Strengthening of Special VHND and Routine Immunization under SAMPurNA Strategy in Odisha

Indian Institute of Public Health, Bhubaneswar (IIPHB)

Strengthening of Special VHND and Routine Immunization under SAMPurNA Strategy in Odisha

(Sishu Abom Matru Mrityuhara Purna Nirakaran Abhijan)

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At the very outset, we are thankful to UNICEF and Government of Odisha for commissioning this piece of work on strengthening VHND and RI under SAMPurNA strategy in Odisha to IIPH Bhubaneswar. Words such as strategy, programme and scheme are being used interchangeably to discuss about this strategy. However, for all practical purposes we consider this new initiative as a strategy. This is a unique exercise in terms of the objective to provide actionable inputs to policy makers, programme managers and planners for strengthening the SAMPurNA strategy in the state.

This report was prepared after synthesizing a lot of primary data collected through visits to the session sites, interviews and focus group discussions. The secondary data collection was highly challenging for various reasons such as paucity of availability of data series, and delay in reporting. Therefore we decided to focus this report on primary data alone.

The report chronologically discusses the study objectives, methodology and results, followed by conclusion and recommendations in a logical fashion. We are confident that the study findings will be useful for preparation of training modules, district-specific implementation plans and SAMPurNA 2.0 strategy for the state.

We are thankful to Dr Meena Som, Dr Brajesh Raj Merta and Dr Anil Pattnaik of UNICEF, Odisha for providing support at all levels of tool finalization, data collection and report finalization. Their inputs were highly useful in finalizing the report. The support by Nodal Officer of Immunization, Govt of Odisha, Dr Tapas Patra is appreciated, as it helped in getting cooperation from the field during data collection. We are very much thankful to Director of Family Welfare (DFW), Deputy Director and other senior officials of the DFW's office. The respondents of the office of the chief district medical officer (CDMO) of select districts were very cooperative for we are thankful to all of them. Last but not the least, we are very much thankful to the community members, key informants and respondents for their contribution, cooperation and support.

Dr Bhuputra Panda, PhD

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ABBREVIATIONS

ASHA:	Accredited Social Health Activist
AWW:	Anganwadi Worker
ARI:	Acute Respiratory Infection
ANM:	Auxiliary Nurse and Mid-wife
ANC:	Ante Natal Care
AVDS:	Alternate Vaccine Delivery System
BCC:	Behavior Change Communication
BPM:	Block Programme Manager
BPO:	Block Programme Organizer
BDO:	Block Development Officer
CDMO:	Chief District Medical Officer
CHC:	Community Health Centre
DPM:	District Programme Manager
FBNC:	Facility Based New born Care
LHV:	Lady Health Visitor
MO:	Medical Officer
PHC:	Primary Health Centre
MMR:	Maternal Mortality Ratio
IPC:	Inter Personal Communication
ILR:	Ice Line Refrigerator
IFA:	Iron and Folic Acid
IMR:	Infant Mortality Rate
MDG:	Millennium Development Goal
NRHM:	National Rural Health Mission
RDC:	Regional Divisional Commissioner
FGD:	Focus Group Discussion
IDI:	In Depth Interview
PRI:	Panchayat Raj Institution
MPW-M:	Multi-Purpose Worker - Male
MPHS:	Multi-Purpose Health Supervisor

RCH:	Reproductive Child Health
MCP:	Mother and Child Protection
RTI:	Reproductive Tract Infection
RI:	Routine Immunization
RMNCH:	Reproductive, Maternal, Neonatal, Child Health
PW:	Pregnant Women
MO:	Medical Officer
SC:	Sub Centre
SDG:	Sustainable Development Goal
SAMPurNA:	Sishu Abom Matru Mrityuhara Purna Nirakaran Abhijan
VHND:	Village Health and Nutrition Day

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EXECUTIVE SUMMARY

INTRODUCTION

Delivery of health services in recent years such efforts have been complimented by many programmes that aimed to further strengthen the existing health systems. Despite of having a sharp pace of decline in the maternal mortality ratio (MMR) during the period 2006-2012, India fell short of meeting the Millennium Development Goals (MDG) on improving maternal health. The National Rural Health Mission (NRHM) aimed to offer a basket of maternal and child health services, such as, antenatal care, child care, immunization, family welfare and adolescent health care services under one platform, branded as "Village Health and Nutrition Day" (VHND) for improving access to maternal, new-born, child health and nutrition (MNCHN) services at the village level. In Odisha, the guidelines for organizing VHND sessions were developed in 2009 and the programme was re-launched as "Mamata Diwas", in which sessions were planned to he held on a fixed day excluding the Fixed Immunization Day (FID); and health and nutrition services to women and children became a priority. In this context in 2017 the state government strategized and expanded the scope of VHND services to difficult-to-reach areas under the brand "*Sisu Abham Matru Mrityuhar Purna Nirakaran Abhijan*" or SAMPurNA, designed to achieve 90% complete immunization coverage by 2020 with special emphasis on the vulnerable pockets across 15 tribal dominated districts of the State, and, in turn achieve the desirable IMR and MMR goals.

During last four years of implementation of SAMPurNA strategy, several sub-district level activities were undertaken: preparation of special micro-plans at sub-district levels for the vulnerable pockets; training of frontline health workers; special VHND sessions for those vulnerable pockets; timely indenting of logistics and supply; efficient cold chain management; timely delivery of vaccines at session sites; and concurrent monitoring cum review of achievements in weekly and monthly meetings. UNICEF Odisha in consultation with the state government commissioned a study to IIPH Bhubaneswar as to undertake a rapid assessment of the current status of implementation of SAMPurNA strategy in 15 high priority districts, to examine the systemic enablers and barriers in such implementation, and to offer actionable recommendations on the basis of key findings. Study objectives are:

1. Undertake a rapid assessment of VHND and routine immunization services under the SAMPURNA strategy with special focus on accessibility, coverage, effectiveness, and quality of services.
2. Explore opinion and perspectives community members, service providers and programme managers about enablers and barriers in successful implementation of SAMPurNA strategy in Odisha.
3. Provide actionable recommendations for strengthening the programme implementation in the State.

A cross-sectional study design was followed with a mixed method approach for data collection and analysis. Out of the 15 intervention districts, 6 districts were selected, proportionately representing all 3 regional divisional commissioners of Odisha. One district from central RDC,

two districts from northern RDC region and 3 districts from southern RDC region were randomly selected and included in this study sample. Further, two blocks from each of the sample districts and four sessions from each of the sample blocks were selected randomly for on-the-site data collection and review of performance reports. Through random sampling, Mayurbhanj, Keonjhar, Sundergarh, Koraput, Rayagada and Nabarangpur were selected as sample districts.

Review of literature, review of performance reports, direct observation VHND sessions; focus group discussions (FGDs) at community levels, and in-depth interview (IDI) with service providers at session sites, programme implementers at block level and managers at district level were undertaken by IIPHB team. In total we observed 48 VHND sessions, conducted 12 FGDs, 12 IDIs with ASHA/ANM, 12 IDIs at block level and 11 IDIs at district level. Ethical approval for the study was obtained from the government of Odisha, Health and Family Welfare Department, before initiation of data collection. A departmental support letter was obtained to support the data collection. Confidentiality of information and anonymity of participants was maintained through coding and segmentation. Informed consent was obtained before conducting FGDs and IDIs.

RESULTS

The vaccine delivery to the session site was mostly done by Alternative Vaccine Delivery (AVD) system (50%) and by the ANMs (41.6%). With regard to mobilization of beneficiaries to the session site, it was found that the ASHA workers (95%) and AWW workers (54%) contributed significantly towards the process of community mobilization to the session sites. In majority of session sites (64.6%) the head count survey registers were present. The vaccination status of the beneficiaries related to the previous sessions are updated in the RCH registers by ANMs in 83.3% of session sites. The SAMPurNA session micro-plan was not available with the ANM in 39.6% of session sites. While ANMs (93.8%) and ASHA workers (72.9%) participated in SAMPurNA session micro-plan preparation, the involvement of AWW workers in micro-plan development needed improvement.

In 79.2% SAMPurNA session sites the updated RCH / VHND+RI registers were available. None of the reporting formats related to VHND+RI were available in 31.2% of SAMPurNA session sites. In as many as 79.2% of sessions no unsafe practices were found to have been followed while providing injection to the beneficiary by the ANM. Almost 50% of the SAMPurNA sites that were visited by the assessment team were not supervised by any immediate supervisors on the day of the visit.

In 70.8% of instances the SAMPurNA (VHND+RI) sessions were organized at the same place where previously RI sessions were planned and held. In 89.6% of sessions, it was found that the ANMs were conducting the session in the same sub centre as their places of posting. It was found that twenty three (67.6%) mobilizers, other than ASHA / AWW, out of 34 respondents were aware of the incentives for mobilization of children at Rs150/-per session.

About 92% of ANMs were found to have been trained on BRIDGE IPC skill training. In about 29% of SAMPurNA session sites no IEC materials were on the display during the visit of the assessment team / on the day of our visit. Further, the ANMs were not properly or effectively disseminating the key messages to each and every beneficiary after vaccination got over. Approximately 50% of the caregivers didn't know or remember the key messages when specifically enquired about.

Caregivers were aware of the management of any discomfort signs or side effects following vaccination. But they were not aware of the requisite number of visits needed to completely immunize their children. Moreover, their awareness about the vaccines that were to be given to their children, next, was very low. It was found that 32 out of 44 ASHA/AWW workers (67%) were aware of the incentives that are being provided to conduct SAMPurNA session in the hard to reach areas.

In some sessions the requisite vaccines were not available for the targeted beneficiaries. The main reason for non-availability was cited as "Not issued" (37.5%) i.e. the requisite vaccine has not been issued from the ILR point for that particular session. Most of the basket of maternal health services was found to be on the offer during SAMPurNA sessions with some exception. Further, it was evident that it could be 'lackadaisical attitude' rather than 'poor knowledge' of the ANM that resulted in compromise with privacy of examination.

In about 52% of sessions, family planning counselling was provided to the eligible women/couples on various spacing and permanent methods. By now it was expected that the beneficiaries remembered the health topics, but this component was not getting the importance that it was due to get. Most of the equipment, vaccines and other logistics arrangements were done appropriately at the SAMPurNA sessions sites. However, examination table with foot-steps and curtained partition are the components which were lacking in most of the session sites.

CONCLUSION

The overall technical knowledge of ANMs and ASHA workers with regard to immunization and ANC care were found to be good, but skills on BCC, IPC and community counselling needed further improvement. Systemic bottlenecks in terms of poor rood and mobile connectivity, reimbursement of incentives, weak reporting system and erratic supply of vaccines and other logistics continued to pose challenges to the programme managers and service providers and supervisors.

From the point of view of beneficiaries, their knowledge on pregnancy, child feeding and danger signs was encouraging. However, poor level of preparedness at the referral hospitals, bad experiences and hidden cost of seeking public health care services acted as barriers from accessing government facilities. Though most of the beneficiaries reposed trust and confidence on the local health workers, they were still reluctant to approach the referral hospitals.

POLICY PRESCRIPTIONS

1. The preparation of micro-plan is a dynamic and consultative process. A particular week can be fixed in a year for the micro-planning exercise, and all stakeholders may be mandated to participate in the exercise.

2. The AVDS support ought to be extended to all special VHND-RI sessions without exception. Extra incentives for AVDS need not be a part of the incentive package given to the workers for their hard work.

3. The head count must be completed every session and an updated due list should be prepared after updating the same in the RCH register and MCP cards.

4. Standard formats like due lists and tally sheets must be used at the session site more often than carrying heavy, troublesome registers.

5. All integrated VHND+RI sessions should have ANMOL tab for service tracking and the same may be used for IEC activities through video-shows.

6. Infusion of simple, innovative technology, such as, geo-tagging and off-line entry provision of session-related data must be introduced in a phased manner as to improve quality of data, increase transparency and reduce reporting-related workload on the front line workers.

7. Refresher training on the critical domains of job profile of frontline workers, such as, on IPC, BCC, reporting system and community mobilization must be imparted to them on a regular, yearly basis. This could be introduced in the nursing curricula which in the long run could strengthen the skills of upcoming ANMs.

8. Medical colleges, public health institutions and district level organizations may be identified and mandated to undertake regular supportive supervision visits to the district / block / session sites.

9. Though the SAMPurNA sites and routine RI sites are not mutually exclusive to each other, accessibility from the perspective of beneficiaries should be given utmost importance than that of the service providers.

10. IPC skills may be incorporated into the ASHA training modules and AWW curriculum. A practical, field-based BRIDGE training may be designed and implemented in a decentralized manner.

11. IEC depicting the various services that are ought to be offered in the SAMPurNA platforms would be more useful than a banner of special VHND-RI session.

12. Delivery of key messages to the beneficiaries must come at the end of every event, without exception. ASHA as a local person would have extensive role in this. Therefore, training ASHA on IEC/IPC must be focused on.

13. Certain areas where AVDS is not working, must actively pursue towards identifying volunteers to carry the vaccines and other logistics to the session site, rather than leaving this activity to the ANM's decision.

14. Counselling of the entire family during the VHND sessions is a significant step towards behaviour change communication. All three frontline workers must be trained adequately on this counselling skill.

15. Availability of essential logistics at the session needs to be further strengthened in terms of identifying volunteers for every site or identifying community based organizations that would be willing to take up such tasks.

16. Decisions related to contraception and reproduction are complex and involve key members of the family. Hence it becomes imperative that the male members also get involved in counselling sessions.

17. More emphasis need to be laid down to BCC strategies. For instance, interactive methods such as folk shows, drama and pico projectors could be used in the session which could not only attract attention of the beneficiaries but also ensure acceptance of the message.

18. Privacy during examination is still a major cause of concern, as ascertained by session site observations and FGDs. Guidelines must be developed / modified as to empower the local decision makers to purchase additional logistics for portable examination chambers. As and where convenient permanent session site structures should be built in a phased manner.

19. The SAMPurNA scheme was conceived to provide VHND and RI services hard-to-reach areas. Poor road and telephone connectivity adds to the challenges of the beneficiaries. Therefore, attempts should be made to involve these departments during planning exercise, and advocacy sessions could be carried out by local representatives to strengthen road and mobile connectivity.

20. The district administration must focus its attention on availability, affordability and quality of services being offered in those referral centres to win trust of the public.

21. Provision of adequate stock of MCP cards at the sub centre level is critical to ensure timely reporting. This activity must be reviewed by the block in monthly meetings.

SPECIFIC RECOMMENDATIONS

1. More FRUs may be made functional in the difficult to reach Blocks in order to reduce the patient load at DHH level.
2. Post natal Wards need to be expanded for expanded basket of services. Dormitory service may be provided to the attendants of the beneficiaries.
3. Additional ILR points, if required, need to be established in select blocks in consultation with the block officials to reduce vaccine transportation time.
4. An incentive-based leader for each village may be selected to ensure transportation of logistics round to year.
5. More *Matru Gruhas*, Janani Express services and stretchers need to be planned for these difficult areas.
6. Need to expedite filling up of all vacant positions of the three A's (ASHA, Anganwadi and ANM) on priority basis.
7. Engagement of local ANMs who have acquaintance with local language would help in proper inter-personal communication. Best practices of some districts can be replicated in other districts.
8. Role of traditional healers may be explored for better FP services. Male involvement in FP decision making is a critical pre-requisite for success of FP services.
9. A prototype of the benefits of integrated VHND+RI with key messages for community on MCH services may be developed and shared with the districts for use.
10. Follow-up visit by ASHA and sharing of emergency contact number with the care giver would be helpful to address unforeseen health needs of beneficiaries.
11. Obstetric history taking need to be given due importance during the session. Adequate time must be devoted to take proper history of all first time pregnancies without exception.
12. Quarterly tour-plans of district and sub-district level officials ought to be developed in tune with integrated VHND+RI session plans.
13. Proper feedback mechanism need to be developed to track incidences of under-the-desk payment by beneficiaries to the ambulance driver. Call centres and / or complaint box should be developed to take feedback from at least 25% beneficiaries from hard-to-reach areas.
14. Vaccine management through eVIN should be monitored seriously to avoid stock outs at any point of time.
15. Pico projector could be used for communicating messages on the health related issues.
16. Best practices on inter-departmental convergence for programme monitoring need to be documented and replicated in other places.
17. Review of the micro-plans based on the distance for beneficiaries need to be carried out regularly in monthly review meetings.

