Assessment of Reasons Behind Low Bed Occupancy and Drop Out from NRC and Services Offered and Facilities Available at NRC as Per Guidelines

By

Vinay Kumar Gupta

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2017-2019

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INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that **Mr VINAY KUMAR GUPTA,** student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone Dissertation training at **STATE NUTRITION MISSION, UTTAR PRADESH** from **11/02/2019 to 11/05/2019.** The Candidate has successfully carried out the study designated to him during dissertation training and his approach to the study has been sincere, scientific and analytical.

The dissertation is in fulfilment of the course requirements.

I wish him all success in all his future endeavours.

Dr Ashok Kaushik

Dean, Academics and Student Affairs

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17 May 2019

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INTEGRATED CHILD DEVELOPMENT SERVICES

DISTRICT AYODHYA (U.P.)

POSHAN Abhiyaan
PM's Overarching Scheme for Holistic Nourishment
सही पोषण - देश रोशन

Certificate of completion of Dissertation

The certificate is awarded to

Mr. Vinay Kumar Gupta

In recognition of having successfully completed his Dissertation in the department of

Integrated Child Development Services

And has successfully completed his Project on

Assessment of reasons behind low admission rate in NRC, drop out from NRC without completing full course of treatment and the facilities available & services offered at NRC in accordance with the guidelines in the Ayodhya District of U.P.

Date-11th February to 11th May 2019

Organization – TINI (The India Nutrition Initiative), TATA TRUSTS

He comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning.

I wish him all the best for future endeavours.

District Programme Officer,
Ayodhya (U.P.)

CERTIFICATE BY SCHOLAR

This is to certify that all ethical issues have been considered while collecting data for my dissertation titled **ASSESSMENT OF REASONS BEHIND LOW BED OCCUPANCY IN NRC & DROP OUT FROM NRC AND FACILITY ASSESSMENT OF NRC** and submitted by Mr VINAY KUMAR GUPTA Enrolment No 0694 under the supervision of **Dr Tanjul Saxena** for award of MBA in Hospital and Health of the University carried out during the period from 11/02/2019 to 11/05/2019 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

Vinay

Signature of student

ACKNOWLEDGEMENT

It is a matter of great privilege for me to express my sincere thanks to all those who helped me through their expert guidance, active co-operation and goodwill in completion of this study even at the cost of their inconvenience.

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I express my gratitude towards my parents for their blessings. I am also thankful to my friends for helping me and the encouragement that they provided to me for carrying out this dissertation work.

Finally yet importantly, I am very much thankful toDPO, DNC, DNS, CDPOs, Aanganwadi Supervisors and Poshan Sakhis of Ayodhya District along with beneficiaries of the field area for their co-operation and participation, without which my study would not have been possible.

Vinay Kumar Gupta

CONTENT

1. Abbreviation

NRC : Nutrition Rehabilitation Center

NNM : National Nutrition Mission

UNICEF : United Nations International Children's Emergency Fund

POSHAN Abhiyaan : Prime Minister's Overarching Scheme for Holistic Nourishment Abhiyaan

SNM : State Nutrition Mission

UP : Uttar Pradesh

DPO : District Program Officer

DNC : Divisonal Nutrition Consultant

DNS : District Nutrition Specialist

CDPO : Child Development Project Officer

AWW: Anganwadi Worker

2. Uttar PradeshSNM State Profile

Topography

Uttar Pradesh is limited by Uttarakhand and Himachal Pradesh on the north-west, Haryana and Delhi on the west, Rajasthan on the south-west, Madhya Pradesh on the south, Chhattisgarh and Jharkhand on south-east and Bihar on the east. Arranged somewhere in the range of 23°52'N and 31°28'N scopes and 77°3' and 84°39'E longitudes, this is the fourth biggest state in the nation as far as zone, and the first as far as populace. Uttar Pradesh can be separated into three particular hypsographical districts.

1.The Shivalik lower regions and Terai in the North

2. The Gangetic Plain in the middle - Highly ripe alluvial soils; level geography broken by various lakes, lakes and waterways; incline 2 m/km

3. The Vindhya Hills and level in the south - Hard shake Strata; differed geology of slopes, fields, valleys and level; constrained water accessibility.

History

The historical backdrop of Uttar Pradesh is perceived in the later Vedic Age as BrahmarshiDesha or Madhya Desha. Numerous incredible sages of the Vedic circumstances such as Bhardwaja, Gautam, Yagyavalkaya, Vashishtha, Vishwamitra

and Valmiki prospered in this state. A few hallowed books of the Aryans were likewise created here. Two incredible stories of India, Ramayana and Mahabharata, seem to have been enlivened by Uttar Pradesh. In the Sixth Century BC Uttar Pradesh was related with two new religions-Jainism and Buddhism. It was at Sarnath that Buddha lectured his first lesson and established the frameworks of his request. A few focuses in Uttar Pradesh like Ayodhya, Prayag, Varanasi and Mathura moved toward becoming rumored focuses of learning.

