A STUDY OF THE INTERFACE BETWEEN HEALTH SERVICES AND ICDS IN INDORE DISTRICT OF MADHYA PRADESH

Thesis submitted to Jawaharlal Nehru University in fulfilment of the requirements

for the award of the degree of

DOCTOR OF PHILOSOPHY

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DECLARATION

I do hereby declare that the thesis entitled "**A STUDY OF THE INTERFACE BETWEEN HEALTH SERVICES AND ICDS IN INDORE DISTRICT OF MADHYA PRADESH**", submitted by me to the School of Social Science, Jawaharlal Nehru University, New Delhi for the award of the degree of "**DOCTOR OF PHILOSOPHY**" embodies the result of bonafide research work carried out by me and that it has not been submitted so far in part or in full, for any degree or diploma of this university or any other university/ institution.

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CERTIFICATE

It is hereby recommended that the thesis may be placed before the examiners for evaluation.

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Dedicated to

ALMIGHTY GOD

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ABBREVIATIONS

AD syringe	Auto Disable Syringe
AHS	Annual Health Survey
AIDS	Acquired Immuno Deficiency Syndrome
ANM	Auxiliary Nurse Mid-Wife
ANP	Applied Nutrition Programme
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Workers
AYUSH	Ayurveda Yoga Naturopathy Unani Siddha and Homeopathy
BCG	Bacillus Calmette Guerin
BDO	Block development officer
BEE	Block Extension Educator
BEmONC	Basic Emergency Obstetric and Neonatal care
BMO	Block Medical Officer
CARE	Cooperative for Assistance and Relief Everywhere
CDPO	Child Development Project Officer
CES	Coverage Evaluation Survey
CEmONC	Comprehensive Emergency Obstetric and Neonatal care
CHCs	Community Health Centres
CMHO	Chief Medical and Health Officer
CMO	Chief Medical Officer
DAM	District Account Manager
DH	District Hospital
DHAP	District Health Action Plan
DHS	Department of Health services
DLHS	District Level Household and Facility Survey
DOTS	Directly Observed Treatment, Short Course
DPM	District Programme Manager
DPO	District Programme Officer
DPMU	District Programme Management Unit
DPT	Diphtheria Pertussis Tetanus
DSWO	District Social Welfare Officer
DT	Diphtheria Tetanus
DUB	Dysfunctional Uterine Bleeding
ECD	Early Childhood Development
ECG	Electro Cardio Graphy
FAO	Food Agriculture Organization

FRU	First Referral Unit
GOI	Government Of India
Hep B	Hepatitis B
HIV	Human Immuno Virus
HMIS	Health Management Information System
HQ	Head Quarter
ICDS	Integrated Child Development Scheme
IEC	Information, Education & Communication
IFA	Iron Folic Acid
IMNCI	Integrated Management of Neonates and Childhood Illness
IMR	Infant Mortality Rate
IPD	Inpatient Department
IPHS	Indian Public Health Standards
IU	International Unit
JMI	Junior Malaria Inspector
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
LBW	Low Birth Weight
NA	Not Available
NFHS	National Family Health Survey
NGO	Non-Governmental Organizations
NIPCCD	National Institute of Public Cooperation and Child Development
NHE	Nutrition Health Education
NHSRC	National Health Systems Resource Centre
NMA	Non –Medical Assistant
NMR	Neonatal Mortality Rate
NRC	Nutritional Rehabilitation Centre
NRHM	National Rural Health Mission
MDG	Millennium Development Goal
MDT	Multi Drug Therapy
MHFW	Ministry of Health and Family Welfare
MP	Madhya Pradesh
MPH	Master of Public Health
MO	Medical Officer
MTCT	Mother To Child Transmission
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
MWCD	Ministry of Women and Child Development

OBC	Other Backward Class
OPD	Outpatient Department
OT	Operation Theatre
ORT	Oral rehydration therapy
PEM	Protein Energy Malnutrition
PHCs	Primary Health Centres
PRI	Panchayati Raj Institution
PSE	Pre-School Education
RCH	Reproductive Child Health
RK	Rogi Kalyan Samiti
RPR	Rapid Plasma Reagin
PRIs	Panchayati Raj Institutions
SC	Scheduled Caste
SCs	Sub Centres
ST	Scheduled Tribe
SNP	Special Nutrition Programme
SRS	Sample Registration System
ST	
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Disease
TT	Tetanus Toxoid
THR	Take Home Rations
U5MR	Under Five Mortality Rate
UNAIDS	United Nations Programme on HIV and AIDS
UNICEF	United Nations International Children's Emergency Fund
URTI	Upper Respiratory Tract Infection
USAID	The United States Agency for International Development
VCTC	Voluntary Counselling and Testing Centre
VHND	Village Health Nutrition Day
VHSC	Village Health Sanitation Committee
WCD	Women & Child Development
WHO	World Health Organization

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Chapter 1: Introduction

1.1 Background

"The lives of children and women are the true indicators of the strength of communities and nations" **(Kishore cited in Madhavi et al., 2011, p. 13).** Survival of the child and mother is an indicator of the level of human development of India **(Citizen's Initiative for the Rights of Children under Six, 2006).** In India there are one million neonatal deaths every year, this represents approximately a quarter of all global neonatal deaths **(Baqui et al., 2008).** Being the most vulnerable segment of the population, under-five children are at greater risk of malnutrition because of poor purchasing power, deficient dietary intake and high load of infections hence deserve special care **(Mridula et al., 2004).**

Proper nutrition of children leading to adequate growth and good health is the essential foundation of human development **(Sharma et al., 2011).** Non-availability of the basic human necessities affects the growth and nutritional status of children **(Mridula et al., 2004).** A child who is malnourished by the age of two has very little chances of ever being fully healthy **(Sinha and Bhatia, 2009).** More than 6,000 Indian children below the age of five die every day due to malnourishment or lack of basic micronutrients such as vitamin A, iron, iodine, zinc or folic acid **(Mendelson, n.d.).** At birth one-third of Indian infants is underweight and 20% are stunted **(Mamidi et al, 2011; Ramachandran and Gopalan, 2011 cited in Gillespie, 2013).**

1.2 Mortality among Children

Gupta and Walia (1980) observed diarrheal disease, respiratory and skin infections to be the main causes of morbidity in children in rural areas of Punjab. The research study found that fever, prematurity, diarrhea and respiratory infections as the major causes of mortality in early childhood in Haryana **(Reddiah et al., 1988)** and **Biswas et al.** (1993) found that in rural West Bengal Acute Respiratory Infections (ARI), diarrhea and prematurity are the important causes of infant and early childhood mortality. A study by **Ansari et al.** (2008) showed respiratory tract infection topping the list of health problems in under-fives followed by skin diseases, diarrhea, eye diseases and worm infestation.

Some studies have pointed out the significance of age of children. The study by **Luthra and Parvan** (2010) concluded that higher numbers of children were undernourished in the age group of 37-60 months as compared to their younger counterparts. **Mittal** (2007) study showed peak prevalence of undernutrition was in 36-47 months age group, whereas another study led by **Saleh and Sharif** (1993) found a peak prevalence in 24-35 months age group.

Baranwal et al. (2011) reported a higher prevalence of Protein Energy Malnutrition (PEM) in children in whom there is the positive history of worm infestation, recurrent diarrhea and Recurrent Upper Respiratory Tract Infections (URTI) as compared to those who had a negative history. Thus, it has been understood that malnutrition and infections are synergistic and are dependent on each other.

Table 1.1 Infant and Child Deaths in Indore District of Madhya Pradesh

S.No	Infant and child deaths –Madhya Pradesh –Indore-Apr'10-Mar'11	
1	Infant deaths within 24 hours of birth	19
2	Infant deaths between 24 hours and under 1 week	21
3	Infant deaths between 1 week and under 1 month	18
4	Child deaths between 1 month and under 1 year	10
5	Total Infant deaths	68
6	Child deaths between 1 yr under 5 years	16
Total deaths		84

Source- District HMIS data analysis Apr'10-Mar'11- Madhya Pradesh [MP]

Infant Mortality Rate (IMR) of the Madhya Pradesh state is 67 **(Sample Registration System [SRS], 2011)**. According to Annual Health Survey 2010-11; Infant mortality rate, Under-five Mortality Rate (U5MR) and Neonatal Mortality Rate (NMR) in Madhya Pradesh is 67, 89 and 44 **(Samvad, 2011).** At Indore Dist. IMR is 68 and Child deaths between 1 to 5 years is 16 so total deaths are 84 **(Health Management Information System [HMIS] 10-11, MP).**

Table 1.2 Causes of Infant and Child Deaths in Indore district of Madhya Pradesh

Causes of Infant Child Deaths- Madhya Pradesh –Indore-Apr'10-Mar'11						
	Pneumonia	Diarrhea	Fever related	Measles	Others	Total
Between 1 month and 11 months	1	2	3	-	4	10
Between 1 year and 5 years	-	7	5	-	4	16
Total	1	9	8	-	8	26

Source- District HMIS data analysis Apr'10-Mar'11- Madhya Pradesh

Along with malnutrition, the cause of deaths in infants and children is communicable diseases such as pneumonia, diarrhea, fever, and measles. In this diarrhea contribute the main role in the cause of deaths among infants and especially in the age group 1-5in Indore District of Madhya Pradesh state **(HMIS 10-11, MP).**

Table 1.3 Millennium Development Goals (Target Achievements of IMR, U5MR, and NMR for Madhya Pradesh)

Status of Madhya Pradesh on MDGs Target Achievements of IMR, U5MR, and NMR					
Indicators	MDGs Target for MP	MP 2007	MP 2008	MP 2009	MP 2010
Infant Mortality Rate (IMR)	39	74	72	70	67
Under 5Mortality Rate	43*	NA	NA	94.2	89
Neonatal Mortality Rate (NMR)	17.7*	NA	NA	44.9	44

Source: Annual Health Survey [AHS] 2010- 11, * National Family Health Survey-1 [NFHS-I] (92-93)

According to Millennium Development Goals (MDGs), the target for IMR in Madhya Pradesh is 39 up to the year 2015 but it was 67 in the year 2010. It has declined only 1.75 points from 2007 to 2010. For achieving this target Madhya Pradesh has to reduce 7.8 points per year, otherwise, it will take 22 years to achieve this minimum target. The U5MR of Madhya Pradesh is 89 and it is really difficult to achieve the

decline of U5MR from 89 to 43. Neonatal Mortality rate based on the Millennium Development Goal 4 will be 17.7 up to 2015 but the annual health survey 2010-11 shows that the NMR of Madhya Pradesh is 44 which trimmed down by 0.9 from 2009 to 2010. For achieving these goals specific interventions and implementation are required at grass root level in Madhya Pradesh state **(Samvad, 2011).**

Joshi et al. (2011) found that the female child had a higher rate of Grade III and IV Protein Energy Malnutrition (PEM). This may be because of the lack of attention that a girl child receives. **Sundararaman** (2010) concluded the shorter duration of breastfeeding, the delays in getting to health care services, the discrimination in feeding, the early induction into housework and care of younger siblings or the curtailment of education because of this health of the girl child is affected during the early years.

The position of women is readily related to child nutrition. A malnourished mother will give birth to a child of low birth weight – the single most important predictor of child survival **(International Food Policy Research Institute cited in Mendelson, n.d.). Joshi et al.** (2011) in their study found PEM is higher in illiterate mothers; it may be because of the absence of awareness among them. According to National Family Health Survey (NFHS) - III, children belonging to the Scheduled Caste (SC), Scheduled Tribe (ST), and Other Backward Class (OBC) and that those with illiterate mothers have the highest rates of malnutrition (NFHS -III).

Luthra noticed a significant correlation with age in undernourished children and found a higher number of undernourished children belong to lower social class during her study **(Luthra et al., 2010).** Caste is one of the causal factors of poverty and lack of power and children below 3 years of age in scheduled tribes and scheduled castes are twice as likely to be malnourished than children in other groups **(Sundararaman, 2010).** Malnutrition increases with advancing age. This might be because of more exposure to poor sanitary conditions and delayed weaning. Prevalence of PEM in girls is higher. The infants having birth order 3 and above were found to have the highest prevalence of severe degree of PEM while infants with birth order 1-2 have a similar design of moderate PEM **(Singh and Tiwari, 2004).**

1.2.1 Diseases leading to deaths in children

More than 50% of deaths among children are attributed to diarrhea, acute respiratory illness, malaria or measles conditions that are either preventable or treatable with low-cost interventions.

Diarrhea. Diarrhea accounts for about one-fifths of child deaths in India. Its socio-medical determinants include malnutrition lack of safe water, lack of sanitation, lack of information about the correct home management of diarrhea with oral rehydration and continued feeding, lack of access to health care services including pediatricians and antibiotics for dysentery. 90% of diarrheal deaths are alleged to be preventable.

Pneumonia Another 5th of U5MR is contributed by pneumonia. Its socio-medical determinants include malnutrition (Poor breastfeeding and weaning practices with little support), lack of information amongst caregivers to be able to recognize the illness and seek care, lack of immunization and lack of access to health care services for correct management with antibiotics. Nearly 65% of deaths from pneumonia are considered preventable.

Measles. Measles contribute a mortality of 1% with similar determinants. The chief point about measles deaths is that they are nearly 100% preventable by immunization. The measles case rate is a clear indictment of the lack of access to and outreach by health care services in any arrangement. The risk of deaths from measles is estimated to be 300 times higher in grade-III malnourished child as compared to a normal child.

Human immunodeficiency virus / Acquired immunodeficiency syndrome [HIV/AIDS].

According to Joint United Nations Program on HIV & AIDS (UNAIDS), 1, 20,000 Indian children were surviving with the HIV virus in 2004. The most usual reason of infection among children is the Mother-To-Child Transmission (MTCT). Other than MTCT; sexual touch including sexual abuse, blood transfusion and a sterilized syringe, including injectable drug use are also sources of infection among children. All over the world children died due to preventable cause's like- perinatal conditions, respiratory infections, and diarrheal diseases, poverty and malnutrition. We hold a successful level of immunization, but still, most of the children drop dead due to vaccine-preventable

diseases. In developing countries Measles accounting for 5% of all deaths in children under five and more severe in malnourished children, especially with vitamin A deficiency **(Blair, 2010).**

The under-five mortality rate (U5MR) is considered to have a close correlation with socio-economic factors. NFHS-2 confirms that neonatal mortality is two times higher in households of the low standard of living and also post-neonatal mortality is three times and 1-4 year child mortality is five times in compare of households with the high standard of living. A system for food security, such as the public distribution shop (PDS), Integrated services like - Integrated Child Development Services (ICDS), systems for access to safe water and sanitation, all have a major role in the prevention of child mortality **(Sundararaman, 2010).**

1.3 A Historical Review of child care services in India

In India, voluntary organizations significantly contribute in child care services, such as the Indian Red Cross Society, Indian council for child welfare, All India's women conference children aid society **(The National Institute of Public Cooperation and Child Development [NIPCCD], 1984).**

Non-Governmental Organizations were pioneers in running educational and welfare program for the pre-school children. Some historical leaders of the country named Mahatma Gandhi who experimented with basic education for children. Shri Biju Bhai in Rajkot, Shri Jagat Ram Duve, and Smt. Tera Bai, who set off a chain of Balmandirs and organized training of workers. Along with this Kasturba Gandhi National Memorial Trust organized Balwadis as part of their program for women and children in the early fifties **(Bhandari, 1990).** Several expert committees were set up to promote services for growth and development of pre-school children like Health survey and development committee (1946), the child care committee (1960) the committee program for child welfare (1968) the study group of pre-school child (1972) and the national policy for children (1974) **(Ratna cited in Bhandari, 1990).** In 1954, a program was introduced for child and women welfare through extension projects. The project provided supplementary feeding, health services, first aid, recreation facilities, adult education and training in arts and crafts. These centres were called Balwadis.

In 1957, welfare extension projects were reviewed because of duplication of some elements between women's and child program carried out in the community development blocks. The program was again reviewed in the first and second plans to improve and enlarge its scope. The scheme suggested the coverage of all children in the age group 1-16 years in selected units with a population of 15,000 children or 5,000 families. Due to administrative constraints, projects were converted into family and child welfare projects in Nov.1967. This scheme focused on the age group 0-6 years. To prevent malnutrition in pre-school, pregnant and lactating women, various nutrition intervention programs introduced like Iron-folic acid and supplement for the prevention of anemia, vitamin A supplementation, prevention of Iodine deficiency disorders and food supplements for prevention of PEM.

During 1970-71, Special Nutrition Program (SNP) was started on reducing morbidity and mortality by providing supplementary nutrition to preschool children, pregnant women, and nursing mothers but SNP were not integrated with health care services. During fifth five-year plan, it was transferred to the state sector and included under the minimum needs program. The Balwadi Nutrition program was started in 1970-71 with the object of providing supplementary nutrition to children in the Balwadi. Due to some financial and administrative problems these programs failed to achieve their objectives.

In 1972, a report by the committee on the pre-school children, feeding program appointed by the planning commission and by the study group on the development of pre-school, appointed by the ministries of education and social welfare stressed on the need to the develop integrated child care services. In response to this report planning commission set up eight teams of representatives from the ministries of education, health, rural development, the home ministry, and planning commission to visit various rural, tribal and urban blocks and observe the organizational structure and the reach of services to children in these areas. At last, the team recommended an integrated package of services to be delivered at the village level.

The Integrated Child Development Services (ICDS) Scheme was launched on October 2nd, 1975, the birth anniversary of the Father of the Nation, Mahatma Gandhi, in pursuance of the National Policy for Children formulated in 1974. Today, the ICDS Scheme represents one of the world's largest and most unique programs for early

childhood development. It adopts a multi-sectoral approach to child wellbeing, incorporating health, education and nutrition interventions **(ICDS-IV project, 2008).** By the end of the Ninth Five-Year Plan (1997-2002), ICDS Scheme has undergone massive expansion with the focus on universalization with quality service delivery.

1.4 Integrated Child and Development Services (ICDS): An Overview

The government of India proclaimed a National Policy on Children in August 1974 declaring children as, "Supremely Important Asset". The policy provided the required framework for assigning priority to different needs of the child. The ICDS was launched on 2nd October 1975 in 33 Community Development Blocks seeking to offer an integrated package of services in a convergent manner for the holistic development of the child. Today ICDS represents one of the world's largest programs for early childhood development. It is today the foremost symbol of India's commitment to her children – India's response to the challenge of providing pre-school education on one hand and snapping off the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality on the other **(CARD and Sambodhi research and communication, 2009-10)**

1.4.1 Objectives of the ICDS program

1. To improve the nutritional and health status of children in the age-group 0-6 years and laid the foundation for proper psychological, physical and social development of the child.
2. To reduce the incidence of mortality, morbidity, and malnutrition.
3. To achieve effective coordination of policy and implementation amongst the various departments to promote child development.
4. To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education **(GOI, 2007).**

The ICDS scheme provides a package of six services comprising:

1. Supplementary Nutrition
2. Immunization
3. Health check-up

4. Referral services
5. Preschool non-formal education
6. Nutrition and health education.

Two new programs targeted at adolescent girls and pregnant and lactating women, respectively called The Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) (SABLA) and Indira Gandhi Matritva Sahyog Yojana (IGMSY) have been launched through ICDS platform in 2010. SABLA is targeted towards nutritional, health and life-skills training needs of adolescent girls (age 11 to 18) that are in school or out-of-school due to various reasons. IGMSY is a conditional cash transfer scheme for pregnant and lactating women with an objective to improve their and the newborn health and immunization status. Both these schemes are presently being implemented in selected districts and are expected to be universalized during the current Five Year Plan. The rapid universalization of the ICDS program since 2008-09 has resulted in some programmatic, institutional and management gaps that needed Redressal. The government of India has decided to strengthen and restructure the ICDS scheme through a series of programmatic, management and institutional reforms, changes in norms, including putting ICDS in a Mission mode.

This will be done in a phased manner during the first three years of Twelfth Five Year Plan (2012-17). Anganwadi centre (AWC) would be repositioned as a 'vibrant ECD centre' (Early childhood care and development) to become the first village outpost for health, nutrition and early learning with a special focus on under-3s **(GOI, Bihar, 2013).**

1.4.2 Progress of ICDS Program

In recent years ICDS has been evaluated by many agencies which resulted in numerous changes to achieve in ICDS goals. Some of the suggestions included: Infrastructure and basic amenities need to be strengthened; Coverage of supplementary nutrition needs to be increased to the maintenance of continuous supply; the quality of food is to be seriously addressed; Critical issues related to raw or cooked food supply need to be analyzed; Food should be given in accordance to the local taste and above all food safety laws must be followed; Reconsideration of the training component of ICDS scheme is a necessity.

There ought to be a reorientation of the workers. Accountability needs to be developed in ICDS team. Supervision and monitoring components need to be reinforced. Immunization activities under ICDS have appreciable credibility. However, non-formal, pre-school, nutrition and health education are not fully functioning in the way they were planned to be. Above all, a better reporting system which is transparent and accountable needs to be put in place. In the 12th five year plan, there are indications that the ICDS will receive a boost through increased allocation and revitalize its activities. The cabinet committee an economic affair approved a plan to bring about substantial strengthening and restructuring of ICDS with increased budgetary allocation. The restructured ICDS will be rolled out in the next three years, starting with 200 high burden districts identified by the government. Thus, we hope that in the near future this program will be able to achieve its objectives as it was envisaged during its inception. In conclusion, the ICDS has a huge potential as a platform to provide comprehensive maternal and child services **(Gupta et al, 2013).**

The ICDS Scheme has undergone massive expansion ever since it was launched. Till the end of the 9th Five Year Plan (1997-2002), the scheme was gradually expanded to 5652 projects (blocks) across the country. The Government of India has now embarked upon a program of universalization of the scheme with the emphasis on quality. During the 10th Five Year Plan (2002-2007), the ICDS Scheme was approved for implementation within the existing sanctions 5652 Projects with no expansion activities due to resource constraints. However, with the mandate of the present Government as enunciated in the National Common Minimum Program (NCMP) and as also decreed by the Supreme Court, through its various rulings, the ICDS Scheme has been expanded twice (in 2005-06 & 2006-07) during the 10th Five Year Plan, increasing the number of ICDS projects from5652 in 2004-05 to 6284 projects (blocks) and that of Anganwadi Centres (AWC) from7.44 lakh to 10.53 lakh by the end of 2006-07. It is expected that a total of 6291 projects (blocks) will be operational in the country by the end of the second year of the 11th Five Year Plan (2007-2012) **(GOI, 2007).**

1.5 National Health Programs for Children in India

Various National health programs are currently in operation for the improvement of child health and nutrition. Mainly these programs are:

- Reproductive and Child Health Program
- Universal Immunization Program
- School health program
- Nutritional program

1.5.1 The Reproductive and child health (RCH) program

The RCH program was launched in Oct 1997.The main aim of the program is to reduce infant, child, and maternal mortality rates. It has 2 phases:

(i) RCH-I The main objectives of RCH-I are as follows:

- To improve the implementation and management of policy
- Improve quality, coverage, and effectiveness of existing family welfare services
- Expand the scope and coverage of family welfare services
- Importance in disadvantaged areas of districts

Some interventions are applied to the fulfillment of these objectives like- Child survival interventions which includes-Immunization, Vitamin A prophylaxis, Oral Rehydration Therapy (ORT) etc. safe motherhood intervention, e.g.- ANC, Immunization for TT, distribution of the IFA, safe delivery. High-quality training at all levels, facility for safe abortions, enhance community participation through NGOs, Panchayat, women's group, adolescent health and reproductive hygiene.

(ii) RCH II- The 2nd phase of the RCH program was launched 1st April 2005 with the following goals:

- The Infant mortality rate should be <30/1,000
- Maternal Mortality ratio <100/100,000 and the Total fertility ratio 2.1

For this, they adopted various strategies which include essential obstetrics care, emergency obstetric care and strengthening the referral system.

1.5.2 Universal Immunization Program

The Universal Immunization Program was launched by the Government of India in 1985. During 1992, it was a part of Child Survival and Safe Motherhood Program but currently, it is important areas under National Rural Health Mission (NRHM) since 2005. Its main aim to achieve 100% of full immunization status by 2009 to 2010. This program consists of vaccination for prevention of seven diseases like-Tuberculosis, Diphtheria, Pertussis (Whooping Cough), Tetanus, Poliomyelitis, Measles, and Hepatitis –B. For getting the objectives, this program adopted various strategies as follows:

1. Strengthen institutional training at all levels
2. Strengthen coordination with national operational guidelines
3. Reaching the underserved by influencing behavior

1.5.3 School Health Program

School health program is a program for school health services under the National Rural Health Mission. The school health program is the only public sector program specifically focused on school age children. Its main focus is to address the health needs of children, both physical and mental. It responds to an increased need, increases the efficiency of other investments in child development ensures good current and future health, better educational outcomes and improves social equality and all the services are provided in a cost-effective manner.

Components of School health program:

1. Screening, Healthcare, and Referral. This component includes general health screening, assessment of nutritional status, dental check-up, behavior problem, etc. Basic medical kit to take care of common ailments and referral services comes under these components.
2. Immunization. It gives as per national schedule and includes fixed day activity.
3. Micro- Nutrients Management. Administration of Vitamin A in needy cases and weekly supervised distribution of Iron folate tablets.
4. Deworming

5. Health Promotion School. Counseling services, health education, adolescent health education, first aid.
6. Capacity Building
7. Monitoring & Evaluation
8. Midday meal

1.5.4 Nutritional program

The various nutritional programs are in operation in India for the 1st five year plan period. International agencies such as the World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF), The Food and Agriculture Organization (FAO), Cooperative for Assistance and Relief Everywhere (CARE) are assisting the govt. In these programs of India to improve the nutrition of the people with special emphasis on mothers and children national program on nutrition-

(i) ***Vitamin A Prophylaxis Program.*** This program was launched by the Ministry of health and family welfare in 1970. Control of Blindness is the main components of this program. 1,00,000 International Units (IU) administered at the age of 9th months and 2, 00,000 IU administered at the age of 15th -16th months, 18th -24th months, 24th – 30th months and 30th -36th months of children.

(ii) ***Prophylaxis against Nutritional Anemia.*** The program was launched in 1970 to prevent nutritional anemia in mothers and children. One tablet of Iron and folic acid containing 60 mg elemental Iron is given to expected and nursing mothers. It was raised to 100 mg elemental Iron but the Folic acid content remained same (0.5 mg of folic acid) Children in the age of 1-5 years are given one tablet of Iron containing 20 mg elemental Iron (60 mg of ferrous sulfate and 0.1 mg of folic acid) daily for a period of 100 days. At the present, it is a part of RCH program.

(iii) ***Special Nutrition Program.*** The program was launched in the country in 1970-71 for the benefit of children below 6 years of age, pregnant and nursing mothers. Improvement in nutritional status of the target group is the main aim of this program. Provide health services including supply of Vitamin A solution and Iron-folic acid supplementary nutrition is the activity of the program. It provides supplementary feeding of about 300 calories and 10 grams of protein for pre-school children and about

500 calories and 25 grams of protein to expect at the nursing mothers for six days a week.

(iv) ***Balwadi Nutrition Program***. This program was started in December 1970.It is being promoted with the help of four national level voluntary organizations, the Indian Council for Child Welfare, Harijan sevak sangh, Bharatiya Adamjati sevak sangh and central social welfare board. The main beneficiaries are the age of 3to 6 years. It provides supplementary nutrition to the extent of 300 calories and 15 grams of protein during 250 days in a year for children attending Balwadi.

(v) ***Applied Nutrition Program (ANP).*** The ANP was first introduced in 1960 in Orissa and Andhra Pradesh. It was extended thereafter to Tamil Nadu in 1961 and Uttar Pradesh in 1962; during 1973 it was extended to all states. Children and women are given supplementary nutrition is worth 25 pairs /day /child and 50 paise /women /day respectively. A single supplementary meal is given weekly for 25 days/ year.

(vi) The Midday Meal Program. This program is also known as "School lunch program". It was started in 1957 in Tamil Nadu and in operation since 1961 throughout the country. 1/3rd of the required food per day for the child is furnished through this program. This program has some principles –Supplementary doesn't substitute, 1/3 total energy and ½ total protein, low cost, easily prepared, locally available food, change the menu frequently. Skimmed milk, banana, rice meals, etc. is provided under this program and cost is fixed as 12 paise per child.

1.6 Review of Literature

This section largely focuses on the review of research studies; mostly research articles, reports, and books. In the field of research on ICDS and Health services, a number of studies had been carried out and there are also various ongoing studies. Review of literature is broadly divided into three themes.

- Convergence at Different Levels
- Beneficiaries Perspectives
- Health Personnel's and Institutions' Outlook

These themes further divided for more exploration of the topic in depth as follows:

1.6.1 Convergence at different levels

1.6.1.1 Convergence at departmental level

Kalita and Mondal (2012) examined the concept of Integration. Integration is frequently applied to co-ordination. This coordination may be applied as a vertical integration of the different level of services like- district hospital, health centres, and health posts. This type of integrated health service is well-functioning procedures for referrals up and down the levels of the system, and between public and private providers. Integration could be applied in human resource convergence like- Interactions between front-line workers- ANM, ASHA and AWW. Integration also is applied in the form of community participation like- Interactions between community, VHSC committee members, and AWWs.

Two Public programs, the Integrated Child Development Services (ICDS) and the National Rural Health Mission (NRHM) are aiming to improve child health and nutrition. Under the ICDS program, out of six, three services, namely -immunization, health check-up and referral services, delivered through the public health system under the direction of the Department of Health and Family Welfare. Due to this co-dependence of these two departments, integration becomes a high priority (Ibid).

A paper by the **Planning Commission** (2007), commented that there must be a convergence between the ICDS and NRHM for prevention and management of malnutrition. Caring the malnourished child is the joint responsibility of the Health Department and the ICDS. ICDS department spots malnourished child and health department makes an arrangement to care for them at the PHC level. Next, nutrition, rehabilitation centres should be set up to care for the malnourished children in areas with high malnutrition. Training of ANMs on nutrition related issues, and permitting the Anganwadi worker to refer malnourished children to the Health Department shows the convergence between both the departments.

Gragnolati et al. (2006) in their study examined mismatches between the ICDS program's design and its actual implementation that prevent it from reaching its potential. The study found the partnership between the AWW and the ANM has been less successful with regard to identifying high-risk pregnancies, providing antenatal and

postnatal care, and conveying adequate health and nutrition messages to adult females. AWWs infrequently inquire whether mothers are registered with the ANM and receiving antenatal care and the ANM's visits to the AWC are not very stable. The study suggested consolidates the convergence between ICDS and RCH will help to ensure the delivery of services to mothers and children.

However, **Cooper et al**. (2008) stated that AWC set up within the community and because of its central location; AWWs have a deep comprehension of the community and their needs. AWWs play a vital role in the supplement to work conducted at Sub- centres. Moreover, ANMs identify and enlist women and children to obtain essential health care services. Under the NRHM, ASHAs intended to provide home-based services, mainly to households who are not capable of reaching government facility care. ASHA, ANM, and AWW were selected by the Panchayat and community for the stake of village health. ANMs, work as a bridge between the community and PHCs and AWWs, ASHAs act as health activists in their communities.

Somaiah and Vijayalakshmi (2007) explored the lack of coordination between health and the WCD department for certain issues. When polio administration is in a mission mode, ANMs and AWWs work together to reach the set target, but this co-ordination not found during immunization program. Also, the health personnel available at the PHC or CHC were fully engaged with the OPD patients and were not able to visit AWCs. For immunization, AWWs have totally depended on the personnel from the health department. This negligence, indicate the lack of coordination/loss of meaningful linkage between the Health Department and DWCD.

Kumar et al. (2011) reported major maternal deaths in India are due to hemorrhage, sepsis, complications of abortion and hypertensive disorders. In children, (<5 years) more than half of deaths occur in the neonatal period because of infections like- sepsis, pneumonia, diarrhea, and tetanus; prematurity and birth asphyxia. The prime focus of NRHM is for a reduction of maternal and child mortality rates. The main aim of ICDS program is to furnish nutritional and developmental needs of the children below six years and services for pregnant women and nursing mothers. The author suggested the need for development and implementation of one plan which includes the activities of the NRHM and the ICDS services to confirm convergence.

1.6.1.2 Human Resource Convergence

Murthy and Mathur (1988) indicated that nearly all AWWs were facing problems in taking the help from ANMs in performing their job duties related to health. Also, few meetings were organized them to promote health and nutrition. Sometimes, situations were opposite, **Jain and Aggarwal** (1983) showed that ANMs were not getting the desired cooperation from AWWs during their visits to AWC. According to them, the reason behind the non-cooperation was that AWWs did not have complete knowledge about their work.

ANM working at the sub-centre level and concerned with the health issues of population. ASHA is working at the village level. Rajasthan state govt put in one worker adjacent to Anganwadi and work with DWCD and DMHS called as 'ASHA Sahyogini', selected by the community people through Gram Panchayat and responsible to the community. ASHA- Sahyoginis and ANM were trained in IMNCI. The study found the lowest level of compliance among ASHA-Sahyoginis because of lack of motivation, monitoring and supervision. Also, ANM was overburdened with various programs, maintenance of records and reports. These problems hindrances in the adherence to IMNCI guidelines and it is known to all reduction in death and the frequency and severity of illness and disability by the utilization of community-based management is the primary objective of IMNCI **(Yadav and Batra, 2016).**

Bajpai and Dholakia, 2011 mentioned that there is an official participation exists between the ASHA and AWW during the monthly Village Health and Nutrition Days (VHND). Both of them together busy counseling and health education on various topics like- nutrition, care of the child, care during pregnancy, an importance of breastfeeding and family planning, etc. Efficient communication of AWWs is very important to contact with the target group, making use of resources, obtaining information from Supervisors, CDPOs and doctors, making contact with ANMs and ASHAs and by updating knowledge through reading and listening to educational programs **(Gupta and Mardia, 1986).**

Gupta and Gumber (2001) also found the lack of co-ordination between various departments had been weak and supervisory staff showed the lack of interest to supervise their subordinates. Socioeconomic and Educational Development Society

(SEEDS) (2005) showed almost, all Panchayati Raj Institutions (PRI) representatives were not contributing towards ICDS. Lack of awareness about ICDS was the main reason not to contribute; Even AWW didn't approach them for service. **Goriawalla and D'Lima** (1985) indicated that Anganwadi supervisors performed their duty to supervise the Anganwadi workers in checking records and reports and their functioning. Very few Supervisors helped in figuring out problems and providing necessary guidance to AWWs.

1.6.1.3 Decentralization and Community Participation

Udani and Patel (1983) found that knowledge of mothers about various health and nutrition components was poor along with various superstitions and beliefs like- measles was good for children, colostrum's was poisonous for infants, etc. It's the responsibility of AWWs to provide necessary Nutrition and Health Education to improve the knowledge of mothers with the support of VHNC committee and community elderly people. In contrast, Gram Panchayats extended help to AWWs in organizing cultural functions at the AWCs to attract public participation. Several reports showed that Maharashtra and Tamil Nadu have active social policies, good indicators of social development, and effective public services **(Department of Economics and Statistics, 2004).**

Tandon et al. (1987) in their study recorded that diarrhea, cough, fever of short duration and sore eyes were the common illnesses among infants in nine. Fever, diarrhea, and prematurity were the three main causes of death and with diarrhea being the commonest (60 per cent). Tetanus and respiratory infections were less important causes of mortality in infants. Diarrhea, fever, sore eyes and common illnesses could be prevented by correct knowledge of home-based prevention which should be given by ANM and ASHA. A study done by **Sampath** (2008) showed that ICDS staff had inadequate knowledge about the basic concept of community participation, and the community also lacked knowledge on community participation. The health of the woman before and during pregnancy relates directly to the birth weight of the children she bears.

1.6.2 Beneficiaries Perspectives

1.6.2.1 Utilization of services by Beneficiaries

Pallikadavath et al. (2004) had examined factors associated with the use of antenatal care in rural areas of North India based on NFHS-2 data in the states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. They found home visits were biased towards households with a better standard of living. The study indicated that higher social and economic status was associated with increased chances of receiving an antenatal check-up, blood pressure measurement, a blood test and urine testing. Consequently, pregnant women from poor and uneducated backgrounds were the least likely to receive antenatal checkups and services in the four large North Indian states. Likewise, women's education showed a positive association with antenatal checkups through visits to a health facility in all the states. Exposure to the media also influenced antenatal visits to health facilities after education.

Nath et al. (2008) studied knowledge regarding the disease prevented; a number of doses and correct age of administration of BCG was high respondents of the urban slums of Lucknow. Respondents, those utilizing private facilities were fully immunized as compared to those utilizing government facilities. Travel time to the facility was taken as a measure of accessibility; those who took less than 20 minutes to reach the immunization site were fully immunized as compare to those who took more than 20 minutes. **Bhatia** (2015) indicated that there were no home visits by the health workers since two months. The majority of mothers were not utilizing the services because of unsatisfactory quality of services. Also, quality of food provided at Anganwadi was not well; told by mothers. The education and economic status of women impact the use of maternal care. **Vora et al.** (2009) showed illiterate mothers and mothers from lowest wealth quintile used less basic maternal health care in comparison to mothers who are literate and belong to wealthiest quintile. Also, availing the institutional delivery and postnatal care by the mothers from lowest quintile was low. These demonstrated the incapability of the public- health system to reach out the poor and illiterate.

Ganatra et al. (1998) indicated that postpartum hemorrhage was the major cause of maternal mortality followed by puerperal sepsis, eclampsia, and cerebral malaria and almost half the women died outside the health facility. The study also

revealed that a number of years of the husband's education were significantly associated with maternal survival. Thus, literate husband's well aware of the use of services for the betterment of their spouse's health. **Noznesky et al.** (2012) on situational analysis on Bihar showed various barriers to delivering the services to mothers. Lack of equipment (weighing scales), supplies (vitamins, contraceptives), poverty, low awareness and health needs and services, women's low social status, caste discrimination are important constraints to both service delivery and utilization. Additionally, government officials and technical experts pointed to weak systems, including program management, purchase, and logistics are obstacles to reaching all vulnerable populations especially mothers. The study also showed gender discrimination in the form of pregnant and lactating mothers, adolescent girls and women eats after everyone else has had their fill.

Trivedi et al. (1994) pointed out that the usage of the ICDS services varies from place to place and depends on the participation of the community in the program. Cooper et al. (2008) study stated three levels of the primary health care system in India. The lowest tier of the Indian primary health care system is the Sub-Centre; the second tier is the Primary Health Centre and the third tier is the Community Health Centre. In addition, numerous existing PHCs and CHCs are understaffed, underfunded, and overworked; as a result, they are unable to provide an entire set of services to the population. As identified by **Mohapatra et al**. (2016) Immunization coverage among the children attending AWCs in Berhampur Municipal Area of Odisha was not sufficient and requires further evaluation. The rationale for incomplete immunization in the Municipal area was; lack of information, lack of motivation, hurdles like long, unsuitable timing, ignorance regarding immunization, 2nd and 3rd dose, place & time of immunization, fear about side effects etc.

Davey et al. (2008) found AWW had visited beneficiaries in last one year and the primary reason for their visit was distributed of polio vaccination and immunization services apart from health education and postnatal care. The majority of the beneficiaries was not satisfied with the services because of non-accessibility and inadequate space at AWCs with the poor quality of food. **Bhatia** (2015) indicated that there were no home visits by the health workers since two months. The majority of mothers were not utilizing the services because of unsatisfactory quality of services. Also, quality of food provided at Anganwadi was not well; told by mothers. **Gupta et**

al. (2000) revealed that mothers were dissatisfied with the food quality, and growth monitoring of children under six was not monitored timely by the AWWs. Participation among community members was poor. In contrast, **Helena** (2014) showed that the majority of children in Municipal Corporation of Andhra Pradesh was satisfied with the food which served at the AWC; with receiving supplementary nutrition.

Harishankar et al., (2004) observed severe malnutrition was further widespread in a scheduled caste as compared to backward caste children in Allahabad district. Poverty, illiteracy, and ignorance were the main factors to lead to severe malnutrition. Major findings showed that large numbers of eligible children from impoverished and food destitute families do not access ICDS services, including supplementary nutrition for infants and small children. Notably, **Collison et al.** (2015) reported barriers to sufficient diets during gestation and breastfeeding vary according to rural and urban residence; not because of costs or religion. In rural residence, lack of food affordability and In urban residence, concern to become fat was emerging as the primary barriers to eat recommended the maternal diet.

Meshram et al., (2016) concluded that the probability of undernutrition was significantly linked with gender, community, household's wealth and mother's literacy. Therefore, in that respect is a requirement to improve the existing nutritional interventions by the role of suitable health promotion activities like- Education of mothers, raising household's socioeconomic and hygienic conditions and improving the health condition of children. **Taneja et al.,** (2012) found that at the nutritional rehabilitation centre (NRCs) the great percentage of the admitted children belonged to the marginalized population groups. Underutilization of the services by the marginalized children may be the reason of suffering from malnutrition in Indore and Ujjain districts.

1.6.2.2 Perception of Beneficiaries

Murthy and Mathur, (1988) showed that most of the mothers were not satisfied with the quantity of food provided to them and the children. They felt it below their dignity to go to AWC for a small portion of food. Similarly, **Davi** (1984) showed that the quantity of food served at the Anganwadi centre was not sufficient and no provision of providing the therapeutic diet for identifying malnourished children.

The study revealed that mothers were dissatisfied with the food quality, and growth monitoring of children under six was not monitored timely by the AWWs. Participation among community members was poor **(Gupta et al., 2000).** Another study Sharma et al., (1992) showed that food items served at the AWCs were not good; it was difficult to digest, not tasty and suitable for consumption. In contrast, **Helena** (2014) study showed that the majority of children in Municipal Corporation of Andhra Pradesh was satisfied with the food which served at the AWC; with receiving supplementary nutrition. **Sampath** (2008) showed that the majority of AWCs buildings were in poor condition, without basic facilities. They were not located within community areas and supplementary nutrition provided was inadequate. All these created bad images and negative attitude between the mothers towards ICDS. **Vinnarasan** (2007)showed that Respondents were fully aware of the provision of supplementary nutrition, but not aware about the special care is given to malnourished children under the supplemental nutrition program (SNP). **Pandey et al.** (2011) found ICDS Scheme contains the best quality of services, but beneficiaries don't realize its significance.

A study done by **Mishra** (2006) found that maternal education played an important role in the growth and development of the child and the rate of suffering from Protein Energy Malnutrition is higher in illiterate mothers because of lack of awareness among them.

Women's literacy levels have the positive correlation with child survival, especially a state like Kerala. The NFHS-2 confirmed that all components of child mortality are observed to decline with increasing maternal education. All child mortality rates are higher amongst illiterate mothers compared to mothers who had completed high school education **(Sundararaman, 2010).** Expectant and nursing mothers had benefited from nutrition services, prenatal and postnatal care and immunization. A large number of children showed increases in growth and weight. Some of the respondents considered supplementary nutrition as the most useful service. All this shows the effect of the ICDS services in an immense manner **(Parmeswaran and Ramaligam, 1985).** The nutritional status of children in ICDS areas was better than that of children in non-ICDS areas **(Sharma et al, 1992).**

Pandey et al., (2011) also concluded that ICDS children had better nutritional status as compared to their non-ICDS counterparts. National Institute of Nutrition (NIN) found

that gross nutritional status of children was better in ICDS centres than those children who were not attending ICDS centres **(NIN cited in Pandey et al, 2011).** The behavior of ICDS children in terms of helping, sharing and friendship pattern was better than their non-ICDS counterparts because of pre-school education conveyed to the children under the ICDS services **(Sood, 1992).**

1.6.2.3 Discrimination

Cooper et al. (2008) identified that discrimination can affect health outcomes either at once or indirectly. There may be directly excluded from the health facilities by health workers and doctors, and people indirectly excluded as a result of distance from the health facilities and cost of transportation and treatment.

The key aspect discussed by **Gerg** (2006) was victim blaming. This study was conducted in Chhattisgarh among tribal communities. Poor people were blamed by health workers for being malnourished and not capable of accessing the government services, put up. This blaming got severe with the women of Dalit families. Further, they were also blamed being lazy, unclean and superstitious and all these lead to a worse health condition of the children. These offended the tribal people and discouraged them to availing the ICDS services. **Behra** (1992) found corruption in the distribution of supplemental nutrition. Those who were not eligible (non-pregnant & non-lactating women) availing the services and for this AWW were created false names in the beneficiary list.

Mander and Kumaran (2006) revealed that next to locate the other important factor determining access to AWC is the service provider. AWW and AWH showed the distinct attitude towards children of different castes and economic backgrounds; and acted as a major role in discouraging the children from disadvantaged castes.

The report shows active social exclusion as Scheduled Caste children being made to sit separately from other children while feeding or their being answered from different utensils. Similarly, the report shows hidden exclusion such as AWW skipped

home visits to Scheduled Caste hamlets not because they are Scheduled Caste hamlets, but because they are physically at a distance. Also, numerous Dalit children were not able to be present at the Anganwadi because it was situated in the upper caste hamlet **(Citizens' Initiative for the Rights of Children under Six (CIRCUS), 2006).**

The study showed that people with a similar standard of living and education level, the health status of SC and ST are lower than their higher caste counterparts. This suggests that in addition to their poverty and education levels SCs suffer from inadequate access to public services, because of caste and untouchability related differentiation and exclusion **(Thorat and Sadana, 2009).**

Acharya (2010) indicated that AWWs had visited Dalit households; they had not gone into the house and required great caution not to touch their children and spent lesser time than they normally would have spent with the non-Dalit children. Almost, all the AWWs served food to the Dalit children at the end at the Anganwadi. Dalit children experienced social exclusion towards health care approach. Discrimination is generally noticeable in delivering the services. **Shariff and Singh** (2002) revealed that huge variations in ANC usage across castes and religious groups, even after controlling for income and education. The report clearly plotted that Muslim women and scheduled caste and tribeswomen received significantly less prenatal and postnatal care in the comparison of upper caste Hindu women. **NFHS-2** (1998-99) report pointed out the among all castes and groups, the highest share of mothers who delivered at home without skilled birth attendants were from ST community. Women who had tetanus immunization and Iron, folic acid supplements during their pregnancy are less in number in comparison with the upper caste women.

1.6.3 Health Personnel's and Institutions' Outlook

1.6.3.1 Anganwadi workers (AWWs)

AWWs are the most important public servant of the ICDS program. Some AWWs took initiative in their workplace, while others did not, because of the poor service conditions and low educational level. AWWs had very small interaction with local level organizations such as Manila Mandals, village Panchayats, and schools,

whereas CDPOs had maintained good contact with them. They had been involved with the community, but the participation was limited **(Bahl,** 1983).

ANMs and AWWs are centre persons which identify and satisfy the needs of children and women. **Agrawal et al.** (2012) found the effectiveness of their functioning depends upon their knowledge, attitude, and practices, as well as other factors. The study showed the better the knowledge of AWWs or ANMs; the higher was the proportion of women visited by them. AWWs who had better knowledge received a more antenatal visit in comparison to those AWWs who had poor knowledge. **Kular** (2014) emphasized that the training of ICDS functionaries needs to be strengthened along with increasing awareness of the community regarding ICDS services.

According to **Bhardwaj et al.** (2016) Growth monitoring is the perfect tool for Anganwadi workers for assessing the growth and development of a child. This study identified that AWWs had insufficient knowledge about the growth chart and how to plot growth charts. The problems faced by AWWs also limited in giving their best in delivering the services to the community. **Dongre et al.,** (2008) found due to the workload of record keeping AWWs neglect of the other primary functions like- nutritional education and informal education.

The AWWs' residence and its length from the Anganwadi centres played an important role in the effective functioning of Anganwadi workers. Sometimes insufficient knowledge of AWWs is the greatest barrier to providing the health services like - vaccines, diseases, and treatment **(Gopalan et al., 1988).**

Kant et al. (1983) studied areas where AWWs needs to be improved like- immunization schedule, identification of nutritional deficiency diseases, balanced diet, ORS etc. these're the main elements. If she receives an adequate knowledge about these services, it will increase the strength of the ICDS services. **Ramana et al.** (1987) indicated there was a lacuna in the knowledge of AWWs regarding child care, which needed to be correct. Thus, knowledge of AWWs is too important as she is the main service provider in ICDS services at the grass root levels.

In **Walia et al.** (1978) revealed that during AWW's training they were not exposed to practical aspects of the health care plan. Mainly training consisted of

theoretical instruction in classrooms while practical experience in a community setting was not supplied. Besides, they were not made aware of the use of forms and registers maintained by other health functionaries. **Salomi et al** (1984) showed that the level of health and nutrition knowledge of AWWs correlated with their educational level and experience in the field. Thither was a poor transfer of knowledge regarding health and nutrition due to lack of communication gap between AWWs and beneficiaries and knowledge of the AWWs.

Chudasama et al., (2016) identified gaps in the PSE activities at AWCs. Thus, there is a need for the regular workshop for ICDS staff to aware them of the importance of PSE activities. **Gupta et al.,** (2000) According to the GOI, education of AWWs should be up to matriculation and to Anganwadi Helper; it's up to primary passed. The survey showed that half of AWWs were matriculated and 1/3 of Anganwadi helper was not literate. **Somaiah and Vijayalakshmi** (2007) highlighted AWWs had to deplete their plenty of time on other activities rather than ICDS services. They had inadequate time to focus on the pre-school activity and bear to assist the women in bank transactions because most of the women were illiterate. AWWs that stayed 4-12 km's away from AWC performed their work as an inefficient and incomplete manner.

The Anganwadi worker (AWW) Selected from the community performed a pivotal role due to close contact with the beneficiaries. The success of the ICDS program may be affected by qualification, experience, skills, attitude, training of the Anganwadi workers. Anganwadi workers felt problem in an inadequate honorarium and excess workload. An increase in honorarium should be an important factor to increase in work efficiency **(Meenal et al, 2011).**

Anganwadi workers are the basic unit of the Anganwadi centres. **Murthy and Mathur** (1988) indicated that the visits of the Supervisors and CDPOs were not many and they didn’t interest to identify problems of AWWs and helping them out. They mostly confined to the Anganwadi records and registers.

Indira et al (1989) found Anganwadi workers faced many problems like – People from the community demanded supplementary nutrition for all children irrespective of their eligibility for it. Many times mothers and children carried their supplementary food to the home. AWWs were hesitant to visit the houses alone because

of treated indecently by the people. **Rane and Narayan** (1989) showed AWWs faced conflicts with parents over some aspects of SNP like - unequal distribution, food not palatable, children falling sick after eating food, no storage space etc.

1.6.3.2 Auxiliary nurse midwife (ANM)

Mavalankar and Vora (2008) indicated shifting of ANM's roles of Maternal Health to FP and immunization. National programs are one of the factors to shift the focus of ANM's from comprehensive reproductive health services to preventive services. **Rao and Shetty** (2012) in their study with the objective learning needs of staff nurses, auxiliary nurse midwives, and lady health visitors concluded that regular in-service training is required and it was effective in the overall performance of the workers. Keeping midwives knowledge and skills through retraining could be essential in maintaining high levels of MCH care skills.

Ved and Dua (2005) pointed out that the Auxiliary nurse midwives mostly focused on family planning and immunization. ANM has to maintain registers and reports and mainly supervised for reports. Most of the sub-centres do not have vaccines storage facility. So, she has to spend more time to collect the vaccines. Lack of physical infrastructure, equipment, and basic amenities overburden the ANM and these affect the home visits for newborn and postnatal mothers. **Mavalankar and Vora** (2008) indicated shifting of ANM's roles of Maternal Health to FP and immunization. National programs are one of the factors to shift the focus of ANM's from comprehensive reproductive health services to preventive services.

Husain (2011) explained most of the auxiliary nurse midwives did not stay at the SCs because of non-availability of quarters for them; although staff quarters were poor in condition with lack of infrastructural facilities and safety concerns. ASHA worker acts as an interface between the community and the public health system. The study reported that induction training and accessibility of medicines in drug kits were not satisfactory. Almost, all the ASHA received training of the first module and ¼ received up to the fifth level. As the training was rare and discontinuous; even do not reach the minimum 12 days training per year. **Seh** (2011) focused on the knowledge of ANMs. Their knowledge regarding vaccination was not complete enough and this is reflected on the state of immunization. This showed the insufficient knowledge and

improper practice of ANMs. Thus, on that point is a substantial need for appropriate training and education to the success of the plan.

Covering of antenatal home visits and newborn care practices was positively associated with the cognitive level of AWWs and ANMs. Initiation of breastfeeding within the first hour of life, clean cord care practice and thermal care practice were significantly higher among women visited by AWWs or ANMs who had good knowledge as compared to those who had poor knowledge **(Agrawal et al., 2012).**

Auxiliary Nurse Midwife (ANM) was assimilated into the Indian Health system as a midwife to provide MCH services. By the time her roles are changing shifts towards more of outreach services and preventive care. She is losing; her clinical and curative skills which need to deliver MCH services. Present days ANM is working as a multipurpose worker at the ground level rather than a midwife or provider's medical care **(National Iron Plus Initiative (NIPI), n.d.)**

ANMs are the fundamental field level functionaries. She assigns with the responsibility of delivering need-based, client-centreed, and demand-driven services at the doorstep of the community. **Ghosh and Chakrabarti** (2015) found dissatisfaction among ANMs existed in certain areas like pay-scale, workload, personal satisfaction and training received irrespective of the geographical location of their designated sub-centres in plains of hilly areas in Darjeeling district.

Nowadays, most of the deliveries are conducted in health facilities and all the Antenatal mothers under the care of registered ANMs. However, unsafe newborn care practices are common. Besides traditions, community practices also appear to be important contributors for such patterns. **Sarin et al.** (2011) pointed out on the urgent need to educate mothers and train health care providers, including ANMs and Anganwadi workers on newborn and early neonatal care. So, there is a need for training and retraining of ANMs on safe delivery practices.

In India, the regulation, training, and practice of midwifery have a long story. Adapt according to program priorities (like- target orientation) leads to the dilution in midwifery role ANMs and resultant de-Skilling; actually, she is increasing playing a

management role against ASHAs and Anganwadi workers **(Prasad and Dasgupta, 2013).**

Kharat et al., (2015) indicated that more than half ANMs had appropriate knowledge and correct practices in antenatal, intranatal, postnatal care and contraception. This fact pointed to the need of continuous retraining and evaluation of ANMs' knowledge. The work also proposed for evaluation of their practices by direct observation in the study. In addition to this **Chandhiok et al.** (2006) pointed out, there is a need for increasing community awareness about the significance of registering with an ANM early for antenatal care, early detection of complications during pregnancy, promptly seeking care and the importance of giving birth in a health facility.

1.6.3.3 Accredited social health activists (ASHA)

ASHA worker acts as an interface between the community and the public health system. **Husain** (2011) reported induction training and accessibility of medicines in drug kits were not satisfactory. Almost, all the ASHA received training of the first module and ¼ received up to the fifth level. As the training was rare and discontinuous; even do not reach the minimum 12 days training per year.

Waskel et al. (2014) showed that most of the ASHAs favored helping with delivery and immunization. It was perhaps because of these activities are also associated with financial incentives. Other jobs like counseling on family planning, referred for MTP, give TB drug etc. we're portraying lesser attention possibly due to lack of incentives. These could be areas requiring the change of direction. **Roy and Sahu** (2013) showed ASHAs suggested the initiation of regular monthly salary, which will help them to motivate in the delivery of effective health services.

Malakar and Sarmah (2016) study findings showed that the ASHA workers of Jorhat and Titabar subdivision of Jorhat district had an average level of knowledge on women and children's health. Some important aspects are known by ASHA worker like-breastfeed within one hour, nutritional requirements of women differ from that of men' especially during pregnancy, Newborn baby's heart rate is about 180 per minute and newborn care, etc. are to be given more emphasis during training period for best performance in providing services to the beneficiaries.

Despite lots of training given to ASHA workers still, there is a lacuna left in their knowledge regarding the various aspects of morbidity and mortality in children less than 5 years of age. So frequency and quality training must be strengthened for ASHA workers **(Mahyavanshi et al., 2011).**

Gerg et al. (2013) showed that ASHAs were satisfied and happy with the training. But their perception about the in job responsibilities seemed to be deficient and improper. Most of them were not aware of their role in facilitating ANM in village health planning, generating awareness on basic sanitation & personal hygiene. Even, they were not well aware of their role in birth and death registration. Similarly, **Shashank et al.** (2015) ASHA workers were not alert about the additional uses and responsibilities been implied in them under different national programs including the immunization guidelines and schedule. All the ASHA workers were conscious about the performance based incentive for their work in the community and it's their right to claim that incentive. **Renuka et al.** (2014) indicated that during feedback from the ASHAs, they themselves recommended in the regular job training as well as review training every 6 months.

ASHA is a significant part of NRHM in reaching the set Millennium Development Goals' by 2015. Her versatile role involving knowledge and practice changing health scenario and society; So, ASHA should have adequate knowledge, aptitude, leadership skills at village health level. Hence, she must be more qualified and receive training and subsequent periodical reorientation **(Kaur et al., 2015).** Within the health system, ASHAs were given inadequate equipment and supplies, delayed payment of incentives, and deficient training for the tasks required. Also, they faced disregard and mistreat from facility-based health staff. Inside the community, ASHAs battle with marginalized people who resisted their advice and guidance due to socio-cultural norms. ASHAs indicated a need for timely incentives, sufficient materials, and training to perform their tasks, and support in reaching out to hard to educate community people **(Sarin et al., 2016).**

Kumar et al. (2017) disclosed that along with health functionaries, beneficiaries and the village heads appreciated the work of ASHAs in the community. Institutional deliveries became high and her presence helped to rural beneficiaries in getting

continuous information about the ANC, immunization, VHND; at the end, which changed into the utilization of health services and active participation in VHND.

Under the NRHM, ASHA is the most important connection between the community and health care. **Padda et al.** (2013) concluded that the maternal and child health service delivery improves after initiation of ASHA worker in the rural community.

Karir et al. (2015) pointed out perception of Sahiyyas / ASHA supervisor about the antenatal component. They were not much aware of blood pressure measurement, blood test, and urine test and still there is a lacuna in the knowledge of Sahiyyas / ASHA supervisor. Sahiyyas' knowledge, as well as skills, needs to be strengthened in the field of maternal health services.

ASHAs are valued for their share towards maternal health education and for their ability to provide basic care, but their role as social activists is much less visible as mentioned in the ASHA operational guideline. Access by ASHAs to fair financial incentives correspond with effort coupled with the poor functionality of the health system are vital components, determining the role of ASHAs both within the health system and within the community in rural Manipur **(Saprii et al., 2015).**

1.6.3.4 Performance of the Institutions

Inadequate infrastructural facilities appear to be the major limitation to the effective functioning of Anganwadi **(Seema, 2001). Ahmad et al.,** (2005) indicated that due to long distance children were not able to use the services provided by Anganwadi Centre.

