Baseline Study for ‘Build It Better’ project in Jharkhand: Final Report

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Executive Summary

Save the Children has collaborated with NITI Aayog and Herbalife to support two of the most affected Aspirational Districts (West Singhbhum and Gumla) in Jharkhand to improve the nutritional outcome for all the children and women in the targeted geography by strengthening the ICDS systems and by creating an enabling environment that results in evidence based, sustainable, multi-sectoral nutrition actions delivered at scale. The intervention will strive to achieve the objective of Sustainable Development Goals target of Zero Hunger (SDG-2). Through the intervention of project ***'Build it Better in Jharkhand'***, Save the Children will fortify its endeavour to strengthen the existing health systems and deliver high impact interventions and campaigns, through capacity-building of personnel from the Integrated Child Development Services (ICDS) and Health departments on early screening of undernutrition, anaemia and referral, growth monitoring, counselling, formation and strengthening of Community Action Groups (CAG) and supportive supervision.

In this endeavour a baseline study is commissioned to create a reference for tracking the result level indicators which contribute towards improving nutrition for all children and women as well as generate local evidence and learnings. The baseline study presents the status of coverage of ICDS services and current knowledge and practices of community (mothers and care givers) as well as service provider at institution level regarding child nutrition and integrated WASH. The present nutritional status among children up to 5 years of age (all three parameters of weight-for-age, weight-for-height, and height-for-age) is also captured along with the present status of the implementation of the ICDS in the study areas. A mix method study involving qualitative and quantitative techniques and tools was adopted for this study. Qualitative survey involved group discussions and personal interviews using discussion guides while the quantitative survey involved personal interviews using structured questionnaires.

Major Findings:

Large majority of AWWs i.e., 9 (90 percent) and 7 (70 percent) reported the year of construction of AWC in Ghagra/Gumla and West Singhbhum/Sonua respectively. Majority (80 percent) of the AWCs were housed in a dedicated building (govt. owned), followed by 15 percent which were housed in a private space. Only 5percent AWCs were housed in a govt. building shared with or owned by other entity

Reported status of basic amenities at AWC was as following - electricity was not present in 60 percent of AWCs, hand pump or piped water was not present in 15 percent of AWCs. 40 percent of AWCs reported of not having storage for clean drinking water and toilet. While 70 percent AWCs reported of using kitchen space, inly 10 percent reported using LPG connection for cooking food. Condition of most of these amenities is far from satisfactory wherein the status of usage where the amenities are present was also low. Additionally, 85 percent, 90 percent, 90 percent, 85 percent AWCs respectively reported of using weighing scale for growth monitoring of infants, weighing scale for growth monitoring of children, height measuring scale for growth monitoring, measuring tape for MUAC respectively.

Government of Jharkhand has parked the responsibility of THR to JSLPS. JSLPS in turn has vested this responsibility to block level SHG Federations. Due to administrative bottlenecks, there was no supply of raw grains and pulses from the govt stock to JSLPS identified SHG federations. The supply of THR stopped from Aug 2020 onwards. In the interim, govt advised AWW that they may supply THR by procuring from open market and getting the cost incurred reimbursed later. Since most of the AWW belong to poor households and are not in a position to spend money in advance. Moreover, traders also refused credit to AWWs without any government order or guarantee. Therefore, the THR part of the AWC was only restricted to children aged 3-6 years, wherein reportedly food stock was provided from the Public Distribution System. During the pandemic Anganwadi centre were functional from April-June 2021, only to stop functioning from mid-June onwards. Since the study was conducted in the end of July, and the data reference frame was past one month, therefore all services related to ration except those of providing it to 3-6 years were stopped.

70 percent of AWWs reported that ASHA supports them. While all the AWWs reported that ASHA supports them in assisting in taking weight of children, 93 percent reported that ASHA supports them in mobilizing mother/caregivers. However, only 64 percent of AWW reported of ASHA's support in bringing children to AWC and 43 percent reported their support in assisting in recording measure on growth monitoring chart and taking weight of the children.

85 percent of the AWWs reported of maintaining a home visit planner. All the AWWs reported of visiting the pregnant women/lactating women to counsel them on 'Balanced diet'. 85 percent AWWs reported of counselling pregnant women/ lactating women on the need to identify and consume the ten food groups for dietary diversity, while all the AWWs reported of counselling mothers of 6-35 months' children towards providing food from recommended seven food groups for children. Food group namely Rice/wheat flour for the children aged 6-35 months was recommended by all the AWWs, followed by 80 percent AWWs who recommended food group - Legumes and nuts. While, 75 percent who recommended food group-egg, 65 percent recommended 2 food groups Coloured fruits & Vegetables and Other Fruits & Vegetables.

65 percent of the AWWs reported of always following the habit of washing hands among children at AWC, while 35 percent of the AWWs reported of sometimes following the habit. All the AWWs reported of counselling the families on the importance of clean drinking water and its safe storage. 80 percent of AWWs reported of counselling beneficiary households on water purification process / method/ technique and also regarding setting up of sanitary toilet at home.

70 percent of the AWWs reported that the first check-up of child after birth on should be on the day of the birth, while 20 percent reported within 3 days of the child's birth. All the AWWs reported that mother's milk as the first food that a new-born should receive. Similarly, all AWW reported that a new-born should be fed with the first milk (Colostrum) of the mother. All the AWWs reported that breastfeeding should be initiated immediately after birth/as soon as mother is in position to breastfeed, and that the new-born should be exclusively breastfed for a period of 6 months. Mean age of 13 months as the age, when child should be provided complementary food to being breastfed, was reported by AWWs.

While 55 percent AWWs reported of attending up to 3 training programmes on nutrition in last 2 years, 30 percent reported of not attending any such training. 80 percent of AWWs who received trainings reported the training to be useful followed by 20 percent reported the trainings as very useful.

Of the 9 AWWs which had organized SAM/MAM trainings at their AWCs, 56 percent reported the challenge of low participation and mothers and caregivers, followed by 44 percent which indicate lack of training aids as the challenge. 1 percent reported challenges of time management and lack of finances. All the AWCs organize God Bharai and Annaprasan ceremonies. Few of them also organize events on the eve of suposhan (nutrition) diwas (day), ECC day, and Health Day.

80 percent AWWs reported of being trained to counsel village households on covid 19 in the past year. 90 percent AWWs reported of being trained on hand wash practices for safety measures of Covid 19.

45 percent AWWs reported of having received training for filling / updating all registers. Another 45 percent AWWs reported of having received training for filling / updating some registers. On the difficulty in filling/updating registers, 40 percent AWWs cannot understand all terminologies, 40 percent find it difficult to calculate, while 35 percent reported of facing no difficulties. 85 percent of AWWs reported of a need for training for filling/updating registers.

AWW suggestions to improve AWC services include Timely availability of ration (90 percent), Timely availability of funds (60 percent), Equipment and machineries for service delivery (teaching, training, event organisation, growth monitoring, cooking, better physical infrastructure at AWC (30 percent), Better training for self (35 percent), Equipment for data collection and reporting (computer, calculator, tablets etc.)-(25 percent), Mobility support (Financial or logistics), Enhanced coordination and support from ASHA / ANM

(10 percent), Enhanced support from other dept. staff (health dept., PWD, rural dept., PHED etc.)- (5 percent).

Majority of the study respondents (pregnant, lactating and mothers of children till 72 months of age) belong to the ST community across the study districts/blocks of Gumla/Ghagra (86 percent) and West Singhbhum/Sonua (86 percent). The respondents and their families are primarily engaged in agriculture and allied activities and daily wage labour. 31 percent of respondents reported to being a homemaker and 44 percent reported to be engaged in agriculture and allied activities. Overall, migration of male members (35 percent) was high in comparison to female members of the family. In Gumla/Ghagra migration of male (fathers of the children) members was reported by 42 percent of respondents whereas in West Singhbhum/Sonua it was 27 percent.

More than 90 percent of respondents reported ownership of land and access to electricity. 63 percent of the respondents have a BPL-red card while 16 percent don't own any ration cards. Of those who own any ration card, around 40 percent of them receive ration either fully or partially.

69 percent of respondents are a member of SHG/JLG whereas 26 percent are not a member of any community-based organization. In West Singhbhum/Sonua, membership of SHG was reported by more than 75 percent of respondents.

Majority of the recently delivered women reported of visiting Anganwadi Centre (AWC) during their pregnancy to avail various services. All the respondents in West Singhbhum/Sonua and 88 percent in Gumla/Ghagra reported visiting the AWC. Furthermore, FGD with the community showed that the AWWs also visit the pregnant women in the first trimester and the last trimester, to make them aware of the vaccination schedule. Respondents reported that the major reasons for which the AWW visits them are around advisory on preparedness for birth (34 percent), nutrition and health counselling (42 percent) followed by supplying THR (32 percent).

Respondents in Gumla/Ghagra seemed more aware of the signs of malnutrition in comparison to their counterparts in West Singhbhum/Sonua. 44 percent of women were not aware of signs of malnutrition in West Singhbhum/Sonua while only 4 percent of women were unaware of the signs of malnutrition in Gumla/Ghagra. ICDS officials also confirmed during the interviews that malnutrition and anaemia are rampant among pregnant women and nursing mothers in the study districts/blocks. The practice of early marriage among tribal households often leads to early pregnancy and associated complications, malnourished and weak children.

With respect to 10 food groups to be consumed by pregnant and lactating mothers, pulses (94 percent), cereals/grains white roots and tubers and plantains and dark green leafy vegetables (74 percent) and other vegetables (54 percent) were mentioned by the respondents. Nuts and seeds were mentioned by only 2 percent of respondents. 94 percent of respondents considered the green leafy vegetables a rich source of iron.

68 percent of respondents in Gumla/Ghagra and 52 percent respondents in West Singhbhum/Sonua considered eating different kinds of food to ensure a safe pregnancy. Overall, half of the respondents said that taking adequate rest and sleep is also required for a safe pregnancy. Though, more than 85 percent of women were not aware of the danger signs during pregnancy. Furthermore, none of the recently delivered women interviewed was referred to the nutrition camp during pregnancy.

60 percent of the recently delivered women reported that the AWW advised them on a balanced diet during the pregnancy. 79 percent of the respondents reported being advised by the AWW on exclusive breastfeeding for the first 6 months of the child. 67 percent of respondents reported advice shared by the AWW on the feeding of colostrum in Gumla/Ghagra whereas the percentage dropped to 39 percent in West Singhbhum/Sonua. 86 percent of respondents were informed by the AWW about the vaccination requirements during the pregnancy.

Advice received from the AWW as part of birth preparedness counselling were mainly around breastfeeding (81 percent), keeping the baby warm (57 percent), maintaining cleanliness (72 percent) & nutrition, and institutional delivery (26 percent).

Overall, 60 percent of respondents were aware of the village health, sanitation, and nutrition committee (VHSNC) and only 5 percent heard but did not know about them. Discussion with the community showed that in almost all the intervention villages, VHSNC committees are formed only on paper and members do not know the existence of such committees. In many cases, the AWWs were not aware of such committee as well. Of those who were aware of the VHSNC, 89 percent participated in the meetings and campaigns organised by the VHSNC.

70 percent of respondents in Gumla/Ghagra and 59 percent respondents in West Singhbhum/Sonua were advised exclusive breastfeeding by the AWW, during home visits. 49 percent of respondents were advised about the number of times to feed the child by the AWW. 41 percent of recently delivered respondents said that they started breastfeeding the child immediately within one hour after delivery whereas 51 percent breastfed their child between 1 to 24 hours after delivery. 85 percent of respondents across the districts responded that they didn't give any food other than mother's milk in the first three days after delivery.

Around half of the respondents said that AWW counselled them on seven food groups for their child for balanced growth and dietary diversity. More than 85 percent of mothers started giving solid/semi-solid food to their children at the age of 6-7 months. 88 percent of mothers reported that their child is still breastfed.

25 percent of respondents reported that their child's growth measures were recorded by AWW one to three months ago whereas 19 percent said that it was done within the past one month. 96 percent respondent's child was not referred to any malnutrition camp.

Respondents' access to Iron Folic Acid, Deworming and Vitamin A tablets for children was low in both the study locations. More than 60 percent of mothers across the districts reported that they did not receive IFA tablets for their children. 59 percent of mothers reported not receiving deworming tablets for their child in the last 6 months. Furthermore, 46 percent of mothers reported that their children who are aged over 9 months have not been provided vitamin A tablets in the last 6 months. The mothers reported receiving an average of 72 IFA tablets and 25 calcium tablets. Out of received tablets, they reported to have consumed around 80 percent tablets.

Across the districts, over 70 percent of mothers of 0- 35 months' children pointed to be counselled about exclusive breastfeeding to the child for 6 months. Similarly, 63 percent of the mothers were counselled by the AWW on proportionately reducing dependence on breastfed nutrition for the child beyond the one-year child.

Overall, 60 percent of the respondents mentioned purifying the drinking water. Boiling as a purification method was adopted by majority of respondents - 86 percent in Gumla/Ghagra and 70 percent in West Singhbhum/Sonua.

Overall, 90 percent of respondents reported to washing their hands after using the toilet and more than half of the respondents reported to washing their hands before cooking and more than 80 percent wash their hands before eating the food. Hand washing using soap and water is the dominant method followed by only using water for handwashing on different occasions.

Overall, 67 percent of respondents reported that weakness is the major symptom of anaemia followed by dizziness/ head reeling (40 percent), tired all the time (28 percent), palled face, lips, nails, etc. (27 percent), while 22 percent saying they don't know. Poor or inadequate diet as the cause of anaemia is identified by the 77 percent and 46 percent respondents in Gumla/Ghagra and West Singhbhum/Sonua respectively. 67 percent of respondents reported weakness as a consequence of anaemia. 75 percent of respondents

reported eating nutritious food will prevent Anaemia. 61 percent of respondents reported ORS to be given to the child in case the child is affected by diarrhoea.

Key Recommendations:

Any program which is designed for enhancing health, nutrition and sanitation of pregnant women, nursing mothers and children in the specified tribal villages of Sonua and Ghagra need to undertake interventions which will take into consideration the entire ecosystem and not look at health, nutrition, and sanitation as isolated aspects only. The entire behavioural change needs to be designed keeping in mind livelihoods, social and economic constraints of the households. The interventions should not be restricted only to capacity building of government machinery and beneficiaries but also include handholding and support to integrate social and livelihoods related activities. Households with proper support in their livelihoods and social systems will find it easier to follow health and nutrition related instructions.

The infrastructure bottlenecks in drinking water, toilets, and condition of AWCs bear a direct hindrance and threat to children and women. The program should integrate critical infrastructural support for better implementation. While the dilapidated AWC structures in various villages should be reported and compulsorily avoided, setting up new model AWCs can be undertaken by the project.

Capacity building of VHSNC members should be conducted separately and include topics like technical aspects of WASH, Nutrition and Health, relevant Schemes, and motivational inputs to contribute to the development of the village and community at large. Exposure visits of members to model VHSNCs within and outside the state should be conducted.

The THR systems including the supply chain, quality of inputs, procurement and disbursement systems etc. need to be standardized and streamlined. Advocacy to include all sections of beneficiaries along with necessary gap filling need to be done to enhance community mobilization.

AWWs and ASHA workers need guidance and capacity building in maintaining appropriate anthropometry data of children as well as other technical aspects of women health. Data collection regarding pregnant women, nursing mothers should be a priority area along with identification of various ailments in women and children.

District and Block level coordination and liaison is necessary for smoother and better management of resources at the village level. The program should develop liaison and converge between various departments to effectively utilize and mobilize resources.

Abbreviation

AAY	Antyodaya Anna Yojana
ANC	Antenatal care
ANM	Auxiliary Nursing Midwifery
ASHA	Accredited Social Health Activist
AWW	Anganwadi worker
AWC	Anganwadi Centre
CAG	Community Action Groups
FGD	Focus Group Discussion
ICDS	Integrated Child Development Scheme
IFA	Iron-folic acid
JLG	Joint Liability Group
MAM	Moderate Acute Malnutrition
MTC	Malnutrition Treatment Centres
NRC	Nutritional Rehabilitation Centres
ORS	Oral Rehydration Salts
PHC	Primary Health Centre
PNC	Postnatal care
RDW	Recently Delivered Women
SAM	Severe Acute Malnutrition
SDG	Sustainable Development Goals
SHG	Self-Help Group
THR	Take Home Ration
VHSNC	Village Health, Sanitation and Nutrition committee
VHND	Village Health Nutrition Day

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Background

Save the Children India, Bal Raksha, Bharat (SC) is a leading child rights organization and an independent member of the International Save the Children Alliance, which works to deliver immediate and lasting improvement to children's lives worldwide. Save the Children was founded in 1919 by Eglantyne Jebb, as a response to the condition in Europe immediately following the First World War. Save the Children, a federation of 28 members with similar vision, mission, and values for children, works in more than 120 countries to form a truly international movement for children. The organization is working on 5 core issues which are Child Protection, Education, Poverty and Inclusion, Health and Nutrition and Emergency and DRR. Save the Children works with children, communities, government, and civil society organizations across 12 states and Union Territories as per new strategy for realization of children's rights, particularly in the areas of quality education, protection from abuse and exploitation, health and nutrition, disaster risk management and climate change adaptation and protection in emergency situations and humanitarian crisis.

The state of Jharkhand needs urgent and adequate investment in nutrition. The prevalence of acute child undernutrition (wasting - 29percent) and severe acute child undernutrition (severe wasting- 11.4percent) in Jharkhand is highest in the country while the prevalence of chronic child undernutrition (stunting - 45.3 percent) is third highest in the country after Bihar and Uttar Pradesh. World Bank estimates showed that early nutrition programs can raise adult wages by 5-50percent; children who are stunted are 33 percent less likely to escape poverty as adults and GDP in Asia can be increased by 4-11 percent through reduction of stunting. This clearly shows the investment case for nutrition. Districts like West Singhbhum/Sonua in Jharkhand has a stunting rate of 62percent, one of the highest in the country.

Save the Children has collaborated with NITI Aayog to support two of the most affected Aspirational Districts (West Singhbhum and Gumla) in Jharkhand to improve the nutritional outcomes in the districts. Save the Children will fortify its endeavour to strengthen the existing health systems and deliver high impact interventions and campaigns, through capacity-building of personnel from the Integrated Child Development Services (ICDS) and Health departments on early screening of undernutrition, anaemia and referral, growth monitoring, counselling, formation and strengthening of Community Action Groups (CAG) and supportive supervision.

Save the Children proposes to improve the nutritional outcome for all the children and women in the targeted geography by strengthening the ICDS systems and by creating an enabling environment that results in evidence based, sustainable, multi-sectoral nutrition actions delivered at scale. The intervention will strive to achieve the objective of Sustainable Development Goals target of Zero Hunger (SDG-2).

The proposed strategy will leverage from Save the Children's formal partnership with NITI Aayog. As part of this partnership, Save the Children will provide programmatic and technical assistance to sectoral departments (with specific focus on ICDS) for improving nutritional outcomes in two districts (West Singhbhum/Sonua and Gumla) of Jharkhand. While it will be providing technical assistance at the district level and indirectly influencing the lives of children and their families, the support of Save the Children will also ensure substantial delivery of nutrition services in targeted

geographies (one block of each district) where thousands of children will be reached directly through impactful interventions. The project will focus on bringing systems in place and piloting innovative models in the districts while improving the capacity of systems, partners, and other stakeholders.

1. Study Methodology

'Build it Better' project is undertaking the following activities services in the intervention districts to contribute towards improving nutrition for all children and women by strengthening ICDS service delivery and creating an enabling environment that results in evidence-based, sustainable, multi-sectoral nutrition actions delivered at scale.

- Technical Assistance
- Strengthen existing public nutrition care and capacity building efforts to improve access and quality of nutrition services
- Provide targeted interventions to improve the nutritional status of children through effective social mobilization, care, and counselling (models which can be scaled up to other districts and states)
- Behaviour Change Communication and Campaigns

The baseline study creates a reference for tracking the result level indicators which contribute towards improving nutrition for all children and women as well as generates local evidence and learnings. It presents the status of coverage of ICDS services and current knowledge and practices of community (mothers and care givers) as well as service provider at institution level regarding child nutrition and integrated WASH. The present nutritional status among children up to 6 years of age (all three parameters of weight-for-age, weight-for-height, and height-for-age) is also captured along with the present status of the implementation of the ICDS in the study areas. This will provide evidence to develop a road map for future programming. The study findings will help Save the Children to develop effective Social Behaviour Change Communication Strategy for respective target groups with respect to knowledge and practices of child nutrition care and WASH among care givers and service providers. Based on the findings, the study presents a few recommendations that will be instrumental in bringing the aspired change through the project.

1.1. Objectives

The objectives of this baseline study are as follows.

1. Assess the present nutritional status among children under 6 years of age (all three parameters of weight-for-age, height-for-age, and weight-for-height) in the intervention blocks
2. Assess the status of ICDS service delivery and its coverage in sampled households (provisioning and functional status and quality of services) related to child nutrition (growth monitoring, supplementary nutrition, nutrition and health education, immunization, health check-up and referral services) and integrated WASH in the intervention blocks
3. Understand the knowledge level and practice among mothers and care givers and service providers related to child nutrition care and WASH in the intervention blocks
4. Determine the enablers and barriers both from demand and supply (systems) perspective for improving the coverage and utilization of key child nutrition and integrated WASH interventions in the intervention blocks

5. Provide recommendations to formulate the strategies for an integrated intervention leading to improved knowledge and practices of the target group and strengthening child nutrition and integrated WASH services in the targeted blocks

1.2. Approach

A mix method study involving qualitative and quantitative techniques and tools was adopted for the study. Qualitative survey involved group discussions and personal interviews using discussion guides while the quantitative survey involved personal interviews using structured questionnaires.

The qualitative survey covered the following stakeholders.

1) Anganwadi worker
2) Village Health Sanitation & Nutrition Committee (VHSNC)
3) Home caregivers
4) Key Opinion Leaders (Community leaders) and
5) Block officials

Anganwadi workers were surveyed using a structured questionnaires with scope for enumerative analysis while the rest of the other stakeholders' opinions were mostly captured as anecdotes, experiences, and opinions.

The quantitative survey captured household level data related to Anganwadi and related services. It was decided in consultation with Save the Children team to cover households across the following 3 major segments of service recipients of Anganwadi program.

1) Pregnant mother
2) Children up to 36-month age and
3) Children between 36-month and 72-month age

Mother of the child was identified as the most appropriate respondent at the household level.

1.3. Coverage & Sampling

'Build It Better' is being implemented in Sonua and Ghagra blocks of West Singhbhum and Gumla districts respectively. In these blocks, the extent of coverage of villages under intensive and non-intensive approaches are as follows.

Geographical coverage

District	Block	No. of Gram-panchayats	Intensive villages	Non-intensive villages
West Singhbhum	Sonua	11	20	101
Gumla	Ghagra	20	20	163

The sampling design decided to spread the baseline coverage among at least 25% of the gram-panchayats so that a balanced representation from across the project geography is achieved. In each of these panchayats, an intensive and a non-intensive intervention village were selected so that the comparative socio-economic and cultural settings remain similar during comparison. Thus, the following spread of study locations were arrived.

Geographical coverage of this study

Sample Units	Intervention approach	Block 1 - Ghagra	Block 2 - Sonua
Panchayat		5	5
Villages	Intensive Non-intensive	5 5	5 5
AWC		10	10

Village selection

Anganwadi centre data of the project blocks show that each panchayat has more than five Anganwadi centres. The data also show that each panchayat consists of 3-5 villages with different population strata. The intervention villages of Save the Children also highlighted.

10 villages from each of the 2 blocks will be covered under this study. The project intends to directly intervene in a set of villages in each block and indirectly through training and other activities in the remaining villages. The 10 villages to be covered under this study will represent both direct intervention villages and other villages. It is proposed that 5 direct intervention villages and 5 other villages will be sampled in each block. Thus, a total of 10 intervention villages and 10 other villages will be covered under the study.

5 gram-panchayats have been selected from each block from an alphabetically ordered list. Random selection was done to identify 1 direct intervention and 1 indirect invention village from each gram panchayat using an alphabetically ordered list. These identified study locations (villages) were discussed with the field team and feasibility aspects determined in terms of logistics and extremist activities and suitable replacements were made in 2 cases. The final list of identified gram panchayats and villages is presented in the table below.

Block	Panchayat	Direct intervention villages	Population	Indirect intervention villages	Population
Ghagra	Adar	Adar Bazar Toli	975	Paunri	620
	Chapka	Bahura	661	Dherhauli	393
	Duko	Duko	1165	Peepartoli	695
	Naudiha	Naudiha (Sarna Toli)	766	Gamhariya	1100
	Shivrajpur	Totambi	727	Chechepat	609
Sonua	Asantaliya	Mahalisai	300	Edelbeda	903
	Bari	Bari B	764	Dhundamra	682
	Bhalurongi	Bhalurongi A	950	Sarasposh	370
	Golmunda	Kulundu	756	Vanjira	1267
	Lonjo	Lonjo A	928	Udaipur ‘A’	666

Under this study, 1 Anganwadi centre was covered from each village. Wherever, a village is found to have more than one Anganwadi centre was selected based on feasibility in consultation with the project team. In cases where the footprint of a village institution is spread across multiple Anganwadi centres, discussions with village institutions tried to capture information with respect to the specific Anganwadi centre covered under this study.

Sample distribution

Numerical coverage of samples was driven by the objective to achieve adequate representation covering maximum segments of residents in the project areas. It was decided to cover a total of 400 households to achieve adequate levels of confidence and margin of error statistically. The final sample coverage under the quantitative and qualitative studies were as follows.

Quantitative survey sample	**Block 1 - Ghagra**	**Block 2 - Sonua**	**Total**
Recently delivered women (Mother of 0–6 months child)	25	25	50
Child aged 6 – 36 months)	75	75	150
Child aged 36 – 72 months	105	105	210
AWW	10	10	20

Qualitative survey sample				
Group Discussions	Village Health Sanitation & Nutrition Committee (VHSNC)	5	5	10
	Home caregiver	3	3	6
Interviews	Key Opinion Leaders (Community leaders)	2	2	4
	Block officials	2	2	4

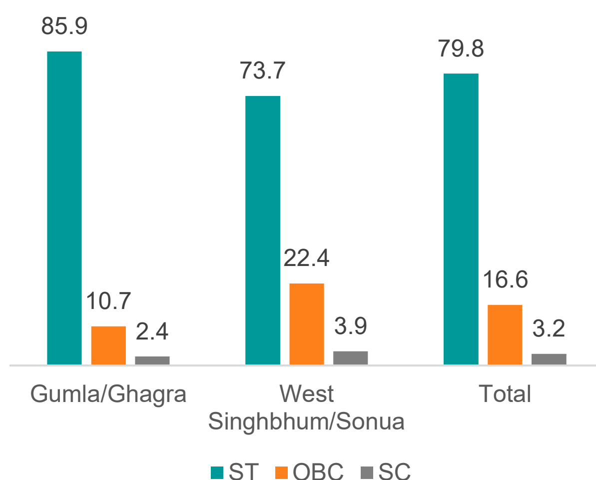
2. Survey Findings

2.1. Socio-economic profile of the target population

This section focuses on the socio-economic profile of the respondents including education, occupation, migration status, ownership of ration card and other amenities of the household.

(a) Social category of the respondents

Figure 1: Caste of the respondents (In percent, n=410)



Overall, nearly 80 percent of the respondents reported that they belong to Scheduled Tribes whereas only 3.2 percent of respondents belonged to the OBC category. 22 percent and 11 percent respondents in West Singhbhum/Sonua and Gumla/Ghagra belonged to the OBC category respectively (See Figure 1). The qualitative findings also indicate that the chosen intervention villages primarily comprise of Scheduled Tribes with *'Ho'* and *'Santhal'* communities dominating the Sonua block while *'Munda'* and *'Santhal'* communities are the major tribal communities in Ghagra.

(b) Education, occupation, and migration status

Figure 2: Occupation of family members of the child (in percent, n=410)

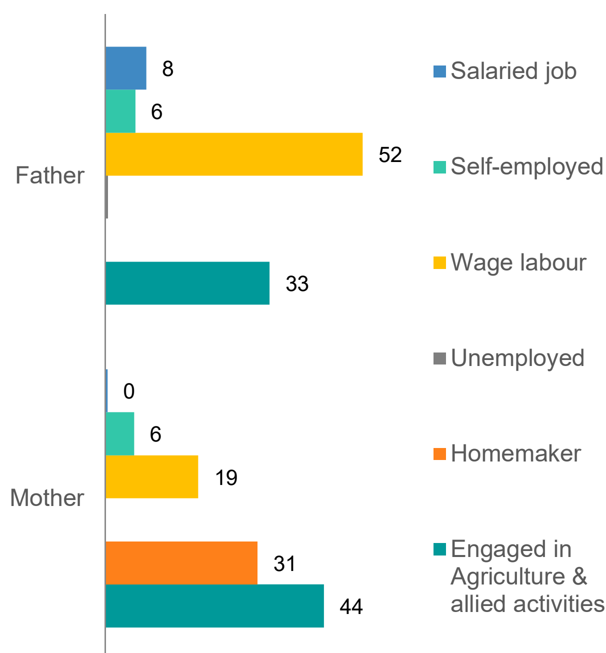
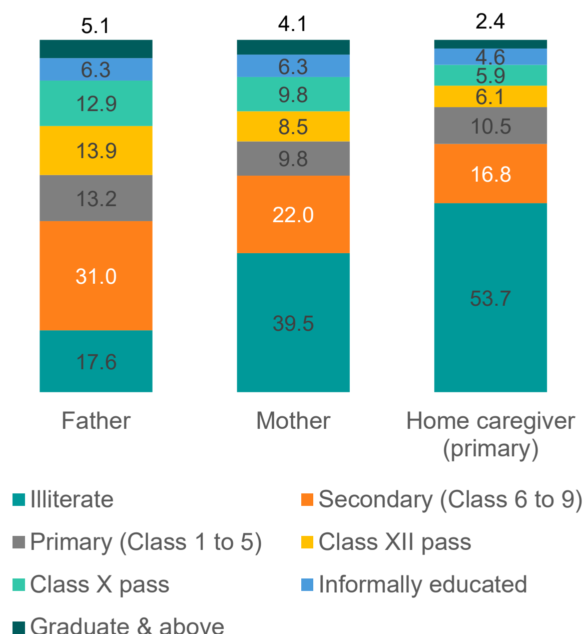
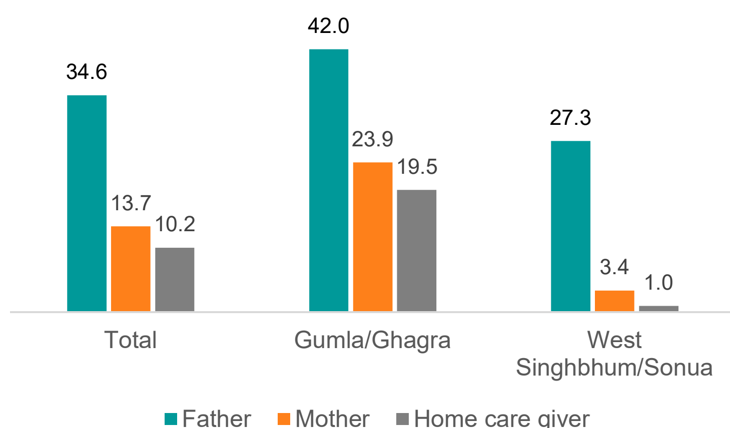


Figure 3: Educational qualification of family members of the child (in percent, n=410)



In total, daily wage labor and agriculture and allied activities were reported as the primary occupation in both the districts. More than 50 percent of respondents reported that the fathers have been working as daily wage laborers. 31 percent mothers were homemakers and 44 percent of mothers engaged in agriculture (See Figure 2). Similarly, 45 percent of primary home caregivers of the child have been engaged in agriculture followed by 24 percent caregivers were reported being the homemaker. The Focus Group Discussion (FGD) with community showed that most of the villagers have their own land and are farmers. Those who do not have their own land are agricultural laborers. Rice and mustard were the main crop cultivated in both the blocks. Maize and vegetables were also grown here.

Figure 4: Migration status of the family members (in percent, n=410)



The largest percentage (40 percent) of mothers are illiterate whereas 22 percent completed their education till secondary. It is also noteworthy that only 4 to 5 percent of the father and mother of the child were graduate and above (See Figure 3).

overall, 35 percent of the respondents reported that the father of the child has migrated to another city or place whereas only 13 percent and 10 percent of respondents mentioned that the mother and primary home caregiver is migrated to another city or place

respectively. Migration in Gumla/Ghagra is higher than in West Singhbhum/Sonua (See Figure 4).

Discussion with community also shows that migration to other states is common among the villagers. Circular migration pattern is evident as the villagers come back during harvesting.

