Enduring Value

RAPID ASSESSMENT STUDY OF MATERNAL CHILD HEALTH & NUTRITION IN RURAL KAMRUP DISTRICT, ASSAM: A REPORT

YOUTHINVEST FOUNDATION

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1. EXECUTIVE SUMMARY

1.1. Introduction

The state of Assam has the highest Maternal Mortality Ratio in India (237 against 130 nationally). It also has a high Infant Mortality Rate (44 against 34 nationally). Kamrup rural district, home to one of the ITC factories, has one of the highest IMR in the state at 601 per 1000 live births and a neonatal mortality rate of 36. Child malnutrition is high, only 42% of pregnant women had 4 antenatal care check-ups, 26% of women (20-24) were married before 18 years and 10% of 15-19 adolescents were already pregnant or mothers2.

In this context, ITC MSK commissioned its MCH programme partner, YouthInvest foundation, to conduct a Rapid Situational Analysis in Rampur and Chhaygaon blocks of Kamrup district to understand the current situation of key maternal and child health and nutrition (MNCHN). A summary of the study findings and programme recommendations to improve maternal and child health and nutrition status based on the findings is presented below.

1.2. Key findings from the Rapid Situational Analysis in Rampur and Chhaygaon

1. **More than 15% of populations in remote, vulnerable areas are not reached by the Health and ICDS programmes, resulting in low coverage of key behaviours and practices.**

Maternal and child health and nutrition indicators in the 2 blocks compared to the nation, state, district

Indicators (percentage)	India	Assam	Kamrup Rural	Rampur & Chhaygaon
Pregnant women consumed 100 IFA	31	32	22	26
Pregnant women received 4 ANC	52	46	42	69
Children breast-fed within 1 hour of childbirth		75	84	50
Children exclusively breast-fed for first 6 months		40	50	2
Underweight children	36	30	28	NA*
Women (20-24) married before 18 years	26	31	18	35
Women using modern methods of family planning	30	39	52	42

*Only 31 per cent of children interviewed were weighed in the last 3 months

2. **Frontline worker (AWW, ASHA, ANM) interaction regarding behavioural practices,**

[1] Annual Health Survey 2012-13
[2] National Family Health Survey, District Factsheet, 2015-16

social and cultural taboos related to MNCHN remain poor, resulting in low awareness and uptake of recommended practices and consequent malnutrition. Further, the involvement of Panchayats is currently not present in any health and nutrition community mobilization activities.

Training and mentoring of AWW, ASHA and ANM (AAA) to reach out to the unreached population and manage malnutrition in a convergent manner is essential. Panchayat involvement will be critical to developing a sustained social behaviour change communication strategy within the Gram Panchayat Development plans (GPDP).

3. **Gaps in infrastructure and supplies in the ICDS system as well as inadequate capacity, lack of supportive supervision & performance rewards/ recognition system affect AWW performance in combating malnutrition.** Many Anganwadi Centres (AWC's) have major infrastructural gaps that include leaking roof, lack of functional toilets and drinking water facilities, lack of weighing machines. Further, AWWs and Supervisors lack capacity and motivation to address home-based nutrition behaviour, growth monitoring and counselling as well as targeting vulnerable population.

4. **Key Government Departments, namely, Social Welfare, Health & Family Welfare and Panchayat & Rural Development are open for collaboration for technical assistance in system strengthening of MNCHN services to reach under-served vulnerable populations.** Department of Social Welfare is looking for partnerships to strengthen ICDS service delivery and the POSHAN platform provides an opportunity for amplification of successful approaches across the state. For improved child nutrition, convergence of AAA and Panchayat is critical.

1.3. Programme recommendations and proposed solution

The main programme recommendations, based on the findings of the rapid assessment situation analysis, are as follows.

A) Improved coverage and sustainable behaviour change among unreached vulnerable populations

- ☑ Support in creating mechanisms for convergence of Health, ICDS (AAA) and Panchayat at village, sub-centre and block levels for improved social and behaviour

change communication (SBCC)

- ☑ Home-based management of malnourished children and referral of sick children

B) Improved quality of service delivery

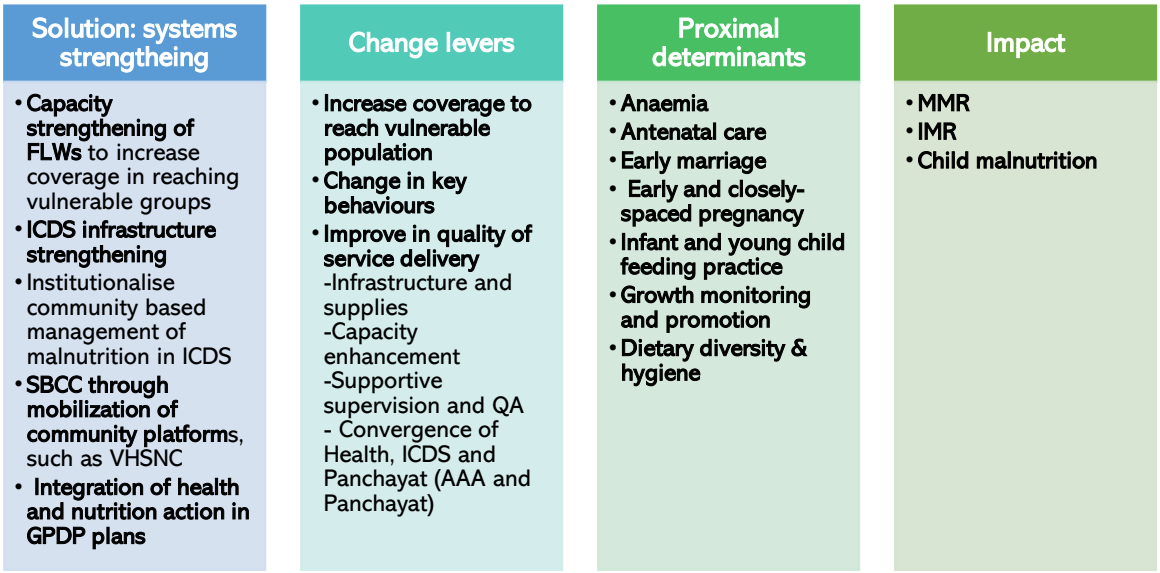
- ☑ ICDS infrastructure strengthening
- ☑ AAA capacity enhancement
- ☑ Supportive supervision and quality assurance

C) Integration of health and nutrition as a key theme in the Gram Panchayat Development Plans for ensuring sustainability

- ☑ Capacity building of Panchayats on MNCHN issues
- ☑ Support in community needs assessment on MNCHN and inclusion of MNCHN and related issues in GPDP plans

