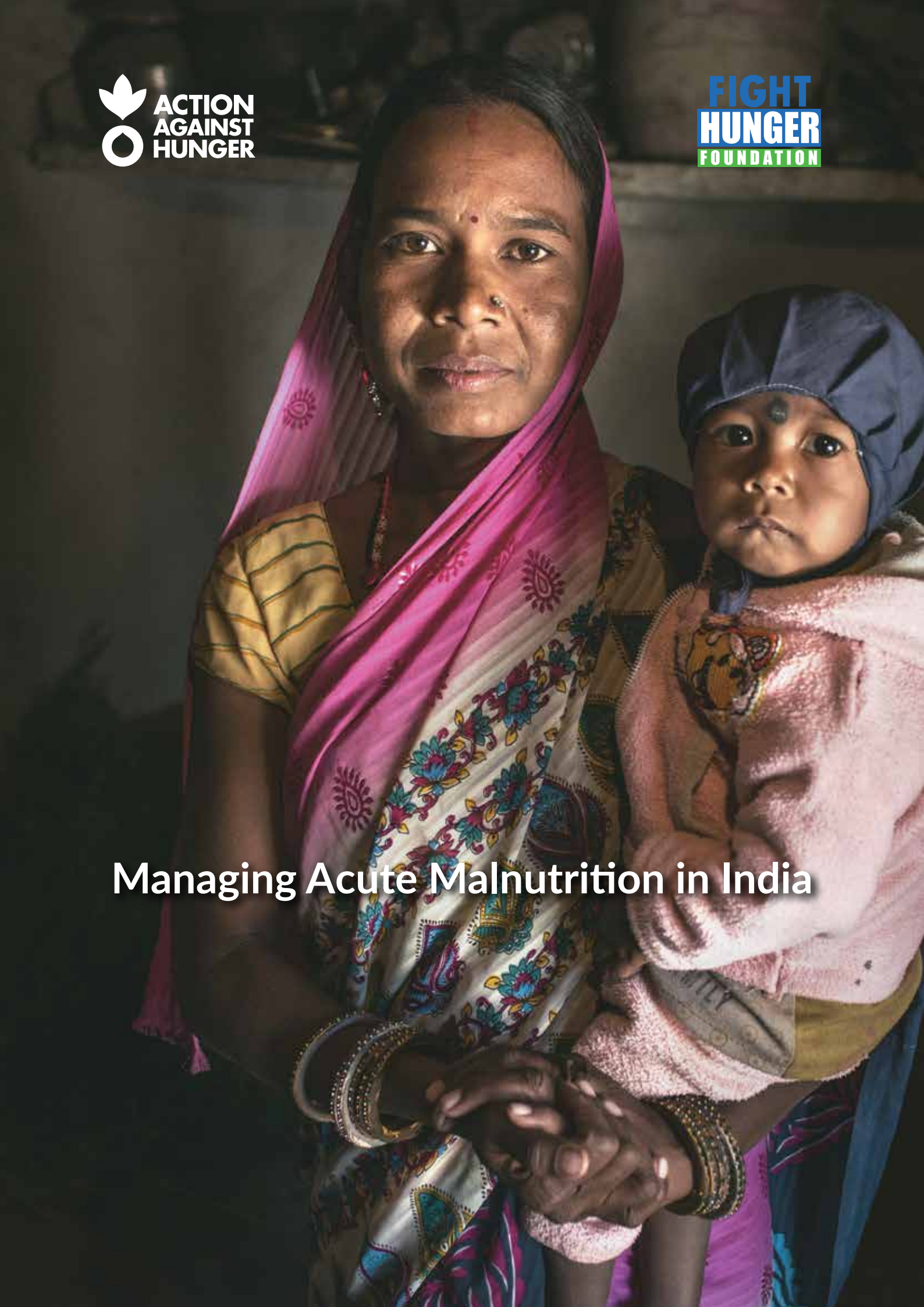


ACTION AGAINST HUNGER

FIGHT HUNGER FOUNDATION

Managing Acute Malnutrition in India

C O N T E N T S

KEY ELEMENTS

Community Based Management of Acute Malnutrition

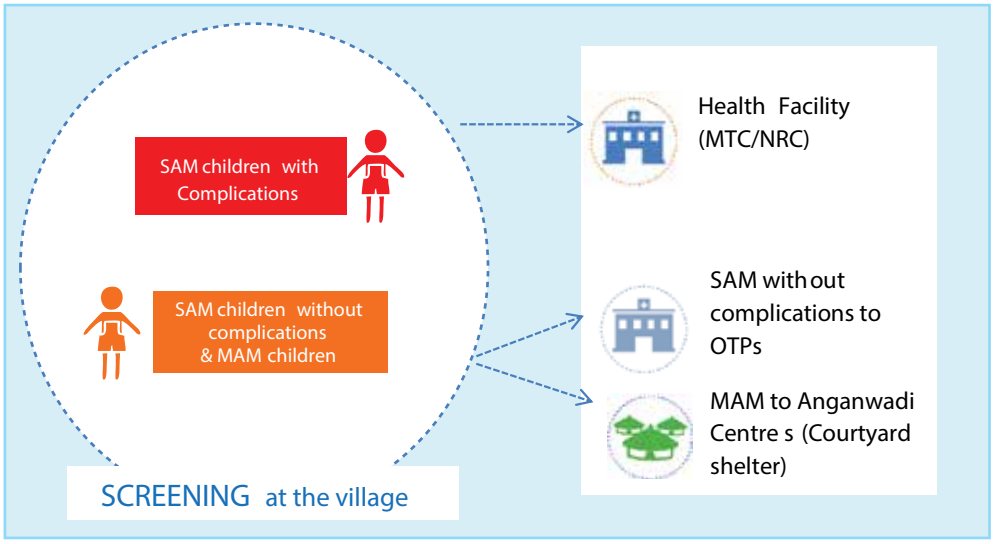
Here, ACF's CHWs are seen assessing a child in a village

1. Identification & Referral

Community Health Workers (CHW) including Accredited Social Health Activists (ASHA) screens the children in the village. They use the Mid Upper Arm Circumference (MUAC) tapes to access the condition of the children and check for medical complications based on which they are referred to, either a health facility or an anganwadi centre for treatment.

As part of a more sustained process the communities themselves have taken a step forward in screening and referrals.

- Most mothers in Laxmipura village now regularly check the growth of their children at home
- Men's group in Rampur Todia and Jaitpura villages regularly hold discussions and refer children to MTCs and AWW centres
- Anganwadi Workers (AWW) in 60 villages of Madhya Pradesh have taken up screening of SAM children on a regular basis and refer them to MTCs
- The village Pradhan (headman) in Khandela Todia village has also made it his priority to detect & refer malnourished children to MTCs



2. Clinical Support – MTCs & NRCs

SAM children with complications are treated in the MTCs/NRCs

The Nutrition Rehabilitation Centre (NRC) or Malnutrition Treatment Centre (MTC) is a 24 hours operational health facility for children. These centres are unique & child-friendly. Here Severe Acute Malnutrition (SAM) cases with medical complications are admitted and treated using measured therapeutic feeding. The parents are counselled on food habits and child care practices with demonstrations. Proper follow-ups of the cases are also carried out after discharge. A proper discharge also entitles the treated SAM children with a nutritious food basket to sustain their good health.

One of the finest

The Mavli MTC in Udaipur district is assessed as one of the best MTCs in Udaipur

An exemplary model is Mavli MTC in Udaipur. This MTC has come up as the best implementer of the CMAM phase one practices. It has a hygienic, child friendly infrastructure, well-functioning kitchen oriented staffs and equipment as per the required protocols. As provider of health services, the staffs have good relationship with the community. Follow-ups of the SAM children are also done regularly along with proper record keeping.

