INTERNSHIP TRAINING

AT

CARE INDIA, BIHAR

To assess the quality of counselling done by Anganwadi (AWW) on MIYCN (Mother Infant Young and Child Nutrition) their interaction with the beneficiaries in Home Visits/VHND in District Patna, Bihar.

BY

Abhinandan Anand

PG/14/001

UNDER THE GUIDANCE OF

Dr. PREETHA GS

POST GRADUATE DIPLOMA IN HOSPITAL AND HEALTH MANAGEMENT

2014-16

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

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TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Abhinandan Anand**, a student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at **Care India, Bihar** from **11th April, 2016**to**10th May, 2016**.

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfilment of the course requirements.

I wish him all success in all his future endeavours.

Dr. A.K. Agarwal
Dean (Academics and Student Affairs)
IIHMR, New Delhi

Dr. Preetha GS
IIHMR, New Delhi

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Completion of Dissertation from Care India, Bihar

The certificate is awarded to

Abhinandan Anand

In recognition of having successfully completed his
Internship in the department of

Nutrition - Technical Support Unit

and having successfully completed his Project on

To assess the quality of counselling done by Anganwadi (AWW) on MIYCN (Mother Infant Young and Child Nutrition) their interaction with the beneficiaries in Home Visits/VHND in District Patna, Bihar.

Date: 12th May, 2016

Care India, Bihar

He comes across as a committed, sincere & diligent person, who has a strong drive & zeal for learning

We wish him all the best for future endeavours

Training & Development **Head-Human Resources**

Certificate of Approval

The following dissertation titled at**"To assess the quality of counselling done by Anganwadi (AWW) on MIYCN (Mother Infant Young and Child Nutrition) their interaction with the beneficiaries in Home Visits/VHND in District Patna, Bihar.""CARE INDIA, BIHAR"** is hereby approved as a certified study in management, carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
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Certificate from Dissertation Advisory Committee

This is to certify that **Mr. Abhinandan Anand,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. He is submitting this dissertation titled **"To assess the quality of counselling done by Anganwadi (AWW) on MIYCN (Mother Infant Young and Child Nutrition) their interaction with the beneficiaries in Home Visits/VHND in District Patna, Bihar"** at "CARE INDIA, BIHAR" in partial fulfilment of the requirements for the award of the **Post-Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge. No part of it has been reproduced from any other dissertation, monograph, report or book.

Dr. Preetha GS
(Institute Mentor),
Associate Dean (Research),
IIHMR-Delhi

Mr. Sharad Chaturvedi
(Organization Mentor)
Deputy Director, N-TSU
Care India, Bihar
Date:

FEEDBACK FORM

Name of the Student : **Abhinandan Anand**

Dissertation Organisation : **Care India, Bihar**

Area of Dissertation :To assess the quality of counselling done by Anganwadi (AWW) on MIYCN (Mother Infant Young and Child Nutrition) their interaction with the beneficiaries in Home Visits/VHND in District Patna, Bihar

Attendance : 100%.

Objectives achieved : Completed the given Project on time.

Deliverables : Knowledge on the functioning of AWCs. ICDS program. Learned the basic organisational Profil.

Strengths : Dedicated to work. the desired goal Hard working. Team player.

Suggestions for Improvement:

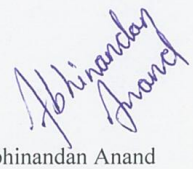
Signature of the Officer-in-Charge/ Organisation Mentor (Dissertation)

Date: 12th May, 2016
Place: Patna

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "**To assess the quality of counselling done by Anganwadi (AWW) on MIYCN (Mother Infant Young and Child Nutrition interaction with the beneficiaries in Home Visits/VHND in District Patna, Bihar**" and submitted by **Abhinandan Anand**, Enrollment No. **PG/14/001** under the supervision of **Dr. PREETHA GS** for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from **11th April, 2016** to **10th May, 2016** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.



Abhinandan Anand
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PGDHM (2014-16) - Health

ABSTRACT

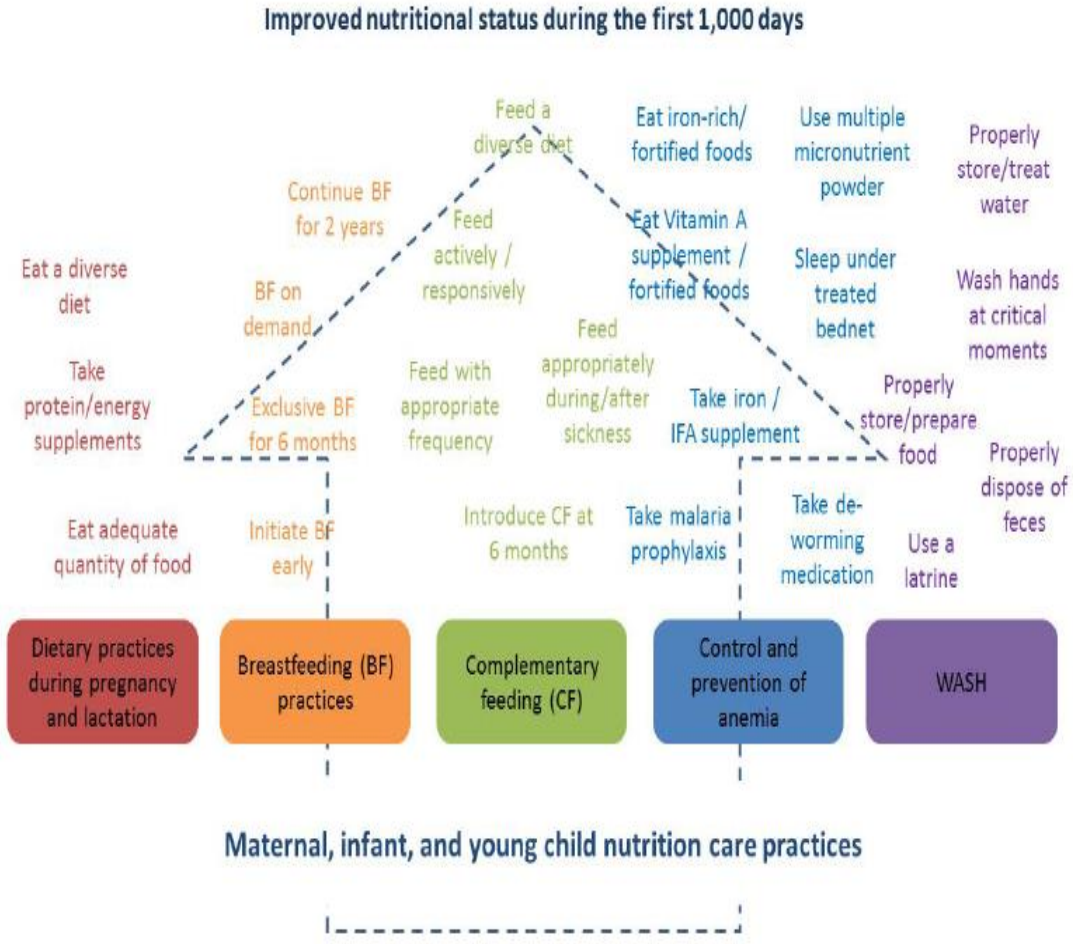
In May 2012, the Sixty-fifth World Health Assembly (WHA) endorsed the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition (MIYCN). The WHA resolution urges Member States to put the MIYCN Plan into practice by including proven nutrition interventions relevant to the country in maternal, child and adolescent health services and care. Interventions carried out should ensure universal access, and establish and engage policies in agriculture, trade, education, social support, environment and other relevant sectors to improve nutrition.
The MIYCN Plan includes six global nutrition targets to be achieved by 2025:
1. A 40% reduction of the global number of children under five who are stunted
2. A 50% reduction of anaemia in women of reproductive age
3. A 30% reduction of low birth weight
4. No increase in childhood overweight
5. Increase the rate of exclusive breastfeeding in the first six months up to at least 50%
6. Reduce and maintain childhood wasting to less than 5%

The MIYCN Plan also proposes five actions to support the achievement of the global targets.
1. Create a supportive environment for the implementation of comprehensive food and nutrition policies.
2. Include all required effective health interventions with an impact on nutrition in national nutrition plans.
3. Stimulate development policies and programmes outside the health sector that recognize and include nutrition.
4. Provide sufficient human and financial resources for the implementation of nutrition interventions.
5. Monitor and evaluate the implementation of policies and programmes.