Strengthening of Special VHND and Routine Immunization under SAMPurNA Strategy in Odisha

BACKGROUND

Globally, several health care service provisions have been initiated over the last decade to support the delivery of available interventions for priority health problems. In recent years such efforts have been complimented by many programmes that aimed to further strengthen the existing health systems (e.g. facility based new born care or FBNC, reproductive maternal new born child and adolescent health or RMNCH+A, to name a few). India, despite witnessing a sharp pace of decline in the maternal mortality ratio (MMR) during the period 2006-2012, fell short of meeting the Millennium Development Goals (MDG) on improving maternal health[1].

In 2010-12, the MMR of Odisha was 35 (SRS). However, the recent SRS estimates on Odisha's MMR is 168 (2015-17) which witnessed a 12 point decline from the earlier reported figure of 180 (SRS 2014-2016). This decline was the second highest (12 points) after Rajasthan (13 points). During the same period, the MMR of India declined from 130 (2014-16) to 122 (2015-17). The IMR of Odisha was estimated at 40 in 2018 (SRS) as against India's IMR of 32; about a decade back, in 2006, the same was 73 and 57 for Odisha and India, respectively. Therefore historically Odisha has been performing sub-optimally with respect to reduction of IMR and MMR[5]. With regard to immunization the National Family Health Survey-4 (NFHS4) of 2015-16 estimated full immunization coverage of Odisha at 79 per cent against the national average of 62 per cent. Further, it was estimated to be scaled up to around 84 percent by 2016 (Integrated Child Health and Immunization Survey). The NFHS4 findings also indicated that complete immunization coverage was relatively low in 14 tribal districts of Odisha as compared to non-tribal counterparts.

With regard to coverage of antenatal care (ANC) and institutional deliveries, it is found that the percentage of mothers who had at least four antenatal care visits increased from 37% in 2005–06 to 52% in 2015–16 and the proportion of institutional births also increased from 39% in 2005–06 to 79% in 2015–16. However this overall improvement masks inequities across geographic and socioeconomic groups[6]. Secondly, there is gradual progress in the performance of RI in India over last few years. Six highly populous states in India contribute to 80% of the 8 million unimmunized children in the country[7]. Several intra- and inter-district factors contribute to such poor coverage of immunization, some of those are: ineffective outreach, weak referral system, poor supervision and inadequate information at the community level[8]. According to the NFHS4, an overwhelming 50.3 percent pregnant woman of age 15-49 years

are anaemic with haemoglobin level of less than 11g/dl. Further, prevalence of under nutrition among children under 5-years of age was estimated at 38.4 percent for stunting, 21 percent for wasting and 35.7 percent for underweight[4].

Vaccines are recognised as one of the most cost-effective public health interventions with the potential to significantly reduce the preventable childhood deaths in the world. Further, with the renewed emphasis by various state governments on universal health coverage, the routine immunisation programme continues to shape the strategic thrust of the entire gamut of maternal and child health[2]. The decade of Vaccines Global Action Plan 2011–2020 aimed at preventing millions of deaths through more equitable access to existing vaccines for people in all communities[2]. Consequently, the state of Odisha explicitly emphasized upon equity in immunization coverage in terms of creating equal opportunities for children across communities and identifying the groups that are at higher risk of remaining unvaccinated so as to bridge the gaps to the extent possible [3].

The National Rural Health Mission (NRHM) aimed to offer a basket of maternal and child health services, such as, antenatal care, child care, immunization, family welfare and adolescent health care services under one platform, branded as "Village Health and Nutrition Day" (VHND) for improving access to maternal, new-born, child health and nutrition (MNCHN) services at the village level. VHND sessions intend to provide a basket of health and nutrition services along with counselling to the community on a pre-designated day, time and place, in every village throughout the country[4].

In Odisha, the guidelines for organizing VHND sessions were developed in 2009 and the programme was re-launched as "Mamata Diwas", in which sessions were planned to he held on a fixed day excluding the Fixed Immunization Day (FID); and health and nutrition services to women and children became a priority. Mamata Diwas became the first point of contact for delivering essential primary health care and nutrition services in convergence with Women and Child Development (W&CD) department.

In this context in 2017 the state government strategized and expanded the scope of VHND services to difficult-to-reach areas under the brand "*Sisu Abham Matru Mrityuhar Purna Nirakaran Abhijan*" or SAMPurNA, designed to achieve 90% complete immunization

coverage by 2020 with special emphasis on the vulnerable pockets across 15 tribal dominated districts of the State, and, in turn achieve the desirable IMR and MMR goals.

The success of SAMPurNA strategy necessitates a robustly designed and responsive health system that is equipped to address local community needs and the demands of service providers. Under the umbrella of RMNCH+A campaign, the delivery of SAMPurNA services at the door steps of difficult-to-reach and tribal dominated pockets essentially aimed to address the challenges of equity, coverage and quality. Micro-management of organizing sessions, timely indenting and supply of logistics, release of financial incentives to the service providers, adequate demand generation and concurrent monitoring were given special emphasis.

During last four years of implementation of SAMPurNA strategy, several sub-district level activities were undertaken: preparation of special micro-plans at sub-district levels for the vulnerable pockets; training of frontline health workers; special VHND sessions for those vulnerable pockets; timely indenting of logistics and supply; efficient cold chain management; timely delivery of vaccines at session sites; and concurrent monitoring cum review of achievements in weekly and monthly meetings. The state government in collaboration with UNICEF proposed to undertake a rapid assessment exercise as to understand the current status of implementation of SAMPurNA strategy in these 15 high priority districts, and to examine the systemic enablers and barriers in such implementation. The Indian Institute of Public Health, Bhubaneswar (IIPHB) conducted this assessment in order to offer actionable recommendations on the basis of key findings, which could be used for further strengthening the interventions. The objectives and research questions of the assessment were:

STUDY OBJECTIVES

4. Undertake a rapid assessment of VHND and routine immunization services under the SAMPURNA strategy with special focus on accessibility, coverage, effectiveness, and quality of services.
5. Explore opinion and perspectives community members, service providers and programme managers about enablers and barriers in successful implementation of SAMPurNA strategy in Odisha.
6. Provide actionable recommendations for strengthening the programme implementation in the State.

SPECIFIC QUESTIONS

We attempted to study the following specific questions during the study:

Table 1 - Research questions, methods and sample details

Assessment questions	Level of assessment	Method of data collection	Sample size
1. Assess the status of sessions planned vs sessions held	SC/Block/District	Desk review	NA
2. Assess the HR planning and availability to conduct the VHND +RI sessions	SC/Block/District	Observation IDI	48 sessions across 6 districts (12 blocks) 12 IDIs with Block officials
3. Review follow-up action on high risk PW, mothers and children	SC	Review of reports	48 sessions across 6 districts (12 blocks)
4. Verify availability and completeness of VHND+RI micro-plan	SC/Block	Review of reports Observation	48 sessions across 6 districts (12 blocks)
5. Assess availability of logistics at the VHND-RI session sites	VHND session/SC	Observation	48 sessions across 6 districts (12 blocks)
6. Review the geographical feasibility of conducting sessions	SC	FGD IDI	12 FGDs 12 IDIs with ASHA/ANM
7. Assess about the current status of vaccine delivery system for conducting VHND+RI sessions (in the absence of AVDS strategy)	SC/Block	IDI	12 IDIs with block officials 12 IDIs with district officials
8. Review the fund flow mechanism, analyse gaps	Block/District	Observation IDI	12 blocks 6 districts IDIs with district officials
9. Assess the pattern of utilization of services	SC/Block	Monthly reports	48 sessions across 6 districts (12 blocks)

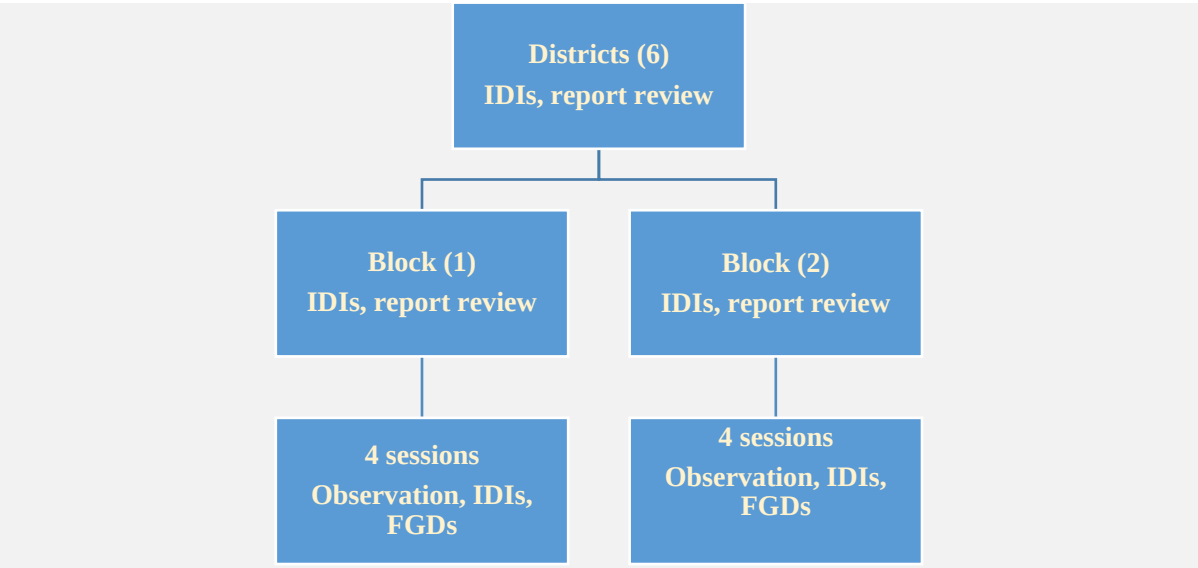
Assessment questions	Level of assessment	Method of data collection	Sample size
after implementation of SAMPurNA			
10. Review the status of joint home visits by ASHA/MPHW	SC	Observation IDI	
11. Review the monitoring system adopted for VHND+RI and action taken to strengthen it	SC/Block	IDI	12 IDIs with ASHA/ANM 12 IDIs with block officials
12. Explore the views of beneficiaries availing services under VHND+RI	SC	FGDs	12 FGDs across 12 blocks.

METHODOLOGY

Study design and sampling

A cross-sectional study design was followed with a mixed method approach for data collection and analysis. Out of the 15 intervention districts, 6 districts were selected, proportionately representing all 3 regional divisional commissioners of Odisha. One district from central RDC, two districts from northern RDC region and 3 districts from southern RDC region were randomly selected and included in this study sample. Further, two blocks from each of the sample districts and four sessions from each of the sample blocks were selected randomly for on-the-site data collection and review of performance reports. Details of sampling frame is given in Figure 1. Through random sampling, Mayurbhanj, Keonjhar, Sundergarh, Koraput, Rayagada and Nabarangpur were selected as sample districts.

Figure 1 - Sampling and data collection technique



Data collection methods

Review of literature and review of performance reports at sub centre (SC), block and district levels was undertaken by the team. We directly observed the VHND sessions; conducted focus group discussions (FGDs) at community levels; and conducted in-depth interview (IDI) with service providers at session sites, programme implementers at block level and managers at

district level. In total we observed 48 VHND sessions, conducted 12 FGDs, 12 IDIs with ASHA/ANM, 12 IDIs at block level and 11 IDIs at district level.

A field team of 8 investigators and research assistants were hired, trained and engaged in data collection. The research team visited one district at a time and collected data from the two blocks (four sessions, each). One member from the research team used to be accompanied by one official from the block program management unit to the session site for data collection. In this process, the research team was able to complete data collection on time. Using a mop-up approach, the team then visited the next district and so forth until all 6 sample districts, 12 blocks and 48 sessions were covered. With some delay in ethical clearance, the data collection actually started in November 2019 and ended in February, 2020. However, most of the secondary performance data obtained from the blocks were either inaccurate or inadequate for analysis. Therefore, this report was prepared only on the basis of all primary data collected by the research team.

The team developed, standardized, piloted and field-tested the data collection tools in a chronological manner. For VHND site observation, we adopted and modified the routinely used VHND and RI monitoring tool and contextualized it to our study needs. The FGD guide consisted of questions and probes about the beneficiaries' perspectives/opinions about the services given under the SAMPurNA sessions. Similarly, the IDI guide contained questions related to assessing the perception and opinion of service providers and managers about the challenges they were facing, opportunities that could be capitalized upon and about the systemic enablers and barriers. All tools for data collection are attached as annexures to the report. The research team de-briefed the district administration (i.e. CDM&PHO, DPM etc.) regarding key observations, before leaving the district.

Research ethics

Ethical approval for the study was obtained from the government of Odisha, Health and Family Welfare Department, before initiation of data collection. A departmental support letter was obtained to support the data collection. Confidentiality of information and anonymity of participants was maintained through coding and segmentation. Informed consent was obtained before conducting FGDs and IDIs.

Data analysis

Session site observations were entered into excel, exported to SPSS and analysed in terms of frequencies and SDs. All FGDs and IDIs were translated and transcribed verbatim and then analysed thematically with the help of Atlas.ti. Most of the secondary data that were collected from the blocks was not adding much to the analysis and thus not included.

RESULTS

RESULTS: SAMPurNA SESSION SITE OBSERVATIONS

Table 2 - Delivery of vaccines at session site

	YES	%	No	%
a) AVD	24	50	24	50
b) ANM	20	41.6	28	58.4
c) ASHA	0	0	48	100
d) AWW	0	0	48	100
e) Others	3	6.2	45	93.8
f) NA	1	2	47	98

It was found that vaccine delivery to the session site was mostly done by Alternative Vaccine Delivery (AVD) system (50%) and by the ANMs (41.6%). In very limited number of instances, volunteers and other community leaders were found to be involved in delivery of vaccines to the session site. Important to mention here that the AVD system was established to refrain the ANMs from additional workload of carrying the vaccines to the session sites so as to enable them focus on conducting the immunization sessions more effectively.

Table 3 - Mobilization of beneficiaries to the session site

	YES	%	No	%
a) ASHA	46	95.8	2	4.2
b) AWW	26	54.2	22	45.8
c) ANM/MPW-M	4	8.3	44	91.7
d) PRI	1	2.1	47	97.9
e) Education Department	0	0	48	100
f) Religious leaders	0	0	48	100
h) Others	1	2.1	47	97.9
i) none	0	0	48	100

With regard to mobilization of beneficiaries to the session site, it was found that the ASHA workers (95%) and AWW workers (54%) contributed significantly towards the process of community mobilization to the session sites. On the other hand, PRI members had very limited role (2.1%) while other line departments and religious leaders didn't play any role in mobilizing beneficiaries to the SAMPurNA sessions. This re-emphasizes the role of ASHA workers and AWW workers in community participation and mobilization for successfully organizing these community-based interventions.

Availability of headcount survey (register/format/paper) at the session site

In majority of session sites (64.6%) the head count survey registers were present. As per the laid down guidelines, the head count register/format ought to be carried to each and every session site to ensure proper recording and reporting of coverage among the identified beneficiaries. Hence, the ANMs need to be given refresher training and orientation about the importance of undertaking the head count exercises at session sites.

Updating vaccination status of beneficiaries in RCH register

The vaccination status of the beneficiaries related to the previous sessions are updated in the RCH registers by ANMs in 83.3% of session sites. The updation of vaccination status in the RCH register and the MCP card helps in smooth conduction of head count exercise: it helps to calculate the complete immunization coverage and in effective identification of potential beneficiaries for the subsequent sessions. Further, in 91.7% of session sites the updated due list was also available for on-the-spot verification by the research team. Further, it was also found that the health workers and AWW workers frequently referred to the due list during the immunization sessions which is reflective of one of the best practices.

