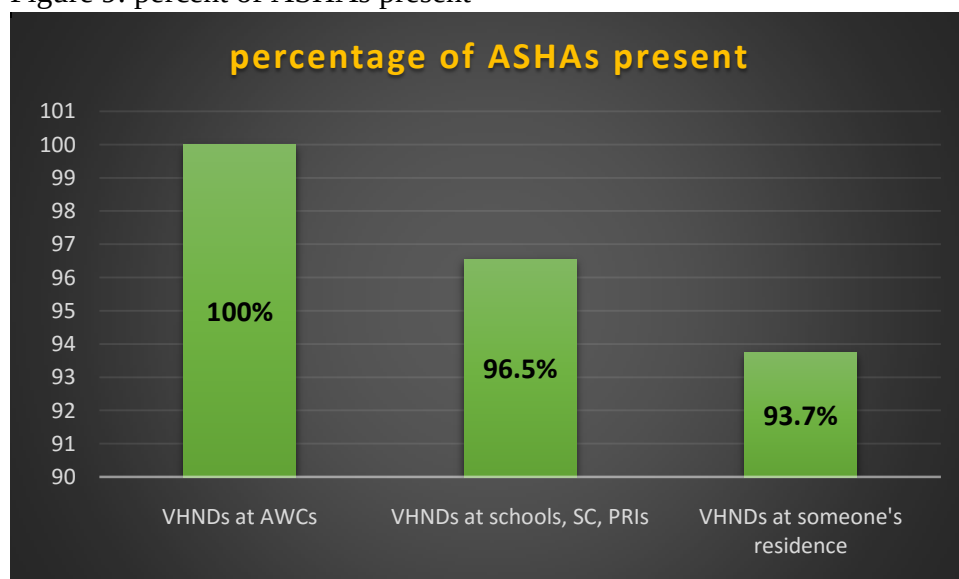
4.2.1: VHNDs as per micro plan: Ninety three percent VHNDs were held as per micro plan at AWCs, 100 percent VHNDs were held as per micro plan at sub centres, schools and PRIs.

Figure 8: percent distribution of VHNDs as per micro plan at various sites



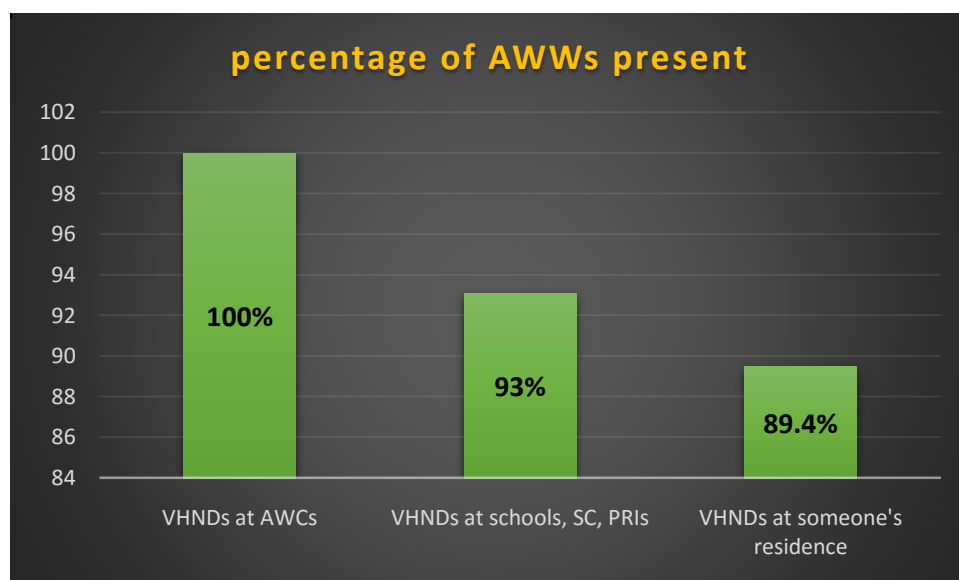
4.2.2: Presence of ASHAs: Almost all ASHAs were present at VHNDs organised at the AWCs, 96.5 percent ASHAs were present at sessions organised at government buildings and around 93 percent ASHAs were present at sessions organised at someone's residence.

Figure 9: percent of ASHAs present



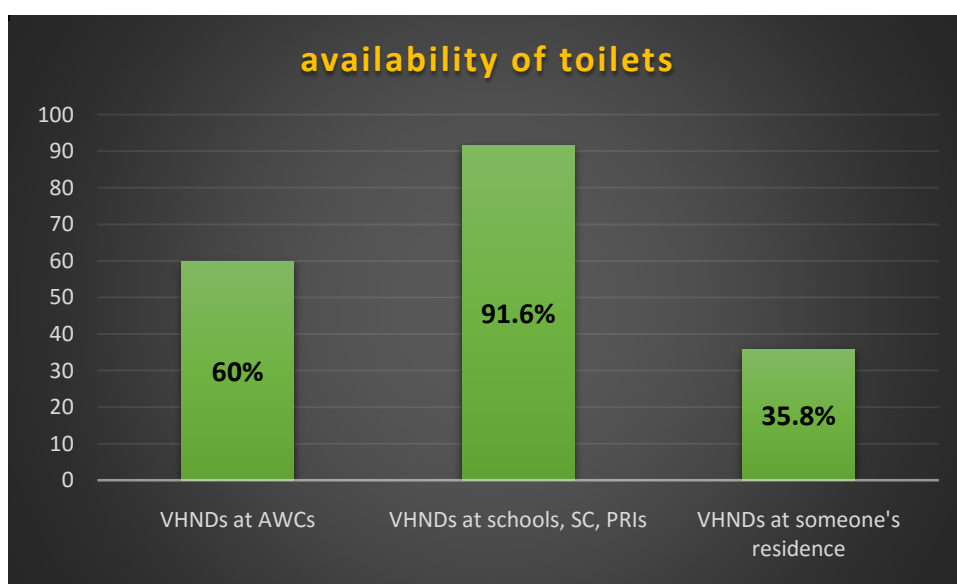
4.2.3: Presence of AWWs: hundred percent attendance of AWWs was observed at sessions conducted at AWCs, presence of AWWs on sessions organised at government buildings was 93 percent and 89 percent of AWWs were present at VHNDs organised at someone's residence.