Action 5 also calls for a well-defined framework, that would allow a harmonized and internationally accepted approach to monitoring of progress towards nutrition targets at both the national and global levels as well as on the actions taken to put the Comprehensive Implementation Plan into practice,. Currently, many national nutrition surveillance and monitoring systems are fragmented and only a handful of indicators are tracked systematically across countries. By providing a globally agreed upon framework, targets and indicators can serve as a benchmark for countries and the international community to measure achievements, identify gaps and trigger corrective actions, and estimate global resource requirements.

Improvements in nutrition require collaboration among multiple sectors. The monitoring framework aims to capture the multi-sectoral nature of nutrition and consider indicators relating to underlying causes of malnutrition and broader policies and actions, including access to health services and policies outside the health sector. The monitoring framework also requires the inclusion of indicators that cut across health, agriculture, environment, as well as different disciplines within these sectors that examine biological outcomes, programme coverage, and the political environment.

The monitoring framework has a **core set of indicators**, to be reported by all countries and an **extended set of indicators**, from which countries can draw to design national nutrition surveillance systems fitting the specific epidemiological patterns and program decisions.



ACKNOWLEDGEMENT

Every successful story is a result of an effective team work, a team which comprises of a good coach and good team players. Likewise this project report is no exception. This has been a meticulous effort of a group of people along with me. I want to take this opportunity to thank each and every one who has been a part of this report.

To start with, I take immense pleasure to thank **Dr. A. K. Khokhar** (*Director-International Institute of Health Management Research-Delhi*) and **Dr. A. K. Aggarwal** (*Dean, International Institute of Health Management Research- Delhi*) for placing me in such an esteemed organization (Care India) to perform my dissertation and start my career with; and my mentor, Dr. Preetha GS for her timely advice and encouragement for the successful conduction of my project.

I am highly indebted to Dr. Sunil Babu, Director, Nutrition Technical Support Unit, Care India, Bihar and Mr. Sharad Chaturvedi, Deputy Director, Nutrition Technical Support Unit, Care India, Bihar, for providing me with this opportunity to be a part of Nutrition TSU team at Care India, Bihar and giving me time and space from the induction and training schedule, to perform my fieldwork.

Also, I wish to thank Smt. Indira Devi and Mr. A. K. Mohan, for their continuous guidance in the training programme and arranging transport and other requirements for the completion of our desired field visit

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LIST OF ABBREVIATIONS

MDGs	Millennium Development Goals
LQAS	Lots Quality Assurance Sample
FLW	Front Lin Worker
IFA	Iron Folic Acid
ASHA	Accredited Social Health Activist
VHSND	Village Health Sanitation and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
BCC	Behaviour Change Communication
MLE	Monitoring Learning Evaluation
AWW	Anganwadi Worker
AWH	Anganwadi Helper
ICDS	Integrated Child Development Services Scheme
MDM	Mid Day Meal
INHP	Integrated Nutrition and Health Programme
SHGs	Self Help Groups
N-TSU	Nutrition-Technical Support Unit
ANM	Auxiliary Nurse Midwife
WHO	World Health Organization
MMR	Maternal Mortality Ratio
EDD	Expected Date of Delivery
TT	Tetanus Toxide
DDK	Disposable Delivery Kit
MoHFW	Ministry of Health and Family Welfare
MoWCD	Ministry of Women and Child Development

DPO	District Programme Officer
CDPO	Child Development Programme Officer
LS	Lady Supervisor
IEC	Information Education Communication
THR	Take Home Ration
HSC	Health Sub Centre
DRG	District Resource Group
BRG	Block Resource Group
ANC	Ante Natal Care
AWC	Anganwadi Centre

ABOUT THE ORGANIZATION

CARE INTERNATIONAL

CARE International is a leading humanitarian organization fighting global poverty. It places special focus on working alongside poor women because, equipped with the proper resources, women have the power to help whole families and entire communities escape poverty. Women are at the heart of their community-based efforts to improve basic education, prevent the spread of disease, increase access to clean water and sanitation, expand economic opportunity and protect natural resources. The organization also delivers emergency aid to survivors of war and natural disasters, and help people rebuild their lives.

In the fiscal year 2015, CARE worked in 95 countries around the world, supporting 890 poverty-fighting development and humanitarian aid projects to reach more than 65 million people.

CARE International is a global confederation of 14 National Members and one Affiliate Member with the common goal of fighting global poverty. Each CARE Member is an autonomous non–governmental organization and implements program, advocacy, fundraising and communications activities in its own country and in developing countries where CARE has programs.

At the beginning, there was a package: a CARE package, aimed to reduce hunger and show solidarity with the people of war-torn Europe.

At the end of World War II in 1945, twenty-two American charities, a mixture of civic, religious, cooperative and labor organizations got together to found CARE. Originally known as the *Cooperative for American Remittances to Europe*, it began to deliver millions of CARE packages across Europe. This was basically a small shipment of food and relief supplies to hungry recipients - with a huge impact on people's lives.

During the next three decades, CARE shifted its focus from helping Europe to delivering assistance in the developing world. It started programs in the areas of education, natural resources management, nutrition, water and sanitation, and healthcare in Southern Africa, South Asia and South America. Broadening the geographic focus and expanding beyond the original food distribution programs, CARE started to assist people affected by major emergencies – from famine in Ethiopia to hurricane recovery in Honduras.

Over the previous decades, Care has continuously developed its approach to reducing poverty. In 1945, CARE was established on the premise that poverty was mainly due to a lack of basic goods, services, and healthcare. As the organization grew, so did their understanding of poverty. CARE's scope widened to include the view that poverty is often caused by the absence of rights, opportunities and assets, largely due to social exclusion, marginalization, and discrimination. In the early 1990's, its work grew into what they call a 'rights based approach' to development.

In 1993, in an effort to reflect the wider scope of its programs, vision and impact, CARE changed the meaning of its acronym to *"Cooperative for Assistance and Relief Everywhere".* By 2007, it started focusing on women's empowerment realizing that women are the key: by empowering women entire families can be lifted out of poverty.

Some key networks in which CARE is involved or is a signatory to are:

- Code of Conduct for the International Red Cross & Red Crescent Movement at NGOs in Disaster Relief
- The Sphere Project
- Humanitarian Accountability Partnership International (HAP)
- Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP)
- People in Aid
- INGO Accountability Charter
- CARE is a signatory to and holds itself accountable to internationally accepted humanitarian standards and codes of conduct, and works with other aid organizations and United Nations agencies to improve humanitarian action and to influence policy.

CORE VALUES

Respect: Affirm the dignity, potential and contribution of participants, donors, partners and staff.

Integrity: Actions consistent with the mission. Being honest and transparent in what they do and say, and accept responsibility for their collective and individual actions.

Commitment: Work together effectively to serve the larger community.

Excellence: Constantly challenge themselves to the highest levels of learning and performance to achieve greater impact.

VISION AND MISSION

Their vision is to seek a world of hope, tolerance and social justice, where poverty has been overcome and people live in dignity and security. CARE will be a global force and partner of choice within a worldwide movement dedicated to ending poverty, and will be known everywhere for it's unshakeable commitment to the dignity of people.

CARE strives to serve individuals and families in the poorest communities in the world. Drawing strength from their global diversity, resources and experience, they promote innovative solutions and are advocates for global responsibility.

CARE INDIA

CARE has been working in India for over 65 years, helping alleviating poverty and social exclusion by facilitating empowerment of women and girls from poor and marginalized communities. In India, CARE focuses on the empowerment of women and girls because they are disproportionately affected by poverty and discriminations; and suffer abuse and violations in the realization of their rights, entitlements and access and control over resources. They do this through well planned and comprehensive programmes in health, education, livelihoods and disaster preparedness and response.