Availability of micro-plan with the ANM

With respect to availability of micro-plan with the ANMs, we found that the SAMPurNA session micro-plan was available in about 59.4% sessions. Conversely, the micro-plans were not available with the ANM in 39.6% of session sites. The availability of micro plan at the session site helps the visiting supervisor to cross check the plan vs the actions and effectively introduce mid-course corrections for subsequent sessions according to the local requirement.

Table 4 - Participation in preparation of SAMPurNA session micro-plan development

	YES	**%**	**No**	**%**
ANM	45	93.8	3	6.2
ASHA	35	72.9	13	27.1
AWW	30	62.5	18	37.5
Others	15	31.3	33	68.7

The ANM and ASHA are the community level personnel who are mostly engaged in preparation of the micro plan. While ANMs (93.8%) and ASHA workers (72.9%) participated in SAMPurNA session micro-plan preparation, the involvement of AWW workers in micro-plan development needs to be improved. It was striking to find out that in three sessions the micro plan had been developed without the involvement of ANMs. This needs to be cross-checked and corrective actions need to be taken. For long-term success of SAMPurNA strategy, the involvement of ANMs, ASHA workers and AWW workers has paramount importance.

Availability of updated RCH registers at SAMPurNA session sites

In 79.2% SAMPurNA session sites the updated RCH / VHND+RI registers were available. The reasons for non-availability of registers in some of the session sites were found were related to logistical inconvenience of carrying such heavy weight registers. Some of the respondents put it, thus: "could not carry as it is heavy and big". For those who didn't carry the registers, when asked about how they are capturing the information, they replied that the information related to the session site was first recorded in a rough paper which was later updated in the RCH / VHND+RI registers as per their own convenience. This indicates that the frontline workers are spending much time in recording the session details which need to be addressed either by reducing the registers to a monthly registers or by introducing digital technology for paperless entry of data.

Table 5 - Availability of reporting format of VHND +RI at the SAMPurNA session site

YES	**%**	**No**	**%**	NA	%
32	66.7	15	31.2	1	2.1

Reporting formats related to VHND+RI were available in about 69% session sites. In other words, none of the reporting formats were available in about 31% SAMPurNA session sites. This is an important finding; availability of reporting formats is a non-negotiable activity which has to be ensured in each and every session site without any exception. The responsibility of compiling the requisite information and submitting the same through reporting formats lies with the ANM. Hence, the ANMs need to be sensitized about the importance of reporting formats and their utilization at the session site.

Table 6 - ANM's injection practices

	YES	%	No	%
Not cutting syringe hub immediately	1	2.1	47	97.9
Touching the needle	3	6.3	45	93.7
Post injection, applying thumb/finger/cotton	2	4.2	46	95.8
No unsafe practices	38	79.2	10	20.8
Not observed	5	10.4	43	89.6

In as many as 79.2% of sessions no unsafe practices were found to have been followed while providing injection to the beneficiary by the ANM. In some limited number of instances, unsafe practices such as touching the needle prior to injection and post injection – applying thumb/finger were observed (4.2%). While this indicates that the ANMs are well trained about the injection practices, continued education regarding safe injection practices and needle stick injury prevention need to be reinforced to the ANMs as a part of their refresher training to sustain this desirable knowledge and skill.

Table 7 - Visit of health supervisor to the session site on the day of visit

	YES	%	No	%
a) Health Supervisor	16	33.3	32	66.7
b) Medical Officer	2	4.2	46	95.8
c) Others	8	16.7	40	83.3
d) None	24	50	24	50

Almost 50% of the SAMPurNA sites that were visited by the assessment team were not supervised by any immediate supervisors on the day of the visit. This signifies the inadequate attention being paid by the immediate supervisors towards these SAMPurNA session activities. In this regard, the senior management at block / district level need to ensure the supervisor's involvement in effective conduction of session activities. The supervisor's field visit tour plan need to be developed in advance and aligned with the SAMPurNA micro-plan. Special focus also need to be given to the feedback or tour report of the supervisors.

Venue and accessibility of SAMPurNA (VHND+RI) sessions

In 70.8% of cases the SAMPurNA (VHND+RI) sessions were organized at the same place where previously RI sessions were planned and held. For the rest of the sessions, new venues were selected according to the accessibility and convenience of the targeted beneficiaries. This

observation is important from the point of view of beneficiaries: the fact that the same session sites are chosen for SAMPurNA as for RI has distinct advantages for the beneficiaries as they would have acquaintance with the old venue. With regard to accessibility of session sites, almost 94% of session sites were found to be accessible for both the beneficiaries and the health care service providers. Very limited proportion of sessions were conducted at inaccessible sites such as a mountain top or in a valley between 2-3 mountain tops: these session sites were more inaccessible for service providers as compared to the beneficiaries.

Table 8 - SAMPurNA sessions conducted at ANM's place of posting

	YES	**%**	**No**	**%**
a) same sub center/ urban health post	43	89.6	5	10.4
b) different sub center / urban health post in the same block / planning unit	5	10.4	43	89.6
c) different block / urban planning unit	0	0	48	100

In 89.6% of sessions, it was found that the ANMs were conducting the session in the same sub centre as their places of posting. The relative importance of this findings lies in the fact that the ANMs chose to conduct the session in the same venue where they were working. This has both advantages and disadvantages which may be contextually analysed from site to site and should be best undertaken by the district managers.

Awareness of mobilizer (other than ASHA/AWW) about financial incentives

It was found that twenty three (67.6%) mobilizers, other than ASHA / AWW, out of 34 respondents were aware of the incentives for mobilization of children at Rs 150/- per session. However, lack of awareness about the same among the rest eleven (32.4%) respondents is a major cause of concern. This observation highlights the need to disseminate financial guidelines (may be in local language) to the lowest rung as to develop confidence amongst the mobilizers about their rights and entitlements. It seems as on the date of the study, the guidelines were available at the district level but were not disseminated to the frontline workers.

Table 9 - Status of BRIDGE IPC skill training among frontline workers

	YES	**%**	**No**	**%**	NA	%
ANM	44	91.7	4	8.3	0	0
ASHA	38	79.2	9	18.7	1	2.1
AWW	33	68.8	10	20.8	5	10.4

About 92% of ANMs were found to have been trained on BRIDGE IPC skill training. On the other hand, less proportion of ASHA workers and still less AWW workers were trained on the same. This skill could be a major booster for most of the health education and health promotion activities at the village level, and need to be given due emphasis during district level planning. Annual rolling plans should be prepared to train all ASHA, ASHA and AWW workers on Inter Personal Counselling skills in order to enhance the field level counselling activities.

Table 10 - Display of IEC materials at the SAMPurNA session site

	YES	%	No	%
Poster	11	22.92	37	77.08
Banner	25	52.08	23	47.92
Wall painting	2	4.17	46	95.83
Other	2	4.17	46	95.83
No material	14	29.17	34	70.83

IEC materials were on the display in 71% session sites and in about 29% of SAMPurNA session sites there was no IEC materials on the display during the visit of the assessment team / on the day of our visit. This may not be helpful in terms of informing the beneficiaries about the package of services and benefits of each service being provided in the session. Thus, special focus need to be laid on reinforcing this activity across the State.

Table 11 - Status of key messages provided by ANM to caregivers regarding vaccination (Caregiver 1)

Activity	Caregiver 1					
	Yes	%	No	%	Not observed	%
ANM explained what vaccine(s) will be given in today's visit and the associated disease(s) prevented	26	54.2	12	25	10	20.8
ANM explained potential side effects following immunization (fever/pain/swelling, etc.) and ways to deal with them	29	60.4	9	18.8	10	20.8
ANM explained when to come for the next vaccination visit	24	50	14	29.2	10	20.8
ANM explained regarding the need to keep the immunization card safe and to bring it along for the next visit	27	56.3	11	22.9	10	20.8
ANM have asked the caregivers to wait with child for 30 min after vaccination	30	62.5	8	16.7	10	20.8

Table 12 - Status of key messages provided by ANM to caregivers regarding vaccination (Caregiver 2)

Activity	Caregiver 2					
	Yes	%	No	%	Not observed	%
ANM explained what vaccine(s) will be given in today's visit and the associated disease(s) prevented	24	50	12	25	12	25
ANM explained potential side effects following immunization (fever/pain/swelling, etc.) and ways to deal with them	25	52.1	11	22.9	12	25
ANM explained when to come for the next vaccination visit	23	47.9	13	27.1	12	25
ANM explained regarding the need to keep the immunization card safe and to bring it along for the next visit	23	47.9	13	27.1	12	25
ANM have asked the caregivers to wait with child for 30 min after vaccination	27	56.3	9	18.7	12	25

We observed that ANMs were not properly or effectively disseminating the key messages to each and every beneficiary after vaccination got over. Approximately 50 % of the caregivers didn't know or remember the key messages when specifically enquired about. Hence, Inter Personal Communication (IPC) should be strengthened by the service providers (ANM / ASHA) in order to ensure effective dissemination of key messages to the targeted beneficiaries. This again highlights the need for imparting skill-based training on IPC.

Table 13 - Source of information for caregivers about SAMPurNA (VHND+RI) session (Caregiver 1)

	Caregiver 1					
	Yes	%	No	%	NA	%
ANM	21	43.7	16	33.3	11	23
ASHA	27	56.2	10	20.8	11	23
AWW	20	41.6	17	35.4	11	23
Neighbours	2	4.1	35	72.9	11	23
PRI	0	0	37	77	11	23
Influencers	0	0	37	77	11	23
Religious leader	0	0	37	77	11	23
Poster/banner	1	2	36	75	11	23
Radio	0	0	37	77	11	22
Miking	0	0	37	77	11	23
Rallies	0	0	37	77	11	23
AV show / Street play - Y/N	0	0	37	77	13	23

	Caregiver 1					
TV	1	2	36	75	11	23
Wall painting	0	0	37	77	11	23
Mobile SMS	0	0	37	77	11	23
Social Media	0	0	37	77	11	23
Mothers' meeting	3	6.2	34	70.8	11	23
Community meeting	0	0	37	77	11	23
Others	0	0	37	77	11	23

Table 14 - Source of information for caregivers about SAMPurNA (VHND+RI) session (Caregiver 2)

	Caregiver 2					
	Yes	**%**	**No**	**%**	**NA**	**%**
ANM	17	35.5	18	37.5	13	27
ASHA	28	58.5	7	14.5	13	27
AWW	19	39.6	16	33.4	13	27
Neighbours	0	0	35	73	13	27
PRI	0	0	35	73	13	27
Influencers	0	0	35	73	13	27
Religious leader	0	0	35	73	13	27
Poster/banner	0	0	35	73	13	27
Radio	0	0	35	73	13	27
Miking	34	70.9	1	2.1	13	27
Rallies	0	0	35	73	13	27
AV show / Street play - Y/N	0	0	35	73	13	27
TV	1	2.08	34	70	13	27
Wall painting	0	0	35	73	13	27
Mobile SMS	0	0	35	73	13	27
Social Media	0	0	35	73	13	27
Mothers' meeting	2	4.2	33	68.8	13	27
Community meeting	0	0	35	73	13	27
Others	0	0	35	73	13	27

In this section, we enquired about the source of information for care givers about SAMPurNA sessions. The field level functionaries such as the ANM, ASHA and AWW workers were found to be successful in spreading the information regarding the conduction of SAMPurNA sessions at the community level. Another effective method of spreading the information was found to be Miking (Announcement done by mike or voice recorder). In session sites where we could not find any respondent, 'Not Appropriate' was ticked.

Table 15 - Caregivers' knowledge about vaccines, visits and MCP cards (Caregiver 1)

Knowledge	Caregiver 1					
	Yes	%	No	%	NA	%
Awareness regarding all vaccine/s given to the child in this visit	9	18.75	27	56.25	12	25
Knowledge regarding the next visit which is due for the child (confirm from MCP card)	15	31.25	21	43.75	12	25
Had the ANM asked you to carry the MCP card during next visit	26	54.17	10	20.83	12	25

Table 16 - Caregivers' knowledge about vaccines, visits and MCP cards (Caregiver 2)

Knowledge	Caregiver 2					
	Yes	%	No	%	NA	%
Awareness regarding all vaccine/s given to the child in this visit	7	14.58	29	60.42	12	25
Knowledge regarding the next visit which is due for the child (confirm from MCP card)	14	29.17	22	45.83	12	25
Had the ANM asked you to carry the MCP card during next visit	26	54.17	10	20.83	12	25

As can be seen in the tables above, the level of awareness among the caregivers about the vaccines that were to be given to their children was very low. The beneficiaries were not much aware regarding the importance of vaccination or the meaning of full vaccination. This situation needs urgent attention and continuous interaction of ANMs with the beneficiaries about the importance of the each vaccine given on the session site and about the utility of completing the immunization schedule (full immunization). Knowledge of the caregivers regarding their scheduled next visit for vaccination was also poor. This can be improved by repeated interaction service providers i.e. ANM, ASHA and AWW workers with the target audience. The ANM in particular should highlight the importance of carrying the MCP card to the session site. The ASHA need to emphasize upon this during home visits.

Table 17 - Action taken by beneficiaries to deal with discomforts following vaccination (Caregiver 1)

	YES	%	No	%	Not Applicable	%
Gave PCM or cold sponge as instructed by ANM	11	22.9	26	54.2	11	22.9
Visited ANM/ ASHA/govt health facility	25	52.1	12	25	11	22.9
Visited private health facility	2	4.2	35	72.9	11	22.9
Visited traditional healer	1	2.08	36	75	11	22.9
Did not take any action	4	8.33	33	68.75	11	22.9
Others	2	4.17	35	72.92	11	22.9

Table 18 - Action taken by beneficiaries to deal with discomforts following vaccination (Caregiver 2)

	YES	%	No	%	Not Applicable	%
Gave PCM or cold sponge as instructed by ANM	9	18.7	27	56.3	12	25
Visited ANM/ ASHA/govt health facility	24	50	12	25	12	25
Visited private health facility	3	6.3	33	68.7	12	25
Visited traditional healer	1	2.1	35	72.9	12	25
Did not take any action	3	6.3	33	68.7	12	25
Others	3	6.3	33	68.7	12	25

It was noticed that the caregivers were aware of the management of any discomfort signs or side effects following vaccination. Most of the caregivers opted to consult the ANM/ASHA/govt. health facility at the time of need. In some instances they themselves managed the situation by administering Paracetamol or applying cold sponge as instructed by the ANM. A small proportion of caregivers opted not to take any action in such situations.

Table 19 - Knowledge of caregivers on complete immunization

	YES	%	No	%	NA	%
Caregiver 1	4	8.4	34	70.8	10	20.8
Caregiver 2	6	12.5	31	64.6	11	22.9

Most of the caregivers were not aware of the requisite number of visits (i.e. seven) for completing immunization under two years of age. Hence, they should be counselled by ANM/ASHA regarding the number of visits under two years required to complete the immunization schedule of the government. They should also need to be sensitized about the associated importance of complete immunization.

Knowledge of ASHA/AWW on the incentives to conduct SAMPurNA sessions

We found 32 out of 44 ASHA/AWW workers (67%) were aware of the incentives that are being provided to conduct SAMPurNA session in the hard to reach areas. But, about one third of the ASHA/AWW workers were not aware regarding the same which is an interesting finding. This is very similar to our earlier findings about knowledge of other mobilizers on incentives for conducting sessions. Hence, the immediate supervisors / block level health officials should disseminate this information to the AWW/ASHA workers, if needed in local language, without exception.

Table 20 - Reasons for non-availability of vaccines at the SAMPurNA session site

	YES	%	No	%	NA	%
Not issued	18	37.5	29	60.4	1	2.1
Not picked up	3	6.2	44	91.7	1	2.1
Picked up but not delivered	0	0	47	97.9	1	2.1
Others	2	4.2	21	43.7	25	52.1

In some sessions the requisite vaccines were not available for the targeted beneficiaries. The main reason for non-availability was cited as “Not issued” (37.5%) i.e. the requisite vaccine has not been issued from the ILR point for that particular session. There could be many reasons for the same: a) proper indenting form had not been submitted by the ANM; b) vaccines were not available at the ILR point; c) appropriate communication by the ANM to the LHV about vaccine requirements was not done. Hence, the immediate supervisor or the block level health officials should review the supply chain / logistic management related issues on a monthly

basis. Corrective measures need to be taken to ensure availability of requisite vaccines at the session site.