Figure 10: percent of AWWs present



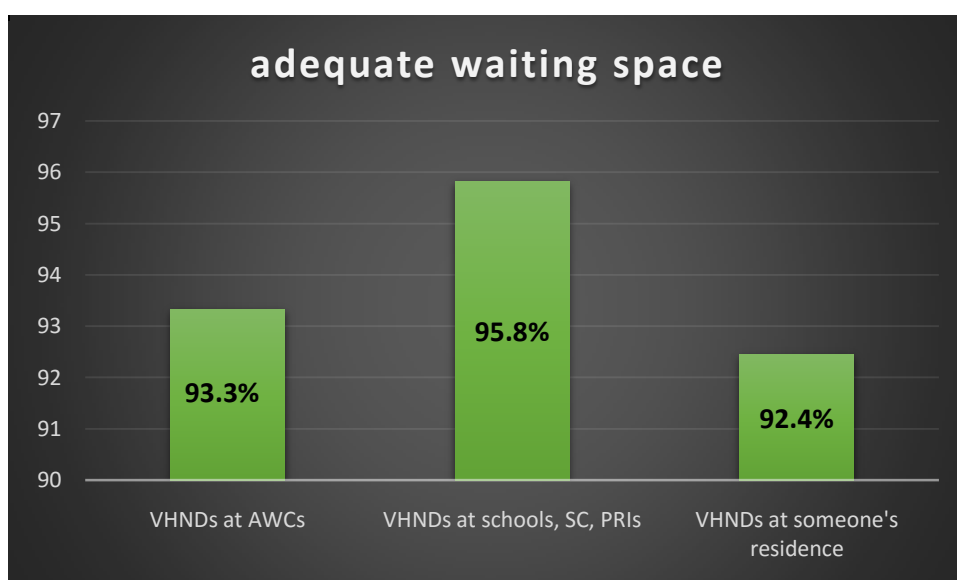
4.2.4: Availability of toilets: only 60 percent of VHNDs held at AWCs had availability of toilets, 91.6 percent VHND sessions organised at government buildings had toilet facilities and only 36 percent of VHNDs organised at someone's residence had the availability of toilets.

Figure 11: percent distribution of toilets at various sites



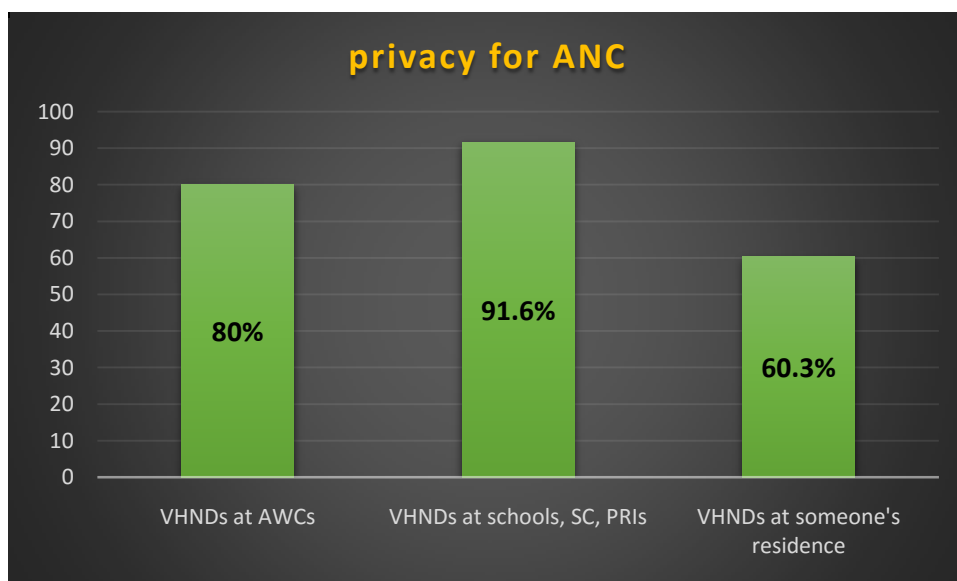
4.2.5: Adequate waiting space: ninety three percent of VHNDs held at AWCs had adequate waiting space for beneficiaries. VHNDs at government buildings and someone's residence was 96 percent and 92 percent respectively which is almost the same.

