

COMBATING MALNUTRITION



Action Against Malnutrition

A Multi-Strategy Intervention in Seven Blocks of Four States



A PROCESS DOCUMENT

AAM CONSORTIUM PARTNERS



PHRS - established in 2008, works towards 'Health for All' by creating capacities and engaging with the public health system. PHRS has rich experience and expertise in operational research for public health and malnutrition.

Ekjut - established in 2002, has a strong field presence in several underserved districts of India, Ekjut successfully evaluated the impact of a community empowerment process on birth outcomes, and recipient of Trial of the year award from Society for Clinical Trials (SCT) in 2011 for the potential impact of their work on humanity.



CINI - founded in 1974 is regarded as one of the most influential institutions working for children in India. CINI runs operations on education, protection, nutrition and health of children, adolescents and women in need in four Indian states using a sustainable development and life-cycle approach.



CHAUPAL- Established in 2006. Chaupal Gramin Vikas Prashikshan Evam Shodh Sansthan is a voluntary organisation based in Chhattisgarh, working primarily with tribals in 15 districts. Its work domain includes Right to food, nutrition and health; Right to equality and dignity; and Tribal people's rights over natural resources.

IDEA- Established in 1991 Institute for Developmental Education & Action (IDEA) is a state level non- profit organization for Bihar. IDEA is working for overall developmental of the deprived people at the grass root level on issues on mother & child/ adolescent health, education, human trafficking, and livelihood.

AAM is financially supported by **Jamsetji Tata Trust**. The **Jamsetji Tata Trust** is an allied trust of the Sir Dorabji Tata Trust. One of the oldest, non-sectarian philanthropic organisations in India, their vision of constructive philanthropy has been sensitive to the fast-growing needs of a developing nation, and the projects and programmes they support bear contemporary relevance.

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A collaborative effort by Public Health Resource Society, Ekjut, Child In Need Institute, Chaupal Gramin Vikas Prashikshan Evam Shodh Sansthan & Institute for Developmental Education and Action
Supported by Jamsetji Tata Trust

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Preface

Malnutrition in very young children has been a particularly stubborn problem for India, even as some gains have been made in the recent past. Particularly, current systems fail to achieve comprehensive outreach to children under the age of three, especially in extremely resource-poor areas. Not enough is known about the determinants and course of malnutrition in this age group because of lack of experience and there is sparse documented information even about their response to various community-based strategies for its management.

Action Against Malnutrition – a project being run in 7 blocks of 4 states of Jharkhand, Odisha, Bihar and Chhattisgarh – was designed to understand the various factors related to malnutrition in very young children living in disadvantaged; mostly tribal, areas, as well as to examine the feasibility of various strategies for community- based management of malnutrition. The following document provides a description of these strategies as well as some early outcomes.

As a group, many challenges have been faced in conceptualizing and implementing this project that has been close to our hearts. However, the rich learnings from this experience have far out-weighed our efforts. We have been warmed by the comradeship of whole villages, women and children and we have witnessed their trials and tribulations as also their struggles and victories. This document is an attempt to share this privilege with you, in the hope that it will create the much-needed insight and empathy to design more appropriate programmes for children; programmes that are better supportive to communities and families so that they may raise their children to their full potential.



Acknowledgement

The AAM Project Management Unit would like to thank the AAM consortium partners for their kind support and valuable suggestions at each step towards the development and completion of the AAM Process Document. We thank the State teams who ensured prompt facilitation for data collection, especially Mr. Rajkumar Gope from Ekjut, Ms. Rajbir Kaur from CINI, Mr. Gangaram Paikra from Chaupal, the PHRS Ranchi team including Mr. Haldhar Mahto for his useful insights at each step; and Mr. Rajesh Sriwastwa and Ms. Shampa Roy for persevering to ensure we understand every detail of project implementation. We would like to especially acknowledge the field staff members of all block teams for giving their time for data collection and encouraging us.

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We would like to thank Jamsetji Tata Trust for financially supporting us for this publication.

Last but by no means the least, we express heartfelt thanks to the mothers of crèche children and the community who cooperated with us by sharing their personal experiences and permitted us to write this document, and crèche children for letting us visit their space and observe their activities.

The core research and writing team of this document- Dr. Vandana Prasad, Dr. Ganapathy Murugan, Dr. Dipa Sinha and Ms. Nidhi Dhingra are responsible for conceptualizing, designing and conducting research, collecting & analysing data, and writing the document. The shortcomings of this document are claimed by them.



Executive Summary

Malnutrition is a multi-factorial challenge requiring a multi-sectoral approach. Various innovations and pilots currently exist to demonstrate separate elements and strategies that have a bearing on malnutrition. However, there are no comprehensive ‘solutions’ to address malnutrition. Some of the critical issues/gaps identified in current programmes relate to the lack of provisions for overall childcare, insufficient human resource and capacities to deal with under-threes, and the lack of systems for community based management of malnutrition, especially severe malnutrition.

Public Health Resource Network (PHRN) through various platforms and most importantly through the Working Group for Children Under Six (WGPU6) have made several recommendations to the Government of India and highlighted several issues related to management of malnutrition¹.

In 2011 Sir Dorabji Tata Trust and Allied Trusts (SDTT & ATs) had expressed keen interest in piloting community based management of malnutrition interventions and was already in discussions with various organizations like PHRN, Ekjut and Jan Swasthya Sahyog (JSS). SDTT & ATs supported a two day consultation meeting, which was hosted and organized by PHRN with participation from experts, public health practitioners, policy advocates and various civil society organisations from the public health and nutrition space.

The consultation led to a blue print for a multi strategy and multi state intervention which was evolved building on existing good practices. The intervention would reach out to **children under three years of age primarily through day care centres/crèches; community mobilization by conducting structured Participatory Learning and Action (PLA) meetings and follow up home visits; and work to strengthen public systems related to health and nutrition.**

In 2012 June the initiative Action Against Malnutrition (AAM) was approved by the Jamsetji Tata Trust with the objective of reducing malnutrition among children below three years. The design was based on existing good practices from JSS, Mobile Crèches, Ekjut and Public Health Resource Society (PHRS).

AAM aims to create a comprehensive model which demonstrates sustainable actions that are predicated by a decentralised process to effectively manage malnutrition at community level. It is being collaboratively implemented across seven blocks in four states by consortium organisations - Public Health Resource Society, Child In Need Institute,

¹ Strategies for children under six, A framework for the 11th Plan, June 2011 and Update and Recommendations for the 12th Plan, April 2012, Working Group for Children Under Six



Chaupal, Ekjut and Institute for Developmental Education & Action (IDEA). Jan Swasthya Sahyog, Ekjut, Mobile Creches and PHRS render technical support to the AAM project.

Presently, AAM activities are spread over four states namely Bihar, Jharkhand, Chhattisgarh and Odisha, reaching out directly to **3200** children in the age group of 6 months to 3 years and over **20000** women. It is engaged in capacity building of 302 field level workers and 87 community mobilizers on community based management of malnutrition. Has trained 115 anganwadi workers on growth monitoring and involve frontline health workers in meetings with women's group on various issues on malnutrition. In the past two years with its own set of challenges the AAM intervention successfully demonstrates a comprehensive programme for community based management of malnutrition in rural India. The document is built from primary and secondary data sources. While the document highlights the positives it could have biases in selection of sample and might suffer from a lack of such a comparison. The document tries to comprehensively capture the AAM story highlighting the various processes from inception to implementation and the changes AAM has brought in the field.



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Abbreviations

AAM	Action Against Malnutrition
ARI	Acute Respiratory Infection
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AHS	Annual Health Survey
ANM	Auxiliary Nurse Midwives
BPO	Block Project Officer
CINI	Child in Needs Institute
CSO	Civil Society Organisation
CBM	Community Based Management
CHC	Community Health Centre
ECCD	Early Childhood Care and Development
EAG	Empowered Action Group
H4A	Height for Age
IYCF	Infant and Young Child Feeding
IDEA	Institute for Developmental Education and Action
ICDS	Integrated Child Development Services
JSA	Jan Swasthya Abhiyan
JSS	Jan Swasthya Sahyog
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MTC	Malnutrition Treatment Centres
MIS	Management Information System
MDM	Mid-Day Meals
MUAC	Mid Upper Arm Circumference
MoHFW	Ministry of Health and Family Welfare
MWCD	Ministry of Women and Child Development
NCPCR	National Commission of Protection of Child Rights
NFHS	National Family Health Survey
NFSA	National Food Security Act
NRHM	National Rural Health Mission
NRC	Nutrition Rehabilitation Centre
PRI	Panchayati Raj Institution
PLA	Participatory Learning and Action
PHC	Primary Health Centre
PMU	Project Management Unit
PDS	Public Distribution System
PHRN	Public Health Resource Network
PHRS	Public Health Resource Society
SAM	Severe Acute Malnutrition
SDTT & ATs	Sir Dorabji Tata Trust and Allied Trusts
SPO	State Project Officer
SS	Systems Strengthening



THR	Take Home Ration
ToT	Training of Trainers
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee
WASH	Water Sanitation and Hygiene
W4A	Weight for Age
WGPU6	Working Group for Children Under Six
WHO	World Health Organization



INTRODUCTION

Action Against Malnutrition (AAM) aims to create a comprehensive model which demonstrates sustainable actions that are predicated by a decentralised and empowering process to effectively manage malnutrition at community level. It is a three year project targeting children in the age group of birth to three years and is being collaboratively implemented across seven blocks in four states by Public Health Resource Society (PHRS) ; Child In Need Institute, Chaupal, Ekjut, and IDEA. AAM is financially supported by Sir Dorabji Tata Trust and Allied Trusts (Jamsetji Tata Trust).

AAM uses multiple community based strategies that have been tried, tested and validated through experience over many decades. The key components of the project include child care for under the age three through crèches, community mobilisation and systems strengthening to ensure better delivery of public health and nutrition services related primarily to Integrated Child Development Services (ICDS) Scheme and the National Rural Health Mission (NRHM).

This document captures the AAM story from it being discussed in consultation to the past advocacy efforts of the partner organisation to it being designed and implemented as a multi strategy-multi partner intervention. The document also tells the story of AAM being translated to field, the process of community acceptance, conflict resolution and other interesting aspects that the team discovered and continues to discover, while implementation. The document is written in broad five chapters: where chapter I discusses the evolution of AAM, giving the background, rationale and its inception; chapter II delves deeply into describing the strategy and the processes of identifying and selecting the implementation sites; chapter III discusses the process of translating the vision of AAM to the field, preparatory processes by the Project Management Unit, and also shares about the pioneering AAM crèche Management Information System (MIS) that has been built to track the growth of crèche children; chapter IV shares the learning and the positive changes that are being observed in the AAM field, this chapter has been built majorly from primary data and methodology of the same is elaborated in the chapter, also providing the way forward and the learning from AAM.

Methodology: This document has been built through primary and secondary data sources. Secondary data sources includes the existing literature of AAM and primary data was collected through direct interviews with implementation partners, block teams and a sample of field staff, and observations of sample crèche functioning and PLA meetings. Methods include review of intervention documents, qualitative semi-structured interviews, discussions both one on one and in group settings for various partners, team members and observations. This process document is written during the mid-term period of AAM intervention and captures the AAM implementation from inception until July 2014.



SECTION 1- EVOLUTION OF THE AAM PROJECT

1.1 NUTRITION STATUS OF INDIA

Malnutrition in India

Malnutrition is the leading cause of death in children in developing countries, especially in India. According to World Health Organization (WHO) in developing countries about 60% of deaths occurring among children aged less than five years could be attributed to malnutrition. Despite high economic growth since the 1990's, child malnutrition rates are worse in the Empowered Action Group (EAG) states in the country than in many Sub-Saharan African countries.

According to National Family Health Survey 3 (NFHS 3) data, the nutritional status of children in India is way below desirable, where 48% of children under five years of age are stunted² and 43% are underweight. According to a more recent Hungama Report (2011), by the age of 24 months 42% children are underweight³ and 58% stunted. The disaggregated urban and rural data reveals that rural children are in a more vulnerable state as compared to urban children.

Key Child Nutrition Indicators	NFHS 3 (2005-06)	Urban	Rural
Children under 3 yrs who are stunted (%)	44.9	37.4	47.2
Children under 3 yrs who are wasted (%)	22.9	19.0	24.1
Children under 3 yrs who are underweight (%)	40.4	30.1	43.7
Children age 6-35 mths who are anemic (%)	78.9	72.2	80.9
<i>*source: NFHS 3, 2005-06</i>			

It has been widely observed that the first three years are very crucial for the health of a child and have a great and lasting influence on the quality of life of a human being. The health, nutrition, education and development opportunities given to a child at this stage determine, to a large extent, his or her health and wellbeing for the entire lifetime.

The child under 3 years is most vulnerable to the vicious cycles of malnutrition, disease/infection and resultant disability all of which influence the present condition of a child at

² A stunted child has a height-for-age z-score that is equal or less than 2 standard deviations (SD) below the median for the World Health Organisation (WHO) Child Growth Standards. Chronic malnutrition is an indicator of linear growth retardation that results from failure to receive adequate nutrition over a long period and may be exacerbated by recurrent and chronic illness.

³ An underweight child has a weight-for-age z-score that is equal or less than 2 SD below the median for the WHO Child Growth Standards. This condition can result from either chronic or acute malnutrition, or both



micro level and the future human resource development of the nation at macro level. Moreover there needs to be an understanding that the “poor nutritional outcomes of infants and children arise from the poor health status of women, overall poverty and lack of hygiene, and inadequate health facilities. In particular, women’s access to clean drinking water, toilet facilities, and clean cooking fuel influence their health outcomes, which are critical for child health and nutrition”.⁴

Malnutrition reflects an imbalance of many factors at the macro and micro level such as poor feeding practices, food insecurity at household level, repeated infections and lack of access to health care, lack of social security and maternity entitlements, poor or lack of childcare services for children of women working in the informal sector and lack of provision of safe drinking water and sanitation. All these factors contribute to mortality, morbidity, impaired cognitive and social development, poor school performance, and reduced productivity in later life.

Current Gaps in Schemes for Managing Malnutrition

Malnutrition is well understood to be a massive multifactorial challenge requiring a multisectoral approach, as frequently mentioned by the Government of India, various professional and civil society groups. Various innovations and pilots currently exist to demonstrate separate elements and strategies that have bearing on malnutrition. However, concentrated action towards demonstrating ‘comprehensive’ solutions that are predicated by a decentralised, empowering process are still lacking. Since these comprehensive community-based strategies are complex to facilitate, there is a tendency to look for quick-fix product based on seemingly easy solutions such as on ready to eat foods or large scale fortification, meanwhile compromising on more sustainable interventions.

Currently the nutrition space in India is highly centralised around two ministries- the Ministry of Health and Family Welfare (MoHFW) and the Ministry of Women and Child Development (MWCD).

The ICDS Scheme led by MWCD is the only national programme that exclusively caters to the needs to children under six. Although the objectives of ICDS include providing comprehensive health, education and nutrition services for children in this age group, it has been seen that there have been major gaps to deliver this mandate. Also, as there is better coverage for children in age group of 3 to 6 year by ICDS, there is neglect of children under two years of age who are mostly at home. The programmatic reforms offered to the States (for 200 Districts in Phase I) by MWCD as part of ICDS restructuring are significant

⁴ T. Nandakumar, Kavery Ganguly, Pravesh Sharma, and Ashok Gulati, Food and Nutrition Security Status in India: Opportunities for Investment Partnerships (ADB Sustainable Development Working Paper Series) No. 16, November 2010



measures but they don't take into account any specific programme for community based management of severe malnutrition.⁵

The MoHFW under the NRHM has set up Nutrition Rehabilitation Centres (NRCs)/Malnutrition Treatment Centres (MTCs). NRC/MTC is a unit in a health facility where children with Severe Acute Malnutrition (SAM) are admitted & managed. However, it is well understood that 80% of children with SAM and without any medical complication can be well managed through a Community Based Management (CBM) approach. NRCs/MTCs also have very limited capacity (a few beds per district) and is a very expensive intervention that should be reserved only to the SAM children who require facility based treatment. The ICDS recommends children with severe malnutrition according to measurements of weight- for- age to be referred to the NRCs/MTCs. But as there are inconsistencies between the referral criteria of ICDS and admission criteria of NRCs/MTCs, many referred children do not qualify for admission and are sent back leading to a waste of effort by the Anganwadi Worker (AWW) and the family. Equally, there would be some children in the community with SAM that do not get included by screening with weight- for- age. To avoid this, AWWs use the only common criterion between ICDS and NRC that can be done at the level of Anganwadi Centre (AWC); the Mid Upper Arm Circumference (MUAC), leading to a further narrowing of the number of children referred and thereby admitted. ⁶ Once discharged from the NRC/MTC after initial improvement (15% weight gain), many children fail to improve and even relapse in the absence of a CBM of malnutrition. Thus, while NRCs/MTCs play a vital and important role in the management of SAM, they do not offer any comprehensive system for 'cure' or even continuity of care.