Table 21 - Maternal Health services provided at SAMPurNA site

	YES	**%**	**No**	**%**	NA	%
Is relevant history (obstetric/past/family/menstrual) elicited especially for women coming for the first antenatal check up	24	50	10	20.8	14	29.2
Is privacy during examination ensured (by way of separate cabin/curtains)	20	41.7	24	50	4	8.3
Is the Blood pressure of pregnant woman measured properly and recorded	40	83.4	4	8.3	4	8.3
Is the pregnant woman weighed and the weight recorded	40	83.4	4	8.3	4	8.3
Is the abdominal palpation for determining fundal height, fetal lie, etc, performed	23	47.9	21	43.8	4	8.3
Is the foetal heart sound auscultated	25	52.1	18	37.5	5	10.4
Are IFA tablets provided to antenatal women	40	83.4	4	8.3	4	8.3
Is advice for next antenatal check-up provided along with dietary and relevant counselling	32	66.6	13	27.1	3	6.3

Most of the basket of maternal health services was found to be on the offer during SAMPurNA sessions with some exception. For instance, obstetric history taking needed to be done properly during the first visit antenatal check-up (ANC). The ANM need to spend considerable amount of time in interacting with the beneficiary and recording the information related to obstetric history. Quality ANC check-up is critical to identify high risk cases, timely referral and thus reduce mortalities. Secondly, privacy during examination (by providing a separate cabin/curtain) was found missing in many session sites. This was mainly due to non-availability of proper/designated space or requisite resources such as examination table and curtains. It could be 'lackadaisical attitude' rather than 'poor knowledge' of the ANM that resulted in compromise with privacy of examination. Thus, ANMs may be provided with orientation to ensure privacy during abdominal examination and how to conduct examination i.e. appropriate palpation to determine fundal height, auscultation of foetal heart sound etc. Further, all front line workers (ANM, ASHA and AWW workers) should be given refresher about the components and importance antenatal check-up.

Table 22 - Child health services provided at SAMPurNA session site

Services	YES	%	No	%	NA	%
Appropriate advice on breastfeeding and complementary feeding provided	27	56.2	18	37.5	3	6.3
Appropriate advice on need for supplementation with IFA and Vitamin A provided	32	66.6	13	27.1	3	6.3
Appropriate advice on danger signs in new-borns and older children for which care is to be sought immediately provided	29	60.4	14	29.2	5	10.4
Are the infants/children up to the age of five years weighed and the weight recorded	34	70.8	12	25	2	4.2
Demonstration on preparation of ORS done	10	20.8	36	75	2	4.2

We found there was room for improvement with regard to several child health services, such as, counselling on appropriate breastfeeding, complementary feeding, and importance of IFA and Vitamin A supplementation, danger signs in new born and importance of height and weight recording of infants/ under-five children. The role of strengthening supportive supervision can hardly be overemphasized here. Demonstration of preparation of ORS and its importance should also be encouraged and reviewed regularly.

Table 23 - Family planning services provided at SAMPurNA session site

	YES	%	No	%	NA	%
Is family planning counselling provided to eligible women/couples on various spacing and permanent methods	25	52.1	20	41.6	3	6.3
Are contraceptives provided to the beneficiaries	17	35.4	28	58.3	3	6.3

In about 52% of sessions, family planning counselling was provided to the eligible women/couples on various spacing and permanent methods. However, in as much as 42% sessions this counselling was lacking. The health service providers need to be encouraged to provide counselling just as the beneficiaries need to practice/avail the family planning services for spacing and reducing family size. Even though Odisha state has achieved the TFR of

replacement level, this segment of the basket of services can't be neglected. The ASHA workers should be encouraged to demonstrate various contraceptives to the beneficiaries.

Table 24 - Conduction of group meeting by ANM/ASHA/AWW

YES	**%**	**No**	**%**	NA	%
37	77.1	10	20.8	1	2.1

The conduction of group meetings should be ensured by ANM/ASHA/AWW for targeted beneficiaries such as pregnant women and adolescent girls during SAMPurNA sessions. These group meetings provide the right platform for counselling and disseminating information about various topics. Hence, it is important to strengthen this activity to ensure better health outcomes/results.

Table 25 - Topic for group counselling

	YES	**%**	**No**	**%**	NA	%
Antenatal Care	12	25	33	68.7	3	6.3
Birth preparedness and complication readiness	11	22.9	34	70.8	3	6.3
Importance of institutional delivery	6	12.5	39	81.2	3	6.3
Postnatal care of mother and new born	8	16.6	37	77.1	3	6.3
Essential new born care	6	12.5	39	81.2	3	6.3
Exclusive breastfeeding	15	31.2	30	62.5	3	6.3
Complementary feeding	7	14.5	38	79.2	3	6.3
Early childhood illnesses (Diarrhoea and ARI management)	9	18.7	36	75	3	6.3
Nutrition for pregnant and lactating mothers	7	14.5	38	79.2	3	6.3
Spacing methods	13	27.1	32	66.6	3	6.3
Permanent methods	7	14.6	38	79.1	3	6.3
Reproductive Tract Infections (RTI)	4	8.3	41	85.4	3	6.3
Hygiene and sanitation	4	8.51	41	85.41	3	6.3
Sex selection	1	2.1	44	91.6	3	6.3
Age at marriage	0	0	45	93.7	3	6.3
Others	4	8.3	41	85.4	3	6.3

SAMPurNA sessions are being conducted for more than two years now. By now it was expected that the beneficiaries remembered the health topics properly. It was found that this component was not getting the importance that it was due to get. As shown in Table 25, the observation of research team with regard to topics for group counselling is reflected in the

table. In most of the instances the topics were ANC, PNC, birth preparedness, breastfeeding, early childhood illnesses and spacing methods. Thus, counselling sessions need to be more effective to give peoples' health in people's hands. Topics like appropriate age of marriage, implications of sex selection, WASH activities, RTIs, Family planning procedures/methods etc. need to be reinforced appropriately.

Table 26 - Observation at SAMPurNA session site (Vaccine + Logistics Availability)

	YES	**%**	**No**	**%**	NA	%
BP Instrument	46	95.8	2	4.2	0	0
Stethoscope	48	100	0	0	0	0
Examination table with foot step	14	29.2	34	70.8	0	0
Curtained partition	19	39.6	29	60.4	0	0
Thermometer	38	79.2	10	20.8	0	0
Digital watch	18	37.5	30	62.5	0	0
Inch tape	41	85.4	7	14.6	0	0
MUAC tape	43	89.6	5	10.4	0	0
Weighing scale (Adult)	45	93.7	3	6.3	0	0
Weighing scale (Baby)	43	89.6	5	10.4	0	0
Glucometer	45	93.7	3	6.3	0	0
Non-invasive Hemoglobinometer	48	100	0	0	0	0
Uristix	44	91.7	4	8.3	0	0
IFA	47	97.9	1	2.1	0	0
Albendazole	37	77.1	11	22.9	0	0
Calcium	42	87.5	6	12.5	0	0
Nutritive Food supplementation available for PW and Children	26	54.2	22	45.8	0	0
BC/BCG Diluent	36	75	12	25	0	0
b OPV	45	93.7	3	6.3	0	0
MR	43	89.6	5	10.4	0	0
MR diluent	43	89.6	5	10.4	0	0
JE	44	91.7	4	8.3	0	0
JE Diluent	44	91.7	4	8.3	0	0
TT	44	91.7	4	8.3	0	0
HWF received training on ANC & PNC services in last one year	14	29.2	34	70.8	0	0

It was observed that most of the equipment, vaccines and other logistics arrangements were done appropriately at the SAMPurNA sessions sites. However, examination table with foot-steps and curtained partition are the components which were lacking in most of the session sites. The reasons elucidated for the same were 'insufficient space' to keep the table and

associated materials in the site. Nutritive food supplements for pregnant women and children were also not available in almost 50% of session sites. This is due to distribution of nutrition supplement/take home ration (THR) by the AWW in their respective catchment areas prior to the conduction of the session. Refresher for Health Worker Female (HWF)/ANMs needs to be strengthened in order to ensure proper counselling at the grass root level.

Table 27 - Observation at SAMPurNA session site (others)

	YES	**%**	**No**	**%**	NA	%
Counselling to mothers on FP	31	64.6	16	33.3	1	2.1
AHD	21	43.7	26	54.2	1	2.1
Growth monitoring	28	58.3	19	39.6	1	2.1
Monitor BMI	18	37.5	29	60.4	1	2.1
Anemia detection	35	72.9	11	22.9	2	4.2
Identify high risk mothers	31	64.6	16	33.3	1	2.1
Line listing (anemia)	27	56.2	20	41.7	1	2.1
Completeness of information	32	66.7	16	33.3	0	0
High risk mother identified	33	68.7	15	31.3	0	0
Red card issued	34	70.8	14	29.2	0	0
Birth preparedness plan	33	68.7	15	31.3	0	0

The data collection team further observed other key activities while the session was going on. It was found that in many sessions BMI monitoring, anemia line listing, growth monitoring and adolescent health day (AHD) observation was not undertaken. Identification of high risk pregnant women, issuing red cards to high risk cases, preparing plans for birth preparedness also needed further reinforcement. These activities are critical for attainment of SAMPurNA objectives and therefore need to be ensured in cent percent sites.

Table 28 - Awareness on hardship allowance

Awareness on hardship allowances	**YES**	**%**	**No**	**%**	NA	%
1. Health worker (Male) – 300 INR	40	83.3	6	12.5	2	4.2
2. Health worker (Female) – 300 INR	44	91.7	3	6.2	1	2.1
3. MPHS (Male/Female) – 300 INR	39	81.2	7	14.6	2	4.2
4. AWW – 150 INR	40	83.3	6	12.5	2	4.2
5. ASHA – 150 INR	42	87.5	5	10.4	1	2.1
6. Session organizing cost – 300 INR	38	79.2	9	18.7	1	2.1
7. Mobility for team-1500	35	72.9	11	22.9	2	4.2

Most of the service providers were aware of the hardship allowance in terms of amount, frequency and methods of claiming. However, regular reimbursement of incentives by the block / district officials is critical for sustaining motivation and smooth conduction of SAMPurNA sessions.

RESULTS: FOCUS GROUP DISCUSSION

Table 29 - Themes and subthemes linked to research objectives of FGD

Objectives	Themes	Sub Themes
Explore experiences of beneficiaries availing services under VHND+RI	Experiences related to availability of health services at session site	Services for children
		Services for pregnant women
		Supplement of medicines
	Advices received from health workers at VHND session site	Advices provided during pregnancy
		Advice related to new born care
		Family Planning
		Referral services
	Lived experiences with SAMPURNA strategy and suggestions provided	Positive experience
		Negative experience
		Suggestions for Improvement of services at session
		Beneficiary's prospective on place of delivery and complementary feeding
Review the geographical feasibility of conducting sessions	Information on VHND/RI session site	Regularity of getting information
		Sources of information
	Accessibility Challenges	Access to the session site
		Access to services
		Access to hospital
		Ambulance services and compensation

In order to improvise maternal and child health in Odisha, the government has been implementing Village Health Nutrition Day (VHND) and Routine Immunization (RI) services for hard to reach pockets in an integrated manner under the brand SAMPurNA. Through in-depth interviews, focus group discussions and key informant interviews the aim was to study barriers related to accessibility, coverage, effectiveness, and quality of services.

A total of 12 Focused Group Discussions (FDGs) were undertaken at community level to understand the perspective of beneficiaries availing VHND and RI services under the SAMPurNA strategy and review the feasibility of conducting sessions in these hard-to-reach pockets of Odisha. Two blocks from each of the sample six districts were included for data collection. One FDG session was convened in each block. Analysis of the FDGs resulted in emergence of five themes, which are presented in the table above.

Theme 1: Experiences related to health services provided at session sites

This theme represents the experience from the services provided to pregnant women and children. Under the SAMPurNA program both the VHND and RI services are provided on the same day. Although the session site activities last for half a day, the front line workers (ANM, AWW) are expected to provide a basket of services that includes antenatal and post natal check-ups, risk assessment and timely referral, immunization as per the micro plan, weighing all children in the session, identifying severe acute malnutrition (SAM) children and their referral to NRC. In all the six districts that were studied, pregnant women reported that they had received all the antenatal services from the ANM. No respondent accounted any negative experience about the services provided by the ANM. They further mentioned that services like distribution of iron tablets, TT vaccination were given at the session and that their blood haemoglobin level and blood pressure was also monitored. Their general health conditions were assessed and extra medication as well as dietary suggestions were provided as and when needed.

> ***P33: Before pregnancy they (service providers) came and to us they provided injection and medicines, checked blood test, blood pressure took measurements. FDG_Nabarangpur.***

The pregnant women were registered and received card for VHND services during the first trimester, in all the six districts except in Rayagada where the beneficiaries reported that they received VHND (MCP) card around 7 months' of pregnancy.

> **P34: *…We all registered after 3 month of pregnancy as we told ASHA didi, she just wrote the details and got the card after 7 months. (All participant). FDG_Rayagada***

The routine immunization services entail vaccination at the right time and assessment of nutritional status of children. Mothers in all the FDGs reported that the ANM workers administered vaccination on time. They were happy to inform that the ANM even reminded the mothers about the next schedule of vaccination. To keep a track on the nutritional status of under-five children, their weight and mid – arm circumference was measured regularly.

> ***P28: We take our children to the session for their vaccination. AWW takes the weight of our children at the session…FDG_Mayurbhunj***

Ideally these special session should be held in the Anganwadi Centres (AWC). In case there is no AWC centre, any existing school building or community hall can be considered for the session. The location is expected to have privacy and have the required logistics as per VHND and RI guidelines. A special team need to carry the vaccines and other logistics while maintaining cold chain. During the FDGs, most of the beneficiaries responded that they had proper places to conduct the session. However women of Potangi, Koraput and Kasipur, Rayagada complained that they did not have proper space for the VHND session and that privacy was not maintained in the site because it was literally an open space.

P32: …No privacy is there because it is an open space… FDG_Koraput

P33: We need a bed for check-up because in this open area we are sitting. A house is needed and also a road by which every problem can be solved…FDG_Rayagada

Theme 2: Advices received from health workers at VHND session site

This theme summarizes advises received by beneficiaries from health workers. According to the guidelines stipulated in the SAMPurNA program, the health workers (MPHW-M)) should be organizing IEC materials in the site - he should be counselling the male members during the session. The MPHS (F) and AWW should be counselling pregnant women about birth preparedness, proper diet and nutrition during pregnancy. The AWW worker is supposed to discuss with mothers of under-five children regarding growth and development of the child, plot the growth chart and discuss with the mother about the nutritional supplements to be given to the child to achieve desired the developmental trajectory.

Pregnant women in the FGDs mentioned that the ANM advised them on birth preparedness, about the need to stay at the '*Matru gruho*' a month before the tentative date of delivery. Beneficiaries further informed that the ASHA would call the ambulance beforehand and accompany them to the hospitals during delivery.

P36: ***They told us to stay at maternity homes one month before EDD (expect delivery date). There is no road connectivity to our village and it is far away from the hospital. So to avoid any emergency or problem during delivery we also preferred staying at maternity homes***. **FDG_Keonjhar.**

The ANM counsels about diet and nutrition during pregnancy. Beneficiaries of all the study areas informed that they were advised to take balanced diet with more green vegetables and proper, adequate rest. They were advised against heavy physical labour during this period. The importance of breastfeeding, post-delivery, was also discussed during these sessions. The FGD pregnant women respondents mentioned that they were advised to breastfeed their children up to six months after birth. When asked about complementary feeding, they could specify that for the infants complementary feeding should start after six months. ANMs in few of the study areas suggested that mothers needed to give colostrum to the new born.