Figure 12: percent distribution of adequate waiting space at different sites



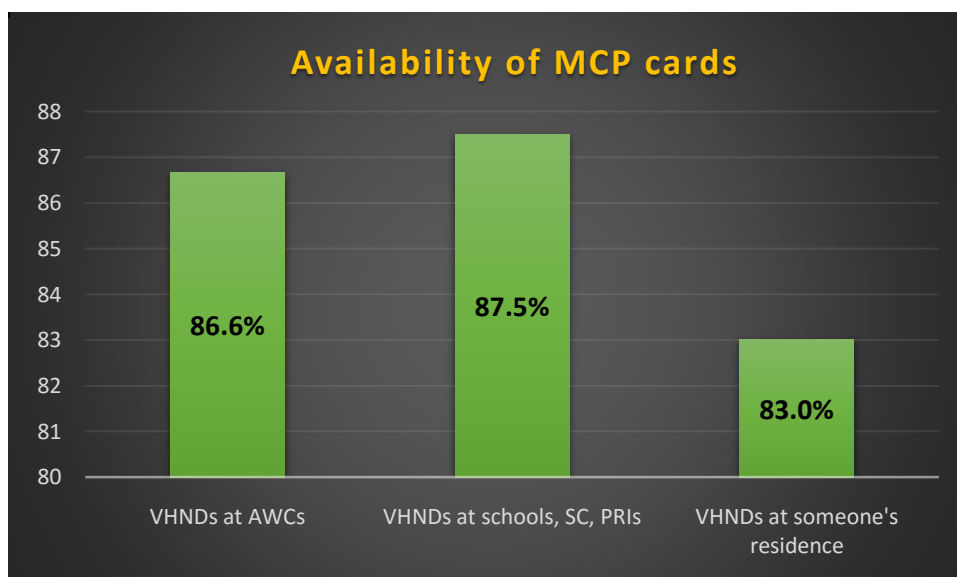
4.2.6: Privacy for ANC: eighty percent of VHNDs held at AWCs had privacy for ANC. Only 60 percent of VHNDs held at someone's residence had privacy for ANC. However 92 percent VHNDs held in government buildings had privacy for ANCs which was quite high as compared to the counterparts.

Figure 13: percent distribution of privacy for ANC at various sites



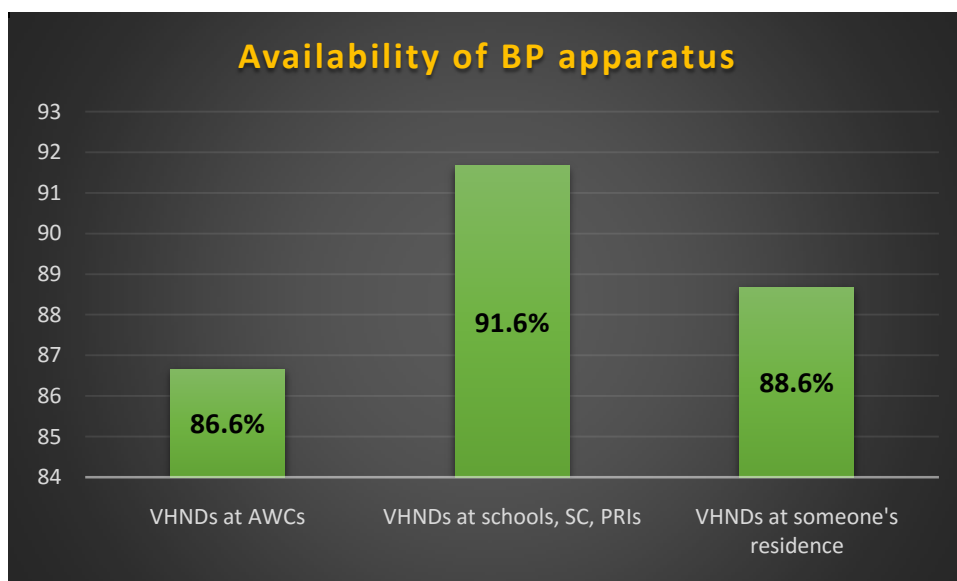
4.2.7: Availability of MCP cards: Eighty seven percent of VHNDs at AWCs had the availability of MCP cards, availability of MCP cards at sessions organised at government buildings was approximately 88 percent and around 83 percent VHNDs held at someone's residence had MCP cards available.

Figure 14: percent availability of MCP cards



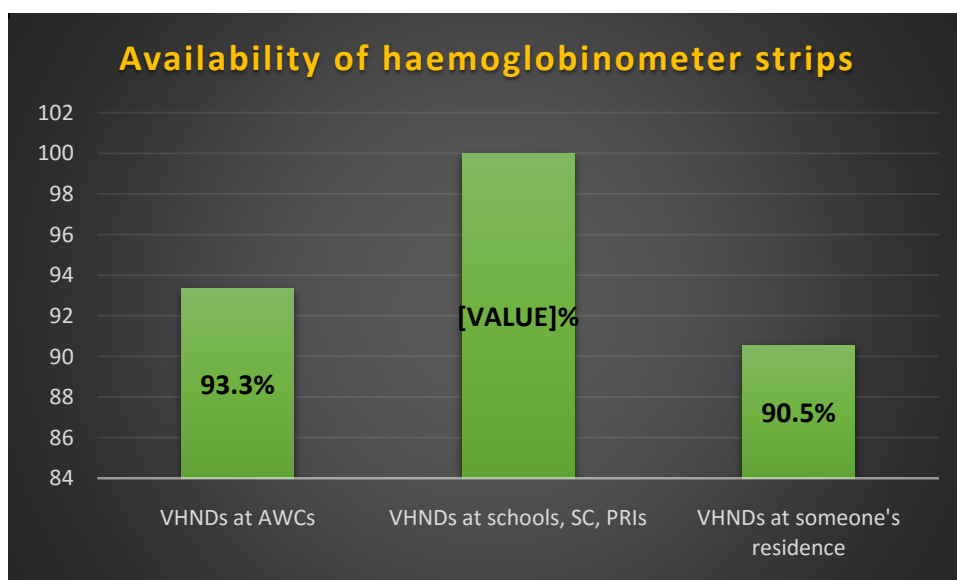
4.2.8: Availability of BP apparatus: eighty seven percent and eighty nine percent VHNDs held at AWCs and someone's residence respectively had BP apparatus available and around 92 percent VHNDs held in government infrastructure had availability of BP apparatus.

