



**SUMMER TRAINING
AT SEVA MANDIR, UDAIPUR FOR
KHUSHI BABY INC., YALE**

(March 28-May 29, 2015)

To conduct a pre study for Randomized control trial for efficacy and impact assessment of Novel mobile health solution for Vaccination record keeping and to determine the socio-demographic profile of mothers in rural Udaipur, Rajasthan

By

Dr. Shirish Dhore

Under the Guidance of

Maj Vinod Kumar SV

MBA- Hospital and Health Management

2014-16



2015

CERTIFICATE

This is to certify that the project work titled ' To conduct a pre study for Randomized control trial for efficacy and impact assessment of Novel mobile health solution for Vaccination record keeping and to determine the socio-demographic profile of mothers in rural Udaipur, Rajasthan' has been done entirely and submitted by Dr. Shirish Dhore, a student of Masters Of Business in Hospital and Health Management-19th Batch from Institute Of Health Management and Research, Jaipur.

The study project was prepared during the internship period from March 28 2015 - May 29, 2015 at Seva Mandir, Udaipur For Khushi Baby Inc., Yale. This is his original work.

I wish him all success for future endeavors.



Col (Dr.) Ashok Kaushik

Dean (Academics & Student Affairs)

IIHMR University



Maj (Dr.) Vinod Kumar S V

Associate Professor

IIHMR University

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr. Shirish Dhore**, student of MBA Hospital and Health Management Batch- 2014-16 from IIHMR University, Jaipur has undergone his summer training with **Khushi Baby m-Health Project, Yale University at Seva Mandir, Udaipur, Rajasthan** from **28th March 2015 to 29th May 2015** as a part of partial fulfillment of the course, under my guidance and supervision. All data used in the study titled below is first hand data collected by him.

To conduct a pre study for Randomized control trial for efficacy and impact assessment of Novel mobile health solution for Vaccination record keeping and to determine the socio-demographic profile of mothers in rural Udaipur, Rajasthan

His approach to the study designated has been sincere, scientific and analytical.

I wish him all success in all his future endeavors.



Ruchit Nagar

Co-Founder/Co-Director @ Khushi Baby
Student PI at Yale School of Public Health



Mohammed Shahnawaz

Senior Research Officer at IIHMR, Jaipur
Co- Primary Investigator of KB RCT

TABLE OF CONTENTS

S.No	Contents	Page No.
1	List of Abbreviations	2
2	Acknowledgement	3
3	About the Organization	4
4	Introduction	7
5	Rationale	14
6	Objectives	15
7	Methodology	16
	1.study design	16
	2.study area	16
	3.study population	16
	4.study period	16
	5.sampling design	16
	6.data collection	16
	7.data preparation	17
	8.data analysis	17
8	Results	18
9	Findings	31
9	Observations & Learning	34
10	Annexure	36
	1. Questionnaire	36
	2.Map of all the Block, Udaipur, Rajasthan	38
11	References	40

List of abbreviations

AEFI	Adverse event following immunization
ANC	Ante natal care
ASHA	Accredited social health activist
BCG	Bacillus Calmette Guerin
CDC	Centers for Disease Control
DLHS	District Level Household and facility Survey
DOTS	Directly observed treatment short course
DPT	Diphtheria, Pertussis, Tetanus
EPI	Expanded program of immunization
FHW	Frontline Health Workers
FI	Fully Immunized
GMSDs	Government Medical Supply Depots
GNM	General Nurse Midwife
GPS	Global Positioning System
Hep	Hepatitis
IDC	International Design Center
IEC	Information Education Communication
IMR	Infant Mortality Rate
KB	Khushi Baby
MCTS	Mother and Child Tracking System
m-Health	Mobile Health
MMR	Maternal Mortality Ratio
NFC	Near Field Communication
NFHS	National Family Health Survey
NGO	Non government organization
OPV	Oral Polio Vaccine
RCT	Randomized control trial
RI	Routine immunization
SEA	South east Asia
SM	Seva Mandir
TBA	Traditional birth attendant
UId	Unique Identity
UIP	Universal immunization program
UNICEF	United Nations Children's Fund
VPD	Vaccine preventable disease
WHO	World health organization

ACKNOWLEDGEMENT

‘The only way to do great work is to love what you do’

- Steve Jobs

This internship was a milestone in my career; it not only helped to broaden my horizons, but also touched those areas of life which lie miles away from more mainstream. At the onset of my report, I would like to acknowledge my sincere thanks to our institute, Institute of Health Management and Research, Jaipur for providing us platform to gain enough knowledge and skills in different aspects of health management.

I express my gratitude and regards to my mentor Major Vinod Kumar S V for his able guidance and useful suggestions which helped me in completing the project work.

Special thanks to Mohammad Shanawaz, Senior Research Officer at IIHMR University and Ruchit Nagar, Co founder of Khushi Baby Inc, Yale University for thinking that I could be a part of this novel innovative idea .

I would like to express my deepest gratitude to all those who provided me the possibility to complete this report. A big Furthermore I would also like to acknowledge with much appreciation the crucial role of the staff of Seva Mandir, who provided me with all the required information I needed to carry out my project. Without the help of Dr. Kusum Mathur and Dr Harshlata it would have been impossible to complete the project. I am thankful to Ms. Shweta ji, Block health in charge of Jhadol for their timely support and guidance. Special thanks go to my co-interns who shared who help me assemble the parts and gave suggestion.

Last but not least the GNMs involved and the SM staff for working with us and supporting us throughout.

About the Organization

Khushi Baby Inc.

Khushi Baby (Happy Child) is an innovation developed in April 2014 out of the Yale Center for Engineering and Design's course on *Appropriate Technology, Yale University for the Developing World*. It was at this juncture that Khushi Baby's project team decided on a pilot study to address the persistent problem of child immunization and its documentation in Rajasthan with the aim to digitize and decentralize patient medical records at the point of care and as a result Khushi Baby partnered with Seva Mandir, a leading grass roots NGO in Udaipur, Rajasthan to conduct its Randomization Control trials through their vaccination outreach program.

Mission:

To track each child's immunization to the last mile so that children do not continue to die from vaccine preventable diseases.

About Khushi Baby System

Khushi Baby (KB) project provides an inexpensive digital necklace and an accompanying mobile app that streamlines the process of vaccinating children. It's an appropriate technology that decentralizes patient information and above all provides a real-time measure of data with the help of a smart phone used by the health worker and a KB necklace for the child.

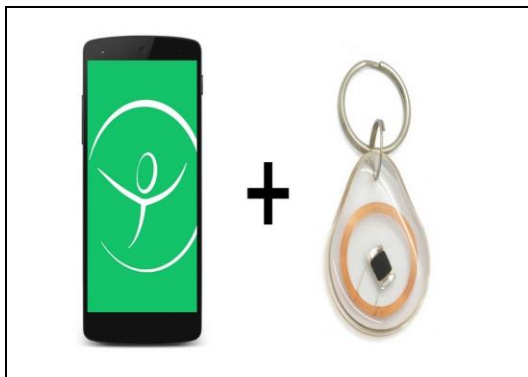


Figure 1: Khushi Baby system- The mobile app and Necklace.

The technology: KB app is a like any other mobile application that can easily be downloaded in a near field communication (NFC) supporting android phone, NFC is a form of short-range communication that enables the wireless transfer of data. The KB necklace has a small NFC chip that stores patients records, the chip is embodied in a plastic body and tied to a black thread for the child.

How to use KB app?

The health worker can feed in the child personal and vaccination data in the app and simply scan the necklace to retrieve, edit and update information. As soon as the phone enters an area with cellular service, it uploads all vaccine data to the cloud database that can then be monitored via the Dashboard that provides real time analytics of the vaccination rates.

Khushi Baby plan for 2015-2016:

Beginning July 1 2015, KB Inc. is conducting a 9 month, 100-camp RCT and nested observational study to validate the efficacy of KB system and its particular features in partnership with Johns Hopkins University, Yale University, and Indian Institute of Health Management Research University, Jaipur.

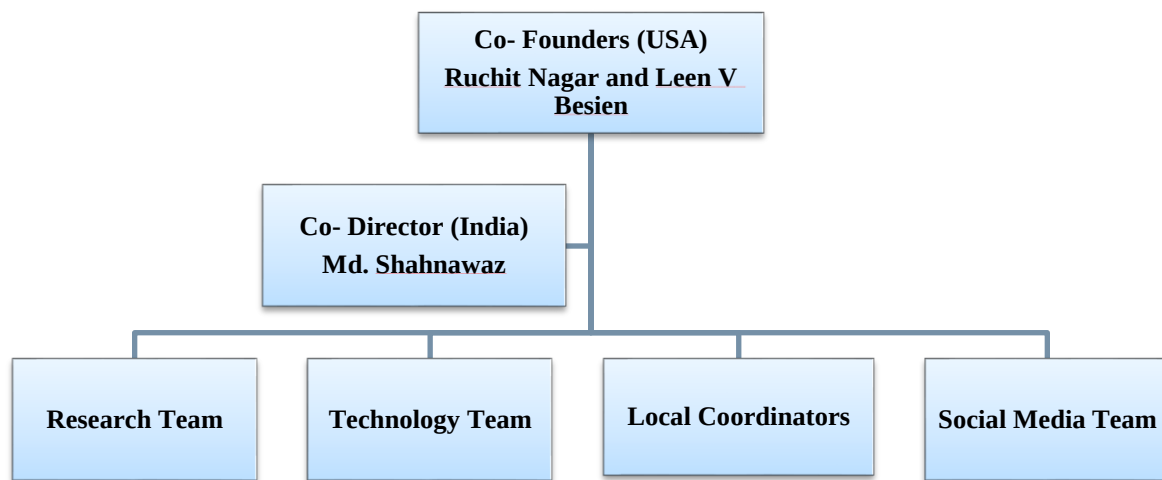
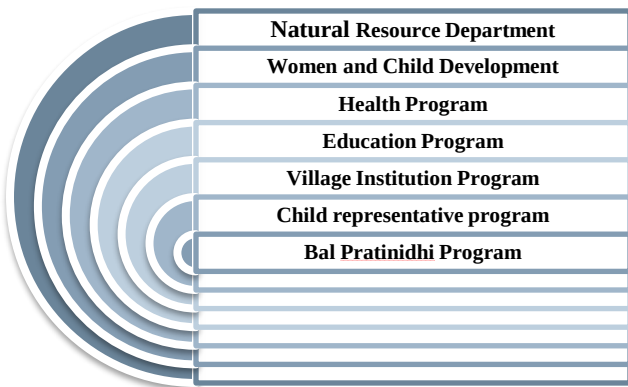


Figure 2: A representation of Khushi Baby Inc. Organogram

Seva Mandir

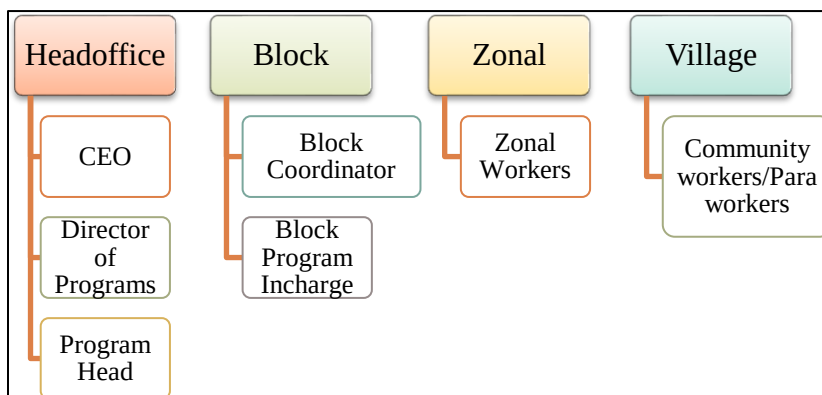
Seva Mandir means the ‘Temple of Service’. It is a voluntary organization registered under the Society Registration Act 1958 and also registered in Rajasthan Public Trust Act, 1959. It is working with rural communities of Udaipur and Rajasamand districts for over 4 decades and covers over 600 villages and a population of 360,000 people living in Jhadol, Girwa, Badgaon, Kotra, Kherwara and Kumbhalgarh Blocks of Udaipur and Rajasamand Districts.