In the medieval period Uttar Pradesh go under Muslim principle and drove the best approach to new amalgamation of Hindu and Islamic societies. Ramananda and his Muslim devotee Kabir, Tulsidas, Surdas and numerous different erudite people added to the development of Hindi and different dialects. Amid the British standard in India, there were sure pockets in Uttar Pradesh that were administered by the English value and custom-based law. In 1773, the Mughal Emperor exchanged the regions of Banaras and Ghazipur toward the East India Company. The East India Company gained the zone of modernday Uttar Pradesh over some stretch of time. The regions involved from the nawabs, the Scindias of Gwalior and the Gurkhas were at first put inside the Bengal Presidency.

History Behind the making of Uttar Pradesh :-

1. In January 1858, Lord Canning continued to Allahabad and framed the North Western Province barring Delhi division.

2. In 1856, Awadh was put under the main magistrate. The locale were later converged with the North Western Province and started to be known as 'North Western Provinces and Oudh' in 1877. The whole territory came to be known as the 'Joined Provinces of Agra and Oudh' in 1902.

3.In April 1937, Lucknow turned into the capital of the region, the name of which was additionally changed to United Provinces.

4. On January 24, 1950, the then senator general of India passed the United Provinces (adjustment of name) Order 1950 renaming the then United Provinces as Uttar Pradesh.

5. On 9 November 2000, another state, Uttarakhand, was cut out from the Himalayan slope locale of Uttar Pradesh.Health Profile

Nutrition Profile

The Stunting (low height for age), the Under nutrition (low weight for age) and the wasting (low weight for height)of the state is 46%, 39.5 % and 10 respectively as per NFHS - 4.

Comparative major nutrition and demographic indicators are as follows:

Ayodhya District Profile

Topography

The geology of Ayodhya is contain alluvial soil, sand, rock. The mountain, level and other topographical reliefs are absent as a whole region has a place with Gangatic plain. The general incline of help is west to east and stretch is around 130 KM. The significant stream is Saryu, Marha.

History

The Faizabad area of Uttar Pradesh will presently be known as Ayodhya. Boss Minister Yogi Adityanath made the declaration in his 2018 Diwali discourse. The Faizabad name change comes not exactly a month after another major UP city Allahabad was renamed as Prayagraj. While UP as of now has a city called Ayodhya, which is a little separation far from Faizabad city and offers its metropolitan cutoff points with the last mentioned, the locale of Faizabad will likewise be known as Ayodhya.

Divisions

Ayodhya is one of the 5 districts of Ayodhya Division.

The district consists of 12 pariyojnas

Demographic Profile-

Indicator	**UP**	**Ayodhya**
IuTotal Population (Census 2011)	19.09 cr	24.68 Lakh
Sex Ratio (Census 2011)	912	962
Child Sex Ratio (Census 2011)	902	931
Total Literacy Rate (%) (Census 2011)	67.68	66.85

Review of literature:-

The growth of the brain is certainly less affected by undernutrition than the growth of the rest of the body (brain sparing). We inquire whether a similar phenomenon occurs within the brain: whether there are differences in sensitivity to undernutrition amongst the brain's component growth processes. We conclude from our review of the literature that, contrary to popular belief, undernutrition depresses the growth rate of various processes within the brain to the same extent. The much quoted “selective” effect on the cerebellum is not an example of an especially sensitive process. It results from expressing deficits as “% of age control values” and disappears when proper comparisons of depression in rates of growth are made. The one growth process which does at first sight appear to be truly especially sensitive is myelin synthesis, in that undernutrition depresses its rate more than that of other growth processes in brain. However, undernutrition also results in fewer fibres being myelinated, and when rate of myelin synthesis is expressed per myelinated fibre the especial sensitivity disappears.

Children are one of the most important population groups in the world and their health is a matter of fundamental importance. In this regard, proper nutrition is a prerequisite for good health. Hence, without ensuring optimal child growth and development, efforts for significant economic development will be unsuccessful.[1],[2],[3] Nutrition has a fundamental role in physical, mental, and emotional development of children, particularly through the formative years of life.[4],[5] The nutritional plans and policies can have important effect on human and social development of communities worldwide.[6] Indeed, malnutrition is considered as one of the most important public health and health policy issues in the world.[7] Malnutrition is a condition causing adverse effects on body form or performance and clinical outcomes due to a deficiency or imbalance of energy, proteins, and other nutrients.[8] Due to their fundamental needs, children are at risk of malnutrition significantly worldwide, especially in developing nations.[9] About 45% of the total mortality is related to under five-year-old children (U5C)[10],[11] among which almost half is attributed to malnutrition.[11] About six million children under age five died in 2015 and the under-five mortality rate in low-income countries was 76 deaths per 1000 live births– about 11 times the average rate in high-income countries (7 deaths/1000 live births).[12] Studies show that despite economic development in developing countries, malnutrition has remained as an important issue.[13],[14] Stunting (low height for age), underweight (low weight for age), and wasting (low weight for height) are key indicators of malnutrition, calculated using anthropometric status of children.[15] In this regard, more than 150 million children suffer from one or more types of malnutrition.[16],[17] The overall prevalence of stunting in the world has been reported 25% which this rate has been 6.6% among Iranian girls. Furthermore, the overall prevalence of wasting among boys in Iran were reported to be 4.11%.[18] Infections and micronutrient and other deficiencies due to inadequate diet are the main causes of malnutrition during childhood.[19] Insufficient food preparation, bad eating habits, psychological factors, family's food security, and certain metabolic disorders as well as diseases are among factors that limit the intake of food and foodstuff.[5] Besides limited accessing to adequate food and suffering from infections, inadequate access to available hygienic services and issues in the living environment as well as socioeconomic and cultural structure of communities are also considered as primary causes of the incidence and prevalence of malnutrition.[20] In this regard, United Nations International Children's Emergency Fund (UNICEF) has provided a conceptual model for understanding causes of malnutrition. In this model, main factors are related to socioeconomic, cultural, and political structure of a society.[21] Iran is one of the developing countries and given the importance of this issue in this country, the aim of