Additionally, services for children in this age group, especially for tackling malnutrition, requires convergence of many departments (ICDS, Health, Water and Sanitation, Public Distribution System, Rural Development, Panchayati Raj Institutions (PRI) etc.), in specific health and ICDS services.

1.2 EFFORTS TO ADDRESS MALNUTRITION

While government interventions⁷ on malnutrition are far reaching they remain poorly implemented and have a lack of community involvement. Several experiments by non-governmental organisations have attempted to work on malnutrition in a limited way and

⁵ NCPCR, Aug 2012- October 2013, "Towards Integrated Management of Malnutrition: NCPCR Interventions"

⁶Prasad, V et al. (2012), "Falling Between Two Stools: Operational Inconsistencies between ICDS and NRHM in the Management of Severe Malnutrition", Indian Pediatrics, Volume 49 and NCPCR, Aug 2012- October 2013, "Towards Integrated Management of Malnutrition: NCPCR Interventions"

⁷ Government interventions that work on addressing malnutrition are Integrated Child Development Services (ICDS) Scheme, Public Distribution System (PDS) and Mid Day Meals Scheme



have shown good results. But these are scattered and do not address all components essential to combat malnutrition at the community level in a comprehensive manner.

Campaigns and Advocacy initiatives to address child health and nutrition

A group of people related to the Right to Food campaign and the Peoples' Health Movement – India (JSA- Jan Swasthya Abhiyan) have been engaged in various ways whether, it be through grassroots action, research or interventions in policy, to promote the need to work on early care and development of children under six years of age.

Working group for Children under Six (WGPU6)

WGPU6 was formulated with members from Right to Food and JSA. The WGPU6 in response to a request from the Planning Commission produced the "Strategies for Children under Six: A Framework for the 11th Plan" in June 2007 and additional recommendations to the 12th Plan in April 2012. WGPU6 laid out a comprehensive framework for protection of rights of children under six with a special focus on nutrition, and for complementary interventions in ICDS such as crèches and maternity entitlements.

The "**Right to Food Campaign**" is an informal network of organisations and individuals committed to the realisation of right to food in India. The campaign believes that the primary responsibility for guaranteeing basic entitlements rests with the state. This has led to a sustained focus on legislation and schemes such as the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), the ICDS, Mid-day Meals (MDM) scheme, and the Public Distribution System (PDS).

The **Jan Swasthya Abhiyaan** is the Indian circle of the People's Health Movement, a worldwide movement to establish health and equitable development as top priorities through comprehensive primary health care and action on the social determinants of health.



WCGU6 suggests that different strategies are required for addressing health, nutrition, care and development needs of children under six, depending on their age. The components of services required by the three age groups (zero to six months, six months to three years, and three years to six years) among children under six is summarised in the table below:

Source: Working Group for Children Under Six

	Birth to six months	Six months to three years (until joining pre-school)	Three years to six years (until joining school)
Food	Counselling and support for exclusive breastfeeding; supplementary nutrition and maternity entitlements for lactating mother.	Supplementary nutrition in the form of nutritious THRs, hot cooked meal, nutrition counselling, nutrition and health education.	Nutritious hot cooked meal at the centre
Childcare and Development	Crèches at worksites and maternity entitlements to ensure proximity of mother and child	Crèches; expanding existing crèche schemes and creating anganwadi cum crèches	Pre-school at the anganwadi centre; crèches/day care facilities for those who might need it
Healthcare	Immunisation, growth monitoring, home based neonatal care, prompt referral when required	Immunisation, growth monitoring, prompt care for childhood illnesses, referral care for sick and malnourished children, de-worming, and iron supplementation.	Immunisation, growth monitoring, prompt care for childhood illnesses, referral care for sick and malnourished de-worming, iron supplementation

WCGU6 highlights the need for maternity entitlements and crèches to ensure proximity of mother and child during the first six months as well as adequate care to both mother and child; breast feeding, Infant and Young Child Feeding (IYCF) and nutrition counselling and support services to families; community based day care services/crèches; pre-school centres; supplementary nutrition; and health care services- predominantly community based, with referral institutions that are required to provide comprehensive early childhood care and development. It may be noted that as a result of these efforts, maternity entitlement have been included in the National Food Security Act (NFSA).



Some community based civil society initiatives to address child health and nutrition

In India there have been a few civil society initiatives/programmes that address child health and malnutrition, such as Child in Needs Institute (CINI)⁸ in West Bengal and Jharkhand, Ekjut⁹ in Jharkhand and Odisha, and JSS in Chhattisgarh¹⁰ in rural settings and Mobile crèches¹¹ in urban settings. Most of these are community based efforts using strategies of community mobilisation and community-based care that attempt to maximize population-level impact through improved coverage, access, and cost-effectiveness of care & treatment.

1.3 ADVOCACY WORK ON CHILD HEALTH AND NUTRITION AND THE EVOLUTION OF AAM

PHRN for years has worked with the objective to contribute and strengthen efforts directed towards 'Health for all'. It has worked in various capacities to strengthen the existing public health system through promotion of public health understanding, social justice and human rights related to the provision and distribution of health services. While PHRN continues to work in the public health space it has also been very actively involved in advocacy work of child health and nutrition.

Senior members of PHRN through various platforms and most importantly through the Working WGPU6 have made several recommendations to the Government of India and highlighted several issues related to management of malnutrition¹². Some of the critical issues/gaps identified in current programmes relate to the lack of provisions for overall childcare, insufficient human resource and capacities to deal with under-threes, and the lack of systems for community based management of malnutrition, especially severe malnutrition.

Partners and friends of PHRN have also been engaged in advocacy work of health and nutrition. CINI in Jharkhand has been working on projects to improve child health and women nutrition. Ekjut works on issues of women's health through community mobilisation, where it has been instrumental to create evidence towards reduction of neo natal mortality by 32% by holding participatory interventions with women's groups in Jharkhand. JSS in Chhattisgarh is running a community health program and is running crèche facility for children of 6 months to 3 years at village level. Chaupal in Chhattisgarh has been involved in rights based work on issues of food security and Institute for IDEA in Bihar works on issues of health, education, and livelihoods.

⁸ more information on the organization can be accessed at <http://www.cini-india.org/>

⁹ more information on the organization can be accessed at <http://www.ekjutindia.org/main.html>

¹⁰ more information on the organization can be accessed at <http://www.jssbilaspur.org/about/>

¹¹ more information on the organization can be accessed at <http://mobilecreches.org/>

¹² Strategies for children under six, A framework for the 11th Plan, June 2011 and Update and Recommendations for the 12th Plan, April 2012, Working Group for Children Under Six



In order to take the work on malnutrition forward, all these organisations got together to discuss interventions for combating malnutrition in children that will address the existing gaps; an intervention that would be comprehensive, give equal weight to prevention, promotion and treatment; attend to nutrition, health and care; ensure continuity of care; and respect principles of universal access and equity while prioritising the most vulnerable. Simultaneously, SDTT & ATs was also keen to invest in malnutrition interventions and was already in discussions with various organisations for the same

Taking the discussions forward with SDTT & ATs, all the collaborative partners decided to have a preparatory workshop that would build the proposal towards a larger consultation meeting. This two day consultation meeting, with support from SDTT & ATs, was organised by PHRN in 20-21 September 2011. This consultation had participation of experts, public health practitioners, social activists, policy advocates and various stakeholders in the public health and nutrition space. The meeting aimed to develop a concept for a pilot intervention on malnutrition in children under three years of age, and to investigate the scope for collaboration to implement this concept.

This consultation meeting resulted in consensus amongst various committed Civil Society Organisations (CSOs) for a need of a comprehensive community based approach to address malnutrition. Thus it was decided to build a multi strategy and multi state intervention where it would build on existing good practices of its network organisations. With consecutive discussions and brainstorming it was decided that the project would reach out to children under three years of age, the community, and work to strengthen public systems mainly of ICDS and NRHM. It was also decided in the meeting that the implementation of this project will be through a consortium of willing partners who were part of the consultation. Ekjut, Chaupal, PHRS and CINI readily agreed to be a part of the consortium, it was decided that SDTT & ATs will also consult some of its grantee organisation working on similar issues and who would be willing to be part of the consortium. JSS as knowledge partner and IDEA as implementation partner joined the consortium subsequently. As PHRS had multi state presence, it was decided to be the lead coordinating agency for this project. The project was built on existing best practices from:

- **CHILD CARE CENTRES/ CRECHE FACILITES adapted from Mobile crèches and JSS**
- **COMMUNITY MOBILISATION OF WOMEN'S GROUP WITH PARTICIPATORY LEARNING AND ACTION adapted from Ekjut**
- **SYSTEMS STRENGTHENING MODEL adapted from PHRS**

Hence, the consortium of PHRS, Child in Need Institute, Ekjut, Jan Swasthya Sahyog, and Chaupal, initiated the project “**Action against Malnutrition (AAM): a multi strategy intervention in seven blocks of four states**”, to improve the nutritional status of children



under threes through community mobilization and community based management of malnutrition. **The purpose to start AAM has been to develop a model based upon the recommendations of Working Group for Children Under Six as well as some of the innovative and best practices available in both public and non-profit sectors.** AAM aims to develop a model for scalability and believes that this model will help inform the central and state governments towards developing and modifying their own strategy.

This project is financially supported by Sir Dorabji Tata Trust and Allied Trusts (SDTT & ATs). AAM has been designed as a long term intervention with current project duration of three years.

The area of intervention was decided based on health and nutrition indicators amongst vulnerable and excluded tribal population. Local presence of partner organisations was also taken as a criterion as it would help implement better. The final proposal for the project was sent to SDTT & ATs in January 2012 and AAM received the formal approval for implementation in May 2012.

1.4 INTRODUCTION TO THE AAM PROJECT

AAM showcases a comprehensive multi strategy approach that aims to combat and reduce malnutrition through community mobilisation and community based management. AAM is planned to address the issues of

I. Care

- pregnancy and maternal care

II. Adequate and quality food

- every child is exclusively breastfed from birth to six months
- complimentary feeding for 6 months – 3 yrs with dietary diversity and quality
- comprehensive action on malnutrition including locally produced calorie dense, protein rich foods

II. Disease prevention, treatment and rehabilitation

- Convergence between WCD and Health Department (ICDS and NRHM) for referral to NRC / MTC and follow up of children discharged from the same, as well as treatment of childhood diseases and immunization

III. Stimulation

IV. Other determinants that would include MGNREGA/PDS/family planning



The specific objectives and strategy adopted by the project are:

OBJECTIVES	STRATEGIES
Working with children 0-3 years	<ul style="list-style-type: none"> • Running child care centres/ crèches that cater to early stimulation, managing malnourished children, and for regular growth monitoring • This is based on direct experience of running the health programme in Mobile crèches and learnings from JSS
Mobilizing communities on malnutrition towards preventive, promotional and curative efforts	<ul style="list-style-type: none"> • Community mobilization and sharing of information through PLA • This is based on learning from Ekjut, where Ekjut has led the designing of PLA and community mobilisation interventions
Strengthening public systems, mainly ICDS and NRHM; but also systems for other social determinants of malnutrition such as water and sanitation, for better service delivery	<ul style="list-style-type: none"> • System strengthening and policy advocacy by working to strengthen and support services of functional AWCs; functional mother's committee; functional Village Health and Sanitation Committee (VHSC); functional Village Health and Nutrition Day (VHND), referral services; convergence; community based monitoring; social audits; networking; and capacity building of government functionaries • This is designed based on the PHRS model where its expertise were utilised to design interventions
Influencing the policy environment towards changes that are essential to tackling malnutrition, on the basis of this project	<ul style="list-style-type: none"> • AAM will work together towards research and documentation for creating evidence base for policy advocacy

AAM is being implemented as an action research. Thus, a full-fledged research protocol and MIS have been developed that will be useful in providing data in situations where there are large time gaps between national and state surveys. This project complements all efforts of the State governments in Bihar, Chhattisgarh, Jharkhand and Odisha on malnutrition and will lead to model-building and greater operational understanding.

The project is operated by the AAM consortium with the Project Management Unit (PMU) based in PHRS Delhi. Ekjut is implementing AAM in 2 blocks in Odisha and 1 block in Jharkhand, CINI in 1 block in Jharkhand, Chaupal in 1 block in Chhattisgarh, IDEA in 1 block in Bihar, and PHRS in 1 block in Jharkhand.

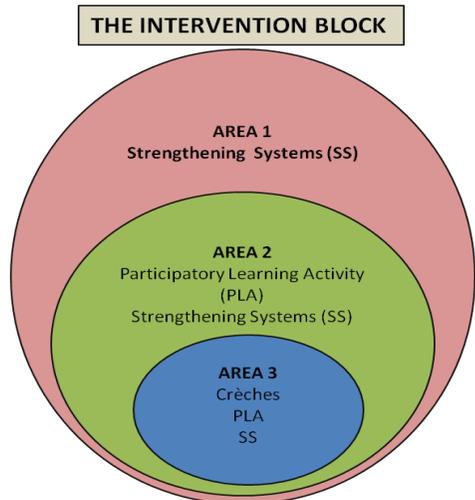


Section 2 – STRATEGY AND COVERAGE

2.1 PROJECT STRATEGY

Building on the collective experience of PHRS, Ekjut and JSS, AAM employs a three-pronged intervention. The intervention includes systems strengthening and policy advocacy by working to strengthen and support health and ICDS services, and other related schemes and programmes mobilizing the community by holding structured PLA meetings, and running day care centres/crèches. This section shares in detail of the implementation process of each of the strategies and coverage.

The design seeks to demarcate 3 areas of nested interventions in the selected blocks. These are – **[Area 1]** with System Strengthening only, **[Area 2]** with Systems Strengthening and Participatory Learning and Action and **[Area 3]** with Systems Strengthening, Participatory Learning and Action and Crèches. Area 3 is saturated with all the three interventions and is aimed to build as key evidence base that help better advocate for systems strengthening across the block and district. The target population for the project is children in the age group of birth to three years.



Crèche/Day care centres

There is increasing recognition of the need for child care services not only where adult care is not available (because mothers are working and so are all adults) within the family but also as an intervention for ensuring health and nutrition. There is growing evidence that women leave young children, especially those under three years of age, at home in care of elders, siblings or neighbours or even alone if there is no choice. The safety and care thus provided is minimal and impacts nutrition, health and development. It also interferes with the right of older children to go to school.¹³

Crèches are being therefore considered a good enabling programme for interventions that lay foundations for growth and development and help fight malnutrition; they provide a framework for overall child care, for delivery of appropriate food supplementation through a day-long period of time and for referral and access to health care. Thus they satisfy many of the requirements for adequate prevention and management of malnutrition. This has been amply demonstrated through programmes such as Mobile crèches in urban areas and the JSS run crèches in rural Chhattisgarh, both of which have anecdotally shown significant

¹³ Ibid 1



impact on the malnutrition status of attending children. Crèches have also been recommended as a major strategy for the ICDS reforms that are expected to emerge during the 12th Five Year Plan. The difficulties, however, pertain to the fact that crèches require well capacitated human resource, adequate infrastructure, and intense supervision, and are relatively expensive to run.

The AAM project runs this strategy in limited areas of identified blocks, which further allows intensification of other strategies of community mobilisation including PLA and systems strengthening, as illustrated in Area 3 of the previous figure.

AAM crèches are being run for children between 6 months to 3 years in Area 3 of each block. It is designed to be a decentralised community based child care centre where mothers leave their children when they are at work. AAM crèches provide locally produced /procured calorie dense foods (3 times a day), and regular anthropometric monitoring which provides as opportunity for early identification of malnourished children. They also allow demonstration of better IYCF practices and menus based on locally available foods (with nutritional inputs from the project team) to prevent malnutrition.