- The paediatrician and the Community Health Centre in-charge Dr. L C Charan states that because of their good relationships with the community, there has been more than 25 admissions during September-November 2016. This emanates as a huge boost to them, as it all contributes to making the MTC unique in itself.

3. Community based Actions to Manage Acute Malnutrition & Community Mobilization

SAM children without medical complications are treated in the OTP centres.

The OTPs cater to the uncomplicated cases of SAM. Here the children are assessed through anthropometry and for appetite before enrolling them in the program. Each week the children are given a packet of RUTF to eat as per requirement and also to carry home for the entire week. Parents are counselled on child care practices along with disbursement of monetary allowances.

MAM children are referred to the anganwadi centres where they are entitled to the benefits of the Integrated Child Development Services scheme.

Some women from a village take an oath to wash their hands before cooking food for their children in an anganwadi centre on the eve of Global Hand Washing day

Inclusive of the treatment of all children the CHWs persistently counsel the parents on:

- Hand Washing
- Sanitation
- Safe drinking water
- Kangaroo mother care
- Immunization
- Breast feeding
- Complementary food
- Hygiene & body massage for the children
- Availing timely treatment for all childhood illness

SUSTAINABLE OUTCOMES

For a more sustainable outcome, the community is also encouraged to take up the following unique activities:

Have a kitchen garden in every household:

These gardens provide easily available vegetables to meet immediate nutrient requirements at each household. Most homes now have a kitchen garden that the family is delighted of and tends to regularly.

Extensive use of a tippy tap:

These simple apparatuses are extensively used for hand-washing with running water where there are no ideal options available. The taps prove to be an asset to families, especially for the children at the anganwadi centres and schools.

Mothers using a MUAC tape:

Mothers' competencies were built to screen and keep track of their own child's growth at home with the help of a Mid Upper Arm Circumference (MUAC) tape. This way the community is empowered to become accountable and take decisions by themselves.

Community Kitchen Garden:

Model AWW centres now have a community kitchen garden where residents of the village share work responsibility and also the fruits of their labour. This has helped the communities to become more accountable towards the health of their children.

Men's group discussions:

All men now participate in group discussions and understand their active role in the management of SAM by referring children to the MTCs and participating equally in delivering care for the child.

Toy Making:

The toy making initiative enhances the care for the child by the mother and develops a bonding between mother and child through this exercise. These toys (rattlers) are hung by their mother over their children beds, when they are working.

Crèches and Foster Parenting:

An AWW in Palasur village has brought many smiles to the children there. She has brought innovative edge to her teaching interventions planning her daily activities with prayers and exercises& breakfast in the morning, followed by group play-sessions, story-telling and singing before its lunch time.

4. Good Governance

Good governance forms an integral part of any successful CMAM program. Some critical factors that worked in the POSHAN program in Rajasthan were:

- Strong Political Will & Leadership
- Effective Partnerships
- Health System Strengthening
- Strategic Approach

1. Political Understanding, Will and Commitment:
   a. Acute malnutrition was identified as a public health priority by the Government of Rajasthan.
   b. National Health Mission (NHM) took proactive leadership towards leading the initiative for addressing SAM within the state.
   c. Resource allocated from the MH&FW department within the state for supporting the project.
   d. State and District level review mechanism was institutionalized.
      - Technical Advisory Group supported the NHM in a structured manner.
      - Data and knowledge management of treatment progress initiated.

1. Strength Based Approach:
   Partners including Rajasthan Drugs & Pharmaceuticals Limited (RDPL), UNICEF, CIFF, GAIN and ACF were brought on board for structured support as per the program needs.
2. Protocols and Guidelines were developed & institutionalized within -
   a. Facility/hospital-based care for SAM children and medical complications at MTC level.
   b. Home/community-based care for SAM children but without medical complications using Medical Nutrition Therapy (MNT).
   c. Capacity Building modules and training models were developed to bridge gaps and enhance competencies.
3. Partners supported implementation of the project and contributed to create a sustainable and replicable model for scale up.
4. Structured process documentation and advocacy was embedded as a part of the design, with media playing a vital role of vigilante within the partnership.