(c) Ownership of household amenities and ration card

Figure 6: Access to electricity (in percent, n=410)

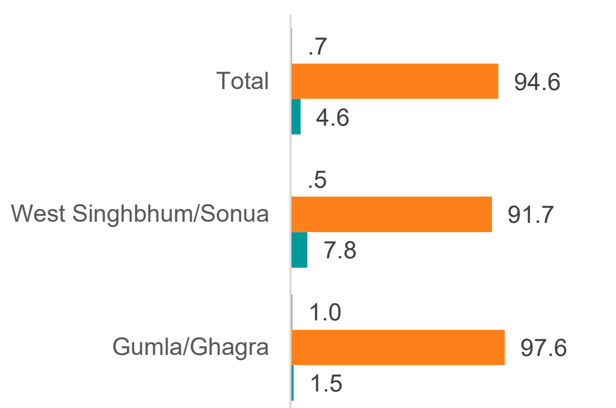
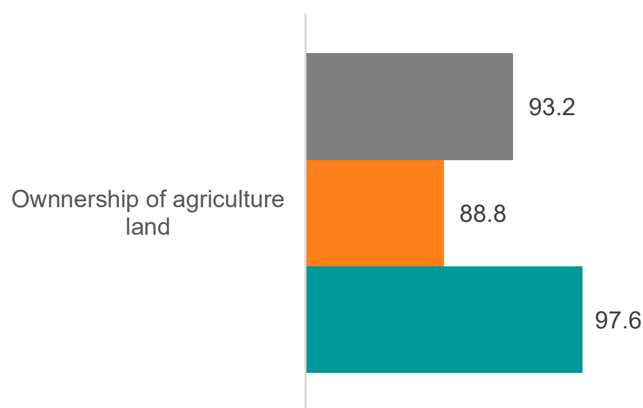


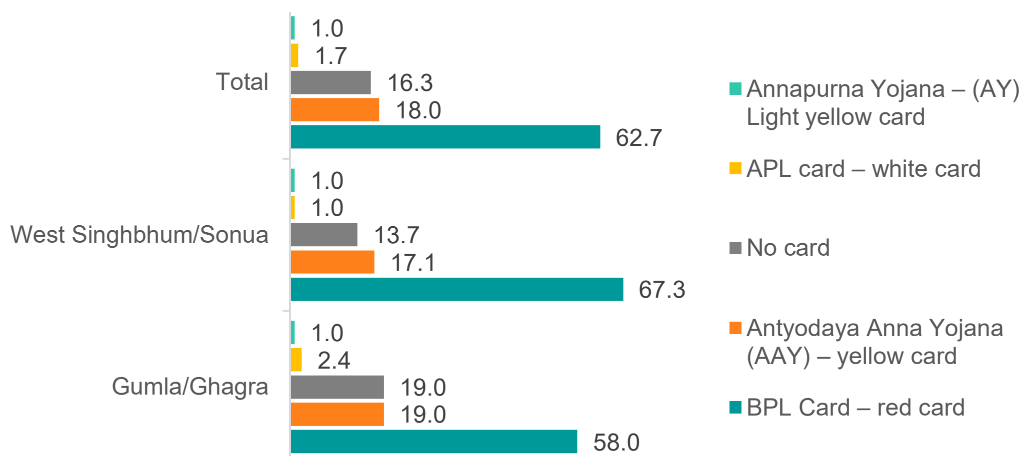
Figure 5: Land ownership (in percent, n=410)



- More than 90 percent of the respondents reported ownership of the land (see Figure 5).
- 95 percent of the HHs have access to electricity i.e., grid power. However, 8 percent respondents of the West Singhbhum/Sonua block didn't have access to electricity at home (See Figure 6).

Ownership of Ration card: Overall, 63 percent of the respondents owned a BPL-red card and 18 percent have Antyodaya Anna Yojana (AAY) whereas 16 percent didn't have any ration card. Only 1 percent of the respondents have Annapurna Yojana cards across the districts (See Figure 7).

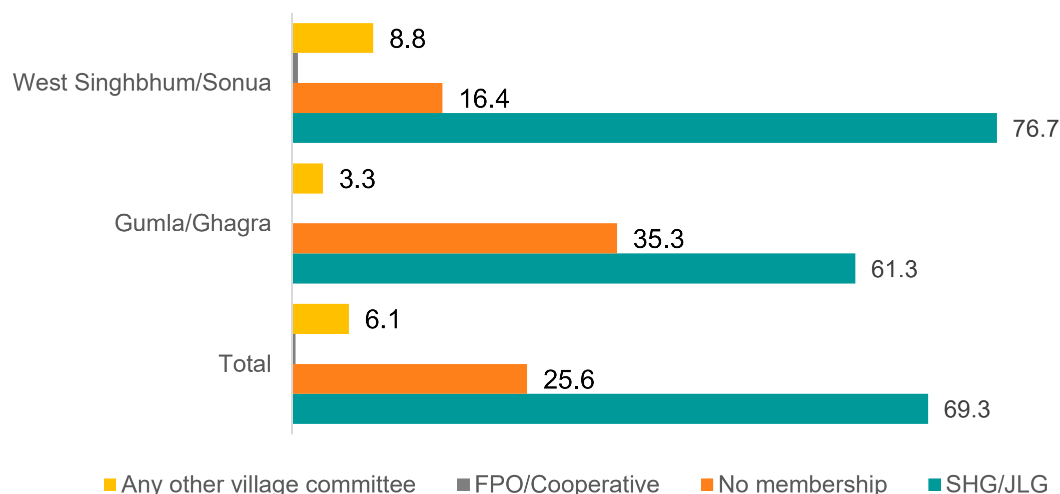
Figure 7: Type of ration card owned by the respondents (in percent, n=410)



Of those who own any of the above cards, 43 percent mentioned that they fully received the monthly ration from PDS, and 40 percent received it partially.17 percent reported no access to ration from PDS (See Table 1 in Annexure I).

(d) Membership of the community-based organization

Figure 8: Membership of any community-based organizations (in percent, n=410)



Membership of SHG or JLG is higher in comparison to other community-based organizations across the districts. 77 percent of respondents pointed to be a member of SHG/JLG in West Singhbhum/Sonua whereas 62 percent of respondents reported being a member of SHG/JLG in Gumla/Ghagra (See Figure 8).

2.2. Nutritional Status of Children (Anthropometric measures)

Table 1: Nutritional Status of Children (Anthropometric Measures)

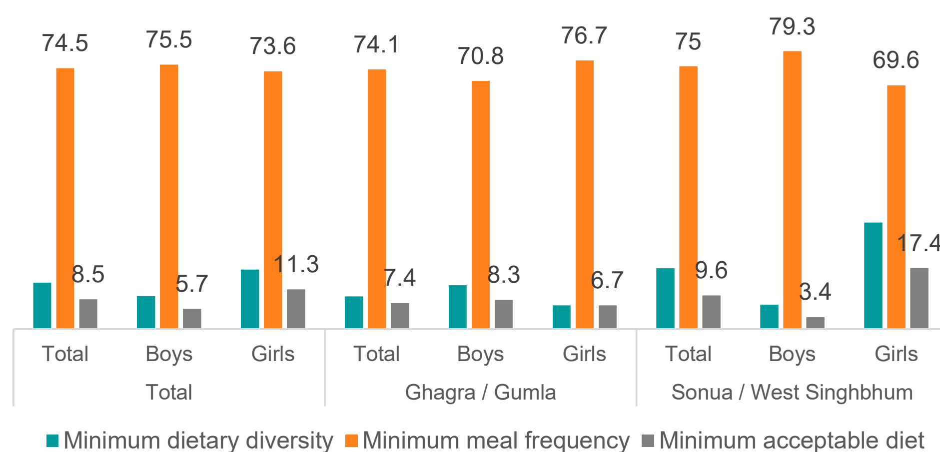
Anthropometric Parameters	Total			Ghagra / Gumla			Sonua / West Singhbhum		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
n	360	190	170	180	93	87	180	97	83
Weight for Age									
Prevalence of moderate underweight	21.60%	18.10%	25.50%	20.80%	20.80%	20.80%	22.40%	15.40%	30.40%
Prevalence of severe underweight	34.80%	33.50%	36.20%	35.60%	31.20%	40.30%	34.00%	35.90%	31.90%
Total Underweight	56.40%	51.60%	61.70%	56.40%	51.90%	61.10%	56.50%	51.30%	62.30%
Height for Age									
Prevalence of moderate stunting	26.40%	21.30%	31.90%	29.50%	23.40%	36.10%	23.10%	19.20%	27.50%
Prevalence of severe stunting	42.20%	43.90%	40.40%	40.90%	41.60%	40.30%	43.50%	46.20%	40.60%
Total Stunting	68.60%	65.20%	72.30%	70.50%	64.90%	76.40%	66.70%	65.40%	68.10%
Weight for Height									
Prevalence of moderate acute malnutrition	10.80%	8.40%	13.60%	12.80%	13.00%	12.50%	8.90%	3.80%	14.70%
Prevalence of severe acute malnutrition	20.70%	19.40%	22.10%	21.50%	18.20%	25.00%	19.90%	20.50%	19.10%
Total Wasting	31.50%	27.70%	35.70%	34.20%	31.20%	37.50%	28.80%	24.40%	33.80%
MUAC									
Prevalence of MAM	9.80%	5.20%	14.90%	8.10%	2.60%	13.90%	11.60%	7.70%	15.90%
Prevalence of SAM	1.00%	0.60%	1.40%	1.30%	0.00%	2.80%	0.70%	1.30%	0.00%
Total MAM and SAM	10.80%	5.80%	16.30%	9.40%	2.60%	16.70%	12.20%	9.00%	15.90%

On the Weight for Age aspect, 56.4 percent of total children were found underweight. While 21.6 percent of children were found to be moderately underweight, 34.8 percent children were found to be severely underweight. Prevalence of underweight was more marked in the case of girls. On Height for Age aspect, 68.6 percent of total children were found stunted. While 26.4 percent of children were found be moderately stunted, 42.2 percent children were severely underweight. Prevalence of severe stunting was more in the case of boys, while the prevalence of moderate stunting was more in the case of girls. On Weight for Height aspect, 31.5 percent children were found to be wasted. While 10.8 percent of children were found to be moderately acute malnutrition, 20.7 percent were found to be severely acute malnutrition. The prevalence was wasting more marked in the case of girls. On the MUAC aspect, 9.8 percent of children were found to be MAM, while 1 percent were found to be SAM. Prevalence of MAM and SAM was more marked in the case of girls.

2.1. Dietary status among children and women (pregnant/ lactating women)

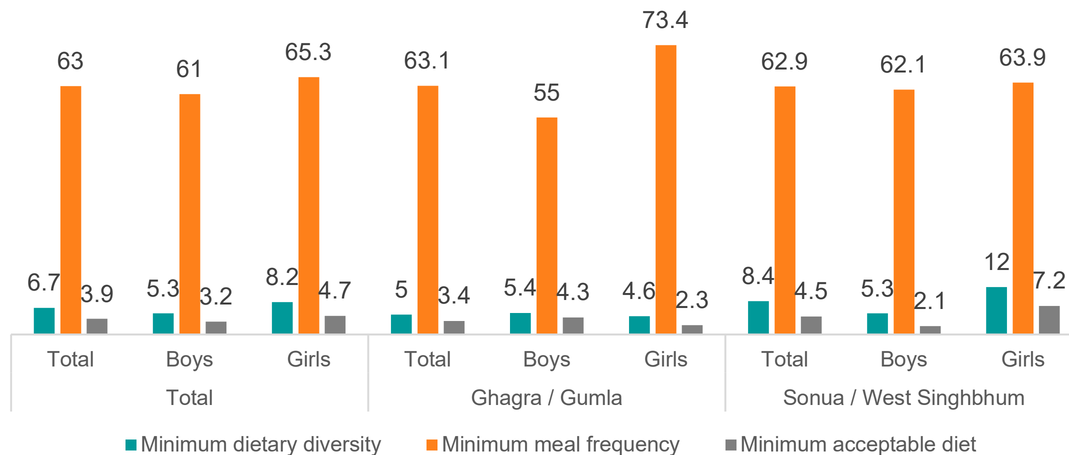
This study looked into the dietary status among children and pregnant & lactating women specifically capturing details related to exclusive breastfeeding up to 6 months of a child's age, minimum dietary diversity, minimum meal frequency and minimum acceptable diet aspects. The findings related the same are presented below.

Figure 9: Dietary status among children aged 6 to 23 months



Around 70% children aged between 6 and 23 months get food as per the desirable and recommended minimum meal frequency. There is no marked difference between boys and girls or among the project districts in this regard.

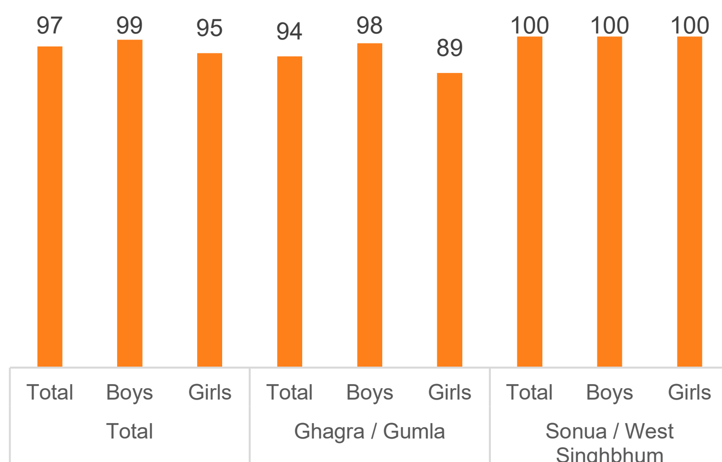
Figure 10: Dietary status among children aged 6 to 60 months



The desirable and recommended minimum meal frequency among children aged between 6 and 60 months lie mostly between 60% and 70% with girls showing a little better availability of number of meals.

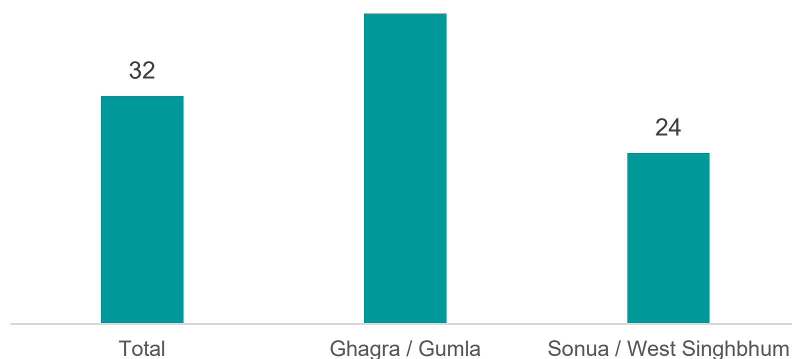
Exclusive breastfeeding up to 6 months of a child's age is a widespread practice in the project areas followed by over 90% of the mothers (See Figure 11). In Sonua, boys and girls were found to be exclusively breastfed up to 6 months by all respondents. However, in Gumla, around 10% mothers of girl child said that they did not follow exclusive breastfeeding up to 6 months of the child's age

Figure 11: Exclusive breastfeeding of children up to 6 months



Significant gaps remain between the recommended and practiced dietary diversity among pregnant and lactating women. Only ¼th of such women were found to have adequate dietary diversity in Sonua while the same was less than ½ the respondents in Ghagra. Overall, just over 30% such women were found to achieve the recommended dietary diversity (See Figure 12).

Figure 12: Women (Mothers) consuming foods from 4 or more food groups - (Percentage of Pregnant / Lactating women)

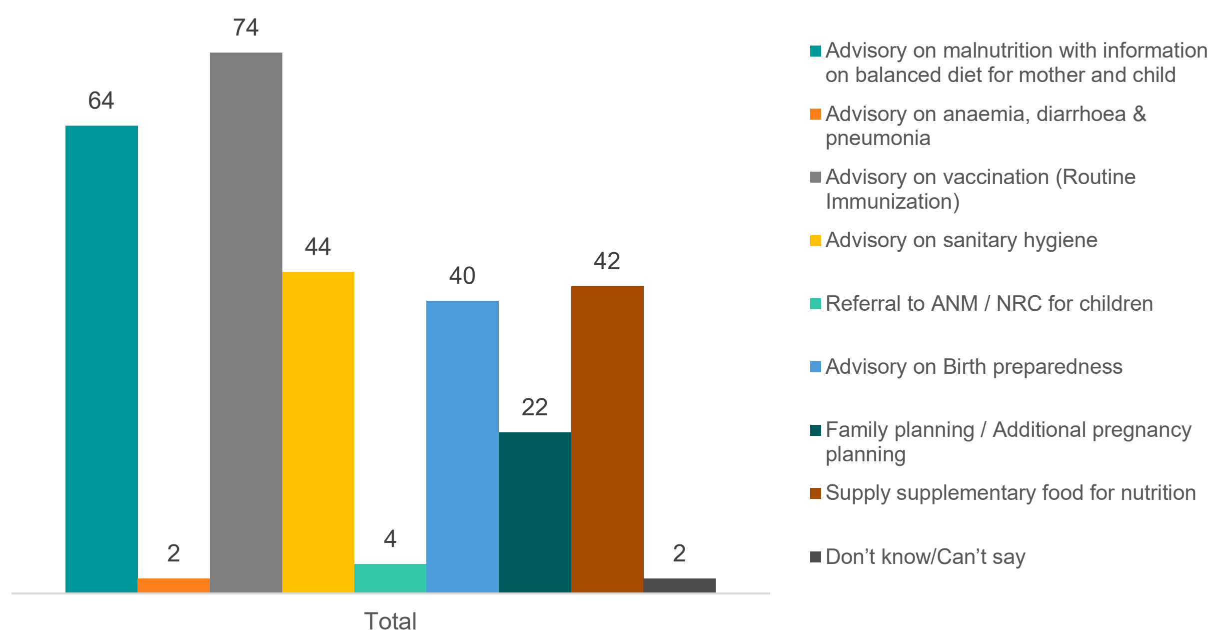


2.2. Nutrition services for women and children under govt. schemes

AWC Services received by recently delivered women: Overall, the respondents received services for advisory on malnutrition with information on balanced diet for mother and child (64 percent), advisory on vaccination (routine immunization) (74 percent) and family planning / additional pregnancy planning (74 percent). Around 40 percent respondents received advisory on sanitary hygiene, advisory on birth preparedness and supply of supplementary food for nutrition.

There is a significant difference between Gumla/Ghagra and West Singhbhum/Sonua with 72 percent and 56 percent respondents reported receiving advisory on malnutrition with information on balanced diet for mother and child by the AWC/AWW respectively. Similarly, 56 percent of respondents in Gumla/Ghagra reported receiving advisory on sanitary hygiene whereas 32 percent of respondents in West Singhbhum/Sonua received this service. Furthermore, only 4 percent of respondents received service of referral to ANM / NRC for children across the districts (See Figure 13).

Figure 13: Various services that are available to the respondent from the AWC / AWW (in percent, n=50)



AWC Services received by mothers of 0-35 month child: Overall, the respondents received services for advisory on malnutrition with information on balanced diet for mother and child (51 percent), advisory on vaccination (routine immunization) (79 percent) and advisory on advisory on vaccination (routine immunization for child) (62 percent).

There is a significant difference between Gumla/Ghagra and West Singhbhum/Sonua with 47 percent and 23 percent respondents reported receiving Take home ration (THR) by the AWC/AWW respectively. Differences can be seen in Table 3 in Annexure I. Gender segregated data presented in Table 4 in Annexure I indicates the mothers of boys have marginally received more services than mothers of girls in both Ghagra and Sonua. The only significant difference can be seen in a higher receipt of THR for mothers of girls in Sonua.

Figure 14: Nutrition services for women and children under govt. schemes - data from mothers of 0-35 month child (Total N=150, G/G=75, S/WS=75) - in percent

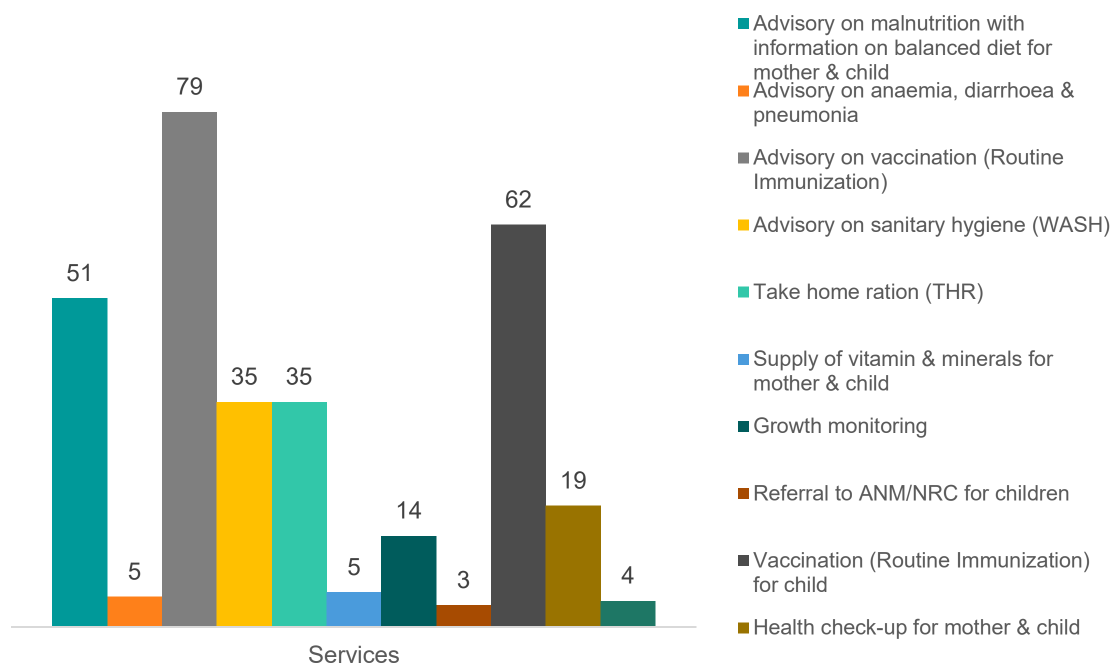
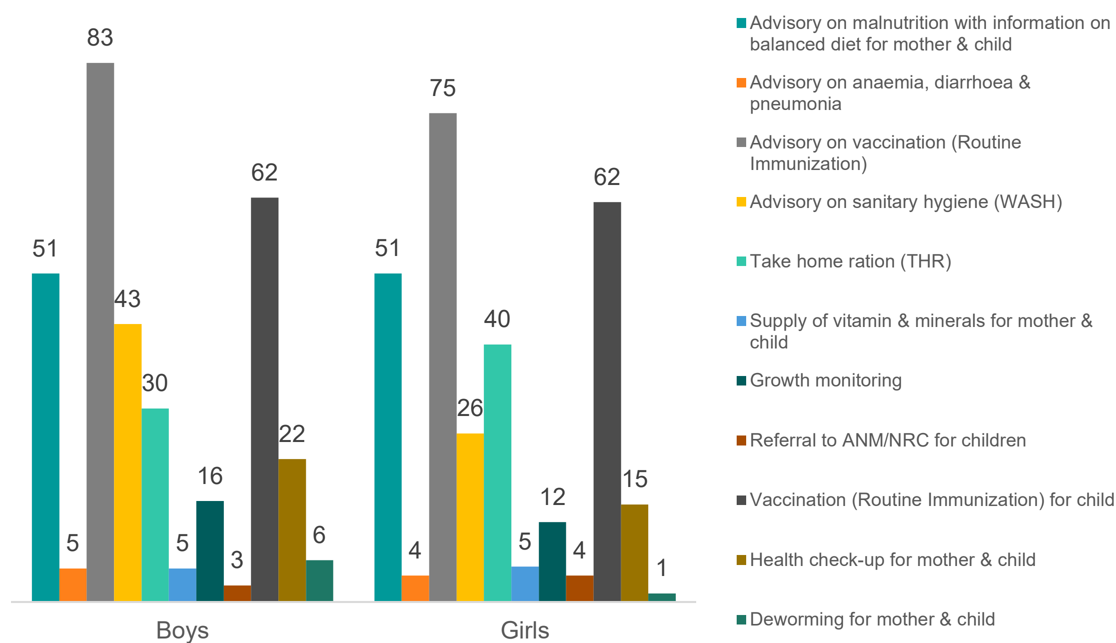


Figure 15: Nutrition services for women and children under govt. schemes - data from mothers of 0-35 month child- Total (N Boys= 77, N Girls= 73); G/G (N Boys= 35, N Girls= 40) S/WS (N Boys= 42, N Girls= 33) – in percent



AWC Services received by mothers of 36-72 month child: Overall, the respondents received services for advisory on malnutrition with information on balanced diet for mother and child (49 percent), advisory on vaccination (routine immunization) (80 percent) and advisory on sanitary hygiene (44 percent).

There is a significant difference between Gumla/Ghagra and West Singhbhum/Sonua with 54 percent and 26 percent respondents reported receiving Take home ration (THR) by the AWC/AWW respectively. Other differences can be seen in Table 5 in Annexure I. While overall, 59 percent mothers of boys reported receiving advisory on sanitary hygiene, it was 40 percent for mother of girls. However, overall gender segregated data presented in Table 6 in Annexure I indicates that receipt of services is marginally better in favour of mothers of boys in Ghagra. In Sonua, the difference is marked in comparison to Ghagra wherein 58 percent of mothers of boys received services for advisory on malnutrition with information on balanced diet for mother and child against 40 percent mothers of girls. However, receipt of THR was reported by 34 percent for mothers of girls against 14 percent by mother of boys in Sonua.

Figure 16: Nutrition services for women and children under govt. schemes - data from mothers of 36-72 month child (Total N=210, G/G=105, S/WS=105) – in percent

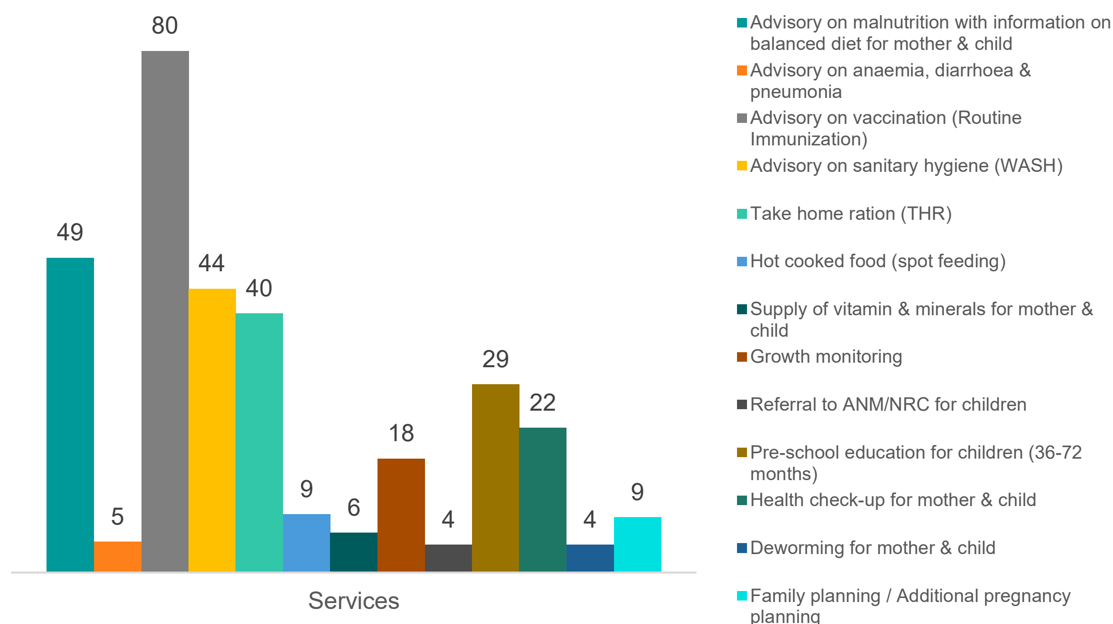
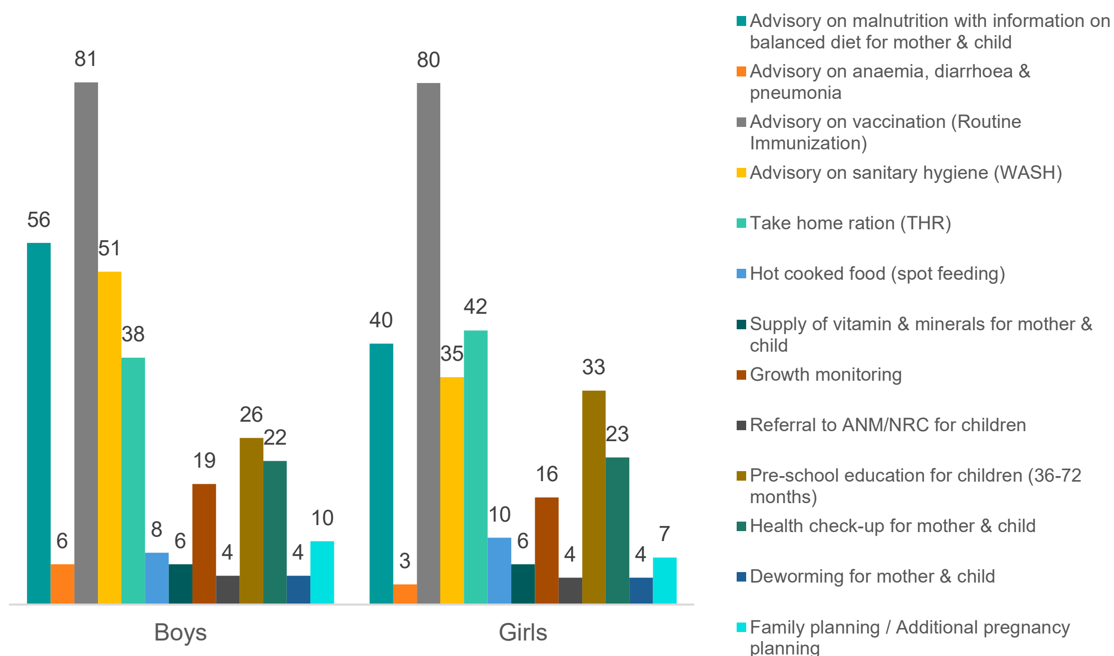


Figure 17: Nutrition services for women and children under govt. schemes - data from mothers of 36-72 month child - Total (N Boys= 113, N Girls= 97); G/G (N Boys= 58, N Girls= 47) S/WS (N Boys= 55, N Girls= 50) – in percent



2.3. Awareness, Knowledge and Practices (AKP) of respondents

2.3.1. AKP of recently delivered women

In this section awareness, knowledge, and practices of recently delivered women around her visits to Anganwadi centre (AWC), reasons for visits, services received from AWC, knowledge of food groups and danger signs during pregnancy have been explored.

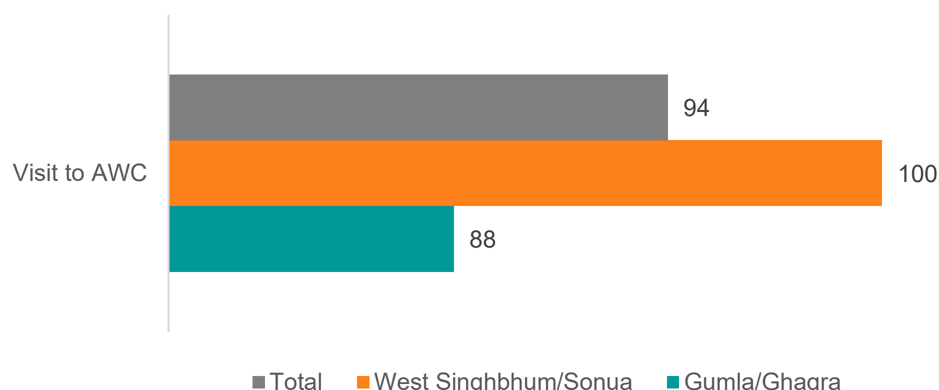
(a) Visits to AWC in connection to pregnancy

All the surveyed recently delivered women of West Singhbhum/Sonua visited AWC during their pregnancy whereas 88 percent respondents of Gumla/Ghagra reported visiting AWC during their pregnancy (See Figure 18).

76 percent respondents of Gumla/Ghagra and 56 percent from West Singhbhum/Sonua reported visiting AWW during the 7th, 8th, and 9th months of their pregnancy (See Table 7 in Annexure I)

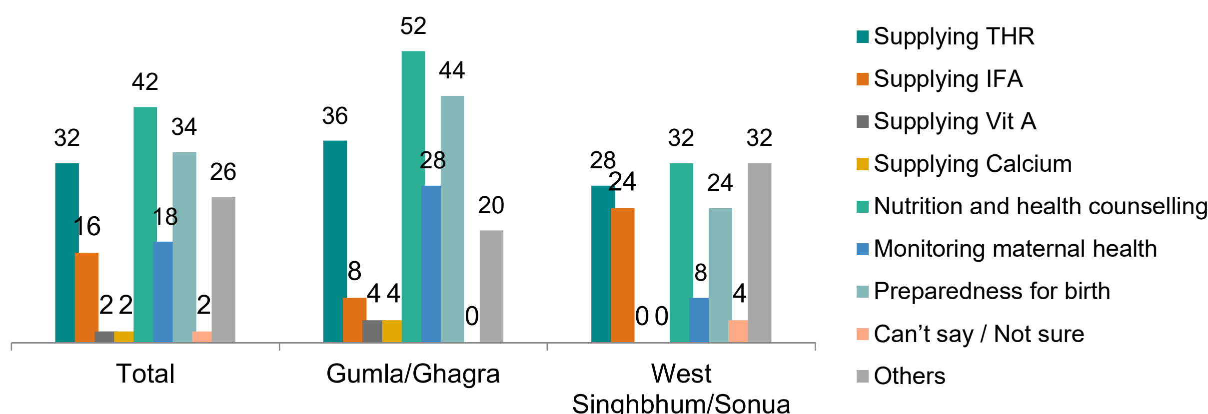
In Ghagra block, focus group discussion with care givers revealed that all the beneficiaries including pregnant and lactating mothers take benefit from the Anganwadi center. They cooperate with awareness and vaccination drive. The AWWs visit the pregnant women in the first trimester and the last trimester and make them aware of the vaccination schedule.

Figure 18: Visits of recently delivered women to the AWC in connection with pregnancy (in percent, n=50)



Reasons for visits made by AWW during pregnancy: Overall, major reasons for which the AWW visits the respondent are advisory on preparedness for birth (34 percent), nutrition and health counselling (42 percent) followed by supplying THR (32 percent). None of the respondents in West Singhbhum/Sonua reported that the AWW visited them to supply vitamin A and calcium tablets. Similarly, in Gumla/Ghagra, only 4 percent of recently delivered women pointed that the AWW visited them to give vitamin A and calcium tablets. Furthermore, 24 percent of respondents in West Singhbhum/Sonua and 8 percent in Gumla/Ghagra mentioned that the AWW visited them to provide the IFA tablets (See Figure 19).

