

PRACTICUM REPORT
“CONCURRENT MONITORING, VALIDATION AND EVALUATION
POSHAN2.0: RAJASTHAN” IIHMR, JAIPUR,

For the partial fulfilment of course requirements of the

MASTER OF PUBLIC HEALTH

Offered by

Johns Hopkins Bloomberg School of Public Health & The IIHMR University

By

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Cohort-5
2017-19

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April 20, 2019

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Ms. N. Meena Kumari** IIHMR-U/07/2017-2019/0028 is a student of Master of Public Health Program offered by IIHMR University, Jaipur in cooperation with the Johns Hopkins Bloomberg School of Public Health, Baltimore has undergone practicum training at IIHMR University from **22/10/2018 to 22/03/2019**.

The Candidate has successfully carried out the study designated to her during practicum training and her approach to the study has been sincere, scientific and analytical.

The practicum training is in fulfillment of the course requirements.
I wish her success in all his future endeavors.


Dr. Mohan Bairwa
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Associate Professor, IIHMR University

CERTIFICATE BY SCHOLAR

This is to certify that the Practicum Project titled “Concurrent Monitoring, Validation and Evaluation POSHAN2.0 : Rajasthan” IIHMR , Jaipur,” submitted by me Mrs. N. Meena Kumari with Enrolment Number IIHMR-U/07/2017-2019/0028 carried out during the period October-22nd 2018 to March – 22nd 2019 under the supervision of Dr Mohan La1 Bairwa for award of Master of Public Health in Johns Hopkins Bloomberg School of Public Health collaboration with The IIHMR University.

The work and experience mentioned in this report is completely prepared by me and it has not formed the basis for the award of any degree, diploma associate ship, fellowship, title. in this or any other Institute or other similar institution of higher learning.



Mrs. N. Meena Kumari.

MPH-5 cohort (2017-19)

Johns Hopkins Bloomberg School of Public Health
The IIHMR University. Jaipur, (R)

CERTIFICATE FROM ORGANISATION



04/04/2019

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Ms. N. Meena Kumari** IIHMR-U/07/2017-2019/0028, Hopkins ID- 672782 student of Master of Public Health Program offered by The IIHMR University, Jaipur in cooperation with Johns Hopkins Bloomberg School of Public Health, Baltimore, USA has undergone Practicum Training under “Concurrent Monitoring, Validation and Evaluation POSHAN2.0 : Rajasthan” IIHMR , Jaipur, from **22/10/2018 to 22/03/2019**.

In this research project, we focused on evaluation of the effectiveness of Community-based Management of Acute Malnutrition (CMAM) through concurrent monitoring and validation and carry out an impact evaluation of phase 2 of POSHAN project. Ms. Meena has successfully carried out the study designated to her during practicum training and her approach to the study has been sincere, scientific and analytical.

Lastly, through her integrity and resilience during the project, she has proven herself as a valuable researcher and public health leader. A person like Ms. Meena Kumari would be a great asset for any institution she will join in future.

I wish her a prosperous academic and professional journey.

Dr. D.K Mangal

Dr. D.K Mangal
Professor & Dean-Research (Corporate)



Table of Contents

1. Introduction.....	6
1.1 About the IIHMR University	6
1.2 Nutritional status of the India.....	8
1.3 Nutritional status of the Rajasthan	9
1.4 Nutrition Status of Under-Five Children in Rajasthan.....	9
1.5 Importance of POSHAN -2 project in public health.	11
1.6 Salient Features of POSHAN II	11
1.7 Learning objectives of the practicum.....	12
1.8 Program planning / Policy development skills.....	13
1.9 Public Health skills	13
1.10 Analytical skills	14
Report on “Concurrent Monitoring, Validation and Evaluation POSHAN2.0: Rajasthan” IIHMR.....	15
2. Introduction.....	15
3. Objective	15
4. Methodology	16
5. Results and Discussion	16
5.1. Key Observation findings at MTC Centre	17
5.2. Key Observation findings on POSHAN Divas	18
5.3. Key observation findings during home visit in Proximity village of Poshan centre.....	21
5.4. Key observation findings in Farthest village of POSHAN centre.	24
5.5. Key observation findings in Non POSHAN implementation village	25
6. Key recommendations for process monitoring and validation under POSHAN-II.....	27
7. Key learnings from Practicum	29
8. Challenges faced during Practicum.....	30
9. Conclusion	30
10. References.....	31

1. Introduction

1.1 About the IIHMR University

The origin of the IIHMR University has its roots in pioneering and significant contribution of Institute of Health Management Research, Jaipur in the last three decades (since 1984) to policy and program management research, and capacity development in health and hospital management in India and South-East Asia, which has enabled it to attain the status of a university.