For age 1 to 3 years there is calorie requirement up to 1240 kcal/day

- AAM crèches provide up to 70% of daily nutritional requirements
- 868 kcal + 15.4 gm protein per day
- Menu based on local foods
- Calorie dense and protein rich foods based on local products for CBM

The crèche workers have also been trained and supported to provide age appropriate stimulation though the main focus of the project is nutrition. Each block under AAM can have a maximum of 30 crèches so as to cover one geographical segment of the block (covering approximately 20% of the total habitation of the block). Each crèche has two workers (one care giver and one helper). These workers manage the crèche logistics, prepare food, take care of children, engage in playing activities and maintain records of the children (growth monitoring, referrals etc). All crèches are provided with toys and other materials required for Early Childhood Care and Development (ECCD). There is one crèche coordinator in each block for the overall supervision and monitoring.

Protocols have been developed for dealing with various nutritional situations, and capacitation and monitoring processes have been established to enable them. A crèche MIS has also been built for regular tracking and growth monitoring of children. More details on the protocols and crèche MIS are provided in section 3.4. A crèche training module has also been developed by JSS under AAM, which provides the details of crèche functioning and is an easy reference to the AAM field staff for crèche related details.



Community mobilization and sharing of information through PLA

There is increased recognition that women need to be empowered to look after their own needs and become key change agents in the community by ensuring adequate knowledge sharing on health, nutrition and related issues.

In recent years there has been documented evidence that show participatory community mobilisation interventions, especially with women's groups, have demonstrated positive maternal and child health outcomes.^{14,15} This evidence arises from interventions that involve local women facilitators helping groups to complete a cycle of monthly PLA meetings. These meetings are forums where local problems of women, new mothers and newborns are identified and prioritised, based on which strategies are developed and implemented. These interventions have been able to substantially (30-45%) reduce neonatal mortality, led to improvements in home care practices and healthcare-seeking, as well as reported increases in solidarity and problem-solving skills among group members. Advocates believe that community involvement can make health services more accessible and sustainable, and thereby enabling communities to explore the consequences of health behaviour which can yield lasting improvement in health outcomes.¹⁶ The WHO has also been giving more importance to strategies that involve community participation and empowering individuals and families to assume more responsibility for their health.

In AAM, Ekjut hypothesises that similar approaches will contribute to the improvement in care-seeking for childhood illnesses and nutrition, caring practices and contribute overall in reducing under nutrition among children. This PLA approach is being implemented in Area 2 (along with systems strengthening) and Area 3 (along with crèche facilities and systems strengthening). The gains from the PLA approach in malnutrition, especially in Area 3, will be reinforced through the provision of crèches and systems strengthening.

¹⁴ Manandhar D et al. Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster randomized controlled trial. *Lancet* 2004; 364: 970-979.

¹⁵ Tripathy P et al. Effect of a participatory intervention with women's groups on birth outcomes in Jharkhand and Odisha, India: the Ekjut cluster-randomised controlled trial. *Lancet* 2010; 375 (9721): 1182-92.

¹⁶Rath et al, (2010), "Explaining the impact of a women's group led community mobilization intervention on maternal and newborn health outcomes: the Ekjut trial process evaluation, BMC International Health and Human Rights, pg. 10-25



Under this component regular meetings in the community on malnutrition, child care, child health and related issues are conducted, as listed in the box below.

Meeting 1	Health and nutrition for women and children - Why is it important? Who is left out?
Meeting 2	The Intergenerational Malnutrition Cycle and the 'Malnutrition - Illness' cycle_
Meeting 3	MUAC measurement and interpretation
Meeting 4	Understanding of Growth promotion & Growth faltering
Meeting 5	Identifying locally available foods and discussing the contents of a balanced diet
Meeting 6	Initiation of complementary feeding
Meeting 7	Identifying & prioritizing nutrition problems among women and children in the community
Meeting 8	Finding causes and solutions to the first two prioritized problems
Meeting 9	Finding causes and solutions to the other two prioritized problems
Meeting 10	prioritizing possible strategies to address under nutrition
Meeting 11	Undertaking responsibilities and deciding on indicators for measuring progress

COMMUNITY MEETING I

Meeting 12	Caring for newborn infants
Meeting 13	Understanding causes for Acute Respiratory Infection (ARI) and care during illness
Meeting 14	Understanding causes for diarrhoea and its prevention
Meeting 15	Preventing fever in children(malaria and infections)
Meeting 16	Reinforcing Strategies for prevention of malnutrition
Meeting 17	Discussing causes and solutions for prevention of malnutrition in children
Meeting 18	Evaluation of impact of PLA by group members

CLUSTER COMMUNITY MEETING II

Under the PLA activities 18 meetings/trainings with women's groups are conducted in selected PLA clusters of the program areas. PLA meetings are mostly attended by 15-25 people including mothers of children who go to crèches, and other mothers with children below 3 years of age, but they also see participation of adolescent girls; frontline workers such as AWWs, ASHAs and PRI members; pregnant women, mothers in law, sometimes men and other villagers. Amidst the PLA meetings cycle- community meetings are conducted that see more participation from the community, frontline workers, officials from Health, WCD, PRI, and other departments. In PLA meetings, knowledge on nutrition,



growth monitoring and related issues are shared in order to facilitate community action including finding local solutions outside of current schemes and programmes. After these meetings are concluded, social audits will be conducted on programmes such as ICDS, MGNREGA and PDS.

For conducting meetings there are 15 facilitators¹⁷ per block¹⁸, each facilitator is responsible for 8 women groups in roughly 8 villages (number varies based on number of groups in the village) in her cluster. In this way, 8 women group meetings are held per month in each cluster. There is one PLA/community mobilization per block to coordinate the PLA Cycle.

These PLA meetings are coupled with regular follow up, where home visits are done for:

- Those mothers who have been identified as marginalized during the ‘power walk’ game
- Children who are identified under red and yellow colour zone in MUAC through women’s group
- Those children whose mothers do not participate in women’s group meeting/ or visit AWC/living in hamlets
- Children identified as malnourished by AWW
- Children in the green category who have had an illness recently
- Children who have been discharged from NRC/MTC for their follow up

During the home visits the facilitators measure the MUAC of each child, based on which parents are counselled on child care and diet and referred to the MTC/NRC, wherever required.

Ekjut has prepared detailed manuals for PLA meetings and home visits under this component. The details of PLA meetings and home visits are recorded every month by the PLA facilitator and the block teams. This is also presented as part of the review meetings, where each block team presents the meeting they are conducting, total number of meetings held, follow up home visits, and challenges, if any. The PMU and Ekjut are presently engaged in building a mechanism that will measure outcomes and evaluate the PLA activities. Additionally they are building a documentation template to record PLA activities, home visits and case studies.

¹⁷ There are approximately 120 women’s groups per block, where one facilitator takes charge of 8 women’s groups

¹⁸ Except Lakhanpur block in Chhattisgarh and Turkaulia block in Bihar- where there are 6 facilitators in the cluster



System strengthening

One key strategy of the project is to improve the delivery mechanism of government programmes through building capacities of communities and service providers and generating pressure and demand. The focus is mainly on ICDS scheme, health services [especially those related to immunization, treatment of childhood illnesses, NRCs/ MTCs]; village level water and sanitation, PDS; and MGNREGA.

It has been observed that there are major issues and obstacles within the system which affect child health and nutrition and that need to be addressed. The existing gaps in effective service delivery include regular provision/quality of supplementary nutrition in AWCs, poor or lack of equipment such as weighing machines at AWCs, irregular or no growth monitoring and identification of faltering growth in children, supervision issues in ICDS and health, limited or no NRCs/MTCs, shortage of beds in NRCs/MTCs and poor convergence amongst different government departments.

This component is very crucial as it aims to provide scalable and sustainable solutions through government interventions. SS aims to work with frontline workers, block and state level officials to ensure that all the services of these mentioned schemes reach their rightful beneficiaries.

Specific activities under systems strengthening include:

- Ensure regular growth monitoring of children each month in each hamlet covering all children (esp. 0-3yrs)
- Ensure growth monitoring at VHNDs, wherein ensuring VHSNC participation, tracking VHND and coverage for Growth Monitoring. (Weighing efficiency), assuring identification of children with ‘faltering growth’ every month
- All children enrolled in AWCs get all mandated services
- Interaction with and capacity building of AWW
- All children identified as SAM get the needed treatment and support till full recovery, referral to NRC/MTC, as required
- Monthly meeting with district and block officials of ICDS and health departments
- Social audit and public hearings on health and nutrition schemes (MDM, PDS, ICDS) - training and support
- Convergence – MGNREGA, Water Sanitation and Hygiene (WASH), horticulture and agriculture and animal husbandry planning- POSHAN plans for panchayats- training PRIs

For SS, a state cell has been constituted in each state with a State Project Officer dedicated to systems strengthening activities, who works in close collaboration with the block team.



PHRS has built a reporting format for this component that verifies the SS activities, collects information at the village/panchayat level and discusses this information at block Level meetings with ICDS and block level health officials. The issues that are not resolved at these block level meetings are then taken up to the district and state level.

The SS information is recorded at village level, the format is filled by the PLA facilitator for the villages in their clusters. Format includes whether regular weighing and growth monitoring is conducted in AWCs, regular SAM referrals to MTCs and NRCs, operational hand pumps, and maternal and child deaths, if occurred. Then, further, this information is collated at block level by the Block Project Officer (BPO), who takes appropriate action to ensure quality growth monitoring in all AWCs, address issues related to safe drinking water and to inform Auxiliary Nurse Midwives (ANMs) regarding child and maternal deaths and prepare a small case study for the records. The verbal autopsy format is presently in pilot stage. A quarterly report is prepared of SS activities and actions taken report at the village and pachayat level, block level, district and state level. This report is shared with the PMU and is also presented at project review meetings. In addition to this, the PMU is in the process of formulating a monitoring and documentation mechanism for SS.

2.2 IMPLEMENTATION PROCESS & COVERAGE

States Selection

The states where the project is being implemented were identified based on poor socio-economic indicators and poorer health and nutrition indicators. These indicators are alarming especially amongst the tribal population in these states. Based on these indicators (from the latest NFHS 3 data as provided in the table below) 4 states were selected - Bihar, Jharkhand, Chhattisgarh and Odisha. Consideration was also given to being able to locate experienced organisation willing to take up this challenge.

		Children under 3 years who are stunted (%)	Children under 3 years who are wasted (%)	Children under 3 years who are underweight (%)	Children age 6-35 months who are anemic (%)
Urban	Bihar	50.1	32.6	54.9	87.4
	Jharkhand	47.2	35.8	54.6	78.2
	Chhattisgarh	52.6	24.1	47.8	80.9
	Odisha	43.9	23.7	39.5	74.0
Rural	Bihar	51.3	32.9	56.3	89.0
	Jharkhand	49.6	37.9	58.0	80.5
	Chhattisgarh	55.1	24.1	50.1	82.1
	Odisha	45.1	25.3	41.2	75.8

Source: National Family Health Survey 3, 2005-2006



Some of the key indicators as per Annual Health Survey (AHS) 2011 from these four states are provided in the table. The very fact that these four states feature amongst the list of nine backward states in the first Annual Health Survey justifies why they are an obvious choice for an intervention to address the problem of malnutrition. Jharkhand, Odisha and Chhattisgarh also have considerable tribal populations who demonstrate poor nutrition and health indicators.

STATE	INDICATOR				
	CBR	IMR	NNMR	U5MR	MMR
Bihar	26.7	55	35	77	261
Odisha	20	62	40	82	258
Jharkhand	23.7	41	26	59	261
Chhattisgarh	23.9	53	35	70	269

Implementation through partners

AAM is being implemented in partnership with four local organisations having a strong local understanding and presence: Chaupal, CINI, Ekjut and IDEA.

Ekjut is implementing in 2 blocks: Saharpada in Keonjhar District and Thakurmunda in Mayurbhanj District in Odisha; and 1 block of Khuntpani in West Singhbhum District in Jharkhand, CINI in 1 block of Gola in Ramgarh District in Jharkhand; Chaupal in 1 block of Lakhanpur in Sarguja District in Chhattisgarh; IDEA in 1 block of Turkaulia in East Champaran District in Bihar, and PHRS in 1 block of Ratu Nagri of Ranchi District in Jharkhand.

Block Selection

AAM is implemented in districts where the collaborative partners (Chaupal, CINI, Ekjut and IDEA) across the four states (Chhattisgarh, Jharkhand, Bihar and Odisha) had a strong presence. In each of selected districts, a rapid situational analysis was done and one block was chosen as the area of intervention based on various socio-economic indicators and health and nutrition indicators. The selection of blocks was further based on vulnerability mapping of indicators like large underserved tribal or/and SC population, low accessibility to quality services due to difficult terrains, lack of proper infrastructure, discrimination against marginalised communities, difficult livelihood options etc.

Each block, for purposes of project evaluation, is trifurcated into three distinct geographical areas (Area 1, 2 and 3). The project is implemented in each of these areas based on the three strategies of intervention. The strategy of system strengthening is implemented in all three geographical areas thereby saturating the entire block with that strategy. In Area 1, in addition to system strengthening, which is a strategy that is implemented across all areas, there would be no additional intervention. In Area 2, in addition to system strengthening there would be PLA and other community mobilization activities. In Area 3, in addition to



system strengthening, PLA and community mobilization activities, direct intervention of crèches services are implemented. Thereby, Area 3 has all the three strategies implemented in it, Area 2 two strategies and in Area 1 one strategy. The final evaluation of the project will have a comparative study against baselines for the three distinct geographical areas so as to understand the merits and scope of each intervention and strategies that constitute the project.

Cluster Allocation Process

The trifurcation of the block into three distinct geographical areas (Area 1, 2 and 3) were done through a clustering process. This clustering process was basically used by Ekjut in their previous PLA interventions. They had divided the blocks into clusters based upon certain characteristics so that the villages that were grouped into each of the clusters had certain homogeneity. The same approach was adapted in AAM and the block was divided into multiple clusters based on the following process and stages:

Cluster Allocation: Stage 1

Objective: To carve out clusters as units of operation for PLA facilitators and systems strengthening in the block, basis geographic area and proximity of groups

Steps involved

1. Based on Census 2001 population data and birth rate, projected population of the block in 2011 was calculated. Also, block maps with panchayat and village boundaries were downloaded from district websites.
2. Based on the maps, most of the villages were visited by 2 teams with 2 members each.
3. Bearing the facilitator's convenience in mind, the villages in the block were mapped by the teams based on:
 - Contiguity of villages
 - Hard to reach area – transport facility, road connectivity etc.
4. As per their understanding of the villages and their location, clusters were allocated.
5. The number of clusters to be allocated was calculated as follows:
 - Based on Ekjut's experience, ideally, the implementation of PLA cycles should be undertaken in a group at 5-600 population level.
 - 5-600 population in one group implies that roughly 4000-4800 population would be covered in one cluster (8 groups in each cluster).
 - In this way, about 16-18 clusters would be allocated in the entire block based on the total population.

Cluster Allocation: Stage 2

Objective: To allocate different components of systems strengthening, PLA and crèches to the clusters, basis the vulnerability of malnutrition



Steps involved

1. Discussions with community leaders, women and service providers in the area were held to understand the prevalence (from the perspective of the community) of malnutrition amongst children in the villages.
2. Mapping of functional health facilities and nutrition services including number of functional Anganwadi centres, mini anganwadi centres, ASHAs, Community Health Centre, Health Subcentre, Primary Health Centre, functional Village Health, Sanitation and Nutrition Committees, CDPOs, ICDS Supervisors, Sevika, Sahayika etc was carried out. Focus was on access and availability of quality care.
3. Safe drinking water sources are mapped.
4. Meetings with medical officers in the block and officials from the ICDS department were organised to identify areas in the block with high malnutrition
5. Collection of ICDS data related to malnourished children.

Comparative vulnerability scores (based on local perception)	AREA 1 (SS)	AREA 2 (SS+ PLA)	AREA 3 (SS+ PLA+ Crèche)*
Low access to quality health care	✘	✓	✓
Low availability of nutrition related services	✘	✓	✓
High malnutrition	✘	✓	✓
Hard to reach area	✘	✓	✓
Absence of sanitation facilities	✘	✓	✓
No safe drinking water source	✘	✓	✘
High number of women engaged in wage labour or other economic activities	✘	✘	✓
Higher migration	✘	✓	✓
Considerable distance from functional health facility	✘	✓	✓
High number of landless families	✘	✓	✓

6. NRC/MTC level data of inpatients and waiting list was collected to map out pockets of malnutrition in the block. NRC/MTC staff could also suggest which pockets in the block tend to have more malnourished children.
7. Subsequently, the allocation of the components was done on the basis of the following matrix:

Note:

“Local perception”- villagers (poor men and women), Health and ICDS service providers and field staff, At each discussion, participants were asked to share comparative perceptions about various ‘sub locations’/panchayats, villages, groups of villages.

