CHILD RIGHTS AND YOU

NIRDPR

# TRAINING MODULE FOR TRACKING VILLAGES TOWARDS MAKING THEM MALNUTRITION FREE

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## Abbreviations

**ANM – Auxiliary Nurse and Midwife**

**ASHA – Accredited Social Health Activist**

**AWC – Anganwadi Centre**

**AWW – Anganwadi Worker**

**AWH – Anganwadi Helper**

**CWC – Child Welfare Committee**

**ICDS – Integrated Child Development Service**

**MoHFW – Ministry of Health and Family Welfare**

**MoPR – Ministry of Panchayati Raj**

**NIRD &PR – National Institute of Panchayati Raj &Rural Development**

**NRC – Nutrition Rehabilitation Centre**

**PRI – Panchayati Raj Institution**

**GP – Gram Panchayat**

**VHSND – Village Health, Sanitation and Nutrition Day**

**VHSNC – Village Health Sanitation and Nutrition Committee**

**WHO – World Health Organisation**

# Section 1: Introduction to the Module

National Institute of Panchayati Raj & Rural Development (NIRD&PR) plays an important role in training and research on rural development. It coordinates with multiple ministries and departments and enhance their capacities for system strengthening at the village level. This module is to contribute to its objective to track and make villages malnutrition free.

Malnutrition among children is a complex outcome of multiple intertwined deprivations. It is an outcome of hunger, inadequate access to micronutrients required for the children to grow physically and mentally, inadequate access to safe drinking water, unhygienic sanitation etc. It is also an outcome of diseases, frequent illness and lack of access to healthcare. Thus, addressing malnutrition calls for addressing multiple issues.

The interventions to malnutrition happen at the village level through different schemes and services. It involves large number of stakeholders from families to communities to governance structures (elected and administrative) at the village and Panchayat level. This module provides information on these structures, systems and their roles. This module, developed for NIRD &PR Fellows is to provide knowledge and tools to track the progress of the villages to make them malnutrition free. In order to realise this intent, the module:

a) Provides information to build a conceptual base on child malnutrition
b) Discusses the determinants of malnutrition
c) Last but not the least, discusses the roles of different stakeholder, especially the Panchayat in eradicating malnutrition
d) Providing tools and equipping Fellows to use them to track the progress of the village in its trajectory towards becoming malnutrition-free?

The qualitative and quantitative tools are to be used by the fellows . The findings are to be used by PRI members, especially the Village Health, Sanitation and Nutrition Committee (VHSNC) members to address the systemic and knowledge gaps.

To reiterate, the intent of creating this module is to equip the fellows with knowledge on actors and factors influencing malnutrition and also equip them with tools that help in both status checking and tracking.

Therefore, as an experienced stakeholder in the field of child-rights, Child Rights and You (CRY) intends to create this module is to equip the fellows with knowledge on actors and factors influencing malnutrition and also equip them with tools that help in both status checking and tracking.

Recognized as India’s most trusted NGO, Child Rights and You (CRY) works tirelessly to ensure happier and healthier childhoods for India’s underprivileged children. CRY addresses children’s critical needs by working with parents, teachers, Anganwadi workers, communities, district and state level governments as well as the children themselves. Over the last 4 decades, CRY has impacted the lives of over 4.7 million children across 19 states in India.

## Section 2: Understanding Child Malnutrition

As a country India's children are suffering from malnutrition for many decades. It has also intervened through schemes providing food and health. Even though over time the nutritional status of India's children has improved but still every 3 out of 10 children are underweight and/or stunted, more than 1 in 2 children are anaemic. It is also evident that malnutrition is more among children who are socially and economically deprived groups.

This section introduces malnutrition as a concept and talks about systemic interventions in place at the village level.

### 2.1 What is nutrition?

As per Oxford Dictionary nutrition is defined as "the process of providing or obtaining the food necessary for health and growth". It is often linked to food we intake for our mental and physical wellbeing. World Health Organisation (WHO) mentions that nutrition is "intake of food, considered in relation to the body's dietary needs."[1]Nutrition is closely related to the quality of food we eat, the quality of water we drink and the healthy and hygienic environment we leave in.

### 2. 2 What is malnutrition?

As per WHO malnutrition means either deficiencies or excesses or imbalances in intake of energy and/or nutrients of a person. It broadly covers 2 broad conditions. First one is commonly known as is 'undernutrition' the other is overnutrition that are manifested through overweight, obesity (such as heart disease, stroke, diabetes, and cancer).[2]

In simple words, human body gets energy and calories from diverse food items. Nutrition depends upon well balanced diets. Intake of food with less micronutrients and energies lead to undernutrition and over consumption of micronutrients and energy dense food lead to obesity and different kinds of diet related diseases.

### 2.3 Importance of child nutrition

Child malnutrition can trigger off from the time children are inside the womb. The first 1000 days [first 1000 days = Pregnancy 270 days + Year 1(365 days) +Year 2 (365 days)] of a human being's life is critical for its rapid brain and overall physical development and immunity building. Around 80% of brain development happen by 2 years and 90% by 6 years. Adequate nutrition is non-negotiable for a child's optimal brain development. As far as physical growth is concerned, weight of a child during birth doubles by four months, triples by the age of one year and almost, half of the adult height is achieved by the age of 2 years.

[1] Source : Association between anthropometric-based and food-based nutritional failure among children in India, 2015 - PMC

[2] Malnutrition (who.int)

The first thousand days play a foundational role and provide a unique window of opportunity for improving health and nutritional status of children by:

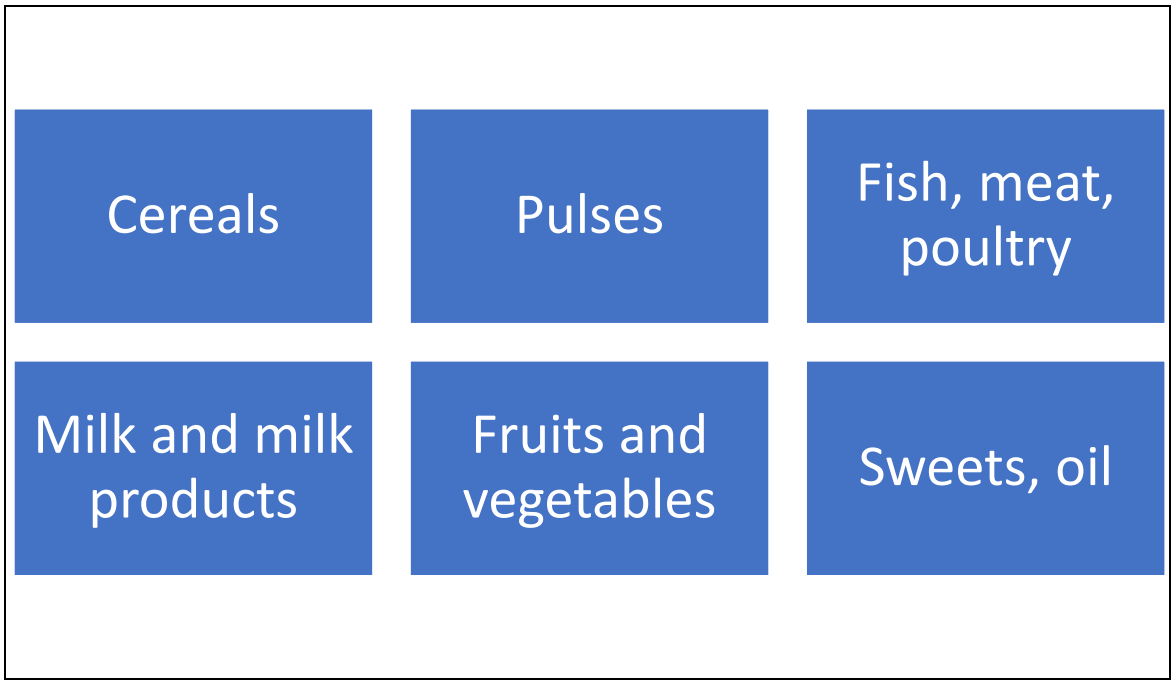
- Breaking the intergenerational cycle of malnutrition
- Improving children's ability to learn
- Improving child's productivity in later life
- Breaking the intergenerational cycle of poverty