The IIHMR University is a leading knowledge institution of the country engaged in teaching, research and training in the domains of Public Health, Health and Hospital Administration, Pharmaceutical Management and Rural Development. Over the past thirty years IIHMR has carved a niche for itself among management institutions, both in India and abroad. IIHMR has already conducted more than 600 research projects and studies on the health, social and developmental systems and policies in India and wider South-East Asian Region. Now stepping in the fourth decade, we strive to generate knowledge to help develop effective health, social and public systems and socially relevant health technologies.

The genesis of IIHMR owes to the pressing need at that time to improve the health systems in India. For a country as large and complex as India, the bottlenecks impeding effective healthcare delivery were aplenty. Although the health systems were characterized by severe deficiencies in physical and human resources which continues to be a major issue, the bigger problem lay in the poor management of healthcare systems. The founding idea of

IIHMR was thus that better management of health systems could significantly affect the operational efficiency of healthcare delivery in India. It is with this vision that the institute was set up.

Over the last three decades, IIHMR has witnessed enormous growth. It first started as a research institute based in the city of Jaipur in north western Indian state of Rajasthan. Assessing the need to build the capacity of health care providers involved at various layers of health systems chain and develop a cadre of health care managers to improve the health systems in India and beyond, it later ventured into training and postgraduate teaching. Indeed, IIHMR has provided a template for health management education in India. The institute takes pride in pioneering the discipline of health management and establishing a full-time MBA program in health and hospital management way back in 1996.

These contributions enabled the institute to attain the status of a University in 2013. IIHMR Jaipur is now a full-fledged university spread across a lush green campus of 15 acre that boasts of research and teaching infrastructure comparable to the best business schools in India. It now runs four full-time MBA programs that include: i) MBA in Health/Hospital Management, ii) MBA in Pharmaceutical Management, iii) MBA in Rural Management, and iv) Master of Public Health. The MPH program is offered jointly with Johns Hopkins University, Baltimore, the university with which IIHMR shares a long and active partnership. Additionally, IIHMR University also offers a full-fledged multidisciplinary Ph.D. program in wide spectrum of health, hospital and pharmaceutical systems and social and behavioural sciences.

IIHMR has also expanded geographically. In addition to its main Jaipur campus, IIHMR has established three other campuses in Bangalore (southern India), Delhi (northern India) and Kolkata (eastern India). The Bangalore and Delhi campuses became operational in 2004 and 2008, respectively, while the Kolkata one is in the final stages of being set up. The selection of these sites in four vastly different regions of the country is strategic. Through its presence across the different regions, IIHMR wishes to realize its goal of improving the geography of health, social and public systems management in India in its entirety.

The prestigious IIHMR University, Jaipur a pioneer health management research and education organization for the health sector in India and continues to carry the legacy of IIHMR, The University strives for excellence in research and education with a mission “to improve the standards of health of the people through high quality management research, education and capacity development of the health professionals at the national and international level”.

1.2 Nutritional status of the India

India is a developing country and have immense potential to lead the world such as science, technological advancements, infrastructure development, attracting business environment, increasing foreign relations, trade collaborations ¹. But there is a disparity in rural – urban health, differentiating health indices with in the states, rising level of NCDs, disproportionate nutritional level, and varying social determinates that impacts health outcomes². These disparity in health economics can act as a serious deterrent to the progress of the nation. Among these nutrition related conditions such as under- nutrition – obesity and malnutrition are said to be a major cause of concern that stunts India’s economic growth³.

Many epidemiological studies evidenced that primary causes of child mortality and main killers of under 5 children were Pneumonia, diarrhoea, low birth weight, Birth asphyxia⁴. Malnutrition is the underlying causes of such deaths. Malnutrition among children are not

equally distributed throughout the world, they were scattered in sub-Saharan region, south asia and other developing countries too⁵. India is one such country in the world with the highest recorded numbers of undernourished and malnourished people⁶.