There was an overall shortage in the services provided by the Anganwadi centres under the ICDS scheme, especially in record keeping when cross checked **(Sharma et al., 2013).** AWWs mentioned about the scarcity of equipment like weighing machines, education kits, toys, even jugs and buckets for water storage **(FORCES, 2007).**

Nalini (1984) pointed out that preschool education provided at Anganwadi centres helped in the improvement of spoken communication, social skills, mental

ability, regularity and physical development of children. Besides this, the **Committee on empowerment of women** (2011) reported that a great number of Anganwadi in the country lack basic infrastructure facilities like – Pucca buildings, drinking water facilities, child-friendly toilets.

Pandey (2004) showed that badly equipped AWCs were the most important factor in affecting the implementation of ICDS. Generally, observed that the program functionaries failed to fully utilization of local surroundings due to inflexible nature and inflexibility in the use of these locally available rich resources. **Beghin and Viteri,** (1973) showed certain limitations of Nutritional Rehabilitation Centres. Firstly, these are not applicable to children <1yrs. Secondly, protein-calorie malnutrition is a family disease that's why there is needed to reach vulnerable persons. Some of NRC's established where there were not enough malnourished children on short distance.

Cooper et al. (2008) stated three levels of the primary health care system in India. The lowest tier of the Indian primary health care system is the Sub-Centre; the second tier is the Primary Health Centre and the third tier is the Community Health Centre. In addition, numerous existing PHCs and CHCs are understaffed, underfunded, and overworked; as a result, they are unable to provide an entire set of services to the population. **Gupta et al.** (2000) emphasized that attendance of children at the AWC is the important indicator of usage of the ICDS services.

Siddalingappa et al. (2016) explored some lacunae in infrastructure and facilities provided for the children under the ICDS program in Mysore. The study revealed that Anganwadis had the minimum required infrastructure and other facilities. Additionally, there is a need to improvise the method of teaching which cover psychosocial, health and nutritional aspects of children.

Gupta et al. (2013) expressed the notion that although the immense increase in ICDS there is a lack of infrastructure and basic amenities. Likewise, non-formal pre-school, nutrition and health education are not fully functioning in the manner they were designed to be.

Mostly, Panchayat Raj Institutions (PRIs) are working in rural areas, under the political influence. They have to be attentive for the ICDS activities, which is the

backbone of rural growth. **Somaiah and Vijayalakshmi** (2007) found that neither the Zilla Parishad (at the district level) nor the Taluka Parishad (at Taluk level) nor the Gram Panchayat (at the village level) shows any interest in ICDS activities.

The general cleanliness of PHCs and CHCs were sadly inadequate, despite the presence of a sufficient number of cleaning staffs. There is a significant gap in the supply of essential drugs to the PHCs. Basic medicines like Albendazole, bandages, cotrimoxazole syrup, etc.; were found to be out of stock **(Gulati cited in Husain**, **2011).**Thus, people buy this medicine from private sectors which leads to out of pocket expenditure, which beat the objective of catering accessible health care services to the people from vulnerable sections **(Husain, 2011).**

NIPCCD (1992) based on a sample of 100 ICDS projects and concurrent evaluation by NCAER (1996) based on 4,000 ICDS project; both are the major nationwide study on ICDS. These studies looked at the long-term impact of ICDS on children. The finding showed that ICDS has played a significant role in improving the health, nutrition, and education of children **(Rao, 2005).**

The primary level health institutions like Primary Health Centres (PHC), Sub-Centre (SC) and Community Health Centres (CHC) are dealing with a huge problem of the absence of health workers. Virtually all health workers, especially the 'doctors' do not want to serve in the rural areas due to overall infrastructural insufficiency and lack of incentives **(Jaysawal, 2015).**

Village Health and Nutrition Days (VHNDs) have been known as an important tool and distinctive program to cover rural health, hygiene, and nutrition. **Mehta et al.** (2016) found that antenatal services like registration, weighing and providing tetanus toxoid to the mother were mainly focused during VHND but other services name as identification of high-risk pregnancy, abdominal examination, blood pressure measurement and hemoglobin estimation needs to be strengthened during Mamta Divas / VHND day. **Panigrahi et al**. (2015) study showed beneficiaries believed that organization of VHND benefited to them. In spite of this, VHND services should be made stronger by giving the quality services. Therefore, capacity building and orientation of service providers and of PRI members must be made out. Communication activities to make awareness among beneficiaries should be amended. **Parmar et al.**

(2014) pointed out that supervision was lacking in a majority of the VHND sessions. Vaccine, logistics and cold chain maintenance were satisfactory. There is a need for periodical training, particularly for Immunization technique for FHWs and Growth plotting for AWWs.

1.7 Main issues emerging from literature survey

It is apparent from various surveys of literature that convergence took place between the Health and ICDS departments at various levels. Convergence could be as in the form of vertical Integration, as a human resource level (mainly -ASHA, ANM and AWW), as a decentralized level (VHSC, Community). The literature survey revealed that Beneficiaries (pregnant and lactating mothers and children 0-5 years) faced problems during utilization of services in the form of accessibility, affordability, distance, unsatisfaction by services, their own perceptions and values, discrimination as belonged to the others caste (ST / SC/ OBC), some sort of corruption etc. It is also evident health personnel's and institutions had their own outlook. Due to inadequate and improper education, lack of refresher training, lack of supervision and communication, the overburden of additional responsibilities indifferent behavior within the health system affected the service delivery by the providers. Insufficient supplies, equipment, infrastructure and human resource also affect the delivery of services.

Herein, researcher trying to gauge into the light of convergence at different levels, beneficiary perspectives and health personnel's and institutions outlook; in Indore district of Madhya Pradesh. Therefore, this study is distinctive in the field of research, especially on convergence level.

1.8 Conceptualization

The ICDS program provides an integrated approach for merging all the basic services for improved childcare, early stimulation and learning, health, nutrition, water and environment sanitation aimed at younger children, expectant and lactating mothers, other women and adolescent girls in the community. The AWW is the most important

function in the ICDS program who delivers services and the main source of information for community people residing in the area. Anganwadi workers (AWWs) along with Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activist (ASHA) are the key personnel in the delivery of the package of services under the ICDS scheme. ANMs are supposed to provide antenatal and postnatal care to pregnant mothers and to carry out immunization of children. ASHA will support the AWW in mobilizing pregnant and lactating women and infants for nutrition supplement. ICDS services provide through Anganwadi centres and Anganwadi workers (AWWs) is the functional unit of Anganwadi centres. As the ICDS program is integrated with the health system so we found interaction among AWWs and health workers- ANM and ASHA. ICDS provides integrated services like – Immunization, health check-up, referral services, nutrition and health education, etc. All these services provided by combined work of health workers and AWWs.

Based on the conceptual framework, an attempt has been made to provide a flow diagram to give it a visual representation (Fig. 1.1)

Figure 1.1 Diagrammatic Illustration of the Conceptual Understanding of the Problem

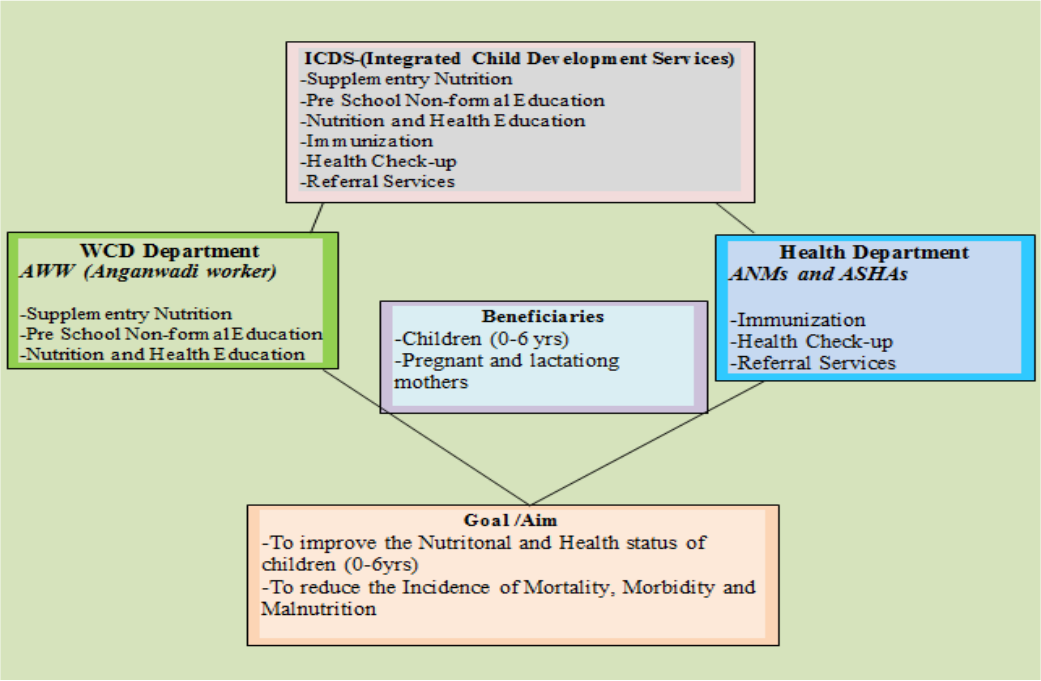


Table 1.4 Convergences of Services among ANM, AWW and ASHA at Village Level

S No	Components	ANM	AWWs	ASHA
1.	VHND	Organize Village Health and Nutrition Day at AWC (Immunization, Antenatal Checkups (ANC), Postnatal Check Ups (PNC), Health Checkups etc.)	Assist in organizing VHND Register children and women For Immunization, ANC, PNC, Health Checkups etc. Mobilize beneficiaries	Assist in organizing VHND Help AWW in registering children and women for Immunization, ANC, PNC, Health checkups, etc. Mobilize beneficiaries
2.	Referral	Attend to refer cases to Priority	Refer sick children, pregnant/ Lactating mothers PHC/CHCs	Refer cases to sub-centre, PHC/CHC
3.	Health & hygiene education	Impart Health & Hygiene Education to the beneficiaries	Assist	Assist AWW
4.	Health services		Depot Holder of Medicine Kit/Contraceptives of ASHA	Receive ASHA Kits / Contraceptives from AWW
5.	Drug administration	Administer drugs as specified by the M/O	Administer selected drugs Distribution of ORS/IFA Tabs, DDK & Condoms.	Administer selected drugs Distribution of ORS/IFA Tabs, DDK & Condoms.
6.	IMNCI	Implement IMNCI. Home visits 1 in 2 weeks pregnancy. (Once in the first week of delivery)	Home Visits- 1 in a month Pregnancy, (Once in The first week of delivery. Second visit in second or the third week as per the need.	Implement IMNCI. 1 in a month Pregnancy. (Once in The first week of delivery).

7.	Maintenance of records	Maintain and Update Eligible Couple Register.	AWW has a long list of records Growth monitoring	Help ANM to maintain and Update Eligible Couple Register.
8.	Delivery	Guide/Counsel women on safe/ Institutional delivery. Guide TBA (Trained Birth Attendant)	Guide/Counsel women on Safe/institutional delivery.	Assist ANM/ AWW in this Work. Escort women for institutional delivery. Guide TBA (Trained Birth Attendant) Facilitate referral of difficult cases.
9.	Nutrition & Health Education.			
10.	Records of village	Share available information with the Village Registrar of Births & Deaths	Share available information with the Village Registrar of Births & Deaths	Ensure registration of all births and deaths of mothers with the Village Registrar of Births & Deaths

Source: Sundararaman and Prasad (2006, p-76, table-42), "Accelerating Child Survival", Book 3, Public Health Resource Network.

ICDS provides an integrated package of health services named as - Supplementary Nutrition (SN), Preschool Education (PSE) and Nutrition & Health Education (NHE), immunization, health check-up and referral services. First, 3 services SN, PSE and NHE provided by AWWs at the AWCs under the ICDS to full fill the objectives related to the nutrition. Immunization, health check-up and referral services provided by ANM and ASHA who belongs to the health department. Children (0-6 years) and pregnant and lactating mothers are the targets of both these departments, especially for the fulfillment of the objectives, improve the nutritional and health status and reducing the incidence of mortality, morbidity, and malnutrition.

These departments interact with each other at various levels. Village Health and Nutrition Day (VHND), referral services, drug administration, Integrated Management of Neonatal Childhood Illness (IMNCI), maintenance of records, delivery services, nutrition, and health education records of village these are few components where AWWs, ANMs, and ASHA interact with each other. This is the Ideal picture, but there are several issues which found from the review of the literature. Almost all AWWs were facing problems in getting the help of ANMs in performing their job responsibilities related to health and very few meetings were organized between these functionaries to promote health and nutrition. Sometimes the situation is opposite ANMs are not getting the desired co-operation from AWWs during their visits to AWs according to them, they do not have complete knowledge, but several AWWs mentioned that during their training, they get only theoretical knowledge not practical so it creates problems for them in the field area.

Some studies state that AWWs have proper knowledge but they don't want to put into practice because of low motivation, inadequate honorarium and an excess of workload, some are not satisfied with their job, workload assigned to them and facilities available at AWCs for their children. They have to be maintaining a lot of registers and records which are difficult and cumbersome task and didn't get enough time to focus on children and services at AWCs.

Most of the AWCs do not have the proper infrastructure, equipment and material for growth monitoring, proper storage facilities and most of the time food supplies were delayed. At the beneficiaries' point of view mothers were not satisfied with the quality and quantity of food supplied to children and also it is not according to their food habits, faced difficulty to digest, had diarrhea problem. They mentioned non-pregnant and non-lactating mothers who are close to AWW they easily get the food and AWW mentioned false names in the registers. Studies show they faced discrimination; attitude of AWWs is different towards children who belong to lower castes. They didn't visit and escape during the time of the home visit.

During MPH work, researcher found similar issues. AWWs were not going for home visits to beneficiaries who belong to lower castes, especially SC in the village of the Indore district. AWWs were forced by her supervisors to give false reports on special nutrition even though children were not getting food at the AWCs and

malnutrition problem prevalent in the children of the village. CDPOs and Supervisors during their visit focus on records, but they do not want to focus on the actual problem in the village. Panchayat members also did not give support to the Anganwadi workers in relation to money matters. ANMs workers when visited by the AWCs were not cooperative and less interaction was found between them. Given the above scenario and based on our review, this thesis examines the gaps in the interaction between the health department and AWCs and issues related to delivering ICDS.

1.9 Research Question

The question to be examined is:

What are the gaps in establishing convergence between Health and Women and Child Health Departments in Indore district of Madhya Pradesh to fulfill the objectives of ICDS?

1.10 Objectives

1. To understand the constraints regarding utilization of services delivered through the ICDS program in Indore district of Madhya Pradesh.
2. To understand the convergence in services related to health and nutrition in Indore district of Madhya Pradesh.
3. To study the provider's perception regarding problems in delivering the services in Indore district of Madhya Pradesh.

1.11 Data Base

The database for this thesis has been collected from primary and secondary sources. Primary data of the thesis mainly constitute the information's collected from the respondents at various levels along with the profile of the beneficiaries and Health workers – ASHA, ANM and AWW through structured questionnaire, In-depth interviews and focus group discussions.

Secondary data include the following sources:

- Literature: Books, Journals, Articles and Magazines
- NFHS, HMIS, SRS, AHS ,DLHS, RHS reports
- State government reports
- Health institutional Record books

1.11.1 Instruments for the Research study: Techniques for Data Collection

For the collection of data, the standardized methods which are commonly used in the Social Science research have been applied. Following instruments have been used for the collection of primary data:

- ***Structured Questionnaire***: In order to study the profile of the beneficiaries and Health personnel's (ASHA, ANM and AWW) on the basis of socio demographic profile, personal information's, education and knowledge Structured Questionnaire were used.

- ***In-depth Interview***: Direct questions to the officials about their experiences, opinions or views; do not elicit useful answers. So, apart from approaching respondents with a fixed list of questions, the respondents have been interviewed in an in-depth fashion. Various probes have been used as desired to get respondents to expand on particular ideas.

- ***Focus Group Discussions:*** A focus group consists of 6 to 12 people with similar characteristics brought together in one place to discuss a topic of interest. Focus groups are intended to reveal some of the complex, profound aspects of the topic of interest, which would not have unfolded during an in-depth interview.

- ***Checklists:*** Checklists were used for systematic recording of observations and assessments of the institutions like- Nutrition rehabilitation centres, sub-centres, primary health centres, community health centres, village health and nutrition day visit, Gram Aarogya Kendra etc.

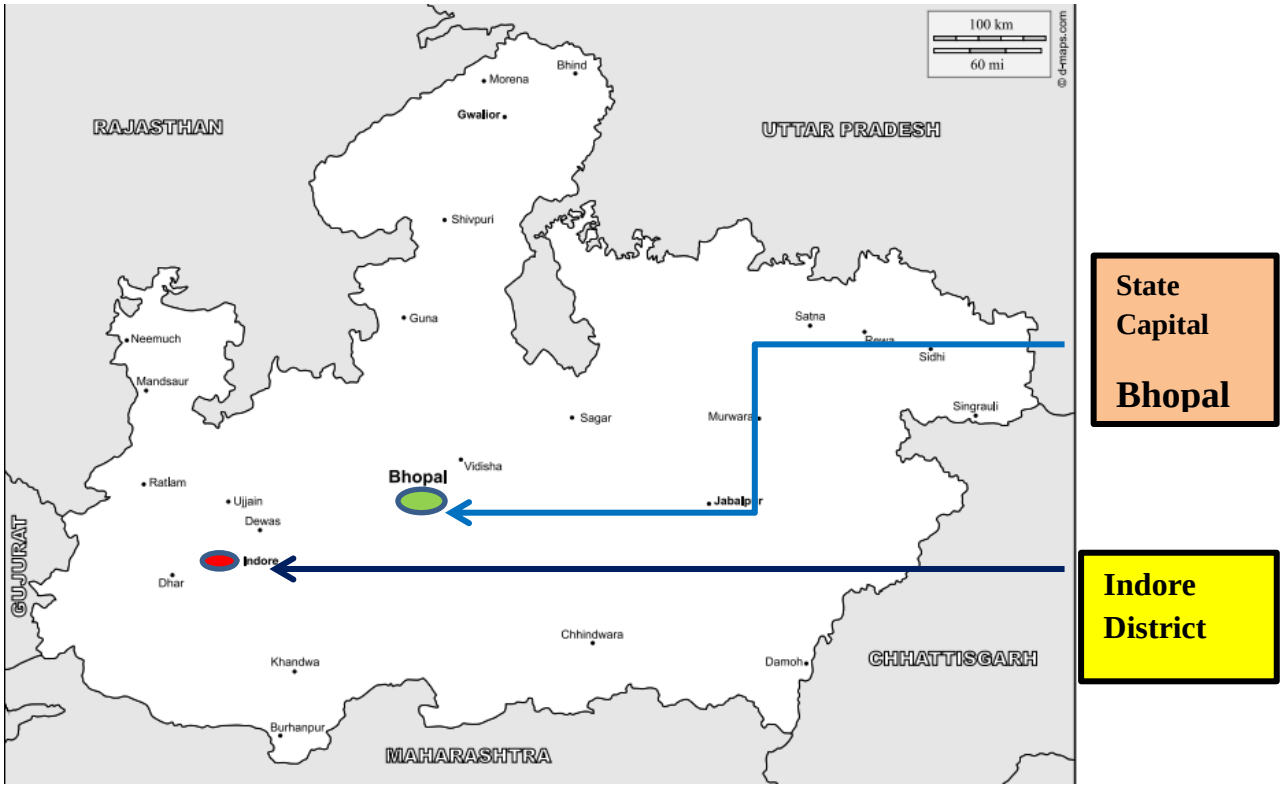
1.12 Methodology

1.12.1 Selection of Study Area

As stated, the study was conducted in Madhya Pradesh state. Madhya Pradesh lies in the middle of India. According to the census of 2011, in Madhya Pradesh % of the share of the total population of India is 6% and it has 6th rank in the comparisons of other states of India. Also, Madhya Pradesh got 2nd in terms of its geographical spread after Rajasthan. The growth rate in the state is higher by 2.66 percent points compared to Country and it is 20.3 during 2001-11. In terms of population density, Madhya Pradesh has 236 in comparison to India 382. Madhya Pradesh has many tribes and high concentration of the ST population. Most prominent tribes are Bhil, Baiga, Gond, Korku, Kol, Kamar, and Maria. In Madhya Pradesh, 3/4 population is rural. Agriculture is the basis of Madhya Pradesh economy. The sex ratio in the state has increased by 11 points since census 2001 (919) to reach 930 at census 2011. The proportion of children 0-6 age group for the total population in MP declined is sharply from 17.87% in 2001 to 14.53% in 2011.

A decline of 3.34% point, even though in India decline from 15.93% in 2001 to 13.12% in 2011 i.e. decline of 2.01% point. As, Millennium development goals set for MP are 39 and 43 respectively, for IMR and under 5 mortality rate up to 2015 but still in Madhya Pradesh it is 67 and 89 respectively for IMR and U5MR **(Annual survey report, 2010-11)**. Since 1975, ICDS services are present in MP which has the goal of reduction in child mortality and morbidity but still, we are not able to achieve the target. Researcher belongs to Madhya Pradesh and very well aware of the health system. This is the reason researcher chosen Madhya Pradesh state.

Map1.1 Map of Madhya Pradesh State



Source- http://d-maps.com/carte.php?num_car=8818&lang=en accessed on 31-5-17

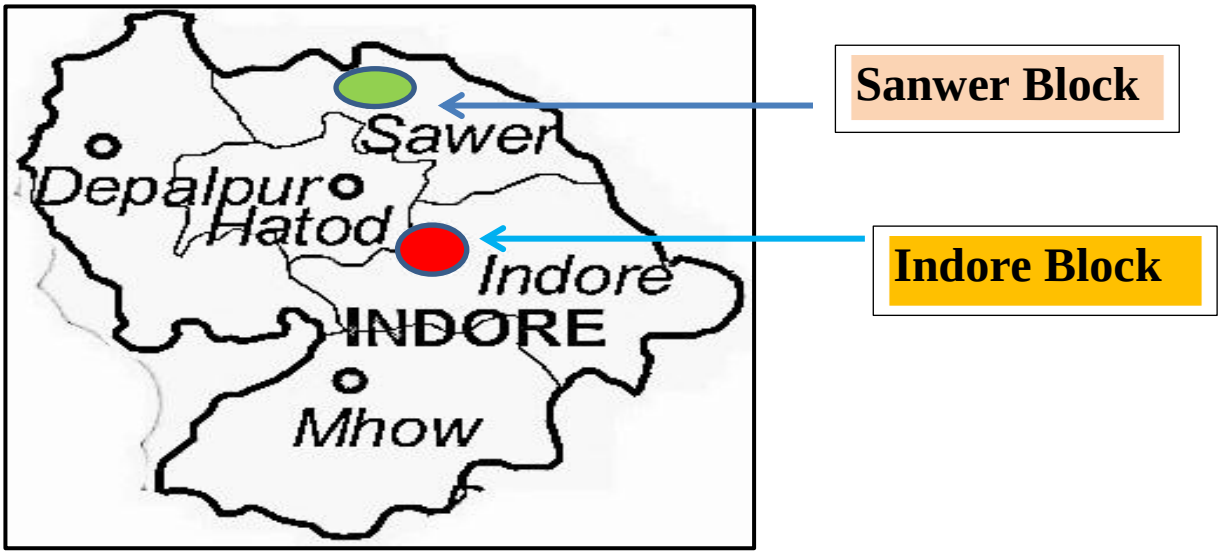
1.12.2 Selection of District

Indore is a tier 2 city (classification on the basis of the population recommended by the sixth central pay commission, 2008), the largest city in the Indian state of Madhya Pradesh. In Madhya Pradesh, it comes under top five districts on the basis of growth rate 32.7 **(census 2011)**. It shows the highest child population (286,302) in comparison to other districts like Bhopal, Jabalpur. Also, child population (0-6 years) to total Population is, 12.5% in Indore **(census 2011).** Still, Indore district has 2,192 'severely malnourished' children, as per the data of Woman and Child Development (WCD) department up to December 2013. Approx. 1.3 % children in the district fall under the category of 'severely malnourished.

The proportion of child stunting, wasting and underweight, anemia, calorie deficit and incomplete immunization status was found to be higher in rural areas of

Indore district, Madhya Pradesh **(Berad and Anwekar, 2013).** So, there is a need to improve the coverage as well as utilization of the child health services through the primary health care system, especially in rural area. Along with this researcher familiar about the district because researcher did a survey of the district health services system during MPH works. Also, language was known, Malvi is used in Indore district and second most important language in terms of the number of speakers is Marathi and Hindi.

Map 1.2 Map of Indore District



Source: http://www.onefivenine.com/india/villag/indore accessed on 31-5-17

1.12.3 Selection of Blocks

There are four blocks in Indore district. These blocks are as follows- Depalpur, Indore, Mhow and Sanwer. The researcher chose two blocks- Indore headquarters and Sanwer block. Indore Headquarter chose because it is the district headquarters and has more public health facilities, as well as good transport and good communication system. Along with this, it has heterogeneous population. On Contrast of this; Sanwer block is scheduled caste majority block. During MPH work researcher found caste-based discrimination, corruption in one of the villages of the Sanwer block. So that's why the researcher chose Indore headquarters and Sanwer block; to compare and know the what are the factors responsible for the better status in one block and lower performance of the others block.

1.12.4 Sample Design and Sample Size

Study Design. Cross-sectional study

In the cross-sectional study, either the total population or subset is selected from the selected population; data are collected to help serve the research inquiries of interest at only one period in time. The researcher collected data on the four levels.

At the First level or state level, Director of Women and Child development -1 and Director of Health Services-1were interviewed from the WCD and Health departments respectively.

At the Secondary level or District level, a District program officer -1 and District program manager -1 were interviewed from the WCD and Health departments respectively. Total 2 officials interviewed at the district level.

At the Third level or Block level: CDPO (1 from Indore slum and 1 from Sanwer= Total 2) and AWW supervisor (1 from Indore slum and 1 from Sanwer block= Total 2) from the WCD department and BMO (1 from Sanwer block), Chief of Medicine (1 from Indore) and ASHA and ANM supervisors (2+2=4, From Indore slum and Sanwer) were interviewed from the health department.

At the Fourth level or Village level, VHSC (5) and PRIs (5) were interviewed.

At the Fifth level or Beneficiaries level, Focus Group Discussions held with the mothers 30 from the Indore slum and 30 from Sanwer block. Total 60 mothers were selected. Currently, pregnant mothers (18- 50 yrs.) and lactating mothers (who delivered the child 1to 6 months before) included in the study. Mothers who are enrolled at Anganwadi centres and utilizing the services were selected for the study.

At the Sixth level or Institutional level, One community health centres (Sanwer CHC), 4 primary health centres (under the Sanwer CHC) and 8 SCs which under the selected PHCs were included in the study. Prakash Chand Sethi Hospital selected from the Indore slum for the study.

Structured questionnaire used for collection of data from Anganwadi centres; 30 from the Indore slum (Which, come under the ICDS Project -5) and 30 from Sanwer block (which come under the villages of selected Sub centres) by using purposive sampling. One NRC from, selected from Sanwer CHC and One of the Cha-cha Nehru Hospital.

At the Seventh or Health personnel's level, 30 ANM from the Sanwer block (chose from the selected SC, PHC and CHC) and 30 from the Indore block (chose from Prakash Chand Sethi Hospital) were included in the study. 30 ASHA from the Sanwer block (chose from the selected villages) and 30 USHA from the Indore slum were included in the study.

30 AWW from the Sanwer block (selected villages come under selected SCs) and 30 from the Indore slum (Come under the ICDS Project -5) were selected for data collection. So, total 60 ANM, 60 ASHA workers and 60AWW workers selected at the health personnel's level.

At the Eighth level or Observation level, Village Health and Nutrition Day (VHND) observed by the use of the checklist. 40 From the Indore slum and 40 from the Sanwer block from the selected AWCs. Total 80 observations made in data collection on the VHND. 40 Gram Aarogya Kendra chose from the selected AWCs where the Gram Aarogya Kendra was established.

Table 1.5 Table showing Sample design and Sample Size

Levels	Officials	WCD	Health Department
1	At State level	Director of Women and Child Development- 1	NHUM Mission Director- 1
2	At District level	DPO- 1	DPM-1
3	At Block level	CDPO (1+1), AWW supervisors (1+1)	BMO-1,Chief Physician-1 ASHA Supervisors(1+1) and ANM (1+1) supervisors
4	At Village level	VHSC-5	PRIs-5
5	At beneficiaries level	Mothers (30+30=60)	
6	At institution's level	AWCs(30+30=60)	CHC-1

		NRC=2	PHC-4 SC- 8 Hospital -1
7	At Health personnel's level	AWW (30+30+60)	ASHA(30+30=60) ANM (30+30=60)
8	At the observation level	VHND (30+30=60) GAK (40)	

1.12.5 Methods of data Collection

Both quantitative and qualitative methods were used to collect data in the study. In quantitative methods structured questionnaire and a checklist were used, while in-depth interview and focus group discussions were conducted with qualitative information. The questionnaire was developed in English at first and translated into the Hindi language. A pilot study was done at the different level as a pre-test and few modifications were made in the content of the Questionnaire.

1.12.6 Data Collection

Researcher herself collected the information at all the levels. The field work was started in the beginning of July 2014 and completed by the end of August 2015.

1.12.7 Methods of Data Analysis

In the research study, Univariate analysis (Percentages, frequency distribution, and graphic presentation, pie chart, histogram, mean) has been used to analyze the data. Categorization and Theme based analysis was used for in-depth interviews and focus group discussions. In-depth interview and focus group discussions were transcribed and translated from Hindi to English. Grounded theory, theoretical frameworks were used. Firstly, categories were identified from them and clubbed together according to themes and interpreted.

1.13 Ethical Consideration

A research study carried out after the ethical clearance from The Ethics Committee: IERB –JNU. The written consent of the respondent sought before collection of the data. Confidentiality of their identities maintained during data collection. Before the interviews and focus group discussions, information on the

objectives of research conveyed to all the participants involved in the study. They had a choice to withdraw from the interview at any stage of the interview. Permission also is sought for using tape recorders for interviews and focus group discussions.

1.13 Limitations of the Study

The research study aims to investigate the comprehensively, all the different levels to understand the complex and subtle information. There needs to be more exploratory research with the large no of sample size. The research study also needs to look the men's participation in women's and child health care. As, the spousal communication influences positive attitudes towards contraceptive, advice for the antenatal check-up and institutional delivery.

1.15 Problems encountered during the fieldwork

Like other research studies, in this research study researcher faced problems and hurdles. Some of those encountered as follows:

- Taking permission from both the departments have been a difficult task as they were busy in meetings, visit the field, press conferences, etc. Along with this official appeared reluctant to share information.
- Since the mothers (beneficiary) chosen for the focus group discussion at the Anganwadi, the place was noisy and chaotic and it interrupted in smooth conversion with them.
- Distance is also the problem during fieldwork at the Sanwer block, especially in winter season. As it took 1hr 30 min to reach there. Because of this, the researcher faced Insufficient/ less time for data collection.

1.16 Significance of the Study

To the researcher, the researcher of this undertaking desire to make a significant contribution to the better improvement and future development of the mother and child health services.

To the health care system, this study gauged in the loopholes of the existing system and probable solutions have been suggested through policy recommendations.

To the community, this research study provides an understanding of their needs and constraints during utilization of services, especially for mothers (pregnant and lactating) and children (0-5yrs) for the betterment of the services.

To the academy, research study serves as a future reference for researchers on the subject of public health and importantly the literature on ICDS services for mother and children are voluminous.

1.17 Organization of the study

1.17.1 Scheme of Chapterization

The scheme of Chapterisation followed in the thesis is:

Chapter 1 Introduction

Chapter 2 VHND and Utilization of Services by Beneficiaries

Chapter 3 Interactive actions between Health and WCD department at different level

Chapter 4 Providers Perceptions in Delivering the Services

Chapter 5 Summary and Conclusions

1.17.2 Plan of Study

Research findings have been presented in five chapters.

- The chapter one presents the introduction, reviews of the available literature, conceptual framework, objectives, research question, database, methodology and chapter organization.
- The profile of beneficiaries and their utilization of services, especially on VHND examined in chapter two.
- A detailed interactive action between the Health and WCD department were studied at different levels in chapter three.
- Providers' profile, their perceptions regarding service delivery and problems faced by them presented in chapter four.

- Chapter five discussed the major findings along with the conclusion, limitation, and recommendations.

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Chapter 2: VHND and Utilization of Services by Beneficiaries

Section A: The Village Health and Nutrition Day

2.1 Introduction

National Rural Health Mission (2005-12) was launched in April 2005 by GOI. It seeks to provide efficient health care to rural populations throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure **(Kapil and Choudhury, 2005).** Village Health and Nutrition Day (VHND) introduced nationally by NRHM guarantee better health results for millions of people in rural areas, particularly those belonging to marginalized and vulnerable communities **(Orissa Technical and management support team (TMST), 2011).** The VHND is to be organized once every month (preferably on Wednesdays and for those villages that have been left out on any other day of the same month) at the AWC in the village **(Government of India (GOI), 2007).** VHNDs provide a basket of health and nutrition services and counseling to the community on a predesignated day, time and place. It is conceived as a platform for inter-sectoral convergence. It is done by workers from both health and WCD departments and seeks the funding of community institutions like SHGs, Adolescent girls' groups etc. **(Chavan, 2012-14).**

Accredited Social Health Activists (ASHAs) along with Anganwadi Workers (AWWs) are accountable for mobilizing the community for VHNDs, with the support of Panchayati Raj Institutions (PRIs), and Auxiliary Nurse Midwives. Auxiliary Nurse Midwives (ANMs) provide Maternal, Newborn and Child health services named as antenatal care (ANC) and routine immunizations. AWWs provide growth monitoring services and referral of children with severe acute malnutrition in addition to distributing supplementary nutrition. The presence of all three Frontline workers (i.e. AWW, ASHA, and ANM) is vital for the supplying of the intended package of services at VHNDs **(The United States Agency for International Development (USAID), 2012).**

2.2 Operational Details

The VHND organized at once a month at a set place along a fixed day of the month for a population of approx. 1,000 either slum dwellers or villagers in rural areas at the Anganwadi Centre (AWC) / Community Centre/ School premises **(Mahajan and Dhingra, n.d.).**

2.3 Services Provided During VHND

1. Supplementary Nutrition
2. Immunization
3. Health Check-up
4. Referral Services
5. Pre- School Education
6. Nutrition and Health Education
7. Water, Sanitation, and Hygiene

Immunization, Health check-up, and Referral services are delivered through the Ministry of Health and Family Welfare (MHFW) and supplementary nitration, pre-school education, nutrition, and health education are provided by the Ministry of Women and Child Development (MWCD) (Ibid).

2.4 Responsibilities of Health Workers

2.4.1 Accredited Social Health Activist (ASHA)

1. Visit households and get to know about VHND services.
2. Prepare a list of pregnant women for ANC check-up and registration.
3. Prepare a list of Infants, who need Immunization and were left out or dropped out, who need care for malnutrition.
4. Co-ordinate with AWW and ANM.
5. Ensure presence of mothers and children during VHND

2.4.2 Anganwadi Workers

1. Ensure Cleanliness of AWC
2. Ensure accessibility of safe drinking water

3. Ensure Privacy for Antenatal check- ups
4. Co-ordinate with AWW and ANM.
5. Ensure treatment of malnourished children and supplementary nutrition
6. Weight monitoring

2.4.3 Auxiliary Nurse Midwives

1. Ensure VHND held on time and make alternative arrangements in case of ANM on leave.
2. Ensure provision of vaccines.
3. Ensure instruments, drugs and other materials available during VHND.
4. Carry Information, Education & Communication (IEC) materials.
5. Ensure reporting of the VHND to Medical officer.
6. Coordinate and guide ASHA and ANM.

2.4.4 Panchayati Raj Institution

1. Ensure all the Village Health and Sanitation Committee (VHSC) members available during VHND sessions
2. Ensure participation of PRIs
3. Ensure accessibility of safe drinking water

2.5 Methods & Materials

Indore district contained four blocks. Sanwer block of Indore district was selected for data collection. Sanwer block is located at the far distance and deprives of the basic health facilities. The majority of the population of this block is Schedule caste. Sanwer block has five primary health centres out of these three PHCs were selected. All 16 sub-centres were selected and out of these sub-centres 40 villages selected for evaluating the VHND by simple random sampling. VHND was observed on Tuesday and Friday.

Because of large numbers of villages, some VHND organized on Friday. Observation checklist was used for data collection. The checklist was prepared on the basis of the guidelines of VHND under NRHM program. The availability of services

during VHND was assessed by the research study. A research study was conducted from February 2016 to July 2016. The ethical committee reviewed and approved the study after clarifications. (The Institutional Ethics Review Board, Jawaharlal Nehru University, New Delhi). Official permission for the study was taken from District women and child development officer (DWCDO) of Indore district. The data were analyzed by Microsoft Excel and percentages are used.

Table 2.1 Blueprint of data collection

S. No	**Levels of data collection**	**No of observations**	**Respondent**	**Methods of data collection**	**An instrument used**
1	Sanwer Villages (Sanwer block)	40	Direct Observation by Researcher	Observations	Checklist
2	Indore slums (Indore block)	40	Direct Observation by Researcher	Observations	Checklist

2.6 Findings

This section presents findings on VHND in relation with human resource, availability of instruments, equipment's and furniture, supplies, maternal and child services and universal services available during VHND.

Table 2.2 Presence of health personnel's during VHND in Sanwer and Indore Slums

S. No	Staffs present during VHND	**VHND**			
		Sanwer (n=40)		**Indore Slums (n=40)**	
		No.	**%**	**No.**	**%**
1	Medical officer	23	57.5%	24	60%
2	LHV	39	97.5%	35	87.5%
3	ANM	27	67.5%	37	92.5%
4	ASHA	35	87.5%	38	95%
5	AWW	40	100%	39	97.5%
6	AWH	37	92.5%	37	92.5%
7	PRIs/VHSC members	19	47.5%	11	27.5%
8	Dai	29	72.5%	4	10%
9	ICDS supervisor	21	52.55	14	35%

Table 2.2 presents presence of health personnel's during VHND in Sanwer and Indore Slum. Data table showed that the medical officer attended VHND in Sanwer and in Indore slums i.e. 57.5% and 60%, respectively, and proportion of presence of a medical officer in Indore slums were higher than Sanwer VHND. LHV was attended VHND in Sanwer (97.5%) and in urban slums (87.5%) but the proportion of presence of LHV was higher in Sanwer as compared to Indore slums.

Also ANM (67.5%) and ASHA (87.5%) respectively; were attained VHND in Sanwer. In Indore slums ANM (92.5%) and ASHA (95%) respectively; were attended VHND. The ratio of attendance of ANM and ASHA was higher in Indore slums as compare to Sanwer. All the AWW (100%) attended the VHND in Sanwer as compared to Indore slums (97.5%). AWH attended VHND in Sanwer and Indore slums i.e. (92.5%) and (92. %) respectively. Fewer numbers of PRIs/ VHSC were presented during VHND in Sanwer (47.5%) and Indore slums (27.5%). The presence of the day was there during VHND in Sanwer and Indore slums i.e. (72.5%) and (10%) respectively. ICDS were also attended the VHND in Sanwer (52.55%) and Indore slums (35%) respectively, and the proportion of ICDS supervisors were more in Indore slums as compared to Sanwer**.**

Table 2.3 Instruments, Equipment's and furniture available during VHND in Sanwer and Indore Slums

S. No		**VHND**			
		Sanwer (n=40)		**Indore Slums (n=40)**	
		No.	**%**	**No.**	**%**
1	Weighing scale – adult	36	90%	37	92.5%
2	Weighing scale – Child (salter scale)	37	92.5%	36	90%
3	Height measuring scale	33	82.5%	38	95%
4	An examination table	28	70%	22	55%
5	Bed screen/ curtain	21	52.5%	19	47.5%
6	Hb – instruments along with tubes and reagent	35	87.5%	38	95%
7	Kits for urine examination	36	90%	37	92.5%
8	Gloves	32	80%	33	82.5%
9	Slides	31	77.5%	33	82.5%
10	Stethoscope	37	92.5%	36	90%
11	BP instruments	39	97.5%	38	95%
12	Measuring tape	25	62.5	30	75%
13	Foetoscope	23	57.5%	29	72.5%
14	Vaccine carrier with ice packs	40	100%	40	100%

15	Fan	29	72.5%	29	72.5%
16	Torch	27	67.5%	22	55%
17	Light source	28	70%	24	60%

Instruments, Equipment's and furniture are necessary requirements for conducting VHND. Data table 2.3 showed that weighing scale for adult available at Sanwer and Indore slums i.e. (90%) and (92.5%) respectively. Weighing scale for a child (Salter scale) was available during VHND (92.5%) in Sanwer and (90%) in Indore slums.

Height measuring scale (82.5%), an examination table (70%), bed, screen/ curtain (52.5%), Hb – instruments along with tubes and reagent (87.5%), kits for urine examination (90%), gloves (80%), slides (77.5%), stethoscope (92.5%), BP instruments (97.5%), measuring tape (62.5%) and foetoscope (57.5%) respectively; we're available during VNHD in Sanwer. Similarly, height measuring scale (95%), an examination table (55%), bed, screen/ curtain (47.5%), Hb – instruments along with tubes and reagent (95%), kits for urine examination (92.5%), gloves (82.5%), slides (82.5%), stethoscope (905), BP instruments (95%), measuring tape (75%) and foetoscope (72.5%) respectively; were also available during VNHD in Sanwer.

All the VHND sessions in Sanwer and Indore slums had a vaccine carrier facility with ice packs in Sanwer and Indore slums i.e. (100%). The fan was presented (72.5%) during VHND followed by torch (67.5%) and the light source (70%) in the Sanwer. Likewise, fan (72.5), torch (55%) and the light source (60%) respectively in Indore slums.

Table 2.4 Supplies present during VHND in Sanwer and Indore Slums

S. No		**VHND**			
		Sanwer (n=40)		**Indore Slums (n=40)**	
		No.	**%**	**No.**	**%**
1	Vaccines for immunization	40	100%	40	100%
2	Vitamin A solution	40	100%	40	100%
3	Iron, folic acid	40	100%	40	100%
4	Condoms	37	92.50%	38	95%
5	ORS Packets	39	97.5%	40	100%
6	Cotrimoxazole	31	77.5%	32	80%
7	Anti-helminthic drug (Albendazole Tab & syrup	38	95%	39	97.5%

8	Paracetamol	37	92.5%	37	92.5%
9	Stains	33	82.5%	32	80%
10	AD syringes	40	100%	40	100%
11	IEC materials	28	68%	30	75%

Table 2.4 presents the Availability of supplies during VHND in Sanwer and Indore Slums. Vaccines for immunization, vitamin A solution and Iron, folic acid tablets were available during VHND in Sanwer and Indore slums i.e. (100%). Condoms were available during VHND in Sanwer (95.50%) and In Indore slums (95%) respectively. ORS packets were available in Sanwer (97.5%) and in Indore, all the VHND sessions had ORS packets i.e. (100%).

Cotrimoxazole (77.5%), anti-helminthic drug (95%) and paracetamol tablet (92.5%) respectively, were available during VHND in Sanwer. In the same way, VHND in Indore slums had cotrimoxazole (80%), anti-helminthic drug (97.5%) and paracetamol tablet (92.5%) respectively. Stains were available in Sanwer and in Indore slums i.e. 82.5% and 80% respectively. All the VHND had availability of AD syringes in Sanwer and Indore slums i.e. (100%). Information, education, and communication (IEC) material were present in Sanwer (68%) and Indore slums (75%).

Table 2.5 Maternal services available during VHND in Sanwer and Indore Slums

S. No		**VHND**			
		Sanwer (n=40)		**Indore Slums (n=40)**	
		No.	**%**	**No.**	**%**
Maternal Services					
1	Registration of Pregnant women	35	87.5%	39	97.5%
2	Antenatal check-ups	33	82.5%	35	87.5%
3	Referral services	27	67.5%	34	85 %
Counselling					
4	Education of girls	15	37.5%	17	42.5%
5	Care during pregnancy	29	72.5%	30	75%
6	Birth preparedness	21	52.5%	24	60%
7	Importance of nutrition	31	77.5%	33	82.5%
8	Institutional delivery	32	80%	34	85%
9	Availability of funds under the JSY	34	85%	34	85%
10	Postnatal care	26	65%	26	65%
11	Care of Newborn	31	77.5%	33	82.5%

Table 2.5 showed the data on maternal services available during VHND in Sanwer and Indore Slums. During VHND registration of pregnant mothers was 87.5% in Sanwer and in Indore slums were 97.5%. The antenatal checkups facility was available during VHND in Sanwer (82.5%) and Indore slums (87.5%) respectively. Also, referral services were available during VHND in Sanwer and Indore Slums i.e. (67.5%) and (85%) respectively.

Few girls received the counseling services on VHND in Sanwer and Indore slums i.e. (37.5%) and (42.5%) respectively. Other counseling services like- care during pregnancy (72.5%), birth preparedness (52.5%), and the importance of nutrition (77.5%) was present in Sanwer. Similarly, care during pregnancy (75%), birth preparedness (75%), the importance of nutrition (82.5%) was present in Indore slums.

Counseling for institutional delivery was given to the mothers in Sanwer and Indore slums i.e. (80%) and (85%) respectively. Counseling on the availability of funds under the JSY (85%), postnatal care (65%) and the care of the Newborn (77.5%) was present during VHND in Sanwer. Also, counseling on the availability of funds under the JSY (85%), postnatal care (65%) and the care of the Newborn (82.5%) were present during VHND in Indore slums.

Table 2.6 Child services available during VHND in Sanwer and Indore Slums

S. No		**VHND**			
		Sanwer (n=40)		**Indore Slums (n=40)**	
		No.	**%**	**No.**	**%**
Infant-1 years					
1	Registration	34	85%	35	87.5%
2	Counselling for breast feeding	29	72.5%	35	87.5%
3	Immunization	37	92.5%	40	100%
4	Weight	28	70%	38	95%
1-3 years					
4	Booster dose of DPT/OPV	39	97.5%	40	100%
5	2nd & 5th doses- Vitamin A	38	95%	39	97.5%
6	Weight	31	77.5%	30	75%
7	Supplementary food (grade I & II)	37	92.5%	38	95%
8	Referral services	30	75%	31	77.5%
9	Counselling	27	67.5%	28	70%
Up to 5 years					
10	Tracking and vaccination of	31	77.5%	35	87.5%

	missed children				
11	Vitamin A supplementation	40	100%	40	100%
12	Case management	31	77.5%	32	80%
13	Management of worm infestation	35	87.5%	38	95%
14	Weight	31	77.55	30	75%

Table 2.6 presents the child services available during VHND in Sanwer and Indore Slums. Infants 0-1 years, registered (85%), received counseling for breastfeeding (72.5%) and Immunization (92.5%) and weighted (70%) during VHND in Sanwer. Similarly, Infants 0-1 years in Indore slums were registered (87.5%), received counseling for breastfeeding (87.5%) and Immunization (100%) and weighted (95%) respectively.

The majority of children 1-3 years received the booster dose of DPT/OPV in Sanwer i.e. 97.5%. In Indore, 100% children between the ages of 1-3 years received the booster dose of DPT/OPV during VHND. The 2nd and 5th doses- Vitamin A received by children 1-3 years in Sanwer and Indore slums were 95% and 97.5%. Children between 1- 3 years were weighted in Sanwer (77.5%) and Indore slums (75%). Availability of supplementary food for grade I & II was during VHND in Sanwer and Indore slums i.e.92.5 % and 95% respectively. Referral services and counseling services for children 1-3 years were present in Sanwer i.e. 75% and 67.5%, respectively. Similarly, referral services and counseling services for children 1-3 years were present in Indore slums i.e. 77.5% and 70%, respectively.

Children up to 5 years checked for tracking and vaccination of missed children in Sanwer and Indore slums i.e. 77.5% and 87.5% respectively. Vitamin A supplementation was 100% in Sanwer and Indore slums. Case management was done for 87.5% children in Sanwer and In Indore slums i.e. 80%. Management of worm infestation in children up to 5 years was present in Sanwer and Indore slums i.e. 87.5% and 95%, respectively. Children, up to 5 years were weighted in Sanwer (77.5%) and Indore slums (75%).

Table 2.7 General Services available During VHND in Sanwer and Indore Slums

		VHND			
		Sanwer (n=40)		Indore Slums (n=40)	
S. No		No.	%	No.	%
Family planning					
1	Information on use of contraceptives	23	57.5 %	33	82.5 %
2	Distribution & provision of contraceptives	37	92.5 %	38	95%
3	Counselling & provision of non-clinical contraceptives	39	97.5 %	38	95%
4	Information on compensation for sterilization	15	37.5 %	30	75%
RTIs and STDs					
5	Counselling on prevention of RTIs & STDs	8	20%	14	35%
6	Construction of sanitary latrines	0	0	0	0
Sanitation					
7	Mobilize community for safe disposal	2	5%	7	17.5 %
Communicable disease					
8	Awareness about TB	13	32.5 %	24	60%
9	Awareness about leprosy	11	27.5 %	22	55%
Gender					
10	Communication activities for prevention of prenatal sex selection	19	47.5 %	21	52.5 %
11	Age of marriage.	21	52.5 %	34	85%
AYUSH					
12	Information related to AYUSH	17	42.5 %	26	65%
13	Home remedies for common ailments	4	10%	3	7.5%
Health promotion					
14	Prevention of chronic disease & counselling like- (Tobacco chewing, Healthy lifestyle and Proper diet)	0	0	0	0
Nutrition					
15	Prevention of disease due to nutritional deficiencies and counselling	27	67.5 %	30	75%
16	Hygienic & correct cooking	14	35%	13	32.5

	practices				%
17	Checking of anemia, advising & referring especially in- (Adolescent girls and Pregnant women)	31	77.5 %	38	95%
18	Importance of Iron supplements, vitamins	33	82.5 %	38	95%
19	Advice on Improve the quality of food, which grown locally	13	32.5 %	11	27.5 %

The availability of general services during VHND in Sanwer and Indore Slums was shown in Table 2.7. In affiliation with family planning services, information on the use of contraceptives was present during VHND in Sanwer and Indore slums i.e. 57.5% and 82.5%, respectively. Similarly, distribution & provision of contraceptives were 92.5 % and 95% during VHND in Sanwer and Indore slums, respectively. Counseling & provision of non-clinical contraceptives and information on compensation for sterilization was 97.5% and 37.5% respectively in Sanwer. Similarly, counseling & provision of non-clinical contraceptives and information on compensation for sterilization was 95% and 75% respectively in Sanwer.

Counseling on prevention of reproductive tract infections (RTIs) and Sexually transmitted diseases (STDs) was present in Sanwer and Indore slums i.e. 20% and 35% respectively. No one was talking about the construction of sanitary latrines during VHND in Sanwer and Indore slums.

Mobilize community for safe disposal was almost negligible in Sanwer and Indore slums i.e.5 % and 17.5% respectively during VHND. In relation to communicable disease awareness about TB and leprosy was 32.5% and 27.5% respectively in Sanwer. Similarly, awareness about TB and leprosy was 60% and 55% respectively in Indore slums.

In affiliation with gender, communication activities for prevention of prenatal sex selection were 47.5% in Sanwer and 52.5% in Indore slums. About the age of marriage, 52.5% in Sanwer and 85% in Indore slums were getting the counseling. AYUSH services were present during VHND. In Sanwer and Indore slums information related to AYUSH were given, i.e. 42.5% and 65%, respectively. Information about

home remedies for common ailments under AYUSH was almost negligible in Sanwer and Indore slums i.e. 10% and 7.5% respectively.

Health promotion activities like- prevention of chronic disease and counseling on tobacco chewing, healthy lifestyle and proper diet was absent in Sanwer and Indore slums during VHND. Prevention of disease due to nutritional deficiencies and their counseling was available during VNHD in Sanwer and Indore slums i.e. 67.5 % and 75%. Hygienic and correct cooking practices were talking in the Sanwer and Indore slums i.e. 35% and 95% respectively during VHND.

Checking of anemia and their advice and referral services were present 77.5% and 95% in Sanwer and Indore slums, respectively. The importance of Iron supplements and vitamins was present in Sanwer and Indore slums i.e. 82.5% and 95% respectively. Advice on Improve the quality of food, which grown locally was given in Sanwer and Indore slums i.e. 32.5% and 27.5% respectively.

Section B: Utilization of Services by Beneficiaries

2.7 Introduction

The Integrated Child Development Services (ICDS) program launched on 2nd October 1975 in India. This is one of the world's greatest and unique designs for early childhood care and growth. It is the principal symbol of the country's commitment to its children and nursing mothers, as a response to the challenge of providing pre-school non-formal education on one hand and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality on the other. The beneficiaries under the Scheme are children belong to 0-6 years, all pregnant and lactating mothers **(Ministry of Women and Child Development, 2009).**

2.8 Objectives of ICDS

The objectives of the scheme are as follows:

- To improve the nutritional and health status of children (0-6 years).
- To set the basis for proper psychological, the physical and social growth of the child.
- To bring down the incidence of death rate, morbidity, malnutrition and school dropout.
- To achieve effective coordination of policy and implementation amongst the several sections to encourage child development; and
- To enhance the capacity of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education (Ibid).

2.9 Services under ICDS

The ICDS Scheme offers a package of six services, like-

1. Supplementary Nutrition
2. Preschool non-formal education
3. Nutrition & health education
4. Immunization
5. Health check-up and

6. Referral services

2.10 Beneficiaries of ICDS services

- Children below 6 years
- Pregnant and lactating women
- Women in the age group of 15-44 years
- Adolescent girls in selected blocks1

2.11 Registration of Beneficiaries

All children below 6 years of age, pregnant women and lactating mothers are eligible for utilizing the services under the ICDS Scheme. BPL is not a criterion for registration of beneficiaries under ICDS. The Scheme is universal for all classes of beneficiaries and in coverage **(Ministry of Women and Child Development, 2009).**

2.12 Services for Beneficiaries

Children under six and pregnant or lactating mothers can access these six main services are followed:

2.12.1 Supplementary nutrition

Vitamin A tablets, food grains and rice, and fortified food packages are available for children and mothers who are showing signs of malnourishment. Weight-for-age growth cards should be maintained for all children less than six years of age - children below the age of 3 should be weighed once a month and children aged 3-6 should be weighed quarterly.

Take Home Rations (THRs) in the form of pre-mixes/ready-to-eat food is provided to children below 3 years of age, pregnant and lactating mothers. Also, for severely underweight children in the age group of 6 months to 6 years, additional food items in the form of micronutrient fortified food and/or energy dense food as THR is provided.

1 https://www.nhp.gov.in/integrated-child-development-services-icds_pg

These norms have also been certified by the Supreme Court in an order dated 22.04.2009. The extent of nutritional supplements to different types of beneficiaries is shown below:

Table 2.8 Revised Nutritional Norms in ICDS (since February 2009)

Beneficiaries	Calories	Protein (g)
Children (6 months to 72 months)	500	12-15
Severely malnourished Children (SAM) (6 months- 72 months)	800	20-25
Pregnant women and lactating mothers	600	18-20

2.12.2 Immunizations

Children received full vaccinations against six preventable diseases: poliomyelitis, diphtheria, whooping cough, tetanus, tuberculosis, and measles. Pregnant women should have a vaccination against tetanus that reduces the maternal and neonatal death rate.

1.12.3 Health check-up

Various health services should be provided for children, including the treatment of diarrhea, de-worming and distribution of simple medicines (along with weight and height monitoring, and immunizations). Antenatal and post-natal checkups should be provided for pregnant women and young mothers.

1.12.4 Referral services

After a health check-up, children or mothers are in need of medical attention they should be brought up to the Primary Health Centre or sub-centres. Severely malnourished children should be referred to Nutrition Rehabilitation Centres (NRCs) and young children with disabilities should be referred to specialists **(Department for International Development (DFID), 2016b).**

2.12.5 Nutrition and Health Education (NHED)

Nutrition and health education is given to all women in the age group 15-45 years. The first concern is given to nursing and expectant mothers. A follow-up is made of mothers whose children suffer from malnutrition or from frequent illness. For health and nutrition education, mass media and other forms of publicity are used especially campaign at suitable intervals, home visits by Anganwadi workers **(Centre for Advanced Research and Development (CARD) Sambodhi Research and Communications, 2010).**

2.13 Methods & Materials

Beneficiaries were selected from the Sanwer block and Indore slums. In Indore, beneficiaries are from the urban slums and in the Sanwer beneficiaries belong to different villages were chosen for the study. Data were collected on the VHND day at the Anganwadi centres. Most of the mothers came on the VHND day at the Anganwadi Centre for the use of services. With the help of the Anganwadi Worker, Anganwadi helper and ASHA; mothers were agreeing to give the information. Mothers who were pregnant and lactating mothers (Who delivered the child 0-6 months before) were included in the study. So, 30 from Sanwer and 30 from Urban slums were selected. Finally, a sample of 60 mothers was included in the study of data collection. All the information was collected through questionnaires. The data were accumulated on different aspects of beneficiaries, like- socioeconomic conditions, types of families, Household Facilities and Asset, services received by pregnant and lactating mothers. For further detail about the utilization of services, their satisfaction level, problems in accessing services, attitudes of health personnel's were explored through Focus Group Discussions. (See Appendix)

Table 2.9 Blueprint of data collection

S.No	Levels of data collection	No of Respondents	Respondents	Methods of data collection	An instrument used
1	Villages (Sanwer block)	30	Pregnant and lactating mothers*	Questionnaire & Interview	Structured questionnaires'& FGD
2	Indore	30	Pregnant and	Questionnaire	Structured

	slums (Indore block)		lactating mothers*	& Interview	questionnaire's'& FGD

*Who were pregnant and lactating mothers (Who delivered the child 0-6 months before)

2.14 Findings

This part presents a profile of the Socio-demographic Characteristics of Beneficiaries in Sanwer and Indore slums.

Table 2.10 Socio-Demographic Profile of Beneficiaries in Sanwer and Indore Slums

		Beneficiaries			
		Sanwer (n=30)		**Indore Slums (n=30)**	
		No.	**%**	**No.**	**%**
Age	<20 yr	14	47%	11	37%
	20-30 yr	16	53.33%	19	63%
Education	Primary (5^{th})	4	13.33%	2	6.66%
	Secondary (8^{th})	8	26.66%	7	23.33%
	High School (10^{th})	7	23.33%	8	26.66%
	Intermediate (12^{th})	10	33.33%	11	36.66%
	Graduate	1	3.33%	2	6.66%
Religion	Hindu	21	70%	9	30%
	Muslim	7	23%	17	57%
	Christian	2	7%	4	13%
Caste	ST	9	30%	4	13%
	SC	12	43%	7	23%
	OBC	3	10%	9	30%
	General	4	7%	10	34%

Table 2.10 presents age, education, religion, and caste of the beneficiaries in Sanwer and Indore slums. The majority of the beneficiaries were in the age group 20-30 years in both the areas and proportion of the age group (20-30yrs) was found to be higher in Indore slums. The maximum percentage of the beneficiaries were from SC (43%) followed by ST (30%) in Sanwer and majority of beneficiaries were from OBC (30%) followed by general (34%) in Indore slums.