However pregnant women in Keonjhar district said that giving colostrum to new born is something they always do traditionally, although no health worker had given this suggestion to them. Beneficiaries from the same district suggested that they were not given any advices regarding feeding, complementary feeding or birth preparedness.

> **P35:** ***Nobody suggested me about breastfeeding and complementary feeding. But I did only breastfeed till the completion 6 month of my child. After that I gave rice, cow milk, vegetables etc to my child. FDG_Keonjhar.***

> **P36:** ***We always give the first milk of mother to our child. Nobody tells us to do that but we usually do that… ASHA nor ANM never suggests about the birth preparedness. FDG_Keonjhar.***

The hamlets/ villages where these special VHND and RI sessions are conducted are usually tribal dominated. Tribal women traditionally give bath to the new born soon after birth, this tradition however has been proven to harm the health of the new born as it causes infection. Beneficiaries reported that the ANMs and ASHA workers suggested against this practise - they suggest that the baby should be given bath only after the naval wound dries up.

Methods of family planning are also discussed in these sessions. However, some of the reactions from the respondents to the idea of contraception indicated that it was not well accepted by the husbands and other family members. According to SAMPurNA guideline the MPHW-M should be counselling the male members of the family. However, during the FGD sessions, it became evident that counselling sessions involving the entire family was not

conducted in the sample geographic areas. The misunderstanding about family planning operation indicates that rigorous counselling of male members of the family needs to be ensuring during these sessions.

> **P27: *…Because family members oppose for adopting family planning. And it becomes difficult for us to do heavy work after family planning operation. If we go for family planning operation then who will take care of our self?* FDG_Mayurbhanj.**

> ***P28: I am telling about myself –this is my 6th pregnancy. Whenever I get pregnant I feel very weak, and suffer with fever. My family members are telling if I do family planning operation then I will not be permitted to worship God. Until I get permission from my husband I cannot go for operation. FDG_Mayurbhanj***

Theme 3: Lived experiences with SAMPURNA strategy and suggestions

The third theme summarises all the lived positive and negative experiences of beneficiaries availing various services under SAMPurNA strategy. The suggestions provided by them to improvise the services are also outlined under this theme. Pregnant women from Keonjhar and Mayurbhanj shared that they had many positive experiences because ASHA workers in those areas used to facilitate their transportation during delivery. They also expressed gratitude to the ANM because she was maintaining the due list.

> **P27*…But ANM manages the vaccination due list. If a child is left out in a particular month then the ANM gives the dose in the next month*. FDG Mayurbhanj.**

Beneficiaries from all districts except Koraput said that they preferred delivery in hospitals because of the various facilities available out there, such as, medicines, free treatment, and medical help in case of critical condition. Some also mentioned that they received monitory compensation if the delivery was done in hospital set-ups. They mentioned to have availed the free ambulance services. Counselling by the ANM and ASHA workers seemed to have motivated pregnant women and their family members to opt for delivery in hospitals.

> **P:27 *…I got free ambulance services. I stayed at maternity home one month before***

my delivery. Because of the distance from hospital I preferred to stay there. After the blood test the ANM informed me that I was in anaemic condition so I had to be there for a long period. FDG_Keonjhar.

However, during the Koraput FDG session, the respondents mentioned that they rarely visited hospital. Even when some of them were convinced about the benefits of delivery in a hospital, their family members do not seem to appreciate this. Some had also complained about the dilapidated condition in which women needed to stay in post-delivery wards. They further mentioned about paucity of beds to accommodate pregnancy cases. The villagers therefore resorted to traditional methods for normal delivery; however, only C-section mode of deliveries were mostly opted in hospitals.

P:33 *….Didi (sisters) are telling if you deliver the baby in the hospital then it is good for the mother and the baby, also there will be no risk but still we refuse to go because no one from our house is going to the hospital. Wow we will go alone if there is no companion?…. I will say that home delivery is good because why to go to hospital and sleep in the veranda after delivery? And another thing is that they will cut the abdomen and take the baby out* …FDG_Koraput

Rigorous counselling of the entire family by health workers regarding the benefits of delivering in hospitals is essential in these sessions. This however should be accompanied by improvised hospital accommodation facility in order to motivate mothers to go for delivery in hospital settings.

Theme 4: Information on VHND/RI session site

One of the other objectives of this exploration was to study the geographical feasibility of conducting the special VHND and RI sessions. A session would become more effective only when information about it is disseminated to people in advance. Hence the fourth theme encapsulates this component. The ASHA worker should mobilize VHND and RI beneficiaries to the session site as per head count. She should also encourage the family of pregnant women to attend family and couple counselling sessions. Women interviewed from all the districts confirmed that they were informed about the VHND and immunization sessions regularly. They further mentioned that the ASHA workers in their places used to visit beneficiaries' home and inform them about the next VHND and immunization date.

P35: ….We get the information about VHND and RI from ASHA and AWW. ASHA and AWW visit our home before the VHND sessions are held, and ask the villagers to attain the VHND and RI session. AWW also visits on day of the session and reminds us about the session. ASHA and AWW tell us to take our children to the session site for immunization…FDG_Keonjhar.

However, none of the respondents mentioned much about the counselling sessions, which is supposed to involve the entire family. ASHA is also expected to inform the entire family about these counselling sessions: this indicates that such sessions need to be strengthened. Lack of knowledge about contraception and about advantages of delivering in hospital settings amongst the family members may be attributed to insufficient of inappropriate counselling sessions.

Theme 5: Accessibility Challenges

The fifth theme sets out challenges faced by beneficiaries while accessing session sites, hospitals and services like ambulance. SAMPurNA essentially caters to those beneficiaries who reside in hard-to-reach areas. These villages are usually located more than 2 kms away from the nearest VHND+RI sites. In other words, the residents of those villages face geographic barriers even to reach out to the nearest VHND site. During the FDGs, some respondents informed that during rainy season their villages are cut off due to overflowing river and flood. They had to cross the rivers against all odds and walk long distances to get their children immunized.

P36: …During rainy season it is difficult to reach our village for the ANM. So we cross the river and cover about 5 kms to reach another village for the vaccine due list of our child… FDG_Keonjhar

We found that most of the beneficiaries understood the significance of timely vaccination; however in absence of all-weather roads, they had to face the fury of Nature, especially during rainy season.

Hospitals are usually located at far off places from the villages. The main challenge faced by the villagers were cited as: poor phone network for calling ambulances. It was the duty of the ASHA worker to keep a track of all pregnancies and their EDDs, so that she could go to a spot with minimum availability of telephone network and call the ambulance; then accompany the pregnant woman to the hospital. Many respondents complained that the mobile network never worked in their localities. People needed to travel long distances to get the cell phone tower working in order to make phone calls.

P27: …During emergency condition someone has to travel at least 10 kms to have the mobile network connectivity to call the ambulance… FDG_Mayurbhanj

The situation becomes even more challenging during the rainy seasons when transportation remains almost impossible due to geographic barriers like over-flowing rivers. Villagers usually carry the pregnant women in stretchers across the river and bring them to a point where the vehicle can reach. The services are supposed to be free of cost. A woman delivering in hospital gets Rs 5000 as compensation, which most of the beneficiaries acknowledged to have received. However some respondents also shared negative experiences. Respondents from Sundargarh and Keonjhar said that they had to pay a certain amount of fees to the ambulance driver. The respondents from Sundargarh complained that the hospitals did not have proper facilities or even beds for patients.

P25:…_During my second child delivery, I delivered on the way to the hospital. After the return of the ambulance, the driver charged money for the transport to the hospital. I argued with the driver and ASHA worker and other health staff because I did not receive free ambulance services. There is nothing like free service because I had pay at hospital and also had to pay money for my medicine. Ambulance charges are 100/-; at government hospitals they charge 100/- for blood test, they also charge 100/- for the check-up of my child. Most of the medicines are not available at government hospital. For that reason I prefer private hospital for better service. If I have to pay any ways, then why not at a private hospital?… FDG_SNG

Some beneficiaries expressed that since the transportation facilities are poor in these areas, coming back from hospital after delivery becomes cumbersome. They suggested that it would have been very helpful if the ambulance would bring the patient back from hospital to their villages, post the delivery.

P27:…After delivery it is very difficult for us to return to our home. Our villagers can travel only by 1 bus. We don't have any other option. We can return from hospital by that bus only. That is the main problem faced by every mother… FDG_Mayurbhanj

Due to hassles in transportation and insufficient amenities available at hospitals, many respondents confirmed that they preferred delivering at home instead of visiting the hospital.

There was evident sense of mistrust on the government health care facilitates amongst these beneficiaries. The mistrust is further fuelled by lack of knowledge and scepticism among the family members.

> ***P31…I will say that home delivery is good, because why to go to a hospital and sleep in the veranda after delivery? And another thing is that they will cut the abdomen and take the baby out…no one from our house is going to the hospital so how we will go alone if there is no companion?… FDG_Koraput***

However this was not the situation in all the districts, most of the respondents said that they would prefer to deliver in hospitals and had received proper remunerations in the past. An anaemic mother shared that she had stayed in *Matru Gruhas* for a month before the delivery, where her food and health related requirements were taken proper care of.

> ***P35:…We prefer hospital than home delivery, because we receive maximum facility at hospital. We get medicine, free treatment and etc. At home we cannot manage a critical condition but at hospital we can avoid that situation. Earlier Janani (vehicle) was not there. For that reason we had to do home delivery. After ambulance facility we always prefer to go to hospital. There is no one to take care of us at home after having delivery. But at the hospital they provide so many facilities, which we need. FDG_Mayurbhanj.***

RESULTS: IN-DEPTH INTERVIEW OF ANM / ASHA WORKERS

Table 30 - Themes and subthemes linked to research objectives of IDIs

Objectives	Themes
Undertake a rapid assessment of VHND and routine immunization services under the SAMPURNA program with special focus on accessibility, coverage, effectiveness, and quality of services	Planning, strategizing and providing services
	Challenges and suggestion

Theme 1: Planning, strategizing and providing services

The first step in the planning exercise of SAMPurNA strategy is to make a list of all difficult-to-reach villages. This decision is taken jointly by the ANM, ASHA worker and the male health worker, on the basis of geographic terrain, difficulties in commuting and coverage of immunization in that village. The micro-plan also consists of dates of every session and the session points. The Plan is then sent to sector level, then block level and finally to the district level, where it gets approved and sanctioned.

> P9***: …The place where VHND is not happening and RI points they are unable to find, those places are taken… Where pregnant mother's life is in danger…IDI_Rayagada***

The primary duty of the ANM during these special VHND sessions is to provide antenatal and post-natal check-ups to the beneficiaries, undertake risk assessment, identify high risk cases and ensure timely referral. She also needs to conduct immunization as per the micro-plan, help the MPHS in organizing the session site and conduct home visits with the MPHS. During the antenatal check-up, the ANM measures and keeps a record of blood pressure, weight and haemoglobin level of the pregnant women (PW). If the PW has severe anaemia, she is referred to the CHC. The ANM also measures the mid arm circumference of under five children to check their nutritional status. If the Child is identified as undernourished he/she is referred to the CHC or NRC depending upon the condition.

> ***P1:…Services including Vaccination, immunization to children under 0 to 5 years, to pregnant mothers... Hemoglobin checkup, BP test, sugar test. If hemoglobin level is below 7 grams, we refer to CHC…(IDI, Keonjhar)***

After conducting the session, the ANM makes a due list for the next session. It is then the responsibility of the ASHA to mobilize them and keep reminding them so that these beneficiaries are available for the next session.

> ***P10:….AWW, ASHA, Supervisor and all other service providers remain present at the session and we inform the beneficiaries to come and attend the session for the next month. Before 4 days ASHA also informs the beneficiaries to come to the session*…(IDI_Koraput)**

The main duty of ASHA is to mobilize VHND and RI beneficiaries to the session site as per head count, inform the family of pregnant women for family and couple counselling sessions. In the hard to reach, far-flung, scattered villages, the mobilization becomes even difficult, very important though. However, the success of the entire program depends on the performance of the ASHA. In the 15 tribal dominated districts where SAMPurNA is implemented, the ASHA plays an additional duty of being a translator, as other health workers rarely understand the local tribal language. She also plays a significant role in counselling and motivating the PW and their family members on availing benefits under various health schemes provided by the government. The ASHA also accompanies the PW to *maa gruha* a week or two weeks before due date, if the PW is in high-risk. She then accompanies the PW to hospital for delivery.

With regard to incentives, an amount of Rs 3000 is provisioned per special session per day. The mobility team is entitled Rs 1500, while hardship allowance is given to all the team members. The HW (M), HW (F) and MPHS (F/M) get Rs 300, each; and the AWW and ASHA get Rs 150, each. The session organisation cost is Rs 300; the ANM and ASHA workers in Keonjhar and Sundargarh said that they did not receive their incentives regularly.

Supervision at the field level is done by block and district officials, mentioned the IDI participants. The DPO, DPM, BPM, BPO, MO and ICDS Supervisors come occasionally to the session sites to supervise the proceedings.

> ***P9:…When supervisor comes, he/she sees whether the programme is continuing correctly or not, whether banner is displayed or not, whether beneficiaries are coming to VHND points .. whether the instruments available or not. The Supervisor and BPM also see the records and verify the records, and due list. If there is any health***

message, they share those messages with mothers. They also motivate beneficiaries to avail the services…(IDI_Sundargarh)

Theme 2: Challenges and suggestions

One of the most mentioned challenges was that there was paucity of infrastructure and proper place for conducting the VHND and RI sessions in most of these hard to reach villages – this was mainly because most of those villages lacked Anganwadi centres. The problems used to get further aggravated during rainy season. Most of the households in these villages did not have a courtyard where the sessions could possibly be conducted.

P1: …During rainy season, problems become more acute. We sit under the tree. There is no veranda in anybody's house. We undertake the VHND under the tree… (IDI_Keonjhar)

The ANM of Mayurbhanj mentioned that they continuously faced insufficient supply of vaccines and they had reported the same in writing to the higher officials.

P2: Vaccine shortage is always there, which we always give in writing. (IDI_Mayurbhanj)

Many respondents mentioned that travelling to the VHND and RI session sites becomes particularly difficult during the rainy season, when the roads are cut off due to excessive rain. They either avoid going to those villages during rainy seasons or had to cross the over-flowing rivers to reach out to the villages.

P4: During normal season there is no problem, but during rainy season it is difficult. We become completely wet and the road condition is very bad and muddy. Now the construction of roads has started…(IDI_NABRANGPUR)

Language difference between the beneficiaries and the ANM cause communication related challenges. Therefore in most cases the counselling sessions are done through the ASHA and Anganwadi didi.

P2:…Firstly here we have language problem. However, we are able to know it through ASHA didi and Anganwadi didi. We counsel mothers basically on the

nutrition part, as they have more number of kids. So, we try to sensitize them more on food and nutrition (IDI_Mayurbhanj)

The female health worker complained about the lack of understanding about contraception amongst the villagers. Even after repeated counselling the women in that area do not go for contraception.

P4:…Aged people they don't understand. They neither go for operation nor use condom. They don't listen to us. One such mother became pregnant when she had one and half years old kid, her age was around 39. ..(IDI_Nabrangpur)

Carrying the essentials required for the session throws up many operational challenges. Under AVDS only Rs 75 to Rs 150 to carry the required materials are paid. Since this remuneration amount is very low, people refuse to come all the way to these difficult areas. Ideally, the male heath worker is supposed to carry all the materials but in few districts there were no male workers, so the ANM had to carry all the essentials all the way to the village in-order to conduct the session.

P10:…No male worker is there, alone I have to carry vaccines and return. Also, every register I have to carry and it's very difficult. Now a day's road construction has started but still one cannot come alone on a Scooty. So, I have to come along with somebody….(IDI_KORAPUT)

The SAMPurNA project has instilled trust amongst the villages on the health system. The number of women going for delivery in hospitals has been steadily increasing by the day. The monitory benefit given to beneficiaries acts as a positive reinforcement. This situation on coverage of RI has also increased over time. The number of beneficiaries turning up for the sessions has also been increasing. With the continued effort from the field workers the situation has become better, yet there is a long way to go, said one of the respondents.