Figure 15: percent availability of BP apparatus



4.2.9: Availability of haemoglobin meter strips: ninety three percent AWCs had haemoglobin meter strips available on VHND sessions. Hundred percent VHNDs held in government buildings had the availability of haemoglobin meter strips and around 90.5 percent VHND held at someone's residence had haemoglobin meter strips available.

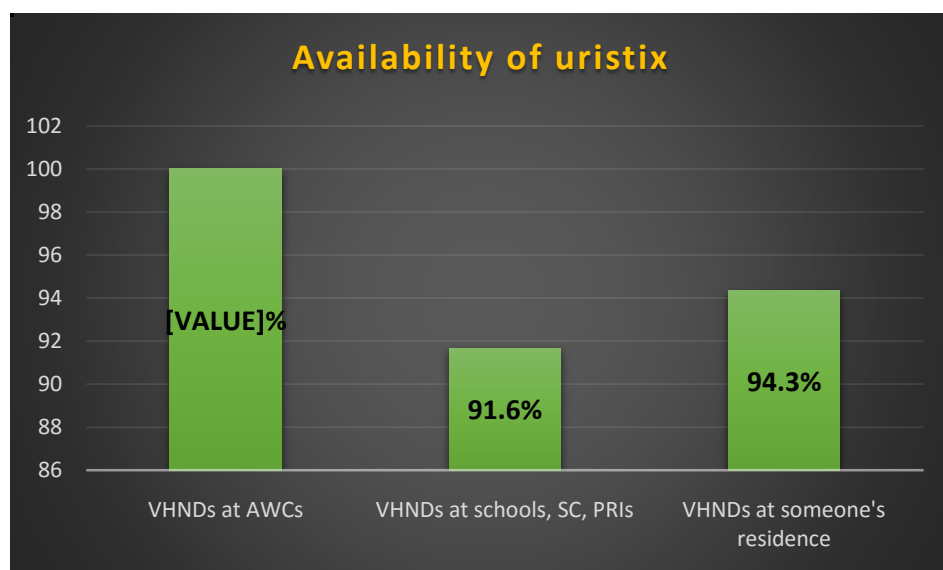
Figure 16: percent availability of haemoglobin meter strips



4.2.10: Availability of Uristix: Hundred percent of VHNDs held at AWCs had availability of uristix however only 60 percent AWCs had the facility of toilets available. Ninety two percent VHNDs held in government buildings had

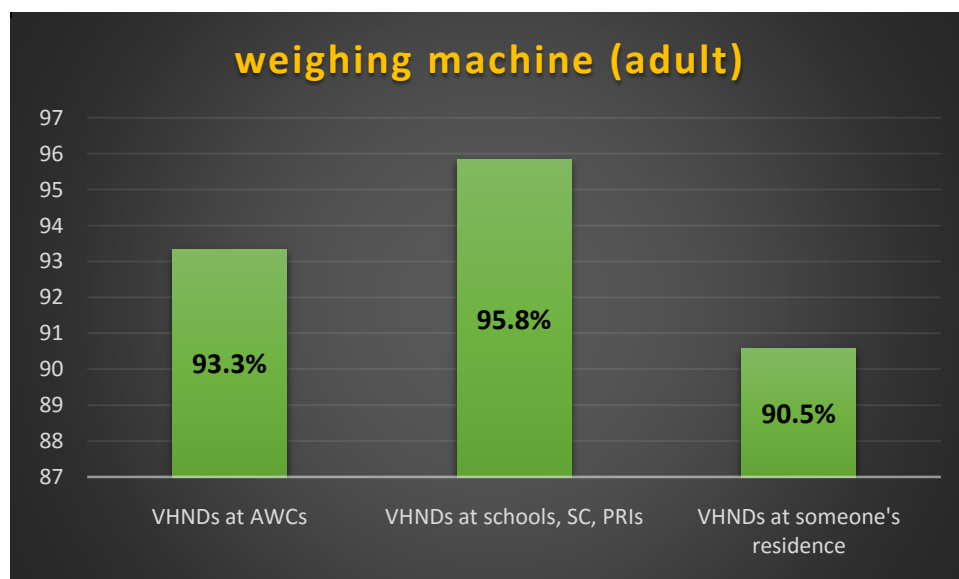
uristix available at session sites and around 94 percent VHNDs held at someone's residence had uristix available on the session.

Figure 17: percent availability of urisix at various sites



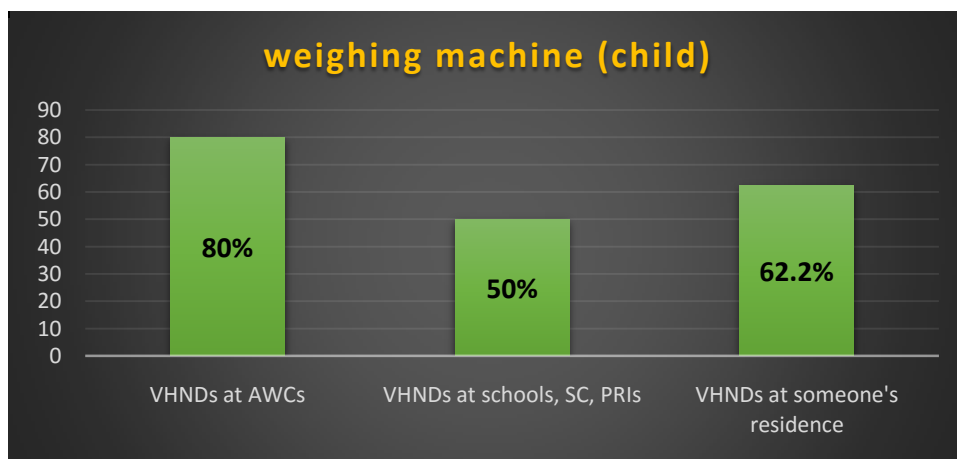
4.2.11: Availability of weighing machine (adult): ninety three percent of VHNDs conducted at AWCs had adult weighing machine available. Around 96 percent of VHNDs held in government infrastructure had adult weighing machine available and around ninety one percent sessions held at someone's residence had adult weighing machines available.