✓ denotes more and ✘ denotes lesser magnitude for given indicators.



* Crèches should be based in the most vulnerable areas.

8. For the allocation of Area 3, community level acceptability of crèche was imperative while for Area 2 existence of women's groups was seen to be convenient. In making these allocations the consideration had been to include rather than exclude-and the allocation is a trade-off between the need, both real and felt, for these interventions and availability of resources at our disposal.

Although, all AAM blocks are in rural areas, the PHRS intervention block has pockets of semi urban settings also. Hence, during the cluster allocation process, it was decided not to include this semi urban area in area 2 and area 3 as that may require different kind of programme strategy.

Crèche Area selection process

The crèches in Area 3 were opened considering the demand from community and high level of acceptability, they were also other factors such as where there are more working mothers who are not able to take care of their children, high population of vulnerable and excluded community, unavailability of AWCs, and to saturate the area (for logistics and ease of the area).

After selecting crèche areas based on these indicators, selection of villages for opening crèches was done in consensus and support of the community. Meetings/gram sabhas were conducted to discuss opening of crèches, in these meetings the community along with members of PRI, mother's committee and gram samiti participated. The community has been involved in identifying physical spaces for establishing crèches. In several villages, the community has given individual rooms and community centers for housing crèches. In many places, community members came together to build new buildings or repair old unused buildings to house crèches. The crèches are the prime point from where community begins to take ownership for their effective functioning and smooth operations.

PHRS organised an exposure visit to JSS crèches in Bilaspur in Chhattisgarh to understand the process of running of crèches. The JSS- Bilaspur training was followed by another week long intensive training in November 2012. AAM crèches were opened in a phased manner from November 2012, varying in each block subject to availability of space and selection of crèche workers.



The table below provides the coverage of AAM across the 4 states.

Coverage of AAM

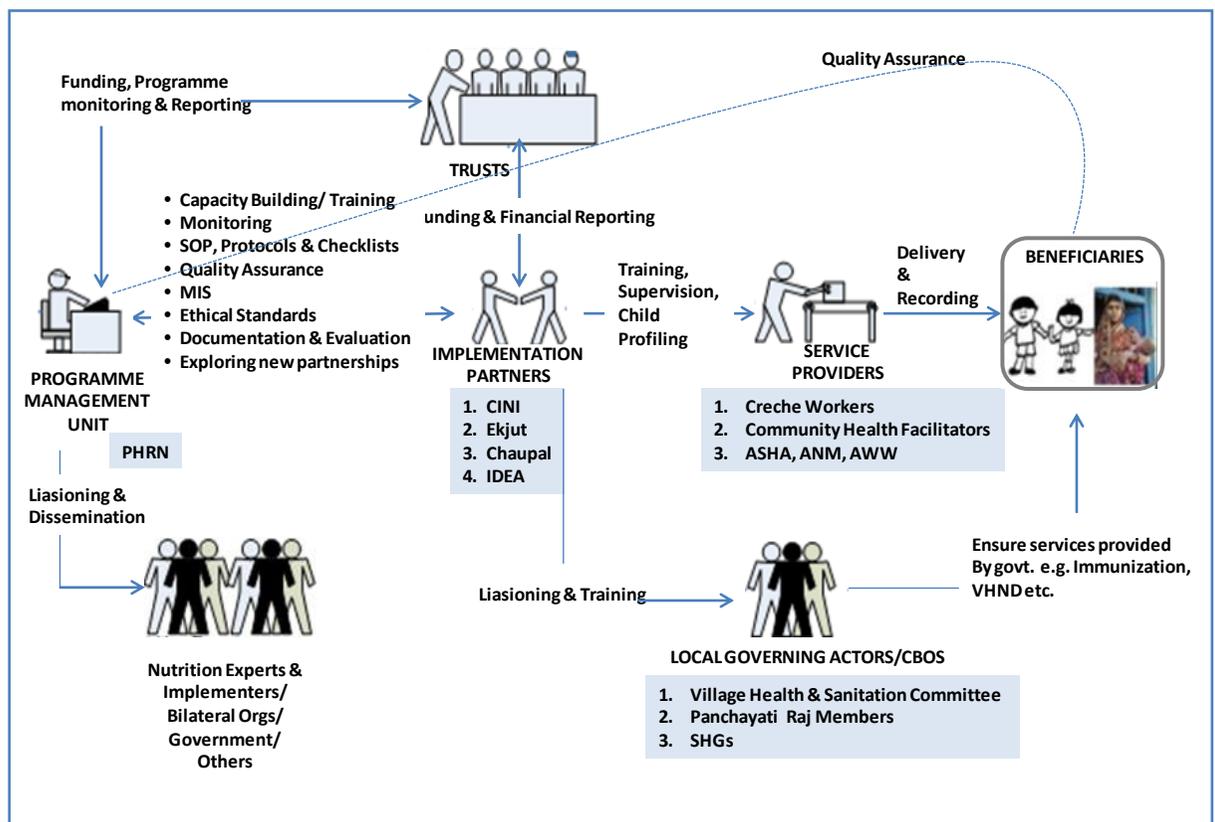
State	District	Block	Total Pop. in the Block	Total Villages in the Block (Census' 01)	Total no. of Clusters in the block	% of ST and SC Population in the block	Total No. of Clusters under PLA area	Total no of Villages Covered under	
								PLA area	Crèche area
Jharkhand	West Singhbhum	Khuntpani	77799	117	18	85% ST 3% SC	15	89	13
Jharkhand	Ramgarh	Gola	125476	86	30	29%ST 8%SC	15	43	9
Jharkhand	Ranchi	Nagri/ Ratu	126376	83	30	48%ST 3%SC	15	61	14
Chhattisgarh	Sarguja	Lakhanpur	117743	99	46	51%ST 8%SC	6	22	16
Odisha	Mayurbhanj	Thakurmunda	102661	165	18	63%ST 14%SC	15	116	15
Odisha	Keonjhar	Saharpada	79310	138	18	58%ST 9%SC	15	115	13
Bihar	East Champaran	Turkaulia	179845	33	8	18%	6	9	3



SECTION 3 – TRANSLATING ORGANIZATION VISION

3.1 PROJECT STRUCTURE

The AAM project structure involves multiple partners; the figure below demonstrates this complex structure and the entity relationships between them. AAM is funded by SDTT & ATs and has its PMU with PHRS. The various roles and responsibilities of PMU are provided in section 3.3. PMU manages the relationships with the Trust, implementation partners, and the experts/advisory group. AAM implementation partners translate the project to the field where the block teams coordinate and manage for effective delivery of project services, block implementation structure is provided in section 3.5. PMU, has a State Project Officer in each of the 4 States, who coordinates between the block team and PMU, s/he also does regular quality checks.



Values

The AAM consortium is driven by values. These core values direct the consortium's initiatives at all levels and underpinning the ways members in which members conduct themselves:

- **Democratic values:** All our endeavours would be driven by the democratic values of equity, justice and respect for all.



- **Integrity:** We must conduct our activities fairly, with honesty and transparency. Everything we do must stand the test of public scrutiny.
- **Understanding:** We must be caring, show respect, compassion and humanity for our colleagues, partnering communities – particularly women and children; and always work for the larger benefit of the communities we serve. Team members with special assignments will be sensitized to imbibe and display qualities required of persons in such positions e.g. for the crèche workers - respect, dignity, equality, love and care, patience, non-discrimination, empathy and professionalism.
- **Excellence:** We must constantly strive to achieve the highest possible standards in our day-to-day work. Highest standards should be maintained in the quality of our facilitation work, the services we provide, the data and information that we collect for analyses and dissemination and the quality of our engagement with the system etc.
- **Unity:** We must work cohesively with our colleagues across the consortium and with our communities and partners to build strong relationships based on tolerance, understanding, mutual cooperation and respect.
- **Responsibility:** We must continue to be responsible and sensitive to the communities and environments in which we work. We must respect the local knowledge systems and abilities. At the same time, we should ensure that our interventions and research are not extractive as we follow the principle of “no survey without service”

3.2 ADVISORY GROUP

Since AAM is a larger scale and complex intervention, it was felt appropriate to establish an Advisory Group and it can provide a valuable channel for the involvement of, and input from, experts working in the field of malnutrition. However, the establishment of an Advisory Group is not a requirement of the Project Management framework. The Advisory Group is not involved either in the management or monitoring. These responsibilities rest with the Project Head, and the Principal Technical Officer respectively. The role of the Advisory Group is purely advisory, and it plays no direct role in the operation of the framework. It is involved in the following activities:

- needs analysis and/or identification of the project’s objectives;
- offer guidance on the preparation of the original project plan;
- offer periodical guidance to the project;
- advise the donor (SDTT & ATs) on any subsequent changes to the agreed objectives as may be necessary as the project proceeds, and how these changes may be accommodated within the project plan.

AAM Advisory is dynamic and unique, where the agenda continues to evolve. It varied from providing guidance on the day-to-day operational challenges to the larger ethical/moral guidance to the project. The advisory group were keen on innovations, eager



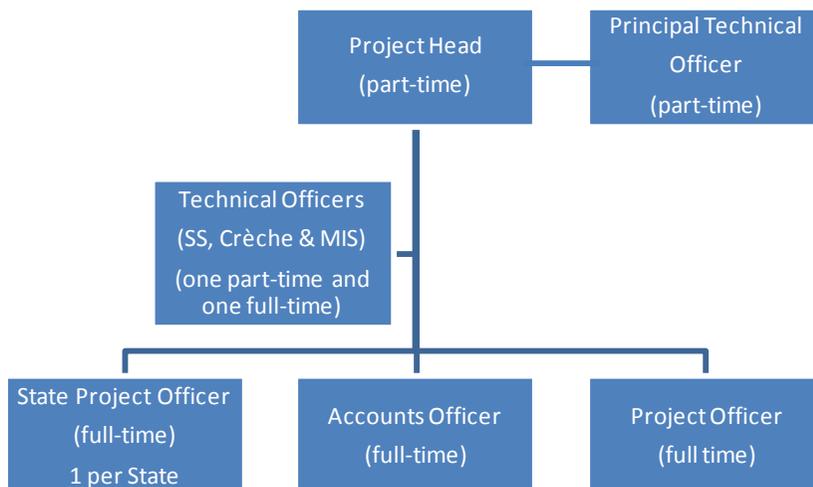
to elicit possibilities and expand the scope of project. The initial AAM advisory group was set up after the first two day consultation meeting in September 2011, and then the group consisted of 15 members, who are experts from leading civil society groups working on similar issues (advisory group members provided in Annexure I).

During 2012-13 there were a few additional members added to the AAM Advisory group. When Dr. Vandana Prasad went to the National Commission of Protection of Child Rights (NCPCR) as Member for Child Health, Dr. Dipa Sinha joined the Advisory group as Principal Technical Advisor; Dr. Ramani Atkuri, who brought expertise from JSS to AAM was moving on from JSS, PHRN decided to retain her in her individual capacity and have Dr. Yogesh Jain joined as a JSS representative. There was also felt a need to include the heads of implementation organisations to the Advisory group, hence Mr. Ranjan Panda of CINI, Mr. Gangaram Paikra of Chaupal, and Mr. Digvijay Singh of IDEA also joined.

3.3 PROJECT MANAGEMENT UNIT

PHRS is playing the role of the Project Management Unit (PMU) for AAM. As PMU, PHRS plays the co-coordinating role in AAM and is responsible for setting up the project management cell. It is the PMU's responsibility to keep the advisory group informed and liaise between the advisory group and all the partners in the consortium. The PMUs structure is as below.

The detailed job description of each PMU member is provided in Annexure II. PMU activities of are as follows:



Operational Management

- Preparing the detailed project management plan from pre-project stage onwards
- Ensuring the project's overall objectives, targets at various key stages, and individuals' responsibilities are clearly understood by all concerned
- Monitoring performance against the plan
- Development of guidelines for selection of personnel and job description
- Human Resources for the project including recruitment, training and capacity building support
- Development of capacity building modules and training on various components of the project.
- Development of MIS formats and co-ordination of MIS training
- Development of MIS and providing MIS support and feedback for project strengthening
- Documentation and research support for the project
- Evaluation support of the project
- Technical inputs and bringing in quality across board
- Providing regular feedback and highlighting areas of slippage and identifying/initiating corrective action
- Arranging meetings with the National Technical Officer and key technical officers of the team at key stages and preparing summary progress reports prior to each meeting
- Organising and conducting review meetings
- Ensuring appropriate communication between the members of the project team and other project stakeholders including, where appropriate, the end users
- Ensuring that the project complies with all appropriate procedures and regulations, e.g. personnel, financial and procurement etc.

Technical Management

- Project Quality Assurance - Providing overall technical leadership to a team of technical officers and enhance technical quality of the project
- Developing manuals and tools that can be implemented throughout the project area
- Capacity building – Training and development
- Representation - Serving as the project's representative at meetings concerning Nutrition and Child Survival
- Dissemination of information - Leading and assisting PMU and technical officers in developing articles for peer-reviewed publication

In addition to the above activities, PMU has been instrumental in effective implementation and monitoring of AAM activities.



3.4 PREPARATORY PROCESS

The preparatory phase included: developing training materials including the PLA and home visit module (refer to section 2.1) developed by Ekjut and crèche training module developed by JSS; developing protocols and guidelines, forms and registers for crèche strategy; procurement of anthropometric tools; and developing and printing growth monitoring charts. This section provides details of protocols, guidelines, forms, and registers; training and capacity building; and the crèche MIS.

With support from partners from the consortium, the PMU has developed and finalized protocols and guidelines for different aspects of crèche functioning and monitoring of children. Protocols have been also translated into hindi by the PMU. Training on the protocols has been provided as part of the Training of Trainers (ToT) workshop held at JSS in Bilaspur. A member of the PMU attended this training as a resource person to train on protocols.

The protocols and guidelines developed are provided below:

Entry Level Protocol	Background information and Child's Health record at the time of admission and
Attendance Register	Includes no. of days child has attended the crèche, reason of absenteeism, any illness in that particular month, any red flag identified by crèche and record of THR and weighing at AWC
Child Health Card	Background information of the child and monthly weighing details, status as per growth chart
Health Check up form	This form records physician's observation when the child goes for health check up
Meal Planning	A detail of food items provided at the crèche, along with special nutrition care
Guidelines for Growth faltering	
Protocol for Growth faltering	
Protocol for severely malnourished	
Protocol for severely stunting	
Guideline for referral	
Home visit guideline	
Red flag register	

All these protocols set standards to be followed in crèches and how these get translated is required to be documented. During implementation, existing state government protocols for MTCs/NRCs and related efforts are adhered to and followed without duplicating state government services.



3.4.1. Capacity Building and Training

PMU has been organizing trainings, workshops and capacity building exercises for the implementation teams. Especially the crèche component required more training and handholding at the inception stage. The key trainings organized, attended and led by PMU are listed below:

- An exposure visit to JSS held at JSS Campus, Ganiyari, Bilaspur, Chhattisgarh from 27 to 29 August, 2012, which included participants from all the partner organizations (Ekjut, Chaupal, CINI, PHRS and IDEA) and representatives of the PMU. During the session, JSS team presented the introduction to the Phulwari programme and also shared their experiences in running the programme, gaps and challenges, logistic management and MIS. The team also presented the technologies used in mother and child health and various innovations made by JSS in instruments and kits.
- A representative of the PMU participated in a three day workshop of training of trainers (ToT) for partnering organisations for first seven meetings of PLA held in Ranchi during September 3-5, 2012. This training workshop was facilitated by Ekjut and attended by members from all partner organisations.
- A three day training of trainer's workshop was organized on Community mobilization from 6- 8 May, 2013 in Nav Bharat Jagriti Kendra, Ranchi. Participants were members from all partner organisations. CINI, Chaupal, Ekjut and PHRS. EKJUT team took the lead in providing the technical support i.e. preparation of training manual and facilitation of training workshop. During the training, topics to be discussed in the PLA meetings number 8-17 were covered.
- Representatives from PMU participated in ToT for crèche programme organised in JSS Ganiyari, Bilaspur during October 29 to November 3, 2012. Participants include Block Project Officers, PLA/Community mobilization Coordinators and Crèche Coordinators of implementing organizations from Jharkhand, Chhattisgarh, and Odisha. Additionally, on behalf of the PMU a resource person was present for training the participants on crèche protocols.
- PMU representative spent two days in Mobile Crèches, Raja Bazar centre to have a first-hand experience in running crèche regarding food, toys, activities, maintaining records in the registers, and MIS.
- Mobile Crèches conducted ECCD training for all block teams was done in three phases: (i) first 5 days training workshop which was organized in Social Development Centre (SDC, Ranchi) from 25- 28 April, 2013 and attended by members comprising of crèche workers. SPOs, Block Project Officers, Crèche Co-ordinators, and PLA Facilitators from CINI, Chaupal, Ekjut and PHRS participated in the training programme; (ii) 5 days exposure visit at Mobile Crèches, Delhi was organized from 22nd to 24th August,



2013 and the SPOs, BPOs, Crèche Coordinators, PLA Coordinators from CINI, Chaulpal, Ekjut, IDEA and PHRS participated. PHRS were a part of this visit; (iii) final 5 days training workshop was held on 20-22 November 2013. SPO, BPO, Crèche Coordinators, PLA Coordinators from CINI, Chaulpal, Ekjut, IDEA. PHRS resource persons provide training to crèche workers in their respective blocks and also extend handholding and supportive supervision.