Mission: To construct the conditions in which citizens of plural backgrounds and perspectives can come together to benefit and empower the least. The commitment is to work for a paradigm of development and governance that is democratic and poly archaic.



For over 45 years, SM has worked in partnership with the people where over 90% of the people rely on agriculture and most live on less than Rs 20 a day, not only to improve their material well-being, but to build stronger and more ethical communities. Through its programs on governance, health, education, sustainable use of natural resources, women’s empowerment, youth development, child care and social enterprise, Seva Mandir makes a tangible and transformative impact.

Figure 3: Shows the seven programs running successfully under Seva Mandir.



SM seeks to institutionalize the idea that development and governance should not just be left to the state and its formal bodies, such as the legislature and the bureaucracy, but that citizens and their associations should engage separately and jointly with the state.

Figure 4: Following is the pictorial representation of SM staff and workers:

Introduction

Vaccines have made a major contribution to public health but vaccines-preventable diseases (VPDs) are still responsible for significant deaths of under-five children. Despite Global efforts, the coverage in two WHO regions namely Africa and South-East Asia (SEA) still remain short of set targets for 2010. As a result, the SEA Regional Director has declared 2012 as the Year for Intensifying Routine Immunization (RI) in the Region.. [1] The recent immunization coverage surveys in India have shown gradual albeit a slow progress in the performance of RI in India over last few years but in some states the coverage is still quite low. Several new initiatives like introduction of Hepatitis B vaccine, second dose of Measles vaccine and pentavalent vaccine (two states), JE vaccine rounds, framing of the National Vaccine Policy, etc. are welcome steps. The challenges and barriers to achieve high immunization rates in the country are well recognized. Almost nonexistence of an effective VPD surveillance system in the country has further compounded the problem. The need is to address all the barriers to achieve high RI rates, which should include induction of innovative methods, proper monitoring of the program, improving operational efficiency and ‘reaching every community’, and integrated delivery of health interventions along with immunization. The development of an efficient VPDs surveillance, adverse event following immunization (AEFI) monitoring and post-marketing surveillance systems will go a long way in ensuring satisfactory performance of the health system. The decades old Expanded Program of Immunization (EPI), which was adopted in India as universal Immunization Program (UIP) also needs a revamp with inclusion of certain new vaccines. Decisions on implementing new and underutilized vaccines require scientific evidence and data, a reliable supply of affordable vaccines, which are adapted to the country’s immunization schedule, and an integrated disease monitoring and surveillance system.

Routine immunization (RI) is an important tool to achieve the UN Millennium Development Goal (MDG)4 by ensuring childhood protection from infectious disease. In 1985, the Government of India launched the Universal Immunization Programme (UIP) to protect all infants (0-12 months) against six preventable diseases: tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, and measles. The goal of UIP was to ensure 100% coverage of all eligible children with one dose of BCG, three doses of DTP and OPV, and one dose of the measles vaccine. According to Coverage Evaluation Survey (CES) 2009, a nationwide survey covering all States and Union Territories of India conducted during November 2009 to January 2010 by UNICEF, the national fully immunized (FI) coverage against the six vaccines included in UIP in the age-group of 12-23 month old children was just 61%. Coverage with third dose of diphtheria, tetanus and pertussis vaccine (DTP3) is a widely accepted global indicator for RI program performance. India national estimates found DTP3 coverage was 72% (WHO India 2011), against a global target of 90 %. The District Level Health Survey 3 (DLHS 3) findings suggest that the retention rate of childhood immunization was in maximum decline between the second round of DT and polio - 70 % and the third round - 56 % [2].

M-Health solution to increase immunization:

[3] In developing nations like India, many parents aren't able to keep track of their child's immunizations. Current solutions such as hard copies of records are easily lost, and there is no centralized location to retrieve this information. Moreover, in rural India, there is little incentive to get children immunized when it is at the price of losing valuable hours in the workday during which parents could otherwise be earning money for the family. These reasons compounded together ultimately mean that there are large hurdles to overcome in order to achieve effective and systematic immunization, and by extension, overall health in society. At the same time, the same rural population has a high growth rate of mobile phone usage. Khushi Baby seeks to leverage this fact to solve the problem of low immunization rates in rural India.

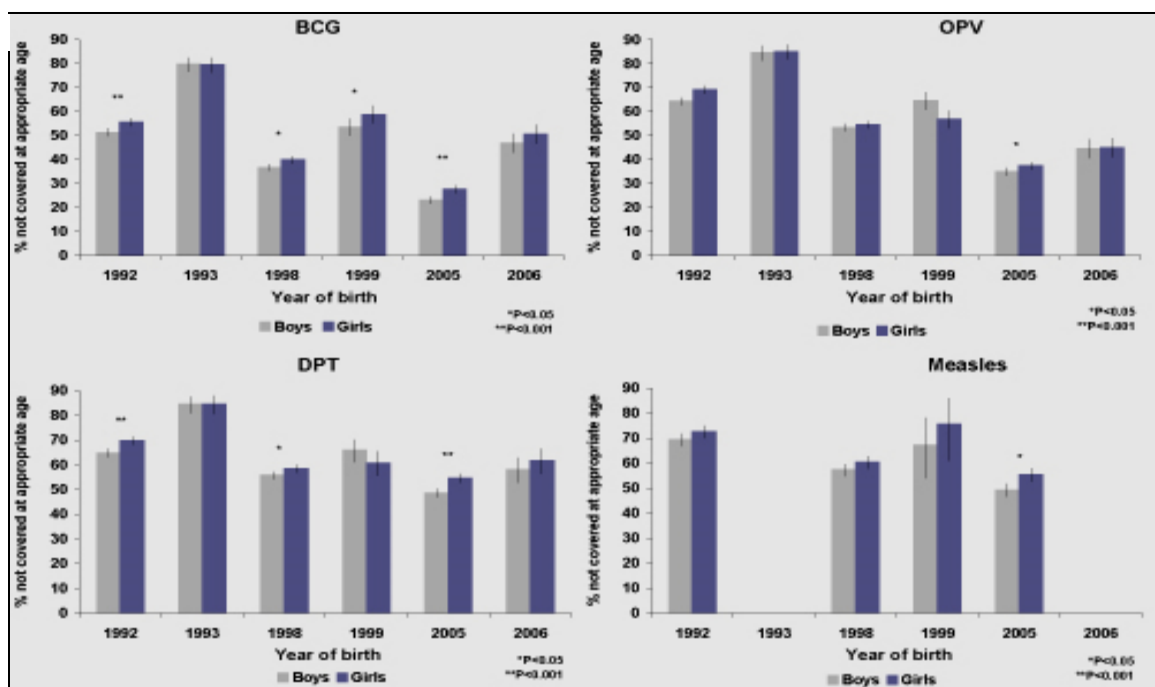


Figure 5: Percentage of children without age-appropriate immunization coverage in India at the time of each NFHS survey, by antigen and gender. In Corsi et al, BMJ 2009.

Existing non-technical strategies:

- Medical Officers draw up micro-plans for immunization. This includes estimating population headcount and by extrapolation calculating an estimate of the number of children in a particular area under the age of 5 who need immunizations. Once the population and areas are determined, then a schedule of vaccination clinics is planned, taking into account the supply and storage of vaccines which requires refrigeration. [4]
- A national cold chain assessment by UNICEF in 2008 revealed that India has 4 national vaccine stores called Government Medical Supply Depots (GMSDs), which receives, stores and supply huge quantity of vaccines, cold chain equipment and logistics all over the country. The current practice of recording and reporting of cold chain equipments, spare

parts, vaccine and logistics at all stores is carried out on paper, and this was found not to be the most efficient away of managing the supply chain and forecasting stock out situations.

- Most immunizations for children take place in public health centers or community clinics. Access to these clinics is a problem for the population who has to travel long distances to get there. In addition, there are difficulties in communicating when and where clinics are being held to the rural population and difficulties in ensuring reliable staffing of these clinics.
- Establishment of immunization camps staffed by a mobile immunization team to deliver vaccinations to rural parts of the country. [5]
- Social worker/community health worker outreach to villagers to identify children requiring immunization, educating mothers about the benefits of immunization and informing mothers and families about the availability of local immunization services [UNICEF] and undertaking directly observed therapy short-term (DOTS) programmes, where they observe and confirm that the vaccinations have taken place.
- Every child is given an official routine immunization card, indicating their name, the name of their parents and the date and type of each immunization performed. The nurse at the immunization centre also keeps a paper logbook of the children who have been vaccinated. [6]

The existing strategies found to be effective in improving immunization coverage, outreach, advocacy and communication, health facility practices, access to vaccines; it also may increase education and training, better data management, resources, changing management practices and allows combinations of above strategies.

Existing m-Health solutions:

The ascending curve of mobile cellular subscriptions is clearly different between developing and developed countries, as states World Bank data, with a higher velocity of increased access of this technology by the population (Figure 2), in the last years, in emerging countries such as South America (Brazil), India and China. For India a huge increase of the use of smart phones is forecasted, however more in urban than rural areas [7].