To be able to bring about lasting change, CARE India addresses underlying causes of poverty and social injustice. For example, they implement a gender transformative framework within their programmes to address unequal power relations at the grassroots level.

Fig 1. CARE in India works across 14 States and 38 projects, touching the lives of 37 million people. (Headquarters in Delhi)

Some of the notable initiatives of CARE India are:

- CARE India response on Cyclone Phailin hit on the Eastern Coast of India.
- CARE India Tsunami relief programme.
- CARE India response to floods in Uttarakhand

CARE India has been working extensively in different parts of India. They work with grassroots initiatives, state and district governments, communities and individual from all over the country.

HISTORY OF CARE INDIA

CARE came to India in June, 1946 when one of its co-founder, Lincoln Clark, signed the CARE Basic Agreement in New Delhi at the Office of Foreign Affairs. The agreement was limited to contributions of technical books and scientific equipment for universities and research institutes. In November 1949, the first Chief of Mission, Melvin Johnson, arrived in India to establish operations. Subsequently on the invitation of the then President of India, he developed a CARE India Food Package that caused a renegotiation of the CARE Agreement to include importation of food through Indo-CARE Agreement on 6 March 1950. The CARE Office during 1950's in Delhi was a hutment (a long, thin building) located in Janpath, Connaught Place. CARE had three additional offices and warehouses in India located in Bombay, Madras, and Calcutta.

Fig 2. Early days of CARE India

The initial programmes those days included assistance to educational institutions, relief camps and assistance to hospitals in form of books, laboratory equipments, tools supplies etc. When the Mid-Day Meal (MDM - school lunch) program started in 1960, state offices were established and the staff in Delhi and state offices increased. Since 1960's CARE has been supporting government's school feeding programs. CARE has been providing nutritious food for the beneficiaries of Integrated Child Development Services (ICDS) on the request of GOI since 1982. CARE supported the Government's ICDS in the states of Andhra Pradesh, Bihar, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and West Bengal. As a part of support

from USAID, CARE implemented a long term project named Integrated Nutrition and Health Project (INHP) from 1996 till 2010 and reached to about 1297 blocks in nine major states of India. Recognized worldwide for its contribution in disaster response and rehabilitation operations, CARE in India has supported the efforts of Government of India and individual state governments as and when major disasters occurred in the country. CARE has provided relief to several natural disasters since 1966 with Jammu and Kashmir floods 2014 and Hud Hud in Andhra Pradesh being the most recent. Some of the efforts include response to flood relief in West Bengal in 1979, cyclone in Andhra Pradhesh in 1977 and in 1996, and earthquake relief in Latur, Maharashtra in 1993, and Odisha super cyclone in 1999.

CARE India's current 'Programme' approach stems from a redrawn vision, under which, working with partners on projects has been overlapped with holistic, long term, deep impact programmes that work directly with key populations to ensure that the root causes of poverty and marginalization of people, particularly poor women and girls, are tackled strategically and collaboratively.

As CARE India moves ahead, their key programming approaches will include social analysis and action, gender transformative value chain approaches, leadership and life skills strengthening, building capacities and leadership roles at multiple levels, advocacy on national and international platforms and facilitating links and dialogues between public, private and civil society.

FOUR MAIN FUNCTIONAL AREAS

Disaster Preparedness

Education

Health

Livelihood

CARE INDIA INITIATIVES IN HEALTHCARE

Delivering healthcare to over a billion people is a very complex challenge. CARE India works in close collaboration with State and Central Government and other partner organizations to secure accessible and quality maternal and child healthcare among marginalized communities. It works towards identifying the root causes of healthcare challenges, provides innovative solutions, and helps implement secure and quality healthcare services in India. CARE India believes that a healthy mother and a healthy baby is the route to a productive and a developed nation. Hence, CARE has specially focused upon providing comprehensive solutions to address public health problems. CARE India promotes essential new born care and immunization, reducing malnutrition, preventing infant and maternal deaths and protecting those affected by or susceptible to HIV/ AIDS and TB. CARE works closely with its partners to achieve good health care for everyone.

Various programmes of CARE India are:

- **EnSIGN:** Enhancing the Sustainable Farming Initiative through Gender and Nutrition. (Bankura District, West Bengal)
- **RACHNA:** Reproductive and Child Health Nutrition & Awareness. (**Rajasthan)**
- **HEVS extending CHCMI:** Health Education among SHG & VHSNC Members. (Puruliya, West Bengal)
- **SEHAT:** Sustainable Education and Health Among Tribals. **(**Sidhi and Shahdol districts of Madhya Pradesh)
- **BRIDDHI:** Ensuring improvement in the nutritional status among severely malnourished children through growth monitoring, Behaviour Change Communication, strengthening Health (including treatment) and Nutrition service delivery system. (West Bengal)
- **SWASTH:** Sector Wide Approach to Strengthen Health. (Bihar)
- **EMPHASIS:** Enhancing Mobile Populations' Access to HIV & AIDS Services, Information & Support. (Delhi NCR, West Bengal, Uttarakhand and Maharashtra)
- **OHSP:** Technical and management inputs to TMST, Government of Odisha Health Sector and Nutrition Plan. **(**15 districts of Odisha)
- **MDR-TB:** Treatment, adherence and follow up of Multidrug-resistant tuberculosis.
  (West Bengal)
- **SKEAP:** Strengthening Kala Azar Elimination Program. (Eight districts in Bihar)
- **Axshya:** Bridging one of the most challenging gaps in Tuberculosis control - diagnosis and treatment of DR-TB - through programmatic activities. (Madhya Pradesh, Chhattisgarh and Jharkhand)
- **BTAST:** Bihar Technical Assistance Support Team. (Bihar)
- **MPNP:** Madhya Pradesh Nutrition Project. (Tikamgarh, Panna and Chhatarpur districts of Madhya Pradesh)
- **Mother and Child Health Project**. **(**Odisha and Madhya Pradesh)
- **UHI:** Urban Health Initiative. (11 cities of Uttar Pradesh)
- **FHI:** Family Health Initiative. (Bihar)
- **N-TSU:** Nutrition Technical Support Unit. (Bihar)

