Summer Training at

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Availability & Quality of ANC Services Provided at VHND: A case study of Mayurbhanj, Odisha

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CERTIFICATE

This is to certify that Dr. Ankur Khare, has completed the summer training at National Health Mission, Odisha from 1.04.14 to 31.05.14

And have conducted the following project under guidance and supervision of Dr. Biswajit Modak. All the data related to the study is the first hand data collected by Himself .

Project-Availability and quality of ANC services provided at VHND (Village Health Nutrition Day) sessions.

His approach to the projects has been sincere, scientific and analytical. This work is partial fulfilment to the course requirements, recommended for the Post Graduate Diploma in Health and Hospital With specialization in Health Management.
I wish him all the success in future endeavours.

Colonel (Dr.) Ashok Kaushik
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Table of Contents

Preface

The PGDHM course is well structured and integrated course of business studies. The main objectives of practical training at PGDHM level is to develop skill in students by supplement to the theoretical study of business management in general. Professors give us theoretical knowledge of various subjects in the institute. But we are practically exposed of such subjects when we get the training in the organization. It is the training through which we come to know that what an organization is and how it works. During this whole training I got a lot of experience and came to know about management practices in real that how it differs from those of theoretical knowledge and the practically in the real life.

It's very beneficial to learn health care delivery system at various levels. I observed the implementation of various National Health Programmes at National/State/District levels, I understood various functions of health systems by interactions with key stakeholders, policy makers, programme managers,academicians and researchers.

During my training period I had an overview of various programmes undertaken in National Rural Health Mission,Odisha including the current status of the programmes. I also carried out a small study on-

"Availability & Quality of ANC services Provided at VHND Session"

I have tried to put my best effort to complete this task on the basis of skill that I have achieved during my studies in the institute.

Acknowledgement

At the onset of the report I would like to express my special gratitude and appreciation Smt. Roopa Mishra, Mission Director for allowing me to pursue my summer internship from National Health Mission, Odisha.

I would also like to acknowledge with much appreciation the crucial role of Mr. Biswajit Modak, Senior Training Consultant, SHSRC, NRHM, who despite of other pre occupations and busy schedule was there to guide me and whose stimulating suggestions and encouragement helped me complete my training.

This training wouldn't have been completed without a substantial support from Dr. D. K. Panda, Team leader and a great number of people so I would like to thank all the consultants in various departments and other staff members at NRHM for being so helpful all the time and making this summer training project an unforgettable experience.

I express my gratitude and respectful regards to my mentor Dr. Neetu Purohit, IHMR, Jaipur for her able guidance and useful suggestions, which helped me in completing the project work .

A special thanks to Mr. Prashant Mishra, DPM, Rayagada and Mr. Vishvaranjan Raut, Deputy manager, RCH, Rayagada and Mr. Kishor Patnaik, BPO, Kolnara CHC for guiding me throughout my field visit.

I would also like to thank my institution and faculty members without whom this project would have been a distant reality. My colleagues, Dr. Ankur Khare, Dr. Atul Rairker And Nethaji Bolla also hold a special mention here for believing in me and supporting me throughout the summer internship training.

Finally, and most importantly, I would like to thank God for allowing me to complete my project, my beloved parents for their blessings and my friends for their help and wishes for the successful completion of this training.

Dr. Ankur Khare

IHMR, Jaipur

Abbreviations

AIDS	Acquired Immuno Deficiency Program
ANC	Ante Natal Check
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Angan Wadi Worker
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha, SowaRigpa and Homeopathy
BPO	Block Program officer
CHC	Community Health Center
CLMIS	Contraceptive Logistic Management Information System
CUG	Closed User Group
DHH	District Health Hospital
GIS	Global Information System
GODMAN	Govt. Doctor's Information Management
HBPNC	Home Based Post Natal Care
HRMIS	Human Resource Management Information System
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
ITEMS	Integrated Training & Evaluation Management System
JSSK	Janani Shishu Surakhsha Karyakram
LBW	Low Birth Weight
MAS	Mahila Arogya Samitis
MDG	Millennium Development Goals
MoHFW	*Ministry of Health and Family Welfare*
NGO	*Non Governmental Organization*
NHM	*National Health Mission*
NHSRC	*National Health Systems Resource Centre*
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
OSMIS	Odisha State Malaria Information System
OVLMS	*Odisha Vaccine Logistic Management* System
PHC	Primary Health Center

PRI	Panchayati Raj Institutions
RKS	Rogi Kalyan Samiti
RMNCH+A	Reproductive Maternal Newborn Child Health+ Adolescent
SAM	Severe Acute Malnutrition
SC	Sub Center
SDH	Sub Divisional Hospital
SHSRC	State Health Sytems Resource Center
SIHFW	State Institute of Health and Family Welfare
TFR	*Total Fertility Rate*
IFA	Iron & Folic Acid
TT	*Tetanus Toxoid*
UHC	Universal Health Coverage
ULB	Urban Local Bodies
UPHC	Urban Primary Health Centre
VHND	Village Health & Nutrition Day
VHSNC	Village Health Sanitation & Nutrition Committee
WHO	World Health Organization

Introduction

National Health Mission ,Odhisa

Background

1.1 This Framework for Implementation lays out the broad principles and strategic directions of the National Health Mission (NHM) encompassing two Sub-Missions, National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM). It is both flexible and dynamic and is intended to guide States towards ensuring the achievement of universal access to health care through strengthening of health systems, institutions and capabilities.

1.2 This Framework draws on several sources. First, it builds on the Framework for Implementation approved by the Cabinet in 2006, for the first phase of the NRHM. The second is the learning from NRHM implementation over the past seven years, documented in several evaluation reports and studies and the experiences of people and practitioners across the rural areas of the country. Third, the Chapter on Health of the Twelfth Plan provides the broad guidance for this Framework. Finally, it also incorporates the comments and suggestions from the Planning Commission, various Ministries, and state governments.

1.3 This Framework document is intended to lay out the approach for the National Health Mission for the period 2012-2017 and beyond.

1.4 The 2006 Framework for Implementation has served the Mission well and has guided the NRHM so far. The Framework for Implementation of NUHM has been approved by the Cabinet on May 1, 2013. These Frameworks will continue to guide the NRHM and the NUHM in so far as they are not inconsistent with any of the provisions of the NHM Framework.

Vision of the NHM

"Attainment of Universal Access to Equitable, Affordable and Quality health care services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health".

