INSTITUTE OF HEALTH MANAGEMENT RESEARCH, JAIPUR

MBA (HOSPITAL AND HEALTH MANAGEMENT)

BATCH 19 (2014 – 2016)

Summer Training At

SEVA MANDIR

Udaipur, India

(01st April 2015-31th May 2015)

Seva Mandir

Transforming lives through democratic and participatory development

Assessment of nutrition status based on height for age indicator of malnutrition among children under 5 years of age in 2 blocks of rural Udaipur.

Under the Guidance of

Dr. Ashok Kaushik

Submitted By

Dr. Swati Mittal

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 Swati Mittal has completed the summer internship at Seva Mandir, Udaipur, Rajasthan from 1st April to 31st May 2015 and has conducted the following project under my guidance,

"Assessment of nutrition status based on height for age indicator of malnutrition among children under 5 years of age in 2 blocks of rural Udaipur".

All the data related to the study is the primary data collected by her.

The approach to the project has been sincere, scientific and analytical. The work is in partial fulfilment to the course requirements recommended for the Master of Business Administration in Hospital and Health Management, 19th Batch from Institute of Health Management and Research, Jaipur.

I wish her success in all her future endeavours.

Col. Dr .Ashok Kaushik

Dean (Academic & Students Affairs)

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PREFACE

The MBA (hospital and health management) course is well structured and integrated course of business studies. The main objective of practical training at MBA level is to develop skill in students by supplement to the theoretical study of business management in general. Professors give us theoretical knowledge of various subjects in the institute. But we are practically exposed of such subjects when we get the training in the organization. It is the training through which we come to know that what an organization is and how it works. During this whole training I got a lot of experience and came to know about management practices in real that how it differs from those of theoretical knowledge and the practically in real life.

It's very beneficial to learn health care delivery system at various levels. I observed the implementation of various National Health Programmes at National/State/District level; I understood various functions of health systems by interactions with key stakeholders, policy makers, programme managers, academicians and researchers.

During my training period I had an overview of various programmes undertaken in Seva Mandir, Udaipur during the current status of the programmes. I also carried out a small study on-
"Assessment of nutrition status based on height for age indicator of malnutrition among children under 5 years of age in 2 blocks of rural Udaipur".

I have tried to put my best effort to complete this task on the basis of skills that I have achieved during my studies in the institute.

ACKNOWLEDGEMENT

At the onset of the report I would like to express my special gratitude and appreciation for my college authorities for allowing me to pursue my summer internship from Seva Mandir, Udaipur.

I would also like to acknowledge with much appreciation the crucial role of Mrs. Priyanka Singh, Chief Executive Officer, who despite of other pre occupations and busy schedule was there to guide me and whose stimulating suggestions and encouragement helped me complete my training.

This training wouldn't have been completed without a substantial support from Mrs. Kusum Mathur and Dr. Neeti Sharma of the Health Department and a great number of people so I would like to thank all the consultants in various departments and other staff members at Seva Mandir for being so helpful all the time and making this summer training project an unforgettable experience.

A special thanks to Dr. Harshlata and Mrs. Indira Dey of People's Management School for guiding me throughout my field visit.

Finally, and most importantly, I would like to thank God for allowing me to complete my project, my beloved parents for their blessings and my friends for their help and wishes for the successful completion of this training.

Seva Mandir

INTRODUCTION

Seva Mandir is one of India's leading development nonprofit organizations. It currently works with 360,000 people across 700 villages of southern Rajasthan, where over 90% of the population relies on subsistence agriculture and most people live on less than Rs. 20 ($0.35) a day.

For over 45 years, Seva Mandir has worked in partnership with these people, not only to improve their material well-being, but to build stronger and more ethical communities. Through its programs on governance, health, education, sustainable use of natural resources, women's empowerment, youth development, child care and social enterprise, Seva Mandir makes a tangible and transformative impact. Every year, 12,000 disadvantaged children receive a quality education in its schools; 8,000 women and children out of reach of hospitals are offered critical health services.

At Seva Mandir, very modest amounts of money go a very long way toward improving people's lives, and success has been recognized through a long list of awards and partnerships with distinguished funders and the Indian government.

What is distinctive about Seva Mandir is that it does not just deliver aid, but instead uses every development project as a way to build stronger communities. This is accomplished through 532 Village Forums and associated Village Funds, which co-manage all Seva Mandir projects and ensure that citizens themselves take responsibility for their village. Over time, these Forums have grown into institutions of just governance, turning Seva Mandir projects into sustained investments in more self-sufficient and equitable communities.

TEAM AND STAFF

Seva Mandir has nearly 300 full time employees and over 1000 village based workers who are from the communities they serve. Their full time employees hail from all over India, 29% is women and 56% hold graduate degrees. Their employees' average length of service is 13 years; a remarkable testament to team's dedication and belief in mission.

WORK AREA

Following are the various departments that work in the five blocks of Udaipur in a collaborated manner.

LOCAL SELF GOVERNANCE:

Strong village institutions are the nucleus for all of Seva Mandir's work. For over 40 years, Seva Mandir has slowly built its alternative village governments into spaces where people are able to participate actively and ethically in the decisions which affect their lives.

HEALTH

Seva Mandir addresses some of the most critical unmet healthcare needs in the rural villages around Udaipur. 422-strong cadre of community health workers has made major strides in improving maternal and child health across 152 villages, and has helped nearly 20,000 people gain access to clean drinking water and sanitation. The Health Program also facilitates access to government services and undertakes rigorous research projects leading to solutions on the ground.

EDUCATION

Through 173 alternative schools, 3 annual Learning Camps and scholarship program, they offer out-of-school children access to quality primary education.

