

**Summer Training at
National Health Mission,
Jaipur**

**Report on Malnutrition Treatment Centre and Community Based
Management of Acute Malnutrition**

**By
Nupur Kapoor**

**Under the guidance of
Dr. Seema Mehta**

**MBA Hospital and Health Management
2015-2017**



**The IIHMR University, Jaipur
2016**

CERTIFICATE

This is to certify that **Nupur Kapoor** student of **MBA in Hospital and Health Management, 2015-17** from the IIHMR University; Jaipur has undergone summer training at **National Health Mission, Rajasthan** from 1st April to 31st May, 2016.

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

The internship is in fulfilment of the course requirements.

I wish her all success in future endeavours.



Col. (Dr.) Ashok Kaushik
Dean (Academics & Student Affairs)
IIHMR University, Jaipur



Dr. Seema Mehta
Associate Professor
IIHMR University, Jaipur



Government of Rajasthan
National Health Mission, Rajasthan
Department of Medical, Health & FW, Swasthya Bhawan, Jaipur.
Tel. No.- 0141-2223862, E mail ID : projectdirectorh@gmail.com

Completion of Summer Training under
National Health Mission, Rajasthan

The certificate is awarded to

Ms. Nupur Kapoor

In recognition of having successfully completed her
Training in the department of

Child Health

And has successfully completed her Project on Malnutrition Treatment Centre and
Community based Management of Acute Malnutrition.

Date 24/06/2016

Organization: **National Health Mission**

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

We wish her all the best for future endeavors


Trainee Mentor


**Mission Director,
National Health Mission
Jaipur, Rajasthan**

Acknowledgment

I am highly indebted to Mr. Naveen Jain (IAS) Mission Director NHM for giving us the opportunity to do our Summer Training at NHM SwasthyaBhawanRajasthan. I am thankful to Dr. AnuradhaAswal SPMO and Dir. RCH for making it possible and providing aid as when required.

I would like to express my sincere thanks to Consultant (Malnutrition Child Health) NHM,Mrs. Priyanka Kanwar who have been my mentor in NHM and for enriching my experience by undergoing learning process through field visits. I thank her,including the CMAM project Team UNICEF(Ms.AnuBothra) ,ACF(Ms.Shivangi Kaushik) and GAIN (Consultants Dr.MolshreeRathore ,Dr.Shelly Dutta and Dr.Aditi Jain) for all the trust and faith they posed on me. I thank to IIHMR alumni Seniors in NHM for their guidance.

I extend my sincere gratitude to IIHMR and to my mentor Associate Professor Dr. Seema Mehta,IIHMR Jaipur and Associate Professor Dr. NeetuPurohit ,IIHMR Faculty for her technical guidance and useful suggestions as and when required along with providing necessary information regarding the project & also for their support in completing the project.

I would like to express my gratitude towards my Family for their kind co-operation and encouragement which help me in completion of this project.

I would like to express my special gratitude and thanks to Organization's Members for giving me such attention and time .

My thanks and appreciations also go to my colleagues in developing the project and people who have willingly helped me out with their abilities.

Table of Abbreviations

ACF: Action contre la Faim

ANM: Auxiliary Nurse-Midwife

ASHA: Accredited Social Health Activist

AWC: Anganwadi Centre

AWW: Anganwadi workers

CHC: Community Health Centre

CFO : Chief Finance Officer

CMAM: Community based Management of acute malnutrition

DWCD: Department of Women and Child Development

EDNS : Energy Dense Nutrition Supplement

GAIN: Global Alliance for Improved Nutrition

GAM: Global Acute Malnutrition

ICDS: Integrated Child Development Scheme

MAM: Moderate Acute Malnourished

MTC: Malnutrition Treatment Centre

MUAC: Mid-Upper-Arm-Circumference

MWCD: Ministry of Women and Child Development

NFHS: National Family Health Survey

NGO: Non-Governmental Organization

PP: PoshanPraheri

SAM : Severe Acute Malnourish

Table of Figures

Figure 1:Case Identification of SAM child.	11
Figure 2: Diagnostic criteria for SAM Children aged 6-59 Months	13
Figure 3:Outline of CMAM.....	15
Figure 4: Malnutrition trends in Rajasthan.....	16
Figure 5: Screening Criteria by MUAC	16
Figure 6: CMAM strategy	17
Figure 7:Causes of Malnutrition according to Community's knowledge.....	20
Figure 8: Knowledge about MUAC.....	22
Figure 9: Reasons for Delay in seeking Treatment for Malnutrition.....	23
Figure 10: Estimate,waiting Time on PoshanDiwas.....	24
Figure11: Knowledge on Breastfeeding after Birth.....	25
Figure 12:Hand washing before Feeding the Child.....	26
Figure13: Impact of CMAM Project on Children's eating habits.....	27
Figure 14:Understanding of CMAM Project by poshanPraheri.....	27

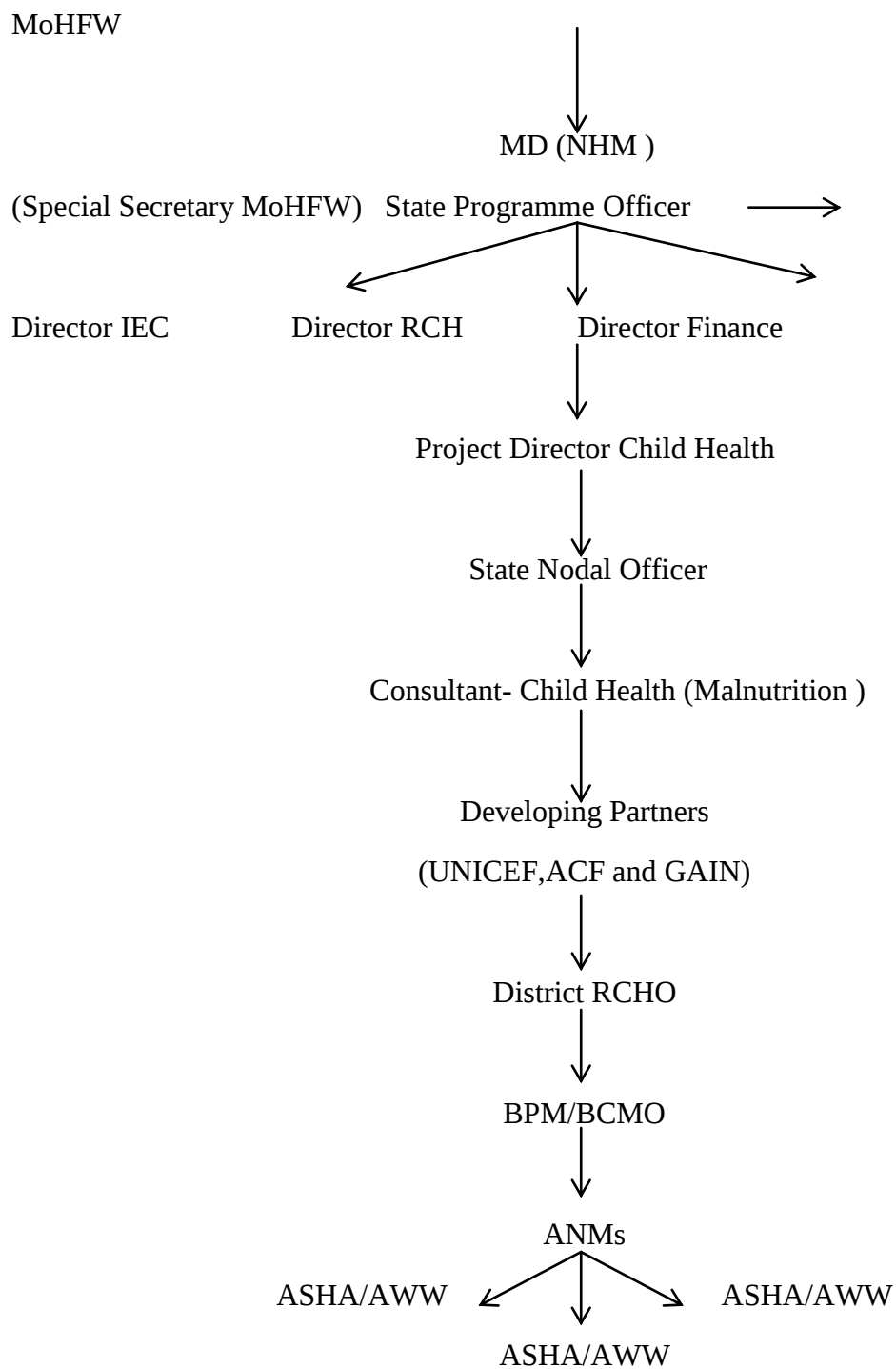
Table of Pictures :

Picture 1 : Intern with the ASHAs and ANM at Home visits.....	31
Picture 2: Field Visit to Sub centre by the Intern.....	31
Picture 3: Anthropometric Instruments at sub- centre.....	31
Picture 4:Monitoring the PoshanYatrabook sub-centre.....	31
Picture 5:CMAM Team with MD NHM Rajasthan	32
Picture 7:Kitchen of Kanwatiya Hospital	40
Picture 8: Toy room at Kanwatiya MTC Where the food is being prepared	40
Picture 9: SAM child Admitted in J.K Lon Hospital.....	41
Picture 10: MTC at savaiMadhopur District visited by the Intern.....	41
Picture 11: The child was weighed by the Intern as to verify the anthropometric Measure.	41

Observational Learning

- Organogram
- About NHM
- Tasks assigned
- Observations and Findings
- Conclusive learnings
- Limitations
- Recommendations for Improvements

Organogram



About National Health Mission

About National Health Mission (NHM): The Union Cabinet vide its decision dated 1st May 2013 has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission. Outcomes for NHM in the 12th Plan are synonymous with those of the 12th Plan, and are part of the overall vision. The endeavour would be to ensure achievement of those indicators are stated below . Specific goals for the states will be based on existing levels, capacity and context. State specific innovations would be encouraged. Process and outcome indicators will be developed to reflect equity, quality, efficiency and responsiveness. Targets for communicable and non-communicable disease will be set at state level based on local epidemiological patterns and taking into account the financing available for each of these conditions³.

Goals of NHM

- Reduction in Infant Mortality Rate and Maternal Mortality Ratio by at least 50% from existing levels in next seven years
- Universalize access to public health services for Women's health, Child health, water, hygiene, sanitation and nutrition
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Ensuring population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles.

The Mission outcomes are expected to follow a phased approach at Community Level

At community Level:

- Availability of trained community level worker at village level, with a drug kit for generic ailments
- Health Day at Anganwadi level on a fixed day/month for provision of immunization, ante/post-natal check-ups and services related to mother & child healthcare, including nutrition
- Availability of generic drugs for common ailments at Sub-centre and hospital level

- Good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level
- Improved access to Universal Immunization through induction of Auto Disabled Syringes, alternate vaccine delivery and improved mobilization services under the programme
- Improved facilities for institutional delivery through provision of referral, transport, escort and improved hospital care subsidized under the Janani Suraksha Yojana (JSY) for the Below Poverty Line families
- Availability of assured healthcare at reduced financial risk through pilots of Community Health Insurance under the Mission
- Provision of household toilets
- Improved Outreach services through mobile medical unit at district-level.

Task Assigned**1. CMAM**

To Assess the Functioning of CMAM Programme through observational study.

To carried out Rapid situational analysison knowledge and Practice of the ASHAs and the Beneficiaries.

2. MTC

To assess the facility based treatment of Severe Acute Malnutrition through comparative study between the high and low performing MTC.

.