While regular trainings are organised, capacity building is an ongoing process where the AAM state and block teams are constantly working with the field staff. There is constant handholding, monitoring visits by the PMU, supportive supervision, and additionally regular follow up based on the data generated by the crèche MIS. AAM review meetings are also conducted once every six months; these meetings are forums to review performance, cross learning, and plan ahead.

3.4.2. Baseline and End-line research component

In order to evaluate the impact, baseline and end-line surveys covering seven blocks has been planned to detect changes in under-nutrition (underweight, wasting, and stunting) among children 6-35 months as well as changes in feeding practices, health care seeking behaviour, hygiene and home care practices.

Dr. Audrey Prost, a senior lecturer at the University College of London is leading this process along with Ekjut. She has been instrumental in designing evaluation tools for research and data analysis for Baseline research. The Baseline Survey has been conducted, data has been analysed and the initial findings have been shared with the PMU.

3.4.3. Crèche MIS

Developing the Crèche MIS

AAM has pioneered in developing a crèche MIS that enables to track all children across intervention sites and it generates reports based on regular growth monitoring. Through the MIS each child's growth chart can be tracked. The decisions for follow up and care for underweight, severely underweight, and growth faltered child is made locally as soon as a malnourished child is identified based on the growth chart of the individual child. The report generated by MIS helps identifying children who are severely stunted and wasted and also identifies underweight, severely underweight, and growth faltered children if they have been missed otherwise. The MIS also plays an important role in pointing out any abnormalities in data. Analysis of data from MIS is used for monitoring how the protocols are being followed, and for giving feedback on the activities to block teams.



The format for recording of crèche data was first discussed during the preparatory workshop and based on the feedback PMU took the initiative in preparing first MIS datasheet in excel format.

In the beginning, block teams used to send the monthly MIS data in excel format to PMU, and after cleaning the data, it was uploaded on the MIS website by PMU. After which the data was accessible to all block teams, by using block specific username and password. But with time it was observed that through this process, there were many errors that had to be corrected manually, which consumed majority of time of PMU staff, hence a need was felt to prepare a more error proof online portal. Presently, this MIS portal allows online data entry at block level and the PMU and implementing partners can instantly refer the reports once the data entry is completed.

Data collection

At crèches, the crèche workers maintain entry forms, attendance register and red flag register. The information is filled in these registers by crèche workers, wherever they are literate to do so, under the supervision of PLA facilitators, and/or the Block team. And otherwise this data is filled by PLA facilitators under the supervision of Block team. All the data is doubly screened by the Block team.

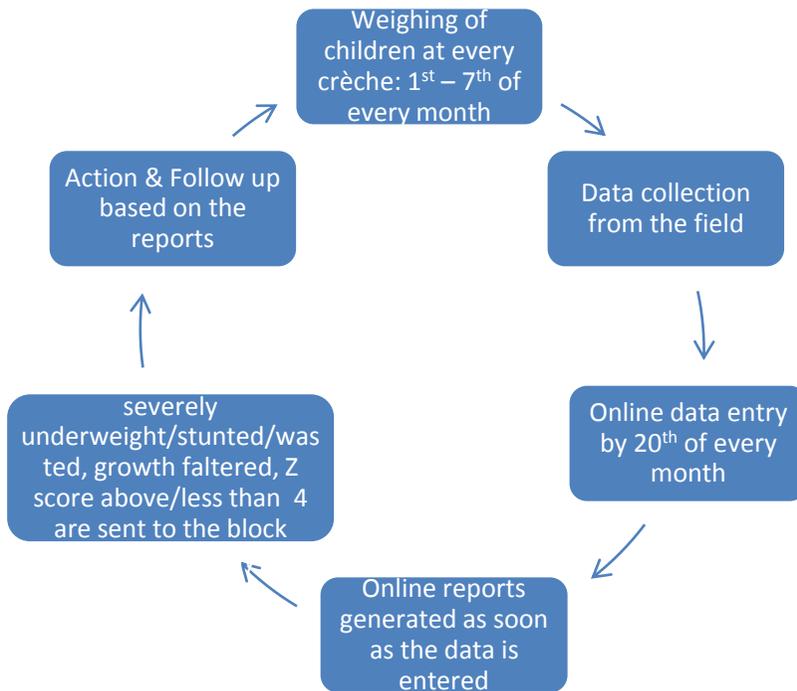
Limitation: The first phase of crèches was started by the end of November 2012. Due to delay in supply of weighing machines there was poor quality data on entry weights in all blocks. The finalising of MIS formats and system of growth monitoring and entering the data also took a few months to be streamlined. Also, until March 2013 new crèches were being opened at regular intervals. It is by March that most of the crèches were in place, hence the data for any analysis is used March onwards.

According to the growth monitoring protocols decided upon for the crèches, every child's weight is to be recorded monthly and height is to be measured once in six months. In April 2013, it was decided that for the purpose of uniformity across crèches, heights would be measured in the months of May and November each year for all children irrespective of their date of admission. The crèches also continue to record heights at admission for new admissions. Each block is required to complete weighing across the crèches from 1st-7th of each month. The data for the crèches is uploaded on 20th of next month. All data is collected and uploaded on a monthly basis.



Weighing of the child is done by either the crèche workers or the PLA facilitators under the supervision of Crèche/PLA coordinators or the BPO. The height is measured by PLA facilitators or the coordinators with the help of the block team. For minimum error in crèche MIS data, there are regular quality checks by block level and PMU.

The figure below demonstrates the process of functioning of crèche MIS:



Data in the AAM Portal

This data generates various reports such as Monthly Reports, consolidated data and child growth chart.

MONTHLY REPORTS:

Monthly records are available from December 2012 onwards and can be accessed crèche wise, block wise, and state wise. The data provided in the monthly reports include:



Data Sheets	Details
MIS Monthly Record	<ul style="list-style-type: none"> attendance of children, no. of drop outs, crèche open days, avg. attendance, no. of children weighed in crèche, no. of children absent more than 3 days, no. of ill children, no. of children referred no. of children underweight, severely underweight, stunted, severely stunted, wasted, severely wasted percentage of children who received THR in AWCs and whose weight was taken at AWCs
MIS growth faltered	<ul style="list-style-type: none"> number of children who have growth faltered for 1 month, 2 months and more than 2 months
MIS red flag	<ul style="list-style-type: none"> number of children who are in the red flag sheet number and percentage of these children referred to health centre, and those admitted to NRC for those who went to NRC, what is no. of days the child stayed in MTC/NRC, number of red flag children who have been put on special diet, number of red flag children who were home visited
Unit data	<p>Provides comprehensive data for each child –</p> <ul style="list-style-type: none"> date of admission, date of birth, sex, birth order, family details and background (type of ration card, mother's education, parent's occupation, Asset status of the family, house type, mother goes out to work) crèche open days, child attendance, no. of days child has been active since admission, no. of days crèche attended since admission, any illness, reason for absenteeism, child's weight in Kgs., Weight for Age (W4A) Z scores, difference in W4AZ scores for 2 months and 3 months, W4A interpretation, any red flag based on Z scores, crèche identified any red flag, reason for red flag by crèche workers child's height Cm., Height for Age (H4A) Z scores, Weight for Length, H4A Interpretation. This data is available when the height is measured, on a half yearly basis. MUAC of each child can view the growth chart of each child.
Absenteeism	<ul style="list-style-type: none"> provides the child's name and reason for absenteeism
Child Left Out (Dead/Drop out)	<ul style="list-style-type: none"> drop out children in the crèche and reason for drop out
System Strengthening Support	<ul style="list-style-type: none"> systems strengthening support provided to the child
Six months unit data comparison	<ul style="list-style-type: none"> provides a comparison of W4AZ score and H4AZ score for the last 6 months
New admissions	<ul style="list-style-type: none"> list of all new admissions each month, along with their weight, height and MUAC measurements



CONSOLIDATED MIS REPORTS

The data is available from December 2012 and is presented block wise for the last three months, consolidated data reports include:

- No. of active children (children attending in that month)
- Average days centre was open
- Percentage of children absent more than 3 days
- Percentage of ill children
- Percentage of children referred
- Percentage of underweight children, severely underweight children, stunted children, severely stunted children, wasted children, severely wasted children,
- Percentage of children who have received Take Home Ration (THR) from AWCs, whose weight was taken in AWCs
- No. of children in the red flag sheet
- No. of children admitted to NRC
- No. of children on a special diet
- No. of drop outs and no. of child deaths

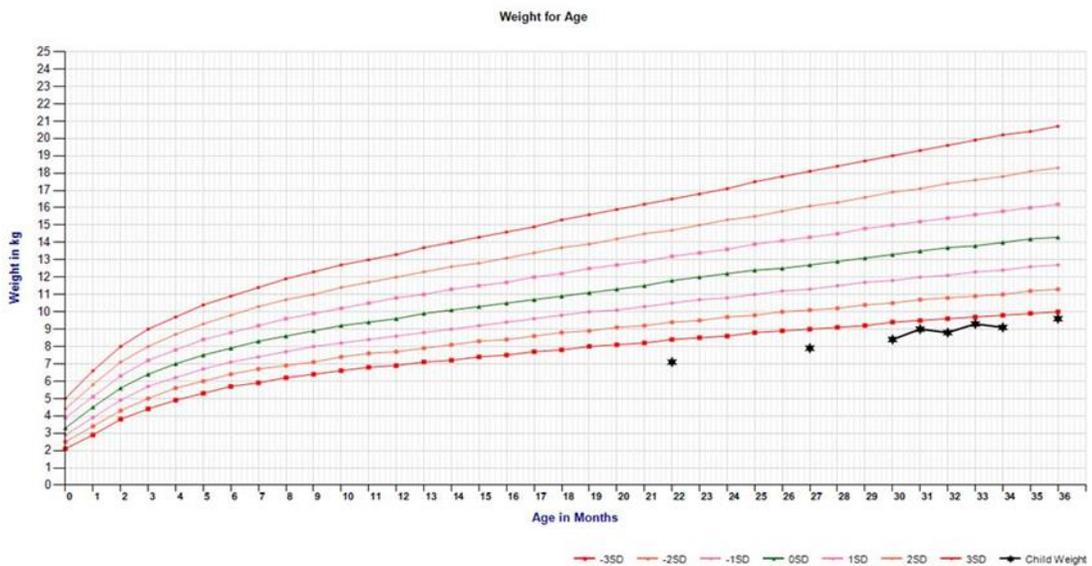
GROWTH CHART

Based on the data entered at the block level, the MIS generates growth charts for each child. This data is used by the block and PMU to track the growth of crèche children. The MIS further calculates Z scores of each child, based on the Z score data. PMU provides the list of children in red flag to block teams for further follow up, and appropriate action, as per the protocols and guidelines. The data is also screened by PMU to identify any gaps.



A sample growth chart generated of a malnourished child, as on March 2014, in Lakhanpur block of Chhattisgarh is below:

Child Growth Card										
Child ID :: 10010		Name ::		State :: Chhattisgarh		District :: Sarguja		Block :: Lakhanpur		Village ::
S No.	Month	No of days creche was open	Child attendance	Age in months	Weight (kg)	Height (cm)	W4A Z-Score	H4A Z-Score	Any Illness	More than 3 days absenteeism reason
1	Jan - 2013	28	13	22	7.10	0.00	-4.24	0	YES	SICK
2	May - 2013	26	1	26	0.00	0.00	0	0	YES	ILLNESS, PARENTS ARE NOT AWARE ABOUT CHILD.
3	Jun - 2013	25	5	27	7.90	77.10	-4	-3.85	NO	HE IS CRYING AND DONT WANT TO STAY .
4	Sep - 2013	20	13	30	8.40	0.00	-3.83	0	NO	
5	Oct - 2013	25	21	31	9.00	0.00	-3.4	0	NO	
6	Nov - 2013	21	18	32	8.80	81.10	-3.65	-3.47	YES	COUGH AND COLD
7	Dec - 2013	20	20	33	9.30	0.00	-3.32	0	NO	
8	Jan - 2014	19	19	34	9.10	0.00	-3.57	0	NO	
9	Mar - 2014	18	17	36	9.60	0.00	-3.27	0	NO	



Although, the AAM project has a designed baseline and end line survey to study the impact of the intervention, the MIS plays a very crucial role to track the growth of crèche children. Moreover, the crèche MIS provides an opportunity to serve as a database for further research. The MIS data is being used to understand various linkages between seasonality, gender, etc. with malnutrition and over time disseminate these learnings at various platforms.



3.5 BLOCK LEVEL

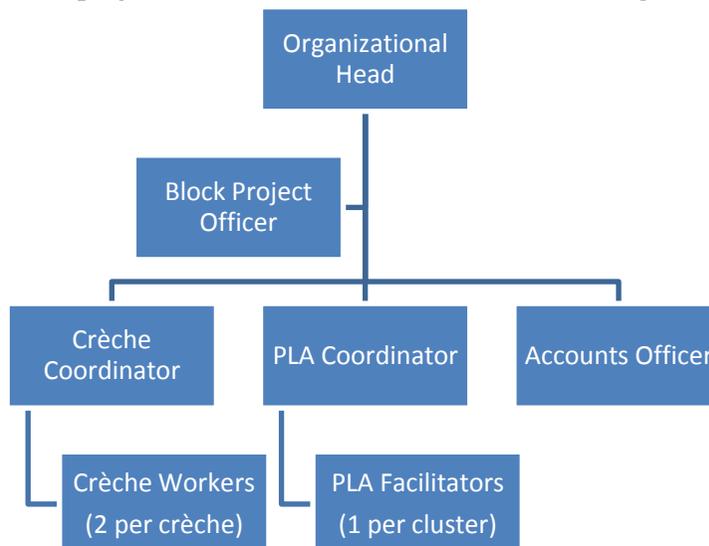
AAM in blocks

AAM is being implemented by local partners across the 4 States. The partners implementing AAM have been close associates and friends of one another, and with good local presence in the area of intervention.

Overview of the Status of AAM implementation across blocks

Implementing Agency	Block	District	Crèches operating
	Saharpada	Keonjhar	19
	Thakurmunda	Mayurbhanj	19
	Khuntpani	West Singhbhum	19
	Gola	Ramgarh	25
 CHAUPAL	Ratu Nagri	Ranchi	25
IDEA	Lakhanpur	Sarguja	24
	Turkaulia	East Champaran	5

At the block level the project structure is as demonstrated in the figure below:



The project staff at the block level is hired locally by implementing partners. The PMU has a State Project Officer in each State who coordinates between the PMU and block teams. The roles and responsibilities of each project staff has been defined by the PMU, as provided below:

Block Project Officer (BPO)

BPO is responsible for all activities at block level under three arms of PLA, SS and crèche. BPO's role has been crucial in setting up AAM sites- where s/he has been responsible in identifying villages for different interventions, identification and formation of clusters for PLA. Under SS s/he is responsible to build rapport with concerned block level officials with the assistance of state team. BPO has also developed a team comprising of coordinators, PLA facilitators, crèche workers and helpers; encouraging and motivating team members, assisting, facilitating, supervising and monitoring the crèche coordinator and PLA facilitator. BPO is also required to support the baseline and other implementation activities such as MIS related activities, and to report regularly to the state team on the progress, gaps, successes, delays etc.