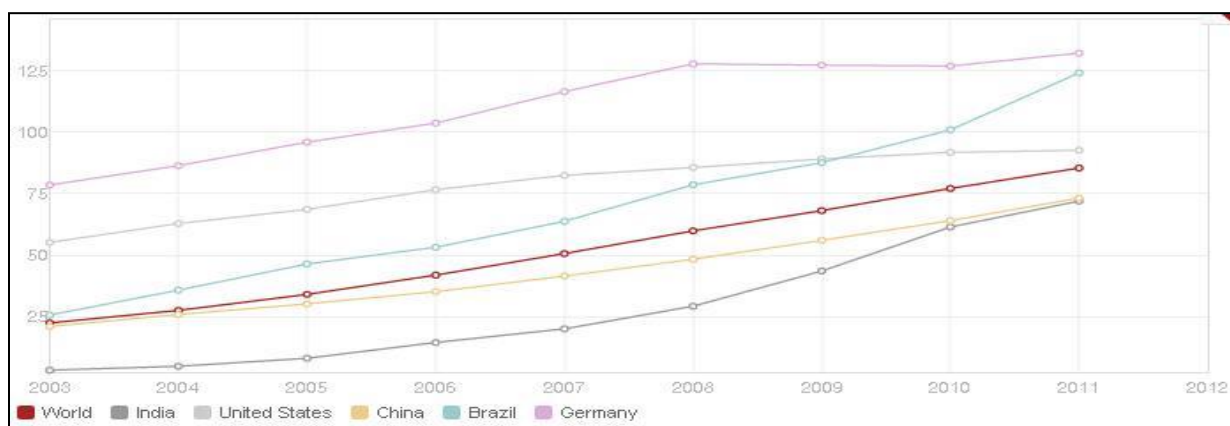


Figure 6: Mobile cellular subscriptions (per 100 people) in developed and developing countries. Source: World Bank.

A similar trend is predicted for smart phones, even if penetration of these devices is low in rural areas. By 2015, forecasts suggest that between 32- 74 million units will exist in India, not including feature phones [8]

- mHealth solutions currently in use are messages distributed by SMS (e.g. SMS for life Frontline SMS; Déglise et al, 2012; Rakotozafy, 2012), internet reach-out campaigns or the use of smart phones and applications (so called apps) for special topics.
- The nationwide Mother & Child Tracking System, a web enabled name based tracking system which aims to track every child for assured delivery of immunization services based on the real time reporting on immunization coverage. The MCTS system is expected to make the immunization services more 'Citizen Centric' by reaching out to families of the beneficiaries through mobile phone (SMS) and interactive voice response system (IVRS). The system is also expected to facilitate the functioning of the frontline health workers (FWs) and health managers at district, state and national level to plan, implement and monitor services more efficiently and effectively by generating work-plans and decision support dashboards based on the real time reporting on immunization coverage.
- In Western Uttar Pradesh, an IVRS updates residents with mobile phones about the next polio vaccination round, prenatal visits to the doctor for pregnant women and much more[9].
- A CDC partnership initiative in Patna, Bihar utilized Geographic Information Systems (GIS) technology. GPS units enabled capture of the geographic coordinates of the various stakeholders (the medical staff and children) and sites (immunization centers and vaccine storage facilities) involved in the immunization programme. Using this information, digital and paper maps were created to plan the most efficient routes to get vaccines and medical staff to the centers [10]

Khushi Baby in collaboration with Seva Mandir as m-Health Solution:

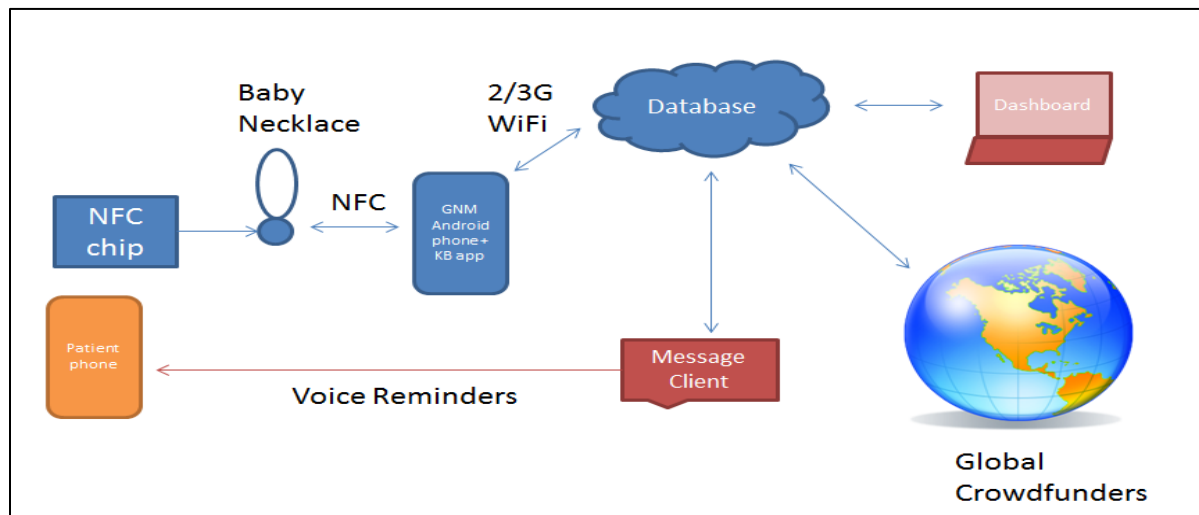


Figure 7: Process Map of Khushi Baby. **Blue** indicates KB responsible components. **Red** indicates SM responsible components.

General process:

- NFC chip stores vaccine record for patient
- Phone interfaces with wearable chip to update vaccines given
- Data is saved on chip, phone, and also sent to the cloud by WiFi / 2G, 3G
- The database is used to inform the messaging client
- The database is used to populate graphs on the web-based, password-protected dashboard
- Key value adds: real time data, collecting new vaccine forecasting information (vaccine denials), automating check-in/check-out process for payment sheets, granular data for crowd funders.

Immunization Camp Process:

Traditional Birth Attendants (TBA) travel to each hamlet inside a village on foot, delivering verbal reminders to mothers about upcoming immunization camps by Seva Mandir.

- There is usually one TBA per village; there may be additional assistance in the form of a Seva Mandir Balsaki (caretaker of young children above age 2)
- This process usually takes place several days before the camp and requires at least 1 day worth of work

- The furthest hamlets can be 3-4 km away
- Mothers may not always be in their husband's house
- They can be in the field
- They can be at their parent's house
- The TBA must mentally keep a note of which mothers have had new births, which mothers are pregnant, and which mothers have children that need to come to the immunization camps
- In some villages, there is access to an overlapping government facility staffed by Anganwadi workers where multispectral resources are available – from immunizations to school supplies; the TBA must also be aware of who has received immunization from the Anganwadi workers before advising them to come to a Seva Mandir immunization camp.

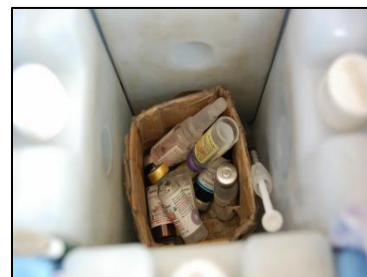
General Nurse Midwives (GNMs) travel from the Block Office to the immunization camp:

- Each village has an immunization camp on a fixed day of the month (e.g. 14th)
- GNMs travel to the camp via motorcycle
- Typically immunization camps will have one GNM
- Teams of two go if they are female GNMs
- And/or assistance will be provided from 1 TBA or Balsaki who stays at the immunization camp

They carry:

- WHO style insulated container
- Vaccines
- Leather bag (heavy)
- Vaccine Supplies (needles, gloves, alcohol)
- Logbooks
- One for pregnant mothers
- One for children
- Other medications (anti-parasitics, nutrient supplements)
- Waste supplies (on their return)
- Sphygmomanometer (to measure blood pressure)

At the camp they may be provided a mat to sit on, lentil bags (stored away in a designated building for the camps participating in the lentils incentive program, and a scale for mothers



Field Workflow (camps run between 1st to 26th of each month)

Upon reaching the camp, GNMs identify the SM board and have either the other GNM / Balsaki / TBA take a picture of them in front of the board

- This picture has a date stamp and serves as a monitoring tool to ensure attendance
- GNMs unpack their leather bag on the provided mat
- An immunization camp is slated to run from 9:30-12:30, but mothers often do not show up until 10:30 or 11 AM, pushing the camps end time closer to 2 pm
- Mothers come on foot to the camp and are treated first come first serve
- Priority is made for mothers with children then for pregnant mothers
- The GNM checks the mothers MAMTA card (a nationally distributed maternal and child health tracking card)
- These cards can be administered by government district hospitals or government health workers (anganwadi's) upon delivery or upon the first immunization checkup

The GNM then correlates the patient with existing records in their child logbook:

- Usually they are able to find the child since there are only about 10 children attending each immunization camp or a new record is made
- The logbook is searched by going to the tab for the current camp and then looking through the list of names
- The GNM can issue a new MAMTA card if the mother has lost the card
- In cases where the child's MAMTA card is empty or incomplete, or if the record is not available, the GNM must ask the mother to estimate the child's birth date – this date is often nonspecific and an estimate of the month the child was born
- The GNM must account for vaccines that were administered from other sources because mothers do not always come to SM for their shots (they could also go to Anganwadis). They may ask the mother if the child has received BCG, HepB, DPT, or polio birth doses.

After confirming the child's birth date, the GNM administers vaccines:

- BCG vaccine vials are only opened if a minimum of five children are seen at the camp
- DPT and Hep are administered on child's legs
- Polio is administered orally
- GNMs do not administer more than 2 injections to avoid creating fear / distress in mothers
- The GNM marks the MAMTA card with the date and the appropriate cell in the logbook with the date of the administered vaccine
- The mother thumbprints in the logbook to verify the vaccine was received
- The mother may be given a bag of lentils, antiparasitics, nutritional supplements before departing
- The process repeats for all mothers

- Pregnant mothers without children are weighed, measured for BP, and given a tetanus vaccine during an antenatal care checkup
- Upon finishing the camp, needles and waste are collected and put in the leather bag
- GNMs take a picture to “sign out”
- They return to the block office and drop off
- The bag
- The vaccine box
- The motorbike

The process repeats for 10-15 days of the month, with GNMs visiting 1 camp per day 0-20 mothers + children are attended to per camp, with 10-40 vaccine doses given.

Rationale

The proposed study site, the Udaipur district of Rajasthan, has traditionally had lower immunization estimates than national levels while also performing poorly in other key developmental indicators, IMR of 63 per 1000 born infants and MMR of 265 per 100,000 women of reproductive age. The most recent immunization estimates for this area were assessed in 2013 by the DHLS-4 survey, but data is incomplete for villages outside of the government’s catchment area.

