Summer Training at
Child in Need Institute, Kolkata
(April 3 to June 2, 2017)

Multi sectoral Initiatives for strengthening Convergent Action in Nutrition, Education and Child Protection Outcomes in Malda, West Bengal

By
Debasish Ghosh

Under the guidance of
Dr. Sazzad Parwez

MBA Hospital & Health Management
2016-2018

Institute of Health Management Research
The IIHMR University, Jaipur
2017

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

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that **Debasish Ghosh** has undergone summer training in **Child In Need Institute (CINI), Kolkata** from 3rd April to 2nd June 2017.

The candidate himself completed the project assigned to him during summer training. His approach to the project was sincere and proactive. This summer training is in partial fulfillment of the course requirement recommended for the award of MBA in Hospital and Health Management.

I wish him success in all his future endeavors.

06/07/17

Col. (Dr.) Ashok Kaushik
Dean (Academic & Student Affair)
The IIHMR University, Jaipur

Dr. Sazzad Parwez
Assistant Professor
The IIHMR University, Jaipur

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur- 302029, Rajasthan, India.
Ph.: 0141- 3924700, 2791431- 32, Fax: 0141 3924738, E-mail: iihmr@iihmr.edu.in, Web.: www.iihmr.edu.in

Ref: Internship / CINI /35/ 2017

Date: 15.06.17

help the mother
help the child ...

Internship Completion Certificate

Certified that Mr. Debasish Ghosh, pursuing Masters of Business Administration in Hospital and Health Management from IIHMR University, Jaipur was placed at Child in Need Institute (CINI) during 3rd April to 2nd June'17 for the purpose of academic internship. He was placed in Malda field under Multi Sectoral Intervention Project of CINI.

During the course of internship, he has met the necessary requirement and worked closely with the programme implementation team. He has been found to be sincere and dedicated to the responsibilities bestowed on him.

We wish to see him well stationed in life with bright academic career.

Mitun Bose.

Ms. Mitun Bose, Assistant Director, Training

CINI Training Unit

Child in Need Institute, Vill. & P.O. Amgachia, via Joka, South 24 Parganas , Pin - 700 104, West Bengal, India
Tele-Fax : +91 33 2497 8240 / 2453 6359; E-mail : cinichetana@cinindia.org; Web. : www.cini-india.org

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Acknowledgement

Initially I want to express my gratitude to the people who guided and helped me during my internship from **CINI INDIA.**

At the onset of my report, I would like to acknowledge my sincere thanks to our institute, Institute of Health Management and Research, Jaipur for providing me the platform to gain knowledge and skills in different aspects of health management.

My Special Thanks to my mentor **Prof. Dr. Sazzad Parwez** IIHMR University, for providing me a support in completing my project successfully as well as giving insight in to my operational issues which came across during the project.

I would like to express my heartfelt gratitude to **Ms. Suparna Roy**, Project Manager, Child in Need Institute, Malda and my Project Mentor **Mr. Bivas Mukherjee**, Monitoring Officer, CINI for those timely course correction and friendly guidance throughout the course of my project study.

I express my gratitude to Field coordinator **Mr. Snehadri Kr Jana**, CINI Malda and all the field facilitators for giving me micro level detail about the Services in all the blocks of Malda District of West Bengal.

At the end I would also like to thank my teachers, without whom this project would have been a distant reality.

Regards,

Debasish Ghosh

HM-21th batch

The IIHMR University

Timeline of Internship Project:

SL. NO	Task Assignment	Timeline	Duration
1.	Orientation and Literature review	3rd April' 17 to 7th April' 17	1 week
2.	Orientation with various checklists. Introduction with HMIS software.	10th April'17 to 14th April'17	1 week
3.	Development of study tool and their input system.	17th April'17 to 21th April'17	1 week
4.	Field study with CINI facilitators to explore their monthly working process and data collection	24th April'17 to 5th May'17	2weeks
5.	Supporting in Data Entry and analysis for the mother project. Supporting in various trainings and meetings.	8th May`17 to 19th May' 17	2 week
6.	Data entry and data analysis	22nd May'17 to 26th May'17	1 week
7.	Finalization of Data and presentations	29th may'17 to 2th June'17	1 weeks
8.	Presentation	12th June'17	1 day

Acronyms:

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BFC	Beneficiary Feedback Mechanism
BLCPC	Block Level Child Protection Committee
CFC	Child Friendly Community
CHC	Community Health Center
CINI	Child In Need Institute
CSR	Child Sex Ratio
ICDS	Integrated Child Development Services
IEC	Information Education Communication
IFA	Iron Folic Acid
JSY	Janani Surakshya Yojana
LBW	Low Birth Weight
MCP	Mother and Child Protection
MIS	Management Information System
MMCH	Malda Medical College & Hospital
MNREGA	Mahatma Gandhi National Rural Employee guarantee Act
NCCS	Nutritional Care and Counseling Session
NGO	Non-Government Organization
NRC	Nutrition Rehabilitation Centre
NREGS	National Rural Employee Guarantee Scheme.
PHC	Primary Health Center
PNC	Post Natal Care
SNA	State Nodal Agency
SC	Sub Center
SHG	Self Help Group
VLCPC	Village Level Child Protection Committee
UN	United Nation

Introduction:

CINI, known internationally as **Child in Need Institute**, is an international humanitarian organization aimed at promoting "sustainable development in health, nutrition and education of child, adolescent and woman in need" internationally. Child In Need Institute is headquartered in Kolkata and operating in some of the poorest areas in India.

The organization reaches out to the communities both in rural & urban locations and seeks to break the fierce cycle of poverty, malnutrition, ill-health, illiteracy, abuse and violence, affecting particularly the children and women with the collaboration with the Indian government and other local and international NGOs. Till date CINI has reached to approx five million people living in the states of West Bengal and Jharkhand. And now with the support of both UN and AID agencies CINI is extending its operations in Asia and other Countries.

CINI has been awarded twice by the Indian Government's National Award for Child Welfare.

CINI acts as a facilitator in engaging local development actors – the community, service providers and elected representatives – in a process aimed to ensure **convergence** and thereby **strengthen good governance** with and for children and women
CINI India has around 1200 Indian professionals. CINI cooperates with various organization like Save the Children, UNICEF, CARE, European Union, the World Bank, the Indian Government & private corporations such as TATA, HCL, ORACLE, DEFID,ITC.

1.1. How CINI is different?

CINI focuses & works on the issues of EPHN (EDUCATION, PROTECTION, HEALTH, and NUTRITION) of children and mothers.

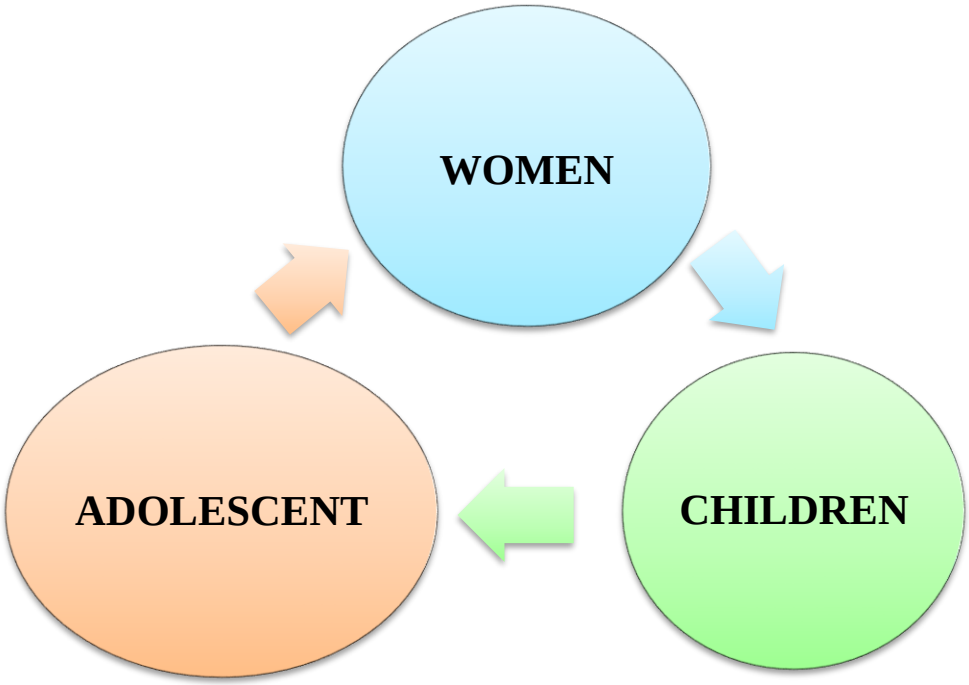
Approaches: CINI is having two different thought processes about their target interventions to prevent malnutrition during the period of intense growth and functional maturation. Identified as 3 vital stages of a healthy life, the critical period of the human lifecycle such as pregnancy, the first two years of life and adolescence it is called as 1000 day approach.