Core Values

- Safeguard the health of the poor, vulnerable and disadvantaged, and move towards a right based approach to health through entitlements and service guarantees.
- Strengthen public health systems as a basis for universal access and social protection against the rising costs of health care.
- Build environment of trust between people and providers of health services.
- Empower community to become active participants in the process of attainment of highest possible levels of health.
- Institutionalize transparency and accountability in all processes and mechanisms.
- Improve efficiency to optimize use of available resources.

Guiding Principles

1. Build an integrated network of all primary, secondary and a substantial part of tertiary care, providing a continuum from community level to the district hospital, with robust referral linkages to tertiary care and a particular focus on strengthening the Primary Health Care System including outreach services in both rural areas and urban slums.
2. Ensure coordinated inter-sectoral action to address issues of food security and nutrition, access to safe drinking water and sanitation, education particularly girls education, occupational and environmental health determinants, women's rights and empowerment and different forms of marginalization and vulnerability.
3. Incentivize states and UTs to undertake health sector reforms that lead to greater efficiency and equity in health care delivery.
4. Ensure prioritization of services that address the health of women and children and the prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
5. Reduce out of pocket expenditure on health care, eliminate catastrophic health expenditures and provide social protection to the poor against the rising costs of health care, through cashless services delivered by public health care facilities, supplemented by contracted-in private sector facilities wherever necessary.
6. Ensure that all public health care facilities or publicly financed private care facilities provide assured quality of health care services.
7. Ensure increased access and utilization of quality health services to minimize disparity on account of gender, poverty, caste, other forms of social exclusion and geographical barriers.
8. Plan for differential financial investments and technical support to cities, districts and states with higher proportions of vulnerable population groups, urban poor and destitute, and with difficult geographical terrain that face special challenges to meeting health goals.

9. Strengthen state level implementation capacity to progress towards achievement of universal health care through flexible and responsive resource allocation, the creation of efficient institutional mechanisms, rules, regulations and processes to enable effective decentralized health planning and management.
10. Incentivize good performance of both facilities and providers.
11. Address shortages of skilled workers in remote, rural areas, and other under-served pockets through appropriate monetary and non-monetary incentives.
12. Promote partnerships with private, for profit, and not for profit agencies including civil society organizations to achieve health outcomes.
13. Facilitate knowledge networks and create effective public health institutions.
14. Encourage and enable the involvement of Panchayati Raj Institutions (PRIs) /Urban Local Bodies (ULBs) representatives in the governance and oversight of health services, and undertake proactive efforts for convergence and concerted action on social determinants of health such as food and nutrition, safe drinking water, sanitation and hygiene, housing, environment and waste management, education, child marriage, gender and social inequity.
15. Establish an accountability and governance framework that would include social audits through people's bodies, community based monitoring and an effective mechanism of concurrent evaluation.
16. Mainstream AYUSH, so as to enhance choice of services for users and to learn from and revitalize local health care traditions.
17. Expand focus beyond maternal and child survival to ensuring quality of life for women, children and adolescents.

Goals, Outcomes and Strategies

1. The key goals of this phase of NHM will be towards enabling and achieving the stated vision, making the system responsive to the needs of citizens, building a broad based inclusive partnership for realizing National health goals, focusing on the survival and well being of women and children, reducing existing disease burden and ensuring financial protection for households.
2. To achieve these goals, NHM will implement the following strategies:

2.1. Support and supplement state efforts to undertake sector wide health system strengthening through the provision of financial and technical assistance.
2.2. Build state, district and city capacity for decentralized outcome based planning and implementation, based on varying diseases burden scenarios, and using a differential financing approach. There will be a focus on results and performance based funding including linkage to case loads.
2.3. Enable integrated facility development planning which would include infrastructure, human resources, drugs and supplies, quality assurance, and effective Rogi Kalyan Samitis (RKS).
2.4. Create a District Level Knowledge Centre within each District Hospital to serve as the hub for a range of tasks including inter alia, provision of secondary care and selected elements of tertiary care, and the site for skill based training for all cadres of health workers, collating and analyzing data and coordinating district planning.
2.5. Improve delivery of outreach services through a mix of static facilities and mobile medical units with a team of health service providers with the skill mix and capacity to address primary health care needs.
2.6. Strengthen the sub-centre/Urban Primary Health Centre (UPHC) with additional human resources and supplies to deliver a much larger range of preventive, promotive and curative care services- so that it becomes the first port of call for each family to access a full range of primary care services.
2.7. Prioritize achievement of universal coverage for Reproductive Maternal, Newborn, Child Health + Adolescent (RMNCH+A), National Communicable Disease Control and Non Communicable Diseases programmes.

2.8 Expand focus from child survival to child development of all children 0-18 years through a mix of Community, Anganwadi, and School based health services. The focus of such services will be on prevention and early identification of diseases through periodic screening, health education and promotion of good health practices and values during these formative years and timely management including assured referral for secondary and tertiary level care as appropriate.
2.9. Achieve the goals of safe motherhood and transition to addressing the broader reproductive health needs of women.
2.10. Focus on adolescents and their health needs.
2.11. Ensure the control of communicable disease which includes prompt response to epidemics and effective surveillance.
2.12. Use primary health care delivery platforms to address the rising burden of Non-Communicable Diseases (NCD).
2.13. Converge with Ministry of Women & Child Development and other related Ministries for effective prevention and reduction of under-nutrition in children aged 0-3 years and anaemia among children, adolescents and women.
2.14. Empower the ASHA to serve as a facilitator, mobilizer and provider of community level care.
2.15. Strengthen people's organizations such as the Village Health Sanitation and Nutrition Committees (VHSNC) and Mahila Arogya Samitis (MAS) for convergent inter-sectoral planning to address social determinants of health and increasing utilization of health and related public services at the community level.
2.16. Create mechanisms to strengthen Behaviour Change Communication efforts for preventive and promotive health functions, action on social determinants and to reach the most marginalized.
2.17. Enable Social Protection Function of Public Hospitals through the universal provision of free consultations, free drugs and diagnostics, free emergency response and patient transport systems.
2.18. Develop effective partnerships with the not-for-profit, nongovernmental organizations and with the for-profit, private sector to bring in additional capacity where needed to close gaps or improve quality of services.
2.19. Improve Public Health Management by encouraging states to create public health cadre, and strengthening/ creating effective institutions for programme management, providing incentives for improved performance and building high quality research and knowledge management structures.
2.20. Support states to develop a comprehensive strategy for human resources in health, through policies to support improved recruitment, retention and motivation of health workers in rural, remote and underserved areas, improved workforce management, required staff to help achieve IPHS norms of human resource deployment, development of mid level care providers and creation of new cadres with appropriate skill sets, and in-service training.
2.21. Enhance use of Information & Communication Technology to improve health care and health systems performance.
2.22. Strengthen Health Management Information Systems as an effective instrument for programme planning and monitoring, supplemented by regular district level surveys and a strong disease surveillance system.
2.23. Ensure universal registration of births and deaths with adequate information on cause of death, to assist in health outcome measurements and health planning.
2.24. Establish Accountability Frameworks at all levels for improved oversight of programme implementation and achievement of goals. Mechanisms for accountability shall range from participatory community processes like Jan Sunwais/Samwads, Social Audit through Gram Sabhas to professional independent concurrent evaluation.
2.25. Implement pilots for Universal Health Coverage (UHC) in selected districts in both

EAG and non EAG States to test approaches and innovations before scaling up.