Due to the criticality of this age group, deficiency of nutrition at this age group may have lifelong effect on their learning, physical capabilities, as well as social, emotional and cognitive development. Adequate nutrition has deep impact on a child's growth and development and contributes to their future ability to speak, think and relate to the world around them.

**2.4 Types of nutritious food?**

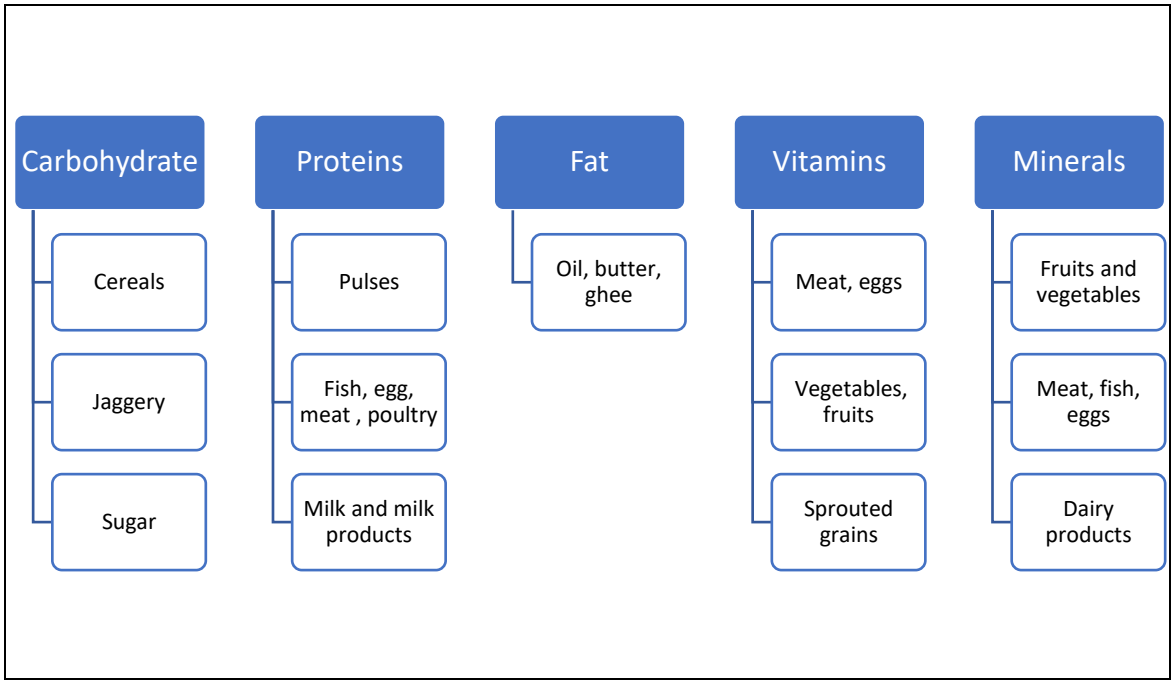
Foods that have the similar kind of nutrients form a food group.

**Fig 2.1a: 6 Broad Food Groups**




If we divide these different types of food under nutrient groups we get the following:

**Fig 2.1 b: Nutrient Groups**




**Water is essential to absorb each type of nutrient hence safe potable water is non-negotiable**

### 2.5 What is nutritious food for children?

Human bodies get nutrition from diverse food. In order to get the required nutrition, children require nutritious food to develop and grow into healthy, physically and mentally active human beings. Since children cannot acquire food for themselves, their families should have economic and physical access to adequate and safe nutritious food.

Type of food children require are different in different ages:

a) The child in the womb gets nutrition from the mother, thus all pregnant women should have access to diverse nutritious food for hers and her child's nutrition security/
b) After birth, for the first six months, children need exclusive breastfeeding and for enabling women to do exclusive breast feeding, women need adequate nutrition, once again for herself and for the child. They also need rest and time to feed the child on demand. Exclusively breastfed babies do not need water. Exclusive breastfeeding ensures that newborns get colostrum, the first thick yellowish milk from the breast that provides protection against infection; colostrum is children's 'first vaccine'.
c) After six months till two years children need complementary feeding of nutritious food along with breast milk. Solid and semi solid food are given to babies along with breast milk after 6 months. Only mother's milk cannot give babies enough nutrition during this rapid phase of growth and development
d) From 1 year onwards children need diverse food comprising of carbohydrate, protein, fat. vitamins and minerals. It is said that children need all colours on their plates

which means children need adequate food from all nutrient categories mentioned in Fig 2.1b

### 2.6 What is child malnutrition?

Malnutrition in children manifests through:

a) Undernutrition – In this situation, the child is either underweight for their age, or their height is less than what the age-appropriate height should be (stunted) or their weight is less for their height (wasted). Under nutrition also manifests through diseases such as anaemia, respiratory diseases etc. Around 50% child death are linked with malnutrition.[3]
b) Obesity – In this situation children are considered overweight and obese if their weight is more for their height. It occurs when the body is consuming more energy (through food) and spending too little energy.