this study was to conduct a systematic review of factors associated with malnutrition among children under 5 years. The results of this study can identify the most important factors of malnutrition among U5C and lead to improving solutions.

The state of uttar Pradesh has 1.3 million severely malnourished children. Nutrition rehabilitation centers (NRCs) were started in the state to control severe malnutrition and decrease the prevalence of severe malnourished children to less than 1% among children aged 1-5 years. **Materials and Methods:** The present study was conducted from November 2008 to October 2009; 100 children admitted to seven different NRCs in Indore and Ujjain divisions of Madhya Pradesh were observed during their stay at NRCs and the follow-up period to analyze the effect of interventional measures on select anthropometric indicators. Mothers of the children were interviewed on health issues and therapeutic feeding practices at the NRCs using a predesigned and pretested interview schedule. **Results:** The study group consisted of 48 boys and 52 girls; 60% were between 13 and 36 months of age. 93 children were analyzed for anthropometric indicators following a dropout rate of 7%. A statistically significant difference was obtained between the weight of children at admission and discharge ($t=14.552$, $P<0.001$); difference of mid upper arm circumference (MUAC) at admission and discharge was statistically significant ($t=9.548$, $P<0.001$). The average weight gain during the stay at the centers was 9.25 ± 5.89 g/kg/day. Though the number of severe malnourished children decreased from 85 to 43 following the stay at NRCs ($\chi^2 = 44.195$, $P<0.001$); 48.78% of the children lost weight within 15 days of discharge from the NRCs. Dropout rates of 9.89%, 23.07%, 42.65%, and 61.76% for the study group were obtained during the follow-up period of 6 months for the four follow-up visits conducted 15 days, 1, 3, and 6 months after discharge. The mothers of the children lacked adequate information on health issues and composition and preparation of therapeutic diets at the centers. **Conclusion:** The NRCs were effective in improving the condition of admitted children, but the effects were not sustained following discharge due to high drop-out rate and lack of adequate parental awareness. There is an urgent need to link these centers with community-based models for follow-up and improve health education measures to maintain the gains achieved.

Introduction:

Nutrition Rehabilitation Center (NRC) has been propelled under community plan of UNICEF and Government of India. It is a unit in a wellbeing office where kids with Severe Acute Malnutrition (SAM) are conceded and oversaw. Kids are conceded according to the characterized affirmation criteria and furnished with medicinal and wholesome remedial consideration. When released from the NRC, the tyke keeps on being in the nourishment recovery program till she/he achieves the characterized release criteria from the program (portrayed in specialized rules). Notwithstanding remedial consideration, extraordinary spotlight is given on opportune, satisfactory and proper bolstering for youngsters; and on improving the abilities of moms and parental figures on complete age suitable minding and encouraging practices. moreover, endeavors are made to fabricate the limit of moms/parental figures through directing and backing to distinguish the nourishment and medical issues in their kid. in-tolerant administration of SAM youngsters is profoundly viable in diminishing case casualty rates, however even under the best conditions inpatient the board won't probably deal with the whole caseload of kids with SAM in a given region. Different issues may incorporate issue of access to the well-being office and long emergency clinic stay expecting parental figures to avoid home and work for a long time. In this way, a network based program for the administration of extreme intense lack of healthy sustenance ought to be set up to supplement the conveyance of administrations by nourishment restoration Centers. All the more critically components should be set up to routinely screen the development of kids with the goal that squandering and development floundering can be recognized in their beginning periods and remedial estimates taken before the kid advances to serious evaluations of under sustenance.

Goals of facility based administration of SAM:

o To give clinical administration and diminish mortality among kids with extreme intense hunger, especially among those with restorative complexities.

o To advance physical and psychosocial development of youngsters with extreme intense hunger (SAM).

o To fabricate the limit of moms and other parental figures in proper encouraging and thinking about babies and youthful youngsters

o To recognize the social factors that added to the tyke slipping into serious intense ailing health.

Recipients of the plans are:

1. Children from 0-6 years,

Specialist co-ops:

1. Medical Officer prepared on Facility Based Care of Severe Acute Malnutrition
2. Nutrition Counselor
3. Medical Social Worker
4. Nursing staffs and so forth.

Real Impact: The program through the objectives will endeavor to diminish the dimension of hindering, under-sustenance

RESEARCH QUESTION:

1. Why parents of SAM children do not get their children admitted in NRC?
2. What are the reasons behind drop out of children from NRC?
3. Are facilities available and services offered at NRC is in accordance with the guidelines?