RESULTS: IN-DEPTH INTERVIEW OF BLOCK / DISTRICT OFFICIALS

Table 31 - Themes and subthemes linked to research objectives of IDIs

Objectives	Themes
Undertake a rapid assessment of VHND and routine immunization services under the SAMPURNA program with special focus on accessibility, coverage, effectiveness, and quality of services	Planning, strategizing and providing services
	Vaccines and logistics supply system
	The fund flow mechanism and monitoring system
Explore opinion and perspectives service providers and programme managers about enablers and barriers in successful implementation of SAMPurNA strategy	Gaps analysis

The SAMPurNA strategy was designed to improve access to essential maternal and child survival services to the vulnerable population of the state, located in difficult to reach areas across 15 tribal dominated districts of the state. In-depth interviews were conducted with the block officials (MOI/c and BPM) and district officials (ADM-FW, DPM, DM-RCH). The objective of these interviews was to understand the process that goes behind implementation of the program, assess the current state of the implementation, and examine the systemic enablers and barriers in the implementation of the scheme. Interpretation of results is presented in four themes. In the first three themes we assess various aspects involved in planning, strategizing and providing services as shown in table. The fourth theme explores the enablers and barriers in the implementation of the program.

Theme 1: Planning, strategizing and providing services

Under this theme we assessed the process of preparing micro-plans. As the IDI participants mentioned during interview, the village is selected based on four points as:

1. Villages/ hamlets situated in more than 2 kms from the existing VHND site.
2. Villages/ hamlets having geographical barrier in reaching out to the existing VHND session (even if in less than 2 kms from the session site).
3. Villages/ hamlets having full immunization coverage of less than 50% (HMIS Data by March 2016).
4. Villages/hamlets having less than 50% coverage of 3 ANCs (HMIS Data by March 2016).

Block and district officers from all the studied districts informed that the villages were selected based on the above mentioned criteria. The hard to reach areas are selected with the help of and inputs from the ANM, the ASHA workers and male health workers at sub center level since they had the best ground level knowledge. This list is re-assessed every year and submitted on or before 30th April. A meeting is then held at block level where all the stakeholders (CDPO, Medical Officer In-charge, PHEO, BPM, Health Supervisor, ICDS Supervisor and BDO) meet and finalize the villages, the list of which is then sent to the district. After selection at block level, the list is then sent to the block and district. At district level final list is compiled and finalized with signature of the District Collector and the Chief District Medical Officer (CDMO).

> ***P: 2 Communication becomes difficulty during the rainy season. Those areas are totally cut off, where communication is totally cut off throughout the year. There is no motorable point to those villages. So, we have decided to implement integrated VHND in those difficulty areas (IDI_Keonjhar)***

Some VHND points are called special integrated VHND sessions, wherein some nearby villages are also clubbed together for the services as it becomes difficult to cover all the villages individually due to difficult geographical conditions and poor connectivity. One of the district programme managers (DPM) mentioned that the list of villages is reviewed every year because large groups of people at times migrate to separate areas and form separate hamlets. These hamlets are usually considered under for special VHND and RI services. The Block Program Manager (BPM) of Nabarangpur informed that the number of villages considered for the special VHND services are coming down every year as the road connectivity is getting better. He also mentioned that while most of the villages are seasonally cut off, very few are completely cut off throughout the year.

> ***P4: …There are 15 villages under one ANM, it is not possible to cover those interior villages within 15 days. So, in extra days, we are covering those difficulty villages. Those who are not able to come to VHND points, those people are coming to integrated VHND points … special points….. Hard to reach areas … those roads are cut off during rainy season. So, we are covering on special days…(IDI, Mayurbhanj)***

One of the DPMs informed that those villages that are selected for special VHND are called

the notified villages, some of these villages are covered quarterly while some are covered monthly depending on the location and connectivity to the village.

The Micro-planning involves decision as to which all villages to be enlisted as 'hard-to-reach' and be covered under special VHND and RI. In cases where few villages/hamlets are to be covered at one go, the location of VHND session is also decided during the micro planning. The planning for the special VHND session is being done separately apart from the planning for regular VHND sessions. Such special micro-plans are prepared by the joint efforts of ANM, ASHA and AWW at sub-center level and they give it to the sector level. Then the sector supervisor and the sector medical officer validates it. When the sector finalizes the plan then the sector supervisor, the sector medical officer and the ICDS supervisor sign the prepared list, after which the document is sent to the block. On receiving the plans from all the sectors, compilation is done at the block level. Thereafter it is forwarded to the district. The district compiles all the plans, clarifies doubts if any and re-validates the same before finalizing the same. Finally the district plan is jointly signed by the Collector and the CDMO for circulation. The micro-plans are reviewed and revised every six months.

Once the micro-planning is done, the field team sticks to the plan: for example, in Keonjhar district the session are usually conducted on Thursdays. In the likelihood of any deviation owing to local events ore festivals or any reason, the CHC notifies the same. For every missing VHND session the 4th or 5th Friday of the month is kept as a reserve day. However, since both RI and VHND are conducted simultaneously, utmost care is taken not to deviate from the micro-plan. Officials of other districts also said that they try their best to not change the plan. In extra-ordinary circumstances the missed sessions are conducted as soon as possible with prior intimation to the beneficiaries. In Rayagada, Mondays are fixed for special VHND and RI session and if they miss out on a Monday then the same is conducted the next Thursday. During rainy seasons, when most of these areas are cut-off from the main land, these sessions are conducted once in three months, according to an official from Rayagada. An official from Mayurbhanj mentioned that these changes in dates usually adds burden on the mobilizers. Due to poor network connectivity, the mobilizers personally go to the houses of the beneficiaries to inform them, therefore any change in plan adds to difficulty on the mobilizers' part.

> ***P 4: Generally, we do not change the dates.. it is a fixed date. Once the date is fixed, anyway, we will conduct the VHND programme. Whether it is holiday or not ….. we***

do not change the dates, because we cannot provide them message. So, we conduct the programme on that fixed date (IDI, Mayurbhanj)

To avoid the seasonal cut offs, plans are made in advance. As one officer from Mayurbhanj mentioned that they usually make quarterly plans, wherein these specific villages are covered before the beginning of the rain season; and the consecutive session is done after two months. Thus, the difficulties related to travelling due to rainy seasons were being avoided. A bi-monthly session planning is done when the number of pregnant women in that area is more.

The services provided during the sessions mainly include immunization of the children and antenatal checkup of the pregnant women. An official from Mayurbhanj informed that they maintained a white board in the VHND center, where the names of pregnant mothers were listed. The mother in high-risk was marked with red color ink. He further highlighted that the ANM workers were instructed to buy curtains from the official fund and use around the areas where checkups were done in the village. However, findings from many other session sites and observation points indicated that privacy during examination continued to pose challenges to the planners.

P19:…the institution walls are painted. Further, we also have done an innovation: when you go to any VHND you will find a white board where you will find the names of all the pregnant mothers, and the high-risk mothers are mentioned in red pen and normal mothers are written in blue color pen. On that, date of delivery is also mentioned. So it catches every one's eyes. (IDI_Mayurbhanj).

Pregnancy above 35 years or below 18 years, pregnant women with history of malaria, high blood pressure during pregnancy, or low level of hemoglobin are categorized as high risk cases. They are provided with red cards, an official from Keonjhar said. The red card has details of the place of referral along with a list of risk factors. Special financial assistance is given to the women in high risk category. The official also mentioned that these high-risk pregnant women are paid special visit by the ANM and LHV jointly during 5th and 8th month of pregnancy. The ASHA didi accompanies these high-risk PW to *Maa Gruha* before a week of the scheduled delivery. While talking about the services provided, the officials, however, did not mention counseling sessions related to maternal and child nutrition, feeding practices, and contraception.

Theme 2: Mechanism followed for supplying the vaccines and logistics

As per the guidelines, the AVDS should carry the vaccines from ILR points for immunization and submit the report after returning. The male health worker is supposed to make available all the required equipment and logistics in the session site. Transportation is the responsibility of the block CHC in charge. The CHC arranges one identified vehicle to take the team to the VHND +RI session site or at least up to the end point of motorable road. The vehicle gets the payment from CHC. A block official from Keonjhar narrated that in that particular block the male health worker was reluctant to carry the vaccines to the site of VHND; hence other volunteers were chosen to do the job for different villages. They were given proper remuneration out of the total funds reserved for mobility of each session. The Keonjhar official at district level said that this is the responsibility of the male health worker. But block officials mentioned that the responsibility has been given to volunteers through the alternative vaccine delivery system (AVDS). It seems the understanding about the role of male health workers in SAMPurNA session was not clear among the district and sub-district officials. The state needs to draw a clear terms of reference for the male health worker.

> ***P3: Initially, one agency had taken the responsibility to transport the vaccine. But that agency did not undertaken the work. So, one male health worker was assigned to carry the vaccines and to take the payment. I told him you are a professional, you should look for another person preferable the husband of ASHA. The husband of ASHA undertook the work happily and got the payment through the AVDS. Now, 12 AVDS volunteers came, and payment made to those 12 volunteers. Payment fixed for those hard to reach areas. Rs. 450 fixed for most hard to reach areas. Rs. 200 fixed for less hard to reach areas (those areas which are within 2 – 3 kms). Nobody will take the vaccine to the interior hard to reach areas with Rs. 200 (IDI_Keonjhar).***

Most of the districts reported that they are using the AVDS for vaccine delivery especially for far-flung, hard to reach locations.

> ***P17:… We have AVDS. There are ILR points in the PHC from there AVD carries vaccines to sub centre. It is about 15 km from the PHC. And from there the ANM or ASHA takes the vaccine to the session site. We have arranged the session place where vaccine can reach about 30 min because for vaccine specific temperature is needed…(IDI_Rayagada)***

One officials from Sundargarh said that separate ILR points should be created for the far-flung and hard to reach areas covered under the SAMPurNA scheme so that it does not take long time to reach the VHND sites. According to the respondent this is important in-order to maintain the ideal temperature for the vaccines.

> ***P1: …Vehicle problems occur when our staff return from the field, I ask them about the problems. There are 2 ILR points in this block. One is at Khuntuna, another is at Lahunipada we demand one additional ILR point for those hard to reach areas…(IDI, Sundargarh)***

Theme 3: The fund flow mechanism and monitoring system

An amount of Rs 3000 is provisioned per special session per day. The mobility team has Rs 1500, hardship allowance is given to all the team members. The HW (M), HW (F) and MPHS (F/M) gets Rs 300 each; the AWW and ASHA worker gets Rs 150, each. The session organisation cost is Rs 300. ASHA will get the beneficiary mobilization cost as approved in PIP. The team is supposed to move in the same vehicle as arranged by block MO. Funds will be provided to the MPHW (F) at block level. Other allowances are to be paid through DBT. The transportation amount is disbursed monthly. Depending on the distance of the session site from the Sub-centre, the cost of vehicle varies.

> ***P5: …When we do the budgeting, we are taking a unit cost it is sometimes high and sometimes low…. it depends. When we add-up, then the total cost comes. At some places the vehicle hiring cost is Rs 1,000 and there may be places you spend only Rs 500 as the cost of the fuel for using a Scooty. At some places where vehicle is not there then 3 people go together, so they spend only Rs 400 to Rs 500. At some places they hire 4-wheelers and spend Rs 3000, all together if you add then the average comes… (Mayurbhanj_IDI)***

The ASHA accompanying beneficiaries to hospitals get a compensation of Rs 1000. The PW gets Rs 1400 and extra Rs 1000 for institutional delivery. If the PW is in high risk, the ASHA gets extra Rs 500. The officials from Koraput informed that the money is given in a decentralized fashion. It is sent from the state level to the district, the district further transfers the funds to the block level from where it is utilized directly.

P12:…Actually, SAMPurNA fund is coming from state to district as a whole. In the block level the funds are reimbursed. We do not have anything. So, every month reimbursement facility is available. Because it is important. If we provide them 3000 INR; for transportation 1500 and incentive 1500, then they will eagerly do their work. So, we do not delay the process. They are getting it…(IDI, Koraput)

After the monthly program, the service providers submit the vouchers at the block level, against which money is given on a regular monthly basis. The ASHA worker and ANM also get incentives when they visit the high-risk pregnant women during the 5th and 8th month of pregnancy.

P20: …Apart from this, visit to the high-risk mother in the 5th and 8th month that is actually being done by ANMs and Supervisors. For that also they get TA…. they can book 200 rupees from which ANM takes 100 rupees and supervisor takes 100 rupees. This is all about financial guidelines of SAMPurNA…(IDI, Mayurbhanj)

The block officers mentioned that before 10th of every month the incentive money is given. This is done religiously, to ensure continued motivation of staff at the ground level.

P23: By 10th of the month we try to clear all the incentives. We are having a incentives matrix in which block officers are involved. Through this matrix we are able to know which ASHA got incentives at what time. We are having ASHA managers and ASHA sathi. During the review meeting if we ever find any issues related to the incentives, then as soon as possible we are trying to solve the matter. We never find any problem related to incentives…(IDI_Sundargarh)

The ASHA, ANM and male health worker submit a report of the activity conducted in a month. These reports are submitted to the block program manager (BPM). The BPM reviews these reports. They also asked to submit photographic proof of the session conducted. The health supervisor and the ICDS supervisor used to monitor earlier. However, now-a-days with increased responsibility and reduced man power, monitoring at field level has become a rarity in some of the districts. In other districts like Koraput and Rayagada the team of health supervisors such as, LHV, MO, BPM, AYUSH MO, BPO, district level officials DPM and wing officers as well as ICDS staff (ICDS supervisor and CDPO) have fixed dates when they

are supposed to visit the site in order to supervise the VHND proceedings. The sector supervisor accompanies the team to the field.

The planning of the supervision and monitoring is done along with the session micro-planning exercise. In Mayurbhanj, the district Collector has shown special interest in monitoring the VHND proceedings. The monitoring officer carries a check-list to the field, where they cross-check item-wise during supervisory visits. The monitoring of the block level activity is done at the district level, at the end of every month - this is usually done before providing new logistics to the sub centres.

P19: …The micro-plan, if you remember, has a block level supervision plan. Block ICDS or health staff undertake supervision. Here the Collector has taken an initiative because of which a team has been formed consisting of a person from health department and another one from another department. Every month we do monitoring of 2 VHND sessions and 2 integrated sessions. The Collector's office shares the list on the same day as to where we have to go. Vehicle is also given by the Collector and. The team jointly visits the site and submit the report to the Collector by the same evening…(IDI_Mayurbhanj)

Theme 4: Challenges and suggestions

Travelling to the field is a huge challenge, given the nature of geographic terrain and systemic bottlenecks. The transportation can be very challenging at times. An official from Sundergarh complained about a particular road that has extraordinary slow traffic movements owing to the existence of mining area in the nearby vicinity and there is only one route to reach out to some of the far-flung sub centres of the state.

Villages that get disconnected due to rivers in rainy seasons hugely suffer, as the VHND and RI sessions are not conducted in those months in those areas. This was a common complaint of all the officials interviewed. One IDI respondent from Keonjhar mentioned about the need to focus on developing motorable roads and mobile connectivity to these villages. Further, lack of staff in some districts adds to the woes of the administrators. Moreover, such vacancies continue to exist for as long as five years.

P1: Presently, there are 7 ANM posts that are vacant. It is too difficult to work. It is out of imagination. If they conduct programmes on a Wednesday in their own sub-

center, on Thursday they conduct another programme in other areas. In this way, the programme is continuing….Even LHV is now doing the VHND programme…(IDI_Sundargarh)

One district level officer of Keonjhar mentioned that the number of ambulances available for services are not enough to cater to the entire population and that there should be ambulances reserved for these hard to reach areas. In most of these villages, the officer mentions, people are reluctant to avail hospital facilities. People prefer delivering at home. Another respondent suggested that counseling and orientation of community is required for behavioural change and to increase trust on the public health system.