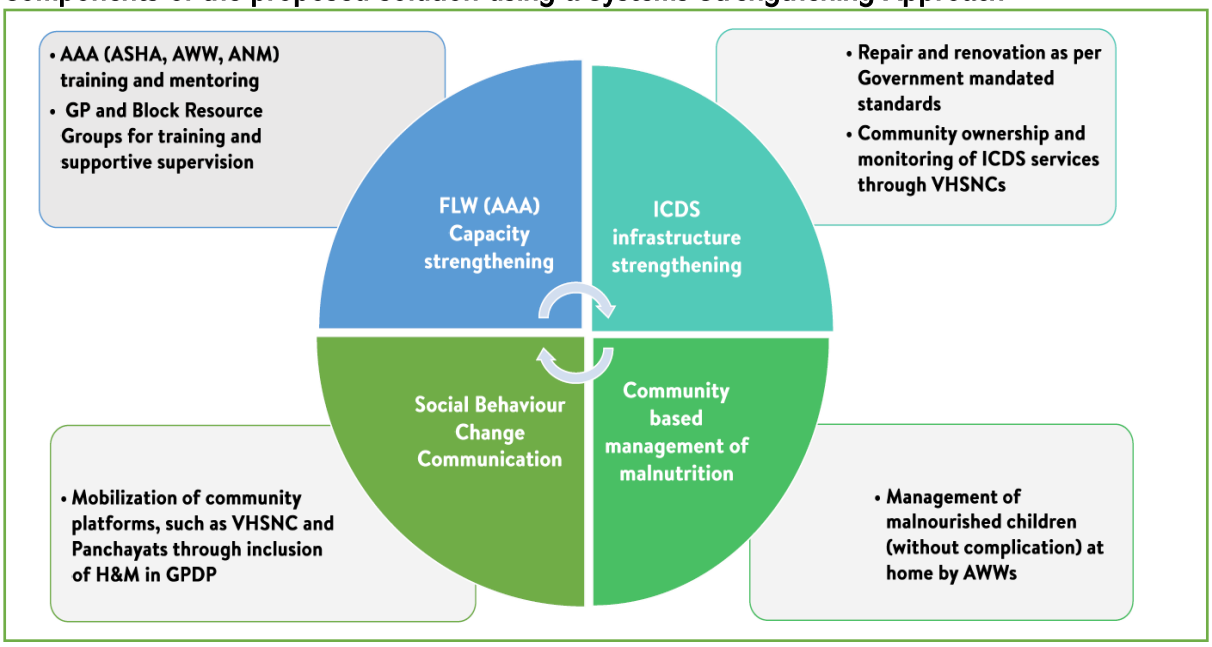
Based on the findings above, the following solutions framework is being recommended (Fig below), focusing on a few critical change levers that have the potential to improve the delivery of ICDS and Health services to the unreached population and bring about sustained uptake of key practices leading to accelerated improvement in malnutrition and maternal health.

Figure 2: Solutions Framework: the pathway to change



It is recommended that the proposed solution have the following component using a **"Systems Strengthening Approach"** through a formal MOU with the ICDS system so that changes brought about are sustainable and could be easily scaled through the system.

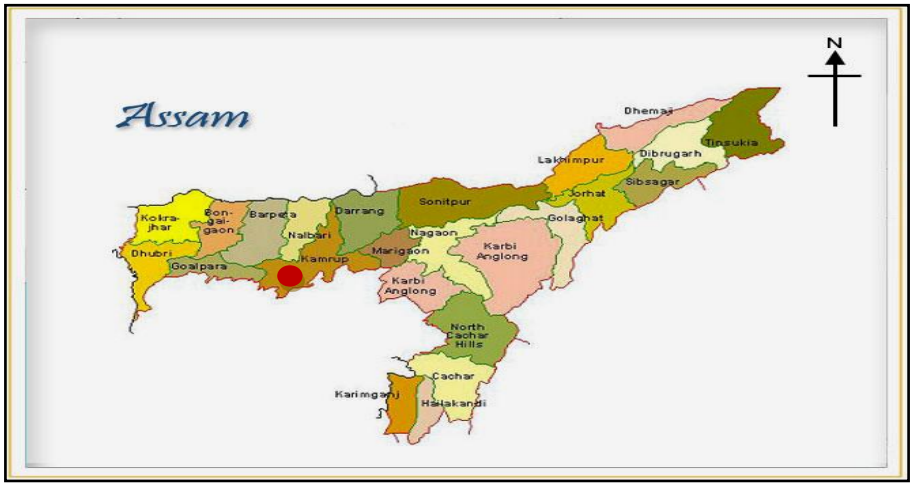
Components of the proposed solution using a Systems Strengthening Approach



2. INTRODUCTION TO THE RAPID SITUATIONAL ANALYSIS

2.1. Background

Improving maternal and child health and survival are central to the achievement of national health and nutrition goals as well as the SDG goals that call for a focus on reducing maternal, newborn and child mortality. The state of Assam has the highest Maternal Mortality Ratio in India (237). It also has a high Infant Mortality Rate (44 against 34 nationally) in the country[3].



Kamrup Rural district located in the north-eastern part of the state of Assam has one of the highest IMR in the state at 60[4] per 1000 live births and a neonatal mortality rate of 36. Maternal care is also poor with only 42% of women having 4 antenatal care check-ups, 31% of pregnant women having 100 IFA and 18% of women still having home delivery. Only 31% of children (11-23 months) were reported to have full immunization. Nutritional status of children is poor with 25% children reported to be born with low birth weight, high rate of child malnutrition (28% underweight) and only 7% of children (6-23 months) received adequate diet. 26% of women aged 20-24 years were married before 18 years and 10% of 15-19 married adolescents were already pregnant or mothers[5]. Use of modern methods of family planning is also low at 29%. A comparative table with key maternal and child health and nutrition indicators is given below.

Table 1. Maternal & child health and nutrition in Kamrup Rural district

Indicator	Kamrup Rural	Assam	India
Infant Mortality Rate	60	44	34
Maternal Mortality Ratio	NA	237	130
Percentage of pregnant women receiving 4 ANC	42	46	52
Percentage of pregnant women receiving 100 IFA	22	32	31
Percentage of institutional delivery	82	71	79
Percentage of 11-23 months with full immunization	37	47	62
Percentage of underweight children	28	30	36
Percentage of women (20-24) married before 18 years	26	31	18
Percentage of women using modern family planning methods	30	39	52

Source: Annual Health Survey 2012-13 and National Family Health Survey, District Factsheet, 2015-16

[3] Sample Registration System
[4] Annual Health Survey 2012-13
[5] National Family Health Survey, District Factsheet, 2015-16

The Government of Assam is committed to addressing childhood malnutrition through multiple programmes, including the flagship Integrated Child Development Services (ICDS), the National Health Mission (NHM), and the POSHAN Abhiyan that calls for a convergent multi-sectoral response to reduce malnutrition. Critical to the success of these programmes in reduction of malnutrition is to what extent these initiatives lead to improved *coverage of essential nutrition interventions,* such as improved infant & young child feeding (IYCF) practice, regular growth monitoring, identification and management of severe and moderate acute malnutrition, as well as *uptake of water, sanitation and hygiene (WASH)* practices. ITC's flagship social development programme *Mission Sunhera Kal* (ITC MSK) is working in Assam to complement efforts of the Government in selected districts of Assam in the fields of health and education.

In this context, ITC MSK commissioned its MCH programme partner, YouthInvest Foundation, to conduct a Rapid Situational Analysis in Rampur and Chhaygaon blocks of Kamrup district to understand the current situation of key MNCHN indicators. The study would be conducted in selected Gram Panchayats of 2 blocks of Kamrup district, namely Chhaygaon and Rampur, which are close to the ITC production unit in the area, to understand the baseline status and determinants of key MNCHN practices. Study findings are expected to inform programme interventions that ITC MSK may initiate to improve maternal and child health and nutrition status in these areas.

2.2. Objectives of the Rapid Situational Analysis

The objectives of the Rapid Situational Analysis carried out in 2 blocks of Kamrup rural district are as follows.