1.1.1. Life cycle approach:

Figure-1:

The beginning of pregnancy (3rd month) up to the birth

The aim is to ensure that the child a birth weight of 2500 grams; then it makes a big survival and a good start.



The adolescence, the time when children are 12-19 years

The third period focuses on girls and boys of 12 years old, as a change of attitude must take place. Here CINI looks into the matter that no child should have early pregnancy, school dropout.

The birth of the baby and the first two years

The next critical period is the first two years of the child (80% growth in the brains, building resistors, obtaining vaccinations). When a child reaches two years, the chances of survival grow very high.

1.1.2. Child friendly community approach:

In a CFC, children along with other duty bearers (local self-government, service providers and adult community groups) participate actively in achieving their rights to Education, Protection, Health and Nutrition (EPHN) – and take the responsibility that comes with such entitlements. They are equal participants in the local governance system along with adult partners, who support them in achieving their goals. A child-centred process facilitates convergent action by different sectors in achieving the well-being of children. During 2015-16, within the framework of CFC, creation of safety net was the priority strategic focus, which enabled the local level committees to take proactive role in protecting the rights of their children and giving them a safe environment.

Child Friendly Community (CFC) is a homogeneous approach whereby nutrition, health, education and protection indicators are improved in children and women, over a identified geographical area. The CFC approach addresses the achievement of Millennium Development Goals (MDGs) by 2015 in EPHN (EDUCATION, PROTECTION, HEALTH, and NUTRITION).

CINI now days are trying to make this Child friendly community a model structure nationally. Before going to a community CINI believes that every community has an inherent capability to accept the changes or positive vibes among them. Some steps CINI used to follow making the CFC are as follows.

Figure-2: Process of making Child Friendly Community.

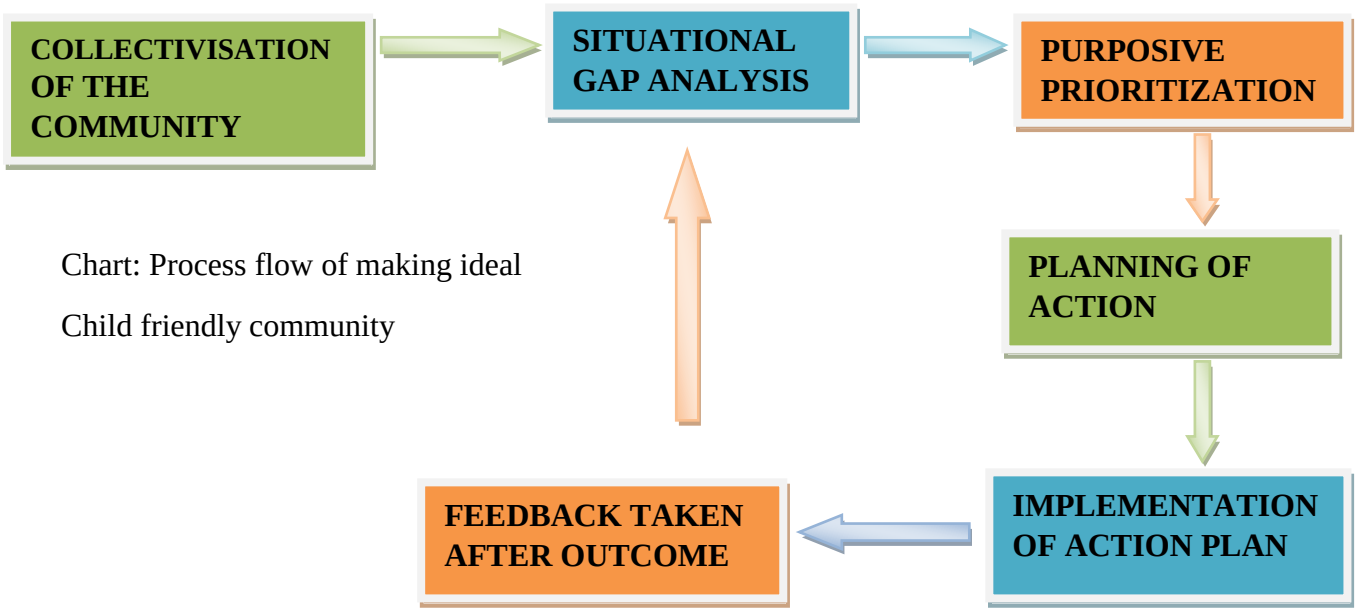


Chart: Process flow of making ideal

Child friendly community

After going to a community CINI collectivize them in a particular place and discuss the situation with them. After the discussion they analyze the situation and prioritize the problem or topic to be focused on. After selection of the topic they plan accordingly and make strategy to improvise the plan. Accordingly the plan is implemented to achieve the goal. After implementation, feedback used to be taken from the community to analyze the result. And according to the result the situation again is analyzed and the process flows afterwards.

The whole summer training is divided into two parts:

A. Field observation.

B. Project data tabulation and analysis.

A. Field observation:

Aim: To assess the level of facilitation provided by the CINI facilitators at various level of Government services and schemes.

Objective:

1. To identify the gaps required to strengthen through MIS system.

Methodology:

I. **Research design:** Descriptive study..

II. **Study area:** 6 Blocks of Malda named Habibpur, Gazole, Ratua-1, Chanchal-1, Harischandrapur-1, and Kaliachak-3.

III. **Study respondent:** CINI facilitators, AWWs, ANMs, ICDS Supervisors, CDPO, Block Secretary, Panchayat Pradhan, Member, BPHN, GP secretary.

IV. **Study tool:** Participatory observation, In depth interview with development actors and stakeholders.

Literature Review:

- *According to Pati Manoj*, 2015, the promotion of breastfeeding is a global priority though in reality most of the mothers are unable to practice exclusive breast feeding or discontinue breastfeeding because of lack of confidence in their ability to breastfeed, infant suckling problem, breast pain, perception of insufficient milk and other difficulties. Some of these problems can be solved if the women are counseled about the benefits of breastfeeding and prepared mentally for exclusive breastfeeding at the antenatal period. Counseling has an inevitable role in successful and sustained exclusive breastfeeding along with early initiation of breastfeeding.
- *According to Journal of Ayurvedic Medical College, Abbottabad 2012; 24,* early initiation of breastfeeding within 1 hour of birth and exclusive breastfeeding for the first 6 months are the key interventions to achieve millennium development goal 1 (MDG 1) and MDG 4, which deal with reduction in child malnutrition and mortality. This is having particular relevance in India where neonatal and infant mortality rates are very high thus effective implementation of these interventions is yet to be achieved. About 16% of neonatal lives could be saved if all infants were breastfed from day 1 and 22% infant lives could be saved if breastfeeding started within the 1st hour of birth.
- *According to Human Development Report*, the rate of child malnutrition in India is five times more than China. In spite of having a good economic growth over last 20 years India the malnutrition among Under-5 children is highest in the world.
- *According to Annual Health Survey`2014*, malnourished adolescent girl cannot deliver healthy babies so there used to be intergenerational cycle of malnutrition. The incidence of girls being married before reaching the age of 18 years is 56.7 percent in Malda.
- 24.9% women aged between 15-19 years who were already mothers or pregnant at the time of the *NFHS-4* survey. Malda District occupies 11th position in terms of Population and it ranks 2nd in terms of Child (0-6 year's) population in the State.
- *According to press information bureau,* Malda is predominantly a rural district, where the women have so far been muted. As the location of the district is very crucial and vulnerable, the flesh traders use Malda district as a transit zone which is connected to Bangladesh, Bihar and Jharkhand.