OBJECTIVES:

1. To assess the reasons behind low admission rate in NRC.
2. To assess the reasons behind drop out from NRC.
3. To assess the facilities available & services offered at NRC in accordance with the guidelines.

MATERIAL AND METHODS:

STUDY DESIGN: cross-sectional, Analytical study

STUDY AREA: Villages and NRC

DURATION OF STUDY: 3 months

SAMPLE SIZE:30 Parents who did not admitted their SAM children to NRC, Parents of 30 SAM children who are drop out from NRC and In charge of NRC

SAMPLING TECHNIQUE: Convenient sampling

DATA COLLECTION PROCEDURE: Questionnaire contains both close and open ended, which is followed by personal interview.

DATA ANALYSIS PLAN: Excel

ETHICAL CONSIDERATIONS: Informed consent will be taken before conducting personal interviews.

IMPLICATIONS OF RESEARCH: The data collected will be utilized to check the reasons behind low admissions in NRC, reasons behind drop out from NRC without completing full course of treatment and available facilities and services of NRC in accordance with the guidelines. That will help us to check the effectiveness of AWW, ASHA, ANM, CDPO & MOIC and loophole in facilities and services of NRC. It will also help us to know the other major reasons, community is facing to get their children admitted in NRC and fulfill the course of treatment.

Rationale: To identify the major reasons behind low bed occupancy in NRC and drop out from it, further it can be used to increase bed occupancy in NRC**.**

Results:

For research question 1 :-

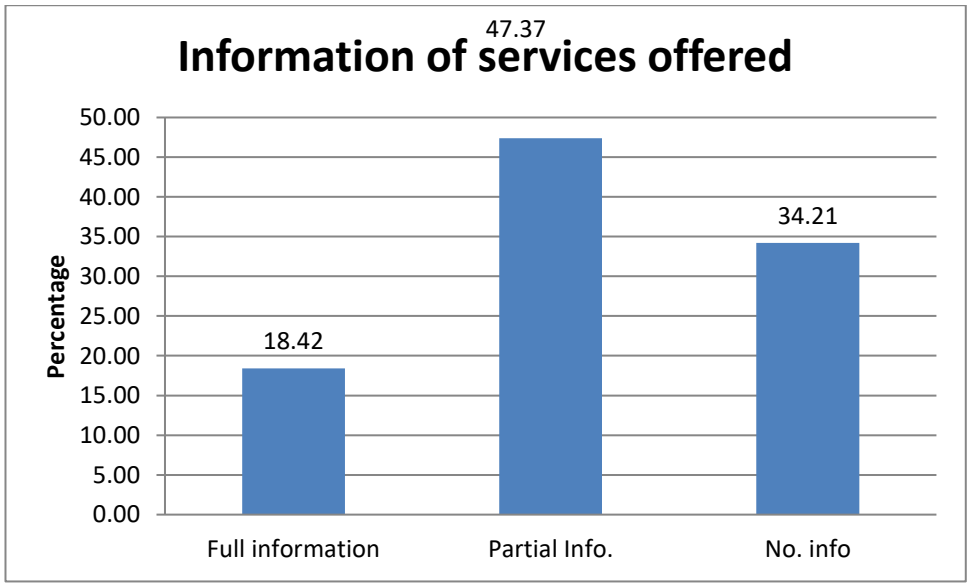

Fig 1. The following table demonstrate that around 81% parents of beneficiary having partial or no information regarding NRC services and 18.42% parents of beneficiary having full information.

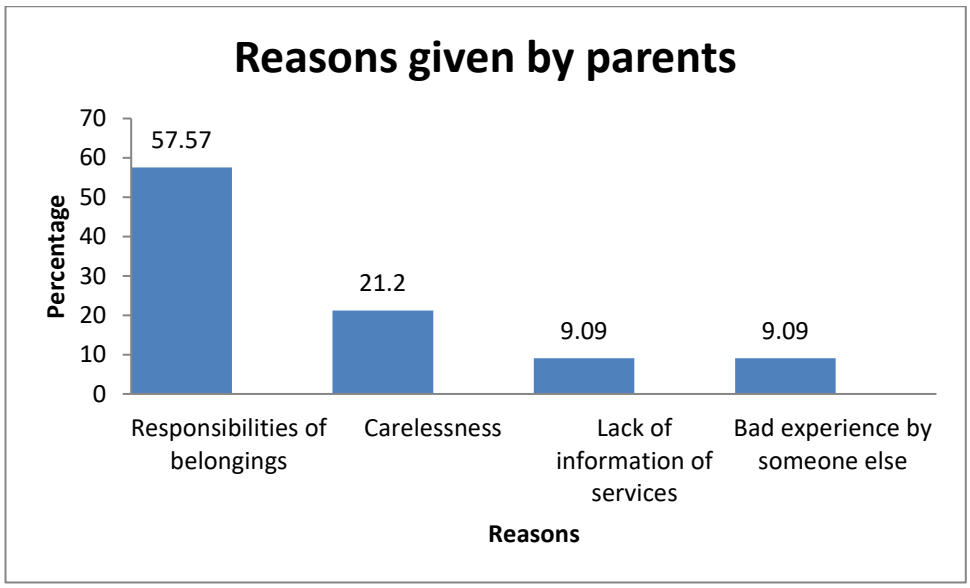

Fig 2. Table reveals that around 57.57 parents of beneficiary did not admitted their children to NRC because they have burden of taking care of their belongings.