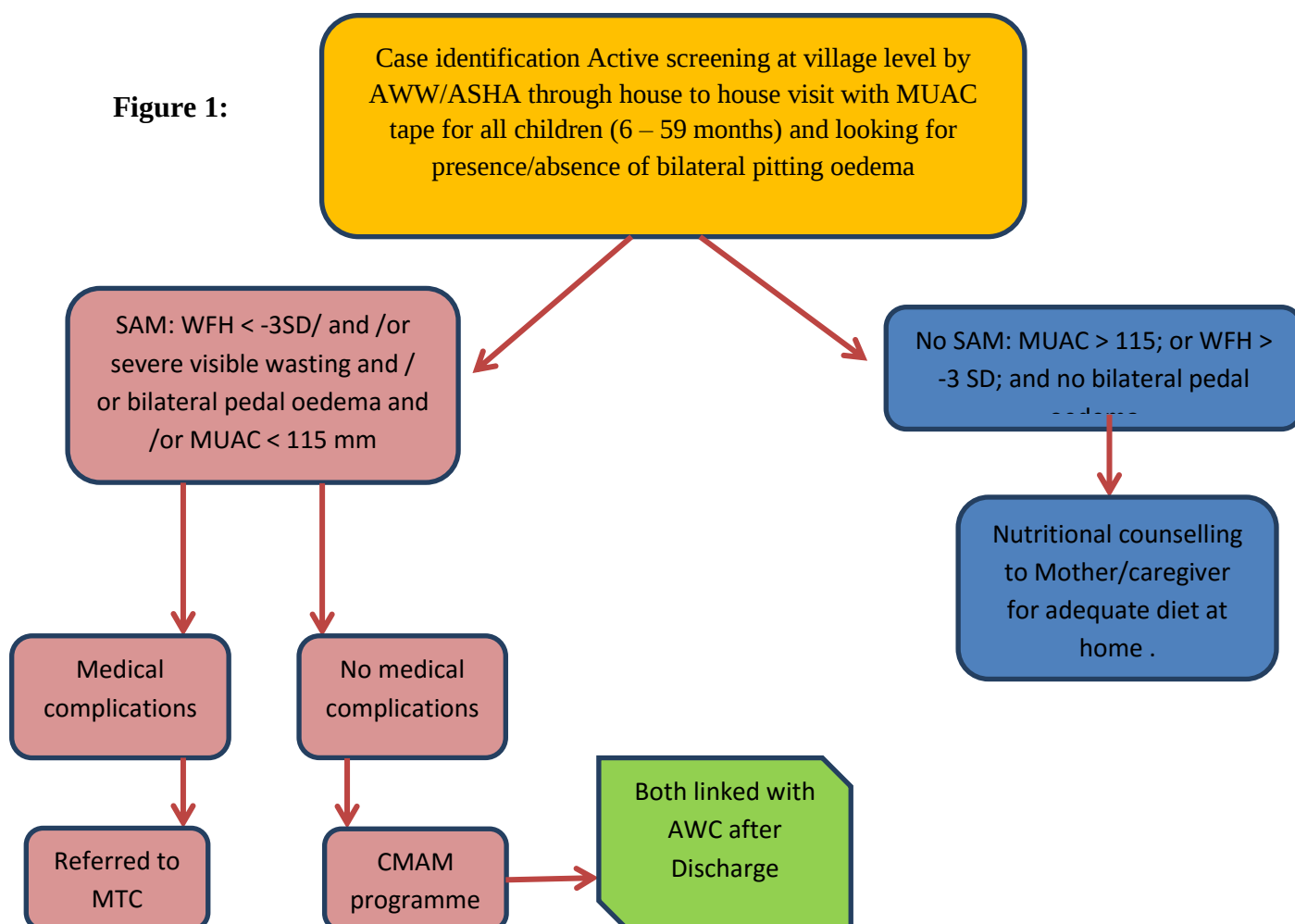
Rajasthan Initiative to treat and manage children with SAM –

Department of Health and Family welfare and UNICEF have jointly initiated facility based care for SAM children and complications. A total of 88 MTCs are fully operational and 59 are in the process of operationalisation. They have treated 9143 children with SAM in these facilities in the year 2014-15. As of now (2015-1016) 140 MTC are operational in which 40 are 10 bedded MTC and 107 has the capacity of 6 beds.

Under the active Leadership of **Mr. Naveen Jain (MD-NHM)**, further interventions were done as to have a more realistic approach for treating Malnutrition was planned out i.e. Community based Management of Acute Malnutrition Pilot project on 22nd December was launched with the objective of Treating SAM at Community grounds. It was tripartite between UNICEF, GAIN and ACF (Development Partners) with Govt.

Total of 13 Districts in which 10 were High priority districts and 3 Tribal Districts were selected by Government and Developmental Partners. CMAM strategy was designed for 13 Districts (Jalore, Jaisalmer, Dungarpur, Rajsamand, Dholpur, Baran, Karuli, Udaipur, Sirohi, Pratapgarh, Banswada, Barmer and Bundi).

Figure 1:



Glance at certain terminologies ...

What is SAM (Severe Acute Malnutrition)?

Severe acute malnutrition is defined by very low weight-for-height/length (Z- score below - 3SD of the median WHO child growth standards), a mid-upper arm circumference <115 mm, or by the presence of nutritional oedema. SAM increases significantly the risk of death in children less than five years of age. It can be an indirect cause of child death by increasing the case fatality rate in children suffering from common illnesses such as diarrhoea and pneumonia.

To prevent deaths due to severe acute malnutrition (SAM), specialized treatment and prevention interventions are required with strong food security and feeding drive. Programmatically, it is helpful to categorize children with SAM into ‘complicated and uncomplicated’ cases based on clinical criteria and can be managed through

- Facility/hospital-based care for SAM children and medical complications. (MTC)
- Home/community-based care for SAM children but without medical complications using Medical Nutrition Therapy (MNT)

What are the types of undernutrition?

The Three indices

- Weight-for-age, height/length-for-age, weight-for- height/length are used to identify three nutrition conditions: underweight, stunting and wasting, respectively. Each of the three nutrition indicators is expressed in standard deviation units (Z-scores) from the median of the reference population based on which undernutrition may be further classified as moderate or severe.

Underweight: Underweight, based on weight -for-age, is a composite measure of stunting and wasting and is recommended as the indicator to assess changes in the magnitude of malnutrition over time. An underweight child has a weight-for-age Z-score that is at least two standard deviations (-3SD) below the median in the World Health organization (WHO) Child Growth Standards.

Stunting: Failure to achieve expected height/length as compared to healthy, well-nourished children of the same age is a sign of stunting. Stunting is an indicator of linear growth retardation that results from failure to receive adequate nutrition over a long period or recurrent infections. It may be exacerbated by recurrent and chronic illness. A stunted child has a height-for-age Z-score that is at least two standard deviations ($-3SD$) below the median for the WHO Child Growth Standards.

Wasting: Wasting represents a recent failure to receive adequate nutrition and may be affected by recent episodes of diarrhoea and other acute illnesses. Malnutrition resulting from failure to gain weight or actual weight loss. Causes include inadequate food intake, incorrect feeding practices, disease, and infection or, more frequently, a combination of these factors. Wasting in individual children and population groups can change rapidly and shows marked seasonal patterns associated with changes in food availability or disease prevalence to which it is very sensitive.

A wasted child has a weight-for-height Z-score that is at least two standard deviations ($-3SD$) below the median for the WHO Child Growth Standards.

Diagnostic criteria for SAM in children aged 6–60 months		
Indicator	Measure	Cut-off
Severe wasting	Weight-for-height	$< -3SD$
Severe wasting	MUAC ²	$< 115\text{mm}$
Bilateral oedema	Clinical sign	
Reference: WHO/UNICEF Joint Statement		

Figure: 2 Diagnostic criteria for SAM Children aged 6-59 Months .

Introduction: Underweight is becoming a leading cause of child Mortality and Morbidity. Underlying causes of malnutrition is Infections, Diarrhoea ,loss of appetite, vomiting ,lack of financial aid. Therefore certain interventions was becoming necessary for overcoming the consequences of Malnutrition NFHS 3 shows that the proportion of children who are stunted or underweight increases rapidly with the child's age from birth to age 20-23 months; peaking at age 20 months even during the first six months of life, when most infants are breastfed, 20-30 percent of children are underweight. it is notable that by age 18-23 months, when many children are being weaned from breast milk, 30 percent of children are severely stunted and one-fifth are severely underweight.

Until recently, the Management of SAM Children has been restricted to Facility approaches but now Community based Management of Acute Malnutrition in Rajasthan has given great success Rate.

Problem statement: The CMAM approach includes community outreach (for community sensitisation and community involvement, active case finding and home follow-up of problem cases), outpatient management of MAM (depending on the context), outpatient management of SAM without medical complications and inpatient management for the stabilisation of SAM with medical complications. CMAM is closely linked with preventive and other curative health and nutrition interventions and social safety nets. This study is done as to assess the Functioning of CMAM Programme through Primary Data collection by Rapid situational analysis on knowledge and practice of ASHAs and Beneficiaries, in Karauli District of Rajasthan undertaken by NHM Rajasthan.

Review of Literature: Community Action and involvement is necessary to adopt the Communitybased Management of Acute Malnutrition approach. Involving caregivers and authorities in planning processes for identification, treatment, and prevention of malnutrition. Without this, there will be no change in the statistics.

The CMAM approach has 4 components:

1. Under-nutrition awareness and prevention to reinforce Community mobilization: the community ownership, early detection and referral with subsequent follow-up.
2. Once the community workers detect the Outpatient Therapeutic Program (OTP): SAM children, they are referred to the nearest OTP. The OTP sites will open once in a week

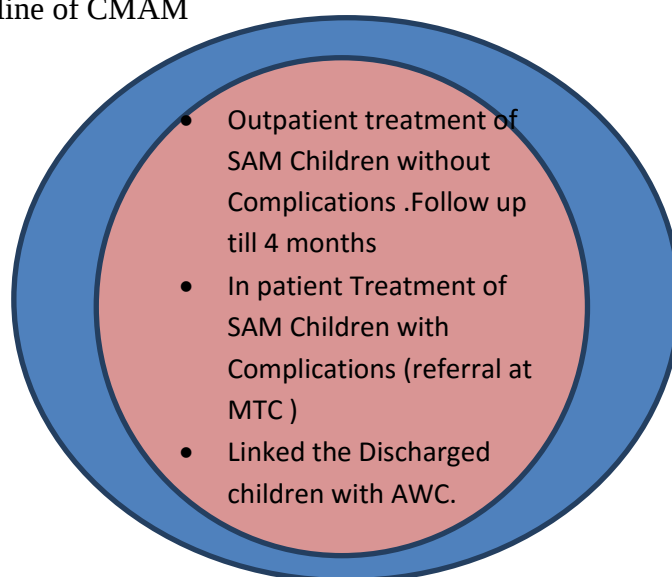
following a regular rotation, and will admit SAM children without medical complications and provide them appropriate follow-up and home-based treatment. The location of these sites will be strategically determined based on the current program catchment area. A clear therapeutic protocol would need to be prior developed and validated based on national guidelines and latest WHO recommendations. An adapted home-based treatment will allow a recovery for SAM children directly within their community, increasing the coverage of the program and easing the follow-up process when compared to the current facilitybased response of 14-day of MTC hospitalization.

3. As currently implemented, moderate Supplementary Feeding Program (SFP): acute malnutrition (MAM) children will keep on being referred to the nearest Anganwadi Centre (ICDS program) to receive supplementary food ration, preventing the risk of deterioration to a SAM condition.

4. In the case of a CMAM approach, this component would mainly Inpatient care: focus on the facility-based treatment of SAM children with medical complications only, threatening their lives and recovery.

The CMAM approach helps creating long-term community-based therapeutic care program to continue throughout the year and decentralizes malnutrition care and treatment, increasing the coverage and making it more accessible to children residing in interior villages.

Figure 3: Outline of CMAM



Investing in prevention is critical but treatment is urgently needed for those who are already malnourished. Until recently, treatment had been restricted to facility-based approaches, thus limiting its coverage and impact. New evidence suggests that large numbers of children with SAM can be treated in their communities without being admitted to a health facility or a therapeutic feeding centre. The community-based approach involves early detection of SAM and provision of treatment to those without medical complications with ready-to-use therapeutic food or other locally produced nutrient dense foods at home. If the community-based approach is appropriately combined with facility-based approach for malnourished children with medical complications at large scale, it could prevent the deaths of thousands.

In India out of Children under 6-59 Months ,6.4% children are Severe acute Malnourished according to (NFHS-3,20005-2006) .85-90% SAM case load can be cured at Community Level and Mortality rate because of Malnutrition can be reduced

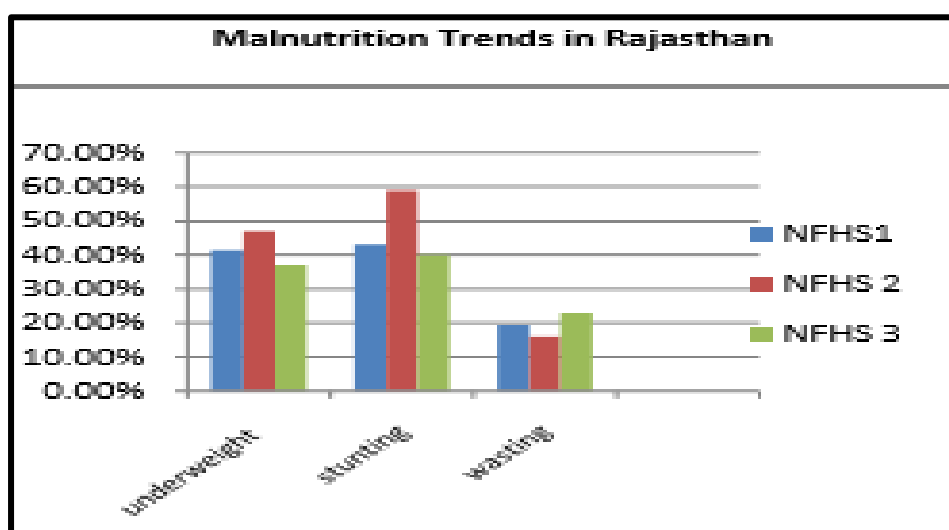


Figure:4 Malnutrition trends in Rajasthan.