Specific responsibilities for crèche related activities:

- identification of crèche sites
- provide spot guidance and handholding to crèche worker after training, early education, pre-school education
- monitor site to ensure quality and check maintenance of various records related to children at crèche and details of beneficiary families
- rapport building with beneficiary families, villages based institutions, PRIs and functionaries at the village level (ICDS, Health, etc)
- ensure growth monitoring (recording weight, plotting on the chart and counselling)
- create awareness on early detection of disability and its referral
- coordinate case by case referrals and child death cases
- ensure health check up of all children once in every year
- logistics arrangement
- identifying, assessing gaps and addressing them if possible or highlighting them to the SPO/PMU, and assessing the progress, developing the strategies for improvements and reporting

Specific responsibilities for PLA related activities:

- conduct review meetings for assessing progress and further action / activities
- collection of field level data and compiling data from the field
- facilitating and handholding to the facilitators (initially)
- developing strategy for each facilitator (based on their strengths and weaknesses)



- any other work related to project given time to time.

Crèche Coordinator

The role of crèche coordinator is to guide crèche workers in planning and organizing delivery of services at the crèche and also give on the spot guidance and training whenever required. Crèche coordinator is a mediator between BPO and crèche workers. Also when the coordinator visits a crèche, s/he does not exercise her duty as an inspector but as a supervising officer, that is to guide & correct crèche worker in performing her duty.

Crèche coordinator is also responsible for identifying location for housing crèches and establishing an effective functional relationship with community mobilizer and contributes in filling up community growth charts along with the community mobilizer.

Specific responsibilities:

- provide continuous spot guidance to crèche worker to bridge the gap between training and job requirements
- conduct monthly meetings with crèche workers
- maintain dairy and record information relating to crèche children, malnourished, severely malnourished children and sick referred children
- identifies severely malnourished children particularly within 3 years of age for home visiting and home visit these children
- assist crèche caretaker to establish rapport with parents of children attending the crèches and winning their trust and confidence
- guide the crèche worker in growth monitoring and in conducting preschool education, create awareness for early detection of disability, its prevention and making appropriate referrals
- collate and check the registers and records received from crèches
- makes arrangement for storage of ration, medicines, early education materials registers and records
- ensure all crèche regulations are complied with, and discipline and decorum are also maintained in all crèches
- prepare and submit regular activity and financial reports to BPO and prepare/assist BPO in preparing relevant anecdotes and case studies
- carry out any other tasks related to project as may be instructed by the BPO

The crèche coordinator was selected by implementing agencies in close coordination with PMU. The crèche coordinator is required to be a graduate with adequate computer skills and has working knowledge of accounts and book keeping.



PLA coordinator

The PLA coordinator coordinates all field activities and does supportive supervision of PLA facilitators to facilitate regular participatory women's group activities. S/he reports to the BPO. The PLA coordinator is required to move around in the block, with the knowledge of local language. The coordinator is preferred to have school education or a graduate, but suitable candidates with matric education were also considered.

Specific roles and responsibilities:

- conduct review meetings of facilitators and give input on further meetings
- collect qualitative and quantitative data from facilitators
- keep record of collected data from field and report to BPO
- regular field visit to support facilitators in conducting meetings
- make rapport with local service providers
- support facilitators in case there is some problem in the field and support in their training
- inform about strengths and weaknesses of facilitators to their line managers so that s/he can make proper strategy to support facilitators individually
- encourage facilitators to make their meetings more effective and interesting and any work related to project given time to time

PLA Facilitator

The facilitator facilitates structured participatory women's group meetings in the villages/hamlets in their respective clusters. Facilitators report to the PLA coordinator. The facilitator is required to have minimum reading and writing skills with additional skills of basic mathematics for simple calculations, preferably studied till class 8-10. S/he should be willing to travel within the cluster. Each facilitator is provided with a bicycle for travelling in the cluster.

Along with facilitating meetings, other responsibilities include:

- home visit to provide counselling to the mother/care givers in the family
- attend review meetings; keep records of the meetings
- write case studies and stories
- encourage women group members for supporting individuals / families in any malnutrition related issues
- encourage women group members for collective action to avail health and other government services
- obtain names of visibly malnourished children from group members/ also from AWWs, home visits these children, takes the MUAC measurement and counsel the family members and refers SAM children to the AWC for linkage with NRC/MTC



The facilitator was selected in consultation with the villagers/community, where community from two to three villages gathered to identify potential candidates.

Crèche Worker

There are 2 crèche workers per crèche, who work for 8 hours daily for which the crèches are open, and report to the crèche coordinator.

They are responsible for:

- taking care of children with special care of malnourished children
- Cooking meals and feeding children
- identifying working couple in the village and assist crèche coordinator in motivating working parents to send their children to the crèche
- supporting crèche coordinator in developing and maintaining profiles of children attending crèche and of their families
- supporting crèche coordinator in maintaining records of children's attendance, growth monitoring and health records

The crèche worker was selected in consultation with the villagers/community, where community from two to three villages gathered to identify potential candidates.



Section 4- LEARNINGS FROM THE FIELD

4.1 INTRODUCTION

AAM is being implemented by partners across the project sites. As mentioned in the previous sections, they are all well established in their respective regions and bring years of experience of working with the community. All of them are also a part of the advisory committee along with other experts.

Although, the initial few months of implementation had its hitches of working with different cultures, locations and communities but the working in partnerships has further benefitted and proved to be very efficient for AAM implementation. For instance, CINI in Jharkhand has its strength of engaging with the government and hence it has been able to achieve a lot in the ‘Systems Strengthening’ strategy, similarly Chaupal has existing strengths in campaign work and community mobilization so it’s been able to conduct PLA meetings very effectively. Ekjut brings special experience in research as well as PLA processes.

The implementation began once the block was divided into clusters. Crèches were opened as the villages and physical spaces were identified. This was followed by PLA activities. Systems strengthening activities started after a few months of crèche and PLA activities. The highlight of AAM implementation has been the high degree of transmission to the field, where each component has been translated almost exactly as designed with minimum or no alternations in the basic concepts. Yet context-specificities have been maintained and the flexibilities in the project have been used. This has been possible due to the collective efforts and a common vision of all partners and PMU.

This section captures the learning from AAM field and voices of the people involved at various levels. The findings are based on field observations and direct interactions with various partners and team members through in-depth interview as described in the section below on methodology. Themes have been then identified from the data that has emerged.

Crèches

A very challenging component of the project has been the starting and running of crèches, as most of the partners had limited experience of this. But with regular mentoring, handholding, and training by the PMU, with support from JSS Bilaspur and Mobile Crèches, the AAM crèches began to open by November 2012. **Presently there are 139 community led crèches covering 3,200 children under three years of age.** Ahead of opening the crèches some of the organizations conducted Gram Sabhas while others used forums



of village meetings to discuss importance of opening crèches and to select the villages for opening crèches. Over subsequent meetings, there was discussion on identifying spaces for opening crèches, and the selection of crèche workers. This process was made participatory and transparent to enhance community ownership, since the very beginning of the project. In addition with the community's suggestion the block teams also looked at the distance of the crèche from AWCs. Amongst these discussions, a few villagers volunteered to provide their house or village/community space for opening crèches. Crèches were opened in a



phased manner, as and when the appropriate spaces crèches were identified.

The selection of crèche caretakers/workers was also preliminarily done by the community through discussions in village meetings where the implementation organizations played a facilitating role. Crèche workers are semi voluntary workers who are representatives of the community. In case of shifting of crèches and as well as granting leave for crèche workers, the community takes the decision.

Participatory Learning and Action

Under this component, the community is mobilized to attend regular meetings that are conducted on issues of malnutrition, child care, child health and related issues based on the PLA approach. Prior to starting meetings, the PLA approach was discussed with villagers during village meetings and other platforms.



These meetings are conducted by PLA facilitators in her clusters and each facilitator is responsible for 8 women's group in roughly 8 villages (the number varies depending on the number of women's groups in one village). Each PLA facilitator is responsible for conducting meetings in her cluster and is provided with a bicycle that helps mobility within the cluster. These



facilitators are also responsible for regular home visits; home visits are conducted based on protocols, as also mentioned in Section II. Presently, AAM reaches out to over 20,000 women through its PLA activities.

Systems Strengthening

The aim of the SS approach has been to improve the delivery mechanism of government programmes through building capacities of communities and service providers addressing



malnutrition, with key focus on ICDS and Health. The specific activities and others aspects of this component have been highlighted in Section II. The SS activities across the block started with orienting the district and block level officials of the AAM project and frontline workers at village level. Systems strengthening activities became stronger as the project got well informed by the gaps and evidences from Area 2 and Area 3.

4.2 METHODOLOGY

The data was collected through direct interviews and observations of crèche functioning and PLA meetings. Methods include review of intervention documents, qualitative semi-structured interviews, discussions both one on one and in group settings for various partners and team members, and observations.

Data was analysed based on interpretations of the researcher, and thematic content analysis. The data was then categorized into themes that were identified as key focus areas during data analysis. Themes identified were: Community participation, challenges and problem solving, impact and success stories, and spin offs.

Sample: The data was collected over a period of three months across seven intervention sites, where one fourth of existing crèches were visited, minimum 5 crèches in each block and one PLA meeting/community meeting attended in each PLA (Area 2) and crèche area (Area 3).



The sample crèches are a combination of better performing, good performing and not so good performing crèches. Performance of the crèches was identified based on how many days the crèche is open in a month, working hours, attendance, community involvement, performance of the crèche workers etc. The direct interviews were conducted with team members and heads of partner organizations, block team, field staff, participating women, and service providers such as AWWs, ASHAs, ANMs, and village committee members.¹⁹

4.3 KEY FINDINGS

The AAM intervention has been able to witness some positive changes in the community. Although this study is not an evaluation of AAM, there are some preliminary findings that have been observed during the course of this process documentation.

While there have been challenges there have been attempts to deal with them; some more successful, some less. On the whole, it is felt that have not been a hindrance for provision of AAM services.

AAM has been able to significantly mobilize the community on issues of child health and malnutrition. As the community continues to participate in crèche and PLA interventions, it has begun to take ownership of these processes. AAM crèches are regularly monitored at the community level, ensuring all services are effectively provided. Women attending meetings look happier and have found a forum to voice their issues, while those whose children attend crèches are happy to see their child get proper food and care. Elder siblings have gone back to schools, not having to look after the younger children any longer. Mothers of crèche children report that they can go to work without worrying about their children and thereby are able to supplement the family income.

The increased knowledge on nutrition and growth monitoring makes the mothers take better decisions for their children and themselves. They are also better informed of public services, leading to increased access to and demand for improved quality of these services.

Generally, children attending crèches are visibly happier and healthier and there is evidence to suggest that there is improvement in children's health, weight and general well-being. The AAM field staff exhibits greater confidence and has found greater respect in their families and communities and are also able to contribute to their family incomes.

4.4 THEMATIC ANALYSIS

4.4.1 Community participation

I. Community's role in starting, supporting, and monitoring the running crèches

¹⁹ The names of beneficiaries and AAM staff are anonymous to maintain confidentiality



Opening crèches has received an overwhelming support from the community, where the community has not only participates but also contributes and is involved in running crèches. However, this support has come after several rounds of discussions and close engagement with the community. Various ways in which the community has supported-

- Identifying physical spaces for opening crèches
- Selection of crèche workers
- Encouraging mothers to send their children to crèches
- Support in logistics of regular supply of food, especially delivery of eggs
- Crèche committee, which includes mothers and other village members, oversees and monitors the crèche functions
- Support of mothers and community members for crèche operations



II. Community Contribution:

The community has immensely contributed to crèches and to the children. Various ways in which the community has contributed-

- Community has supported to identify a suitable place for opening crèches and also provide infrastructure support, where they have provided their labour to construct broken rooms to crèches, helped in building fences, and other support as required.
- Firewood and fuel for the crèche kitchen are contributed by the community
- Mothers of crèche children and other villagers give green leafy and seasonal vegetables and other food items, that might be otherwise expensive to buy on a regular basis for crèche meals
- Contributions by AAM employees, where BPO of Thakurmunda and crèche coordinator of Turkaulia contributed clothes, BPO Ratu Nagri contributed bed sheets and mats
- An NGO in Thakurmunda block contributed 20 bed sheets



- Other things such as clothes, mats, and toys for crèche children



In a few crèches of Ratu Nagri block the mother's groups have contributed money to use as a common pool and so far they have bought a pair of ducklings, poultry birds for mothers of all crèche children. In another area, the crèche workers and the mothers have decided to keep two goats in the crèche. By doing this these women say they have found a sustainable way to provide protein based food for children and also have a source for livelihoods.

COMMUNITY CONTRIBUTION to AAM crèches

"I am very happy to share that a crèche has provided a pair of duckling to each mother of crèche children. It costed Rs. 60 per ducklings. They provided to eight mothers. For rest of the mothers they will purchase soon, they have sufficient fund for that."

Crèche workers are discussing with mothers on extra care protocols for under weight and severely under weight. This is an effort by this crèche to go beyond discussion on extra care at home also. They are intending to start ensuring eggs to the children at home. The logic behind doing so is that mother will get some extra income. This will help them to provide eggs/ increase feeding options at home. The children are getting eggs (twice a week) at crèche but difficult at home. By the end of March this ducklings will start laying eggs. We do not know what will happen. But we feel the desire of mothers and our crèche workers for the children. The best thing was they were not suggested by any one of us to do so.

Actually we never expected that such things can happen through crèche without spending anything. This is their second contribution, first was on cloths and mats."

BPO, Ratu Nagri (January 2014)

"Teen aged girl of Jaratoli went through a vocational training course on stitching / tailoring. She stitched frocks for the crèche children. Though they were not perfectly stitched and all were frocks. The crèche decided and the children wear them. As per the crèche worker they all looked very nice and in a uniform"

"Some of the mothers and teen aged girls have prepared THEKUA (sweet snack) for crèche children. The crèche workers were finding difficult to spare time for it."

One crèche in Ratu Nagri block



III. Community management of malnourished children

SAM children in PLA area (Area 2) as identified by MUAC measurements, who do not attend crèches and have been unable to go to NRC/MTCs have improved through regular counselling and follow up home visits. Of course, this is possible where mothers have been able to provide extra feeding and care based on counselling sessions and discussions at PLA meetings, leading to an improvement in the health of children.



CASE STUDY: Sushila was married early and had 2 children and was pregnant for the third time. Her second child Mina was 10 months old and weighed only 5.1kgs (Red in growth Chart). During the home visits, the PLA facilitator along with the coordinator counselled her on feeding and caring practices. Sushila also attended the group meetings regularly. In just 7 months, Mina's weight increased to 8.3 kgs (Green zone) as of February 2014. Last month Sushila delivered a healthy baby

with a birth weight of 3 kgs.

4.4.2 Challenges and Problem Solving/ Innovations/good practices

I. Crèche Spaces

Finding suitable spaces for crèches: Selecting spaces for crèches took multiple rounds of discussion between the community and block teams. The crèche required a space that would be at a suitable place in the village- where villagers could oversee its operations; mothers can easily drop their children, a place that is safe, clean and hygienic, where preferably the cooking area is outside or away from the main room. For this a few villagers offered a room in their houses or some volunteered to repair half broken rooms, roof-less rooms for a crèche. There were few cases where the crèche space selected turned out to be inappropriate, due to reasons that neither the villagers nor the block team had thought would be hindrances for functioning of crèche such as the location as it should be centrally located and which is easily accessible for the community as well; a separate area for cattle, proper lighting and ventilation; adequate playing area for children; separate cooking area. A few crèches continue to have these constraints, while alternate spaces for them are being identified by the community there are serious constraints of such infrastructure in these areas, especially in Turkaulia and Lakanpur blocks of Bihar and Chhattisgarh.



“They selected a house which is not suitable. In the same house (in one part) the family keeps the cattle. Another option is a government building. It is not in a very good condition. But it does not look so bad. It has door (locked). It has windows (closed). The roof looked damp. The platform is around 1 and half feet above the ground level on which the floor of the house is situated. I requested them to search for alternative place.

Suggestion came from one of the men present that by filling some soil around the community hall and fencing will convert this space as most suitable. Hand pump is close to it. It is situated near Akhara (the meeting place). On the back side food can be cooked. In the rainy season the shed outside the room can be used. The women were also convinced about the idea.”

BPO, Ratu Nagri Block, Jharkhand

II. Operational challenges of running crèches

Operationalising and smooth running of crèches has been a challenge, especially to manage the logistics of crèches with the demanding AAM terrain. But these challenges are being handled by the community and block teams with utmost speed and sincerity.

Human Resources: There was an initial challenge to find suitably qualified women manpower as the intervention sites are in remote tribal districts, both for crèche workers and PLA. And even though crèche workers and a few PLA facilitators have limited or no education, with regular handholding and supervision they have been able to fully comprehend the demands of their work. As it is observed around the field these workers have taken much ownership and are putting in a great effort to fulfil the demands of their jobs.