Data on the religion of beneficiaries showed that the majority of beneficiaries were Hindu (70%) in Sanwer and Maximum beneficiaries were Muslim (57%) in Indore slums. Additionally, data on education showed that in total, beneficiaries were intermediate passed (33.33%), Secondary (26.66%) and High School (23.33%) passed

in Sanwer. Also, beneficiaries were intermediate (36.66%), High School (26.66%) and Secondary (23.33%) passed in Indore slums.

Table 2.11 Economic Profile of Beneficiaries in Sanwer and Indore Slums

		Beneficiaries			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
Type of house	Kacha	7	23%	5	17%
	Pakka	9	30%	17	57%
	Semi Pakka	14	47%	8	26%
Building of houses	Rented	11	36%	7	23.33%
	Self-constructed	14	47%	11	36.66%
	Relative's house	5	17%	12	40%
Monthly income	Up to 1,000	3	10%	-	-
	1001-3,000	11	37%	1	3.33%
	3,001-5,000	7	23%	8	26.66%
	5,001-10,000	9	30%	21	70%
Occupation of husband	Daily wages, worker	4	13	1	3.33%
	Working in private company	5	17%	12	40%
	Farmer	7	23%	-	-
	Working in others field	11	37%	-	-
	Not working	3	10%	-	-
	Self-business	-	-	17	56.66%
Occupation of mother	Housewife	4	13.33%	8	26.66%
	Private sector	9	30%	9	30%
	Agriculture	14	46.66%	-	-
	Home based Business	3	10%	13	43.33%

Table 2.11 presents the type of house, the building of the house, monthly income, the occupation of Husband's and mothers. It was found that in total 14 (47%) beneficiaries had Semi pakka house, 9 (30%) beneficiaries had the pakka and 7 (23%) beneficiaries had Kacha house in Sanwer. In total, 17 (57%) beneficiaries had the pakka house, 8 (26%) beneficiaries had semi pakka and 5 (17%) beneficiaries had Kacha house in Indore slums. The majority of the beneficiaries (47%) lived in self-constructed building followed by renting a building (36%) in Sanwer. In contrast, maximum (40%) beneficiaries lived in a relative's house, followed by self-constructed buildings (36.66%) in Indore slums.

It was found that 11 (37%) beneficiaries' families had a monthly income of Rs.1, 001-3,000, 9 (30%) earned between Rs.5000-10, 000, 7 (23%) earned between Rs. 3,001-5,000 and 3 (10%) earned below Rs.1, 000 i.e. was below the poverty line in Sanwer. In Indore slums maximum 21 (70%) beneficiaries' families had the monthly income between Rs.5, 000-10,000 and 8 beneficiaries' families had (26.66%) Rs.3, 001-5,000. As compared to Sanwer no family was earned below Rs.1, 000.

In relation to Husband's occupation majority were working in others field (37%) followed by the farmer (23%), working in private company (17%) and (13%) daily wage worker in Sanwer. In contrast majority (40%) husbands were working in private companies in Indore slums. The majority of the beneficiaries (46.66) was working in the field followed by private sector (30%), housewife (13.33%) and home based business (10%). In contrast, maximum (43.33%) beneficiaries had a home based business followed by working in private company (30%) in Indore slums.

Table 2.12 Household Facilities and Asset Profile of Beneficiaries in Sanwer and Indore Slums

		Beneficiaries			
		Sanwer (n=30)		**Indore Slums (n=30)**	
		No.	**%**	**No.**	**%**
A source of water	Tap water	18	60%	19	63.33%
	Hand pump	4	13%	3	10%
	Well	3	10%	-	-
	River	3	10%	-	-
	Tanker	2	7%	8	26.66%
Toilet facility	Own toilet	11	36%	21	%
	Public toilet of any type	2	7%	9	%
	Open field	17	57%	-	-
Animal holding	Cow	6	15%	5	16.66%
	Goats	5	12%	8	26.66%
	Chicken	8	20%	11	36.66%
	No animals	21	53%	6	20%
Fuel used in house	LPG	5	17%	19	63.33%
	Coal	4	13%	1	3.33%
	Kerosene	3	10%	2	6.66%
	Wood	7	23%	1	3.33%
	Dung cakes	9	30%	4	13.33%
	Electricity	2	7%	3	10%

Data table 2.12 showed that Tap water was the main sources of water supply in the Sanwer (60 %) and Indore slums (63.33%) respectively. Also, maximum beneficiaries had a toilet facility in Sanwer (11%) and Indore slums (21%) respectively. Beneficiaries from Sanwer possessed assets like cow (15%), goats (12%) and chicken (20%) respectively. The majority (53%) of beneficiaries had no animal in Sanwer block. The majority of the beneficiaries had chicken (36.66%), followed by goats (26.66%), cow (16.66%) and no animals (20%). No one had the camel in both the areas. Data on fuel used in beneficiaries' houses showed that beneficiaries used dung cakes (30%), wood (23%), LPG (17%), coal (13%), kerosene (10%) and electricity (7%) respectively in Sanwer. Maximum beneficiaries were using LPG (63.33%) as a fuel followed by dung cakes (13.33%) and electricity (10%) in Indore slums.

Table 2.13 Services received by Pregnant Mothers in Sanwer and Indore Slums

		Pregnant Mothers			
		Sanwer (n=15)		**Indore Slums (n=15)**	
		No.	**%**	**No.**	**%**
Confirmation of pregnancy	ASHA	8	53.33%	5	33.33%
	ANM	4	26.66%	4	26.66%
	AWW	2	13.33%	2	13.33%
	Self	1	6.66%	4	26.66%
Who talked about antenatal registration?	ASHA	2	13.33%	9	60%
	ANM	9	60%	4	26.66%
	AWW	4	26.66%	2	13.33%
Who did antenatal registration?	ASHA	1	6.66%	3	20%
	ANM	11	73.33%	10	66.66%
	AWW	3	20%	2	13.33%
Place of antenatal registration	VHND	11	73.33%	6	40%
	Home visits	-	-	5	33.33%
	SC	1	6.66%	-	-
	PHC	2	13.33%	-	-
	CHC	1	6.66%	-	-
	Hospital	-	-	2	13.33%
	Dispensary	-	-	2	13.33%
MCP card	Yes	10	66.66%	15	100%
	No	5	33.33%	-	-
Antenatal check-up done by	AWW	2	13.33%	1	6.66%
	ASHA	2	13.33%	2	13.33%
	ANM	11	73.33%	5	33.33%
	LHV	-	-	-	-
	Doctor	-	-	7	46.66%
Mobilization	AWW	2	13.33%	3	20%

for Antenatal check up	ASHA	5	33.33%	4	26.66%
	ANM	8	53.33%	6	40%
	Family	-	-	2	13.33%
A place for Antenatal check up	AWC	9	60%	7	46.66%
	At home	1	6.66%	2	13.33%
	SC	3	20%	-	-
	PHC	2	13.33%	-	-
	CHC	-	-	-	-
	Hospital	-	-	6	40%
Counseling services received	Yes	5	33.33%	8	53.33%
	No	10	66.66%	7	46.66%
Follow the instructions	Yes	11	73.33%	15%	-
	No	4	26.66%	-	-
Mobilized for institutional delivery	ASHA	3	20%	5	33.33%
	AWW	4	26.66%	2	13.33%
	ANM	10	66.66%	6	40%
	Doctors	-	-	-	
	Family members	-	-	2	13.33%
Place choice for delivery	Home	-	-	-	-
	SC	3	20%	-	-
	PHC	-	-	-	-
	CHC	6	40%	-	-
	Govt hospital	-	-	7	46.66%
	Private hospital	6	40%	8	53.33%
Reason	Incentives	7	46.66%	5	33.33%
	Safety	-	-	2	13.33%
	Hygiene	-	-	8	53.33%
	Less money	8	53.33%	-	-

Services received by Pregnant Mothers in Sanwer and Indore slums table 2.13 elicited that the majority of the confirmation of pregnancy was done by ASHA in Sanwer (53.33%) and Indore slums (33.33%) respectively. Additionally, confirmation of pregnancy was done by ANM (26.66%), AWW (13.33%) and self (6.66%) respectively in Sanwer. The confirmation of pregnancy was done by ANM (26.66%), AWW (13.33%) and self (26.66%) respectively urban slums. Most of the mothers talked about antenatal registration by ANM (60%). Other talked by AWW (26.66%) and ASHA (13.33%) respectively in Sanwer. But in Indore slums, ASHA (60%) was the person to talk about antenatal registration. Others talked by ANM (26.66%) and AWW (13.33%) respectively.

Maximum antenatal registration is done by ANM (73.33%) followed by AWW (20%) and ASHA (6.66%) in Sanwer. Similarly, registration is done by ANM

(66.66%), ASHA (20%) and AWW (13.33%). An affiliation of the place of antenatal registration maximum (73.33%) was done at VHND followed by PHC (13.33%), SC (6.66%) and CHC (6.66%) in Sanwer. Likewise, the maximum number of registrations (40%) done during VHND and Home visiting (33.33%). Remaining registration was done at the hospital (13.33%) and in the dispensary (13.33%) respectively in Indore slums.

The majority of pregnant mothers had the Mother and Child Protection Card (MCP) in Sanwer (66.66%) and all mothers (100%) had the MCP card with them in Indore slums. Data on antenatal check-up affiliation of beneficiaries showed that maximum antenatal check-up did by ANM (73.33%) followed by AWW (13.33%) and ASHA (13.33%) in Sanwer block. In contrast, most of the antenatal check-up (46.66%) caused by Doctors, ANM (33.33%), ASHA (13.33%) and AWW (16.66%) respectively.

Maximum no of mobilization for the antenatal check-up of pregnant mothers was done by ANM (53.33%) and ASHA (33.33%) and AWW (13.33%) mobilized mothers for an antenatal check-up respectively in Sanwer. In Indore slums, ANM (40%), ASHA (26.66%), AWW (20%) and family members (13.33%) mobilized pregnant mothers for antenatal checkups. Maximum times (60%) antenatal check-up was done at the AWC and remaining were registered done at SC (20%), PHC (13.33%) and at home (6.66%) during the home visit in Sanwer. Also, in Indore slum antenatal check-up was done at AWC (46.66%) and at the hospital (40%) and remaining (13.33%) done at home during home visits.

Only one-third (33.33%) mothers received the counseling services and remaining (66.66%) were received no counseling services in Sanwer. Similarly, a majority (53.33%) mothers received counseling services and others (46.66%) did not receive the counseling services. Data showed that the majority (73.33%) of pregnant mothers followed the instructions given by the health personnel's and few (26.66%) did not follow the instructions given by the health personnel. Besides, this all (100%) the pregnant mothers had followed the instructions given by health personnel in Indore slums.

Nearly two third (66.66%) of pregnant mothers mobilized for institutional delivery by the ANM and remaining mobilized by AWW (26.66%) and ASHA (20%) respectively in Sanwer. Similarly, in Indore slums, pregnant mothers were mobilized by ANM (40%), ASHA (33.33%) and AWW (13.33%) respectively. The majority of pregnant mothers preferred CHC (40%) and private hospital (40%) for delivery and remaining mothers chose SC (20%) for delivery in Sanwer. Similarly, in Indore slums, pregnant mothers prefer private hospital and Govt hospital (46.66%) for delivery respectively. In Sanwer because of the less money (53.33%) and incentives (46.66%) mothers prefer the places and in Indore slums because of Hygiene (53.33%), Incentives (33.33%) and safety (13.33%) prefer the places of delivery.

Table 2.14 Services received by Lactating Mothers in Sanwer and Indore Slums

		Pregnant Mothers			
		Sanwer (n=15)		**Indore Slums (n=15)**	
		No.	**%**	**No.**	**%**
Transport facility	Yes	4	26.66%	6	40%
	No	11	73.33%	9	60%
Delivery ward facility	Yes	8	53.33%	15	100%
	No	7	46.66%	-	-
Post natal diet	Yes	4	26.66%	13	86.66%
	No	11	73.33%	8	53.33%
Care /hygiene	Yes	2	13.33%	10	66.66%
	No	13	86.66%	5	33.33%
Vital signs monitoring	Yes	8	53.33%	12	80%
	No	7	46.66%	3	20%
Neonatal care	Yes	9	60%	11	73.33%
	No	6	40%	4	26.66%
Post natal exercise	Yes	2	13.33%	10	66.66%
	No	13	86.66%	5	33.33%
Place of Delivery	Home	1	6.66%	-	%
	SC	2	13.33%	-	%
	PHC	3	20%	-	%
	CHC	4	26.66%	-	%
	Govt hospital	-	-	4	26.66%
	Private hospital	5	33.33%	11	73.33%
Reason for Delivery	Distance	9	60%	-	%
	Better facility	3	20%	7	46.66%
	Hygiene	-	%	4	26.66%
	They can afford	3	20%	4	26.66%
Informed about	AWW	3	20%	4	26.66%
	ASHA	4	26.66%	5	33.33%

institutional delivery	ANM	8	53.33%	5	33.33%
	LHV	-	-	-	-
	Doctor	-	-	-	-
	Family members	-	-	1	6.66%
Accompanied during delivery	AWW	2	13.33%	-	-
	ASHA	6	40%	10	66.66%
	ANM	1	6.66%	-	-
	Family members	6	40%	5	33.33%
Did you receive JSY money?	Yes	10	66.66%	12	80%
	No	5	33.33%	3	20%
Who gave post natal care?	AWW	1	6.66%	-	-
	ASHA	3	20%	2	13.33%
	ANM	11	73.33%	13	86.66%

Table 2.14 represents the utilization of services by Beneficiaries in Sanwer and Indore Slums showed that most of the mothers utilizing AWC facilities in Sanwer (60%) and Indore slums (56.66%) respectively. A few mothers were not utilizing the services in Sanwer (40%) and Indore slums (43.33%) respectively.

According to the need of the mothers, some visited AWC last week (36.66%), 15 days before (26.66%), 2-3 days before (20%) and one month before (16.66%) respectively in Sanwer. Similarly, some mothers visited AWC last week (40%), 15days before (23.33%), one month before (20%) and 2-3 days before (16.66%) respectively.

In affiliation with supplementary nutrition, most of the beneficiaries' got the Take Home Rations (THR) in Sanwer (83.33%) and Indore slums (93.33%) respectively. Only a few were not getting the THR in Sanwer (16.66%) and Indore slums (6.66%) respectively. Also, Maximum mothers were sharing the food with the family members in Sanwer (90%) and Indore slums (93.33%) and small numbers of the mothers were not shared the food with the family in Sanwer (10%) and Indore slums (6.66%) respectively. Most of the mother consumed food in Sanwer (80%) and Indore slums (83.33%) respectively. Only a few were no consumed food in Sanwer (20%) and Indore Slums (16.66%) respectively.

The majority of children were registered at the AWC from Sanwer (96.66%). Besides, all the children (100%) were registered at the AWC in Indore slums. Most of the children were going regularly (40%) followed by sometimes (23.33%), occasionally (20%) and not going (16.66%) in Sanwer. Similarly, maximum children were going

regularly (56.66%) followed by sometimes (23.33%), occasionally (10%) and not going (10%) in Sanwer. All the children got the hot cooked food at the AWC in Sanwer and Indore slums i.e. (100%). The majority of children consumed on the spot in Sanwer (70%) and Indore slums (80%) respectively, and few were consumed food on the spot in Sanwer (30%) and Indore slums (20%) respectively. All the children got the hot cooked food daily in Sanwer and Indore slums i.e. (100%).

According to mothers, their children weighed once in a two month (46.66%), once in four months (26.66%), once in a month (16.66%) and don't know (10%) respectively in Sanwer. Besides, mothers from Indore slums, said once in a two month (50%), once in four months (33.33%), once in a month (10%) and don't know (6.66%) respectively. Most of the mothers saw growth chart is drawn on an MCP card in Sanwer (70%) but a few were not acknowledged (30%). Similarly, the majority of mothers saw growth chart is drawn on an MCP card in Sanwer (60%) but a few were not seen (40%).

2.15 Focus Group Discussion with the Beneficiaries

A focus group discussion (FGD) is:

- A method of qualitative research;
- A situational method;
- A multi-dimensional communication process2

A focus group discussion was conducted with the mothers at the Anganwadi centres to collect explorative information about the services utilized them and problems faced and their opinion about ICDS services in Sanwer and Indore slums.

2.15.1 Focus Group Discussion with the mother in Sanwer

Some beneficiaries in the Sanwer blocks faced the indifferent behavior by the health personnel. As they belonged to the SC /ST caste, Anganwadi workers were not paid attention to them. They gave first priority to the upper caste women and not visited the house of SC/ ST caste beneficiaries. AWW used to tell them to come at AWC on VHND. Once one of the beneficiary' child got sick, she gave paracetamol tablet and did not check properly for the child.

"Madam ji Anganwadi bahanji hum se thik se baat nahi karti he. Hum neechi jati k he na. Hamare ghar bhi nahi aati hai. Koi dikkat ho to keh deti hai mangal diwas par aa jana. ANM madam aaigi to unse apni samashya batana……Aur ek bar mere bacche ki tabiyat kharab thi, use thoda bukhar tha to bas goli de di, thik se dekha bhi ……me use phir chote wale asptal le gai"

(Beneficiary, Focus group discussion, Sanwer block)

Also, children from the SC/ ST caste faced the problem during the Anganwadi sessions. One beneficiary shared that her child slap by the upper caste children and AWW, did not support the children belonged from SC/ST category. Even they did not have a right to tell anyone.

"Madamji Mere bachhe ko Thakur k bete ne us din mara. Bacho me to ladai ho jati he to bhi Anganwadi bahenji ne mere bete ko bola. Ab hum kuch keh bhi nahi sakte he. Anganwadi bahenji to unka hi paksh leti he….."

(Beneficiary, Focus group discussion, Sanwer block)

Some of the beneficiaries did not receive the proper Take home rations as they prepare for their use and fulfil their requirements. AWW used to order the few beneficiaries to come afterward for a Take-home ration and few beneficiaries hardly go to collect the Take home Ration. Through the girls, AWW sent the packets to others.

" ye Anganwadi wali madam he na humko bolti he baad me aana. Abhi packet nahi hai. Baad me ek sath de dugi. Aur hum to lene bhi kabhi kabhi aate hai. Aur dusaro ko khud se ladkiyo k hath bhijwa deti hai……"

(Beneficiary, Focus group discussion, Sanwer block.)

Some of the beneficiaries consume the Take-home rations and some were not interested because of the taste of the food. Some beneficiaries modified the food by the use of butter while cooking and shared with the other family members.

"Packet wala khana hamko acha legta hai. Ghee daal kar hum ghar me bana lete hai khichdi ko. Aur sattu aur halwa mix bhi aata hai vo bhi acha hai. Hum sab log khate he ghar bhar…."

(Beneficiary, Focus group discussion, Sanwer block)

Few beneficiaries did not like the taste of the Take-home ration. They felt dry and unhappy with the taste.

"Mujhe to bilkul bhi acha nahi legta. Skukha sukha legta he khane me….aur teaste bhi nahi aata he…."

(Beneficiary, Focus group discussion, Sanwer block)

Mothers shared their opinion regarding the reason for availing the ICDS services. Few mothers had to go to work in the field. For them, it's difficult to carry the child so that they left the children at home with the mother in law. Children eat food and learn poems at the AWC.

"mujhe to khet par jana padta hai madam ab bacche ko kaise sath me le jaye. Ghar parchor dete hai. Ma ji usko anganwadi bhej deti hai. Kuch kha pi leta hai Anganwadi me aur kavita bhi sikhate he wanha….."

(Beneficiary, Focus group discussion, Sanwer block)

The economic status of some of the beneficiaries was not good. Private institutions situated at the long distance and they charged more money that's why they come to the AWC. Even the first delivery was normal.

"Hamarer pas paise nahi hai. Private asptal bhi dur padta hai wo paise bhi zyada lete hai isliye hum to yaha aate he. Aur meri pahli delivery bhi normal hui thi…..

(Beneficiary, Focus group discussion, Sanwer block)

Other women shared non-availability of health staff on Sub-centres and primary health centres. One beneficiary did not get Sub-centre staff and she went at PHC, the ANM left the PHC before 1.30 pm. Later she went CHC and she faced a lot of discomfort on that day.

"Jab meri delivery hone wali thi na madam tab yaha koi nahi tha. (Means at the Subcentre) aur phir Dakachya (PHC) jana pada to madam chali gai thi.Dedh baje (1:30pm). Ab bade aspatal jana pada. Badi dikkat hui thi us din……"

Availability of the referral services even worse. Sanwer has more than 100 villages and availability 108 ambulance was very less. Even van stands outside the villages at the very long distances, especially at the police Chowkis. The 108 services did not reach to

the needy people because they used the other work of the police people. According to the collector order, they have to stand on the Police Chowki. Whoever needs to make a call and received the services.

"Sanwer me lagbhag 100 gaon he aur 108 nahi milti he. 108 par call kya tha par wo to thane par khadi rahti hai na. us din pata nahi kisi police wale k kam se gai thi…collector ne kaha he 108 police chowki par kahdi rahagi aur jab jarurat ho call karo aur suvidha lo.."

(Beneficiary, Focus group discussion, Sanwer block)

Some of the beneficiaries aware about the JSY scheme, but still delivered the child in private hospitals as they don't satisfy the services available at the govt sectors. According to them, they had strong financial status so they don't want to take any support from govt. Beside Govt medicine were not good in quality. They took private medicine and even family members support them. They agreed private institutions charged more but maintain cleanliness. They only wish wealth of the child.

" Hamare ghar me paisa hai to hum kyo sarkar se paisa le. Sarkari dawa bhi achi nahi hai. Hum to private dawaiya lete hai. Hamare parivar wale bhi kehte hai. Aur waha safai bhi rahti he. Ha thoda paisa to hai par dekte acha he. Aur baccha acha rhe humhe aur kuch nahi chajiye…."

(Beneficiary, Focus group discussion, Sanwer block)

Some shared their opinion regarding experience during availing the services. ANM came at the AWC and checked the BP of the antenatal mothers. ANM checked the eyes of the mothers and whenever she feels check the Hb of the mother.

"Mangal diwas par aate hai to ANM madam BP dekh leti he aur wajan le leti hai bas. Ager kisi ki aankhe pili dikti he to khoon ki jach karti hai ……."

(Beneficiary, Focus group discussion, Sanwer block)

BP and weight monitoring services were present during the VHND. No abdominal palpation was present and counseling for care during pregnancy, sleep during pregnancy present. Counseling for diet during pregnancy and institutional delivery was very less.

As maximum antenatal services were provided by the ANM and they did not get any incentives they were not taking interest in other things. ANM only focus on the BP and weight monitoring. Calling mothers for an antenatal check-up are the responsibility of the ASHA because of govt giving the incentives for this work.

"ANM madam to wajan aur BP lete he.Pet ki janch to nahi karte hai…Garbhavstha me kaise dekhbhal karna he aur sona he ye to madam batate he…aur bolte hai ki sansthagat prasav karnwana hai. Madam jayda tar jach karte he aur BP aur wajan lete hai. ASHA hamko bulane aati hai…"

(Beneficiary, Focus group discussion, Sanwer block)

Child feeding practices and care during illness

One beneficiary shared her child eats a variety of food. The child is 21/2 year old and they gave dal and rice. The child was not consuming green leafy vegetables, but eat roti with milk. Whenever a child got sick they took medicine from AWC and from ANM, during the visit of the houses.

"mere bache to sabhi prakar ka khana khate he. Hum to dal chawel dete he. Abhi ye chota wala 2 ½ saal kai. Sabji to nahi khate he. Roti doodh kha lete he .....Ager bacha bimar hota he to Anganwadi se dawa le lete hai nahi to ye ANM madam aati he pass me baithi he usne dawa le lete he…"

(Beneficiary, Focus group discussion, Sanwer block)

Immunization of the children and mothers

One beneficiary shared she experienced that she received a dose of TT injection before delivery and after delivery, her child received the BCG injection. The child got sick after injection, but she gave medicine as is given by the ANM during VHND.

"Delivery hone se pahle mujhe tike lege the TT k…aur ….aur mere bache ko bhi ek tika lega tha upper hath me , thoda bukhar aaya tha, madam boli ye bukhar ki goli de dena to mere khila de thi……"

(Beneficiary, Focus group discussion, Sanwer block)

2.15.2 Focus Group Discussion with the mother in Indore Slums

The organization of the community is differing according to the place, ethnicity, and religion. In Indore slums, most of the beneficiaries belonged to the Muslim religion. Focus group discussion was carried out with the mothers at the Anganwadi centre.

An experience shared by pregnant and lactating mothers about antenatal and postnatal care as follows:

All the beneficiaries used the antenatal services provided through the Anganwadi centre especially during VHND. ANM checked the BP and did the weight monitoring along with the antenatal registration. Some instructions were mentioned in Hindi on the MCP card and also ANM were guided for the next visit, then they visit at the right time for availing the services. Whenever ANM feels she checked the Hb of mothers and instruct them for an emergency.

Even ASHA visit their house for TT immunization and antenatal care. During the first delivery, she accompanied by the ASHA and family members was also present during delivery. She received JSY money after institutional delivery.

"Hamari jach hoti he. Madam BP aur wajan leti he.aur card bhi banta he. Mere pass vo card he. Usme hindi me bhi likha he ki kab kab aana he. Aur madam phle se bhi bata deti he tarikh, to hum log aa jate he. Khoon ki jach to kam hoti he ager lega to madam check kar leti hai sui se. aur kahti hai to koi dikkat ho to bata dena dispensary par….."

" ASHA bhi achi se ghar par aa jati hai. Puch leti hai aur tike k liye bhi bol dete hai. Meri phli delivery k samay ASHA aur mere pariwar wale the mere sath. Aur meri pahli delivery normal hai aur Janani surakhaha ke paise bhi mile the govt aspatal me delivary karwane k…''

(Beneficiary, Indore slums, Focus group discussion)

One beneficiary shared her experience about the delivery. She checked for BP and Vital sign. She instructed by the staff for breastfeeding of the child at the interval of 2 hours and consumption of healthy diet during the postnatal period.

"Jab hospital me delivery hui thi to madam ne BP liya tha aur bukhar bhi dekha tha aur bache ko 2-2 ghante se doodh pilane k liye bhi bola tha.aur acha khana khane k liye bola tha…."

(Beneficiary, Indore slums, Focus group discussion)

Some of the beneficiaries faced discrimination and indifferent behavior by the health personnel. Beneficiaries shared that they scold by the staff because they had more than two children. Her pregnancy influence of the family members, but health staff showed indifferent attitudes towards them.

"me gayi thi jach k liye to madam chilla rahi thi. Boli itne itne bache kyo paida kar lete ho. Ab pariwar wale chahte hai to kya kare. Madam acche se baat nahi karti hai. Bahut datti hai ....."

(Beneficiary, Indore slums, Focus group discussion)

Opinion about supplementary nutrition and child feeding practices

Beneficiaries from the Indore slums enjoyed Take home ration. They modified food by adding peas, potatoes and have along with small children. Even the children enjoyed the hot cooked provided at the AWC. They received a variety of hot cooked food at the AWC.

"khichdi,sattu aur halwa mix accha legta hai. Hum ghar par bante he matar, aaloo dalkar ache se bahgar kar. Ghar k chote bache bhi khate hai….baccho ko Anganwadi ka khana pasand hai. Garam garam khana aata he. Khir puri, khichdi, halwa, upma ..."

(Beneficiary, Indore slums, Focus group discussion)

Beneficiaries shared about food pattern of the children. They had a variety of food at their home but the children liked processed food. Children consume food but quantity was small. Children eat at home and they received the hot cooked food from the AWC.

"Ghar me khane k liye to bahut he par hamare bacche to kurkure jayda kahte he aur chips bhi. Khana khate to he par thoda sa hi. Ider udhar ka kuch kuch kha lete hai to pet bhar jata he. Aur yaha se bhi to garam khana mil hi jata he ..."

Facility from the AWC

Beneficiaries shared that there is the lack of sitting facility for their children. Even children did have a facility of the toys and most of the toys were broken. That's the reason children took the food and back to home. AWW taught the children's poem and local payers. They have to do household chores that why they send children to the AWC. Children learn something along with the food at the AWC. Children who were 2-3 years sent to the AWC and elder children sent to the school by the beneficiaries.

"baccho k baithne ki acchi vyavastha nahi hai, dariya fati hui hai aur bacche ko khelne k khilone bhi nahi hai.sab tute tute hai.isliye bacche khana le kar ghar aa jate hai. Madam bhi to kavita sikhati hai aur prayer bhi hoti he. Humko ghar ka kam bhi hota he islye baccho ko bhej dete hai. Bacche kha bhi lete hai aur kuch padh bhi lete hai. Bade bacche ko hum school bhej dete he. 2-3 saal ke baccho ko hi hum bhejte hai…"

(Beneficiary, Indore slums, Focus group discussion)

Referral services

Most of the beneficiaries used the facilities available at the sub-district hospital because it's situated near to their residence. They did not feel the need to call 108 but during an emergency, they need 108 when no one is at home. She went to the hospital by auto during her delivery.

" Praksh chand sethi aspatal to pass me hi hai, nahi to MY bhi pass me hi hai.108 ki to jarurat nahi hoti hai par kabhi koi ghar par na ho to jarurat pad jati he…meri delivery k Samay to mai auto se gai thi…"

(Beneficiary, Indore slums, Focus group discussion)

Affordability and Awareness of the beneficiaries

One beneficiary shared that she checked for antenatal services, but at the end baby changed the position. Dr. said for operation and family members were insisted for the private delivery because govt staff did not check properly and govt institutions did not maintain cleanliness. The child is first priority said by husband that's motivted her for private institution delivery and the same Dr. who was in the hospital did my operation in her private clinic.

"maine madam se jach karwai thi par akhiri mahine me baccha ghum gaya. Madam ne kaha operation hoga. Pariwar wale bhi bole private me delivery karwa lo. Govt. me acche se nahi dekhte hai aur safai bhi nahi rahti hai. Baccha jayada jaurui hai aisa meri saas aur husband bole.isliye maine private me delivery karwai aur yahi madam ka hi to private clinic hai…"

(Beneficiary, Indore slums, Focus group discussion)

One beneficiary said her child was sick once. She brought her to the dispensary and took the fever medicine from pharmacy as the ANM used to come late. She knew about cold sponging care during fever.

"Meri ladki ko bukhar tha ek din.me to use yahi par dispensary par le aai thi. ANM madam thodi der se aate hai to mere ye bahiya se bukhar ki goli ye aai thi….mujhe pata bhi tha to thande pani ki patti bhi rakh di thi…."

(Beneficiary, Indore slums, Focus group discussion)

Immunization

One beneficiary said after the confirmation of pregnancy, she received two doses of TT injections. Her children have also received the immunization. On VHND ANM provided the immunization services, children were weighted by the AWW and ASHA also take care of mothers and accompanied them.

"pregnancy ka pata chalne k baad mujhe TT k do injections lege the. aur mere phle baccho ko bhi sare tike lege he. ANM Mangal Diwas par aati he aur tike legati he….Anganwadi wali madam bhi baccho ka wajan leti he aur khana bhi deti he….ASHA bhi ache se dekte he aur sath me jati he ……"

(Beneficiary, Indore slums, Focus group discussion)

Some beneficiaries shared their decision were affected by the family members and husband's opinions. One beneficiary said that she had a second girl child and did not want to conceive. Even her husband did not earn too much, but her mother in law wants a male child that's why she conceived the third time. She received the JSY money after delivering in the govt hospital.

"Meri dusari bhi ladki he. Me aur bache ab nahi chahti hu. Jayda pasie bhi nahi kamate hai mere husband. par meri sas ko beta chahiye. Isliye ab ye tasari

pregnancy he ….pahle bhi delivery govt. asptal me karwai thi to paise mile the …..aur sab ache se ho gaya tha…"

(Beneficiary, Indore slums, Focus group discussion)

2.16 Summary

Village Health and Nutrition Day is the day for utilizing the services by children, pregnant and lactating mothers. Health personnel's from the Women and Child Health Department and Health and Family Welfare Department were working for providing the services to reach the targeted Millennium goals. Data collected on different aspects like- the presence of health personnel's during VHND in Sanwer and Indore Slums named as the Medical Officer, LHV, ANM, ASHA, AWW, AWH, PRIs/VHSC members, Dai and ICDS supervisors.

Information on instruments, equipment's and furniture and supplies were collected and showed through the tables. Maternal health services like - registration of Pregnant women, antenatal checkups, referral services, counseling on care during pregnancy, birth preparedness, the importance of nutrition, institutional delivery, availability of funds under the JSY, postnatal care and care of newborn information were shown by the use of the tables. Child health services for 0-1 years like- registration, counselling for breastfeeding, immunization, weight monitoring and for 1-3 years like- booster dose of DPT/OPV, Vitamin- A, weight monitoring, supplementary food (grade I & II), referral and counselling services and up to 5 years like tracking and vaccination of missed children, vitamin A supplementation, case management, management of worm infestation and weight monitoring were studied in this chapter. General services named as family planning, RTIs, and STDs, sanitation, communicable disease, gender, AYUSH, health promotion, and nutrition saw in this chapter.

In this chapter, an attempt has been made to evaluate the utilization of services through the ICDS program among the beneficiaries named pregnant and lactating mothers (who has child 0-6 months). Through data collection information gathered on the socio- economic profile like – age, education, religion and caste in Sanwer and Indore slums. Economic profile showed by the use of the table on the type of house, the building of a house, monthly income, and occupation of husbands and beneficiaries.

Houses hold facilities and asset profile of beneficiaries also studied on Sanwer and Indore slums in this chapter. Source of water, toilet facilities, animal holding, fuel used in the house were seen in the beneficiaries in Sanwer and Indore slums.

Services received by pregnant mothers showed through the table. Confirmation of pregnancy, antenatal registration, health personnel's who provided antenatal registration, place of registration, availability of MCP card, providers for antenatal check-up, mobilization of antenatal check-up, place of antenatal check-up, counselling services, whether beneficiaries were following the instructions or not, mobilization for institutional delivery, place of delivery choice and reason behind them all were gauge through services utilized by pregnant mothers.

Data was collected on utilization of services by lactating mothers at transport facility, facility of delivery ward, postnatal diet availability, received postnatal Care /hygiene, vital signs monitored after delivery, neonatal care, postnatal exercise, place of delivery, reason for delivery in the institutions, they were informed about institutional delivery or not, accompanied during delivery by health personnel or not, they received JSY money or not and service providers for postnatal care.

Also, utilizing AWC services and mothers' last visit to AWC, availability of supplementary nutrition and Take Home Ration, whether they shared with the family or not, consume the food all these information were collected. Additionally, utilization of services by children seen like- they registered at the AWC, frequency to go to AWC, they received hot cooked food and consume food on the spot, frequency to get hot food and weight monitoring, growth chart drawn on MCP card or not all were seen in this chapter.

Chapter 3: Interactive actions between Health and WCD department at different level

3.1 Introduction

Data were collected from the Sanwer and Indore blocks from the different levels. At the Institutional level Anganwadi centres (AWCs) and Nutrition Rehabilitation Centres (NRCs), Subcentres (SCs), Primary Health Centres (PHCs), Community Health Centres (CHCs) and Prakash Chand Sethi Hospital were chosen by the use of purposive sampling. At the village level Village Health and Sanitation Committee (CHSC) and Panchayati Raj institutions (PRIs) were selected. At the Block level, Child Development Project Officer (CDPO) and Block Medical Officer (BMO) were selected from each department. District program officer (DPO) and District program manager (DPM) were chosen from each department at the District level. Directorate of Women & Child Development or Director RCH and Directorate of Health Services (DHS) or NRHM Mission Director was chosen for the data collection from the Women and Child Health Department and Health Department. Prior made the meeting with health officials and explained them the purpose of research and objectives. In-depth interview method and Checklist were used for data collection from the different levels as- Institutional level, Village level, Block level, District and State level. Quantitative data were analyzed by the use of SPSS and Qualitative data analysis based on categorization approach called "coding".

Table 3.1 Blueprint of data collection

S. No	Levels of information aggregation	No	Respondents		Methods of data collection	An instrument used
			WCD	Health		
1	At Institutional level	60	-AWC -GAK (40) -NRC (2)	-SC (4) -PHC (2) -CHC (1)	Checklist	Observations
2.	Village level	5	VHSC	PRIs	In-depth Interview	Interview schedule
3	At Block	1	CDPOs	BMO	In-depth	Interview

	level	Each Dept			Interview	schedule
4	At District level	1 Each Dept	DPO	DPM	In-depth Interview	Interview schedule
5	At state level	1 Each Dept	Directorate of Women & Child Development or Director RCH	Directorate of Health Services (DHS) or NRHM Mission Director	In-depth Interview	Interview schedule

3.2 Institutional levels

3.2.1 Gram Aarogya Kendra (GAK)

The Dept. of Public Health and Family Welfare of the Government of Madhya Pradesh implements various elements of the National Rural Health Mission throughout the state of Madhya Pradesh. The innovation brought in has been to promote the conjunction of health and ICDS and also to strengthen community ownership of programs at the village level. This is being tried to be accomplished through the establishment of Anganwadi-cum-Gram Aarogya Kendra (Village Health Centre) in each village. The Department of Health and Family Welfare along with the Department of Women and Child Development started a new initiative under the "Health for all" campaign to supply essential health and nutrition services at the village layer through the formation of "Anganwadi –cum-Gram Aarogya Kendra" in each village **(Madhya Pradesh Technical Assistance and Support Team (MPTAST), n.d.).**

The Sub-centre was visualized as the first contact point between the primary health care system and the community. However, due to some administrative, physical and communication problems, Sub-centres are not able to provide services as per the desired plans, and that is why the idea of GAK was evolved specifically for Madhya Pradesh. Gram Aarogya Kendra (GAK) is the source of health activities, Village related information, and information on the source of drinking water **(Kot, 2012).**

Department of Health and Family Welfare, Madhya Pradesh, upgraded the activities of ASHA workers and other service providers in order to enhance constant surveillance through Gram Aarogya Kendra. **(National Rural Health Mission, Madhya Pradesh, 2013)**. Village Health and Nutrition Day organized at the gram Aarogya Kendra with the aim of reaching out to most areas and every person **(Department of Health and Family welfare Madhya Pradesh and Department for International Development, 2016).**

ANM is the main functionary for the VHND along with ASHA. The day includes ANC checkups, Immunization of children, Health and Nutrition counseling of expectant mothers, distribution of IFA tablets, Tests for hemoglobin, malaria, Urine sugar and Albumin and treatment of minor health problems by the ANM. Organization of Village Health and Nutrition Day, Antenatal and postnatal check-up, Immunization of pregnant mothers and children, check-up for an ill person, blood test, distribution of medicine, meeting of Gram Sabha Swasthya Tadarth Samiti, health training, etc. are the main activities of the Gram Aarogya Kendra **(Madhya Pradesh Technical Assistance and Support Team (MPTAST), n.d.).**

3.2.1.1 Village Health Sanitation and Nutrition Committee

The Village Health Sanitation and Nutrition Committee were known as Village Health and Sanitation Committee under NRHM **(Semwal et al., 2013).** The Committee meeting is organized every month with the ASHA worker and discussion is centred on referral services for severe illnesses, provision of free treatment and availability of medicines etc. (OCA production, 2015). Gram Sabha Swasthya Tadarth Samiti keeps surveillance on- the progress of work, expenditure pattern, monitoring of weight of children and pregnant mothers at AWCs, distribution of supplementary food to pregnant and lactating mothers, registration of pregnant mothers and distribution of Iron and folic acid tablets, conditions of medical implements, cleanliness of centre, dissemination activities etc.

There are 48 Village Health Committees in the Sanwer block of Indore district. 1 The Village Health and Sanitation Committees are entitled to an annual untied fund of Rs.10, 000 **(Ministry of Health and Family Welfare, n.d.).** Village Health and Sanitation Committee and ASHA are responsible for the maintenance of the bank

account. VHSC and ASHA maintain a register on the utilization of funds. This untied fund is used for furniture and instruments at AWCs **(Kot, 2012).** The Village Health Sanitation and Nutrition Committees maintain records on- Total population of the village, the number of households, number of BPL families with their religion, caste, language, list of beneficiaries of water supply and sanitation and provision of nutrition especially for marginalized people **("Guidelines for Village Health", n.d.).**

Untied funds of Rs.10, 000 is available for purchasing instruments/equipment and Medicines/articles such as BP machine, stethoscope, thermometer, foetoscope table and chair, ANC examination table, infant weight machine, a child weighing machine, ORS packets, chloroquine and IFA tablets, etc. Gram Sabha Swasth Gram Tadarth Samiti has control over the use of untied funds. [2]

3.2.1.2 Gram Swasth Prahari Dal

A committee called "Gram Swasth Prahari Dal" is established to ensure successful and easy delivery of services at Gram Aarogya Kendra with the Medical Officer - as convener and - male multipurpose health supervisor, LHV, MPW, ANM as members. The Prahari Dal has the power to visit the villages in its sector for at least eight days every month. Gram Swasthya Prahari Dal (GSPD) plays an important role in the performance of GAK and assists in preparing the village level health plan. In alliance with BMO, the team examines the malnourished children and ensures health services in problem areas **(Madhya Pradesh Technical Assistance and Support Team (MPTAST), n.d.).**

The centres are currently graded according to certain performance indicators such as infrastructure and drugs available and 57 other parameters and are graded into categories A, B & C for implementation & monitoring purposes.

3.2.1.3 Methodology

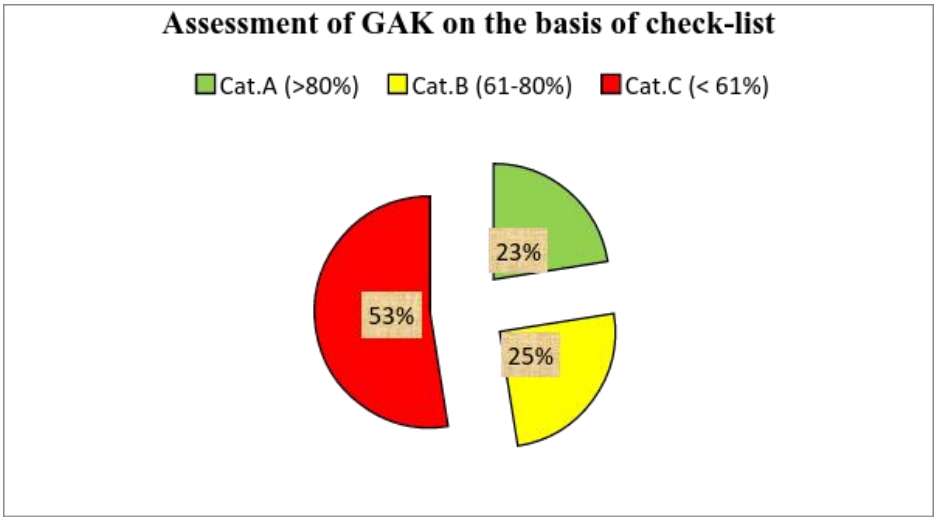
The present study was conducted in Sanwer block of Indore district. Sanwer is block situated 35 km away from the Indore city and lacks basic health amenities. Furthermore,

2http://mpwcdmis.gov.in/DataEntryVHC.aspx

Sanwer block has a majority of the Scheduled Castes population. It has five primary health centres and twenty-five Sub-centres. 40 Gram Aarogya Kendra (GAK) was selected for data collection by using simple random sampling. The GAK Supervision Checklist prepared by- Madhya Pradesh Technical Assistance and Support Team (MPTAST) was adopted for data collection to collect information on services like availability of medicines & consumables, instruments/Furniture availability, infrastructure & basic amenities, details of information displayed at the GAK etc.

3.2.1.4 Findings

Pie Diagram 3.1 Assessment of GAK on the basis of checklist



The pie diagram 3.1 indicates that 22% (9) Gram Arogya Kendra fall into category A, 25% (10) falls into category B and 53% (21) fall into category C.

The status of GAK on Infrastructure and basic amenities showed in percentage. Basic information about the village is available in 68%; Village health plan is available at 58%. The contact information of CMHO, DPM, BMO, CDPO, Janani Express, etc. is 53% available, details of birth, death & registration of marriage available in 85%, details of the self-help group; mothers help committee is available at 60%. Details of mid-day meal scheme group 88%, details and lists of immunization, TB, Leprosy, Diarrhea, Malaria patients available is 83%, information about married & target couples, pregnant women, newborns, under five children, malnourished children, children registered in AWC available 93%, list of temporary methods of family

planning is 85%, details of the information of health services provided by ANM and MPW is 70%, names and service provided by ASHA, AWW and Sahayika are 100%, information about the village health committee available 83% and VHC has details of the information about the funds received from Health department, women and child development department and its expenditure is 78%.(Bar diagram 3.2)

Bar Diagram 3.2 Status of GAK (Infrastructure & Basic amenities in %)

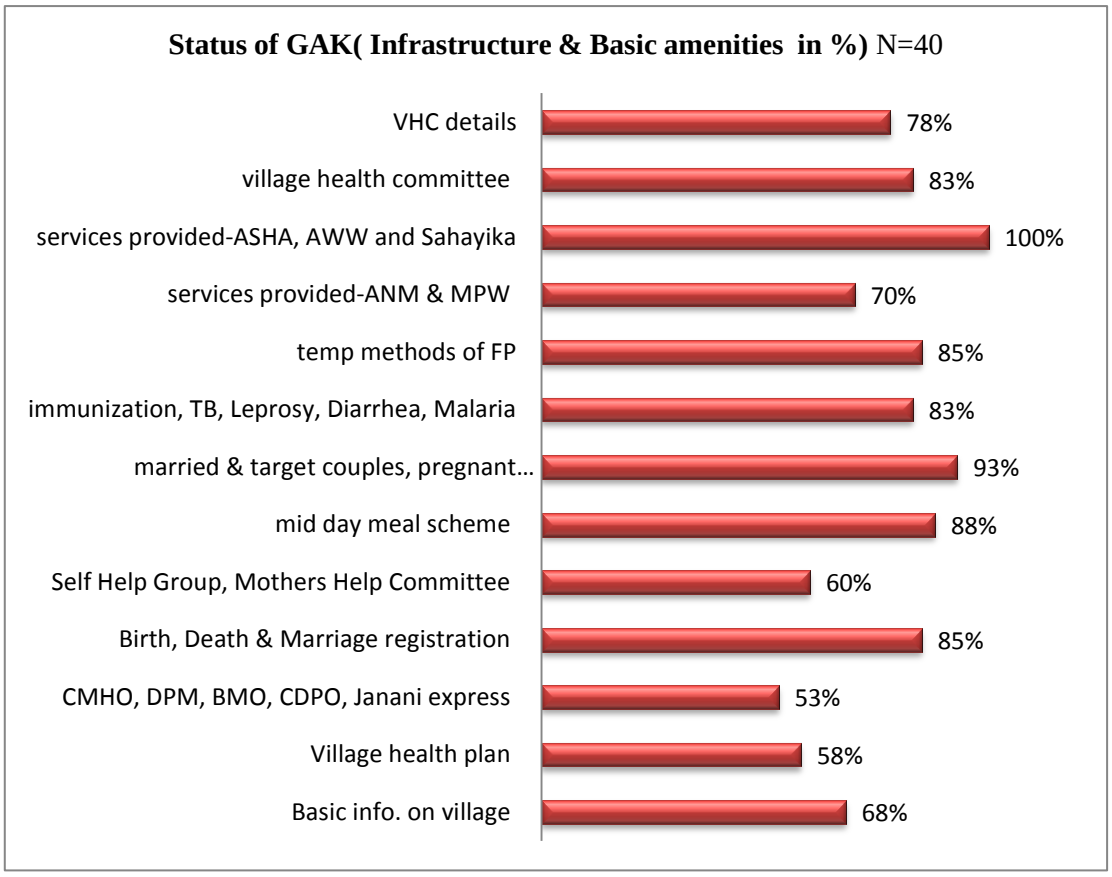


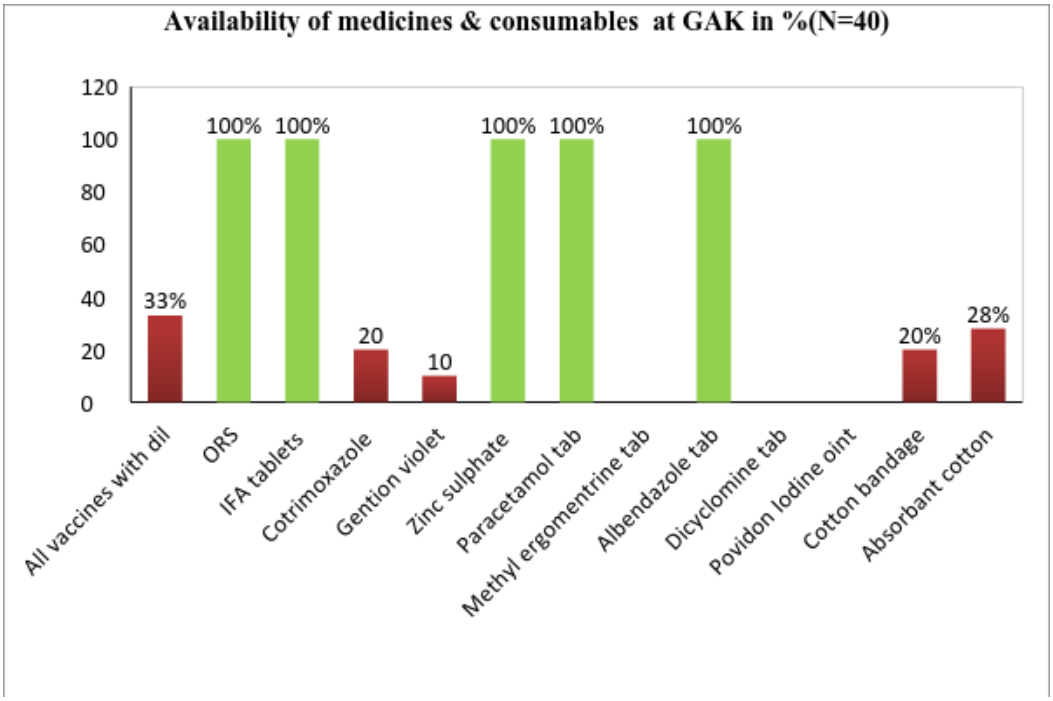
Table 3.2 Status of GAK regarding Instruments/Furniture availability (N=40)

No.	Items	No.	%
1	Chair	35	88
2	Table	34	85
3	Bench	23	58
4	ANC examination table	21	53
5	Stool for ANC table	17	43
6	Weighing machine for baby	30	75
7	Infantometer for newborn	19	48
8	Weight machine for children	29	73
9	Weight machine for adults	38	95
10	Haemoglobinometer	28	70
11	Stethoscope	28	70

12	Curtains	15	74
13	Fetoscope	15	38
14	Spirit lamp	27	68
15	Functional BP instrument	27	68
16	Hub cutter	20	50
17	Thermometer	31	78
18	Test tubes	14	35
19	Slides	25	63
20	Torch	26	65
21	Almirah	13	33
22	Box	8	20
23	Water tank	14	35
24	Glass	20	50

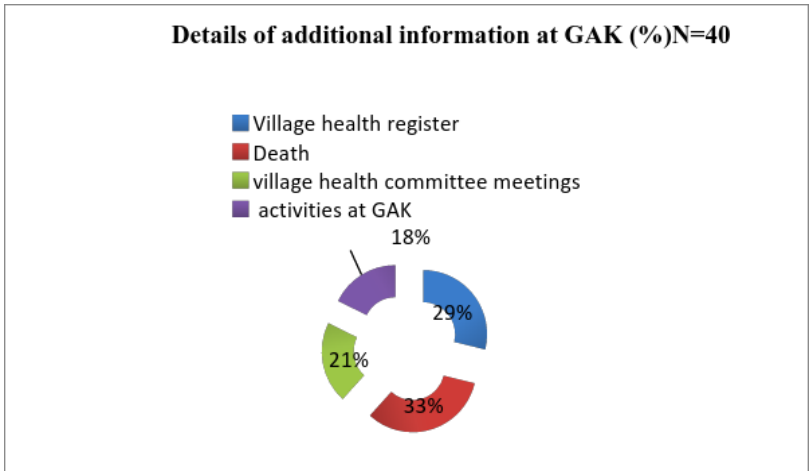
Table 3.2 shows that the status of GAK regarding availability of instruments/furniture. The table contains 23 items under the parameter of availability of instruments/furniture. Availability of chair was 88%, table 85%, bench 58%, ANC examination table 53%, stool for ANC 43%, weighing machine for baby 75%, infantometer for Newborn 48%, weight machine for children 73%, weight machine for adults, 95%, haemoglobinometer 70%, stethoscope 70%, curtains 74%, fetoscope 38%, spirit lamp 68%, functional BP instrument 68%, hub cutter 50%, thermometer 78%, test tubes 35%, slides 63%, torch 65%, Almirah 33%, Box 20%, water tank 35% and, glass 50%.

Bar diagram 3.3 Availability of medicines and consumables at GAK in %



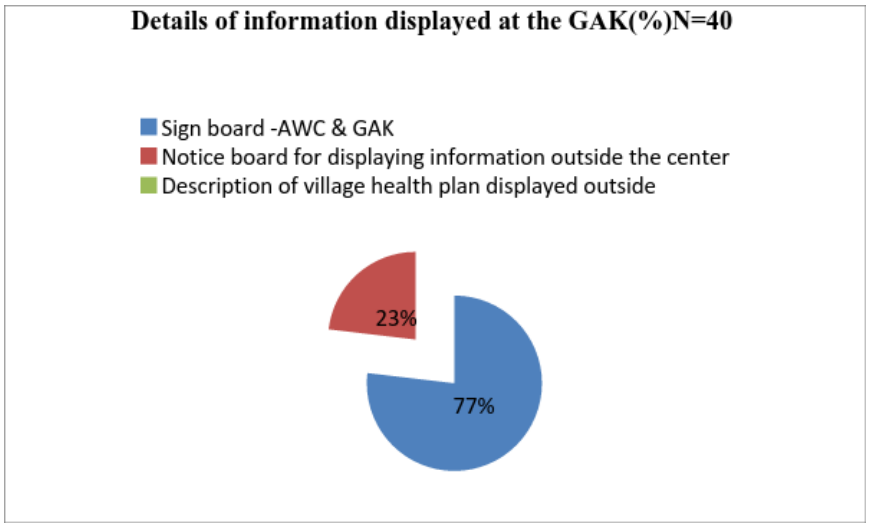
The bar diagram 3.3 shows the availability of medicines and consumables at GAK. Availability of ORS, IFA tablets, Zinc Sulfate, Paracetamol tablet and Albendazole tablets were 100%. All vaccines with the diluent present 33%, Cotrimoxazole 20%, Gentian violet 10%, cotton bandage 20% and absorbent cotton present 28%. Methylergometrine tablet, Dicyclomine tablet, and povidone iodine ointment were totally absent 0%.

Pie diagram 3.4 Details of additional information at GAK (%)



The pie diagram 3.4 shows the details of additional information at GAK. Details on the village health register available 18%, death related information available 33%, Details of village health committee available 20% and register of activity at GAK available 33%.

Pie diagram 3.5 Details of information displayed at the GAK (%)



The pie chart 3.5 shows details of the information at GAK. A sign board for AWC & GAK is available 77%, a notice board for displaying information outside the centre is 23% and description of the village health plan displayed outside is totally absent.

3.2.2 Anganwadi Centre (AWC)

3.2.2.1 Introduction

Anganwadi Centres (AWCs) are the community-based, service-delivery section of the ICDS which provides primary medical care and nutrition services to infants and their mothers in the community **(Yatsu, 2012).** Anganwadi centres run by Anganwadi workers (AWWs). AWC is the focal point for delivering the health service to its beneficiaries under the ICDS program. Anganwadi worker (AWW) manages AWC with the help of Anganwadi helper **(Haider et al., 2014).**

The significance of the word "Anganwadi" in English terminology is "courtyard shelter". Anganwadi word is derived from the Hindi word "Angan" which refers to the courtyard of a home. Angan is a rural Indian term for "a place where people get together to discuss, greet and socialize their matters". AWW is the pillar of the program. Her task is to run the Anganwadi, survey all the families in the neighborhood, enroll eligible children, ensure that food is served on time every day, conduct the pre-school education, activities, organize immunization sessions with the ANM, make home visits to pregnant mothers, etc. **("Role of Anganwadi..", n.d.)** An Anganwadi normally covers a population of 1000 in both rural and urban areas and 700 in tribal areas **(Thakare et al, 2011).**

All children less than 6 years of age, pregnant and lactating mothers are eligible for utilizing the services under the ICDS Scheme. Below Poverty Line (BPL) is not a criterion for registration of beneficiaries under ICDS **(Kular, 2014).**

3.2.2.2 Methodology

The present study was carried out in Sanwer and urban slums of Indore district. Total 105 Anganwadi centres are running under the urban slums. By the use of the

simple random sampling 30, Anganwadi centres were chosen for data collection. So, total 30 AWWs were selected for research study from Indore slums. Likewise, Sanwer form of the 147 villages and has 147 Village Health and Sanitation Committee. Approx. 135 Angawadis running under the Sanwer block. 30 Anganwadi centres were chosen for data collection by use of simple random sampling. So, total 30 AWWs were selected for research study from Sanwer. Total 60 Anganwadi selected for the research work.

Each AWC was visited by the researcher from Monday to Friday. The researcher observed the functioning of the Anganwadi's to assess- Mothers and children visited the AWC, activities at the AWC, supplementary nutrition distribution, physical assets, and the availability of pre- School education kit, types of Supplementary Nutrition and status of malnourished children. A prepared checklist was used for the data collection from the Anganwadi centres. (See Appendix)

The gathered data were recorded and studied by using SPSS and presented through a table in the form of number and percentage.

3.2.2.3 Findings

Collected data were analyzed and explained by the use of tables are given below:

Table 3.3 General Information's and Facilities available at the Anganwadi centres in the Sanwer and Indore Slums

		Anganwadi centres			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
Distance of AWC from residence	200m-500m	23	76.66%	30	100%
	600m-900m	7	23.33%	-	-
	1km-4 km	-	-	-	-
AWC Building	Government	22	73.33%	2	6.66%
	Private	3	10%	-	-
	Rented	5	16.66%	28	93.33%
Indoor space available	Adequate	12	40%	13	43.33%
	Inadequate	18	60%	17	56.66%
Outdoor space available	Adequate	17	56.66%	11	36.66%
	Inadequate	13	43.33%	19	63.33%
Toilet facility	Available	14	46.66%	15	50%
	Not available	16	53.33%	15	50%
Drinking	Hand Pump	21	70%	6	20%

water facilities	Tap water	5	16.66%	24	80%
	Other source	4	13.33%	-	-
Electricity Facility	Yes	19	63.33%	27	90%
	No	11	36.66%	3	10%
Availability of medicine	Yes	18	60%	21	70%
	No	12	40%	9	30%

Data table 3.3 showed that in affiliation with the distance of AWC from residence showed that the maximum number of the AWC (76.66%) situated within the 200m-500m followed by 600-900m (23.33%) in Sanwer. Besides this, all the AWC situated within the range of 200m-500m i.e. 100%. In Sanwer, AWCs were running in govt building (73.33 %), private building (10%) and in rented buildings (16.66%), respectively. In contrast, Maximum number of AWCs was running in a rented building (93.33%) and govt building (6.66%), respectively.