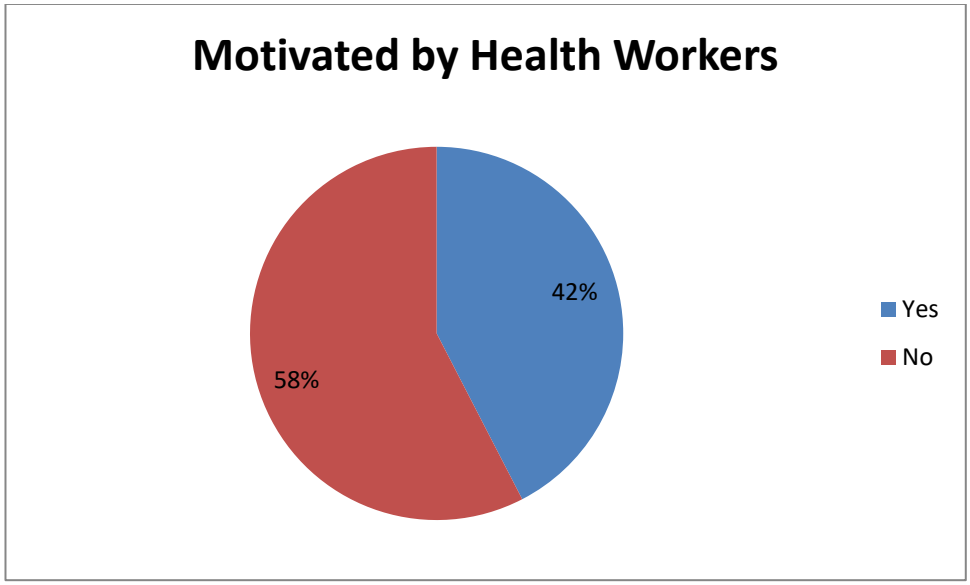

Fig 3. Chart reveals that only 42% parents were motivated by health workers to admit their children in NRC

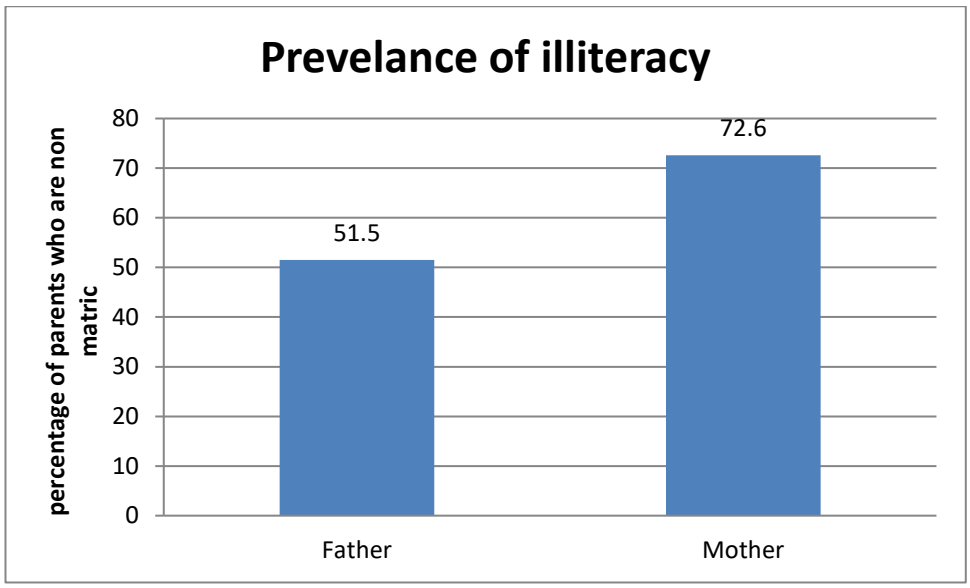

Fig 4. Table reveals that more than 50 % parents of children who didn't went to NRC both father and mother having less than matriculation qualification.