SUSTAINABLE NATURAL RESOURCES

Over 90% of the people Seva Mandir works with rely on subsistence agriculture, but the region's natural resource base is severely degraded. For over 35 years, across more than 400 villages, Seva Mandir has protected and developed 16,000 hectares of common land, made sustainable watersheds for 6,000 families, and helped another 10,000 farmers improve their agricultural yields.

WOMENS EMPOWERMENT

Seva Mandir helps communities transform gender relations by creating ways for women to come together in their individual and collective struggles. 48 women's groups give grassroots leaders the unity, confidence, and authority to redress individual cases of abuse and discrimination

YOUTH DEVELOPMENT

Seva Mandir runs 21 youth centers that mobilize young people, link to livelihood opportunities, and serve as hubs for sexual health & gender training.

CHILD CARE

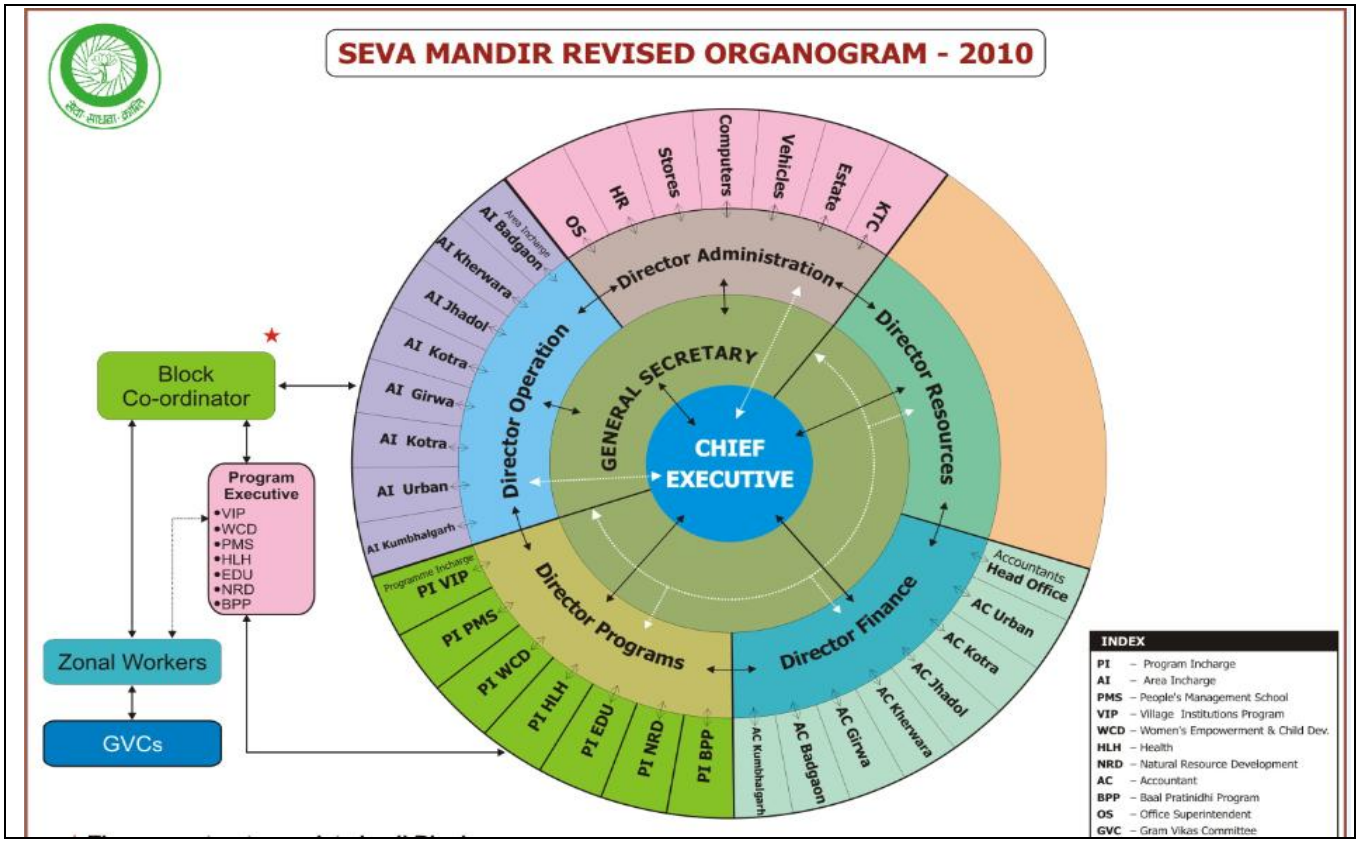
Seva Mandir's work on early childhood care is centered on 187 quality community preschools called *Balwadis* that cater to the educational, nutritional and all-around developmental needs of children aged 1-5. Each *Balwadi* is run by a local woman whom Seva Mandir has trained to work with

young children. Seva Mandir also runs a Child Representative Program that sends children to school and promotes the participation of children in the community development process. In Udaipur's urban slums, Seva Mandir has set up a safety net of 16 childcare and extracurricular programs.

MISSION

Seva Mandir's mission is to make real the idea of society consisting of free and equal citizens who are able to come together and solve the problems that affect them in their particular contexts. The commitment is to work for a paradigm of development and governance that is democratic and polyarchic. Seva Mandir seeks to institutionalize the idea that development and governance should not just be left to the state and its formal bodies, such as the legislature and the bureaucracy, but that citizens and their associations should engage separately and jointly with the state. The mission, briefly, is to construct the conditions in which citizens of plural backgrounds and perspectives can come together to benefit and empower the least advantaged in society.