DEPARTMENT WORKED IN : -

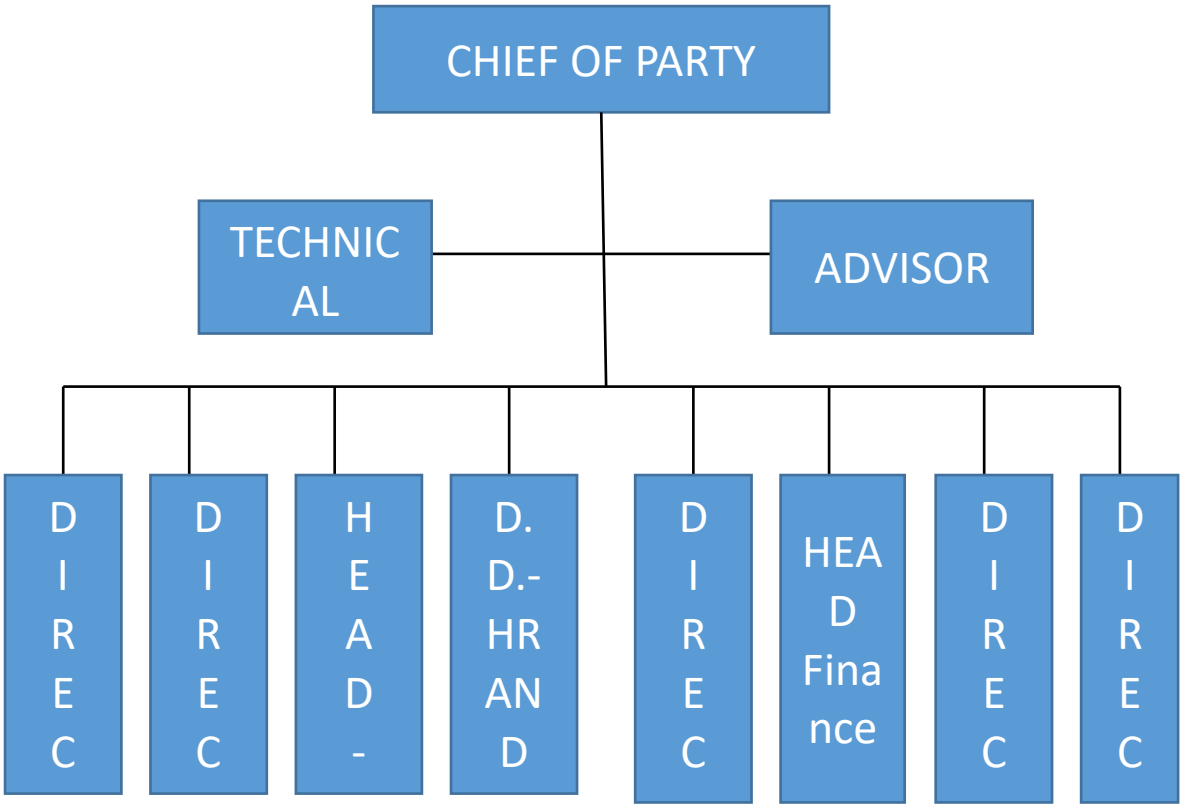
NUTRITIONAL TECHNICAL SUPPORT UNIT

For CARE India, the N-TSU project, funded by the BMGF, offers an opportunity to provide long term support to the Bihar state government's Integrated Child Development Services (ICDS) scheme. The ICDS scheme attempts to harness human, institutional and financial resources to do more, with high quality and with increased precision and efficiency. The goal of N-TSU is to achieve greater impact on the overall development of children in the state by addressing under-nutrition, especially focusing on Young Child Feeding practices, mainly through giving vigorous Home visits by the various stakeholders to the households of beneficiaries.

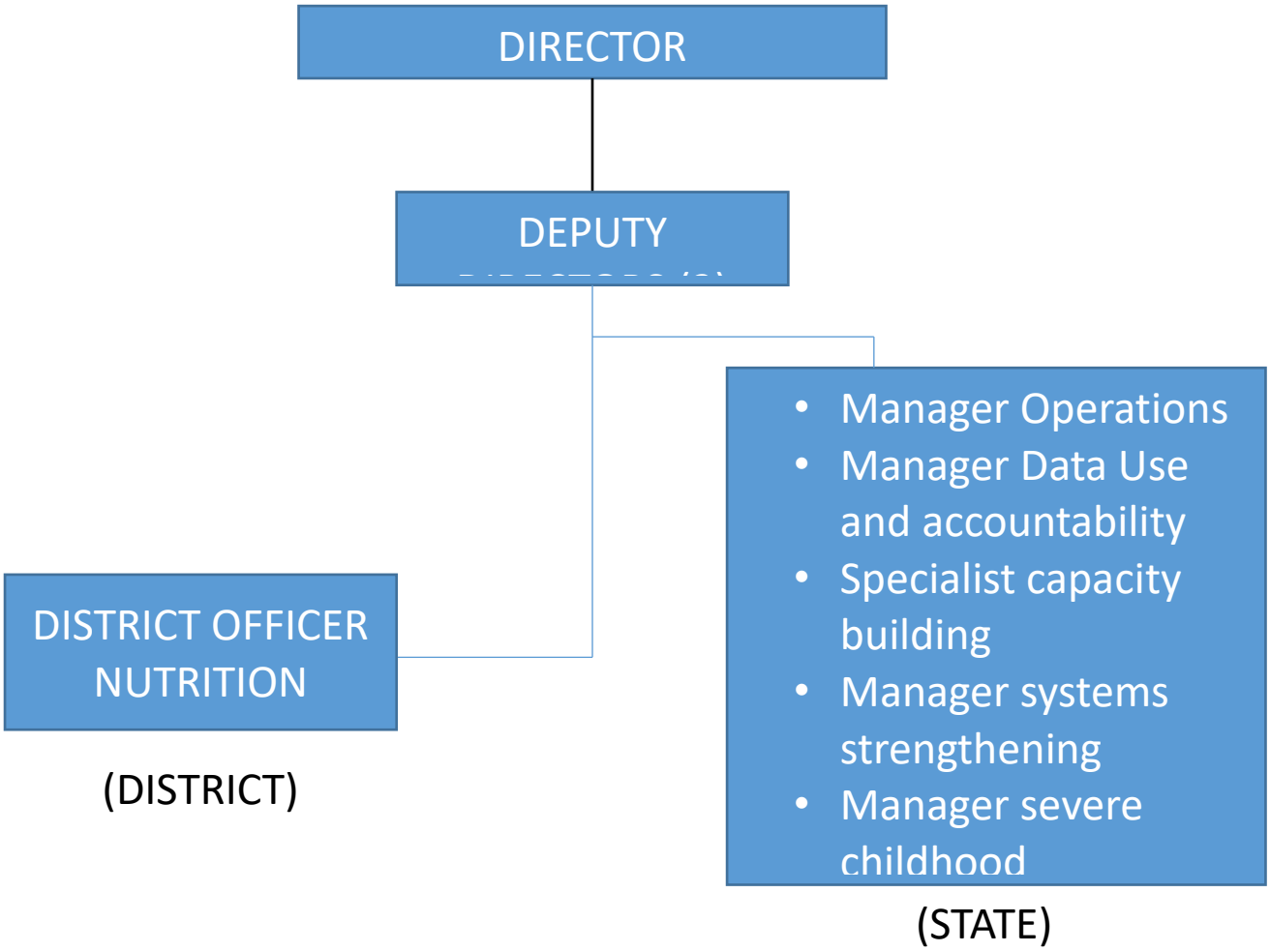
Recognizing that the Ministry of Women and Child Development alone cannot meet the needs of all children, CARE India is assisting the government to undertake convergence with other ministries and departments. CARE India is drawing from its field-tested, proven approaches to systematically create an enabling policy environment for ICDS, build trust across sectors, document models and promote convergence. Besides this, CARE India is facilitating training and capacity building of government functionaries, promoting safe drinking water, hygiene and sanitation at the household and community levels, promoting wheat fortification carrying BCC intervention, undertaking community mobilization and participatory governance. Finally, CARE India is responsible for working with block and district level ICDS personnel to improve their capabilities in data-driven management – using information to make evidence-based decisions to iteratively strengthen programs and improve outcomes.

Through monthly convergence meetings, N-TSU plans to re- establish the importance of convergence and coordination amongst the different government departments and other stake holders that contribute in reduction of malnutrition.

BIHAR MANAGEMENT TEAM:-



N-TSU PROJECT TEAM:-



KEY LEARNINGS

- An entire set of programmes are running under the MoHFW and MoWCD in the state of Bihar, but the ground level implementation and performance is in a miserable state.
- There is a huge communication gap and too much overlap and confusions in the work profiles of FLWs of ICDS and Health Department.
- Work profiles of government officials, i.e. DPOs, CDPOs and LSs in the Department of Social Work, Government of Bihar, is heavily loaded with add-on responsibilities like election duties, land issue resolutions, etc; which often results in a compromise with their actual job-specific work.

- The agony of cultural taboos is still widely prevalent in Bihar. Also, the caste system affects the functioning of the AWCs at large. There are a few communities like Mushahar and Passi, the presence of which is not acceptable to higher caste groups like Rajputs and Yadavs, which often results in preventing their children from going to AWCs if AWW or AWH belong to any other community or other caste groups are also benefitted at the same AWC.

- The physical state of AWCs is miserable, with unmaintained dust-filled registers, unreadable IEC on walls, no electricity and an acute shortage of space for the conduction of AWC functions, especially on VHSNDs.

- AWCs are equipped with Nutritional and Health education kits and materials, to be used by the FLWs on VHSNDs for educating women; but they are mostly unaware of the proper message to be communicated or the way to deliver it.

- People tend to look at an AWC as a spot to merely provide them ration and vaccinations, and thus are widely uninterested in the other services provided, and consider it to be a waste of time.

- There is a severe shortage of home visits by the FLWs, and this result in an improper knowledge of women on topics like exclusive breast feeding, complimentary feeding, family planning and birth preparedness.

- Since long, the entire focus in the field of healthcare in Bihar has been on immunization and institutional deliveries only, and thus the nutrition component was missed heavily, which has resulted in very high malnutrition rates in Bihar.