1. Understand the status of maternal, newborn, child health and nutrition (MNCHN) in selected Gram Panchayats of Chhaygaon and Rampur blocks.
2. Understand key determinants of MNCHN behaviours and practices at individual, relationship, family, community and provider (system) level.
3. Develop recommendations for programme design to improve MNCHN status in these areas

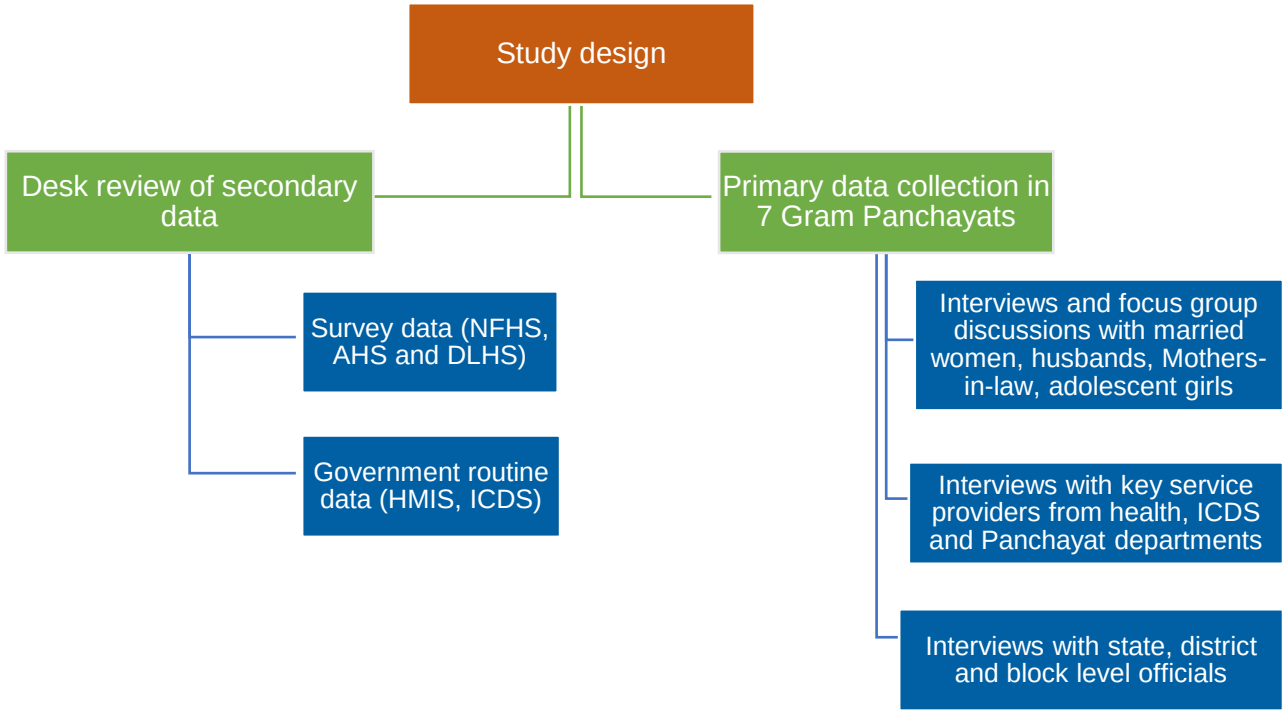
2.3. Design and methodology

The Rapid Situational Analysis was conducted in July 2019 with a mix of quantitative and qualitative methods. Both secondary and primary data were analyzed to complement each other and develop a theory of change along with proposed interventions for a future programme in the two blocks.

Methods for primary data collection were chosen in such a way to bring out maximum information from each group within a limited time. The following methods were used.

- **In-depth Interviews** (IDI) – IDIs were conducted with married adolescent women and their husbands, mothers-in-law, community leaders and service providers.
- **Focus Group Discussions** (FGD) – FGDs were conducted with young adolescents to understand their knowledge level and practices relating to a range of issues impacting their reproductive and sexual health (RSH).

The details of the study design are depicted below.



For each category of participants for the FGDs and IDIs, open-ended semi-structured questionnaires were used. IDIs and FGDs were conducted in the Assamese language to collect appropriate information. A total of 125 IDIs and 18 FGDs were conducted with the target respondent groups.

Table 2. Details of participants

Target group	Number
Young married women (15-24 years)	56
Husbands of young married women	25
Mothers-in-law of young married women	25
Unmarried adolescent girls (10-19 years)	16
Community leader (Panchayat member)	6
ASHA/ AWW/ ANM	24
Block-level functionaries (CDPO, Block Programme Manager, Medical Officer)	11
District and State level officials	6

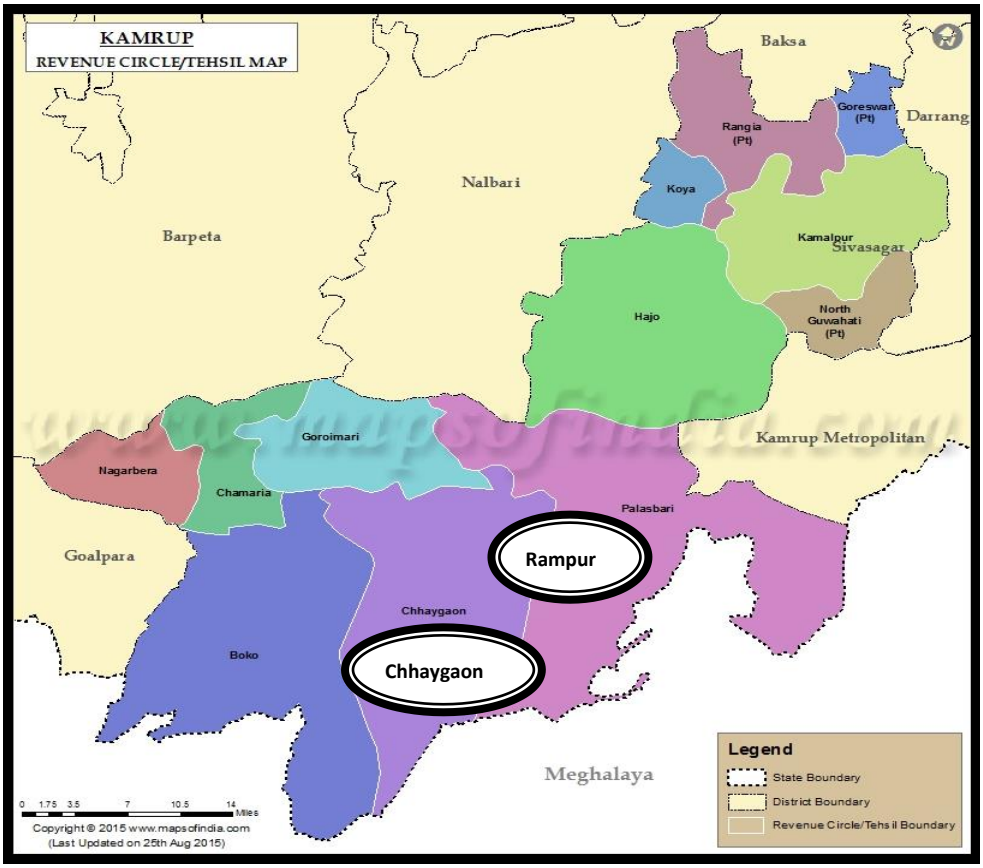
2.4. Study area

The area for the Rapid Situational Analysis was spread over 7 Gram Panchayats. The GPs and villages were selected on discussion with the Government block level functionaries based on the vulnerability and poor MNCHN indicators. In each GP a sub-centre was taken as the unit and 2 villages near the sub-centre were selected for data collection. Data were collected from 12 villages in 7 GPs covering the 2 blocks.