ORGANOGRAM



RESOURCE MOBILZATION UNIT

The Changing Funding Scenario:

- Up until now, philanthropic grant-making institutions from the west have been the main source of funds, but this has been rapidly changing. Donors from the west have been pulling out, partly because of India's image as a developing economy with a high growth rate. Some donors have also changed sectoral priorities. Seva Mandir has over the years been fortunate to have donors who supported its comprehensive plans (three-year strategic and operational plans). For almost 25 years, more than half of the organization's receipts were for comprehensive plans, allowing us the flexibility to respond to community needs, use new opportunities, experiment and innovate. But in the last few years this kind of support has been reducing and is being replaced by project-based funding.
- The new hope is the corporate that are an emergent category: from 1% in 2012-13 their share has risen to almost 17% in 2014-15.The concern, however, is that their grants are short-term, making any medium- or long-term planning very difficult.
- Servicing Donors: While different programmes continued to service their respective donors with support from RMU, the RMU made special efforts to service the following donors. Give India Seva Mandir continued to raise funds for various projects and for the plantation program (Make My Trip Green Initiative) through Give India. In addition to posting regular reports for the Give India donors, visit from Give for their due diligence was also facilitated. Global Giving during the reporting period, the Fellowship Project was withdrawn from the Global Giving Competition, as it was not receiving many donations. Two staff members attended a workshop organized by Global Giving in Delhi in September 2011 to understand strategies of encouraging individual donors and using the social media for creating more visibility amongst a particular segment of individual donors. New Directions in Fundraising In January 2012 a brainstorming meeting on fundraising with a group of friends and well-wishers of Seva Mandir was held in Delhi. The discussion generated useful ideas on potential fund raising while also bringing to fore the challenges of fund raising.
- Coordinating with friends groups: Friend of Seva Mandir–USA: The RMU team leader visited the US for two months to update Seva Mandir’s donors and supporters in America about the recent happenings of Seva Mandir. Efforts were also made to explore possibilities of initiating a chapter in Chicago as well as building on our existing support base in Boston. Friends of Seva Mandir - UK: A part time staff of FSM- UK visited Seva Mandir to understand its work in the field.

INTEGRATED NUTRITION PROJECT

INTRODUCTION

In the world, India has the largest population of children under the age of five years. India contributes nearly 2 million under 5 deaths, highest for any nation, globally. High prevalence of malnutrition contributes to over 50% of child deaths. The national family health survey 3 in 2006 confirmed that the child malnutrition rate in India is 46%, almost double that of sub Saharan Africa and is ranked 66 among 88 countries surveyed by International Food Policy Research Institute (IFPRI).

Integrated Nutrition Project: An initiative taken by Plan India and Seva Mandir, to improve the nutritional status of the children under 5years of age in two blocks of Udaipur district. A comprehensive approach that targets children less than 5 years of age, aims to reduce the prevalence of malnutrition

Duration of the programme: 3 years

Core components to be addressed

1. Low birth weight to be addressed through ANC components and Nutrition for pregnant mothers.

2. New Born and Mother Care

3. Early and Exclusive Breast Feeding.

4. Complementary Feeding-Right age, right amount & right type

5. Supplementary Feeding through Balwadi

6. Immunization-complete for all under 3 children

7. Micro Nutrient- Iron, De-worming & Vitamin A

8. Family Based Intervention- food availability and consumption.

9. HH & Institutional level WASH - Hand hygiene, water hygiene and food hygiene

10.Growth monitoring

Proposed key Interventions

- Community awareness / IEC:
- Awareness generation of families and community on healthy, nutritious and diverse food to be prepared for children at home.
- Counselling (group / individual):

- Appropriate hand washing and water hygiene practices for all individuals and Community level activities.
- Capacity building for stakeholders:
- Capacity building of mothers/women on the early and exclusive BF and timely intervention of appropriate CF.
- Nutritional services provision at Balwadi for children in the age group 1 to 5 years:
- Supplementary nutrition, iron supplement, de-worming, Vit. A and treatment for common illnesses and Growth Monitoring of children.
- Health support through Mini Malnutrition Treatment Centres and health camps at Kojawara Referral Health Centre:
- Complete immunization of children up to 2 yrs of age/Catch up immunization. Regular and complete ANC (antenatal checkup) , proper delivery (institutional delivery) and PNC(post natal checkup).

Working area of the programme:

Base line and pilot of the programme was carried out in two blocks viz. .Kherwara and Girwa blocks of Udaipur district.

Udaipur district is situated in the southern region of Rajasthan and is close to Gujarat. The district is bounded in the north by Rajsamand, in west by Sirohi, in northeast by Chittorgarh, in southeast by Pratapgarh and in south by Dungapur districts of Rajasthan. The district covers an area of 11724km with a population density of 242 people /sq km.

DEMOGRAPHIC PROFILE:

Demographic Profile

Indicators	**Rajasthan**	**Udaipur**
No. Districts	33	1
No. Blocks	244	11
No. Villages	44672	2511
Population (2011)	68621012	3067549
Male	35620086	1,566,781
Female	33000926	1,500768
Decadal Growth rate	21.44	23.63
Sex ratio	926	958
Child Sex ratio	883	920
Literacy rate		
Total	67.06	62.74
Male	80.51	75.91
Female	52.66	49.10
Density of population	201	242

Rationale of the programme:

KEY HEALTH INDICATORS:

Key health and service indicators	**Rajasthan(Source)**	**Udaipur (Source)**
Infant mortality Rate(IMR)	57 (AHS 2011-12)	61 (AHS 2011-12)
Neo-natal mortality Rate (NMR)	38(AHS 2011-12)	40(AHS 2011-12)
Maternal mortality rate (MMR)	388 (census 2011)	
OPD	63467115 (HMIS2012-13)	2584234(HMIS2012-13)
IPD	2811655(HMIS2012-13)	84720(HMIS2012-13)
Ante Natal Care (ANC)	1866803 (HMIS2012-13)	110027(HMIS2012-13)
Safe Birth Attended (SBA)	44221(HMIS2012-13)	2581(HMIS2012-13)
Post Natal Care (PNC)	991434(HMIS2012-13)	49263(HMIS2012-13)

Immunization	1297581(HMIS2012-13)	68906(HMIS2012-13)
Unmet need for FP	17.9(spacing +limiting method) (Source-DLHS2007-08)	21.6 (CM&HO)

Kherwara Block

Covers 110211 hectares of land and shares borders with Gujarat and Dungarpur district in the south.located in the Aravalli mountain range, it is predominantly rural with only one urban settlement. Kherwara block has 268000inhabitants, three quarters of which are tribal. People primarily depend on agriculture and animal husbandry for survival. in the non agriculture sector, a substantial portion of the population migrates mostly to Gujarat to find labour.

Current status of the programme:

-Capacity building of community workers through review meetings, orientation and zonal meetings.
-Provision of nutritional supplements at Balwadis
-Monthly health camps, weekly visits of pediatricians to Kojawara hospital.
-A base line survey is ongoing based on the information obtained from the follow up survey.

Publicity and Social Marketing:

All the hamlets covered under the programme are covered by the balsakhis and traditional birth attendants.

Gram sabhas are conducted in conjunction with the education department for spreading the awareness of the programme.

FOLLOW UP SURVEY

- A follow up study was designed to be carried out in 7 hamlets of Kherwara block of Udaipur district with the following objectives:
- To assess the malnutrition status of children below 5 years of age based on height for age indicator of malnutrition.
- To estimate the difference in the malnutrition status after introduction of the interventions suggested under integrated nutrition project.
- To assess the role of Balwadis in reducing the prevalence of malnutrition among children under 5 years of age in these 7 hamlets of Kherwara.

Rationale

Poor health indicators of the Udaipur district.

Research methodology

The study was carried under pre scheduled 4 phase programme as described under.

PHASE 1-

Design of the study:

Details of research methodology are provided: quantitative research method, research tools, sampling methodology, data collection and analysis techniques are provided.

Quantitative methods:

Household/mother and child survey questionnaires were used as research tools to collect quantitative data such as migration and socio economic status ,sanitation hygiene, mother's health and nutrition child's illness and nutritional status. Additionally, anthropometric data height and weight of the child were recorded using standard measures.

Research tools:

Survey:

Survey was conducted in order to understand the current nutritional status based on height for age indicator of malnutrition, of children less than 5 years of age in 7 hamlets of Kojawara panchayat in Kherwara block of Udaipur district. This is a pilot study undertaken to understand the nutritional situation. All the children under 5 years present at home during the visit and their mothers were interviewed.

Household/mother's questionnaire:

This aimed at seeking the responses from the mothers of children between 0-5 years to understand the household status and mothers literacy as well as nutritional information of the family.

Child questionnaires:

All the children in the age group 0-5 years in each of the household were covered and anthropometric measurements and other related information was recorded.

Sampling:

Sample frame: all the children under 5 years of age and their mothers in the 7 hamlets of Kherwara block, Udaipur.

Sample size: 280 children under 5 years of age.

Number of girls: 111 girls

Number of boys: 169 boys

Selection of respondents for interview:

In every household mother or the care taker of the child under 5 years of age were interviewed.

Quality assurance procedures:

Testing the survey tool: a pilot of the survey questionnaire was performed to ensure that the questions are in the correct order and was appropriate to gain insights on the key indicators. The survey questionnaire was piloted in ten households of dara fala in Kojawara.

Training and scheduling the survey with the balsakhis: household visits were made along with the balsakhis who were trained on recording the anthropometric measurements weight and height.

PHASE 2: field work

Home visits and personal interview with the beneficiaries:

Recording of the anthropometric measurements:

Data collection:

Each of the households in the 7 hamlets where children under 5 years of age resided were visited for collecting information on the indicators under consideration. Visits were made along with the balsakhis to each household.

Data Corrections:

Filled in questionnaires were then assessed for any error and thereafter data was feeded into SPSS.

PHASE 3

DATA ANALYSIS:

SPSS files were then imported to WHO Anthro software for statistical analysis based on 3 indicators of malnutrition viz. height for age, weight for age and weight for height. The information obtained was fed into excel for further analysis. Based on the analysis, relevant inferences were drawn for each objective question. Reporting officer was consulted for further clarifications.

PHASE 4 : Report Writing

Final reporting was done in consultation with the reporting officer Dr.Kusum Mathur and recommended corrections were made.

Scope of the study: this can be viewed through

Scope for the organization:

The study directs the focus on the nutritional status of children specifically under 2 years of age based on height for age indicator of malnutrition. This not only builds the grounds on which the base line survey is being conducted but also indicates the necessity to target children under 2 years of age with specific interventions to reduce the prevalence of stunting.

Scope for myself:

Hands on with the ground reality and understanding of functioning of community workers and the problems they face while executing them.

Learning the intricacies of working on a research project.

Limitations:

-Collection of information by way of filling in questionnaires was very tedious
-Response error and biased answers in some of the cases is another limitation of the study.
-Language barriers were one of the difficulties in the study.