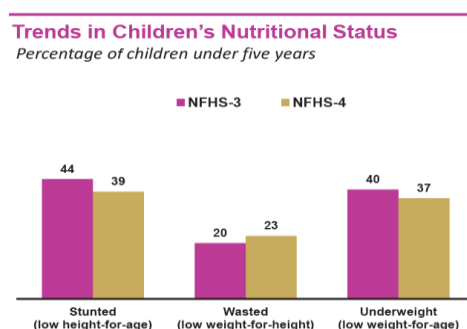
1.3 Nutritional status of the Rajasthan

The state of Rajasthan lies in the north-western part of India. The population of the state in 2011 was 6.86 crores (Census 2011) and an estimated number in 2017 was 7.71 crores. Among these numbers, 15.5 per cent contributed by under five years of age children in 2011. The percentage of rural population in the state is 75.1 % and urban population is 24.9%. Status of nutritional indicators of this age group children in Rajasthan tells that 39.1 per cent are stunted, 23 per cent are wasted, and 36.7 per cent are underweight in 2015-16 (NFHS 4). The nutritional status of children below five years has improved in the last ten years due to various focused efforts by the State Government and other supporting organizations in Rajasthan. However, the status remains poor compared to the national average and other states in the country. The table below summarises the key nutrition indicators of the state.

1.4 Nutrition Status of Under-Five Children in Rajasthan

Indicator	Status
Children under 5 years who are stunted (NFHS 4)	39.1%
Children under 5 years who are wasted (NFHS 4)	23.0%
Children under 5 years who are severely wasted (NFHS 4)	8.6%
Children under 5 years who are underweight (NFHS 4)	36.7%
Children aged 6-35 months who received Supplementary food from Anganwadi Centers (RSOC 2013-14)	33.7 %
Children aged 6-35 months who received supplementary nutrition for 21 or more days from Anganwadi Centers in the month prior to the survey (RSOC2013-14)	26.5%

The above table shows that about one out of three children below the age of five years in the state of Rajasthan is stunted or underweight. **The proportion of children with severe acute malnutrition in the state is 8.7% (NFHS 4 Rajasthan).** It is also evident from the above table that only one in four children in the age group of 6-35 months receives supplementary nutrition from Anganwadi regularly.



The state of Rajasthan lies in the north-western part of India. The population of the state in 2011 was 6.86 crores (Census 2011) and an estimated number in 2017 was 7.71 crores⁷. Among these numbers, 15.5 per cent contributed by under five years of age children in 2011. Status of nutritional indicators of this age group children in Rajasthan tells that 39.1 per cent are stunted, 23 per cent are wasted, and 36.7 per cent are underweight in 2015-16 (NFHS 4)⁸. The nutritional status of children below five years has improved in the last ten years due to various focused efforts by the State Government and other supporting organizations in Rajasthan⁹. However, the status remains poor compared to the national average and other states in the country⁹. The indicators shown that about one out of three children below the age of five years in the state of Rajasthan is stunted or underweight¹⁰. The proportion of children with severe acute malnutrition in the state is 8.7% (NFHS 4 Rajasthan). It is also evident from the above table that only one in four children in the age group of 6-35 months receives supplementary nutrition from Anganwadi regularly¹¹.

1.5 Importance of POSHAN -2 project in public health.

POSHAN stands for **Proactive Optimum Care of Children through Social Household Approach for Nutrition**. The basic idea behind POSHAN was that the services of Malnutrition Treatment Center (MTC) to be available at the doorstep of the child suffering from undernutrition.

1.6 Salient Features of POSHAN II

POSHAN – II is the continuation of POSHAN -I but adopted a more wholesome approach for implementation: Integrated Management of Acute Malnutrition (IMAM) which aligns with the National Nutrition Strategy. This approach targets under-nutrition across the life cycle with a special focus on the first few years of life.

- POSHAN Phase 2 will focus on preventive measures at every level, from conception up to 5 years, along with treatment of SAM (Severely Acute Malnutrition):
 - Improved supplementary nutritional support during pregnancy and lactation.
 - Improved antenatal care - including health and nutrition counselling and family support for extra diet and rest to ensure adequate weight gain), IFA supplementation, consumption of adequately iodized salt, and screening /management of severe anaemia
 - Early initiation (within 1 hour of birth) and exclusive breastfeeding for the first six months of life
 - Timely and appropriate complementary feeding after six months, along with continued breastfeeding for two years or beyond
 - Improved newborn care; timely and complete immunization of infants against vaccine-preventable diseases.