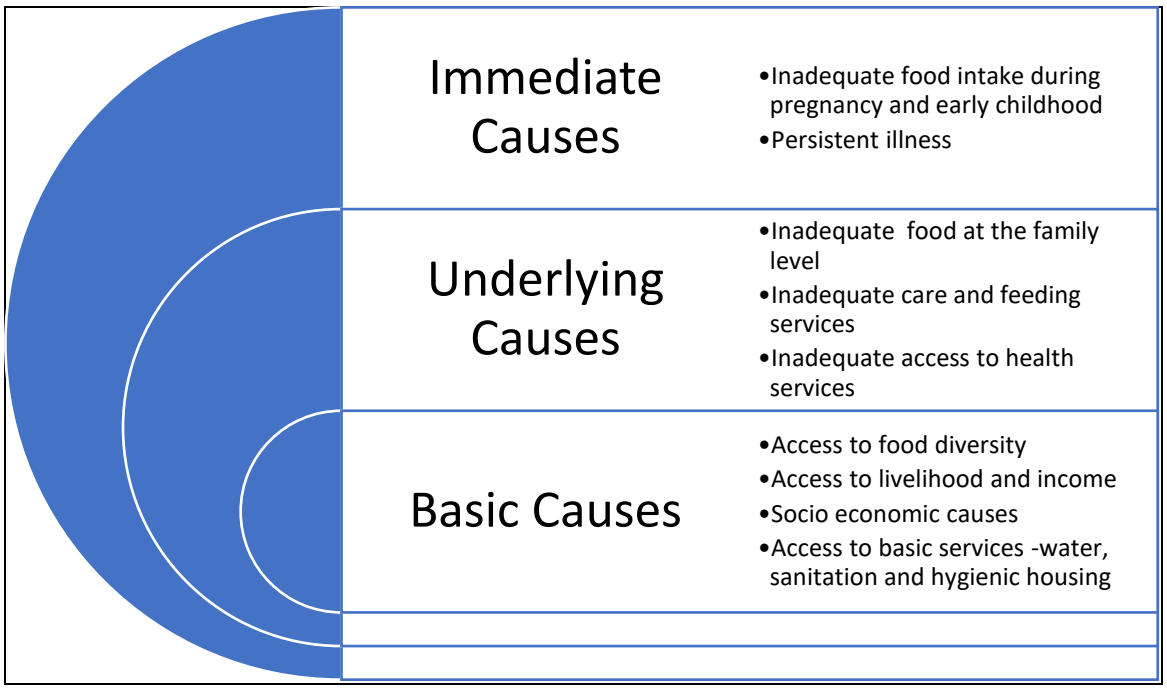
Since India's present challenge is malnutrition, this module will focus on malnutrition that manifests through under nutrition. Inadequate dietary intake leads to weight loss, growth failure, lower immunity leading to increased incidences of disease, severity of disease leads to appetite loss, nutrient loss, altered metabolism

According to WHO, globally 390 million children are underweight, 149 million are stunted and 571 million women of reproductive age group are affected by anaemia[4]

### 2.7 What are the causes of child malnutrition?

## Fig 2.2: Causes of malnutrition

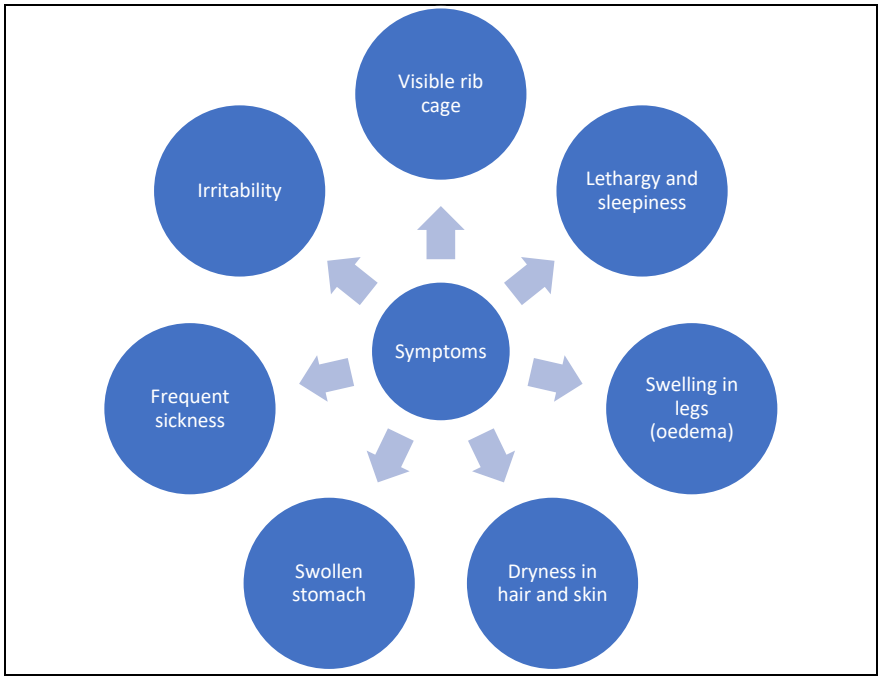
[3] Source: Half of all child deaths are linked to malnutrition - Our World in DataHalf of all child deaths are linked to malnutrition - Our World in Data
[4] https://www.who.int/news-room/questions-and-answers/item/malnutrition#:~:text=An%20estimated%2037%20million%20children%20under%20the%20age,approximately%20half%20would%20be%20amenable%20to%20iron%20supplementation accessed in December 2024




Malnutrition is a complex issue. It occurs due to coming together of many deprivations such as food, safe water, quality health services, availability of adult care giver and proper feeding practices. In order to address malnutrition, it is important to address immediate causes along with basic and underlying causes in an integrated manner.

### 2.9. Symptoms of malnutrition

**Fig 2.3: Symptoms of malnutrition**



## 2.10. Measurement of Malnutrition

Nutritional status of children can be assessed through growth monitoring. Growth monitoring is done through anthropometric measures.

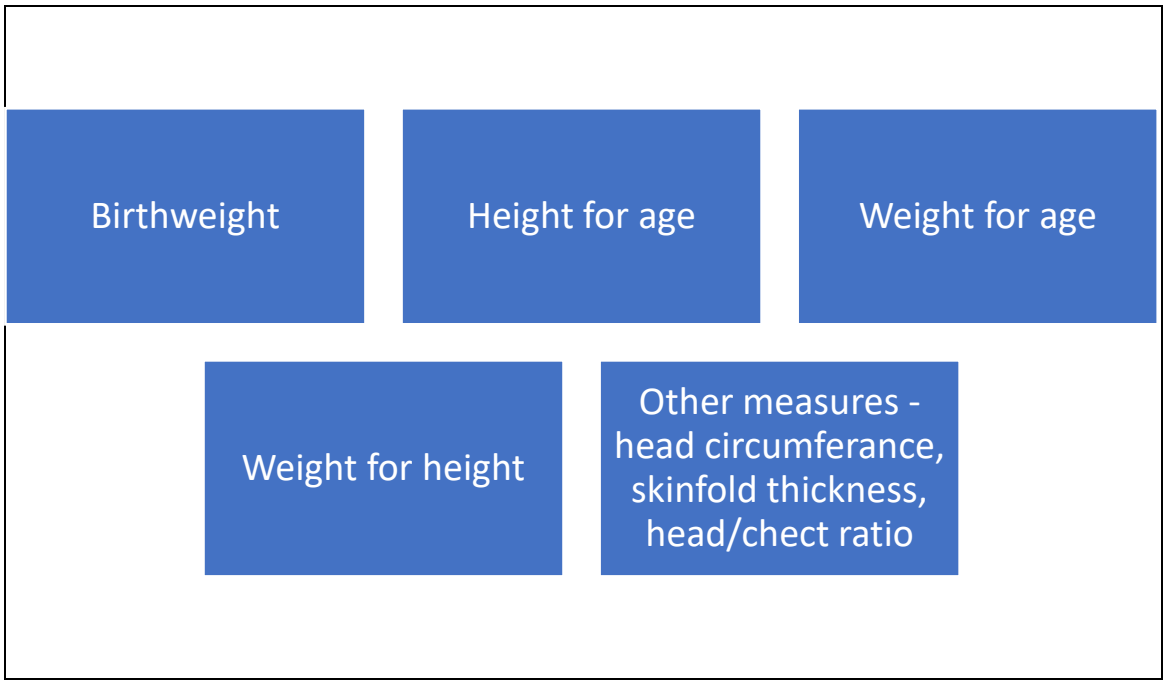
*What is anthropometry*:

Anthropometry is the measurement of body height, weight & proportions

It is important to note that:

- Height and weight vary by age and sex
- In children, anthropometry is used to assess physical growth
- Individual measures are compared with reference data of the same age and sex to evaluate nutritional status

**Fig 2.4: Anthropometric measurements**




Z scores are calculated based on the comparison of the child's weight or height compared to the range of weight and height of the same age group and sex that are considered normal. The z scores can indicate normal, moderate and severe. Children whose anthropometric measurements fall below a particular z score can be moderate or severely underweight, stunted and wasted.

**Table 2.1: Categorisation of Nutrition Status**[5]

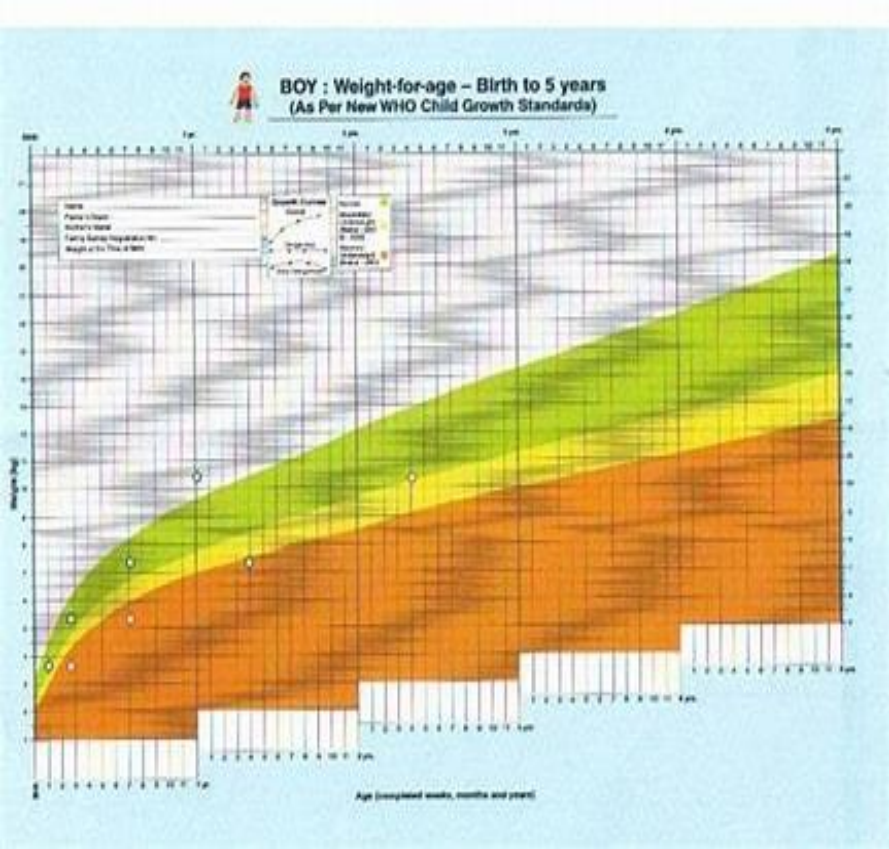
| Indicator | Z Score | Interpretation |
|---|---|---|
| Weight for age | Greater than or equal to -2 | Normal weight for age |
| | Less than -2 but greater than equal to -3 | Moderately under weight |
| | Less than -3 | Severely underweight |
| Weight for height | Greater than or equal to -2 | Normal weight for height |
| | Less than -2 but greater than equal to -3 | Moderately wasted |
| | Less than -3 | Severely wasted |
| Height for age | Greater than or equal to -2 | Normal height for age |
| | Less than -2 but greater than equal to -3 | Moderately stunted |
| | Less than -3 | Severely stunted |

**Nutrition status in Anganwadi Centres (AWC) is captured on growth charts for each child and their nutritional status is tracked on a regular basis.**

**Sample of a weight for age growth chart for boys tracked in AWC. Similarly, weight for age, height for weight and age are also tracked in AWCs for both boys and girls.**

**Fig 2.5: Sample Growth Chart**

[5] Table Courtesy: Public Health Resource Society




Equipped with the conceptual knowledge on malnutrition, its determinants, symptoms and measurement we now move to the next session that briefly discusses the roles and responsibilities of Panchayati Raj Institutions in tackling malnutrition.

## Section 3: Role of Panchayat and Rural Development in Addressing the Issue of Malnutrition

Article 243G of the Constitution of India provides power to Panchayats to function as "institutions of self-government". They are responsible for planning and implementing activities for social and economic development for the matters that are mentioned under the 11th schedule of the Constitution. Women and children are part of this list.

In order to expedite the realisation of Sustainable Development Goals (SDGs), the Ministry of Panchayati Raj (MoPR) has aggregated 17 SDG goals under 9 themes. Under these themes. Theme 3 is on child friendly villages which comprise of intersectoral indicators.[6]

There is need for clarity on ensuring that the local governance structures and community environment prioritize and address the needs and rights of children. It needs to cover issues like protection, health, education, and overall well-being of children. There is also need to incorporate conducting regular community awareness program. The Gram Panchayats need to play a crucial role to guide and support the families to take care of children. to make various programs for children effective and to solve local problems. Child Friendly village's theme covers SDGs 1,2,3,4 and 5 that include goals on poverty, hunger, education, protection, non-discrimination etc. However, since this module only focusses on malnutrition, we shall discuss the role of panchayats restricted to addressing malnutrition.

One of the major aims of Theme 3 is creating malnutrition free villages through implementation of welfare programmes and practicing inclusion. Since malnutrition of mothers result in malnutrition in new borns, restricting child marriage is also a critical objective.

A handbook by MoPR[7] lists down the following action points that are relevant for combatting malnutrition:

• Liaising with relevant departments/agencies to improve the facilities and infrastructure of Anganwadis;

•Create an in depth understanding of the term 'poverty' among the Panchayat committee and other community volunteers

• Disseminate information about various schemes for poor and vulnerable through ASHA workers, Anganwadi workers and schoolteachers

• Develop criteria for identification of the poor, destitute and vulnerable; initiate participatory surveys for their identification and need assessment

• Ensure transparency in the selection process/providing benefits; set the goals and targets for your Gram Panchayat.