Literature review:

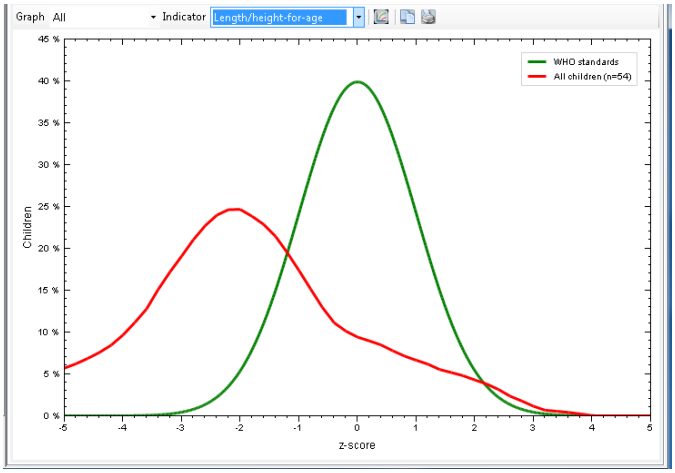
- Under nutrition in children and pregnant women is a cause of chronic energy deficiency in adults. Chronic energy deficiency in adults increases the risk of low birth weight among the children. This cycle continues across generation (mother- child- mother undernourishment)(Radhakrishna and Ravi 2004)
- Despite a 10% annual economic growth in India, approximately 8 million children under the age of 5 years are severely malnourished (Chatterjee 2007).
- K.R.G. Nair study demonstrated the insufficiency of economic growth to address the issue of malnourishment (Nair 2007).
- Bhutia et al enist the determinants – socio cultural factors affecting feeding practices, maternal nutrition, maternal literacy, poverty ,income, urban rural difference ,lifestyle, health services, age, birth order, and birth interval – of protein energy malnourishment among preschool children in India.(Bhutia 2014).
- Improper breast feeding and weaning seems to be a cause of malnutrition in developing countries where awareness on this matter is insufficient (Motarjemi, kaferstein etal 1993).
- In tackling child under nutrition, there has been a shift from efforts to reduce underweight preva-
  lence (inadequate weight for age) to prevention of stunting (inadequate length/height for age). There is better understanding of the crucial importance of nutrition during the critical 1,000-day period covering pregnancy and the first two years of the child's life, and of the fact that stunting reflects deficiencies during this period. The World Health Assembly has adopted a new target of reducing the number of stunted children under the age of 5 by 40 per cent by 2025.(UNICEF report on "Improving child nutrition –the achievable imperative for global progress).

DATA –ANALYSIS

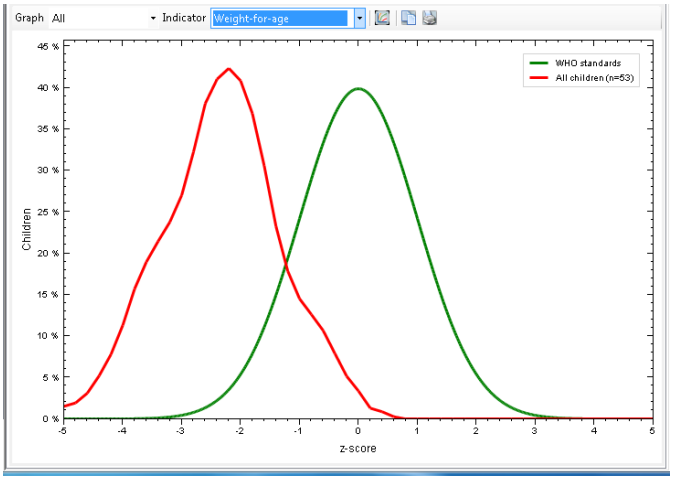
In this study 280 children under 5 years of age were covered. The data thus obtained has been analyzed as follows:

1) Various indicators that were considered for measuring the nutritional status of the study population.

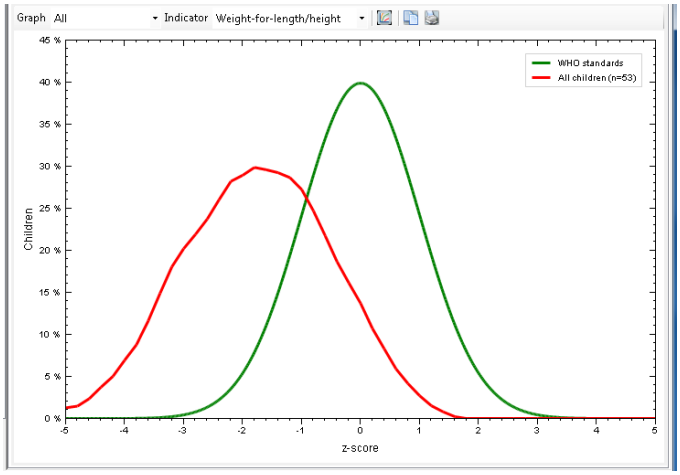
Fig.1. Normal distribution of nutritional status of the population under study is plotted against the standard as suggested by WHO.



Height for age Z-scores



Weight for age Z-scores



Weight for height Z- scores

Figure 1.

The mean value for all the variables viz. height for age, weight for age and weight for height are more than 2 standard deviations away (towards left) as shown by the red line, when plotted against the WHO standard graph(green line) indicating significantly higher number of children are malnourished(stunted ,underweight and wasted).