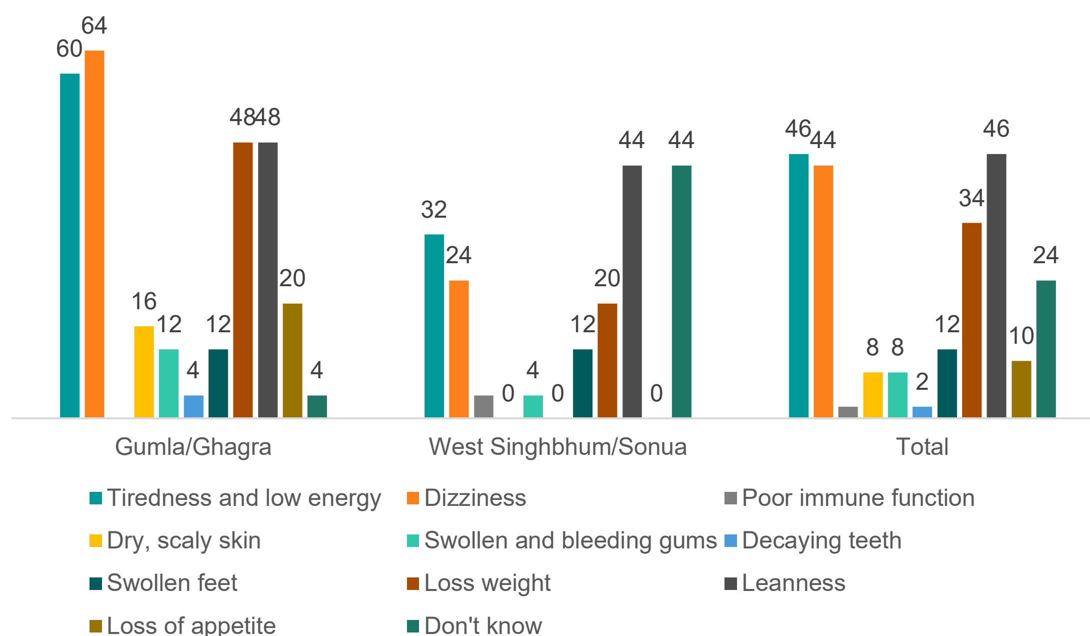
Figure 19: Reasons for visits of AWW (in percent, n=50)



(b) Awareness of malnutrition signs and reasons

Signs of malnutrition: 56 percent of respondents in Gumla and 44 percent in West Singhbhum/Sonua pointed to be advised about malnutrition either by AWW or ASHA Sahyogini. Furthermore, the women in Gumla/Ghagra seemed more aware of the signs of malnutrition in comparison to the women in West Singhbhum/Sonua. It is noteworthy that 44 percent of respondents in West Singhbhum/Sonua did not know any signs of malnutrition (See Figure 20).

Figure 20: Signs of malnutrition reported by the recently delivered women (in percent, n=50)



Reasons for malnutrition: 80 percent of respondents in Gumla/Ghagra opined that not taking grains, roots and tuber can lead to malnutrition whereas only 32 percent of respondents in West Singhbhum/Sonua mentioned that malnutrition can happen due to non-consumption of grains, roots, and tubers. 52 percent

of women in Gumla/Ghagra also said that not taking other fruits and vegetables can cause malnutrition. Again, 44 percent of respondents in West Singhbhum/Sonua were not aware of the causes of malnutrition (See Table 8 in Annexure X).

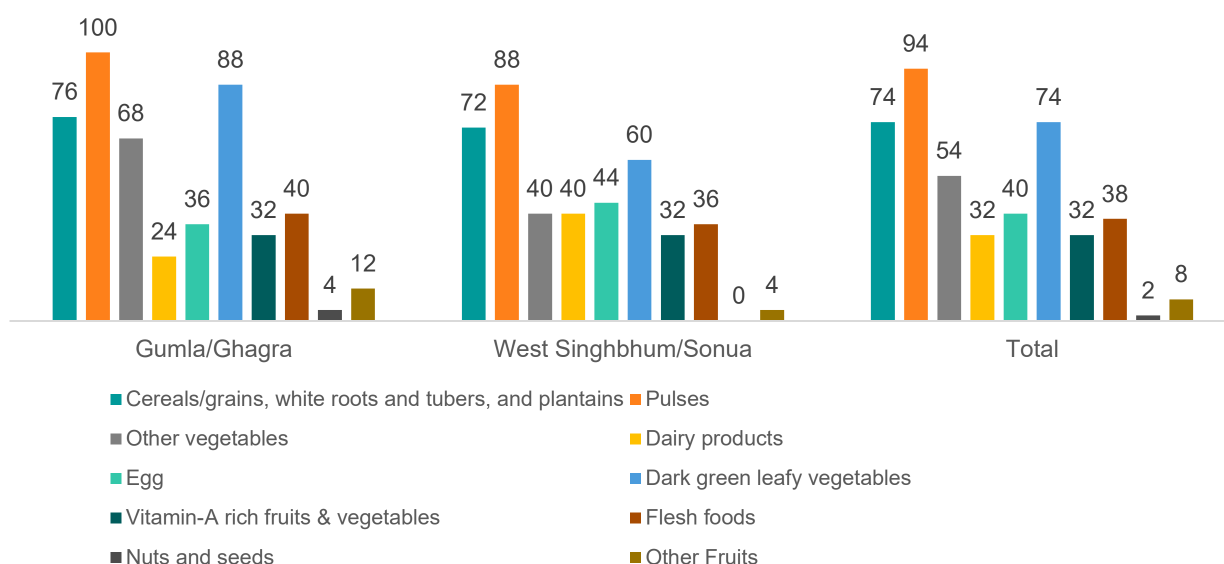
ICDS officials stated during the interviews that malnutrition and anaemia is rampant among pregnant women and nursing mothers but since there is no official communication or schemes associated with mothers, systematic information and data is not captured at the AWC or block level. It was reported that low age of marriage among tribal households often lead to early pregnancy issues and malnourished and weak children.

(c) Education of Food groups

In total, 44 percent of the recently delivered women reported that the AWW educated them on the 10 food groups to be consumed by the pregnant women (See Table 9 in Annexure I).

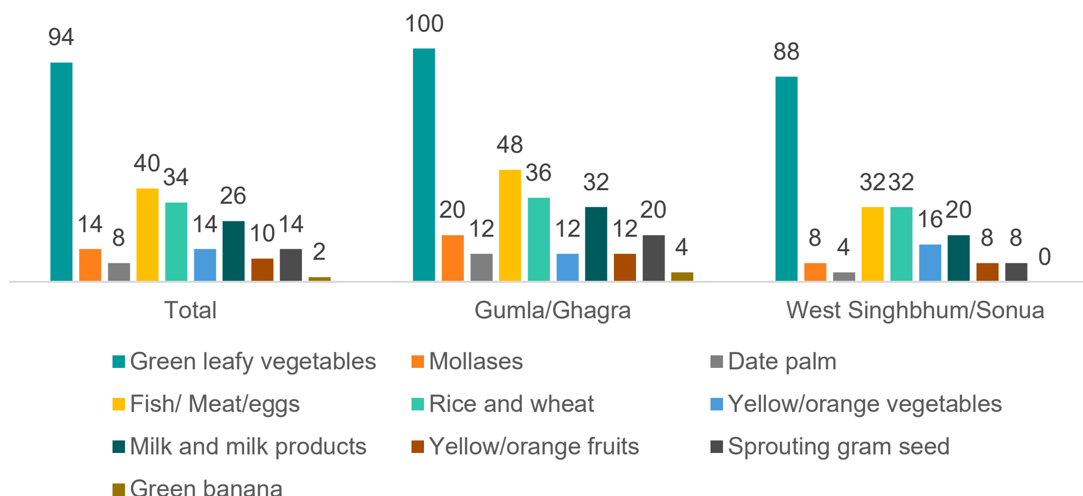
94 percent of them could recall the pulses, 74 percent recalled cereals/grains white roots and tubers, and plantains and dark green leafy vegetables and 54 percent recalled the other vegetables. In comparison to the respondents of West Singhbhum/Sonua, respondents of Gumla/Ghagra were more aware of food groups like cereals/grains, white roots, tubers and plantains, pulses, other vegetables, dark green leafy vegetables, flesh foods, nuts, and seeds (see Figure 21).

Figure 21: Awareness about 10 food groups (in percent, n=50)



<u>Awareness of iron-rich food:</u> Overall, green leafy vegetables are considered a rich source of iron among the respondents (94 percent). Similar to the awareness level of 10 food items, awareness of iron-rich food items among the respondents in Ghagra/Gumla is higher than the respondents in West Singhbhum/Sonua. It can be noted that other than the green leafy vegetables, awareness about other sources of iron is very low across the districts (See Figure 22).

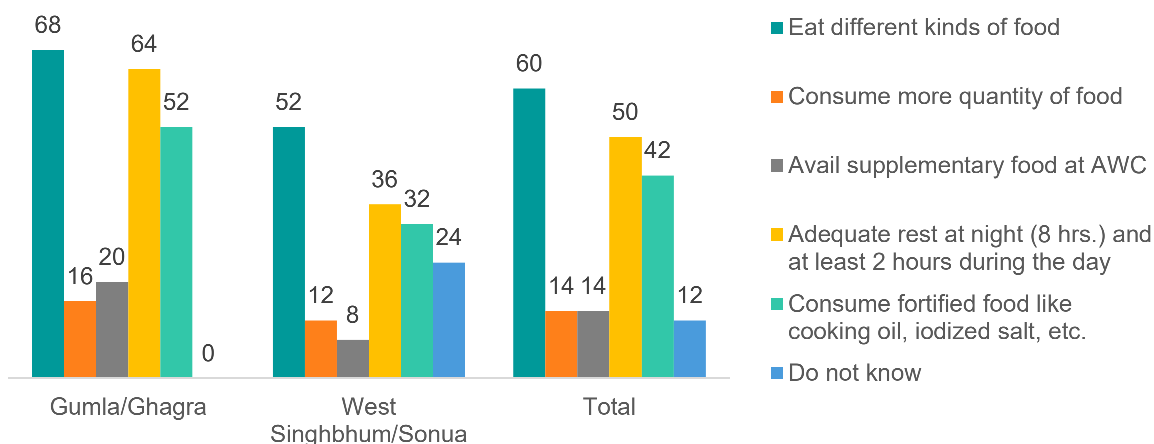
Figure 22: Awareness of food items that are rich in iron (in percent, n=50)



(d) Precautions during pregnancy and signs of danger

Precautions to ensure safe pregnancy: Eating different kinds of food or having a diversified diet (60 percent) and taking adequate 8 hours to sleep at night and at least 2 hours' rest during the day (50 percent) will ensure a safe pregnancy as reported by the recently delivered women. There is a difference in the knowledge level of the respondents between West Singhbhum/Sonua and Gumla/Ghagra. It is noteworthy that only 8 percent of respondents in West Singhbhum/Sonua reported that availing supplementary food at AWC will lead to safe pregnancy whereas 20 percent of respondents in Ghagra/Gumla agreed to the same. Furthermore, in West Singhbhum/Sonua, 24 percent of respondents were not even aware of the precautions to be taken by an expecting mother to ensure safe pregnancy (See Figure 23).

Figure 23: Precautions to be taken by an expecting mother to ensure safe pregnancy (in percent, n=50)



Awareness of danger signs during pregnancy: In total, about 86 percent of respondents were not aware of any danger signs during pregnancy. There is a marginal difference between West Singhbhum/Sonua and

Gumla/Ghagra with 88 percent and 84 percent respondents unaware of the danger signs during pregnancy respectively (See Table 10 in Annexure I).

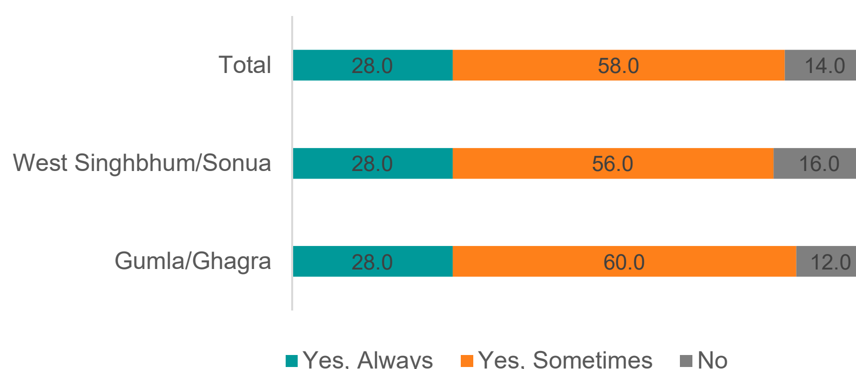
Danger signs during pregnancy: Overall, of the seven, recently delivered women who are aware of danger signs during pregnancy, 86 percent reported bleeding during pregnancy, excessive bleeding during delivery or immediately after delivery. 29 percent also reported that headache, blurring vision, fits and swelling over the body as danger signs during pregnancy (See Table 11 in Annexure I).

Reference to nutrition camp during pregnancy: During health check-ups and growth monitoring, sick or malnourished children, in need of prompt medical attention, are referred to the Primary Health Centre (PHC) or its sub-center. None of the recently delivered women was referred to a nutrition camp (MTC/NRC) for malnutrition during pregnancy (See Table 12 in Annexure I).

(e) Advisory services provided to the recently delivered women

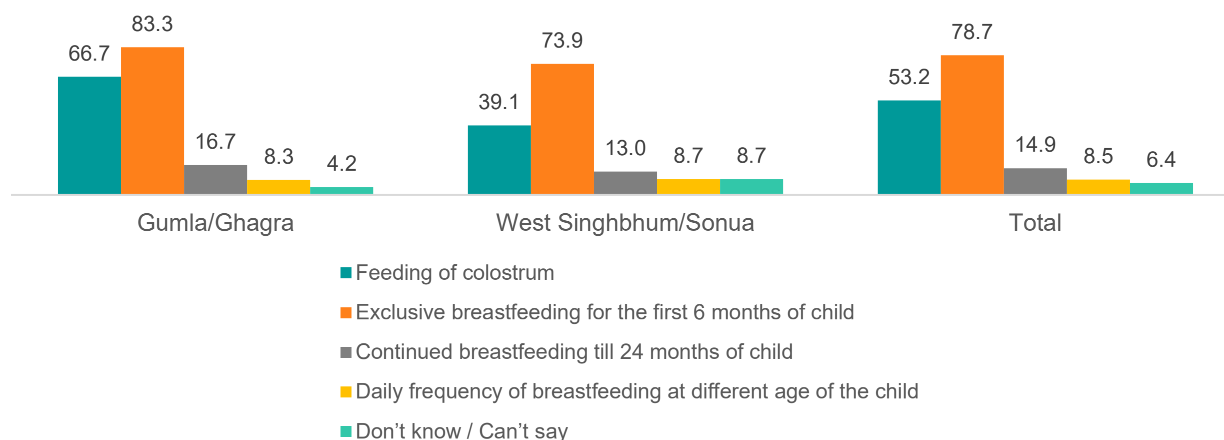
Advisory on balanced diet: In total, 60 percent of the recently delivered women reported being advised on a balanced diet during the pregnancy by the AWW (See Figure 24).

Figure 24: Whether AWW advised on 'Balanced diet during the pregnancy (in percent, n=50)



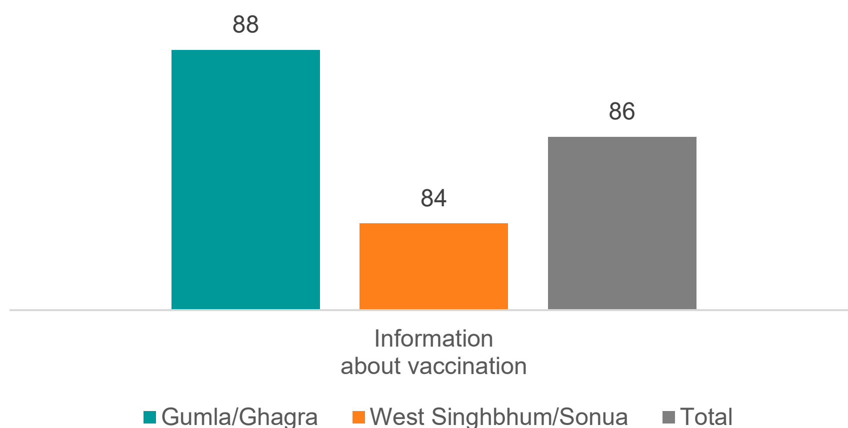
Advice on exclusive breastfeeding: Overall, 79 percent of recently delivered respondents reported that they were advised by the AWW on exclusive breastfeeding for the first 6 months of the child whereas only 9 percent reported being advised on the daily frequency of breastfeeding at different ages of the child. There is a significant difference between West Singhbhum/Sonua and Gumla/Ghagra with 39 percent and 67 percent of respondents reporting advice shared by the AWW on the feeding of colostrum respectively (See Figure 25).

Figure 25: Advice shared by the AWW in context of breastfeeding (in percent, n=50)



Information about the vaccination requirements during your pregnancy: In total, 86 percent of respondents reported that they were informed by the AWW about the vaccination requirements during the pregnancy (See Figure 26). There is a marginal difference between West Singhbhum/Sonua and Gumla/Ghagra with 84 percent and 88 percent of respondents reporting information shared by AWW about the vaccination requirements during the pregnancy respectively.

Figure 26: Whether AWW inform about the vaccination requirements during the pregnancy (in percent, n=50)

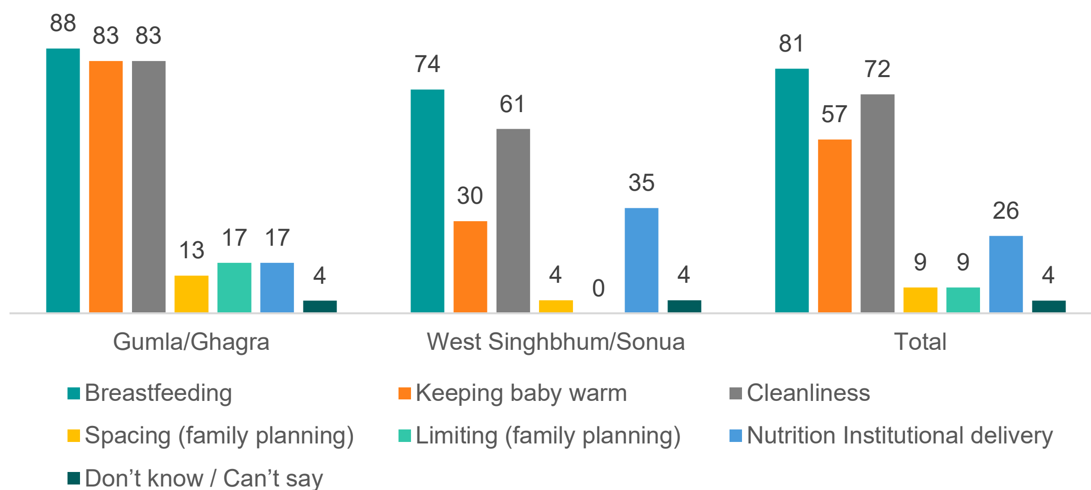


Overall, 74 percent of the respondents mentioned that they got vaccinated twice during their pregnancy. 28 percent of respondents in West Singhbhum/Sonua pointed to be vaccinated thrice whereas only 4 percent of respondents in Gumla/Ghagra reported being vaccinated 3 times (see Table 13 in Annexure I).

Advisory by AWW as part of birth preparedness counselling: More than 80 percent of respondents in Gumla/Ghagra reported that they received advice from AWW on breastfeeding, keeping the baby warm and maintaining cleanliness whereas, in West Singhbhum/Sonua, only 30 percent recently delivered women said that they were advised by the AWW on keeping the baby warm, maintaining cleanliness (61

percent) and breastfeeding (74 percent). Overall, only 9 percent of respondents pointed to be advised on spacing and limiting for family planning (see Figure 27).

Figure 27: Advice received from the AWW as part of birth preparedness counselling (in percent, n=50)



2.3.2. Awareness, Knowledge & Practices of mothers towards child nutrition and care

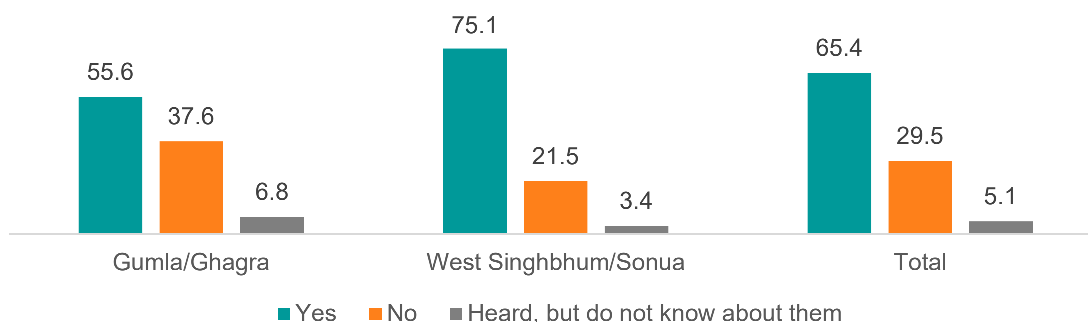
In this section awareness and knowledge of mothers about village health nutrition and sanitation committee (VHSNC), participation, services received by attending meetings organized by VHSNC, food practices, advisory services received by AWW, awareness food groups for the child have been presented.

(a) Awareness, participation, and services received through VHSNC

Awareness of VHSNC: Overall, more than 60 percent of respondents were aware of the village health, sanitation, and nutrition committee (VHSNC) and only 5 percent heard but did not know about them. There is a significant difference between West Singhbhum/Sonua and Gumla/Ghagra with 75 percent and 56 percent of respondents reporting awareness about VHSNC respectively (see Figure 28).

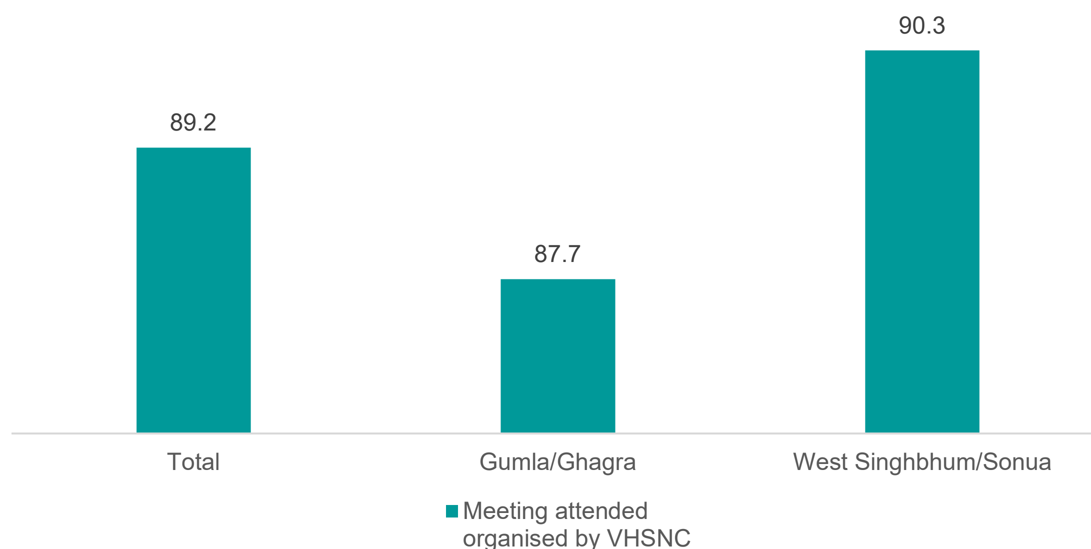
According the CDPO officials, there is a provision of setting up Village Health, Sanitation and Nutrition Committee (VHSNC) at the village level. Since the payment of ASHA workers are linked to the formation and meeting of this committee at regular intervals, there are registers with minutes of meetings and signatures of VHSNC members which are regularly submitted at the block level. However, in almost all the intervention villages, such committees were formed only on paper and members did not know the existence of such committees. In many cases the AWWs were not aware of such committee as well.

Figure 28: Awareness of the Village Health, Sanitation and Nutrition Committee (VHSNC) (in percent, n=410)



Participation in VHSNC: Overall, of those who were aware of the VHSNC, 89 percent of respondents said that they participated in meetings or campaigns organized by VHSNC. There is no significant difference between West Singhbhum/Sonua and Gumla/Ghagra with 90 percent and 88 percent of respondents reporting participation in meetings or campaigns organized by VHSNC respectively (See Figure 29).

Figure 29: Whether participated in any meeting or campaign organized by VHSNC (in percent, n=268)



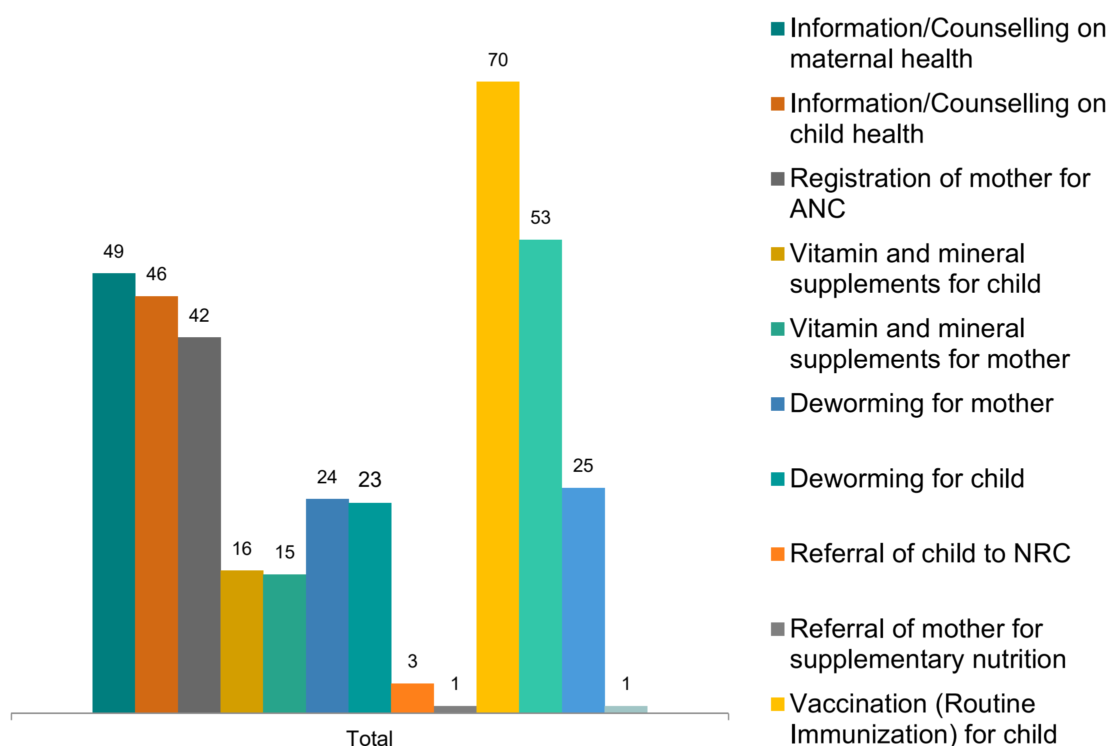
Discussion with various village level key opinion leaders revealed that members do not get compensated in any form in participating in the VHSNCs and thus there is no motivation for them to attend the meetings. It was also reported by a few ASHA workers that any new committee formed by the government will just add another register to be maintained but actually the same meeting will be referred to by different names.

Services received by participating in meeting or campaign organized by the VHSNC: Overall, the respondents received services for routine immunization for the child (70 percent), health check-ups (53 percent), information or counselling on maternal health (49 percent), information or counselling on child health (46 percent) and registration of mother for ANC (42 percent) (See Figure 30).

There is a significant difference between Gumla/Ghagra and West Singhbhum/Sonua with 60 percent and 41 percent respondents reported receiving services on information or counselling on maternal health by participating in meeting organized by VHSNC respectively. Similarly, 25 percent of respondents in Gumla/Ghagra reported receiving vitamin and mineral supplements for child whereas only 9 percent of respondents in West Singhbhum/Sonua said that they received this service by participating in meetings or campaigns organized by the VHSNC. Furthermore, around 70 percent of respondents received routine immunization for their child across the districts.

During FGDs, the VHSNC members informed that the VHSNC maintains records of expecting mothers, lactating mothers, and other beneficiaries. The key role and responsibilities of VHSNC are looking after the cleanliness of village, spreading awareness about malaria, Covid and other diseases, helping ASHA & ANMs, guiding the beneficiaries to avail benefits from the AWCs, helping to conduct weekly VHND events, conducting monthly events and distribution of THR.

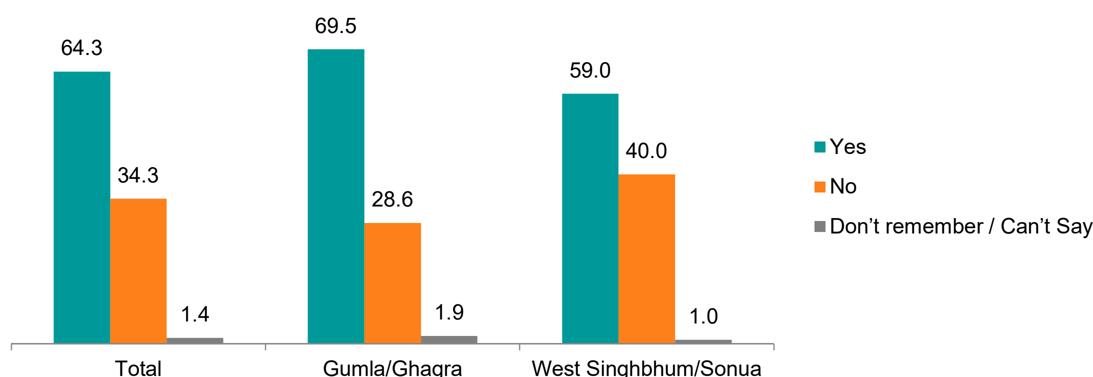
Figure 30: Services received by participating in meeting or campaign organized by the VHSNC (in percent, n=243)



(b) Advisory services provided to the mothers

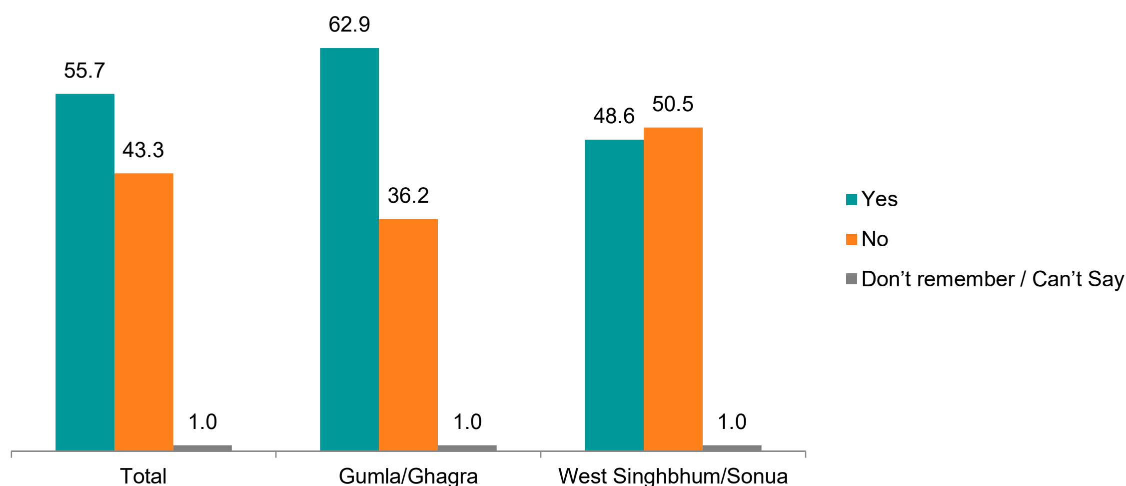
Advisory by AWW about exclusive breastfeeding: In total, 64 percent of mothers pointed to be advised by the AWW about exclusive breastfeeding during visits. 70 percent of respondents in Gumla/Ghagra responded that they were advised about exclusive breastfeeding during visits made by the AWW. The percentage goes down to 59 percent in West Singhbhum/Sonua (See Figure 31).

Figure 31: Whether AWW advised about exclusive breastfeeding during her visits (in percent, n=210)



Counselling of mothers about the frequency of feeding the child: 63 percent of respondents in Gumla/Ghagra reported that the AWW advised them about the frequency of feeding the baby whereas in West Singhbhum/Sonua 49 percent of mothers mentioned receiving advice from the AWW on the frequency of feeding the child (See Figure 32).

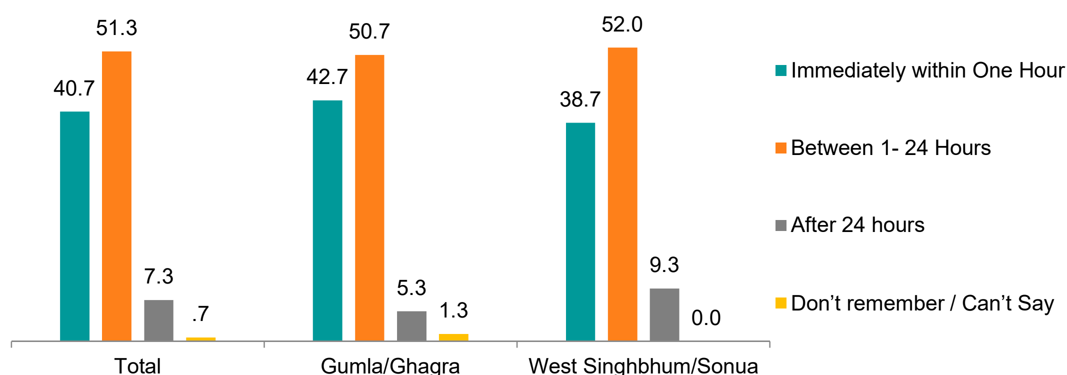
Figure 32: Whether AWW advised about the number of times to feed during her visits (in percent, n=210)



Counselling of mothers about balancing breastfeeding and complementary food after 6 months: 66 percent of respondents in Gumla/Ghagra responded that they were counselled by the AWW during her visits about the balance of breastfeeding and complementary food to be provided after 6 months. The percentage goes down to 49 percent in West Singhbhum/Sonua (See Table 14 in Annexure I).

Start of breastfeeding the child after delivery: Overall, 41 percent of recently delivered respondents pointed to start breastfeeding the child immediately within one hour after delivery whereas 51 percent said that they breastfed their child between 1 to 24 hours after delivery (See Figure 33).