At most of the AWCs, in Sanwer and Indore slums, indoor space was inadequate, i.e. 60% and 56.66%, respectively. Also, some AWCs i.e. 40% and 43.33% had the adequate space in Sanwer and Indore slums, respectively. Adequate outdoor space available at the AWCs from the Sanwer and Indore slums was 56.66% and 36.66%, respectively. Less than half (43.33%) AWCs at the Sanwer and approx. 2/3 AWCs (63.33%) in Indore slums had the inadequate space.

In Sanwer, more than half AWCs did not have the toilet facility and less than half AWCs had the toilet facilities i.e. 53.33% and 46.66%, respectively. In Indore slums, half of the AWCs had toilet facility and had did not have toilet facilities i.e.50 % and 50%. In Sanwer, most of the AWCs took water from the hand pump (70%) followed by Tap water (16.66%) and another source (13.33%), respectively. In Indore slums, 80% of AWCs used tap water and only 20% used the hand pump as a source of drinking water.

Approx. 2/3 (63.33%) of AWCs had the electricity facility and more than1/3 (36.66%) AWCs did not have the electricity facility in the Sanwer, respectively. In Indore, almost all the AWCs had electricity facilities, i.e. 90% and few AWCs i.e. 10% did not have the electricity, respectively. In Sanwer and Indore slums, 60% and 70%, respectively; AWCs had the availability of medicines and 40% and 30%, respectively, in the Sanwer and Indore slums did not have the availability of medicine.

Table 3.4 Physical Assets present at the Anganwadi Centres in the Sanwer and Indore Slums

No	Items	Anganwadi centres			
		Sanwer (n=30)		Indore Slums (n=30)	
		No	%	No.	%
1	Chairs & tables	15	50%	19	63.33%
2	Blackboard	8	26.66%	14	46.66%
3	Durries	13	43.33%	17	56.66%
4	Charts	16	53.33%	20	66.66%
5	Toys	11	36.66%	18	60%
6	First aid box	13	43.33%	21	70%
7	Weighing Machine	19	63.33%	24	80%
8	Files, registers and records	24	80%	29	96.66%
9	Tumblers, plates and spoons	25	83.35%	28	93.33%
10	Two or three vessels with lids for cooking	24	80%	28	93.33%
11	Brooms and other cleaning material.	12	40%	16	53.33%

Data Table 3.4 shows the physical assets present at the Anganwadi centres in the Sanwer and Indore slums. Chairs & tables were (50%), blackboard was (26.66%), Durries were (43.33%), charts were (53.33%), toys were (36.66%), first aid box was (43.33%), weighing machine was (63.33%), files, registers and records were (80%), tumblers, plates and spoons were (83.35%), two or three vessels with lids for cooking ware (80%) and brooms and other cleaning material were (40%), respectively, available at the AWCs of the Sanwer during the visit.

Besides, chairs and tables were (63.33%), blackboard was (46.66%), Durries were (56.66%), charts were (66.666%), toys were (60%), first aid box was (70%), weighing machine was (80%), files, registers and records were (96.66%), tumblers, plates and spoons were (93.33%), two or three vessels with lids for cooking ware (93.33%) and brooms and other cleaning material were (53.33%), respectively, available at the AWCs of the Indore slums during the visit.

Table 3.5 Activities present at the Anganwadi Centres in the Sanwer and Indore Slums

No.	Items	Anganwadi centres			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
1	Indoor activities	22	73.33%	24	80%

2	Outdoor activities	13	43.33%	8	26.66%
3	Storytelling/poem	23	76.66%	27	90%
4	Preschool Education	12	40%	19	63.33%
5	Poem recitals	20	66.66%	21	70%
6	Color and shape recognition	8	26.66%	13	43.33%
7	Group games	16	53.33%	12	40%
8	Nature trails	15	50%	17	56.66%

Various activities present at the Anganwadi centres in the Sanwer and Indore slums were showed by table 3.5. Presence of indoor activities were (73.33%), outdoor activities were (43.33%), the storytelling / poem was (76.66%), pre-school Education was (40%), poem recitals was (66.66%), colour and shape recognition was (26.66%), group games was (53.33%) and nature trails were (50%), respectively, present at the AWCs of the Sanwer. Similarly, presence of indoor activities were (80%), outdoor activities were (26.66%), the storytelling / poem was (90%), pre-school Education was (63.33%), poem recitals was (70%), color and shape recognition was (43.33%), group games was (40%) and nature trails were (56.66%), respectively, present at the AWCs of the Indore slums.

Table 3.6 Pre- School education kit available at Anganwadi Centres in the Sanwer and Indore Slums

No.	**Items**	**Anganwadi centres**			
		Sanwer (n=30)		**Indore Slums (n=30)**	
		No.	**%**	**No**	**%**
1	Flash cards for story telling	19	63.33%	24	80%
2	Building blocks	11	36.66%	14	46.66%
3	Stuff toys and dolls for role play	12	40%	15	50%
4	Matching and seriation cards	19	63.33%	21	70%
5	Dominoes	-	-	-	-
6	Beads and thread	-	-	-	-
7	Wheel toys	13	43.33%	17	56.66%
8	Colors	10	33.33%	16	53.33%
9	Small drum	7	23.33%	11	36.66%

Table 3.6 presents the availability of pre-school education kit at the Anganwadi centres of the Sanwer and Indore slums. Flash cards for storytelling was (63.33%), the building blocks were (36.66%), stuffed toys and dolls for role play were (40%), matching and seriation cards was (63.33%), wheel toys were (43.33%), colors were

(33.33%) and small drum was (23.33%), respectively, available at the Sanwer. Similarly, Flashcards for storytelling was (80%), the building blocks were (46.66%), stuffed toys and dolls for role play were (50%), matching and seriation cards was (70%), wheel toys were (56.66%), colors were (53.33%) and small drum was (36.66%), respectively, available at the Indore slums. Dominoes and beads and thread were totally absent at the AWCs of the Sanwer and Indore slums.

Table 3.7 Availability of registers at the AWC in Sanwer and Indore slums

No.	Items	Anganwadi centres			
		Sanwer (n=30)		Indore Slums(n=30)	
		No.	%	No	%
1	School attendance registers	19	63.33%	20	66.66%
2	Feeding register	27	90%	30	100%
3	Immunization register	30	100%	30	100%
4	Growth monitoring register	28	93.33%	30	100%
5	Antenatal/Post natal	24	80%	29	96.66%
6	Stock register	16	53.33%	19	63.33%
7	Health check-up register	17	56.66%	21	70%
8	Medicine stock register	18	60%	23	76.66%
9	Expenditure register	17	56.66%	22	73.33%
10	Daily Diary	18	60%	24	80%
11	Birth and Death register	30	100%	30	100%
12	Mahila Mandal register	16	53.33%	18	60%
13	Home visits register	20	66.66%	24	80%
14	Beneficiary Attendance register	30	100%	30	100%

The availability of registers at the AWC in Sanwer and Indore slums shows in the table 3.7. Availability of the school attendance register was (63.33%), feeding register was (90%), growth monitoring register was (93.33%), Antenatal/Postnatal register was (80%), stock register was (53.33%), health check-up register (56.66%), medicine stock register was (60%), expenditure register was (56.66%), Daily Diary was (60%), Mahila Mandal register was (53.33%), home visiting register was (66.66%), respectively, available at the Sanwer. Also, Immunization register, birth, and death register and beneficiary attendance register were 100% at the Sanwer.

Similarly, the availability of the school attendance register was (66.66%), Antenatal/Postnatal register was (96.66%), stock register was (63.33%), health check-

up register (70%), medicine stock register was (76.66%), expenditure register was (73.33%), Daily Diary was (80%), Mahila Mandal register was (60%), home visiting register was (80%), respectively, available at the Indore slums. Feeding register, immunization register, growth monitoring register birth and death register and beneficiary attendance register were 100% at the Indore slums.

Table 3.8 Service Delivery at the Anganwadi Counters' in Sanwer and Indore slums

No.	Items	Anganwadi centres			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
1	Availability of growth charts	20	66.66%	26	86.66%
2	Electronic weighing machine	21	70%	27	90%
3	Salter scale/Spring balance	27	90%	29	96.66%
4	MUAC scale	16	53.33%	23	76.66%
5	Regular health check-up of children at AWC	17	56.66%	22	73.33%
6	Immunization of children	30	100%	30	100%
7	Availability of PSE material	19	63.33%	23	76.66%
8	Immunization against tetanus	30	100%	30	100%
9	Early registration of pregnancy at AWC (in first 3 months)	27	90%	29	96.66%
10	IFA tablets given to pregnant women	30	100%	30	100%
11	Weight monitoring of children	19	63.33%	24	80%
12	Availability of supplementary food	30	100%	30	100%

Table 3.8 shows the service delivery at the Anganwadi centres of Sanwer and Indore slums. Various services like - availability of growth charts were (66.66%), electronic weighing machine was (70%), Salter scale/Spring balance was (90%), MUAC scale was (53.33%), regular health check-up of children at AWC was (56.66%), availability of PSE material was (63.33%), early registration of pregnancy (90%) was and weight monitoring of children was (63.33%), respectively, present at the Sanwer.

Similarly, availability of growth charts was (86.66%), electronic weighing machine was (90%), Salter scale/Spring balance was (96.66%), MUAC scale was (76.66%), regular health check-up of children at AWC was (73.33%), availability of PSE material was (76.66%), early registration of pregnancy (96.66%) was and weight monitoring of children was (80%), respectively, present at Indore slums.

Immunization of children, Immunization against tetanus, IFA tablets distribution to pregnant women and availability of supplementary food were 100% at the Sanwer. Also, Immunization of children, Immunization against tetanus, IFA tablets distribution to pregnant women and availability of supplementary food were 100% in Indore slums.

Table 3.9 Beneficiaries Enrolled at the Anganwadi centres in the Sanwer and Indore Slums

		Anganwadi centres			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
Who attained/ Enrolled Beneficiaries	6 months - 3yrs	1416 /1624	87 %	1200/2570	46.69 %
	3yrs - 6 yrs	1055 /1976	53.39 %	1559/3034	51.38 %
Who Attained the AWC Total No Enrolled children		2471 3600	68.63%	2759 5604	49.23%
Who attained / Enrolled beneficiaries	Pregnant women	308 / 350	88 %	299/ 573	52.18 %
	Lactating mothers	333 / 342	97.36 %	281/551	50.99 %
	Adolescent Girls	743/1404	52.92 %	1038/1793	57.89 %

Table 3.9 shows the enrolment of the beneficiaries at the Anganwadi centres of the Sanwer and Indore Slums. In Sanwer, the total number of enrolled beneficiaries under 6 months -3yrs was 1,624 out of which 1,416 (87%) the attained the AWCs. Similarly, 2,570 were the total beneficiaries at the Indore slums out of which 1,200 attained the AWCs i.e. (46.60%).

Beneficiaries under the 3years - 6 years was 1,976; out of which 1,055 were attained the AWCs i.e. 53.39% in Sanwer. Similarly, 3,034 beneficiaries were attending the AWCs in Indore slums; out of which 1,559 i.e. 51.38% were attending the AWCs.

So, total children (6 months to 6 years) who enrolled at the AWCs were 3,600 and 1,055 out of this i.e. 68.63% were attending the AWCs in Sanwer. Similarly, total children (6 months to 6 years) who enrolled at the AWCs in the Indore slums were 5,604 and 2,759 out of this i.e. 49.23% were attending the AWCs in Indore slums. The proportion of attending the AWCs was higher in Sanwer as compared to Indore slums.

The total number of pregnant women enrolled at the AWCs were 350, lactating mothers were 342 and adolescent girls were 1,404 i.e. 88%, 97.36%, and 52.92%, respectively in Sanwer. Similarly, the total number of pregnant women enrolled at the AWCs were 299, lactating mothers were 551 and adolescent girls were 1,793 i.e. 52.18%, 50.99%, and 57.89%, respectively in Indore slums.

Table 3.10 Types of Supplementary Nutrition (SN) given to Beneficiaries at the AWCs in the Sanwer and Indore Slums

Type of SN		Anganwadi centres			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
Hot Cooked Food (HCF)	6 months -3yrs	30	100%	30	100%
	3yrs - 6 yrs	30	100%	30	100%
	Pregnant women	18	60%	21	70%
	Lactating mothers	18	60%	19	63.33%
	Adolescent Girls	15	50%	18	60%
Take home Ration	6 months -3yrs	19	63.33%	20	66.66%
	3yrs - 6 yrs	23	76.66%	23	76.66%
	Pregnant women	28	93.33%	30	100%
	Lactating mothers	28	93.33%	29	96.66%
	Adolescent Girls	24	80%	25	83.33%

Types of Supplementary Nutrition (SN) give to the beneficiaries at the AWCs in the Sanwer and Indore slums show in the table 3.10. All children under the 6 months - 3years and 3years - 6 years received the hot cooked food (HCF) i.e. 100% in Sanwer and Indore slums.

In answer, pregnant women who received the hot cooked food was 60%, lactating mothers were 60% and Adolescent girls who received hot cooked food was the 50%, respectively. Besides, in Indore slums, pregnant women who received food were 70%, lactating mothers are 63.33% and Adolescent girls who received the hot cooked food were 60%, respectively.

Table 3.11 Status of Malnutrition in enrolled children (6 months-5 years) at the Anganwadi centres in the Sanwer and Indore Slums

	Criteria	Anganwadi centres			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
Malnourished Children	Normal (Green)	2198 /2471	88.95 %	2400 / 2759	86.98%
	Moderately Underweight (Yellow)	250/ 2471	10.11 %	311/ 2759	11.27%
	Severely Underweight (Orange)	23/2471	0.93%	48/ 2759	1.73%

Status of malnutrition in enrolled children (6 months-5 years) at the Anganwadi centres in the Sanwer and Indore slums is shown in the table 3.11. Children who attained the AWCs was 2,471 out of which 2,198 (88.95%) were normal children, 250 (10.11%) were moderately underweight and 23 (0.93%) were severely underweight in the Sanwer. Similarly, in Indore slums out of 2,759 children, 2,400 (86.98%) were normal, 311 (11.27%) were moderately underweight and 48 (1.73%) were severely underweight.

3.2.3 Nutrition Rehabilitation Centre (NRC)

3.2.3.1 Introduction

The nutrition and health statistics of Madhya Pradesh (M.P.) have not been inspiring. The infant mortality rate of MP is 67 per 1000 live births, according to the Sample Registration System (SRS) 2009. As per NFHS-3, under 5 mortality rate of MP is 94.3 per 1000 live births, 60% of the children are undernourished and 12.6 % are seriously wasted **(Choudhary, 2014).**

The Nutrition Rehabilitation Centre (NRC) is a part of a health facility where children with Severe Acute Malnutrition (SAM) are admitted and treated according to their needs. Children are admitted according to the set admission criteria and provided with medical and nutritional care. Once released from the NRC, the child goes forward to be in the Nutrition Rehabilitation program till she/he attains the defined discharge criteria for the program **(Ministry of Health and Family Welfare, 2011).**

3.2.3.2 Human resource

1. Doctor -1
2. Female feeding demonstrator -1
3. Nurses -2 (10 bedded NRC)/ Nurses- 3 (20 bedded NRC)
4. Cook -1 (10 bedded NRC)/ Cook- 2 (20 bedded NRC)
5. Caretaker -2 (10 bedded NRC) / Caretaker - 3 (20 bedded NRC) [1]

3.2.3.3 Admission Criteria

A. Children 6-59 months

Apply any of the following formats:

1. MUAC < 115mm or 11.5 cm with or without any form of edema
2. WFH < -3 SD with or without any form of edema
3. Bilateral pitting edema +/++ (children with oedema +++ always need inpatient care)

Along with the following complications: (Anorexia, fever, Persistent vomiting, Severe dehydration, very weak, unconscious, convulsions, Hypoglycemia, Severe Anemia, Severe pneumonia etc.)

B. Infants < 6 months

Infant is too weak or independently of his/her weight-for-length / weight-for-length < -3SD / Visible severe wasting in infants <45cm / Presence of edema both feet

3.2.3.4 Diets used in Nutrition Rehabilitation

Therapeutic diet regime follows in NRC based on phase I and II.

A. Therapeutic diet for phase I

1. From the morning 7 a.m. to every 2-hour interval (12 times) provide the F-75 therapeutic diet to the children.
2. An increase 10 ml every day in the F-75 diet.

1 nrcmis.mp.gov.in

3. After increasing diet, if there is no case of vomiting or diarrhea than every day interval of 3 hours (8 times) provide the F-75.
4. Children who have severe edema (+++) prepare a diet plan according to 100 ml/ kg/day. [1]

Transition phase

1. When a child is back to his/ her natural hunger, then slowly changes F-75 therapeutic diet to F-100 therapeutic diet.
2. In a transition phase gives 8 feed/ 3 hrs. Interval of F-100 therapeutic diet.
3. Encourage mother for breastfeeding to the child between F-100 diets when a child is able to take breastfeed.

B. Therapeutic diet for phase II

1. On the third day of transition phase when the child is able to take 75% intervals of 3 hrs. Then phase two therapeutic diets should go.
2. A child under the phase –two, gives F-100 therapeutic diet from 7 am to 10 pm along with three diets of special feed made in NRC.
3. Fresh drinking water provides to the children after food.
4. Diet for the severe malnourish child specially daliya without salt/ Kichadi should include available vegetables like- spinach, carrot, bottle gourd, tomatoes, peas, beans, cauliflower, potatoes and so on

Whole therapeutic diet at the NRC prepares under the supervision of a nutritional counselor/trainer. The caretaker is responsible for the evening and night diet.

3.2.3.5 Criteria for discharge from NRC

1. A 15 % increase in weight compared to weight at the time of confirmation
2. No swelling in the legs of a child for 10 days
3. Without complications

Afterward, along the discharge confirm the four follow-ups at the interval of 15 days. During the follow-up, doctors confirm necessary check-up of the malnourish child.

3.2.3.6 Methodology

Two NRC was selected for the study. One belonged from Sanwer CHC and another from the Cha-Cha Nehru hospital in urban slums. Data were collected on different topics related to admission, discharge, and duration of stay, facility, and staff available at the NRC with the use of the checklist. Data were examined with the use of the micro soft word and demonstrate in the form of numbers and percentages.

3.2.3.6 Findings

Data were compiled from the two NRCs, one was from Sanwer block running under Community Health Centre and another belonged to Indore slums, Cha- Cha Nehru Hospitals. The checklist was used in the different topic like – human resource, general info about the NRC, Ward and kitchen equipment, medicine Supply and facilities available at the NRC. Information is present by the use of tables and given below:

Table 3.12 General Information about the NRC in Sanwer and Indore Slums (2015-2016)

	NRC			
	Sanwer (CHC)		**Indore Slums (Cha-cha Nehru)**	
	No.	**%**	**No.**	**%**
Admission	1,191		1,929	
Recovered	921	77.32 %	1578	81%
Defaulter / Lama	100	8.39 %	124	6.42%
Medical transfer	57	4.7 %	70	3.6%
Non responder	112	9.4 %	156	8.08%
Death	1	0.08%	1	0.05%
Gender				
Male	564	47.35%	937	48.57%
Female	627	52.64%	992	51.42%
Age wise distribution				
<6months	12	1%	21	1.08%
6-23 months (2yrs)	784	65.82%	1321	68.48%
>24 months	395	33.16%	587	30.43%
Caste				
SC	483	40.55%	558	28.92%
ST	316	26.53%	641	33.22%
OBC	340	28.54%	443	22.96%
General	52	4.36%	287	14.87%
Medical Complication wise				

Fever	318	26.70%	611	31.67
Pneumonia	121	10.15%	223	11.56
Dehydration	112	9.4%	165	8.55
Lethargy	196	16.45%	272	14.10
Severe anemia	121	10.15%	187	9.69
Vitamin A deficiency	283	23.76%	449	23.27
Persistent vomiting	22	1.84%	33	1.71
Anorexia	45	3.77%	44	2.28
Any other	32	2.68%	33	1.71
Referred by				
AWW	769	64.56%	1211	62.77
ASHA / USHA	137	11.5%	267	13.84
Doctors (OPD)	232	19.47%	384	20
RBSK team	19	1.59%	28	1.45
Self	71	5.96%	39	2.02

General information about NRC in Sanwer and Indore Slums is presented in Table 3.12 showed that according to the population total no of admission in Sanwer NRC was 1,191 and in Cha –Cha Nehru NRC (Indore slums) was 1,929 during the year 2015-2016. Out of 1,191 admitted children total 921 children were recovered, i.e. 77.32% in Sanwer NRC and In Cha-cha Nehru NRC, out of 1,929 admitted children 1,578 children were recovered i.e. 81 %.

Total 100 children came under the list of defaulter i.e.8.39 % in Sanwer NRC and 124 children came into the defaulter/lama list i.e. 6.42%. Total 57 medical transfers happened from the Sanwer NRC to the district hospital NRC and 70 medical transfers from Cha-cha Nehru NRC to the district hospital NRC i.e. 4.7% and 3.6%, respectively. The proportion of medical transfer was high in Sanwer NRC as compared to Cha-cha Nehru NRC. The total number of non-responder in Sanwer NRC and Cha-cha Nehru NRC was 112 (9.4%) and 156 (8.08%) respectively. Only one death found in the Sanwer and Cha –cha Nehru NRC i.e. (0.08%) and (0.05%) respectively.

In affiliation with gender total, 564 (47.35%) were male and 647 (52.64%) were female in Sanwer NRC during 2015-2016. Similarly, total 937 (48.57%) were male and 992 (51.42%) were female in Cha-cha Nehru NRC during 2015-2016. In both the NRCs the proportion of female children was higher in comparison to the male child.

In age wise distribution 12 (1%) children from Sanwer NRC and 21 (1.08%) children from Cha-cha Nehru NRC came into the category <6 months. 784 (65.82%)

and 1,321 (68.48%) children from Sanwer NRC and Cha-cha Nehru NRC, respectively; came under the category 6-23 months i.e.2 years. 395 (33.16%) and 587 (30.43%) children belonged to the category >24 months from Sanwer NRC and Cha-cha Nehru NRC respectively.

The maximum percentage of children were from scheduled caste (40.55%) followed by a scheduled tribe (26.53%), OBC (28.54%) and general (4.36%) respectively in Sanwer NRC. Similarly, the Maximum percentage of children were from the scheduled tribe (33.22%) followed by scheduled caste (28.92%), OBC (22.96%) and general (14.87%) respectively in Cha-cha Nehru NRC.

Data on the affiliation of medical Complication wise category showed that total, fever cases were 26.70%, pneumonia 10.15%, dehydration 9.4%, lethargy 16.45%, severe anemia10.15%, vitamin A deficiency 23.76%, persistent vomiting 1.84%, anorexia 3.77% and any other 2.68% respectively in Sanwer NRC. Similarly, data showed that total, fever cases were 31.67%, pneumonia 11.56%, dehydration 8.55%, lethargy 14.10%, severe anemia 9.69%, vitamin A deficiency 23.27%, persistent vomiting 1.71%, anorexia 2.28% and any other 1.71% respectively in Cha-cha Nehru NRC.

The maximum number of cases referred by AWW in Sanwer NRC and Cha-cha Nehru NRC i.e.64.56 % and 62.77% respectively. Referred cases by doctors were 19.47%, by ASHA 11.5%, by self-5.96% and By Rashtriya Bal Swasthya Karyakram (RBSK) team was 1.59% in respectively in Sanwer NRC. Also, referred cases by doctors were 20%, by USHA 13.84%, by self-2.02% and By Rashtriya Bal Swasthya Karyakram (RBSK) team was 1.45% in respectively in Cha-cha Nehru NRC.

Table 3.13 Human Resources at the NRC in Sanwer CHC and Cha-cha Nehru Hospital

S no	Staff	Sanwer	Indore Slums
1	Medical officer (Pediatrician)	Present	Present
2	Nursing staff	Present	Present
3	Nutrition counselor	Present	Present
4.	Cook cum caretaker	Present	Present
5	Cleaner	Present	Present

Data from the table 3.13 presents that the human resource at the NRC in Sanwer and Indore slums. All the required staffs were in position in Sanwer and Cha-cha Nehru NRC i.e. Medical Officer (Pediatrician), nursing staff, nutrition counselor, cook cum caretaker, and cleaner.

Table3.14 Essential ward equipment at NRC in Sanwer CHC and Cha-cha Nehru Hospital

S no	Items	Sanwer	Indore Slums
1	Glucometer one	Present	Present
2	Thermometers two	Present	Present
3	Weighing scales three	Present	Present
4	Infantometer one	Present	Present
5	Stadiometer one	Present	Present
6	Resuscitation equipment	Present	Present
7	Suction equipment (low pressure)	Present	Present

Data table 3.14 showed the presence of essential ward equipment at NRC in Sanwer and Indore Slums. All the essential ward equipment like glucometer-one, thermometers - two, weighing scales-three, infantometer-one, stadiometer-one, resuscitation equipment and suction equipment (low pressure) presented during the visit at Sanwer NRC and Cha-cha Nehru NRC.

Table 3.15 Other wards equipment at the NRC in Sanwer and Cha-cha Nehru Hospital

S no	Items	Sanwer	Indore Slums
1	I/V stand	Present	Present
2	Room heaters	Present	Present
3	IEC – Audio/visual materials	Present	Present
4	Toys	Present	Present
5	Clock	Present	Present
6	Calculator	Present	Present
7	Refrigerator	Present	Present

The other ward equipment at the NRC in sanwer and Cha-cha Nehru hospital like -I/V stand, room heaters, IEC – Audio/visual materials, toys, clock, calculator, and refrigerator were all present during the visit to the NRCs (Table 3.15)

Table 3.16 Kitchen equipment at the NRC in Sanwer and Cha-cha Nehru Hospital

S no	Items	Sanwer	Indore Slums
1	Cooking gas	Present	Present

2	Dietary scale	Present	Present
3	Measuring jars	Present	Present
4	Water filter	Present	Present
5	Refrigerator	Present	Present
Utensils			
6	Large container	Present	Present
7	Cooking utensils	Present	Present
8	Feeding cup	Present	Present
9	Spoon	Present	Present
10	Glasses	Present	Present
11	Plates	Present	Present
12	Jars	Present	Present

Data table 3.16 showed the availability of kitchen equipment at the NRC in Sanwer and Indore Slums. Kitchen equipment like cooking gas, dietary scale, measuring jars, water filter and refrigerator all were present in Sanwer NRC and Cha-cha Nehru NRC. Also, utensils like- large container, cooking utensils, feeding cup, spoon, and glasses were present at the Sanwer NRC and Cha-cha Nehru NRC during the visit.

Table 3.17 Medicine Supply at the NRC in Sanwer and Cha-cha Nehru Hospital

S no	Items	Sanwer	Urban Slums
Antibiotics			
1	Ampicillin/Amoxycillin/Benzyl penicillin	Present	Present
2	Chloamphenicol	Present	Present
3	Cotrimoxazole	Present	Present
4	Gentamycin	Present	Present
5	Metronidazole	Present	Present
6	Tetracycline or Chloramphenicol eye drops	Present	Present
7	Atropine eye drops	Present	Present
General Medicines			
8	ORS Packets	Present	Present
9	Potassium chloride	Present	Present
10	Magnesium chloride/sulfate	Present	Present
11	Iron syrup	Present	Present
12	Multivitamin tablets	Present	Present
13	Folic acid tablets	Present	Present
14	Vitamin A syrup	Present	Present
15	Zinc Sulfate or dispersible Zinc tablets	Present	Present
16	Glucose (or sucrose)	Present	Present

17	I/V Fluids Ringer's lactate solution with 5% glucose Normal saline	Present	Present

Data table 3.17 presents the medicine supply at the NRC in Sanwer and Indore Slums. All the antibiotics were available at the Sanwer NRC and Cha-cha Nehru NRC i.e. Ampicillin / Amoxycillin / Benzylpenicillin, chloramphenicol, cotrimoxazole, gentamicin, metronidazole, tetracycline or chloramphenicol eye drops and atropine eye drops. Also general medicine like -ORS packets, potassium chloride, magnesium chloride/sulfate, Iron syrup, multi-vitamin tablets, folic acid tablets, vitamin A syrup, zinc sulfate or dispersible zinc tablets, glucose (or sucrose), I/V Fluids, ringer's lactate solution with 5% glucose and normal saline were available at the Sanwer NRC and Cha-cha Nehru NRC during the visit.

Table 3.18 Facilities available at the NRC in Sanwer and Cha-cha Nehru Hospital

S no		Sanwer	Indore Slums
Hand Washing			
1	Hand washing facility	Present	Present
2	Hand washing Practice among staff	Present	Present
3	Hand washing before feeding	Present	Present
Mother's Hygiene			
4	Bathing facility	Present	Present
5	Hand washing before feeding	Present	Present
General Cleanliness			
6	Daily bed sheet change	Absent	Present
7	Hot-water facility	Absent	Present
8	Floor Cleaning	Present	Present
9	Toilets Cleaning	Present	Present
10	Dishes Cleaning	Present	Present
Feeding			
11	Food served at the right time	Present	Present
12	Children's encouraged to eat	Present	Present
13	Recording of left Over	Present	Present
Weighing			
15	Weighing scale functioning	Present	Present
16	Scale set up to to zero	Present	Present
17	Weighting without clothes	Present	Present
18	Read correctly	Present	Present
19	Correctly plotted	Present	Present
Antibiotics			
20	Antibiotics at a prescribed time	Present	Present
21	Folic acid	Present	Present
22	Multivitamin	Present	Present

23	Iron tablet	Present	Present
24	Vitamin A	Present	Present
Physical facility			
25	24 hours uninterrupted power supplies	Present	Present
26	24 hour water supply	Present	Present
27	Proper light and ventilation	Absent	Present
28	Window with the mosquito screen	Present	Present

Data table 3.18 showed the facilities available at the NRC in Sanwer and Cha-cha Nehru NRC. Hand washing facility, hand washing practice among staff and washing before feeding, was present in Sanwer NRC and Cha-cha Nehru NRC. In relation to mother's hygiene, bathing facility and hand washing before feeding among mothers in both the NRC were present. In affiliation with general cleanliness, daily bed sheet changed hot-water facility, floor cleaning; toilets, cleaning and dishes cleaning were present in the Cha-cha Nehru NRC. Daily bed sheet change and hot-water facility were absent in the Sanwer NRC another facility like floor cleaning, toilets, cleaning and dishes cleaning were present in the Sanwer NRC.

As seen in the table during the weighting the child-staff members set scale set up to zero, weighed without clothes, read correctly and correctly plotted in the card in Sanwer and Cha-Cha Nehru NRC. Antibiotics, folic acid, multivitamin, Iron and vitamin-A tablets was given on time in both the NRCs i.e. Sanwer and Cha-cha Nehru NRC, respectively. Also, physical facilities like 24 hours uninterrupted power supply, 24-hour water supply, ventilation and window with the mosquito screen were present at the Sanwer NRC and Cha-cha Nehru NRC. Only proper light and ventilation facility was lacking at the Sanwer NRC.

To explore more the utilization of services at NRC in Sanwer and Indore Slums one case study was performed with the mothers in each NRC.

Case study from the Sanwer NRC

The first case study took from the Sanwer NRC. One child whose name was Rahul Kumar and his mother's name was Mrs. Mamta Prakash admitted at the Sanwer NRC. He was 2 ½ years old and had grade III malnutrition and stayed with the aunt. She shared her experience about the services available at the NRC.

She lived with her nephew at the Sanwer NRC. They received food on time. They got to know that his nephew weight was less by the AWW then they came to the Sanwer NRC. She stayed with him because of the child's mother have to take care of other children at home. They received dal, roti, and sweets and children received milk, rice, power supplement. NRC staff sent all the children at home because of the two days holiday. At present child's weight increased, but it will not remain same because his mother is not taking care of him. We will leave from here, but we have to come for follow up. They are given timely medicine, but other small children deny to take medicine and food also. For 2 hour interval, they provide food for the children.

"Me apne bhatie k sath yaha rahti hu. NRC achi hai. Yaha khane ko milta he time se. Rahul ka wajan kam tha, Anganwadi se pata chala tha. Uske baad hum usko lekar yaha aaye.. .. Me ruki hu uske sath yaha kiyoki ghar par aur bhi bacche he, unko kon dekhega, isliye me yahu hu Rahul k sath….. yaha hari sabji, dal, roti, khir milti he jo sath me rahta he aur bache ko doodh, bhuna channa, chawel, aur power milta he khae ko….. hum 10 din se yaha hai abhi bich me 2 din ki chute thi to sab baccho ko ghar bhej diya tha, hum bhi chale gaye the …..abhi kuch wajan bada he uska, par ghar jayga to phir khana nahi khayga, iski ma dyan hi nhai deti he…..kuch dino me hum ghar jayge aur shayd phir checkup k liye aana padega… yaha dawa bhi samay par dete he …. Par dusare bacche jo aur chote he dawa pite nahi he…. Kabhi kabhi to kahna bhi nahi kahte…. Har do ghate me khane ko dete he bacche ko ….kabhi kabhi bache kahete nahi he.."

Case study from Cha-cha Nehru NRC

Another case study took from the Cha-cha Nehru NRC. One girl child whose name was Rubi stayed with her mother's name was Mrs. Razia Bee admitted at the Cha-cha Nehru NRC. She was 1 years old and had grade III malnutrition. She shared her experience about the services available at the Cha-cha Nehru NRC.

A mother shared that she stayed at the NRC for five days because her child weight was less. She consults with the doctors. Her child did not want to eat. At the NRC, she got the food along with the water and bed facility. She did not stay longer because of the other work at the home. They provide timely medicine along with food at the interval to the children. Even mothers get the timely food, including local food. The NRC staff insist for the breastfeeding. Her child used to take breast milk more apart from food. During the holidays NRC opens and the proper light facility also available. She wished to increase in weight of her child.

"Me yaha 5 din se hu meri bacchii ka sath. Iska wajan kam tha , doctor ko bhi dikhaya tha. Ya kuch kahtai hi nahi hai…yaha khane ko milta he sari suvidha he pani, sone ki vawastha bi achi he …. Hum yaha jayda nahi ruk sakte he ghar bhi dekhna hota he, ghar k kam bhi hote he ….. dawa samay par dete he … aur thodi thodi der baad ya kuch ghate k baad bacche ko kahne ko milta he … bado ko bhi milta he sabji roti, doodh, dal chawel, aur power bhi dete he…… aur bacche ko doodh pilane ko bhi bolte he ….. meri beti kahati kam se aur mera doodh jayda piti hai….. chutti wale din bhi yaha koi na koi rahta he …. aur light bhi rahti he….. bas jaldi se iska wajan bad jaye to hum ghar jaye".

3.2.4 Sub- Centre

A Sub-health Centre (Sub-Centre) is the subsidiary and first contact point between the primary health care system and the community. A Sub-Centre provides linkage to the community at the grass-root level and provides all the primary health care services. Sub Centre provides some important packages of services such as immunization, antenatal, natal and postnatal care, prevention of malnutrition and common childhood diseases, family planning services and counseling. They also provide basic drugs for minor ailments such as ARI, diarrhea, fever, worm infestation, etc. Besides the above, the government implements several national health and family welfare programs, which are delivered through these Frontline workers **(Ministry of Health & Family Welfare, 2007)** Sub-centre covers the 5,000 populations in plain areas and for every 3,000 population in hilly/tribal areas. [2]

3.2.4.1 Functions of Sub- Centre

1. Sub centres Provides basic medical services to the community. Every Sub-Centre is equipped with medical kits containing common medicines for minor ailments.
2. Sub-centres provides maternal and child health services like Immunization, health education etc.
3. Sub-Centre provides family planning and welfare services like contraception, maintaining eligible couple registers
4. Sub centres Provides diarrhea control services like ORS, well chlorination etc.

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2 http://www.health.mp.gov.in/institution/insti/establishment-rural.htm

5.Sub-centres help in building up an Interpersonal communication in order to bring about behavioral changes in the community.[3]

3.2.4.2 Methodology

Sanwer block has one Community Health Centre and five Primary Health Centres and 26 Sub-centres. Out of 26, ten Sub-centes was selected by the use of purposive sampling. Each sub-Centre was visited by the researcher from Monday to Friday. The researcher observed facilities available in the sub-centres, human resource, Infrastructure and facilities, availability of furniture by the use of the checklist. (See Appendix)

The gathered data were recorded and studied by using SPSS and presented through a table in the form of number and percentage.

3.2.4.3 Findings

Findings about the sub-centres was explained through the use of the data table in the human resource, aviablity of services, equipment and furniture etc.

Table 3.19 Human Resources at Sub-centres

S no	Human Resource	N=10
1	Health worker Female – 2 (essential)	Filled
2	Health worker male – 1 (essential)	Filled
3	Staff nurse/ANM-1 (For type B-SC/If no of deliveries is more than 20)	Filled
4.	Contractual safai worker – 1	Filled

Table 3.19 shows the availability of human resource at the sub- centres. Health worker Female -2, health worker male-1, staff nurse/ANM-1 and contractual safe worker-1all these posts were filled at the all the sub-centres.

http://beingthedoctor.com/sub-centre-of-healthcare/

Table 3.20 Infrastructure and medical facilities available at the Sub-centres

S no	Items		N=10	
Building			No	%
1	Govt Building	Present	10	100%
2	Boundary wall	Present	7	70%
		Absent	3	30%
3	Clinic Room	Present	10	100%
4	Labour room		10	100%
5	Deliveries being conducted		10	100%
Facilities in Labour room				
6	A labour table with Mattress, pillow		10	100%
7	Mackintosh Sheet		10	100%
8	Suction machine	Present	7	70%
		Absent	3	30%
9	Facility for Oxygen administration		10	100%
10	Sterilization equipment		10	100%
11	24-hour running water		10	100%
12	Electricity supply with back-up facility (generator)		10	100%
13	Attached toilet facilities		10	100%
Newborn Corner				
14	Resuscitation		10	100%
15	Provision of warmth		10	100%
16	Weighing machine		10	100%
Emergency drugs				
17	Injection Oxytocin		10	100%
18	Injection Magnesium sulfate	Present	3	30%
		Absent	7	70%
19	Injection Methyl Ergometrine maleate	Present	1	10%
		Absent	9	90%
20	Examination room		10	100%
21	Drinking water facility		10	100%
22	Regular electricity facility		10	100%
23	Waste disposal system		10	100%
24	Communication facility		10	100%
25	Transport facility	Present	6	60%
		Absent	4	40%
26	Nearest Public Health Facility	Present	5	50%
		Absent	5	50%
Residential facility				
27	Available		5	50%
28	Not available		5	50%

Infrastructure and medical facilities available at the Sub-centres is shown in the table 3.20. All the sub-centres were running in govt building, i.e. 100%. 70% of sub-

centres had the boundary wall and 30% were without boundary wall. All the sub-centres had the clinic room and labor room in the building i.e. 100%.

In affiliation with facilities in the labour, room showed that all sub-centres had the labour table with mattress, pillow and Mackintosh sheet, the facility for oxygen administration, sterilization equipment, 24-hour running water, electricity supply with the backup facility (generator) and attached toilet facilities i.e. 100%. Besides, few sub-centres lack suction machine (30%) and more than half sub-centres had the suction machine (70%), respectively. All the sub-centres had the newborn corner with the facility of resuscitation, provision of warmth and weighing machine i.e. 100%.

Emergency drugs like- Injection Oxytocin was present in all sub-centres. At few sub-centres Injection Magnesium sulfate was available, i.e. 30% and InjectioMethyl Ergometrine maleate was almost absent at all the all sub-centres i.e. 70%. All the sub-centres had the facilities of the examination room, drinking water facility, regular electricity facility, waste disposal system and communication facility i.e. 100%. Few sub-centres were lacking the transport facilities i.e.40 % and more than half had the transport facilities i.e. 60%, respectively. Half-half sub-centres had the closest public health facility, i.e. 50% and 50%, respectively. 50% sub-centres had the residential facilities and 50% did not have any residential facilities.

Table 3.21 Furniture available at the Sub-centres

		Sub-centres	
		Sanwer (n=10)	
		Present/ Absent	No (%)
1	Examining Table 1	Present	10 (100%)
2	Writing table 3	Present	10 (100%)
3	Armless chairs 5	Present	10 (100%)
4	Medicine Chest 1	Present	10 (100%)
5	Labour table 1	Present	10 (100%)
6	Screen 1	Present	10 (100%)
7	Foot step 1	Present	10 (100%)
8	Bedside table 1	Present	10 (100%)
9	Stool 2	Present	10 (100%)
10	Almirahs 1	Present	10 (100%)
11	Lamp 3	Present	10 (100%)
12	Side Wooden racks 2	Present	10 (100%)
13	Fans 3	Present	10 (100%)
14	Tube light 3	Present	10 (100%)

15	Basin stand1	Present	10 (100%)

Table 3.21 showed the required furniture available at the Sub-centres. All the sub-centres had the one examination table, three writing tables, five armless chairs, one medicine chest, one labor table, one screen, one footstep, one bedside table, two stools, one almirah, three lamps and two side wooden racks and fans i.e. 100%.

Table 3.22 Services available at the Sub- centres (SCs)

		Sub-centres		
		Sanwer (n=10)		
		Present / Absent	No	%
1	Antenatal care	Present	10	100%
2	Intra-natal care	Present	10	100%
3	Postnatal care	Present	10	100%
4	Child Health	Present	10	100%
5	Family Planning and Contraception	Present	10	100%
6	Counselling and appropriate referral	Present	8	80%
		Absent	2	20%
7	Assistance to school health services	Present	5	50%
		Absent	5	50%
8	Disease surveillance	Present	10	100%
9	Curative Services	Present	10	100%
10	Training, CoordinationandMonitoring	Present	9	90%
		Absent	1	10%
11	Record of Vital Events	Present	10	100%
12	National Health Programs	Present	10	100%
13	Record maintenance and Reporting	Present	10	100%

All the sub-centres had the facilities of antenatal care, intra-natal care, postnatal care, child health, family Planning and Contraception, disease surveillance, curative services, the record of vital events, national health programs and record maintenance and reporting i.e. 100%. Half of the sub-centres, assisted in the school health services i.e. 50% and Training, Coordination and monitoring services were available i.e.90 %. (Table 3.22)

3.2.5 Primary Health Centre

In 1946, the Bhore Committee gave the concept of a PHC as a basic health unit to provide an integrated curative and preventive health care to the rural population with importance on preventive and promotive aspects of health care. The 6th Five year Plan (1983-88) proposed the reorganization of PHCs on the base of one PHC for every 30,000 rural population in the plains and one PHC for every 20,000 population in hilly, tribal and desert areas for more efficient reporting. PHCs should provide round the clock services with the provision of 24 × 7 nursing facilities **(Ministry of Health & Family Welfare, 2011).**

The aim of the National Rural Health Mission is to provide quality of the services like preventive, promotive, curative and rehabilitative care through the strengthening of the PHC. One PHC is serving the population of 30,000 in rural plain areas and 20,000 in tribal-hilly areas. The NRHM developed the standards to improve the quality of the care at PHCs, is called Indian Public Health Standard (IPHS) **(Indian Public Health Standards cited in Ninama et al., 2014)**

3.2.5.1 Services Provided by PHC

1. Prevention and control of endemic disease
2. Collection of vital events
3. Health education and behavior change
4. Referral services
5. Training Basic laboratory services
6. Medical care 24 * 7
7. Maternal and child care services
8. MTP facility
9. Management of RTI and STI
10. Promotion of safe drinking and basic sanitation

3.2.5.2 Methodology

Sanwer block has one Community Health Centre and five Primary Health Centres and 26 Subcentres. All the Primary health centres were selected for the study. Each Primary health centre was visited by the researcher from Monday to Friday. The

researcher observed facilities available at the primary health centres like - human resource, Infrastructure and facilities, availability of furniture and facilities available at the PHCs by the use of the checklist. (See Appendix)

The gathered data were recorded and studied by using SPSS and presented through a table in the form of number and percentage.

3.2.5.3 Findings

Table 3.23 Human resource at the Primary Health Centres (PHCs)

S no	Staff	Type A	Type B
		Status	Status
1	Medical officer MBBS – one	Filled	Filled
2	Medical officer AYUSH – one	Filled	Filled
3	Data entry operator –one	Filled	Filled
4	Pharmacist –one	Filled	Filled
5	Pharmacist –AYUSH- one	Filled	Filled
6	Nurse midwife (staff nurse) - three	Filled	Filled
7	Health worker female –one	Filled	Filled
8	Health assistant male -one	Filled	Filled
9	Health assistant female/lady health visitor –one	Filled	Filled
10	Health educator –one	Filled	Filled
11	Lab technician –one	Filled	Filled
12	Cold Chain & Vaccine Logistic Assistant- one	Filled	Filled
13	Multi skilled Group D worker- one	Filled	Filled
14	Sanitary worker cum watchman – one	Filled	Filled
	Total – 16		

Table 3.23 presents the human resource at the Primary Health Centres (PHCs). All the posts were in position at the all primary health centres (type A and type B) as followed: Medical Officer MBBS-one, medical officer AYUSH-one, data entry operator-one, pharmacist-one, pharmacist-AYUSH- one, nurse midwife (staff nurse)-three, health worker female-one, health assistant male-one, health assistant female/lady health visitor-one, health educator-one, lab technician-one, cold chain and vaccine logistic assistant- one, multi-skilled group D worker- one and sanitary worker cum watchman-one.

Table 3.24 Infrastructure facility presents at the Primary Health Centres (PHCs)

			PHCs		
			Sanwer (n=5)		
			Present /Absent	No	%
1	PHC building	Own	Present	5	100%
2	Boundary wall		Present	3	60%
			Absent	2	40%
3	Clinic room		Present	5	100%
4	Labour room		Present	5	100%
5	Delivery conducted		Present	5	100%
Labour room facilities					
6	Labour table with Mattress, pillow		Present	5	100%
7	Mackintosh Sheet		Present	5	100%
8	Suction machine		Present	5	100%
9	Facility for Oxygen administration		Present	5	100%
10	Sterilization equipment		Present	5	100%
11	24-hour running water		Present	5	100%
12	Electricity supply with back-up facility (generator)		Present	5	100%
13	Attached toilet facilities		Present	5	100%
Newborn Corner					
14	Resuscitation •		Present	5	100%
15	Provision of warmth		Present	5	100%
16	Weighing machine		Present	5	100%
Emergency drugs					
17	Injection Oxytocin		Present	5	100%
18	Injection Magnesium sulfate		Present	5	100%
19	Injection Methyl ergometrine maleate		Present	5	100%
20	Examination room		Present	5	100%
21	Regularly drinking water facility		Present	5	100%
22	Regular electricity facility		Present	5	100%
23	Proper waste disposal system		Present	5	100%
24	Communication facility		Present	5	100%
25	PHC has transport facility		Present	5	100%
26	Residential facility		Present	3	60%
			Absent	2	40%

The entire primary health centres were running in own building, i.e. 100%. 60% of primary health centres had the boundary wall. Also, all the primary health centres had the clinic room, labor room facilities and delivery was being conducted at all primary health centres. Labour tables with mattress, pillow, Mackintosh sheet, suction machine, the facility for oxygen administration, sterilization equipment, 24-hour running water, electricity supply with the backup facility (generator), attached toilet

facilities; all these labour room facilities were available at the all primary health centres i.e. 100%. (Table 3.24)

All the emergency drugs named as Injection Oxytocin, Injection Magnesium sulfate, and Inj. Methylergometrine maleate was available at the all primary health centres, i.e. 100%. Also, examination room, regular drinking water facility, regular electricity facility, proper waste disposal system, communication facility and transport facility were available at all the primary health centres i.e. 100%. More than half i.e. 60% of the primary health centres had the residential facility and less than half i.e. 40% primary health centres lacked the residential facility. (Table 3.24)

Table 3.25 Services available at the Primary Health Centres (PHCs)

		PHCs		
		Sanwer (n=5)		
		Present / Absent	No	%
1	Rabies vaccine	Present	1	20%
		Absent	4	80%
2	Malaria	Present	5	100%
3	Tuberculosis	Present	5	100%
4	Leprosy	Present	5	100%
5	AYUSH	Present	5	100%
6	Free of cost	Present	5	100%
Curative services				
7	Primary management of wound	Present	5	100%
8	Minor surgeries	Present	1	20%
		Absent	4	80%
9	Primary management of burn	Present	5	100%
Reproductive and child health services				
10	Antenatal clinics organized	Present	5	100%
11	Facility for gynecological examination	Present	5	100%
12	Treatment of gynecological disorders	Present	5	100%
13	Facility for family planning methods	Present	5	100%
14	MTP free of cost	Present	2	40%
		Absent	3	60%
15	low birth-weight babies	Present	5	100%
16	Pneumonia	Present	5	100%
17	Management of diarrhea, dysentery and fever	Present	5	100%
Laboratory services				
18	Blood examination facility	Present	5	100%
19	Malaria parasite	Present	5	100%

20	Sputum examination	Present	2	40%
		Absent	3	60%
21	Urine examination	Present	5	100%

Table 3.25 presents the services available at the primary health centres. Malaria medicine, tuberculosis and leprosy treatment, AYUSH all these facilities were present at all the primary health centres i.e. 100%. Rabies vaccine was available only at one primary health centre, i.e. 20% and remaining primary health centres were lacking Rabies vaccine i.e. 80%, respectively. Primary management of wounds and primary management of burn, all these curative services were available at the all primary health centres i.e. 100%. Only one primary health centre had the facilities of minor surgeries, i.e. 20% and remaining primary health centre were lacking this facility i.e. 80%, respectively.

Reproductive and child health services named as- organization of antenatal clinics, the facility for gynecological examination, treatment for gynecological disorders, facility for family planning methods, management of low-birth-weight babies, pneumonia, and management of diarrhea, dysentery, and fever; all were available at the all primary health centres i.e.100%. Besides, 40% of primary health centres had the medical termination of pregnancy (MTP) facility and 60% primary health centres were lacking the MTP facility.

Laboratory services like- blood examination, detection of the malaria parasite and urine examination were available at the all primary health centres i.e. 100%. Only 40% PHCs had the sputum examination facility and 60% PHCs were lacking sputum examination facility.

Table 3.26 Equipment, furniture and diagnostic kits available at the Primary Health Centres

S no	Items	Availability		
			No	%
1	Normal delivery kit	Present	5	100%
2	Equipment for assisted vacuum delivery	Present	5	100%
3	Equipment for new natal & newborn care	Present	5	100%
4	IUCD insertion kit	Present	5	100%
5	Refrigerator	Present	5	100%
6	ILR(small) with voltage stabilizer	Present	5	100%
7	Vaccine carriers with 4 ice packs	Present	5	100%

8	Spare ice pack boxes - 8	Present	5	100%
9	Computer including net	Present	5	100%
10	Radiant warmer for new born	Present	5	100%
11	An adult weighing scale	Present	5	100%
12	Baby weighing scale	Present	5	100%
13	Height measuring scale	Present	5	100%
14	Phototherapy unit	Present	5	100%
15	Self inflating beg and mask neonatal	Present	5	100%
16	Mucus extractor	Present	5	100%
17	Feeding tube for baby	Present	5	100%
18	Suction machine	Present	5	100%
19	Delivery table	Present	5	100%
20	Sterilization of equipment	Present	5	100%
21	24 hours running water	Present	5	100%
22	24 hour electricity	Present	5	100%
23	Attached toilet	Present	5	100%
24	Torch	Present	5	100%
25	Ambu (ventilatory) bag and face masks	Present	5	100%
26	Towels to wipe dry and cover the baby	Present	5	100%
27	A source of warmth for the baby (bulb/baby warmer)	Present	5	100%
28	Baby weighing scale	Present	5	100%
29	Dressing drums	Present	5	100%
30	Hemoglobinometer –sahli	Present	5	100%
31	BP apparatus	Present	5	100%
32	Basin stands	Present	5	100%
33	Bed Sheet	Present	5	100%
34	Macintosh Sheet	Present	5	100%
35	IV stands	Present	5	100%
36	AD syringes	Present	5	100%
37	IFA	Present	5	100%
38	TT shots	Present	5	100%
39	Stethoscope	Present	5	100%
40	Fetoscope	Present	5	100%
41	Hub and needle destroyer	Present	4	80%
		Absent	1	20%
42	Oxygen administration equipments	Present	5	100%
43	Kelly’s haemostat forceps	Present	5	100%
44	Cusco’s Speculum	Present	5	100%
45	Sims Speculum	Present	5	100%
46	Cheatles forceps	Present	5	100%
47	Tooth forceps	Present	5	100%
48	Plain forceps	Present	5	100%
49	Kidney tray	Present	5	100%

50	Vial opener	Present	3	60%
		Absent	2	40%
51	Vaccine carrier	Present	5	100%
Common drugs				
52	Ibuprofen	Present	5	100%
53	Paracetamol	Present	5	100%
54	Ampicillin	Present	5	100%
55	Benzylpenicillin	Present	5	100%
56	Cephalexin	Present	-	-
		Absent	5	100%
57	Gentamicin	Present	5	100%
58	Mebendazole	Present	5	100%
59	Vitamin A	Present	5	100%
Laboratory facilities				
60	Reagent of cyan meth for Hb	Present	5	100%
61	Utistix – for urine albumin	Present	5	100%
62	-ABO & Rh	Present	5	100%
63	Gram stain	Present	5	100%
64	RPR test syphilis kits	Present	4	80%
		Absent	1	20%
65	Swab and swab sticks	Present	5	100%

Table 3.26 presents the availability of equipment, furniture and diagnostic kits at the primary health centres. Normal delivery kit, equipment for assisted vacuum delivery, equipment for new natal and newborn care, IUCD insertion kit, refrigerator, ILR(small) with voltage stabilizer, vaccine carriers with 4 ice packs, spare ice pack boxes – 8, computer including net, radiant warmer for newborn, adult weighing scale, baby weighing scale, height measuring scale, phototherapy unit, self-inflating bag and mask neonatal, mucus extractor, feeding tube for baby, suction machine, delivery table, sterilization of equipment, 24 hours running water, 24 hours electricity, attached toilet, torch, ambu (ventilatory) bag and face masks, towels to wipe dry and cover the baby, source of warmth for the baby (bulb/baby warmer), baby weighing scale, dressing drum, hemoglobinometer –sahli, B.P. Apparatus, basin stand, bed sheet, Macintosh sheet, IVstand, AD syringes, IFA, TT shots, stethoscope, foetoscope, oxygen administration equipment, kelly hemostat forceps, Cusco's speculum, Sims speculum, tooth forceps, cheatle forceps, plain forceps, kidney tray, vaccine carrier all these equipments were available at all the primary health centres i.e. 100%. One primary health centre was lacking hub and needle destroyer facility, i.e. 20% and 40% PHCs were lacking Vial opener, respectively.

Common drugs named Ibuprofen, paracetamol, ampicillin, benzylpenicillin, gentamicin, mebendazole and Vit A; all these medicines were available at the primary health centres i.e. 100% expect the cephalexin. The reagent of cyan meth for Hb, Utistix – for urine albumin, ABO & Rh., gram stains, swab and swab sticks all these facilities were available at the primary health centres. 80% of PHCs had the RPR test syphilis kits facility expect one PHC was lacking these facilities i.e. 20%, respectively.

Table 3.27 Consumable at the Primary Health Centres

S no	Items	Present/Absent	No (%)
1	Disposable gloves	Present	100%
2	Mucus extractor	Present	100%
3	Foley's catheter (Adult)	Present	100%
4.	Dipsticks for urine test for protein and sugar	Present	100%
5	Specimen collection bottles	Present	100%
6	Black Disposal bags	Present	100%
7	Red Disposal bags	Present	100%

Table 3.27 presents the availability of consumable at the Primary Health Centres. All the consumable were present at all the PHCs named as disposable gloves, mucus extractor, Foley's catheter (Adult), dipsticks for a urine test for protein and sugar, specimen collection bottles, black disposal bags and red disposal bags i.e. 100%.

3.2.6 Community Health Centre

Health care delivery in India has been expected at three levels namely primary, secondary and third. The secondary level of health care unit includes Community Health Centres (CHCs), composing the First Referral Units (FRUs) and the Sub-district and District Hospitals. CHC is a 30-bedded hospital and provides specialist care in Medicine, Obstetrics and Gynaecology, Surgery, Paediatrics, Dental and AYUSH **(Ministry of Health & Family Welfare, 2012).**

3.2.6.1 Functions of CHC

The delivery of primary health care is the main function of the Community health centres. Services offered by the community health centre are as follows:

1. Free community counseling and support services are available
2. Community health promotion activities

3. Medical and nursing services
4. Dental health
5. Allied health, including audiology, dietetics, exercise physiology, occupational therapy etc.

Other services may include:

1. Aged care services
2. Alcohol and drug programs
3. Career respite
4. Maternal and child health services
5. Mental health programs
6. Disability services
7. Outreach services
8. Problem gambling programs
9. Rehabilitation programs
10. Support for self-help [5]

(5 https://www.betterhealth.vic.gov.au/health/healthyliving/community-health-centre)

3.2.6.2 Methodology

Sanwer community health centre was selected for the research study to know the availability of services for the beneficiaries in the Sanwer. Researcher visits the CHC and collected all the information needed for the research study.

3.2.6.3 Findings

Table 3.28 Human resource at the Community Health Centre (CHC)

S no	Staff	In position
1	Block medical officer /medical superintendent – one	Filled
2	Public health specialist – one	Filled
3	Public health nurse -one	Filled
Specialty services		
4	General surgeon – one	Filled
5	General duty medical officer – two	Filled
6	Medical officer AYUSH – one	Filled
Nurse and paramedical		

7	Staff nurse – one	Filled
8	Pharmacist –one	Filled
9	Pharmacist –AYUSH- one	Filled
10	Lab technician –two	Filled
11	Radiographer – one	Filled
12	Dietician-one	Filled
13	Ophthalmic assistant -one	Filled
14	Dental assistant -one	Filled
15	Cold Chain & Vaccine Logistic Assistant- one	Filled
16	OT technician - one	Filled
17	Multi rehabilitation worker – one	Filled
18	Counselor -one	Filled
Administrative staff		
19	Registration clerk – two	Filled
20	Statistical assistant /data entry -two	Filled
21	Account assistant -one	Filled
22	Administrative assistant -one	Filled
Group D staff		
23	Dresser –one	Filled
24	Ward boy/nursing orderly – five	Filled
25	Driver – one	Filled
	Total - 33	Filled

Table 3.28 presents the human resource at the Community health centre (CHC). All the post block medical officer /medical superintendent – one, public health specialist-one, public health nurse-one, general surgeon-one, general duty medical officer-two, medical officer AYUSH-one, Staff nurse-one, pharmacist-one, pharmacist-AYUSH- one, lab technician -two, radiographer- one, dietician-one, ophthalmic assistant -one, dental assistant-one, Cold Chain and Vaccine Logistic Assistant- one, OT technician- one, multi rehabilitation worker-one and counselor-one was filled at the CHCs.