2) COMPARISON OF THE WEIGHT FOR AGE Z-SCORES OF THE BASELINE SURVEY AND THE FOLLOW UP SURVEY

Weight for age Z-scores from survey in 2014

Weight for age Z-scores from the follow up survey in 2015

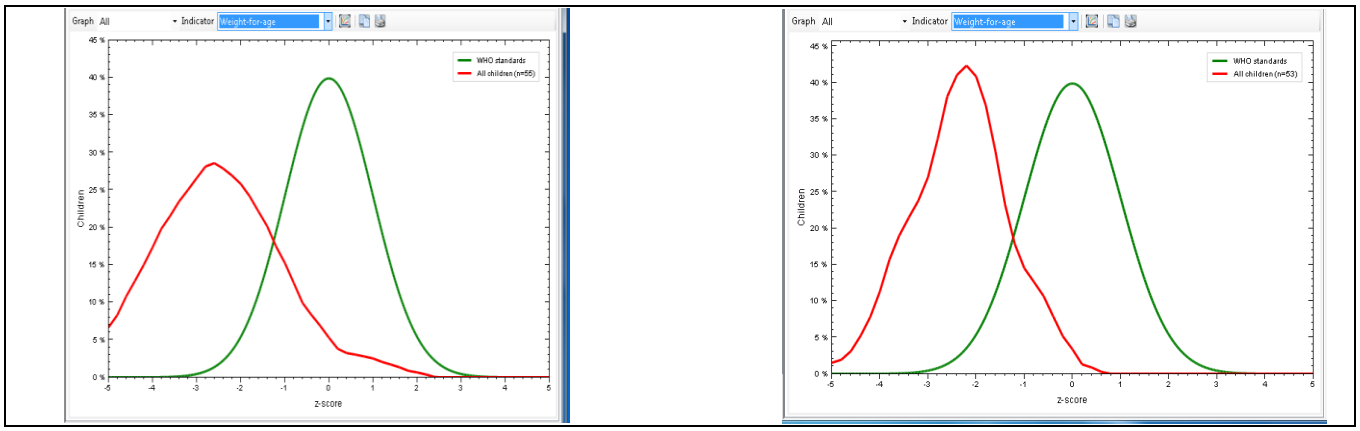


Figure 2

As per these two plots, there is an overall shift in the mean values towards right (shown by the red lines in the two graphs). This clearly indicates that there has been an improvement in the malnourishment status (underweight) over this period. The mean value (indicated by the red line) in

the second plot is more closer to the WHO standard (green line)as compared to the first plot. Moreover greater number of children are concentrated towards the mean value indicating an overall improvement in the nutritional status of all the children considered under the study.

3) Estimating the status of malnutrition among the study population based on height for age z –scores.

Figure 3. The following pie-chart represents the percentage of children in severely malnourished, moderately malnourished and well nourished categories as determined by the height for age Zscores .

63% of the children are severely malnourished while considering the HAZ scores and only 18% of the children under 5 years of age are well nourished and moderately malnourished .

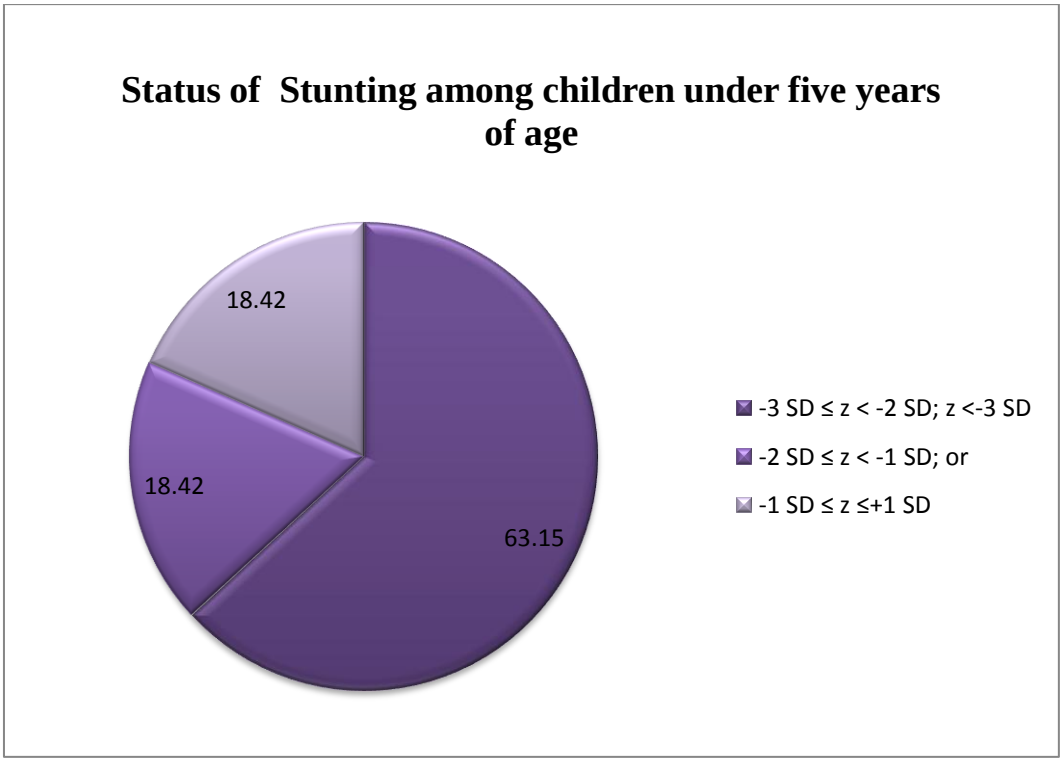


Fig. 3

4) Estimating the status of malnutrition among children under two years of age in the study population based on height for age z-scores.

Figure 4. The following pie chart shows the percentage distribution of stunting among children under 2 years of age as per the height for age Z-scores. It clearly shows that nearly 65% of these children are severely malnourished indicating higher prevalence of stunting among children under 2 years of age.