In addition to potentially being able to increase demand for vaccination, the NFC chip pendant will improve the quantity and quality of immunization services available through a more efficient monitoring and outreach system.

The reasons for conducting this pre RCT phase are

- collection of data
- to refine the functioning of KB application
- to digitize data so that manual system can be replaced with Khushi Baby System
- to find out the levels at which immunization program run by SM needs improvement

Objectives

Primary Objectives:

1. To conduct a pre study for Randomized control trial for efficacy and impact assessment of Novel mobile health solution for Vaccination record keeping in rural Udaipur Rajasthan.
2. To determine the vaccine awareness of mothers in rural Udaipur.
3. To compare the time effectiveness of KB App over Manual method.
4. Institutional, on field, & independent training of GNMs

Secondary Objectives:

- i. To find out vaccination related awareness of women who came to immunization camps.
- ii. To design IEC material (Leaflet, Audio, Video) for GNM, TBA, Balsakhi training.
- iii. To record the GPS co-ordinates of different campsite via e-Trex (GPS device).
- iv. To find out whether there is Mobile Network connectivity at campsites.
- v. To determine the bugs with respect to App crash from the field.
- vi. To take monthly GNM user feedback.
- vii. To digitize immunization data of past 6 months in MS-Excel.
- viii. To verify authenticity of data synced and compare it with logbooks.
- ix. To follow up immunization camp in the month of may and see the retention of pendants.

Methodology

- **Study Design:**

- ❖ Qualitative Research
- ❖ Quantitative Research

- **Study Area:**

- ❖ The study areas were 5 Blocks of Udaipur district of Rajasthan (Girwa, Badgaon, Kherwara, Kotra & Jhadol).

- **Study Population:**

- ❖ 357 mothers of all the blocks who came for immunization camps in the month of April & May month(ANCs + child immunization)

- **Study Period:**

- ❖ The study was carried out for 2 months from 28th March -29th May 2015.

- **Sampling Design:**

- ❖ Purposive sampling- All the parents of children who came to Seva Mandir's immunization camps were selected for the study.

- **Data Collection:**

- ❖ **Interview method** - Face to face interview were taken of mothers who came to immunization camps. Relevant primary data was collected by interviewing the respondents with the questionnaire on different variables/parameters.
- ❖ **Semi-structured Questionnaire** – A questionnaire of close ended and open ended questions was made to get specific and relevant information from parent regarding the vaccination information.

- ❖ **Data Entry Time-** Time recorded by stop watch to know the logbook and KB App data entry time

- **Data Preparation:**

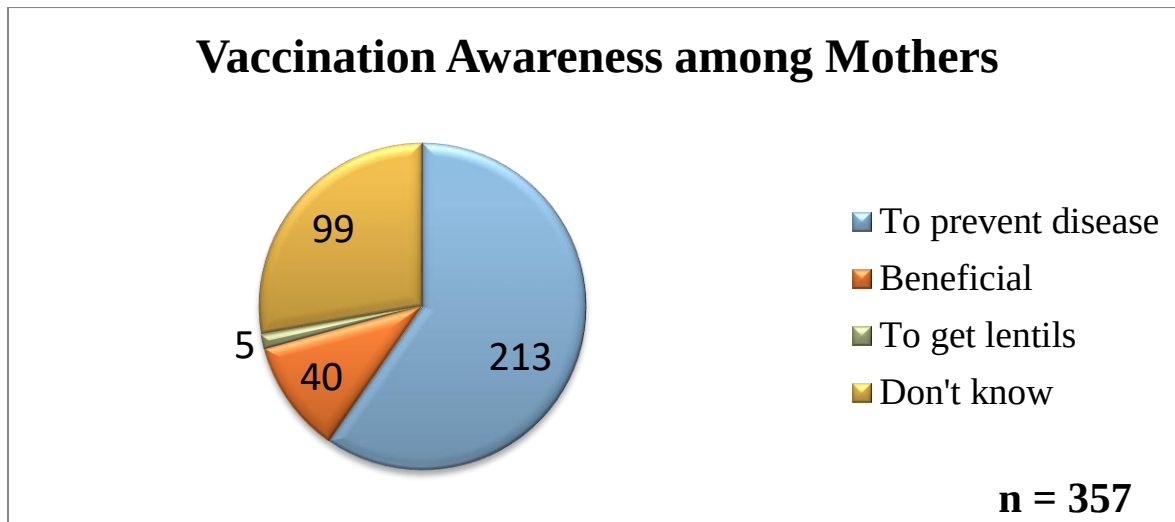
- ❖ Data Entry- All the responses were entered into SPSS software
- ❖ Coding of data- Different responses from the respondent were coded numerically for the closed ended questions and entered in SPSS software.
- ❖ Cleaning of data- Missing values were removed from the dataset.

- **Data Analysis:**

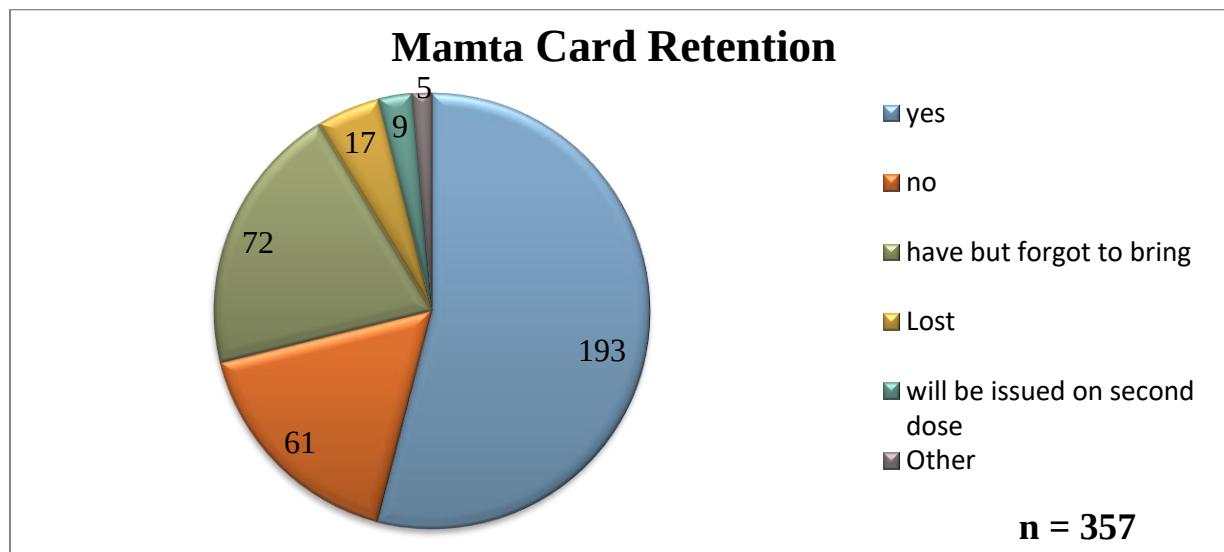
- ❖ Level of measurement – nominal and ordinal
- ❖ Frequencies and Percentages of different parameters were found out using SPSS software
- ❖ Graphical Representation was done using Ms Excel Software.

Results

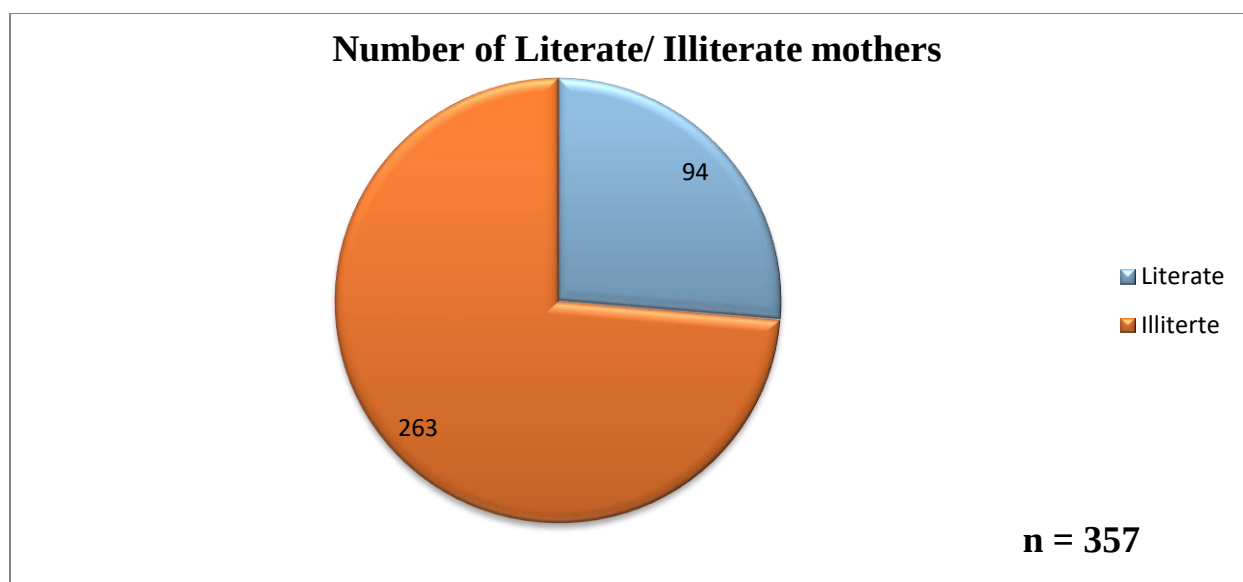
I) a. Figure 8 : Vaccination Awareness



b) Figure 9 : Mamta Card Possession



c) **Figure 10 : Women who could read write and understand**



2. **Figure 11 : To design IEC material (Leaflet, Audio, Video) for GNM, TBA, Balsakhi training**