Source:NFHS

CMAM programme:

1. Screening by ASHA at Community level, MUAC - > 11.5 cm
2. Identification by ANM, MUAC - >11.5 cm and Z score > -3 SD.

Band	Colour	MUAC point.	Nutrition Status
Green		≥ 12.5	Normal Child
Yellow		11.5 to 12.5 cm	MAM Child
Red		≤ 11.5 cm	SAM Child

Figure 5: Screening Criteria by MUAC

3. In identification Appetite Test is also done for children in the age group of 6-59 Months.

Why appetite test is being done?

- Reasonably accurate assessment of the appetite is often the only way to differentiate a complicated from an uncomplicated case of SAM.
 - By far the best sign of severe metabolic-malnutrition is a reduction in appetite, and the appetite test is the most important criteria to decide if a patient should be sent for in- or out- patient management.
4. Enrolment: SAM without Complications enrolled.
 5. Treatment Phase: Energy Dense Nutrition supplement was given for 2 months, and weakly Poshandiwas have been celebrated for anthropometric Measurements and to monitor progress.
 6. Post Treatment Phase (Follow up phase): In which monthly follow up was done after Treatment has been done till four months and PoshanDiwas is celebrated every month by ANM at sub centre, No EDNS is being distributed in this phase.

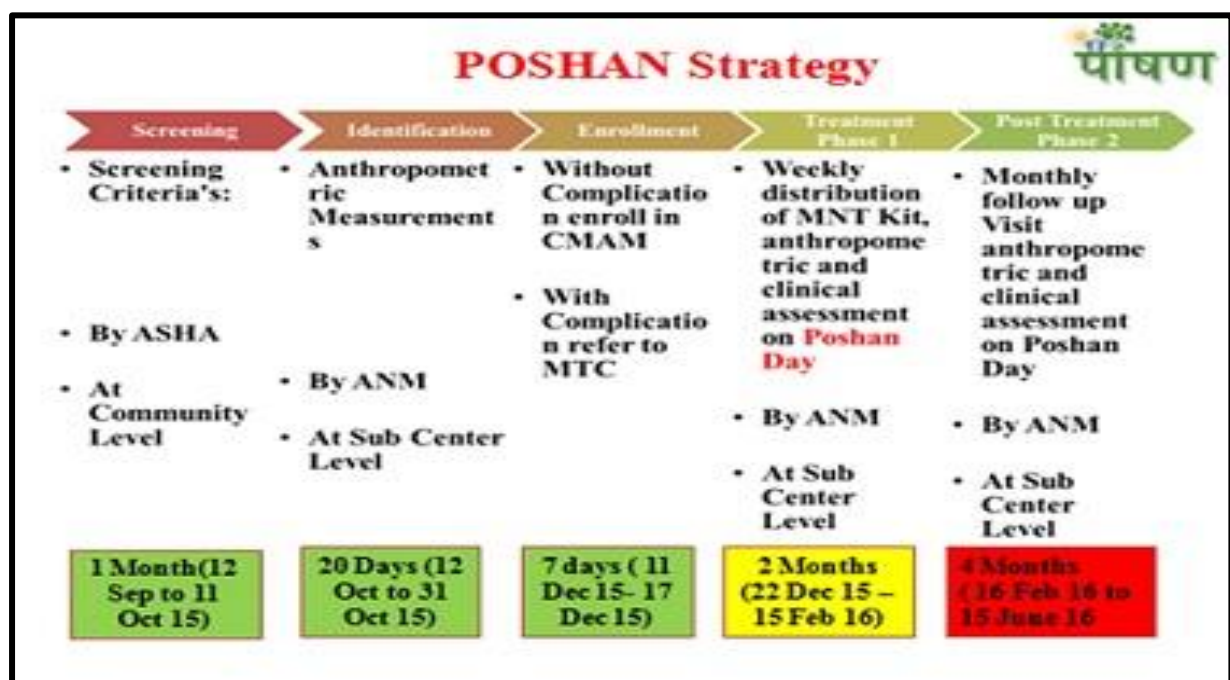


Figure 6: CMAM strategy, source: NHM Rajasthan portal, poshan page.

Rationale:

Childhood undernutrition is a concerning issue for public health and development. Challenges in India for undernourished children have significantly higher risk of mortality and morbidity. Besides increasing the risk of death and disease, undernutrition also leads to growth retardation and impaired psychosocial and cognitive development.

Though Rajasthan Govt. has well planned monitoring and evaluation system for their programmes still, a rapid qualitative situational analysis was done to find the gaps in the functioning for MTC and for CMAM gaining knowledge and skills.

Objective :

1. To assess the knowledge and practice of Beneficiaries regarding Malnutrition and the CMAM Programme.
2. To analyse the knowledge and Practice of ASHA for CMAM programme.

RESEARCH METHODOLOGY:

Study Design: Exploratory Study Design

Study Location: Mandreyal Village Sub centre Sapotra block, Karauli District , Rajasthan .

Sample size: 20 Parents of enrolled children in CMAM programme, 11 ASHAs (poshan Praheri)

Sampling Method: Non-probability, Convenience Sampling

Sample selection criteria:

Inclusion Criteria:

1. Mothers who were willing and available during the period of study.
2. Mothers whose children were enrolled in the CMAM Project and who are in age group of 6 to 59 Months.

Exclusion Criteria:

1. Mothers who have children with history of Complications.

2. More than 59 Months children were not included.

Study Duration: One month

Study Respondents: Parents of Enrolled Children in CMAM

Methodology: For Primary Data collection: According to convenience sampling the intern was told to visit Mandreyal village of Block Sapotra, Karauli District. As poshan diwas is celebrated on one day in Follow –up month, only one sub centre is visited. The study is confined to one sub –centre only as to gain knowledge of the system. A Rapid Situational analysis tool was prepared for ASHA and the parents of SAM Child enrolled, at their home setting in Mandreyal village the Questions were asked and the responses were recorded. The Questions were close ended as to explore whether the Target population falls into that Range of responses, with the intent to find Probable reasons.

DATA ANALYSIS PROCEDURE:

Data is interpreted through coding in MS-Excel.

The Questionnaire records responses from the parents of the enrolled Children and ASHAs of the sub centre.

- The coding for the answers given by them is recorded as CODE-1
- The coding for the options not given by the respondents is recorded as CODE -0 .
- The Data collected is interpreted and analysed with the help of diagrams and Graphs.

RESULTS:

- When the Questions based on knowledge and Practice were asked from the Parents of the enrolled SAM Children. Results of Some Indicators are highlighted as related to

❖ On Knowledge

1. **Chart Addressing probable causes of Malnutrition by the Parents on the basis of their Knowledge (N=20), where N is No. of Respondents .**

❖ CAUSES OF MALNUTRITION

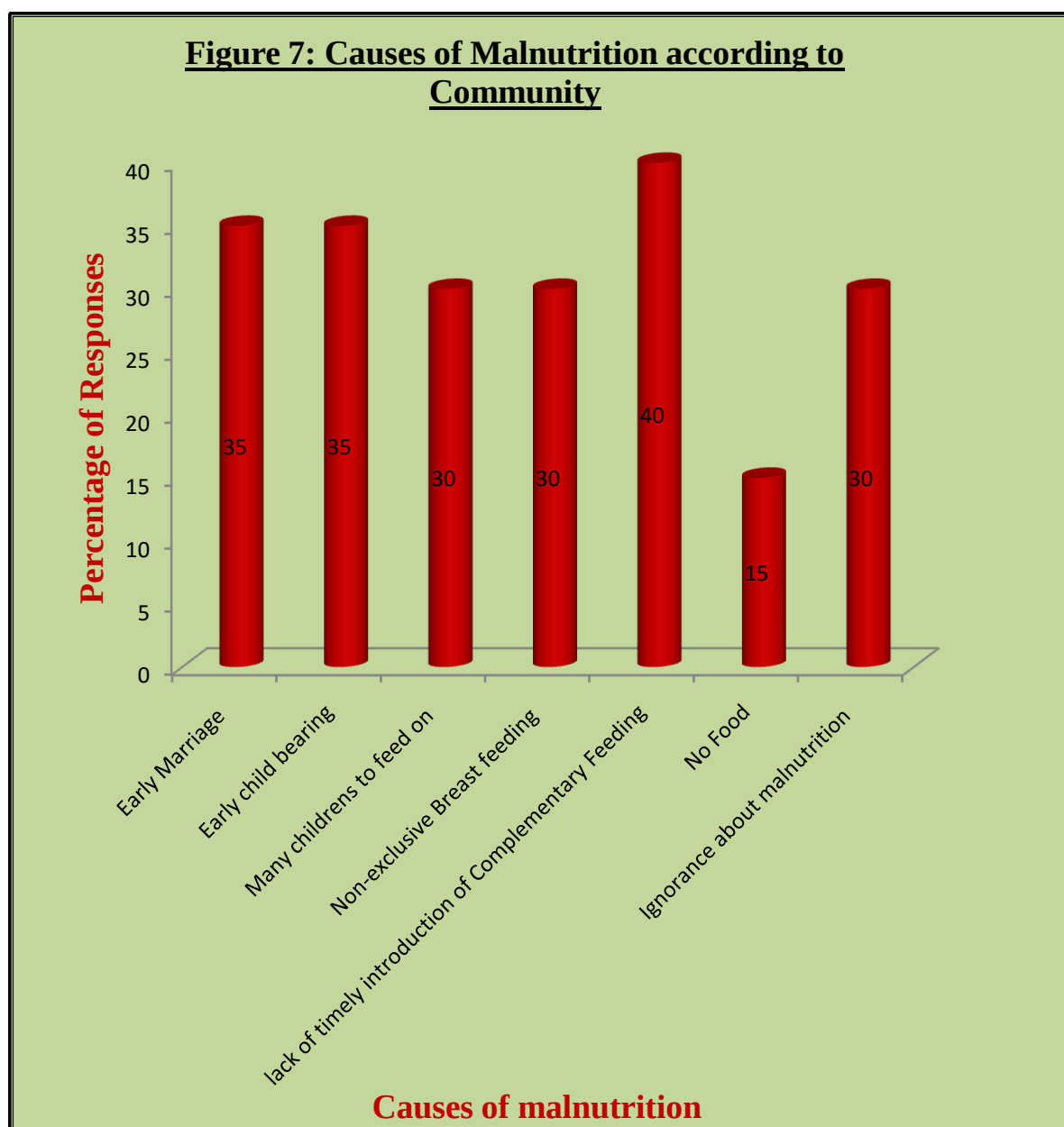


Table 1:Causes of Malnutrition.

Knowledge	Early Marriage	Early child bearing	Many children to feed on	Non-exclusive Breast feeding	lack of timely introduction of Complement ary Feeding	No Food	Ignorance about malnutrition
Percentage% (Yes)	35	35	30	30	40	15	30

Interpretation:

1. The Major causes of Malnutrition which were recorded are Early Marriages and Child Bearing .Along with that knowledge on Breast Feeding was not given Importance at early stages of Child's development ,which then became the Major reason of their Child being a Target Of Malnutrition .

