IMPROVING LIVES OF CHILDREN IN JAMUI DISTRICT

A project implemented by

SAMAGRA SEVA

supported by

CRY

Assessment Report

February 2020

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1.Introduction

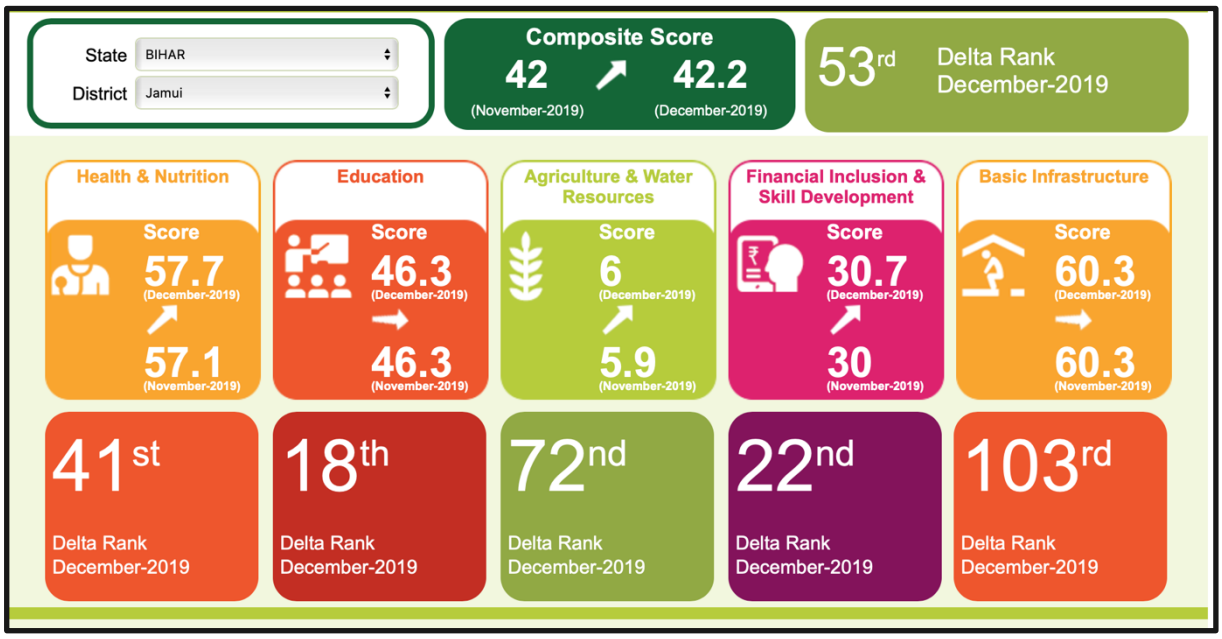
1.1.District Profile

Jamui district with a population of 17,60,405 ranked as per the District Development Index 587th amongst 599 districts in India with 59.5% of households living below the poverty line. 63.6% of households are involved in agriculture but only a third of the population has ownership of any agricultural land. Only 1 in 2 women are literate with half of girls between 20-24 yrs old reporting being married when they were less than 18 years old.

The district based on the NFHS4 data has nearly 85% of households practising open defaecation with no access to improved sanitation facilities.

Nutrition status in Jamui is alarming with 45.9% of children stunted ; 29.4% of children wasted and 47.2% children underweight. 61.3% of children (0-59 months) were found to be anaemic despite significant decrease in anaemia prevalence between 2002 and 2016.

The district was included in the Aspirational districts programme in 2018 and in the first delta ranking was ranked 72 out of the 112 participating districts. The district has made some progress and as per the dashboard display in December 2019 was ranked 53rd.



The project operational in 13 selected Gram Panchayats in the Jamui Sadar, Jhajha and Khaira blocks of the district reaching out to 2858 households. The population in the project area belong to the Maha Dalit Musahar community , other Dalit communities, tribal populations and Muslims too who are amongst the most vulnerable owing to various socially discriminatory practices in addition to economic vulnerability. project aimed to improve nutritional status of children working closely with the ICDS and primary health services to improve services and increasing utilisation of these services coupled with awareness of proper child nutrition and good caring practice in the communities. The project liaises with 32 AWC and 12 Health subcentres.