- To ensure equitable health care and to bring about sharper improvements in health outcomes, a systematic effort to effectively address the intrastate disparities in health outcomes would be undertaken. 25% of all districts in each state that are in the lowest quintile of composite health index have been identified as high priority districts. All tribal and LWE affected districts which are below the state's average of composite health index have also been included as high priority districts. Further, all the LWE districts have been identified as special focus districts. These districts would receive higher per capita funding, relaxed norms, enhanced monitoring and focused supportive supervision, and encouraged to adopt innovative approaches to address their peculiar health challenges. Technical support from all sources is being harmonised and aligned with NHM to support implementation of key intervention packages.
- There is a shared conviction among policy makers and public health experts that it would be at least two to three plan periods before India can provide UHC to all its citizens. NHM represents the prime vehicle for achieving UHC. The government has already taken steps towards provision of free maternal, and child health services, including newborn care, immunization, adolescent health, and family planning. Free diagnostic and treatment services are provided for major communicable and a selected range of non communicable diseases. These need to be further expanded and strengthened.
- The NHM will essentially focus on strengthening primary health care across the country. The emphasis would be on strengthening health facilities and services upto the district level in urban and rural areas. The Twelfth Plan document states that expenditures on primary health care should account for at least 70% of the health care expenditure. Tertiary care and regulatory functions should be a part of the other Central Sector and/or Centrally Sponsored scheme, namely, Human Resources & Medical Education.
- Outcomes for NHM in the 12th Plan are synonymous with those of the 12th Plan, and are part of the overall vision. Specific goals for the states will be based on existing levels, capacity and context. State specific innovations would be encouraged. Process and outcome indicators will be developed to reflect equity, quality, efficiency and responsiveness. Targets for communicable and non communicable disease will be set at state level based on local epidemiological patterns and taking into account the financing available for each of these conditions.

1. Reduce MMR to 1/1000 live births
2. Reduce IMR to 25/1000 live births
3. Reduce TFR to 2.1
4. Prevention and reduction of anaemia in women aged 15–49 years
5. Prevent and reduce mortality & morbidity from communicable, non- communicable; injuries and emerging diseases
6. Reduce household out-of-pocket expenditure on total health care expenditure
7. Reduce annual incidence and mortality from Tuberculosis by half
8. Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts
9. Annual Malaria Incidence to be <1/1000
10. Less than 1 per cent microfilaria prevalence in all districts
11. Kala-Azar Elimination by 2015, <1 case per 10000 population in all blocks

STATE INITIATIVES

- *Swasthya Kantha* Campaign: To provide health related communication information to rural population by writing the information on specific walls meant for the purpose. The walls are located at strategic points in most villages. The major issues tackled are "maternal health, child health, malaria and tuberculosis".
  As a result of the *Swasthya Kantha* campaign, there is increased knowledge on health and sanitation issues of the village with improved health seeking behaviour of the people.

- Innovations in relation to ASHA workers
  - ASHA HBPNC : Home based post natal care for mother and infant by ASHA. ASHAs are being trained for home based post natal care which has increased record keeping of immunization, breast feeding and better reporting of LBW babies.
  - Bicycles to ASHAs : ASHAs have been provided with cycles so that they can deliver better services. Cycles help in easy commuting of the ASHAs to the areas that she covers, even in areas where roads are not available. After provision of cycles, there has been an increase in immunization coverage, ANC and institutional delivery.
  - ASHA fixed day payment : To address the grievances of payment of incentives, the government has come up with the policy of having a fixed day for payments of incentives. There are 32 different incentives for ASHA workers.
    With this innovation there has been an increased motivation of ASHA workers towards their work.
  - ASHA *Gruha* : It is a resting place for ASHAs who accompany pregnant women to the hospitals for their delivery.
    The ASHAs feel very secure to accompany pregnant women even at night. As she feels safety for herself during the visit to district hospitals.

- The Government of Odisha has started the 108 Ambulance Service this year

- *Gramsat* to promote health provisions was put up to disseminate innovations and information of health issues and to review the various programmes in place. It is an excellent opportunity for discussions with block and district health officials.

- Public- private partnership:

  1. Urban Slum Health Project: Targeted for outreach and vulnerable areas. Provides services for health, hygiene, sanitation and nutrition.
  2. *AROGYA* Plus project: Specially targeted at Naxalite areas for providing health services to these areas. This project functions similarly as mobile health units
  3. PHC New project: 32 PHC (New) in very outreach areas
  4. Vulnerable Group Project : Meant for primitive tribe groups
  5. Maternity Waiting Home: Providing PNC support to pregnant women in outreach areas. Providing temporary home for expectant mothers living in hard to reach tribal areas, where they come 5-7 days before EDD and can wait for delivery

- Mobile Health Unit : To provide preventive, promotive & curative health services in the inaccessible areas and difficult terrains which are un-served /underserved under usual circumstances. With the advent of MHU's there has been an increase in the number of cases treated and referred. The MHU's function for 22 days in a month, reaching far of villages to provide quality services to them.

- *Janani* Express: Free referral transport system to promote institutional delivery and reduce out of pocket expenditure by providing nonstop free transport facility and contributing in reduction of infant and maternal mortality. The average patient load has been on a gradual increase.

- Mobile Boat Clinic: To provide basic health services to people of most inaccessible and difficult areas of *Malkanagiri* district (Naxalite area). But after its introduction, giving services to the outreach people has become easier.

- *Tika* Express: An alternate vaccine delivery system for children of difficult and tribal dominated pockets to enhance immunization coverage and strengthen routine immunization programmes. Due to this initiative, percentage of full immunization has been on a constant increase.

- Sick New Born Care Unit: To improve neonatal survival and provide special level- II care to neonates including low birth weight and sick neonates. Special initiatives like "autoclaved cotton dress", "kangaroo care bag" and "oil cloth – with key message" are taken up. It has led to an increase in successful management of a huge number of babies.