- There are huge gaps in the logistics or supplies of the essential materials like registers, growth charts, IFA tablets, THR, etc at the AWCs, which majorly affect their day to day functioning.

- A lot of meetings like ANM Tuesday meetings, HSC meetings, Sector meetings, DRG meetings, BRG meetings, etc are a part of general operations of the various stakeholders of health, but their regular conduction is a matter of question and a major challenge for the development partners like CARE.

DISSERTATION PROJECT

INTRODUCTION:

Infant and Young Child Feeding (IYCF) is a set of well-known and common recommendations for appropriate feeding of new-born and children under two years of age. IYCF includes the following care practices:

- **Early Initiation of Breastfeeding** means breastfeeding all normal newborns (including those born by caesarean section) as early as possible after birth, ideally within first hour. Colostrum, the milk secreted in the first 2-3 days, must not be discarded but should be fed to newborn as it contains high concentration of protective immunoglobulin and cells. No pre-lacteal fluid should be given to the newborn.

- **Exclusive breastfeeding for the first 6 months** means that an infant receives only breast milk from his or her mother or a wet nurse, or expressed breast milk, and no other liquids or solids, not even water. The only exceptions include administration of oral rehydration solution, oral vaccines, vitamins, minerals supplements or medicines.

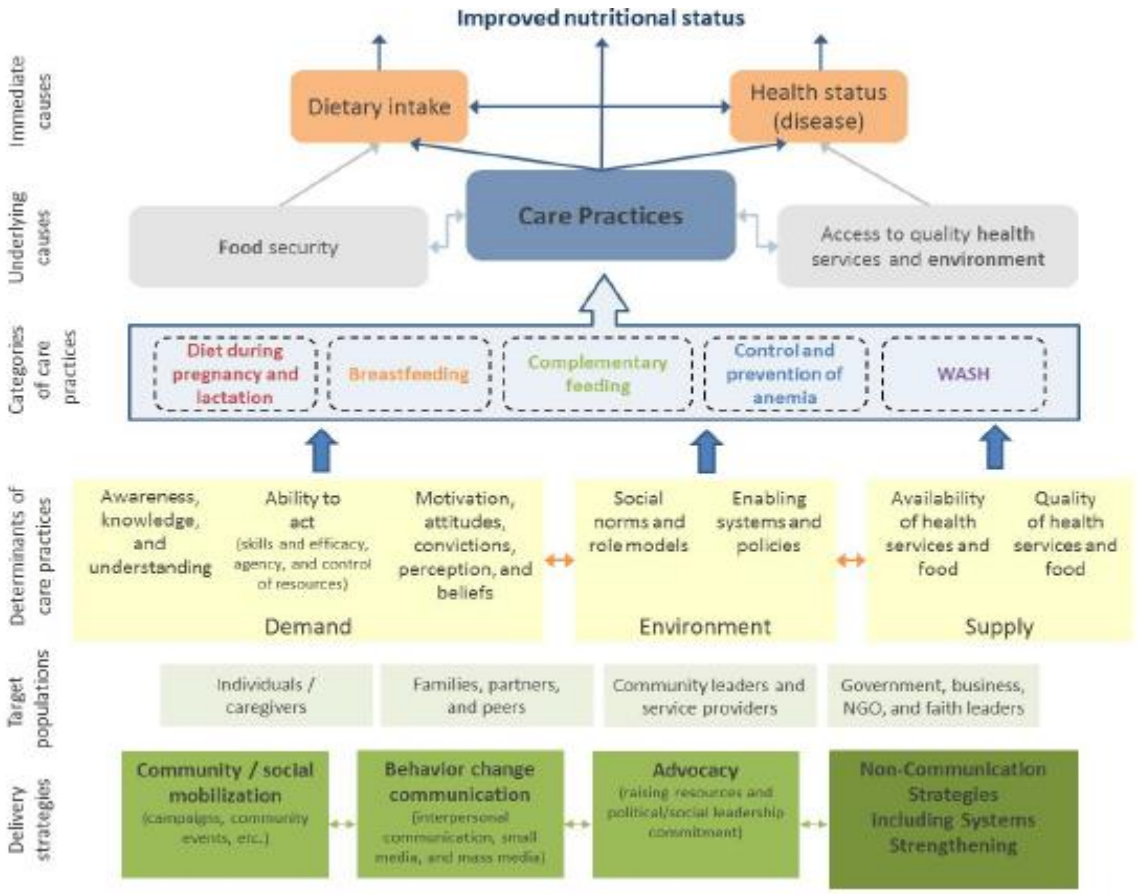
- **Complementary feeding** means complementing solid/semi-solid food with breast milk after child attains age of six months. After the age of 6 months, breast milk is no longer sufficient to meet the nutritional requirements of infants. However infants are vulnerable during the transition, from exclusive breast milk to the introduction of complementary feeding, over and above the breast milk. For ensuring that thee nutritional needs of a young child are met breastfeeding must continue along with appropriate complementary feeding. The term "complementary feeding" and not "weaning" should be used.

- **Timely** – meaning that they are introduced when the need for energy and nutrients exceeds what can be provided through exclusive breastfeeding.

- **Adequate-** meaning that they provide sufficient energy, protein and micronutrients to meet a growing child's nutritional needs.

- **Safe-** meaning that they are hygienically prepared and stored, and fed with clean hands using clean utensils, and not bottles and teats.

Source: National Guidelines for Infant and Young Child Feeding


Improved nutritional status
Immediate causes
Dietary intake
Health status (disease)
Underlying causes
Care Practices
Food security
Access to quality health services and environment
Categories of care practices
Diet during pregnancy and lactation
Breastfeeding
Complementary feeding
Control and prevention of anemia
WASH
Determinants of care practices
Awareness, knowledge, and understanding
Ability to act (skills and efficacy, agency, and control of resources)
Motivation, attitudes, convictions, perception, and beliefs
Demand
Social norms and role models
Enabling systems and policies
Environment
Availability of health services and food
Quality of health services and food
Supply
Target populations
Individuals / caregivers
Families, partners, and peers
Community leaders and service providers
Government, business, NGO, and faith leaders
Delivery strategies
Community / social mobilization (campaigns, community events, etc.)
Behavior change communication (interpersonal communication, small media, and mass media)
Advocacy (raising resources and political/social leadership commitment)
Non-Communication Strategies Including Systems Strengthening

PROBLEM STATEMENT

The WHA resolution urges Member States to put the MIYCN Plan into practice by including proven nutrition interventions relevant to the country in maternal, child and adolescent health services and care. Interventions carried out should ensure universal access, and establish and engage policies in agriculture, trade, education, social support, environment and other relevant sectors to improve nutrition.

The MIYCN Plan includes six global nutrition targets:

1. A reduction of the global number of children under five who are stunted
2. A reduction of anaemia in women of reproductive age
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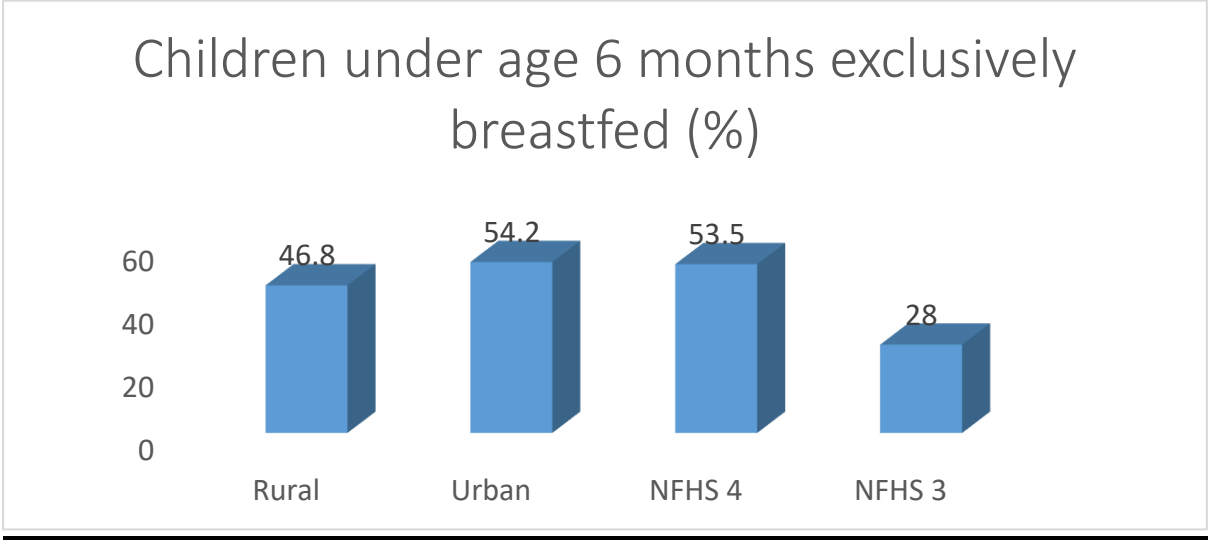
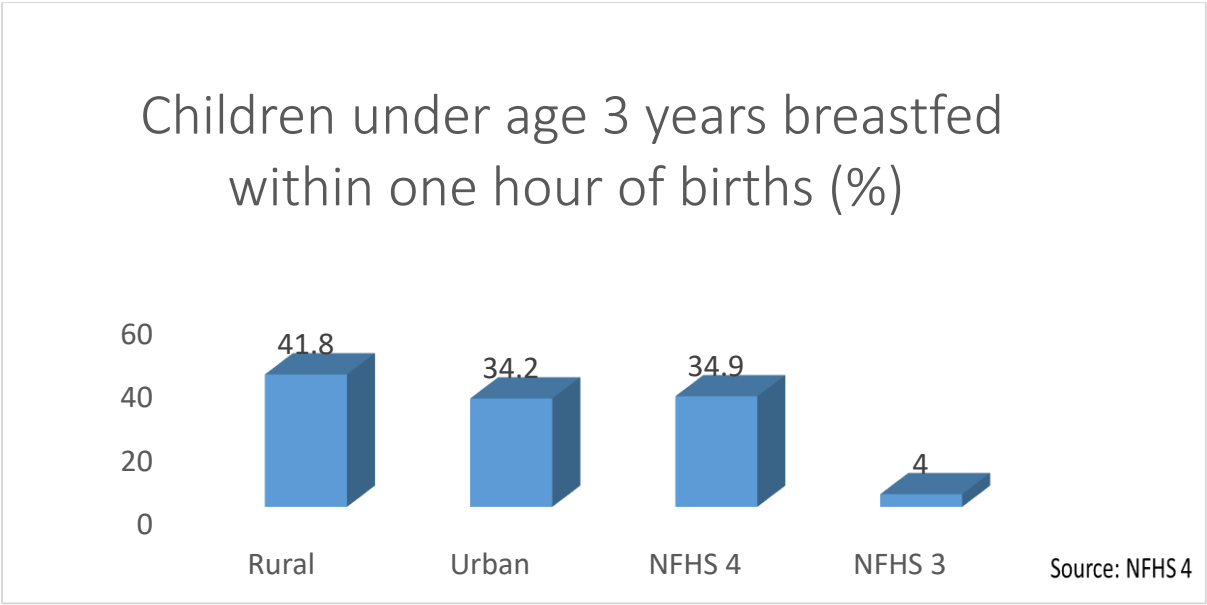
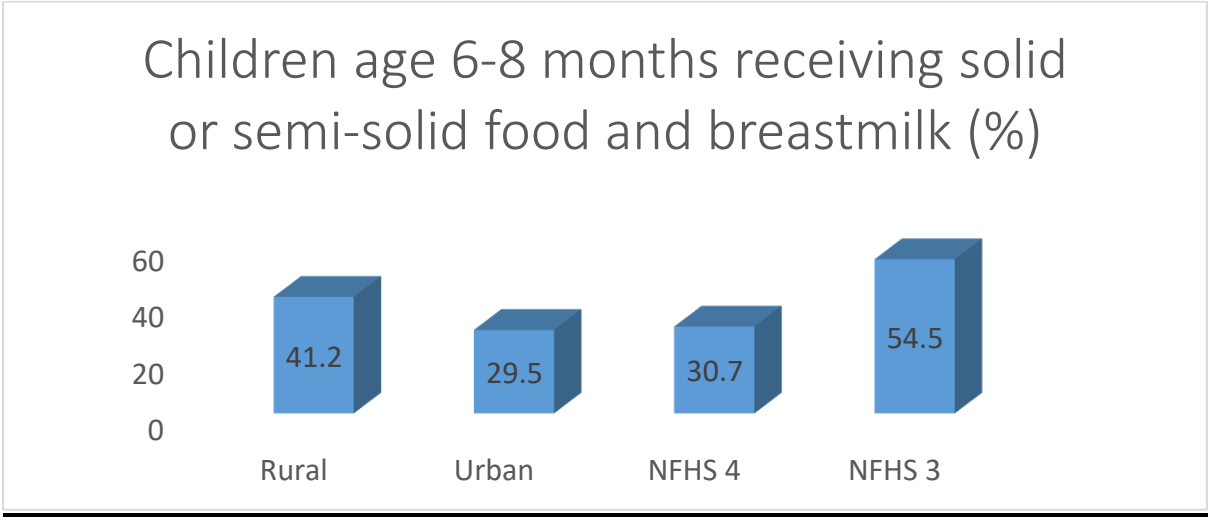
5. Increase the rate of exclusive breastfeeding in the first six months
6. Reduce and maintain childhood wasting




Children under age 3 years breastfed within one hour of births (%)
60
40
20
0
41.8
34.2
34.9
4
Rural
Urban
NFHS 4
NFHS 3
Source: NFHS 4


Children age 6-8 months receiving solid or semi-solid food and breastmilk (%)
60
40
20
0
41.2
29.5
30.7
54.5
Rural
Urban
NFHS 4
NFHS 3

RATIONALE

In 1000 days window opportunity for:

- The time duration in which malnutrition start from the conceiving till 2 years after the birth and thus our intervention is primarily focus in the field.
- A primarily requirement for any intervention during the pregnancy registration timely, which can be then focused and various other intervention (Early initiation of breastfeeding, exclusively breastfeeding, complementary feeding and also the nutrition for the mother at the time of pregnancy).
- Direct intervention targeting malnutrition in a child only perform after birth.
- Breastfeeding is one of the most important determinants of the child survival, birth spacing, and prevention of childhood infections. The importance of breastfeeding has emphasized in various studies. The importance of exclusive breastfeeding and the immunological and nutritional values of breast milk have been demonstrated.
- The beneficial effects of breastfeeding depend on the breastfeeding initiation, its duration, and the age at which the breast-fed child is weaned. Breastfeeding practices vary among different regions and communities. In India, breastfeeding in rural areas appears to be shaped by the beliefs of a community, which are further influenced by social, cultural, and economic factors.
- In this study, we are trying to look at the quality counselling done by FLW (ASHA/ANM/AWW) of IYCF (Infant & Young Child feeding) to beneficiaries during home visit. Hence, the study with these relationships helps in orienting the breastfeeding promotional activities.

RESEARCH QUESTION

- Assessment of the quality of counselling done by AWW on MIYCN (Mother Infant Young and Child Nutrition) in district Patna, Bihar.

OBJECTIVES:

- To understand the knowledge of AWW regarding MIYCN practices.
- To find out the gaps using a standardized check list in the message delivered by AWW.
- To find out the existing mechanism of MIYCN counselling training in their curriculum.

REVIEW OF LITERATURE:

The Bihar government has many state/district level campaigns and programs to improve the undesirable health indicators of the state .With over 24,000 front line workers working, the poor performance of the state indicates the poor knowledge, practices and motivation of the FLWs. Prior reports have suggested wide gaps between the knowledge, practices and motivation of FLWs. A huge contrast between the Anganwadi Workers' knowledge and their practices has been observed .Their inability to empathetically engage with caregivers, disregard for taking the feeding history of children, poor active listening skills and their inability to provide need-based advice are some of the concerns, the program manager/ trainer should focus on. Several reports recommends to ensure enhanced interaction between the Anganwadi Workers and caregivers on infant and young child feeding practices ,for which a paradigm shift in training is required, making communication processes and counselling skills central to the training .