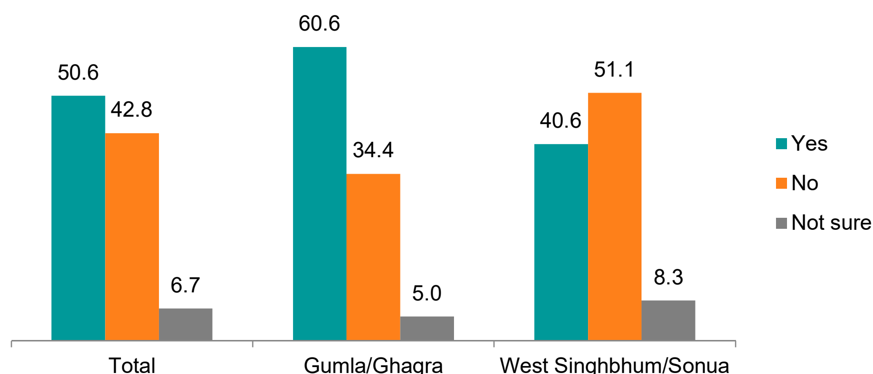
Figure 33: The respondent started breast feeding the child after delivery (in percent, n=150)



Counselling on seven food groups for the child for balanced growth and dietary diversity: Overall, 51 percent of respondents said that AWW counselled them on seven food groups for their child for balanced growth and dietary diversity. There is a significant difference between West Singhbhum/Sonua and Gumla/Ghagra

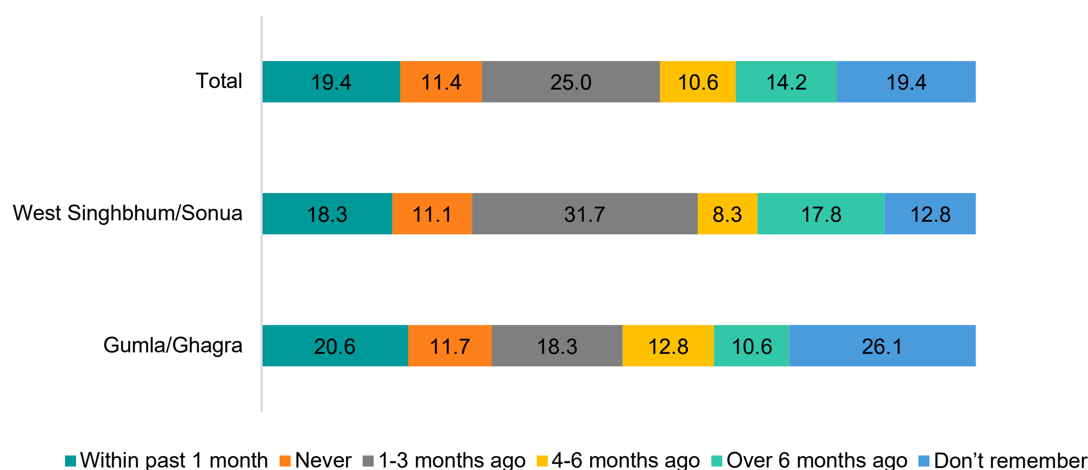
with 41 percent and 61 percent respondents reporting counselling by AWW on seven food groups for balanced growth and dietary diversity of their child respectively (See Figure 34).

Figure 34: Whether AWW counsel the respondent on seven food groups for their child for balanced growth and dietary diversity (in percent, n=360)



<u>Recording growth monitoring:</u> Growth Monitoring and nutrition surveillance are two important activities that are undertaken under ICDS. Overall, 25 percent of respondents reported that their child's growth measures were recorded by AWW one to three months ago whereas 19 percent said that it was done within the past one month. There is a significant difference in West Singhbhum/Sonua and Gumla/Ghagra with 32 percent and 18 percent respondents reported recording child's growth measures 1-3 months ago. More than 10 percent of respondents said that it was never measured by the AWW across the districts. It is also noteworthy that 26 percent of respondents in Gumla/Ghagra could not even recall the time of the event (See Figure 35).

Figure 35: Last time when the child's growth measures were recorded by AWW (in percent, n=360)



40 to 42 percent of respondents in West Singhbhum/Sonua and Gumla/Ghagra respectively said that their child was in the green category in the growth chart while monitoring of growth by the AWW.

Overall, 45 percent could not remember in which category was their child in the growth chart.

96 percent of respondents said that their child was not referred to any malnutrition camp (See Table 10 in Annexure I). According to the CDPOs of Sonua and Ghagra, twenty-five children were referred to MTC in Sonua whereas no child was referred to MTC in Ghagra. They pointed out that mothers were reluctant to part with their children and send them to MTC for treatment.

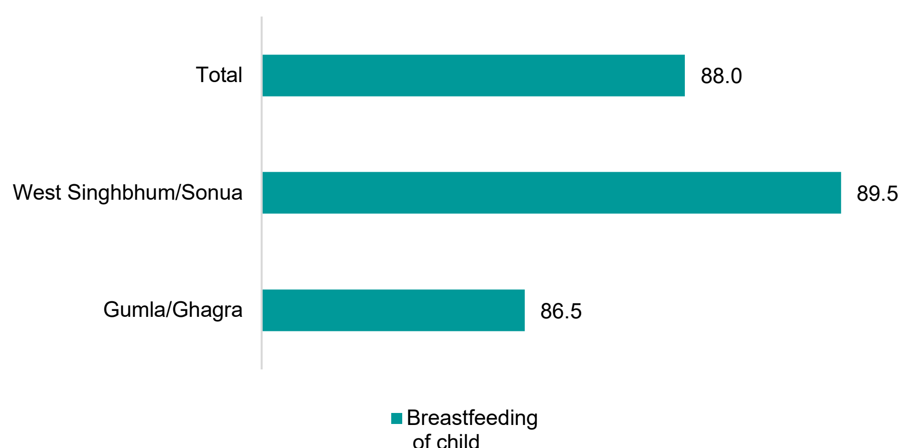
(c) Feeding practices of mothers

Initiation of giving solid/semi solid food: Overall, 87 percent of the mothers started giving solid/semi solid food to their children at the age of 6-7 months. In Gumla/Ghagra and West Singhbhum/Sonua, 84 percent and 89 percent of respondents started feeding fluids, semi-solids, or solids at the age of 6-7 months respectively (See Table 16 in Annexure I).

Overall, 35 percent of the mothers reported that their child ate solid/semisolid other than liquids, 3 times in a day whereas 22 percent mentioned giving solid/semisolid food 4 times in a day (See Table 17 in Annexure I).

Breastfeeding of child: Overall, 88 percent of respondents said that their child was currently breastfed. There is a marginal difference between West Singhbhum/Sonua and Gumla/Ghagra with 90 percent and 87 percent of respondents reporting breastfeeding of their child at present respectively (See Figure 36).

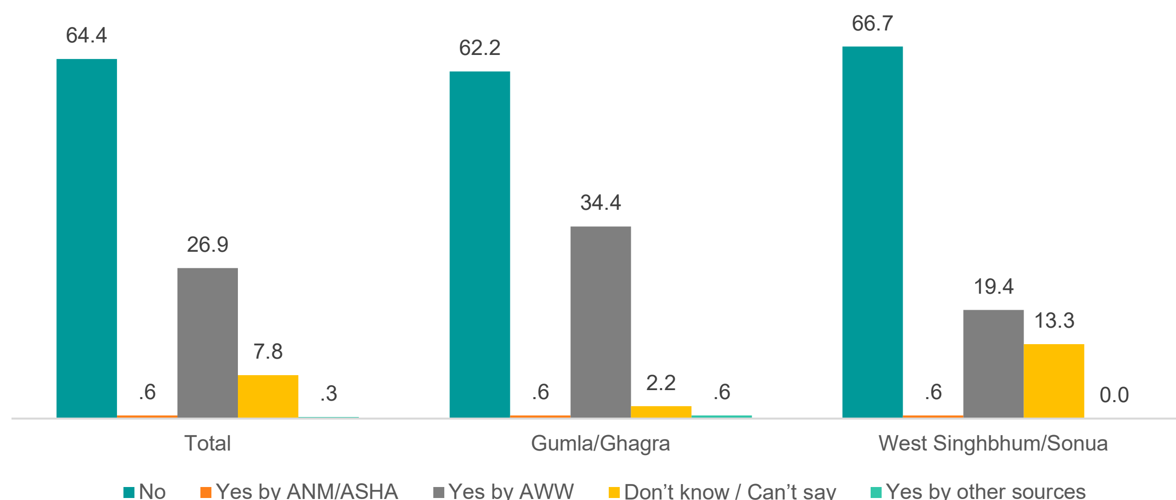
Figure 36: Whether the child currently breast fed reported by the respondents (in percent, n=210)



(d) Provision of IFA, Calcium, Deworming tablets for mother and child

Access to IFA tablets: More than 60 percent of mothers across the districts reported that they did not receive IFA tablets for their children. However, 27 percent in Gumla/Ghagra and 34 percent in West Singhbhum/Sonua reported receiving IFA tablets by the AWW (See Figure 37).

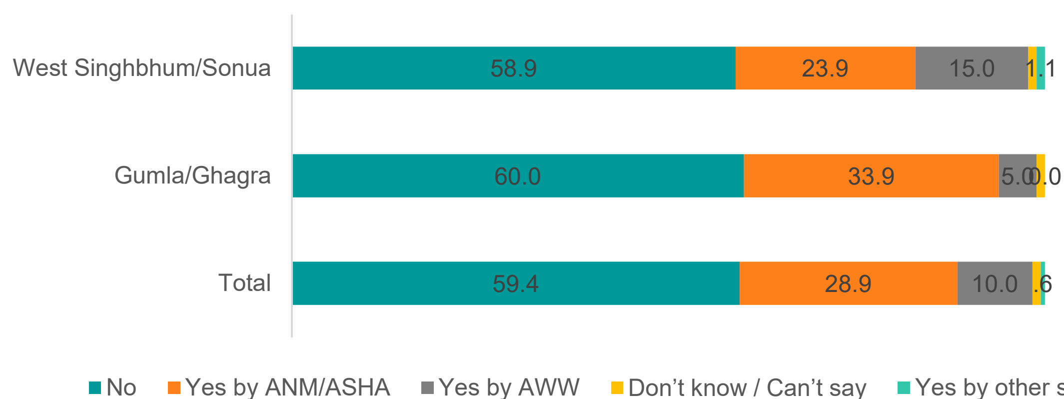
Figure 37: Whether received IFA tablets for the child aged over 6 months (in percent, n=360)



Consumption of IFA tablets: Of those who received IFA tablets for their child, 69 percent of mothers in West Singhbhum/Sonua and 50 percent in Gumla/Ghagra reported feeding of the IFA tablets to their child. Overall, 57 percent of respondents fed the IFA tablets to their children (See Table 18 in Annexure I).

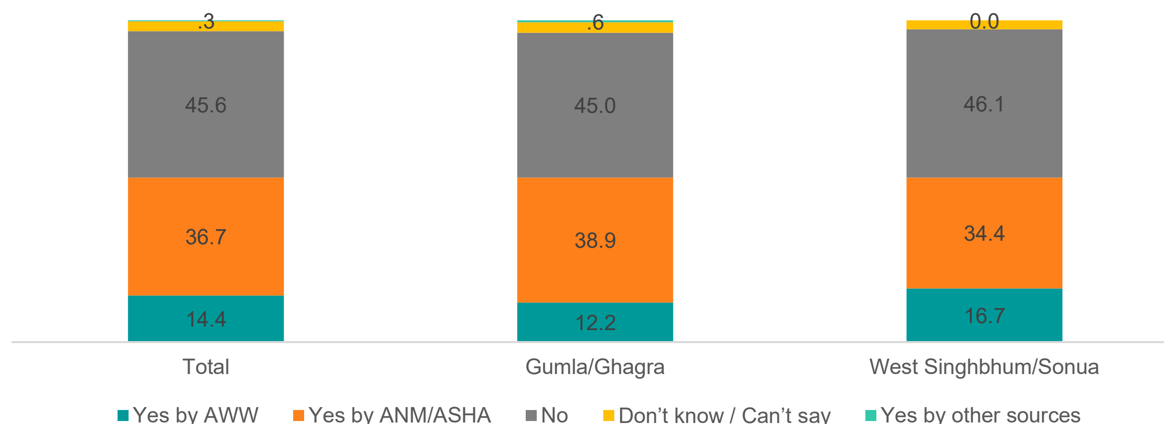
Access to deworming tablets: Overall, 59 percent of mothers reported that their child has not been provided deworming tablets within the last 6 months. However, 34 percent in Gumla/Ghagra and 24 percent in West Singhbhum/Sonua reported receiving deworming tablets for their child by ANM/ASHA (See Figure 38).

Figure 38: Whether the child been provided deworming tablet within the last 6 months (in percent, n=360)



Access to Vitamin A tablets: Overall, 46 percent of mothers reported that their children who are aged over 9 months have not been provided vitamin A tablets within the last 6 months. However, 39 percent in Gumla/Ghagra and 34 percent in West Singhbhum/Sonua reported receiving vitamin A tablets for their child by ANM/ASHA (See Figure 39).

Figure 39: Whether the child been provided Vitamin A tablet within the last 6 months (in percent, n=360)



Mothers receiving IFA and calcium tablets: Furthermore, the mothers who received and consumed IFA and calcium tablets are given in the below tables (See Table 2).

Table 2: Average number of IFA and calcium tablets received versus consumed

#	Particulars	Average No. Received	Average No. Consumed	Cut off No. as per NFHS
1	IFA tablets	72	59	100 or more for Recently Delivered Women and 180 or more for mothers of children of 0/35 months
2	Calcium tablets	25	20	

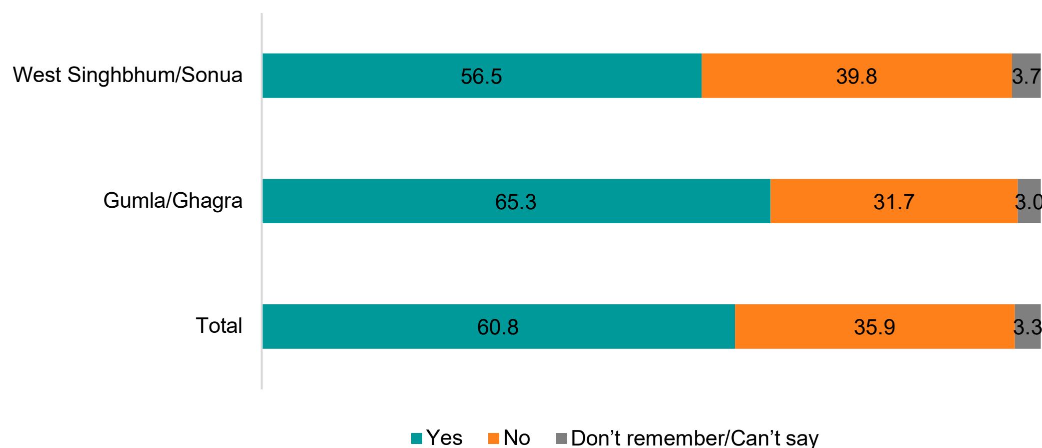
The mothers reported receiving an average of 72 IFA tablets and 25 calcium tablets. Out of received tablets, they consumed around 80 percent tablets. While NFHS recommended cut off for IFA tablets and calcium tablets is 100 or more for Recently Delivered Women and 180 or more for mothers of children of 0/35 months. Hence, IFA tablets' consumption data reported by the latter mother group turns out to be around 10% of the NFHS recommended consumption.

It is noteworthy that majority of the mothers do not know the meaning of 'Vitamins', 'Iron', 'Calcium' etc. when asked during the discussion. Thus, most of them do not understand the dosage of various mineral supplements they receive or are entitled to receive from ANM and Anganwadi centres.

(e) Visits of the Anganwadi Workers and services provided during visits

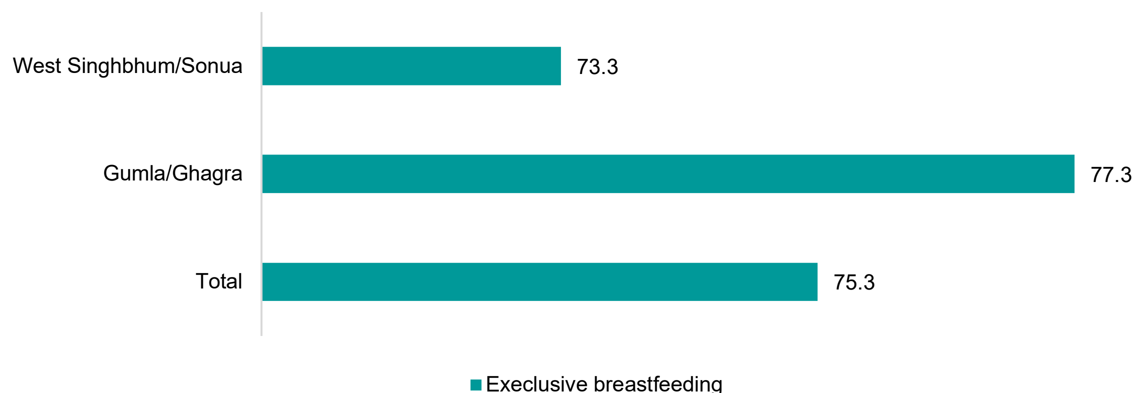
Visit of AWW after childbirth: In total, 61 percent of mothers responded that AWWs visited them after childbirth. Gumla/Ghagra has a higher number of visits by AWW after childbirth whereas West Singhbhum/Sonua has a lesser number of visits by AWW. In Gumla/Ghagra and West Singhbhum/Sonua, 32 percent and 40 percent of mothers reported that AWWs didn't visit them after childbirth (See Figure 40).

Figure 40: Whether the AWW visited the respondent after childbirth (in percent=210)



Counselling of mothers about exclusive breastfeeding the child after 6 months: Over 70 percent of respondents across the districts pointed to be counselled about exclusive breastfeeding to the child for 6 months. The percentage of respondents counselled about exclusive breastfeeding is a little higher by 4 percent in Gumla/Ghagra than the West Singhbhum/Sonua which stands at 73.3 percent (See Figure 41).

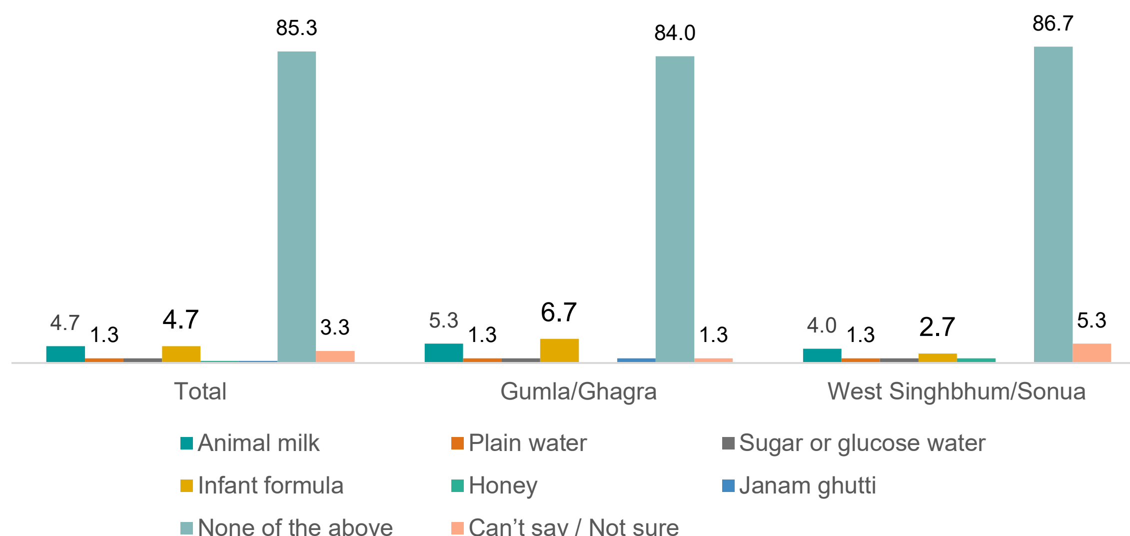
Figure 41: Whether AWW counsel the respondent on exclusive breastfeeding child for 6 months (in percent, n=150)



63 percent of the mothers said that AWW counselled them on proportionately reducing dependence on breastfed nutrition for the child beyond one-year child (See Table 19 in Annexure I).

Food items were given to the child in the first three days after delivery: In both the districts, 85 percent of respondents responded that they didn't give any food (e.g., Janam ghutti, honey, infant formula, sugar, plain water, and animal milk) other than mother's milk in the first three days after delivery. The percentage of children exclusively consuming mother's milk in the first three days after delivery is 87 percent in West Singhbhum/Sonua/ Sonua whereas the number drops by 3 percent in Gumla/Ghagra (See Figure 42).

Figure 42: Items given to the child in the first three days after delivery (in percent, n=150)



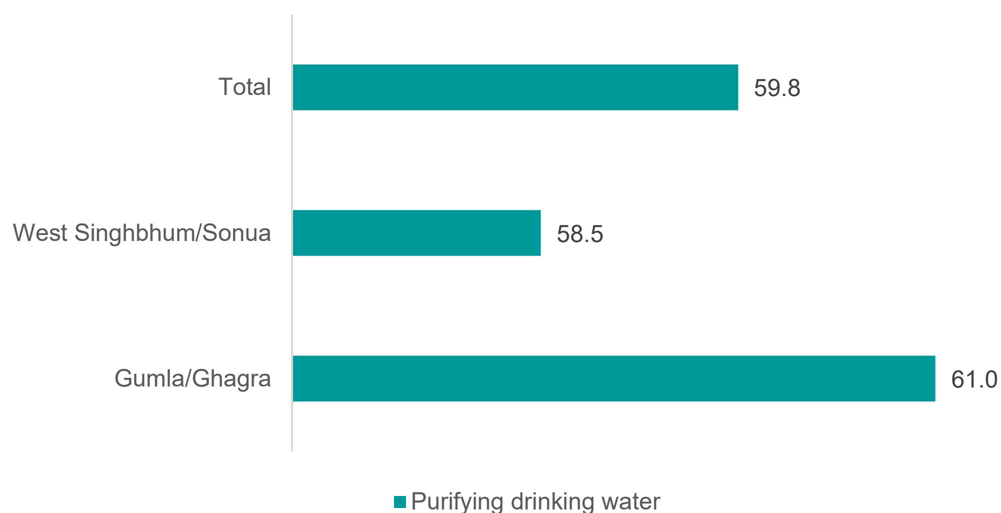
2.3.3. Awareness, knowledge practices of mothers towards WASH

In this section, awareness, knowledge and practices towards hand wash, occasions of hand wash, water purification, methods of purification are given.

(a) Water treatment practices and methods

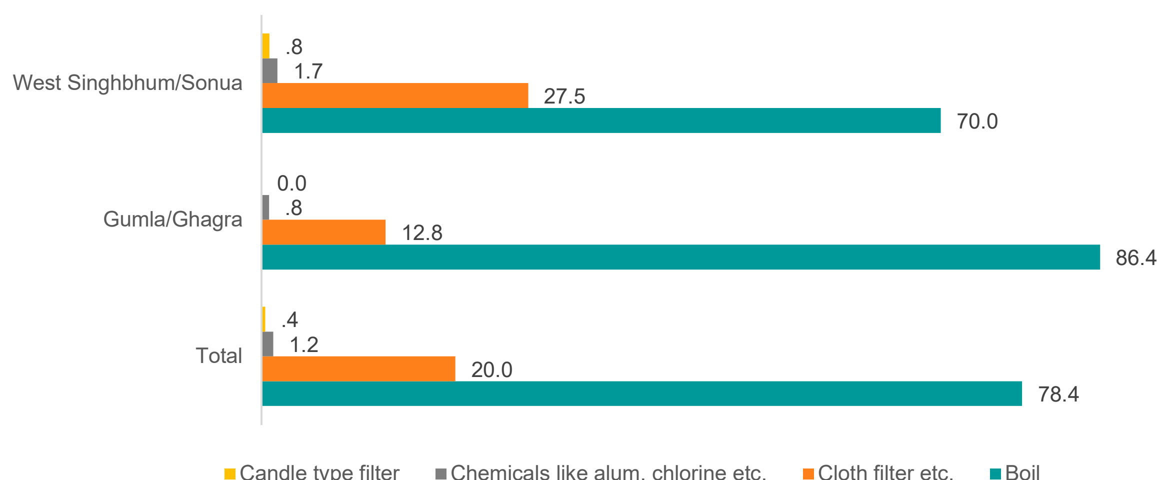
Purification of drinking water: In total, 60 percent of respondents said they purified drinking water. There is a marginal difference between West Singhbhum/Sonua and Gumla/Ghagra with 56 percent and 61 percent respondents reporting purifying drinking water respectively (See Figure 43).

Figure 43: Whether the respondents purify drinking water (in percent, n=410)



Methods of purification of drinking water: Boiling is the most dominant method of purifying drinking water in both the districts, followed by cloth filters etc. In total, 78 percent of respondents boil the water and 20 percent use cloth filters etc. for purifying the water. In Gumla/Ghagra, boiling of water has a higher dominance over cloth filter with percentage values standing at 86 percent and 13 percent respectively. In West Singhbhum/Sonua the gap between respondents boiling water and using cloth filter is narrowed down with percentage values of 70 percent and 28 percent respectively. Other methods of purifying water like candle type filter and usage of chemicals are marginal with values mostly around 1 percent (See Figure 44).

Figure 44: Methods of purification adopted by the respondents (in percent, n=245)

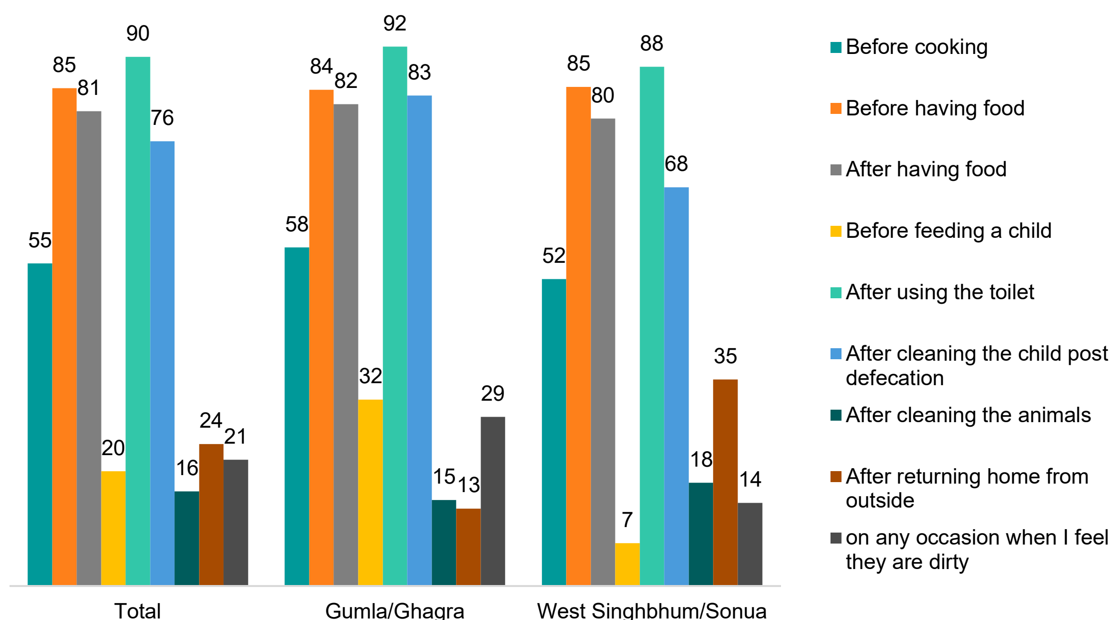


(b) Handwashing practices and methods

Hand washing practices on various occasions: Hand washing after using the toilet is the most dominant hand washing practice. More than 90 percent respondents reported of practising it, 92 percent of respondents from Gumla/Ghagra and 88 percent from West Singhbhum/Sonua reported washing hands after using the toilet. In total, after cleaning the animal handwashing phenomenon is the least with only 16 percent of respondents following hand washing practices. Individually, in Gumla/Ghagra handwashing after coming home from the outside is the least with only 13 percent of respondents doing so. Whereas in West Singhbhum/Sonua washing hands before feeding a child is least with as little as 7 percent of respondents doing so.

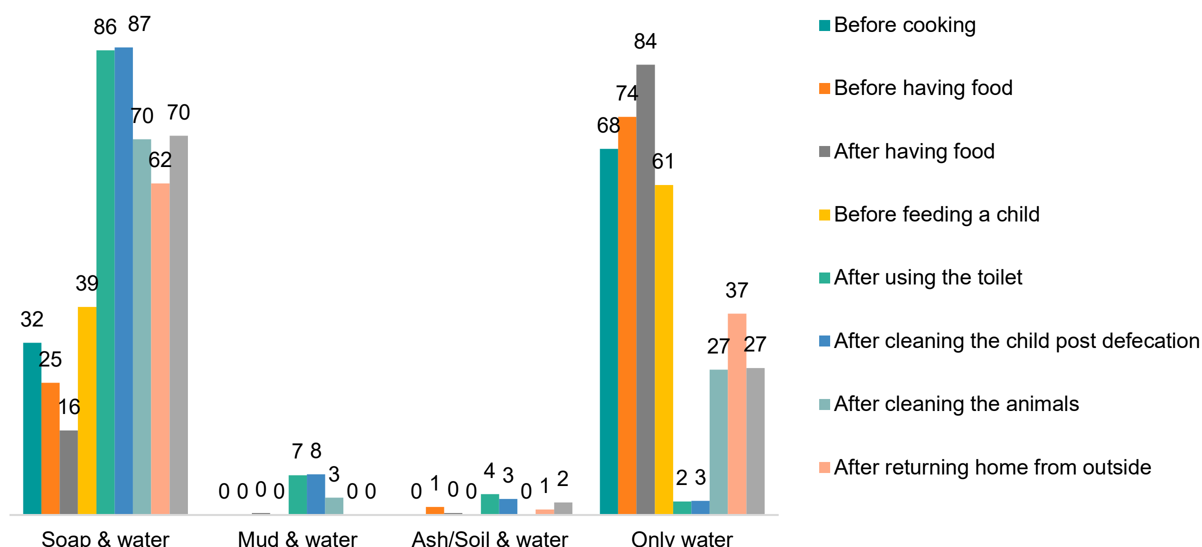
Percentage of respondents, handwashing before having food, after having food, after cleaning the child after defecation and before cooking are 85 percent, 81 percent, 76 percent, and 55 percent respectively in total (See Figure 45).

Figure 45: When does the respondent wash their hands (in percent, n=410)



Products used for handwashing: Hand washing using soap and water is the dominant method followed by only using water for handwashing. Soap & water usage for handwashing is higher on occasions like after cleaning the child after defecation, after using the toilet, after cleaning animals and after returning home from outside with percentage of respondents doing so are 87 percent, 86 percent,70 percent, 62 percent respectively. In the same line usage of only water for hand washing is seen more dominantly on occasions like after having food, before having food, before cooking, before feeding a child with percentage respondents doing so are 84 percent, 74 percent, 68 percent, and 61 percent respectively. Usage of mud & water, as well as ash/soil & water, is mostly marginal with below 8 percent of respondents using these on few occasions like after using the toilet and after cleaning the child post defecation (See Figure 46).

Figure 46: Products or things mostly used to wash on different occasions (in percent, n=410)

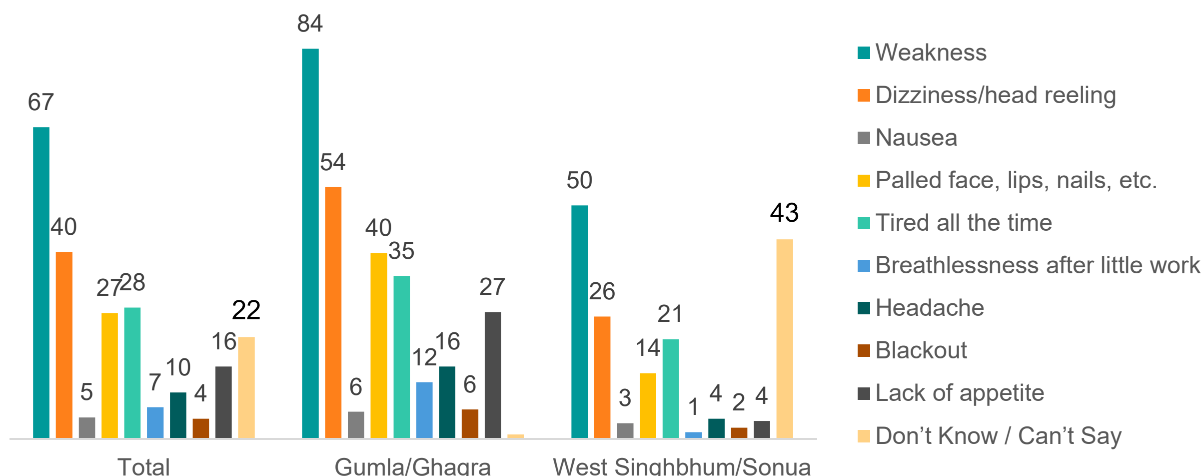


67 percent of the respondents reported that their family practice hand wash with soap every time they enter the house after going outdoors child (See Table 20 in Annexure I).

(c) Management of childhood diseases and anaemia

<u>Symptoms of anaemia:</u> In total, 67 percent of respondents reported that weakness is the major symptom of anaemia followed by dizziness/ head reeling (40 percent), tired all the time (28 percent), palled face, lips, nails, etc. (27 percent) and 22 percent saying they don't know. Blackout, nausea, and breathlessness after little work are the least reported symptoms with 4 percent, 5 percent, and 7 percent reporting these respectively in total.

Figure 47: Symptoms of anaemia reported by the respondents (in percent, n=410)



In Gumla/Ghagra, 84 percent of respondents reported 'weakness' to be the most significant symptom followed by 54 percent who reported 'dizziness' as the symptom. In West Singhbhum/Sonua, 50 percent

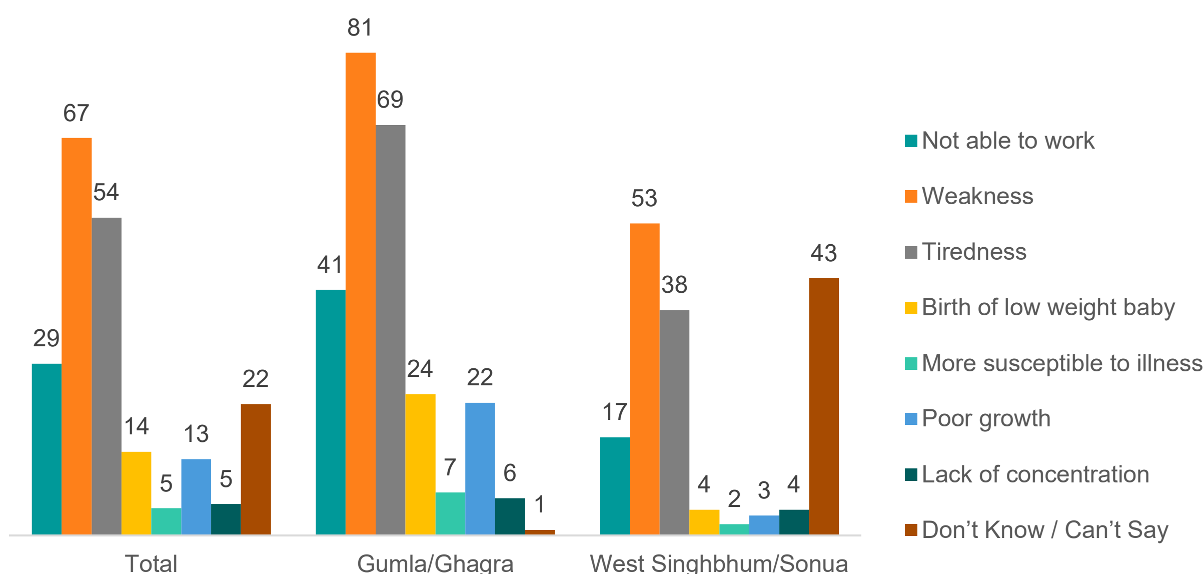
reported weakness as the most significant followed by 43 percent who either don't know or can't say (see Figure 47).