Table 3. List of Villages where the study was conducted

Block	Gram Panchayat	Villages
Chhaygaon	Guimara	Gusaipara and Karipara
	Champaknagar	Kukurmara and Kulhuapara
	Gumi Bankakata	Pukhuripar and 1 No Uttar Simolubari
	Pantan	Balijori Bananigaon
Rampur	Sapartari	Saportari and Kolohipar
	Bezortari	3no Bezortari and Bangshar
	Satpakhali	Bagisapara

Figure 2. Study area



2.5. Study process

In order to understand the MNCHN status and issues and their determinants, YouthInvest undertook

the study in a phase-wise process. In Phase 1, YouthInvest officials visited certain service delivery points in the villages and conducted meetings with key officials of Health and Social Welfare Department in the state and block level to identify the vulnerable populations with low levels of MNCHN indicators in the Rampur and Chhaygaon blocks. The discussion with the CDPOs bought to the forefront the presence of some pockets in these 2 blocks where access to services was low and the presence of malnutrition cases among children in these villages were cause for concern.

In Phase 2, based on the discussions and understanding from the field visit, YouthInvest designed instruments for the qualitative study to understand the determinants of the poor health and social behaviours using a socio-ecological model that recognizes behaviours as influenced by multiple factors at individual, interpersonal and societal level.

YouthInvest engaged local Research Investigators (mix of male and females) to collect data, under the guidance of core Management Team of YouthInvest Foundation, for following primary target groups – (i) 15-24 married women (having children above 1 year and below 5 years) and (ii) 10-19 year adolescent girls. In addition, data was collected from husbands and mothers-in-law of young women, community leader and frontline health & nutrition service providers, namely AWWs, ANM and ASHAs for a comprehensive understanding of MNCHN behaviours and their drivers.

In Phase 3, YouthInvest team analyzed the data to determine the problems at multiple levels and understand the systemic gaps and factors driving these in the study population. Potential interventions to address the barriers and challenges of the problems were brainstormed and prioritized based on evidence and feasibility. This exercise informed in developing the design of the programme intervention framework and strategy.

2.6. Data collection

2 teams comprising of 2 Research Investigators in each team, visited the villages in both the blocks to conduct FGD and IDI. Data collection tools were developed and reviewed by experts from YouthInvest. Effectiveness of the tools was re-evaluated following analysis of the findings after one round of data collection. The qualitative sessions were facilitated and documented by the Research Investigators. The team of field researchers was oriented by YouthInvest Foundation core team. A team of two field researchers were engaged for each session. One of them facilitated the interaction and the other was responsible for documentation. Participation in the FGDs and IDIs was voluntary.

The Research Investigators collected data from the married young women, unmarried adolescent girls, husbands, mothers-in-law and service providers. However, YouthInvest team members themselves collected data from Panchayats, service providers, block-level functionaries, District and State level officials.

2.7. Limitations

The sample for qualitative assessment was small in comparison to the study area population. However, triangulation of data collected from different types of respondents on the same issues helped in mitigating this limitation. District and block-level data, opinion of the service providers, health-seeking behaviour and actual practices of the community people helped in understanding the gaps that need to be addressed.

3. KEY FINDINGS

3.1. Coverage of maternal & child health and nutrition services

Findings from the Rapid Situational Analysis in the 2 blocks reveal that key maternal and child health and nutrition (MNCHN) indicators are poor and need improvement. Primary data collected in the 7 GPs clearly shows that majority of the indicators, apart from the antenatal checkup, institutional delivery and immunization, are much lower in comparison to Kamrup Rural District data (Table 4). Exclusive breast-feeding is practically non-existent in the study area with majority introducing some other food during the first 6 months. Weighing among under 6 children was also very poor with only 31% of children reported to be weighed in the last 3 months preceding the study. More than 15% of populations in remote, vulnerable areas are not reached by the Health and ICDS programmes, resulting in low coverage of key behaviours and practices. (Table 1).

This clearly shows that these areas are some of the most vulnerable and poorly performing in Kamrup Rural district, which itself is among the most poorly performing districts in Assam.

Table 4. MNCHN status in the study area compared to Kamrup Rural, Assam and India

Indicator	India *	Assam*^	Kamrup Rural*^	Study area (Rampur & Chhaygaon) #
Percentage of pregnant women received 4 ANC	52	46	42	69
Percentage of pregnant women consumed 100 IFA	31	32	22	26
Percentage of institutional delivery	79	71	82	96
Percentage of children breastfed within 1 hour of childbirth	NA	75	84	50
Percentage of children exclusively breastfed for first 6 months	NA	40	50	2
Percentage of 11-23 months with full immunisation	62	47	37	88
Percentage of underweight children	36	30	28	NA*
Percentage of women (20 – 24) married before 18 years	26	31	18	35
Percentage of women using modern methods of family planning	30	39	52	42

Source: *National Family Health Survey, 2015-16, ^ Annual Health Survey 2013-14, # Primary data from Rapid Situational Analysis, Rampur and Chhaygaon 2019

*Only 31 per cent of children interviewed were weighed in the last 3 months.

Study findings reveal the following key issues arising from the above findings.

- More than 15% population from critical vulnerable pockets (inaccessible, tribal, minority population) in these 2 blocks remain unreached from the coverage of the health and nutrition services.
- The population in these pockets those not accessing service could be of a substantive proportion contributing to the low MNCHN data in the Kamrup district.
- High cases of early marriage may lead to early pregnancy, thereby increasing the risk of morbidity and mortality among mother and child.
- Late initiation of breastfeeding (absence of colostrum feeding practise) and absence of exclusive breastfeeding in the first 6 months of the child may lead to increased risk of child morbidity and mortality.

More than 15% population remain unreached in vulnerable areas – that are inaccessible and has more tribal, minority population – by the health and nutrition services. This increases the risk of morbidity and mortality among women and children.

There are gaps in MNCHN coverage, key behaviours and practises in these two blocks which need to be addressed in order to improve the current situation.

3.2. MNCHN behaviour and practice

3.2.1. Antenatal care

Care during pregnancy is an important determinant of the future health status of the mother and child. Thus, it becomes crucial for a would-be mother to follow certain parameters to give birth to a healthy child.

Nutrition during Pregnancy

There is generally very little diversity in dietary intake among the people in the villages of Rampur and Chhaygaon blocks. Most women reported that their daily diet consists of rice, chapati, pulses, vegetable (mainly potato) while egg, fish and meat were taken occasionally. The most preferred food, as reported by married young women was having "*rice and aloo pitika*" (mashed potato) which means a largely carbohydrate diet.

There is generally no change in diet during pregnancy; very few women added milk, meat or '**Horlicks'** to the daily diet. Supplementary food received from the Anganwadi Centre, twice

or thrice during pregnancy, was shared with all members in the household. Some women, however, could not eat certain items as they smelt fish in them which caused nausea. Restriction during pregnancy was found among some women which were mostly on not having banana flower, papaya, sour and chilly food, pineapple, tamarind and non-vegetarian food items.

Antenatal check-up

Awareness about antenatal care was found to be widespread. Antenatal check-up among pregnant women was found to be moderately good as apart from 31% women, all pregnant women have received 4 ANC checkups. Generally, pregnant women prefer to avail health services from Government Health Centres during pregnancy as the services are good and the majority of them can't afford to visit private doctors. However, some of the husbands and almost all mothers-in-law were unaware of the number of ANC checkups taken by the pregnant women. Majority of the mothers have received only one postnatal check-up, barring a few who received 2 check-ups after childbirth.