The present study is aimed to assess the Anganwadi Workers knowledge of early childhood nutrition and their ability to counsel and influence caregivers regarding these practices.

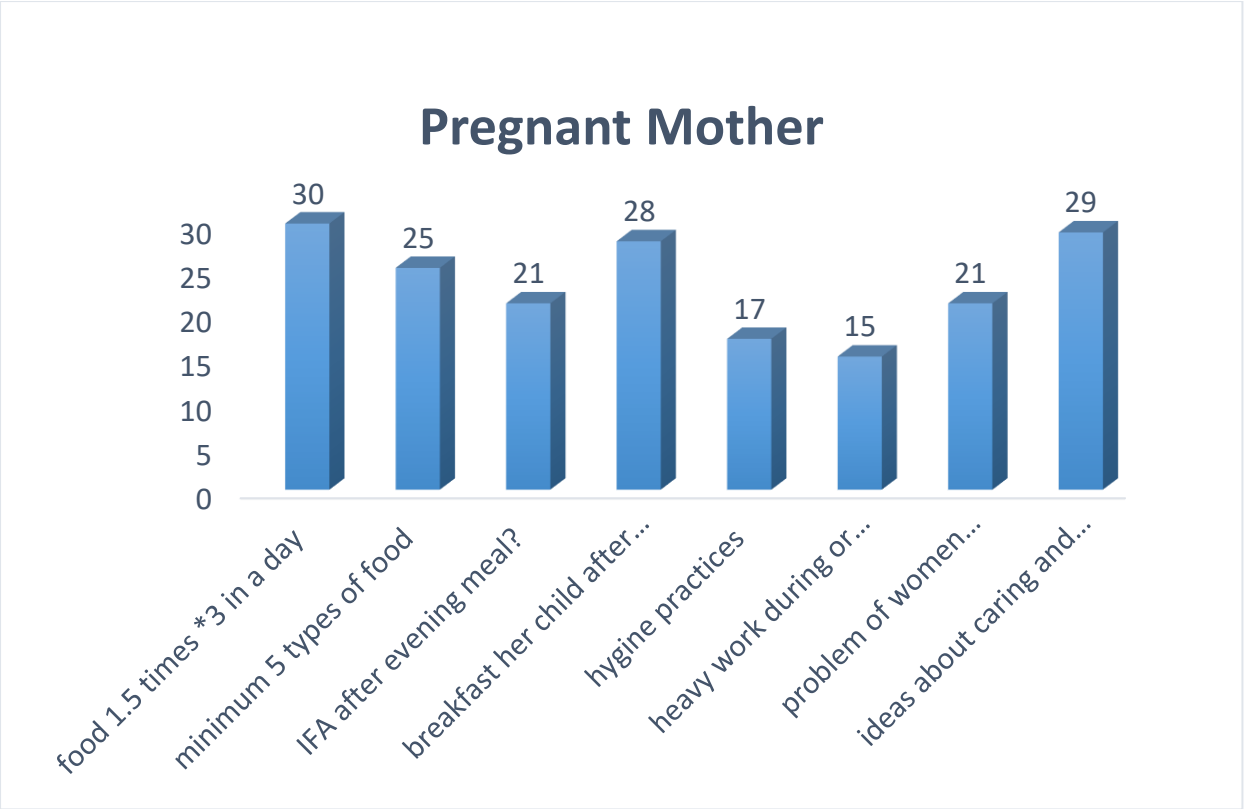
METHODOLOGY:

- **Study type-** Descriptive cross-sectional study
- **Study area: -**Patna
- **Study duration:-** 11th April 2016 to 10th May 2016
- **Study respondents-** The respondents for the following study will be AWWs of Patna.
- **Sources of Data: -** Primary data will be collected filling the checklist by accompanying the AWW during home visit/VHND
- **Sample method-** Multistage random sampling.
- **Sample size-** 67 (Population size is 3937, confidence level is 90%, Margin of error is 10%)
- **Data collection Techniques:-** Checklist
- **Data collection Tools:-** Checklist

LIMITATIONS:

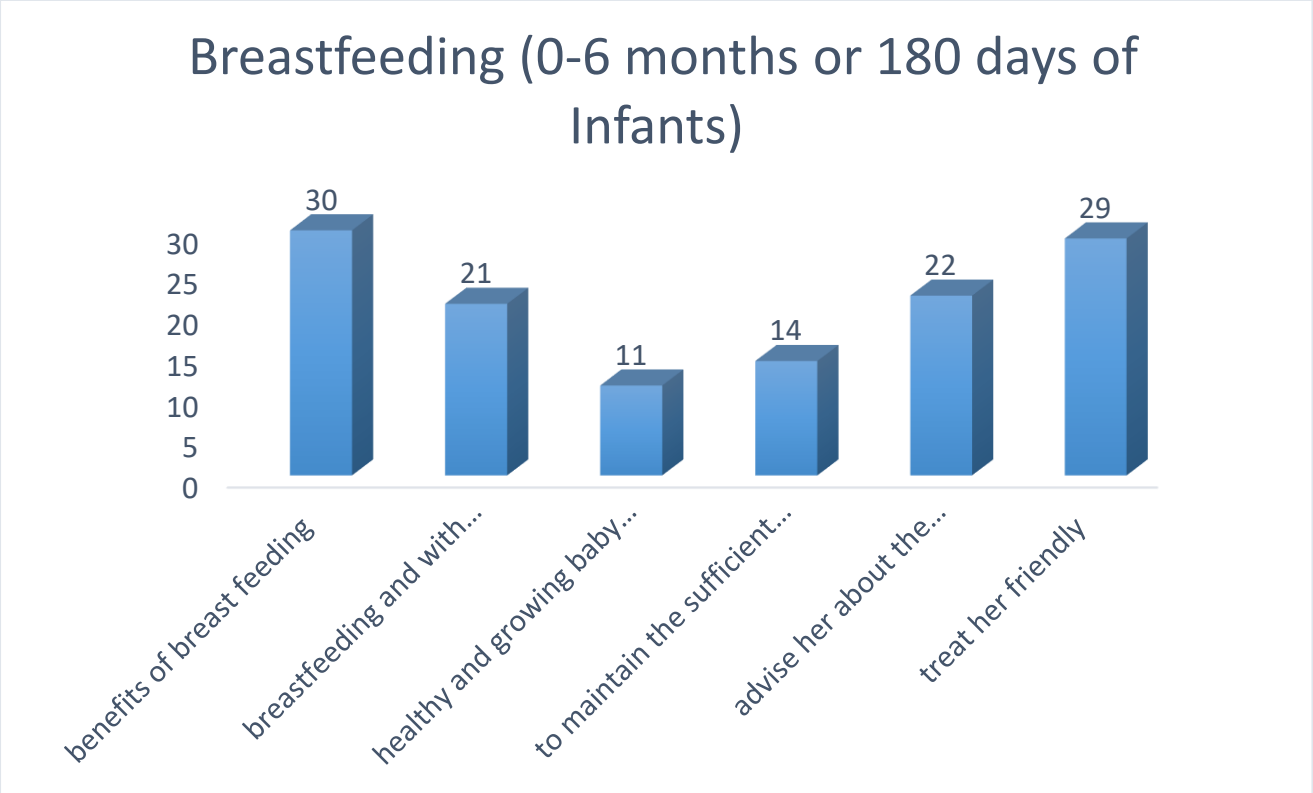
- Due to lack of time, I only collect the 30 sample of the AWW for the counselling of the MIYCN by the checklist on the Home visit or VHND.
- Due to a limitation of time for data collection, the intended sample size could not be met, which can result in a greater margin of error, and thus the results may have a slight deviation from the true picture of the study population.