For research question 2:-

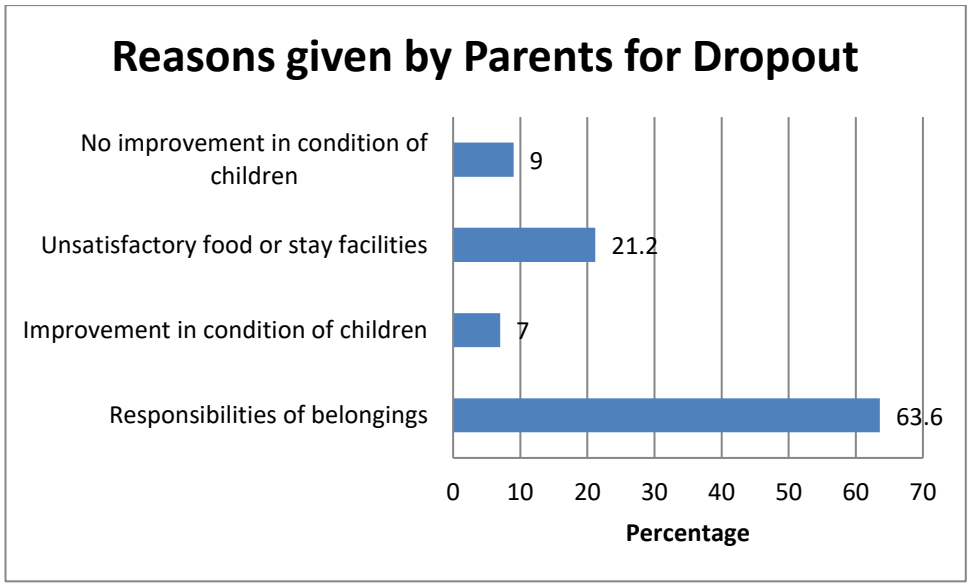

Fig 5:- Table demonstrate that more than 63 % parents who were drop out from NRC without completing full course of treatment of their children said that they did it because of burden of taking care of their belongings.

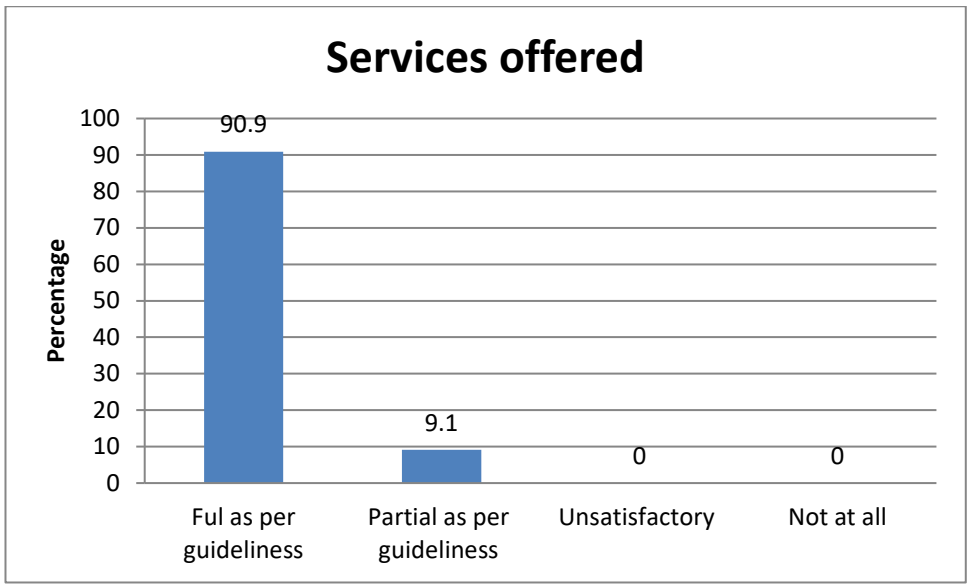

Fig 6:- Table demonstrate that more than 90 % parents whose children were admitted in NRC were given all the services as per guidelines.

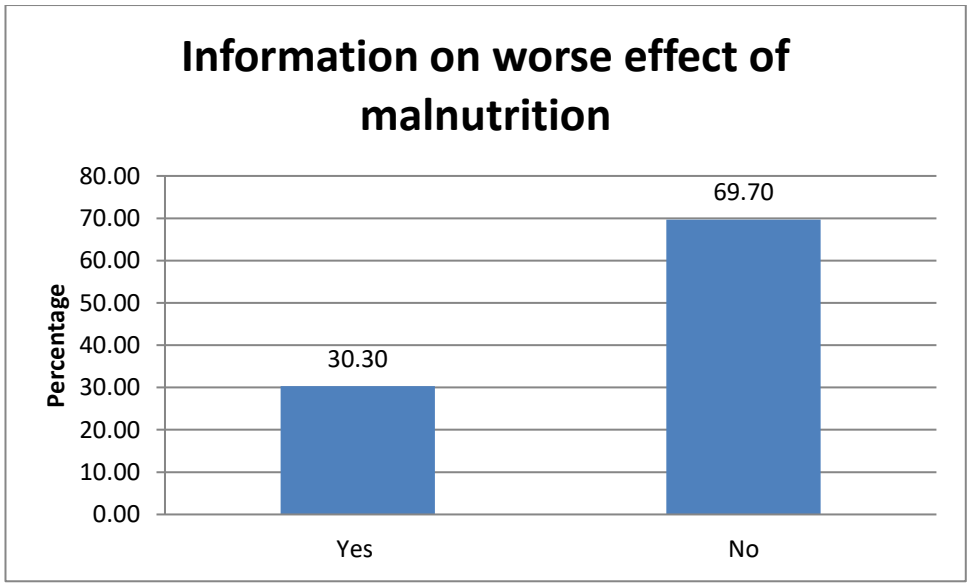

Fig. 7 Chart reveals that around 70 % parents of children who were admitted in NRC were not told about the worse effect of malnutrition.