1.2 Objective and Methodology of the Assessment

The objective of the assessment was to capture the positive changes in the project area; identify possible mechanisms by which the project contributed to this change and provide strategic guidance for the next phase of the programme.

The assessment included a 2 day visit to the project area and ICDS centres and community meetings and house visits were conducted. Introductory and debriefing meetings with the Samagra Seva (SS) team were also held. The consultant was accompanied by team members of SS at all times in addition to the Programme Coordinator of CRY. Site visits were as decided by the SS team. The consultant had access to the Annual reports and some MIS data of the project. The list of Anganwadi centres visited is annexed. (Annex 2)

Observations and recommendations in the report must be viewed keeping in mind the limited duration of the field visit and the brief interactions with the community and the project team.

2. Findings

2.1. Community Awareness and Mobilisation

As emerged from discussions and interactions with the Anganwadi workers and PLW the project has undertaken many activities in the 3 year period to promote awareness on infant and young child feeding practice ; to encourage pregnant women to attend the VHSND (Village Health Sanitation and Nutrition Day) held in the AnganWadi Centre (AWC) every month where the ANM is also present and encourage mothers to send their children to the AWC daily. Organisation and participation in the special days observed in the AWC mentioned by the project team was ratified by pregnant women and mothers of infants recalling the Godh Bharai ceremony and the Annaprasan ceremony where the health workers were present.

Recent events like the Breast feeding month in August and Poshan Maah in September have been observed jointly with the AWWs ; Project workers mention that the former event drew much appreciation from block and district level functionaries with requests to scale it up beyond the project area. 3 lactating women with infants below 6 months of age were interviewed ; all of whom mentioned that they were breastfeeding exclusively and knew when to start complementary feeding but could not elaborate further.

Mothers of infants who were underweight and who had returned from the NRC were provided with the sprouted lentil and sprouted wheat flour called Poshan Sattu to be given to children ; mothers mentioned using it regularly for their children in various ways but it was clear that they did not know clearly how to prepare it themselves and looked to SS to provide this to them.

All mothers who came with their children to the VHSND came with the MCPC card; they were aware of the importance of immunisation and most of them knew the weight of their child and if the child was red/yellow or green and the significance of this colour coding. However the growth chart in all MCPC cards was not filled.

Pregnant women mentioned taking the IFA pill but on closer questioning they revealed that they had not gone back to the AWC to replenish their stocks ; no particular reason was accorded for this ; in a few cases it was seen that the centre was very close to the homestead. A couple of women from obviously very impoverished households had not registered their pregnancies in time; mentioned not having the necessary documentation to avail of the maternity benefit despite clearly being the ones who most needed it.

The project has taken first steps to promote vegetable gardening in the villages ; seeds are provided by the project staff a few examples were seen of relatively large patches of land growing many vegetables. These were in all cases families who have farming land and the plots were close to a water source. Only in one of the five AWCs visited was there a yard which was fenced off with some flowering plants and a few greens growing in it. AWWs and project staff mention that despite their interest to grow fresh vegetables the lack of space is a serious constraint.

Besides working with mothers and children the project has also reached out to adolescents in the project areas and set up Adolescents groups centred around the Anganwadi in the area. These adolescents both school and non-school going mention receiving the weekly Iron and Folic acid tablet and also attending some information sessions on health and hygiene held jointly with SS field staff and the AWW. They are aware of the pitfalls of early marriage and mention that they often discuss these issues amongst themselves and pass on information to others who are not part of the group. They were not aware in particular of issues of child malnutrition or the work of the project regarding this.

2.2. Collaboration with the Government systems

The field workers mention visiting the Anganwadi centre routinely particularly on the Take Home Ration (THR) distribution days to assist the AWW and the VHSND again to assist with the weighing and filling up of the MCP cards. In 3 of the 5 centres visited; a printed poster recording the quarterly anthropometric data of individual children is displayed. This is a recent effort from the project which is filled up by the project staff on the weighing days. Children are identified with their own names and those of parents – all children are known by name to the ICDS worker and the ASHA. The ICDS centres in the district (and possibly the state) do not have the Growth Monitoring Registers that were used earlier – newly instituted registers now record height and weight. The only visual tool now is the MCP card. Mother's meetings are held on THR days occasionally; women in the communities did mention attending information sessions on child feeding particularly in the Anganwadi centre.