Figure 18: percent availability of adult weighing machine



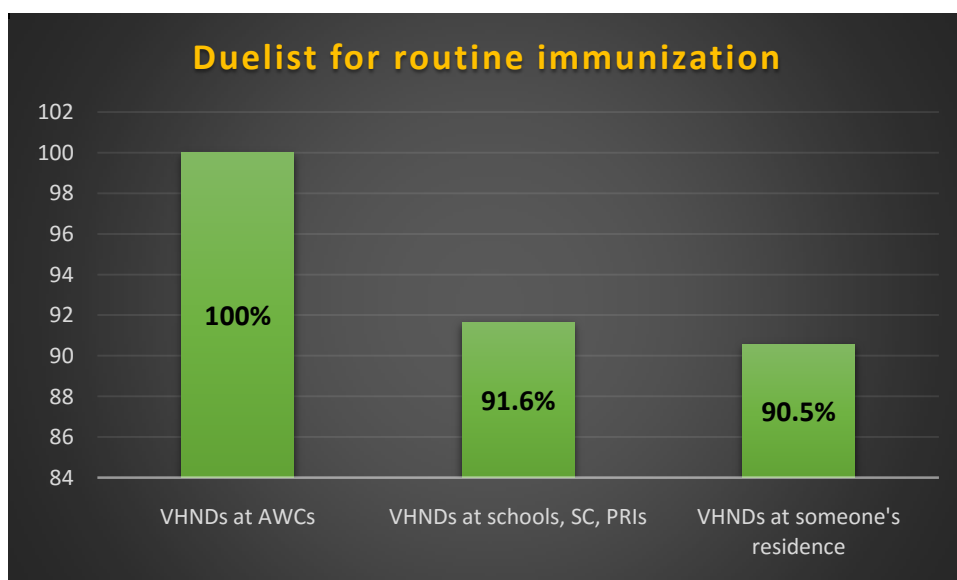
4.2.12: Availability of weighing machine (child): around 80 percent VHNDs at AWCs had the availability of child weighing machines, 50 percent VHNDs held in schools, PRIs and SC had child weighing machine available and around 62 percent VHNDs held at someone’s residence had the availability of child weighing machine.

Figure 19: percent distribution of child weighing machines at various sites



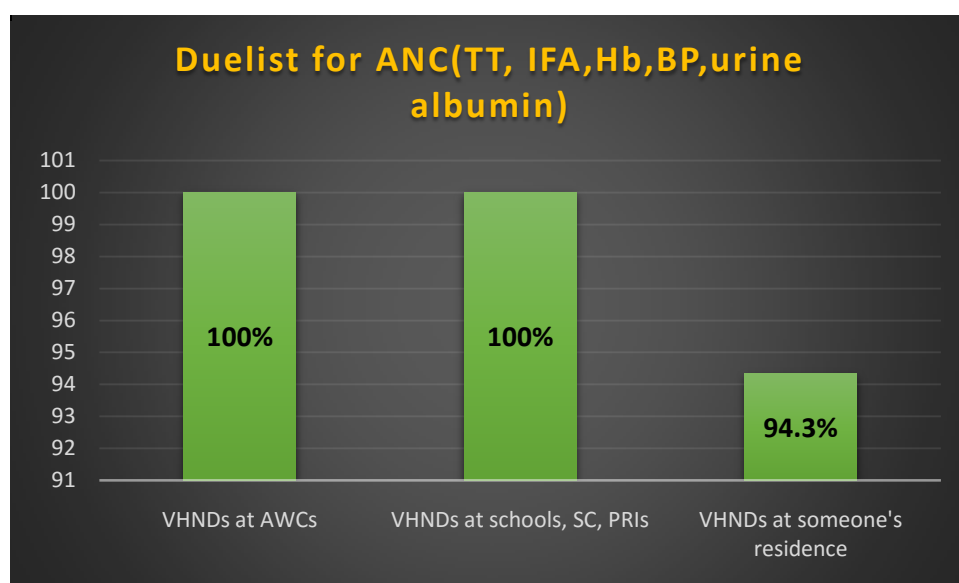
4.2.13 Due list for routine immunization: Almost 100 percent of VHNDs held at AWCs had due list prepared for routine immunization. Ninety two percent of VHNDs held at government buildings had due list prepared and around 91 percent sessions organised at someone’s residence had due list available.