Anaemia and IFA intake

> **"Anemia is a disease…having vitamin and egg white prevent anemia"**
>
> Husband, 22 years

Almost all married women, husbands and mothers in law were unaware of iron deficiency anaemia. However, awareness of anaemia among young married men was found to be better. As per BPM of Rampur block, the prevalence of anaemia is high, over 60%. Inadequate intake of iron-enriched vegetables plays a major role in iron deficiency. During pregnancy, women avoid these vegetables out of fear of constipation. As per BPM, Chhaygaon block, ***"adolescent girls over 15 years and pregnant women were found to be more anaemic; about 2-3% are severe anaemic (haemoglobin level below 7)".***

There is a wide difference in actual practice and perception of health services officials regarding IFA intake. According to the Block Programme Managers of both the blocks, 70% of pregnant women consume the entire dosage of IFA given to them. Interviews with ANMs revealed that they felt 100% pregnant women consume all IFA tablets. However, the study

found that only 26% married women took iron tablets regularly during pregnancy. Some of the myths for not consuming iron tablets during pregnancy as narrated by married women are given below.

- "I did not take iron tab regularly during pregnancy because I think it will make the baby grow abnormally '', married women.
- Another woman stated that "staying dirty causes anaemia and is cured by eating non-vegetarian food".

3.2.2. Infant and child feeding practices

Malnutrition among children is largely related to feeding practices during infancy and childhood. The feeding practices in the select areas reflect on the malnutrition levels among infants and children.

Breastfeeding practice

Initiation of breastfeeding takes place mostly within 1 hour to 3 hours of childbirth, but exclusive breastfeeding is not at all practised in these communities. Along with breast milk they feed honey, water, cow milk, Lactogen, Horlicks, Cerelac, Nestum and even rice flour during the first six months of the childbirth.

According to the ANMs and ASHAs, 100% of children were exclusively breastfed for the first six months and even water was not given to the baby during the summer season. However, the AWWs of both blocks were aware that water and honey are given to the child in the first six months. Also, the CDPO and BDO of Rampur are cognizant on the ground reality and accept the fact that exclusive breastfeeding is not practised among children below 6 months.

"Exclusive breastfeeding is not practiced by all mothers. They provide honey, water, diluted cow milk and tinned milk to the children below 6 months".

"A common practice found in this region, is that if a child cries, some mothers and almost all mother in laws touch honey dew in the child's lip as the sweet taste enables to stop crying of the child".

CDPO, Rampur

On the contrary, the Supervisors of Chhaygaon block were found to be in denial as they felt that exclusive breastfeeding was religiously followed by all mothers in the villages. Supervisors of Rampur block felt helpless in not being able to convince the mothers on the importance of exclusive breastfeeding during the first 6 months of the child.

"Mothers are exclusively breastfeeding the child and there is no problem of malnutrition". However, when we shared our field experience on exclusive breastfeeding, they opined that, **"such things are not reported to us by the AWWs".**

Supervisors of Chhaygaon

"Though we conduct meetings and distribute leaflets for awareness generation but that doesn't work as the mothers think that giving outside food is good for the child and it is a status symbol also".

Supervisors of Rampur

Complementary Feeding Practice

Complementary feeding starts generally after *Annaprasan*, the first rice eating ceremony that takes place after 11 months. This is late compared to other parts of India where *Annaprasan* generally takes place between the 6-8th month. The ASHAs and AWWs campaign to initiate complementary feeding at six months of the child but it does not yield results. After 6 months of the child, he/she is given all kind of food that is eaten by the household members along with biscuit, chips, Maggie, etc.

"In our village, we do not feed rice till the child completes one year. After six months we feed them (children) breast milk and Britannia biscuit".

FGD with married women, Chhaygaon

Children were given complementary food 3-4 times a day (mostly thrice). Some said children were fed when they felt hungry. Mothers continue breastfeeding their children during this stage. Majority of the mothers and mothers-in-law were not aware of the importance of weaning.

"Complementary feeding starts generally after 11 months, after *Annaprasan*. ASHAs/ AWWs campaigns to start complementary feeding after six months, however, the ritual prohibits performing it earlier".

CDPO, Rampur

3.3. Weighing and identification of malnourished children

Malnutrition among infants and children has a long-lasting effect even when a child grows up. So, arresting severe to moderate malnutrition at an early age is extremely crucial for the wellbeing of any children. The first critical step towards identification of malnourished children is to weigh them, and the study investigated weighing practices in the Integrated Child Development Services Programme (ICDS) in the study area.

3.3.1. Absence of regular weighing and inadequate identification of malnutrition

The percentage of underweight children below 5 years is 14.8% in Chhaygaon block and 11.7% in Rampur block. Regular weighing of children, the most simple but effective way of identifying malnutrition among children, is not done on a regular basis in the villages of these 2 blocks as weighting machines are not available or not functional in a majority of the Anganwadi Centres. Thus, the weighing of children is done only on routine immunization days, which is not done consistently every month. Thus, malnutrition data quality is inconsistent and not reliable.

> **"In most of the centres, weighing machines are malfunctional or not available. Some of the AWWs have bought weighing machine personally for using in the centre. He also pointed out that, there is probability of non-reporting cases of malnourished child to avoid criticism".**
>
> Rampur block CDPO

> **"Generally, weight of children is not taken in the villages as weight machines are not available. The ASHA's have been trained on the use of MUAC tape but they are not effective in identifying malnourished children".**
>
> Nutrition Officer

In the absence of functional weighing machine, the ASHAs were trained to identify malnourished children in the villages by using the Mid-Upper Arm Circumference (MUAC) tape but they are not able to use the tape successfully. Thus, identification of malnourished children happens only when they come to the BPHC for treatment of some ailments or when malnutrition camps are done. This leads to a gap in identification as very few children visit the BPHC and camps are held monthly in one village in the block.

3.3.2. Referral of malnourished children

In the last 1 year, 14 SAM and 43 MAM children visited Chhaygaon BPHC for treatment and 14 SAM and 55 MAM children have been screened in the camps held in the villages. The MAM children are counselled to feed nutritious food and the ASHA's follow up to ensure that they abide by the advice given. SAM children are referred to the Nutrition Rehabilitation Centre (NRC) in Guwahati Medical College (GMC) but families are reluctant to go as one parent must stay with the child for 14 days. This leads to problem where the family has smaller children at home. Moreover, GMC, being far away from these villages poses a problem in transportation of the child and mother. Even if some SAM child receives treatment in the NRC, the malnourishment recurs as the parents are unable to continue similar nutritious food at home.

> **"The SAM children are referred to NRC but as mother and child have to stay in the hospital for 14 days they don't go to the hospital. Even if a SAM child gets treated in the hospital, the problem does not end as they cannot afford to have nutritious food back at home".**
>
> Nutrition Officer, Rampur

Thus, a gap exists in weighing, identification of malnourished children and referral for SAM. Clearly, early identification, home-based management of malnutrition with a change in dietary practice would be most effective in improving the status of children.

3.4. Community mobilization and involvement of VHSNCs and Panchayats

Community mobilization and social behaviour change communication (SBCC) is of utmost importance to bring about changes in behaviour and practices related to maternal and child health and nutrition among the community members at all levels. The study looked into the functioning of Village Health Sanitation and Nutrition Committees (VHSNC) and Panchayat involvement in community mobilisation activities.