Height scales were available in all centres visited ; not all AWWs were fully conversant with the correct procedure of measuring height of children as was observed. An instance of measuring children at home using a tailor's tape was also mentioned – this was done to ensure that the display chart was filled up in time for the planned visit in collaboration with the project field worker.

Most ICDS centres visited within the scheduled opening times or earlier saw many children in attendance ; workers mention that there are many older and younger siblings who need to be accommodated with the preschool age group and that on most days all children registered in the centre attend. Seasonal migration is rife in these areas particularly to the brick kilns for extended periods of time and children from such families are registered but absent.

All AWWs met were using the CAS which has been in place for nearly 2 years now in Jamui district. AWWs are to varying extents familiar with using the smart phone and in 3 out of 5 centres visited were able to demonstrate a few functions.

Only one out of 5 centres had a functioning toilet ; in all other centres the toilet pan was intact or broken and there was no drainage or pit system. 2 out of 5 had a handpump on the premises of the centre; the others brought in water for cooking and supposedly for washing from the nearest pump which was in all cases very close to the centre. Anganwadi workers as well as project field workers did mention that children were taught handwashing before meals at the centre and that this was a practice that was followed back at their homes as well but this could not be substantiated by observation or through questioning mothers.

Project documents mention 15 severely wasted children being referred to the NRC in the past 3 years; at the time of the visit 3 children were admitted in the NRC and on visiting the NRC it was clear that they would stay the full recommended period of 14 days. On interviewing 2 mothers of children who had been to the NRC it was clear that they were more aware of child care and feeding practice even if careless about hygiene as was observed. These women in turn were encouraged by the field workers to speak to other mothers and encourage them to avail of the services of the NRC if their child was severely wasted. Convincing mothers to go to the NRC remains a big challenge as is elsewhere in the country. Even the prospect of the wage compensation which is given if one goes to the NRC is not incentive enough for them as there are various constraints holding them back.

2.3. Capacity Development & Monitoring systems

Capacity development for the project staff has been done at regular intervals for selected members of the project team there have been trainings organised for few members of the team on an annual basis. Training on anthropometry and on data collection using the new digitised system was given to all project staff. List of trainings is annexed (Annex 3)

CRY has introduced a digital monitoring information system in 2019 for all their projects which was introduced to the project under discussion also. All field workers were given a tablet with uploaded software customised for the project and a couple of trainings have been conducted on data entry. It was not feasible to understand fully the purpose, process and the format of the entry system for this project in the time available. Observations made here are based on a brief discussion with the project staff and the MIS coordinator

- Field workers are happy with the tablet provided and are able to use it with ease – most of them are familiar with the use of a smart phone which has made their work easy.
- Initial listing of household information was done- this is a one-time task and this took some time but is now completed for every worker.
- There are separate forms for tracking pregnant women and for children 0-5.
- There have been problems with some of these sub menus requiring entering information twice over which was already available in another form or in the main household information sheet.
- Despite the entry in the tablet the field workers keep record of all information on paper thus duplicating the work. The reason they cited was that they feared that if the tablet malfunctioned they would lose all the work done.

- They do not get any summary reports/ alerts which can help them prioritise household visits. They refer to the immunisation and other alert systems that exist in the CAS software for the AWW and are of the opinion that a similar system would be useful.

It appears that all the monitoring that is done by both SS managers and the CRY team is more managerial and compliance related – it is not clear what ongoing technical support is available to the project team.

3. What has worked so far?

The project after 3 years of completion has by virtue of its presence in the working areas and regular interactions with the community and in particular working alongside the ICDS system initiated change. Keeping the Key result areas in mind as defined for every project year it can be said that the project activities and most processes adopted are in line to achieve each of the results defined. To document objectively the change attributable to the project is beyond the scope and means of this assignment. It can be said however that in villages with some of the most marginalised communities the presence of an organisation working alongside the AWW and ASHA has improved the outreach of the workers themselves and also helped to create awareness. The AWW has an extra pair of hands on special days and the frequent visits by project teams ensures follow up of prioritised households on time.

The intervention by the project to report on the non-availability of weighing scales in the Anganwadi centres to the ICDS officials and follow up consistently ensured that this was prioritised and equipment provided; one can say with confidence that the project hastened a process that would have taken much longer in the normal course.