1. System Strengthening
   Support to the health system Equipment's: Provisioning of anthropometric scales & Mid Upper Arm Circumference (MUAC) tapes in all 555 sub centres in the 13 districts.

1. Capacity Building:
   a. Skill gap / need assessment at different tiers within the state.
   b. State level sensitization of District collectors as the lead to oversee the program.
   c. State level orientation of Regional training cum resource centres including mentors.
   d. Divisional orientation of Block Chief Medical & Health Officers, District teams on CMAM.
   e. Training of trainers (district trainers) at the regional training cum resource centres.
   f. District/ block level skill training of all the grassroots level service providers.

1. Prioritization: Needs-based identification of areas at district and sub district level for interventions within the state.
2. Screening & Identification: Anthropometric measurements by trained ASHAs and ANMs at sub centre level within two month's timeframe
3. Enrolment: Categorical enrolment in CMAM and referrals to MTCs based on complications of children within a week post identification
4. Treatment Phase I:
   a. Weekly distribution of MNT Kit. Anthropometric measurement and clinical assessment on POSHAN day by ANM at sub centre level continuously for a period of 2 months.
   b. Providing incentives to Poshan Prahari's for daily visits to review appetite, consumption of Poshan Amrit, maintenance of general and food hygiene and status of child.
   5. Treatment Phase II: Monthly follow up visit, anthropometric and clinical assessment on POSHAN day by ANM at sub centre level post treatment phase I continuously for 4 months timeframe.

Dilip-A fight for survival

Hello everyone!

I am Dilip Sahariya. I am 2 years old. I live in Jaitpura Rundi village in Baran with my mama and papa. I have three siblings and my parents work outside in the field daily. Earlier, I stayed with my grandma all day and ate very little. I had a pain in my tummy and I cried a lot.

Papa came and told me that there was an ugly worm in my tummy. It was not my friend and making me weak. So he brought some medicine from the local doctor in the village to make me feel stronger.

But it did not work. I felt worse, sad and afraid. I also could not play with my friends anymore. So mama and papa took me to the ASHA didi (sister), who referred me to a sub centre for treatment.

There, I enrolled in the POSHAN programme along with some of my friends. My mama used to take me to each POSHAN day. She learnt how to take care of me. Now I like it even more when she does. During each POSHAN day, I was also given a yummy paste to eat and also to carry home.

The POSHAN programme made me heal from the nasty worm. I am healthy and strong again. I can now play with my friends! And I look forward to the moments where my mama takes care of me. I am also happy to eat the food that mama is cooking for me. I want to thank the POSHAN programme for making me a strong boy again.

Many of my friends still look weak. I wish the POSHAN programme restarts soon, to help my friends become healthier once again.

Vimla-A true agent of change

Namaste!

My name is Vimla Sahariya. I live in Moida village with my husband and 2 children. My husband is a migrant labourer and works in the fields. We both have to work hard to feed our whole family. We have almost nothing. We frequently have to migrate to seek more work. I do not spend so much time with my little ones and did not feed them properly.

I have recently endured the most difficult journey of my life. Varsha, my second child fell very sick during the last summer. She did not eat properly, grew very weak and she could not even cry. The local medicine also did not help. One night I sat beside her and wept the whole night. I thought she was going to die.

The POSHAN programme was actually a boon for us. As advised by the health workers after screening, Varsha was first admitted to the Medical Treatment Centre (MTC) in Baran. During the treatment there, I learnt a lot of new things & understood that the need for care is very important for a child. Yet Varsha was still not recovering. My worries only kept increasing.

Fortunately, POSHAN started afterwards and I brought Varsha to each of the POSHAN days. I learnt how to bathe and massage my dear Varsha, prepare nutritious food, maintain hygiene and feed her time regularly. I also learnt the colour codes in the mid upper arm circumference (MUAC) tape and its usages. I am so proud of my new knowledge. I now regularly screen all children in my locality by myself.