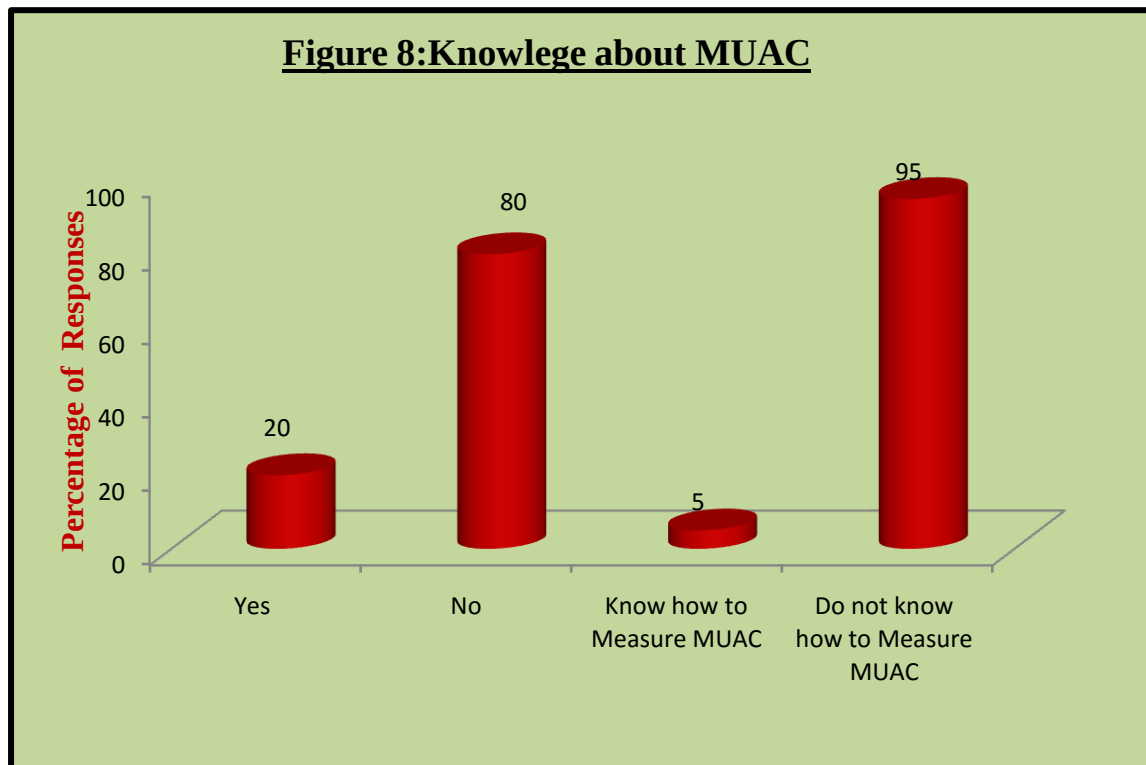
2. Knowledge about MUAC

Chart addressing Knowledge of MUAC (Mid Upper Arm Circumference) and How to measure MUAC through MUAC tape.

Table 2 :Knowledge in MUAC.

Knowledge	Yes	No	Know how to Measure MUAC	Do not know how to Measure MUAC
Yes(%)	20	80	5	95

❖ KNOWLEDGE ON MUAC



3. Out of the sample, there are only 20% who know about MUAC and out of those only 5% know how to measure Mid Upper arm Circumference (MUAC) from MUAC Tape. If Parents are unsure about their Child's health they will certainly not report for the same. Accountability of parents on their child's Health status was unclear in the minds.
4. **Chart depicting probable causes of Delay in action for seeking Treatment for Malnutrition.**

❖ REASONS FOR DELAY IN TREATMENT

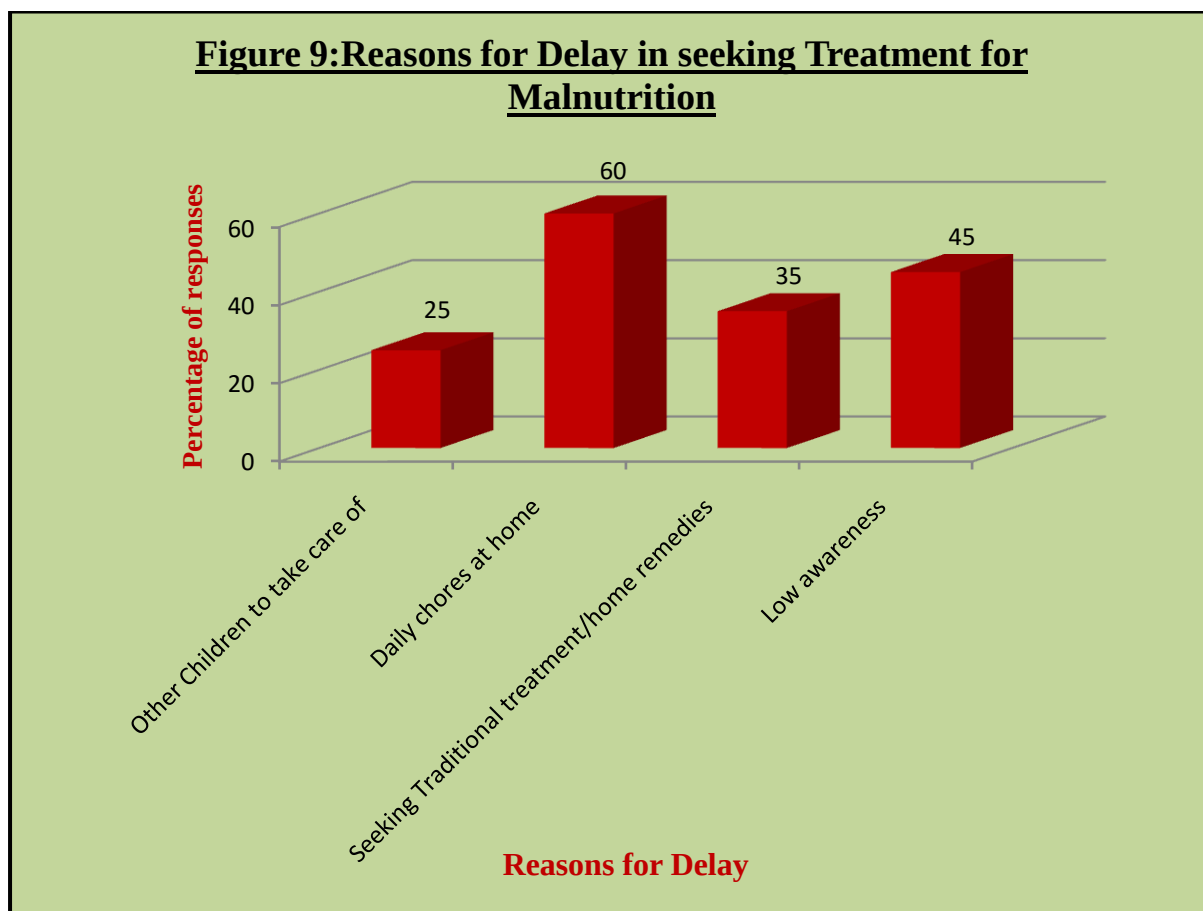


Table 3: Reasons of delay in Treatment.

Knowledge	Other Children to take care of	Daily chores at home	Seeking Traditional treatment/home remedies	Low awareness
Yes(%)	25	60	35	45

3. According to Health belief model, the Delay in action should be addressed as according to Parents the Delay in seeking Treatment for Malnutrition was low awareness, many other Children to be taken Care of daily chores at home side and opting for Traditional treatments and Home remedies were noted.

5. Chart displaying the estimated waiting time by the parents of enrolled children for anthropometric Measurements on PoshanDiwas.

❖ **ESTIMATE TIME ON POSHAN DIWAS**

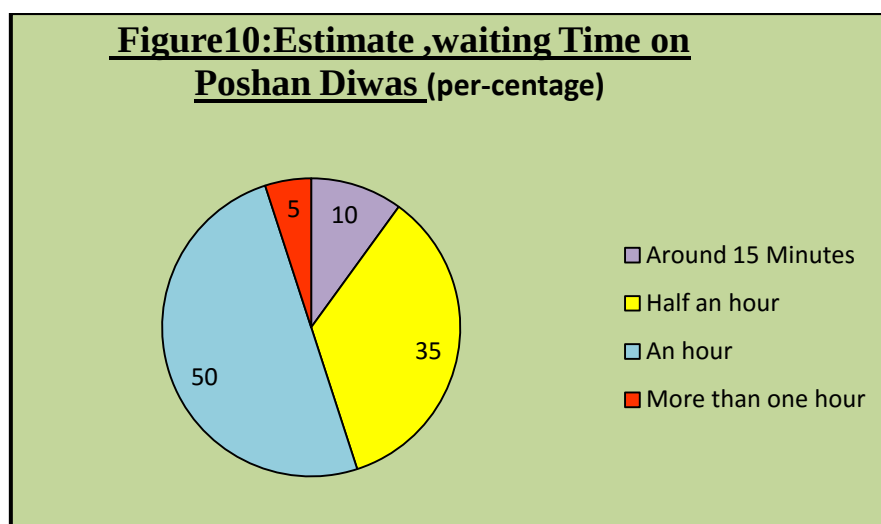


Table 4:Estimate time on PoshanDiwas

Knowledge	Around 15 Minutes	Half an hour	An hour	More than one hour
Yes (%)	10	35	50	5

3. On average 50% respondents said their waiting time for their turn is around an hour, which makes parents uneasy in hot summer to take their child on the PoshanDiwas. This time is ideally can be used for counselling activities, as such at the sub centre no activities were seen at the moment.

6. Chart showcasing the Knowledge of mothers regarding Breast feeding (N=20)

❖ KNOWLEDGE OF BREAST FEEDING

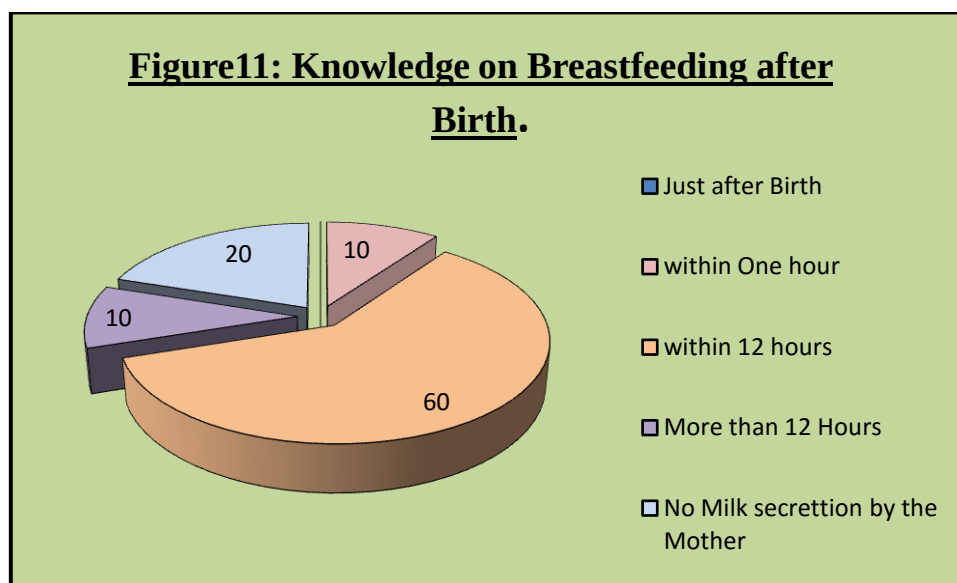


Table 5: Knowledge on Breast Feeding.

Knowledge	Just after Birth	within One hour	within 12 hours	More than 12 Hours	No Milk secretion by the Mother
Yes(%)	0	10	60	10	20

5. Approximate 60% women Breast fed their Child within 12 hours after Birth, which should ideally be after an hour of Birth, the Child should be breastfed as this First milk, Colostrum is rich in Nutrients ,protects the child from Infections and Immunes the Child's Body.