Causes of Anaemia: Poor or inadequate diet as the cause of anaemia is identified by the 77 percent and 46 percent respondents in Gumla/Ghagra and West Singhbhum/Sonua respectively. Furthermore, lack of iron in the diet is also reported by 37 percent and 14 percent respondents in Gumla/Ghagra and West Singhbhum/Sonua respectively 67 percent of the respondents reported that their family practice hand wash with soap every time they enter the house after going outdoors.

Overall, suffering from severe ailment (13 percent), parasitic infection (9), haemorrhage (7 percent), pregnancy (5 percent) and heavy flow during menstruation / rapid growth during puberty (3 percent) were reported as other causes of anaemia. interestingly, 27 percent of respondents reported not being aware of the causes of anaemia (See Table 21 in Annexure I).

Consequences of anaemia on health: 67 percent of respondents reported weakness as a consequence of anaemia. Other major consequences reported are tiredness (54 percent), not able to work (29 percent), the birth of low weight baby (14 percent) and poor growth (13 percent). 22 percent of respondents reported either they don't know or can't say about the consequences of anaemia. Both lack of concentration and more susceptibility to illness is reported by 5 percent of respondents (see Figure 48).

Figure 48: The consequences of anaemia on health reported by the respondents (in percent, n=410)

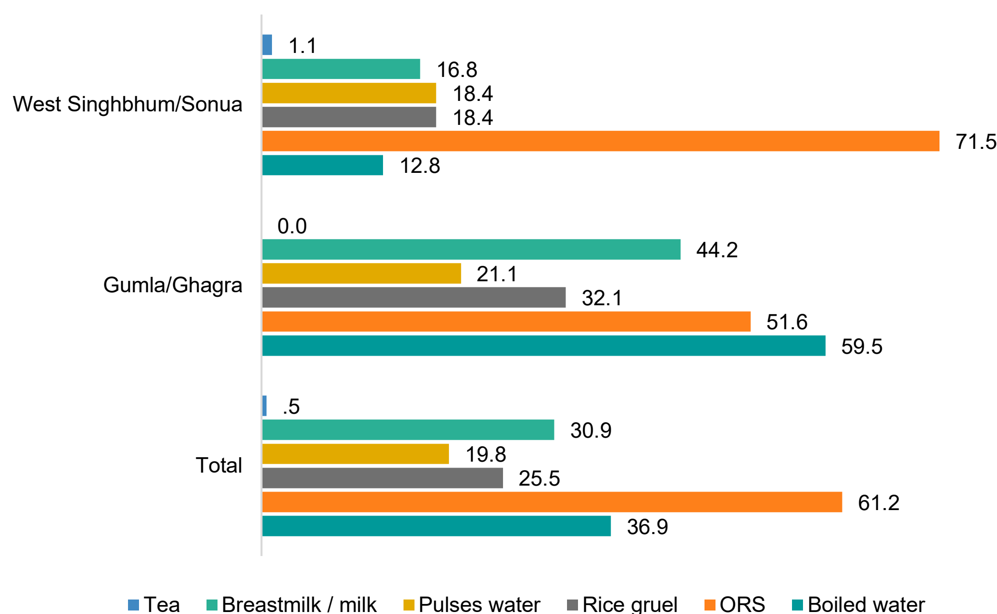


Methods to prevent anaemia: 75 percent of respondents reported eating nutritious food will prevent Anaemia. For the same question, 93 percent of respondents in Gumla/Ghagra and 57 percent of respondents in West Singhbhum/Sonua have reported nutritious food as a prevention for Anaemia. In total, intake of iron-rich food, taking iron and folic acid tablets, intake of vitamins and minerals, getting enough rest and don't know are the other major prevention methods for Anaemia with percentage responses of 25 percent, 21 percent, 23 percent, 15.4 percent, 22 percent respectively (See Table 22 in Annexure I).

Food to be given if the child is affected by diarrhoea: 61 percent of respondents reported ORS to be given to the child in case the child is affected by diarrhoea. The second preferred response was boiled water (37 percent) followed by breastmilk (31 percent), rice gruel (26 percent), pulses water (20 percent). In

Gumla/Ghagra highest percentage of respondents (60 percent) reported boiled water to be given to a child in case of diarrhoea, whereas 72 percent of respondents in West Singhbhum/Sonua/ Sonua reported ORS for the child affected by diarrhoea (See Figure 49).

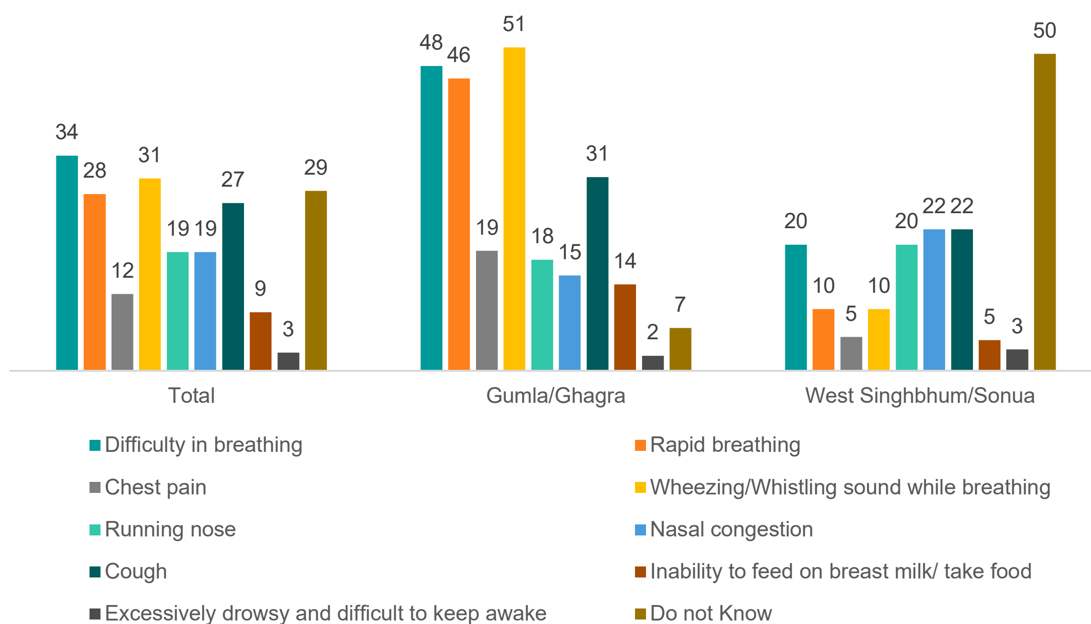
Figure 49: Food to be given in case the child is affected by diarrhoea (in percent, n=369)



<u>Symptoms of severe diarrhoea among infants/children</u>: The highest number of 61 percent respondents reported weakness as a symptom of severe diarrhoea followed by loose motion (58 percent), vomiting (30 percent), inability to feed on breast milk/ take food (30 percent) and restlessness (23 percent). Other minor symptoms reported were dehydration (12 percent), don't know (7 percent) and blood in the stool (2 percent). In Gumla/Ghagra loose motion was reported as the major symptom of severe diarrhoea 64 percent response and in West Singhbhum/Sonua Weakness is the most significant symptom reported with 64 percent (See Table 23 in Annexure I).

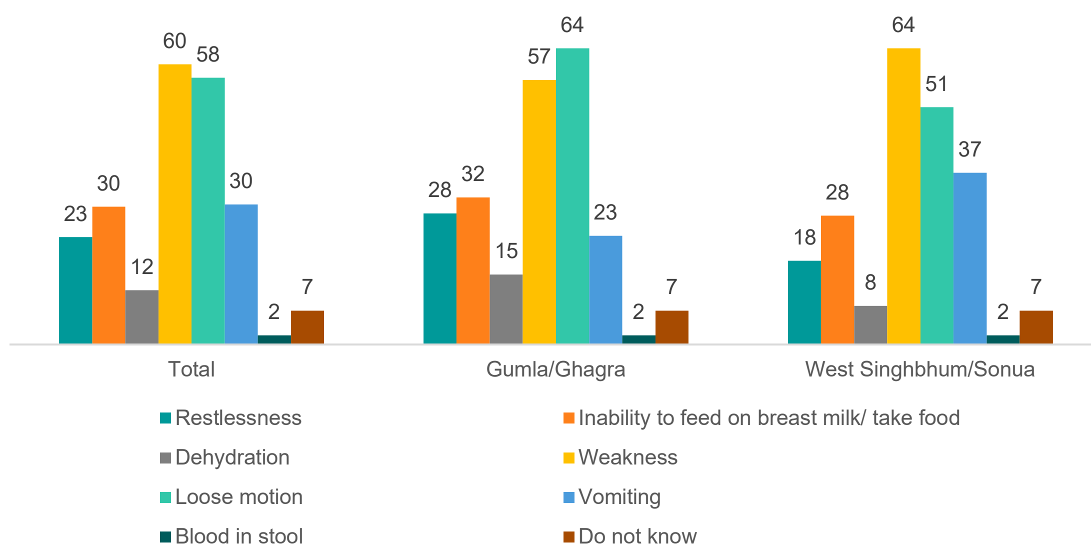
<u>Symptoms of pneumonia</u>: 34 percent of respondents reported difficulty in breathing as the symptom of pneumonia. Wheezing/whistling sounds while breathing, rapid breathing, cough, running nose and nasal congestion are other reported symptoms with 31 percent, 28 percent, 27 percent, and 19 percent responses respectively. In Gumla/Ghagra Wheezing/whistling sound while breathing is the most significant response with 51 percent reporting so and in West Singhbhum/Sonua 50 percent of respondents did not know the symptom of pneumonia (See Figure 50).

Figure 50:Symptoms of pneumonia reported by the respondents (in percent, n=410)



<u>Symptoms of severe diarrhoea and care</u>**:** Overall, weakness (61 percent), loose motions (58 percent), Inability to feed on breast milk or take food (30 percent) and vomiting (30 percent) were the major symptoms reported by the respondents (see Figure 51).

Figure 51: Symptoms of severe diarrhea reported by the respondents (in percent, n=410)



ORS is preferred by 55 percent of respondents followed by boiled water (33 percent) and breastmilk or milk (28 percent) when the child is affected by diarrhoea (See Table 24 in Annexure I).

2.4. Status of AWC and AWW

Following section presents findings of the status of Anganwadi Centre (AWC) in terms of its infrastructure, service provision to the registered beneficiaries along with the Awareness, Capacity of Anganwadi Worker (AWW). In discussion with STC, the findings are presented by comparing the intensive and non-intensive villages.

2.4.1. Status of AWC

(a) Age of AWC

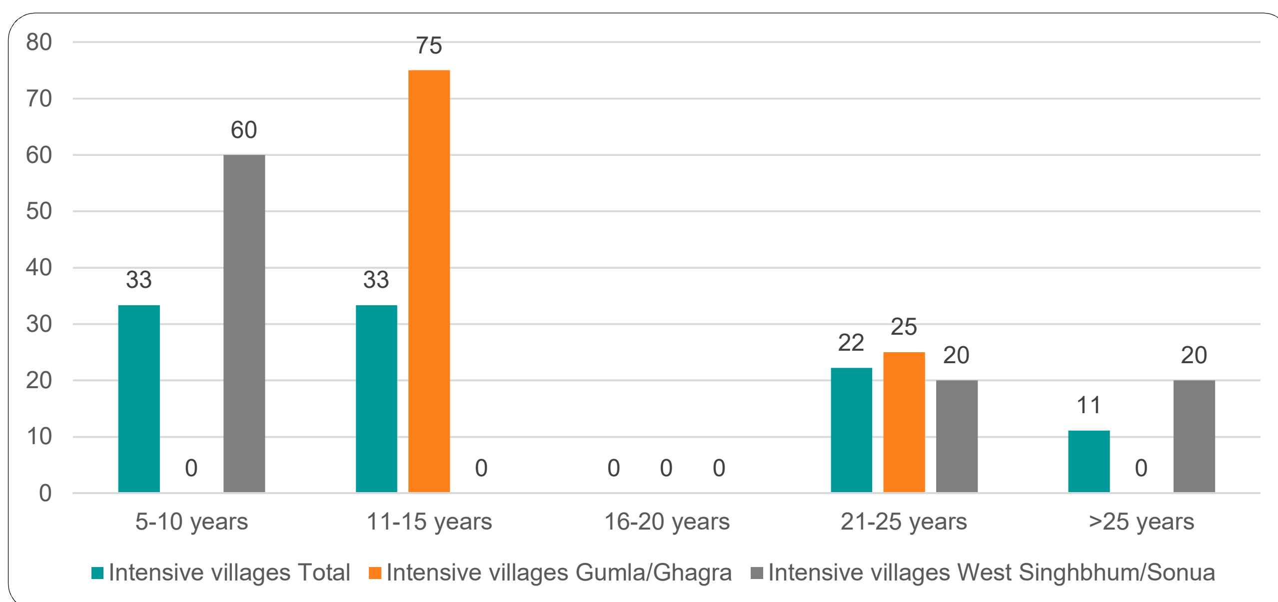


Figure 52: Age of AWW (intensive villages)

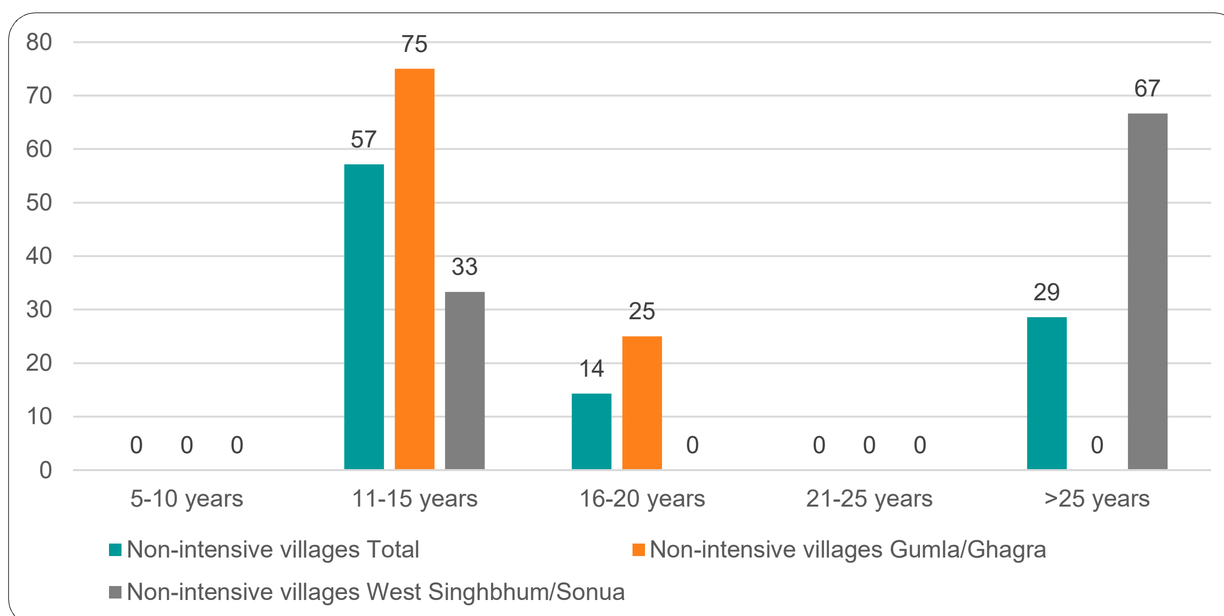


Figure 53: Age of AWC in years (non-intensive villages) – in percent

While 33 percent of AWCs in intensive villages started functioning 5-10 years, another 33 percent reported to be 11-15 years old followed by 22 percent who were 21-25 years old. Only 11 percent reported to be more than 25 years old. Similarly, 57percent of AWCs in non-intensive villages reported to be 11-15 years old followed by 14 percent who were 21-25 years old. 29 percent reported to be more than 25 years old.

(b) Status of construction of AWC building

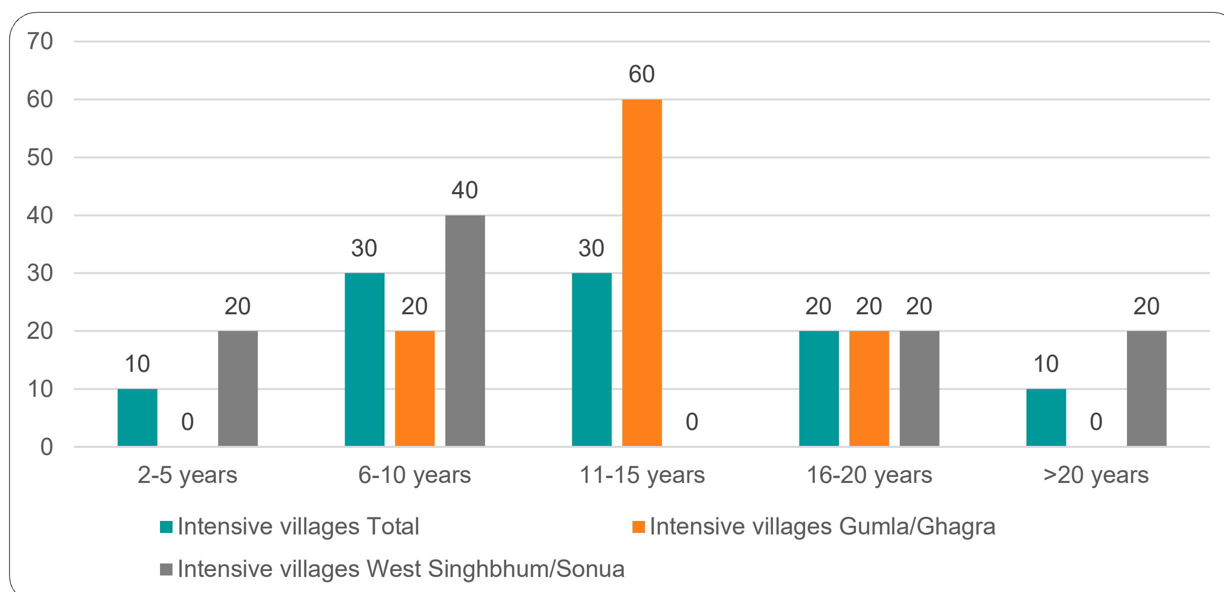


Figure 54: Age of AWC Construction (intensive villages) – in percent

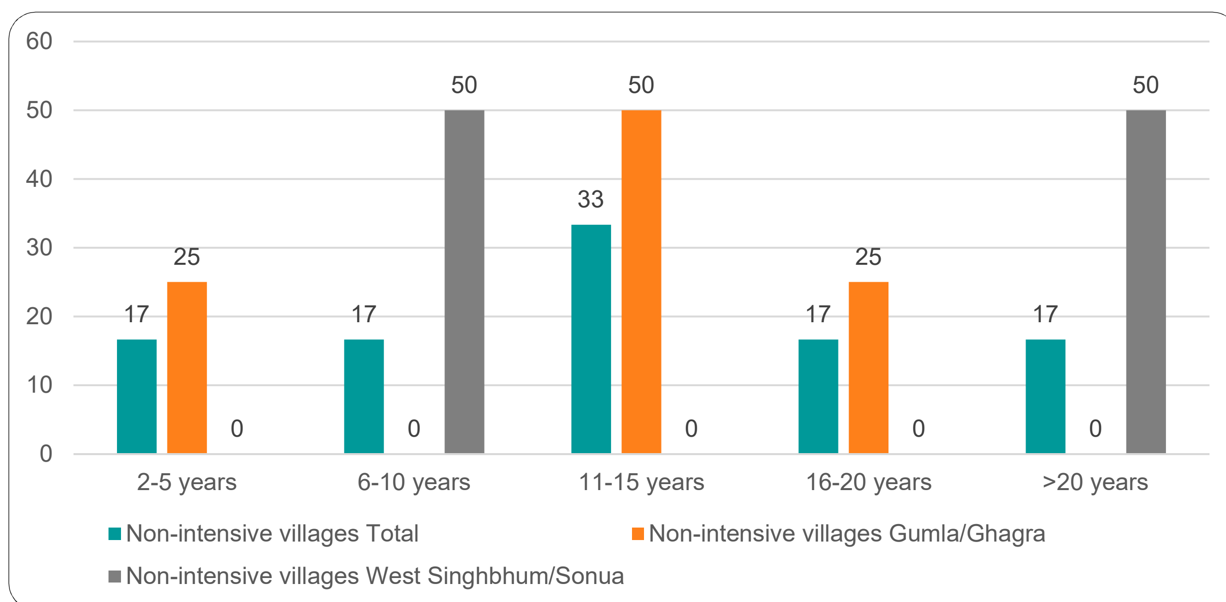


Figure 55: Age of AWC Construction (non-intensive villages) – in percent

While 9 (90 percent) of AWWs could report the year of construction of AWC in Ghagra/Gumla, 7 (70 percent) could report the same in West Singhbhum/Sonua. 1 (10 percent) AWC building is not constructed in Sonua. While all the AWCs had a constructed AWC building in the intensive villages of both the blocks, only 4 (40 percent) and 2 (20 percent) AWCs in the non-intensive villages of Ghagra and Sonua blocks respectively reported of a constructed AWC building.

(c) Status of AWC space for functioning

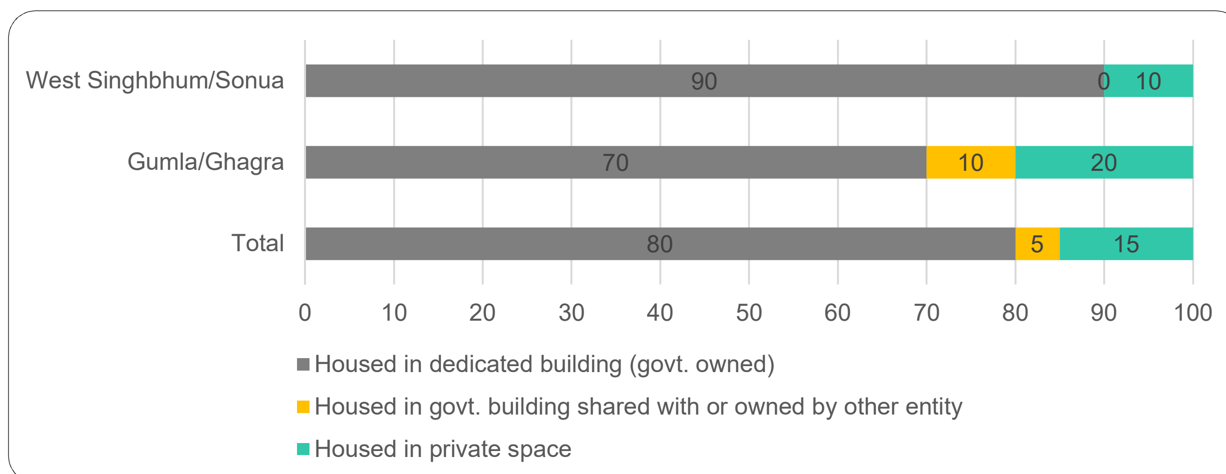


Figure 56: Status of AWC space for functioning (overall) – in percent

Majority (80 percent) of the AWCs were housed in a dedicated building (govt. owned), followed by 15 percent which were housed in a private space. Only 5percent AWCs were housed in a govt. building shared with or owned by other entity.

(d) Status of amenities at AWC

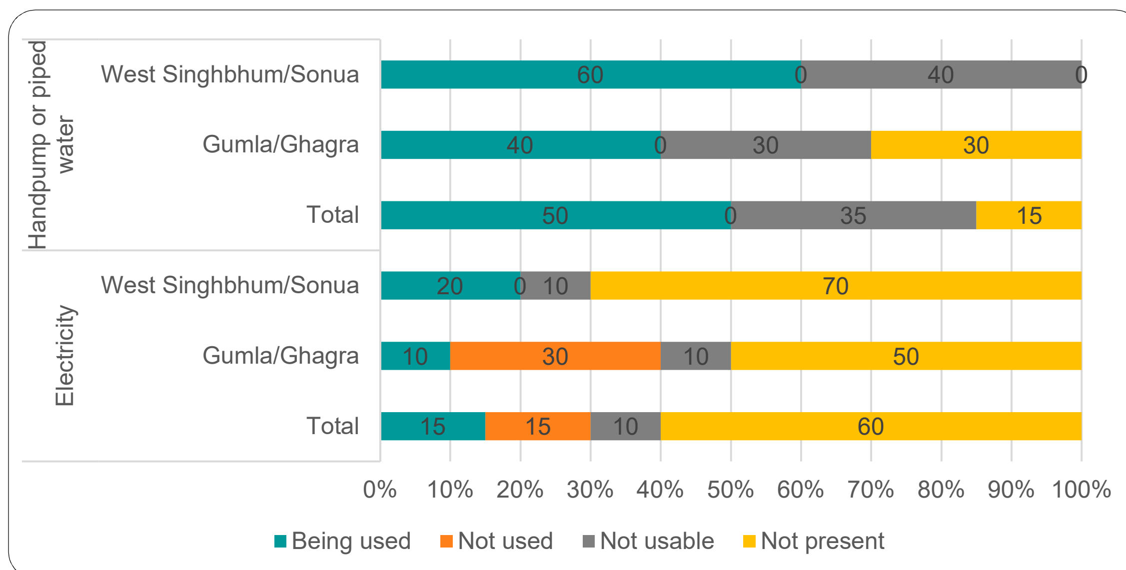


Figure 57: Status of Amenities at AWC-1 (overall) – in percent

While electricity was not present in 60 percent of AWCs, hand pump or piped water was not present in 15 percent of AWCs. Similarly, while only 15 percent AWCs reported of using electricity, 50 percent of AWCs reported of using hand pump or piped water.

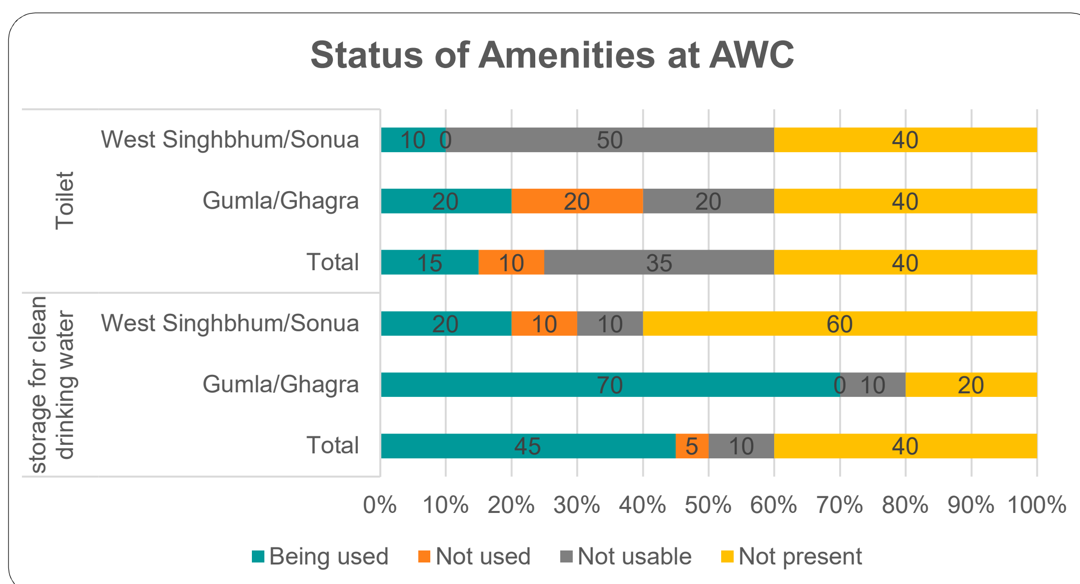


Figure 58: Status of Amenities at AWC-2 (overall) – in percent

40 percent of AWCs reported of not having storage for clean drinking water and toilet. 45 percent of AWCs reported to using storage for clean drinking water, while only 15 percent reported using toilet. Moreover, 10 percent of AWCs reported of storage for clean drinking water and 35 percent of AWCs reported of toilets as unusable.

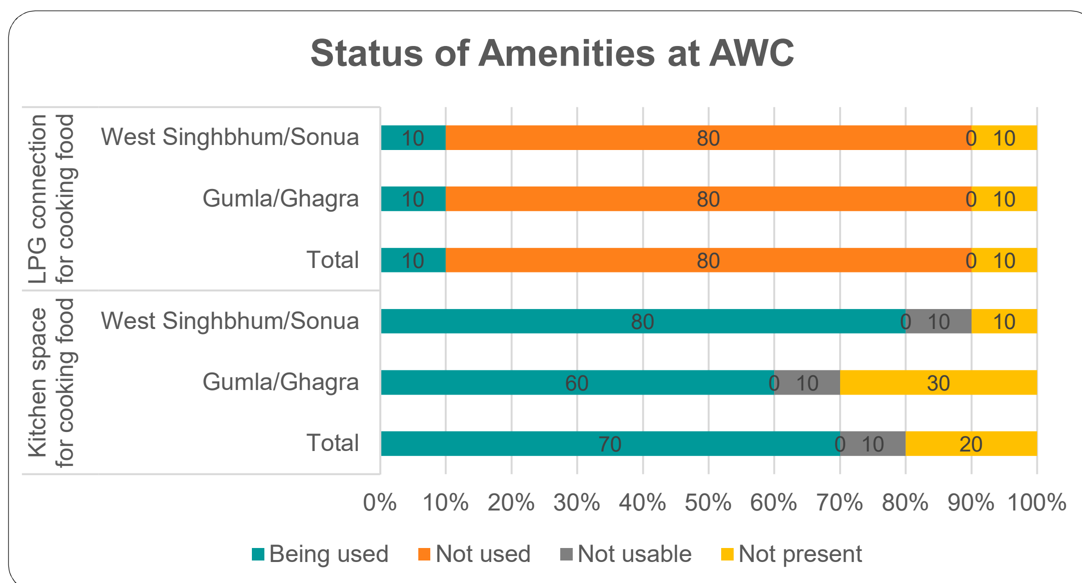


Figure 59: Status of Amenities at AWC-3 (overall) – in percent

While 70 percent AWCs reported of using kitchen space, inly 10 percent reported using LPG connection for cooking food. 80 percent of the AWCs reported of not using LPG connection for cooking food.

Save the Children

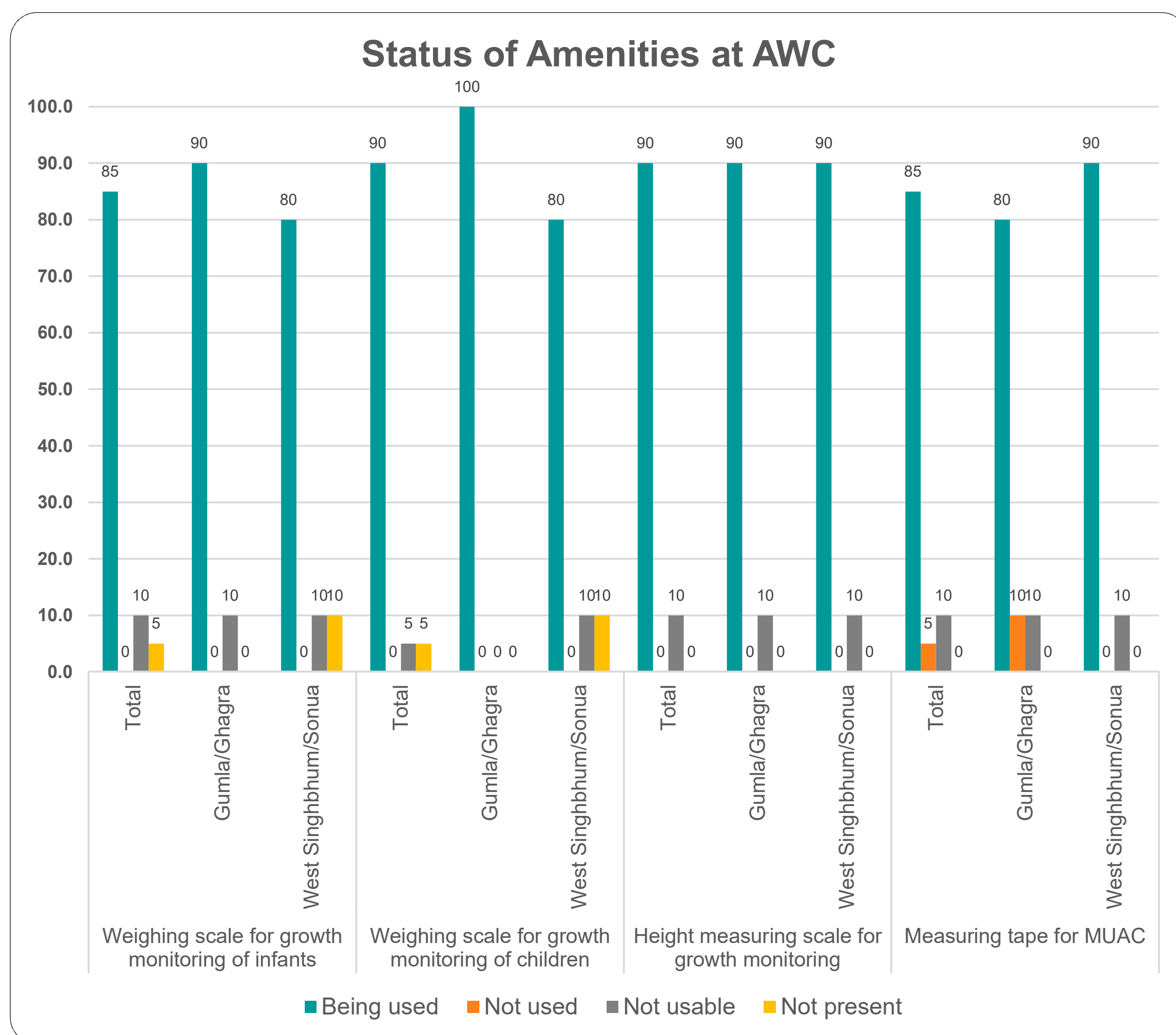


Figure 60: Status of Amenities at AWC-4 (overall) – in percent

85 percent, 90 percent, 90 percent, 85 percent AWCs respectively of using weighing scale for growth monitoring of infants, weighing scale for growth monitoring of children, height measuring scale for growth monitoring, measuring tape for MUAC respectively.