In case of crèches, where the crèche worker is illiterate there is a constraint of documentation and MIS data recording, but in such cases the PLA facilitators and the block team provide support. Also initially a few crèche workers were unable to work well, due a lack of ownership and limited understanding of the project, where they thought of the crèche as a space for providing food to children with limited understanding of other crèche activities. In such cases these workers were regularly counselled which helped them perform better, while in some cases the worker was changed with consensus from villagers.



There was also a constraint highlighted during the study, of finding substitute crèche worker for three months during the maternity leave period of regular crèche worker. Especially in Odisha, where so far 16 crèche workers have taken maternity leave in Thakurmunda and 11 in Saharpada. In Jharkhand, 10 crèche workers in Khuntpani have taken maternity leave, 1 in Ratu Nagri and 7 in Gola; 6 in Lakhanpur Chhattisgarh and 1 in Turkaulia Bihar.

“After 3 months, in this crèche attendance started to reduce. On interacting with villagers and a few mothers they shared that they feel that a crèche worker is a witch. On close investigation it was discovered that these rumors were being spread by a woman of the same village who wanted to be a crèche worker. We wanted to handle this situation, without harming the sentiment of the community and retain the crèche worker, as she is a very efficient and sincere in her work.

Then at the parents meetings, I started appreciating the efforts of this crèche worker and sent her for an in house training of crèche workers to other villages, which she took very well. As a result the rumors of her being a witch have been proven false. The mothers, who were not leaving their children with her, have come to appreciate and respect her dedication towards her job. The worker is also happy and feels secured about her job.

The mother who spread the rumor is also appreciated by our team, as each person in AAM is contributing to the project.”

BPO, Thakurmunda block

Background: *One of the crèche workers crèche changed her religion from Sarna to christianity, which had an impact on the community and the community decided to replace her without any consultation with the block teams.*

“We discussed the matter with villagers to not to replace the crèche worker as she is excellent in her work and we have trained her very closely. They were explained that religion is very personal thing and every individual is free to practice any belief. We told them not to mix crèche with religion. We were waiting for their village meeting, they met twice. They told us not to come in the village till they finalize the issue and till that period they closed the crèche.

On doing some fact finding we got to know the villagers were spreading rumours of her organizing Sunday prayer in crèche house and that she had fed some guest with beef on the plates of crèche. With time we are realizing that villagers have started to look at the crèche workers role as an attractive occupation and hence spread rumours to replace the existing workers. After discussion with PMU, we decided told to be firm as removal of any crèche worker cannot be done without a consultation with the block team. With close consensus and discussion with the villagers, we were able to retain these crèche workers.”

BPO, Ratu- Nagri, November 2013



Logistics: Regular supply of food to crèches on a monthly basis has been a challenge due to the terrain but some members from the community have come forward to help with supply of food. In a few crèches of Chhattisgarh and Odisha the panchayat members or family of crèche workers help with the supply of food.

In remote crèches of Odisha, delivery of eggs was a challenge as the terrain would not allow them to reach safely without breaking, especially during the rainy season. In Saharpada block, as a response from the community they decided to purchase boiled eggs at a little higher cost and the husband of a crèche worker has taken responsibility to deliver eggs to these crèches.

Others: *No flat surface for weighing-* for crèches in the initial months, weight measurements of children were very inconsistent. With time it was discovered that it was due to the absence of a flat surface where weight could be taken, leading to incorrect measurements. Thus the block teams installed tiles on the floor to ensure flat surface for weighing in these crèches.

Clean drinking water: there is an issue of finding local and affordable means of providing clean drinking water to crèches. Presently the water at the crèches is boiled for consumption and crèche spaces usually are found where there is an easy access to a hand pump. The advisory group has recommended the systems strengthening team to ensure that through current schemes and programmes of WASH, hand pumps/potable water are made available to the village where crèches are located. At village level the team is engaged with the mukhya and PRI members for this.

III. Alcoholism

Alcoholism is a major issue in a few tribal regions of Jharkhand and Chhattisgarh. On close investigation it was observed that consumption of alcohol is a common practice in these villages. Alcoholism also leads to domestic violence in a few families and family disharmony in others. This may lead to poorer ability of parents to take care of the child, and relatively lower expenditures on nutrition, which has seen to be associated with slow and poor growth of the child. At other times, it has been observed that people disrupt PLA meetings under the influence of alcohol.

While the PLA facilitators and block teams regularly discuss these issues with the villagers, it is a sensitive issue, which requires to be handled carefully. With regular engagement with the community on these issues, there are few cases in the blocks of Chhattisgarh and Jharkhand where villagers have started to change this habit and are also giving more importance to their and the child's health. The PMU has been in discussion with a mental health resource group 'SAARTHAK' to see how the team may best work on community- based approaches to alcoholism in these areas.



IV. Long periods of absence

There are long periods of absence of children due to seasonal migration, travel to relative's house during festive season (Nani ghar and Mama ghar), for agricultural labour and for 'mahua' and 'tendu' leaves collection. Mahua and tendu leaves collection is a major economic activity for tribals of Jharkhand, Odisha, and Chhattisgarh. Tendu leaves is used for 'bidi' production and are collected from March to June, whereas mahua leaves is a major source for alcohol and is collected in the months of March to April. The busy agricultural months are the kharif crop season from June to September and rabi crop season from October to February.

NANI GHAR- MAMA GHAR

In the crèche MIS it was observed that the reason of absenteeism for more than three days is Nani ghar and Mama ghar. There are monthly reports of many such children, to this it was assumed that all such cases had happy/positive reasons but on close investigation, the Ratu Nagri block team found some unpleasant and sad facts revealing distress migration largely due to domestic problems, alcoholism at household levels. Some cases below:

Shubha Horo went to Nani ghar, his father has broken everything in the home and beaten his wife and mother very badly. They were thrown out of the house. So the child is in Nani Ghar. Father is alcoholic and probably willing to sell some land. Crèche workers and community not sure about his returning.

Shubham's mother is also a victim of domestic violence, but the only difference is that her mother tolerates the violence, may be because she is less welcomed in Nani ghar. She is attending the crèche regularly.

In another crèche one such child is in Nani ghar since last six month or so. She is a drop out from the crèche list. The villagers have seen her and her mother crying and hiding themselves several nights in open out of house, but no one dared to help her as they are scared of the father.

In a crèche, Neeraj and Komal (brother and sister) are weak and at Nani ghar, Mother works in a brick kiln and father is alcoholic. Mother burnt herself with kerosene and is in hospital. Fortunately the Nani ghar is in the crèche area, so the children have been admitted there.

Anamika is very weak and she constantly visits Nani ghar. Her mother is the second wife of her father, and during paddy season he remarried his third wife and sent his other two children to their maternal house (Nani or Mama ghar).

In Khuntpani the reason for Mama ghar for some cases are being identified as domestic violence, in this region 'diang' (a dense form of rice beer) becomes as part of the breakfast in the agricultural season.



It has been observed that during this time attendance in crèches falls and there is also negative effect on the health of their children. During these times, women leave home early morning, as a response the AAM crèches have made their timings flexible so that these children can be left at the crèche while the women go to work. Absence of women from the meeting's cycle leads to gaps in appropriate knowledge sharing thus affecting impact. Also it affects regular home visits and follow-up of SAM children.

V. Initial challenge of gathering women together to attend meetings

A key challenge at the beginning was to gather women and other community members to attend PLA meetings. As malnutrition was not a known issue people were not interested to attend meetings. Also it was a challenge to get the women together at the same time in a village, although the facilitator would arrange the meeting at a time suitable for all women. There have been challenges such as reluctance from the community, not available due seasonal migration, and agriculture labour or festive seasons. In the initial few months, PLA facilitators used to go house to house to encourage women to attend meetings. Even presently, some clusters face challenges to make women sit throughout the entire meeting. Villagers also expect some snacks and refreshments during the meetings and often complain that they do not get anything.

VI. Parents unable to take their children to NRCs / MTCs

There are cases where parents are unable to take their severely malnourished children to NRCs/MTCs. This is mainly when mothers of these children are unable to stay away from their families for long periods, as there is no one else to support the family. There are also a few cases where parents don't think it's important to take their child to NRCs/MTC. However, as these parents have been regularly counselled they are able to give more care and feeding to their children, which is leading to improvement in health of the children.



CASE STUDY:

Ramesh's parents belong to OBC (Yadav) caste. Ramesh's father has a "Puchhka thela" and his mother assists him. Ramesh is the first child of the couple. During the 2nd PLA meeting the AWW saw Ramesh, who looked very weak and was 11.5 in MUAC. The AWW and PLA facilitator discussed the matter with Ramesh's parents and told them about the MTC. The couple showed interest and took their child to the MTC with the help of the PLA facilitator on 30 March 2013. Unfortunately Ramesh stayed there only 6 for days and returned home on 4 April 2013.



Background- Ramesh's mother had early marriage at the age of 14years. The couple is a part of joint family comprising of 6 brothers and families. She was pregnant within one year of marriage. Due to a lot of responsibilities – agriculture, cattle rearing (milk), household chores, Ramesh's mother was not able to take adequate rest during her pregnancy and had a difficult delivery.

Why did Ramesh not stay in the MTC?

Ramesh's mother was threatened by her sister in law who told her that if she did not return they would not allow her to come back home. Ramesh and his mother returned home after 6 days. At home, the AWW and the PLA facilitator counselled her on feeding the child properly. The facilitator continued visiting Ramesh and his mother twice or thrice in a month. The mother fed Ramesh with kitchdi, munga, and soya bari at regular intervals. Ramesh gradually gained weight and is regaining health; he is 13.1 cm (MUAC) and 7.7 kgs (AWC) as on 21.12.2013.

VII. Provision of toilets

Presently, there is no provision of toilets in villages which forces the crèches children to defecate in the open making them more vulnerable to infections. The advisory group has asked each partner organization to explore and innovate on this front and share information. And additionally put up supplementary proposals to allow for construction of toilets in the crèches.

VIII. Phasing out children

All children above 3 years need to be enrolled in AWCs so that they may partake of the centre-based programme. However, in a few areas the AWC services not available and at others they are either not available or of poor quality and it becomes a challenge to easily phase out the older children from AAM crèches and enrol them into the AWC. In such circumstances, even if the child is over 3 years, but is malnourished and from a very poor family, he/she is permitted to stay little longer in the crèche.



IX. Working with the public system

Limited support from frontline workers- there was an initial challenge where frontline workers did not support and cooperate with the field staff; this has been largely resolved where now frontline workers go all out to support AAM. However, in a few areas there are continuous efforts by the AAM team to constantly engage AWWs, PRI members and ASHAs/ANMs with the project activities.

Poor government services – The project depends upon government systems for health checks, treatment of illnesses and micronutrient supplementation. However, these have been difficult to access given the lack of robust child health systems in general and in tribal areas in particular. Moreover, there are serious limitations on the quality of services available. Especially health and ICDS services such as limited or no convergence between health and ICDS, poor referral systems, limited services provided at VHNDs, no weighing and growth monitoring happening at some AWCs and unavailability of weighing scales at some AWCs, unavailability of THR rations at AWCs quality of care/food/and other services at MTCs/NRCs, norms of referral to NRCs, unavailability of Vitamin A and Iron Syrups and irregular health check ups. Also few crèche mothers across the blocks do not have ration cards which prevents them from buying ration at subsidized rates. The systems strengthening team by constantly engaging with the government at various levels has had been able to make positive changes, these are more extensively discussed in the subsequent section.

Unavailability of Vitamin A and Iron Syrups: The problem of lack of supply of iron syrups in the field, the difficulties of accessing iron through the government system and its repercussions on the management of acutely malnourished children has been a major constraint in the AAM field areas. All partner organization have made multiple efforts to put this to the notice of the government and this has also been extensively discussed in the Advisory group in which various possibilities were discussed such as to mount pressure on the government through RTI and advocacy efforts or the possibility of providing iron supplementation using the untied funds in the village will also be scoped. It was decided in principle, to provide Iron supplementation to the crèche children through the AAM project. However, there are some reservations on being able to implement this in light of practical difficulties of dosage, maintaining stocks, keeping track of expiry dates, handling side effects etc. which are valid concerns. The advisory is in the process of finding a sustainable solution for this.

Repeated change of block level officials- this affects prompt follow up on actions as requested by the project block staff, thus slowing the process.



4.4.3 Impact

I. Improved health of children

There is improvement in the health of children in AAM sites which is being observed as a general trend across the crèche intervention areas. This we believe has been due to children attending crèches, mothers attending PLA meetings who are regularly counselled and by referring SAM children to NRCs/MTCs. There has also been an improvement in the health of SAM children at AAM crèches, who were unable to go to NRC/MTC. These identified SAM children are provided extra feeding and additional care at the crèches which has led to improvement in their health.

CASE STUDY: Pawan Munda (20 months old) joined the crèche when he was 9 months, his progress was slow, he was weak physically with very little appetite. With support of the block team, the crèche worker took extra care and feeding. After 2 months his health improved and he started walking, plays with other children and enjoys taking his meals.



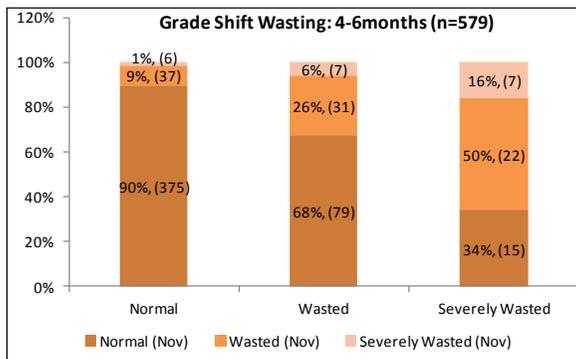
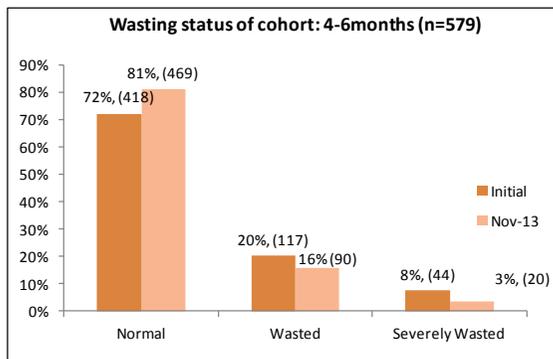
Pankhudi was born underweight. Her mother regularly attended PLA

meetings, from the very beginning and asked for advice to improve her child's health. The facilitator also visited her home for counseling. The child was taken to Pustikar divas from where she was referred to the MTC. Gradually her health has improved and she has now moved to green zone in the growth chart.

DOB- 17 May, 2011; Weight at Birth- 1.9 kg (Red) (May'11); recent weight- 10.4kg (Green) as of February 2014



The crèche MIS also reveals significant impact on the health of children- that among the severely wasted while 16% show no improvement, 50% moved into a moderate wasting category and 34% to normal category over a 4-6 month intervention period (May to July and May to November). Thus, 84% show a positive shift of grade. Among the moderately wasted, 26% showed no improvement and 6% declined to a severely wasted category, whereas 68% moved to normal category.



II. Increased awareness

There is increased awareness and understanding amongst the community regarding malnutrition issues which has led to increased ownership in dealing with these issues. Mothers are now familiar with the concept of growth monitoring where they look forward to the growth of their child's weight month after month, there are also a few mothers who support the AWW in weighing and plotting on the growth charts. Increased awareness has also led to better participation of women in PLA meetings, at AWCs, and at other forums.

Mothers and other members of the community now freely participate in PLA meetings and view these meetings as forums to discuss issues and share knowledge. Also as the community understands the importance of dealing with malnutrition, there has also been an increase in demand for crèches in non-crèche areas where the successes of AAM crèches is widely known.

Enhanced knowledge of various public interventions has led to increased access of services such as AWCs, government health facilities, NRCs/MTCs, and VHNDs. While access has increased there are also cases where the community has started to demand for improved quality of these services.

III. Improved public services and better convergence:

Improved Anganwadi services: A crèche coordinator of Gola block (Jharkhand) says, *“In the same village- where there are both crèche and AWC running, there is pressure on the AWW to work well and provide services. With the opening of AAM crèche people have also become aware of the AWC services.”* It has been a general observation across blocks that the AWC services have become more effective, this we believe could be through regular interaction with the AWWs and AWWs observation of effective running of AAM work. The community has also started to demand adequate services from AWCs. There is also increased cooperation by the block and district level ICDS officials.