Table-1:- Demographic Profile & District Profile

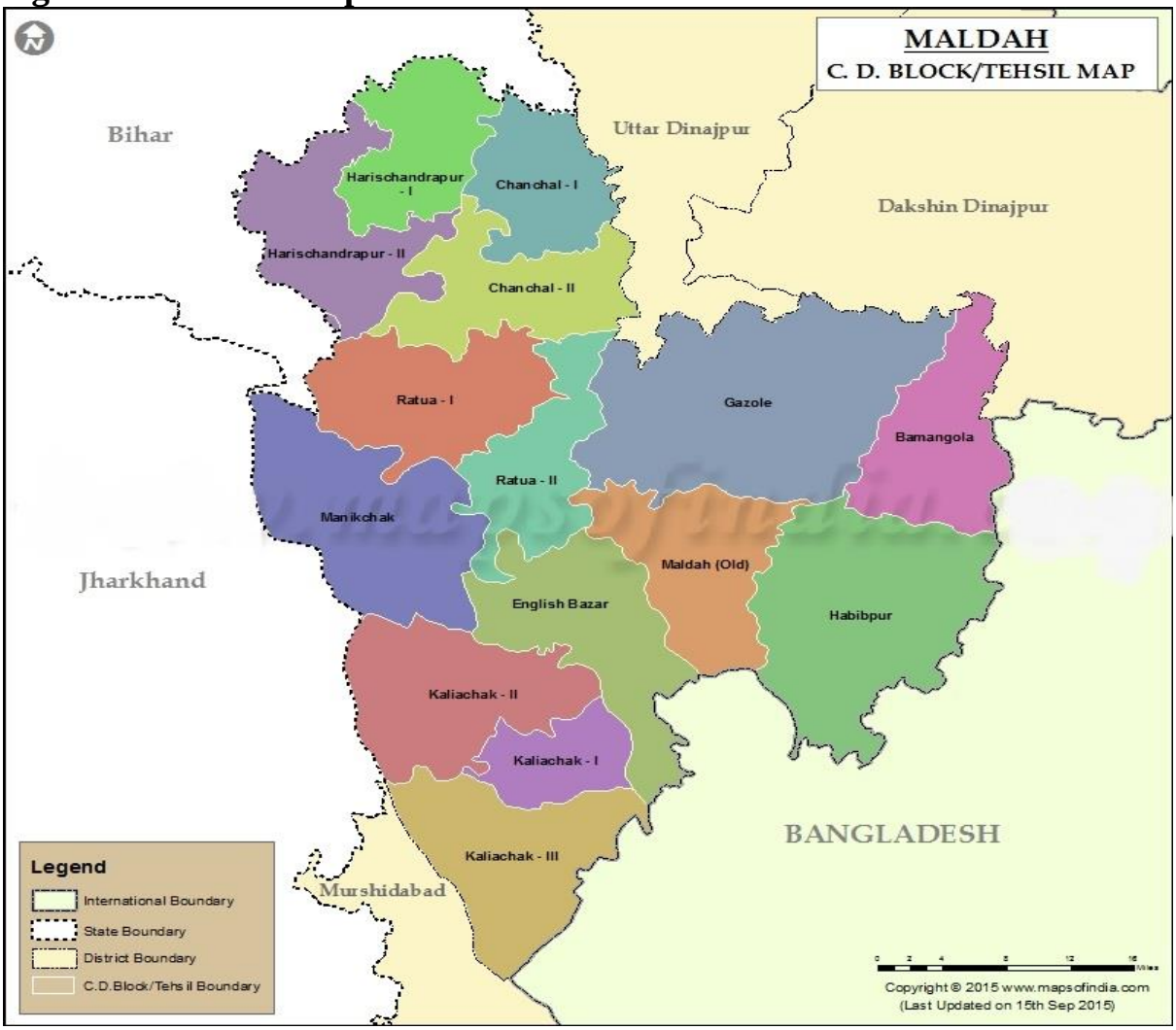
DESCRIPTION	MALDA	WEST BENGAL
Total Population	3,988,845	91276115
Male Population	2,051,541 (51.43%)	46809027
Female Population	1,937,304 (48.56%)	44467088
Child(0-6) population	609,040 (15.26%)	10581466
SC population	835,430 (20.94%)	21463270
ST population	313,984 (7.84%)	5296953
Population density (Person per km^2)	1069	1028
Decadal population growth rate(2001-2011)	21.5%	13.93%
Sex ratio	944	950
Child sex ratio	950	956
Literacy rate	62.71%	76.26%
Male literacy rate	66.24%	81.69%
Female literacy rate	56.96%	70.54%
Geographical area (in sq. Km)	3733	88752
Total worker	1,050,995	34756355
Agricultural labour	545759 (51.93%)	10188842
Cultivator labour	255,182 (24.29%)	5,116,688
Total no of block	15	341
Total no of village	1771	40203
Inhabited village	1613 (91.07%)	37468
Uninhabited village	158 (8.93%)	2735

[Source: census 2011, malda.gov.in, NFHS-4]

District profile

Malda is one of the oldest settled regions in Bengal which has spread over an area of 3733 sq.km and covers 4.2 percent of the total landmass of the state of West Bengal. According to 2011 census report Malda consists 4.37 % of the total State population. In the West the district is bounded Bihar and Jharkhand States, North Dinajpur District in the North, South Dinajpur in North-East, Murshidabad district in the South-West and shares international border with Bangladesh in the East. There are stark regional differences within the Malda district in terms of the socio-economic position of the population. Overall, the SC and ST population are the most backward both economically and educationally and it is, therefore imperative that the district level development initiatives focus on the marginalized communities. A large number of displaced populations from Bangladesh have settled in the bordering areas of Bamangola, Habibpur and Kaliachak. Over all Malda district Muslims are 51%, Hindus are 48%, others are 1%.

Figure-3:- District Map Block Wise



District statistics:

Table-2:- Health Infrastructure status

Health Centre	NRHM Guideline	Required as per population	Present as per population	Lacking
CHCs	1/120000 Population	31	16	15(48%)
PHCs	1/30000 Population	124	35	89(72%)
Sub Centers	1/5000 Population	746	511	235(32%)

All these health facilities have a total of 1259 beds for indoor treatment. The medical college & hospital sees a huge influx of patients, particularly newborn children on a daily basis, who come in from adjoining districts of the State as well as from Bihar and Jharkhand.

Table-3:- Vital Health indicators

Vital statistics	West Bengal	India
Infant mortality rate (IMR)	31	41
Neonatal mortality rate (NNMR	19	26
Perinatal mortality rate (PNMR)	18	24
Under-5 mortality rate (U-5MR)	30	45

Though the infant mortality rate (IMR) in the State stands at 31, which is less than the national average of 43, there are certain pockets in West Bengal where infant deaths are a routine affair. MMCH is located in one such pocket in one of the poorest districts of Bengal. Experts say that malnutrition among women, early marriage and absence of health facilities are the reasons for such deaths. *The Hindu.*

Table-4: Nutritional status of Under-5 children:

Nutritional Indices	Severe	Moderate
Underweight	37.2%	
Stunting (height for age)	37.2%	
Wasting (weight-for-height)	22.8	8.2
Anemic status of (6-59) age **Hemoglobin level <11.0g/dl**	55.2%	

Table-5: Nutritional and anemia status of Adults:

Indices	Male (15-49)	Female (15-49)
Body mass Index (BMI) **(<18.5kg/m$^{2)}$**	15.4%	23.9%
Anemic Hemoglobin level	58.4% (<13.0 g/dl) (%)	59.0% (<12.0 g/dl) (%)

[Source: NFHS-4]

The District Action Plan for Children (DPAC) of Malda was prepared to address the issues of reproductive and child health and nutrition, wash, education and child protection in aligning national and state priorities. UNICEF West Bengal state office contributes its support towards further strengthening of the district level review mechanism with a special focus on implementation of national flagship programmes with equity and quality. To achieve the desired results of DPAC in Malda district, a decision was taken to engage CINI as a partner with a funding agreement with UNICEF for the activities of community level interventions, community mobilization and participation, facilitate monitoring and supervision, feedback to system and program review to boost-up the nutrition interventions in ICDS and RMNCH+A programs in the district.

Data analysis plan:

CINI facilitators used to collect data from field by using different checklist for data entry process. After data entry is over those are analyzed to monitor the information regarding development. As to strengthen MIS system I queried those development actors at certain point of time. According to the response, I assessed the filled up checklist and suggested the further proceedings at different level of interventional activities.

Working schedule of CINI facilitators:

A. Health activities:

1. Feeding demonstration Training.
2. Feeding demonstration session.
3. VHND.
4. Household visit.[mother category]
   - 4.1. Pregnant woman
   - 4.2. Mother with child
   - 4.3. Combined
5. Sub Centre visit.
6. 4th Saturday Meeting.

B. Community activities

1. Community meeting.
2. Anganwadi centre visit.
3. Block Convergence Meeting.
4. School Visit.
5. 3rd Saturday Meeting.
6. BLCPC/VLCPC/DLCPC.

Observation:

FEEDING DEMONSTRATION TRAINING

Method (participatory): Discussion with the participants (Frontline workers, AWW, ASHA) with the help of flip book and posters. Chart paper was used for group presentation. Training date used to be fixed with prior discussion with CDPO. The AWWs and ASHA were informed by the ICDS supervisors prior to the meeting.

Pic: Gazole GP Feeding Demonstration Training by ICDS supervisor.

OBSERVATION	SUGESSION
1. Proper arrangements of meeting hall and tools were absent. 2. The ASHA/AWWs were divided into three groups and they have been given assignment of what? How? Why? From the topic discussed. 3. As CINI facilitators were lacking organize the meeting properly, a chaos situation was created by ASHA/AWW, which is uncommon. 4. Here the role of ASHA was less and the co-operation was not there in between ASHA and AWW. As both of the AWW and ASHA has different category of practice area but the training been same for both. 5. After all the discussion, it came out that early marriage was the root cause of every problem. 6. The pre and post assessment was not a part of the training.	1. AWWs need to be evaluated on a timely basis after training for assessing their knowledge on the services. 2. The age of retirement from the job should have to be fixed as; age is a barrier in this case. 3. CINI facilitators should do their assigned jobs of facilitating the government system. 4. CINI facilitators should have to take the responsibility of making family or beneficiary aware about their rights to Government systems.

Community meeting

An Anganwadi centre used to be selected for the meeting. Anganwadi worker have that prior information about the meeting Along with the pregnant woman, mothers from that area are also called. ICDS supervisor sometimes present in the meeting.