2.4.2. Status of registration at AWCs as reported by AWW

(a) Total no. of children registered under sampled AWCs as reported by AWW

Table 3: Total no. of children registered under sampled AWCs as reported by AWW

AWC in West Singhbhum/Sonua AWC in Intensive Villages	Total no. of children registered under sampled AWCs
Mahalisai	32
Bari B	25
Bhalurongi A	35
Kulundu	28
Lonjo A	56
Non-Intensive Villages	
Edelbeda	68

AWC in West Singhbhum/Sonua	Total no. of children registered under sampled AWCs
Dhundamra	68
Sarasposh	37
Vanjira	94
Udaypur ‘A’	61
Total (West Singhbhum/Sonua)	**504**
AWC in Ghagra/Gumla Intensive Villages	**No. of children are enlisted / registered under sampled AWCs**
Naudiha (Sarna Toli)	60
Totambi (Kend Toli)	77
Bahdura	80
Adar Bazar Toli	73
Duko	46
Non-Intensive Villages	
Gamhariya	60
Chechepat	71
Dherhauli (Kathar Toli)	20
Paunri	53
Peepartoli	45
Total (Gumla/Ghagra)	**585**

(b) No. of registered Pregnant women, Lactating mothers of infants (0-6 m) and children segregated by gender and age

Table 4: No. of registered Pregnant women, Lactating mothers of infants (0-6 m) and children segregated by gender and age

Target Beneficiaries	Total Registered across 10 sampled AWCs			
	West Singhbhum/Sonua		Ghagra/Gumla	
	Registered in total no. of AWCs	Total Number	Registered in total no. of AWCs	Total Number
Pregnant Women	10	79	10	80
Lactating mother (of 0-6 months old child)	10	69	10	81
Total Women	**-**	**148**	**-**	**161**
Children (boys) age (0-6 months)	10	44	9	43
Children (girls) age (0-6 months)	9	51	9	37
Children (boys) age (7-12 months)	10	53	9	59
Children (girls) age (7-12 months)	10	47	10	77
Children (boys) age (13-35 months)	10	157	10	160
Children (girls) age (13-35 months)	10	133	10	138
Children (boys) age (36-72 months)	9	139	10	178
Children (girls) age (36-72 months)	9	120	10	160
Total boys	**-**	**393**	**-**	**440**
Total girls	**-**	**351**	**-**	**412**
Total children	**-**	**744**	**-**	**852**

(c) Number of registered beneficiaries who were provided services by AWCs in Ghagra

Table 5: Number of registered beneficiaries who were provided services by AWCs in Ghagra

Figures in Number

AWC Services provided last month	*Pregnant women*	*Lactating mother*	*Ghagra* Children age (months) *7-12*		*13-35*		*36-72*	
			Boys	***Girls***	***Boys***	***Girls***	***Boys***	***Girls***
1. Delivery of THR	23	6	9	17	9	4	123	105
2. Serving hot cooked meals	0	0	0	0	0	0	0	0
2. Delivery of IFA	0	0	0	0	0	0	0	0
3. Vitamin A	40	0	4	3	15	15	17	12
4. Delivery of Calcium tablets	0	0	0	0	0	0	0	0
5. Delivery of deworming medicine	0	0	0	0	0	0	0	0
6. Growth Monitoring	0	24	36	39	58	58	97	80

(d) Number of registered beneficiaries who were provided services by AWCs in Sonua

Table 6: Number of registered beneficiaries who were provided services by AWCs in Sonua

Figures in Number

AWC Services provided last month	*Pregnant women*	*Lactating mother*	*Sonua* Children age (months) *7-12*		*13-35*		*36-72*	
			Boys	***Girls***	***Boys***	***Girls***	***Boys***	***Girls***
1. Delivery of THR	47	18	20	16	54	33	119	101
2. Serving hot cooked meals	0	0	0	1	6	5	0	0
2. Delivery of IFA	11	3	0	0	0	0	0	0
3. Vitamin A	0	0	0	0	0	0	0	0
4. Delivery of Calcium tablets	4	1	0	0	0	0	0	0
5. Delivery of deworming medicine	0	0	0	0	0	0	0	0
6. Growth Monitoring	19	10	28	18	79	53	62	55

Government of Jharkhand has parked the responsibility of THR to JSLPS. JSLPS in turn has vested this responsibility to block level SHG Federations. Due to administrative bottlenecks, there was no supply of raw grains and pulses from the govt stock to JSLPS identified SHG federations. The supply of THR stopped from Aug 2020 onwards. In the interim, govt advised AWW that they may supply THR by procuring from open market and getting the cost incurred reimbursed later. Since most of the AWW belong to poor households and are not in a position to spend money in advance. Moreover, traders also refused credit to AWWs without any government order or guarantee. Therefore, the THR part of the AWC was only restricted to children aged 3-6 years, wherein reportedly food stock was provided from the Public Distribution System.

During the pandemic Anganwadi centre were functional from April-June 2021, only to stop functioning from mid-June onwards. Since the study was conducted in the end of July, and the data reference frame was past one month, therefore all services related to ration except those of providing it to 3-6 years were stopped.

Data towards segregation of children based on their age and gender could not be provided by the AWWs since they do not capture such segregated data in their registers. However, in response to our question on sharing gender and age wise data, they manually counted figures to provide the data. During the course of analysis, it was found that the registered beneficiary data (total with gender and age segregation) and data segregated by age and gender varies by a great margin. Therefore, we would suggest that segregated data not be used for the purpose of baseline and such data be collected under

supervision of STC during the course of the project. It is highly likely that the AWW who are not adequately educated (most below X class) committed errors of calculation either of omission or duplication resulting in above mentioned discrepancy.

2.4.3. Status of Provision of Services by AWCs

(a) Impact of pandemic on AWC's services and its delivery

In the intensive villages, 3 (60 percent) AWCs in Sonua had to stop their services, 80 percent AWCs reported of continuing the services but at a lesser frequency, 40 percent reported of reducing the coverage, while 60 percent reported of reduction in the quantum of service provided to the registered beneficiaries. In the intensive villages, all the AWWs both in Ghagra and Sonua visited the house of registered families to provide services during the pandemic. In the non-intensive villages while all the AWWs in Ghagra visited the house of registered families to provide services during the pandemic, only four (80 0percent) of AWCs reported of the same in Sonua.

In the intensive villages, while 20 percent of AWCs in Ghagra and 25 percent AWCs in Sonua reported that Mothers visited AWC. In the non-intensive villages, 20 percent of AWCs in Ghagra and 40 percent AWCs in Sonua reported that Mothers visited AWC. None of the AWCs were visited by the caregivers of the registered families, both in the intensive and non-intensive villages of Ghagra. However, 50 percent AWCs in intensive and 40 percent AWCs in non-intensive were visited by caregivers of registered families to avail services. In the non-intensive villages, only 1 (20 percent) AWC in Sonua reported of no service provision. In the intensive villages, 1 (20 percent) AWW reported of calling mothers/caregivers to their homes to provide services.

(b) Mitigation measures taken to overcome pandemic challenges

While most of the AWWs reported of not taking any mitigation measures to overcome the challenges posed by pandemic, few reported of visiting homes (since AWC was closed) to counsel and provide services as mitigation measures. AWW however, reported following precautionary measures including, not allowing crowding at AWCs or during home visits, maintaining social distance while speaking to beneficiaries, wearing masks, washing of hands and use of sanitizer while undertaking home visits, providing services separately to children distinguished on the basis of age. There is no marked difference on mitigation and precautionary measures in the intensive and non-intensive villages. One AWW shared that pandemic has resulted in a beating of their social status and quoted that *"THR na milne par CDPO se jaakar baat ki taaki THR baata ja sake par abhi tak mil nahi paya hai, iske liye gaon ke log mujhe kehte hai ki aap ko milta hai par aap kha jaate hai"*

(c) Status of parameters checked during growth monitoring of children

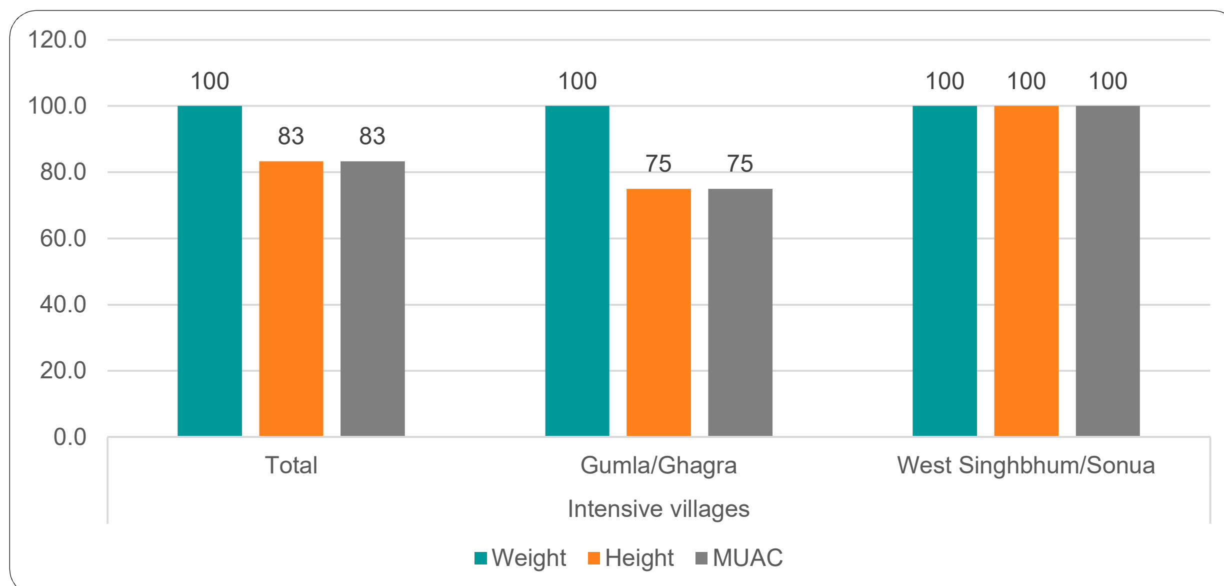


Figure 61: Status of parameters checked during growth monitoring of children (intensive villages) – in percent

In the intensive villages, while all the AWWs reported of measuring weight, 83 percent AWCs reported of measuring height and mid upper arm circumference (MUAC) as part of growth monitoring of children.

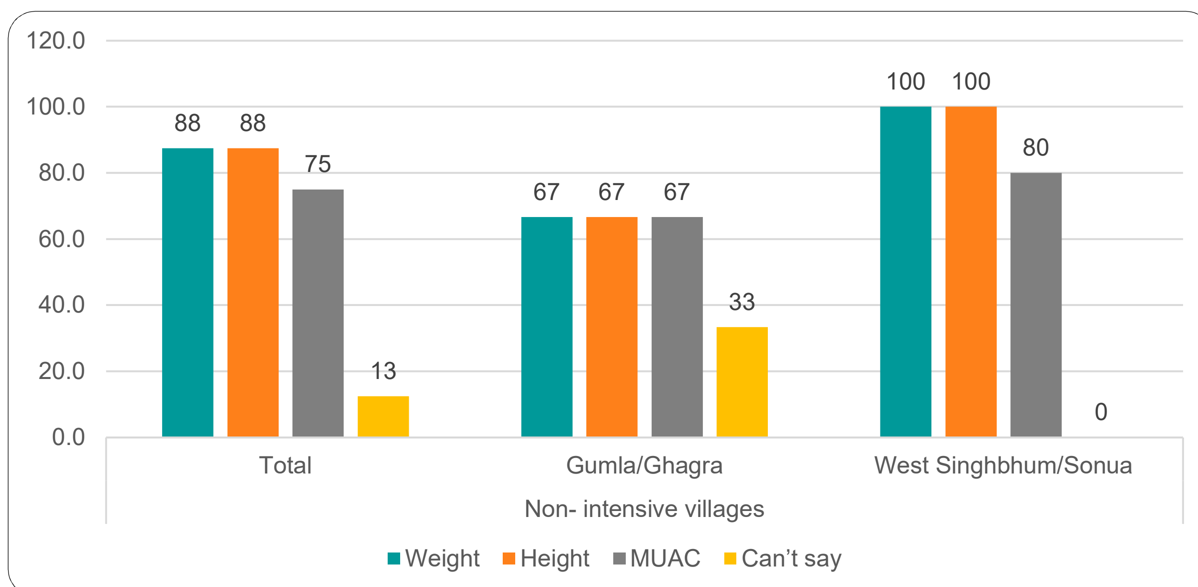


Figure 62: Status of parameters checked during growth monitoring of children (non-intensive villages) – in percent

In the non-intensive villages, 88 percent of AWWs reported of measuring both weight, height, while 75 percent reported of measuring mid upper arm circumference (MUAC) as part of growth monitoring of children. 13 percent, however, could not report on the status.

(d) Support received from ASHA in growth monitoring of children

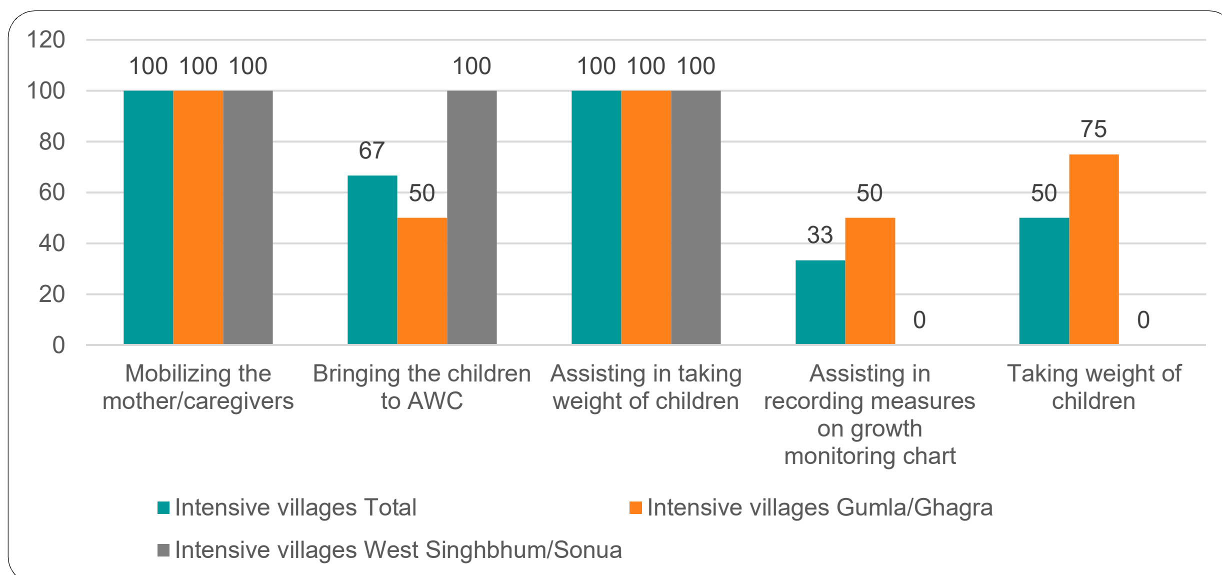


Figure 63: Support from ASHA (intensive villages) – in percent

In the intensive villages, all the AWWs reported that ASHA supports them in mobilizing mother/caregivers and assisting in taking weight of children. However, only 67 percent of AWW reported of ASHA's support in bringing children to AWC and 33 percent reported their support in assisting in recording measure on growth monitoring chart and 50 percent in taking weight of the children.

In the non-intensive villages, all the AWWs reported that ASHA supports by assisting in taking weight of

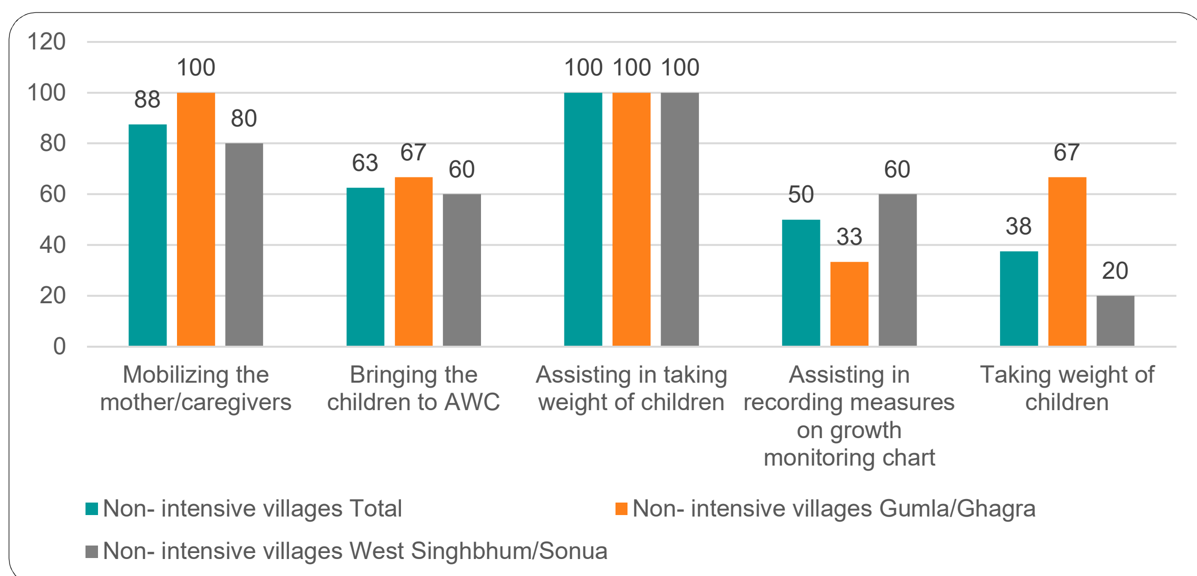


Figure 64: Support from ASHA (non-intensive villages) – in percent

children. However, 88 percent of AWW reported of ASHA's support in mobilizing mother/caregivers, 63

percent reported of ASHA's support in bringing children to AWC and 50 percent reported their support in assisting in recording measure on growth monitoring chart and 38 percent in taking weight of the children.

2.4.4. Status of Anganwadi Worker

(a) AWW maintaining a home visit planner

All the sample AWWs in the non-intensive villages reported of maintaining a home visit planner. In the intensive villages, 80 percent of AWWs in Ghagra and 60 percent AWWs in Sonua reported of maintaining a home visit planner.

All the AWWs, both in the intensive and non-intensive villages reported of counselling registered pregnant women on birth preparedness between 7th and 9th month of pregnancy. Similarly, all the AWWs reported of counselling pregnant women for institutional delivery. All the AWWs, both in the intensive and non-intensive villages reported of counselling pregnant women and their families to prepare for financial resources, and support system for birth.

All the AWWs, both in the intensive and non-intensive villages reported of visiting homes for HBYC follow up on nutrition of child on 3rd, 6th, 9th, and 12th month after birth. All the AWWs, both in the intensive and non-intensive villages reported of counselling lactating mothers on exclusive breast feeding for initial 6 months after delivery.
All the AWWs, both in the intensive and non-intensive villages of Ghagra reported of counselling lactating mothers on the frequency of breast-feeding infants below 6 months. While the same was reported in the non-intensive villages of Sonua, 1 AWW reported in negative.

Diet and Food Groups

Counselling on 'Balanced diet': All the AWWs, both in the intensive and non-intensive villages reported of visiting the pregnant women/lactating women to counsel them on 'Balanced diet'.

Counselling pregnant women/ lactating women on the need to identify and consume the ten food groups for dietary diversity: In the non-intensive villages, all the AWWs reported of counselling pregnant women/ lactating women on the need to identify and consume the ten food groups for dietary diversity. In the intensive villages, 2 (40 percent) of AWWs reported of not doing the same.

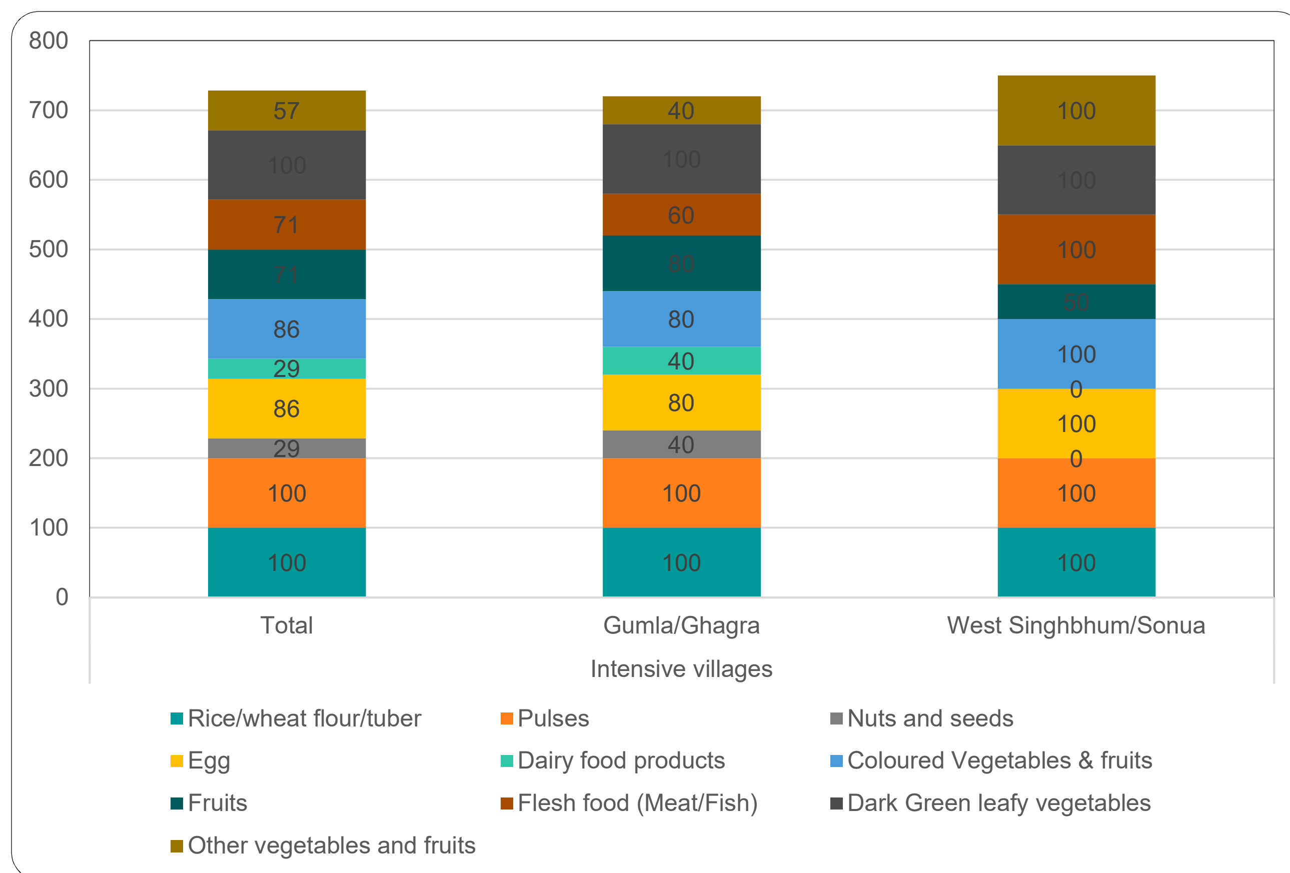


Figure 65: Food groups recommended to pregnant women (intensive villages) – in percent

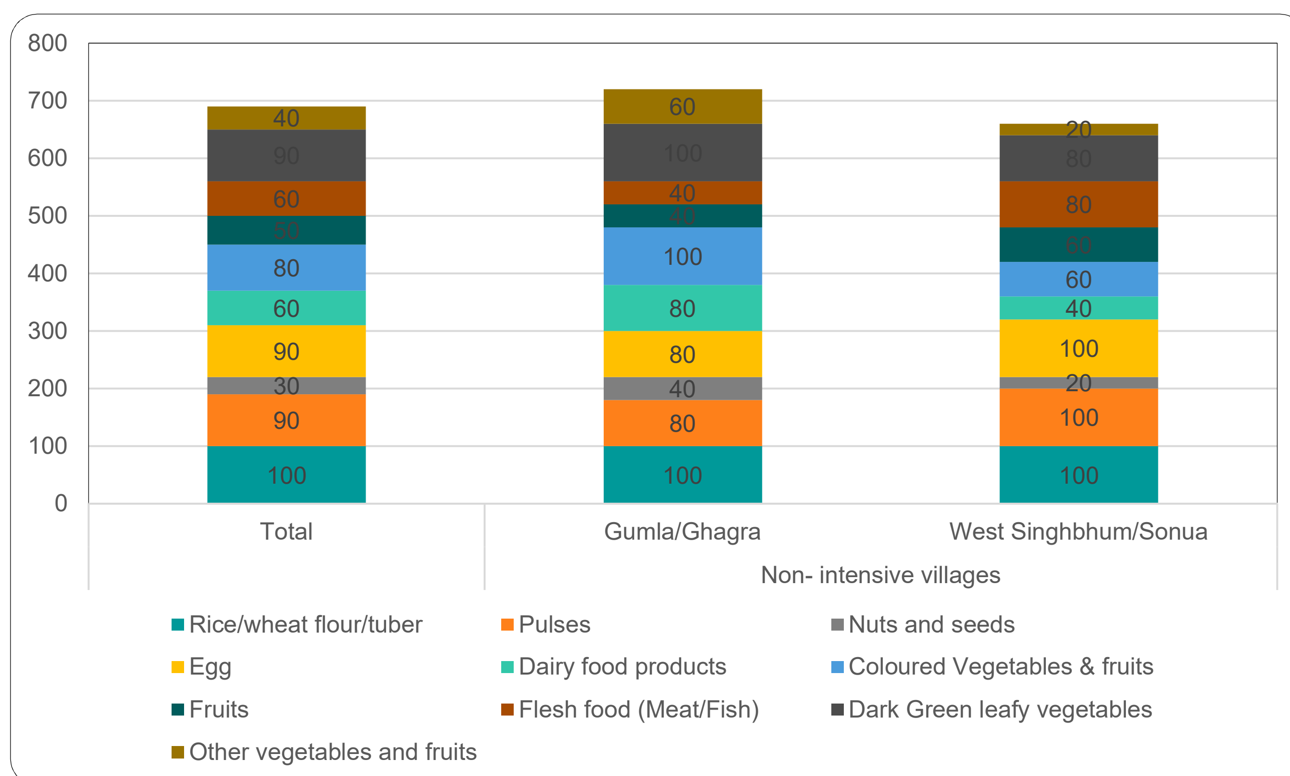


Figure 66: Food groups recommended to pregnant women (non-intensive villages) – in percent

All the AWWs in the intensive villages reported of recommending 3 food groups namely Rice/wheat flour/tuber, Pulses and Dark Green Leafy Vegetables, followed by 86 percent reported of recommending 2 food groups namely Egg and Coloured Vegetables & fruits in the intensive villages. 72 percent of AWWs from the intensive villages reported of recommending another 2 food groups namely Fruits and Flesh food (Meat/Fish). 57 percent of AWWs reported of recommending food group comprising of other vegetables and fruits. Only, 29 percent of AWWs from the intensive villages reported of recommending another 2 food groups namely Nuts and seeds & Dairy food products.

In the non-intensive villages only 1 food group namely Rice/wheat flour/tuber was reported to be recommended by all the AWWs. 90 percent AWWs reported of recommending 3 food groups namely Pulses, Dark Green Leafy Vegetables and Eggs while 80 percent reported of recommending 1 food group namely Coloured Vegetables & fruits. Similarly, only 60 percent of AWWs reported of recommending 2 food groups namely Flesh food (Meat/Fish) and Dairy food products, followed by 40 percent and 30 percent of

AWWs who reported of recommending food groups namely nuts & seeds and Other vegetables and fruits respectively.

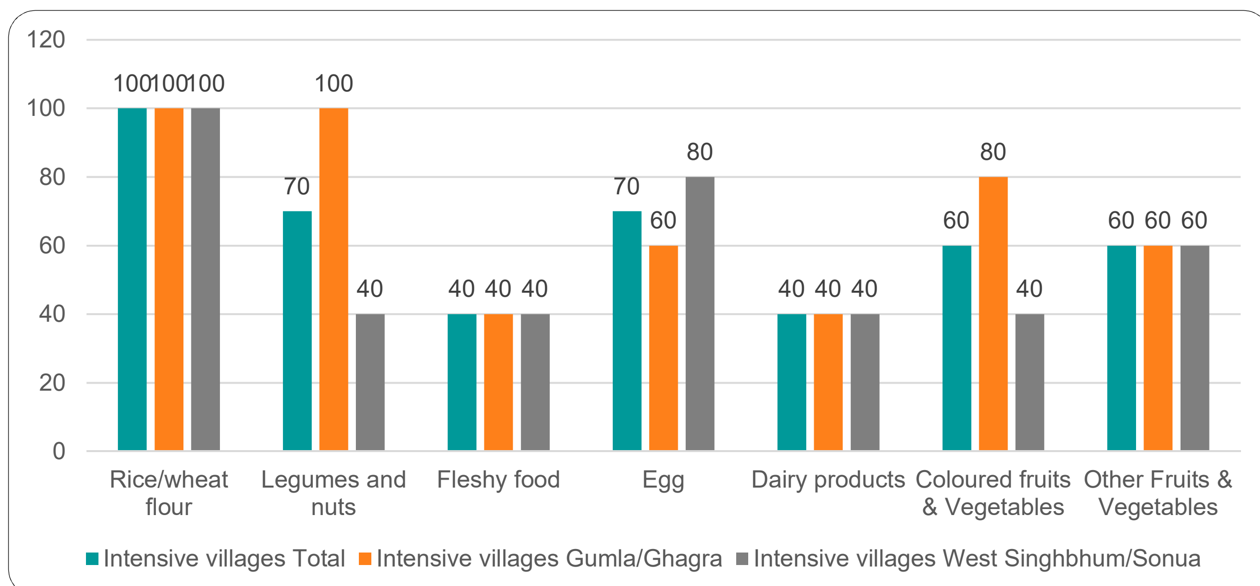


Figure 67: Food groups recommended for 0-35 month aged children (intensive villages) – in percent

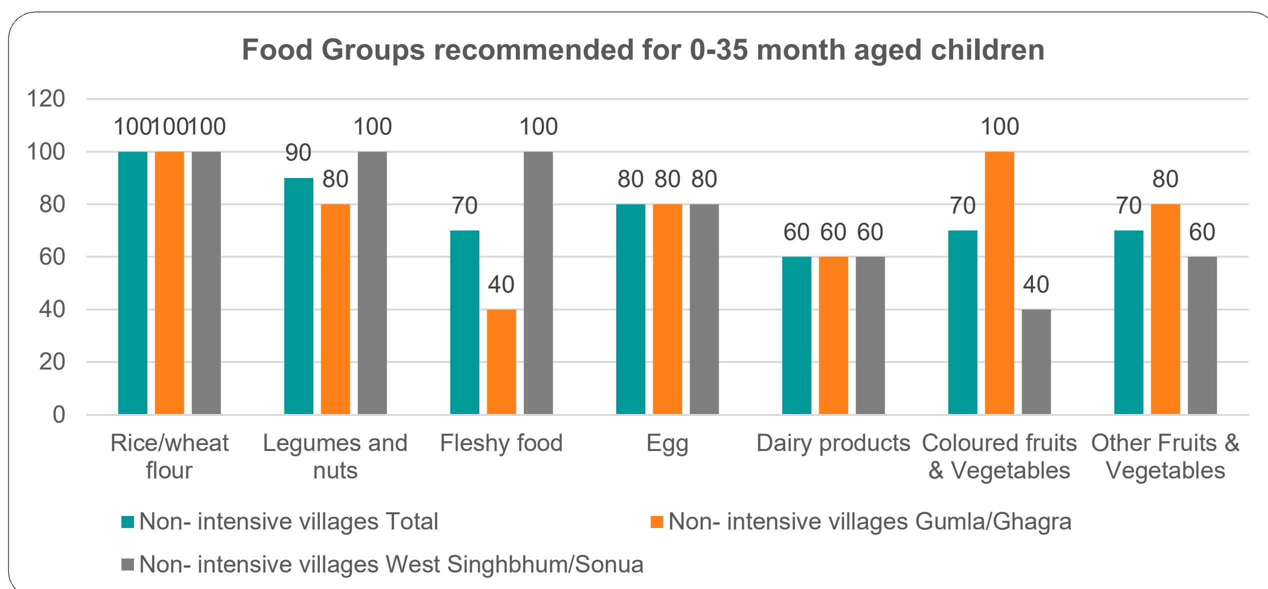


Figure 68: Food groups recommended for 0-35 month aged children (non-intensive villages) – in percent

All the AWWs, both in the intensive and non-intensive villages reported of counselling mothers of 6-35 months' children towards providing food from recommended seven food groups for children. In the intensive villages food group namely Rice/wheat flour for the children aged 6-35 months was recommended by all the AWWs, followed by 70 percent AWWs who recommended 2 food groups namely Legumes and nuts & Egg. Similarly, 60 percent AWWs recommended 2 food groups namely Coloured fruits & Vegetables and

Other Fruits & Vegetables followed by 40 percent AWWs who recommended Fleshy food & Dairy products for the 0-35 month aged children.

In the non-intensive villages, food group namely Rice/wheat flour for the children aged 6-35 months was recommended by all the AWWs, followed by 90 percent who recommended the food groups-Legumes and nuts. While 80 percent AWWs recommended food group – egg, 70 percent AWWs recommended 3 food groups namely Legumes and nuts, Coloured fruits & Vegetables and Other Fruits & Vegetables, followed by 60 percent AWWs who recommended Fleshy food & Dairy products for the 0-35 month aged children.

Counselling mothers of 6-35 months' babies on proportion of breastfed and non-breastfed food: All the AWWs, both in the intensive and non-intensive villages of Gumla reported of counselling the mothers of 6-35 months' babies on proportion of breastfed and non-breastfed food. However, in the Sonua 60 percent and 80 percent of AWWs from the intensive and non-intensive villages respectively reported of doing the same.