Positive changes in ICDS services (as on May 2014)

Bihar

- 2 AWCs have started weighing of children and counselling which was not happening earlier

Chhattisgarh

- 20 AWCs (of the project area) assessed by the team and the gaps identified in this activity were discussed with the CDPO, Lakhanpur
- Team facilitated selection of AWW in a village
- AWWs involved in growth monitoring activity at AAM crèches

Jharkhand

- AAM project enlisted under ICDS restructuring as a model
- District Level Review Meeting organized and orders have been released to ensure THR at AWCs, streamline immunization and for training of AWWs
- Mobilized community to demand for strengthening growth monitoring at AWCs. In several villages the AWWs have begun seeking help of AAM team to help with growth monitoring. In some places women have decided to do growth monitoring on a day after VHND.
- In Gola block, the AAM team facilitated distribution of weighing machines at all AWCs. Also, separate days for immunization during VHND and THR distribution have been introduced in the block.
- In Gola, 39 AWWs and crèche workers jointly trained on growth monitoring, plotting and counselling whereas 103 crèche AWWs trained on growth monitoring and its interpretation in Ratu/Nagri.
- An assessment process of different services available at AWCs has been introduced. Under this, 60 AWCs have been assessed to understand the status on growth monitoring in Ratu Nagri. Further, systematic growth monitoring processes initiated in 4 AWCs in Ratu Nagri and in 30 AWCs in Khuntpani.
- VHSNC in a village in Ratu Nagri purchased a weighing machine for children out of their own funds.

Odisha

- Motivated by AAM, some of the AWWs have started conducting home visits which was not considered an important activity by them.
- Through the continuous efforts of the team, THR ensured to almost every family of the crèche area of both the blocks.
- 10 AWCs identified and efforts being made for timely supply of IFA and albendazole



Cases of other improved public services and better convergence

Repair of local hand pump- In Gola block (Jharkhand), the block team lisoned with Village Health Sanitation and Nutrition Committee (VHSNC) for repair work. In the a few villages the Chapakal (community hand pump) was surrounded with stagnant water and lacked appropriate waste disposal to soak pit. Towards this the AAM block team facilitated a meeting where ward member, SHG members, and Sahiyya attended, along with other community members, who decided to repair this. The chapakal was repaired within a week.

Bore well installed in 10 villages: Due to consistent efforts of the Saharpada block (Odisha) team and regular follow up, the block team has been able to facilitate the process of getting bore well installed in 10 villages.

IV. Capacity building of staff and empowerment:

The field staff has gained increased trust and recognition in the community through their AAM work. The work has been empowering to raise their confidence level and has led to receiving more respect from families. They are also able to contribute to family incomes.



AAM Staff members

“I try to understand the purpose of the project and I am trying to imbibe it myself. Learning from the project and the children I also try to be neat and hygienic. I have been able to see the changes in myself, I have a routine now, as opposed to how I use to live earlier. Due to this job I feel empowered and disciplined and I have been able to change every aspect of my life.”

Crèche worker, Odisha

“I joined in April 2013, earlier I use to do forest work like collecting woods etc. but that work use to fetch me very less or no income. Now being in the crèche I have extra income. Also earlier the children were very untidy and un-kept but as I work with them, my quality of life has also improved.”

Crèche worker, Jharkhand

“I have been able to challenge my fear of talking to village people, I am more courageous now, I am more comfortable to ride a cycle more freely”

PLA facilitator (Crèche Area), Lakhanpur

“Community meetings have motivated me to do better at my job; people have started to know us and are seeking support from us to encourage members of the Samuh”

PLA facilitator, Jharkhand

“Earlier I did not interact with the govt. officials, engage with them and seek their help, now I talk with them and take their support and share with them the AAM work, which has been very useful. Earlier I was scared in meetings, now I am confident, I am able to share, there’s a new learning every day.”

BPO, Lakhanpur, Chhattisgarh



V. Behavioural change amongst children

Increased hygiene and cleanliness of crèche children and improved sanitation habits. Children have picked up the habit to eat food with a spoon and to wash hands before meals at the crèches, and demand the same at home. There are also cases of improved hygiene of children in PLA areas with regular counselling and follow up home visits.



VI. Improved literacy

There is a general trend being observed that due to opening of crèches, the elder siblings of crèche children are now able to attend school. While earlier they had to stay at home to take care of their younger siblings as parents would go to work.

VII. Change in food fads and food habits:

It has been observed that villagers have poor dietary intakes where consumption of vegetables and lentils is limited. Through PLA meetings and counselling, the importance of consuming different types of food, availability of local foods and how to enhance their nutrition intake in discussed. Community is also encouraged to



contribute different vegetables to crèches and a few crèches also have kitchen gardens that grow different vegetables. There have also been cases where through attending meetings, regular counselling, and PLA facilitators have been able to make a positive change in the diets of pregnant women encouraging them to eat more nutritious food.

“In a village of Gola block of Jharkhand, it is said that pregnant women cannot take high protein foods, so these women would eat rice and vegetable that too just twice a day and after delivery only rice and salt to be given as food for a month. With regular counselling of mother in law jointly, by the PLA facilitator and Sahiyya, there is now a change regarding the beliefs regarding these food fads.”

VIII. Increased referral to NRCs/MTCs and facilitating access to health facilities:

There is increased convergence with constant engagement and dialogue with the frontline health workers and block and district health officials. This has led to more cooperation from these workers in crèche activities and for better convergence within health and ICDS, where ANMs, ASHAs, and AWWs have started to visit AAM crèches, there is also an increase recognition for NRC/MTC referral, and an improved access to health facilities.

Across all blocks there is increase access and referrals to NRCs/MTCs. And of the referrals, majority of parents take these children to NRCs/MTCs for the required 21 days and regularly follow up. There is also an improvement in the quality of services at some NRCs/MTCs.

- 104 children admitted to NRCs/MTCs at Jharkhand and 25 SAM children referred in Bihar.
- Complete follow up of 25 children and at least one follow up for 23 children out of 68 children referred to NRC/MTC from Ratu Nagri in Jharkhand.
- Improvement in quality of food and regularization of one additional ANM post at NRC/MTC in Gola in Jharkhand.
- In Bihar, NRC/MTC coordinator gave a brief orientation to PLA facilitators on activities and services provided by NRC/MTC.
- In an NRC/MTC of Turkaulia Bihar, children are admitted only from targeted blocks at a particular time. However, the team has been successful for getting children admitted at the NRC/MTC even when Turkaulia was not the targeted block. And through constant dialogue with NRC/MTC officials, SPO NRC has issued letter to all districts that admissions will be done from all districts/blocks come and no targets will be fixed.
- In the Turkaulia block in Bihar even the sarpanchs are motivating mothers and families to take SAM children to NRC/MTC.



Facilitating access to health facilities- there is growing trust of the community amongst field staff which has led the community to consult the staff for any health related problems. The field staff along with the support from frontline health workers encourages the community to avail government health facilities, which has led to an increased access to health facilities across the blocks. However, the availability of health services within accessible reach is a major challenge. The project as a response has been instrumental in organizing regular health camps across the 7 blocks.

Chhattisgarh

- Health check up camp was organized at Community Health Centre (CHC), Lakhanpur in which 48 children from 4 clusters were covered. During the check-up, albendazole was given to all children covered under the camp. The team is in conversation with BMO to organize another camp as soon as possible.
- 35 SAM children from 8 crèches became part of Malnutrition Day organized by ICDS at CHC Lakhanpur.

Jharkhand

- 2 special health camps in the field and 6 Health Check-up Camp at CHC Gola were organized in which 303 children were covered.
- In Ratu Nagri, 296 children covered in cluster meeting health check up camps by the Health Department and 209 children covered during check up at CHC and Primary Health Centre (PHC).
- In Khuntpani, 60 children were covered under health check-up camp organized through Mobile Medical Unit of Health Department.
- Further efforts are being made to send Mobile Medical Units to the project area in Khuntpani.
- In addition to the referral of malnourished and ill children, a few children with special needs have been identified. 3 such children from Ratu Nagri were referred for auditory test and speech therapy to a private institute in Ranchi. The team is also exploring possibilities for collecting funds/contribution for a hearing aid for these children.

Odisha

- Referral cases have increased from crèche as well as PLA areas especially from Thakurmunda to sub-district hospital at Karanjia; 3 referral cases from PLA area admitted at the hospital.
- Shri Ramachandra Bhanj (SCB) Medical College, Cuttack agreed to admit two children (one from crèche area and another from PLA area) who have been referred from the NRC for tertiary level care



- Micro plan prepared along with NRHM for organizing health camps at village level in both the blocks through Mobile Medical Unit of Health Department in June, 2014 in all the crèche villages.

IX. Innovations

The AAM crèches have had certain innovations, a few listed below-

- In Gola block crèches- resource map with indicated house of malnourished children displayed in every crèche; and charts displaying month-wise weight status of crèche children being used as a tool to initiate discussion with mothers. In this block community advocates have been identified to reach out to the underserved families.
- There are kitchen gardens within a few crèche premises of Gola block (Baghakudar and Barki hesel crèches) and of Khuntpani block (Sassakalo).
- In a few Khuntpani crèches, crèche workers are using old bed net to cover utensils and cooked food to protect it from flies.



- In Khuntpani block, some crèches have piloted the smokeless chulhas, while this chulha is smokeless it is also found to be using lesser amount of firewood. The advisory group recognizes the importance of smoke free environment on child health, and has asked all partners to explore and innovate on this front and share information. Following this the PMU plans to put supplementary proposals to allow for crèches to be made smoke-free as a demonstration for the village.
- The Ekjut team has taken initiative to orient crèche workers on diarrhea (causes and possible strategies for prevention) so that during summer session they can minimize diarrhea cases among crèche children.



- In Ratu Nagri block for crèche food- although the ingredients and quantity of food is fixed, the mothers and crèche workers work together to make different recipes and make the food interesting for children.

X. Spin offs

Opening of crèches has been a success story for AAM, wherein the community has not only accepted the concept of crèches but also supports its smooth functioning. The PLA meetings have also been able to generate awareness amongst community, where they now understand issues of malnutrition and their role in addressing these issues. And the regular engagement with frontline workers and other government officials has created closer associations of these workers with the community, where the community is able to now discuss and demand for regular public services. The regular activities of AAM along with target outcomes have witnessed several changes and spinoffs in the community. This success story of the AAM further adds to our confidence in the communities' willingness and ability towards management of malnutrition. Provided below are the key spinoffs of AAM

Enhanced livelihood opportunities

The PHRS block team was keen to understand if there were any spinoffs being created due to the opening of crèches and any additional benefits they provided to crèche mothers. So in order to understand this more deeply they went around 10 crèches to speak with mothers and families of crèche children.

Findings

The AAM crèches have been instrumental in providing mothers with some extra time that has helped these women explore opportunities for work. These women have found work in different areas- a few mothers in Kudlong and Gagitolla cluster are now earning (Rs. 120 to 180 per day) in either a brick kiln or at a MGNREGA site. Some mothers are earning as agricultural labour (Rs. 80 per day). Earlier these women would either not work as they would need to take care of the children or if they would work they would leave their children at home with elder siblings with minimum or no care and inadequate feeding. Few of the elder siblings of these crèche children are now able to attend school, as their mothers would go out to work.

Another mother had learnt stitching when she was unmarried. She started stitching women's clothes after leaving her child to the Tikratoli crèche. There are four such mothers who have expanded their stitching business. One woman learnt mushroom farming in her free time, another started a grocery shop and another started working in an electricity board office.



While, the crèches have contributed to improving the health of children, they have also added to the well being of these mothers. This has helped these women to contribute to their family income, which in turn has helped them gain more dignity amidst their families. Additionally, there have been cases where the mother was pregnant and has been able to take better rest and care, while sending her child to the crèche.

Emerging opportunities for partnerships and collaboration

As a spinoff from AAM, PHRS is exploring and is being invited for projects and opportunities. PHRS is now involved in nutrition work with PRADAN and IFPRI through the POSHAN project. Ekjut has also got into a collaborative project CARING (Community Action Research for Growth and Nutrition) Trial, involving PHFI and UCL, which involves scaling up of the PLA strategy in several states including Odisha and Bihar.

AAM has been widely shared through the RTF campaign and it was desirable that elements of AAM would be incorporated by participating organizations in their grassroots work. AAM work is also increasingly being recognised by important nutrition players and by the government.



4.5 CONCLUSION

AAM has been able to significantly mobilize the community on issues of child health and malnutrition. As the community continues to participate in crèche and PLA interventions, it has begun to take ownership of these processes. AAM crèches are regularly monitored at the community level, ensuring services are effectively provided. The initiative has also built a pioneering MIS for tracking all the crèche children.

Women attending meetings have found a forum to voice their issues, while those whose children attend crèches are happy to see their child get proper food and care. Mothers of crèche children report that they can go to work without worrying about their children and thereby are able to supplement the family income and also feel respected. The increased knowledge on nutrition and growth monitoring makes the mothers take better decisions for their children and themselves. Crèches have not only opened windows for livelihood opportunities for women but also gives the time and space to pregnant women to rest and care for themselves.

While AAM has engendered much learning, the critical issues at the juncture of two years are institutionalization of this learning and engagement with the state governments to take up the anganwadi cum crèche and PLA. Respective state governments have been informed of AAM and the learnings emerging from it.

The strategy of systems strengthening of ICDS and NRHM services through AAM facilitation has achieved limited impact since there was no formal by-in of the system with the AAM programme at its inception. However, the strategy of participatory learning and action with women's groups on nutrition is finding its way into current government programmes at state level. This potential needs further exploration, research and policy advocacy.

Despite hopeful initial results at the policy level, the crèche component has not yet been implemented by any government interventions even as the ICDS restructuring demands 5% AWC-cum-crèches to be opened. AAM demonstrates that a community-led crèche model is effectively able to ensure proper feeding, safety and care, growth monitoring, help fight malnutrition and lay a foundation for growth and development for children under three. AAM has aimed to develop a model for scalability and believes that this model will help inform the Government towards developing and modifying its own strategy in the Restructured ICDS.



ANNEXURES

Annexure I: Advisory group members enlisted below:

1. Dr. Audrey Prost
2. Mr. Balram
3. Mr. Biraj Patnaik
4. Mr. Digvijay Singh
5. Dr. Dipa Sinha
6. Dr. Ganapathy Murugan
7. Mr. Gangaram Paikra
8. Ms. Jayeeta Chowdhary
9. Dr. Jonny Oommen
10. Mr. J.P. Mishra
11. Dr. Prasanta Kishore Tripathy
12. Dr. Suranjeen Pallipamula
13. Ms. Sulakshana Nandy
14. Mr. Ranjan Panda
15. Mr. Rafay Khan
16. Dr. Ramani Atkuri
17. Mr. Sachin Jain
18. Dr. Vandana Prasad
19. Dr. Veena Shatrughana
20. Dr. Yogesh Jain



Annexure II: Role and responsibilities of PMU members

Project Head drives the project forward from the implementation stage to completion.

Principal Technical Officer provides overall vision, plan and guidance for the multi-strategic interventions; serves as technical resource and also in securing additional technical resources and expertise for the intervention; leads in documentation and dissemination of the project intervention's experiences by publishing relevant reports and peer-reviewed papers in international scientific literature; and provides overall technical leadership to the team of project management and direct line management to all other technical officers.

Technical Officer, Systems Strengthening works with the Principal Technical Officer on strengthening necessary systems to ensure sustainable and efficient delivery of effective health and child care services at the different levels of care; provides technical oversight in the planning, implementation and monitoring of the project's policy and systems initiatives; participates actively in the provision of technical assistance to the government agencies and stakeholders at all levels to develop/review, implement and monitor health and child development systems policies and strategies.

Technical Officer, MIS reports to the Principal Technical Officer and provide regular periodic updates to the Project head; primarily responsible for leading monitoring and evaluation initiatives in all seven blocks; and responsible for coordinating project design, implementation and monitoring and supervising, Project Officers and Consultants, in the state and project blocks.

Project Officer provides quality support to the project management team and technical advisors on their respective interventions; works in close coordination with the State Secretariat and also with the concerned implementing organizations; also responsible for coordinating the day to day activities of project management secretariat and also discharge different administrative support functions at block level; site visit on regular basis to provide supportive supervision, conduct state and block level review meetings for review and planning.

State Project Officer undertakes the activities of the state project management unit/secretariat; provides techno-managerial, supports in training, reporting, monitoring, supervision, and implementation in the assigned State and Blocks according to project implementation plan; undertakes activities of systems strengthening in the state and blocks (where the project is implemented) under the guidance and supervision of the project management secretariat. The State Project Officer will involve in supporting the MIS processes.







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