Pic: Shahbazpur AWC.

OBSERVATION	SUGESSTION
1. The centers were in a dull and unhygienic situation. One of the centers is still running in an open space where pre- school education service is nowhere. The same was having only hay fuel system. 2. The IEC materials (poster, banner) were either absent or in bad condition. Few children were interested about pictorial images. 3. Home delivery was at peak in both the centers (in that village). A very few people had institutional delivery as they felt severe pain during delivery. 4. Instead of having interest to go for institutional delivery those mothers were not carried to hospital by their family members. 5. Male dominancy and gender inequality was clear from the situation.	1. In case of organizing a mother meeting CINI facilitator must be informed about the situation by the AWW. 2. AWWs must need to take the responsibility of calling or informing the mothers in the village to attend the meeting. 3. Those mothers who had institutional birth, need to be informed and given responsibility to aware more or few other pregnant women to come to meeting. 4. Sometimes male persons or head of the family should be called to attend the meeting to get rid of the gender issues. 5. AWWs need to be more informative about NRC process.

Sub centre visit.

CINI facilitator used to go to the sub centre with a checklist to collect information to do a gap analysis based on supply and services of health.

Pic: Shahbadpur Sub Center.

OBSERVATION	SUGESSTION
1. Both TFR and birth rate were very high. 2. CINI facilitator significantly lacks the skills to collect sub centre data. 3. The check list provided to them is very complex in nature for collecting information. As Sub centre check list questionnaires are different from the sub centers registers. 4. Sometimes or some days there used to be very rush or crowded situation at the centers. 5. The sub centre was situated at a kaccha rented house. 6. People mostly come here to have ORS with an excuse of diarrhea. 7. Examination table were present but the condition was very untidy and rough. 8. The tinplate and IEC materials were not visible clearly. 9. The contraception was not taken by the villagers just as because of religious and rigid mindset.	1. The sub centre visit checklist must be changed according to the sub centre register. 2. The facilitator should be given training on sound skills of sub centre for easy collection of data. 3. Sub centre visit should be avoided on weekly vaccination day. 4. Facilitator can raise the issue at VHND and VLCPC/BLCPC meeting to resolve the infrastructural issue of any sub centre.

Feeding Demonstration Session:

After successful demonstration training the trained AWWs used to practice the session with pregnant women and malnourished children. They used to monitor them by using NCC Roaster and mothers meeting. The session continues for 30 days.

Pic: Feeding demonstration session.

OBSERVATION	SUGGESTION
1. Session continued in most of the AWCs but the attendance of children and mothers were very few (4/5) in some places. 2. Most of the mothers came initially at the session but after few days/ weeks they didn't as it took time. 3. Problem of more attendance was clear as those poor villagers used to take a family member with them as they were getting food at free of cost from the AWCs. 4. Technical mistake was clear as some of the AWWs have taken the count of normal children in the roster. After data entry the scenario was significantly different as in 6 blocks approx 40% children counted in the roster were normal as per WHO norms of nutrition.	1. More intervention required from Government side to train the AWWs. 2. CINI facilitator should follow up the session with more priority. 3. In case of organizing a training session the trainer should be efficient with lay mans language. 

Home visit: Mothers & Pregnant women

With the help of AWW, CINI facilitator goes to the house hold of the same beneficiary (Mother/ pregnant women) attended the session at AWC. The main objective of the home visit is to know the awareness and practice level of what they have learnt at the session.

OBSERVATION	SUGESSTION
1. Though few mothers were trained for 12 days at the session but they didn't practice the same at home. So the situation remains same as previous. 2. They were aware about the nutrition and health related matter but the portion of WASH unknown to them.	1. VHSNC committee should take up the responsibility to initiate awareness about water and sanitation health**.** 2. CINI facilitator should find out the VHSNC at the GP level to work on the same**.**

Anganwadi Centre Visit

With prior information to AWW the facilitator visits the AWC with a checklist to collect data related to MCH and WASH.

OBSERVATION	SUGGESTION
1. Few centers were in a dull and unhygienic situation. Few of them are still running in an open space where pre-education service is nowhere. The same was having only hay fuel system for cooking. 2. The IEC materials (poster, banner) were either absent or in bad condition. Few children were interested about pictorial images. 3. Almost all/most of the registers were not updated. 4. Sometimes helper don't used to come so cooking couldn`t be done. 5. Stock room were absent in most of the centers.	1. Only by rigorous training the efficiency of the AWWs can be increased. 2. CINI facilitator should monitor about the IEC material. 3. Government action is required to strengthen the AWC system. 

4th Saturday Meeting:

It's a meeting held on every 4th Saturday of month at the Block/Gram Panchayat office. It's a convergent platform for Health, ICDS, PHE, PRI and other services unit of state and central Government. Most of the NGO working in the same block used to be present at the meeting with their agenda and issues. The child protection officer from police used to be present at the meeting.

Pic: Rishipur GP Office 4TH Saturday Meeting

Agenda discussed:

1. Child Protection.
2. Early marriage.
3. Role ASHA
4. Water & Sanitation.
5. Role of VHSNC
6. Status of MNREGA
7. Status of NREGS
8. Importance of Institutional birth.
9. Importance of Contraception
10. Importance of Community meeting.

Block convergence meeting

It's a meeting held on every block of a purposively fixed date at block office of every block. Here every issue regarding schemes/services used to be discussed. All of the attendees have a tendency to take the attention of Block Development Officer or joint B.D.O.

OBSERVATION

1. Most of the attendees didn't even know or didn't hear about it at Ratua-1 block.
2. CINI facilitators tried a lot to make them gather at one place but they failed as on that date there was some other training process for Pradhan.
3. It's very common that Panchayat Pradhan don't used to be present at the meeting with several reminders from B.D.O. and this scenario is same for every month.
4. Most of the representatives of BMOH, Pradhan, and Panchayat Member used to attend the meeting which I think is useless as they do have a tendency to just sign in the attendance register and left off.

Figure-4: Overall important suggestion to be follows up

FEEDING DEMONSTRATION TRAINING

1. Proper orientation and rigorous training is required for AWW.

COMMUNITY MEETING

1. Male persons should be included.
2. Viewers (positive deviant) point should be taken.

HOME VISIT

1. Proper follow up is required at FD session.
2. VHSNC and WASH should be taken in care

SUBCENTRE VISIT

1. ANM sub center visit checklist should be corrected and the questionnaire should be in patterned way.

AWC VISIT

1. CINI facilitator should monitor the availability of IEC material.
2. Registers should be updated on a timely basis.
3. IEC material should be visible and clean.

1. On 4th Saturday meeting the issue in health systems should be raised.
2. The issue of VHND and VHSNC should be raised on Block Convergence Meeting.

B. Project data tabulation and analysis:

Aim: The study was to assess the status of counseling on knowledge and practices of mothers regarding breastfeeding under IYCF mandate for ICDS.

Background:

Interventions promoting infant and young child feeding are known to improve child survival, growth and intellectual development. Infant and Young Child Feeding (IYCF) practices are simply a set of recommendations for appropriate feeding of new-born and children so that they achieve optimal nutrition status and include the well-known and common practices of:

(1) Initiating of breastfeeding within one hour of birth (with colostrums feeding).

(2) Exclusive breastfeeding for the first six months of child.

(3) Appropriate complementary feeding starting at 6 months of age.

According to NFHS-4, presently, 31.5 percent children in West Bengal under-5 years are reported to be underweight and 32.5 percent are stunted. In Malda, according to NFHS-4, 43.3 percent Children under 3 years breastfed within one hour of birth and 63.7 percent Children under age 6 months exclusively breastfed

Looking at the national scenario of child malnutrition, it is apparent that early preventive action is crucial for accelerating reductions in infant and young child under nutrition and related mortality, on a large scale.

Methodology:

The cross sectional observational study was carried out at 6 blocks of Malda district namely Habibpur, Gazole, Ratua-1, Chanchal-1, Harischandrapur-1, and Kaliachak-3. Firstly, those blocks were selected and among those blocks few Anganwadi centre has been selected. With the help of Anganwadi worker those mothers fallen under that centre have been interviewed. The beneficiaries falling under each AWW were selected purposively. Total 234 beneficiaries were interviewed by using the prepared interview schedule. The key learning's from the interview are discussed below.

Hypothesis: Social backwardness, bad health indicators and knowledge about health of Malda district can directly attribute to gaps and barriers in utilization of ICDS and Government schemes.

Objective:

- To assess the behavior change after intervention through counseling and training on ANC check up and Breastfeeding practices to the beneficiaries.
- To evaluate the understanding of the messages among beneficiaries.

Primary Data: Primary research is done in form of interview schedule of different category of mothers (beneficiary) in 6 allotted blocks.

Sampling Unit: Malda is among the 183 high priority districts in India. 6block of Malda district namely (I) Habibpur; (II) Gazole; (III) Kaliachak-3; (IV) Ratua-1; (V) Chanchal-1; (VI) Harischandrapur-1 was selected for study.