❖ On Practice :

1. Chart displaying the practice of Hand washing by women before feeding their child either Breast Milk or food.

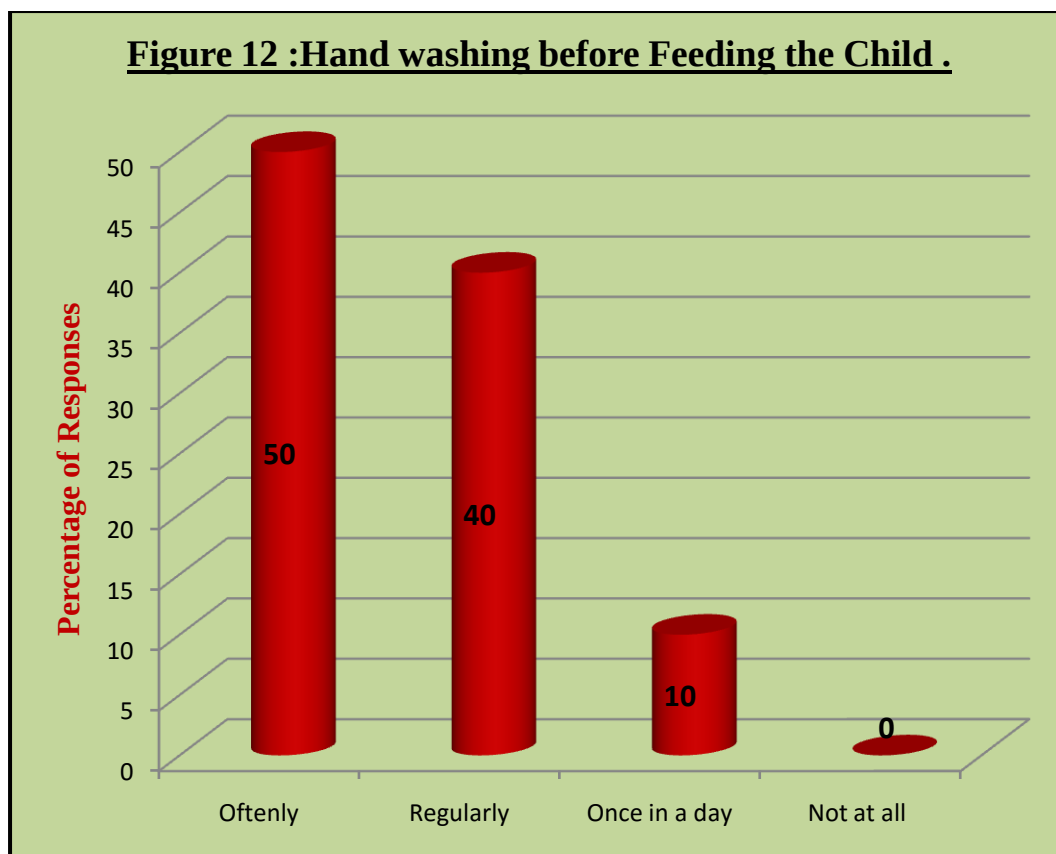
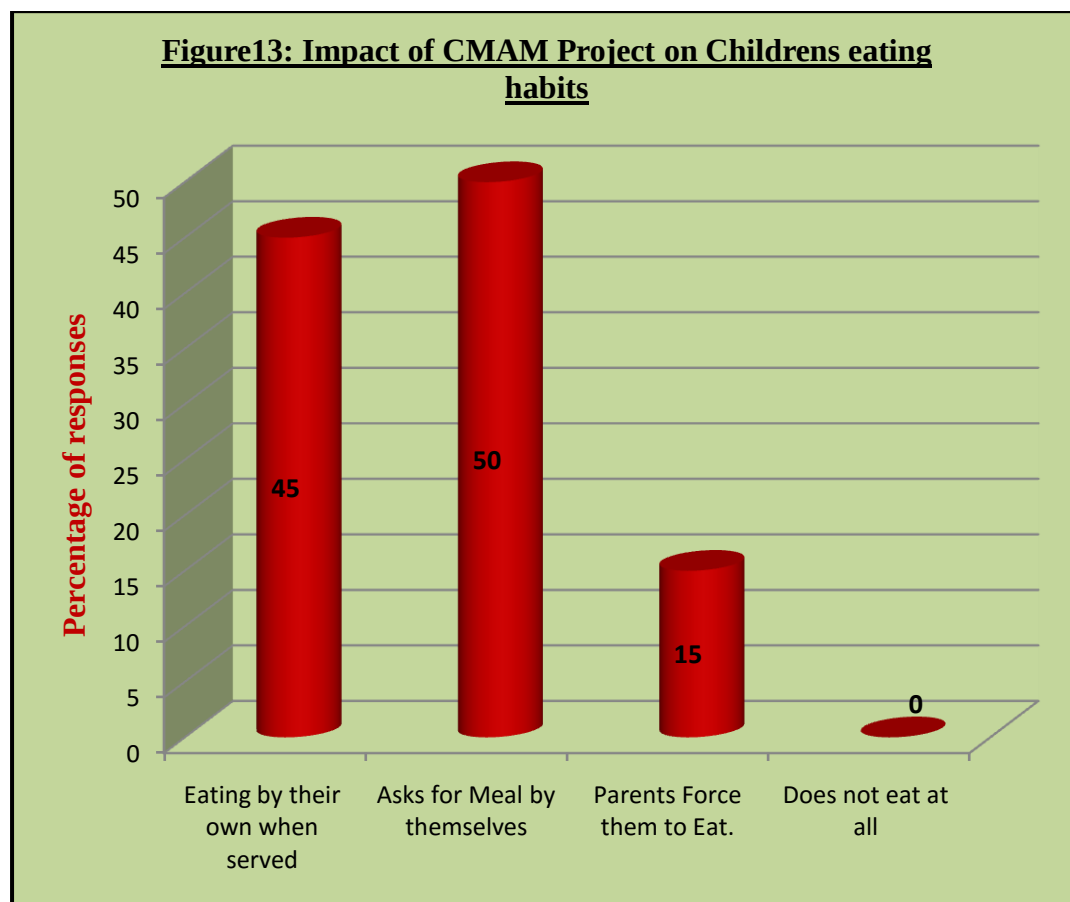


Table 6: Hand washing before feeding

Practice	Often	Regularly	Once in a day	Not at all
Yes(%)	50	40	10	0

On Practice of parents :1.Hand washing is practiced at hardly 50% of respondents, they are those who do not have basin but do wash hands in washrooms .This practice although not assures that hand washing technique is practiced with Soap, which lowers infection.

Chart depicting impact of children Eating Habits after enrolling into the programme CMAM (Community Based Management Of Acute Malnutrition).



When the Questions based on knowledge and Practice were asked from the Parents of the enrolled SAM Children. Results of Some Indicators are highlighted as related to:

- ❖ **On Knowledge:** 1. Chart showing the understanding about what CMAM is meant for and for whom by the PoshanPraheris (ASHA). Where sample size , n=11

Poshanpraheris

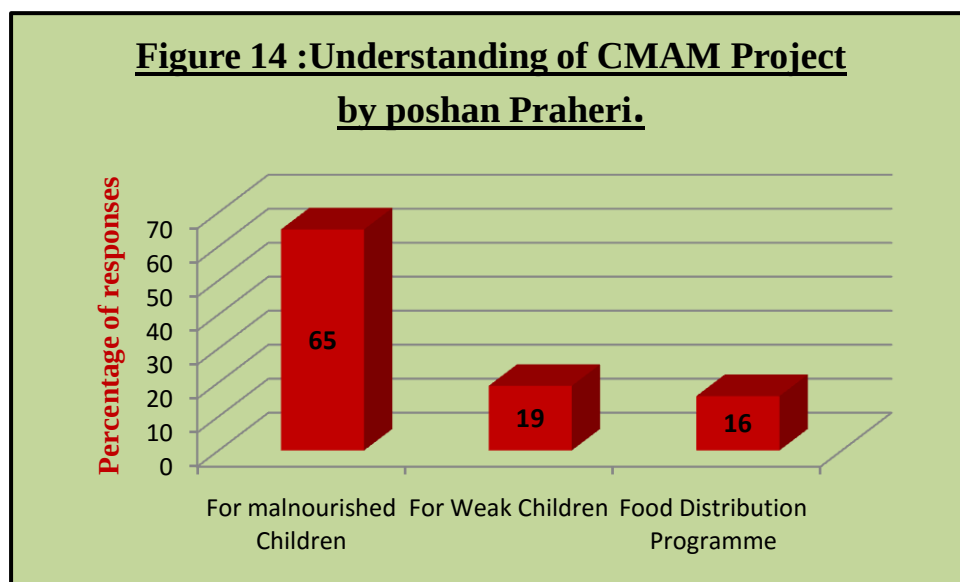


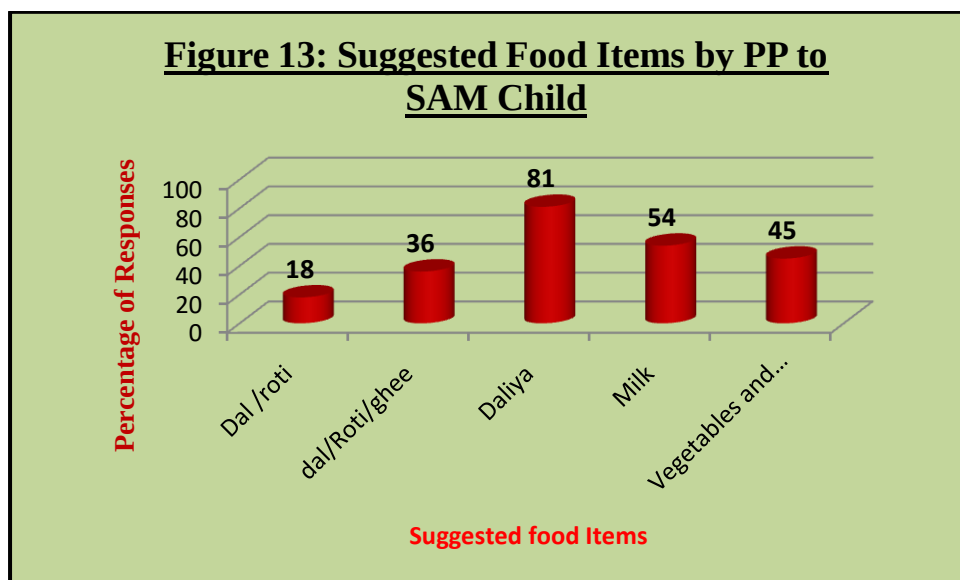
Table 8: Understanding of CMAM by PP.

Knowledge	For malnourished Children	For Weak Children	Food Distribution Programme
Yes	65	19	16

On knowledge of PP:Hardly 65% know the difference between a malnourished child and a weak Child, ideally the screen the SAM children she should be clear what all malnourishment Includes (Stunting, Wasting, Underweight).

2. Chart displaying the Food items suggested by the Poshanpraheri to parents as home-made food in follow –up Phase. Where sample size, n=11 poshanpraheri.

❖ **SUGGESTED FOOD ITEMS BY POSHAN PRAHERI.**



2.ASHA were active in nature and good Nutrients enriched foods are being suggested by them to the Mothers of Enrolled Children as Home Made food like Daliya,Dal-roti,ghee,vegetables and Fruits.

3. Chart displaying the Probable factors for which Parents attend poshan diwas according to poshan Praheri's knowledge .

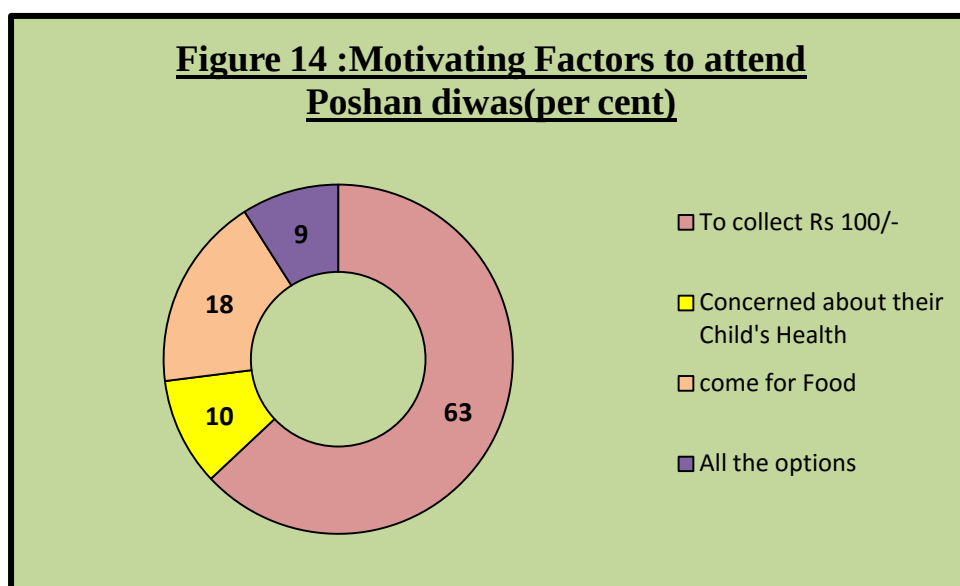
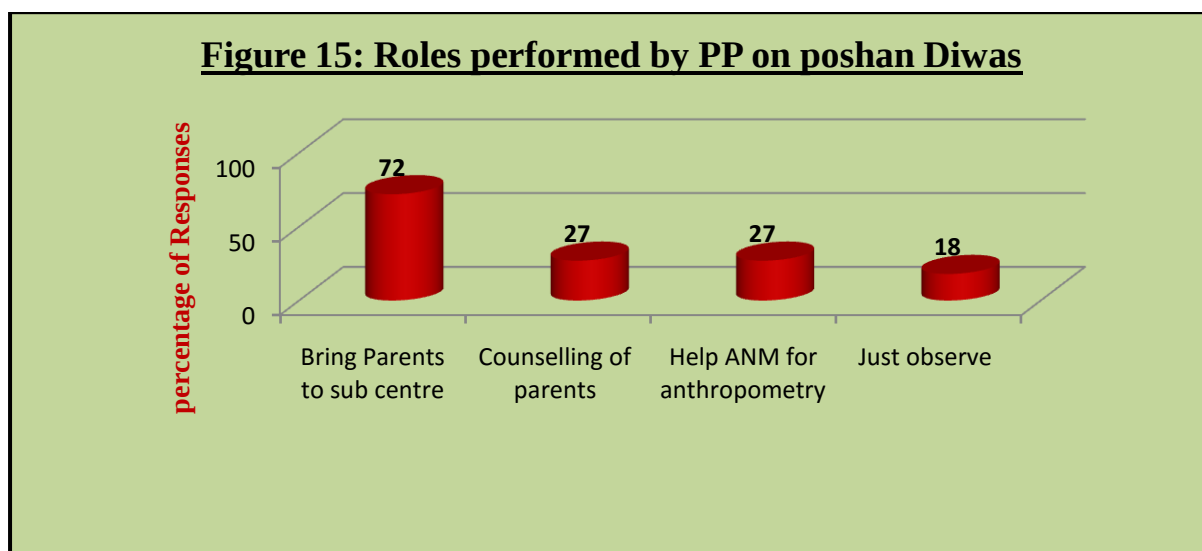


Table 10:Motivating Factors for Beneficiaries.