FINDINGS



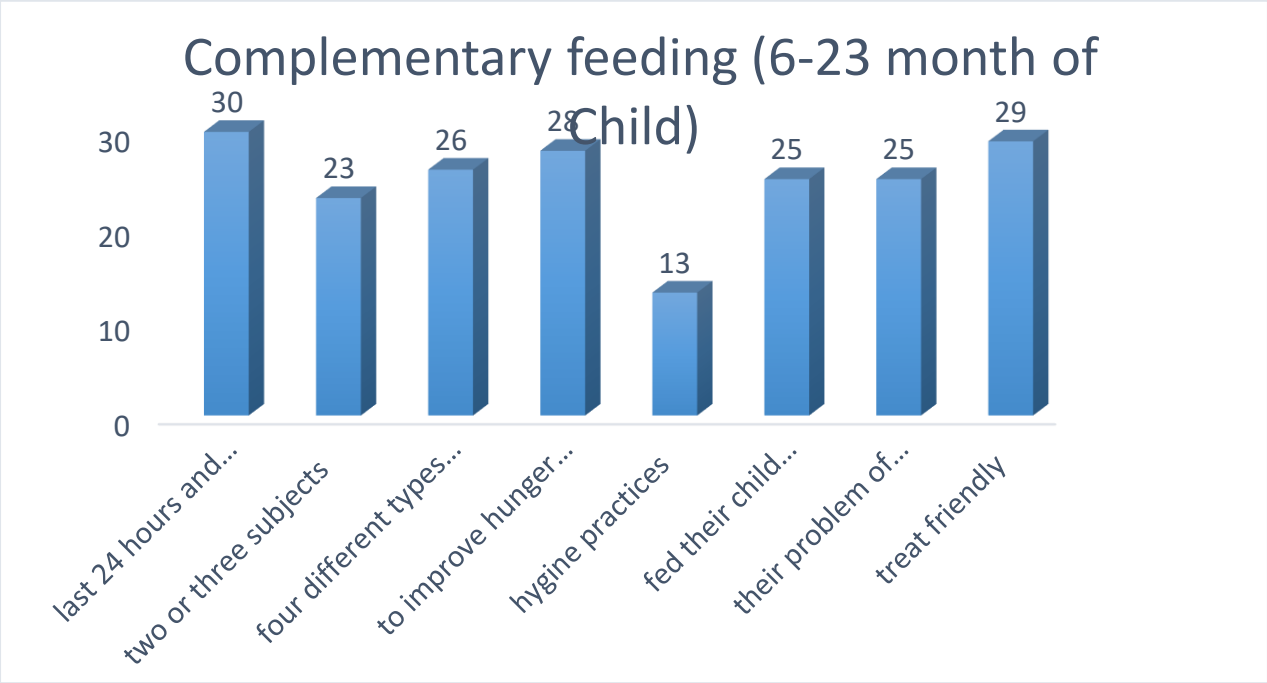
The format of counselling are for pregnant women are:

- Is AWW asked to the mother about her food and remember her that to take food 1.5 times *3 in a day
- Is AWW asked mother, What she had eaten in last 24 hours and remember her to eat daily minimum 5 types of food (e.g: Daily product, Egg, Fish, Orange, and green leafy vegetables, Pulses with additional one spoon Oil) to eat?
- Is AWW remember to mother to take tablet of IFA after evening meal?
- Is AWW remember mother to breakfast her child after birth and not any edible item to give?
- Is AWW remember mother to wash their hand after toilet use, or washing waste product of child and before cooking food or feeding her child?
- Is AWW remember mother to not to do heavy work during or after 6 months pregnancy and to rest at least one hour in a day?
- Is AWW listen the problem of women carefully?
- Is beneficiaries praise the AWW and treat her kindly while giving ideas about caring and breast feeding?



The format of counselling are for Breastfeeding (0-6 months or 180 days of Infants) are:

- Is AWW remember to mother to breastfeed to her child for six months and not to give any additional food such as water or milk to their child and benefits of breast feeding?
- Is AWW help the mother according to the condition of child while breastfeeding and with attachments to breast?
- Is AWW workers remember mother's how to know the lacking of milk to her child (healthy and growing baby urinate 6 times in a day, sleep well and play?
- Is AWW remember mother's to maintain the sufficient amount of milk, such as to breastfeed at short internal and not to give water to child
- Is AWW listen the problem of mother carefully and advise her about the breast problem such as smelling of breast, fever and pain in breast etc.
- Is beneficiaries praise the work of AWW and treat her friendly?



The format of counselling are for Complementary feeding (6-23 month of Child) are:

- Is AWW asked what you have given to child in last 24 hours and told about the food what to give the child or what not to give?
- Is AWW advice about two or three subjects and asked mother is she understand or not?
- IS AWW daily to give four different types of food to child such as dairy products, egg, fish, orange, fruits, and green leafy vegetables, pulses and extra one spoon edible oil and to continue breast feeding
- Is AWW remember you to improve hunger and to show the demo?
  A. While fooding take to child, entertain him and parise him
  B. Not to feed the child forcely, praise the child to take the food and eat by himself
  C. Feed the child nutrients product and what him like
  D. Feed the child when he is hungry and ready to eat or when he is not sleeping

E. Take proper time while feeding the child
F. Not to feed the child stomach filling product such as water, chips, juice, biscuit etc.

- Is AWW remember mother to wash their hand after toilet use, or washing waste product of child and before cooking food or feeding her child?
- Is AWW remember mother's how to feed their child while they are sick.
  A. In low internal and too long duration of breastfeeding and in night also
- Is AWW listen their problem of mother carefully?
- Is beneficiaries praise the work of AWW and treat friendly?

DISCUSSION

WHO has identified Ten Guiding Principles for optimal complementary feeding of the breastfed child to achieve optimum nutrition during this critical time of life. Mothers and other caretakers should:

- Exclusively breastfeed from birth to six months of age, and introduce complementary foods at six months of age (180 days) while continuing to breastfeed
- Continue to breastfeed frequently on demand until two years of age or beyond
- Practice responsive feeding, applying the principles of psycho-social care
- Practice good hygiene and proper food handling
- Start at six months of age with small amounts of food and increase the quantity as a child gets older, while maintaining breastfeeding
- Gradually increase food consistency and variety as the infant gets older, adapting to the infant's requirements and abilities
- Increase the number of times that the child is fed complementary foods as he/she gets older
- Feed a variety of foods to ensure that nutrient needs are met
- Use fortified complementary foods or vitamin-mineral supplements for the infant, as needed
- Increase fluid intake during illness and after illness, give food more often than usual and encourage child to eat more

The timing of the counselling/support has been found to be important. Prenatal and postnatal breastfeeding counselling interventions, whether alone or in combination, have been found effective in improving breastfeeding practices including duration of exclusive breastfeeding and any breastfeeding. In a systematic review of effectiveness of breastfeeding interventions that involved 38 trials, prenatal breastfeeding interventions significantly increased the rate of

any short-term breastfeeding (1 to 3 months) rate by 39% compared to the usual care while combined prenatal and postnatal interventions significantly increased both the rates of intermediate (4 to 5 months) and long-term (6 to 8 months) any breastfeeding compared to usual care by 15% and 33%, respectively. Postnatal interventions significantly increased the rates of short-term exclusive breastfeeding (1 to 3 months) by 21%. In another systematic review that involved 20 trials, only interventions with a post-natal component were found to be effective in improving breastfeeding practices whereas there was no evidence to suggest effectiveness of antenatal counselling/support. This study, which involves home-based personalised counselling/support during pregnancy and one year following delivery, will provide further evidence on the effectiveness of combined antenatal and postnatal counselling/support.

CONSLUSION

- All of the AWW are not know the counselling for the MIYCN practices.
- They only know the few one for the counselling for MIYCN practices.
- Home visit are also poor in the area of all AWW.
- During VHND they all are busy in the RI process on this day the counselling given to the AWW are very few for the beneficiaries.
- The training of the counselling of AWW are not up to the mark.
- Some AWW are very good in counselling skills.
- Review of findings, consensus building and adjustment of materials.
- Counselling cards for both community and facility health workers
- Take home brochures for mothers and caregivers
- Posters on breastfeeding and ante-natal care
- Corresponding training materials

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- NFHS-4, visit http://www.rchiips.org/nfhs
- Alive and Trive checklist used during my report.