Table 3.29 Availability of Services and Infrastructure at the Community Health Centre (CHC)

S no	Services	Present / Absent
1	The population covered	2,37,139
Availability of specialist services		
2	Medicine	Present
3	Surgery	Present
4	OBG	Present
5	Paediatrics	Present
6	National health program services (NHPs)	Present
7	Emergency services	Present

8	Laboratory	Present
9	Blood storage services	Present
Infrastructure		
10	Area of building	Present
11	OPD rooms	Present
12	Waiting room for patients	Present
13	No of bed –male	Present
14	No of beds –female	Present
15	Operation theatre	Present
16	Labour room	Present
17	Laboratory	Present
18	X ray room	Present
19	Blood storage	Present
20	Pharmacy	Present
21	Water supply	Present
22	Electricity	Present
23	Garden	Present
24	Transport facility	Present

Table 3.29 presents the availability of services and infrastructure at the Community health centre (CHC). Total population covered by the community health centre was 2, 37,139. Availability of specialist services named as Medicine, Surgery, OBG, pediatrics, national health program services (NHPs), emergency services, laboratory and blood storage services all were present at the CHCs. Area of the building, OPD rooms, waiting room for patients, No of bed for male and female, operation theatre, labour room, laboratory, X- ray room, blood storage, pharmacy, water supply, electricity, garden, and transport facility; all these infrastructure facilities were available at the CHCs.

3.2.7 Prakash Chand Sethi Hospital

Sub-district (Sub-divisional) hospitals are below the district and above the block level (CHC) hospitals. These hospitals act as First Referral Units for the Tehsil/Taluk/Block population in which they are geographically situated. In big districts, the sub-district hospitals occupy the gap between the block level hospitals and the district hospitals **(Ministry of Health & Family Welfare, 2011).** Prakash Chand Sethi Hospital is a sub-district hospital situated 1 kilometers away from the urban slums (which choose for the research study).

3.2.7.1 Functions of the Sub-district hospital

The Sub-district hospital has the following functions:

1. It provides effective, affordable health care services (curative including specialist services, preventive and promotive) for a defined population.
2. It covers both urban population and the rural population of the subdivision.
3. Function as a referral centre for the public health institutions below the Tehsil/Taluka level, such as Community Health Centres, Primary Health Centres, and Sub-centres.
4. Provide education and training for primary health care staff.

3.2.7.2 Findings

Table 3.30 Human resource at the Prakash Chand Sethi Hospital

S no	Staff	In position
1	Hospital Superintendent-1	Filled
2	Medicine Specialist-1	Filled
3	Surgery Specialist-1	Filled
5	O&G specialist-1	Filled
6	Paediatrician-1	Filled
7	Anaesthetist (Regular/trained)-1	Filled
8	ENT Surgeon-1	Filled
9	Opthalmologist-1	Filled
10	Radiologist-1	Filled
11	Casualty Doctors/General Duty Doctors-3	Filled
12	Orthopedician-1	Filled
13	Public Health Manager-1	Filled
14	Forensic Expert-1	Filled
15	Pathologist with DCP/MD (Micro) /MD (Path) /MD (Biochemistry) -1	Filled
16	Psychiatrist-1	Filled
17	Dermatologist/Venereologist-1	Filled
18	Dental Surgeon-1	Filled
Nurse and paramedical		
19	Staff nurse – 18	Filled
20	General Duty Attendant/hospital workers -6	Filled
21	Ophthalmic Assistant/Refractionist-1	Filled
22	ECG Technician-1	Filled
23	Audiometrician-1	Filled
24	Laboratory Technician (Lab + Blood storage) -3	Filled
25	Laboratory Attendant (Hospital Worker)-1	Filled

26	Radiographer-1	Filled
27	Pharmacist -3	Filled
28	Dietician-1	Filled
29	Dental Assistant/Dental Technician/ Dental Hygienist-1	Filled
30	Physiotherapist/occupational therapist/ rehabilitation therapist-1	Filled
31	Multi Rehabilitation worker-1	Filled
32	Statistical Assistant-1	Filled
33	Medical Records Officer/Technician-1	Filled
34	Electrician-1	Filled
35	Plumber-1	Filled
36	Cold Chain & Vaccine Logistics Assistant-1	Filled
Administrative staff		
37	Junior Administrative Officer/Office Superintendent	Filled
38	Accountant -two	Filled
39	Computer Operator-4	Filled
40	Driver-1	Filled
41	Peon-1	Filled
42	Security Staff-1	Filled

As seen in the table 3.30, all the post at the Prakash Chand Sethi hospital named as- hospital Superintendent-1, medicine Specialist-1, surgery Specialist-1, O&G specialist-1, pediatrician-1, anesthetist (Regular/trained) -1, ENT Surgeon-1, ophthalmologist-1 and radiologist-1, casualty doctors/general duty doctors-3, orthopedician-1, public health manager-1, forensic expert-1, pathologist-1, psychiatrist-1, dermatologist/venereologist-1, dental surgeon-1 were filled. Another post for nurse and paramedical named as- staff nurse – 18, general duty attendant/hospital workers -6, ophthalmic assistant/refractionist-1, ECG Technician-1, audiometrician-1, laboratory technician -3, laboratory attendant -1, radiographer-1, pharmacist -3, dietician-1, dental Assistant-1, physiotherapist/occupational therapist/ rehabilitation therapist-1, multi rehabilitation worker-1, statistical assistant-1, medical records officer/technician-1, electrician-1, plumber-1 and cold chain and vaccine logistics assistant-1 were filled. Another, administrative staff junior administrative officer/office Superintendent, Accountant –two, computer operator-4, driver-1, peon-1and security staff-1; all the posts were filled at the Prakash Chand Sethi hospital.

Table 3.31 Availability of Services at the Sub-district hospital

S no	**Obstetrics & Gynaecology**	Availability
1	Bleeding during the first trimester	Present
2	Bleeding during the second trimester	Present
3	Bleeding during third trimester	Present
4	Normal Delivery	Present
5	Abnormal labour	Present
6	PPH	Present
7	Puerperal Sepsis	Present
8	Ectopic Pregnancy	Present
9	Hypertensive disorders	Present
10	Septic abortion	Present
11	Medical disorders complicating pregnancy	Present
12	Bronchial asthma	Present
Gynecology		
13	RTI/STI	Present
14	Dysfunctional Uterine Bleeding (DUB)	Present
15	Benign disorders	Present
16	Breast tumors	Present
17	Cancer Cervix screening	Present
18	Cancer cervix/ovarian	Present
19	Infertility	Present
20	Prevention of MTCT	Present
21	MTP/MVA services	Present
22	Tubectomy	Present
Paediatrics		
23	ARI/Bronchitis Asthmatic	Present
24	Diarrheal Diseases	Present
25	Protein Energy Malnutrition and Vitamin Deficiencies	Present
26	Pyrexia of unknown origin	Present
27	Bleeding Disorders	Present
28	Diseases of Bones and Joints	Present
29	Childhood Malignancies	Present
30	Liver Disorders	Present
31	Pediatric Surgical Emergencies	Present
32	Poisoning, Sting, Bites	Present
Neonatology		
33	Attention at birth (to prevent illness)	Present
34	Hypothermia	Present
35	Birth asphyxia	Present
36	Hypoglycemia	Present
37	Convulsions (seizures)	Present
38	Meconium aspiration syndrome	Present
39	Low Birth Weight (LBW)	Present
40	Pre-term	Present
41	Neonatal diarrhea	Present
42	Blood disorders	Present

Table 3.29 presents the availability of services at the sub-district hospital. Treatment for bleeding during the first trimester, bleeding during the second trimester, bleeding during the third trimester were available, facility for normal delivery, abnormal labour, PPH, puerperal sepsis, Ectopic Pregnancy, treatment for hypertensive disorders, septic abortion, medical disorders complicating pregnancy and bronchial asthma, all these obstetrics and gynecology services were available at the sub-district hospital. Another, gynecology services named as: RTI/STI, dysfunctional uterine bleeding (DUB), benign disorders, breast tumors, cancer cervix screening, cancer cervix/ovaries, infertility, prevention of Mother to child transmission (MTCT), medical termination of pregnancy (MTP) services and tubectomy services, were also present in the sub-district hospital.

Pediatric services like - Acute respiratory infection (ARI/bronchitis, asthma), diarrheal diseases, protein energy malnutrition and vitamin deficiencies, pyrexia of unknown origin, bleeding disorders, diseases of bones and joints, childhood malignancies, liver disorders, pediatric surgical emergencies, poisoning, sting, bites were available for the children. Attention at birth (to prevent illness), hypothermia, birth asphyxia, hypoglycemia, convulsions (seizures), meconium aspiration syndrome, low birth weight (LBW), preterm, neonatal diarrhea and blood disorders all neonatal services were in the sub-district hospitals.

3.3 Village Level

3.3.1 Village Health Sanitation and Nutrition Committee

One of the central components of the National Rural Health Mission is the Village Health, Sanitation, and Nutrition Committee (VHSNC). The committee act as a sub-committee of the Gram Panchayat. It admits the minimum 15 members. An ASHA worker from the village shall be the member secretary and convener of the committee. **(Ministry of Health and family welfare, 2013)**

3.3.1.1 Roles and Responsibilities of VHSC

Roles and responsibilities of the VHSNC are as follows:

1. They are creating awareness about nutritional topics.

2. They too carry out the survey on nutritional status and nutritional deficiencies in the village, especially among women and children.
3. They help in identifying locally available foodstuffs of high nutrient value and make aware the community people about those foodstuffs and their uses.
4. VHSNC members' inclusion of Nutritional needs in the Village Health Plan.
5. The committee does the in-depth analysis of the causes of malnutrition at the villagers and household levels, by involving the ANM, AWW, ASHA and ICDS Supervisors.
6. Monitoring and Supervision of Village Health and Nutrition Day to ensure that it is organized every month in the village with the dynamic participation of the members of the village.
7. Provide facility for early detection of malnourished children in the community; and referred them to the nearest Nutritional Rehabilitation Centre (NRC) as well as follow-up for sustained outcome.
8. Supervise the functioning of Anganwadi Centre (AWC) and facilitate its working on improving the nutritional status of women and children.
9. Act as a Grievances Redressal forum on health and nutrition issues **(Ministry of Health and family welfare, 2013)**

3.3.1.2 Structure of the Village Health Nutrition and Sanitation Committee (VHNSC)

Village Health Nutrition and Sanitation committee formed at the level of the revenue village. The Village Health and Sanitation Committee consist of:

1. Gram Panchayat members of the village.
2. ASHA, AWW, ANM
3. SHG leader, village representative of the community-based organization working in the village, user group representative.

3.3.1.3 Methodology

Five Village Health Nutrition and Sanitation were selected for the data collection. Prior permission was taken from them and fixed the meeting with the VHSNC members according to their convenience. Explained about the study and the

purpose behind the collection of information. In-depth interview was taken to explore the situations at the village level. Data gathered and after analysis divided them into categories. The collected information is given below:

3.3.1.4 Findings

The collected data were divided into different themes are as follows:

1. Awareness among the village people.

According to the VHSNC members, the villagers were not educated. A maximum number of community people were busy in earning of daily bread. Even females were going along with the family members for earning either in field/working in private companies. Pregnant mothers and lactating mothers who were left at the home busy in the household works. Women are coming only for seeking ante-natal care, required medicines, and immunization of children. Those who had the low economic status prefer to seek JSY benefits because they can't afford.

"yaha k log pade likhe nahi he, roj kam par jate he. Mahlaye bhi parivar k sath jati he. Grabhvati aur dhatri mahilaye ghar par rahti he baccho k sath. Mahilaye apni jach karwane, dawai aur bacho k tike k liye yaha aati he. Jo garib ghar se he vo log sansathgat prasav karwate hai."

2. Nutritional status of children.

Children' status was also not good in the village. Children's health got affected because mothers were going to work and those who in the home they are not educated and not very much concern about the child' health. When the child gets very ill, then they got them to the health centre. Even they were not properly fed in the house. Children came at the Anganwadi centres, but the amount of food was not sufficient for all the children, sometimes. Children did not uphold their personal hygiene and got sick easily. Due to improper food intake and hygiene, they got sick easily.

"Baccho ki halat thik nahi he gaon me. Jo mahilyae ghar par he vo padi likhi nahi hai aur baccho par dyan bhi nahi deti he isliye baccho ki taboyat kharab hoti he. Ager bache bimar hote he to clinic par le jate he. Ghar me baccho ko ache se khilat

nahi hai. Nganwadi par jo khana milta hai vo pura nahi hota he, bacche ache se khate nahi hai aur safai bhi nahi rakhte he isliye bimar padte hai."

3. Village health and Nutrition Day

Pregnant and lactating mother received the services from the Anganwadi. ANM was coming on the VHND day immunized them and gave the Iron, folic acids and offer the necessary suggestion. Children are also immunized at the Anganwadi centres on VHND day. Anganwadi workers took the weight of the children's and referred the malnourished children to the NRC. ASHA workers were also helped in assisting the ANM and provide the necessary guidance to the mothers. We were visiting the VHND sites. All the health personnel's were imparting their own responsibility. We received suggestions from them and according to our capability and situations, we solve the problems.

"Anganwadi se mahilaye sauvidha leti hai, mangel diwas par ANM aati he, dawai aur kuch baate batati hai. AWW wajan leti hai aur kuposhit baccho ko NRC bhej deati hai. ASHA, kam madat kar deti hai. Hum jati hai mangel diwas par, sab apna-apna kam karte hai,hamari kabliyat k anusar hum madat karte hai."

4. Village health plan

ASHA workers shared the issues with us and on the basis of the information, we tried to solve the problem. Some people in the village very stubborn they don't want to hear anyone. In our village, one lady had the 7 children and currently, she is pregnant. They didn't have to eat, but yet they were not utilizing the services available at the Anganwadi centres and didn't desire to accept the family planning services. Hence, sometimes our activities got affected by the behavior of community people.

"ASHA apni problem batati hai hum use dur karte hai. Gaon k kuch log to sunte hi nahi he, ek mahila ko 7 bacche he abhi vo phir prgannant hai, unke pass kuch khane ko nahi hai aur parivar niyojan bhi apnate nahi hai, isliye kabhi –kabhi kam ache se nahi hota hai."

5. Referral services

Malnourished children who need care and treatment referred to the NRC, mainly by the AWWs. There is no provision for transport of the children to the NRC. They used personal and private transport system to carry them to the NRC. Services of 108 for pregnant mothers were really short. Sometimes vehicles had no patrol or busy in other activities. Hence, village people faced the problem to utilize the services.

"Jin baccho ko jarurat hai ya kuposhit baccho ko hum NRC bhej dete hai, aksar AWW bhejati hai, bacho ko NRC bhejne k liye koi suvidha nahi hai. 108 bhi bahut kam milti hai, isliye gaon k logo ko parshani hoti hai"

6. Supervision of Anganwadi centres

We supervised the activities of the Anganwadi's and provided the necessary support for them the especially arrangement of AWC on VHND, on the special the program in the village like – immunization, health check ups etc. and during the visit of higher officials in the village or at the Anganwadis.

"Hum anngawadi ka kam dekh lete hai aur jaruri salah dete hai magel diwas k ayogen k liye, jaise ki tika karan, swasthya jach, aur jab kabhi kabhi jab adhikari aate hai gaon me to hum dekh lete hai"

7. Problems

Community people were not aware of utilization of health services. We need their help for active participation. Only a few people took part in the village matters otherwise all were busy in their own life. They showed the indifferent behavior towards our suggestions. Health personnel are fulfilling their duties so community people have to listen to them and utilized more services provided by the govt free of cost.

"Gaon k logo ko gyan nahi hai, unki hamhe jarurat hai, kuch log hi aage aate hai baki to apni jindagi me busy hai. Vo log udasin rahte hai hamhari baato k liye, sabhi apna kam karte hai jimadari k sath isliye gaon k logo ko sunna chahiye jabki sarkar ne free me suvidhaye di hai."

3.3.2 Panchayati Raj Institutions (PRIs)

The Balwant Rai Mehta Committee recommended a 3-tier Panchayati Raj System, which includes Zila Parishad at the district level, Panchayat Samiti at the block/ tehsil/ Taluka level and Gram Panchayat at the village level.

3.3.2.1 Functions of the Gram Panchayat

According to the amended 1995 obligatory duties of Gram Panchayat are as follows:

1. Sanitation, conservancy and drainage and the prevention of public nuisance
2. Therapeutic and preventive measures in respect of any infectious disease
3. Supply of drinking water and the cleanup and disinfecting the sources of supply and storage of water
4. Maintenance, repair, and building of village roads
5. The management of common grazing grounds burning places and public graveyards
6. Organizing voluntary labour for community work and works for the upliftment of its fields
7. They are regulating places for the disposal of dead bodies and carcasses and other offensive materials
8. They are assisting the development or agriculture, forestry, animal farming, poultry fisheries etc.
9. They are registering births, deaths, and marriages and submitting records to the Zilla Panchayat

3.3.2.2 Methodology

Gram Panchayat is the functional unit at the village level working under the PRI system. Sarpanch acts as a supervisor. He provides the necessary supervision and coordinates the various activities of the Panchayat. Prior permission required from them for the data collection and fixed the meeting with the members according to their convenience. A research study was explained to the members. In-depth interview was taken to explore their functioning within the system at the village level. Information collected and after analysis divided them into categories. All the relevant information is given below:

3.3.2.3 Findings

The collected data were divided into different themes are as follows:

1. Activities at the village level.

Members of the Gram Panchayats supervised the general public activities in the village. They offer the sanitary facilities at the village level. They keep observation on infectious diseases and provide the necessary support to the community people. They also provide the facilities of safe drinking water to the community. They provide their support in maintaining the infrastructure of the Anganwadi centres and made the provision of safe drinking water along with the provision of proper electricity supply and furniture to the Anganwadi centres.

"Panchyat k log gao me jarui chijo ko dekte hai, vo jan suvidhaye dekte hai aur bimariyo ki nigrani karte hai, aur gaon walo ko madat karte hai, Anganwadi ke rakh rakho me bhi madat karte hai pine ki pani ki aur light ki suvidha karte hai aur funitre ki uplabhta karwate hai."

2. Records and reports

We collect the birth, death and census date with the help of the health personnel's. The status of a child was not up to the mark in the village. Most of the villagers are poor and belonged to the SC and ST categories. Status of the women's health was not good. Most of them are anemic and weak. The proportion of children is more in the village. They become sick easily. Their family status was not good and they all were not educated.

"sawasthya karmchriyo ki madat se janam aur mritiue ki jankari lete hai, bacho ki halat jayda thik nhai hai gao n me, gaon wale garib hai aur bacht se niche jati k bhi hai, mahilao ki isthiti bhi thik nahi hai, kamjor aur khoon ki kami rahti hai unme. Gaon me baccho ki sankhiya bhi jayda hai, vo jaldi bimar bhi padte hai, unke parivar ki hal bhi thik nahi hai aur vo bimar bhi rahte hai."

3. Support to the Anganwadi

We offer the needed support in ordering the fuel for cooking at the Anganwadi, and the necessary help according to the situation. We helped in the getting to required furniture at the Anganwadi centres. When we have sufficient budget, we helped in the maintenance of the infrastructure of the Anganwadi centres.

"Angwadi par kahne ki jaruti chijo ko hum dekte hai aur madat bhi karte hai. Jaruri furniture ko bhi hum dete hai. Jab hamare pass paise hote hai to hum jarur madat karte hai."

4. Budget

Really, for the proper functioning at the village level, we required sufficient budget. We were lacking the budget. Most of the part of the budget, we used for the provision of drinking water, electricity, construction of road and other necessary activities of the village. It consumed more money and a very few amount left for the care of the Anganwadi centres. Sometimes nothing is left for the other work. Even sometimes we were out of the budget.

" Gaon me madat k liye hamare pass budget nahi hai.budget ki kami rahti hai, saff pine ke pani, light, raod banwana aur dusare jaruri kamo me budget ko kam me le lete hai, duasre kamo me jayda buget kam me aata hai isliye agnawadi k liye kuch nahi bachta hai, aur kabhi to budget hota hi nahi hai."

5. Village health and Nutrition Day

Village health and nutrition day were carried at the Anganwadi centres on a set day. We asked the necessary information from the Anganwadi workers for the proper functioning at the Anganwadi centre level like information of the child mortality and morbidity in the community and morbidity among pregnant mothers. We check for the functioning of the health workers like –ASHA, AWW and ANM whether children got the ammunition for the infectious diseases are not and mothers received the TT dose or not, etc. Also, observed the health check-up status in the children at the Anganwadi centres especially on the VHND day. Sometimes we were visiting the VHND sessions and received the necessary suggestions and help them to solve the problem easily.

"Mangel diwas hota he har magelvar ko, hum jaruti jankari le lete hai bacho se jaise kitne bacho ki taboyat kahrab hai ya kitne mar gaye, hum ASHA, Angwawadi aur ANM ka kam dekh lete hai ki vo thik se kam kar rahi hai ya nhai jaoise tike lgana, baccho ki jach karna magel diwas par. Kabhi jate hai mangek diwas par aur jaruri salah aur madat kar dete hai."

6. Other activities

We were prepared the necessary circular for the implantation of any health camp in the village. Make the community aware of the services deliver through the health camp and make more beneficial to the community people. We are also preparing the notice boards for the required information and time to time arrange the Gram Panchayat meetings for the successful utilization of services by the beneficiaries.

" Ager gaon me koi sawasthya mela hota hai to hum parchi banwa dete hai, gaonk logo ko jagruk banate hai achi sawasthya suvidhaiye de kar. Hum notice board bhi bana dete hai jaruri jankarti k liye aur Gram panchayat ki meeting bhi rkahte hai gaon walo ko suvidhaye uplabdh karane k liye"

7. Problems

We lack the budget so many times. It is the hurdle in providing the services to the beneficiaries. Likewise, proper distribution of the budget, according to the need is not going. We made the community people aware about the health services but they showed the indifferent behavior. Through proper counseling and funding, we can make them aware of the services delivered through the health system.

"*Kai bar humhe budget nahi milta hai , ye gao walo ko suvidha dene k liye mushibate dalta hai, jaisi jarurat ho viase buget nahi hota hai, hum gain walo ko jagruk bante hai par vo log sunte hi nahi hai, jarurai salah aur jankari de kar hum unko swaystha suvidhao k bare me jagruk bana sakte hai."*

3.4 Block Level

At the block level, Child development project officer (CDPO) and Block Medical Officer (BMO) were contacted. Prior information was collected about the CDPO in the Indore block from the ICDS office and; then contacted him and fixed the meeting for data collection. Concerned with BMO at the CHC (Community health centre, Sanwer) and fixed the meeting with him according to his convenience.

3.4.1 Child Development Project Officer

One CDPO is appointed for one ICDS project. The guidelines specify that CDPO should be ideally a woman having a master's degree in any of the following subjects:

1. Child Development
2. Social Work
3. Home Science
4. Nutrition
5. Any other allied fields

Attainment of ICDS objectives of the project area largely depends on the abilities and skills of the CDPO; who act as a team leader **(NIPCCD, 2006).**

3.4.1.1 Functions of CDPO

CDPO is the principal functionary at the block level. His responsibilities are:

1. The CDPO provides the link between ICDS functionaries and govt administration.
2. He/she supervises the AWW supervisors and AWWs in the service delivery within the block.
3. He/she provides training to supervisors and AWWs to upgrade their work skills.
4. He/she is responsible for storage, shipping, and distribution of supplies at a block level.
5. Allocate monthly and yearly budgets to each Anganwadi centre and will issue funds for running Anganwadi activities.

6. Oversee and direct the work of the entire project team, including supervisors and Anganwadi workers. For this role, he will undertake study visits and call staff meetings periodically at the project office.
7. Help the Anganwadi workers in the initial stages in carrying out a quick and simple census survey of the project. On the base of these survey reports, supplemented by his own accumulation of information, the CDPO will prepare a project report containing all the necessary and relevant baseline data.
8. Ensure the right maintenance of registers and records both at the project and the Anganwadi centre levels. He will inspect these records periodically.
9. Make necessary arrangements for procurement, transportation, storage and distribution of various supplies indicated in the Integrated Child Development Services Program. For this role, he will maintain necessary links with District and State Level Officials.
10. Ensure that all the equipment and material furnished in the ICDS program are accounted for and used and maintained properly.
11. Act as the Convener of the Project Coordination Committee or Functional Committee. He will arrange meetings of the Committee; prepare agenda notes and record and minutes. He will accept all necessary steps to secure a coordinated implementation of project programs and services.
12. Act as an integral part of the Block team. He will set up a functional liaison with the Block-Headquarters, Primary Health Centre, Panchayati Raj Institutions and voluntary organizations operating in the country.

3.4.1.2 Methodology

The child development project officer is the main supervisory person at the block level from the Women and child health department. One CDPO was selected from Sanwer and one is from the Indore slums for in-depth interviews to exploring the information about the functioning and delivering the ICDS services. Prior permission was acquired at the district level and also permission took from them and fixed the meeting with them according to their convenience. Information was collected and after analysis divided them into categories. All the relevant information is given below:

3.4.1.3 Findings

1. Status of children and mothers in their areas

According to the CDPO in the Sanwer, the majority of beneficiaries were belonging to the SC, ST and OBC category. They are not educated and well aware of the services delivered through the Anganwadi centres. Most of the women were coming for the Immunization of the children and antenatal check-up, but they didn't follow the proper instructions given by the health personnel's like consumptions of the Iron-folic acid, family planning methods, proper feeding practices, diet during pregnancy, care of the newborn; all these affected the health of the mother and children also.

Besides, CDPO from the Indore slums, said that the status of mother and children is ok in the Indore slums. The areas which come under the ICDS project 5, the majority of people were Muslims. Women are not much educated and aware about their own rights. Their decision was affected by the family members; and mainly by the husbands. Most of the women had more than two children and they don't want to accept the family planning services. Frequent delivery, unawareness about their own body all these affected their health and also affect the health of the children.

2. Supervision

CDPO from the Sanwer Block said that she got, the less time for the supervision of the AWCs because she has to attain the meetings with the higher officials and sometimes they have to go to the out of the city go for an official tour. According to her, it's the duty of the Anganwadi Supervisor to check the activities of the Anganwadi centre and whenever needed we help them. It is also difficult to visit the Anganwadi because it's situated at the very far distance.

Also, CDPO from Indore slums, said that she visited the AWCs situated within her territory, but most of the time she busies in other administrative works like – arranging the supplies for the Anganwadi. She also has to attain the meeting at district and state level with the higher officials.

3. Convergence with the Health Department

CDPO (Sanwer) shared that they made contact with the health department and arrange the joint meeting with each other for the planning of the program and its implementation at the Anganwadi centre, school and at the community level like-Immunization (Pulse polio), distribution of Albendazole tablet, etc.. They planned with each other how to maximize coverage of the child population for the successful implementation of these programs with the help of the Frontline workers like-ASHA, AWW and ANM.

Similarly, CDPO (Indore slums) said that they arranged the joint meeting at the district level and develop the plan for the implementation of the program like-Immunization, health check –ups, the distribution of the Iron-folic acid tablets and Albendazole tablet, vitamin A distribution among the school children and Anganwadi centres etc.

4. Training of the functionaries

CDPO (Sanwer) said that they arranged the training program for the Anganwadi workers regarding growth monitoring, nutrition, health, and hygiene demonstration, primary management of the malnourished child and care during illness etc. periodically they checked the registers and records for a smooth functioning of the ICDS program. Also, provide the necessary guidance to the Anganwadi supervisors for how to guide and supervise the Anganwadi workers, how to convey the messages and information to the Anganwadi workers and Anganwadi helpers etc.

Similarly, CDPO (Indore slums) said that they arranged the training plan for the ICDS functionaries in their field for the correct growth monitoring techniques, nutrition, and hygiene demonstration etc. Also, they provide the necessary guidance to the Anganwadi supervisors for successful implementation of the program.

5. Budget

According to CDPOs (Sanwer and Indore slums) budget is not sufficient for the smooth running of the program. We needed more money for time to time arrangement of the training programs, meeting with other departments, for planning of the program

at the block level according to the needs of the community and beneficiaries, the money for the smooth running of the Anganwadi centres, provision of supplementary nutrition, Equipment, registers, and PSE kits at the Anganwadi centres etc. budget is limited for some functions got affected by lack of proper budget.

6. Hurdles

Budget, lack of community support and their unawareness and indifferent behavior, is the main hurdle in delivering, AWCs running in the rented building, improper management of records and reports, problems in distribution of supplementary nutrition, discrimination within the community people, indifferent behavior by the health workers these are the hurdles to success of the ICDS program according to the CDPOs in Sanwer and Indore slums.

7. Suggestions

Increase awareness among the people according to the need of the community through the utilization of the IEC materials. The periodically training program should be conducted for the better services. The budget should be increased and used in a systematic manner according to the priority of the area. Increase the human resources as the Anganwadi workers busy in answering the other work and ignored their own prime responsibilities towards the beneficiaries.

3.4.2 Block Medical Officer of Health

The Block Medical Officer of Health is the in charge of the curative, preventive and promotive Health services to the people of the entire Block area.

3.4.2.1 Functions of Block Medical Officer of Health

His responsibilities are:

1. Health Administration

- To discharge administrative functions in arranging total health care to the population of the Block.

- To provide proper monitoring and effective supervision over all facets of Health services of the Block.
- To render supervising visits to the new PHC/SHC, other Health Institutions in the Block area and Sub-centres.
- To manage manpower, material support and fiscal aspects involved in his administrative jurisdiction.
- To maintain optimum rapport with the collateral administrative bodies, Community Organizations, Vol. Organizations and the People's representatives.
- To build up effective public relationships and derive active people's participation for getting the Health Program/functions achieved effectively.
- To assess the requirement of medicine/vaccine/equipment, etc. and make requisition regular for his/her Block.
- To maintain transport properly.

2. Medical Care Service

1. To arrange proper running of the indoor/OPD services in the Block-level PHC and advice M.O., New PHC/SHC accordingly for proper running.
2. To effectively deploy the services of the staff in the indoor and OPD.
3. To supervise the services of other Medical Officers in the PHC services
4. To maintain records and registers of the Medical Care Services.
5. To attend Block Level co-ordination meeting convene by the BDO/ Sabhapati, Panchayet Samiti etc.
6. To reply to any other functions at the Block Level relevant to him/her **(Health and Family Welfare Department, 2011)**

3.4.2.2 Methodology

The block medical health officer was chosen from the Sanwer for the data collection in association with services availability especially at the NRCs for the management of the malnourished children in the rural regions. Prior permission took from the district level and according to his convenience meeting was fixed on the decided day. In-depth interview was taken from him. Data were analyzed and divided into different categories which are as follows:

3.4.2.3 Findings

1. Status of the children and women's

Most of the children in the Sanwer are from the marginalized areas. According to population composition, maximum people belong from SC, ST and OBC categories. Their educational and economic status is low. Caste wise discrimination among the community also exists. All these situations affect the health of the women and children. Women are uneducated and have low social awareness because of this pregnant and lactating mother is not utilizing the service available at the health centres. Malnutrition also exists among the children, especially under the 2-3 years of children.

2. Service Provision

Treatment of malnourished children, according to the level of malnutrition, curative, preventive and emergency services for children, the mothers, laboratory and blood bank facilities, organization of immunization services at the CHC, oral rehydration therapy in diarrheal diseases, family planning services, provision for institutional delivery, antenatal and postnatal care all these services are available at the CHC for the children and mothers.

3. Management at the NRC

At the NRC most of the cases referred by the Anganwadi workers followed by ASHA and ANM. Some children find during the OPD hours in the CHC. Bilateral edema, wasting, persistent vomiting, etc. all is the criteria for the admission. Children get the therapeutic diet; receive the treatment, according to the medical complications, 24hour facilities for monitoring the children, all facilities available at the NRC.

4. Budget

Money is required for different activities like- purchasing the equipment, supplies, foods, toys for children, kitchen and storage items, electricity to provide warmth, antibiotics, and transportation of child from the village to NRC, Rs. 90 for per day per child to the mother for compensation for her wage loss. We have to manage other departments in the CHC, including water, electricity, cold storage, maintenance,

etc. hence; the budget is an important factor in the provision of better services for the malnourished children. We have the limited budget, increases the provision of budget form the govt is actually required.

5. Focus on mothers' Education

Mother plays an important role in the health of the child. At the NRC level, we are trying to increase the awareness among the mothers regarding the care of malnourished children, feeding pattern, hygiene, the importance of breastfeeding and weaning diet. For imparting this knowledge we used documentary movies and organized a counseling session at the individual level according to the need of the child. Also, after the discharge from the NRC, follow-up is continuing to provide necessary guidance and support.

6. Suggestions

Awareness should be increased among the mother and family members of the child at the very beginning level. Frontline workers should be skilled in early detection and management of children at the Anganwadi levels. Preventive level activities should be performed at a village/community level. Most of the children belonged to the marginalized population, so there should be a better facilities arrangement for the children at the district level. Provision of the budget should be increased at the NRC level.

3.5 At the supervisory level

3.5.1 ASHA Facilitator (i.e. Block Facilitator)

ASHA Facilitator is a paid worker at the block level and she is in the direct touch with the ASHA workers. National Rural Health Mission emphasizes on the ASHA Facilitator facilitating the activities of ASHA through providing support, supervision and on the job training to the ASHA in their villages **("Guidelines for ASHA Facilitators", n.d.)**

Selection Criteria of ASHA Facilitator

The concerned CDHO (Chief District Health Officer) of the district and the BHO (Block Health Officer) are responsible for the selection of ASHA Facilitator. Her main duty is to strengthen, monitor and facilitate ASHAs to improve the implementation of activities of NRHM. ASHA Facilitator should be 12th pass or have a higher qualification. Also, who worked as an ANM helper should be given priority. At least she should have minimum 2 years of work experience as ASHA or ANM Helper. ASHA Facilitator should have interpersonal communication skills, leadership skill, knowledge of local language etc. ASHA Facilitator got an honorarium for the fixed amount of field visits in a day is Rs.150/- per visit for maximum 15 visits per month (Ibid).

3.5.1.1 Functions of ASHA Facilitator

Responsibilities of ASHA Facilitator are:

1. Each ASHA Facilitator holds the activities of about 10 ASHAs.

2. She should facilitate day to day work of ASHA in the respective areas.

3. She should have to interact with the Gram Panchayat for the functioning of Village Health Sanitation & Nutrition Committee and ICDS functionaries' like- AWW and Supervisors for implementation of the nutritional program including VHND.

4. She should visit each ASHA in her village and accompany her during home visiting.

5. She should assist ASHA to organize community meetings.

6. ASHA Facilitator should support ASHA in mobilizing women and children to attend VHND day.

7. She should check the content and availability of drug kit with the ASHA.

8. The ASHA drug kit has to be refilled at PHC on the day of the PHC level monthly

Meeting and ASHA Facilitator would be responsible for the refilling the kit.

12. It is the ASHA facilitator's task to obtain information from ASHA and maintain the necessary report and records.

13. She should organize a monthly meeting with ASHAs for performance review and planning, discuss common issues and problems faced by ASHA **("Guidelines for ASHA Facilitators", n.d.)**

3.5.1.2 Methodology

One ASHA Facilitator was selected for the data collection. She has supervised 10-20 ASHAs workers in the community. Prior permission was taken from the health department at the district level and fixed the meeting. In-depth interview was conducted to explore the information related to the research study. Collected information was gathered and expressed by different themes are given below:

3.5.1.3 Findings

1. Supervision

Supervise the ASHA in early detection of pregnancy, finding the complication like –bleeding, anemia, etc., care of newborn like- breastfeeding, immunization, nutrition, and motivate the lactating mothers for family planning and hygiene practices. Also, supervise them in the treatment of tuberculosis (T.B.), distribution of bed nets etc. we provide the necessary support in the maintenance of the drug kits like- what are the treatment for minor ailments common medicine, how to check expiry date etc. Besides, Help ASHAs workers in proper maintenance of the records and reports and cross check the data and assist them in correcting filling of the data.

"Pregnancy ka pata lagane k me, bleeding, khoon ki kami me, navjaat ko doodh pilane uar tike aur unke khanpan aur parivar niyojan aur safsafai ki jarurat me hum log ASHA ki madat karte hai. TB ke ilaj aur net batwate hai,dawaiyo ko kaise batna hai unki expiry date ko kaise panda hai isme guide karte ha, iske sath sath kise report banana hai ye sab bhi batate hai."

2. Institutional delivery

Support the ASHA workers in motivating the pregnant mothers for institutional delivery and motivate mothers for antenatal care. Explain the mothers about the benefits of Janani Suraksha Yojana for mothers and the importance of care of the newborn during the delivery. Encourage the mothers for immunization for the prevention of the diseases. Motivate them for the exclusive breastfeeding and importance of the weaning diet.

"ASHA ki madat karte hai mahilyo ko motivate karne k liye santhgat delivery k liye, mahilo ko Janani Suraksha Yojana ki janari uske labh mahilao aur bacho k liye aur navjaat k liye ye sab bhi batate hai, tike k liye mahilao ko utsahit karte hai, unko doodh pilane aur purak aahar k bare me batate hai"

3. Training of ASHA workers

ASHA Facilitator trained the ASHA workers. During training explained about the NRHM, Develop the skills regarding how to communicate within the system, with the community people and village representatives, with the mothers and motivate them for institutional delivery. Also, provide the practical knowledge about the antenatal and postnatal care of mothers along with the care of newborn and child.

"ASHA ko training bhi dete hai , NRHM k bare me batate hai aur kiase sawasthya sansthanme kam karna hai ye batate hai, gaon walo se kaise baat karna hai aur representatives se kaise baat karna hai ye batate hai, iske sath sath Practical jankari bhi hum dete hai jaise grabhavastha ki janch, prasav k baad ki janch aur nav jaat ki dekh bhal."

4. Co-ordination activities

Mobilize the local authorities and coordinate with them. Organizing the meeting, including ASHA, VHNSC, PRIs members and provide the necessary guidance and discuss the issues related to the ASHA workers in the community. Conducted meeting with the ASHA workers at the PHC for effective functioning.

" Local logo se baat karne me hum madat dete hai, ASHA, panchayat aur VHNSC ke sath meeting rakte hai aur ASHA ki dikkato ko suljhate hai, sahi se kam karne k liye hum ASHA ke sath PHC par kam karte hai."

5. Activities at the AWC level

Monitor the activities at AWC during the organization of the VHND session. Ensure the list of the beneficiaries' like- pregnant and lactating mothers and children for receiving of immunization and antenatal check-up. Supervise the ASHA, ANM and AWW during VHND. Whenever needed to make a contact with the Lady Health Visitors for the proper supervision, especially during the organization of the VHND session.

" Mangel diwas k aayojan par angnwadi kenrda k activity delhte hai jaise- garbhavti aur dhatri mahilalo ko tike lege ya nahi, unki jach hui hai ya nahi, ASHA, ANM aur Anganwadi ko mangel diwas par dekte hai, jab jarurat ho LHV se baat kar lete hai, especially jab mangel diwas ka ayojan ho tab"

6. Home visits

Once in a month for the home visiting go to the ASHA worker in the community. Visit those families who had malnourished children, guide them for proper care, hygiene, dietary practices, etc. Also visit the family who had the pregnant and lactating mothers for the advice for antenatal and postnatal care, motivation for institutional delivery, family planning practices, encourage mothers for breastfeeding and weaning diet.

"Mahine me ek bar ASHA k sath grah bhat k liye jate hai, jinke ghar me kuposhit bache hote hai unko kya khana hai, safai k bare me batate hai. Jaha garbhvati mahilaye hai unko grabhavasta ke pahle ki jach aur parsav k baad ki care k bare me batate hai, unko sansthagat prasav, arivar niyojan, doodh pilane aur purak aahar k bare me batate hai."

3.5.2 Anganwadi Supervisor / Mukhya Sevika

The Anganwadi Supervisor has the obligation of supervising the 20, 25 and 17 Anganwadi Workers in rural, urban and tribal projects respectively. The Supervisor / Mukhya Sevika guide the Anganwadi workers in planning and coordinating the delivery of ICDS services through AWC. Anganwadi Supervisor / Mukhya Sevika also gives on the spot guidance and training required according to the situations (**National Institute of Public Cooperation and Child Development, 2006**).

3.5.2.1 Functions of Anganwadi Supervisor

Anganwadi Supervisor / Mukhya Sevika have the following job responsibilities:

1. She guides the AWW in conducting the surveys and updating them quarterly.
2. She checks the enlisted beneficiary who belongs from Low economic stature and malnourished especially under 5 children.
3. She helps in the assessment of correct weight measurement and guides them in the correct plotting of weights in growth charts.
4. Guide the AWW in conducting pre-school activities by demonstrating techniques of storytelling, group play identification of colors etc.
5. She demonstrates the Anganwadi workers in providing effective health and nutrition education services to mothers.
6. She guides AWW in prevention and early detection of early childhood deformities.
7. During the home visit, she guides the AWW and mothers for the care of the malnourish child.
8. Check the birth and death register, immunization register and guide them in proper maintenance of the register.
9. She checks the arrangement for storage, preparation, and distribution of food and stock of supplies such as supplementary nutrition, medicines, necessary registers, and records.
10. She helps the AWW in organizing the Mahila Mandel activities.
11. She makes the proper coordination with village leaders, Panchayats, primary school and involves them in the ICDS program.

3.5.2.2 Methodology

One Anganwadi Supervisor / Mukhya Sevika was selected for the data collection. She has supervised 10-20 Anganwadi workers under the ICDS program. Prior permission was taken from the Women and Child Health Department at the district level and fixed the meeting. In-depth interview was conducted to explore the information related to the research study. Collected information was gathered and expressed by different themes are as follows:

3.5.2.3 Findings

1. Job guidance and supervision

She provides the support in the household surveys and updating their data on the quarterly basis. Help them in the assessment of the child and correct plotting of the growth charts especially for the malnourished child. She visits the AWW once in a month and provides the necessary guidance. She checks the enlisted beneficiaries and utilization of ICDS services deliver through the AWC. Check the records on immunization and health check-ups and guide them in the proper filling.

"Survey aur jankari me hum Anganwadi ki madat karte hai,bacho ko kaise dekhna hai aur kaise unka growth chart bante hai ye sab batate hai. Anganwadi workers se hum mahine me ek bar milte hai aur jaruri guidenace dete hai, hum labhatiro ki jankari lete hai aur unki madat karte hai, tika karan ki aur health checkup ki jankari k records bharene me madat karte hai"

2. Referral services

She helps in identification of the at-risk child in the community and after the proper assessment referred them to the primary health centres or hospitals or NRC. Also, help the AWW in the rehabilitation of the children. Early detection of the children was done along with the AWW at the AWC and during the home visiting.

" Jin baccho ko jarurat hai unka pata legate hai aur PHC ya NRC bhej dete hai. Unke aage koi dikat na aaye to madat bhi kar dete hai. Anganwadi worker ke

sath milkar Anganwadi Kendra par hum phale se hi bacho k sawasthya k bare me pata legte hai grah bhet k doran"

3. AWC activities

Time to time guide in the pre-school education, activities conducted at the Anganwadi centres like- group organization, indoor activities. Along with this explain the correct method of health and nutrition education methods to the AWW regarding care of mother and children.

Look the proper availability of supplementary nutrition to the children, pregnant and lactating mothers and adolescent girls. Check the supplies, medicine, materials, preschool kits, registers and records at the AWW. Guide in the arrangement of the VHND day and ensure all the services available to the children and pregnant mother's delivery through the AWC on the VHND day. Make a liaison with the ASHA, ANM, and AWW regarding the proper service delivery to the beneficiaries.

"Shala purv shiksha k bare me batate hai, bacho ko kaise khar sikhna hai isme madat karte hai, iske alawa kaise khanpan aue sawathya ki jankari dena hai mahilao ko is bare me Anganwadi worker ki madat karte hai."

4. Home visits

Visit the households, especially for malnourished children and make warn them regarding the care of the child, diet, hygiene, their food management. Also, support them by explaining the treatment of the child at the NRC. Explain the facilities available at the NRC and the importance of services in the health of the children.

"Ghar-ghar ja kar grah bhet karte hai, khas tor par jo bache kuposhit hai unke parivar walo ko bache ki care aur khanpan k bare me batate hai, iske sath NRC par uplabdha suvidhao k bare me batate hai aur unka mahtav bhi batate hai.

5. Work under the CDPO

We have to give the report to the CDPO regarding immunized children, problems of AWW in the field, the status of the children, AWW working properly or

not, their job training required or not, payment of the AWW and AWH. Also organizing the monthly meeting with CDPO and AWW at the office and discuss the issues. Plan the activities for the reaching the target and better service delivery through the AWC.

" hum ko CDPO ko sab jankari dene padti hai ki kitne bacho ko tike lege, Anganwadi worker ko kya dikkate aa rahi hai aur bacho ki kya isthiti hai, Anganwadi worker ache se kam kar rahe hai ya nahi, unko training ki jaraurat hai ya nahi, AWW aur AWH ki payment k bare me jankari dete hai. CDPO aur AWW k sath office me meeting rakhte hai aur unki musibato ko discuss karte hai. Target tak pahuchne k liye hum activity plan karte hai aur suvidhye pradhan karte hai Anganwadi Kendra k madiyum se."

6. Training of the AWW

Provide time to time in service training at the district level or at the headquarters for correct skill development regarding the correct plot of the growth chart, early assessment of children, primary management of the children, preschool education activities, general information about the immunization, the proper nutritive value of the food, home-based food for the good health of the children and mothers.

"Hum samay-samy par Anganwadi worker ko jile level par trining dete hai taki vo log sahi se growth chart banana, baccho ki jadi pahchan karna, primary dekhbhal karna, shala purv education, titakka ran ka bare me samanaya jankai, kis khane me itni nutritive value hai,ghar ka khana bacho aur mahilo k liye ityadi par taining dete hai."

3.5.3 Lady Health Visitor

Lady Health Visitor supervised the functions of the auxiliary nurse midwives. She provides a variety of services to urban and rural areas. Mainly they provide basic nursing care, maternal child health services, and training of health workers at the PHC level etc.

3.5.3.1 Responsibilities of Lady Health Visitor

1. Provide the maternal and child health services in the community at the sub-centre, primary health, and community health centre level.

2. She assists the community people and educates them on the use Family Planning (FP) methods also explain the adverse effects, contraindications of the Family Planning (FP) products.
3. She makes the necessary reports and maintains all the records like – death and birth, total delivery cases, referred cases, FP services and permanent sterilization etc.
4. Make provision of FP services, i.e. condoms, pills and safe insertion of Intra Uterine Contraceptive Devices (IUCDs) at a camp organized on monthly basis in their the respective areas.
5. Participate in integrated planning and cooperation, and help identify opportunities for future projects.

3.5.3.2. Methodology

One Lady Health Visitor was selected for the data collection. Prior permission was taken from the health Department at the district level and fixed the meeting. In-depth interview was conducted to explore the information related to the research study. Collected information was gathered and expressed by different themes are as follows:

3.5.3.3 Findings

1. Supervision

LHV supervise and guide the ANM at the Subcentre level in the community. LHV said that she supervises the activities in antenatal care and postnatal care, cares during delivery, care of the newborn and weight monitoring, MTP, finding on the danger sign of pregnancy, weight monitoring of mother and blood examination etc. She supervises in the family planning activities at the sub-centre level. Also, check the necessary reports and records related to the birth, death, total delivery, cases, management of the malnourished and sick child, diarrhea and T.B. Cases at the sub – centre level.

"Lady health visitor, ANM ka supervision aur community level par guidance deti hai. LHV ke ausar vo grabhavasta k doran, prasav ke baad ki dekgh bhal, delivery k doran care, nav-jat ki dekha bhal, unka wjan kaise lena hai, MTP, pregnancy

k gambhir lakhsan, mahilo ka wajan aur baccho ka wajan ityadi me ANMs ko guide karti hai. Sab-centre par vo family planning k bare me bare me batati hai, iale sath sath jaruri records ka rakha rakhao jaise janam, mitru, delivery cases, kuposhit baccche ki dekha bhal, bimar bacho ki dekha bhal, diarrhea aur T.B. cases k prabandhan me madat karti hai."

2. Institutional delivery

According to LHV, she guides and encourages mothers for antenatal delivered at the institution during the visit at the sub-centres and Primary health centres. They help and guide the mothers for getting the JSY money after the completion of all formalities at the sub-centres. After the delivery help in getting the birth certificate from the sub-centres.

"LHV ka anusar, vo garbhavati mahilao ko jab vo sub-centre ya primary health centres aati hai to sansthagat prasav k liye protsahet karti hai aur unhe delivery k baad sabhi jaruri kariya wahi k baad JSY money lene me madat karti hai. Aur delivery ke baad janam ka certificate sub-centre se lene me madat karti hai."

3. In services Training program for ANM

LHV provides the necessary training to the ANM. During the in-service training demonstrate the antenatal and postnatal examination, including palpitations, auscultation, total head to toe examination, weight monitoring, plotting of partogram during the delivery, care of newborn, cord care, MTP procedure, family planning methods and sterilization etc. Along with demonstration provide the enough practical knowledge during the cases handling and during the OPDs.

"LHV, ANM ko jaruri training deti hai. In-service training k doran kaise grbhavastha aur uske baad dekhna hai, kaise pet touch karker examination karna hai, wajan lena hai, delivery k doran kaise partogram banana hai, navjat ki care, cord ki care, MTP aur family planning kaise karna hai ityadi sab shikhaya jata hai. OPD ke doran OPD cases k liye jaruri practical knowledge diya jata hai."

4. Coordination activity

Mobilize the local authorities and coordinate with them. Organizing the meeting, including ASHA, VHNSC, PRIs members and provide the necessary guidance and discuss the issues related to the community. Likewise, organized the meeting at the PHC level for the effective performance.

"Local authority ko unke sath jaruri smanvaya banana k liye protsahet kaerti hai, ASHA, PRIs, VHNSC k sath milkar meeting rakhi jati hai aur community people k bare me discuss kya jata hai. Aur, aise hi PHC level par bhi ache kam k liye meeting rakhi jati hai."

5. Activities at the AWC level

Collect the necessary information about the VHND like- total immunization of the children and pregnant mothers, health checkups, registration of the pregnant mothers, etc. guide and help in the preparation of the list of unimmunized / left out children. Take the necessary actions when the immunization was not fully done in the concern areas. Make a provision of all the medicine for the VHND day and organized the boxes to carry the injections at the VHND sites.

Also, check for the cold chain maintenance up to the injection sites. Provide the guidance for the correct site of immunization and stressed the ANM to explain the side effects to the mothers and family members during the immunization of the children. Also, guide them to provide necessary medication after the immunization.

Also, stress the ANM to impart information about institutional delivery along with their full immunization of the mother. Provide the health and nutrition education to the mothers and community people and acceptance of family planning methods.

"Mangel diwas k bare me jaruri jankari ikatha kiati hai jaise kitne bacho anr garbhavti mahilo ka tika karan hua, kitno ka health checkup hua, kitni mahilao ka registration kya gaya is bare me jaruri jankari ikattha karti hai. Tika karan k liye chute huye bacho ki list banana me madat karti hai. Mangel diwas k liye jaruri dawao ko uplabh karane aur injection ko le jane k liye boxes ka intjam karti hai."

"Cold chain ki maintenance k liye check karti hai aur sahi jagh legane k liye guide karti hai. ANM ko injection k side effect mothers aur parivar k logo ko batane k liye jaruri guide karti hai aur tika karan k baad jaruri dawai dene me guide karti hai."

"ANM ko sansthgat prasav k liye mahilao ko jaruri jankari aur unke pure immunization k bare me puri janakari k liye dabav dalti hai. Mahilao aur community k logo ko jaruri sawasthya aur nutrtion k bare me aur parivar niyojan k bare me jankai deti hai."

3.6 District Level

A department at the district level, District Program Officer (First Class) of the 41 District Women and Child Development Officer (second class) 34, the main directory, Anganwadi Training Centre (Class II) of 10, superintendent, government organization (second class) 12 designation is approved.

3.6.1 Women and Child Health Department (WCD)

The core functionaries of the WCD department are as follows: District program officer, child development project officer, Anganwadi supervisors, Anganwadi workers, and assistants.

3.6.1.1 District Program Officer

At the district level, the District Program Officer is the overall in charge of the WCD department. He has to perform managerial and administrative duties. He is to perform different duties.

3.6.1.2 Functions of District Program Officer

His obligations are:

1. He is the overall in charge of the office of the district program (ICDS cell).
2. Coordinate with the other concerned departments.

3. Submission of proposal to the Directorate in respect of scheme and annual budgets.
4. He guide, instruct, supervise and inspect the work of all subordinate officers in the District.
5. Inspect Women and Child Welfare programs in Mahila Mandals.
6. Tour for a minimum period of 15 days in the month covers the entire District once in 2 months in his Jurisdiction.
7. He goes to the Zillah Parishad meetings.
8. Establish and Maintain good working relationship with Districts Collectors, Chairman Zillah Parishad, Presidents of MPPS.
9. Visit a fair number of voluntary organizations in every month.
10. Having Financial and Administrative powers.
11. Convene conference of CDPOs every month to review the progress of work in the area.
12. Conduct detailed annual inspection to all the Offices, Institutions, etc., in the District.[6]

At the district level contacted DPO (District program officer) ICDS Cell and DPM (District program manager) from Health department. After a concert with them clear about the meeting and explained them the purpose of research and objectives. In-depth interview was taken according to their convenience and time.

3.6.1.3 Methodology

The district program officer contacted for the permission of the data collection on the respective areas at the district level. After taking the permission meeting was fixed according to the convenience of the officer. In-depth interview was conducted to explore the management at the district level and information related to the research study. Collected information was gathered and expressed by different themes are as follows:

6 http://www.mp.gov.in/web/guest/administrative_arrangement

3.6.1.4 Findings

1. General views on child malnutrition and maternal health

In the district approx. 26.5% SC and 5% ST population exists. Total 1,636 Anganwadi centres are running in the district. Status of women and child is not up to the mark. The female is not educated, especially in slums; mothers are not aware of the care of the child. Proper initiation of breastfeeding is not present; even mothers knowledge about the nutritious food is low. Most of the mothers in slums and rural areas had more than 2 children and the gap is less than 2 years. All those affected the health of children and mothers. The ratio of institutional delivery is low, even JSY scheme is running in the district.

2. Convergence

Convergence is taking place at the village level among the front line workers; ASHA, ANM, AWW, and AWH. At the district level, we plan the various programs together like- immunization, health checkups, IFA distribution, etc. for the success of the program at the district level. We organize the combine training program at the district level for the Frontline workers' level.

3. Combine strategy

Immunization, health check-up, referral services to the health facilities, vitamin A distribution, Iron, folic acid and Albendazole tablets distribution all these combine strategies we follow.

4. Major contribution of the department

Mangal Diwas (VHND) organized at the AWC level, Suposhan Abhiyan in which find out the malnourished child, Anganwadi Chalo Abhiyan in which create the awareness among the community all are running at the district level for fighting the malnutrition. Also, our department provides the supplementary food, take home ration, health education services and care of sick and malnourished child these initiatives are taking by our department.

5. Hurdles / Problem faced by the department

Lack of human resources, less number of trained AWW and AWH, lack of budget for the smooth running of the ICDS services all are hurdles faced by our departments. Due to lack of budget; supplies at the AWC, equipment, and food storage facilities are interrupting.

6. Suggestions

Combine training of the front line workers, increase in the budget at the district level and increase in human resource. Also, make combine strategies for working together at the state level.

3.6.2 Health Department

3.6.2.1 District Program Manager

At the district level, the District Program Manager is the overall in charge of the health department. He has to perform managerial and administrative responsibilities at the district level. He is an expert in public and private health system along with coordination and networking skills. He is to perform different duties.

3.6.2.2 Functions of District Program Manager

His obligations are:

1. He has to help the civil surgeon convener to the overall management of human and financial resources under the NRHM program.
2. He is organized and makes liaise with other consultants on the NRHM program at Central/state/territory level.
3. He is to provide necessary support to district and peripheral level program.
4. Oversee human resource including contractual staff under NRHM program.
5. Assist the civil surgeon in overall control of financial and logistics management.
6. Monitor managerial, administrative and financial aspect of NRHM program in the district.
7. Analyze financial and physical progress report and submit corrective measures for improving yield.

8. Identify the unreasonable delay in the accomplishment of milestones under the NRHM program.
9. He is to provide regular report/feedback on the program to the civil surgeon of the district.
10. He is to advise on the further evolution of the program.[7]

3.6.2.3 Methodology

The District Program Manager contacted the health department for the permission of the data collection. After taking the permission meeting was fixed according to the convenience of the officer. In-depth interview was conducted to explore the management at the district level and information related to the research study. Collected information was gathered and expressed by different themes are as follows:

3.6.2.4 Findings

1. General views on child malnutrition and maternal health

The sex ratio in the Indore district is 911 according to the census report 2011. About 66 % of institutional delivery were conducted in the district last year. Fever, respiratory infections, diarrhea is playing the major contribution to the child morbidity in the Indore district. Mostly 6- 11 months children suffered from these diseases.

2. Convergence

Convergence takes place between the health and WCD departments. During VHND, ASHA, ANM, AWW together in the provision of services to the beneficiaries. At the district level immunization, health checkups, IFA distribution, screening of children these activities are running with combine afford.

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7 http://www.pbnrhm.org/docs/tor_various_posts.pdf

3. Combine strategy

Immunization, supplementation of Vitamin A, distribution of IFA tablets, antenatal and postnatal care, supplementary nutrition, arranging health camps, referral services etc. all these combine strategies we follow.

4. Major contribution of the department

Immunization of BCG, DPT, polio, and measles, supplementation of Vitamin A, distribution of IFA tablets, antenatal and postnatal care provided by ANM, physical examination, B.P., and urine examination, etc. is the contribution of our department. Also, the advice is provided for the mothers regarding consumption of green leafy vegetable, fruits, IFA distribution, advice for Breastfeeding etc. is the contribution of our department.

5. Hurdles / Problem faced by the department

Our department playing responsibilities very well. WCD has to check their loopholes. All the post is filled at the district level from our department side. Budget is sufficient to manage the health facilities at the district level. If WCD fulfills their responsibilities, then we will easily reach our target. Also, trained and skilled health personnel's required at the village level specially ASHA and USHA workers for better health coverage.

6. Suggestions

There should be state level policy for working with the convergence to combat the child maintain and reduction in child mortality and morbidity rate. Increase the level of knowledge and skills among the health workers through the proper training program.