• Develop a comprehensive programme based on need assessment, goals and targets through GPDP; Converge different agencies, their programmes and schemes and community organizations which can support the Gram Panchayat Develop a monitoring mechanism for the action

[6] MoPR book
[7] MoPR book

Some of the indicators on child friendly villages that can improve malnutrition in children are:

| Malnutrition free villages | Access to Food | Full Immunization | Child Marriage FreeVillage | Health and Hygeine |
|---|---|---|---|---|
| •No Moderately or severely underweight children below 2 years<br>•No moderately or severely stunted children under 2 years<br>•No moderately or severely wasted children in the village | •Access to AWC<br>•Access to PDS<br>•Access to PMMVY by pregnant women<br>•Kitchen garden in AWC | •Immunusation of all pregnant women<br>•Full immunisation of all children below 2 years of age | •No girl child getting married before 18 years of age<br>•CWC in the villages functioning to prevent child marriage | •Safe drinking water<br>•Open defecation free<br>•Low incidence of diarrhoea<br>•Low incidence of anaemia among pregnant women<br>•Low incidence of anaemia among children<br>•Active VHSNC |

### 3.1 What are the schemes available in the country to fight malnutrition

India has a number of welfare schemes that are implemented at the ground level. Implementing these schemes are part of Panchayat's action points. The list of schemes and their benefits are as follows:

**Pradhan Mantri Matrutva Vandana Yojana (PMMVY)**

The scheme provides Rs 5000 to each pregnant woman in two instalments fulfilling certain conditions (such as immunisation, pre and ante natal check-ups etc). This scheme is mandated under National Food Security Act). This scheme is for pregnant women above 19 years of age and for their first live birth. However, they are eligible for the scheme if their second child is a daughter.

**Integrated Child Development Services (ICDS) Scheme**

This scheme is mandated under the National Food Security Act (NFSA) which mandates universal access to the services.

Supplementary Nutrition Programme (SNP) to children in the age group of 6 months to 6 years, pregnant and lactating women. One of the objectives of the scheme is to improve health and nutrition status of children., pregnant and lactating mothers.

- Immunization to children and women.
- Health check- ups for children and women
- Growth monitoring and referral to the NRC
- Referral services for children and women.

• Nutrition and Health Education to mothers and adolescent girls, though the VHND and Home visits.

• Non- formal pre-school education to children 3-6 years old

There is a lot of thrust on nutrition under this scheme and hence it plays an important role in eradicating malnutrition

Nutrition Rehabilitation Centre (NRC) -A health facility where children with Severe Acute Malnutrition (SAM) are admitted and managed. A steady linkage with ICDS identifies and refers severely malnourished children in the community using weight-for-height indicator.

The admission criteria in facilities (mainly Nutrition Rehabilitation Centres or NRCs) are children who are severely wasted (i.e., those with weight-for-height Z scores less than –3SD), and/or oedema (swollen feet) or medical complications. However not all the severely underweight children may or may not fulfil the criteria for NRC admission for treatment. Children who do not have medical condition can be managed at the community level (please refer to Section 2). The community-based approach may lead to timely detection and intervention of severe acute malnutrition in the community through ICDS services and home-based services.

Village Health Sanitation and Nutrition Committees (VHSNC)

There are around 5.53 lakh VHSNCs had been constituted at the village level across the country in order to strengthen village level health care planning and monitoring of nutrition. They are responsible to conduct Village Health Sanitation & Nutrition Days (VHSNDs) where tracking and addressing of malnutrition and anaemia takes place. This Committee is responsible to monitor services of ASHA, AWW. This Committee act as a subcommittee under Panchayati Raj Institution.

24 x 7 Services and First Referral facilities

In order to ensure mother and child health services. Around 10000 PHCs around the country are operational 24x7. Also, other facilities (including 698 DHs, 712 SDHs and 1543 CHCs and other level) have been operationalised as First Referral Units (FRUs) under NHM.[8]

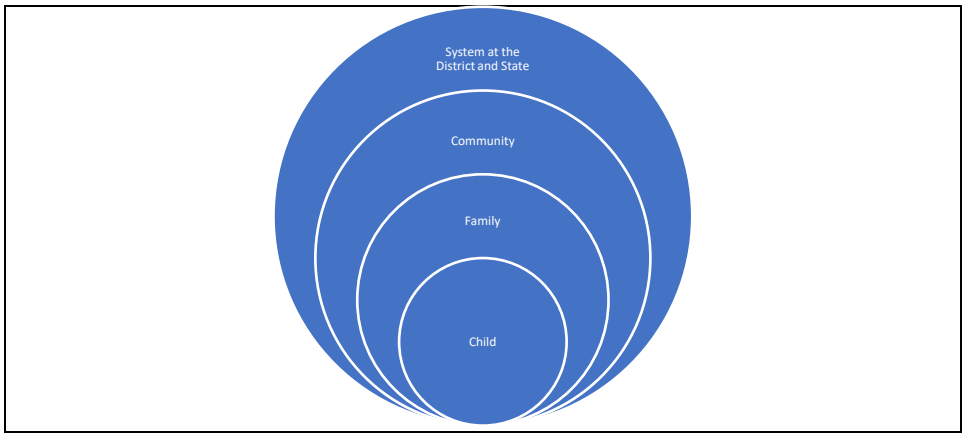
**Swachh Swasth Sarvatra[9]**

This is a joint initiative of the MoHFW and Ministry of Drinking Water and Sanitation and was launched in December 2016 to achieve better health outcomes through improved sanitation and increased awareness on healthy lifestyle. Under this initiative, one-time grant of Rs.10 Lakh is provided to the non-Kayakalp awardee CHC located in the open defecation free (ODF) Blocks

[8] Annual Report 2020-2021-Ministry of Health and Family Welfare (MoHFW)
[9] Ibid

### 3.2 Who are the main stakeholders?

**Fig 3.1 The eco-system**




In the eco-system drawn above, the closest circle to the child is the family. In order to address malnutrition, the AWC, PDS, VHSNC etc operate at the PRI level where the community exist. Beyond that is the state and district level s3ervices like NRC, District level hospitals etc and the administration to ensurend handhold the community level system.

### 3.3 How to manage malnutrition

- Identification of malnutrition through weight and height monitoring in AWCs
- Implementing government developed protocol on Community Based Management of Accute Malnutrition (CMAM). Telengana government is also implementing Supervised Supplementary Feeding Programme (SSFP) specifying protocols for managing SAM/MAM children. The above protocol can be implemented
- Food – care-health interventions
- Comprehensive management by addressing immediate to underlying causes of malnutrition
- Community based or NRC based management of severe malnutrition
- Follow up of the SAM cases
- Capacity building of parents, frontline functionaries, VHSNC members and local leaders on malnutrition
- Ensure that children who are sick are referred to the ASHA/ANM at the earliest
- Community-based creches can be started in villages where possible so that children receive adequate nutrition even in the absence of their mothers.
- Demand, monitor, and support services under ICDS and Village Health and Nutrition Day.
- Promoting of good practices and lessons learnt from ANMs/ASHAs

## Section 4 Objectives and Methodology

This section provides research tools to be used by fellows of National Institute of Panchayati Raj & Rural Development (NIRD&PR), whose responsibilities will be to track the trajectory of villages to become malnutrition free.