P2: …People should be oriented and when orientation is given by the ANM, people should accept it. When they suffer from pain, at that time, they should come immediately to the hospital. …(IDI_Keonjhar)

P5:…In the difficult villages, we need to do special campaigns to create awareness on priority … (IDI_Mayurbhanj)

Some of the special VHND and RI sessions are supposed to be attended by women from more than one nearby villages. In such situations, at times the foot fall is less. The PW from far off villages do not prefer travelling to distant places on foot for these special VHND sessions.

P2:…Due to more distance, some people do not come to integrated VHND and RI points and to medical centre (IDI_Keonjhar)

Block level officers in Mayurbhanj informed that since these are primarily tribal dominated districts, language often becomes a barrier. The workers try and learn their languages in order to communicate with the villagers.

P4:…One barrier is language barrier. We are facing problems in exchanging our views... we have to learnt some words, concepts, languages....Initially we faced language barriers. I have now learnt some languages. I am now able to understand their language too… (IDI, Mayurbhanj)

One district official from Koraput mentioned that he conducts BCC in local language as to make it effective for transmitting information and enabling behavior change. Similar statements were also received from a Rayagada official.

> ***P12… In every integrated VHND and RI sites, if street play or role play could be done in local language, then they could understand and get knowledge. That may be on various topics: institutional delivery, low birth weight, NCD and communicable diseases etc. Also, we have proposed to the NHM and district administration to produce a movie in local language related to health issues and services of the government…(IDI_Koraput)***

A district level officer of Koraput suggested that at times they cannot transfer funds allocated for the project to the block level due to lack of staff (like accountant) at the district office. This further leads to delayed disbursement of funds at the block level.

> ***P12:…lack of human resources like accountant is challenge. In many places, the position is vacant. Somehow, we are adjusting and from another block we have provided an accountant to that block. So, if the account could not settle the bill, then the process of getting money gets delayed… (IDI_Koraput)***

Carrying the non-perishable logistic items required for conducting the session through these rough, often non-existing or washed away roads, becomes a herculean task. The district level officer of Nabarangpur suggested that at the village level, a leader can be selected, who can take charge of these non-perishable items and safe guard them to be used in subsequent sessions. This could also instill a sense of community-based monitoring of activities.

> ***P13: Instruments need to be provided to session sites….weighing machines, test kits and other logistics need not have to be carried to that village every time. One identified leader in the village can keep those instruments at local level for use in subsequent sessions – through this mechanism the villagers can also keep a track of the sessions and the presence of health providers in each and every session… (IDI_Nabarangpur)***

Non-availability of a suitable place for conducting the sessions is yet another problem mentioned by most of the district level respondents. In many of the session sites, there is no

building/ house/ covered space that could be used to hold the session. Having such infrastructure would not only offer privacy to the PW but also provide shelter and shade for the service providers.

> ***P19: place is one issue and privacy is another. Privacy is very important when antenatal checkup is being done. So in VHND we have provision. But in case of integrated VHND they have to be arranged at local level. They carry old banners and prepare a small hut kind of structure to put up a bed and carry out the antenatal checkup… (IDI_Mayurbhanj).***

CONCLUSION

Through this comprehensive assessment exercise, an attempt was made to decipher the session site practices, logistics availability and operational challenges in conducting SAMPurNA sessions in the high priority pockets of Odisha. The overall technical knowledge of ANMs and ASHA workers with regard to immunization and ANC care were found to be good, but skills on BCC, IPC and community counselling needed further improvement. Systemic bottlenecks in terms of poor rood and mobile connectivity, reimbursement of incentives, weak reporting system and erratic supply of vaccines and other logistics continued to pose challenges to the programme managers and service providers and supervisors.

From the point of view of beneficiaries, their knowledge on pregnancy, child feeding and danger signs was encouraging. However, poor level of preparedness at the referral hospitals, bad experiences and hidden cost of seeking public health care services acted as barriers from accessing government facilities. Though most of the beneficiaries reposed trust and confidence on the local health workers, they were still reluctant to approach the referral hospitals.

The points of similarities and differences in the thinking of beneficiaries and service providers were evident on some of the contentious issues, such as, trust on the system, cost of services, skills of providers and availability of enabling factors to entice the desired actions.

Policy makers must focus attention on strengthening the building blocks of the district health systems in general and that of referral centres in particular, develop mechanisms to strengthen the non-health ingredients (e.g., road and mobile) to optimize health outcomes, and introduce innovative, technology-based solutions to overcome staff shortage, over-burdening of responsibilities and logistics supply related challenges. Programme managers must renew their commitment towards development of participatory plans, timely implementation, regular reviewing and supervising the sessions. Service providers need to demand financial incentives due to them at the end of every session, develop alternate strategies to ensure privacy during examination and spend considerable amount of their time and energy in learning and practicing IPC, BCC and counselling skills.

POLICY PRESCRIPTIONS

1. The preparation of micro-plan is a dynamic and consultative process that involves various stakeholders such as ANM, ASHA and AWW at the session level and the Medical officer and program managers at the block level. Absence of even one of these stakeholders could create difficulties in the subsequent implementation of the plan. A particular week can be fixed in a year for the micro-planning exercise, and all stakeholders may be mandated to participate in the exercise.

2. The AVDS support ought to be extended to all special VHND-RI sessions without exception. The AVD volunteer who manages well to carry vaccines in time may be offered a differential rate for hard-to-reach areas depending upon the hardship gradient. Such extra incentives for AVDS need not be a part of the incentive package given to the workers for their hard work.

3. The special VHND-RI caters to a limited number of vulnerable population, and having a list of exact details of the beneficiaries is critical to reach out to them. In other words, the head count must be completed every session and an updated due list should be prepared after updating the same in the RCH register and MCP cards.

4. Standard formats like due lists and tally sheets must be used at the session site more often than carrying heavy, troublesome registers. However, conduction of sessions without having reporting formats must invite punitive action. Getting the signature or thumb impression of beneficiaries might improve accountability.

5. All integrated VHND+RI sessions should have ANMOL tab for service tracking and the same may be used for IEC activities through video-shows.

6. Infusion of simple, innovative technology, such as, geo-tagging and off-line entry provision of session-related data must be introduced in a phased manner as to improve quality of data, increase transparency and reduce reporting-related workload on the front line workers.

7. Refresher training on the critical domains of job profile of frontline workers, such as, on IPC, BCC, reporting system and community mobilization must be imparted to them

on a regular, yearly basis. This could be introduced in the nursing curricula which in the long run could strengthen the skills of upcoming ANMs.

8. Medical colleges, public health institutions and district level organizations may be identified and mandated to undertake regular supportive supervision visits to the district / block / session sites.

9. Though the SAMPurNA sites and routine RI sites are not mutually exclusive to each other, accessibility from the perspective of beneficiaries should be given utmost importance than that of the service providers.

10. IPC skills may be incorporated into the ASHA training modules and AWW curriculum. A practical, field-based BRIDGE training may be designed and implemented in a decentralized manner.

11. IEC depicting the various services that are ought to be offered in the SAMPurNA platforms would be more useful than a banner of special VHND-RI session.

12. Delivery of key messages to the beneficiaries must come at the end of every event, without exception. ASHA as a local person would have extensive role in this. Therefore, training ASHA on IEC/IPC must be focused on.

13. Certain areas where AVDS is not working, must actively pursue towards identifying volunteers to carry the vaccines and other logistics to the session site, rather than leaving this activity to the ANM's decision.

14. Counselling of the entire family during the VHND sessions is a significant step towards behaviour change communication. All three frontline workers must be trained adequately on this counselling skill.

15. Availability of essential logistics at the session needs to be further strengthened in terms of identifying volunteers for every site or identifying community based organizations that would be willing to take up such tasks.

16. Decisions related to contraception and reproduction are complex and involve key members of the family. However during VHND sessions, counselling is imparted

mainly to the female beneficiaries. It rarely translates into a reality unless the husband also comes into the loop. Hence it becomes imperative that the male members also get involved in counselling sessions.

17. More emphasis need to be laid down to BCC strategies. For instance, interactive methods such as folk shows, drama and pico projectors could be used in the session which could not only attract attention of the beneficiaries but also ensure acceptance of the message.

18. Privacy during examination is still a major cause of concern, as ascertained by session site observations and FGDs. Guidelines must be developed / modified as to empower the local decision makers to purchase additional logistics for portable examination chambers. As and where convenient permanent session site structures should be built in a phased manner.

19. The SAMPurNA scheme was conceived to provide VHND and RI services hard-to-reach areas. Poor road and telephone connectivity adds to the challenges of the beneficiaries. Even though these are non-health related factors, but they have serious health outcome related implications. Therefore, attempts should be made to involve these departments during planning exercise, and advocacy sessions could be carried out by local representatives to strengthen road and mobile connectivity.

20. Lack of sufficient beds and other basic amenities in the nearby referral hospital was found to be a major disincentive for local people which prevented them from approaching hospitals for maternal and child health related services. The district administration must focus its attention on availability, affordability and quality of services being offered in those referral centres to win trust of the public.

21. Provision of adequate stock of MCP cards at the sub centre level is critical to ensure timely reporting. This activity must be reviewed by the block in monthly meetings.

SPECIFIC RECOMMENDATIONS

1. More FRU may be made functional in the difficult to reach Blocks in order to reduce the patient load at DHH level.
2. Post natal Wards need to be expanded for expanded basket of services. Dormitory service may be provided to the attendants of the beneficiaries.
3. Additional ILR points, if required, need to be established in select blocks in consultation with the block officials to reduce vaccine transportation time.
4. An incentive-based leader for each village may be selected to ensure transportation of logistics round to year.
5. More *Matru Gruhas*, Janani Express services and stretchers need to be planned for these difficult areas.
6. Need to ensure filling up of all vacant positions of the three A's (ASHA, Anganwadi and ANM) on priority basis.
7. Engagement of local ANMs who have acquaintance with local language would help in proper inter-personal communication. Best practices of some districts can be replicated in other districts.
8. Role of traditional healers may be explored for better FP services. Male involvement in FP decision making is a critical pre-requisite for success of FP services.
9. A prototype of the benefits of integrated VHND+RI with key messages for community on MCH services may be developed and shared with the districts for use.
10. Follow-up visit by ASHA and sharing of emergency contact number with the care giver would be helpful to address unforeseen health needs of beneficiaries.
11. Obstetric history taking need to be given due importance during the session. Adequate time must be devoted to take proper history of all first time pregnancies without exception.
12. Quarterly tour-plans of district and sub-district level officials ought to be developed in tune with integrated VHND+RI session plans.
13. Proper feedback mechanism need to be developed to track incidences of under-the-desk payment by beneficiaries to the ambulance driver. Call centres and / or complaint box should be developed to take feedback from at least 25% beneficiaries from hard-to-reach areas.
14. Vaccine management through eVIN should be monitored seriously to avoid stock outs at any point of time.

15. Pico projector could be used for communicating messages on the health related issues.

16. Best practices on inter-departmental convergence for programme monitoring need to be documented and replicated in other places.

17. Review of the micro-plans based on the distance for beneficiaries need to be carried out regularly in monthly review meetings.

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PHOTO GALLERY


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UNDER MMR & IMR MISSION


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SAMPurNA Session data collection tool

District: _____ Date: _ _ / _ _ / _ _ Monitoring time: _ _ : _ _ to _ _ : _ _
Name of Block: _____ Planning Unit: _____ Sub center/: _____ Village: _____
Name of session site:_____ Name of staffs present in the site: ANM_____ASHA_____ AWW_____
Name of Data collector: _____

Session site	1	Vaccines / logistics delivered by? **a)** Alternate Vaccine Delivery **b)**ANM **c)** ASHA **d)** AWW **e)** Others :_____	
	2	Beneficiaries are being mobilized to session site today by: **a)** ASHA **b)** AWW **c)** ANM/MPW-M d) PRI e) Education Dept f) Religious leaders h) Others---------- i) none (Tick multiple responses at appropriate)	
Headcount Survey / Duelist	3	Is record of headcount survey (register/format/paper) available at the session site? (Look for physical record)	Yes / No / Headcount survey not conducted
	4	Has ANM updated vaccination status of beneficiaries in RCH register / records following the previous session? (Not applicable when it is No / Headcount survey is not done)	**Yes / No / Not applicable**
	5	Is updated due list available? [Updated = New born may have been included, children(<2yrs)/ Pregnant women rolling over for missed or next antigen as applicable following last session]	**Yes / No / Due list not available**
RI Logistics other than Vaccine	6	Is a copy of SAMPurNA Session (VHND+RI) micro plan available with the health worker (ANM)? **Yes / No**	
	7	Who participated in the preparation of SAMPurNA Session (VHND+RI) micro plan development process? ANM / ASHA / AWW /others specify? (Multiple responses may be ticked, as appropriate)	
	8	Is updated RCH / VHND+RI register available at VHND+RI SAMPurNA session site? **Yes / No**	
	9	Is reporting format of VHND +RI available at the SAMPurNA session site? **Yes / No**	
injection practices and Supervisio	10	Observe ANMs injection practices & encircle: **a)** not cutting syringe hub immediately **b)** touching the needle **c)** post injection, applying thumb/finger/cotton **d)** no unsafe practices **e)** not observed	
	11	Has any supervisor visited the session site today: **a)** Health Supervisor **b)** Medical Officer **c)** Others (specify)**:** …… **d)** None	
Other Questionnaires	12	Is this SAMPurNA (VHND+RI) session site located at the same place where RI session is held? (From RI microplan / interview ANM): Yes / No / Don't know	
	13	Is the place of vaccination accessible to all? (for beneficiaries and health workers)	**Yes / No / NA**
	14	Place of posting of this ANM? a) same sub center/ urban health post b) different sub center / urban health post in the same block / planning unit c) different block / urban planning unit	
	15	If the mobilizer (other than ASHA/AWW) assigned to this session, ask if he/she is aware of incentives for mobilization of children @ Rs 150/= per session: **Yes / No / NA**	

Communication Questionnaire

BRIDGE Training and IEC visibility	16	Status of frontline worker on BRIDGE IPC skill training: ANM – Y / N / Not available; ASHA – Y / N / Not available; AWW – Y / N / Not available
	17	Did you see any of the following IEC material related to Immunization and VHND displayed at SAMPurNA session site (multiple responses possible**): (Description may be given if any)** **a)**Poster –RI/VHND: Yes / No **b)** Banner –RI/VHND: Yes / No **c)** Wall painting- RI/VHND: Yes / No **d)** Any other: Yes / No, If Yes- Specify: …… **e)** No IEC material displayed
	18	What are the learning points for ANM, ASHA and AWW from BRIDGE IPC skill, describe:_____

	Observe immunization of two children and record if ANM is giving key messages	Caregiver of child 1	Caregiver of child – 2
ANM providing key messages	19 Explain what vaccine(s) will be given and the disease(s) prevented	Done / Not done / Not observed	Done / Not done / Not observed
	20 Explain potential side effects following immunization (fever/pain/swelling, etc.) and how to deal with them	Done / Not done / Not observed	Done / Not done / Not observed
	21 Explain when to come for the next visit	Done / Not done / Not observed	Done / Not done / Not observed
	22 Explain to keep the immunization card safe and to bring it along for the next visit	Done / Not done / Not observed	Done / Not done / Not observed
	23 Ask the caregivers to wait with child for 30 min after vaccination	Done / Not done / Not observed	Done / Not done / Not observed