3.7 State level

3.7.1 General Information of Madhya Pradesh

3.7.1.1 Historical Background

Madhya Pradesh is situated in the central region of India spread over an expanse of 308,245 square kilometers with the population of 60.4 million; it sustains a great ratio of scheduled castes and tribes (15.17% and 20.27% respectively) with 73% of the population living in rural regions. The State is typically characterized by difficult terrain, high rainfall variability, uneven and limited irrigation, deforestation and land degradation.

Despite substantial progress in socio-economic development over the last decade, the country goes forward to be afflicted with more or less of the worst indicators in India. These include low literacy rates, high degrees of morbidity and mortality and 37% of the population living under the poverty line. 89% of the population in rural regions are dependent on farming **(Ministry of Health & Family Welfare, 2007).**

3.7.1.2 Health Indicators of Madhya Pradesh

Table 3.32 Health Indicators of Madhya Pradesh

S.No	Indicators	M.P.
1	Total Population (In Crore) (Census 2011)	7.26
2	Decadal Growth (%) (Census 2011)	20.30
3	Crude Birth Rate* (SRS 2013)	26.3
4	Crude Death Rate* (SRS 2013)	8
5	Natural Growth Rate* (SRS 2013)	18.4
6	Infant Mortality Rate* (SRS 2013)	54
7	Maternal Mortality Rate* (SRS 2010-12)	230
8	Total Fertility Rate* (SRS 2012)	2.9
9	Sex Ratio (Census 2011)	930
10	Child Sex Ratio (Census 2011)	912
11	Schedule Caste population (in crore) (Census 2001)	0.91
12	Schedule Tribe population (in crore) (Census 2001)	1.22
13	Total Literacy Rate (%) (Census 2011)	70.63
14	Male Literacy Rate (%) (Census 2011)	80.53
15	Female Literacy Rate (%) (Census 2011)	60.02

*Sample Registration Survey 2014

Note- Demographic, Socioeconomic, and Health Profile of Madhya Pradesh. Adopted from "Madhya Pradesh Health Systems Assessment Report" by the Department for International Development, ACCESS Health India. p-9. Copyright 2016 by ACCESS Health International.

3.7.2 Directorate of Women and Child Development (WCD)

At the state level organization of the Women and Child Health Department is as follows; Directorate in the Commissioner / Director and a Project Director - an office, Additional Director-2, Joint Director-5, Deputy Director -5, Director Bal Bhavan-1, Assistant Director operator-10, and the Accounting Officer-2.

Madhya Pradesh Directorate of Women and Child Development

Commissioner (IAS)
↓
Director (IAS) (1)
↓
Additional Director (2)
↓
Joint Director (5)
↓
Deputy Director (5)
↓
Director Bal Bhavan (1)
↓
Assistant Director (10)
↓
Accounts Officer (2)
↓
Office staff (third category)

(Source- http://www.mp.gov.in/web/guest/administrative_arrangement)

3.7.2.1 Job Responsibilities of the ICDS Cell

1. The ICDS Cell at the state level, headed by Program Officer. He will provide the secretariat assistance to the Secretary, Social Welfare or Director, Social Welfare.
2. He will responsible for the formulation of state policy for the implementation of ICDS program.

3. He assures the coordination at the central level along with the other departments in the province for the fluent and continuous running of the program.
4. He will supervise and monitor the ICDS program at the state level.
5. Plan and organize training facilities in the state for ICDS functionaries to various institutional levels.
6. Ensure the selection of the Anganwadi workers under the ICDS program.
7. Selection and posting the other supervisory staff come under the ICDS project.
8. Make coordination with the health department in relation to the posting of medical and paramedical staff and their orientation in the ICDS program.
9. Analyzing and review the progress report and identify deficiencies and manage them through appropriate measures.
10. Compile all statistical data and evaluate the ICDS program.
11. He has to endure for a tour in the ICDS project areas in the nation and ensure successful implementation of the plan with full coverage of the target group.
12. Time to time define the program and motivate ICDS staff to accomplish the targets.

3.7.2.1 Methodology

At the state level information was collected from the Directorate of Women and Child Development (WCD) department. Prior permission was taken from and fixed the meeting. The research study was explained to the ICDS officer and later on, the in-depth interview was taken from them. Collected information was gathered and analyzed after analysis put them into different categories which are as follows:

3.7.2.1 Findings

1. General views on child malnutrition and maternal health

Madhya Pradesh witnessed the highest rate of underweight children below five years of age as revealed from the results of National Family Health Survey (NFHS) – 3 (2005-06). The survey reported that 60% of the children below 5 years in Madhya Pradesh were underweight; 50% children were stunted and 35% children were wasted, with severe wasting in children being the highest in India (12.6%).

Considering these high levels of undernutrition in the state, in addition to the basic services provided through the ICDS scheme (viz. Immunization, Supplementary Nutrition, Health checkup, Referral services, pre-school non-formal education and Nutrition and Health information) and State Health Mission under (NHM) that has continually strengthened the coverage and outreach of health services to the most marginalized, Government of Madhya Pradesh took several initiatives in convergence with ICDS of WCD and NRHM of Health Department.

The changing status of Child Nutrition indicators in Madhya Pradesh from 2005-06 to 2015-16 as a result of the remarkable effect of various interventions and initiatives taken by ICDS and NHM can be seen through National Family Health Survey Report for the year 2015-16.

Table 3.33 Change in Nutrition Status of Children under 5 years in the State of Madhya Pradesh over a period of 8 years

Sr. No.	Indicator	NFHS III (2005-06) (%)	NFHS IV (2005-06) (%)	% Reduction from NFHS III
1.	Percent children below 5 years underweight	60.0	42.8	28.7
2.	Percent children below 5 years wasted	35.0	25.8	26.3
3.	Percent children below 5 years, severely wasted	12.6	9.2	27.0
4.	Percent children below 5 years stunted	50.0	42.0	16.0

Source: Interview with the Directorate of Women and Child Development (WCD) officials

2. Support from the WCD department

According to the Directorate of Women and Child Development (WCD) officials, their department is getting the support from the health department. Like- All support required for implementation and roll out of ICDS as per the mandate of GoI, MWCD regarding the provision of health services viz. Immunization, health checkups, referrals and management of sick patients, and/or any new initiative under ICDS requiring support from the health department.

3. Combine strategy

All the work done in the state of MP towards reducing child malnutrition is a joint effort of ICDS and Health department along with all the line departments concerned with women and child social welfare.

4. Major contribution of the department

Major initiatives were taken under ICDS:

On 14th May 2010, the State Assembly adopted a set of 70-point resolutions which included one on setting up the "Atal Bal Arogya Evam Poshan Mission" (then renamed as "Atal Bihari Bajpai Bal Arogya Evam Poshan Mission"). ABM Platform outlined a comprehensive plan for both treating children with SAM and preventing undernutrition in the long-run through an integrated mission mode approach to bring about an improvement in the nutrition and health status of children in Madhya Pradesh and address the problem of child malnutrition.

The main objectives of ABM are as follows:

1. To strengthen ICDS and fill in the gaps primarily in the State Health and Nutrition programs.
2. To undertake evidence based pilots with a view to scaling up on the basis of results.
3. To serve as a platform for convergence of various schemes of different departments.
4. To promote decentralized planning through district specific action plans

In Madhya Pradesh, the ICDS Mission was rolled out in 30 high burden districts identified by the GOI. Also, Initiatives under ICDS mission, according to the Directorate of Women and Child Development (WCD) are as follows:

Special interventions and drives for tackling the menace of undernutrition, increasing the demand for use of services provided by Anganwadi centres and motivating community participation:

1. Mangal Diwas

Madhya Pradesh has taken the initiative to place the issue of community education at the highest priority through focused counseling of adolescent girls, pregnant and lactating women, and mothers of children enrolled in the AWCs on Mangal Diwas.

Mangal Diwas (on Tuesdays) is celebrated by organizing God Bharai, Anna Prashan, Janam Diwas Samaroh and Kishori Balika Diwas activities. These Mangal Diwas are institutionalized and targeted theme based focused 20 topics.

2. Suposhan Abhiyan

A focused community-based intervention with two pronged strategies viz. Curative strategy (12 days Sneha shiver + 18 days learning by doing) and preventive strategy (Strengthened Home visits and counseling with 20 themes based counseling sessions, 6 VHNDs, and 25 IEC sessions) implemented for a continuous six months in convergence with various line departments to curb the problem of undernutrition.

3. Anganwadi Chalo Abhiyan

To make the community aware of the services provided through AWCs under ICDS so as to increase the demand of ICDS services in the entire state.

4. Sneha Sarokar

To sensitize the community regarding undernutrition and its consequences, the importance of health and nutrition of women and children and services provided by AWCs and to motivate community to take responsibility for underweight children to ensure their health and development.

5. Incorporation of SNP under Lok Sewa Guarantee and Food Security Act 2013

To ensure provision of SNP to the beneficiaries

5. Hurdles / Problem faced by the Department

- Budget constraint
- Human resource constraints
- Training Backlog

6. Future Plan

Convergence with various stakeholders, development partners for effective service delivery.

3.7.3 Directorate of Health Services / Director NRHM

Directorate of Health Services is the overall in charge of Health Administration at the state level.

3.7.3.1 Functions of Directorate of Health Services / Director NRHM

Responsibilities of this department are:

1. To ensure support for the development of capacity at all levels.
2. To appraise District Health Plans and finalize them based on resource availability.
3. To determine planning norms and suggested interventions for the State, holding space for invention.
4. To free the resources to Districts and to meet accounting and auditing measures and demands.
5. To engage professionals, NGOs, as per need to ensure that the finest human resources meet the needs of the Mission.
6. To lead and train health team at all levels and to arrange for quality technical assistance to districts.
7. To get independent studies done to determine progress against benchmarks.
8. To establish transparent, timely and quality procurement procedures.
9. To finalize formats for survey and reports and to ensure timely submission.
10. To converge with other departments and seek to facilitate administrative instructions for effective action.
11. To encourage a culture of transparency, accountability, and strength.
12. To involve non-governmental providers and to develop models of effective risk pooling **(Ministry of Health and Family Welfare, 2005).**

3.7.3.2 Methodology

At the state level information was collected from the Director NRHM. Prior permission was taken from and fixed the meeting. The research was explained and the later in-depth interview was taken from NRHM officer. Collected information

was gathered and analyzed after analysis put them into different categories which are as follows:

3.7.3.3 Findings

1. General views on child malnutrition and maternal health

In, Madhya Pradesh malnutrition is the big problem. According to National Family Health Survey (NFHS) -3 severe acute malnutrition is 12.6% in the country by the time it declines up to the 9.2 means 3.6% decline. At the national level, Madhya Pradesh is in the 7^{th} position. Lack of the early initiation of the breastfeeding, exclusive complementary feeding, lack of counseling on preventive measure and pneumonia, diarrhea, neonatal cases, childhood anemia all contribute in the malnutrition among the children.

According to Health Director, WCD follows the weight of age criteria and Health department follows the Height for age criteria. If WCD follows the Weight for Age criteria; then the child is malnourish but from our side child is not malnourished. Thus, this type of mismatch found in both the sections.

2. Convergence

According to the Health Director, they are getting the support from the Director of Women and Child Development (WCD) officials. According to them convergence is good at the state level, but if we move down from a height to bottom this convergence is lacking like- district level, CDPO and BMO level and at functionaries level.

3. Major contribution of the department

At the state level, dastak campaign is initiated among the people, which includes health promotion, specific protection and early diagnosis and rehabilitation services. The problem is not solved only by the building infrastructure, increasing human resource and equipment. Community people have a lack of awareness; that's why our section started active mode means active screening at the community level (Going towards to the community people at their doorstep for providing the health services) through the "***Dastak Abhiyan".***

In which they are bringing out the convergence model by including ANM, AWW, ASHA, Panchayat and PRIs members. "***Dastak Abhiyan"*** includes the following-

1. Management of the severe anemia
2. Active case findings of SAM children
3. Management of diarrhea and distribution of ORS. Integrated diarrhea control fortnight (IDCF) strategy also includes by active case finding especially during June and July along with the distribution of ORS packets.
4. At home catches all the cases during the visit
5. Treatment for visible congenital defects, cataract etc. in the early stage to reduce the disability.
6. Vitamin A supplementation as it reduces the incidence the measles, diarrhea, and anemia.
7. Increase the awareness among the people regarding Infant and Young Child Feeding (IYCF) practices.

5. Hurdles / Problem faced by the department

- Lack of synergism at the grass root level
- Ignorance of the community
- Increase not only supplies to the community also demand side should be active to receive the services
- Failure of the community side like- Lack of parental care
- Failure of the govt side like- no livelihood security so purchasing power is less
- Human resource constraints, especially for Dr. they don't want to go to the rural areas.
- Training Backlog

6. Future Plan

1. Focus on the food diversity and make aware the community people.
2. Distribution of assorted vegetable seed packets to among mothers before leaving the NRC.
3. Focus on the community-based management as the most of the malnutrition cases present because of the lack of nutrients and improper feeding practices.

4. Bridging the human resource courses
5. Increase community empowerments through counseling services.

3.8 Summary

In this chapter, researchers explored the Interactive actions between Health and WCD department at different levels. At the Institutional level Gram Aarogya Kendra (GAK), Anganwadi centres (AWCs), Nutrition Rehabilitation centres, Sub-centres, Primary health centres and Community health centres were studied. In affiliation with the Institutional level presence of human resource, facilitates available at the institutions, equipment, instruments, physical Infrastructure and medicine facilities, furniture and availability of diagnostic kits at the SC, PHC, CHC, AWC, and services delivered by health institutions to the beneficiaries.

At the village level, Village Health and Nutrition Committee (VHSC) and Panchayati Raj Institutions (PRIs) were studied throughout the in-depth interviews to explore their responsibilities towards the beneficiaries, managements of AWC and active role in community participation, etc.

At the supervisory level, ASHA Facilitator, Anganwadi supervisor / Mukhya Sevika and Lady Health Visitor were interviewed. As they are in direct contact with the health providers and their guidance plays very important role in the functioning of these grass root functionaries. At the block level, Child Development Project Officer and Block Medical Officer of Health is responsible for the management ICDS and health services. The in – depth interview was conducted for getting the necessary information.

Women and Child Health Department (WCD) and Health Department are responsible for the overall management of the ICDS and Health programs at the district level. They guidance plays very important role in the functioning and success of the program as they act as a leader for the programs. The interview was conducted to explore the information in depth.

At the state level, Directorate of Women and Child Development (WCD) and Directorate of Health Services / Director NRHM was contacted for the data collection. The state is responsible for the whole sole management of the program. The health

indicators of the Madhya Pradesh are not up to the mark and to reach the target their planning and management at the state level plays the important role.

In this chapter, an effort was made to explore and collect the information, including the various levels of-Village, block, district, state, health institution level, supervisory level etc. to better understanding the research problem.

Chapter 4: Providers Perceptions in Delivering the Services

4.1 Anganwadi Workers (AWWs)

4.1.1 Introduction

ICDS is a centrally sponsored program implemented by the department of women and child development and Ministry of Human resource development of the government of India **(Gupta et al, 2013).** The objectives of ICDS are consistent with the MDGs for reducing child death rate, improving maternal health, and eradicating extreme poverty and hunger **(Planning Commission, 2011).** The grass- root level workers of the Integrated Child Development Services are the Anganwadi workers. Anganwadi workers provide primary health care, education, nutrition services and early childhood education to the children and health services and health education to expectant and nursing mothers **(Joshi and Parikh, 2015).**

According to Government of India (2013), the Anganwadi workers should be a female from the local village and acceptable in the local community. The AWW selected by a committee consisting of the District Social Welfare Officer (DSWO), the block development officer (BDO), the Child Development Project Officer (CDPO), the Medical Officer of the Primary Health Centre, the President of the Taluka Panchayat / Block Advisory Committee, the district representative of the State Social Welfare Advisory Board and any other non-officials which the State Government may consider appropriate. Under recently approved restructured ICDS Scheme, the minimum qualification for selection of Anganwadi Workers has been fixed as Matriculation and the age as 18-35 years.

The significance of the word Anganwadi in English terminology is Courtyard Shelter. Anganwadi word is derived from the Hindi word "Again" which refers to the courtyard of a home. Health workers are the most important nexus between the rural people and health care system. AWW is the mainstay of the program **(Thakare et al, 2011).** An Anganwadi is a centrepiece for the delivery of ICDS services to children and Pregnant and lactating mothers. An Anganwadi normally covers a population of 1,000 in both rural and urban areas and 700 in tribal areas. Services at Anganwadi centres are delivered by Anganwadi workers **(Sandhyarani and Usha, 2013).**

Her task is to run the Anganwadi, survey all the families in the neighborhood, enroll eligible children, ensure that food is served on time every day, conduct the preschool education, activities, organize immunization sessions with the ANM, make home visits to pregnant mothers, etc. An Anganwadi normally covers a population of 1000 in both rural and urban areas and 700 in tribal areas **(Thakare et al, 2011).**

AWW document information on population, births, and deaths of children, maternal deaths, pregnancy, and delivery, no. of children attended AWC, supplementary food distribution, pre-school education, and nutritional status of children by weight for age, information on nutrition and health education, and home visits as a monthly progress report. Similarly, AWW's prepare a half-yearly progress report on the literacy standard of AWW, training details of AWW, increase/ decrease in weight of children, details on space for storing rations at AWC, availability of health cards, availability of registers, availability of growth charts, etc. AWW, obligatory send a monthly progress report (MPR) by the 5th day of following month to CDPO' In-charge of an ICDS Project. Besides, she mandates to send the half-yearly progress report (HPR) to CDPO by 5th April and 5th October every year **(Government of Madhya Pradesh (GOMP), 2016).**

4.1.2 Method and Materials

The present study was carried out in Sanwer and urban slums of Indore district, Madhya Pradesh. There are 81 Panchayat in Indore block. The researcher selected Azad Nagar, Ajay Bagh colony, Musa Khedi, Yadav Nagar and Khati Mohalla etc. under Indore slums for data collection by using purposive sampling. Total 105 Anganwadis running under these areas. 30 Anganwadis centre chose for data collection by using simple random sampling. So, total 30 AWWs were selected for research study from Indore slums. Similarly, Sanwer has the 147 villages along with a total population 2, 41,310 and has 147 Village Health and Sanitation Committee. Total 135 Anganwadis running under these villages. 30 Anganwadis centre chose for data collection by using simple random sampling. So, total 30 AWWs were selected for research study from Sanwer.

Each AWC was visited by the researcher from Monday to Wednesday from 9 am to 2 pm. All the AWWs have filled the structured questionnaire. A structured questionnaire was used to gather the data on the Socio-demographic and economic profile of Anganwadi workers, General information related to work experience, their knowledge about ICDS services and skill connected to weight monitoring (See Appendix).The collected data were entered and analyzed by using SPSS. To explore more detailed information on VHND, referral services, work experience and constraints during the work, focus group discussion was carried out (See appendix).

Table 4.1 Blue print of data collection on AWW

S .No	Levels of data collection	No of respondent	Respondents	Methods of data collection	An instrument used
1	Villages (Sanwer block)	30	Anganwadi Workers	Interview & Questionnaire	FGD & Structured questionnaire
2	Indore slums (Indore block)	30	Anganwadi workers	Interview & Questionnaire	FGD& Structured questionnaire

4.1.3 Findings

Table 4.2 Socio-Demographic profile of Anganwadi workers in Sanwer and Indore Slums

		Anganwadi workers			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
Age	<21 yr	1	3.33%	-	-
	21-30 yr	6	20%	5	16.66%
	31-40 yr	8	26.66%	13	43.33%
	> 40yr	15	50%	12	40%
Education	Secondary (8^{th})	9	30%	-	-
	High School (10^{th})	8	26.66%	2	6.66%
	Intermediate (12^{th})	11	36.66%	10	33.33%
	Graduate	2	6.66%	18	60%
Religion	Hindu	30	100%	25	83.33%
	Muslim	-	-	5	16.66%
Caste	ST	7	23.33%	2	6.66%
	SC	10	33.33%	5	16.66%
	OBC	4	13.33%	11	36.66%

	General	9	30%	12	40%
Marital status	Married	27	90%	29	96.66%
	Unmarried	-	-	-	-
	Widow	2	6.66%	1	3.33%
	Separated	1	3.33%	-	-

Table 4.2 exhibits the social, demographic profile of Anganwadi workers in Sanwer and Indore Slums. In affiliation with Age, half of AWW (50%) were under the age of > 40 yrs, followed by 31-40years (26.66%), 21-30 years (20%) and < 21 years (3.33%), respectively in Sanwer. Also, less than half i.e. 43.33% and 40% AWW were under the age of 31-40 years and >40 years, respectively; and few AWW were i.e. 16.66% were < 21 years.

In relation with education level, some of the AWW passed Intermediate, Secondary, High School and few were graduate i.e. 36.66%, 30%, 26.66% and 6.66%, respectively in Sanwer. More than half AWW in Indore slums, were graduate i.e. 60% and some were intermediate passed and few have high school education i.e.33.33 % and 6.66%, respectively.

In Sanwer and Indore slums, about all the AWW were Hindu i.e. 100% and 83.33%, respectively; few AWW were Muslims in the Indore slums i.e.16.66 %. In affiliation with caste, SC was 33.33%, ST was 23.33%, and OBC was 13.33% and general were 30%, respectively in the Sanwer. In Indore slums, less than half of the AWW i.e. 40% and 36.66% were belonged to the general and OBC category, respectively. Few AWW were SC and ST i.e. 16.66% and 6.66%, respectively in Indore slums.

Nearly all the AWW were married in Sanwer and Indore slums i.e.90 % and 96.66%, respectively. Only 6.66% were widowed and 3.33% were separated from husband in the Sanwer. Few AWW i.e. 3.33% were widowed in the Indore slums.

Table 4.3 Economic profile of Anganwadi workers in Sanwer and Indore Slums

		Anganwadi workers			
		Sanwer (n=30)		**Indore Slums (n=30)**	
		No.	**%**	**No.**	**%**
Family Structure	Joint Family	29	96.66%	23	76.66%
	Nuclear Family	1	3.33%	7	23.33%

Monthly income	3,000-5,000	13	43.33%	5	16.66%
	5,001- 7,000	17	56.66%	11	36.66%
	7,001-9,000	-	-	14	46.66%
Occupation of husband	Working in private company	12	44.44%	11	37.93%
	Govt Sector	3	11.11%	2	6.89%
	Farmer	9	33.33%	-	-
	Self-business	-	-	15	51.72
	Not working	3	11.11%	1	3.44%

The economic profile of Anganwadi workers in Sanwer and Indore Slums were shown in Table 4.3. All the AWW lived in a joint family in Sanwer i.e. 96.66%. Similarly, 76.66% AWW lived in a joint family in Indore slums and fewer were living in the nuclear family in Indore slums i.e. 23.33%. More than half of the AWW had the monthly income between Rs.5, 001-7,000 i.e. 56.66% and less than half of the AWW had a monthly income between Rs.3, 000-5,000 i.e. 43.33%, respectively in Sanwer. Similarly, 46.66% AWW had the family income between Rs.7, 001-9,000, 36.66% had between Rs.5, 001-7,000 and 16.66% had Rs. 3,000-5,000, respectively.

In affiliation with the occupation of AWWs' husband, 44.44% were working in private company, 33.33% were the farmer and 11.11% was working in govt sector and 11.11% AWWs' husband were not working, respectively in Sanwer. Similarly, more than half of the AWWs' husband had self-business, i.e. 51.72%, more than one-third were working in private company, i.e. 37.93% and few were working in govt sector and a few were not working i.e. 6.89% and 3.44%, respectively.

Table 4.4 General Information of Anganwadi workers in Sanwer and Indore Slums

		Anganwadi workers			
		Sanwer (n=30)		**Indore Slums (n=30)**	
		No.	**%**	**No.**	**%**
Years of Experience	<5 yrs	4	13.33%	4	13.33%
	5-10 yrs	10	33.33%	21	70%
	11-15 yrs	1	3.33%	1	3.33%
	16-20 yrs	2	6.66%	4	13.33%
	21-25 yrs	13	43.33%	-	-
Residence	Within the village	23	76.66%	29	96.66%
	Outside the village	7	23.33%	1	3.33%
Pre-services Training	Yes	27	90%	30	100%
	No	3	10%	-	-

Refresher training	Yes	17	56.66%	20	66.66%
	No	13	43.33%	10	33.33%
How many years before	1yr	2	11.76%	4	20%
	2 yr	5	29.41%	6	30%
	3 yr	7	41.17%	10	50%
	More than 4 yrs	3	17.64%	-	-
Frequency to arrange meetings with mothers	Weekly	1	3.33%	3	10%
	Once in 15 days	7	23.33%	5	16.66%
	Once in a month	12	40%	13	43.33%
	More than 1 month	10	33.33%	9	30%
Type of survey conducted	Population	-	-	-	-
	Ration card survey	-	-	-	-
	Children survey	-	-	-	-
	Pregnant mother surveys	-	-	-	-
	All	30	100%	30	100%

As seen in Table 4.4, less than half of AWWs had 21-25 years of experience, i.e. 43.33%, one-third had 5- 10 years of experience, i.e. 33.33% and few had the experience < 5 years, i.e. 13.33% and 16-20 years i.e. 6.66% and only 3.33% had 11-15 years of experience, respectively in Sanwer. Besides, most of the AWWs had 5-10 years of experience, i.e. 70%, few had < 5 years and 16-20 years' experience, i.e. 13.33% and 13.33%, respectively and only 3.33% had the experience between 11-15 years in Indore slums.

Most of the AWWs lived within the village area in Sanwer i.e. 76.66% and Almost all the AWWs lived / within the territory of a population of the beneficiaries i.e. 96.66%, respectively. Few AWWs' lived outside the village i.e. 23.33% in Sanwer and only 3.33% lived in the outside the beneficiaries of coverage in Indore slums.

Almost all the AWWs from the Sanwer received the pre-services, training, i.e. 90% and a few didn't receive the pre-services training i.e. 10%. In contrast, all the AWWs received the pre-services, training i.e. 100% in Indore slums. More than half i.e. 56.66% AWW received the refresher training and 43.33% didn't receive the refresher training in the Sanwer. Likewise, two third of the AWWs received refresher training, i.e. 66.66% and a few didn't receive the refresher training in Indore slums i.e. 33.33%, respectively.

With respect to how many years before, some received 3 years before i.e. 41.17%, some received 2 years before i.e. 29.41%, some received more than 4 years before i.e. 17.64 and few received 1 year before i.e. 11.76%, respectively in Sanwer. Almost half of the AWWs received refresher training 3 years before and 30% and 20% received 2 years and 1 year before, respectively in Indore slums. 40% of AWWs arranged the meetings with mothers once in a month and one-third i.e. 33.33% AWWs arranged more than one month, 23.33% were arranged once in 15 days and few i.e. 3.33% were arranged meetings weekly, respectively in Sanwer. Similarly, 43.33% of AWWs arranged the meetings with mothers once in a month and 30% AWWs arranged more than one month, 16.66% were arranged once in 15 days and few i.e. 10% were arranged meetings weekly, respectively in Indore slums. Almost all the AWW had to do population, ration card, children and pregnant mother survey in Sanwer and Indore slums i.e. 100%.

Table 4.5 Problem faced by Anganwadi workers in Sanwer and Indore Slums

No.	Items	Anganwadi Workers			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
1	Inadequate salary	23	76.66%	24	80%
2	Discontinue of salary	21	70%	18	60%
3	Infrastructure related	19	63.33%	10	33.33%
4	Work overload	14	46.66%	30	100%
5	Excessive record maintenance	30	100%	30	100%
6	Lack of community support	18	60%	7	23.33%
7	Logistic supply related	20	66.66%	18	60%
8	Inadequate supervision	23	76.66%	24	80%
9	Discrimination by community	21	70%	5	16.66%
10	Low attendance of children	17	56.66%	15	50%

Table 4.5 presents the problem faced by Anganwadi workers in Sanwer and Indore Slums. In affiliation with the problems faced by AWWs showed that three fourth, i.e. 76.66% AWW had the problem related to inadequate supervision and inadequate salary and 70% faced discontinue of salary and discrimination by community, two third i.e. 66.66% faced logistic supply related problem and 63.33% faced infrastructure-related problem, 60% received a lack of community support. More

than half faced low attendance of children, i.e. 56.66% and 46.66% work overload problem, respectively in the Sanwer.

Also, all the AWW faced the problem of excessive record maintenance i.e. 100%. Similarly, inadequate salary and inadequate supervision was the problem of AWWs in Indore slums i.e. 80%. More than half faced discontinue of salary and logistic supply related problems i.e. 60%, half of the AWW faced the problem of low attendance of children, i.e. 50%, one-third had Infrastructure related, i.e. 33.33%, 23.33% faced the lack of community support and 16.66% faced discrimination by community members in the Indore slums. All the Anganwadi faced the over workload and excessive record maintenance problems, i.e. 100% in Indore slums.

Table 4.6 Awareness regarding the role and responsibilities of Anganwadi workers in Sanwer and Indore Slums

No.	Items	Anganwadi Workers			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
1	Caring of children (0-6yrs)	30	100%	30	100%
2	Growth monitoring (0-6 yrs)	25	83.33%	30	100%
3	Supplementary food distribution (0-6 Yrs)	27	90%	29	96.66 %
4	Supplementary food to pregnant and lactating mothers	28	93.33%	30	100%
5	Supplementary food distribution to adolescent girls	21	70%	25	83.33 %
6	Distribution of Iron and folic acid to mother and adolescent girls	24	80%	26	86.66 %
7	Participation in immunization	22	73.33%	27	90%
8	Health check up	23	76.66%	25	83.33 %
9	Treatment of minor ailments	13	43.33%	22	73.33 %
10	Preschool education to children	18	60%	26	86.66 %
11	Community survey	30	100%	30	100%
12	Arranging mother’s meeting	13	43.33%	18	60%
13	Arranging and organizing VHND	30	100%	30	100%
14	Attending VHSC meeting	19	63.33%	21	70%

As seen in Table 4.6 all the AWWs in Sanwer were aware of the care of children (0-6yrs), community survey, arranging and organizing VHND and provision of supplementary food to pregnant and lactating mothers i.e. 100%. 90% of AWW aware about supplementary food distribution (0-6 Years), 83.33% and 80%, respectively aware about growth monitoring (0-6 years) and distribution of Iron and folic acid to mother and adolescent girls, 76.66% aware about health check-up and 73.33% aware about their participation in immunization, 70% aware about distribution of supplementary food to adolescent girls, 63.33% aware about attending VHSC meeting, 60% were aware about preschool education to children and 43.33% AWW aware about arranging a mother's meeting and treatment of minor ailments in the Sanwer.

All the AWWs in Sanwer were aware of the care of children (0-6yrs), Growth monitoring (0-6 years), community survey, arranging and organizing VHND and the provision of supplementary food to pregnant and lactating mothers i.e. 100%. 96.66% of AWW aware about supplementary food distribution (0-6 Years), 86.66% aware about distribution of Iron and folic acid to mother and adolescent girls and preschool education to children, 83.33% aware about supplementary food distribution to adolescent girls, and health check-up, 73.33% were aware of the treatment of minor ailments, 70% aware about attending VHSC meeting and 60% were arranging a mother's meeting in Indore slums.

Table 4.7 Knowledge of Anganwadi workers regarding services delivered at AWC in Sanwer and Indore Slums

S no	Content	Total no of questions asked	Correct Responses			
			Sanwer (n=30)		Indore Slums (n=30)	
			No.	%	No.	%
1	Immunization	(7*30) 210	92	43.80%	160	76.19%
2	Nutrition and health education	(4*30) 120	54	45%	80	66.66%
3	Supplementary nutrition	(3*30) 90	35	38.8%	60	66.66%
4	Growth monitoring	(4*30) 120	46	38.33%	94	78.33%
5	Health check-up	(4*30) 120	41	34.16%	84	70%
6	Referral services	(2*30) 60	22	36.66%	45	75%
Total		720	290	40.27%	623	86.52%

Table 4.7 showed the knowledge of Anganwadi workers regarding services delivered at AWC in Sanwer and Indore Slums. As seen in the table total number of questions on immunization was seven, on nutrition and health education was four, regarding supplementary nutrition was three, regarding growth monitoring and health check-up was four and about referral services were two. Total 24 questions were asked to the 30 AWW. So, 720 questions were asked to 30 AWW and out of which 290 questions were correctly answered by the AWW in Sanwer i.e. 40.27%. Similarly, out of 720 questions, 623 were answered correctly by the AWW in Indore slums i.e. 86.52%. Less than half i.e. 43.80% and three-fourth, i.e. 76.19%, respectively AWW gave the correct answers regarding immunization in Sanwer and Indore slums. Similarly, less than half i.e. 45% and two third of AWW were correctly answered questions on nutrition and health education.

38.8% and 66.66% AWW were correctly answered about supplementary nutrition in Sanwer and Indore slums, respectively. Regarding growth monitoring, 38.33% and 78.33% gave the correct answers. 34.16% and 70% were correctly answered regarding health check-up and 36.66% and 75% were correctly answered regarding the referral services in the community by the AWW in Sanwer and Indore slums, respectively.

Table 4.8 Knowledge level of Anganwadi workers in Sanwer and Indore Slums

Level of Knowledge	**Sanwer (n=30)**		**Indore Slums (n=30)**	
	No.	**Percentage**	**No.**	**Percentage**
Poor (<33%)	6	20%	3	10%
Average (33% to 66%)	20	66.66%	11	36.66%
Good (>66%)	4	13.33%	16	53.33%

Total Ques. 24 *Poor- <8 (<33%) *Average – 8-16(33-66%) *Good- > 16(> 66%)

Table 4.8 presents the knowledge level of Anganwadi workers in Sanwer and Indore Slums. Two third of AWW had the average knowledge, i.e. 66.66%, followed by 20% had poor knowledge and 13.33% had good knowledge about the service delivered through AWC in the Sanwer. Similarly, 53.33% had good knowledge, 36.66% had an average knowledge and 10% had the poor knowledge regarding services delivered through the AWC in Indore slums.

Table 4.9 Skill Assessment level of Anganwadi workers regarding Growth monitoring in Sanwer and Indore Slums

Skill	Sanwer (n=30)		Indore Slums (n=30)	
	No.	**Percentage**	**No.**	**Percentage**
Poor (<33%)	5	16.66%	2	6.66%
Average (33% to 66%)	18	60%	15	50%
Good (>66%)	7	23.33%	13	43.33%

Total Ques. 30 *Poor- <10 (<33%) *Average – 10-20 (33-66%) *Good- > 20 (> 66%)

Table 4.9 presents the skill assessment level of Anganwadi workers regarding growth monitoring in Sanwer and Indore Slums. About 60% of AWW had the average skill regarding the growth monitoring of the children followed by 23.33% had the good and 16.66% had the average skill about growth monitoring in Sanwer. Similarly, 50% AWW had an average skill level followed by 43.33% had average and 6.66% had poor skill regarding the growth monitoring in Indore slums.

4.14 Focus Group discussions with AWWs

Focus group discussion was conducted with the AWWs at the AWC in Sanwer and Indore slums. Total 30 Anganwadi workers were included in focus group discussion. Before conducting focus group discussions, the objectives of the research study were explained to the AWW in detail. FGD was recorded and after analysis divided into themes which are as follows-

1. Activities at the AWC

According to the AWW, enrolled beneficiaries (children 1-5 years, pregnant and lactating mothers and adolescent girls) come to the Anganwadi and received the services. Children come to the AWC received the pre-school education, develop the communication skills and eat hot cooked supplementary food at the Anganwadi centres. Also, those children who are malnourished children received the THR. Time to time growth monitoring was done from 0-5 years of children. Anganwadi helper was called to the children for AWC in Sanwer and Indore's slums. Pregnant and lactating mothers and adolescent girls were also received the THR.

"*Didi 1 se 5 saal tak ke bacche, garbhati aur dhatri mahilaye aate he anganawdi par.chote baccho ko hum kavita, ginti aur kahaniya sunate he. Aur bacche*

khalte bhi he. Unko yaha se khana milat he aur unks awajan bhi lete he hum log. Subh Anganwadi helper ghar –ghar jati he bulane…. garbhati aur dhatri mahilao aur kishori balikao ko bhi packet milte he yaha se. kichdai, halwa mix, sattu k packet hote he ye sab….."

(AWWs Sanwer and Indore slums, FGD)

2. VHND activities and convergence

During VHND pregnant mothers were coming to the AWC and registration was done by the ANM. They were checked for BP and those who were looking anemic checked for hemoglobin. Weight monitoring was also done during VHND. Children have received the immunization and growth were taking place during VHND. Nutrition and education, counseling were provided to pregnant and lactating mothers and those whose children were malnourished and anemic. Proper health check-up was done.

"Didi, mangal diwas par garbhati mahilao ka regisatration hota he aur ANM karti he.unka wajan lena, B.P. check karana aur jiski aakhe pili dekhe unko khoon ki janch karna ye sab hota he. Jinko tika legna he unko ANM tika legati he aur wajan bhi liya jata he. garbhati aur dhatri mahilao ko kya kahna he, Iron ki dawai samay par lena he, aram karna he……. Ye sab bataya jata he mangel diwas par"

(AWWs Sanwer and Indore slums, FGD)

On VHND ANM came for immunization and weight monitoring. If a child is sick, she gave them paracetamol tablet and if a child's weight is less, refer them to the NRC. According to her mothers busy in the house-hold works and do not pay attention to the children's. Children used to eat Kurkure and do not eat properly, that's why they easily get sick and anemic. We gave the Albendazole tablet to them and take the proper weight of those who are weak.

"Mangel diwas par ANM aati hai tikakaran aur wajan aur khoon ki jach karti he , ager koi bacha bimar ho to paracetamol de deti he ,ager bache ka wajan kam ho to hum unko Cha-cha Nehru (NRC) bhej dete he……mahilaye dyan nahi deti he ghar k akam me lagi rahi he aur bacche kurkure kahta he, kahna to

thik se kahte hi nahi he, isliye bimar pad jaate he bache aur khoon ki kami bhi rahte he , hum krimi nasak dawa pilate he, baccho ka wajan lete he jo kamjor he ….."

(AWWs, Indore slums, FGD)

AWW used to work with the ASHA and ANM without any problem. ASHA called to pregnant mothers and AW helpers called the children and ANM provide the immunization and necessary suggestions. We don't face the big problem and worked together. We helped ANM along with ASHA. We bring children for immunization and who ever needs, we took the weight of them and referred to NRC.

"Hum mil kar kam karte hai ASHA anr ANM k sath koi deikkat nahi hoti he, ASHA garbhvati mahilo ko bula leti he, helper baccho ko bula leti he aur ANM tikakran aur jaruri salah de deti hai, koi jaydaparsahni nahi hoti he hum miljulkar kam karte hai, hum aur ASHA, ANM ki madat karte he, baccho ko titkakar k liye late he aur jinko jarat ho wjan le kar aur puri jach karker hi NRC ya hospital bhjete he "

(AWW, Indore slums, FGD)

Here no one comes on VHND day. We only discuss with the supervisor about the census, about the files, duty in pulse polio immunization all these will discuss during the meetings. Nobody asked about the functioning of the AWC.

"*yaha koi nahi aata he mangel diwas par, bas ager hamri meeting bhi hoti he supervisors k sath to kitni jangdana hui, kini file ban gai, pluse polio me duty kaise legna he , yahi baate hoti he, angawadi ko koi puchta hi nahi hai"*

(AWW, Indore slums, FGD)

According to them, No officers come to supervise them. They only meet at the PHC. They do all their work by self. If we have a problem, then we hesitate to speak publicly and officers tell us to do your work we will see.

"Madam yaha koi adhikari nahi aata he aur supervisor bhi nahi aate hai, bas jab meeting hoti he PHC par tab hum milte he , baki to sara kam hum khud karte he, koi samsaya ho to meeting me bolna padta he to hum log

boltene se darte hai nahi he aur adhiakri sirf soon lete he, bolte hai aap pana kam karte rahiye, baki hum dekh lege “

(AWW, Sanwer, FGD)

3. Problems

Anganwadi workers faced lots of problems during the delivering of services in the Sanwer and Indore slums named as –Excessive workload, the indifferent behavior of community people, lots of paperwork, blamed from supervisors, inadequate salary, work pressure, extra work, no remuneration for extra work etc. They had to prepare the files and each file contains 20 rupees. They were not eligible to take any money from the beneficiaries. Prior beneficiary used to get five checks and all are merged into one. We already gave the reports to the office, but they demand 2007-2008 reports within the 2 days. Day and night we are busy only in this work. We have no personal life and misunderstanding occurs with the family members. Today is VHND day and we are busy in preparing the files. Now a day deworming program is going on, ASHA helps us, but we have to fill all the information. We have a duty in pulse polio program after fifteen days. Before this, we worked for the collection of census data. Prior we used to sit from morning 7.30 to evening 6.30 and they gave too much work to us. How we can do the work of the Anganwadi and still we do not get any money for previous work.

“didi humko ye filele banana padti he. Ek file banana ka 20 rupyee lagte he jo ki hum hitgrahi se nahi le sakte he…. Ye filele puranai he…phale hitgarahi ko paach check milte the is yojana me, ab sab ko milakar dena he….. iski report hum pahle hi de chukde he par fir hum se magi he……. 2007-2008 ki report haumn banakar di he 2 din me……. hum raat din isi me lege juye he,hamri koi apni life bhi nahi he, parivar walo se bhi khatpat ho jati he……. Aaj mangel diwas he aur hum ye file bana me busy he. Abhhi deworming ka bhi kam cha rahe he, ASHA madat karti he par humko likhana pata he sari jankari, ab 15 dino ke baad pulse polio karyalarm he usme duty he, iske pahle bhi jangadna me duty thi ……. Pahle bhi hum subh 7.30 se sham ke 6.30 beje tak baithe he .....hum se itna kam karwate he… hum Anganwadi ka baki kam kaise karege batiye….. aur jo kam karte bhi he uske humne aaj tak paise bhi nahi mile he…”

(AWWs, Indore slums, FGD)

One AWW said that she went house to house for the collection of census data from morning to evening and she finished the BLO work but she still did get any money. They were not allowed to speak to the supervisors and they create pressure on

us to do work and tell us how much do you work and how many Sunday's you spend for work.

"didi mene to ghar ghar jakar gandgi me jangandna ka kam kiya he subh se sham tak aur meri duty BLO ka kam karne me bhi legit hi aur abhi tak koi paise bhi nahi mile he….. hum apne supervisor ko kuch nahi bol sakte he, hum par dabao banaya jata he ki kam karo, tum kam hi kitna karte ho… aur kitne Sunday tum ruk gaye ho…."

(One AWW, Indore slums, FGD)

One AWW said since two years she did not receive money for preparing the voter ID cards and they do not provide money and used us for work.

"Mujhe to 2 saal ho gaye aaj tak parichaya patra banana k paise bhi nahi mile he …. Aur kam bhi karwate he paise bhi nahi dete."

(One AWW, Indore slums, FGD)

One of the AWW said that officers do not have the idea about how to utilize the AWWs and put the work upon us.

"Adhikariyo ko sanjhe hi aata he ki Angawadi karkartao se kis prakar se kam le, bas hum par kam ko thop dete he aur dabao dalte he ki karo"

(One AWW, Indore slums, FGD)

Madam, we faced many problems as we are from the lower class, very few people send their children to the AWC. When ANM is here, then they come. Officers told us to go into the houses, but as we belong to the lower caste we are not eligible to enter the house of the upper caste, what we do? Children from the upper caste come here only for immunization and they do not take any food from here. We distribute these foods to others. They took only take home rations.

"*Madam yaha gaon me kam karne me kai dikkate he jiase ki hum logo me se kuch niche jati k he to yaha Anganwadi par kam hi bacche aate he, jab ANM aati eh tabhi aate he….adhikari kehte he ghar ghar jao kaise jaye humhe ghar ke under to aane nahi dete ….kuch to ghar k bar se hi bhaga dete he….hum kya kare ….uchi jati k bacche to yaha sirf tika karan k liye hi aate he … aur yaha ka khana bhi*

nahi le jate he….hum to dusaro ko dete he ……bas yaha ye purak aahar k packet hi le jate he ….”

(AWWs, Sanwer, FGD)

People from here do not want to hear us and do not want to the Anganwadi. The Govt is spending a lot of money on them still they delivered in the private institutions. Officers told us you do not counsel them properly. After the lots of the counseling, some people delivered and immunized the child in private institutions. Beneficiaries told us they give the best treatment and medicines were not harmful to us. They have money to spend on the treatment.

“Yaha k log sunte hi nahi he kitna hi bol do, Anganwadi bhi nahi aate he, sarkar in logo k liye kitna kuch kar rahi he, par phir bhi private me deliverykarwate he, adhikari bolte he ki tum log sahi tarike se maholao ko nahi batate ho….kuch log to kitna sakjhe k bavjud privete me delivery aur tike legwate he…..kehte he vaha ache de dekhte he aur vaha ki goliya bhi nuksan nahi karti he …. Un logo k pass paisa bhi to hai kharch karne k liye.”

(AWWs, Sanwer, FGD)

Because of the caste problem we have less ASHA workers in our village and other villages. They do not send their daughters in law and daughters into the house of lower caste people, that's why no one wants to become an ASHA worker and we have to do their work in the village like- called the pregnant mothers, we faced problems.

“hamare yaha yahi jati k karan ASHA worker hai hi nahi aur kuch aur gao me bhi nahi he, unke ghar wale niche jati me apni bahu – betiyo ko nahi bejhna chate he jiske karan koi bhi ASHA banana ko tayar hi nahi hota he aur unka kam bhi hum ko karna padta he jaise grabhvati mahoilao ko bulana badi dikkat hoti he”

(One AWW, Sanwer, FGD)

Sometimes ANM do not talk to us properly because we are educated that much and belongs to a lower caste.

"kabhi kabhi ANM bhi sahi se baat nahi karti kehti hai kiyo ki hum uthe pade likha nhai hai aur niche jati se hai."

(One AWW, Sanwer, FGD)

4. Co-operation

AWW in Indore slums were found cooperation from the ASHA and ANM. ASHA helped us, now the deworming program is going on so we went together to the school, houses and ASHA brought the pregnant mothers on the VHND day. Our ANM is also good and she helped us and we worked together.

"Humhe to ASHA madat karti he, abhi bacho ko kimi nasak dawa pilana ka karuya karam chal raha hai to hum sath sath jatehe gharo aur school me aur magel diwas par bhi ASHA garbhati mahilao ko lekar aati he, hamari ANM madam bhi achi he madat karti he, hum mil kar kam karte he.

(AWWs, Indore slums, FGD)

5. Referral services-

After the consultation with ANM, we referred the malnourished child to NRC. If any pregnant mother faced any problem, they went to the MY hospital or Prakash Chand hospital, they situated nearby and there is no problem.

"Jo bache kam wajna wale hote hi unko ANM se ek bar dekha kar ya baat karke hum log NRC bhj dete he, age koi garbhavti to koi dikkat ho to yaha MY ya Prakah chand sethi hospital chali jati hai, pas me hi he koi dikkat ki baat nahi hai"

(AWWs, Indore slums, FGD)

Here we faced a problem to send the child because of the non-availability of 108. In the whole area, we have only two 108. We carry the child to the NRC. We received 100 Rs for this. There is no facility here in the Sanwer and we faced the problems to send the child to the NRC in Sanwer.

"Madam yaha bacho ko le jane me badi dikkat hai 108 ki suvidha hi nahi he kewel do 108 he pure area me , vo bhi kabhi patrol nahi he to aurduasre kamo me lagi rahi he, hum to baccho ko khud hi le jate he Sanwer NRC par ,

paise to milte hai 100 rupyee , yaha Sanwe me koi sadhan bhi nahi hai, badi muskil se lejate he hum kupashit baccho ko"

(AWW, Sanwer, FGD)

5. Suggestions and experience

According to the problem faced AWW gave some suggestions and shared their experience about Focus group discussions.

Officers should correctly plan on how to use the Anganwadi workers. We will get the money for which we worked and understand our problems and do not pressurize us for work. We feel good someone is here to hear us and send our talks to the upper authorities members.

"*Adhikariyo ko thik se plan karna chahiye ki Anganwadio se kis parakar kam karwana he. Humhe paise bhi mil jaye jo hum ne kam kya he.aur humhari baato aur samsayao ko bhi samjhe, hum par dabao na dale….Humko acha lega humhe bhi koi sunne aaya he ..aap hamari baato ko upper tak pahuchye"*

(AWWs, Indore slums, FGD)

No one comes here to see us, you are here, we feel good. Tell our problems to the higher authorities as we faced the problems.

"Madam yaha koi nahi aata he dekhne k liye, aap aaye acha lega, hamari samsiyao ko upper tak aap puchchana aur batana ki hamhe kin musibato ka samna karna padta he"

(AWW, Sanwer, FGD)

4.2 Accredited Social Health Activists (ASHA)

4.2.1 Introduction

The Government of India established the National Rural Health Mission (NRHM) in 2005, under which many innovations have been inaugurated in the provinces to deliver health care services. ASHAs are female community health workers (CHWs) aged between 18-45 years, selected from the villages they belong (1/1000 population), with a minimum of eight years of education **(Sarin et al., 2016)**. The aim

of ASHA worker is to provide primary medical care, advice on sanitation to the community, hygiene, prenatal and postnatal care, escorting expectant mothers to the hospital for safe delivery etc. **(Shashank and Angadi, 2015).**

Table 4.10 Blueprint of data collection on ASHA

S.No	Levels of data collection	No of respondent	Respondents	Methods of data collection	An instrument used
1	Villages (Sanwer block)	30	ASHA Workers	Interview & Questionnaire	FGD & Structured questionnaire
2	Indore slums (Indore block)	30	USHA workers	Interview & Questionnaire	FGD& Structured questionnaire

4.2.2 Method and Materials

The present study was carried out in Sanwer and urban slums of Indore district, Madhya Pradesh. There are 81 Panchayat in Indore block. The researcher selected Azad Nagar, Ajay Bagh colony, Musa Khedi, Yadav Nagar and Khati Mohalla etc. under Indore slums for data collection by using purposive sampling. Total 105 Anganwadis running under this area. So, 30 USHA workers, who were working in relation with AWCs, were selected for research study from Indore slums. Similarly, Sanwer has the 147 villages along with a total population 2, 41,310 and has 147 Village Health and Sanitation Committee. Total 30, ASHA workers were chosen for data collection by using simple random sampling from Sanwer for the research study.

All the ASHA workers have filled the structured questionnaire. A structured questionnaire was used to gather the data on the Socio-demographic and economic profile of ASHA workers, general information related to work experience, awareness regarding role and responsibilities, record Maintenance, their knowledge about Maternal and child services and skill related to ORS preparation (See Appendix).

The collected data were entered and analyzed by using SPSS. To explore more detailed information focus group discussion was carried out to explore the referral

services, coordination with the other front line worker, experience and constrains during the service delivery etc. (See appendix).

4.2.3 Findings

Table 4.11 Socio-Demographic profile of ASHA workers in Sanwer and Indore Slums

		ASHA workers			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
Age	<20 yr	-	-	-	-
	20-30 yr	22	73.33%	21	70%
	31-40 yr	7	23.33%	9	30%
	> 40yr	1	3.33%	-	-
Education	Primary (5^{th})	11	36.66%	-	-
	Secondary (8^{th})	7	23.33%	3	10%
	High School (10^{th})	8	26.66%	5	16.66%
	Intermediate (12^{th})	3	10%	13	43.33%
	Graduate	1	3.33%	9	30%
Religion	Hindu	28	93.33%	21	70%
	Muslim	2	6.66%	9	30%
Caste	ST	3	10%	5	16.66%
	SC	16	53.33%	7	23.33%
	OBC	7	23.33%	8	26.66%
	General	4	13.33%	10	33.33%
Marital status	Married	28	93.33%	27	90%
	Unmarried	-	-	-	-
	Widow	-	-	2	6.66%
	Separated	2	6.66%	1	3.33%

Table 4.11 presents the Socio-Demographic Profile of ASHA workers in Sanwer and Indore Slums. Most of the ASHA workers from age group 20-30 years, i.e. 73.33%, followed by 23.33% belonged between 31-40 years and 3.33% belonged to > 40 years in Sanwer. Similarly, the majority of ASHA workers i.e.70 % belonged to 23- 30 years and few i.e. 30% ASHA workers were > 40 years in Indore slums.

In affiliation with the education 36.66% ASHA were primary passed, 26.66% were high school passed, 23.33% were secondary passed, 10% were Intermediate passed and few i.e. 3.33% ASHA worker was graduated in the Sanwer. Similarly, 43.33% ASHA were Intermediate passed, 30% ASHA were graduated, 16.66% were high School passed and only 10 % were primary passed in Indore slums.

Most of ASHA workers in the Sanwer were Hindu i.e. 93.33% and few ASHA worker were Muslim i.e. 6.66%. Similarly, 70% of ASHA workers were Hindu in Indore slums and 30% ASHA were Muslim. In relation to caste, most of ASHA workers were SC i.e. 53.33%, followed by OBC i.e. 23.33%, general i.e.13.33 % and ST i.e.10 %, respectively in Sanwer. In contrast, one-third i.e. 33.33% ASHA were general, 26.66% were OBC, 23.33% were SC and few i.e. 16.66% were ST in the Indore slums. The majority of ASHA workers was married i.e. 93.33% and 90% in Sanwer and Indore slums, respectively. Few ASHA workers were separated, i.e. 6.66% in Sanwer. Similarly, 6.66% were the widow and 3.33% were separated in Indore slums.

Table 4.12 General Information about ASHA workers in Sanwer and Indore Slums

		ASHA workers			
		Sanwer (n=30)		**Indore Slums (n=30)**	
		No.	**%**	**No.**	**%**
Years of Experience	<1 yrs	5	16.66%	-	-
	1-5 yrs	14	46.66%	27	90%
	6-10yrs	11	36.66%	3	10%
Residence	Within the Village	30	100%	30	100%
Pre-services Training	Yes	18	60%	27	90%
	No	12	40%	3	10%
Refresher training	Yes	10	33.33%	19	63.33%
	No	20	66.66%	11	36.66%
How many years before	1yr	4	13.33%	5	16.66%
	2 yr	3	10%	7	23.33%
	3 yr	3	10%	6	20%

As seen in the table 4.12 more than half i.e. 46.66% ASHA worker had 1-5 years of experience followed by 36.66% had 6-10 years and 16.66% were had < 1 years in the Sanwer. Besides, the maximum number of ASHA workers had 1-5 years of experience, i.e. 90% and few i.e. 10% ASHA worker had 6-10 years of experience in the Indore slums. All the ASHA workers were the resident of the village i.e. 100% in the Sanwer and Indore slums, respectively. 60% of ASHA worker received the pre-services, training and 405 did not receive the training in Sanwer. Similarly, maximum numbers of ASHA workers received the pre-services, training, i.e. 90% and a few were not receiving the pre-services training i.e. 10% in Indore slums.

Two third of ASHA workers, i.e. 66.66% and one third i.e. 33.33% ASHA received the refresher training in Sanwer. Similarly, 63.33% of ASHA workers received the ASHA refresher training and 36.66% were not receiving the refresher training in Indore slums. In affiliation with refresher training, how many years before 13.335 received four years before, 10% received two years before and another 10% received three years before, respectively in Sanwer. Similarly, 23.33% ASHA has received refresher training two years before, 20% received three years before and 16.66% were receiving refresher training one year before in Indore slums.

Table 4.13 Awareness regarding the role and responsibilities of ASHA workers in Sanwer and Indore Slums

No.	Items	ASHA Workers			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No	%
1	Help with immunization	11	36.6%	21	70%
2	Accompany delivery cases	30	100%	30	100%
3	Family planning	22	73.33%	27	90%
4	Assist in ANC and PNC care	30	100%	30	100%
5	Advice on breast feedings to mothers	21	70%	30	100%
6	Hygiene and health practices	20	66.66%	25	83.33%
7	Reproductive and sexual health problems	18	60%	24	80%
8	Motivating and mobilizing communities	19	63.33%	25	83.33%
9	Village health plans	21	70%	30	100%
10	Birth and death registration	25	83.33%	30	100%
11	Treatment and referral	17	56.66%	24	80%
12	Reduce IMR and MMR	19	63.33%	24	80%
13	Home visits for new born	21	70%	30	100%
14	Prevent malnutrition and feeding problem	18	60%	30	100%

Table 4.13 presents the awareness of ASHA workers in Sanwer and Indore Slums in relation to their role and responsibilities. 100% of ASHA workers aware about the responsibilities for accompanying mother's during delivery and assist in the ANC and PNC care in Sanwer. 83.33% were aware of their responsibilities in birth and death registration, 73.33% aware about family planning, 70 % aware about home visits for newborn, advice on breast feedings to mothers and Village health plans, 66.66% aware about hygiene and health practices, 63.33% aware about the reduction of IMR and

MMR and motivating and mobilizing communities, 60% were aware about reproductive and sexual health problems and prevent malnutrition and feeding problem, 56.66% were aware of treatment and referral services and 36.6% aware of provide help in immunization in Sanwer.

All the ASHA workers aware about their responsibilities in accompanying mothers during delivery cases assist in ANC and PNC care, advice on breast feedings, preparation of Village health plans, during birth and death registration, during home visits for newborn and prevent of malnutrition and feeding problems i.e. 100% in Urban slums. 90% of ASHA workers aware about family planning, 83.33% were aware of hygiene and health practices and motivating and mobilizing communities 80% were aware of reproductive and sexual health problems and reduce IMR and MMR along with treatment and referral services and 70% were aware in helping in immunization during VHND in Indore slums.

Table 4.14 Records Maintenance by ASHA workers in Sanwer and Indore Slums

No.	Items	ASHA Workers			
		Sanwer (n=30)		Indore Slums (n=30)	
		Correct Answers			
		No.	%	No	%
1	ANC records	23	76.66%	30	100%
2	New born visit record	26	86.66%	30	100%
3	Home delivery record	18	60%	30	100%
4	Institutional delivery record	30	100%	30	100%
5	Immunization records	18	60%	27	90%
6	Family planning records	23	76.66%	28	93.33%
7	Birth and death registration	27	90%	30	100%
8	Household survey records	24	80%	26	86.66%
An inspirational force behind record maintenance					
9	Gram Pradhan	11	36.66%	-	-
	ANMs	2	6.66%	-	-
	Supervisors	17	56.66%	30	100%
The factors motivating you to do the work					
10	To provide health services	2	6.66%	3	10%
	To earn money	13	43.33%	12	40%
	To do something (Time pass)	9	30%	5	16.66%
	Hoping for absorptions in govt job	6	20%	10	33.33%
Satisfied with the incentives					
11	Yes	6	20%	2	6.66%
	No	24	80%	28	93.33%

Expectations					
12	Better incentives	12	40%	5	16.66%
	Fixed regular monthly payment	11	36.66%	18	60%
	Incentives for more work	5	16.66%	4	13.33%
	Incentives for good work	2	6.66%	3	10%

As seen in the Table 4.14, 60% of ASHA workers had to maintain records on home delivery and Immunization, 76.66% maintained the ANC and family planning records, 80% maintained household survey records, 86.66% maintained new born visit record, 90% were maintained the birth and death registration records in Sanwer. All the ASHA workers have maintained the 100% records on institutional delivery in Sanwer. Similarly, ANC, newly born visit, home delivery, Institutional delivery and birth and death records were 100% maintained by the ASHA workers in Indore slums. 93.33% ASHA workers have maintained family planning records, 90% maintained Immunization and 86.66% were maintained household survey records in Indore slums.