Study respondents:

Beneficiaries: Following Women falling under the different AWCs.

1. Mother with child.
2. Pregnant women.
3. Combined (pregnant with child).

Sampling design:

AWW were identified from supervisor list by CINI facilitator.

Beneficiaries as listed above are selected purposively by respected AWW.

Tools & techniques:

PAPI interview schedule was done for beneficiaries with a preformed checklist.

Sampling size: (Please refer Table-1)

With the help of 40 AWWs, 234 beneficiaries were interviewed from 6 different blocks.

Limitations of the study:

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

b) There was scope for more in-depth probing of various components making the study more interesting.

c) Time constraints for various activities of the project.

d) Information bias: Information bias is where the caregivers tend to opt for answers they feel the investigator would like to hear, or answers that are pleasing (less humiliating to them). Thus, the data collected might not have been exact or reliable with what was actually happening due to the incorrect responses. This was minimized by use of a standardized structured checklist.

e) Selection bias: Selection bias is due to use of non-random method of snow ball for selecting the sample.

f) Response burden: This could have been a limitation to the study in such a way that the participants might have gotten tired due to the length of the questionnaire.

Mode of counseling:

From the survey it is found that, the counseling was given to beneficiaries very well and all the 234 respondents told that everything was told to them and they found it relatively easy to understand. As observed from the field health workers convey those messages in their local and regional languages so that beneficiaries face no difficulty. But every health worker uses different medium of communicating the messages. From the study, most of the respondents told that messages were conveyed verbally and through IEC materials as a mode of communication.

Empirical Analysis:

A total of 234 beneficiaries were interviewed and all were included in the analysis.

Table-6:- Block wise data of different class of mother.

SL. NO	NAME OF THE BLOCK	PREGNANT MOTHER	MOTHER WITH CHILD (0-6 months)	COMBINED (PREGNANT WITH CHILD)
1.	**HABIBPUR**	22	17	6
2.	**GAZOLE**	16	27	3
3.	**KALIACHAK-3**	21	9	15
4.	**RATUA-1**	19	22	4
5.	**CHANCHAL-1**	6	12	8
6.	**HARISCHANDRAPUR-3**	11	9	7
	TOTAL=	95	96	43

Table-7:- Socio demographic characteristics of mothers under different age group

RELIGION →	**HINDU**			**MUSLIM**			**OTHERS**		
Mother Age Group (In Year)	PW	WC	C	PW	WC	C	PW	WC	C
≤ 18	4	0	0	9	6	0	6	0	0
19-21	8	11	0	16	6	0	9	9	1
22- 25	3	4	2	10	28	12	5	10	0
26- 29	11	6	2	2	13	0	0	4	5
≥ 30	0	10	0	4	5	2	2	4	5
Total	**26**	**31**	**4**	**41**	**58**	**14**	**22**	**27**	**11**

[PW: Pregnant Women; WC: Woman with Child; C: Combined (Pregnant mother with Child]

Observational Findings:

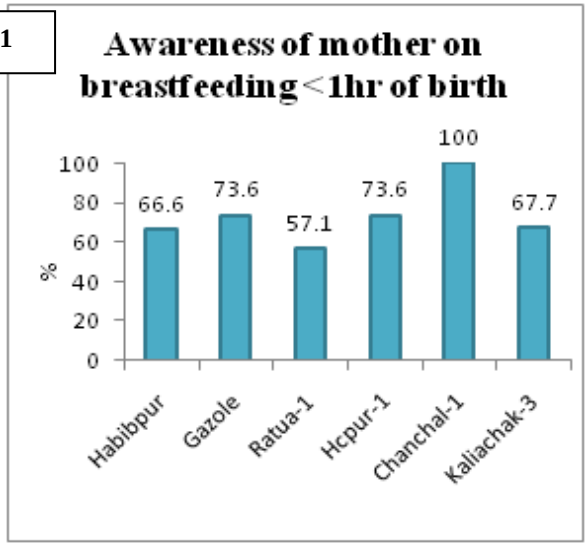
Habibpur (n=33), Gazole (n=38), Ratua-1(n=35), Hcpur-1(n=19), Chanchal-1(n=23), Kaliachak-3(n=31)

Here I have collected the responses of 2 types of beneficiaries:

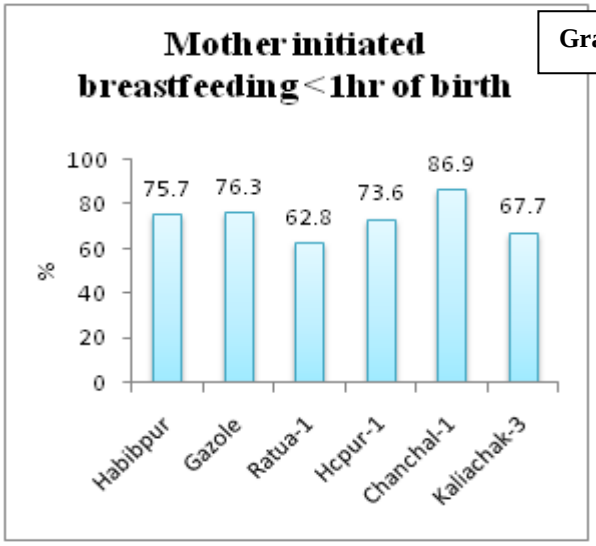
1. Mother with child.
2. Combined (Pregnant with child)

The below shown graph depicts the awareness and practise level of mothers

Graph-1

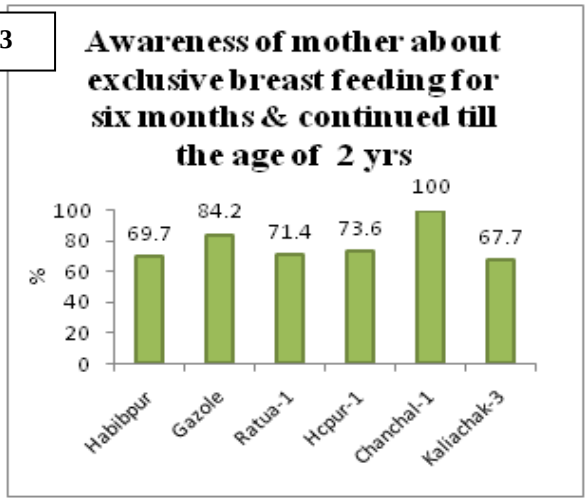


Graph-2

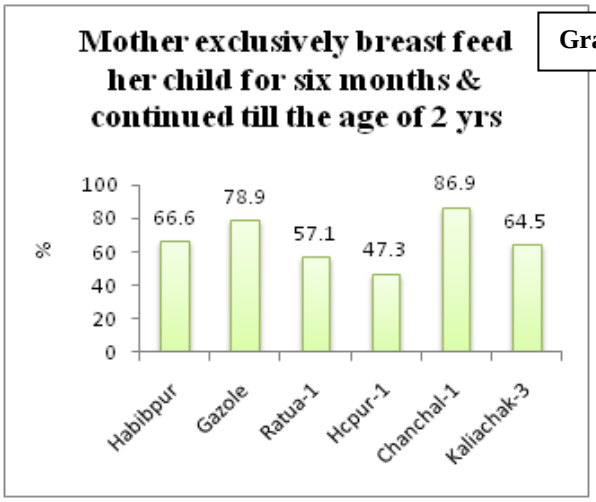


- It is clear from the above two graphs that practice of **breastfeeding within one hour of birth** is higher or similar than the awareness of the same except Chanchal-1 block. This is the effect of intervention of counseling to the beneficiaries.

Graph-3

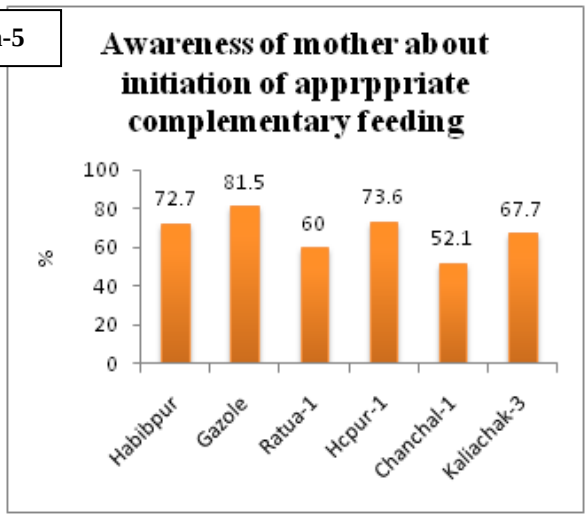


Graph-4

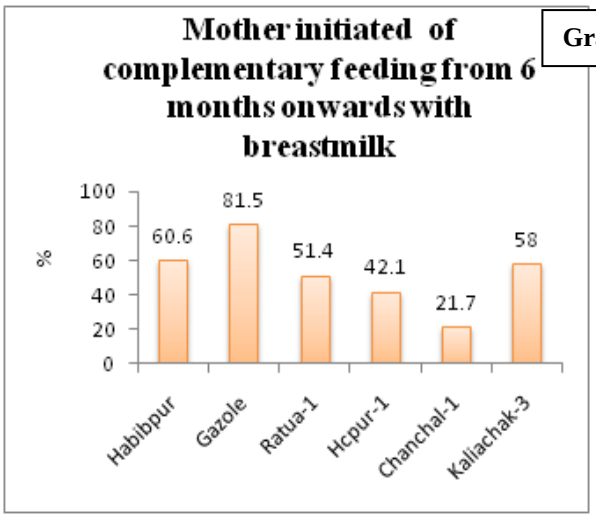


- Here the scenario was different in case of practice of **exclusive breastfeeding for 6 months** as in every block the practice level is very low than the awareness level. This might be the reason of non supportive family member and non practice of the mother.