Leaflet for guidance of GNMs

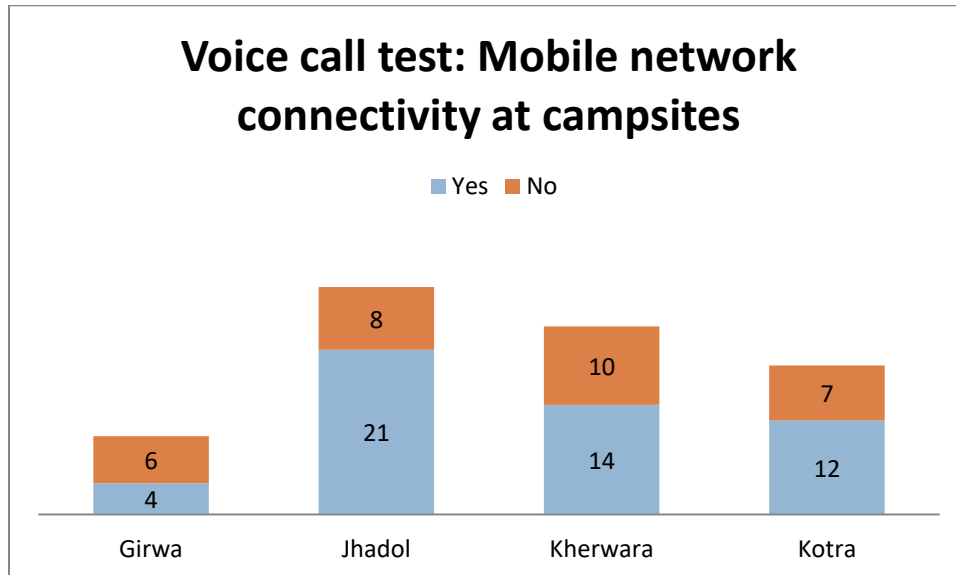
Id	Block	Days before appointment	Time	Recording	Created at	Updated at
1		0	2000-01-01 14:27:00 UTC	Doma_Voicenote1	2015-04-11 02:28:55 +0530	2015-04-29 08:38:03 +0530
2	Badgaon	0	2000-01-01 18:58:00 UTC	Aman_Voicenote3	2015-04-29 18:57:55 +0530	2015-04-29 19:06:01 +0530
3	Girwa	0	2000-01-01 13:49:00 UTC	Doma_Voicenote4	2015-05-03 13:49:44 +0530	2015-05-03 13:50:07 +0530

A view of Dashboard showing voice call rules

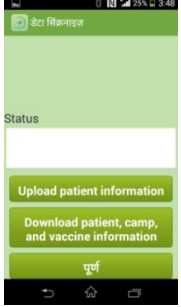
3. To record the GPS co-ordinates of different campsites via e-Trex (GPS device):

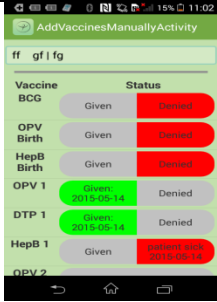
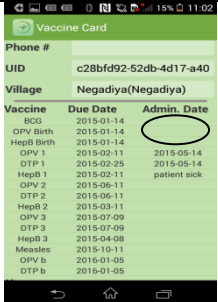
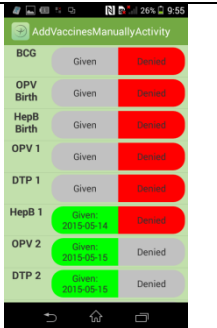
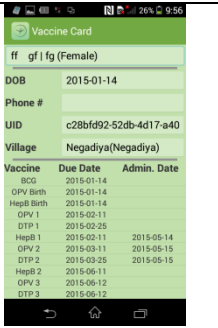
Hamlet(team 1)		Hamlet(team 2)	
	elevation: 1948 ft , N 24° 36.617' E 73° 41.171'		elevation: 1937 ft , N 24° 12.346' E 73° 27.977'
Magra		Peelak	
	elevation: 2324 ft , N 24° 14.540' E 73° 25.222'		elevation: 2052 ft , N 24° 30.343' E 73° 18.472'
Dudhia Dev		Chittoriya Phala	
	elevation: 1902 ft , N 24° 15.075' E 73° 21.853'	Semla	
Magra Babra			elevation: 1493 ft , N 24° 23.459' E 73° 19.309'
	elevation: 1931 ft , N 24° 13.297' E 73° 28.189'	Upli Birothi	
Upla Naivela			elevation: 1935 ft , N 24° 12.088' E 73° 26.860'
	elevation: 2244 ft , N 24° 13.640' E 73° 28.422'	Ghata	
Dara Phala			elevation: 968 ft , N 24° 23.146' E 73° 18.245'
	elevation: 1102 ft , N 24° 17.274' E 73° 26.554'	Basiwada	
Jogniya Phala			elevation: 991 ft , N 24° 18.281' E 73° 18.275'
Badoliya		Nava Ghar	
Kolyara			elevation: 1928 ft , N 24° 10.174' E 73° 22.731'
	elevation: 1871 ft , N 24° 11.825' E 73° 25.989'	Bada Bhilwada	
Mala Phala			elevation: 1123 ft , N 24° 28.007' E 73° 21.175'
	elevation: 1988 ft , N 24° 29.661' E 73° 28.004'	Khuda	
Naal Ghati			elevation: 1017 ft , N 24° 12.557' E 73° 23.044'
	elevation: 1988 ft , N 24° 29.661' E 73° 28.004'	Darangi	
Ranjeetpura			elevation: 1375 ft , N 24° 23.268' E 73° 20.481'
	elevation: 1191 ft , N 24° 19.595' E 73° 30.599'	Nichla Sahiwada	
Naadi			elevation: 2005 ft , N 24° 30.769' E 73° 27.585'
	elevation: 1984 ft , N 24° 09.799' E 73° 22.107'	Mahudiya	
Nava Ghar			elevation: 1989 ft , N 24° 10.309' E 73° 21.039'
	elevation: 1905 ft , N 24° 23.11827' E 73° 25.990'	Jher Phala	
Bharbhat			elevation: 1226 ft , N 24° 25.246' E 73° 20.253'
	elevation: 1905 ft , N 24° 23.11827' E 73° 25.990'	Gadhla	
Kyariya Ghativela			

4. **Figure 12 : Mobile Network connectivity at campsites**



5. App crash from the field

1. The newly added zones and other advances do not show Hindi translation.			Bug Description: <short description here> Steps To Reproduce: 1.Change dictionary to Hindi 2.Select Zone and village 3. Sync data Expected Behavior: <Hindi conversion of the texts > Actual Behavior: <The newly added zones and village show English text. >
2. The 5th denial reason in Hindi has some font error.			Bug Description: <the Hindi text of 5th denial reason i.e mother denies multiple shot is incorrect> Steps To Reproduce: 1.Enter patient information 2.Add vaccines manually 3.Denied reason no. 5 Expected Behavior: <मौने कई इंजेक्शन से इनकार किया > Actual Behavior: <मौने कई इंजेक्शन से मना??? या>

3. If GNM only adds a denial reason in the entire process then all the previous denial reason gets deleted.			Bug Description: <Adding a denial reason leads to loss of previously added denial reasons > Steps To Reproduce: 1.Enter patient information 2. Open Add vaccines manually 3.Put any denial reason Expected Behavior: <Addition of the new denial reason with all other information unchanged > Actual Behavior: < The old denied reasons gets deleted>
4. If GNM gives a shot that was denied earlier and changes the denied as given then the entire denial reasons is deleted with the updated given.			Bug Description: <When GNM gives a shot that was denied before then the entire denial reasons gets deleted > Steps To Reproduce: 1.Add vaccines manually 2.Change to given 3. etc. Expected Behavior: <Change denied to given with other denial reasons unchanged > Actual Behavior: <The given is displayed but other denied reasons get deleted >

6. **Figure 13 : Verify authenticity of data synced and compare it with logbooks**