Practices	To collect Rs 100/-	Concerned about their Child's Health	come for Food	All the options
Yes(%)	63	10	18	9

3. According to Poshanpraheeri the Parents come to sub-centre for attending poshandiwas as to collect Rs100/- which is given as a Travelling allowance to parents .The remaining are really concerned about their Child's Health and the rest come for Food .

❖ **On practice1.**Chart showing the Roles performed by the Poshanpraheeri on Poshandiwas, which she need to be aware of according to her.

**Table 11:Roles of PP on PoshanDiwas.**

Practices	Bring Parents to sub centre	Counselling of parents	Help ANM for anthropometry	Just observe
Yes(%)	72	27	27	18

On Practice:

1. Around 72% ASHAs responded that their task on PoshanDiwas is just to bring the Parents at the Sub –centre. Rest says counselling and helping the ANM in

anthropometry Measurement is their role, although they were not seen doing the same, they were just observing the work.

LEARNINGS:

1. The intern has gained extensive knowledge about the program through Literature Review.

2. The Intern has attended various meetings for CMAM including Rajasthan Action Plan with UNICEF and ICDS in which she learned how to put forth one's opinions and suggestions in front of Development Partners. Meeting Minutes of previous meeting is given keen emphasis on, as based on those further discussions is carried out.

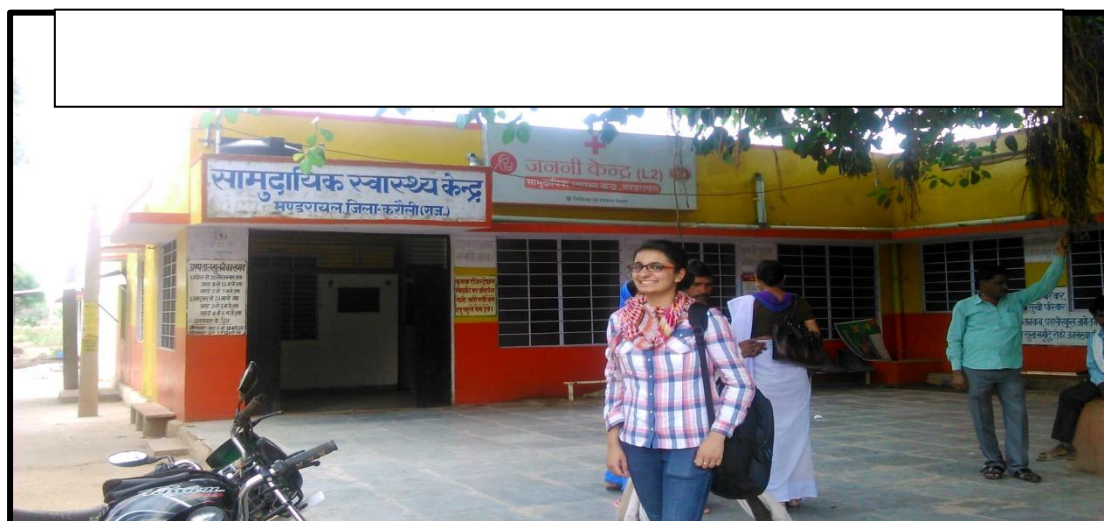
3. She learned to make Budget proposals and gave some inputs for BARAN CMAM Project which was planned as Phase –II of CMAM.

4. Field Visits Learnings: The purpose of field visit was to develop an understanding of the CMAM Project as to do the Situational Analysis.

- Before going to field learned Measurement Indicator of the CMAM Project as how to measure MUAC (Mid Upper Arm Circumference) and Z-score from Z score Table i.e. Weight for Height.
- Celebration of Poshan Diwas at Sub centre, in which Measurements are recorded on Poshan Yatra Book of enrolled Children. Where the Intern Learned the Monitoring and Evaluation skills from the State Monitor.
- Home visits: It was impressive to see meeting people and expanding my own personal boundaries. The Data collection could not have been possible if home visits were not done, the real impact of the Programme can be known by sharing experiences from the Beneficiaries personally.



Picture 1: Intern with the ASHAs and ANM at Home visits.



Picture 2: Field Visit to Sub centre by the Intern



Picture 3: Anthropometric Instruments at sub-centre.



Picture 4: Monitoring the PoshanYatra Book of enrolled Children

- Attended POSHAN Retreat for Brainstorming on CMAM Project for subsequent phases, where the Intern interacted with UNICEF CFO and GAIN Country Head, how they Provide Technical and Financial support to Government of India. the Intern also learned the Leadership qualities from **MD NHM, IAS Naveen Jain**, how he is determined for his work and take all the Development partners under one umbrella .

Picture 5: CMAM Team with MD NHM Rajasthan



CHALLENGES FACED DURING DATA COLLECTION :

- Two months' time period was becoming short to study huge sample.
- Sample size taken is small and size might not represent the entire universe of the study.
- Bias may be introduced depending on the location used for data collection.

RECOMMENDATIONS:

Based on the project work:

1. Extensive Training Modules should be made which can teach the ASHAs and ANMs on counselling part and the Mothers on their child's Health and on Breastfeeding knowledge, related to Importance of First Milk

2. ASHAs can exclusively use the Poshan Diwas waiting time of Parents to counsel them on their Child's Health as to avoid relapse cases, which will save their time for Home visits too in hot summers.

3. The only way to guarantee Development of the Public Health is to focus on the systematic and sustainable solutions from the community itself.

Based on the Programme understanding at State Level:

1.Strengthen Community Mobilisation : If community is unaware about the services provided, they will not utilise it to the fullest. Who are the target population, where to get the access from and what are the benefits will be unexplored by them. This confusion will act as threats which will then not convince others too to take the advantage. A community mobilisation strategy should be planned and implemented before the start of treatment activities in the health facilities.

Connecting with them at their door steps may not be possible every time but what connects them can be thought of where communication mobilisation can be planned out.

Various community mobilisations are suggested:

1. Audio and Video plays at Ration shops, while villagers wait in a Queue.
2. Nukadnatak by Health volunteers and social personnel's on weekends.
3. Preliminary meetings with community leaders could be held and enlist their support to Mobilize community participation.
4. Radio is extensively used in villages as a source of information, radio audio can be a better Option.
5. Male members should be made accountable as they are generally the decision makers in the village settings. Counselling done for them could be an asset for the families health.

2.Management Information system : This is where the Pilot Project was lacking behind, the database is something on which the further Implementations and formulations are planned.

Suggestions as follows:

1. Handling of the software by NIC.
2. PPP (Public Private partnership) will ensure Data handling seriously, Giving Project to third Party.

Project Report

INTRODUCTION:

One in every twelve children under five in the world today is suffering from a condition that is preventable. These children are at risk of dying because of Acute Malnutrition. What is shocking is that India contributes to the maximum number of wasted children in the world. According to UNICEF, every year 1 million children under the age of 5 die due to malnutrition related causes in India. The statistics were becoming alarming. Therefore, Under National Rural Health Mission, Nutrition Rehabilitation Centres have been set up with the intention to improve the quality of care being provided to children with SAM and to reduce child mortality.

The Department of Medical and Health Services, Department of Women and Child Development, Government of Rajasthan, and UNICEF took the lead in addressing acute undernourishment in children, by operationalizing Malnutrition Treatment Centres (MTCs) as a pilot initiative.

AIM:To assess the Malnutrition Treatment Centre as a functional and structural unit in District Hospitals and Community Health Centre.

LITERATURE REVIEW:

Operational Definitions:

Admission Indicators

1. New admission: An admitted patient who has never been in the programme before.
2. Re-admission: A defaulter who has come back to the program within 2 months.
3. Relapse: A patient who has been discharged as cured from the programme within the last 2 months but is again eligible for admission to MTC. A large number of relapses are often a sign of food insecurity.

Exit Indicators Exit indicators provide information about the proportion of patients completing the treatment successfully or not successfully (recovered, defaulter, death). They are calculated as a percentage of the total number of exits (discharges) during the reporting month.

1. Recovery (or cured) rate: number of beneficiaries that have reached discharge criteria within the reporting period divided by the total exits.

2. Defaulter rate: number of beneficiaries that defaulted during the reporting period divided by the total exits. Defaulter will be a child with SAM admitted to the ward but absent (from the ward) for three consecutive days without been discharged.

3.Non-respondent: This exit category includes those beneficiaries who fail to respond to the treatment e.g. the patient remains for a long period of time under the target weight. if after investigation there are no specific reasons for failure or actions that can be taken to improve the treatment, the patient should be referred to an appropriate higher level facility.

Acceptable levels of Care

Indicators	Acceptable	Not acceptable
Recovery Rate	>75%	<50%
Death Rate	<5%	>15%
Defaulter Rate	<15%	>25%
Weight Gain (g/kg/d)	≥ 8 g	<8g
Length of stay(weeks)	1-4	<1 and >6

Admission criteria

Criteria for admission for inpatient treatment Children 6-59 months

Any of the following:

- MUAC<115mm with or without any grade of oedema
- WFH < -3 SD with or without any grade of oedema
- Bilateral pitting oedema +/-++ (children with oedema +++ always need inpatient care)

WITH

Any of the following complications:

- Anorexia (Loss of appetite)
- Fever (39 degree c) or Hypothermia (<35 c) Persistent vomiting
- Severe dehydration based on history and clinical examination
- Not alert, very weak, apathetic, unconscious, convulsions
- Hypoglycaemia
- Severe Anaemia (severe palmar pallor)
- Severe pneumonia
- Extensive superficial infection requiring IM medications
- Any other general sign that a clinician thinks requires admission for further assessment or care.

In addition to above criteria if the caregiver is unable to take care of the child at home, the child should be admitted.

- Infants < 6 months infant is too weak or feeble to suckle effectively (independently of his/her weight-for-length).OR
- WFL (weight-for-length) < -3SD (in infants >45 cm) or Visible severe wasting in infants <45 cm OR
- Presence of oedema both feet
- Other reasons for inpatient enrolment
 - Readmission: child previously discharged from in-patient care but meet admission criteria again.
- Return after default: child who returns after default (away from in-patient care for 2 consecutive days) and meets the admission criteria.

The principles of management of SAM are based on 3 phases: Stabilization Phase, Transition Phase and Rehabilitative Phase.

Stabilisation Phase: children with SAM without an adequate appetite and/or a major medical complication are stabilized in an in-patient facility. this phase usually lasts for 1–2 days. the feeding formula used during this phase is Starter diet which promotes recovery of normal metabolic function and nutrition-electrolytic balance. All children must be carefully monitored for signs of overfeeding or over hydration in this phase.

Transition Phase: this phase is the subsequent part of the stabilization phase and usually lasts for 2-3 days. The transition phase is intended to ensure that the child is clinically stable and can tolerate an increased energy and protein intake. the child moves to the transition Phase from Stabilization Phase when there is: At least the beginning of loss of oedema And Return of appetite And no nasogastric tube, infusions, no severe medical problems And is alert and active the only difference in management of the child in transition phase is the change in type of diet. there is gradual transition from Starter diet to catch up diet (F 100).the quantity of catch up diet (F100) given is equal to the quantity of Starter diet given in stabilization Phase.