ASHA workers in Sanwer agreed for the inspirational force behind record maintenance was supervisors i.e. 56.66%, 36.66% said Gram Pradhan and 6.66% ASHA workers said ANMs. In contrast, all the ASHA workers were agreed for supervisors were the inspirational force behind record maintenance in Indore slums. Less than ASHA workers i.e. 43.33% were working to earn money, 30% were working for Time pass / do something, 20% were working for absorption in govt job and few i.e. 6.66% were working for providing health services to the community people in Sanwer. Similarly, in Indore slums 40% ASHA workers were workers for earning money, 33.33% were working for absorptions in govt job, 16.66% were working for time pass and some i.e. 10% were working for providing health services. The majority of ASHA workers was satisfied with the incentives i.e. 80% and 93.33%, respectively, in Sanwer and Indore slums. 20% and 6.66%, respectively, ASHA workers were not satisfied with incentives in Sanwer and Indore slums. 40% of ASHA workers were expected better incentives, 36.66% expected the fixed regular monthly payment, 16.66% expected incentives for more work and few i.e. 6.66% expected incentives for good work in Sanwer. Similarly, the majority of ASHA workers were expect fixed, regular monthly payment, 16.66% expected better incentives, 13.33% expected incentives for more work and 10% expected incentives for good work in Indore slums.

Table 4.15 Knowledge of ASHA workers regarding Maternal and Child health services in Sanwer and Indore Slums

S no	Content	Total no of questions asked	Correct Responses			
			Sanwer (n=30)		Indore Slums (n=30)	
			No.	%	No.	%
1	Maternal Health	(12*30) 360	186	51.66%	279	77.5%
2	Child health	(12*30) 360	193	53.61%	283	78.61%
Total		720	379	52.63%	562	78.05%

Table 4.15 presents the knowledge of ASHA workers regarding Maternal and Child health services in Sanwer and Indore Slums. In affiliation with maternal health, 51.66% ASHA were correctly answered and 53.61% were correctly answered for Child health services in the Sanwer. Total 720 questions were asked to ASHA about Maternal and Child health, out of which 379 questions answered correctly by ASAH workers in Sanwer i.e. 52.36%. Similarly, 78.61% and 77.5% were correctly answered about Maternal and Child health services, respectively in Indore slums. Total 78.05% ASHA were correctly answered for Maternal and Child Health.

Table 4.16 Knowledge level of ASHA workers in Sanwer and Indore Slums

Level of Knowledge	Sanwer (n=30)		Indore Slums (n=30)	
	No.	Percentage	No.	Percentage
Poor (<33%)	5	16.66%	-	-
Average (33% to 66%)	19	63.33%	14	46.66%
Good (>66%)	6	20%	16	53.33%

Total Ques. 24 *Poor- <8 (<33%) *Average – 8-16(33-66%) *Good- > 16(> 66%)

As seen in the Table 4.16, 63.33% ASHA workers had average knowledge about maternal and Child health services followed by 20% had good knowledge and 16.66% had poor knowledge in Sanwer. Similarly, 46.66% ASHA workers had an average knowledge and 53.33% had good knowledge about the Maternal and child health services in Indore slums.

Table 4.17 Skill Assessment level of ASHA workers regarding antenatal assessment in Sanwer and Indore Slums

Level of Knowledge	Saner (n=30)		Indore Slums (n=30)	
	No.	Percentage	No.	Percentage
Poor (<33%)	4	13.33%	-	-
Average (33% to 66%)	16	53.33%	11	36.66%

Good (>66%)	10	33.33%	19	63.33%

Total Marks 50 *Poor- <16 (<33%) *Average -16-32 (33-66%) *Good- > 32 (> 66%)

Table 4.17 showed the skill assessment level of ASHA workers regarding the antenatal assessment in Sanwer and Indore Slums. More than half i.e. 53.33% were performed average, 33.33% were performed good and 13.33% were performed poorly in antenatal assessment in Sanwer. 63.33% were performed well in antenatal assessment and 36.66% was performed average in Indore slums.

1.2.4 Focus Group discussions with ASHA

Focus group discussion was conducted with the ASHA and USHA workers in the Sanwer and Indore slums. The objectives of the study were explained to all ASHA workers in detailed and make a rapport with them. Focus group discussion was carried out in Prakash Chand Sethi hospital with the USHA and in Sanwer this FGD was carried at the AWC near to the Primary health centres, Dakachya, Sanwer. FGD was analyzed and divided into themes which are discussed below-

1. Motivation for becoming USHA/ASHA worker

Some of the USHA workers in the Indore slums were working as a voluntary worker since 1998 but after the few years of starting of NRHM programs, USHA workers were selected as a USHA worker in Indore slums. Most of them were working for the welfare of the community as they were voluntary workers.

The motivational factor of ASHA workers was different as from the USHA worker in Indore slums. Most of them were working because of a low socioeconomic condition.

One ASHA worker said that her family condition was not good that why she became an ASHA worker. Apart from her others ASHA workers also do not have a good family status that's why they also work as an ASHA worker.

"Madam ji hamhare gahr ki parivarik isthiti achi nahi thi isliya me ASHA karyakarta ban gai, mere alawa aur bhi ASHA he jinki parivarik isthiti achi nahi he, isliye vo bhi ASHA ban kar kam kar rahi hai"

(One ASHA workers, Sanwer, FGD)

2. Problems

Almost all the USHA workers disrespected by the doctors, family members, respective office worker like -–blood bank, laboratory etc. even by a peon and a security guard. They laugh at them, but they were doing their own job.

One USHA worker said that she went to the blood bank office in an emergency then office worker said to her why you are coming now, it's about to 1 o'clock and then laughed at her. She replied in a respectful manner and said to him since morning I was busy in one patient's delivery and now in an emergency, I am here then he became silent.

"Me ek patient k liye emergency me gai thi blood bank k office me form lene to office bola kya madam ab aa rahe ho ek baj rahe he aur mujh par hasa, mene aadar se kaha me subh se ek patient ki delivery me busy hu aur abhi emergency me aai hu ….phir uski hasi band ho gai"

(One USHA worker, Indore slums, FGD)

Some were given the suggestion for not to work as a USHA worker and demoralized them and directed them.

Some hospital staff said to them, why you became an ASHA worker. You have to run a lot. Day and night you have to run with the delivery patients and very less money you receive.

"Kuch kehte hai are tum kaha ASHA ban gai, bada bhagna padta he,raat din deliervy walo ke sath bhago aur pasie bhi kitne kam milte he tum logo ko"

(USHA workers, Indore slums, FGD)

USHA worker said that when they entered the hospital the peon and security guard used to laugh at them and said now doctors are here, with delivery patients. Also asked them where you want to go? Are you a doctor? You are just a USHA worker. Even doctors used to tell them now maid is here. Whenever we stay with the delivery patient, they said come and you do delivery and we are going outside. This kind of behavior we faced.

"Jab hum log delivery k liye aate he to peon or security guard bhi hum par haste he, aa gaye doctors delivery walo k sath, aur bade gande tarike se kaehte hai kaha jana he, doctor ho kya, USHA hi to ho……..Aur doctors bhi kehti he aa gai baiya…. Hum patient k sath rahte hai to kehti he tum hi delivery karwa lo hum jate he bahar ….is tarah se humare sath vaivhar kya jaata he"

(USHA workers, Indore slums, FGD)

Sometimes family members were not cooperative with the USHA worker. One USHA worker said that one patient's has suffered from severe bleeding and referred to MY hospital. Any complication happened at the end of the delivery, but her family members got angry at her. We have to suffer a lot they said before her daughter in law normally delivered the child but now because of her they in the health institution and delivery being conducted by the operation. Better we delivered at the private hospital. In this way, family members got angry at her.

"Madam ek patient ko achank se bleeding hone legi thi aur use M.Y. refer kar diya tha, koi bhi complication ho saktehe end time par, par uske parivar wale mujhe par guassa karne lege ya USHA le kar aa gai yaha par hum to private me delivery karwa lete, itna parashan hona padta hai hum ko …..phle bhi normal delivery hui thi ab USHA yaha le aai to operation se bacha hua,is se acha to hum private me hi karwa lete…aisa keh kar mujh par gussa karne lege uske parivar wale.

(USHA workers, Indore slums, FGD)

3. Lost respect among beneficiaries

We taught that we have to stay with the patient up to the full delivery procedure and the patients feel some known person is here with us, but doctors through them outside because of this we lost faith among the beneficiaries and we lost respect. Once I went to MY hospital for delivery of one patient, but one doctor scolds me like anything and asked who are you, doctor? Oh USHA worker, you are here for delivery, come and deliver the patient.

"Humko sikhya jata he ki patient k sath rahna he puri delivery tak, aur patient ko bhi acha legta hai hamari jan pahchna wala koi under hai par doctors log hamhe bhaga deti hai aise me hum par hitgrahiyo ka vishwas kam hota hai aur humari izzat kam hoti he …Me ek bar MY gai thi ek patient ki delivery k liye ek doctor ne mujhe

data aur kaha kon ho doctor, acha USHA ,aa gai delivery karwane, aao delivery karwa lo."

(One USHA worker, Indore slums, FGD)

4. Corruption

Doctors don't want to stay USHA workers with the delivery patient. They disrespected and demoralized them and at the end, they did the brainwash of delivery patient and made fake reasons and motivate them for caesarean delivery and earn money. These doctors instructed peon and security to disrespect them because after demoralization less USHA will come and those gynecologists easily get the patients for caesarean section.

One USHA worker said that she wanted to bring the 37 weeks pregnant mother for institutional delivery, but she suffered from diarrhea and bring to earlier. I stayed with her one night. The next day she had a back pain and I knew that it is not the delivery pain, but doctors scold me and kept away from her and after she did caesarean of the patient. We received only 200 Rs but we work honestly.

"Me ek patient ko 37 weeks me delivery k liye yaha lane wali thi par achank use diarrhea ho gaya aur use jaldi lana pada, me uske sath ek raat ruki, agle din use kamar me hlaka sa dard shru ho gaya vo delivery ka dard nahi tha, par madam ne mujhe data kar bhej diya aur baad me uski caesarean delivery ho gai…….kewel 200 rupyee milte he par phir bhi hum imadari se kam karte he "

(One USHA worker, Indore slums, FGD)

At the end doctors wrote on the paper no motivation for normal delivery and not present during the delivery for the USHA worker, even the whole nine months they spent their time with the pregnant mothers and get done their full antenatal check-up.

"Hum pure no-no mahine grabhvati mahila k sath rahte he par end time par report me doctors likh deti thi USHA nahi thi aur koi motivation nhai diya gaya normal aur institutional delivery k liye ….jut like deti he hamare bare me."

(One USHA worker, Indore slums, FGD)

5. Discrimination and indifferent behavior of the community

ASHA workers in Sanwer have faced discrimination by the community members and some faced work interference by the family members and some were not free to practice their own duty.

Among us, few are from lower castes and few are from upper caste. Our family members were allowed to go with the people from lower castes and told us not to stay outside during the night. We follow the purdah system and we do not allow to be among the other male, these are our problems and even the nurses do not behave properly and they delivered the patients and we are not allowed in the delivery room.

"Hum me se kuch nichi jati ki ASHA hai to kuch uchi jati ki, hamare parivar wale hamhe niche jati walo k sath jane nahi dete, aur kehte hai hum se ki raat me nahi jaana aur hamare yaha to parda hai, dusare mardo ke bich me bhi nahi ja sakte hai, ye sab hamari samyahye he ……aur hospital me nurse bhi ache se baat nahi karti hai….kud hi delivery karwati hai aur hamhe under bhi aane nahi deti hai."

(ASHA workers, Sanwer, FGD)

One ASHA worker said that she went to the home for polio immunization, but his grandmother stopped me and said ANM will give the medicine because I am from the lower caste that's why she said like this, I feel so bad.

"Me ek din ek bacche ko ghar par polio ki dawai pilane wali thi, uski dadi ne rok diya, ANM madam pilayge …me nichi jati se hu to aisa keh diya us bacche ki dadi ne, mujhe acha nahi lega"

(One ASHA worker, Sanwer, FGD)

When we went for pulse polio immunization in the well-educated colony, the residence people asked that are this medicine is good or harmful? Did you wash hands before giving the pulse polio immunization?

"Achi colony me jab hum baccho ko pulse polio pilane jate hai to, vaha k log kehte hai ye dawai achi hai, kharab to nahi hai, tumne hath dhoye bacche ko dawa pilane se phle ……" (USHA workers, Indore slums, FGD)

6. Referral services

There is no problem faced by USHA workers in Indore slums regarding referral services, but ASHA workers always faced the problem related to the referral of the pregnant mothers.

In this area frequency of 108 is very less and we have to take pregnant mothers to the hospital and we faced a lot of problems. It is our responsibility so we have to pay attention to her and roads are broken in some places so we faced problems.

"yaha par 108 ki services bahut hi kam hai, hamhe kud hi private sadhan se le jana padta hai mothers ko, isme bajut dikkat hoti he, hamari puri jimadajri hoti hai kbhi kuch mahila ko ho jaye to humhe dyan dena padta he….aur sadke bhi kahi kahi tuti tuti hai to badi dikkat hoti he."

(ASHA workers, Sanwer, FGD)

7. AWC and VHND sessions

All the ASHA and USHA were participating actively on VHND at the AWCs in Sanwer and Indore slums.

We bring the mothers to the VHND sessions and a full check up along with TT immunization was done during VHND. We helped the ANM and along with AWW, we went for the pulse polio immunization. Give the de-worming tablets to the children these are the works which we have to do. If child left for immunization then we brought to them to the AWC, we worked together.

"Hum mangel diwas par grabhavti mahila ko le jate hai puri jach karwate hai aur TT k pure dose legwate hai, ANM ki madat bhi karte hai, aur AWW ke sath milkar Pulse polio me jate hai, baccho ko krimi nasak pilana ye sabhi kam karte hai hum log…ager koi bacha chuct jaye tikakaran k liye use AWC le kar aate hai, hum milkar kam karte hai"

(USHA workers, Indore slums, FGD)

During the VHND, all the ASHA workers bring the mothers to the AWC for a full check up like- weight monitoring of the patient, blood check-up, BP monitoring and helped the AWW also in weight monitoring.

"yaha mangel diwas par sabhi ASHA apne area ki grabhvati mahilo ko Anganwadi le kar aati hai aur puri jach karati hai jaise wajan lena, khoon ki jach karna, B.P. lena, aur hum AWW ki bhi madat kar dete hai wajan lene me .."

(ASHA workers, Sanwer, FGD)

8. Suggestions

USHA and ASHA workers suggested some points regarding their problems. USHA workers in Indore slums demand their respect and cooperation from the community members. They also suggested removing the corruptions during institutional delivery. ASHA workers from the Sanwer suggested the availability of 108 services and create awareness among the community people regarding caste related problems.

"Madam humko sammna milna chihiye, hum bhi mehnat karte he vo bhi puri imandari k sath aur community walo ka support bhi chhiye taki hum ache se kam kar sake. Iske alawa jo corruption ho raha hai doctor k dwara uski bhi jach honi chhiye"

(USHA workers, Indore slums, FGD)

In the village, there is less provision of the 108 service that why we faced problems. Govt has to take the firm decision, so we take the mothers for the institutional delivery and govt create some awareness among the society of caste system and we worked easily.

"Gaon me 108 ki suvidha kam hai jaiske karan dikkat hoti hai to sarkar ko koi thos kadam uthne chahiye taki grabhavti mahila sansthagat delivery k liye ja sake aur ye samaj me jo jati ke karan dikkat hai uske liye sarkar koi jagrukta jagye taki humhe kaam karne me aasani ho sake"

(ASHA workers, Indore slums, FGD)

4.3 Auxiliary Nurse Midwives (ANMs)

4.3.1 Introduction

Auxiliary nurse midwives (ANMs) providers and handle the rural health sub-centre in a community area. They act as an intermediary between the community and health system for the Maternal and Child Health Program in India **(Barua and Kurz, 2001 cited in Kumar and Mahapatro, 2013).**

ANM has had a two-year nurse midwifery course based on the maternity services in the local terminology. She has nine months of elementary nursing followed by 15 months of midwifery. Moreover, subject area practice for two or three months at a primary health centre. The ANM mainly spends the mornings at home visiting and in the afternoon she performs clinic-based actions **(Franz and Rosa, 1967).**

4.3.2 Method and Materials

The researcher selected Azad Nagar Dispensary, Prakash Chand Sethi Hospital and M.Y. Hospital for a selected of ANM by using purposive sampling. Total 30 Auxiliary Nurse Midwives selected from Indore slums by using Simple random sampling. Likewise, Auxiliary Nurse Midwives from Sub-centres, Primary Health centres, and CHC were included in the research study by the use of purposive sampling and out of these institutions, 30 ANMs were selected for data collection. Finally, total 60 ANMs were selected from Sanwer and Indore slums.

Each institution was visited by the researcher from Monday to Friday. All the ANMs were filled the structured questionnaire. A structured questionnaire was used to gather the data on the Socio-demographic and economic profile of Auxiliary Nurse Midwives, General information related to work experience, their knowledge about maternal and primary health care services and Immunization schedule and skill related to maternal assessment during delivery (See Appendix). The gathered data were recorded and studied by using SPSS. To explore more detailed information on, referral services, activities on VHND, work experience and constraints, job satisfaction, coordination with ASHA and AWW etc. focus group discussion was carried out (See appendix).

Table 4.18 Blueprint of data collection for ANM

S.No	Levels of data collection	No of respondent	Respondents	Methods of data collection	An instrument used
1	Sanwer block	30	ANM	Interview & Questionnaire	FGD & Structured questionnaire
2	Indore slums	30	ANM	Interview & Questionnaire	FGD& Structured questionnaire

4.3.3 Findings

Table 4.19 Socio Demographic profile of Auxiliary Nurse Midwives in Sanwer and Indore Slums

		ANM			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
Age	21-30 yr	7	23.33%	5	16.66%
	31-40 yr	20	66.66%	19	63.33%
	> 40yr	3	10%	6	20%
Education	High School (10^{th})	6	20%	3	10%
	Intermediate (12^{th})	14	46.66%	18	60%
	Graduate	10	33.33%	9	30%
Religion	Hindu	25	83.33%	12	40%
	Muslim	2	6.66%	8	26.66%
	Christian	3	10%	10	33.33%
Caste	ST	5	16.66%	3	10%
	SC	6	20%	3	10%
	OBC	4	13.33%	5	16.66%
	General	15	50%	19	63.33%
Marital status	Married	27	90%	29	96.66%
	Unmarried	2	6.66%	-	-
	Widow	1	3.33%	1	3.33%

Table 4.19 presents the Socio-Demographic Profile of Auxiliary Nurse Midwives in Sanwer and Indore Slums. Two-thirds of ANM were between the 31-40 years of age group, 23.33% were between the age group of 21-30 years and 10% ANM was > 40 years in Sanwer. Similarly, 63.33% were between the age group 31-40 years, 20%

ANM were > 40 years and 16.66% ANM belonged to 21-30 years of the age group in Indore slums.

In affiliation with the education, 46.66% were Intermediate passed and 33.33% ANM were having the graduation degree and 20% ANM had been high school passed in the Sanwer. Similarly, 60% ANM were Intermediate passed, 30% were graduated and 10% ANM were High School passed in Indore slums. 83.33% of ANM were Hindu, 10% were Christian and 10% ANM were Muslim in Sanwer. Similarly, 40% of ANM were Hindu, 33.33% were Christian and 26.66% were Muslim in Indore slums.

In affiliation with caste 50% of ANM belonged to general category, 20% belonged form SC category, 16.66% belonged to ST category and 13.33% were OBC in Sanwer. Similarly, 63.33% were belonging from general category, 16.66% belonged to OBC, 10% were SC and another 10% belong to ST category in the Indore slums. The majority of ANM was married i.e. 90%, 6.66% were unmarried and 3.33% were widowed in Sanwer. Similarly, 96.66% ANM were married and few i.e. 3.33% were widowed in the Indore slums.

Table 4.20 Economic Profile of Auxiliary Nurse Midwives in Sanwer and Indore Slums

		ANM			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
Family Structure	Joint Family	17	56.66%	15	50%
	Nuclear Family	13	43.33%	15	50%
Monthly income	Up to 10,000	12	40%	11	36.66%
	10,001-20,000	16	53.33%	12	40%
	20,001-30,000	2	6.66%	7	23.33%
Occupation of husband	Working in private company	25	83.33%	21	70%
	Govt Sector	2	6.66%	5	16.66%
	Retired	3	10%	4	13.33

Table 4.20 presents the economic profile of Auxiliary Nurse Midwives in Sanwer and Indore Slums. As viewed in the table more than half of the ANM were living in the Joint family i.e.56.66 % and less than half i.e. 43.33% were living in a nuclear family in the Sanwer. Likewise, half of the ANM were living in a Joint family

and half of the ANM were living in Nuclear family, i.e. 50% and 50% respectively in Indore slums.

More than half of the ANM' monthly income was between Rs.10, 001-20,000 i.e. 53.33% and 40% had a monthly income up to Rs.10, 000 and few ANM i.e. 6.66% received their monthly income between Rs. 20,001-30,000 in Sanwer. 40% ANM' were received monthly income between Rs.10, 001-20,000, 36.66% had monthly up to Rs.10, 000 and 23.33% were received between Rs.20, 001-30,000 in Indore slums. In affiliation with the occupation of husband', the majority of ANM' husband was working in private company i.e. 83.33%. 10% were retired and 6.66% were working in govt sector in Sanwer. Similarly, 70% ANM' husband was working in private company, 16.66% were working in govt sector and 13.33% were retired in the Indore slums.

Table 4.21 General Information of Auxiliary Nurse Midwives in Sanwer and Indore Slums

		ANM			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
Years of Experience	<5 yrs	2	6.66%	1	3.33%
	5-10 yrs	6	20%	3	10%
	11-15 yrs	9	30%	13	43.33%
	16-20 yrs	11	36.66%	7	23.33%
	21-25 yrs	2	6.66%	6	20%
Residence	Within the village	-	-	2	6.66%
	Outside the village	30	100%	28	93.33%
Pre-services Training	Yes	30	100%	30	100%
	No	-	-	-	-
Refresher training	Yes	19	63.33%	21	70%
	No	11	36.66%	9	30%
How many years before	1yr	3	10%	3	10%
	2 yr	6	20%	8	26.66%
	3 yr	7	23.33%	8	26.66%
	More than 4 yrs	3	10%	2	6.66%

As seen in the table 4.21, in association with years of experience 36.66% ANM were having 16-20 years of experience, 30% were having 11-15 years of experience, 20% were having 5-10 years of experience and 6.66% were having 21-25years of experience and another 6.66% had < 5 years of experience in Sanwer. Similarly, 43.33% ANM had 11-15 years of experience, 23.33% had 16-20 years experience, 20%

had 21-25 years of experience, 10% ANMs had 5-10 years and 3.33% had < 5 years of experience in Indore slums.

Nearly all the ANM in Sanwer and Indore slums were living outside the village / out of the residence of the urban slums i.e. 100% and 93.33%, respectively, and in Indore slums, few were living in the residence of the urban slums i.e. 6.66%.

All the ANMs received pre-services, training in the Sanwer and Indore slums i.e. 100%. Approx. 63.33% ANM have received the refresher training and 33.66% were not receiving the refresher training in the in the Sanwer. Similarly, 70% of ANM have received refresher training and 30% were not received refresher training in the Indore slums.

In relation with how many years before, 23.33% were received refresher training three years before, 20% were received two years before, 10% were obtained one year before and another 10% received more than four years before in Sanwer. Likewise, 26.66% ANM received refresher training two years before and another 26.66% received three years before and 10% received one year before and few received more than four years before i.e. 6.66 % in Indore slums.

Table 4.22 Problem faced by Auxiliary Nurse Midwives during work in Sanwer and Indore Slums

No.	Items	ANM			
		Sanwer (n=30)		Indore Slums (n=30)	
		No.	%	No.	%
1	Excessive work	18	60%	21	70%
2	Less support from ASHA worker	11	36.66%	6	20%
3	Lots of meetings have to attain	8	26.66%	10	33.33%
4	Shortage of skilled staff	14	46.66%	5	16.66%
5	Family problems	12	40%	2	6.66%
6.	Less support from AWW worker	12	40%	8	26.66%
7.	In different behavior of community	23	76.66%	19	63.33%

Table 4.22 shows the problems faced by Auxiliary Nurse Midwives during work in Sanwer and Indore Slums. As seen in the table three fourth of ANM faced with

different behavior by the community people, i.e. 76.66%, 60% were faced excessive work problem, 46.66% were faced shortage of skilled staff problem, 40% were faced family problems, another 40% were faced less support from AWW worker, 36.66% were faced the problem of less support from ASHA workers and 26.66% were having to attend lots of meetings in the Sanwer. Similarly, 70% of ANM faced an excessive work problem, 63.33% were faced with different behavior by community, 33.33% had to attain lots of meetings, 26.66% got less support from AWW, 20% got less support from ASHA workers, 16.66% faced a shortage of skilled staff, few were faced family problems i.e. 6.66% in Indore slums.

Table 4.23 Knowledge of Auxiliary Nurse Midwives regarding services delivered in Sanwer and Indore Slums

S no	Content	Total no of questions asked	Correct Responses			
			Sanwer (n=30)		Indore Slums (n=30)	
			No.	%	No.	%
1	Primary Health care	(7*30) 210	163	77.6%	174	82.85%
2	Maternal Health care	(7*30) 210	157	74.76%	182	86.66%
3	Child Healthcare	(6*30) 180	145	80.55%	157	87.22%
Total		600	465	77.5%	513	85.5%

Table 4.24 shows knowledge of Auxiliary Nurse Midwives regarding services delivered in Sanwer and Indore Slums. Total 600 questions were asked to the 30 ANM from Sanwer and Indore slums. In association with Primary health care total number of questions were 210 out of which 163 correctly answered by ANM i.e. 77.6%, the total number of questions on maternal care were 210 out of which 74.76% were correctly answered and 180 questions was on child care out of which 145 correctly answered; So total 465 questions were correctly answered out of 600 questions i.e.77.5 % by ANM in Sanwer.

Similarly, 82.85% were correctly answered by ANM for Primary health care, 86.66% were correctly answered by the maternal care and 87.22% were correctly answered for childcare out of 210, 210 and 180, respectively in Indore slums; So total 513 questions were correctly answered out of 600 questions by ANM from Indore slums.

Table 4.24 Knowledge level of Auxiliary Nurse Midwives in Sanwer and Indore Slums

Level of Knowledge	Sanwer (n=30)		Indore Slums (n=30)	
	No.	Percentage	No.	Percentage
Poor (<33%)	2	6.66%	-	-
Average (33% to 66%)	10	33.33%	7	23.33%
Good (>66%)	18	60%	23	76.66%

Total questions 20 *Poor- <7 (<33%) *Average – 7-14 (33-66%) *Good- > 14(> 66%)

Knowledge level of Auxiliary Nurse Midwives in Sanwer and Indore Slums is shown in the table 4.25. In Sanwer 60% of the ANM had good knowledge, 33.33% were having an average knowledge and 6.66% had poor knowledge. Similarly, approx. Three-fourth ANM had good knowledge, i.e. 76.66% and 23.33% were having an average knowledge in Indore slums.

Table 4.25 Knowledge level of Auxiliary Nurse Midwives regarding Immunization in Sanwer and Indore Slums

Level of Knowledge	Sanwer (n=30)		Indore Slums (n=30)	
	No.	Percentage	No.	Percentage
Poor * (<33%)	-	-	-	-
Average* (33% to 66%)	7	23.33%	-	-
Good * (>66%)	23	76.66%	30	100%

Total questions 48 *Poor- <16 (<33%) *Average – 16-32 (33-66%) *Good- > 32(> 66%)

Table 4.25 exhibits the knowledge level of Auxiliary Nurse Midwives regarding Immunization in Sanwer and Indore Slums. Approx. Three-fourth of the ANM had good knowledge about Immunization and 23.33% were having average knowledge about immunization in Sanwer. All the ANM had good knowledge about Immunization in Indore slums i.e. 100%

Table 4.26 Skill Assessment level of Auxiliary Nurse Midwives regarding Antenatal care in Sanwer and Indore Slums

Skill	Sanwer (n=30)		Indore Slums (n=30)	
	No.	Percentage	No.	Percentage
Poor* (<33%)	2	6.66%	-	-
Average* (33% to 66%)	6	20%	5	16.66%
Good * (>66%)	22	73.33%	25	83.33%

Total questions 44 *Poor- <15 (<33%) *Average – 15-29 (33-66%) *Good- > 29(> 66%)

Table 4.26 shows the skill Assessment level of Auxiliary Nurse Midwives regarding Antenatal care in Sanwer and Indore Slums.73.33% ANM was having good knowledge while performing antenatal care, 20% were having average knowledge while performing antenatal care and few were having poor knowledge while performing antenatal care i.e. 6.66% in Sanwer. Similarly, the majority of ANM had good knowledge while performing antenatal care, i.e. 83.33% and 16.66% were having an average knowledge while performing antenatal care in Indore slums.

4.3.4 Focus Group discussions with ANM

Focus group discussion was conducted with the ANMs in the Sanwer and Indore slums. The objectives of the study were explained to all ANM in detailed and make a rapport with them. Focus group discussion was carried out in Prakash Chand Sethi hospital with the ANMs and in Sanwer FGD was carried at the Community Health Centres Sanwer. FGD was analyzed and divided into themes which are discussed below-

1. VHND and coordination

Children's, pregnant and lactating mothers come to the AWC on the VHND day. ASHA helps us to bring the pregnant women to the AWC and assist us in the total health examination of the mothers like- BP, weight monitoring, blood checkup, TT immunization and do the antenatal registration. AWH call to the children and AWW weighted them. If any child is sick and have less weight according to the guidelines we referred them to the NRC after giving a primary treatment like- give the paracetamol tablets for fever, ORS for diarrhea, etc. We provide health and nutrition education to pregnant and lactating mothers and also who has the sick and malnourished child in the house. Guide and instruct them for home based food preparation to cure the child easily in a home setting without any problem. ASHA and AWW provide the necessary support to us and helps in finding out the children who left for immunization.

PRIs/VHNSC and supervisors from both the departments were sometimes come to observe and supervised the VHND but whenever we needed PRIs/ VHNSC members to help us according to their convenience.

(ANMs, Sanwer, FGD)

" bacche, grabhvati aur dhatri mahilaye aati hai mangel diwas par Anganwadi Kendra par. ASHA grabhvati mahilao ko Anganwadi par lane aur unka pura check up karne me madat karti hai jaise BP dekhna, wajan lena, TT ke tike legwana aur unka panjikaran karwana.helper bacho ko bula kar lati hai aur AWWunka wajan leti hai. Ager bacha bimar hai aur manak k anusar wajan kam hai to jaruri prathmic puchar de kar hum NRC bhej dete hai jaise- bikhar ka liye paracetamol tablet, diarrhea k liye ORS. Hum grabhavti , dhatri aur jinke ghar me bimar aur kuposhit bache hai unko jaruri salah deti hai. Hum unko salah dete hai taki ghar me hi rah kar bache ghar k khane we bache ka ilaj kiya ja sake. ASHA aur AWW humko jaruri madat karti hai aur job bache tika karan k liye chut gaye hai unko dudne me madat karti hai.

Gaon k adhyakash aur dono jagah k supervisors bhi kabhi kabhi aate hai mangel diwas par jab bhi jarurat hoti hai to unko suvidha k anusar madat karte hai.

(ANMs, Sanwer, FGD)

2. Problems

Community people don't want to hear us, we are providing the immunizations facility, but they still want to go to the private institutions. According to them, they gave the painless injection to their children and I asked how do know that injection is painless, beneficiaries replied that the doctor told us we are giving your child's painless immunization.

"Log hamari baate nahi sunte hai, hum unko tika karan ki suvidha dete hai par phir bhi vo private me jana pasand karte hai, uske k anusar hospital wale unke bache ko painless tika legate hai amen pucha tumher kaise malum ki vo painless tike hai, to kaha doctor ne kaha hum aap k bache ko pain less tika legayege."

(ANMs, Indore slums, FGD)

People showed the indifferent behavior for immunization, care of children, care of pregnant mothers, about the hygiene of the children and diet, breastfeeding and weaning diet, etc. All this leads to the disease among the children and they became anemic and malnourished.

"Yaha k log udaseen vivhar karte hai bacho k tike k liye, bacho ki dekhbhal k liye, pregnant mahilao ki dekhbhal k liye, bacho ki hygiene aur khane k liye, samay par

doodh pilane k liye aur purak aahar k liye. Ye sabhi baate bacho me bimariya lati hai aur vo kuposhit aur khoon ki kami se graset ho jate hai."

(ANMs, Sanwer, FGD)

3. Discrimination among the community members

Caste wise discrimination is the major problem here. The caste system very prominent in some villages in the Sanwer. If ASHA or AWW is from a lower caste, people don't want to hear them, they do not want to follow them all these created difficult situations and increase the burden on us. Because of this govt do not reach the target and faced the failure. It's also harmful to the growth of the community people and makes difficult to cure the malnutrition problem especially among the children.

"Caste k anusar bhedbhav yaha ki badi dikkat hai. Caste system yaha kuch gaon me bhut jayda prabhavi hai. Ager ASHA ya AWW niche caste se hote hai to log unhe nahi sunte hai aur unki baate bhi nahi mante hai, ye muskile khadi karta hai aur hum par kam ka bhojh bhi bad jata hai. Is sabhi ka karan sarkar apne nirdharit lakhya tak nahi pahuch pati hai aur hark a samna karna padta hai. Ye community k logo k liye bhi nuksandayat hai and bacho k bich se kuposhan ki smasshya ko dur karne me parsahnai karta hai.

(ANMs, Sanwer, FGD)

4. Corruptions

We have continuously motivated the mothers for institutional delivery, but doctors for their own sake took the cases at their private clinic. We are small people, that's why they don't want to hear us and it makes difficult to increase the number of institutional deliveries in Indore slums.

"Hum logo ko lagatak sansthagat prasv k liye protsahit karte rahte hai par doctors apne bhale k liye cases ko apne clinic me le jate hai. Hum to chote log hai isliye koi hamari baate nahi suntan hai jis se sansthgat prasav ki sankhya badne me dikkat hoti hai.

(ANMs, Indore slums, FGD)

Some private doctors said about painless injections and beneficiaries easily agreed for injections by paying more amount and we are giving the same injections free of cost.

"Kuch private doctors kahte hai hum painless tika lagayege aur hitgrahi asani se man bhi jate hai aur hum vahi injection bina nishulk lagate hai."

(ANMs, Indore slums, FGD)

5. Suggestions

Primarily we have to remove the caste system from the village. It makes the health program difficult. As we are spreading the awareness about health care and hygiene, but govt has to improve more with great effort to generate the awareness among the community people.

"humhe sab se pahle is jati ki vayvastha ko kahtam karna hai. Ye sawasthya karyakarmo ko muskil bana dete hai. Jaise ki hum sawasthya aur safai k bare me batate hai par sarkar ko bhi uchit kadam uthane chahiye taki hum logo me jagruakta la sake."

(ANMs, Sanwer, FGD)

People who live here are stubborn. Sometimes it's very difficult to convince them for family planning and immunization of the children and institutional delivery. Higher authority should also visit the Anganwadi centre and arrange the public meeting, which create great impact on community people.

" Yaha k rahne wale log sunte hi nahi hai. Kabhi kabhi to unko perivar niyogen k liye raji karne, bacho k tika karan k liye aur sansthagat parasav k liye raji karne me dikkat ho jati hai. Adhikariyo ko Anganwadi aana chahiye aur public meeting me karna chahiye jo ki bada parbhav dalti hai logo par. "

(ANMs, Sanwer, FGD)

4.5 Summary

In this chapter, an endeavor has been made to focus on the Providers Perceptions in delivering the Services in Indore slums and Sanwer. Mainly these providers are Anganwadi workers, ASHA workers, and ANM. Socio- demographic, the economic profile of these providers were studied. Awareness of job responsibilities and general problems faced by the providers were also studied in this chapter.

Their knowledge of maternal and child services was studied by the researcher. The skill of the AWW in weight monitoring, the skill of ASHA worker in ORS preparation and ANM' skill during the delivery were being observed and studied by the researcher.

For a detailed exploration of the problems faced by the providers (AWW, ASHA, and ANM) a focused group discussion was carried out. Also, coordination among these providers and suggestions were noted by the researcher in this chapter. As their role plays an important role in the delivering the services to the beneficiaries, especially pregnant and lactating mothers and children under five; and the success of the health program, we need to improve their knowledge level and more competent in motivating the people for availing the services which are provided by the govt free of cost.

CHAPTER 5: SUMMARY AND CONCLUSION

5.1Introduction

The present study is an attempt in the direction of exploring the aspect of convergence between Health and ICDS services, utilization of services by beneficiaries and providers' perceptions, in Indore district of Madhya Pradesh. The research study contains five chapters, i.e.: the first chapter, presenting "*Introduction*", the second chapter, "*VHND and Utilization of Services by Beneficiaries*", the third chapter is "*Interactive actions between Health and WCD department at different levels*" *(State, District, Block level, health personnel's, Supervisory level and Institutional level)*", the fourth chapter is "*Providers Perceptions in Delivering the Services*", and last chapter comprises "*Summary and Conclusions*" of the research study.

The main thrust of the present work is-

1. To understand the convergence of health and nutrition related services.
2. To study the provider's perception regarding problems in delivering the services.
3. To understand the constraints regarding utilization of services delivered through the ICDS program.

In the following Section, the main findings of the research study have been summarized.

5.2 Summary of findings

The **First Chapter** comprises of the introductory section stating the background of the study, research problem and includes objectives of the study, brief description of the study area, review of literature related to different aspects of accessibility and utilization of maternal and child health services, the conceptual framework, research question, data sources, methodologies and relevance of the study, data collection methods of data analysis, ethical consideration, limitations of the study, problems encountered during the fieldwork, organization of the study, scheme of chapterization followed by the references.

The **Second Chapter** comprises the VHND and Utilization of Services by Beneficiaries in Indore district of Madhya Pradesh. The principal findings of the study highlighted the fact that most LHV, ANM, ASHA, AWW, AWH were present during the VHND sessions in Sanwer and Indore slums and the presence of the Medical officer, PRIs/VHSC members, and ICDS supervisors were very few during the VHND sessions in Sanwer and Indore slums.

All the instruments, equipment's and furniture and supplies were available during the VHND sessions. Maternal health services and child health services also offered to the beneficiaries. General services named as family planning, RTIs, and STDs, sanitation, communicable disease, gender, AYUSH, health promotion, and nutrition are given to the beneficiaries, but the construction of sanitary latrines and prevention of chronic disease and counseling was all missing. Equally, they are also the important constituent for the healthy being or community.

The majority of the beneficiaries were in the age group 20-30 years in both the areas and proportion of the age group (20-30yrs) was found to be higher in Indore slums. Data on the religion of beneficiaries showed that the majority of beneficiaries were Hindu (70%) in Sanwer and Maximum beneficiaries were Muslim (57%) in Indore slums. The maximum percent of the beneficiaries were from SC (43%) followed by ST (30%) in Sanwer and majority of beneficiaries were from OBC (30%) followed by general (34%) in Indore slums. In relation to Husband's occupation majority were working in others field (37%), in contrast, the majority (40%) married men were working in private companies in Indore slums. It was found that 11 (37%) beneficiaries' families had a monthly income of Rs.1, 001-3,000 in Sanwer and in Indore slums maximum 21 (70%) beneficiaries' monthly income between Rs.5, 000-10,000. It shows that peoples' lives in the Indore slums had the good socioeconomic background in compared to the people lived in the Sanwer.

Pregnant mothers received the services like- confirmation of pregnancy, antenatal registration, availability of MCP card, mobilization for the antenatal check-up, counseling services, mobilization for institutional delivery, place of delivery choice etc. Apart from this Lactating mothers also utilized the services like-transport facility, facility of the delivery ward, postnatal diet availability, postnatal Care /hygiene, Vital

signs monitored, neonatal care, accompanied during delivery by the ASHA workers in the Sanwer and Indore slums.

Focus group discussion with the beneficiaries showed that they faced the discrimination behavior of the health personnel during seeking of health facilities in Sanwer. **Cooper et al. (2008)** study identified that discrimination can affect health outcomes either at once or indirectly. There may be directly excluded from the health facilities by health workers and doctors, and people indirectly excluded as a result of distance from the health facilities and cost of transportation and treatment. Beneficiaries from the lower caste either mothers or children's both faced the indifferent behavior of people from upper caste in Sanwer. **Pallikadavath et al. (2004)** found home visits were biased towards households with a better standard of living. The study indicated that higher social and economic status was associated with increased chances of receiving an antenatal check-up, blood pressure measurement, a blood test and urine testing. **Vora et al. (2009)** study showed illiterate mothers and mothers from lowest wealth quintile used less basic maternal health care in comparison to mothers who are literate and belongs to wealthiest quintile.

Even few beneficiaries did not receive the Take Home Rations form the AWCs and this food easily accessible by the other community people. The staff at the sub-centre were not available during the need and accessibility for other's institutions were creating more problem for the beneficiaries of the Sanwer because of very less availability of the 108 services in Sanwer. Beneficiaries have expressed dissatisfaction with respect to the quantity, taste, lack of variety and non-acceptability of supplementary nutrition due to altered food habits. **(Sampath, 2006)** Sometimes the quality of supplementary nutrition (SN) was not good, and it caused poor image and negative attitude towards ICDS services. All the beneficiaries had the MCP cards in Indore slums as compared to the Sanwer. **Kalita et al. (2006)** study was carried out in Shivpur district of Madhya Pradesh on Effectiveness of MCP card. The MCP Card is a fruitful community management tool, which allows mothers to take responsibility and influence for mother and child health. It was observed that use of MCP card makes mothers' understanding about the care of children and self-responsibility.

Focus group discussion with the beneficiaries in Indore slums showed that they were quite happy with the services provided by the ICDS and health as compared to the

beneficiaries lived in Sanwer. Most of them were happy with food available at the AWC, VHND sessions. This may be because of the most of the beneficiaries from the Indore slums were educated and aware about the primary management of the children and minor elements. **Pallikadavath et al. (2004)** found women's education shows the positive association with antenatal check-ups through visits to a health facility in all the states. Exposure to the media also influenced antenatal visits to health facilities after education. **Trivedi et al.** (1994) pointed out that the usage of the ICDS services varies from place to place and depends on the participation of the community in the program.

In the **third chapter,** an attempt has been made to explore the level of convergence between the Health and WCD department at different levels. These levels are named as Institutional level, Village level, Block Level, Supervisory level, District and State Level. Gram Aarogya Kendra (GAK), Anganwadi Centre (AWC), Nutrition Rehabilitation Centre (NRC), Sub- Centre, Primary Health Centre, Community Health Centre and Prakash Chand Sethi Hospital were studied at the Institutional level. GAK started at the AWC for the provision of basic health services for the marginalized people. Still, Most of the GAK falls into category " C" means the facilities available at the GAK was <61%, according to the checklist used by the Madhya Pradesh Technical Assistance and Support Team (MPTAST) to assess the GAK in Madhya Pradesh state.

Anganwadi Centres were located in pucca buildings. AWCs in the Sanwer were running in govt building where as most of the AWCs were running in the rented building. Overall, all the Anganwadi in Indore slum had inadequate space for outdoor and indoor activities in comparison to Anganwadi centres located in the Sanwer block. Pre- school Education kit contains - toys, counting frame, picture books, play materials and equipment were lacking in most of the AWCs in Indore slums and Sanwer. Dominoes and beads and thread were totally absent at all AWCs. **Gupta et al. (2013)** expressed the notion that although the immense increase in ICDS there is a lack of infrastructure and basic amenities. Likewise, non-formal pre-school, nutrition and health education are not fully functioning in the manner they were designed to be. Availability of the sufficient number of cooking and serving utensils is also important for well to do of AWCs **(NIPCCD, 2006).** In both the areas, availability of serving utensils was almost negligible because, at all AWCs, children carried their own utensils to take in their own food.

Different types of registers like- School attendance register, feeding register, immunization and growth monitoring register, antenatal/post natal register, stock register, health check-up register, Birth and death register, beneficiary attendance register all were present at the AWCs of Sanwer and Indore slums. Besides, registers available at Indore slums, well maintained as compared to Sanwer.

More beneficiaries were attending the AWCs in Sanwer as compared to the Indore slums. All the beneficiaries from the Indore slums and Sanwer received the Hot Cooked Food (HCF) and Take Home Ration in the form of the khichdi mix, wheat and soya-barfi mix, etc. Percentages of the normal children were more in the Sanwer block as compared to Indore slums. It may be because of children in the Sanwer used to eat roti with dal our milk, but children's in the Indore slums mostly includes Kurkure, chips, chocolates in their diet. Moderately underweight children were almost similar in Indore slums and Sanwer. The ratio of severely underweight children was more in the Indore slums as compared to the Sanwer.

A number of admitted children were more in the Indore slums. In both the NRC's the proportion of female children was higher in comparison to the male child. **Patel et al. (2013)** study showed that females (under five) had a higher proportion of malnutrition in compared to male. **Haddad (2011)** revealed that low caste is associated with poor access to services. The ratio of malnutrition is more in the children who belonged from the Sanwer as compared to the Indore slums. Human resource, essential ward equipment, kitchen equipment and medicine were present at the both of the NRCs. Case study data showed that more facilities available at the NRC of Indore slums as compared to the Sanwer NRC. Human resource, basic facilities for health care were available at the Sub-centres Primary health centres and Community health centre and Prakash chand sethi hospital. At the village level, PRIs/ VHNSC members were providing necessary support to the community people, but because of the lack of budget, they were not able to put their full effort in the successful delivery of the services at the village level. At the block level, Block Medical Officer of Health and CDPOs were responsible for the service delivery. According to them, they were fulfilling their job responsibilities and blamed the each other for failure to reach the targets. It is also noted that CDPOs and BMOs were pre-occupied and as a result of this coordination was missing at the block level. Similarly, At the

district level, both the departments blamed each other, but at the state level scenario was different. They showed mutual cooperation and understating for achieving the target at the state level; they were also accepted about the lacuna present from district to village level.

The **Fourth Chapter** comprises Providers Perceptions in delivering the services named as ASHA, ANM, AWW. Half of AWW (50%) were under the age of > 40 yrs, followed by 31-40years (26.66%) in the Sanwer and less than half i.e. 43.33% and 40% AWW were under the age of 31-40 years and >40 years, respectively in Indore slums. More than half AWW in Indore slums were graduate whereas most of the AWW was Intermediate passed in the Sanwer. Less than half of AWWs had 21-25 years of experience, i.e. 43.33%, one-third had 5- 10 years of experience i.e. 33.33. In contrast, most of the AWWs had 5-10 years of experience, i.e. 70%, few had < 5 years and 16-20 years' experience, i.e. 13.33% in Indore slums. As the AWWs were less educated in Sanwer but they had more experienced as compared to the AWWs in Indore slums.

Most of the AWWs faced the problem of inadequate supervision and salary in the Sanwer along with the discontinuation of salary and discrimination by the community, logistic supply related problem and infrastructure-related problem and a lack of community support. Along with all these problems, AWWs from Indore slums faced the problem of excessive record maintenance i.e. 100%.

AWWs in Sanwer and Indore slums were aware of their job responsibilities like - the care of children (0-6yrs), community survey, arranging and organizing VHND and the provision of supplementary food to pregnant and lactating mothers, supplementary food distribution (0-6 Years), health check up, participation in immunization, treatment of minor ailments.

43.80% and 76.19%, respectively AWW gave the correct answers regarding immunization in Sanwer and Indore slums. Similarly, 45% and two third of AWW were correctly answered questions on nutrition and health education. 38.8% and 66.66% AWW were correctly answered about supplementary nutrition in Sanwer and Indore slums. Regarding growth monitoring, 38.33% and 78.33% gave the correct answers. 34.16% and 70% AWW were correctly answered regarding health check-up and 36.66% and 75% were correctly answered about the referral services in the community by the AWW in Sanwer and Indore slums, respectively. The AWWs who belonged to

the Indore slums had the more knowledge about the services and they were more skilled in weight monitoring as compared AWWs from Sanwer. Excessive workload, the indifferent behavior of community people, tons of paperwork, blamed from supervisors, inadequate pay, work pressure, extra study, no remuneration for extra work, etc. these were the troubles confronted by the Anganwadi workers, especially in the Indore slums.

The majority of the ASHA workers belonged to the age group 20-30 years in Sanwer and Indore slums. Most of the ASHA workers were primary passed in Sanwer whereas SHA workers from the Indore slums were Intermediate passed. The majority of ASHA workers were Hindu in both the areas. The majority of ASHA workers were from the SC and OBC caste in the Sanwer. Whereas ASHA workers from the Indore slums were from general and OBC category.

Most of the ASHA workers had 1-5 years of experience in the Sanwer and Indore slums and all were received pre-services training in both the areas. Refresher training ratio was higher in the ASHA workers from the Indore slums. All the ASHA workers aware about their responsibilities like- accompanying mothers during delivery, assist in the ANC and PNC care, advice on breast feedings, preparation of Village health plans, birth and death registration, home visits for newborn and prevention of malnutrition etc. in both the areas. ASHA workers maintained the records on home delivery, Immunization, ANC and family planning records, household records, new born visit record, birth, and death registration records in Sanwer and Indore slums. All the ASHA workers have maintained the 100% records on institutional delivery in Sanwer and Indore slums. Knowledge level of ASHA workers on Maternal and child health was higher in the Indore slums as compared to ASHA workers from Sanwer. Also, the skill level of ASHA workers regarding antenatal assessment was higher as compared to ASHA workers in Sanwer. ASHA workers were disrespected and demoralization by the hospital staff in the Indore slums. As a result of this ASHA workers were losing faith among the beneficiaries of Indore slums. Doctors used this situation and become successful to carry the cases in their private clinics by doing the brain washing of the beneficiaries.

Most of the ANMs were between the 31-40 years of age in Sanwer and Indore slums. Almost all the ANMs were Intermediate passed and having the nursing degree. The majority of ANMs workers were Hindu and Christian in both the areas and most of

them belonged from the general category. ANMs from Sanwer had the 16-20 years of experience, whereas ANMs from Indore slums had 11-15 years of experience. ANMs from Sanwer were more experienced as compared to the ANMs form Indore slums. ANM faced indifferent behavior of the community, excessive work and shortage of skilled staff, sometimes less support from AWW and ASHA workers, lots of meetings, etc. knowledge level of ANMs on Primary health care, Maternal and Child Healthcare were more in the Indore slums as compared to the ANMs from Sanwer. Also, knowledge about the immunization and skills regarding antenatal care, were higher in the ANMs from Indore slums as compared to the ANMs from Sanwer.

ANMs from Indore slums and Sanwer focused mainly on immunization and family planning. **Ved and Dua (2005)** pointed out that the auxiliary nurse midwives mostly focused on family planning and immunization. ANM has to maintain registers and reports and mainly supervised for reports. **Mavalankar and Vora (2008)** indicated shifting of ANM's roles of Maternal Health to FP and immunization. National programs are one of the factors to shift the focus of ANM's from comprehensive reproductive health services to preventive services.

5.3 Conclusion

The research study explored the gaps of convergence between Health and Women and Child Health Departments in Indore district of Madhya Pradesh to fulfill the objectives of ICDS. The convergence was taking place at different levels named as Village level, institutional level, Supervisory level, Block level, District level and State level. Children's and pregnant and lactating mothers are the foremost beneficiaries of the ICDS services. These services provided by the three primary health providers named as the Anganwadi worker, ASHA, and ANM. Thereby, to promote the utilization of ICDS services, there is a crucial need to upgrade and strengthen the health care delivery system at different levels along with the efficient and skillful health providers for the success of the program. This can be done through well planned, realistic and necessity based provision of services to the beneficiaries; by the collective efforts for the satisfactory functioning of health facilities; taking care of the needs of the vulnerable sections of the community; by strict legal steps towards the corruption; encourage the involvement of the representatives at the village level and by absolute and pragmatic synergy between the Health and Women and Child Health Departement.

The conclusion is established in the context of three main objectives set in the first chapter of the research study.

- ***Beneficiaries Perspective:***

From the beneficiary's perspective, it can be highlighted that the general awareness should be the increase in the optimal utilization of ICDS services among the community people. For immunization and health check up mothers often rely on the ANMs and ASHA worker. Also, most of the beneficiaries depend on the AWWs for food provisioning. Discrimination exists for the people belonged to the lowest caste. The concerted effort must be made for optimal utilization of services provided by the health workers. Community participation should be encouraged by the involvement of elders and the menfolk in the family, opinion makers in the community at the village level.

Physical barriers which prevent mothers from using the services like poor roads and long distances; non-availability of the 108, financial barriers, including indifferent provider attitudes should be removed with the concerted efforts. Due to improper transportation facilities, the poor infrastructure of public health institutions along with less skilled staff and the demoralization of mothers; the proportion of institutional deliveries is less. Although the ASHAs and ANMs spread awareness about institutional delivery, most of the beneficiaries are conscious of problematic and complication issues related to the delivery. An increase in the provisions must be made at the institutional level for optimal utilization of the services. Proper provisioning, easy accessibility and good quality of care received by the beneficiaries viewed as the success of ICDS program.

- ***Convergence and Synergy:***

Success in the health programs equally depends on the convergence and integration of various departments at the different level. At the Institutional level, there is a need to strengthen the services, especially at the Gram Aarogya Kendra level as these establishments for catering the services at a very basic level. Also, there is a provisioning of services at 24 hours for the malnourished children, especially at the NRC's which cater the services for vulnerable population mainly malnourished child.

Through constant effort make aware the community for the home based care of the malnourished children to make mothers comforted in the home setting, who stays at the NRCs. Strengthen the health care delivery institutions by the provision of the necessary equipment, supplies, and more skilled staff, especially in the sub-center and primary health center level along with the better transport facility system. At the village level involvements of PRIs/VHNSC should be encouraged for better health care managements. Panchayats could play a crucial part in determining the health seeking behavior of the people. The health financing system needs to be reviewed. As the PRIs/ VHNSC were lacking sufficient budget at the village level. Also, the flow of funds must be made more flexible so it can be utilized efficiently and on time.

At the block and district level blaming of each other among the officials from both the departments was observed. There must be proper coordination and convergence should be stressed out through the policy implications and constant and integrated training programs and meetings at the block and district level. Health officials should not be 'Desk bound' because it affects the proper channelization of the program from top to down. At the supervisory level make the constant and efficient support to the ASHAs, ANMs, and AWWs by the supervisors, but most of them were concerned with the paperwork and administration apart from support and guidance in practical based situations. At the state, the level scenario was very different, both the department showed cooperative behavior and proper synergism was found. They should instruct and guide at the block and district level by the arrangements of integrated meetings and health camps for better functioning and understanding; and it would definitely help in reaching the target at the village, block, district and state level.

Convergence involves the inter-sectoral coordination. Inter-sectoral coordination, ensure better integration of various departments in bringing out the improvement in the health delivery mechanism. Sufficient human resources, finance, infrastructural integration, integrated service delivery, training, supervision, and counseling help in the better inter-sectoral coordination. During the VHND sessions and normal routine works, guidance and supervision were lacking. For the betterment of the Intra-sectoral coordination, there must be time to time supervision and guidance required for smooth functioning of the program from top to bottom through arranging the meetings and proper supervision at the practical ground level.

❖ ***Provider's Perspective:***

From the provider’s point of view, it can be highlighted that Health personnel faced the lots of the problems. AWWs were mainly busy in the paper work apart from providing the services to the children at the Anganwadi centres. Also, they faced the work pressure created by the supervisors and officers. Officials should give the freedom of speech to the AWWs and sort out the problems for better and easy delivery of the services. ASHA workers also disrespected by the doctors for their own benefits and mothers were demotivated by the doctors as a result of this less institutional delivery was happening. There should be strict actions required for removal of the corruption for their own sake. Mostly ANMs focusing on the Immunization and Family planning that why other primary care hampered, especially at the sub-centre and primary health centre level. Refresher training also required for all the providers to develop better understanding and skills in delivering the services. Discrimination presents due to the existence of the caste system. Through counseling and community participation along with the involvement of the PRIs/ VHSNC, NGOs, ASHAs, ANMs, and AWWs make the community aware of services and resolve the issues. For developing the multi-skilled staff, systematic and continuous skill up-gradation required from time to time arranging of training programs for the service providers.

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Annexure-I

Checklist for VHND Section A: Services available on VHND

S no	Services	Provided on the VNHD Yes 1 No 2	Given by whom MO I ANM II ASHA III AWW IV PRI/VNSC V members No one VI	Remarks ,if any
Maternal health				
1	Are the registrations of pregnant mothers done?			
2	Are they done antenatal checkup?			
3	Are they referred the pregnant mothers who had signs of complications?			
4	Are they done Counseling on-			
	Education of girls Care during pregnancy Birth preparedness Importance of nutrition Institutional delivery Availability of funds under the JSY Postnatal care Care of newborn			
Child health (infant up to 1 year)				
5	Child health (infant up to 1 year)			
6	Counseling for care of newborn & feeding & nutritional supplements			
7	Complete routine examination			
8	Immunization for BCG and measles			
9	Weighing of children			

Children up to 1- 3 years					
10	Booster dose of DPT /OPV				
11	Second and fifth dose of vitamin A				
12	Tablet IFA to children with clinical anemia				
13	Weighing				
14	Provision of supplementary food for grade I and II children				
15	Referral in cases of severe malnutrition				
	Counseling on nutrition, supplementation & balance diet				
Below 5 years					
16	Tracking and vaccination of missed children by AWW /ASHA/ANM				
17	Case management of those suffering from diarrhea and acute respiratory infections				
18	Organizing ORS depot				
19	Vitamin A supplementation				
20	Management of worm infestation				
Family planning					
21	Information on use of contraceptives				
22	Distribution & provision of contraceptives				
23	Counseling & provision of non-clinical contraceptives such as condoms				
24	Information on compensation for loss of wages resulting from sterilization and insurance scheme for family planning				
Reproductive tract infection and sexually transmitted diseases					
25	Counseling on prevention of RTIs & STDs, including HIV/AIDS and referral of cases for diagnosis and treatment				
Sanitation					
26	Construction of sanitary latrines				
28	Mobilization community actions for safe disposal of the households refuse.				
Communicable disease					
29	Group communication activities for raising awareness about signs and symptoms of leprosy suspected cases, referrals.				