Graph-5

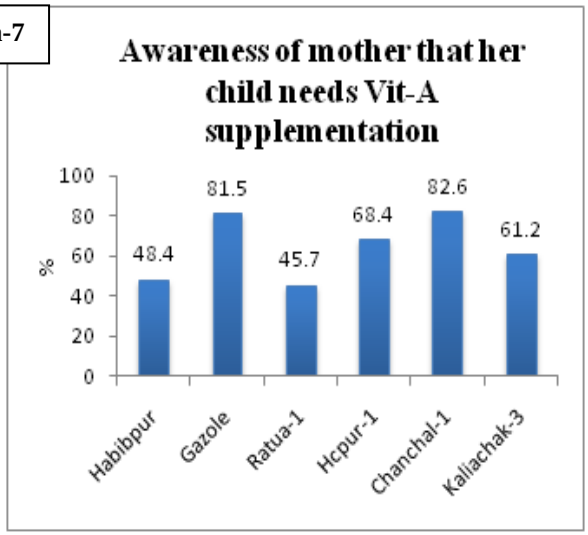


Graph-6

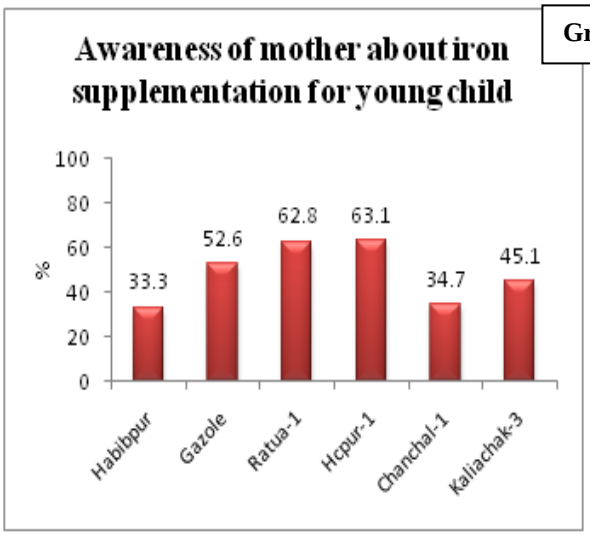


- Except Gazole block the practice of **complementary feeding from 6 months onwards with breast milk** is lesser than the awareness of the same. This might happen that those mothers started complimentary feeding before 6 months.

Graph-7

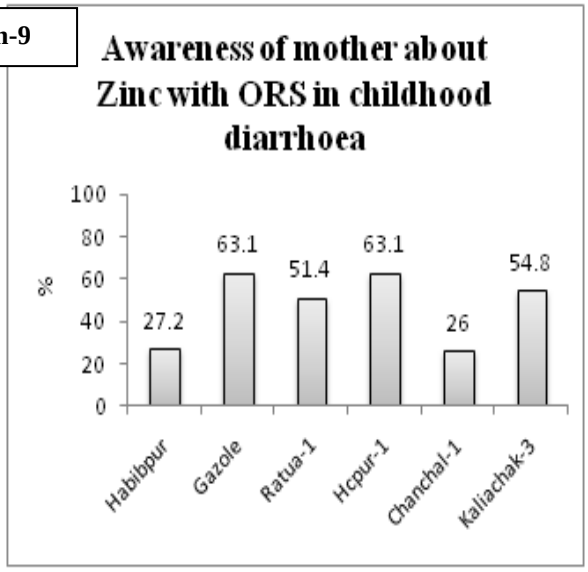


Graph-8

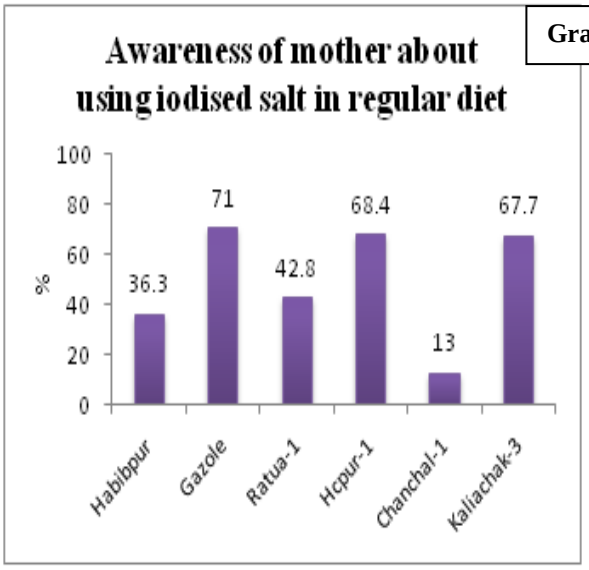


- The awareness of mothers about her child needs **Vitamin-A supplementation** was 45.7% in Ratua-1 block followed by 48.4% in Habibpur, 61.2% in Kaliachak-3, 68.4% in Harischandrapur-1, 81.5% in Gazole, 82.6% in Chanchal-1 block.
- The awareness of mothers about **Iron supplementation** was very low in Habibpur block with 33.3% and highest in Harischandrapur-1 with 63.1%.

Graph-9

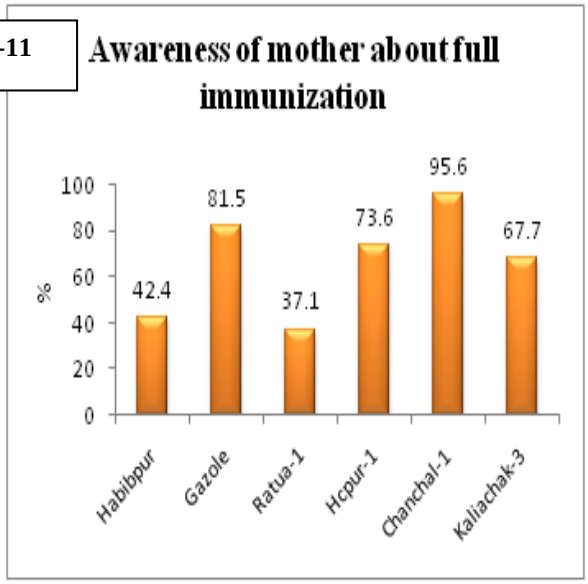


Graph-10



- The awareness level of mothers about **giving Zinc with ORS (Oral Rehydration Salt)** in case of childhood diarrhoea were 63.1% at Gazole and Harischandrapur-1 block where as the level was as low as 26% at Chanchal-1 Block.
- The awareness of mothers about **using iodized salt** in regular diet were very less in Chanchal-1 block with 13% whereas the same was highest in Gazole block with 71%.

Graph-11



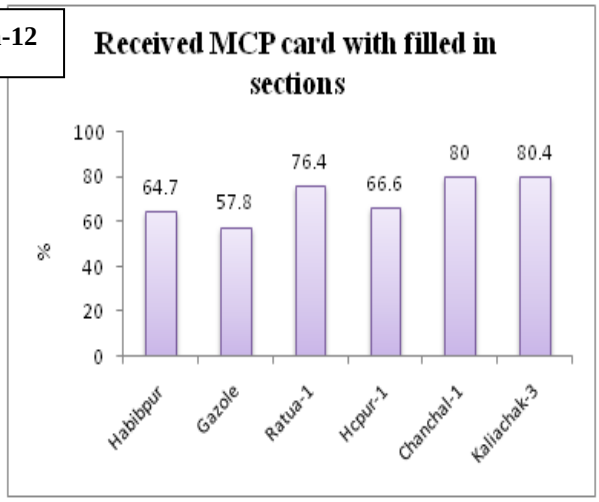
- With the highest 95.6% in Chanchal-1 block the mothers were aware about **full immunization** for their child and in Ratua-1 block 37.1% mothers were aware about the same followed by 42.4% of Habibpur, 67.7% of Kaliachak-3, 73.6% of Harischandrapur-1 and 81.5% of Gazole block.

Habibpur (n=34), Gazole (n=19), Ratua-1 (n=34), Harischandrapurpur-1(n=21), Chanchal-1(n=15), Kaliachak-3(n=41).