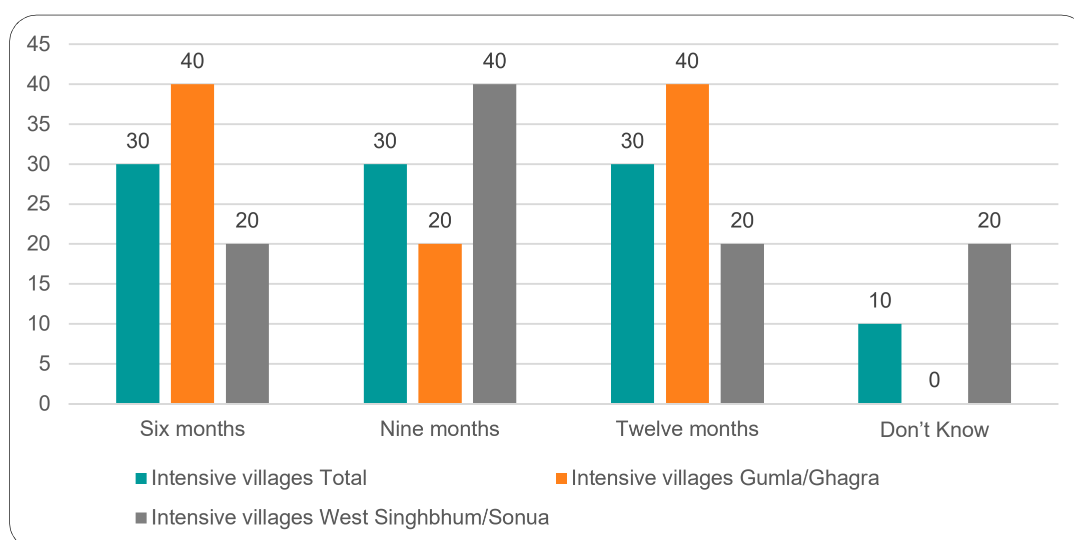


Figure 69: Home visit to a child aged 6-35 months (intensive villages) – in percent

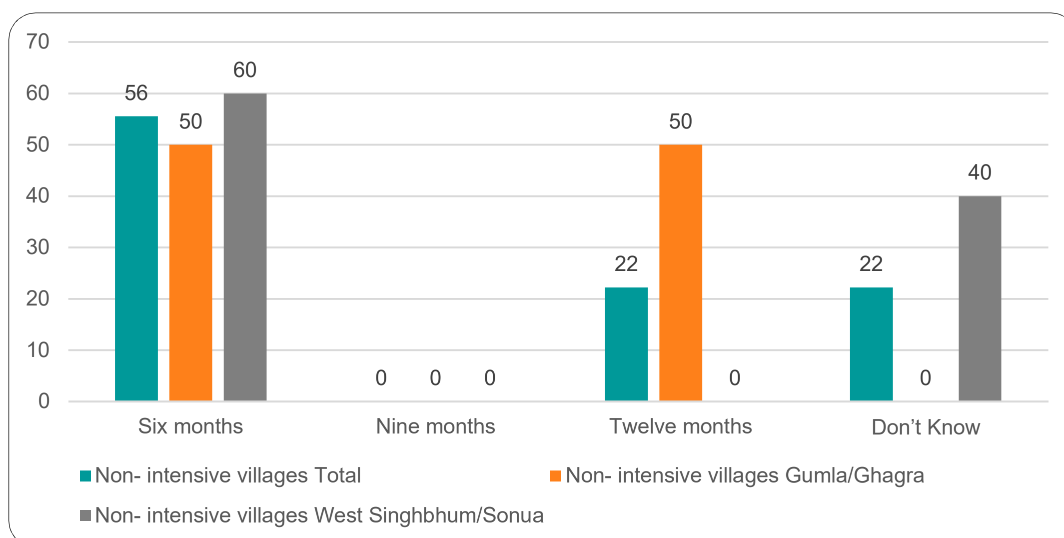


Figure 70: Home visit to a child aged 6-35 months (non-intensive villages) – in percent

AWWs reported of making a home visit to a child aged 6-35 months at 3 age intervals viz. six months, nine months, and twelve months. In the intensive villages 30 percent of AWWs reported of visiting the home of a child aged 6-35 months at six, nine, twelve months. Similarly, in non-intensive villages while 56 percent reported to visiting at 6 months, followed by 22 percent reported of visiting at 12 months. None of the AWWs reported to visiting at 9-month age of the child while 22 percent reported that they do not know when the visits are to be made. Interestingly, in the non-intensive villages of Ghagra 20 percent AWWs reported of visiting every month.

In the past one year, both in the intensive and non-intensive villages, 30 percent of AWWs reported that their AWC were part of special camp for SAM/MAM, while 70 percent AWCs were not. The district level difference is, however, marked. In the intensive villages of Ghagra and Sonua, 40 percent of AWCs and all the AWCs respectively were not part of special SAM/MAM camps in the past one year. In the non-intensive villages of Ghagra and Sonua, 60 percent of AWCs and 80 percent AWCs respectively were not part of special SAM/MAM camps in the past one year. Interestingly, 9 AWWs – 7 in intensive villages and 2 in non-intensive villages reported of MAM children and 10 AWWs – 7 in intensive villages and 3 in non-intensive villages reported of SAM children.

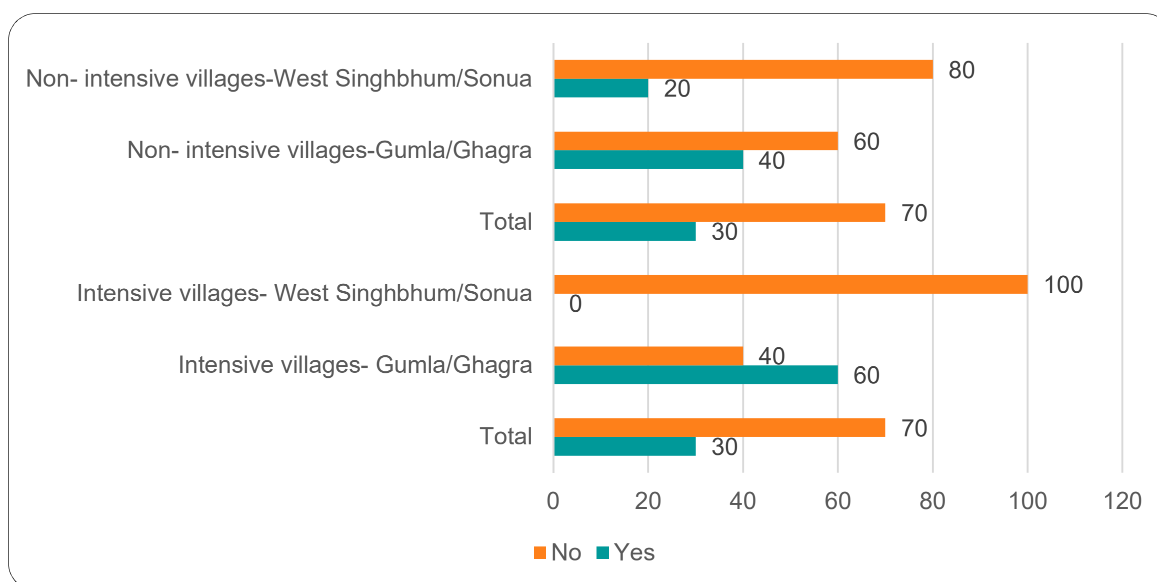


Figure 71: AWC part of special camp for SAM/MAM – in percent

Inculcation of the habit of washing hands among children at AWC: In the intensive villages, 6 (60 percent) of the AWWs reported of always inculcating the habit of washing hands among children at AWC, while 4 (40 percent) of the AWWs reported of sometimes inculcating the habit. Similarly, in the non-intensive villages, 7 (70 percent) of the AWWs reported of always inculcating the habit of washing hands among children at AWC, while 3 (30 percent) of the AWWs reported of sometimes inculcating the habit.

Figure 73: Practice of Washing hands among children at AWC (intensive villages) – in percent

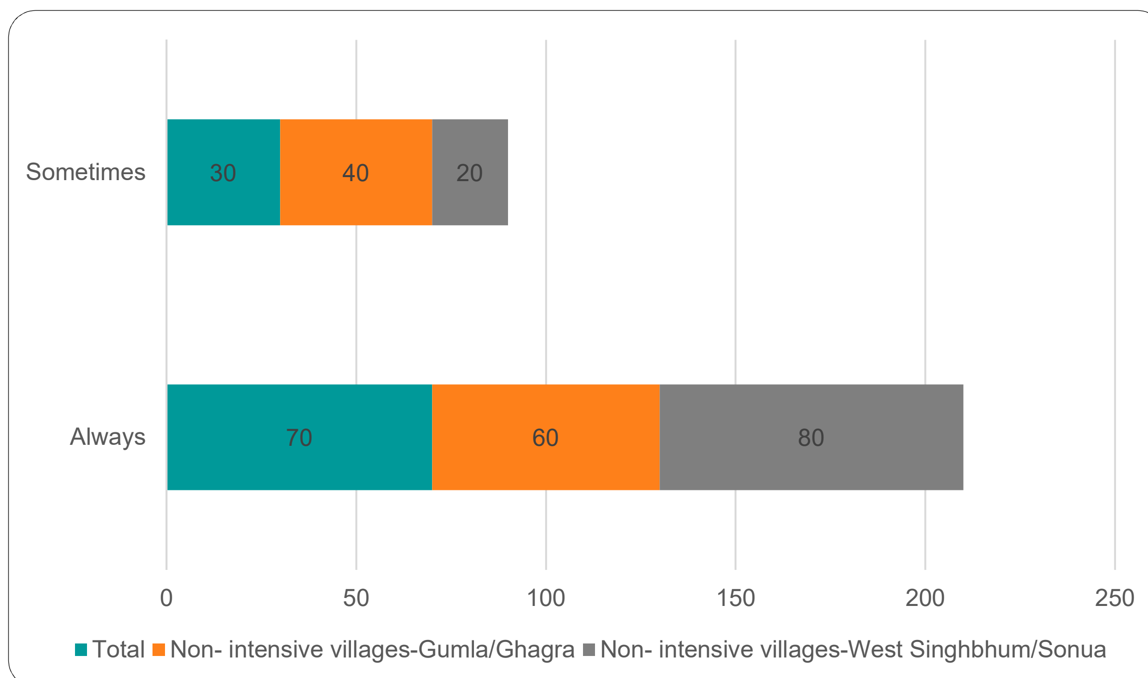


Figure 72: Practice of Washing hands among children at AWC (non-intensive villages) – in percent

Training/Educating mothers to wash their hands: Except for 1 AWW from the intensive villages of Sonua, all the AWWs reported of educating mothers to wash their hands.

Educating mothers to wash hands with soap and water and six steps of handwashing on these occasions:

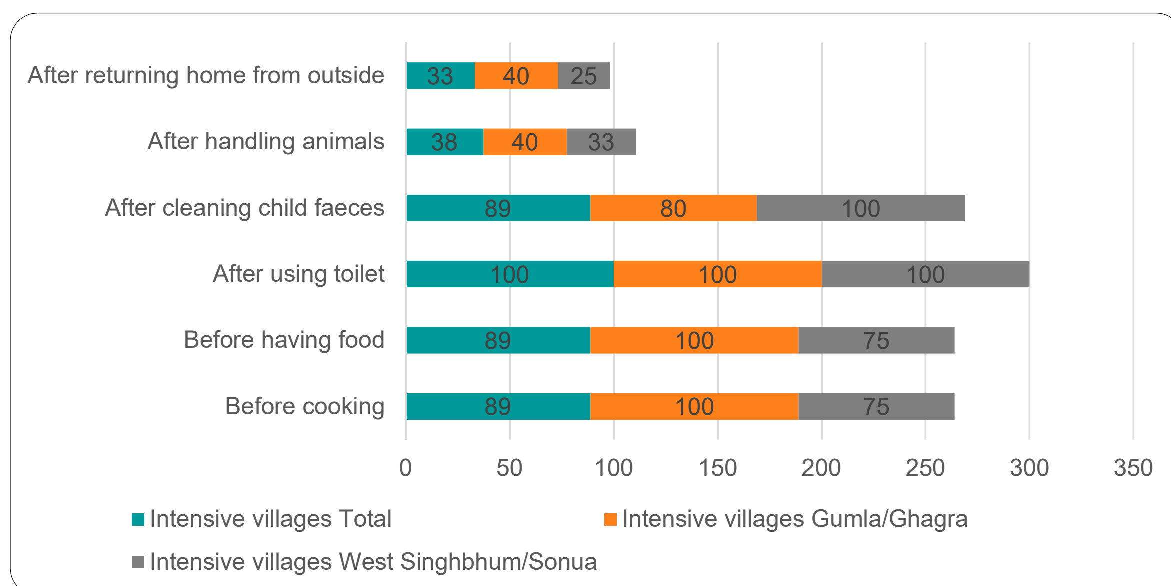


Figure 75: Educating Mothers on Hand Wash with soap and water (intensive villages) – in percent

Figure 74: Educating Mothers on Hand Wash with soap and water (non-intensive villages) – in percent

Counselling families on the importance of clean drinking water and its safe storage: All the AWWs, both in the intensive and non-intensive villages have reported of counselling the families on the importance of clean drinking water and its safe storage.

Counselling families on water purification process / method/ techniques: Large majority of AWWs viz. 90 percent and 78 percent from the intensive and non-intensive villages have reported of counselling families on water purification process / method/ techniques.

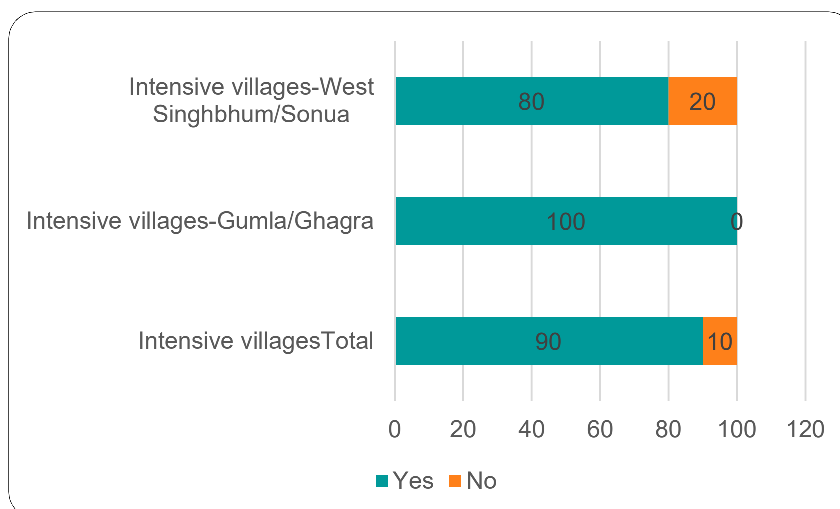


Figure 76: Counselling on water purification (intensive villages) – in percent

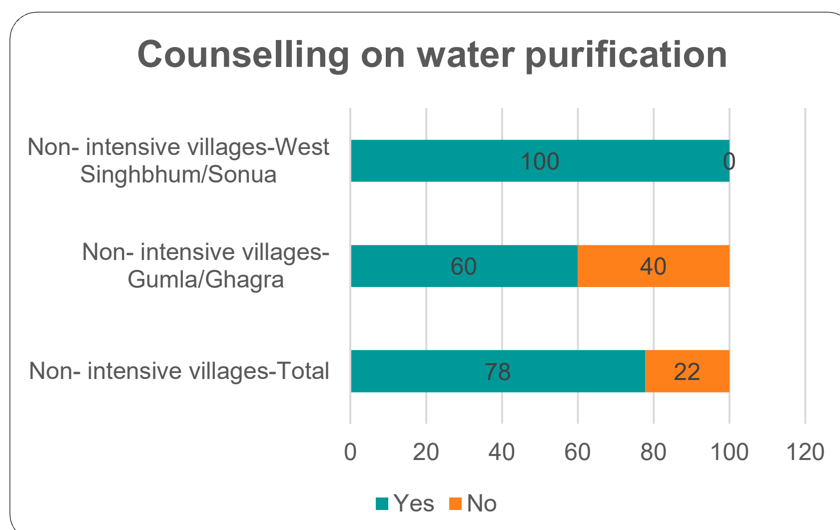


Figure 77: Counselling on water purification (non-intensive villages) – in percent

Counselling beneficiary households regarding setting up of sanitary toilet at home: Except for 3 AWWs from the intensive villages who reported of not counselling the beneficiary households regarding setting up of sanitary toilet at home, all the AWWs in the intensive and non-intensive villages of both the districts reported of counselling the beneficiary households.

2.4.5. Knowledge level of AWW

Age of the first health check-up of a child done after birth:70 percent of the AWWs in the intensive villages reported the first check-up of child after birth on the day of the birth, while 30 percent reported within 3 days of the child's birth. In the non-intensive villages while 70 percent of the AWWs in the intensive villages reported the first check-up of child after birth on the day of the birth, while 20 percent reporting between 8-15 days of birth followed by 10 percent reporting within 3 days of the child's birth.

Breastfeeding and First food that a new-born should receive: All the AWWs, both in the intensive and non-intensive villages, reported that mother's milk as the first food that a new-born should receive. Similarly, all AWW reported that a new-born should be fed with the first milk (Colostrum) of the mother.

All the AWWs, both in the intensive and non-intensive villages, reported that breastfeeding should be initiated immediately after birth/as soon as mother is in position to breastfeed, and that the new-born should be exclusively breastfed for a period of 6 months.

Age at which the child should be provided complementary food to being breastfed: In the intensive villages, mean age of 12 months as the age, when child should be provided complementary food to being breastfed was reported by AWWs, while mean age of 14 months was reported by AWWs in non-intensive villages.

2.5. Capacity building of AWW (Refer to AWCs training related questions in AWC tool)

Training programs attended on Nutrition in last 2 years: In the intensive villages, while all the AWWs in Gumla/Ghagra reported of attending up to 3 training programmes on nutrition, AWWs of West Singhbhum/Sonua reported of attending none. In the non-intensive villages, while 60 percent AWWs from both the blocks reported of attending up to 3 training programmes on nutrition, 40 percent, and 20 percent AWWs from Gumla/Ghagra and West Singhbhum/Sonua respectively reported of attending 4-6 training programmes.

Usefulness of training program: In the intensive villages, 80 percent of AWWs who received trainings reported the training to be useful while 20 percent reported the trainings as very useful. In the non-intensive villages, 78 percent of AWWs who received trainings reported the training to be useful while 22 percent reported the trainings as very useful.

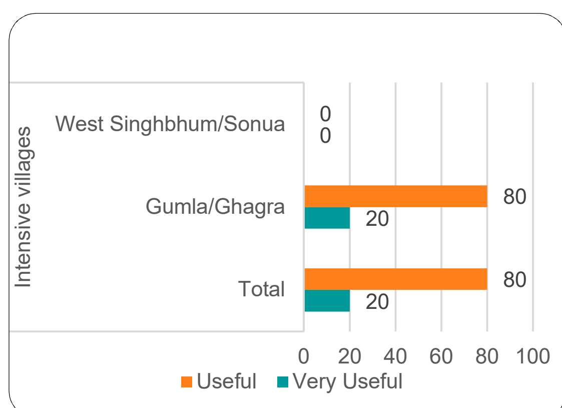


Figure 78: Usefulness of Trainings (intensive villages) – in percent

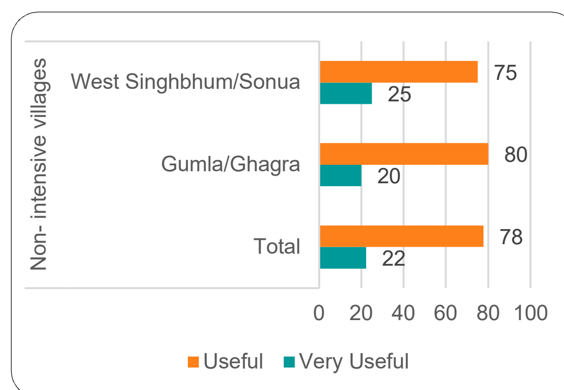


Figure 79: Usefulness of Trainings (non-intensive villages) – in percent

Understanding of the subjects discussed in the training programs: In the intensive villages, 40 percent of AWWs who received trainings reported that they were fully able to understand the subjects discussed the training, while 60percent reported of partial understanding. In the non-intensive villages, 67 percent of AWWs who received trainings reported that they were fully able to understand the subjects discussed the training, while 33 percent reported of partial understanding.

Satisfaction with the quality of training imparted: Large majority of AWWs i.e., 80percent in intensive villages and 89 percent in non-intensive villages were satisfied with the trainings. None of the AWWs were very satisfied with the trainings.

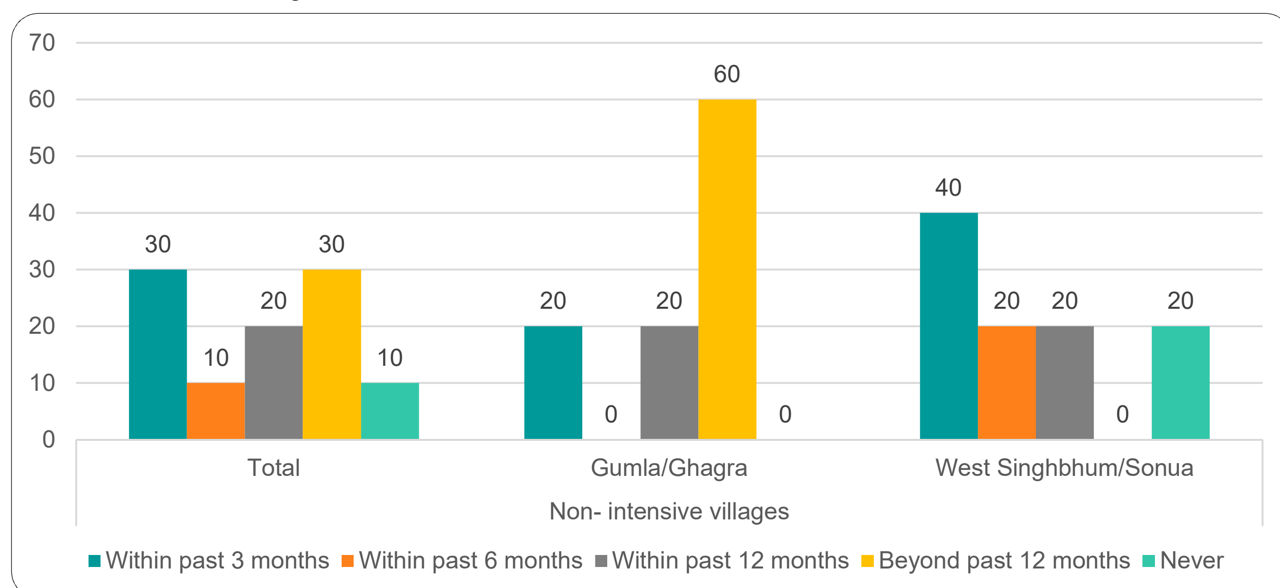


Figure 80: Last Nutrition Training Programme attended (non-intensive villages) – in percent

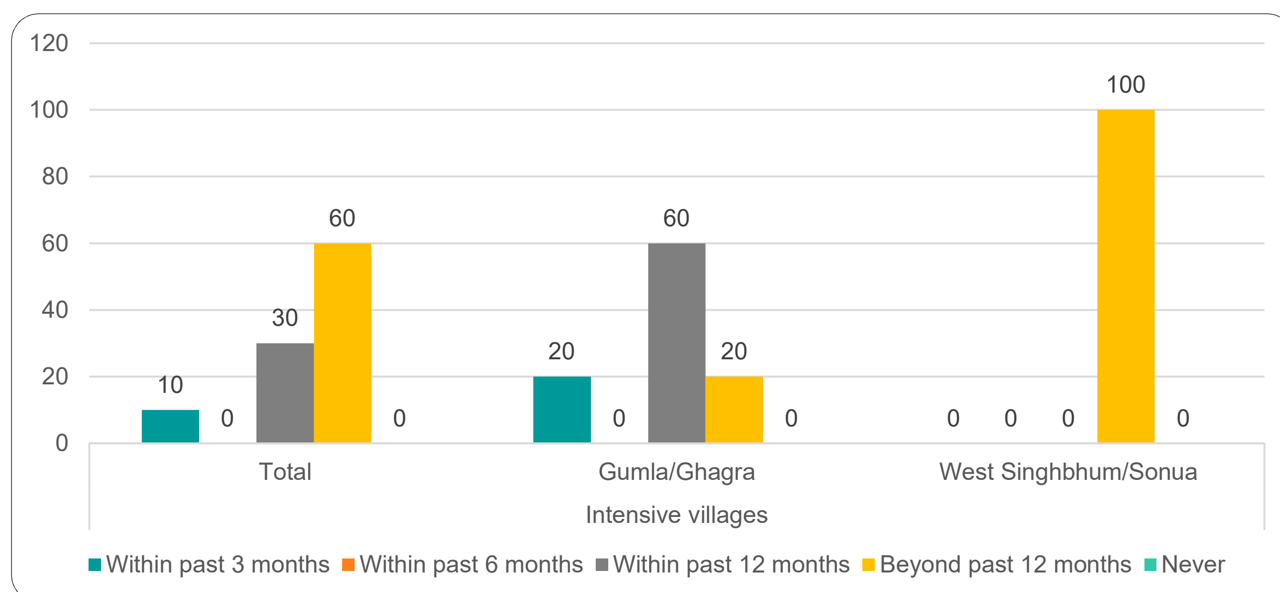


Figure 81: Last Nutrition Training Programme attended (intensive villages) – in percent

Conduct of special training sessions on managing SAM/MAM in your Anganwadi Centre: 70 percent and 50 percent AWWs reported of not conducting any special training sessions on managing SAM/MAM in their Anganwadi Centre.

Challenges faced in organizing these training sessions:

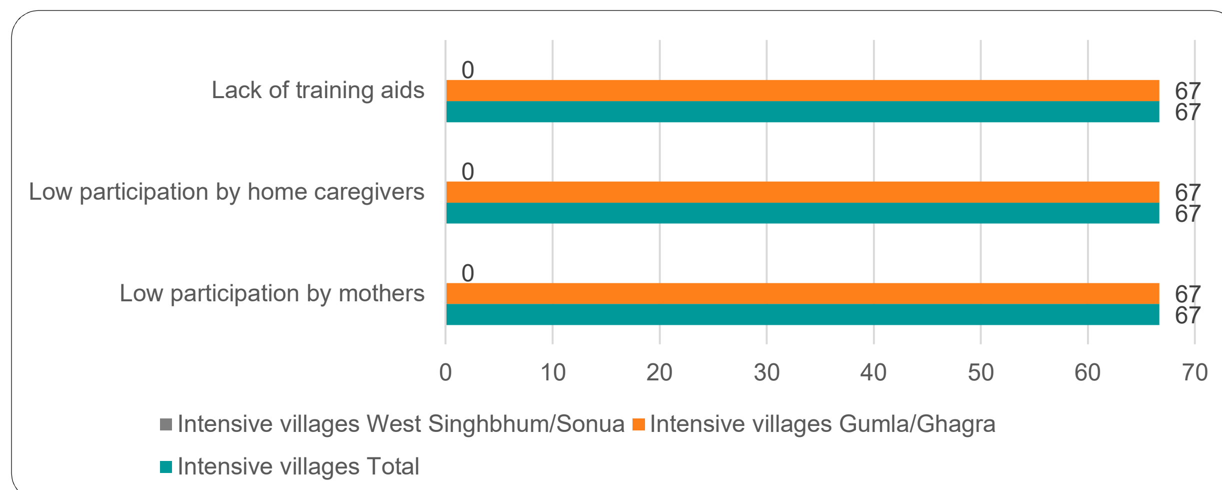


Figure 83: Challenges in organizing SAM/MAM trainings (intensive villages) – in percent

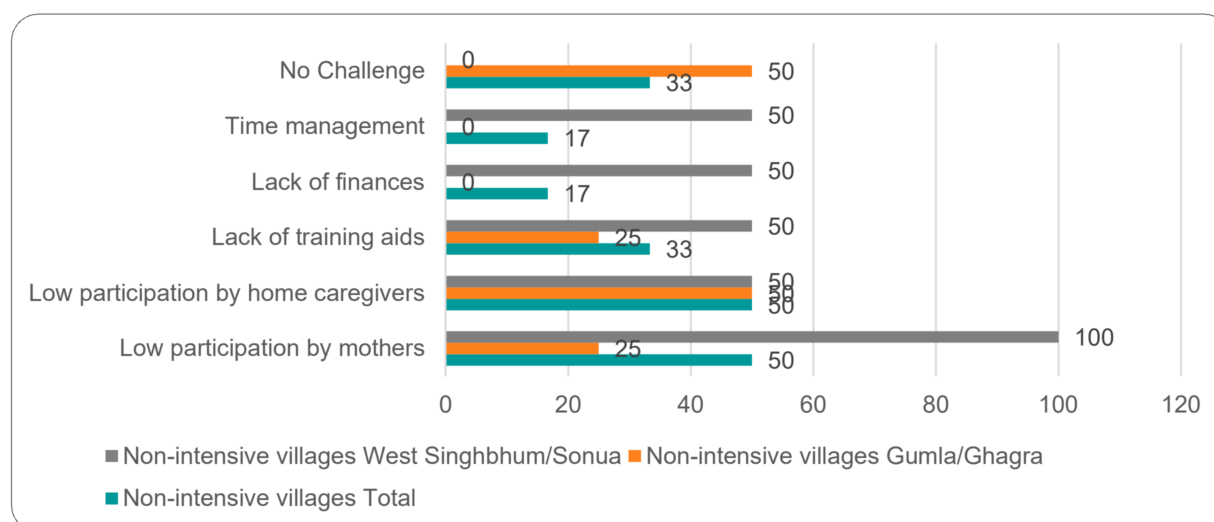


Figure 82: Challenges in organizing SAM/MAM trainings (non-intensive villages) – in percent

Events organised at the AWC: All the AWCs, both in the intensive and non-intensive villages, organize God Bharai and Annaprasan ceremonies. Few of them also organize events on the eve of suposhan (nutrition) diwas (day), ECC day, and Health day.

Status of AWWs trained to counsel village households on covid 19 in the past year: 70 percent AWWs in the intensive villages and 90 percent in non-intensive villages reported of being trained to counsel village households on covid 19 in the past year.

<u>Status of AWWs trained on hand wash practices for safety measures of Covid 19</u>: 80 percent AWWs in the intensive villages and 100 percent in non-intensive villages reported of being trained on hand wash practices for safety measures of Covid 19.

<u>Training received for filling / updating the registers:</u> In the intensive villages, all the AWWs have received trainings, albeit 30 percent for all registers while 70 percent for some registers. In the non-intensive villages, 90 percent AWWs have received trainings, albeit 67 percent for all registers while 22 percent for some registers. Around 11 percent AWWs reported of having note received any training.

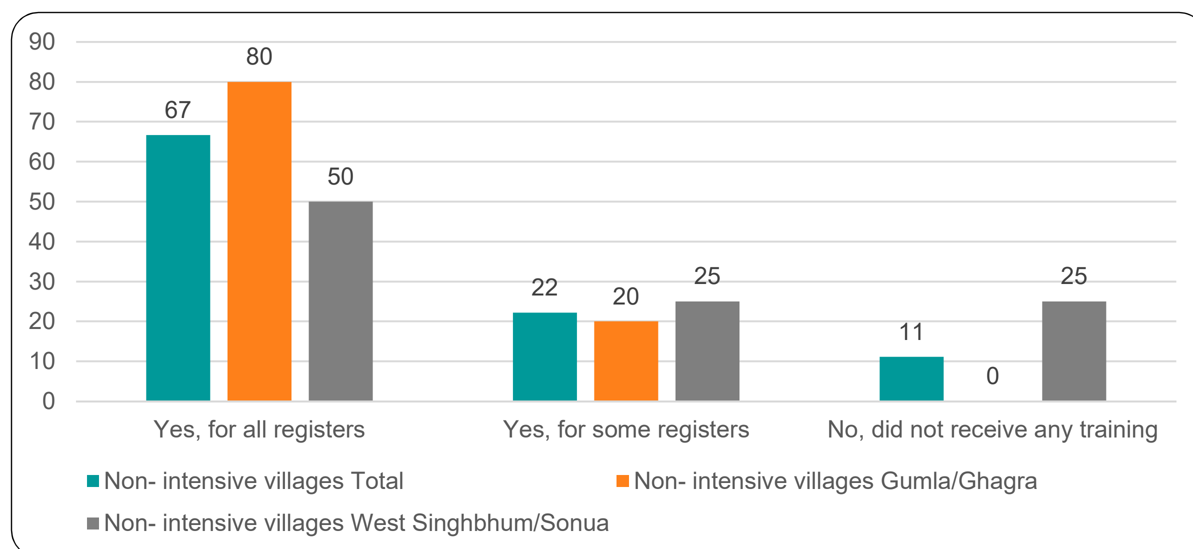


Figure 84: Training received for filling/updating registers (non-intensive villages) – in percent

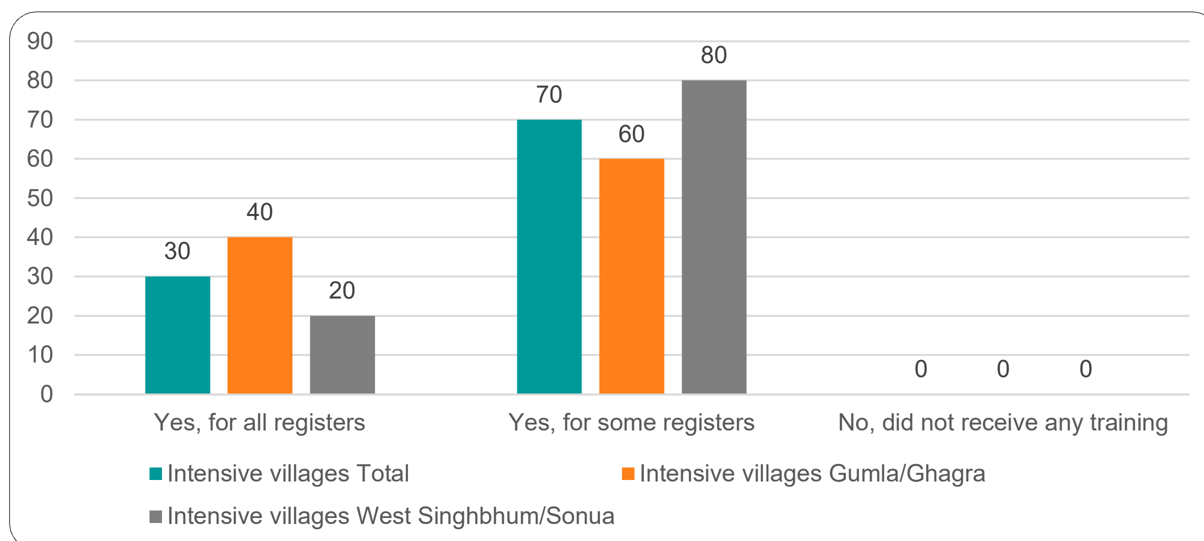


Figure 85: Training received for filling/updating registers (intensive villages) – in percent

<u>Difficultly in filling/updating registers:</u> In the intensive villages, 50 percent of AWW reported of sometimes facing difficulties in filling/updating registers, while 10 percent reported of always facing difficulty. 40 percent reported of facing difficulty with new formats. In the non-intensive villages, 70 percent of AWW reported of never facing difficulties in filling/updating registers.

