



Process Monitoring of Village Health and Nutrition Days (Mamta Days) In Navsari District, Gujarat, India

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ABSTRACT

Background: Village Health and Nutrition Day (VHND) identified as an important tool to provide a unique platform at village level to deliver health and nutrition services to RMNCH+A programme beneficiaries.

Objectives: (1) to assess the availability of logistics and supplies at VHNDs and (2) to monitor the process of services at VHNDs.

Method: It was a cross-sectional study, in which 15 VHNDs selected from Navsari district by multi-stage random sampling method. Out of total 15 planned visits, 14 completed in a calendar year. Data analyzed using MS Excel software.

Results: All VHND sessions visited were as per the microplan, equipped with key staff, logistics and supplies like weighing scale, mamta card, and growth chart, vaccines (except BCG- not available at 20% sites), medicines and supplements were available at all sites. BP instrument, thermometer, hemoglobinometer and uristrix strips were available at 70-90% sessions. Immunization and growth monitoring, two main services of VHND were satisfactory at all sites. Skill of blood pressure measurement and Hb estimation was satisfactory where it was available. However, antenatal examination, nutrition counselling, family planning counselling and supportive supervision were deficient at majority sites.

Key words: Monitoring, Process, Availability, Village Health and Nutrition Day

INTRODUCTION

Mother and child health care (MCH) is an important determinant of a nation's overall health condition. Village Health and Nutrition Day (VHND) identified as an important tool to provide a unique platform at village level to bring about the convergence of health and nutrition services at primary care level.¹ National Rural Health Mission (NRHM) conceptualized the concept and operational guidelines of Village Health and Nutrition Day (VHND) with support from Maternal & Child Health division of Government of India and United National Population Fund (UNFPA), India.^{2,3} Ministry of Health and Family Welfare, Government of India (MOHFW, GOI) issued a guideline for its effective implementation in 2007.⁴

As per the guidelines, VHND need to be organized once every month (preferably on Wednesdays) at the Anganwadi centres (AWCs) in the village to ensure uniformity in organizing the VHND.

In Gujarat state, Village Health and Nutrition Day (VHND) is known as "Mamta Day" which is part of Mamta Abhiyan to deliver RMNCH+A services at doorstep to the community. Beneficiaries are pregnant women, lactating mothers, children below 5 years and adolescent girls. VHND Guidelines suggested provision of package of services including registration of pregnant women, immunization, growth monitoring, appropriate management of malnourished children, family planning services, and health education among others.⁵

VHND is seen as platform for interfacing between community & health system & if monitoring of these were not done then its lost opportunity to deliver quality RMNCH+A services to the community. In this scenario, the present study was planned to assess the availability and quality of various health and nutrition services at VHND with an attempt to find deficiencies in the provision of services and recommendations for the improvement of the situation.

MATERIAL AND METHOD

Under the National Rural Health Mission, an initiative was taken to provide integrated maternal health, child health, and nutrition services through outreach sessions like the Village Health and Nutrition Days (VHNDs). Such sessions are organized in the village at a fixed day, place and time through convergent actions by the department of health and the department of women and child development. In Gujarat state, Village Health and Nutrition Days (VHNDs) are organized at village level on Wednesday every month.

Health and Family Welfare Department of Government of Gujarat started SRIM (State Routine Immunization Monitoring) activity by involving community medicine experts from different Medical Colleges in the state. Under this scheme, community medicine department of each government medical college in the state allotted districts in their region. Assistant professor/Tutor in the community medicine department has to visit two VHND sessions in a month in the district allotted to him/her. He/she has to monitor the activities carried out on VHND, record the findings in the prescribed format/checklist, and submit the report to the family welfare department, Govt. of Gujarat. Findings of the monitoring visit are also to be share with concerned PHC medical officer, Taluka health officer as well as district RCH officer for improvement in the services.