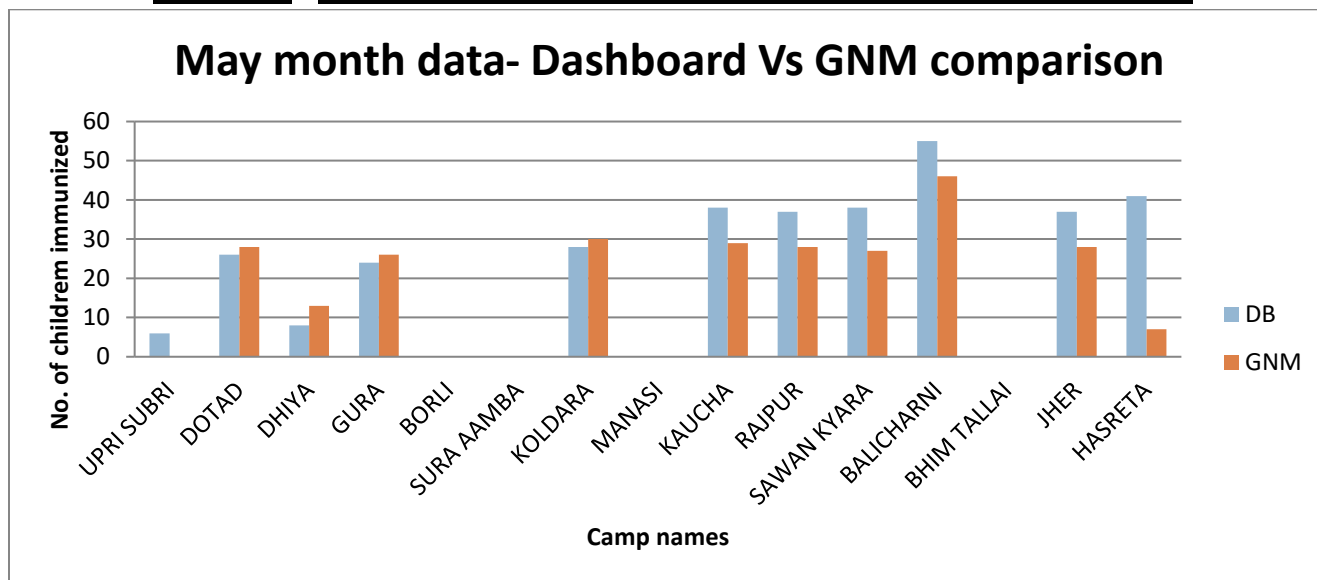


Figure 14 (a) : GNMs Manual and KB app feedback in likert scale

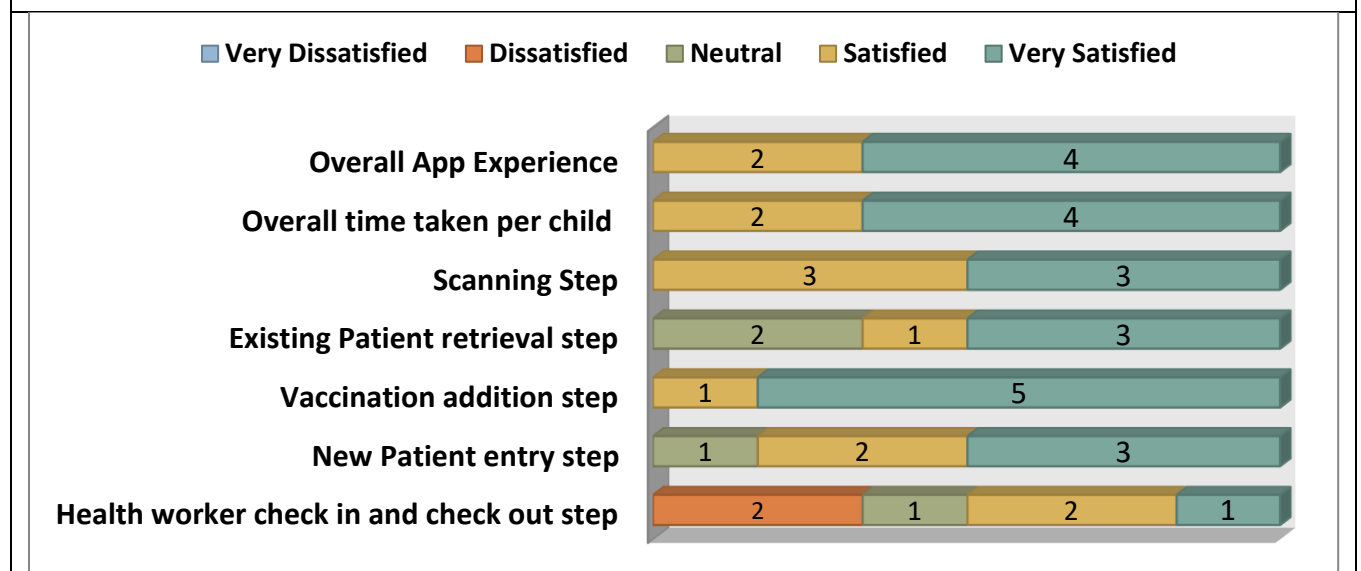
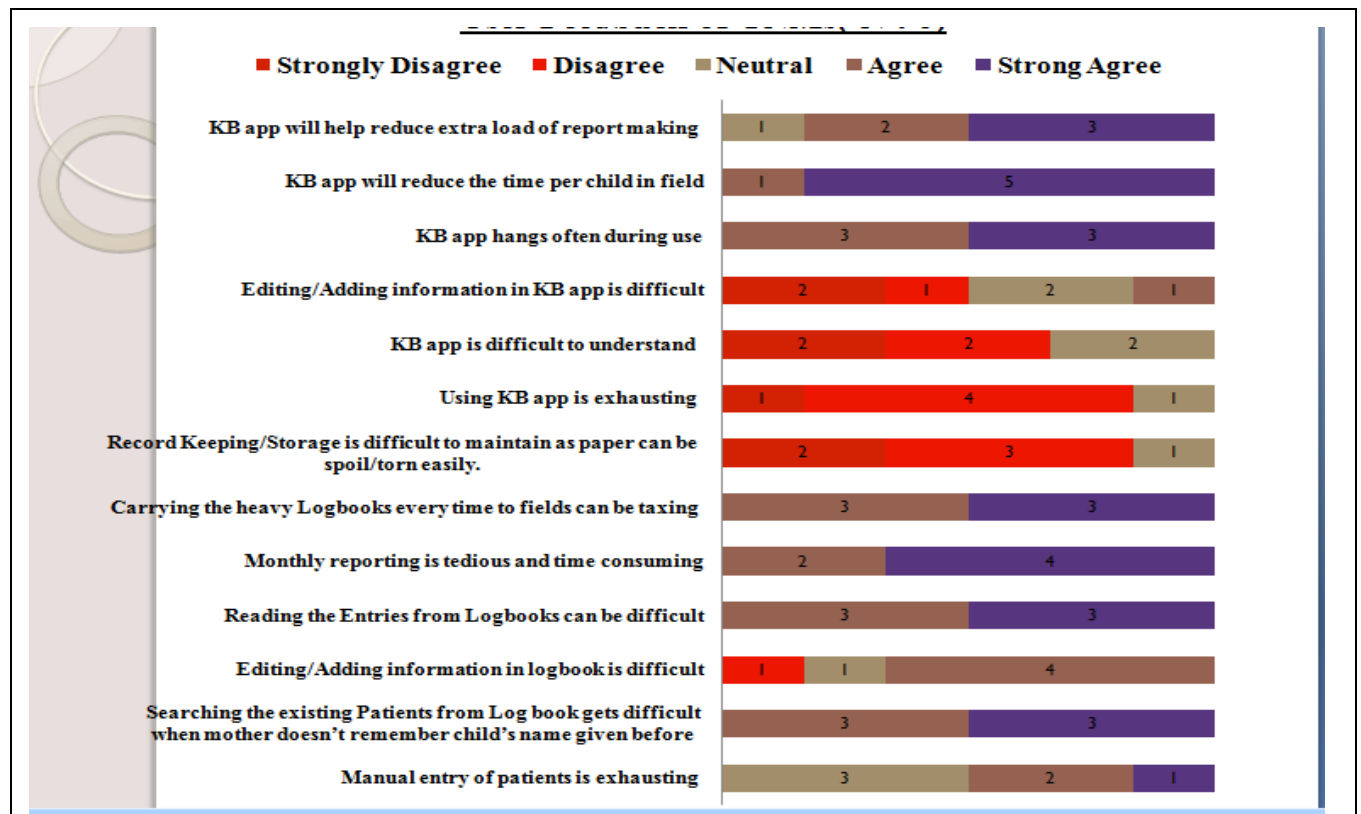


Figure 14(b): GNMs Manual and KB app feedback in likert scale

7. Figure 15 : Time Efficacy of KB App Vs Logbook:

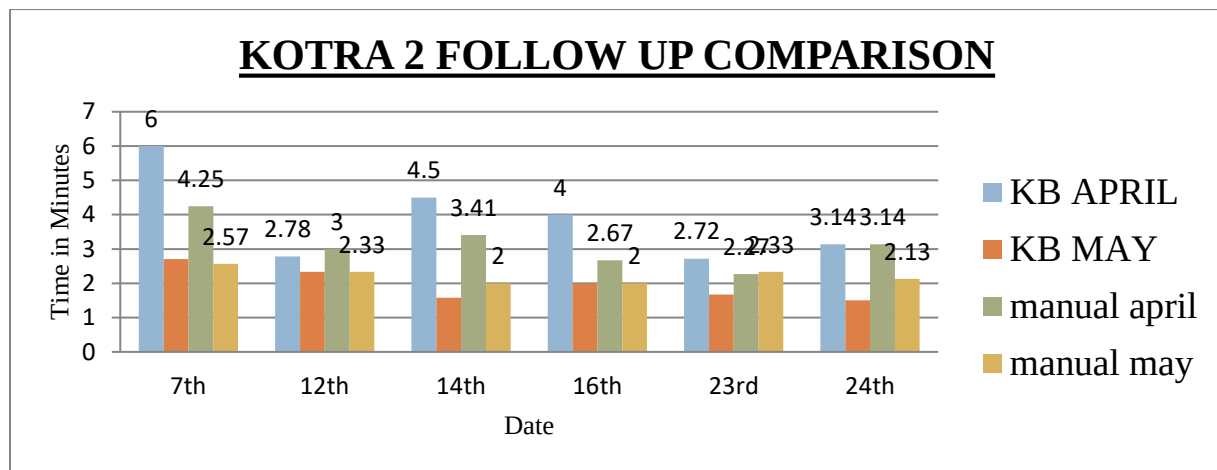
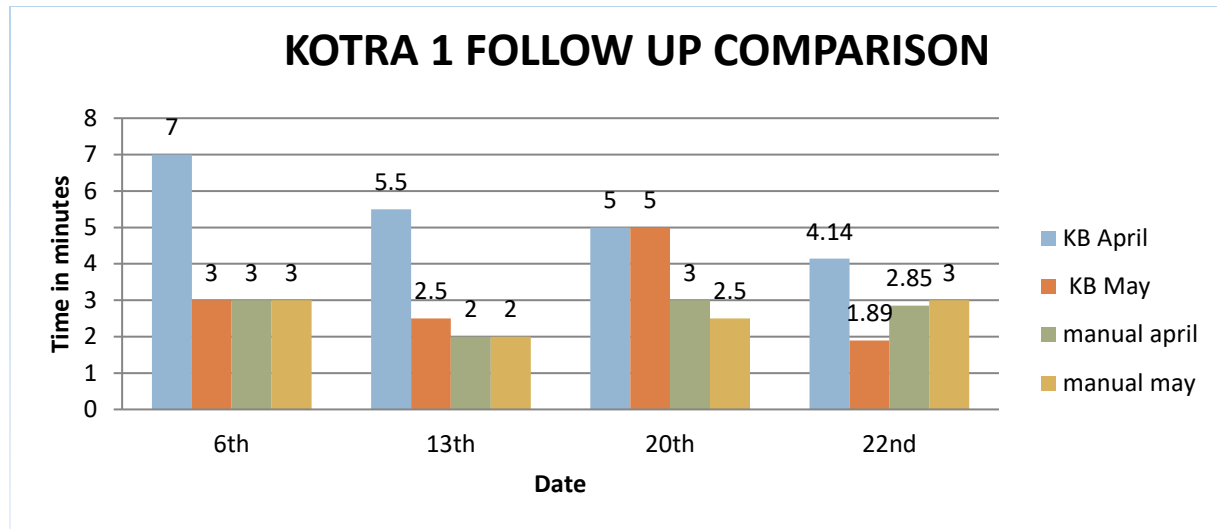