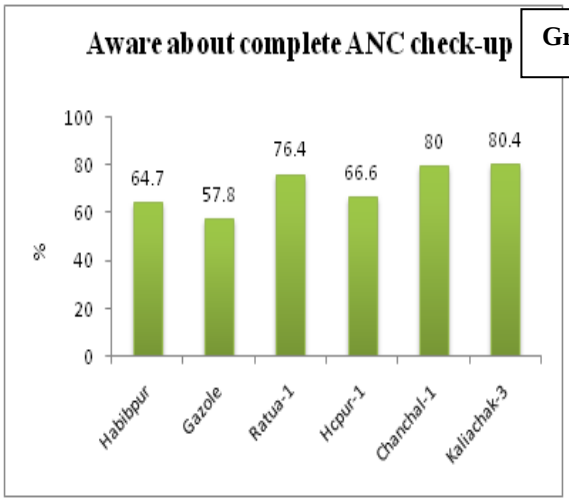
Here I have collected the responses of 2 types of beneficiaries:

1. Pregnant women.
2. Mother with child.

Graph-12

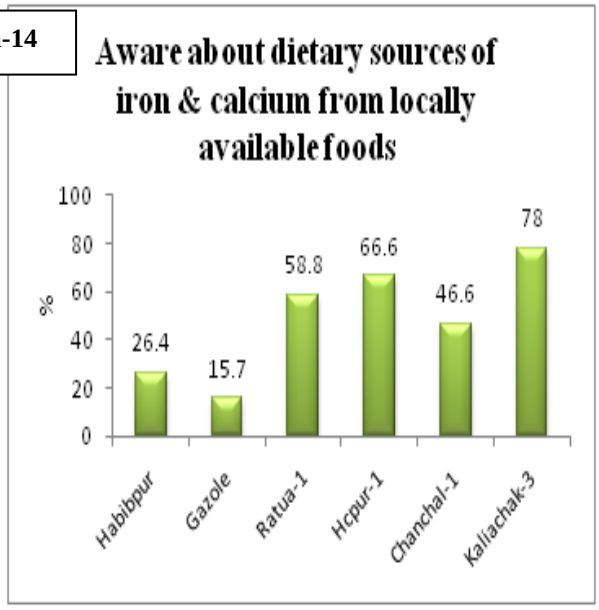


Graph-13



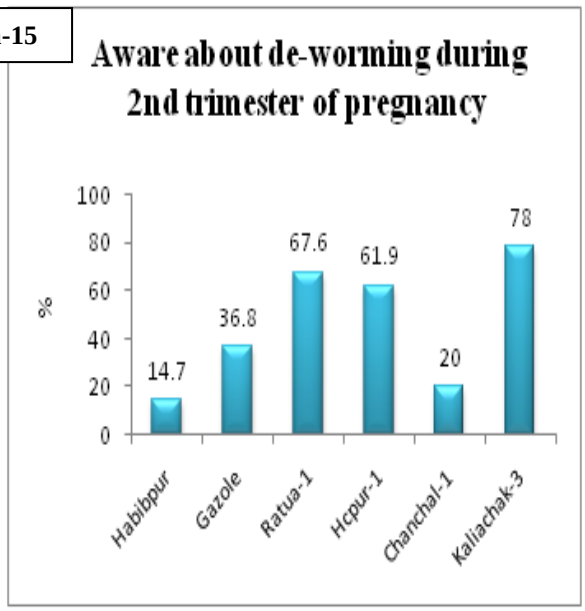
- In this section 57.8% of the mothers and the pregnant women of Gazole block received mother and child protection card with filled in sections followed by 64.7% of Habibpur,66.6% of Harischandrapur-1,76.4% of Ratua-1, 80% of Chanchal-1 and 80.4% of Kaliachak-3 block respectively.
- From the graph is clear that 57.8% of women in Gazole block are aware about complete ante natal check up whereas 80.4% mothers of Kaliachak-3 block were aware about the same.

Graph-14



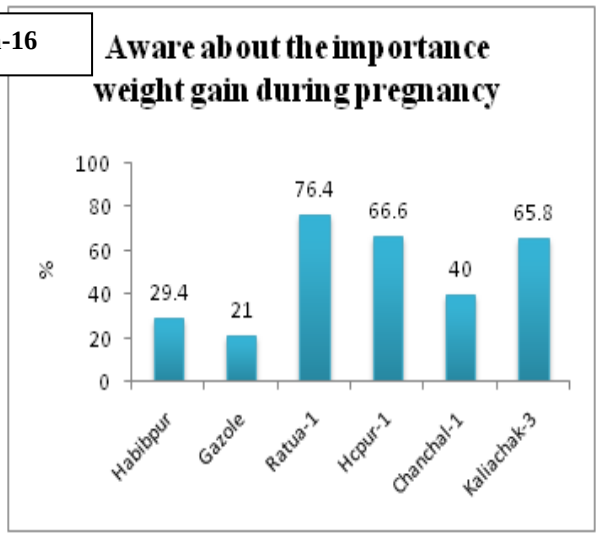
- 78% of mothers of Kaliachak-3, 66.6% of Harischandrapur-1, 58.8% of Ratua-1, 46.6% of Chanchal-1, 26.4% of Habibpur and 15.7% mothers of Gazole were aware about dietary source of iron and calcium from locally available foods.

Graph-15



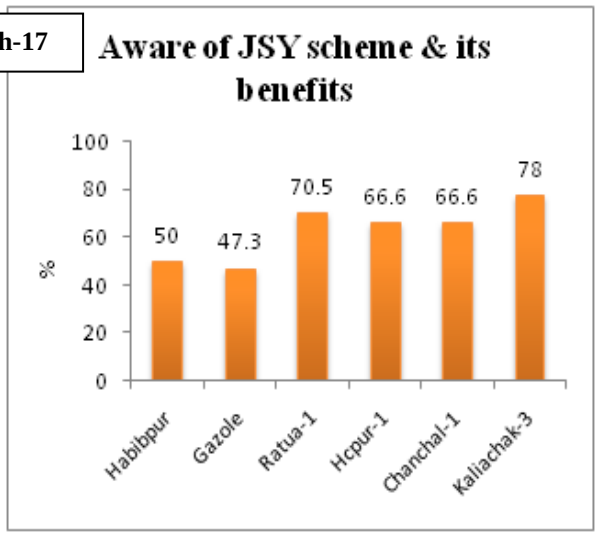
- It is evident from the graph that 14.7% women of Habibpur block were about de-worming during second trimester of pregnancy whereas significantly 78% of women of same category of Kaliachak-3 were aware about the same.
- De-worming used to be done by giving Albendazole-400 mg tablet.

Graph-16



- 21% of Gazole followed by 29.4% of Habibpur, 40% of Chanchal-1, 65.8% of Kaliachak-3, 66.6% of Harischandrapur-1 and 76.4% women of Ratua-1 block were aware about the importance of weight gain during pregnancy period.
- Pregnancy weight gain is very important as it reduces the chance of delivering low birth weight child.

Graph-17



- The awareness of Janani Suraksha Yojana was average in every block as 50% in Habibpur and 78% in Kaliachak-3.
- In case of JSY a delivering mother will get some monetary help from the Government.

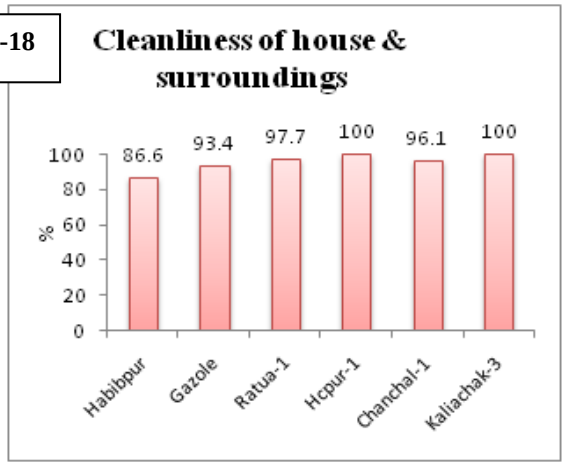
Habibpur (n=45), Gazole (n=46), Ratua-1(n=45), Harischandrapurpur-1(n=27), Chanchal-1(n=26), Kaliachak-3(n=45)

Here I have collected the responses of all types of beneficiaries:

1. Pregnant women.
2. Mother with child.
3. Combined (Pregnant with child)

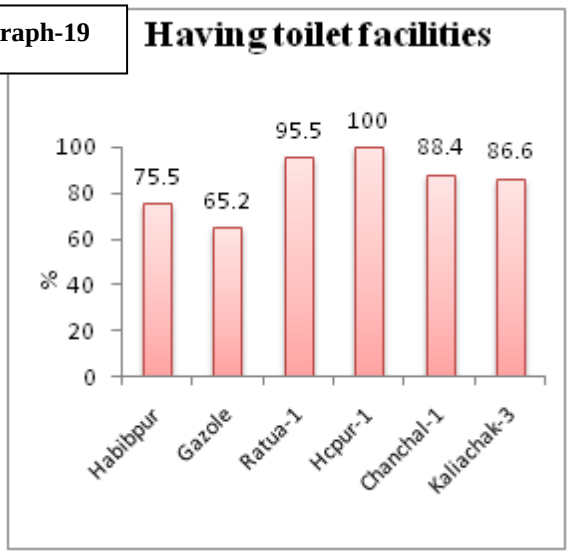
In this tool the questionnaire was same and common for all the beneficiaries. Thus the sample size is higher in number.