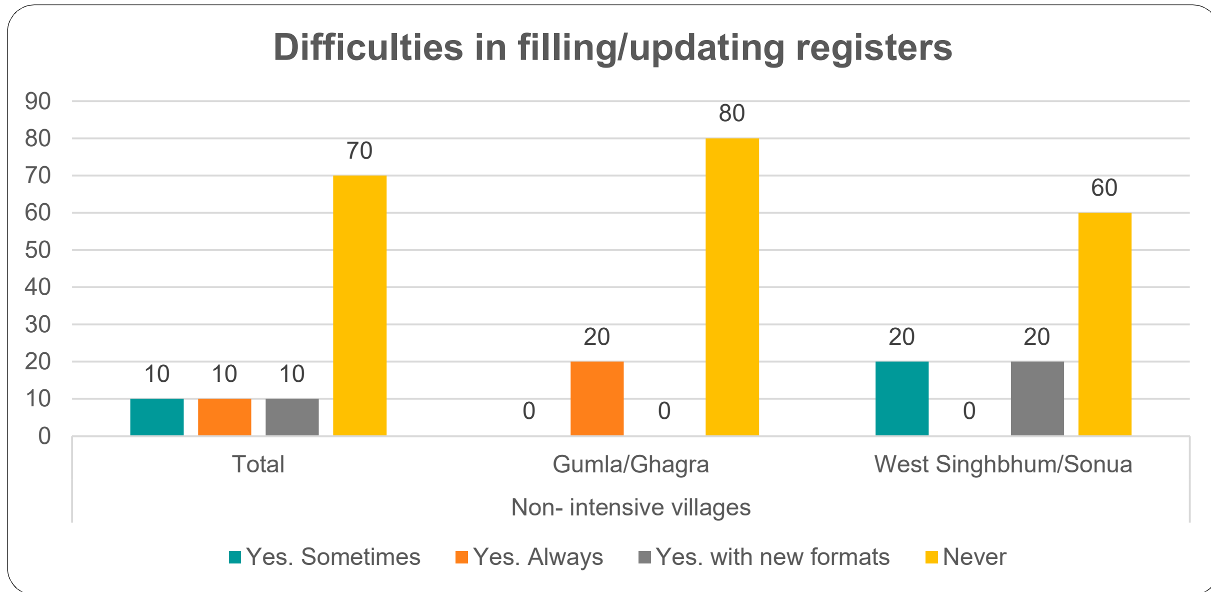


Figure 87: Difficulties in filling/updating registers (non-intensive villages) – in percent

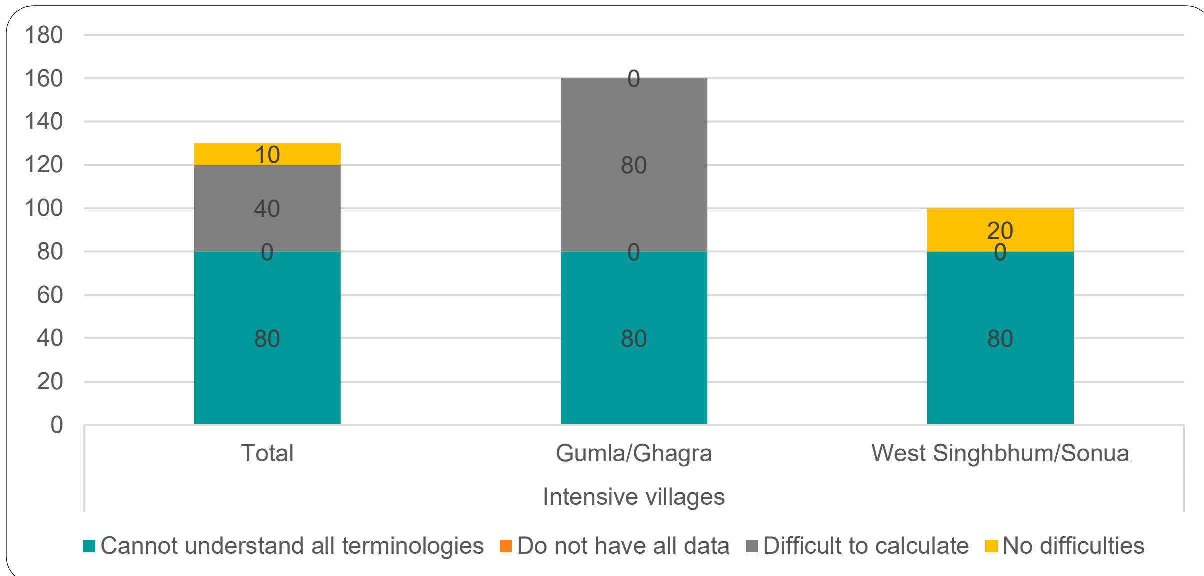


Figure 86: Difficulties in filling/updating registers (intensive villages) – in percent

<u>Kinds of difficulties faced: </u>In the intensive villages, 80 percent of AWW reported of not able to understand all terminologies used in the registers, following by 40 percent who find it difficult to calculate. In the non-intensive villages, 40 percent of AWW reported of finding calculation difficult.

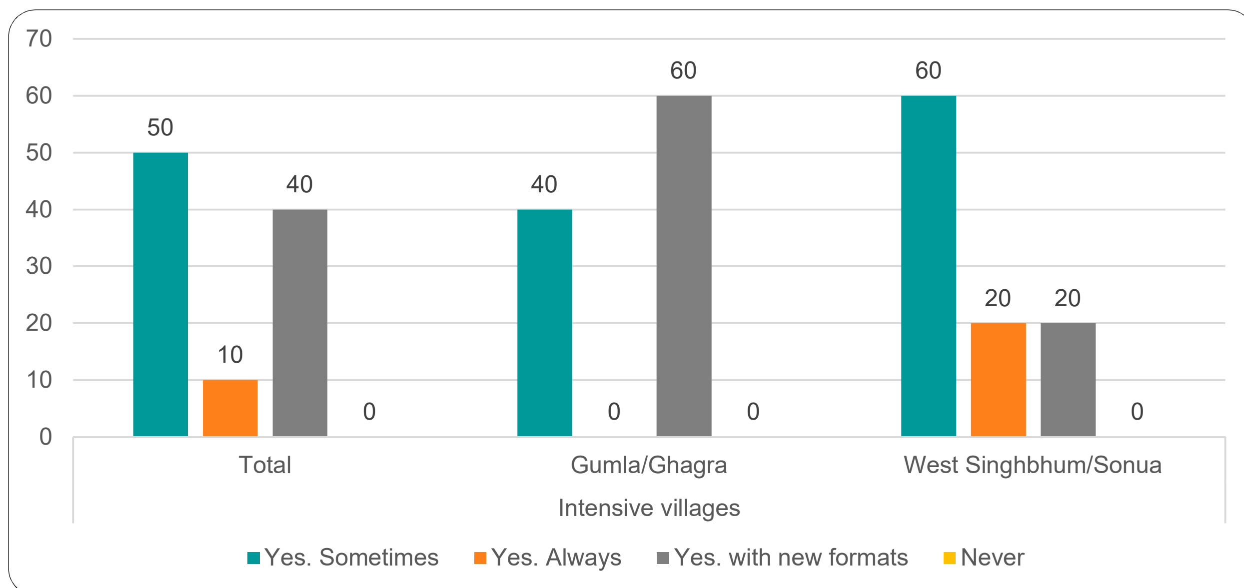


Figure 88: Kinds of difficulties faced (intensive villages) – in percent

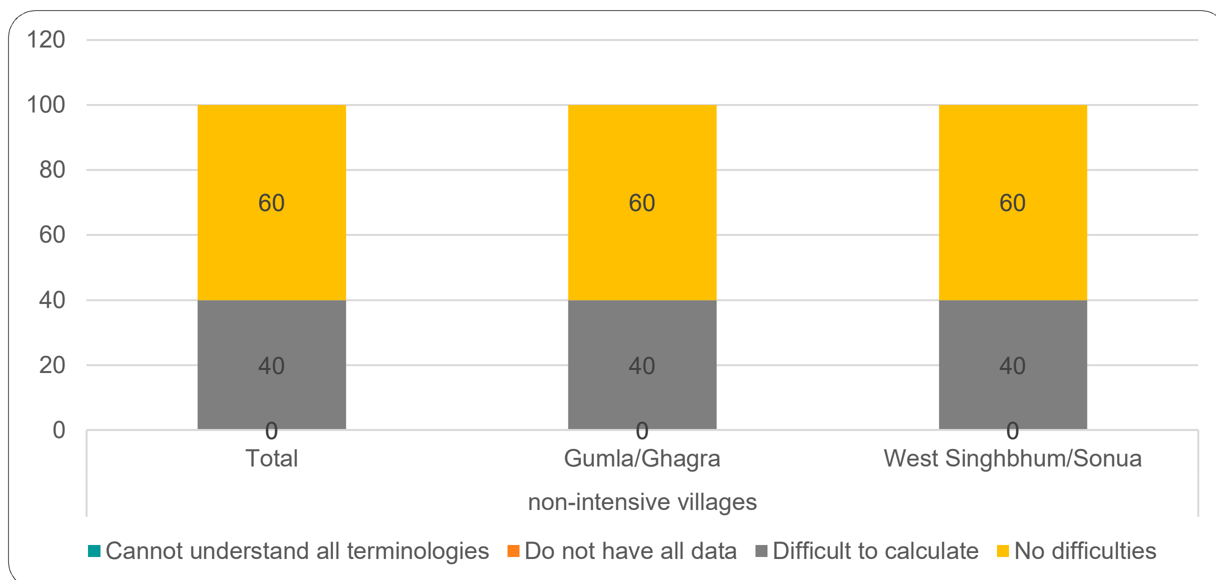


Figure 89: Kinds of difficulties faced (non-intensive villages) – in percent

Need for training for filling/updating registers: All the AWWs in the intensive villages reported need for training for filling/updating registers, while70 percent AWWs reported the need for the same In the non-intensive villages.

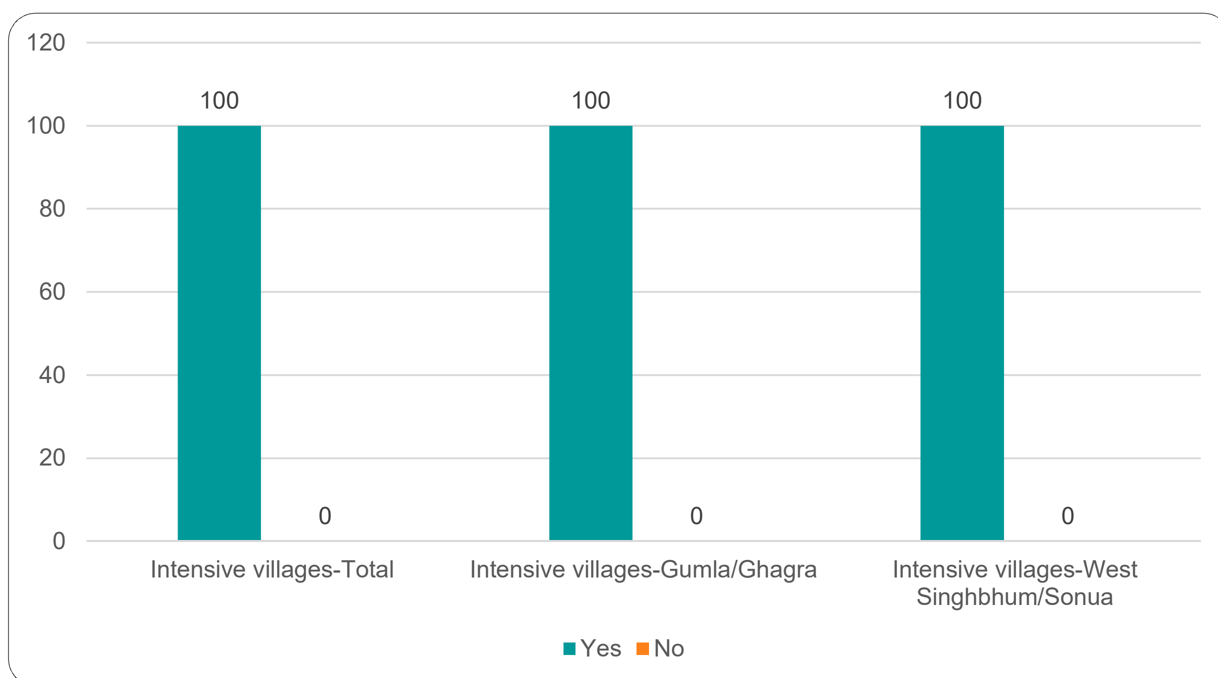


Figure 90: Need for training for filling/updating registers (intensive villages) – in percent

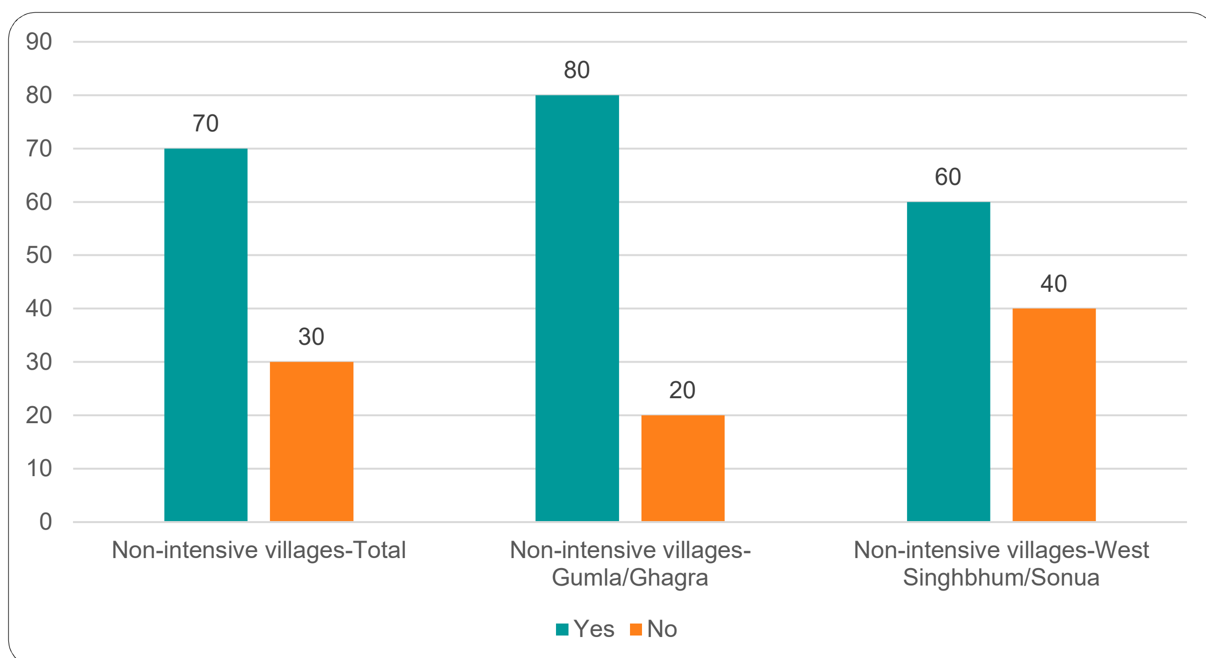


Figure 91: Need for training for filling/updating registers (non-intensive villages) – in percent

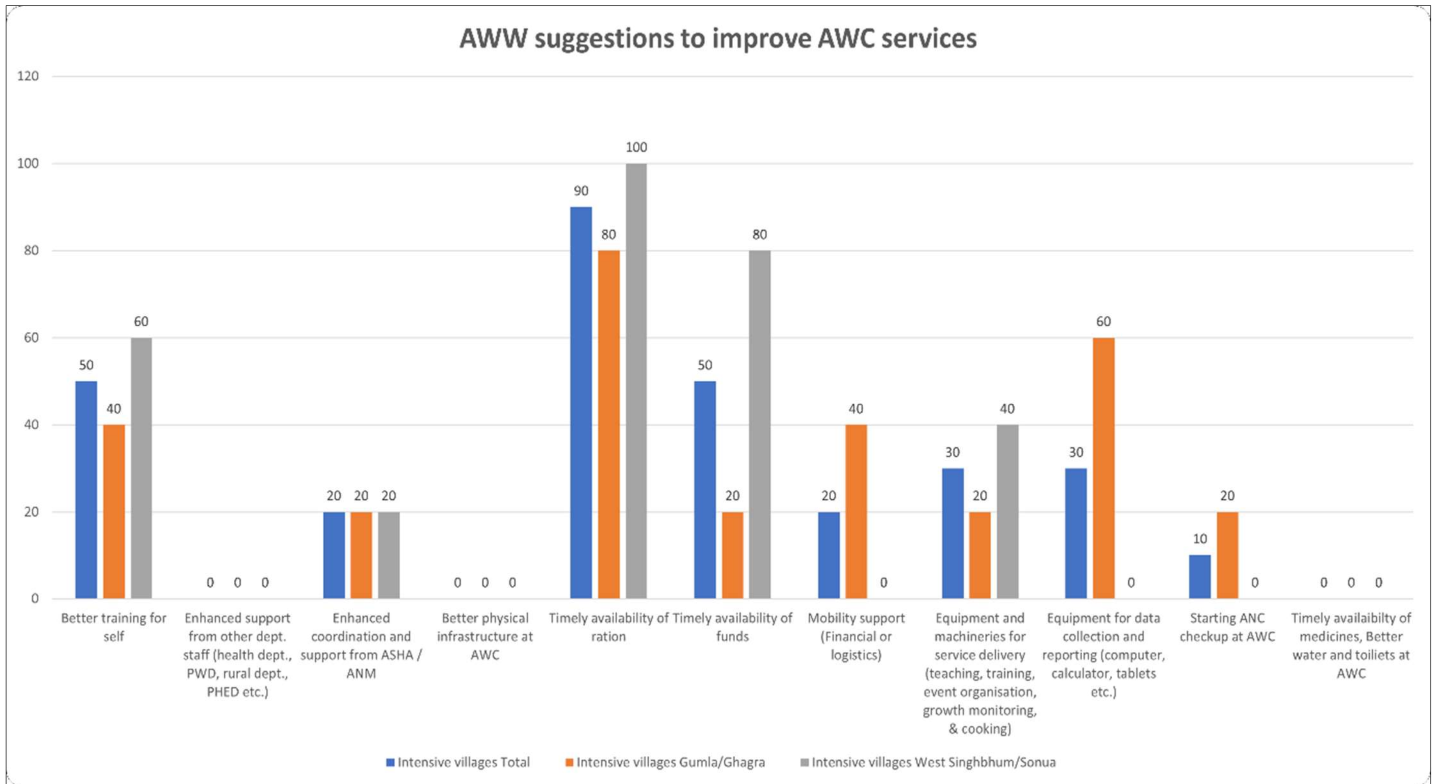


Figure 92: AWW suggestions to improve AWC services (intensive villages) – in percent

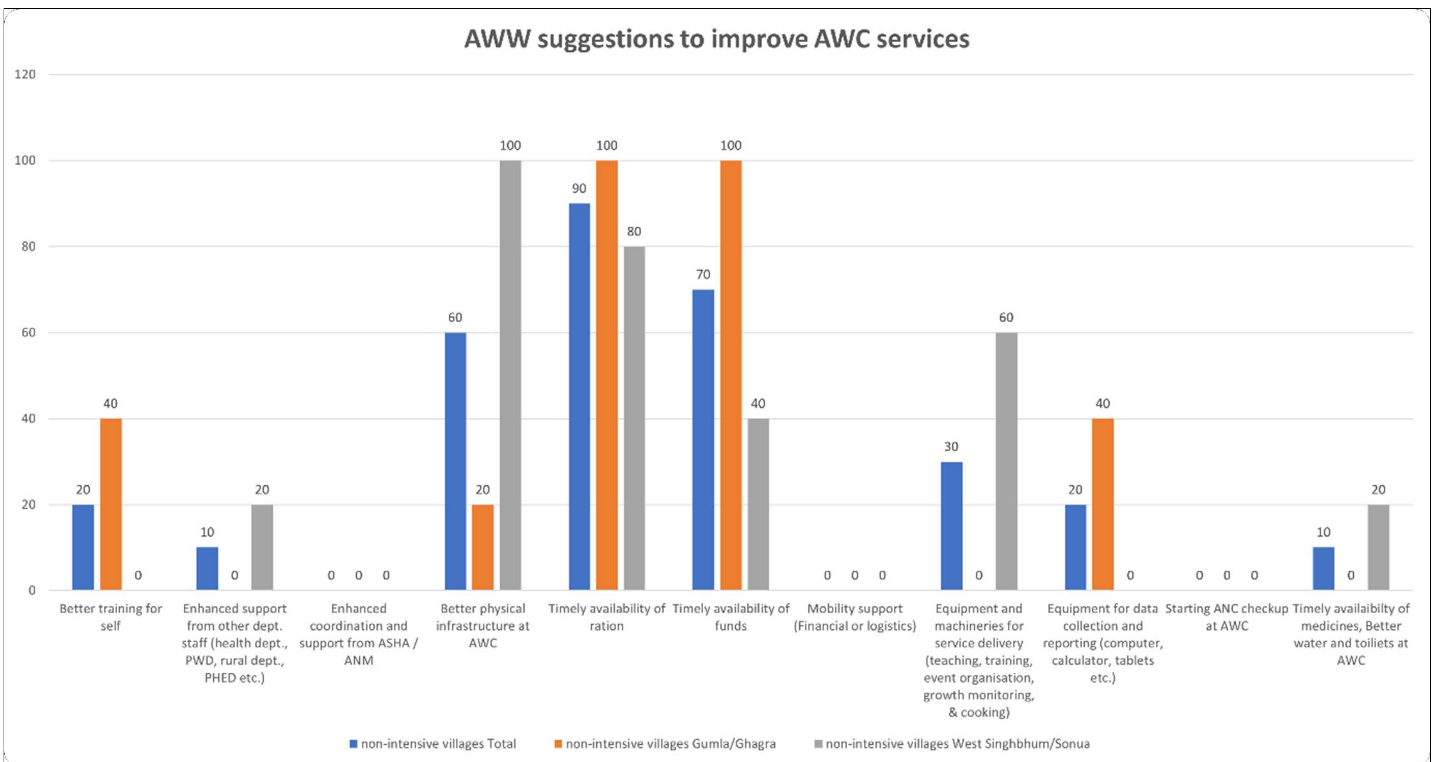


Figure 93: AWW suggestions to improve AWC services (non-intensive villages) – in percent

3. Synthesis & Recommendations

1. Programme Level

- The chosen intervention villages primarily comprise of Scheduled Tribes with Ho and Santhal communities dominating the Sonua block while Munda and Santhal communities are the major tribal communities in Ghagra.
- The staff at the Department of Women, Child Development and Social Security of both the blocks informed that although the awareness levels of beneficiary households are low regarding various schemes and services and aspects of health, sanitation and nutrition, there has been improvements in recent years as compared to initial years of (early nineties) Anganwadi Centre operations. Social rituals like *God Bharai* and *Annaprashan* are now being organized by AWCs, and women are made aware of the benefits and rights under various programs.
- The department of Women, Child Development and Social security in both the blocks of Sonua and Ghagra, primarily works in isolation with very little coordination with other block level departments like the Department of Health, Medical Education and Family Welfare or the Department of Drinking Water and Sanitation. There is no nodal officer to manage the inter-departmental and intra-departmental matters in the block. Under special drives like Covid-19 vaccination initiatives driven by the district level administration, the Lady Supervisors and Anganwadi workers often receive direct orders and guidelines from District level officials through the respective CDPO. While ASHA workers (Sahayika) were found to work closely with the Anganwadi Worker (Sevika) and ANM at the village level in day to day health and WASH related activities, the coordination at the block level between the departments are not visible.

2. Infrastructure, Sensitive and Access issues

- Some of the Anganwadi centres are in remote and geographically inaccessible areas. 51 such centres of Sonua and another 22 centres in Ghagra are remotely located. Apart from the geographical inaccessibility due to lack of adequate roads and communication, there are areas which are also Naxalite affected and service of Anganwadis in these villages are severely impaired due to law and order issues. With major, social security government schemes being provided with the help of Aadhar and similar identification cards, the provision of such schemes in these remote and Naxalite affected areas is a major problem since majority of the households do not have such identification. Naxalite areas reported Aadhar cards of residents being seized by extremists to prevent govt. support. Likewise, the penetration of financial inclusion in these areas are also very low with small number of functional bank accounts in each household which is a major bottleneck in DBT schemes by Govt.
- Many of the Anganwadi centres constructed in both the blocks by the government are in absolute dilapidated condition. While some of the have been condemned as not fit for use, (31 in Ghagra) most of them continue to be used by all concerned. Many meetings of women and children are conducted in these highly unsafe building which carry high risk and hazard for women and children. While most of them are supposed to be equipped with kitchen, the actual condition of many of the kitchens of the Anganwadi centres are precarious and beyond usage. Makeshift cooking stoves in the open are often prepared as an alternative. Since the break of the pandemic, Anganwadi centres are officially closed and no cooking activities are being undertaken, making the infrastructure more dismal.
- The infrastructure bottlenecks of the AWCs are also associated with piped drinking water and toilets availability as well. Only 36% of the AWCs in Sonua and around 15% of them in Ghagra respectively have access to piped drinking water while another 39% in Sonua and 22% AWCS have toilets in Sonua and Ghagra respectively. Most villages reported that the quality of construction of toilets was very poor under Swachh Bharat Mission and that majority of the toilets constructed are defunct. Likewise, *'Pani Minar'* or water towers constructed with the help of solar operated pumps and tanks supplying water to households as well as public taps run defunct for the want of maintenance in around 2-3 years' time. Almost half of the drinking water infrastructure set up by the government are thus defunct.
- A newly developed software app POSHAN Tracker has been launched to collect and report data. Presently, online report updating is prevalent. Due to lack of training, non-availability of smart devices

and network issues, usage of this tracker and accessing online report services has been a major challenge for the AWWs.

3. Implementation Level

- **Inadequate manpower:** There are severe staff crunch at the block level where, 5 out of 6 Lady Supervisor positions are vacant in Sonua while 4 out of same 6 positions are vacant in Ghagra. Thus, there is pressure on the existing staff to perform additional duties. However, discussions with LS revealed that there is a continuous preference of Lady Supervisor staff to be posted in their home locations or blocks. The motivation of the staff and efforts undertaken thus grossly depends on their place of posting. Honorarium of the workers are also not paid regularly.
- **Services Provided:** Each AWC generally caters to 70-75 beneficiaries. Food supply, awareness about food groups, supply of supplementary nutrition, deworming medicines, growth monitoring, managing referrals of SAM/MAM are the services that are provided by AWCs. In this year, Sonua reported around 125 SAM children, while Ghagra reports 28 SAM children. Sonua also reported that 25 children were referred to MTC while no child was in Ghagra was referred. They said that there is a severe reluctancy among mothers to part with their children (SAM) and send them to MTC for treatment. Moreover, currently Take Home Ration (THR) is only being provided to children from 3-6 years. The ration consists of Rice, Pulses, Oil, Groundnut, Sugar, Jaggery, Potato and Semolina (Sooji). The supply chain is not standardized and, in some villages, the AWW purchases the items from shops to distribute the same. While in other cases there is centralized purchase at the block level. However, the Rice is often supplied by the PDS through different channels. The supply of Rice is irregular and inconsistent.
- **Low awareness levels:** With overall low awareness levels as well as low interest regarding various services offered by the Anganwadi centres in both the blocks the demand for such services is also low. The ability of the Anganwadi worker and Asha workers to mobilize mothers and children to come to the centre is largely dependent on the ration and food provided in the centres which has been reported to be a major pull factor for mothers and children to use the Anganwadi centres. The recent hindrances in supply of Take Home Ration (THR) due to the pandemic and issues between the government and implementing agencies (Jharkhand State Livelihoods Promotion Society) to distribute Rice and other ration, has severely affected the participation of women in the Anganwadi activities.
- **Barriers for participation:** It was also reported from both the blocks, that the workload on women in the household to perform various activities comprising of Agriculture and other livelihoods, household level cooking and maintenance, looking after children etc. pushes the long-term benefits of health and ICDS schemes down the priority list where these engagements are perceived as more important and urgent than enrolling at Anganwadi. Religious belief and social background of beneficiaries also affect the access to services offered by the AWW and Asha Workers since in almost every village there are households from Birsai communities wherein taking oral medicines or injections are prohibited. These households, although less in number, do not take medicines in any form due to their social belief systems.
- **Lack of Coordination:** Staff in both the blocks reported that malnutrition and anaemia is rampant among pregnant mothers and nursing women but since there is no official communication or schemes associated with mothers, systematic information and data is not captured at the AWC or block level. It was reported that low age of marriage among tribal households often lead to early pregnancy issues and malnourished and weak children. Affected by poverty and lack of financial resources, the consumption of prescribed nutritious food is also largely compromised.
- **Awareness, and Training of AWW:** Poshan Abhiyan has been initiated in both the blocks but clarity among staff regarding its guidelines was observed to be low. No administrative structural changes have been suggested by the district administration under Poshan Abhiyan and hence there is neither any designated nodal officer nor inter-departmental meetings for proper collaboration. IEC materials in the form of posters and charts have been received at the block level which have been forwarded to AWCs. Training of AWWs under Poshan Abhiyan has been conducted in the following manner.
    - AWWs are reportedly trained on 21 modules where the training is provided by CDPO and LS. No external resource person or other officials from Health or WASH has been part of the training sessions. The training however was not comprised of formal classroom sessions and components of the training was delivered through normal meeting sessions. The training was

completed in Ghagra on 17th May 2021. Booklets provided by Poshan Abhiyan was the major reference materials. A 15-day gap was supposedly provided between each module.

- However, there was no special recall of this training during the discussions with AWWs. Many AWWs could not recall the name of the program as 'Poshan Abhiyan' as well.
- **Need for strengthening VHSNC:** At the village level there is a provision of setting up Village Health, Sanitation and Nutrition Committee (VHSNC). Since the payment of ASHA workers are linked to the formation and meeting of this committee at regular intervals, there are registers with minutes of meetings and signatures of VHSNC members which are regularly submitted at the block level. However, in almost all the intervention villages, such committees are formed only on paper and members do not know the existence of such committees. In many cases the AWWs don't know of such committee as well. ANM's visit to the local health centre is however regular in both the blocks. On such ANM visit dates, vaccinations are scheduled, THR is distributed (whenever available and applicable) and meeting registers of all other activities like VHND, monthly meetings etc. are filled. In most cases the signatures of VHSNC members are already taken in advance and only short generic minutes are written atop the signatures. In most cases, signatures have been taken in advance for the entire year. Neither the village administration authorities like Sarpanch or Ward members are actually aware of the functions of the VHSNC or VHND agenda. Thus, even if information on VHSNC is received as per govt. records, the actual reality in field is completely different. No training in whatsoever form has ever been conducted for any VHSNC in any of the surveyed villages. Thus, the role of the members is not clear. Deeper probing with various village level key opinion leaders reveal that members do not get compensated in any form in participating in the VHSNC and thus there is no motivation for them to attend meetings. It was reported by some ASHA workers that any new committee formed by the government will just add another register to be maintained but actually the same meeting will be referred to by different names.
- As mentioned before, the overall awareness level of households on health, sanitation and nutrition of mother and child are extremely low. Awareness efforts by the government as well as NGOs and other projects have been largely ineffective in generating awareness and interest regarding various aspects of health, sanitation, and nutrition. As an example, majority mothers do not know the meaning of 'Vitamins', 'Iron', 'Calcium' etc. Thus, most of them do not understand the dosage of various mineral supplements they receive or are entitled to receive from ANM and Anganwadi centres.
- Save the Children and its partner implementing agencies are organizing a separate committee named 'Stand up Nutrition Committee' to discuss various aspects of nutrition and health among pregnant women and nursing mothers. The recall of majority mothers regarding any 'meeting' and 'committee' to discuss health issues conducted is often referred to this committee meeting.

4. Recommendations

- Any program which is designed for enhancing health, nutrition and sanitation of pregnant women, nursing mothers and children in the specified tribal villages of Sonua and Ghagra need to undertake interventions which will take into consideration the entire ecosystem and not look at health, nutrition, and sanitation as isolated aspects only. The entire behavioural change needs to be designed keeping in mind livelihoods, social and economic constraints of the households.
    - The interventions should not be restricted only to capacity building of government machinery and beneficiaries but also include handholding and support to integrate social and livelihoods related activities. Households with proper support in their livelihoods and social systems will find it easier to follow health and nutrition related instructions.
    - The infrastructure bottlenecks in drinking water, toilets, and condition of AWCs bear a direct hindrance and threat to children and women. The program should integrate critical infrastructural support for better implementation. While the dilapidated AWC structures in various villages should be reported and compulsorily avoided, setting up new model AWCs can be undertaken by the project.
    - Capacity building of VHSNC members should be conducted separately and include topics like technical aspects of WASH, Nutrition and Health, relevant Schemes, and motivational inputs to contribute to the development of the village and community at large. Exposure visits of members to model VHSNCs within and outside the state should be conducted.

- The THR systems including the supply chain, quality of inputs, procurement and disbursement systems etc. need to be standardized and streamlined. Advocacy to include all sections of beneficiaries along with necessary gap filling need to be done to enhance community mobilization.
- AWWs and ASHA workers need guidance and capacity building in maintaining appropriate anthropometry data of children as well as other technical aspects of women health. Data collection regarding pregnant women, nursing mothers should be a priority area along with identification of various ailments in women and children.
- District and Block level coordination and liaison is necessary for smoother and better management of resources at the village level. The program should develop liaison and converge between various departments to effectively utilize and mobilize resources.