- Single Window: *Janani Sewa Kendra* for JSY beneficiaries to reach upto a mark of 100% birth registration and to provide all major MCH related benefits at facility level. With this service in place, there has been an increase in distribution of birth certificates and delivering of other services to the beneficiaries.

- IT initiatives: Various IT applications have been used to achieve the desired objectives.

    - Program monitoring applications
        - *E Swasthya Nirman*
        - Drug Testing and Data Management System
        - *E Sanjog*
        - FRU Montoring System
        - Contraceptive Logistic Management Information System (C LMIS)
        - Odisha Vaccine Logistics Management System (OVLMS)
        - Integrated Training & Evaluation Management System (ITEMS)
    - Human Resource Monitoring & Management
        - E Attendance
        - Human Resource Management Information System (HRMIS)
        - Govt. Doctor's Information Management (GODMAN)
        - Mission Connect (CUG)
    - Citizen Centric Applications
        - E Blood Bank
        - Grievance Redressal System for JSSK Scheme
        - Telemedicine
    - Applications for Planning and Management
        - Odisha State Malaria Information System (OSMIS)
        - GIS in Odisha State Healthcare Planning & Management

List of people interacted during training period

S.No	Name	Designation
1.	Smt. Roopa Mishra, I.A.S.	Mission Director
2.	Dr. D. K. Panda	Team Leader
3.	Mr. Biswajit Modak	Senior Training Consultant
4.	Dr. P.K. Senapati	Sr. Maternal Health Manager
5.	Mr. Adait Kumar Pradhan	State Programme Manager
6.	Dr. Jyoti Prakash Samal	MCH & FP Expert
7.	Dr. Manoranjan Mohapatra	Consultant QA & QI (Management), NHM
8.	Dr. Shridhar Kadam	Associate professor, IIPH, Bhubneswar
9.	Ms. Mithun Karmakar	GIS Mapping
10	Mr. Bhagaban Meher	Deputy Manager, RCH, NHM Mayurbhanj
11	Mr.Deepak Kumar Sahu	DPM, Mayurbhanj
12	Dr. P.K.B. Patnaik	Jt. Director Public Health (NCD)
13	Mr. Chandanesh Mishra	Consultant Adolescent Health
14	Dr. Bikas Patnaik	Jt. Director Public Health (IDSP)
15	Dr. Prameela Baral	Dept. Director IDSP (Disaster management)
16	Dr. M. M. Pradhan	Dept. Director NVBDCP (Malaria)
17	Mr. K. K. Das	Deputy Director SIHFW (Training)
18	Mrs. Ranjita Patnaik	Jt. Director Health services (Rural Health

Research Summery

Research Topic

A study on assessing Availability & Quality of ANC services provided at VHND Session

INTRODUCTION

Village Health and Nutrition Day (VHND), "Mamata Diwas", a concept for interdepartmental convergence having desirable health outcomes of children below five years, and for maternal health is being run in the State of Odisha by the Department of Health and Family Welfare. This provides the first point of contact for essential primary health care and works as the common platform for convergence amongst service providers of Health, ICDS (Integrated Child Development Services) and the community. Strategically, trainings is given at State, regional, district and sector level to various categories of functionaries.[1]

Beneficiaries	Services
Pregnant Women	Registration of Pregnant Women **Quality ANC** • Weighing • BP • Hb • Urine examination • Abdominal checkup, IFA and T.T) services
Lactating Mother	• Quality PNC (Counseling and distribution of family planning aids • Referral for IUD(Intrauterine devices insertion) • Counseling on promotion of breastfeeding & on birth registration) • Identification of danger signs (fever, bleeding and abdominal pain) and referral Weighing of newborn • Identification of danger signs (fever, rapid breathing, skin eruptions) and referral
Children 0 to 5 yrs	• Growth monitoring (weighing of Children and plotting) • MUAC(Middle Upper Arm Circumference) • Counseling of parents for growth promotion through MAA O SISHU SURAKHYA CARD • Cooking and preparation of food for children 6-12 months • Using locally available food ingredients • IFA supplementation of children (six

	months to two years: liquid IFA)

All Services for ANC Mothers under VHND Guidelines[1]

- Registration for ANC
- Identify pregnant women left out from services and provide them services
- Blood pressure examination
- Weighing
- Abdominal examination
- Hb% estimation
- Urine albumin/protein estimation
- Iron folic acid 100/200 (100 tabs for mild anaemic & 200 for moderate,seveare anaemic
- 2 TT(Tetanus Toxoid) injection
- Referral for high risk pregnancies

List of Equipments

- Examination Table
- Stethoscope, Foetal Stethoscope & BP Instrument
- Weighing Machine Adult / Child
- Bed Screen / Curtain
- Haemoglobinometer / Talquist paper (if available)
- Uristix for urine examination
- Measuring tape

Medicines

- Oral Pills / Condoms
- IEC / BCC Materials(Information, Education, communication)/(Behaviour Change Communication)
- IFA Small / Large, Liquid IFA, IMNCI drugs, ORS and common medicines for minor ailments

The programme is organized once a month in every Anganwadi Centre on a fixed day basis (either Tuesday or Friday) with joint efforts of ANM (Auxiliary Nurse Midwife), AWW (Aganwadi Worker) and ASHA (Accredited Social Health Activist). On an average, there are six to eight AWCs (Anganwadi Centers) under the operational jurisdiction of one Sub Centre and thus there are about eight fixed days in a month per Sub Centre[1] .WHO defines maternal mortality as the death of a woman during pregnancy or in the first 42days after the birth of child due to causes directly or indirectly linked with pregnancy.

REVIEW OF LITERATURE

1. According to United States Agency for International development (USAID) funded Vistaar Project conducted in Dec 2008 in U.P. and Jharkhand.
    - Systems strengthening leads to programme improvements at scale: It is important to strengthen multiple systems to achieve improvements in VHNDs.
    - Inter-departmental convergence at various levels facilitates quality improvement.

2. UNICEF Country programme for 2013-2017 aims to advance the "rights of children, adolescents and women to survival, growth, development, participation and protection which are the major goals of VHND**.**

3. Studies in Ethopia ,India, Nigeria ,Senegal and Zimbabwe shows that lack of antenatal care was an important factor for maternal health by Shelah Bloom Theo Lippevold And David Wypij

4. Maternal complications and poor perinatal outcomes are highly associated with non-utilization of delivery and antenatal care services and poor socioeconomic condition of the patient.[2]

RESEARCH QUESTION

1. What is the availability and quality of the services available for ANC Mothers on VHND day as per the guidelines?

Objectives

1. To assess the availability of prescribed services for Pregnant Women on VHND(Village Health Nutrition Day) as per the guideline .