Objectives:

a) To track and longitudinally monitor status of malnutrition among pregnant women and children under 5 years in the villages under specific Gram Panchayats (GP)
b) To understand the social and economic vulnerability of children with persisting malnutrition
c) To understand the immediate, basic and underlying causes of malnutrition and how the Panchayats are addressing it through building awareness and system strengthening
d) To understand which strategies of Panchayats had worked in this regard
e) To enable systemic action plan from Panchayat to state level to lead to malnutrition free villages[10]

Methodology

The fellows will use both quantitative and qualitative tools. However, most of the tools are quantitative in nature and simple to use. Data will be analysed to make brief reports on the findings. These tools will be used every six months to track the progress of the villages towards becoming malnutrition free. The knowledge acquired from these tools will increase coordination and strengthen interventions as it includes coming together of departments of rural development, health, child welfare along with communities and local leadership.

Parallelly, secondary data will be compiled from ICDS MIS and Poshan tracker and other secondary sources through cross sector collaborations

**Tools**

| | |
|---|---|
| Tool1 – Pregnant and lactating women (interview) | Tool 2– Parents (Interview) |
| Tool 3 – AWWs (interview) | Tool 4 – Panchayat Secretary and Pradhan (interview) |
| Tool 5 - VHSNC Members (FGD) | |

## Section 5. The Tools and Their Use

[10] https://upsc.medcampus.io/poshan-abhiyaan/

## Tool 1 – Pregnant and lactating women

1. Gram Panchayat Name _____
2. Village _____
3. Category
   i) Pregnant woman:
   ii) Lactating woman:
4. Name of the respondent _____
5. Age _____
6. Disability Status: Yes No
7. Social Category:
   i) SC:
   ii) ST
   iii) OBC
8. For pregnant women only:
   a) Trimester:
   b) No of antenatal check ups
   c) No. of TT vaccine
   d) Taking IFA tablets: Yes No
   e) Number of days taking IFA tablet:
   f) Are you anaemic? Yes No

**For both**

   a) Enrolled in AWC: Yes No
   b) Accessing PHC/ CHC: Yes No
   c) Accessing District Hospital/Medical College Yes No
9. Type of food received: THR Cooked food
10. a) Accessing PDS Yes No

    b) Type of Card _____

11. If THR is accessed, Is the food shared by other family members?

    Yes No

12. How many times do you eat the following in a week:

| Type of food | Frequency per week | Frequency once in two weeks and above | No of times in a day When you consume the same |
|---|---|---|---|
| a) Cereals | | | |
| b) Pulses | | | |
| c) Vegetables | | | |
| d) Fruits | | | |
| e) Milk or Milk | | | |

| | | | |
|---|---|---|---|
| products | | | |
| f) Eggs/ Fish/Meat (any type) | | | |
| g) Butter/ Ghee | | | |

**13.** Number of ANC check-ups have you been through**:**

14. a) Did you receive IFA Tablets from AWCs/PHC/other sources? Please tick

Yes No Don't know

b) Did you consume IFA tablets?

Yes No
If yes, no. of days consumed:

c) Did you go through any dietary restrictions during pregnancy?

Yes No

d) If yes please give reasons and the details of restrictions followed

**Use and objective of this tool:**

The objective of this tool is to capture the food intake within families in AWCs and health support received from PHCs and AWCs

The tools are easy to use as it captures numbers and answers in Yes and Nos. The compilation of data will help to capture a base line and identify gaps in food, nutrition and health level intervention gaps and strategies can be made to fill up the gaps. This data can be updated every six months to see the progress of the status in health status, food intake and food diversity

## Tool 2: Parents of children under 6 (underweight/stunted or wasted)

1. GP Name _____
2. Village _____
3. Name of the child _____
4. Age of child
5. If SC/ST/OBC Yes No
6. Disability status Yes No
7. For the mother:

During pregnancy were you anaemic? Yes No

Did you have premature delivery Yes No

8. a) Do you access PDS?
   b) Is it regular? Yes No

9. How many times in a day does the child consume:

| Food item | No. of times a day (i) | No. of times a week (ii) | Food item | No. of times a day (i) | No. of times a week (ii) |
|---|---|---|---|---|---|
| a) Fish/Meat | | | f) Rice/wheat/millets | | |
| b) Eggs | | | g) Pulses | | |
| c) Milk | | | h) Vegetables | | |
| d) Fruits | | | i) Nuts/food from forest collection | | |

10. Were you consuming food from AWC during lactation and pregnancy?

    Yes No

11. In which colour does the heigh and weight fall?

| Colour | Height | Wight |
|---|---|---|
| Green | | |
| Yellow | | |
| Red | | |
| Blue | | |
| Dark blue | | |

12. What is her/his weight?
13. What is her/his height?
14. a) What are the immunisations your child received?[11] Please tick if yes:

Birth to 9 months

OPV 0
OPV 1
OPV 2
OPV 3

[11] ttps://nhm.gov.in/New_Updates_2018/NHM_Components/Immunization/Guildelines_for_immunization/MCP_Guide_Book.pdf#:~:text=The%20MCP%20Card%20is%20used%20in%20your%20routine,AWCs%2C%20for%20recording%20immunizations%20availed%20by%20children%20etc accessed in January 2025

BCG
Hep B
DPT 1
DPT 2
DPT 3
Penta 1
Penta 2
IPV 1
IPV 2
MR 1
JE 1

15. Has your child received from PHC (for parents of children who are wasted)?

| | | |
|---|---|---|
| Medical assessment at PHC | Yes | No |
| Iron Supplementation | Yes | No |
| Vitamin A | Yes | No |
| Deworming | Yes | No |

16. Do you monitor MCH card of your child? Yes No
17. How frequently is weight measured in AWC?
18. Do you attend VHNSD? Yes No
19. What happens in VHSND?

20. Does the AWC has a kitchen garden? Yes No
21. What all vegetables and fruits are grown there? _____
22. Do the children consume the food in kitchen garden? Yes No

23. Do you know the names of committee members from communities who monitor AWCs? What are the names?
24. Do you attend meetings called by AWWs to discuss nutrition?

Yes No

25. What are their roles in intervening in your child's malnutrition status?

26. Do you attend Gram Panchayat meetings

Yes No

27. Is the nutrition status of children in the villages discussed in the Gram Sabha?

    Yes  No

28. What is discussed?

29. If your child is malnourished what change have you brough in her/his/their diets?

| | Introduced | Increased quantity | Increased Frequency |
|---|---|---|---|
| Fruits | | | |
| Green vegetables | | | |
| Milk/Milk Products | | | |
| Fish/Meat/eggs | | | |
| Any other | | | |

30. Has your child been sent to NRC?

    Yes  No

31. If yes, how long did the child stay there?

32. After NRC how is the child's nutrition tracked?

33. What is needed for the child to reach normal status?

34. Did the AWW visit your home to give information on how to take care of your child, what is to given to the child?

    Yes  No

35. What messages were given by AWWs after she identified your child as malnourished?
36. Did your child receive any type of special food from AWC? If yeas what?
37. How many times does she visit your home in a month?