- Micronutrient supplementation and annual deworming.
- Institutional deliveries, lactation management, improved post-natal and newborn care.
- Regular tracking and promotion of child growth and counselling of mothers/families using the Mother-Child Protection Card (MAMTA card)
- Active engagement of ICDS at all levels with NHM team, to ensure early detection, prevention and sustainability; Improved mapping of the Anganwadi Centers against Health Sub Centers.
- Desired change oriented interpersonal communication at multiple platforms for behaviour change of the community at large.

Monitoring and Evaluation Project Rationale

The project intends to:

- a) Evaluate the effectiveness of Community-based Management of Acute Malnutrition (CMAM) through concurrent monitoring and validation,
- b) Carry out an impact evaluation of phase 2 of POSHAN project and,
- c) Understand the socio-cultural issues which influence the planned program output.

1.7 Learning objectives of the practicum

The main objective of this practicum was to imply the knowledge of key competencies which were achieved during the course work of MPH.

In this practicum, I have identified following skills and convert them in to competencies.

1. Policy Development/Program Planning Skills
2. Public Health Sciences Skills.
3. Analytical/Assessment Skills

I was enrolled as practicum trainee in POSHAN – 2.0 project under IIHMR University, Jaipur under collaboration of National Health Mission (NHM), Integrated Child Development

Services (ICDS), Tata Trusts, Action Against Hunger (ACF) and Global Alliance for Improved Nutrition (GAIN) to codify the collaborative arrangements. Under POSHAN-II screening and identification of SAM children based on weight for height below 3SD of the WHO standards and on a MUAC cut-off of 11.5 cm. Those identified SAM children were examined for Pitting oedema, infection, poor appetite and they were referred to malnutrition treatment centres. Each enrolled child was provided with medical nutrition therapy kit comprising deworming Tab, antibiotics, EDNS for 8 to 10 weeks. All children were weekly reviewed for their nutritional status.

1.8 Program planning / Policy development skills

I have been given the responsibility of Monitoring and evaluation of POSHAN -II for PISANGAN block, Ajmer district. The process monitoring and evaluation included screening, identification and then sharing the lists of all MAM children with DD ICDS of the respective district, sending all identified children with SAM having medical complications to the MTC and then tracking those children to see the changes. The additional household visit has organized to review the status of the children back to MTC and finally good practices were documented.

The monitoring and evaluation also reviewed the linkages of POSHAN II with the ICDS activities at district, block and village level and also specially to the AWW on community mobilization, home visits, mothers' meetings, demonstration of home-based feeding and care, regular growth monitoring and referral of the sick children etc.

1.9 Public Health skills

I have been given responsibility for PISANGAN block, Ajmer district. The plan of a visit as follows to enhance my public health skills

visit Day-0 (Monday) - Visit the MTCs to observe/record the activities and prepare a weekly report of no of SAM children admitted, discharged, failed to recover, and their nutritional status.

Day-1(Tuesday) - Visit the POSHAN Centre and observe the POSHAN session, interact with the ANM & family members, observe the referral process, carry out anthropometric measurements i.e. Height/length, weight & Mid Upper Arm Circumference (MUAC) of approximately 1/3rd of children available at the session.

Day-2(Wednesday) - Visit households of enrolled SAM children in an implemented village and assess utilization of EDNS by the SAM child, interviewing the mother and observe the feeding practices.

Day-3(Thursday) - Visit households of the SAM children in a remote programme village and assess utilization of the EDNS by the SAM child, interview the mother, observe the feeding practices.

Day-4 (Friday) - Visit an HSC village of a Non-Poshan block within the same district and observe activities related to management of SAM children by ANM/ASH and AWW, interview the mother, observe the feeding practices.

1.10 Analytical skills

The study analysed the data for monitoring & validation based on the information collected through the standard checklist to be used at MTC to understand the performance & process, poshan centre to observe the screening, identification, registration and referral of the SAM cases, Visit to the household of the SAM children to observe the change in practices of intake (EDNS), maintenance of cleanliness and other behaviour change at the POSHAN 2 programme village and non-programming village.

All enrolled children were followed for 8-10 weeks at the end of requisite weeks data were analysed to identify the household of the SAM children, to observe the change in practices of intake, EDNS and other behaviour change at the POSHAN 2 programme implemented village and non-program implemented village.

Report on “Concurrent Monitoring, Validation and Evaluation POSHAN2.0: Rajasthan” IIHMR.