I am grateful to the POSHAN programme, which has helped to save the life of my little love, and of so many children.

HUNGER BELT OF INDIA

and state of under nutrition and malnutrition in high burden states

Out of the 16 million SAM children in the world, nearly **38%** are in India (Source: UNICEF)

6,60,000
new borns die every year in India due to different causal factors of malnutrition

The estimated economic and human potential loss due to hunger in India will be **38.6 Billion Euros / 32.8 Billion Pounds / 42 Billion US dollars***

*Source- Save The Children report 2013

WHO WE ARE

ACTION AGAINST HUNGER (ACTION CONTRE LA FAIM)

presence in India - 4 states and 3 slum pockets

Number of villages we are present in since 2012 : **477** (4 Indian states)

- Technical Advisory in **Jharkhand** since 2016
- Presence in **3 slum pockets** in Mumbai since 2016

Maharashtra Rajasthan Madhya Pradesh Jharkhand

Total population we impact: **7,19,133**

WHAT WE DO

Curative and **preventive** care for **malnourished children**

Community Interventions for raising awareness about malnutrition, health and hygiene, food security livelihoods, infant and young child feeding practices, mental health care practices and gender

Institutional strengthening through capacity building, infrastructure developmentand support

IMPACT

Number of **Direct beneficiaries :** **TOTAL (49,229)**

- Children under 5 years
- Caregivers- mothers/parents grandmothers (community info sessions held)
- Training conducted for various government and community stakeholders
- Nutrition Rehabilitation centre staff - trained
- Government health workers- AWW, ASHA, Sahayikas etc- trained
- Doctors and Nurses trained

Our **Outreach :** **TOTAL (311,209)**

- Children under 5 years - **41,974**
- MAM supported children - **11,426**
- RUTF treated children - **1,281**

29% of the villages within our intervention areas have become malnourishment free

42% of the villages have demonstrated decline in incidence of undernourishment

4,205 frontline workers trained

79.83% participants gained knowledge

Models Created

3 Nutrition Rehabilitation Centres, 3 OTPs and **5 AWCs** have been strengthened by us as models for community management of malnutrition

PARTNERSHIPS

- NGO partnerships
- MoUs with governments
- Institutional partnerships

GOING FORWARD

Our target for the year is to :

support about **12, OOO** SAM and **17, OOO** MAM children

&

build the capacity of approximately **6OOO** frontline workers

COSTS

Cost of treatment per SAM child:	Cost of treatment per MAM child:	Cost of community activities per village:	Cost of one food basket or a WASH basket per household:	Cost of training health workers per session:
€ 76.84	€ 44.76	€ 20.96	€ 20.96	€ 13.97

INDICATORS

21,519 Community sessions conducted

1,86,545 Participated in Community sessions

155 Trainings conducted

41, 974 Currently being screened

22,800 Average number of children screened in 1 year

4,449 SAM children successfully identified and treated

6,439 MAM received take home ration (THR)

631 Food baskets distributed

ACF BUDGET 2017

Total Budget : **€ 2.87 million**

Cost of Treatment of Children : € 1.93 million

- Cost for treating MAM : **€ 755,245**
- Cost for treating SAM : **€ 923,077**
- Post treatment care : **€ 251,000**

Cost of Community Activities

- Educating community and assisting behaviour change

Cost of Evaluation of Surveys

- Monitoring Programs

Cost of Training Health Workers

- Training health workers

Operations and Admin Costs : **€ 260,000**

- Total Budget : **€ 2.87 million**
- Total Beneficiaries : **560,000**
- Cost per Beneficiary : **€ 5.14**

Working towards a hunger free India.

Name : Raj Kumar
Village : Bhawangarh

BEFORE

AFTER

Name : Nina
Village : Garda

BEFORE

AFTER

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