A significant contribution has been the successful referral of children identified to be in Severe Acute Malnutrition (SAM) to the Nutrition Rehabilitation Centre (NRC). This process in which the ASHA and the AWW also participate has been strengthened with mothers being visited at least once in the NRC by one or the other project staff. The close follow up of the child after the return to the community and provision of the Poshan Sattu is a highlight of the project intervention.

The first steps towards encouraging consumption of fresh vegetables through establishing vegetable gardens is taking root slowly; growing vegetables consciously in a small portion of land next to the main crop appears not to have been something done earlier. The provision of seeds from the project funds is an incentive that households look forward to.

As all of these are in line and in coordination with the work of the ICDS system and the Health system

4. What can be done ahead?

4.1.Strategic considerations - CRY

From its inception the project has laid out the intention of working with and strengthening Government institutions at the community level such as the AWC and working to increase service access by the community. It is imperative that this continues as the next phase is rolled out.

Jamui is as mentioned earlier, an aspirational district and progress has been very slow even if there is some as seen in the 2nd Delta Ranking. A multisectoral approach to addressing malnutrition is being adopted nationwide and there is a strong thrust on this particularly in Aspirational districts. CRY as an organisation which is rights based and working on Education Protection and Health is well placed to pursue a multisectoral approach in its projects particularly where it aims to address malnutrition as in the current project. The Aspirational district programme has a clear set of outcomes with defined indicators – aligning project outcomes to this and incorporating the same indicators into the project MIS even at the block level is something to be considered.

For the project and the implementing partner to find a seat at the table in district forums and to be able to demonstrate the work it is ideal that at least a full block be covered. Currently, the project is spread over selected Gram Panchayats in 3 blocks.

The digitisation of the MIS in the project (even if could not be examined in detail) needs to be re-examined particularly to see if it fits with the strategy of working to strengthen Government institutions and service delivery. The MIS which now looks to individually track beneficiaries within the project area appears to be running in parallel with the ICDS CAS even if far from as efficient or comprehensive. The project team is yet to see how this will improve and assist their own work on ground.

In addition to the broad strategic considerations laid out above some actions which can be implemented at a local level in a phased manner are outlined below.

4.2.Working with the Anganwadi centres

- Establish a hand washing station in Anganwadi centres where there is no handpump within the premises. – a Tippy tap is a simple arrangement and can be done with local materials. Instructions on this video - https://www.youtube.com/watch?v=Qdpd3roZjYw Even where there is one it can help to set one up for children to conveniently wash their hands.
- In addition to the large posters with the anthropometric information of the children displayed obtaining community growth charts is to be considered. The community growth chart is a useful visual aid to illustrate and explain to the mothers the nutritional status of children in the centre. The practice of the growth chart being filled up in all MCP cards needs to be ensured so that the mother has a tool with her. All mothers coming to the GM sessions must be instructed to carry the MCPC cards – currently the GM charts in the MCPC cards are not filled in – it is perhaps unrealistic to expect that all of the will be filled in – perhaps an instruction to start with the children who are moderately or severely underweight. This will serve to alert the ANM also during immunization days and more importantly for the mother to use it to show the family members to explain the nutritional status of the child. . This finds mention even in the Jan Andolan Guidelines recently formulated as part of the Poshan Abhiyan.

- Currently there are vegetables/ greens in the khichdi/ pulao rarely. It is restricted to some greens sourced by the AWW.
    a. Can a discussion be initiated during one of the Anganwadi Vikas Samiti meetings which are held monthly on the importance of vegetables in the meal and how this can be included? There are examples in other states of this being done through community contribution in kind - this needs to be carefully explored here.
    b. Most of the workers were keen if supported to develop a kitchen garden within the premises. Options like bag gardens to be explored where there is no soil space available. Keeping in mind the dry season the bag garden is a suitable option requiring minimum water and in which more than one type of vegetable/ greens can be grown. Some of the AWWs also mention that what they lacked was guidance and ideas on what can be done and if guided will be able to execute it within their limited resources. The option of bag gardens needs to be explored for AWCs also. Samagra Seva has links with the Krishi Vikas Kendra ; the multisectoral approach rests on intersectoral convergence – availability of seeds and technical expertise must be harnessed in place of providing inputs from the project itself.
- Open defaecation seems to be the norm rather than the aberration in the gram panchayat's visited. Women had no hesitation in admitting to it; statistics also clearly confirm this. Within the remit of the project a few steps can be taken towards improving the situation. From a quick assessment of the 32 Anganwadi centres within the project area only 9 have toilets of which 6 are functional. This clearly demands a concerted Advocacy plan – the project will do well to prioritise restoring functionality and usage in all centres where there is a toilet and starting dialogue in the community, with the Anganwadi Vikas Samiti and with the Panchayat even if it is not within the envisaged mandate.
- In the long run with sufficient involvement of all stakeholders it would be useful to draw up a template for a Model Anganwadi Centre – what does this mean for the Anganwadi worker- the department? What does it mean for the mother? The community? In the project design and initial implementation there has been till date little consultation with the community – the reasons for this are well appreciated – with a clear foothold now in the community it is imperative to mobilise the community.