2. Introduction

The state of Rajasthan lies in the north-western part of India. The population of the state in 2011 was 6.86 crores (Census 2011) and 15.5 per cent contributed by under five years of age children in 2011. The nutritional status of this age group children in Rajasthan was 39.1 per cent are stunted, 23 per cent are wasted, and 36.7 per cent are underweight in 2015-16 (NFHS 4)

The recovery rate of POSHAN-I was 88% total of 9,640 children with Severe Acute Malnutrition (SAM) aged between 6 - 59 months. Following the POSHAN-I success, POSHAN-II was implemented with the objective of focus on preventive measures at every level, from conception up to 5 years, along with treatment of SAM. A MoU was signed between National Health Mission (NHM), Integrated Child Development Services (ICDS), Tata Trusts, Action Against Hunger (ACF) and Global Alliance for Improved Nutrition (GAIN) to codify the collaborative arrangements.

3. Objective

A **Process Monitoring and Evaluation Unit (PMEU)** of POSHAN II project was done by IIHMR University, Jaipur, Rajasthan with the objective of conducting concurrent

monitoring & validation, evaluation and socio-cultural study of children with Severe Acute Malnutrition (SAM) under POSHAN II Project in 20 districts of Rajasthan.

4. Methodology

The monitoring, validation and evaluation of the POSHAN 2 were done on a sample basis in the programme implementation areas i.e. 52 blocks in 20 Districts of Rajasthan. The programme districts in Rajasthan was divided into 5 geographical zones i.e. east, west, north, south and central to have the geographical, cultural, social and economic variations in coverage and performance. The monitoring, validation and evaluation team from IIHMR selected one program district in each zone with one programme block. In this regard IIHMR with consultation with the GAIN selected 5 districts randomly as follows: Ajmer, Baran, Rajsamand, Jaisalmer and Udaipur and cover 8 POSHAN Centre in each block in the 1st phase of the programme.

In each POSHAN Centre, two villages were identified for validation of the activities performed under the project. One village was proximity, and another was the farthest village from the POSHAN health sub-centre. The house visit was done in both villages to observe the feeding practices and other practices relevant to the feeding of SAM children.

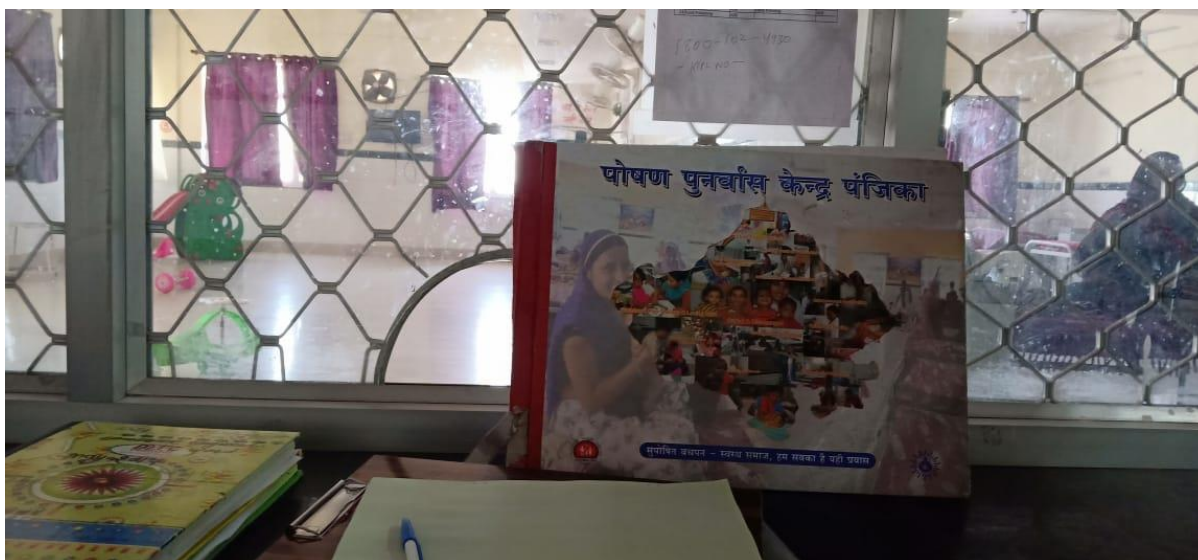
5. Results and Discussion

Ajmer district was divided in to 8 Blocks and by simple random sampling IIHMR selected Pisangan block for Process monitoring and evaluation. In Pisangan Block 8 poshan centres were chosen like Jetnana, Brichiyawas-1 and 2, Bhanwata, Govindgarh, Pagara, Gola kesarpura Block for observation.