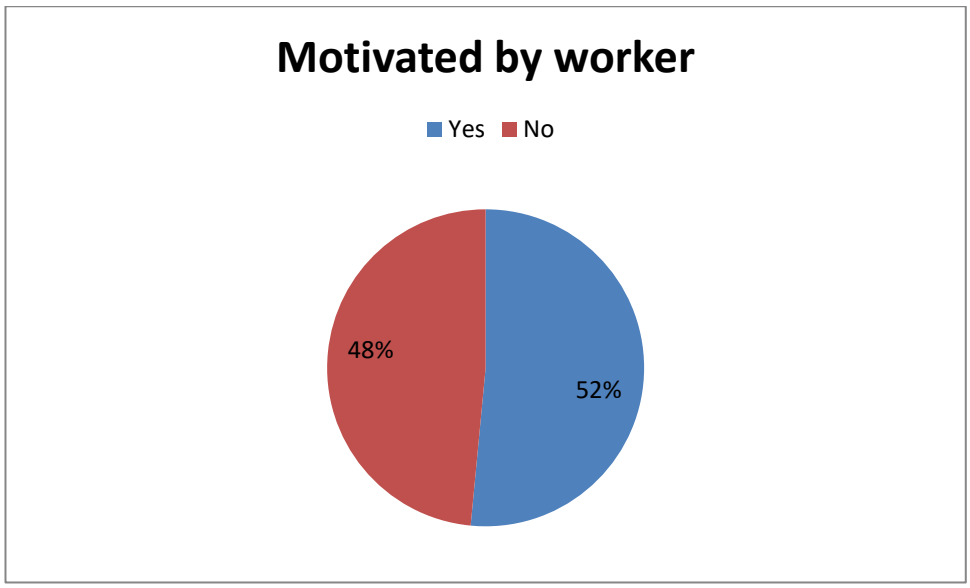

Fig. 8 Chart demonstrate that only about half of the parents of children who were admitted in NRC were motivated by health workers to complete full course of treatment of their children in NRC.

For research question 3 :-

Staffing: -

Staff position	Suggested Number	Assigned
medical officer	1	1
Nursing Staffs	4	4
Nutrition advisor	1	1
Cook or caretaker	1	1
Attendant or cleaners	2	2
Medical Social Worker - Social Assessment	1	Nil

Fig. 9 shows that except medical social worker all the staffs are assiged as per the guidelimes.

Essential Ward Equipment's: -

Equipment's	Suggested Number	Available
glucometer	4	4
thermometers	4	4
Weighing scales - ward - outpatient - emergency area	3 1 1 1	3 - 1 - 1 - 1
ifamtometer - inpatient ward - nutrition rehabilitation centre	2 1 1	2 -1 -1
stadiometer	1	1
Resuscitation equipments	1	1
Suction equipments	1	1

Fig. 10 checklist reveals that all the Essential ward Equipment's are availale as per suggested guidelines.

Other ward Equipment's: -

Equipment's	Availability – Yes/No
IV stands	Yes
almirah	Yes
Shoe rack	Yes
dustbin	Yes
Room heaters	Yes
IEC materials - TV - DVD Player - Other	 - Yes - No (DTH)
Toys	Yes
Clock	Yes
Calculator	Yes
Reference height and weight charts	Yes

Fig.**11** checklist demonstrate that all the ward Equipment's are available as per the suggested guidelines.

Infrastructure	Available – Yes/No
Patients area	Yes
Play & counselling areas	Yes
nursing station	Yes
Kitchen & food storage	Yes
attached toilet & bathroom facilities	Yes

Infrastructure :-

Fig.**12** checklist reveals that Infrastructure meets the requirements of guidelines.

Training: -

Position of staff	Training Package	Done – Yes/No
Medical officer	Facility based care of severe acute malnutrition	-

Fig.13 checklist reveals that medical officer assigned has to gone through the training of facility based care of severe acute malnutrition.

Observe	Yes/No – Comments
Are correct feeds given in corrected amounts?	Yes
Are feeds given at the prescribed time, even on nights, holidays and weekends?	Yes
Are children held & encouraged to eat (never left alone to feed)?	Yes
Are children fed with a cup (never a bottle)?	Yes
is food intake (and any vomiting/diarrhoea) recorded correctly after each feed?	Yes
Are leftovers recorded accurately?	Yes
Are amounts of Starter diet kept the same throughout the initial phase, even if weight is lost?	-
After transition, are amounts of Catch-up diet given freely and increased as the child gains weight?	-
Warming	
is the room kept between 25° - 30° C (to the extent possible)?	Yes
Are blankets provided and children kept covered at night?	Yes
Are safe measures used for re-warming children?	Yes
Are temperatures taken and recorded correctly?	Yes
Weighing	
Are scales functioning correctly?	Yes
Are scales standardized weekly?	Yes
Are children weighed at about the same time each day?	Yes
Are they weighed about one hour before a feed (to the extent possible)?	-
Do staff adjust the scale to zero before weighing?	Yes
Are children consistently weighed without clothes?	-
Do staff correctly read weight to the nearest division of the scale?	Yes
Are weights correctly plotted on the Weight Chart?	Yes
Do staff immediately record weights on the child's case sheets?	Yes
Giving antibiotics, medications, supplements	
Are antibioticsss given as prescribed (correct dose at correct time)?	Yes
When antibiotics are given, do staff immediately make a notation on the daily care charts?	Yes
is folic acid given daily and recorded?	Yes
is vitamin A given according to schedule?	Yes

is a multivitamin given daily and recorded?	Yes
After children are on Catch-up diet for 2 days, is the correct.	-
Dose of iron given twice daily and recorded?	Yes
Ward environment	
Are surroundings welcoming and friendly?	Yes
Are mothers given a place to sit and sleep?	Yes
Are mothers taught/encouraged to be involved in care?	Yes
Are staffs consistently courteous?	Yes
As children recover, are they stimulated and encouraged to move and play?	Yes