Figure 16 : Jhadol

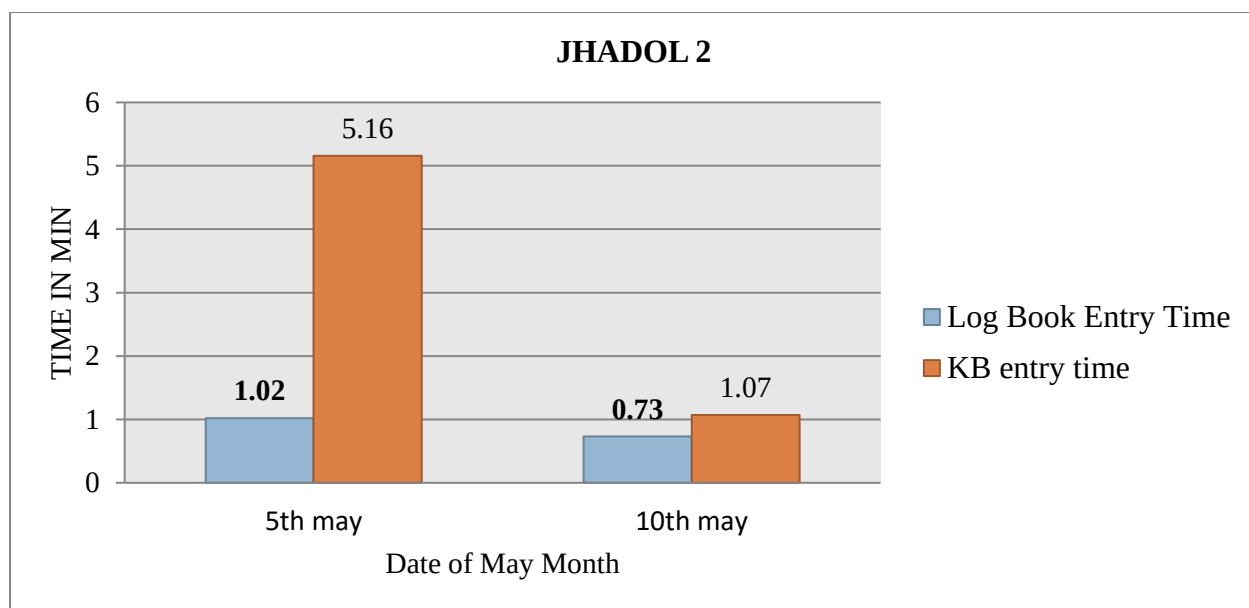
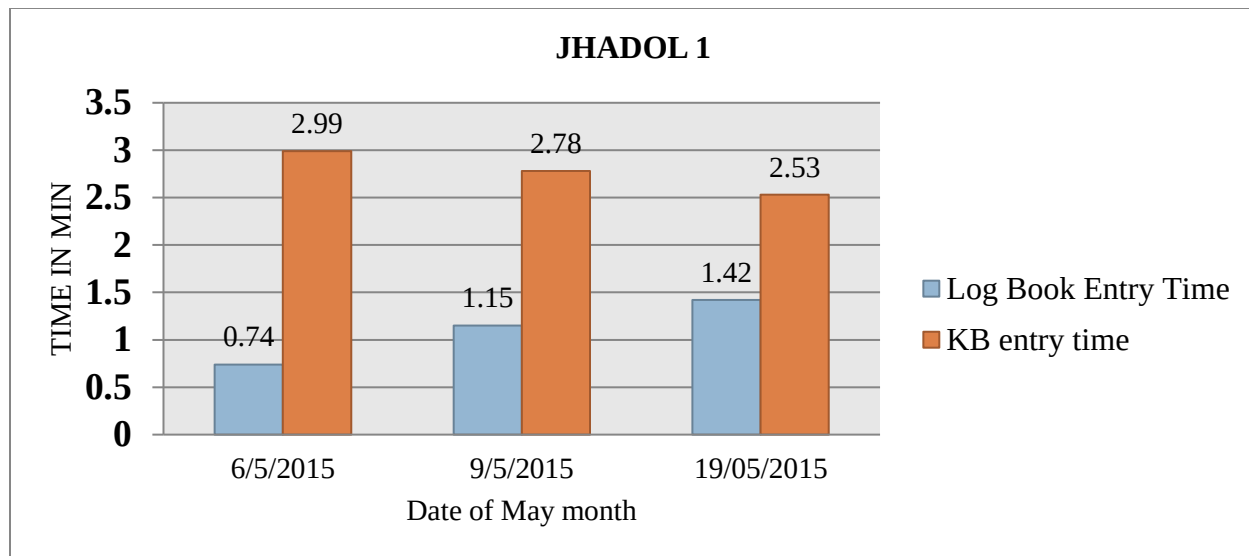


Figure 17 : Kherwara

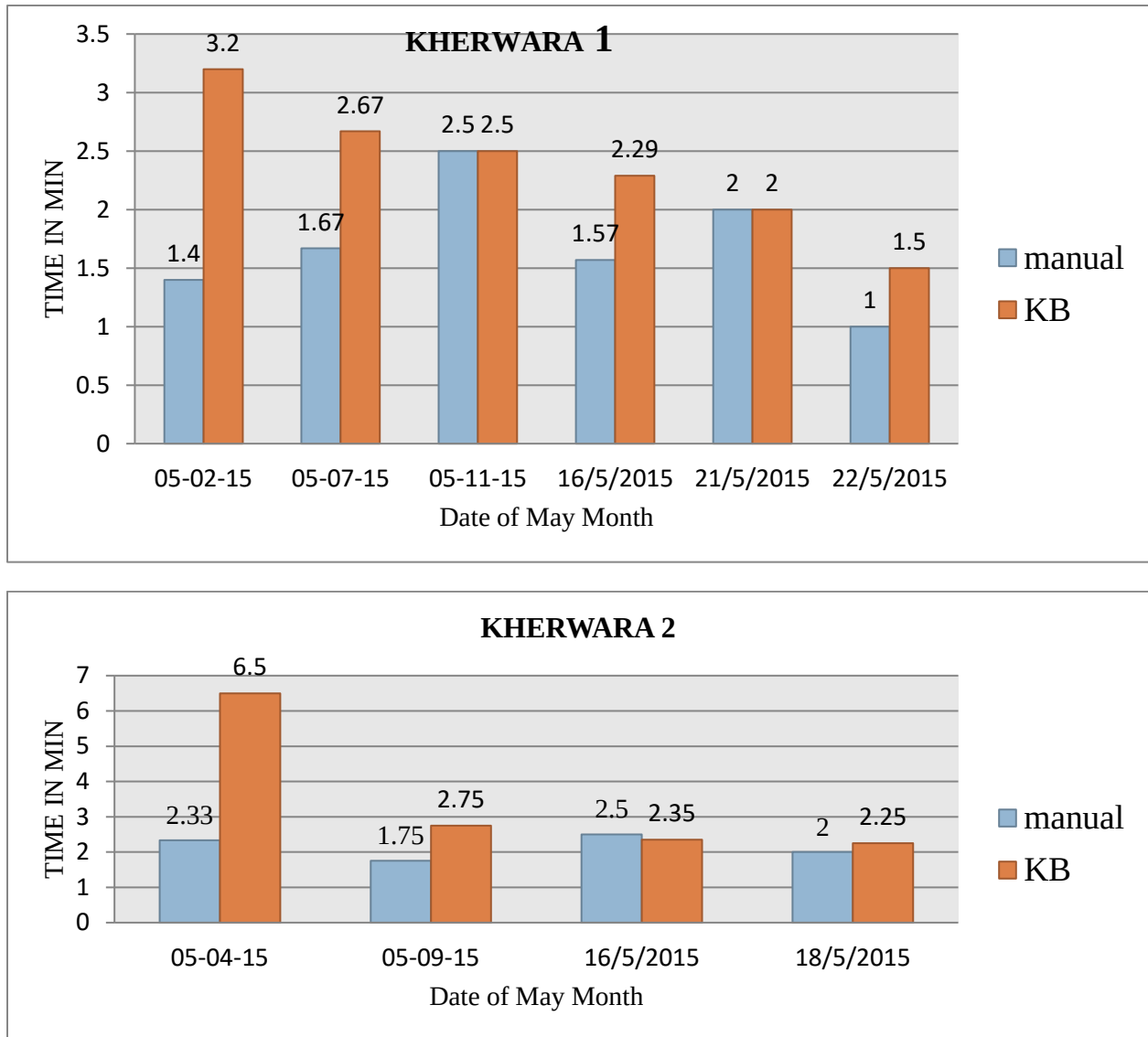
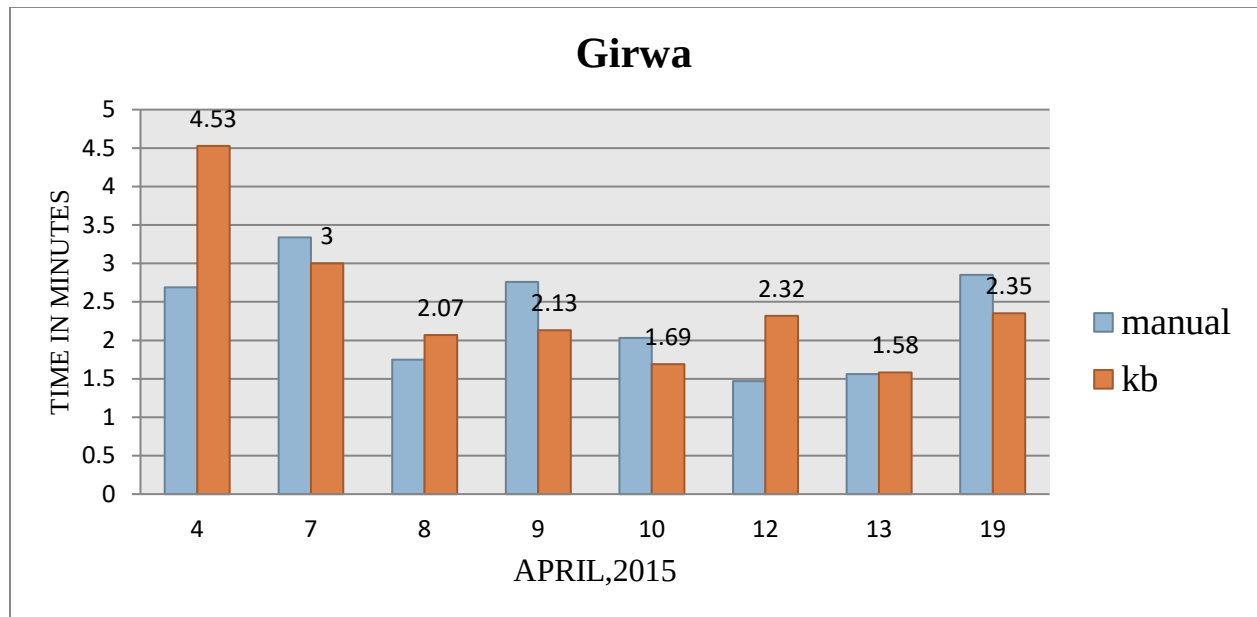


Figure 18: Girwa



8. Pendant Retention in month of May-2015

S.No	Camp Site	Expected for follow up	Returned	Retention Of Pendants
1	Paoti phala	2	2	2
2	Aamli chapar	4	3	3
3	Amliya phala	2	1	1
4	Kaucha	11	6	6
5	Koldhara	3	3	3
6	Kada phala	4	3	3
7	Sawan kyara	8	3	3
8	Balicharni	3	3	3
9	Talab bhamra	8	3	3
10	Kakra pana	11	4	4
11	Hasreta	8	6	6

S.No	Camp Site	Expected for follow up	Returned	Retention Of Pendants
1	Ava Phala	16	7	7
2	Amba ka Vela	4	3	3

Findings :

Figure 8 :

- 60 % (213) of the total mothers who came to immunization camps answered that vaccinations helps to prevent diseases.
- Only 11% (40) of mothers replied that vaccination was beneficial.
- 28 % (99) of mother were unaware about the importance of vaccination and came to immunization camps on persuasion of TBAs / Informer / Balsakhis.
- Only 1% (5) of mothers said that they came to immunization camp for getting Incentives.

Figure 9 :

- 54 % (193) of mothers who came to immunization camps said they had mamta card with them while 17 % (61) did not have mamta card because of some reasons.
- 20 % (72) of mothers forgot to bring their card at the campsites, while 5 % (17) mothers had lost mamta card.
- 3 % (9) had come for first ANC check up so mamta card would be issued in subsequent visits

Figure 10 :

- 74 % (263) mothers was Illiterate while only 26 % (94) of mothers was Literate. (Literate here means women, who could read, write and understand.)