5.1. Key Observation findings at MTC Centre

There was an MTC centre at Block PHC Pisangan, but it was not functioning properly due to inadequate facilities for special treatment, therefore, children were referred to Government Amrit Kaur Hospital, Beawar. In Govt Hospital at Beawar 7, SAM children were admitted for treatment. Among them, 2 children were gained appropriate weight for age and they were discharged. finally, 1 child was failed to recover, and one more child was under the continuation of treatment. 3 children were defaulters for taking treatment regularly.





5.2. Key Observation findings on POSHAN Divas

POSHAN Day was conducted on every Tuesday. Among all 8 Poshan centres in Bhawata PHC all enrolled 10 SAM children were reported on Poshan Divas. At Jethana PHC, 13 SAM children were enrolled but only 10 children reported, and 3 children did not report, Brichiyawas I & II PHC only 6 SAM children were enrolled which is less compared to all centres, but 3 children reported, and 3 children did not report. In Govindgarh PHC 18 SAM children were enrolled., only 15 children were reported, and 3 children didn't report on POSHAN Divas. Poshan centre at Pagara Subcentre was inaccessible by the families of SAM children due to improper roads and Transport facilities, therefore the reporting rate was only 13 among 17 enrolled SAM children. Same was observed in Poshan centre in Gola to 12 SAM children were enrolled. During POSHAN Divas only 07 children were reported. 5 children didn't report.

All villages were screened for SAM children except Bhawata and Pagara Poshan centre. In Villages assigned under Bhawata subcentre, in Majethia village screening of SAM children was not done due to non-availability of ANM, because ANM was transferred to 4 months before further Anganwadi worker and ASHA also not assigned because the population of Majethia village was only 600. Same was observed Ramnagar village in pagara poshan

centre, it covers only 750 population. Anganwadi is not functioning due to Asha, AWW Worker also not assigned therefore Screening of SAM children were not done.

All 8 POSHAN centres ANM checked weight, Height, MUAC and oedema for all reported SAM children following Standard procedures. Sometimes ANM were less skilful in identifying olecranon and acromion process, obviously ANM Swapna in Pagara poshan centre checking MUAC by holding tape upside down. Averagely 300 gm of weight was increased in all reported.

EDNS was checked and distributed to caregivers for the following week. Most of the children were taking EDNS less than the requirement per day very fewer children only taking the EDNS in the appropriate quantity and it was observed in changes in their weight gain too. children. During the distribution of EDNS, one mother reported that there is a difference in appearance, taste and consistency of EDNS compared to earlier EDNS pockets.

Most mothers were Going for work for economic assistance to the family. So, the SAM children were taken care by caretakers like Grandmother, sister, or father. In kesarpura When mothers or family members are not able to collect EDNS ASHA are bringing the child from their assigned population and collecting the EDNS too. There was a Knowledge dilution, Health education given to caretakers has not reached the mothers properly., POSHAN DIVAS was not attended by Direct caretakers, like mother or Grandmother, so the Health education has not reached effectively to direct caretaker of SAM children.

Similarly, all the POSHAN centres' caregiver of SAM children were receiving their honorarium except Gola, Pagara, and Govindgarh POSHAN Centre. In Gola and Pagara POSHAN Centre even though money was withdrawn, the medical officer has not distributed the Honorarium to any of the mothers and caretakers, but in Govindgarh in charge medical

officer was on leave so they could not able to withdraw money from the bank for Distribution of honorarium.

If any village the total population was less than 1000 No Anganwadi worker and ASHA was assigned e,g Majethiya, Ramnagar village. There is also a shortage of supply of POSHAN bag, Container and clip too so most of the mothers were not received air tight container and not kept EDNS properly after consumption. Daily Home visit record of SAM children for ASHA also not supplied adequately.

Major reasons for not attending POSHAN Divas was parents were gone to work for economic gain. Most of the mothers were held with House Hold work so they can't able to come to attend POSHAN Divas regularly. Caregivers also were not getting time to attend POSHAN Divas and they were engaged in other Household works like food preparation and taking care of siblings. The other contributing factors were caregiver non-belief, preference to seek care from a traditional healer, migration to another village, transport problems, improper Roads to reach POSHAN centre further mothers had believed that consumption of EDNS causing vomiting and Diarrhoea in their children.