Equipment's	**Yes/No – Comments**
Cooking gas	Yes
Dietary scales (to weigh 5gms)	Yes
Measuring jars electric Blender (or manual whisks)	Yes
water filter	Yes
Refrigerator	Yes
Cooking utensils	Yes
Feeding cups	Yes
Containers	Yes
Saucers	Yes
Spoos	Yes
Jugs	Yes

Ward procedures :-

Fig. 14 checklist reveals that nearly all the ward procedures are up to mark of guidelines.

Kitchen Equipment's: -

Fig. 15 checklist demonstrates that all the kitchen equipments are available as required per guidelines.

Pharmacy Supplies: -

Essentials	Available Yes/NO (Comments)
Antibiotics(Ampicillin/Amoxycillin/Benzyl penicillin)	Yes
Chloamphenicol	Yes
Cotrimoxazole	Yes
Gentamycin	Yes
Metronidazole	Yes
Tetracycline or Chloramphenicol eye drops	Yes
Atropine eye drops	Yes
ORS	Yes
Electrolyte and minerals	Yes
Potassium chloride	Yes
Magnesium chloride/sulphate	Yes
Iron syrup	Yes
Multivitamin	Yes
Folic acid	Yes
Vitamin A syrup	Yes
Zinc Sulfate or dispersible Zinc tablets	Yes
Glucose (or sucrose)	Yes
Iv fluids (ringer's lactate solution with 5% glucose; 0.45% (half normal) saline with 5% glucose; 0.9% saline (for soaking eye pads)	Yes
Cannulas	Yes
Iv sets	Yes
Pediatric nasogastric tubes Kitchen Supplies	Yes

Fig. 16 checklist reveals that all the pharmacy supplies were available as per the guidelines.

Hygiene: -

Indicators	Yes/No – Comments
Staff's cleanliness Are hands washing facilities available for staff?	Yes
Does staff wash hands every time with sanitizer ?	Yes
Are their nails are clean?	Yes
Do staffs wash hands before handling/cooking food?	Yes
Do staffs wash hands for each & every patient?	
Mothers' cleanliness Do mothers have facility for bath, and do they use it regularly?	Yes
Do mothers wash hands with soap/sanitizer after coming out of the toilet or changing diapers of their children?	Yes
Do mothers wash hands with soap/sanitizer before giving diet to their children?	Yes
Bedding and laundry Is bed sheets changed regularly or when soiled or wet?	Yes
Are diapers, soiled towels and rags, etc. kept in bag, And washed or disposed properly?	Yes
Is there a place for care takers to do wash clothes?	Yes
Is clothes washed in warm water?	
General maintenance Are floors swept?	Yes
Is trash disposed properly?	Yes
Is the ward kept as free as possible of insects and rodents?	Yes
Food storage Are ingredients and food kept covered and stored at the proper temperature?	Yes
Are leftovers disposed? **Dishwashing**	Yes
Are dishes cleaned after each feeding?	Yes

Are dish washed with hot water with soap/deterget?	
Toys Are toys cleanable ? Are toys washed regularly, and after each child uses them.	Yes -

Fig. 17 reveals that all the parameters of hygiene is practiced as per the guidelines.

Results :-

(1) 30 parents who didn't took their children to nutritional rehabilitation centre were interviewed ad it was found that more than 80% parents were not having full information of all the services they ca avail before, during and after treatment at nutritional rehabilitation centre. More than 55% parents said that they didn't take their children to NRC because they had to take care of their other belongings. More than 50 % were not motivated by any of the health workers for the same. Those parents who had not admitted their children to NRC among them more than 50 % father ad more than 70 % mothers were having less than matriculation qualification.

(2) parents of 30 children who didn't completed their full course of treatment was interviewed ad it was found that more than 60 % parents didn't completed full treatment due to responsibilities of their belongings, who were at home. Around 70% parents were not having knowledge of worse effect of malnutrition. More than half parents were not motivated by any of the health workers to complete full course of treatment.

(3) checklists was filled by asking charge of the nutrition rehabilitation centre ad it was found that about all the things fulfil the parameters of the guidelines except appointment of medical social worker and also the medical officer of the NRC has not gone through the training of facility based care of severe acute malnutrition.

Conclusions :- (1) There were several reasons affecting the decisions of parents for not admitting to NRC for incomplete treatment of their children at NRC. Some of the reasons served were lack of awareness of the services, overburden of responsibilities towards their belongings, ineffective counselling by the health workers and the educational background of the parents.

(2) The study conducted also revealed the lack of human resource ad skill development.

Suggestions:-

(1) There should be proper counselling by the health workers motivating the parents for the regular and complete checkups of their wards at NRC and they should be made aware of the services to lower down tier financial burden to enhance the decision making power of individual.

(2) There should be proper allocation of human resource as per the guidelines ad capacity building programs should be organised on a regular basis to meet the requirement.

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