**Use and objective of this tool:**

The objective of the tool is to understand the food diversity and food intake by the child suffering from malnutrition. In addition to it captures the intervention of the system (health

and nutrition also in implementing VHND and Kitchen gardens)). There are some questions that capture qualitative data to see if malnutrition is addressed in Gram Sabha and VHSNC meetings. The objective of this data is to identify gaps and take steps in plugging the gaps required in roles of families, community and PRI (with support from state) and also to bring changes in nutrition and health status of children.

## Tool 3: Anganwadi workers (interview schedule)

1. Name of AWW-
2. Name of Panchayat –
3. Village –
4. How many AWCs run in this PRI?
5. Location of AWC

6.

| Does AWCs have | Yes | No |
|---|---|---|
| a.AWW | | |
| b. AWH | | |
| c.Safe drinking water | | |
| d. Toilets for children | | |
| e. Regular inflow of food grains | | |
| f. Regular inflow of THR | | |
| g. Regular supply of eggs | | |
| h. Regular supply of milk | | |
| i. Weighing machine | | |
| J Machine to capture length/height | | |
| k. Growth chart to track underweight and stunting for every child | | |
| l. Maintaining of growth charts for every child | | |
| m. MCH Card for every child | | |

7

| | Total | Girls | Boys | General | SC | ST | OBC |
|---|---|---|---|---|---|---|---|
| No. of children registered in AWC | | | | | | | |
| No. of children moderately underweight | | | | | | | |
| No. of children severely underweight | | | | | | | |
| No. of children | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| moderately stunted | | | | | | | |
| No. of children severely stunted | | | | | | | |
| No. of children wasted | | | | | | | |

8

| How frequently are | Frequency for all children (i) | Frequency for malnourished children(ii) |
|---|---|---|
| a) Children under 2 weighed? | | |
| b) Children between 2 to3 years weighed | | |
| c) Children between 3 to 6 weighed | | |
| d) Lengths of birth to 2 years taken? | | |
| e) Heights of 2 to 6 years taken | | |
| f) Children given fruits in a week? | | |
| g) Children given milk in a week? | | |
| h) Children given eggs in a week? | | |
| i) Children given vegetables in a week? | | |
| j) Nutrition and health Counselling of parents take place | | |

9.What extra food do malnourished children receive?

10. Do you know about the protocols for CMAM or protocols for SSNP? If yes, How do you implement them?

11. When do you refer a child to NRC?

12. How do you track a child when the child is back from NRC?

13.

| In tracking and leading the child to normal status what role do the following play | |
|---|---|
| a) PHC | |
| b) ANM | |
| c) ASHA | |
| d) VHSNC members | |

14. a) Does the AWC has a kitchen garden?

b) What is grown there?

14.a) How many times do VHSND/community meeting on nutrition happen in a quarter?

b) What happens there?

c) Are god bharai celebrated? Yes No

d) Are anna prashan celebrated? Yes No

e) What kind of messages are given there?

f) Are you the member of VHSNC? Yes No

g) If yes how frequently do you meet?

h) What is discussed?

i) How many child relapsed into malnutrition is last month?

i) How do you think this village can be malnutrition free?

**Use and objective of this tool**

This is a tool which captures both qualitative and quantitative data. Since AWW is central to the intervention to malnutrition and does continuous monitoring, the objective is to understand the diversity of food and menu for children, the intervention of malnourished children at the centre level and the status of coordination with health department. This data will highlight systemic gaps and activate AWWs and VHSNC members to strengthen system and activate responsibilities of different stakeholders.

## Tool 4: Panchayat Pradhan/Secretary: Same tool

1. How many children under 5 years of age are there in this village?
2. How many are:
a) Underweight
b) Stunted
c) Wasted
3. How many times do you visit AWC?
   a) Daily b) Weekly c) Monthly d) Quarterly e) Half yearly f) Never
4. How do you track that?
5. How many members are there in VHSNC?
6. How many times do they meet in a quarter?
7. Do you attend VHSNC meetings?
8. What is discussed there?
9. How is malnutrition discussed in the Panchayat and Gram Sabha meetings? What kind of decisions are taken?
10. Do you monitor the implementation the decisions?
11. Are funds provided for initiatives to address malnutrition?
12. What kind of initiative have you taken to make the village malnutrition free?
13. How do you think your village can become malnutrition free?
14. What are the challenges?
15. How can those problems be solved?
16. Do you track the indicators of child friendly Panchayats?
17. Did you ever receive any awards as Child friendly panchayat?
18. Do you know about Poshan Tracker?
19. What role do you think you have to make the panchayats malnutrition free?

**Objective and Use of this tool**

This tool captures the awareness and involvement of PRI leaders on the issue of malnutrition. The qualitative information will be tracked to see the knowledge level and practice level change of the local leaders over a period of time

**Tool 5: VHSNC Members – FGD guiding questions**

1. How many children under 5 are there in the village?
2. Since when are you working as VHSNC members?
3. How is the VHSNC constituted (process)?
4. What is the maximum tenure of each VHSNC member within the committee?
5. What are your roles as VHSNC member?
6. How many times do you meet in 6 months?
7. What is discussed in the VHSNC meeting?
8. Are the issues then discussed in Gram Sabha meeting?
9. What happens on the VHND?
10. How do you track malnutrition in the villages?
11. How do you intervene? Please elaborate?
12. How many malnourished children are there in the village?
13. How do you plan to make it malnutrition free?
14. What role do you think the following have in it:
    a) PRI
    b) ICDS
    c) NRC
    d) Parents
    e) Local leaders

**Objective and Use of the Tool**

This tool is the only FGD tool as the intent is to activate this group and its interaction and involvement with AWC, PRIs and communities

The primary data should be collected and recorded. The recorded data needs to be coded and analysed in Excel Sheet/Word/NVivo and be tracked every six months so that change in attitude, knowledge, and practice can be captured.

## Annexure 1: Analysis and Compilation of Data

## Quantitative Data Analysis for Tool 1

Codes for villages under the same Panchayat: Village x -1, Village y -2 etc

Beneficiary Code -W Vill Code Panchayat Code1, W Village code Panchayat Code2, etc

Code – Yes as 1 and No as 2

Code – Pregnant women -i Lactating women -ii

For Pregnant Women only

**Table 1.1**

| Beneficiary Code | Trimester | No. of antenatal check-ups | TT Vaccine Y/N | IFA table Y/N | No. of days taking IFA | Anaemic (Y/N) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

From this Table calculate:

a) % of women:
-taken at least 2 antenatal check-ups,
- had TT vaccination,
-consuming IFA tablets
- taking for 90 days
-anaemic

The findings from the table will provide information on pregnancy health care. The gaps are the spaces ofc intervention. For example, what is the % of women taking vaccination, antenatal check up IFA tablets? Are they less than 100%? If so, strategise for intervention.

Similarly, % of women anaemic is a red flag for intergenerational malnutrition

**Table 1.2: Receiving AWC services in terms of food**

| Beneficiary Code | Enrolled in AWC | Type of food received | THR shared with family members |
|---|---|---|---|
| | | | |

Table 2 compiles the % of women:

- Receiving benefits in terms of supplementary nutrition from AWC
- Receiving THR and receiving cooked meal
- Sharing THR with family member

This table provides whether the intended supplementary nutrition is going to the pregnant and lactating women.