Figure 20: percent distribution of RI due list at various sites



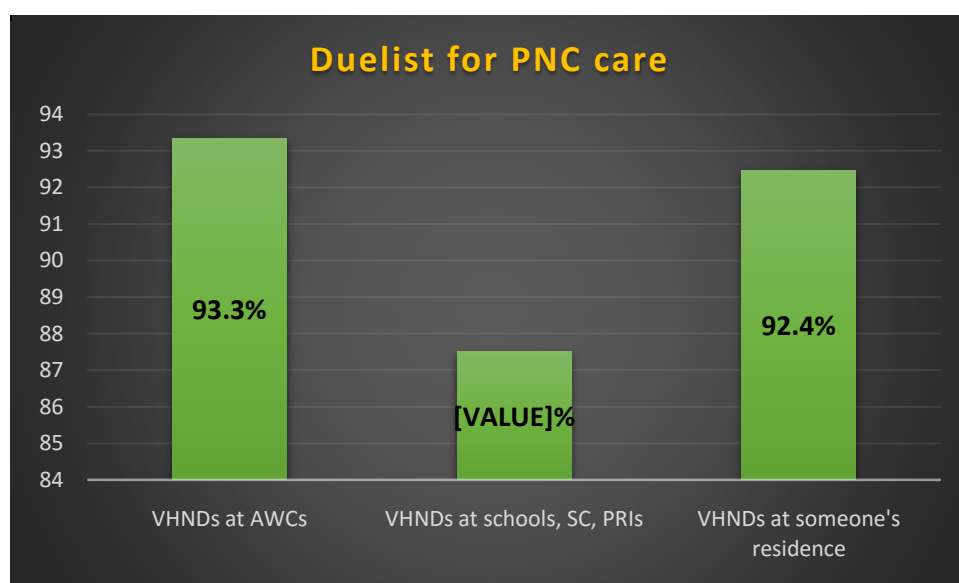
4.2.14: Due list for ANC: VHNDs held at AWCs and government buildings had 100 percent due list preparation for ANC check-up and around 94 percent sessions arranged at someone’s residence had due list prepared for ANC.

Figure 21: percent distribution of ANC due list



4.2.15: Duelist for PNC care: VHND held at schools and sub centres and PRIs had only 88 percent due list prepared for ANC care whereas due list preparation at AWCs and at someone's residence was 93 percent and 92 percent respectively.

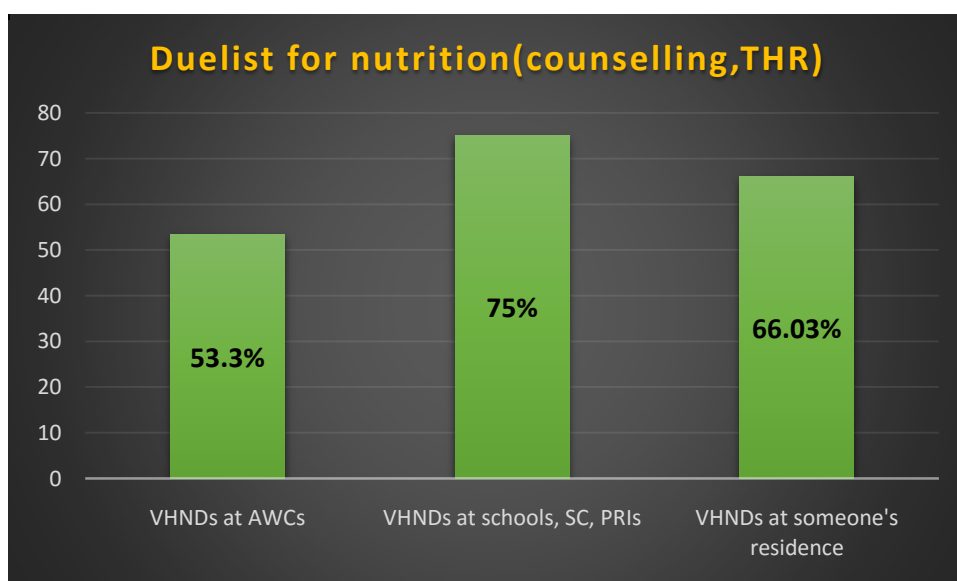
Figure 22: percent distribution of PNC due list



4.2.16: Due list for nutrition (counselling, THR): Fifty three percent of VHNDs at AWCs had prepared due list for nutrition services. Seventy five percent of VHNDs

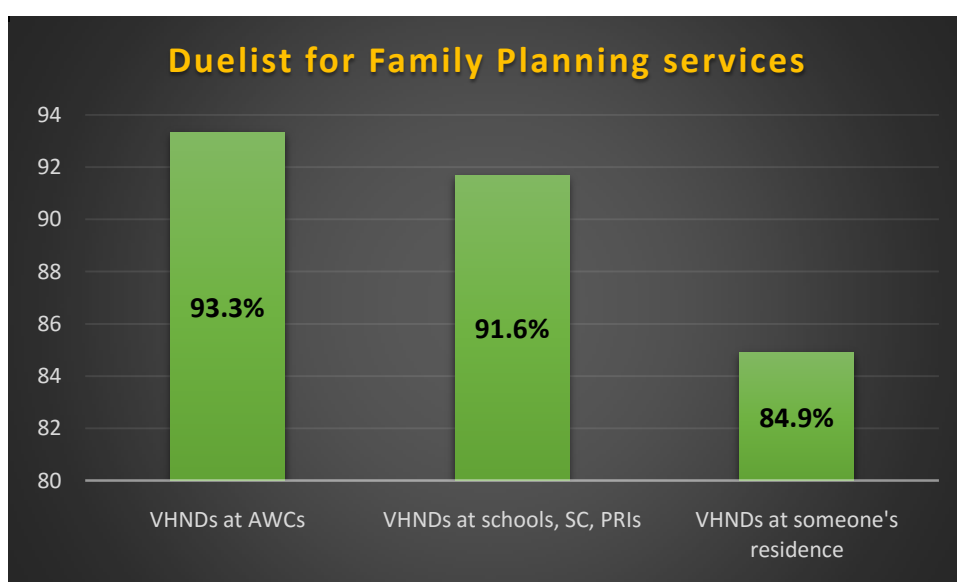
held at government buildings had prepared due list for nutrition services and around 66 percent of VHNDs held at someone's residence had prepared due list for nutrition.