   .

   INDICATORS

- % of women whose weight is measured at each visit.
- % of women whose blood pressure is measured at each visit.
- % of women whose urine sugar test is being tested at each visit.
- % of women whose albumin test is being tested at each visit.
- % of women who received T.T./booster dose injection.
- % of women with100 ≥ IFA tabs is provided.

2. To assess the quality of services provided to Pregnant woman as per guideline mentioned.

   INDICATORS

- % of women whose relevant history(obstetric/past/menstrual) is to be taken.
- % of VHND sessions where privacy during examination is maintained.
- % of VHND sessions where sphygmomanometer is functional
- % of institution where Hb estimation is done using Sahli-Adams tube
- % of women whose abdominal palpation for determining fundal height, foetal lie etc., done and recorded.
- % of women whose foetal heart sound examined / auscultated and recorded in MCP card.
- % of women who have counseled for danger signs and action to be taken during pregnancy.

Quality of services :

For evaluating quality services provided under VHND , Diagnostic Criteria has been selected. In this criteria Haemoglobin test is taken for assessment of quality because 7% of mothers died due to anaemia

Haemoglobin Test- Material required

A pair of gloves, spirit swabs, lancet, N/10 HCL, distilled water and dropper
Haemoglobinometer with comparator on both sides, pipette and stirrer, Sahli-Adams tube

Procedure-

1. Clean the Tip of the woman's ring finger with an alcohol swab.
2. Prick the finger using the lancet and discard the first drop of blood.
3. Allow a large drop of blood to form on the fingertip (do not press the fingertip to take out blood) Dip the tip and suck blood up to the 20cmm mark on the pipette.
4. While sucking blood, care should be taken to prevent the entry of air.
5. Wipe the tip of the pipette with cotton. Immediately transfer the 20 cmm (0.02ml) of blood

from the pipette into the Hb tube containing N/10 HCL

6. Rinse the pipette two to three times by drawing up and blowing out the acid solution.

7. Leave the solution in the tube for about 10 minutes (for conversion of Hb into haematin).

8. After 10 minutes, dilute the acid by adding distilled water drop by drop. Mix it with stirrer

9. Note down the reading (lower meniscus) when the colour of the solution exactly matches that of the comparator on both sides of the haemoglobinometer. This express the Hb

RATIONALE

Ensuring quality of maternal health services in VHND through improved skills of frontline workers is one the key interventions for reducing maternal mortality and morbidity. There is strong global evidence to show that increasing the skilled health workers to population ratio has led to improvement MMR (Maternal mortality rate).

Antinatal care is one of the four pillars of safe motherhood initiative. Routine anti natal visits may raise awareness about the need for care at delivery[4]. It has been estimated that 25 %of maternal deaths occur during pregnancy, with variability between countries depending on the prevalence of unsafe abortion, violence, and disease in the area.[5]

VHND form the platforms of integrated health, nutrition and WASH (Water, Sanitation and Hygiene) service delivery at community level. Strengthening these platforms for integrated and qualitative MCH service delivery is the prime focus for the DoHFW (Department of Health and Family Welfare) in 2013-14 and this necessitates rapid skill assessment and capacity building of ANMs in the network. It also requires a periodic assessment of available equipment, instruments and consumables as well as provision of equipment, as necessary, in order to ensure adequate supplies for all VHNDs. In addition, there is a need to streamline procurement of logistics along with strong supply chain management and maintenance processes.[6]

RESEARCH METHODOLOGY

Study Type – Descriptive research

Study Duration- Two Months

Study Area- Study area is AWC (Aganwadi Centre) & SC situated in Mayurbhanj district.

- **Sampling-**
- **Sampling Techniques- Non Probability, Purposive Sampling**

- **Selection of Respondent-**

  Service Provider : ANM's

  Beneficiaries : PNC mother

  (Willing and satisfying the criteria of study)

- **Techniques- Face to Face Interview**
- **Tools-Questionnaire (Semi structured)**
- **Sample Size- 31PNC mother, 13ANMs**
- **AWC and SC visited during scheduled timeline of study**

Place visited	AWC
Bhandagao Sub Centre	Kushhalda & Kwamara-B
Khunta Block	Girish Chandrapur
Samakhunta Block	Balubasa-2
Baripada Block	Damdarpur
Baripada Block	Devendrapur
Muruda Block	Kisantandi

Data Analysis Plan

Data collected by ANM and beneficiaries(Postnatal care mothers) who received anti natal care services will be entered into excel sheet and percentage of various indicators will be found out.

Limitation

- Two months period is very less for quality of VHND services.
- Language is a barrier for communication.
- Sample size is very small.

Ethical Considerations

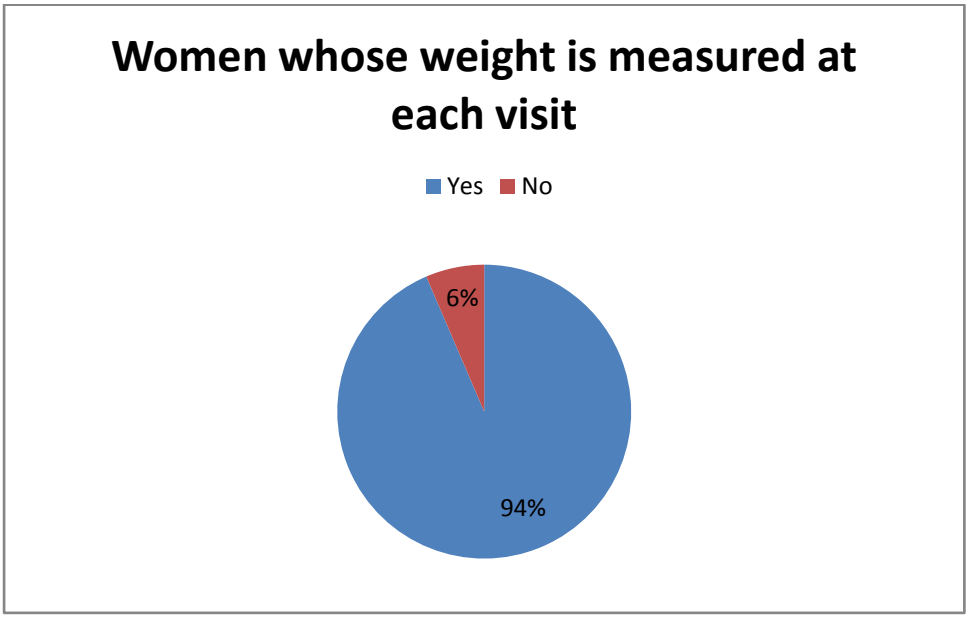
- Confidentiality of the respondents will be maintained during the study.
- Respect and dignity of the respondents will be taken care during the study.
- Information received by the respondents will not be misused in any form.