5.3. Key observation findings during home visit in Proximity village of Poshan centre.

Most of the house visit was done either along with ASHA/AWW or alone. Children consumed EDNS daily less than the requirement per day. Majority of the homes EDNS were clipped and properly placed in the container. In Pagara poshan centre the Clip was not distributed to mothers. Mothers and caregiver were aware of hand hygienic practices while feeding EDNS to the SAM child. ASHAs were visiting the house regularly and given health education on EDNS and immunisation. In some villages, ASHAs has not visited the houses regularly. Mother had knowledge of locally available supplementary foods like Dalia, Kheer and dhal kichadi etc. Along with EDNS, children were taking additional foods like Rice kitchidi, Dal kitchidi, Sevai, Dhood Kher, Sabudhan kheer and Daliya, Urad Laddu during

winter time. The Urad dhal Laddu is made up of Badam, cashews, kismis, Dry coconut and Jaggery to feed child during the winter season.

In some houses, Caretakers does not have adequate time to take care of both small children. In some villages when the caretakers could not able to give care to SAM children ASHA were bringing the SAM children to Anganwadi and feeding the EDNS during lunch time





5.4. Key observation findings in Farthest village of POSHAN centre.

Most of the House visit was done either along with ASHA/AWW or alone. Children consumed EDNS daily less than the requirement per day. Majority of the homes EDNS were clipped and properly placed in the container. ASHAs were visited house daily and given health education on EDNS. In some villages, ASHAs have not visited the houses regularly. In some houses, Caretakers does not have adequate time to take care of both small children, so the children were not taken bath and looked unhygienic. ASHA was not received their daily Home visit



5.5. Key observation findings in Non POSHAN implementation village

As an inspection team from Nidhi Ayog and Gain agreed to take village where no SAM children were screened as Non-Poshan implementation village, therefore Arjunpura village was taken as Non-poshan implementation village to observe the activities of VHND at Anganwadi centres. Ms Asha Sandhya- ANM, Ms Santu-A.W. W and Lalitha Vaishnav - ASHA has regularly conducting VHND at AWC. ANM regularly checked the height, Weight, and MUAC for all children but not followed the recommended procedure while assessment, further they followed the recommended procedure for Oedema by both ANM and AWW. ANM has given counselling on Hygienic practices, immunisation, and Diarrhoea management to mothers but failed to explain preparatory methods for supplementary foods given for children. ANM distributing Albendazole regularly and explained mother about the pattern of tablet consumption of albendazole, but amoxicillin tablets were not distributed. All children were looked neat and disciplined.

Similarly, at Gola Poshan Centre, In Alipura village 2 Anganwadi was functioning. Anganwadi -I and II. Anganwadi -I contain 3 SAM children and Anganwadi -II has no SAM children, therefore, Anganwadi -II has taken as non poshan implementation village to observe Anganwadi activities. Ms Pista Chouhan (ANM), Munni Godha (ASHA) Ms Mumtaz Banu (AWW) was conducting VHND. Total 43 children were enrolled. Monthly their weight and Height were checked and recorded in Height and weight register. Every 6 months children were given Albendazole tablets for deworming. Pregnant mothers and Lactating mothers were receiving nutritive supplementary food – 750 and under 5 children receiving supplementary food – 550 regularly.

Same as above Brichiyawas Poshan centre Bithur village was taken as Non-poshan implemented village. Ms Indu- ANM, Ms Shamim Javed A.W. W and Lucy -ASHA has regularly conducting VHND at AWC and total 20 children were enrolled. ANM regularly

checked the height, Weight, and MUAC for all children. but not followed the recommended procedure while assessing for Oedema by both ANM and AWW. ANM has given counselling on Hygienic practices, immunisation, and Diarrhoea management to mothers. ANM distributing Albendazole regularly and explained mother about the pattern of tablet consumption of albendazole, but amoxicillin tablets were not distributed. All children were looked neat and disciplined.

In Govindgarh Poshan centre at samrathpura village, Mini Anganwadi is functioning, Ms Lakshmi ANM is visiting the Anganwadi centre regularly. No woman was nominated for ASHA by sarpanch still, even it is covering Population of 1500. village sarpanch is not assigned any ASHA till now for that village even though ANM given request notice to sarpanch, therefore, No ASHA is Available. AWW, Ms Gyana Devi Rawat.is checking height, weight and MUAC for all children, distributing albendazole and maintaining the weight Registers.