3.4.1. Involvement of VHSNCs and Gram Panchayats

The study found that although VHSNCs are formed in the villages, they do not function effectively owing to the absence of clear direction or agenda. Village Health & Nutrition Days (VHND) are observed on a fixed date once a month but neither do they mobilize the community people nor is there any proper monitoring of the activities. The members meet infrequently but Panchayat members, as well as community members, are not involved and plans for community awareness activities are also lacking. Awareness of government schemes related to health and nutrition is limited among VHSCN members, although this is supposed to take place on VHND days. Moreover, understanding of roles and responsibilities of VHSNCs is lacking among ASHA, AWW and ANMs. Thus, although meant to be, VHSNCs do not function as a structured interaction platform for interaction between Panchayats and ASHA, ANM and AWW (AAA).

- **"I do not know much about VHSNC, but my member attends VHND".**
- **"We have no idea of VHSNC. We do not go to the VHND as the ASHA does not call us".**
- **"We would like to work on health and nutrition issues; we need support in identifying issues and developing plans".**

Interviews with Panchayat members

The Panchayats undertake Gram Panchayat Development Plan (GPDP), but it is mostly

focused on rural infrastructure development, such as road construction, renovation of sub-centres and schools etc. Currently, the Panchayats are not involved in any health and nutrition community mobilization activities. However, the Panchayat members opined that they are interested and willing to work on health and nutrition issue, but they need capacity development on the issue and support in developing plans.

The study findings show that

- ✓ **VHSNCs do not function as a structured interaction platform for interaction between Panchayats and ASHA, ANM and AWW (AAA).**
- ✓ **There is huge potential in involving VHSNC and Panchayat members in improving health and nutrition status of the community people. Panchayats are keen to engage in**
- ✓ **Integrating health and nutrition in the GPDP plans will ensure that these issues are addressed by the Panchayats and community in a sustainable way.**

3.5. Health & nutrition service delivery system: gaps and opportunities

The study also attempted to understand the strengths and gaps in public health and nutrition delivery in the study area. This was of importance as several areas in Chhaygaon and Rampur are in hard-to-reach, inaccessible locations. Further, these places become cut-off from services during specific times of the year, such as the monsoons when heavy rainfall occurs, and floods are common.

3.5.1 Infrastructure and supplies

Generally, the study found the infrastructure of the health system is better in comparison to the ICDS system. The roof which generally is made of tin, and floor of most of the Anganwadi Centres (AWC), are found to be in bad condition. Functional toilets and drinking water are also lacking in many of the centres. AWWs reported that during the monsoon, many of the AWCs remain closed due to heavy waterlogging. Lack of functional weighing machine is also a frequent

"In most of the centres, weighing machines are malfunctional or not available. Some of the AWWs have bought weighing machine personally for using in the centre"

CDPO, Rampur

complaint amongst AWWs that hinder them from regular weighing and growth monitoring of children.

"Many of the AWC needs repair as they are in bad condition after the floods."
Rampur CDPO

According to the CDPOs of both Rampur and Chhaygaon, there is a need for renovation of the majority of the AWCs so that services could be offered throughout the year in a child-friendly environment. Further, provisions for functional toilets and proper drinking water facilities are also needed. Out of the 249 AWCs in Rampur Block, 169 are run in own building, 66 in rented building and the remaining 14 in places of makeshift arrangements. Out of the 289 AWCs in Chhaygaon block, 244 are run in own building and 49 in places that are ad-hoc and make-shift and neither owned nor rented.

"There are a lot of AWCs which needs repair and we welcome support in this regard".
Chhaygaon CDPO

3.5.2. The capacity of frontline workers' to reach out to vulnerable unreached communities

Interviews with mothers, mothers-in-law and husbands in the vulnerable pockets, show that frontline workers' (AWW, ASHA, ANM) interaction regarding behavioural practices, social and cultural taboos related to MNCHN remain poor, resulting in low awareness and uptake of recommended practices and consequent malnutrition.

The study found that training programmers for health system staff are more frequent and consistent than the ICDS. However, understanding and capacity on vital issues such as understanding of the role of VHSNCs, targeting vulnerable population, segmented behaviour change communication messaging etc. are lacking among ASHAs and ANMs who

"AWWs need training on practical demonstration…more awareness needs to be done at the village level along with practical demonstration in order to bring about change in behaviour".
CDPO, Rampur

focus on routine work. The capacity of AWWs and Supervisors of the ICDS system also need strengthening, particularly focusing on home-based nutrition practices, growth monitoring and counselling.

"I have received job training and a 5-day training in my 20 years of service. Training is very infrequent, and we want more training on ways to change community eating habits".

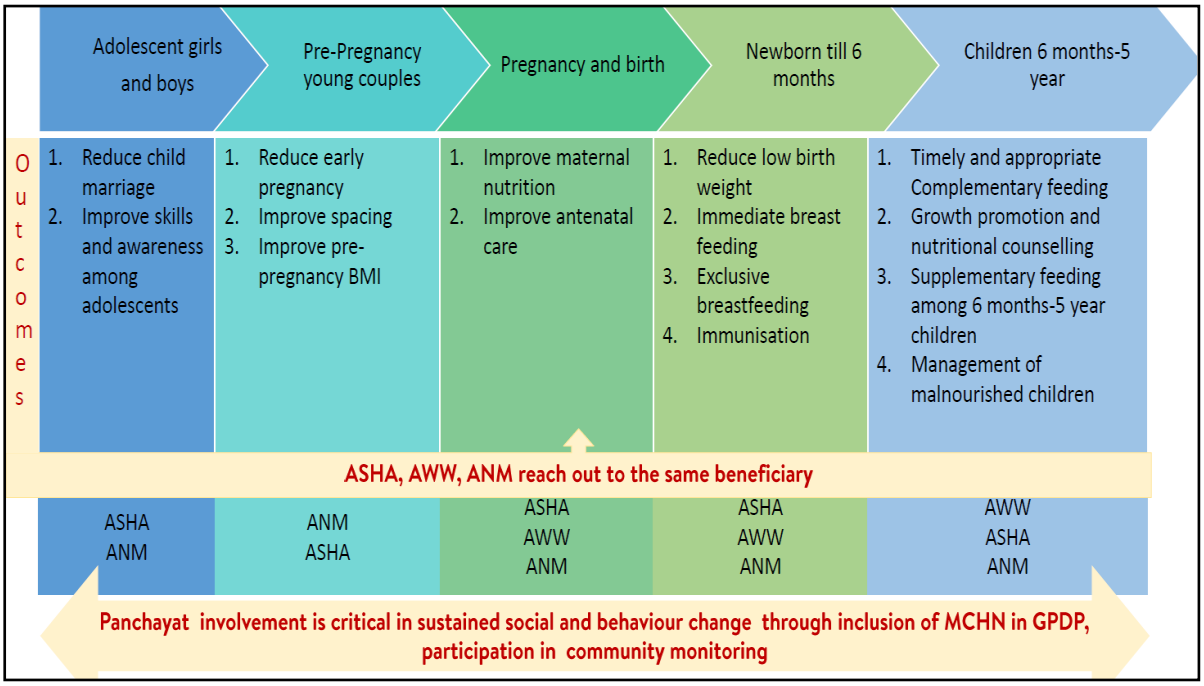
ICDS Supervisor, Chhaygaon

As the three frontline workers, namely, AWWs, ASHAs and ANMs (AAA) reach out to the same group of the target population, capacity building and mentoring of AAA to reach out to the unreached population and manage malnutrition in a convergent manner is essential. Very frequently, AAA is not able to work in a convergent manner to identify and reach out to missed-out and unreached beneficiaries as there is no mechanism for data-sharing between functionaries of different line departments. Excepting national campaigns, such as Polio, block-level convergent communication materials, joint behaviour change campaign strategies and activities are also missing in Assam, unlike other states.