Graph-18

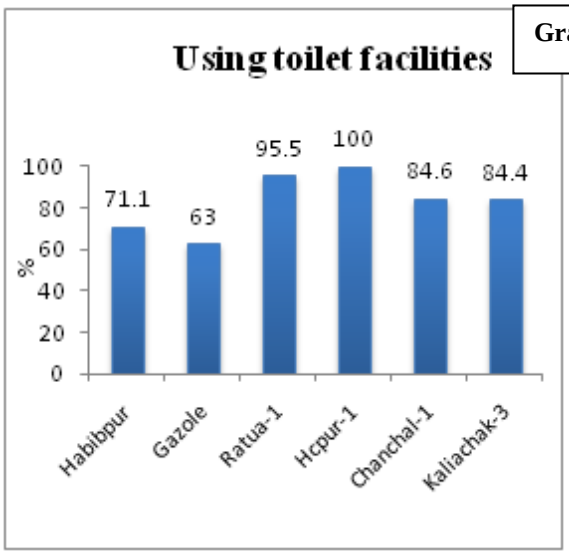


- In this case almost high percentage of women was aware about cleanliness of household and surroundings.
- As Habibpur is a backward block, the percentage was little lower than others. 86.6% of women of Habibpur were aware about the same.

Graph-19



Graph-20



- It is evident that without having toilet facilities those all are not in use in few blocks. In Gazole block 65.2% of household were having toilet facilities in their households. Though the use was 63% in Gazole block. The same situation was in Habibpur,
- But in case of Harischandrapur-1 block both the availability and use of toilet was 100% which is very significant.

Suggestion:

Here all the block facilitators are giving their whole to accomplish their working target. Sometimes they had to do more than their potential. For a whole month averagely they work for 287 hours. But the situation is, the information from the field is not coming to the management side. Here they lack communication and information system. Almost very less information used to be with the unit office and with the managers.

- So I think there should be some format to be followed up by the facilitators for regular working process. Hence I have prepared some format with the help of project manager which are given on annexure.

CINI should arrange a meeting and discuss the issue of permission taking process. For taking permission from a Government officer a facilitator of CINI spends averagely 27 hours a month, which should be minimized.

- The frequency of home visit should be increased to aware about the actual practice by the beneficiary.
- Mothers should be informed about the WASH and VHSNC.
- In some cases the awareness level is high but the practice level is very low. Hence counseling is required. Community meeting will be a good platform.
- In case of home delivery the behavior must be changed as asking the head of the household in the meeting. There the discussion of contraception and family planning can also be done.
- Focusing more on community meeting and feeding demonstration session can increase the level of practice. Thus the prevalence of low birth weight will decrease.
- And complimentary feeding will increase thus way.

Conclusion:

This study on effect of counseling on knowledge and practices was conducted in Malda district. The study found that maternal educational level is a significant factor in determining the knowledge of ANC and breastfeeding. It is expected that educated women are more likely to be aware about their health status and seek health knowledge.

Knowledge and practice among current pregnant women for breastfeeding depends on counseling given by ANM and AWW. Counseling by AWW give better health outcomes but practice among beneficiaries during lactating period depends on both beneficiary and her family. But in this study it was good result shown by very few beneficiaries. The effect of IEC for communication was less in all the places as those were not in use.

Knowledge of breastfeeding and government services was found to be adequate in the study area. However, practices of the same were found to be satisfactory. Knowledge of ANC was found to be also satisfactory but in case of type of beneficiaries got good response. To improve community awareness, information, education and communication activities should be increased on mother and child health through community campaign. There is a need to motivate women to utilize maternal care services which are freely available in all the government health setups.

Reference:

1. *Press information bureau, 2015.*
2. *Pati Manoj Kumar et al. Breastfeeding practices and child nutrition in India.*
3. *Indian institute of population sciences, national family health survey-3.*
4. *Indian institute of population sciences, national family health survey-4.*
5. *www.worldbank.org/en/news/feature/2013/05/13/helping-india-combat-persistently-high-rates-of-malnutrition.*
6. *Human development report, 2004.*
7. *Health on March, West Bengal-2014.*
8. *Ahmad Muhammad Owais, Sughra Ume, Kalsoom Umay , Imran Muhammad , Hadi Usman*
9. *Effect of Antenatal Counseling on Exclusive Breastfeeding. Journal of Ayurvedic Medical College, Abbottabad 2012; 24.*

Annexure:

Annexure: 1

Format for whole activity analysis:

					Activity plan
NAME	BLOCK	BLOCK CONVERGENCE MEETING		COMMUNITY MEETING	
		ACHIEVED	TARGET	ACHIEVED	TARGET
ANAMIKA SARKAR	Chanchal-1	1	2	10	15
ANUPAMA SARKAR	Chanchal-2	1	2	10	15
ATIKA KHATUN	Ratua-1	1	1	15	15
MILAN PODDAR	Ratua-2	0	1	10	15
KHOKAN MANDAL	Gazole	1	1	5	15
ANIMA MANDAL	Gazole	0	1	5	15
MRINALINI HEMBRAM	Gazole	1	1	10	15
SAJAL SOREN	Habibpur	0	1	10	15
SAGARMOY GHOSH	Habibpur	0	1	5	15
PANKAJ GHOSH	Habibpur	0	1	12	15
SAFIQUL ISLAM	Kaliachak-3	0	1	10	15
MD. HASSANUJAMAN	Kaliachak-4	0	1	16	15

Annexure 2

Format of Monthly action plan for field facilitator:

CINI

ACTION PLAN Month: .....

Block Name: ....., Project Title: .....

Facilitator Name: ....., Submission Date: .....

DATE	ACTIVITY			
	9 -11 AM	11:30 AM – 2 PM	2:30 PM- 4:30 PM	6PM- 8PM

Annexure 3

Format for community meeting attendance register:

COMMUNITY MEETING						
THEME:						
MONTH:		**BLOCK:**				
		T O T A L P A R T I C I P A N T S				
DATE	**GRAM PANCHAYAT**	**PREGNANT WOMAN**	**LACTATING WOMAN**	**ADOLESCENT GIRL**	**OTHERS**	**TOTAL**

Annexure 4

Format of Facilitator working time study:

ACTIVITY	PLANNING	PERMISSION TAKIN	CONVEY MESSAG	VENDOR SELECTIO	LOGISTICS	TRANSPORT	GROUP MAKING	AGENDA	COOKING	CHECKLIST	TOTAL	
BLOCK CONVERGENCE MEETING												
COMMUNITY MEETING												
FEEDING DEMONSTRATION TRAINING												
FEEDING DEMONSTRATION SESSION												
HOME VISIT FOR MOTHERS												
CDPO /SUPERVISOR MEETING												
ANGANWADI CENTRE VISIT												
SCHOOL VISIT CHECKLIST												
VHND SESSION												
SUB-CENTRE VISIT												
BLCPC MEETING												
VLCPC MEETING												
3RD SATURDAY MEETING												
4TH SATURDAY MEETING												
NAME OF FACILITATOR: PANKAJ GHOSH										TOTAL=		(HOURS)
BLOCK: HABIBPUR												
TOTAL TIME TAKEN:					HOURS							
			SPECIAL EVENT:									
			BILL PREPARING:									
			MALDA OFFICE :			(3DAYS)						
			OTHER ACTIVITIES:									
			REPORT PREPARE :									
				TOTAL=								

Annexure 5

Format of record keeping of Feeding demonstration training and session:

FEEDING DEMONSTRATION TRAINING and SESSION					
START DATE:.....			MONTH OF:.....		
SL. NO.	AWC NAME	AWC CODE	GP NAME	AWW NAME	PHONE NO.

Annexure 6

Format for facilitator individual activity report keeping:

INDIVIDUAL MONTHLY REPORT								
NAME:								
MONTH:					BLOCK:			
	Section A: Financial							
SL.	ACTIVITY	TARGET	ACH	TOTAL PARTICIPANT	% age of ach	Variation	TOTAL ALLOTED	Total amount spend
1	Block convergence meeting							
2	Community meeting							
3	Feeding demonstration training (AWW & ASHA)							
4	Feeding demonstration session							
5	4th Saturday meeting							
6	3rd Saturday meeting							
7	CDPO meeting							
	Section: B Non Financial							
SL.	ACTIVITY (fill up checklists)	TARGET	ACH	Cumulative	Remarks if any			
1	AWC Visit							
2	Home Visit							
3	Sub centre visit							
4	VHND							
5	School							
6	VLCPC							
7	BLCPC							
8	Child Marriage Free villages							
	Section: C							
	Special activity: if any							
1	Nutrition Week							
2	Breast Feeding Week							
3	Any other (Please specify)							