Work Plan

S No.	Task	Timeline	Duration
1)	Document study and development of study design and tools	2nd April'14 to 23rd April'14	3 weeks
2)	Field testing of tools ,field study and data collection	24th April'14 to 7th May'14	2 weeks
3)	Data analysis	8th May'14 to 15th May'14	1 weeks
4)	Finalization of Data And Presentation	16th May'14 to 23rd May'14	1 week
5)	Relieved from NRHM	24th May'14	

Results

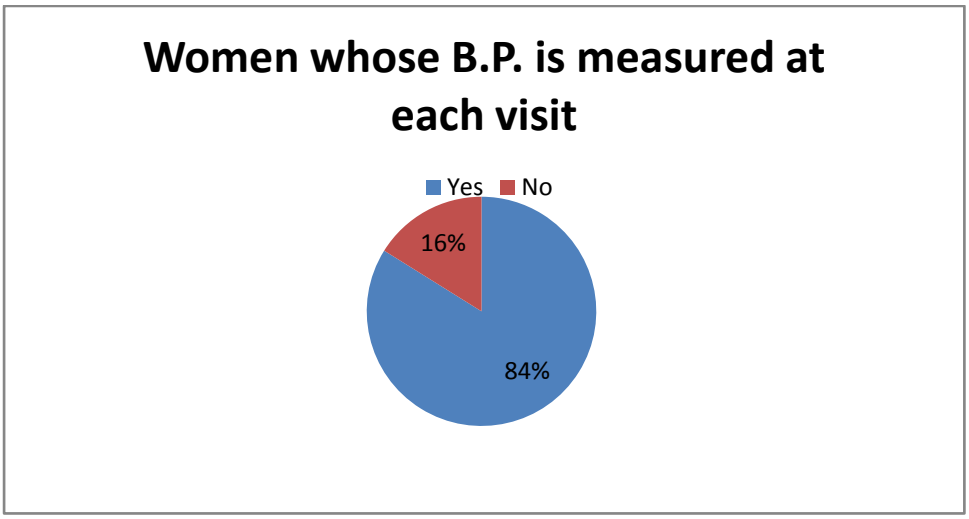
1. **Per cent of Women weighted at each visit.**



N=31	
By Sahli's	**29**

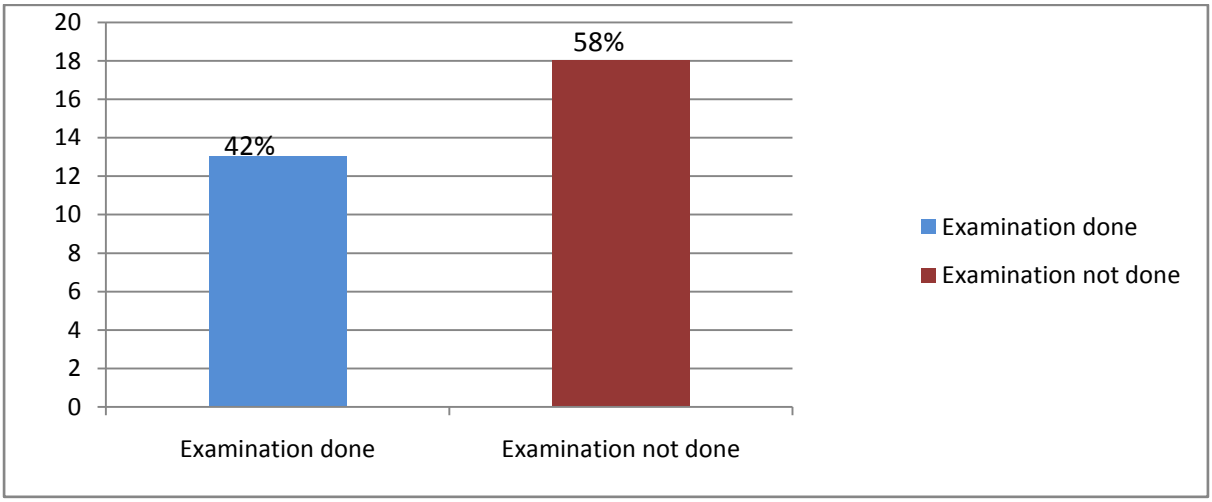
By Telequest	**02**

2. **Per cent of women whose BP is measured at each ANC visit.**



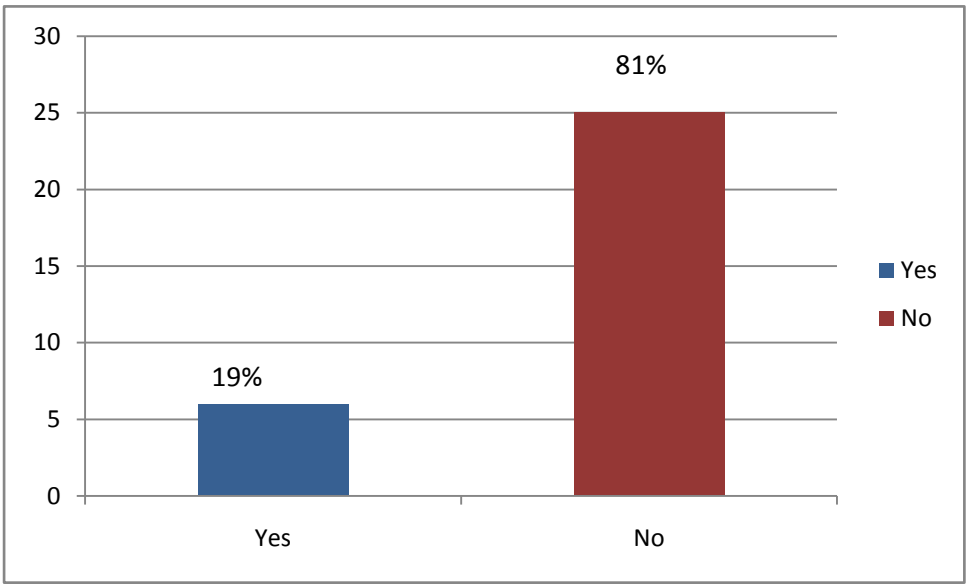
N=31	
By Sahli's	**26**
By Telequest	**05**

3. **Per cent of women whose abdominal palpation for determining fundal height, foetal lie etc. done and recorded.**