AAA data-sharing and convergent communication platform is much needed to increase targeted outreach for unreached and missed-out population groups.

AAA collaboration along with Panchayat involvement will be critical to developing a sustained social behaviour change communication strategy within the GPDPs (Fig. 2).

Figure 2. Capacity building of AAA and Panchayat involvement is critical to increasing coverage of MNCHN key outcomes to vulnerable, unreached populations



3.5.3. Supportive supervision and quality assurance mechanism

One of the major factors that contribute to improved performance is worker motivation. Lack of supportive supervisory mechanism and performance rewards are often found to be major factors hindering motivation among workers.

The study found that in the health system, there is a system of performance review and recognition involving supervisors. ASHAs are supervised by the Supervisors and the Supervisors in turn report to the Block Community Mobiliser. 8 ASHAs reports to one Supervisor. The BPM consults the ANMs while selecting good performing ASHAs for felicitation. There is a performance review system of the ASHA's based on certain parameters which are done quarterly. Those who perform well are felicitated in the yearly ASHA convention meet.

> ***"3 ASHAs per block are felicitated yearly in the ASHA Convention where they get a trophy and Rs. 3000".***
>
> BPM, Rampur

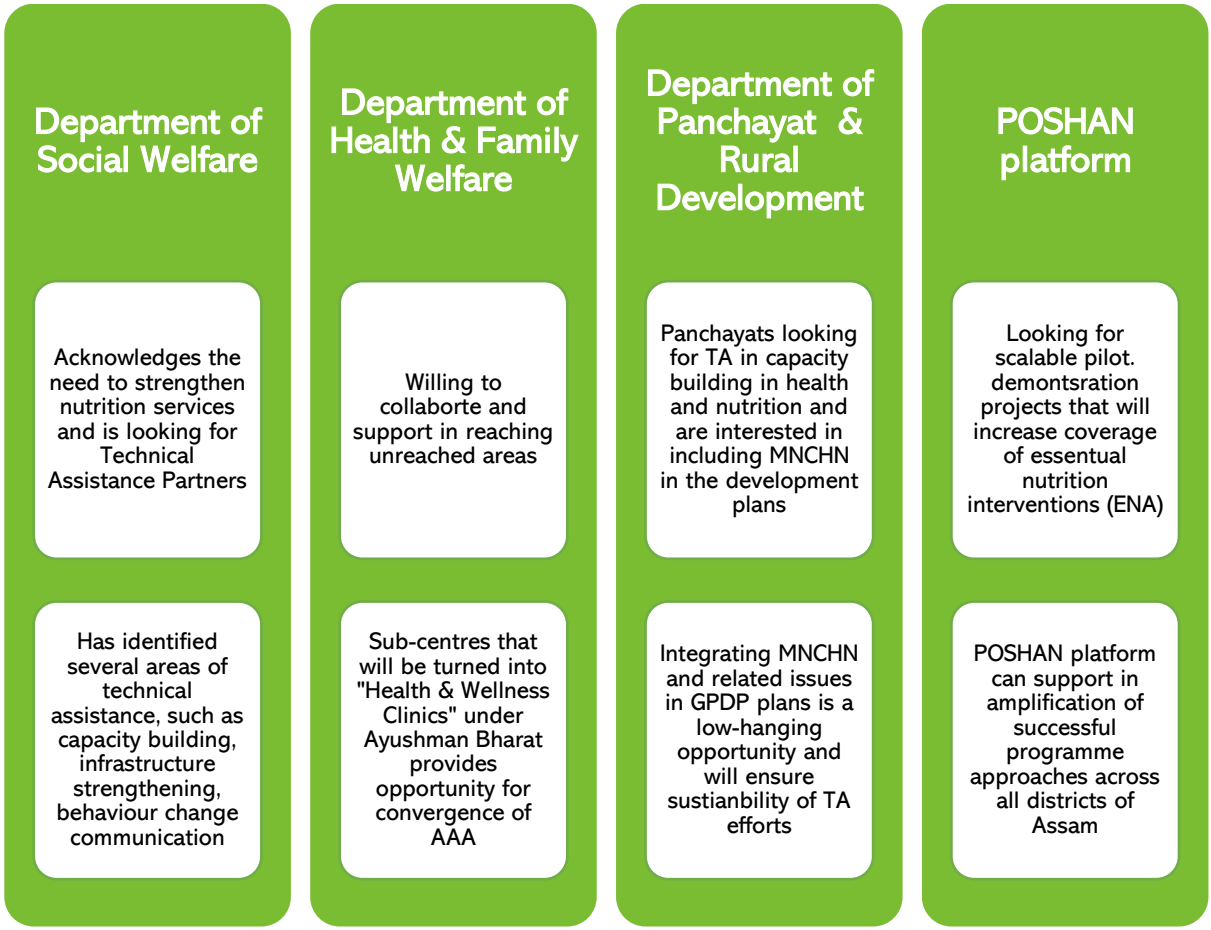
In the ICDS system, however, although Supervisors are in place, field supervision and quality assurance system were found to be inadequate and inconsistent. Further, according to interviews with Supervisors and CDPOs, there is a lack of regular performance review or performance rewards/ recognition system, resulting in low worker motivation in issues related to weighing and growth counselling. Lack of weighing machines exacerbates the problem.

3.5.6. Opportunities for collaboration

Discussions with officials from the Departments of Health & Family Welfare, Social Welfare and Panchayat & Rural Development, as well as POSHAN at the state, district and block levels brought out that there are opportunities for collaboration with the Government system that are planning of ways to reach out their service to the doorstep of the people who are unreached and need the services most. A

summary of need and opportunities for collaboration with the key departments and programmes is provided below (Fig 3).

Fig 3. Opportunities for collaboration and TA to the public system to improve health and nutrition



4. WAY FORWARD

4.1. Conclusions

The study findings demonstrate that in Rampur and Chhaygaon blocks of Rural Kamrup district, communities that are vulnerable and unreached by public health and nutrition services exist, and there is clear need to improve coverage and sustained behaviour change among these unreached vulnerable populations.

- More than 15% of populations in remote, vulnerable areas are not reached by the Health and ICDS programmes, resulting in low coverage of key behaviours and practices.

- Frontline worker (AWW, ASHA, ANM) interaction with vulnerable populations regarding behavioural practices, social and cultural taboos related to MNCHN remain poor, resulting in low awareness and uptake of recommended practices and consequent malnutrition. Training and mentoring of AWW, ASHA and ANM (AAA) to reach out to the unreached population and manage malnutrition in a convergent manner is essential.

- The involvement of Panchayats is currently minimal in any health and nutrition community mobilization activities. However, Panchayat involvement will be critical to developing a sustained social behaviour change communication strategy within the Gram Panchayat Development plans (GPDP).

- Gaps in infrastructure and supplies in the ICDS system as well as inadequate capacity, lack of supportive supervision & performance rewards/ recognition system affect AWW performance in combating malnutrition. Many Anganwadi Centres (AWC's) have major infrastructural gaps that include leaking roof, lack of functional toilets and drinking water facilities, lack of weighing machines. Further, AWWs and Supervisors lack capacity and motivation to address home-based nutrition behaviour, growth monitoring and counselling as well as targeting vulnerable population.

- Key Government Departments, namely, Social Welfare, Health & Family Welfare and Panchayat & Rural Development are open for collaboration for technical assistance in system strengthening of MNCHN services to reach under-served vulnerable populations. Department of Social Welfare is looking for partnerships to strengthen

ICDS service delivery and the POSHAN platform provides an opportunity for amplification of successful approaches across the state. For improved child nutrition, convergence between the AAA and Panchayat is critical.