Work distribution at VHND session: Female Health Worker (ANM) is overall in-charge for the session and carrying out vaccination, nutrition counselling, family planning counselling, management of health problems in children less than 5 years as per IMNCI protocol, treatment and referral for health problems in other beneficiaries and documentation of activities. Anganwadi worker is primarily looking after growth monitoring of children. Responsibility of informing the beneficiaries' day before VHND session primarily lies with ASHA along with Anganwadi worker. Mobilization of beneficiaries to the VHND center on the day of session done by ASHA.

The study design was cross-sectional. VHND sessions were selected by multi-stage sampling method. The study was carried out in Navsari district (located in south Gujarat region having rural as well as tribal area). Navsari district has five blocks (talukas); from each block, three PHCs were selected randomly. In next stage, one VHND session was selected randomly from each PHC from the microplan. Out of total 15 planned visits, 14 completed. Duration for the study was one calendar year from January to December 2009. Assessment of availability of various resources and process monitoring of various services was carried out during each visit.

Data analyzed in a MS Excel software.

RESULTS

Sessions were organized as per the micro-plan at all VHNDs visited. Out of 14 sessions observed, 12 were organized at anganwadi center, one at sub-centre and one at community hall of the village. Banner displaying the VHND (Mamta Divas) was present at 12 (86%) sites. Timing for VHND session was 8 AM to 5 PM; and all the visited sessions were open at the time of visit. Female health worker, anganwadi worker and anganwadi helper were present at all 14 sites. ASHA was present at the VHND center in 10 sessions and in the field for beneficiary mobilization at 4 centres. At 8 sessions, male health worker was present additionally to support the activities. PHC level supervisor (female health supervisor) was present at five sites whereas block level supervisor (block health visitor/IEC officer) was present at two sites for supervisory activities as per their schedule. ICDS supervisor was not present at any of the site. List of eligible beneficiaries was available at all the sites. Community mobilization was seen at all sites. Bio-medical waste (BMW) buckets with color-coded bags were available in all VHNDs.

Availability

Table 1 shows the availability for different equipments and stationary materials. Main reason given for non-availability of different items was that they did not bring it from subcentre to the session site on VHND. At two sites, Hb meter was available but was non-functional; not having HCl.

Table 2 shows that all vaccines, medicines and supplements were available in adequate quantity at all VHNDs visited except BCG vaccine, which was not available at three sites and IFA Pediatric tablet/syrup, which was not available at one site.

Table 1: Availability of Equipments and Stationary Material at VHND session

Item	Availability (%) (n=14 VHND sessions)
Equipments (functional)	
Adult weighing scale	14 (100)
Newborn weighing scale	11 (78.6)
Child weighing scale	14 (100)
Blood Pressure measuring Instrument	12 (85.7)
Thermometer	10 (71.4)
Hemoglobinometer	12 (85.7)
Uristrix Strips (adequate)	10 (71.4)
Stationary Items (adequate)	
Mamta (Immunization) card	14 (100)
Growth Chart (Individual)	14 (100)
Community Growth Chart	8 (57.1)
MCH Register	14 (100)

Table 2: Availability of Vaccines and Medicines/Supplements at VHND session

Item	Availability (%) (n=14 VHND sessions)
Vaccines (adequate quantity)	
BCG	11 (78.6)
OPV	14 (100)
DPT	14 (100)
Measles	14 (100)
Medicines/Supplements (adequate quantity)	
IFA Tablet (adult)	14 (100)
IFA Tablet/Syrup(pediatric)	13 (92.9)
Calcium Tablet	14 (100)
Vitamin A Syrup	14 (100)
ORS Sachet	14 (100)
Paracetamol Tablet	14 (100)

On exploring the reasons for non-availability of BCG vaccine, it was found that FHW was not bringing the BCG vaccine to the VHND site if only one or nil eligible beneficiary at the session site as per the beneficiary list. They were sending the beneficiary to the next nearby session. Reason given by them was to avoid wastage of BCG vial.