Finally, poshan centres from pagara and Bhawata All the villages were covered under POSHAN – 2 projects, therefore, Non-Poshan implementation village was not able to be observed.





6. Key recommendations for process monitoring and validation under POSHAN-II

- Refreshment Training was needed to all staffs for checking HT, WT, MUAC to enhance skill and to promote consistency in findings.
- The supply of EDNS should be uniform and consistent because mothers reported that there is a difference in appearance, taste and consistency of EDNS compared to earlier EDNS pockets.
- There is shortage of supply of bag, Container, clip at certain POSHAN Centre. The total number of Bags and clips were supplied less than Required number, so most of the mothers were not received and not kept EDNS properly after each consumption by the child. Daily Home visit record for SAM children also not given to ASHA as per requirement. Therefore, monthly stock of supplies must be checked regularly by competent authorities to ensure uninterrupted supplies of accessories.

- Selection of Subcenter for POSHAN Centre should be based on accessibility and it should be easily accessible by all mothers and care givers. Further there should be proper Roads and transport facilities to reach POSHAN centres without difficulty which will enhance 100 % of reporting by SAM children.
- There should be a proper distribution and timely distribution of Honorarium to SAM children mothers and caregivers which compensate their economic loss of attending POSHAN divas.
- POSHAN centres and Anganwadi centres should work jointly in taking care of SAM children because most of the care takers were find difficulty in feeding the EDNS when 2 siblings were for care concurrently. Therefore, SAM children above 2 years can take their EDNS at their respective Anganwadi centres.
- ANM was Not followed the POSHAN day theme, not educating mother about Vit A supplementation and providing Vit A and iron-rich foods to their child. Therefore, periodic review meeting should be arranged.
- The Health education given by ANM on POSHAN Divas has not reached the mothers properly, therefore health education should be reinforced by ASHAs during home visit too.
- POSHAN DIVAS was not attended by Direct care takers, like mother or Grandmother, so the Health education has not reaching effectively to direct care taker of SAM children.

- ASHA workers should be encouraged to bring the SAM child to collect EDNS on POSHAN Divas from their assigned population when mothers or family members are not able to collect EDNS due to household work.
- Feeding of SAM children by low cost, highly nutritious and locally available seasonal supplementary foods like Dalia, Kheer and dhal kichadi should be encouraged among mothers and care takers.
- ASHA workers must visit the SAM children regularly at their home to ensure adequate consumption of EDNS packet per day.
- All villages should be screened for SAM children therefore availability of ANM, ASHA and AWW must be ensured.
- No SAM children were identified from the villages where VHND was conducted properly and periodic checking of height, Weight, and MUAC for all children was done regularly. Therefore, activities of Anganwadi must be monitored regularly and periodic review meeting must be arranged to know the status of the enrolled children.

7. Key learnings from Practicum

I adored my time working with my preceptor Dr D. K. Mangal, Professor, Mentor. Dr. Mohan Bairwa, Associate professor, Mr Laxman, Associate professor, Ms Shobana, research

officer at IIHMR during my practicum. I learned a lot about tour plan, field visit, decision-making skills, professionalism what to do in certain field related situations. I have confidence in going through this practicum experience drew me to become more confident in public health skills, analytical skills and further enabled me to suggest actions for better implementation of POSHAN.2.0 project as a policy-making skill too. All above-mentioned competencies will also help in the future as I am well prepared for what will be expected in a work atmosphere as an epidemiologist. I sincerely appreciate that this practicum experience influenced my career goals, and it could be directly benefiting the community and my work would give me a determination and enhance my life.

8. Challenges faced during Practicum

There were common difficulties come upon the internship. Some of them I faced were language, communication barriers and cultural shock as I am from the south side of the country and moved to Northern states for the study. Internship challenges do knockout hard because it was the first time that I was going to field after 20 years of teaching at the college level. But I was lucky enough to get smooth run throughout my practicum by the preceptor, supervisors, research officers and block monitors ease to face my challenges and overcome the issues by their patience guidance.

9. Conclusion

The practicum is a vital and required component of the Master of Public Health program, that provides students with hands-on experience in public health practice. I developed a special interest in epidemiology, wants to develop more in public health, policy making and analytical competencies in view to support my profession in future to solve the public health issues.

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