Rehabilitation Phase: Once children with SAM have recovered their appetite and received treatment for medical complications they enter Rehabilitation Phase. The aim is to promote rapid weight gain, stimulate emotional and physical development and prepare the child for normal feeding at home. the child progresses from transition Phase to Rehabilitation Phase when:

- S/he has reasonable appetite; finishes > 90% of the feed that is given, without a significant pause
- Major reduction or loss of oedema no other medical problem

OBJECTIVES:

To assess the functioning of Malnutrition treatment centres in 10 Bedded District Hospitals.

RESEARCH METHODOLOGY:

Research design: The study is cross sectional descriptive in nature.

Study Location: 10 bedded District Hospitals, J.K Lon Hospital, Kanwariya Hospital, Dausa District Hospital and SavaiMadhopur district Hospital in Rajasthan.

Study duration: One month

Study respondents: MTC In charges and Paramedical staff, few parents.

Methodology: According to the Convenience the Intern was told to Visit 4 District hospitals which are 10 bedded .The 4 hospital's MTCs (Malnutrition Treatment Centre) were visited on separate Days. The questionnaire is made from the checklist from Rajasthan govt. Guidelines for MTC /NRC. The questionnaire were asked from the MTC Incharge and

Paramedical staff , the records were verified from the Record Booklets and asked from the Parents of the admitted children with SAM. The Primary Data collected is open ended and descriptive in nature as to know the pros and cons of the system functioning. The lacunae in the functioning of poor performing MTC were recorded and Suggestions and Recommendation is provided in the study.

DATA ANALYSIS PROCEDURE :The Data is analysed through the comparison tool ,based on the checklist filled by the Intern .The differences in the checklist is used as the Probable causes of low performing MTC i.e. for Dausa and SavaiMadhopur MTC .The comparison is based on the structural ,working ward conditions .

DATA INTERPRETATION AND CONCLUSION:

Scale: **Satisfactory**–More than 70%

Unsatisfactory -40%-70%

Poor- less than 40%

Table 12: Comparative analysis

PARAMETER	Kanwatiya	J.K Loan	Dausa	SavaiMadhopur
1. Hygiene				
Hand washing	Satisfactory	Unsatisfactory	Unsatisfactory	Poor
Mother's cleanliness	Satisfactory	Unsatisfactory	Unsatisfactory	Poor
Bedding and laundry	Satisfactory	Satisfactory	Unsatisfactory	Unsatisfactory
General maintenance	Satisfactory	Satisfactory	Unsatisfactory	Unsatisfactory
Food storage	Satisfactory	Satisfactory	Poor	Poor
Dish washing	Satisfactory	Unsatisfactory	Satisfactory	Poor
Toys	Unsatisfactory	Unsatisfactory	Satisfactory	Poor
2. Ward procedure				
Feeding	Satisfactory	Satisfactory	Unsatisfactory	Unsatisfactory
Warming	Unsatisfactory	Unsatisfactory	Poor	Poor
Weighing	Satisfactory	Satisfactory	Unsatisfactory	Unsatisfactory
Giving antibiotics, medications, supplements	Satisfactory	Satisfactory	Unsatisfactory	Poor
Ward environment	Satisfactory	Satisfactory	Poor	Poor

Conclusion:Based on the Comparison on the subjective Scale decide by the Intern ,the comparison is done and it was found that Kanwatiya and J.K lon District Hospitals are

performing well as they have good hygienic conditions ,well maintained record on Ward procedures ,Hospitality .On the contrary Dausa and SavaiMadhopur Hospitals are lagging behind due to which they have poor performance .proper documentation was not done of the Children.The ward environment was not Patients friendly which may prolong theAverage length of stay.

KEY OBSERVATIONS:

During Field Visit it was observed:

Some which are common in all MTCs.

- **Water and Sanitation:** The availability of safe drinking water and sanitation facility was assured by the hospital in all the centres visited. Mothers reported that the attached toilet and bathroom is well maintained by the hospital staff.
- The IEC materials related to F75 and F100 diet make up or for counselling by staff were pasted on walls but it fails to have a real Impact.
- **Record of the admitted and discharge children:** The centres have maintained the record book to key track on the treatment of each SAM child admitted in the centre.But It was seen the records were maintained just to send the reports on state level ,proper monitoring and tracking of children were lacking after they have been discharged. The Quality work is being compromised.
- Some distinct Observations specific to MTCs, **InKanwatiya District Hospital**



**Picture 7:Kitchen of Kanwatiya Hospital
Where the food is being prepared.**



Picture 8: Toy room at Kanwatiya MTC

In Savaimadhopur.

- Hospital management has separated the paediatric ward with the MTC,therefore the Doctor was not able to give time to MTC.

- The hospital staff did not know about the financial budget allocation for spending the funds.
- F75 and F100 diet was not given to Admitted children, rather the children who are less than 2 years old are fed khichdi which is of poor quality. Daily requirement as per number of children is received from the common kitchen.
- The bed size is extremely small for a mother and her Child to accommodate for long, especially for 10-15 Days.
- Availability of kitchen area: As per operational guidelines by Ministry of Health and Family Welfare Kitchen and food storage area should be attached to ward, or partitioned in the ward, with enough space for cooking, feeding and demonstration. On visiting the MTCs we found that there is no kitchen area attached to any of the centre visited and the food is prepared in the common kitchen of the hospital.



Picture 9: MTC at savaiMadhopur District visited by the Intern.



Picture 10: The child was weighed by the Intern as to verify the anthropometric Measure.

In Dausa ,district Hospital:

- Space is not adequately utilised.
- F75 and F100 diet was not given to Admitted children,rather the children who are less than 2 years old are fed khichdi which is of poor quality. Daily requirement as per number of children is received from the common kitchen.
- The record keeping On various Indicators such as Recovery Rate, Death rate , Defaulter Rate ,are calculated randomly without proper formulae .

RECOMMENDATIONS:

Admission and Discharged Criteria:First and foremost some centres were unclear about the admission criteria for SAM children, as the staff admits just on the basis of the Doctor referring the Child to MTC .The discharge criterion as per the govt. guideline needs to be followed properly and a proper follow up mechanism needs to be put in place. Strong convergence between health & ICDS in regard to admission, discharge and their follow up of SAM children needs to be established.

- Generating awareness of Government Guidelines and Support on MTC among general public and field level service providers.

- Staff employment at SavaiMadhopur at the earliest including the recruitment of Nutrition counsellor who will take the responsibility of counselling the parents of the admitted children.
- A good documentary could be made which can be played twice a day while the counsellor is counselling the Parents at those MTC, which have Television Facility or it can be projected at other MTC too.
- MTC trained human resources needs to be at priority.
- Establishment of Child Friendly environment is also important as providing toys for showcasing them is of no use if it is not influencing children to play and a space for playing should be cleaned regularly
- Institutionalize system of follow up of discharged/LAMA cases by frontline Workers. As the Incentives for follow up by ASHA has been removed which in turn not keeping them motivated to bring children for Follow –up.

DISCUSSION:

- **Mother's illiteracy:** It has been observed that the mothers of the admitted children are illiterate and do not possess knowledge regarding malnutrition and its treatment nor do they know much about the condition or improvement in the health of their children. Most of the mothers reported that they have not been to school ever and early marriage with early child bearing is one of the reasons.
- **Age of the mothers:** While the interviewer was asking questions about their age, some of them hardly know their age even though some know they were not sure about the exact ages and were below 20 when they got married. Since early marriage resulting in early child birth is one of the major reasons resulting in low birth weight and weight of a newborn determines the survival chances of the child and has long-term health, physical and psychological development. Therefore, children born to teenage mothers are at high risk of malnutrition and mortality.
- **Behaviour of staff/doctors:** It has been observed that doctors are not sensitized towards the issue and severity of malnutrition. On inquiring that whether they contact any AWW or ASHA for follow up of the discharged children, they refused to do so and if they said yes, they do not have updated contact details of the locality. It was observed that doctors or staff doesn't give any importance towards the counselling of mothers regarding the care and feeding practices of children. On inquiring parents,

they reported that neither the doctor nor the staff nurses counsel them about the importance of nutritious food, cleanliness and clean drinking water for the child, except the **Kanwatiya Hospital**.

ETHICAL CONSIDERATION

- Confidentiality of the respondents was maintained throughout the study as to ensure anonymity.
- Respect and dignity of the respondents were taken care during the study and respondents were offered clear explanation of the study intentions, post which they were asked for approval of participation in the form of Informed Consent Form.
- Information received by the respondents will not be misused in any form.

BIBLIOGRAPHY :

- a) Acute Malnutrition: An everyday emergency Baran, Rajasthan. (2016). *Action Contrelafaim*. Retrieved from http://blog.actioncontrelafaim.org/ACF_India_Baran_Rajasthan_report.pdf
- b) *Acute Malnutrition: Situational Analysis in the States of Rajasthan and Madhya Pradesh*. (2010). <http://www.fighthungerfoundation.org/>. Retrieved 4 July 2016, from http://www.fighthungerfoundation.org/supporting_files/Library/Acute%20Malnutrition%20Situational%20Analysis.pdf
- c) Dr Sujata S. Pol,. (2015). *A Child with Chronic Severe Malnutrition in a Tribal Village of Maharashtra – A Case Study*.. Mumbai: Dr Sujata S. Pol1, Dr Pallavi S. Shelke2, Dr Deepika P. Vora3, Dr Ramesh M. Chaturvedi2. Retrieved from http://www.journalofcomprehensivehealth.co.in/archive/jan2015/Case_Report.html
- d) Duggan, C., Walker, W., & Watkins, J. (2003). *Nutrition in pediatrics*. Hamilton, Ont.: B.C. Decker.
- e) Duggan, C., Watkins, J., & Walker, W. (2008). *Nutrition in pediatrics*. Hamilton: BC Decker. *Framework for integration of management of SAM into national health systems | ENN*.(2016). *Ennonline.net*. Retrieved 4 July 2016, from <http://www.ennonline.net/fex/43/framework>
- f) *Module 6: Supplementary Feeding for the Management of Moderate Acute Malnutrition (MAM) in the Context of CMAM*. (2016) (1st ed.). Retrieved from http://www.fantaproject.org/sites/default/files/resources/CMAM_Training_Mod6_ENGLISH_No_v2008.pdf
- g) Nagar, R. P., Nagar, T. & Gupta, B. D. (2016) Treatment outcome in patients with severe acute malnutrition managed with protocolised care at malnutrition treatment corner in Rajasthan, India: a prospective observational study (quasi-experimental). *International Journal of Research in Medical Sciences*, 4 (1), 238-245. doi:10.18203/2320-6012.ijrms20160037
- h) *NATIONAL TRAINING STRATEGY for IN-SERVICE TRAINING UNDER NATIONAL RURAL HEALTH MISSION*. (2016) (1st ed.). Ministry of Health & Family Welfare Government of India NirmanBhawan New Delhi – 110 011. Retrieved from http://nrhmmeghalaya.nic.in/guidelines/National_Training_Strategy_Final.pdf

- i) *Operational Guidelines on Facility Based Management of Children with Severe Acute Malnutrition*. (2011) (1st ed.). INDIA. Retrieved from <http://www.cmamforum.org/Pool/Resources/Operational-guidelines-on-facility-based-management-of-children-with-severe-acute-malnutrition-India-2011.pdf>
- j) PAIRVI. (2016). *Working of Malnutrition Treatment Centers: An assessment of MTCs in Rajasthan May, 2013 New Delhi, India* (1st ed.). RAJASTHAN: Public Advocacy Initiatives for Rights and Values in India. Retrieved from <http://WORKING OF MALNUTRITION TREATMENT CENTERS An Assessment of Malnutrition Treatment Centers in Rajasthan>
- k) Shukla, Y., Tiwari, R., Kasar, P. K. & Tomar, S. P. (2016) Risk factors for severe malnutrition in under five children admitted to nutritional rehabilitation centre: a case-control study from Central India. *International Journal of Community Medicine and Public Health*, 3 (1), 121-127. doi:10.18203/2394-6040.ijcmph20151484
- l) *SWOC (STRENGTHS, WEAKNESSES, OPPORTUNITIES, CHALLENGES) ANALYSIS OF CHILD MALNUTRITION TREATMENT CENTRE (CMTC), MAHUVA BLOCK, SURAT DISTRICT*. (2016). *Scopemed.org*. Retrieved 4 July 2016, from <http://www.scopemed.org/fulltextpdf.php?mno=220266>
- m) *TRAINING GUIDE FOR COMMUNITY-BASED MANAGEMENT OF ACUTE MALNUTRITION (CMAM) AND PRACTICE HANDOUTS*. (2008).
- n) *Working of Malnutrition Treatment Centers: A Sport Assessment Study*. (2016) (1st ed.). INDIA. Retrieved from <http://www.pairvi.org/Publications/Rajasthan%20MTCs%20Assessment.pdf>

Annexure 1**Questionnaire related to CMAM Programme****For Parents of Enrolled Children****Questions related to Knowledge**

1. What were the symptoms of weakness in your child before the initiation of the programme?

- a) Loss of Appetite
- b) Vomiting
- c) Loose Motions
- d) All the Above

2. What are the common terms used for weak child?

- a) Kamzoor
- b) Kuposhit
- c) Kanghisa
- d) Sukhasa
- e) Patlasa
- f) All of the above
- g) Others.....