4.3.Enhancing Community mobilisation and outreach

This has been the mainstay of the project – in addition to the successful organisation of events it is critical that the community be provided information on their entitlements and the procedures of realising them. At a time when there is widespread dissemination of information on Government schemes in all media it might perhaps seem superfluous. However within marginalised populations like in the project area mere knowledge of the entitlement is not helpful; the process of realising it can be complex. This is particularly true for communities which migrate seasonally; where ANC registration is still low. This would require first for project staff to be fully conversant with procedures and schemes so as to be able to provide complete information and ensure that communities for whom the schemes are intended fully benefit from them.

Adolescent groups that have been formed can be further strengthened. Structured information sessions at regular intervals coupled with the Weekly Iron and Folic tablets need to be considered.

5. Annexes

5.1 List of Anganwadi centres with equipment status

S. No.	Anganwadi centre	Functional Salter weighing scale with bag (Yes/No)	Functional Adult weighing machine Yes/No	Height scale Yes/No	Water source/Handpump within AWC	Toilet Functional (F) Toilet Dysfunctional (DF) No toilet (X)
1	West Harijan Tola Baliyadih	Yes	Yes	No	No	X
2	Salayatand	Yes	Yes	No	No	X
3	East Muslim Tola Baliyadih	Yes	Yes	Yes	No	X
4	Maniyadda Mushari Tola	Yes	Yes	Yes	No	F
5	Mishir Maniyadda Mushari Tola	Yes	Yes	Yes	Yes	X
6	Nimnawada Mushari Tola	Yes	Yes	Yes	Yes	X
7	Amba Mushari Tola	No	No	No	No	X
8	Kanhayadih	No	No	No	No	X
9	Kumaini	Yes	Yes	Yes	No	X
10	Dighi Musahari	No	Yes	Yes	Yes	DF
11	Kanbeya Musahari	Yes	No	Yes	No	X
12	Borar	Yes	Yes	Yes	No	X
13	Lathane Musahari	No	Yes	Yes	No	X
14	Chaura Mushari Tola	N0	Yes	Yes	No	DF
15	Lotan Mushari Tola	N0	No	Yes	No	X
16	Diba Mushari Tola	Yes	Yes	Yes	No	DF
17	Keshopur Mushari Tola	Yes	Yes	Yes	Yes	F
18	Ramdaspur Mushari Tola	Yes	No	Yes	Yes	F
19	Machindra Mushari Tola	Yes	Yes	Yes	Yes	F
20	Aghara East Tola	Yes	Yes	Yes	No	X
21	Aghara West Tola	Yes	Yes	Yes	Yes	F
22	Lalunagar	Yes	Yes	Yes	No	X
23	Baruatta West	Yes	Yes	Yes	Yes	X
24	Khairi Rampur	Yes	Yes	Yes	No	X
25	Kakan Mushari Tola	Yes	No	Yes	No	X
26	Sonay Muslim Tola	Yes	No	Yes	No	X
27	Sonay Mushari Tola	Yes	No	Yes	No	F
28	Balathara Mushari Tola	Yes	No	Yes	No	X
29	Simeriya Mushari Tola	Yes	Yes	Yes	No	X
30	Dumarkola Musahari	Yes	Yes	No	No	X
31	Kharuhi Musahi	Yes	Yes	No	No	X
32	Bariyapur Musahari	Yes	Yes	No	No	X