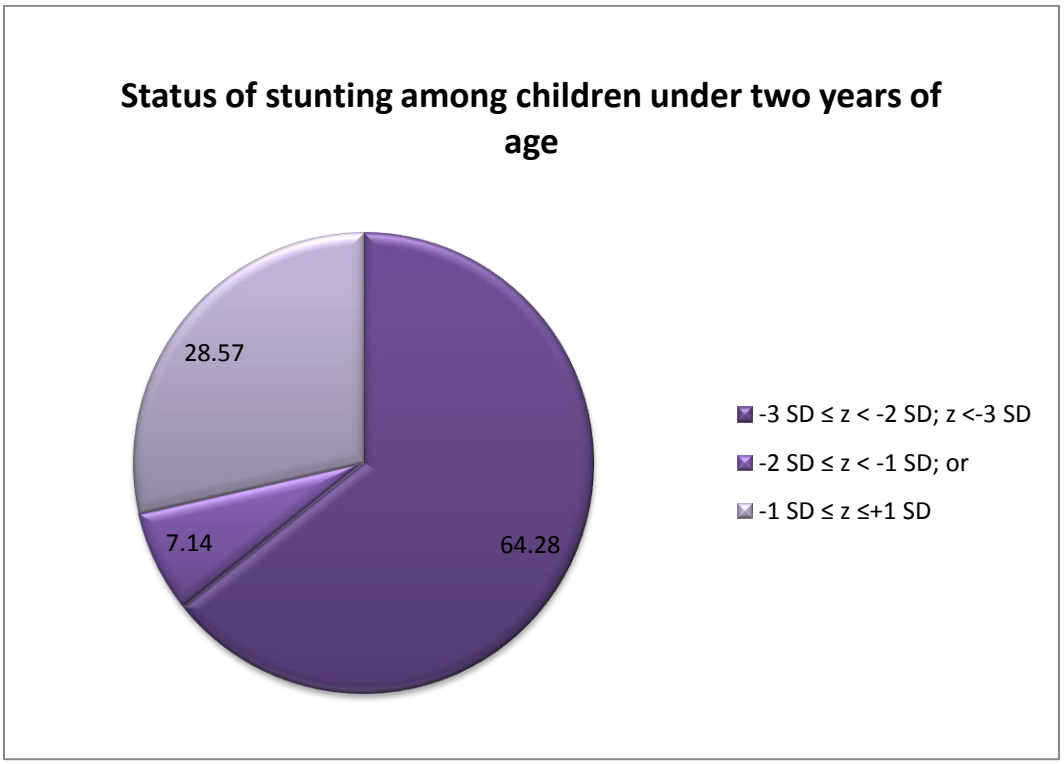


Fig. 4

5) Comparison of the percentage of severely malnourished children under two years of age and between 3 -5 years of age.

Figure 5.The following pie chart shows the percentage distribution of stunting between children under 2 years of age and children between 3-5 years of age. Almost 30% of the total children included in the study are under 2 years of age.

While 41% of children under 2 years of age come under severely malnourished category as per the height for age Z-scores. This indicates higher degree of malnourishment prevailing in this age group.