Quality of service delivery Monitoring

Services like vaccination, weighing of children/antenatal women/postnatal women, vitamin A supplementation, IFA and calcium supplementation to ANC/PNC, and service registration in MCH register were satisfactorily at all VHNDs. Provision of prophylactic IFA supplementation to the children less than 5 years was absent at 11 (78%) sites. Community growth chart is the education and counseling tool used by female health supervisor/female health worker for demonstrating the growth monitoring on single large growth chart to the mother/caretakers of the children. The chart was available at only eight VHND sessions, usage seen at 6 sessions and correct usage at 4 ses-

sions. Antenatal examinations done at only one session site. Reasons mentioned for not conducting antenatal examination were- no examination table and no separate room for audio-visual privacy. Blood pressure measurement done correctly at all 12 VHND sessions where functional BP instrument was available. Out of 12 VHND sessions, where functional Hemoglobinometer was available, Hb estimation done at 5 sessions only. Reasons explained were, PHC nearby, irregular/no supply of HCL/distilled water and one prick will serve for all required tests at PHC. Out of 10 VHND sessions, where uristrix strips were available, only three using it. Remaining FHWs were referring the beneficiaries to the PHC for urine test. Reason mentioned was no facility of toilet. Appropriate treatment and referral for minor health problems done by FHWs at all the sites. Nutrition counseling of beneficiaries was not seen at almost all VHNDs. Family planning counseling by FHW was seen at six (43%) session sites. Out of 7 session sites where supervisor available, most of them were not aware about their role on VHND session. Except two supervisors, none of them was doing community growth monitoring (which they have to do as per the guidelines). In addition, most of them doing work of FHW and helping FHW, instead of supervising her work and suggest necessary corrections where necessary.

DISCUSSION

Village Health and Nutrition Day (VHND) was a major initiative under the National Rural Health Mission (NRHM) to improve access to maternal, newborn, child health and nutrition services at the village level. The present study was conducted to monitor the process of VHND and thereby to identify the gaps in service provision and to provide technical input & suggestions, which can help, strengthen the existing VHND strategy.

In the present study, all the VHND sessions were conducted as per the microplan. Regular sessions are important for expectation of beneficiaries. Parmar A et al⁶ and Khandhedia S A et al⁷ reported similar findings whereas Patel T et al⁸ reported 30% VHND sessions as per microplan. The place for VHNDs was anganwadi center at majority of sites. Kotecha I et al⁹ reported it to be 93% whereas Barua K et al¹⁰ and Ninama R D et al¹¹ observed it in almost three fourth sessions. Female health worker, anganwadi worker and ASHA are the key staff for conduction of VHNDs. They all were present in 100% sessions. Ninama R D et al¹¹ and Parmar A et al⁶ also reported similar findings. In the current study, supervisor from health department like medical officer, female health supervisor,

block health visitor were present at half of the sites whereas ICDS supervisor was not present at any of the site. The results were analogous with Sanghavi M M et al¹² and Ninama R D et al¹¹, who also found supervision component deficient in their study. Community mobilization is very essential, because the health seeking behavior of beneficiaries usually remains poor, especially in rural area. List of eligible beneficiaries is pre-requisite for community mobilization. In the current study, the monitor could see list of eligible beneficiaries as well as community mobilization in practice at all VHND sites. Variable numbers have been reported by Parmar A et al⁶, Patel T et al⁸ and Ninama R D et al¹¹ for the availability of list of beneficiaries as 8%, 54% and 85% respectively. However, they saw existence of community mobilization at majority of VHND sessions.

Availability of equipments, logistics and supplies is vital for effective delivery of services at VHNDs. In the present study, equipments like weighing scale, mamta card, growth chart and MCH register were available at all VHND sessions; newborn weighing scale, blood pressure measuring instrument, thermometer, hemoglobinometer and uristrix strips were available at 70-90% sessions whereas community growth chart was available at half of the sessions only. Khandhedha S A et al⁷ and Shah J et al¹³ reported similar findings in their study on monitoring of immunization services at VHNDs. On the contrary, Saxena V et al¹⁴ reported less than 50% availability of important equipments at VHNDs.