4.2. Recommendations and way forward

4.2.1. Key recommendations

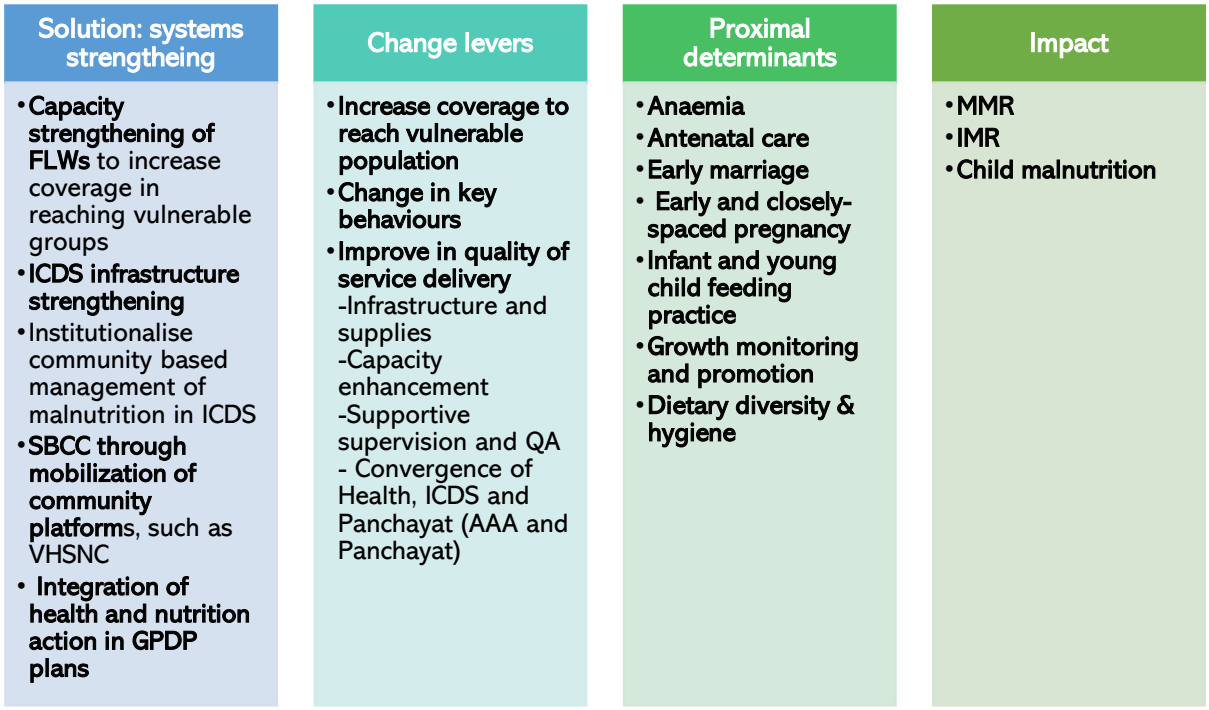
1. **There is a need to improve coverage and sustainable behaviour change among unreached vulnerable populations through**
   - ☑ Supporting strengthening/ creation of mechanisms for convergence of Health, ICDS (AAA) and Panchayat at village, sub-centre and block levels for improved social and behaviour change communication (SBCC)
   - ☑ Strengthen the capacity of AWWs in home-based management of malnourished children and referral of sick children
2. **It is critical to improving the quality of services**
   - ☑ ICDS infrastructure strengthening including ensuring AWC infrastructure to be at per with government-mandated parameters and child-friendly
   - ☑ Capacity enhancement of AAA, particularly through the development of block and district level joint capacity strengthening and supportive supervision mechanism involving ICDS, Health and Panchayat functionaries for improved data sharing, joint planning and action to reach out to unreached, most vulnerable populations
3. **Integration of health and nutrition as a key theme in the *Gram Panchayat Development Plans i*s essential for ensuring sustainability**
   - ☑ Capacity building of Panchayats on MNCHN issues to ensure that Panchayats can understand MNCHN issues in their communities and can include MNCHN issues in yearly GPDP plans
   - ☑ Support in community needs assessment on MNCHN and inclusion of MNCHN and related issues in GPDP plans

4.2.2. Proposed solutions framework and intervention approach

Based on the findings and recommendations, the following solutions framework is being recommended (Fig below), focusing on a few critical change levers that have the potential to improve the delivery of ICDS and Health services to the unreached population and bring about

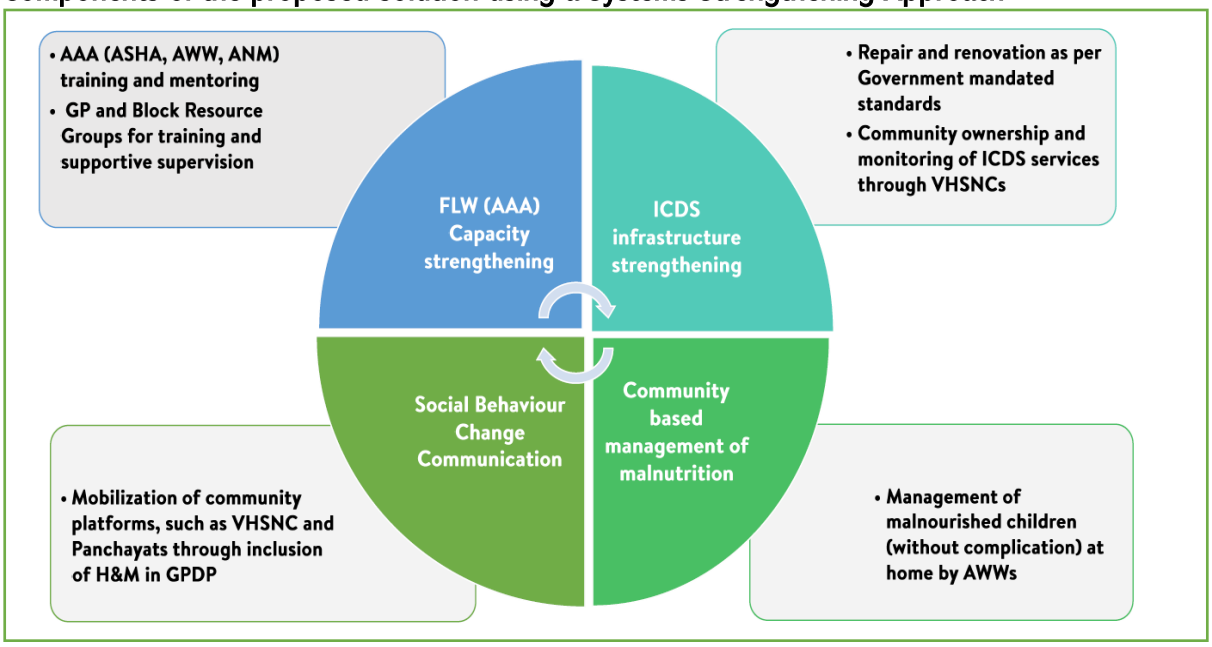
sustained uptake of key practices leading to accelerated improvement in malnutrition and maternal health.

Figure 2: Solutions Framework: the pathway to change



It is recommended that the proposed solution have the following component using a **"Systems Strengthening Approach"** through a formal MOU with the ICDS system so that changes brought about are sustainable and could be easily scaled through the system.

Components of the proposed solution using a Systems Strengthening Approach



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