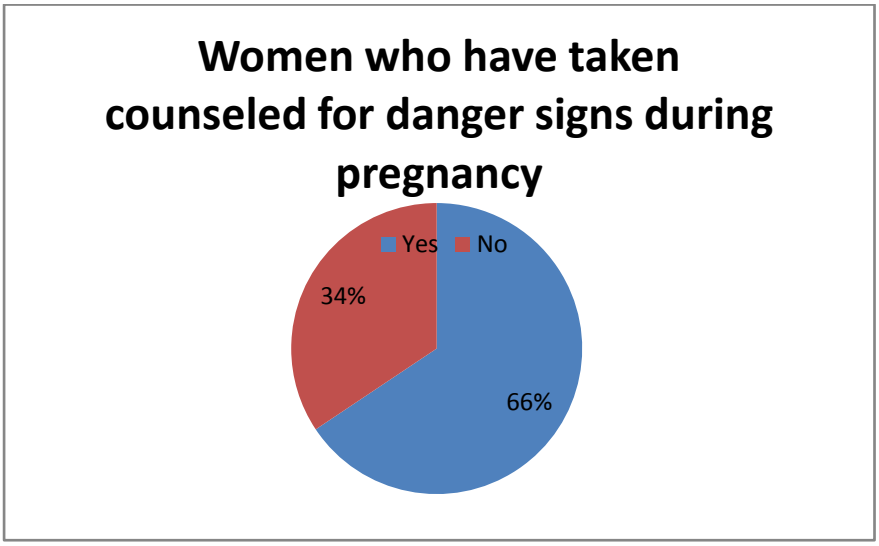
N=4	
By Sahli's	**03**
By Telequest	**01**

4. **Per cent of women whose FHS is examined and recorded in MCPcard**



N=31	
Yes	**06**
No	**25**

5. **Per cent of women who have been counseled for danger signs and action to be taken during pregnancy.**

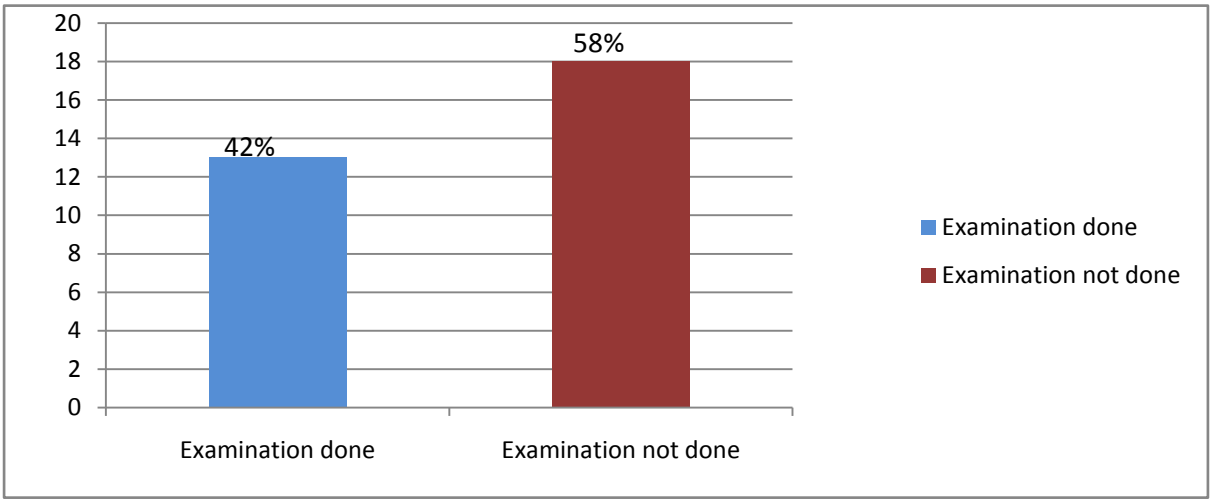


N=31	
Yes	**21**
No	**11**

6. **Per cent of VHND sessions where Hb estimation is done by Sahli's Adam Tube**