Uninterrupted supply of vaccines, medicines and supplements is necessary for regular services, which were available in adequate quantity at all VHNDs visited except for BCG vaccine (not available at three sites) and IFA pediatric tablet/syrup (not available at one site). Patel T et al⁸, Saxena V et al¹⁴ and Parmar A et al⁶ also reported similar findings with non-availability of BCG vaccine at some of the sessions. Reason explained by female health workers for non-availability of BCG vaccine was that if beneficiary for BCG vaccine were very less or nil, they do not bring the BCG vaccine at session site to avoid wastage and calling the beneficiary to her next nearby session site.

Effective delivery of the services is vital to achieve the objectives of VHNDs. Immunization and growth monitoring; the two key services among children were satisfactory at all VHNDs visited. As opposed to the findings of current study, Saxena V et al¹⁴ and Kotecha I et al⁹ reported poor growth monitoring of children in their studies. Availability and correct usage of community growth chart was meagre, whereas prophylactic IFA supple-

mentation to the children less than 5 years was absent in current study.

IFA supplementation, calcium supplementation and weighing was good among antenatal and postnatal women. Similar finding was reported by Kotecha I et al⁹ in their study. Antenatal examination, the essential component of antenatal care was absent at all the sessions except one. Non-availability of examination table and audio-visual privacy were the reasons reported. Saxena V et al¹⁴ and Kotecha I et al⁹ found it to be 8.3% and nil respectively. Two basic services under antenatal care are blood pressure measurement and hemoglobin (Hb) estimation. In the present study, the skill of blood pressure measurement was satisfactory at all sites where functional instrument available. Hb estimation was in practice only at five sites (42%) out of 12 sites where functional hemoglobinometer was available. Reasons elucidated were non-availability of HCL/distilled water and PHC located nearby. Hb estimation by Sahli's method requires skill, time and regular supply of reagents, so it may not be suitable at field level especially at VHNDs. Saxena V et al¹⁴ reported Hb estimation at 29.2% sites and blood pressure measurement at less than half sites in their study.

Counselling of beneficiaries for nutrition was very low in the present study. Saxena V et al¹⁴, Ninama R D et al¹¹ and Barua K et al¹⁰ reported it to be 20.9%, less than 50% and 100% respectively. Responsibility of growth monitoring and counselling for nutrition primarily lies with anganwadi worker who comes under the department of women and child development. Effective coordination between health and WCD departments at different level must be ensured for effective results in the section of nutrition. Counseling for family planning was seen at six sites (42.8%) only, that too in postnatal women only and not in antenatal women. Kotecha I et al⁹ also noted the same finding.

Supportive supervision is crucial for success of any program by finding the lacunas and onsite correction of the same. In the present study, this component was deficient as out of seven session sites where supervisor available, most of them were not aware about their role at VHNDs. They were doing work of FHW and helping her, instead of supervising her work and do necessary onsite corrections. The results were comparable to the findings of Kotecha I et al⁹ and Parmar A et al⁶.

Monitor who visited the VHNDs in the study gave suggestions and made necessary onsite corrections. In addition, feedback was given to the medical officer as well as to the district and state level officials.

CONCLUSION

All the VHND sessions were according to microplan and adequately equipped with key staff. Availability of instruments, vaccines, medicines and other supplies was sufficient at almost all sites. Mostly, immunization, growth monitoring, blood pressure measurement and community mobilization were the focus areas in VHNDs; whereas components like antenatal examination, supportive supervision, Hb estimation, nutrition counselling and community growth monitoring were lacking.

Recommendations

Results of the study indicates the need of providing examination table and audio-visual privacy at VHNDs for antenatal examination. Skills of female health worker should be improved in the area of antenatal examination, nutrition counselling and community growth monitoring by their capacity building trainings. Alternate easy option of sahlí's method is required to increase Hb estimation at VHNDs. Supervisors also need training to improve their supervisory skills.

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