			Caregiver-1			Caregiver-2		
Caregiver Interview	24	What is your source of information for immunization services? Allow caregiver to respond spontaneously for multiple responses; and then probe for remaining options and select responses accordingly.	ANM- Y/N	Religious leader- Y/N	Wall painting- Y/N	ANM- Y/N	Religious leader- Y/N	Wall painting- Y/N
			ASHA- Y/N	Poster/banner- Y/N	Mobile SMS- Y/N	ASHA- Y/N	Poster/banner- Y/N	Mobile SMS- Y/N
			AWW- Y/N	Radio-Y/N	Social Media- Y/N	AWW- Y/N	Radio-Y/N	Social Media- Y/N
			CMC- Y/N	Miking- Y/N	Mothers' meeting-Y/N	CMC- Y/N	Miking- Y/N	Mothers' meeting-Y/N
			Neighbors-Y/N	Rallies- Y/N	Community meeting-Y/N	Neighbors-Y/N	Rallies- Y/N	Community meeting-Y/N
			PRI- Y/N	AV show / Street play - Y/N	Others- Y/N	PRI- Y/N	AV show / Street olay - Y/N	Others- Y/N
			Influencers- Y/N	TV- Y/N	None	Influencers- Y/N	TV- Y/N	None
	25	Whether you are aware of all vaccine/s which are given to your child in this visit (match responses with MCP card?	Yes/No/NA			Yes/No/NA		
	26	Whether you know when the next visit is due for your child (Please confirm answer through MCP card)?	Yes / No / NA			Yes / No / NA		
	27	Did ANM ask you to carry MCP card during next visit?	Yes/No/ NA			Yes/No/ NA		

	28	What all actions were taken by you in case of discomfort after vaccination (Multiple response possible)	a) Gave PCM or cold sponge as instructed by ANM b) Consulted ANM/ Informed ASHA/Visited Government health facility c) Visited Private Health facility d) Visited Quack e) did not take any action f) /Others	a) Gave PCM or cold sponge as instructed by ANM b) Consulted ANM/ Informed ASHA/Visited Govt health facility c) Visited Private Health facility d) Visited Quack e) did not take any action f) /Others
	29	How many visits are required to get your child completely immunized till 5 years age? Please tick Yes if caregiver response is seven.	Yes/ No	Yes/ No
ASHA Incentive	30	Is ASHA /AWW know about their incentives for conducting SAMPurNA Session?		Yes / No / NA
	31	Reason for non-availability of vaccines/logistics?	a) Not issued b) Not picked up c) Picked up but not delivered d) Others (specify) :	
Maternal Health Service Delivery	32	Is relevant history (obstetric/past/family/menstrual) elicited especially for women coming for the first antenatal check up?	☐ Yes ☐ No ☐ N/A	
	33	Is privacy during examination ensured (by way of separate cabin/curtains)?	☐ Yes ☐ No ☐ N/A	
	34	Is the Blood pressure of pregnant woman measured properly and recorded?	☐ Yes ☐ No ☐ N/A	
	35	Is the pregnant woman weighed and the weight recorded?	☐ Yes ☐ No ☐ N/A	
	36	Is the abdominal palpation for determining fundal height, fetal lie etc performed?	☐ Yes ☐ No ☐ N/A	
	37	Is the foetal heart sound auscultated?	☐ Yes ☐ No ☐ N/A	
	38	Are IFA tablets provided to antenatal women?	☐ Yes ☐ No ☐ N/A	
	39	Is advice for next antenatal check up provided along with dietary and relevant counseling?	☐ Yes ☐ No ☐ N/A	
Child Health Service Delivery	40	Is case based appropriate advice related to the following aspects rendered? • breast feeding and complementary feeding	☐ Yes ☐ No ☐ N/A	
	41	• need for supplementation with IFA and Vitamin A	☐ Yes ☐ No ☐ N/A	
	42	danger signs in newborns and older children for which care is to be sought immediately	☐ Yes ☐ No ☐ N/A	
	43	Are the infants/children up to the age of five years weighed and the weight recorded?	☐ Yes ☐ No ☐ N/A	
	44	Was demonstration on preparation of ORS done?	☐ Yes ☐ No ☐ N/A	

FP Service Delivery	45	Is family planning counseling provided to eligible women/couples on various spacing and permanent methods?	☐ Yes ☐ No ☐ N/A	
	46	Are contraceptives provided to the beneficiaries?	☐ Yes ☐ No ☐ N/A	
Counseling	47	Did the ANM/AWW/ASHA conduct group meetings with any of the target groups? • Women • Adolescent girls	☐ Yes ☐ No ☐ N/A	
	48	What was the topic for group counseling?	Antenatal Care ☐ Birth preparedness and complication readiness ☐ Importance of institutional delivery ☐ Postnatal Care of mother and newborn ☐ Essential New born care ☐ Exclusive Breast feeding ☐ Complementary feeding ☐ Early Childhood illnesses (Diarrhea and ARI Management) ☐	Nutrition for pregnant and lactating mothers ☐ Spacing methods ☐ Permanent methods ☐ Reproductive Tract Infections (RTI) /Sexually Transmitted Infections (STI) ☐ Hygiene and Sanitation ☐ Sex Selection ☐ Age at marriage ☐ Others(Specify)_____
SAMPurNA Session Vaccine + Logistics Availability	**Observation at SAMPurNA session site (Vaccine + Logistics Availability)**			
	49	BP Instrument	a) Yes b) No	If No, give reasons _____
	50	Stethoscope	a) Yes b) No	If No, give reasons _____
	51	Examination table with foot step	a) Yes b) No	If No, give reasons _____
	52	Curtained partition	a) Yes b) No	If No, give reasons _____
	53	Thermometer	a) Yes b) No	If No, give reasons _____
	54	Digital watch	a) Yes b) No	If No, give reasons _____
	55	Inch tape	a) Yes b) No	If No, give reasons _____
	56	MUAC tape	a) Yes b) No	If No, give reasons _____
	57	Weighing scale (Adult)	a) Yes b) No	If No, give reasons _____
	58	Weighing scale (Baby)	a) Yes b) No	If No, give reasons _____
	59	Glucometer	a) Yes b) No	If No, give reasons _____
	60	Non-invasive Hemoglobinometer	a) Yes b) No	If No, give reasons _____
	61	Uristix	a) Yes b) No	If No, give reasons _____

	62	IFA	a) Yes b) No If No, give reasons _____
	63	Albendazole	a) Yes b) No If No, give reasons _____
	64	Calcium	a) Yes b) No If No, give reasons _____
	65	Nutritive Food supplementation available for PW and Children	a) Yes b) No If No, give reasons _____
	66	BC/BCG Diluent	a) Yes b) No If No, give reasons _____
	67	b OPV	a) Yes b) No If No, give reasons _____
	68	MR	a) Yes b) No If No, give reasons _____
	69	MR diluent	a) Yes b) No If No, give reasons _____
	70	JE	a) Yes b) No If No, give reasons _____
	71	JE Diluent	a) Yes b) No If No, give reasons _____
	72	TT	a) Yes b) No If No, give reasons _____
	73	Health worker (Female) received training on ANC & PNC services in last one year	a) Yes b) No If No, give reasons _____
	Observation at SAMPurNA session site (others)		
	74	Counseling done to mothers on Family Planning needs?	a) Yes b) No If No, give reasons _____
	75	Adolescent Health Day practiced for Adolescents (To be verified from the available documents)?	a) Yes b) No If No, give reasons _____
	76	Monitoring the growth of child development by service provider done? (From observation and verification from growth monitoring chart document)	a) Yes b) No If No, give reasons _____
	77	Monitoring of BMI score done?	a) Yes b) No If No, give reasons _____
	78	Anemia detection done?	a) Yes b) No If No, give reasons _____
	79	Identification of high risk pregnant cases and referral to higher institutions done? (To be verified from registers)	a) Yes b) No If No, give reasons _____
	80	Line listing of identified anemia cases is done? (To be verified from registers)	a) Yes b) No If No, give reasons _____
	81	Completeness of information regarding the high risk pregnant women ensured? (To verified from MCP card and high risk line listing register)	a) Yes b) No If No, give reasons _____
	82	Number of high risk pregnant women identified in last six months? (To be verified from the registers)	a) Yes Number_____ b) No If No, give reasons _____

	83	Number of red cards issued in last six months? (To be verified from the red card issue register)	a) Yes Number_____ b) No If No, give reasons _____
	84	Number of birth preparedness plan available in last six months? (To be verified from birth preparedness plan format)	a) Yes Number_____ b) No If No, give reasons _____
	85	Monthly counseling topics discussed during SAMPurNA sessions? (To be verified from the registers)	a) If Yes, what is the topic _____ b) If No, give reasons _____
	Observation at SAMPurNA session site (financial provisions for service delivery)		
	86	Ask about the mode of transportation to the session site and about the financial provisions for the same	_____
	87	Ask about the hardship allowances 1. Health worker (Male) – 300 INR 2. Health worker (Female) – 300 INR 3. MPHS (Male/Female) – 300 INR 4. AWW – 150 INR 5. ASHA – 150 INR 6. Session organizing cost – 300 INR 7. Mobility for team-1500	1. Yes b) No If Yes, up to which month you have received _____ 2. Yes b) No If Yes, up to which month you have received _____ 3. Yes b) No If Yes, up to which month you have received _____ 4. Yes b) No If Yes, up to which month you have received _____ 5. Yes b) No If Yes, up to which month you have received _____ 6. Yes b) No If Yes, up to which month you have received _____ 7. Yes b) No If Yes, up to which month you have received _____

In depth interview (IDI) of ANM/ASHA Worker

STRENGTHENING VHND AND RI UNDER SAMPurNA STRATEGY IN ODISHA

Indian Institute of Public Health, Bhubaneswar

Instructions: Introduce yourself, explain the purpose of conducting IDI and brief the participants about the ethical aspects of participating in the IDI.

1. Introduce yourself (Name, designation, duration of posting in this area, total period of job)
2. How did you select this site for special VHND & RI (SAMPurNA) session?
    a. Discuss about the process followed for site selection
3. How do you ensure that all the targeted beneficiaries are enrolled and availing the services at this combined session?
    a. Means adopted for communication
    b. Means adopted for community mobilization
4. How you are transporting the vaccines and logistics to the session site?
    a. Who carries the vaccines
    b. How the vaccines are delivered
    c. How are the vaccines taken back to the ILR point
5. What are the challenges you are facing in conducting the special sessions?
6. What kind of support you are getting from higher officials for conducting the special sessions?
7. What processes do you follow for updating the VHND & RI (SAMPurNA) micro-plan?
    a. About the micro-plan, communication plan, logistic plan, HR plan, due list of beneficiaries, vulnerable and high risk beneficiaries, etc

8. What all trainings you have received and when?
    a. For ANM – Immunization, AEFI, BRIDGE, SAB, MAA, HIV/Syphilis testing and other related trainings
    b. For ASHA up-to six and seven module
    c. For AWW – MAA and BRIDGE

9. How do you follow-up the identified clinical high risk pregnant women?
    a. Joint home visits- frequency, time, duration, etc
    b. Active community-based monitoring

10. What are the referral documents used?

11. Are you aware about the protocol for referral? Please explain in brief.

12. Do you know about the incentive mechanism for conducting special VHND & RI (SAMPurNA)?
    a. Are you availing the incentives
    b. Timeliness of getting the incentives
    c. Regularity of getting incentives

13. Please explain about the monitoring and supervision plan of your area?
    a. Probe about the frequency of plan preparation and about how the plan is modified and discussed
    b. If no plan is available, probe about the reasons for not preparing the plan
    c. If the plan is available, probe about the personnel who are visiting SAMPurNA session sites for monitoring and for offering supportive supervision services

14. What are the issues and challenges in conducting the combined sessions?

15. What is your suggestion to further strengthen the VHND/RI (SAMPurNA) sessions?

THANK AND CLOSE THE IDI

In depth interview (IDI) for block officials (MO I/c & BPM) and district officials (ADM-FW, DPM, DM-RCH)

STRENGTHENING VHND AND RI UNDER SAMPurNA STRATEGY IN ODISHA

Indian Institute of Public Health, Bhubaneswar

Instructions: Introduce yourself, explain the purpose of conducting IDI and brief the participants about the ethical aspects of participating in the IDI.

1. Introduce yourself (Name, designation, total duration of job, duration of current posting, etc)

2. Please briefly explain about the process of identifying the hard to reach villages for VHND & RI sessions (SAMPurNA) for availing financial aid

3. What transportation mechanisms are followed for supplying the vaccines and logistics to the session site?

    a. Who carries, how vaccines are carried, regularity of supply, incentives for carrying vaccines

4. In your opinion, is the RI and VHND micro plan (SAMPurNA) in your area complete and updated?
    a. Availability of micro-plan
    b. Regular updatation of the micro-plan
    c. Is the micro-plan available for physical verification

    If the micro-plan is not available, probe about the reasons

5. Please explain about the monitoring and supervision plan of your area?
    a. Probe about the frequency of plan preparation and about how the plan is modified and discussed
    b. If no plan is available, probe about the reasons for not preparing the plan
    c. If the plan is available, probe about the personnel who are visiting SAMPurNA session sites for monitoring and for offering supportive supervision services

6. Can you please explain the number of sessions monitored in last quarter?
    a. _____ out of _____ special VHND & RI sessions (SAMPurNA)

b. Probe about availability of filled-in monitoring checklists for verification

c. Enlist the designation of the monitor and number of sessions monitored per individual (Cross verification through the available monitoring checklist/register)

7. What feedback mechanisms are available for the monitoring the visits?

8. What are the corrective measures taken during last three months on the basis of findings of the monitoring visit reports?

9. What mechanisms are followed for disbursement of incentives to the service providers?

    a. Probe about timing, timeliness, regularity and challenges

10. What are the operational and programmatic challenges you are facing in conducting the combined sessions for difficult areas?

    a. Probe about demand side and supply side challenges

11. Please suggest about how this initiative can be further strengthened?

THANK AND CLOSE THE IDI

Focus Group Discussion (FGD) of beneficiaries

STRENGTHENING VHND AND RI UNDER SAMPurNA STRATEGY IN ODISHA

Indian Institute of Public Health, Bhubaneswar

Inclusion criteria:

- Include at least two to three identified clinical high risk pregnancy women
- Include earlier identified clinical high risk pregnancy women who have already delivered

Exclusion criteria:

- Don't include any other person who is not a direct beneficiary of the VHND and RI combined session (SAMPurNA)

Instructions: Introduce yourself, explain the purpose of conducting FGD and brief the participants about the ethical aspects of participating in the FGD.

Topic guide:

1. Could you please briefly introduce yourself (name, duration of stay in the village, and services availed under VHND and RI (SAMPurNA))?
2. How do you get information regarding the VHND/RI (SAMPurNA) session site?
    a. Regularity of getting information
    b. Source of information
3. What services are you receiving at the session site?
    a. Immunization, ANC, PNC, Preliminary pathological test, counselling services, medicines, etc
    b. Discuss about the different tests done at VHND & RI site
    c. Discuss on medicine (common medicine) and supplements (IFA, Calcium, Deworming) at VHND & RI site (SAMPurNA)
    d. If the beneficiaries do not talk of any of these services, probe as to why they didn't receive that service or group of services
4. When did you get registered for ANC checkups?
    a. Facilitator should try to probe and elicit responses about the gaps in delay in registration
    b. Probe about the reasons for such delay
5. Please explain your experience of getting examined in the VHND/RI (SAMPurNA) session?

6. Could you please explain about the importance of vaccination during pregnancy?
7. What is/was your preferred place for delivery?
8. What has been your experience about the kind of advice/s you receive/d from the health workers at the VHND session sites?

   (Probe about specific experience on ANC services, diet/nutrition during pregnancy, personal hygiene, danger signs during pregnancy, birth preparedness tips, importance of breast feeding, immunization, new born care, family planning, referral services and institutional delivery)
9. In your view what are the difficulties in accessing the session site on the assigned day or during rainy season?
10. What are the additional services you are expecting from these VHND/RI (SAMPurNA) sessions?
11. What are your good practices/experiences related to the service providers?
    a. ANM
    b. ASHA
    c. AWW
    d. Health worker (Male)
12. Have you ever been informed/counselled regarding birth preparedness plan by any service provider for ensuring a safe delivery?
    a. When to move, where to move and how to move – vehicle, accompanying person, monetary support, etc
13. Which service provider has helped you in birth preparedness?
14. What is your opinion/experience about issuing the card during your pregnancy period
    a. Timeliness of issuing card
    b. Information about the usage and advantage of RED card
15. What are your views on transportation services provided for referral to higher institutions?
16. Any other issue the respondents wish to highlight?

THANK AND CLOSE THE FGD

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