Figure 23: percent distribution of nutrition due list



4.2.17: Due list for Family Planning services: 93 percent of VHNDs held at AWCs had due list prepared for FP services. Ninety two percent VHNDs at SC, schools and PRIs had prepared due list and around 85 percent sessions conducted at someone's residence had prepared due list.

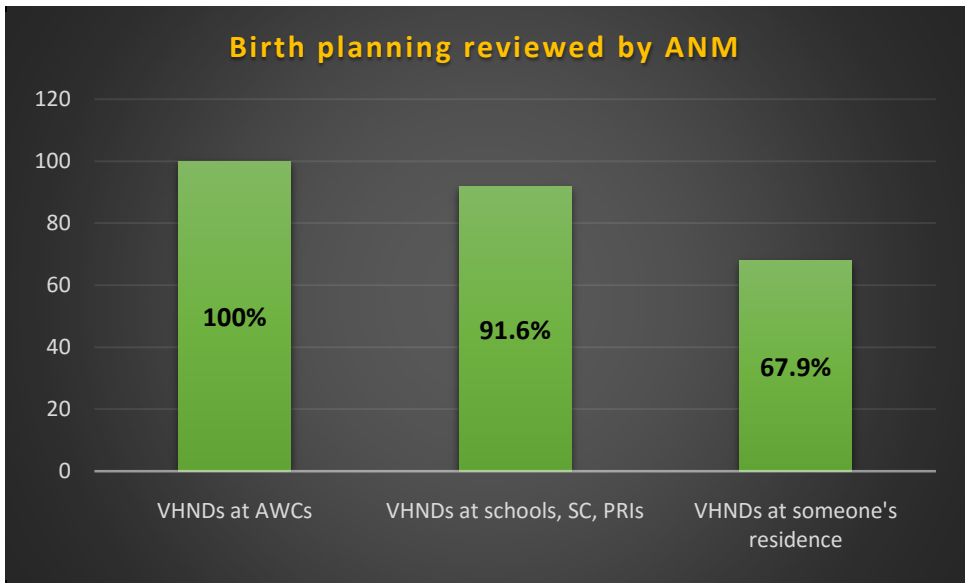
Figure 24: percent distribution of FP due list



4.2.18: Review of Birth Plan: review of birth plans prepared by ASHA was 100 percent at AWCs. Ninety two percent VHNDs held in government institutions were such where

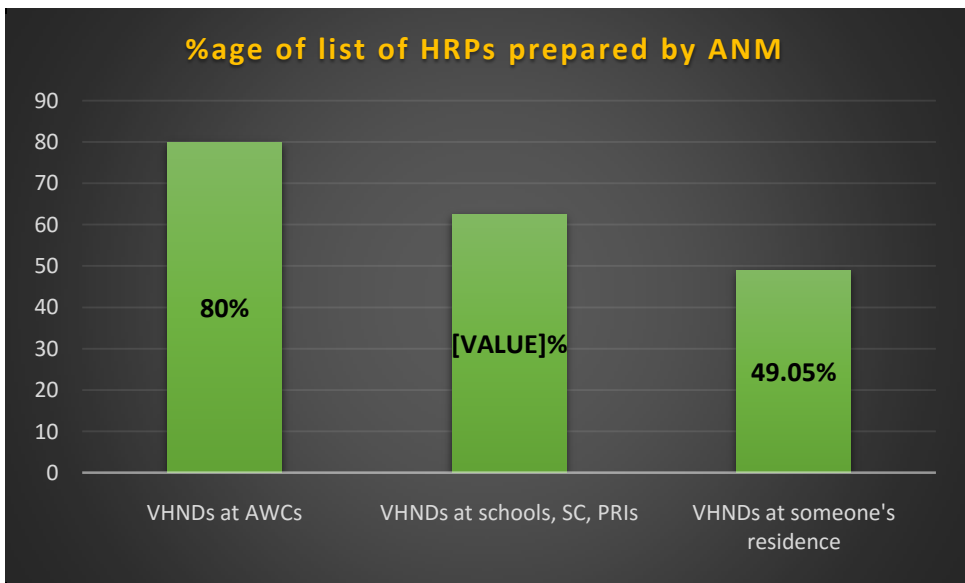
birth planning was reviewed by ANM and around 68 percent VHNDs held at someone’s residence where such where ANM reviewed birth plans prepared by ASHA.

Figure 25: percent distribution of review of birth plan by ANM at different sessions



4.2.19: Line listing of High Risk pregnancies: Around 80 percent of VHNDs held at AWCs were such where line listing of HRPs was done by ANM. Around 63 percent VHNDs held in government buildings were such where ANM had prepared line listing of HRPs and only 49 percent of VHNDs held at someone’s residence where such where ANM had prepared line listing of HRPs.

Figure 26: percent distribution of line listing of HRPs at various sites



5.0: Discussion:

Total number of VHND sites assessed were 92. Out of 92 sessions, only 80 sessions were held as per micro plan. Out of total sessions, only 16.3 percent were held in AWCs, 26 percent held in sub centres, schools and PRIs and 57 percent sessions held at someone's residence.

Around all the sessions observed percentage of ASHAs and AWWs present was 94 percent and 92 percent respectively. On an average, only 24 percent VHNDs had toilet facility available. Sixty percent VHNDs held at AWCs had toilet facility whereas only 36 percent of VHNDs held at someone's residence had toilets available which is very less as most of the VHNDs were held at someone's residence i.e. 57 percent.

Privacy for ANC was around 80 percent and 92 percent at AWCs and government institutions respectively and only 60 percent at someone's residence.

On an average availability of MCP cards was around 85 percent. Availability of BP apparatus was around 89 percent. Around 93 percent and 95 percent of VHNDs had availability of haemoglobin meter and uristix. Slightly less number of logistics was found when VHNDs were conducted at someone's residence.