5.2 List of trainings done

S. No	Topic of the training	Participants	Facilitators	Duration
1	Training on symptoms, causes and Indices of malnutrition- its effect - Community level management and institutional management to address the issue of malnutrition	Project coordinator and field animators	Associate General Manager	2 day
2	Training on identification of SAM and MAM children through various anthropometric indices viz. stunting (weight vs Height), wasting (weight vs. Age) and underweight	All Samagra Seva staff	Associate General Manager	2 day
3	Capacity building on Life skill through child center module	Project Coordinator, field animator	CRY	5 days
4	Capacity building on preparing Plan of Action of cascading child centre module in the field	Project Coordinator, field animator	CRY Team	2 days
5	Refresher training on Life skills	Field animators	CRY team	4 days
6	Capacity building on MIS data collection through tab followed by two refresher training and on process MIS	Project Coordinator, field animator	CRY M&E	8 days
7	Capacity building on various schemes related to health and nutrition	All staff	Associate General Manager	1 day
8	CB on documenting success stories	Project Coordinator, field animator	CRY team	1 day
9	Capacity building on formats like Home base newborn care (HBNC), Home based young child care (HBYC)	All Staff	CRY	1 day
10	CB on roles and responsibilities of Anganwadi Vikas Samiti members- (Community based monitoring mechanism)	All staff	CRY	1 day
11	CB on current updates of financial as well as statutory compliances	Project coordinators, Finance person	CRY team	2 days
12	Capacity building on Health Systems	PC and Field worker	Organized by Jan Swasthya Abhiyan- National Health Assembly-3	2 days

5.3. Case study template

How to prepare a Case Study

The purpose of a case study is to provide a more thorough analysis of a situation or "case" (often the story of an individual) which will reveal interesting information to the reader. Often they are used in social development to describe a person's life.

Guidelines of writing the Case Study

1. Mention the name of the character/s in the case study(with due consent of the person/s in subject)
2. Images should be inserted that portrays a happier or better-off context of the beneficiary
3. Use a snappy attracting title if you can think of one. Catch the reader's attention. Consider your audience carefully.
4. Try to keep your report to one page. This means that each word must count.
5. Avoid writing the name of the Health Worker/ project staff; remember that the **beneficiary** is the **subject** in the case study
6. Your analysis should locate the beneficiary's words and circumstances within the wider situation. The story should therefore be illustrative.
7. Depending on the context, consider using the problem – solution – benefit flow, explaining how our work addresses the problem and how the beneficiary has benefitted from our intervention.
8. Within the report, you may use quotes in local language as expressed by the beneficiary within quotation marks.
9. Avoid unnecessary descriptions of poverty that might humiliate "she was dressed in rags", etc.
10. Don't exaggerate. Don't underestimate the knowledge of the reader.

Background/ Overview
A brief summary of the beneficiary. Mention of the context with problem statement / challenges faced by the beneficiary
Solution
Benefits / support received from the project
Results
How the project intervention has solved the beneficiary's problem?
Conclusion
What has been the beneficiary's learning from the project? How the beneficiary would continue to receive support from the project in future?

5.4. Key Result areas – Year wise

3 years envisaged outcomes		
Key Result Area- Reduction in Malnutrition level		
2016-17	Community understood the complexity of malnutrition issue and also recognize the importance of service delivery points meant	Community is aware based on interactions with women; utilisation of ICDS centres has increased.
	VHSND and BACHPAN DIVAS will be regular and functional in presence of all stakeholders	Functional VHSND was observed; and special days were recalled by mothers in the AWC
2017-18	Community started taking care of all malnourished children through community based model.	No progress/ no structured effort towards this.
	Institutional reforms in 24 ICDS centres in operational area in form of ensuring VHSND, 100% GMC regularization and identification of SAM, referral to NRC.	ICDS centres in operational areas appear to be better equipped
	Govt institutions taking steps to ensure linkages for institutional child birth and ANC, mentioning the birth weight in document and management of LBW babies.	MCP cards which were seen had the birthweight recorded
2018-19	Reduction of malnutrition among children under 3 years	Monitoring data shows children moving from red to yellow to green as per the GM
	Mothers are taking comprehensive action for new born children's health and nutrition care	Mothers are aware of EBF and practising it; aware of complementary feeding timing.
	Empowered adolescent groups started discussing about their nutrition requirements	Adolescent groups are formed