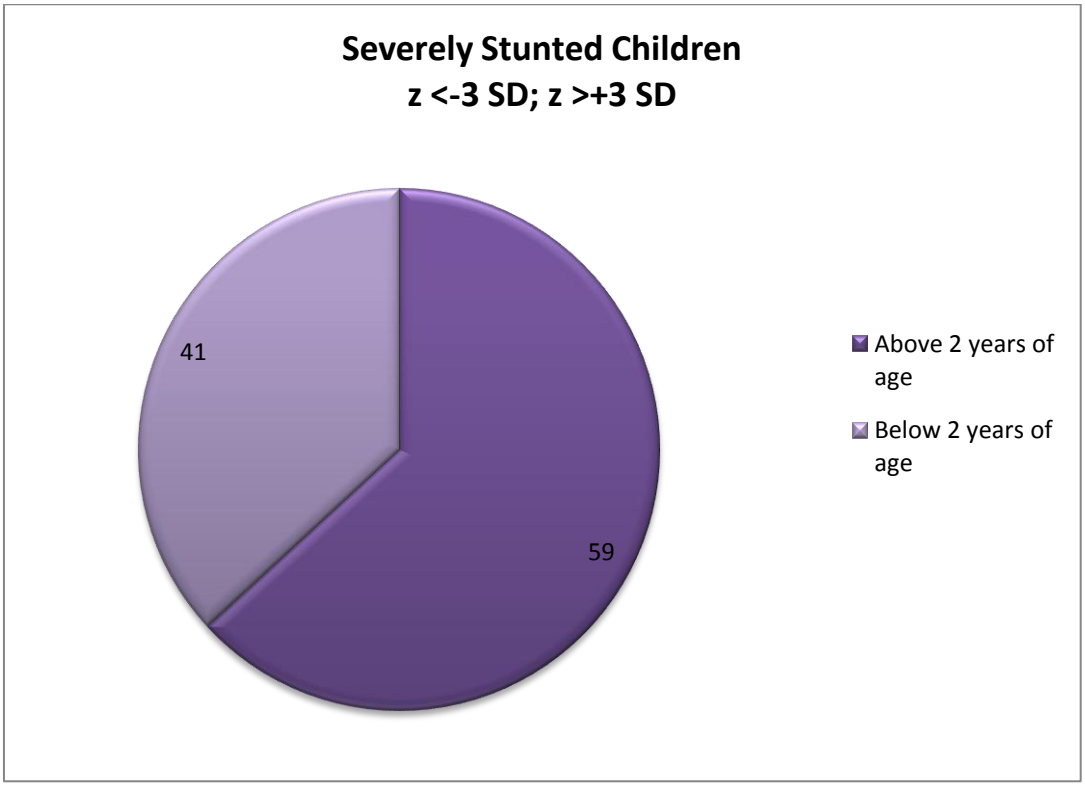


Fig.4

OBSERVATIONS AND FINDINGS

1) Learning's from the research study-

- Due to lack of community people's knowledge on maternal & child health and nutrition, children become malnourished by evitable causes.
- Monitoring and Evaluation:
- Development of M& E tools for baseline data collection
- Format for tracking of Children age 0-5 years
- Development of M&E tools for pregnant mothers and children.
- Reductions in stunting and other forms of under nutrition can be achieved through proven interventions. These include improving women's nutrition, especially before, during and after pregnancy; early and exclusive breastfeeding; timely, safe, appropriate and high-quality complementary food; and appropriate micronutrient interventions
- Timing is important – interventions focus on the critical 1,000-day window including pregnancy and before a child turns 2. After that window closes, disproportionate weight gain may increase the child's risk of becoming overweight and developing other health problems.
- Efforts to scale up nutrition programmes are working, benefiting women and children and their communities in many countries. Such programmes all have common elements: political commitment, national policies and programmes based on sound evidence and analysis, the presence of trained and skilled community workers collaborating with communities, effective communication and advocacy, and multi-sectoral, integrated service delivery.
- Communication for behavior and social change can promote behavior change in communities, raise awareness about nutrition services and stimulate shifts in social norms in order to improve the enabling environment for good nutrition in communities.

The sustainability of the project throughout 3 years can be maintained by:

- By training Balsakhis/AWWs and community representatives as trainers, their acquired know-how will be accumulated in the target area and they will spread the knowledge on nutrition to community people.
- Pregnant & lactating mothers, with males' support to childcare, will continue preventing children from being malnourished and improving children's nutritional status at home level based on the acquired knowledge and know-how, through feasible and practical approaches such as exclusive breast-feeding and complementary-feeding(solid food) with available ingredients.
- Community Nutrition Workers will become community leaders through this project, and are expected to contribute to nutrition improvement in the target area as resource persons (with knowledge on nutrition) even after the project.
- State/district level government staff are involved in activities from the beginning of the project. Through regular progress sharing and workshops, we shall show/present outcomes of the partnership-project with government (= improvement of children's nutritional status) to government officials.

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ANNEXURES:

A survey questionnaire was designed for the purpose of estimating the prevalence of Stunting in children below five years of age. This questionnaire consisted of five sections as enumerated below.

INTEGRATED MALNUTRITION PROJECT

Mother and Child Questionnaire

Section A: General Information

Panchayat:_____ Village:_____ Hamlet:_____.

Date of visit:_____. Name of the child:_____.

Serial No.	Question	Answer
1	Name of the Father.	
2	Name of the mother.	
3	What is the caste of the Father?	
4	Is mother the care taker of the child?	
5	In the absence of the mother, who takes care of the child?	
6	Total number of children born to the single female in the hh.	
7	Number of girls to a single mother.	
8	Number of boys to the single mother.	
9	Total number of children below 5 years of age in the family.	
10	Total number of members in the family.	
11	Occupation of the father.	
12	Occupation of the mother.	
13	How many hours does the mother work?	
14	Total number of earning members in the family.	

Section: B Water and Sanitation Hygiene Information.

Serial Number	Question	Answer
1	What is the source of drinking water?	
2	How far is the source of water from the house?	
3	What is the method of storage of drinking water?	
4	Do you use filters or some cloth to filter the water?	
5	Do you have toilet facility or bathroom in your house?	
6	If no, then where do you take your child for defecation?	
7	Do you wash hands after defecation?	
8	Do you wash the hands of the child after defecation?	
9	What do you use to clean your and child's hands?	
10	Do you wash hands before feeding the child?	
11	With what do you clean your hands before feeding the child?	
12	Do you keep soap to clean the hands?	

Section C: Information on Nutritional status of Mother and Child.

Serial Number	Question	Answer
1	Place of birth of the child.	
2	Was there any qualified person present at the time of delivery?	
3	Were there any complications at the time of delivery?	
4	What was the weight of the child at the time of birth?	
5	When did you first feed the child with mother's milk?	
6	For how long did you feed the child with mother's milk?	
7	What else have you used to feed the child for the first six months?	
8	When did you start the complementary feed for the child?	
9	Did you breastfeed the child along with the complementary feeding?	
10	How many times do you feed the child in a day?	
11	What is the source of drinking water that you give to the child?	
12	How many meals does the mother take in a day, at present?	

13	Did the mother take any medicine during her pregnancy?	
14	How many times did the child fall ill in last one month?	
15	How many times was the child taken to a doctor?	
16	What is the current location of the child?	
17	Since what age is the child going to Balwadi?	
18	Does the child takes the regular supplements provided at the Balwadi?	

Section D: Immunization Status of the Child

Serial Number	Question	Answer
1	Do you have the immunization card of the child?	
2	At what all sites has the child received an injection?	
3	How many times has the child received an injection?	
4	At which place was the child immunized?	
5	Did the child develop fever, diarrhea etc after immunization?	
6	Has the entries been made properly in the immunization card?	
7	Do balsakhis and traditional birth attendants gave timely information about the immunization to be received?	
8	Do balsakhis make regular visits to your house, how often?	

Section E: Recording of Anthropometric Measurements of the Child.

Serial Number	Measurement to be made	Value
1	Age of the child in months	
2	Weight of the child(in kg)	
3	Height of the child (in cms)(standing position for child above 18 months of age and recumbent position for child below 18 months of age).	