Availability of adult weighing machine was around 92 percent overall.

Availability of child weighing machines in VHNDs constituted around 62 percent. Only 50 percent of VHNDs held at government institutions had the weighing machine available.

Due list prepared for nutrition services were only 53 percent in AWCs, 75 percent in schools and PRIs and 66 percent at someone's residence.

On an average, only 79 percent of birth planning prepared by ASHA was reviewed by ANM and around only 69 percent was reviewed by ANM when VHNDs were conducted at someone's residence and 92 percent VHNDs held at Government institutions where such where ANMs reviewed the birth planning prepared by ASHA.

Out of the total VHNDs assessed, only 58 percent sessions where such where ANM has prepared line listing of High Risk Pregnancies. Line listing of HRPs at AWCs was 80 percent. Sixty three percent listing of HRPs at sessions held at other government institutions

and only 49 percent sessions held at someone's residence were such where ANM had prepared the line listing of pregnancies.

6.0: Conclusion:

The study was an effort to review the status and quality of Village Health and Nutrition Day conducted in Faizabad. The assessment helped in understanding the gaps especially from the service providers' point of view.

The study clearly reveals that VHNDs held are not up to the mark. Most of the VHNDs were held at someone's residence and not at the AWCs and other government institutions. Most of the VHND sessions lacked the toilet facilities and around only 36 percent VHNDs held at someone's residence had toilets. So it was be very difficult for beneficiaries especially those who had to undergo urine albumin examination.

As most of the sessions were held at someone's residence, only 60 percent sessions had privacy for ANC. So it was very difficult in most of the sessions for pregnant women to undergo abdominal examination as there was no availability of bed screens.

Also one more observation was that only 62 percent VHNDs had child weighing machines available, thus compromising the child growth monitoring.

Due list prepared by AWWs on nutrition services was quite low. They didn't know how to fill the growth monitoring cards.

Percentage of birth planning reviewed by ANMs was quite low at the VHND sessions. Also the line listing of High Risk Pregnancies was as low as 58 percent.

Required quality indicators to improve the quality of VHND sessions

Current services	required services
Service delivery to beneficiaries	
Ante natal check up • Registration of pregnant women • Weighing • BP, Hb, urine examination • Abdominal check up • T.T • IFA	• Height to be measured • Ensuring early registration of PW to get first ANC in first trimester • Monthly tracking of +90 IFA consumption • Counselling on danger signs, birth planning

Weighing and plotting of children under 5 years

- Growth monitoring
- Counselling of parents
- Preparation of food for children
- Liquid IFA supplementation of children

- Weighing and plotting of children in 0-3 years instead of 0-5 years
- Separate day to be fixed for weighing of children of 3-5 years
- Involvement of mothers in growth monitoring of children
- Identification and referral of SAM children with complications
- Counselling of mothers on child feeding practices

Required measures

- Supervisory visit to ensure proper weighing and plotting on the spot.
- Agenda based sector meeting focusing on the progress of weighing of 0-3/3-5 years
- Ensure follow up of referral children by supervisory visit.
- Assessment of quality services through concurrent monitoring.

7.0: Limitations of the study:

- 1) The study focussed mainly on the service provide aspect and not much on the beneficiary aspect.
- 2) The study has conducted in a small area and in only one district of Uttar Pradesh so findings cannot be generalized for the whole state.

References

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- 2) http://www.intrahealth.org/files/media/improving-the-coverage-and-quality-of-village-health-and-nutrition-days/VHND_UP
- 3) https://www.ids.ac.uk/files/dmfile/DFID_ANG_Synthesis_
- 4) http://www.who.int/nutrition/topics/Lancetseries_Undernutrition3.pdf
- 5) https://en.wikipedia.org/wiki/Malnutrition_in_India

Annexure:

VHND Assessment Tool

- Q1 VHND held as per the micro plan
- Q2 No. of ASHAs supposed to be present
- Q3 No. of ASHAs actually present
- Q4 No. of AWWs supposed to be present
- Q5 No. of AWWs actually present
- Q6 Place of VHND - 1. SC, 2. AWC, 3. Panchyatbhawan, 4. School, 5. Someone's residence, 6. Open area
- Q7 Toilet facility available
- Q8 Adequate place available for waiting the beneficiaries
- Q9 Privacy available for ANC
- Q10a Availability of logistics - MCP card
- Q10b Availability of logistics - BP apparatus
- Q10c Availability of logistics - Haemoglobin strip / meter
- Q10d Availability of logistics - Uristix (urine protein test)
- Q10e Availability of logistics - Weighing machine (adult)
- Q10f Availability of logistics - Weighing machine (child)
- Q11_1a Availability of due lists and services provided (Due list available)
(Service provided as per due list) - Routine immunization (OPV, BCG, DPT, measles, JE)
- 11_2a Availability of due lists and services provided (due list available) (Service provided as per due list) - Antenatal care (TT, IFA)
- Q11_3a Availability of due lists and services provided (due list available)
(Service provided as per due list) - Antenatal check-up (BP, HB, urine albumin)
- Q11_4a Availability of due lists and services provided (due list available)
(Service provided as per due list) - Postnatal care (counselling, check-up of mother & baby)
- Q11_5a Availability of due lists and services provided (due list available)
(Service provided as per due list) - Nutrition support (counselling, services-THR)
- Q11_6a Availability of due lists and services provided (due list available)
(Service provided as per due list) - Family planning (counselling, services)

- Q12 Birth planning prepared by ASHA is reviewed by ANM
- Q13 Line listing of high risk pregnancies available with ANM