**Table 1.3: Regularity and Access to Food Diversity**

| Beneficiary Code | cereals | pulses | vegetables | Fruits | Milk and milk products | Eggs/Fish/Meat | Oil, Butter Ghee |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

This table will provide information on % of women and frequency

-consuming all food items everyday

- consuming milk

-consuming animal proteins

-consuming fruits

-consuming cereals, pulses and vegetables twice a day

From this table the food access and adequacy should be calculated. % of women who are not having twice a day cereal, pulses, vegetables, one helping of milk, one helping of fruits are at risk. Women from families that are non-vegetarians are getting at least one helping of protein once a day.

Table 1.1, 1.2, 1.3 will provide information on how the healthcare and care from AWC for pregnant and lactating women were happening and the status of food intake. The lower the percentage of access to services, and food intake, red flags need to be raised and interventions are needed.

The last question will capture the % of women who are from socially and economically vulnerable communities

## Quantitative Data Analysis for Tool 2

Child needs to be coded as C Village Code Panchayat Code 1, C Village Code Panchayat Code 2 etc

Yes -1, No - 2

**Table 2.1: Families and Mothers' Access to Schemes and Health Status**

| Child Code | Whether from SC/ST Community | Mother anaemic during pregnancy | Premature delivery | Access PDS | PDS regular | Accessing SNP regularly during pregnancy and lactation |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

This table will compile the % of malnourished children:

-from socially and economically vulnerable groups

-with mother anaemic during pregnancy

- born premature

-whose family accessing PDS

-whose mothers got services from AWC

**Table 2.2: Child's Access to Food Diversity within Families**

| Child Code | cereals | | pulses | | vegetables | | fruits | | Milk and milk products | | Eggs | | Oil, Butter Ghee | | Meat/Fish | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | /d | /w | /d | /w | /d | /w | /d | /w | /d | /w | /d | /w | /d | /w | /d | /w |
| | | | | | | | | | | | | | | | | |

This table is most important as it provides info on the access to food diversity and adequacy for the child who is malnourished.

## Qualitative Information from Tool 2

Q10 to Q27 are questions to understand the awareness of parents on the status of the child and their interaction with system like AWC and NRC in terms of weighing, medical intervention and intervention for severity

Questions on what is needed for the child to reach malnutrition is an awareness question. On the basis of the responses received from parents, the responses need to be divided into need for intervening into:

-immediate causes

-underlined causes

-basic causes

This will be used to develop multipronged strategies against malnutrition.

## Quantitative Data Analysis for Tool 3

Following the same way each AWW will be coded as Panchayat code village code AWW1, Panchayat Code Village Code AWW2 etc.

Yes – 1, No – 2

**Table 3.1: Access to Services and Regularity**

| Does all AWCs have | AWW Code 1 | AWW Code 2 etc |
|---|---|---|
| a. AWW | | |
| b. AWH | | |
| c.Safe drinking water | | |
| d. Toilets for children | | |
| e. Regular inflow of food grains | | |
| f. Regular inflow of THR | | |
| g. Regular supply of eggs | | |
| h. Regular supply of milk | | |
| i. Weighing machine | | |
| J Machines to capture growth/height | | |
| k. Growth chart to track underweight and stunting for every child | | |
| l.Maintaining of growth charts for every child | | |
| m. .MCH Card for every child | | |
| n. AWC having a kitchen garden | | |

By compiling Table 3.1 we get % of AWCs having

-AWW

-AWH

-Drinking water

-Toilets

- Regular inflow of food grains

- Regular THR supply

- Regular supply of eggs (if given in AWCs)

- Regular supply of milk (if given in AWCs)

- Regular maintenance of growth chart

-Regular maintenance of MCH Card

-Availability of weighing machine

-Availability of machines to measure length/height

-Availability of kitchen garden in the AWC

The table will provide data on regularity of SNP distribution in AWCs, tracking of malnutrition in AWCs and also provide information on availability of tools and equipment to track malnutrition.

Table 3.1

Code Frequency of weighing/taking height

1 -Once in a month

2 -Once in 3 months

3 -Once in 6 months

6. Once a year
7. Others

All children represented by (i)

Malnourished children by (ii)

**Table 3.2: Regularity to services and food diversity in AWCs**

| How frequently are | AWW Code 1 Frequency (i) | AWW Code 1 Frequency (ii) | AWW Code 2 Frequency (i) | AWW Code 2 Frequency (ii) |
|---|---|---|---|---|
| a) Children under 2 weighed? | | | | |

| | | | | |
|---|---|---|---|---|
| b) Children between 2 to3 years weighed | | | | |
| c) Children between 3 to 6 weighed | | | | |
| d) Lengths of birth to 2 years taken? | | | | |
| e) Heights of 2 to 6 years taken | | | | |
| f) Children given fruits in a week? | | | | |
| g) Children given milk in a week? | | | | |
| h) Children given eggs in a week? | | | | |
| i) Children given vegetables in a week? | | | | |
| j) Nutrition and health Counselling of parents take place | | | | |

Table 3.2 provides information on % of children and malnourished children of different age groups who are weighed and height taken:

-weighed once a month

-weighed once in 3 months

-weighed once in 6 months

-receiving milk

-receiving fruits

-receiving eggs

-receiving vegetables

It also provides the % of parents receiving national and health counselling regularly

The objective of this table is to identify gaps in accessing nutritious food, food diversity accessed and also to identify systemic gaps if any in tracking children's height and weight

## Qualitative Data from Tool 3

The qualitative data from Q6 to Q9 is to capture the awareness of AWW on multistakeholder involvement, role of NRC and role of community in managing malnutrition at the community level.

The qualitative data from Q 11 will provide the regularity of VHND, the discussions that take place there and using god bharai and anna prashan as events to spread awareness on nutrition and food security.

## Qualitative data from Tool 6 and 7

Tool 6 and Tool 7 captures mainly qualitative data that provide information on understanding of their roles, responsibilities and involvement in making the village malnutrition free. It provides information of the involvement of community leaders in managing malnutrition at the community level, enabling both families and scheme-based services through their active involvement.

## Overall Findings from the tools

1. Access to food diversity during pregnancy and lactation
2. Access to healthcare during pregnancy
3. Access to AWC during pregnancy
4. Regularity of services accessed during pregnancy
5. Existence of anaemia during pregnancy and lactation
6. Access of malnourished children to food diversity at the family level and AWC level
7. Regularity of tracking malnutrition and interventions.
8. Awareness building processes on malnutrition through VHND, Nutrition and Health Counselling, post NRC malnutrition management
9. Functioning of health system, AWC, VHSNC, NRC.
10. Understanding of functionaries, local leaders on malnutrition and clarity on how to make the village malnutrition free. The question "how do you think the village can be malnutrition free" has been asked to all stakeholders to understand their capacity and will.
11. The findings from 1 to 11 will be used to analyse the gains and challenges, strategise for intervening in immediate, underlying and basic causes of malnutrition in terms of awareness building, system strengthening and active involvement of all stakeholders informed.