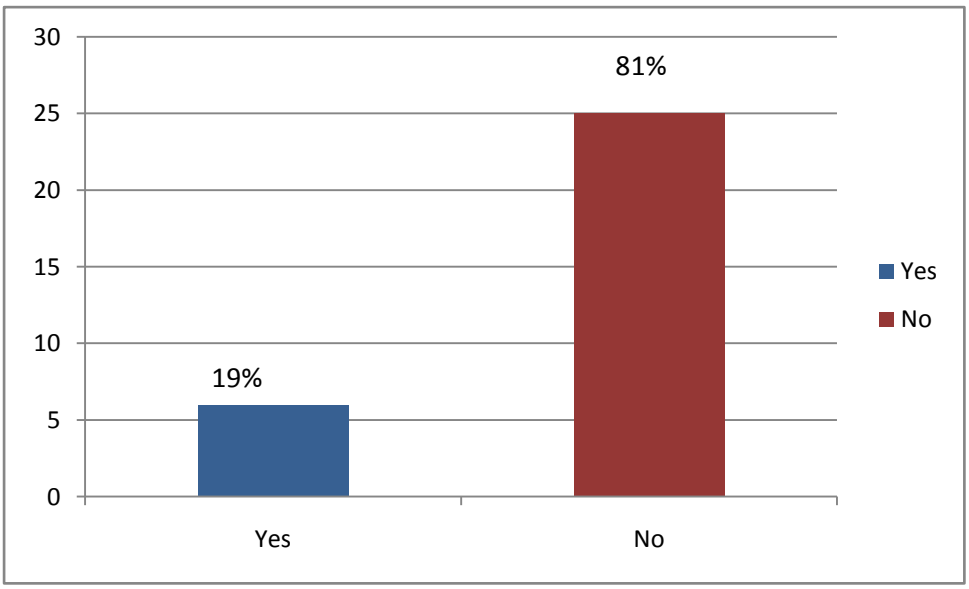
N=4	
Yes	**03**
No	**01**

7. Per cent of women whose abdominal palpation for determining fundal height, foetal lie etc. done and recorded.

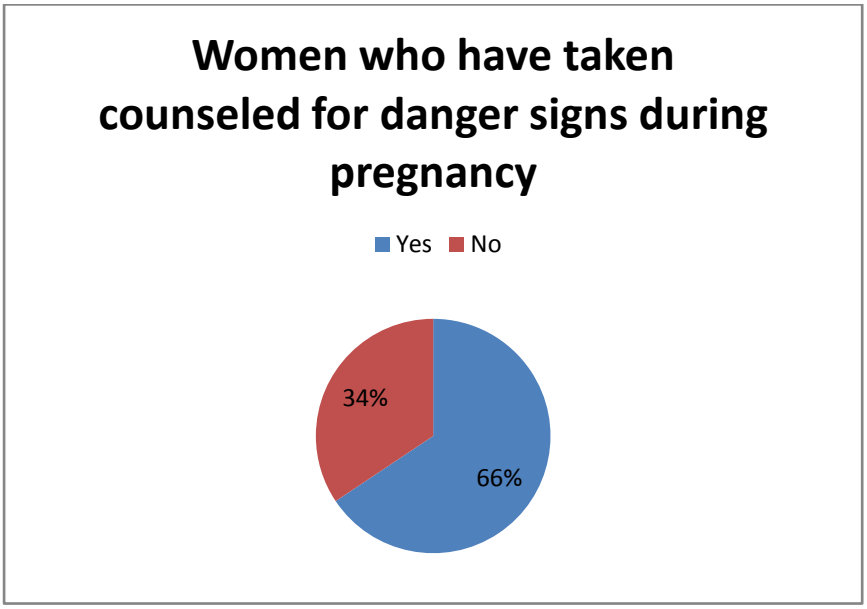


N=31	
Examination Done	**13**
Examination not Done	**18**

8. Per cent of women whose FHS is examined and recorded in MCPcard



9. Per cent of women who have been counseled for danger signs and action to be taken during pregnancy.



N=31	
Yes	**21**
No	**10**

Findings

- 94 per cent of women weighed during each visit at VHND.
- 87 per cent of women received 100≥ IFA tablets.
- In about 75 per cent of VHND sessions, Hb estimation is done by Sahli's method.
- Privacy during ANC checkup have not maintained.

Major Gaps

- 5 ANM out of 13 were lacking proper skills for Hb estimation(specially in colour matching) in Sahli's method.
- 81 per cent of women were not examined for Auscultated FHS and it was not recorded in MCP card.
- 4/7 Anganwadi centers and 3/4 SC lacked regular supply of IFA and Uristick.

Limitations of study

- Sample sizes were taken was small and the size might not represent the entire universe of the study

- Time constraints for various activities of the project.
- Language was the barrier .

Recommendation

- Continuous mentoring of ANMs to ensure better confidence in following skills
  1. Measuring FHS by Foetoscope/Stethoscope
  2. Hb estimtion by Sahli's method
- Local resources can be used for maintaining privacy during Anti Natal check-ups. Fund of VHSC can be utilized for it.
- Uninterrupted & Adequate supply of IFA
- Uristics,MCP card.

References

1. Mamata Diwas Village Health & Nutrition Day Operational Guidelines
2. Impact of Antenatal Care on Maternal and Perinatal outcome: A Study at at Nepal Medical College Teaching Hospital By. Tuladhar H1, Dhakal N2 1Department of Obs/Gyn, KIST Medical College, Imadole, 2Nepal Medical College, Jorpati
3. Monthly village health nutrition day guidelines for awws/ashas/anms/pris
4. "Does antinatal care make a difference to safe delivery? A study in urban Uttar Pradesh, India by Shelah Bloom Theo Lippevold And David Wypij
5. "Antenatal Care" by Ornella Lincetto,Seipati Mothebesoane-Anoh,Patricia Gomez,Stephen Munjanja
6. Improving the Coverage and Quality of Village Health and Nutrition Days by USAID and VISTAAR

Annexure

Availability & Quality of ANC services Provided at VHND Session

Interview Schedule

(For Beneficiaries – Pregnant Ladies and ANM)

Informed consent: I would like to thank you for taking the time to meet me. My name is Ankur khare. I would like to talk to you about your experience regarding the ANC visits

during your pregnancy. The interview should take about 10 minutes. The responses will be kept confidential. This means that the interview responses will be shared only with the research team and we will ensure that any information that we include in our report does not identify you as the respondent. Remember, you don't have to talk about anything that you don't want to and you can end the interview at any time.

Are you willing to participate in the interview?

Interviewee Signature

Sub center	
Village	
Serial No	
Date of Interview	

Interaction with PNC mothers

Q.1 Was relevant history(obstetric/past/menstrual) taken during First ANC visit?

1.Yes
2.No

Q.2 Did you receive the Mother & Child Protection card ?

1.Yes
2.No

Q.3Was your blood pressure measured at each visit?

1.Yes
2.No

Q.4 Was your oedema checked at each visit?

1.Yes
2.No

Q.5 Was your weight recorded at each visit?

1.Yes
2.No

Q.6 Was abdominal examination done?

1.Yes

2.No

Q.7 Was your abdominal palpation for determining fundal height foetal lie.etc. done and recorded in MCP card?

1.Yes

2.No

Q.8 Was your foetal heart sound examined / auscultated and recorded in MCP card.

1.Yes

2.NO

Q.9Were any lab tests done

1.Yes

2.No

(a)Was Pregnancy confirmation done using Nishchay kit?

1.Yes

2.No

(b) Was Hemoglobin estimation done at each visit?

1.Yes

2.No

(c) Was Urine Sugar estimation done each visit?

1.Yes

2.No

(d) Was Urine albumin estimation done each visit?

1.Yes

2.No

Q.10 Were any counseling method used for danger signs during pregnancy?

1.Yes

2.No

Q.11 Was IFA supplementation provided & counseling done for it?

1.Yes

2.No

Q.12 Were 100 IFA tablets provided?

1.Yes

2.No

Q.13 Did you receive the TT injections?

1.Yes

2.No

Q.14 Did you get both the doses of TT?

1.Yes

2.No

Q.15 Is abdominal palpation for determining fundal height,foetal lie etc,done and recorded

1.Yes

2.No

Q.16 Is advice for next antenatal check-up provided along with dietary and relevant counseling?

1.Yes

2.No

Section -B

(For ANM only)

Questionnaire for ANM

Informed consent: I would like to thank you for taking the time to meet me. My name is Ankur Khare. I would like to ask you some questions about availability of services for pregnant women at VHND session. The interview should take about 10 minutes. The responses will be kept confidential. This means that the interview responses will be shared only with the research team and we will ensure that any information that we include in our report does not identify your details.

Q.1 Is privacy during examination ensured(by way of separate cabin/curtains/sheet)?

1.Yes

2.NO

Q.2 How do you use sphygmomanometer for taking B.P.?

Q.3 Do you use Nischay kit for conforming pregnancy?

Q.4 Do you use Sahli' Adams tube for measuring Hb?

Q.5 What is the value of Hb for high risk cases?

Q.6 Is foetal heart sound examined/ausculted using foetoscope?

Q.7 How do you calculate EDD(expected date of delivery)?

Q.8 Is there timely supply and replenishment of drugs and equipment?