Figure 12 :

- 12/19 camps attended in Kotra have Mobile network connection.
- In Kherwara 14/24 camps have Mobile network connection.
- In Jhadol 21/29 camps have Mobile network connection.
- In Girwa 4/10 camps have Mobile Network connection.

Figure 13 :

The Dashboard data showed some minor variation with that of GNMs logbook data. This variation was however due to the following reasons:

- Entry of test patients while GNMs training
- Double entry made by GNM due to app crash
- Missing data due to data syncing error

Figure 15 :

- In Kotra 1 & 2, Time taken by GNM to enter the data in KB App shows declining trend.
- Average time in May month was 3.09 min. as compared to April month average time 5.41 min. while Logbook data entry time shows consistent trend.

Figure 16 :

In Jhadol, average time taken by GNM to enter the data in KB App was 2.76 minutes in team 1 and 2.41 minutes in team 2.

Figure 17 :

In Kherwara it shows 2.36 minutes and 3.46 minutes in team 1 & team 2 respectively.

Figure 18 :

In Girwa average time taken by GNM to enter the data in KB App was 2.45 min.

Observations & Learning from the Field

Human Resource Department

- High Attrition rate of General Nursing and midwifery (GNM)
- Lack of guidelines and training
- Compromised health and Safety of GNM's
- Low wages and financial incentives
- Over burdened with work

Supply Chain Management

- Shortage of Drugs and Vaccines
- Improper storage of Vaccines
- No storage facility for Pentavalent vaccines
- Inefficient procurement of drugs and vaccines from CHC.
- Unavailability of Mamta Card (Jhadol) and non cash incentives (lentils and utensils)

Health and Safety management

- Deferring from standard immunization protocol.
- Improper disposal of syringes, cotton swabs and urine containers at the campsite.
- Unhygienic surrounding for vaccine administration.

Community

- Low awareness about health and vaccination
- Lack of education
- Negative perception about vaccinating their children
- Existing superstitious practices (eg. Daam)
- Preference to marriage and other ceremonies over vaccination.
- Prevalent child marriages and polygamy

- Lack of family planning

Community Workers

- Low incentives
- Lack of motivation
- mismanagement of vaccination coupons
- Camp attendance increases where mobilizers are involved. Ex. Balsakhi's.

Record Keeping

- Poor maintenance of the logbooks and discrepancies in data.

ANNEXURES

1. QUESTIONNAIRE FORMAT

Type of questions: semi structured

Hamlet

TBA

Informer

GNM

1. Mothers Personal details:

1. Can we take some information about you?
2. What is your name?
3. Your age?
4. What is your husband's name?
5. How old is he?
6. How many Children do you have
7. How old is the child who is getting the vaccination
8. Do you have MAMTA card? If no? Why not?
9. Till what grade have you attended the school
10. Who helps remind you of the camp, who do you, go to camp with?

2. Mothers education and immunization knowledge

Do you have your child's coupon?

How often do you take your child to get vaccinated: a.) Every month b.) Every two months c.) less than once every two months . d.) first visit

How often has your child got sick in past 6 months?

How will vaccination be helpful for your child? And why do you think so?

How many vaccination shots should the child get overall

Name any vaccine preventable disease

3.Economic status

Do you have a phone? Or in your family? If yes who?

Do you know the no.? Can you share with us?

What will be the most apt time to call you?

How far is your house from the camp?

Do you have mud/thatched / metal roof

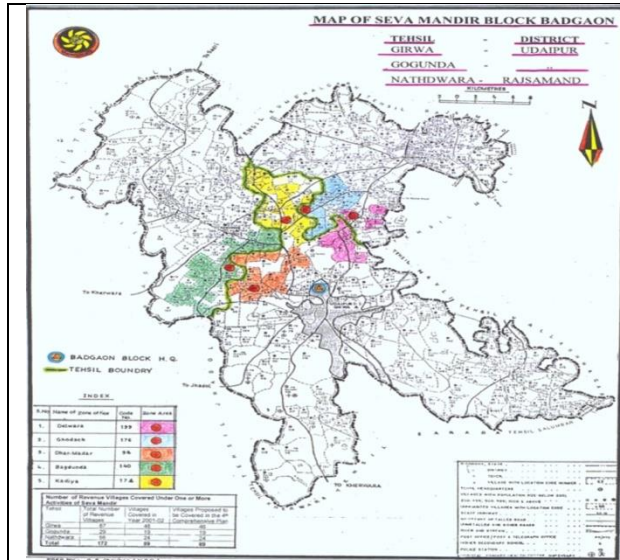
What type of latrine do you have

Do you have electricity

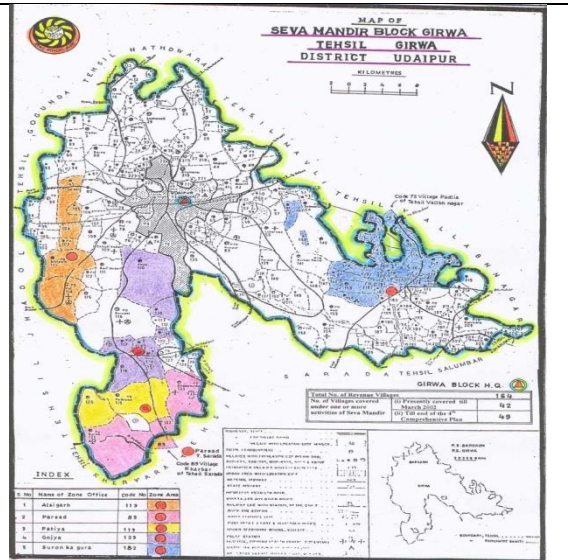
Do you have access to running water

What type of fuel do you use for cooking

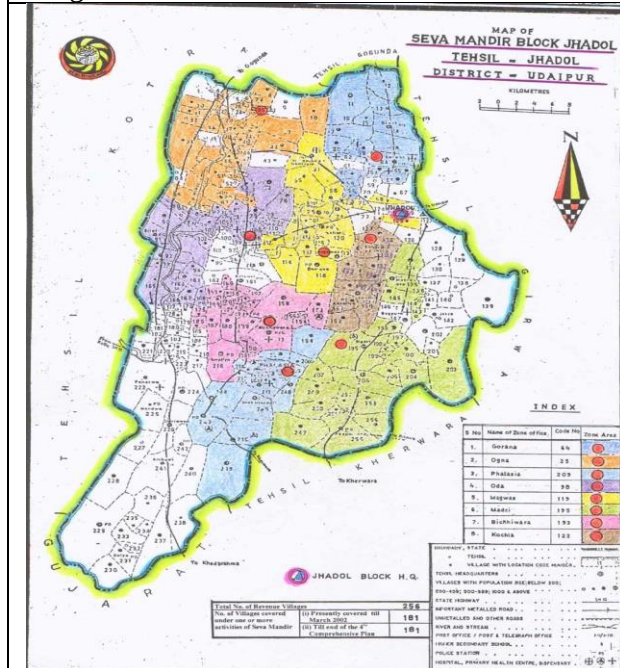
1. Seva Mandir, Block Maps:



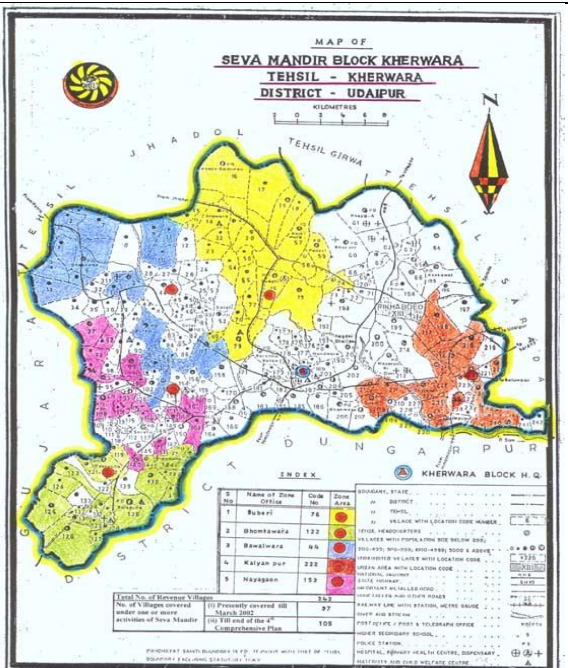
Badgaon



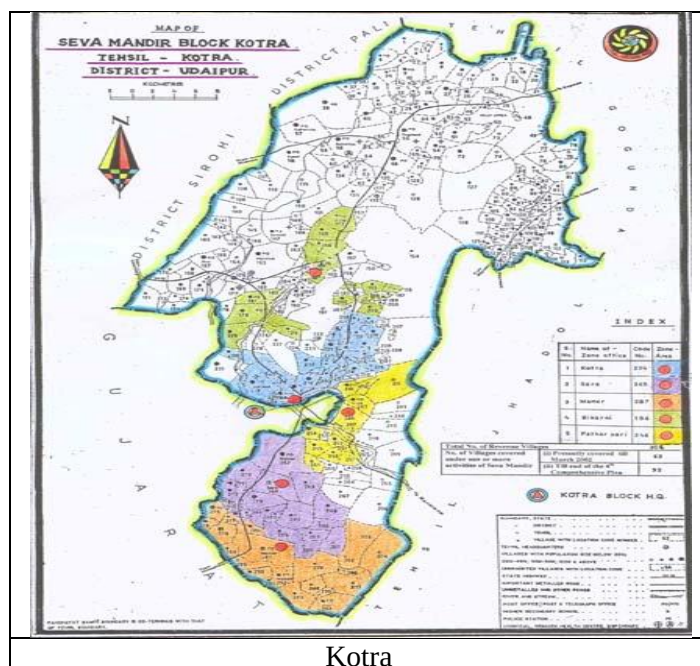
Girwa



Jhadol



Kherwara



REFERENCES

- [1] <http://medind.nic.in/ibv/t12/i5/ibvt12i5p357.pdf>
- [2] (Shekhar & Yadav, 2013)
- [3] <https://novoed.com/mhealth/reports/48624>
- [4] [Department of Health and Family Welfare, Government of India, 2008](#)
- [5] [J-Pal Policy Briefcase, 2011](#)
- [6] Banerjee et al 2010, BMJ
- [7] (Watson et. al., 2012)
- [8] (IDC 2010; Strategy Analytics 2011, taken from Watson et. al, 2012; [Watkins et al, 2012](#))
- [9] [Malaviya, 2010, AudienceScapes](#)
- [10]. [CDC, 2009]