3. What are the reasons for Malnutrition?

- a) Early Marriage
- b) Early Child bearing
- c) Many children to feed on
- d) Non Exclusive Breast Feeding
- e) Lack of timely introduction of Complementary Feeding
- f) No Food
- g) Ignorance about Malnutrition
- h) All of the above
- i) Others.....

4. What are the motivational factors which made you to enrol your child in the programme once they are under eligibility criteria?

- a) Grandmother told me to enrol
- b) Any other Family Member
- c) By oneself
- d) Under pressure by ASHA
- e) PoshanPreheri
- f) Other Block/District Officials
- g) Others.....

5. Do you know what Middle Upper Arm Circumference (MUAC) is?

- a) Yes
- b) No

If Yes, than do you know how to measure it?

- a) Yes
- b) No

6. Why there was a delay before, in seeking treatment for malnutrition?

- a) Other children's to take care of
- b) Daily Chores at homes
- c) Seeking traditional treatment/Home remedies
- d) Low Awareness
- e) All of the Above
- f) Others.....

7. What were your expectations from this programme?

- a) Healthy Child
- b) Free from Diseases
- c) No expectations
- d) Free food /Monetary funds

8. What challenges have you faced while visiting to Poshan Centre on PoshanDiwas?

- a) Due to pending work at home
- b) Far from home

- c) No Conveyance
- d) Others.....

9. Are you satisfied with your child Health status now ?

- a) Yes
- b) No

10. What is the waiting time of your turn on poshandiwas?

- a) Around 15 mins
- b) Half an hour
- c) An hour
- d) More than one hour

11. When did you first breast feed your child?

- a) Just after Birth
- b) Within 1 hour
- c) Within 12hours
- d) More than 12 hours
- e) Not at all

Questions related to Practice

1. After enrolment do you find any change in the appetite of your children?
 - a) Yes
 - b) No

2. Have you notice activeness in your Child after enrolling in this Programme?
 - a) Yes
 - b) No
 - c) Already Active

3. Do you Wash your hands before feeding your child a diet?
 - a) Often
 - b) Regularly
 - c) Once in a day
 - d) Not at all

4. What is the impact of this programme on eating habits of your child?
 - a) Eating by their own when served
 - b) Asks for meal
 - c) Force him/her to eat
 - d) Does not Eat at all

5. How many times you breastfeed your child per day?
 - a) 1-3 times
 - b) 5-6 times
 - c) 10-12 times
 - d) Not at all

6. Do you currently breastfeed?
 - a) Yes
 - b) No

If No, than how old was your child when you stopped breastfeeding?

- a) 2 months
- b) 6 months
- c) 9 months
- d) 1year

If No, than who suggested you to stop breastfeed?

- a) By oneself
- b) Mother in Law
- c) Husband
- d) Mother
- e) Relatives
- f) No body

Annexure 2**For ASHA Workers****Questions related to Knowledge**

1. What do you understand by Poshan Project?
 - a) KuposhitBachonKeLiyeKaryakram
 - b) KamzoorBachonKeLiyeKaryakram
 - c) KhaneKe Packet Batna
 - d) Others

2. Do you know what MUAC stands for?
 - a) Middle Upper arm Circumference
 - b) Mid Upper Arm Circumference
 - c) All the Above
 - d) Don't Know

3. What is the value of Mid Upper Arm Circumference at discharge of child from programme?
 - a) 11.5
 - b) 12.5
 - c) 12
 - d) Don't Know

4. Are non- respondents referred to higher Centres for treatment?
 - a) Yes
 - b) No

5. Did you counsel the parents of Moderately Acute Malnourished children to visit Anganwadi Centre?
 - a) Yes
 - b) No

6. What food items you suggest to the parents to feed their children at home.
- a) Dal/Roti
 - b) Dal/Roti/Ghee
 - c) Daliya
 - d) Milk
 - e) Vegetables and Fruits
 - f) All the Above
 - g) None of the Above

Questions related to Practice

1. How many times do you visit the allotted household?
 - a) Daily
 - b) Twice a week
 - c) Once a week
 - d) Visit according to Convenience

2. According to you, what motivates parents to attend PoshanDiwas?
 - a) To collect Rs.100
 - b) Concerned about their child's Health
 - c) KhanaLeneKeLiye
 - d) All the above

3. How do you motivate the parents of the defaulter?
 - a) By Counselling
 - b) Refer to ANM
 - c) Consult with Block Officer
 - d) Others.....

4. Do you communicate with ANM about Severely Acute Malnourished Children with Complications?
 - a) Yes
 - b) No

5. What role do you perform for poshandiwas?
 - a) Bring parents to Poshan Centre
 - b) Counselling of Parents
 - c) Help ANM
 - d) Just Observe
 - e) Don't Know

6. Do you fill the PoshanYatraPostikaGraha Brahman form daily?
 - a) Yes b) No

Annexure 3:**Checklist for MTC**

b) Name of MTC:

District:

c) Date of visit:

Supervised By:

d) No. of Beds:

Observe	Satisfactory	Unsatisfactory	Poor
Hand washing			
Are their working hand washing facilities in the ward?			
Does staff consistently wash hands thoroughly with soap?			
Are their nails clean?			
Do they wash hands before handling food?			
Do they wash hands between each patient?			
Mother's cleanliness			
Do mothers have the place to bathe, and do they use it?			
Do mothers wash hands before feeding children?			
Do mothers wash hands with soap after using the toilets			
Bedding and laundry			
Is bedding changed every day or when soiled/wet?			
Are diapers ,soiled towels and rags, etc. stored in bag, then washed disposed of properly?			
Is there a place for mothers to do laundry?			
Is laundry done in hot water?			
General maintenance			
Are floors swept?			
Is trash disposed of properly?			
Is the ward kept as free as possible of insects and rodents?			
Food storage			
Are ingredients and food kept covered and stored at the proper temperature?			
Are leftovers discarded?			
Dishwashing			
Are dishes washed after each meal?			
Are they washed in hot water with soap ?			
Toys			
Are toys washable? Are toys washed regularly, and after each child uses them?			

--	--	--	--

Observe	Satisfactory	unsatisfactory	Poor
Feeding			
Are correct feeds served in correct amounts?			
Are feeds given at prescribed times, even on nights and weekends?			
Are children held and encouraged to eat (never left alone to feed)?			
Are children fed with a cup (never a bottle)?			
Is food intake (and any vomiting/diarrhoea) recorded correctly after each feed?			
Are leftovers recorded accurately?			
Are amount 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 degree -30 degree C (to the extent possible)?			
Are blankets provided and children kept covered at night?			
Are safe measures used for re-warming children?			
Are temperature taken and recorded correctly?			
Weighing			
Are scales functioning correctly?			

Are scales standardized weekly?			
Are children weighed at about the same time each day?			
Are they weighed about one hour before a feed (to the extent possible)?			
Do staff adjust the scale to zero before weighing?			
Are children consistently weighed without clothes?			
Do staff correctly read weight to the nearest division of the scale?			
Do staff immediately record weights on the child's case sheets?			
Are weights correctly plotted on the weight chart?			
Giving antibiotic, medications , supplements			
Are antibiotics given as prescribed (correct dose at correct time)?			
When antibiotics are given, do staff immediately make a notation on the daily care chart?			
Is folic acid given daily and recorded?			
Is vitamin A given according to schedule?			
Is a multivitamin given daily and recorded?			
After children are on catch-up diet for 2 days, is the correct.			
Dose of iron given twice daily and recorded?			
Ward environment			
Are surroundings welcoming and			

cheerful?			
Are mothers offered a place to sit and sleep?			
Are mothers taught/ encouraged to be involved in care?			
Are staffs consistently courteous?			
As children recover, are they stimulated and encouraged to move and play?			

Observe	Satisfactory	Unsatisfactory	Poor
Do any staff member accompany the mother while feeding the child ?			
Is the staff clear about the Diet plans and the Intervals in which they are going to Feed the Child ?			
Need for a Nutritional Counsellor.			
After Discharge ,do they communicate with the ASHA to follow-Up for 2 months ?			
Is the Child referred to Higher Facility if not responding at the MTC (Non-respondents)?			

Observe	Yes	No	Comments
Feeding			
Are correct feeds served in correct amounts?			
Are feeds given at prescribed times, even on nights and weekends?			
Are children held and encouraged to eat (never left alone to feed)?			
Are children fed with a cup (never a bottle)?			

Is food intake (and any vomiting/diarrhoea) recorded correctly after each feed?			
Are leftovers recorded accurately?			
Are amount 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 degree -30 degree C (to the extent possible) ?			
Are blankets provided and children kept covered at night?			
Are safe measures used for re-warming children?			
Are temperature taken and recorded correctly?			
Weighing			
Are scales functioning correctly?			
Are scales standardized weekly?			
Are children weighed at about the same time each day?			
Are they weighed about one hour before a feed (to the extent possible)?			
Do staff adjust the scale to zero before weighing?			
Are children consistently weighed without clothes?			
Do staff correctly read weight to the nearest division of the scale?			
Do staff immediately record weights on the child's case sheets?			
Are weights correctly plotted on the weight			

chart?			
Giving antibiotic, medications , supplements			
Are antibiotics given as prescribed (correct dose at correct time)?			
When antibiotics are given, do staff immediately make a notation on the daily care chart?			
Is folic acid given daily and recorded?			
Is vitamin A given according to schedule?			
Is a multivitamin given daily and recorded?			
After children are on catch-up diet for 2 days, is the correct.			
Dose of iron given twice daily and recorded?			
Ward environment			
Are surroundings welcoming and cheerful?			
Are mothers offered a place to sit and sleep?			
Are mothers taught/ encouraged to be involved in care?			
Are staffs consistently courteous?			
As children recover, are they stimulated and encouraged to move and play?			

Annexure 4:

KanwatiyaHospital:

Observe	Yes		No
	Satisfact ory	Unsatisfac tory	
Mother's cleanliness	88%	12%	0
Hand washing	80%	20%	0
Bedding and laundry	100%	0	0
General maintenance	100%	0	0
Food storage	100%	0	0
Dishwashing	100%	0	0
Toys	30%	70%	0
Feeding	100%	0	0
Warming	30%	70%	0
Weighing	100%	0	0
Giving antibiotic, medications , supplements	100%	0	0
Ward environment	100%	0	0

J.K Lon:

Observe	Yes		No
Observational Parameters	Satisfact ory	Unsatisfac tory	No
Mother's cleanliness	34%	66%	0
Hand washing	20%	80%	0
Bedding and laundry	75%	25%	0
General maintenance	66%	33%	0
Food storage	100%	0	0
Dishwashing	50%	50%	0
Toys	40%	60%	0
Feeding	75%	12.5%	12.5%
Warming	25%	75%	0
Weighing	100%	0%	0
Giving antibiotic, medications , supplements	100%	0	0
Ward environment	100%	0	0

Dausa:

Observe	Yes	No
---------	-----	----

	Satisfactory	Unsatisfactory	poor
Mother's cleanliness	0%	66%	34%
Hand washing	30%	50%	20%
Bedding and laundry	0%	50%	50%
General maintenance	33.3%	33.3%	33.3%
Food storage	0%	40%	60%
Dishwashing	55%	45%	0%
Toys	75%	25%	0%
Feeding	12.5%	50%	37.5%
Warming	0%	12.5%	87.5%
Weighing	33.3%	44%	22.7%
Giving antibiotic, medications , supplements	14.5%	57%	28.5%
Ward environment	0%	20%	80%

SavaiMadhopur.

General maintenance	0	66%	34%
Food storage	0	50%	50%
Dishwashing	0	0	100%
Toys	40%	0	60%
Feeding	12.5%	62.5%	25%
Warming	0	40%	60%
Weighing	22%	44%	34%
Giving antibiotic, medications , supplements	13%	42%	45%
Ward environment	0	30%	70%