30	Awareness about TB (coughing for more than two weeks)importance of continued treatment			
	Gender			
33	Communication activities for prevention of prenatal sex selection			
34	Age of marriage. Especially the importance of rising age at marriage for girls			
	AYUSH			
35	Home remedies for common ailments based on certain familiar herbs like Tulsi found in the locality.			
36	Information related to other AYUSH components, including drugs for treating conditions like anemia.			
	Health promotion			
37	Prevention of chronic disease & counseling like- Tobacco chewing Healthy lifestyle Proper diet			
	Nutrition			
38	Prevention of disease due to nutritional deficiencies and counseling			
40	Hygienic & correct cooking practices			
41	Checking of anemia, advising & referring especially in- a. Adolescent girls b. Pregnant women			
42	Importance of Iron supplements, vitamins			
43	Advice on Improve the quality of food, which grown locally			

Instruments, Equipment's and furniture

S no	Items	Is these items available	
		Yes 1	No 2
1	Weighing scale – adult		
2	Weighing scale – child (salter scale)		

3	Height measuring scale		
4	An examination table		
5	Bed screen/ curtain		
6	Hb – instruments along with tubes and reagent		
7	Kits for urine examination		
8	Gloves		
9	Slides		
10	Stethoscope		
11	BP instruments		
12	Measuring tape		
13	Foetoscope		
14	Vaccine carrier with ice packs		
15	Fan		
16	Torch		
17	Light source		

Supplies-

S no	Supplies	These supplies are available during services Yes 1 No 2	Remark if any
1	All Vaccines for immunization according to NIP		
2	Vitamin A solution		
3	Iron folic acid		
4	Condoms		
5	ORS Packets		
6	Cotrimoxazole		
7	Anti-helminthic drug (Albendazole Tab & syrup)		
9	Paracetamol		
10	Stains for fixing blood sample		
11	AD syringes in sufficient quantity		
12	IEC materials for communication & counseling		

Manpower

S no	Needed personnel's	Is these personnel's presented during VHND Yes 1 No 2	How long they stayed For few minutes 45 minutes 1 hour 2 hours Upto whole session (min 4 hours)
1 2 3 4 5 6 7 8 9	Medical officer ANM LHV ASHA AWW AWH PRIs/VHSC members Dai ICDS supervisor		

General information			
9	At which place normally VHND organized.	AWC 1 SC 2 Panchayat Bhavan 3 Any other open space 4	Remark if any
10	VHND is organized on the fixed day?	Yes 1 No 2	
11	Generally, how many days before they impart information on village health and nutrition day?	Two days before 1 One day before 2 On the same day 3 No information imparts to community people 4	
12	What methods they are used for publicizing village health and sanitation		

	day? Wall written in the local language -1 Hoarding at one or two prominent places in the village- 2 Handbills & pamphlets -3 Informed by ANM /ASHA one day before during the home visit - 4		

Annexure-II

Questionnaire on beneficiaries: Pregnant and lactating mothers

Name of block- Name of SC- Name of the village-
The population covered- Name of beneficiaries-

A. General information

S no	1-Demographic profile	Remark.If any
(I)	Age of respondent - <20 yrs - 20 to 30 yrs - 30 to 40 yrs - >40 yrs	
	2-Education profile	
(I)	Educational status- -Literate (ability to read & write) - 1 -Illiterate -2	
(II)	Education level- Primary school- 1 Primary school completed - 2 Middle school completed -3 High school completed -4 Higher secondary completed -5 Graduate and above -6	
	3-Social profile	
(i)	Religion- Hindu -1 Muslim -2 Christian -3 Sikh -4 Others, specify -5	
(II)	Social class- Schedule tribe -1 Schedule caste -2 Other backward class -3 General -4	
	4-Economic profile	
(i)	Type of house Kachcha-1 Semi Pucca- 2 Pucca -3	
(ii)	Building of houses Rented house -1 Self-constructed house- 2 Living in a relative's house - 3 Govt. House - 4	
(iii)	Average monthly income (in rupees) Up to 1,000 -1 1001-3,000- 2 3001-5,000 - 3 5001-10,000 - 4 10,001 -15,000 -5 More than 15,000 -6	
(iv)	Occupation of husband- Daily wages, worker -1	

	Working in private company -2 Working in govt sector -3 Farmer-4 Not working – 5	
(v)	Occupation of mother- Housewife -1 Private sector-2 Govt sector – 3 Agriculture -4	
5 – household facilities		
(i)	A source of water- Tap water-1 Hand pump-2 Well-3 River-4 Tanker-5 Other-6	
(ii)	Toilet facility- Own toilet-1 Public toilet of any type-2 Open field-3	
6. Asset profile		
(i)	The animal is holding- Cow-1 Goats-2 Camels-3 Chiken-4 No animals -5	
(ii)	Fuel used in house- LPG-1 Coal-2 Kerosene-3 Wood-4 Dung cakes-5 Electricity -6 Others-7	
(iii)	Household items- Television-1 Sewing machine-2 Refrigerator- 3 Telephone/mobile-4 Bicyle-5 Car-6	

Are you BPL card holder-
Yes-1 No-2 Are you getting Ration from PDS- yes-1 no-2
BPL card no-
For currently pregnant women-

S no	Response	Remark.If any
(I)	Who informed you, when you are pregnant? -ASHA -ANM -AWW -Self	
Enrollment		
(I)	Who talked about antenatal registration after the confirmation	

	of pregnancy? -ASHA -ANM -AWW -Others	
(II)	Who did antenatal registration? ASHA -ANM -AWW -Others At where antenatal registration is done? -During VHND -Home visit -SC -PHC -CHC	
III	Do you have (MCP) a mother and child protection card? Yes- No-	
IV	By whom antenatal checkup is done? -AWW -ASHA -ANM -LHV -Doctor	
V	Who mobilize you for an antenatal check-up? -AWW -ASHA -ANM -Others	
VI	The place where the antenatal checkup is done? -AWC -At home -SC -PHC -CHC - Hospital	
VII	What type of antenatal services you are getting? -Weight monitoring - 2 dose of TT -Abdominal palpation -Auscultation -Hb testing -Malaria testing	
VIII	a. Are you getting counseling services? -Yes -No b. Who is giving you counseling services? -ASHA -AWW -ANM -LHV -Doctor c. What is the content of counseling services? -Antenatal diet - Hygiene	

	-Consumption of IFA tablets -Rest and sleep -Avoiding heavy work -Proper Iron, folic acid intake -Antenatal exercises -Breast feeding -Family planning -Weaning diet -Knowledge on danger signs of pregnancy (Swelling, deficiency of Iron. High fever, excessive bleeding, convulsions) d. Do you follow all the instructions? Yes No	
IX	Who mobilize you for institutional delivery? -ASHA -AWW -ANM -Doctors -Family members	
X	a. At which place you delivered the child? -Home -SC -PHC -CHC -Govt. Hospital -Private hospital b. Who delivered the child? -AWW -Dai -ASHA -ANM -LHV -Doctors C. Now at present where you want to go for delivery? -Home -SC -PHC -CHC -Govt Hospital -Private hospital d. Reasons /Why? -Incentives -Safety -Hygiene -Less money -Close to home	

Lactating Mothers (Delivery in last 6 months)

S no	Response	Remark .if any
(a)	What are the services you got during delivery? -Transport facility -Delivery ward facility -Post natal care 1. Diet 2. Care /hygiene	

	3. Vital signs monitoring 4. Neonatal care 5. Post natal exercise	
(b)	a. Where did you deliver the child? -SC 1 -PHC 2 -CHC 3 -District Hospital 4 -Private hospital 5	If 5, then follow next question
(c)	What the reason is for delivering the child? -Distance -Better facility -Hygiene -They can afford	
(d)	Who told you about institutional delivery? -ASHA -AWW -ANM -LHV -Doctor -Family members	
(e)	Who accompanied you during delivery? -AWW -ASHA -ANM -Family member	
(f)	Did they practice five clean during delivery? -Hand wash before assisting delivery -Clean surface for delivery -Clean cloth to receive the child -Clean tread to tie cord -New clean blade to cut	
(g)	Did you get the incentives? Yes- No-	
(h)	Who helped you in getting the incentives? -AWW -ASHA -ANM -Others	
(I)	a. What type of postnatal care you got from health workers? -Weight monitoring –Child - Postnatal examination -Breast care -Immunization of child at birth -Newborn care -Exclusive breastfeeding -Referral to the hospital in case of illness b. Who provided the post-natal care? -ASHA -ANM -AWW -Others C. Place where you get postnatal care? -Home during home visit	

	-AWC during VHND -SC -PHC -CHC	
(j)	What are the advices you get from the workers after delivery? -Importance of breast feeding -Importance of immunization -Importance of weighing of the child -Diet during lactation -Exclusive breast feeding -Importance of weaning diet -Family planning	
(k)	What type of advices did you get regarding breast feeding practices? -Breast feeding immediately after birth / colostrum - Breast feeding within 1 hrs -Breastfeed on demand -Breast feed within 2 hours - Breastfeed up to the first six months	

B-Utilization of services

S no		Remark.If any
(1)	Utilization of services from AWC- (a) Are you utilizing AWC services during last one years- Yes-1 No-2? (b) At last, When did you visit AWC? One month before-1 15 days before-2 Last week -3	
	2. Supplementary nutrition	
	a. Are you getting the Take Home Ration? Yes- No- b. Do you share with the family members? Yes- No- c. Do you Consumption the food Yes No d. Reason -It is not good in quality -Family members oppose -AWC is far off -AWW does not give -AWW don't tell when the food is distributed -Nobody is there to go and take the food -It is not sufficient -Not tasty -Creating bowl problem -Not easy to digest -Food is ok, but require some modification	If no then go to d
	3 .Utilization of preschool services	
1	Your child is registered at the Anganwadi Centre? Yes No	
2	How frequently they are going to AWC?	

	-Regularly -Sometimes -Occasionally - Not going	
3	Did Your children get hot cooked food? Yes No	
4	They are consuming food on the spot? Yes No	
5	Types of services utilized by a child in the AWC- -Basic education -Numbers counting -Poems -Crafting -Storytelling -Health and hygiene practices -Playing tools	
6	How frequently your child gets the hot cooked food from the AWC? -Daily -Occasionally -Once in a week -Not providing by the Centre	
7	How frequently your child weighted at the AWC? -Once in a month -Once in a two month -Once in four months -Don't know	
8	Does the growth chart, prepare or draw in the MCP card? Yes No	
9	Who prepares the growth chart of your child? -AWW -ASHA -ANM	

Focus group discussion for beneficiaries

A .Services getting on Special nutrition

1. Do you have information about the services delivered through the AWC?

2. What do you like best about the services which are delivered through AWCs?

3. What do you think of special nutrition is available for 300 days in a year?

4. How do you feel about the quantity of food getting from the AWCs?

5. Suppose the child is severely malnourished, then what special food you would get from AWC?

6. How did you feel about the hot cooked food getting from the AWC for children?

B. Health related facilities and information

1. Tell me about the malnutrition problem among the children?

2. Which kind of information do you get about NRCs for the treatment of the malnourished children and who will tell about this?

3. Who and what influences your decision to avail the services at AWC?

4. How did you know about the preparation of nutritious food for a child?

5. Do you have to pay for special services at AWC/during the home visit?

C. Infrastructure, functions and resource availability at AWCs

1. What do you think AWC operated regularly from Monday to Saturday?

2. What do you think of the AWC is loaded facilities like – safe drinking water, proper light, toilet, seating arrangement etc.?

3. What do you think of resources available at the AWC during ANC/Weighing of the children /immunization/health checkup?

D. Utilization of services

1. Have you ever faced health workers restrain you for availing the health services at AWC?

2. a. Have you ever faced the discrimination based on caste, class and religion during availing the services at the AWC/Home visit? b. What you did?

3. How do you feel about the transport facility available for Delivery and emergency services?

4. How did you feel about the pre-school education, activities at the AWC?

5. How did you feel about the immunization service of children and pregnant ladies?

E. Nutrition and health education

1. What advices you get on the food and health care requirements of the mild malnourished child?

2. What advices you get on care during the pregnancy?

3. Did the health workers make you aware about the danger signs of pregnancy?

4. What advices you get on the health care requirements for the sick children? (Diarrhea, pneumonia, high grade fever, TB, AIDS)

D. General opinion

1. What can each of us do to make the ICDS facilities better?

2. We have talked about a lot, what is most important to you?

Annexure-III

Checklist for Anganwadi centres

S. No.	Place	
1	District	
2	Block	Indore 1 Sanwer 2
3	Community health centre	
4	Primary health centre	
5	Sub centre	
6.	Name of village	
7.	Name of a respondent	

S No	Questions	Response		
1	Year of starting			
2	a. Situated within the village	Yes No	1 2	If 1,then skip to 3
	b. Distance from the village.	One km Two km More than3 km	1 2 3	
3	Anganwadi centre is easily accessible for disadvantaged people?	Yes No Specify if no	1 2 3	Remarks
4	Type of AWC?	Main AWC Mini AWC	1 2	
5	The AWC is running at.	Own building Rented building AWWs house Panchayat Bhavan Others (Specify)	1 2 3 4 5	
6	Number of enrolled children at the AWC and their attendance? a. Total- b. Enrolled- c. Average attendance /week	 -6 months to 3 yrs -3 yrs to 6 yrs -6 months to 3 yrs -3 yrs to 6 yrs -6 months to 3 yrs -3 yrs to 6 yrs		
7	Facilities in place at the AWC	Yes 1 No 2	What is the condition? Good 1 Fair 2 Poor 3 Very poor 4 Not observed 5	Remarks
	a electricity			
	b. Electric fan			
	c.Telephone			
	d.Safe drinking water on the premises			
	e toilet facility			
	f. Space for indoor activity for preschool			
	g. Space for cooking			
	h. Storage facility for food			

	i. Storage facility for equipment			
	J space for VHND/Immunization/Health check up			
8.	Condition of AWCs	Yes 1 No 2 Not clear 3		
	a.AWC needs repair			
	b.AWC is adequately ventilated			
	c.Adequate light			
	d.AWC has boundary wall			
9	Does the AWC have the following equipment in adequate quantity and of satisfactory quality?	Is it available? Yes 1 No 2	What is the condition? Good 1 Fair 2 Poor 3 Very poor 4	Remarks
	a.Medicine Kit			
	First Aid Box			
	c.Baby Weighing scale			
	d.Adult Weighing Machine			
	e.Vessels for Cooking			
	f.Indoor Play Equipment			
	g.Vessels for Storing Drinking water			
	h.Utensils for serving hot cooked meals			
	i. Mats for children to sit on			
	j.Growth charts (separately for boys and girls)			
	k.Posters/IEC Material			
	l.Take Home Ration Stocks			
	m.Record keeping Registers			
10.	Availability of drugs	Yes 1 No 2	Frequently used a Never used b	Remarks if any
	Iron, folic acid (for Pregnant ladies)			
	Iron, folic acid (for Adolescent girls)			
	Albenzole tab			
	Albendazole syrup for children			
	Ors packet			
	Tab paracetamol			
	Antiseptic ointment/lotion			
	Thermometer			
	Cotton / Bandage			
	Tab. Chloroquine			
	Others,specify			

Annexure-IV

CHECKLIST FOR THE NUTRITION REHABILITATION CENTRE

A. General information

- Name of the block
- No of beds

S no	Indicators	No in last quarter	Rates
1	Admission		
2	Recovered children		
3	Relapse		
4.	Death		
5	Defaulter		

Monthly record-

S no	Indicators	Boys	Girls	Total
A	**Admission-**			
	SC- ST- Backward Class- General -			
2	Admission criteria-			
	-3SD			
	MUAC <11.5 mm			
	Bilateral pitting edema			
3	Referred by -			
	Frontline workers- ANM ASHA AWW			
	RBS camp			
	Pediatric OPD			
4	Duration of stay-			
	< 7 days			
	7 to 12 days			
	7 to 15 days			
5	Achieved target weight (15% weight gain)			
B	**Outputs**			
	Discharge from NRC			
	Defaulters			
	Non responders			
	Deaths			
	Children due to follow up			
	Children followed up			
	Death during follow up			
	Relapse			

B. Staff at the NRC-

S no	Staff	In position	Vacant
1	Medical officer(Pediatrician)		
2	Nursing staff		
3	Nutrition counselor		
4.	Cook cum care taker		
5	Cleaner		

C.Essential ward equipments-

S no	Items	Yes	No	Condition Good -1 Fair - 2 Poor - 3 Very poor - 4
1	Glucometer 1			
2	Thermometers 2			
3	Weighing scales 3			
4	Infantometer 1			
5	Stadiometer 1			
6	Resuscitation equipments			
7	Suction equipment (low pressure)			

D.Other ward equipments-

S no	Items	Yes	No	Condition Good -1 Fair - 2 Poor - 3 Very poor - 4
1	I/V stand			
2	Room heaters			
3	IEC – Audio/visual materials			
4	Toys			
5	Clock			
6	Calculator			
7	Refrigerator			

E .Training of staff-

S No	Personnel's	Trained by	Duration (min 3 days)	Place of training
	Medical officers Nurses Nutrition counselor	Senior pediatricians of Medical Colleges National F-IMNCI Facilitators.	1 day 2 days 3 days	At NRCs At district hospitals At CHCs Medical college hospital

F.Kitchen equipments-

S no	Items	Yes	No	Condition Good -1 Fair - 2 Poor - 3 Very poor - 4
1	Cooking gas			
2	Dietary scale			
3	Measuring jars			
4	Water filter			
5	Refrigerator			
6	Utensils -large container -cooking utensils -feeding cup -spoon -glasses -plates -jars			
7	Kitchen supplies	Estimated cost /month		
	Dried milk Whole milk Skimmed milk Dal Rice Vegetable oils			

G .Pharmacy supply-

S no	Items	Yes	No	Estimated cost /month
1	Antibiotics-			
	(Ampicillin/Amoxycillin/Benzyl penicillin Chloamphenicol Cotrimoxazole Gentamycin Metronidazole tetracycline or Chloramphenicol eye drops Atropine eye drops			
2	General medicine-			
	ORS Packets			
	Potassium chloride			
	Magnesium chloride/sulphate			
	Iron syrup			
	Multivitamin tablets			
	Folic acid tablets			
	vitamin A syrup			
	Zinc Sulfate or dispersible Zinc tablets			
	Glucose (or sucrose)			
	I/V Fluids ringer's lactate solution with 5% glucose Normal saline			

H .Hygiene

S no	**Hand washing-**	Yes	No	Comments
1	Hand washing facility is present at the NRC?			
2	Does staff wash hands thoroughly?			
3	Do staff to wash hands before and after touching the patients?			
4	Do they wash hands before giving foods?			
	Mother's hygiene-			
5	Do mothers have a place for a bath?			
6	Do mothers wash hands before feeding the child?			
7	Do mothers wash hands with soap after using the toilet?			
	General cleanliness-			
8	Is bed sheet changed every day?			
9	Bathroom has a hot-water facility?			
10	Is the floor swept every day?			
11	Are toilets cleaned every day?			
12	Are the dishes washed every day?			
	Feeding-			
13	Is right feed served at the right time and amount?			
14	Are children encouraged to eat?			
15	Are left over recorded accurately?			
	Weighing-			
16	Are weighing scale functioning correctly?			
17	Do children weighted at the same time?			
18	Does staff adjust the scale to zero before weighing?			
19	Are children weighted without clothes?			
20	Does the staff read correctly?			
21	Are weights correctly plotted on the weight chart?			
	Giving antibiotics-			
22	Did antibiotics give at a prescribed time?			
23	Is folic acid given daily?			
24	Is multivitamin given daily?			
25	Is Iron tablet given daily?			
26	Is vitamin A given according to schedule?			
	Physical facility -			
27	Does NRC have a 24 hour uninterrupted power supply?			
28	Does NRC have 24-hour water supply?			
29	Proper light and ventilation are present at NRC?			
30	Does the window cover with the mosquitoes screen?			

Annexure-V

CHECKLIST FOR THE SUB CENTRE

A. General information

- Name of the block Name of the CHC
- Name of the PHC Name of the SC
- Type of SC Name of the Village
- Distance from the PHC Population covered by the SC

B. Availability of the Staff

S no	Staff	Responses	
		Yes	No
1	Health worker female – 2 (essential)		
2	Health worker male – 1 (essential)		
3	Staff nurse/ANM (if staff nurse is not available) -1 (For type B-SC/If no of deliveries is more than 20)		
4.	Contractual safai worker – 1		

C. Infrastructure and facilities-

S no	Questions	Responses	
		Yes	No
1	Does SC have designated govt building?		
	If no, what type of building Rented Panchayat owned Others, specify		
2	Does the boundary wall with gate exist at the SC?		
3	Has Clinic Room been available at the SC?		
4	a. Is Labour room available at the SC?		
	b. Deliveries are being conducted into the labour room?		
	C. Facilities, Present in the labour room 1. A labour table with Mattress, pillow 2. mackintosh Sheet 3. Suction machine 4. Facility for Oxygen administration 5. Sterilization equipment 6. 24-hour running water 7. Electricity supply with back-up facility (generator) 8. Attached toilet facilities 9. Newborn Corner - Resuscitation • Provision of warmth • Weighing the neonate Emergency drugs- Inj. Oxytocin Inj Magnesium sulphate Inj. Methyl ergometrine maleate		
	d.If labour room is not being used for deliveries, what are the possible reasons? Poor condition of the labour room No power supply in the labour room Non availability of the staff Any other reason		

5	Is the Examination room is available at the SC?		
6	Does SC have a regular drinking water facility?		
7	Does SC have a regular electricity facility?		
8	Does SC have the proper waste disposal system?		
9	SC has communication facility? Mobile connectivity 1 Landline connection 2		
10	SC has a transport facility?		
	How far is the nearest public health facility? Name- Type- Distance-		
11	a. Residential facility available to the staff- 1.Health worker female 2.Health worker Male 3.Staff nurse		
	b. If yes, Does ANM stays at SC? Health worker stays at SC? Staff nurse stays at SC?		
	C. What is the Condition of the rooms? Needs repair Is adequately ventilated Has adequate light		
12	Toilet facility is available at SC? For the staff For the general people		

D.Services

S no	Questions	Responses	
		Yes	No
1	Does the doctor visit the Sub-Centre at least once in a month?		
2	Does day and night time to visit fixed?		
3	Are the residents from the village aware of the timings of the doctor's visit?		
4.	Is the Antenatal care (TT injection IFA tablets, weight and BP check-up) provided in the Sub-Centre?		
5	Does the ANM/ASHA any trained personnel accompany the woman in labour to the referred care facility at the time of referral?		
6	Are the immunization services as per government schedule provided by the Sub-Centre?		
7	Is the treatment of diarrhea and dehydration available in the Sub-Centre?		
8	Is the treatment of minor illness like fever, cough, cold, etc. available in the Sub-Centre?		
9	Is the facility for taking blood smear in case of fever for detection available in the Sub-Centre?		
10	Are the contraceptive services like insertion of Copper – t, distributing Oral contraceptive pills or condoms provided by the Sub-Centre?		
11	Are the Services of the Sub-Centres being utilized by SC, ST or other backward classes? Total number of beneficiaries (last quarter)- SC- ST- Other backward classes-		

E. Equipments-

S no	Items	Is it available?		Condition	
		Yes	No	Good 1 Fair 2 Poor 3 Not Observable 4	Remarks
1	Delivery table				
2	Ambu (ventilatory) bag and face masks				
3	Towels to wipe dry and cover the baby				
4	A source of warmth for the baby (bulb/baby warmer)				
5	Baby weighing scale				
6	Dressing drum				
7	Hemoglobinometer –sahli				
8	BP apparatus				
9	Basin stands				
10	Bed Sheet				
11	Macintosh Sheet				
12	IVstand				
13	Misoprsotol (Tablet)				
14	Oxytocin				
15	AD syringes				
16	IFA				
17	TT shots				
18	Stethoscope				
19	Fetoscope				
20	Hub and needle destroyer				
21	Oxygen administration equipments				
22	Kelly's haemostat forceps				
23	Cusco's Speculum				
24	Sims Speculum				
25	Cheatles forceps				
26	Tooth forceps				
27	Plain forceps				
28	Kidney tray				

F .Consumables

S no	Items	Yes	No
1	Disposable gloves		
2	Mucus extractor		
3	Foley's catheter (Adult)		
4.	Dipsticks for urine test for protein and sugar		
5	Specimen collection bottles		
6	Black Disposal bags		
7	Red Disposal bags		

Annexure-VI

CHECKLIST FOR THE PRIMARY HEALTH CENTRE

A. General information

- Name of the block-
- Name of the CHC-
- Name of the PHC-
- Type of Primary health centre-
  Type A- Type B-

(Type A: PHC with delivery load of less than 20 deliveries in a month,

Type B: PHC with delivery load of 20 or more deliveries in a month) Indian Public Health Standards (IPHS)

- Distance from the CHC-
- The population covered by PHC-
- No of SC covered PHC-
- Total no of population-
- No of the village-

B. Staff at the PHC-

S no	Staff	Type A		Type B	
		In position	Vacant	In position	Vacant
1	Medical officer MBBS – one				
2	Medical officer AYUSH – one				
3	Data entry operator –one				
4	Pharmacist –one				
5	Pharmacist –AYUSH- one				
6	Nurse midwife (staff nurse) - three				
7	Health worker female –one				
8	Health assistant male –one				
9	Health assistant female/lady health visitor -one				
10	Health educator –one				
11	Lab technician –one				
12	Cold Chain & Vaccine Logistic Assistant- one				
13	Multi skilled Group D worker- one				
14	Sanitary worker cum watchman – one				
	Total – 16				

B Services utilization -

S no	Questions	Responses Yes 1 No 2	
	Availability for specific medications		
2	Is anti rabies vaccine available at the PHC?		
3	Is drug for malaria available at the PHC?		
4.	Is drug for tuberculosis available at the PHC?		
5	Is drug for leprosy available at the PHC?		
6	Is AYUSH medicine available at the PHC?		
8	Are all the medicines given free of cost at the PHC? Yes 1 No 2		

Curative services			
9	Is the primary management of wound present at the PHC?		
10	Are minor surgeries done at the PHC?		
11	Is the primary management of burn present at PHC?		
Reproductive and child health services			
12	Are antenatal clinics organized at the PHC?		
15	Is facility available for a gynecological examination?		
16	Is treatment available for gynecological disorders?		
17	Is facility available for family planning methods?		
18	Is facility available for MTP free of cost at PHC?		
19	Is facility available for low birth-weight babies?		
20	Is treatment available for the pneumonia?		
21	Is management child suffering from diarrhea, dysentery and fever done at the PHC?		
Laboratory services-			
22	Is the blood examination facility available?		
23	Is the detection of malaria parasite done at PHC?		
24	Is sputum examination done at PHC?		
25	Is urine examination for pregnant women done at PHC?		

C Infrastructure facility

S no	Questions	Responses	
		Yes	No
1	Does PHC have designated govt building?		
	If no, what type of building Rented Panchayat owned Others ,specify		
2	Does a boundary wall with gate exist at the PHC?		
3	Has Clinic Room been available at the PHC?		
4	a. Is the labor room available at the PHC?		
	b.Are deliveries being conducted into the labour room?		
	C. Facilities, Present at the labour room 1. A labour table with Mattress, pillow 2. mackintosh Sheet 3. Suction machine 4. Facility for Oxygen administration 5. Sterilization equipment 6. 24-hour running water 7. Electricity supply with back-up facility (generator) 8. Attached toilet facilities 9. Newborn Corner - Resuscitation Provision of warmth Weighing the neonate **Emergency drugs-** Inj. Oxytocin Inj Magnesium sulphate Inj. Methyl ergometrine maleate		
5	Is the Examination room is available at the PHC?		
6	Does PHC have a regular drinking water facility?		
7	Does PHC have a regular electricity facility?		
8	Does PHC have the proper waste disposal system?		
9	PHC has communication facility? Mobile connectivity 1 Landline connection 2		

10	PHC has a transport facility?		
11	a. Residential facility available to the staff- 1.MBBS doctors 2Health worker female 3Health worker Male 4. Lady health visitor 5.Staff nurse		

Equipment, furniture and diagnostic kits-

S no	Items	Is it available?		Condition	
		Yes	No	Good 1 Fair 2 Poor 3 Not Observable 4	Remarks
1	Normal delivery kit				
2	Equipment for assisted vacuum delivery				
3	Equipment for new natal & newborn care				
4	IUCD insertion kit				
5	Refrigerator				
6	ILR(small) with voltage stabilizer				
7	Vaccine carriers with 4 ice packs				
8	Spare ice pack boxes – 8				
9	Computer including net				
10	Radiant warmer for new born				
11	An adult weighing scale				
12	Baby weighing scale				
13	Height measuring scale				
14	Phototherapy unit				
15	Self inflating beg and mask neonatal				
16	Mucus extractor				
17	Feeding tube for baby				
Labour room					
18	Suction machine				
19	Delivery table				
20	Sterilization of equipment				
21	24 hours running water				
22	24 hour electricity				
23	Attached toilet				
24	Torch				
25	Ambu (ventilatory) bag and face masks				
26	Towels to wipe dry and cover the baby				
27	A source of warmth for the baby (bulb/baby warmer)				
28	Baby weighing scale				
29	Dressing drum				
30	Hemoglobinometer –sahli				
31	BP apparatus				
32	Basin stand				
33	Bed Sheet				
34	Macintosh Sheet				
35	IVstand				

36	AD syringes				
37	IFA				
38	TT shots				
39	Stethoscope				
40	Fetoscope				
41	Hub and needle destroyer				
42	Oxygen administration equipments				
43	Kelly's haemostat forceps				
44	Cusco's Speculum				
45	Sims Speculum				
46	Cheatles forceps				
47	Tooth forceps				
48	Plain forceps				
49	Kidney tray				
50	Vial opener				
51	Vaccine carrier				
Emergency drugs					
52	Misoprsotol (Tablet)				
53	Inj Oxytocin				
54	Inj diazepam				
55	Inj mifedepin				
56	Inj magnesium sulphate				
57	Lignocaine hydrochloride				
	Vial opener				
Common drugs					
58	Ibuprofen				
59	Paracetamol				
60	Ampicillin				
61	Benzylpenicillin				
62	Cephalexin				
63	Gentamicin				
64	Mebendazole				
65	Vit A				
Laboratory facilities					
66	Reagent of cyan meth for Hb				
67	Utistix – for urine albumin				
68	-ABO & Rh				
69	Gram stain				
70	RPR test syphilis kits				
71	Swab and swab sticks				

Consumable

S no	Items	Yes	No
1	Disposable gloves		
2	Mucus extractor		
3	Foley's catheter (Adult)		
4.	Dipsticks for urine test for protein and sugar		
5	Speciman collection bottles		
6	black Disposal bags		
7	Red Disposal bags		

Annexure-VII

CHECKLIST FOR THE COMMUNITY HEALTH CENTRE

A. General information

- Name of the block Name of the CHC-
- No of the PHC under CHC - No of SC under each PHC-
- No of a village covered- No of the population covered-
- Distance from the District Health care facilities-

B Staff at the CHC-

S no	Staff	In position	Vacant
1	Block medical officer /medical superintendent – one		
2	Public health specialist – one		
3	Public health nurse -one		
	Specialty services		
4	General surgeon – one		
5	General duty medical officer – two		
6	Medical officer AYUSH – one		
	Nurse and paramedical		
7	Staff nurse – one		
8	Pharmacist –one		
9	Pharmacist –AYUSH- one		
10	Lab technician –two		
11	Radiographer – one		
12	Dietician-one		
13	Ophthalmic assistant -one		
14	Dental assistant -one		
15	Cold Chain & Vaccine Logistic Assistant- one		
16	OT technician - one		
17	Multi rehabilitation worker – one		
	Counselor –one		
	Administrative staff		
18	Registration clerk – two		
19	Statistical assistant /data entry -two		
20	Account assistant -one		
21	Administrative assistant -one		
	Group D staff		
22	Dresser –one		
23	Ward boy/nursing orderly – five		
24	Driver – one		
	Total – 33		

S no	Services	Existing Yes 1 No 2	Remarks
1	The population covered		
2	Specialist services available		
3	Medicine		
4	Surgery		
5	OBG		
6	Paediatrics		

7	National health program services (NHPs)		
8	Emergency services		
9	Laboratory		
10	Blood storage services		
Infrastructure			
11	Area of building		
12	OPD rooms		
13	Waiting room for patients		
14	No of beds, male		
15	No of beds –female		
16	Operation theatre		
17	Labour room		
18	Laboratory		
19	X ray room		
20	Blood storage		
21	Pharmacy		
22	Water supply		
23	Electricity		
24	Garden		
25	Transport facility		

Service utilization-

S no	Questions	Responses Yes 1 No 2	
Availability for specific medications			
3	Is anti-rabies vaccine available at the CHC?		
4	Is drug for malaria available at the CHC?		
5	Are ART drug and services available at the CHC?		
6	Is drug for tuberculosis available at the CHC?		
7	Are drugs for leprosy available at the CHC?		
8	Is AYUSH medicine available at the CHC?		
9	Is a homeopathic medicine available at the CHC?		
10	Are all the medicines given free of cost at the CHC? Yes 1 No 2 Some medicines are given and other have to buy from medical. Stores – 3 Mostly, we have to buy from medical stores – 4 -No information		
Reproductive and child health services			
11	Are antenatal clinics organized at the CHC?		
12	Delivery services available at CHC for 24 hours? Total no of deliveries- SC, ST Backward class General BPL card holder, emergency case referred-		
13	Are they used proper septic techniques (5 cleans)?		
14	Is facility available for a gynecological examination?		
15	Is treatment available for gynecological disorders?		
16	Is facility available for family planning methods? -Oral contraceptives - condoms -IUD insertion sterilization		
17	Is facility available for MTP free of cost at CHC?		
18	Is facility available for low birth-weight babies?		
19	Is treatment available for the pneumonia?		
20	Is management child suffering from diarrhea, dysentery and fever done at the CHC?		

Laboratory services-			
21	Is the blood examination facility available?		
22	Is the detection of malaria parasite done at CHC?		
23	Is sputum examination done at CHC?		
24	Is urine examination for pregnant women done at CHC?		
25	Is there corruption present at the CHC extra money for services)		
26	Is there discrimination faced by people? (SC,ST, OBC, minority people)?		

Equipments & diagnostic kits

S no	Items	Is it available?		Condition	
		Yes	No	Good 1 Fair 2 Poor 3 Not Observable 4	Remarks
1	Normal delivery kit				
2	Equipment for assisted vacuum delivery				
3	Equipment for new natal & newborn care				
4	IUCD insertion kit				
5	Refrigerator				
6	ILR (small) with voltage stabilizer				
7	Vaccine carriers with 4 ice packs				
8	Spare ice pack boxes - 8				
9	Computer including net				
10	Radiant warmer for new born				
11	An adult weighing scale				
12	Baby weighing scale				
13	Height measuring scale				
14	Phototherapy unit				
15	Self-inflating bag and mask for neonatal				
16	Mucus extractor				
17	Feeding tube for baby				
Labour room					
18	Suction machine				
19	Delivery table				
20	Sterilization of equipment				
21	24 hours running water				
22	24 hour electricity				
23	Attached toilet				
24	Torch				
25	Ambu (ventilatory) bag and face masks				
26	Towels to wipe dry and cover the baby				
27	A source of warmth for the baby (bulb/baby warmer)				
28	Baby weighing scale				
29	Dressing drum				
30	Hemoglobinometer –sahli				
31	BP apparatus				
32	Basin stand				
33	Bed Sheet				

34	Macintosh Sheet				
35	IVstand				
36	AD syringes				
37	IFA				
38	TT shots				
39	Stethoscope				
40	Fetoscope				
41	Hub and needle destroyer				
42	Oxygen administration equipments				
43	Kelly's haemostat forceps				
44	Cusco's Speculum				
45	Sims Speculum				
46	Cheatles forceps				
47	Tooth forceps				
48	Plain forceps				
49	Kidney tray				
50	Vial opener				
51	Vaccine carrier				
Emergency drugs					
52	Misoprsotol (Tablet)				
53	Inj Oxytocin				
54	Inj diazepam				
55	Inj mifedepin				
56	Inj magnesium sulphate				
57	Lignocaine hydrochloride				
Common drugs					
58	Ibuprofen				
59	Paracetamol				
60	Ampicillin				
61	Benzylpenicillin				
62	Cephalexin				
63	Gentamicin				
64	Mebendazole				
65	Vit A				
Laboratory facilities					
66	Reagent of cyan meth for Hb				
67	Utistix – for urine albumin				
68	-ABO & Rh				
69	Gram stain				
70	RPR test syphilis kits				
71	Swab and swab sticks				
Equipments for anesthesia					
72	Cuffs for endotracheal catheters				
73	Larynogoscope				
74	Breathing tubes				
75	Vaporiser				
76	Needle,spinal ,stainless set -4				
Kits for blood transfusion					
77	Bovine albumin 20% testing agent				
78	Centrifuge				
79	Pipette				
80	CPDS anti-coagulant				

Annexure-VIII

Questionnaire for ANM A –Socio demographic profile

Name of block- Name of CHC and PHC and

Name of the village- The population covered- Name of AWW-

S No	Socio demographic	Responses	Remark
1	Age	< 21 yrs (1) 21 -30 yrs (2) 31-40 yrs - 3 > 40 yrs- 4	
2	The class passed	5th pass -1 8th pass -2 10th pass- 3 12th pass -4 Graduate and above -5	
3	Marital Status	Married -1 Widowed- 2 Divorced-3 Separated-4 Unmarried-5	
4	Religion	Hindu -1 Muslim -2 Christian -3 Sikh -4 Other (specify) -5	
5	Caste	SC- 1 ST-2 OBC-3 General-4 Others-5	
General in formations			
6	How long you have been working as an ANM?	<10 yrs -1 10 -20 yr-2 21- 30yrs-3 31-40 Yrs-4 ➢ 40 yrs-5	
7	Are you resident within the premises of the sub centre?	Yes – 1 No-2	
8	What is the reason behind not to stay within the premises of the sub centre? -Rooms need repair 1 - Not adequately ventilated 2 -Has no adequate light 3 -Has no water facility 4 -Has no electricity supply 5 -Family leaves away from the Sub centres 6 -No facility of child's education 7 -No facility for necessary requirement (transportation, food) 8		
10	Income: Rs_____/m		

11	Have you undergone training?	Yes-1 No- 2	
	If yes	When, Where	
12	Have you undergone refresher training?	Yes-1 No-2	
	If yes, how many years back?	1 yr 2yr 3 yr 4 yr	
13	During training, did you receive enough practical experience?	Yes 1 No 2	
14	Husband‘s occupation	Working Not working	
15	What problems faced by you during the working place? (Don’t read options, only mark relevant options) Excessive work 1 Less support from ASHA worker 2 Lots of meetings have to attained3 Shortage of staff 4 Family problems 5		
16	What type register, you have to maintain. (Don’t read options, only mark relevant options) Institutional deliver 1 Eligible couple 2 JSY beneficiaries 3 Birth and death register 4 Population register 5 -Others 6		

Section B- Awareness regarding role and responsibilities

S no	What are your responsibilities as an ANM? (Don’t read options, only mark relevant options)	Remarks
	✓ Registration of ANC and PNC-1 ✓ Providing antenatal and postnatal check-up - 2 ✓ Assist MO and LHV in ANC and PNC-3 ✓ Conducting deliveries -4 ✓ Supervision and assist (if necessary) deliveries conducted by Dais -5 ✓ Family planning services- 6 ✓ Referrals-7 ✓ Accompany pregnant women for health facility- 8 ✓ Follow up services for patients discharged from health facility- 9 ✓ Test and analysis of blood and urine-10 ✓ Immunization of pregnant and children -11 ✓ Treatment of minor ailments -12 ✓ Control management of communicable disease - 13 ✓ Vital event recording and reporting -14 ✓ Training of Dai and ASHA -15 ✓ Co ordinate with ASHA,AWW,PRIs and VHSC members-16 ✓ Educate mothers -17 ✓ Reports making –weekly ,monthly , quarterly , yearly -18 ✓ Distribution of IFA tablets -19 ✓ Follow up of newborn of home delivery -20 ✓ Weight of newborn- 21	

	✓ Advice on breast feeding- 22 ✓ Identifying cases of malnutrition and take necessary action -23	

Section C –Knowledge about different aspects

Knowledge assessment scale for ANM

Total no of questions-20. For a wrong answer-0 For correct answers-1

S no	Questions	Correct Answer (1)	Wrong Answer (0)
1	What is the correct age of adolescent's girls? 10-19 yrs 9 -15 yrs 10-20 yrs 15-20 yrs		
2	What are the common problems due to lack of menstrual hygiene? Vaginal discharge Burning during urination Genital itching All of above		
3	The risk of maternal death is higher in the women. In 15-19 yrs In 20-35 yrs		
4	Deworming of the pregnant ladies should be done- During 1st trimester During 2nd trimester		
5	Dose of Albendazole in pregnant ladies 400mg 500 mg		
6	Syphilis should be tested during. First antenatal visit During second antenatal visit During third antenatal visit		
7	Danger signs of diarrhea disease- Lethargic Not able to drink Do not pass urine All of above		
8	Danger signs of pregnancy are- Swelling of hands and feet's Paleness/anemia Excessive bleeding Weak /no moment of the fetus All of above		
9	To prevent anemia women need to take one iron tablet daily- From starting After 3 months of pregnancy After 4 months of pregnancy		
10	How much iron tablet she must take during pregnancy- 100 200 150 250		
11	What is the average weight of new born?		

	2.5 kg 2.6 kg 2.7 kg 2.8 kg		
12	Exclusive breastfeeding to be newborn should be done for 4Months 6 months 8 months 10 months		
13	Termination of pregnancy is legal under the provision of MTP act- Up to 40 weeks Up to 50 weeks Up to 20 weeks Up to 30 weeks		
14	When children have minor ailments like- Cough, fever, cold, then what you will do for the immunization of the children? Should we stop immunization? It should be given to the child.		
15	Breast feeding during illness Stop breast feeding Continue breast feeding		
16	Minor side effects after immunization Mild fever Mild rash after measles All of above		
17	How did you manage if a child has a mild fever after immunization? Give 1/4th tablet of paracetamol Give 1/2th tablet of paracetamol Give 1 full tablet of paracetamol		
18	Correct age to start the complementary feeding? 6 to 12 months 4 to 12 months 9 to 12 months 10 to 12 months		
19	Management of diarrhea disease is/are- Continue feeding Give extra fluids Give ORS sol All of above		
20	HIV transmitted by- Unsafe sex Through infected blood Infected mother to child Infected syringes and needle All of above		

Knowledge assessment scale for on Immunization

S no	Drug	Time to be given	Dose	Route	Site
For Pregnant Ladies					
1	TT -1	Early in pregnancy Late in pregnancy	0.5 ml 5.0 ml	I/M S/C	Upper arm Buttocks
2	TT- 2	4 weeks after TT 1	0.5 ml	I/M	Upper arm

		Within 1 week	5.0 ml	S/C	Buttocks
For infants					
3	BCG	At birth At 2nd month	0.005 ml 0.05 ml	I/D S/C	Left upper arm Right upper arm
4	OPV	0,6,10,14 weeks 0,9,14 weeks	2 drops 4 drops	Oral S/C	Oral S/C
5	DPT	6.10.14 weeks 9,14 weeks	0.5 ml 5.0 ml	I/M S/C	Buttocks Mid outer thigh
6	Measles	9 months 14 months	0.5 ml 5.0 ml	S/C I/M	Left upper arm Right upper arm
7	vit A	At 9 months with Measles At 18 months	1 ml 2 ml	Oral S/C	Oral S/C
For children					
8	DPT Booster	16-24 months 24 months	5.0 ml 0.5 ml	I/M S/C	Mid outer thigh Buttocks
9	OPV booster	16-24 months 24 months	2 drops 4 drops	Oral S/C	Oral S/C
10	Vit A	16 months with DPT & OPV 24 months	2 ml 1 ml	Oral S/C	Oral S/C
11	DT	5 yrs 4 yrs	0.5 ml 5.0 ml	I/M S/C	Upper arm Buttocks
12	TT	10 yrs 12 yrs	0.5 ml 5.0 ml	I/M S/C	Upper arm Buttocks

Clinical assessment rating scale For ANM

S. No.	SKILLS	0	1	2	3	4	5
ANTENATAL CARE							
1	Hand washing						
2	Head to toe examination						
3	Examination of the face for puffiness, pallor skin						
4	Chest examination for breathing, heart rate						
5	Abdominal – Inspect size and shape						
6	Palpation – fundal						
7	Pelvic palpation						
8	Auscultation						
9	Extremities for edema, cyanosis						
10	Blood pressure						
11	Weight and height						
12	Urine examination for sugar						
13	Urine examination for protein						
14	Blood examination for hemoglobin						
15	Advices for antenatal exercises						
INTRANATAL SKILL							
16	Beginning of Labor						
17	Dilatation of cervix						
18	Rupture of membrane and amniotic sack						
19	Baby move through the birth canal						
20	Demonstrates descent of the fetal head						
21	Demonstrates flexion						
22	Demonstrates internal rotation of the head						
23	Demonstrates extension of the head						

24	Demonstrates restitution						
25	Demonstrates internal rotation of the shoulder						
26	Demonstrates external rotation of the head						
27	Demonstrates lateral flexion						
28	Monitors labour using Partograph						
29	Performs Controlled Cord Traction						
30	Performs uterine massage to expel clots						
Post natal							
31	Vital signs						
32	Check weather mother is anxious, worried, depressed						
33	Skin condition –pallor /jaundice						
34	Perineum –clean, intact						
35	Lochia- amount of bleeding						
36	Color –red /yellow /white						
37	Odor – foul smelling /fishy odor						
NEW BORN CARE							
38	Cleans the airway						
39	Covers the baby						
40	Cord Care						
41	Initiates Breast Feeding						
42	Kangaroo mother care						
43	Weighs the new born						
44	Breast care						

Interview -ANM

(1) VHND (Village health and nutrition day)

(A) **Immunization-**

(a) What do you think; AWW keeps the Centre ready for holding an immunization session during VHND?

(b) Does AWW keep track of which child is due and encourage families to attend an immunization session? Share your experience?

(c) How does AWW capable of support you during an immunization session? Share your experience?

(d) What's your opinion; does ASHA assist and help the AWW to keep the Centre ready for holding an immunization?

(e) Does ASHA help the AWW in registering children and women for immunization? Share your opinion?

(f) Do ASHA and AWW are able to mobilize the beneficiaries? Share your experience?

(B) **Antenatal and postnatal checkup-**

(a) Does AWW arrange the venue for the provision of antenatal care and keeps track and ensuring supplementary nutrition to the pregnant ladies?

(b) What do you think; AWW provides supplementary nutrition for lactating mothers and promotes breast feeding?

(c) Does ASHA worker able to find out all pregnant ladies in the village and motivate them for an antenatal check-up?

(d) What do you think does ASHA have the knowledge of antenatal and post natal check-up and capable to assist you during the checkup?

(e) Along with the post-natal care, what are the contents of the health education? Does ASHA cover the importance of breast feeding along with the weaning diet? Share your experience?

Referral

(a) What do you think AWW capable of finding sick children and refer them to PHC/CHC?
(b) In your view, AWW does prompt referral of grade III and IV children to NRC?
(c) What do you think ASHA worker able to find the danger sign of pregnancy and refer cases to SC/PHC/CHC?

Health and hygiene education

(a) What's your opinion during health and hygiene education AWW provides assistance to you, and ASHA workers assist the AWW along with you in imparting the health education to the beneficiaries?

Health services

(a) What do you think AWW function as a depot holder of medicine kit/contraceptives to ASHA worker and ASHA would receive medicine kits /contraceptive from AWW?
(b) Is there any conflict between AWW and ASHA worker on holding and distribution of medicine kit/Contraceptives in the village?

Maintenance of records

(a) What do you think ASHA workers help to AWW to maintain the records?
(b) Does ASHA worker provide assistance to you while maintaining records on pregnant women, eligible couple and birth and death of children?

Delivery services

(a) How does AWW help in guide /counsel women on institutional delivery? Please share experience?
(b) What is the role of ASHA as an escort for institutional delivery? Please share your experience?

Nutrition and health education

(a) What's your opinion, AWW is capable of identifying and counsel families with severe malnutrition?
(b) What do you think AWW is responsible for supplementary nutrition for all and gives special effort on grade, I and II malnourished child?
(c) What do you think does AWW provides regular deworming and iron tablets for the children?

Records of village

(a) AWW shared the available information with you and the ASHA worker before submitting to village registrar?
(b) ASHA ensures the registration of all births and deaths of mothers and children and shared with you and AWW?

Constraints

(a) What is the constraints during work faced by you? Share your experience?
(Service delivery, coordination with ASHA and AWW, supervisory level, supplies, workload, maintenance of records etc.)

Work experience and suggestions

(a) What do you think about the overall work experience of you with the AWW and ASHA workers?

(b) According to you, what type of support you want from AWW and ASHA to improve the health and nutrition status among the children? Share your opinion?

Annexure-IX

Questionnaire for ASHA

A –Socio demographic profile

Name of block-

Name of CHC and PHC- Name of the village-

S No	Socio -demographic	Responses	Remark
1	Age	Less than 20- 1 20-30 yrs -2 31-41yrs - 3 More than 41vyrs- 4	
2	The class passed	8th pass -1 10th pass- 2 12th pass -3 Graduate -4	
3	Marital Status	Married -1 Widowed- 2 Divorced-3 Separated-4 Unmarried-5	
4	Religion	Hindu -1 Muslim -2 Christian -3 Sikh -4 Other (specify) -5	
5	Caste	SC- 1 ST-2 OBC-3 General-4	
General in formations			
6	How long have you worked as an ASHA?	Less than 1 yr -1 1-5yrs-2 6-10 yrs -3 11-15 yrs-4 More than 15 yrs-5	
7	Are you resident of this village?	Yes – 1 No-2	
8	Have you undergone training?	Yes-1 No- 2	
9	Husband‘s occupation	Working Not working	

Section B- Awareness about her responsibilities

S no	What are the duties / responsibilities of you as an ASHA worker?	Remarks
1	(Don’t read options ,only mark relevant options) • Help with immunization • Accompany delivery cases • Family planning • Provide ANC and PNC care • Advice on breast feedings to mothers	

	• Hygiene and health practices • Reproductive and sexual health problems • Motivating and mobilizing communities • Village health plans • Birth and death registration • Treatment and referral • Reduce IMR and MMR • Home visits for new born • Prevent malnutrition and feeding problem	
	Regarding record keeping	
2	What type of records you should have with you?	
	(Don't read options, only mark relevant options) • ANC records • New born visit record • Home delivery record • Institutional delivery record • Immunization records • Family planning records • Birth and death registration • Household survey records	
3	Who is the inspirational force behind record maintenance?	
	-Gram Pradhan 1 - Family members 2 - ANMs 3 - Others 4	
4.	What are the factors motivating you to do the work?	
	✓ To provide health services-1 ✓ To earn money -2 ✓ To do something (Time pass) -3 ✓ Serving /helping the community-4 ✓ Hoping for absorptions in govt job -5	
5	Are you satisfied with the incentives which you get? Yes 1 No 2	
6	What are the expectations from you for good work? • Better incentives 1 • Fixed regular monthly payment 2 • Incentives for more work 3 • Incentives for good work 4 • Others 5	

Section C –Knowledge about different aspects

Knowledge assessment scale for ASHA–

Totals no of questions – 20 For correct answers- 1 For the wrong answers 0

S no	Questions	Correct Answer (1)	Wrong Answer (0)
1	What are the complications you have to look during delivery? -Excessive bleeding -Convulsions -The fetus dies in mother's womb -All of the above		

2	Minimum no of visits should be made during pregnancy? -Only 1 visit -2 visits -3 visits -4visit		
3	The danger sign of diarrhea is- - Lethargic - Not able to drink - Do not pass urine - All of above		
4	What action you have supposed to take during danger signs of pregnancy -Take her to the nearest PHC/FRUs -Ask her to consult ANM next day -Refer her to govt hospital - Wait for some time		
5	The first dose of TT should be taken -During 3rd trimester -During first antenatal visit/First trimester -During 2nd trimester		
6	To prevent anemia women need to take one iron tablet daily- -From starting -After 3 months of pregnancy -After 4 months of pregnancy		
7	How much iron tablet she must take during pregnancy 100 200 150 250		
8	What is the average weight of new born? - 2.5 kg - 2.6 kg - 2.7 kg - 2.8 kg		
9	Exclusive breastfeeding to be newborn should be done for - 4 months - 6 months - 8 months - 10 months		
10	What are the signs of fetal distress during delivery? - Decreased movement felt by the mother - Increased / decreased fetal heart rate - Maternal High BP during delivery - All of above		
11	When a child has minor ailments (Cough, fever, cold) then what should you have to do for Immunization of Child- - Immunization should be stopped - Immunization should be given		
12	What is the right time for administration of Measles? - 9 months - 10 months - 1 yr - 2 yrs		
13	Best time to start Mala D is-		

	- 1st day of period - 5th day of period - 7th day of period - 14 days of period		
14	What are the complications of oral contraceptives? -Breast tenderness -Headache -Dizziness -All of the above		
15	Minor side effects after immunization is- -Mild fever -Mild rash after measles -All of above		
16	How did you manage if the child has the mild fever after immunization? -Give 1/4th tablet of paracetamol -Give 1/2th tablet of paracetamol -Give 1 full tablet of paracetamol		
17	What are the danger signs of pregnancy? - Swelling of hands and feet -Paleness/anemia -Excessive bleeding -Weak /no moment of the fetus -Convulsion -All of above		
18	Correct age to start the complementary feeding? - 6 to 12 months - 4 to 12 months - 9 to 12 months - 10 to 12 months		
19	Management of diarrhea is- -Continue feeding -Give extra fluids -Give ORS solution -All of above		
20	HIV is not transmitted by- -Touching a person -Mosquito bites -Using common bathrooms and toilets -All of above		
21	How to take care of a cord of newborn -Apply coconut oil -Apply power on cord -Apply cream on cord -No need to apply anything		
22	How many pills available in a packet of Mala- D -27 -28 -26 -25		
23	Under JSY Mother's package is (in rural) and (in urban) respectively- -1400 and 1,000 -1,500 and 6,00 -1,000 and 7,00		
24	What immunization a child should receive at birth-		

	-BCG, OPV -BCG, DPT, OPV -BCG, Measles -BCG only		

Clinical skill assessment of ASHA worker

S. No.	SKILLS	1	2	3	4	5
	ANTENATAL EXAMINATION					
1	Clean hands					
2	Explain the procedure					
3	Measures weight and height					
4	Measures blood pressure					
5	Measures Fundal height					
6	Assesses fetal presentation					
7	Assesses fetal heart sound					
8	Examines urine for protein					
9	Examines urine for sugar					
10	Examines blood for hemoglobin					

(5 * 10= 50)

Interview –ASHA worker

1. **VHND (Village health and nutrition day)**

A. Immunization-

(g) What do you think, AWW keeps track of children is due and counter check with you before immunization?

(h) Share your experience on AWW is support during immunization?

(i) What ANM will do when children remained immunized? Share your experience?

(j) Share your work experience with ANM during immunization?

B. Antenatal and postnatal checkup-

(f) Before arranging the venue for the provision of antenatal care AWW makes a list and concern with you? Share your experience?

(g) What do you think, AWW support you in the promotion of breastfeeding by the health education to the mothers?

(h) In your opinion, what type of services ANM is provided to the pregnant mother during the antenatal checkup?

(i) If a pregnant lady comes with the any danger signs of pregnancy, then how she will take care of the lady? Share your experience?

(j) What do you think AWW encourage pregnant ladies for institutional delivery?

(k) In your view, how does AWW keep track on antenatal mothers?

Referral

(a) When you tell ANM about the refer cases, then what she will do?

(b) What do you think AWW worker able to find sick child and refer cases to SC/PHC/CHC?

Health and hygiene education

(a) What are the contents of health and hygiene education provided by ANM to the beneficiaries?

(b) On which component ANM is focused more during health and hygiene education?

(c) How does AWW worker assist you in health and hygiene education to the beneficiaries?

Health services

(a) Explain what type of health services provided the ANM to the beneficiaries?

(b) Does AWW act as a depot holder for receiving medicine kit/Contraceptives in the village?

Drug administration

(a) After the health checkup, ANM administered the drugs as specified by the medical officer?

(b) Do you think AWW worker administered selected drugs (Albendazole, paracetamol) and distributed ORS/IFA tablets to the beneficiaries?

Maintenance of records

(a) What is the experience during maintenance of records? Share your view?

(b) Does AWW worker help you for maintaining records on pregnant women, eligible couple and birth and death of children?

(c)ANM maintaining her own record or she relied on you and AWW worker?

Delivery services

(a) How does ANM guide /counsel women on institutional delivery? Please share experience?

(b)What is the role of AWW in institutional delivery? Please share your experience?

Nutrition and health education

(a) If AWW is identified families with severe malnutrition than she discuss with you for necessary steps? Share your experience?

(b)What do you think AWW is regularly given supplementary nutrition to all without any problem and gives special effort on grade I and II malnourished child?

(c)In your view, does AWW make a referral for grade III and IV children and con cent with you?

(d)When a malnourished child comes to the AWC than what type of advices AWW gives to the family members to improve the health condition of a malnourished child?

(k) When ANM conducts health checkups for screening for children than she expected, which type of assistance from you? Share your experience?

(l) Whenever you inform about the grade III & a grade IV child to the ANM then what she will do? Either she directly referred to the NRCs or she will do the health checkup and manage before referral? Share your experience?

(m) In your opinion, AWW is counsel family members for health and nutrition education?

(n) According to you AWW facilitates and support family for access to basic entitlements for food? Share your experience?

Records of the village (a) Does ANM counter, check the available information with you and the AWW worker before the share with the village registrar?

(b)AWW ensures the registration of all births and deaths of mothers and children and other records. She shared information with you and ANM before submitting to the village registrar?

Constraints (a) What is the constraints you faced during the work? Share your experience? (Service delivery, coordination with AWW and ANM, VHSC, PRIs, supervisory level, supplies, work load, maintenance of records, etc.)

Work experience and suggestions

(a)What do you think about the overall work experience of you with the AWW and ANM?
(b) According to you, what type of support you want from AWW to improve the health and nutrition status of the children? Share your opinion?

Annexure-X

Questionnaire for AWWs

A –Socio demographic profile

Name of block – Name of CHC and PHC and SC-

Name of the village – Population covered-

Total no of children- Total no of pregnant and lactating mother-

Total no of adolescent girls- Name of AWW-

S No	Socio demographic	Responses	Remark
1	Age	< 21 yrs (1) 21 -30 yrs (2) 31-40 yrs - 3 > 40 yrs- 4	
2	The class passed	5th pass -1 8th pass -2 10th pass- 3 12th pass -4 Graduate and above -5	
3	Marital Status	Married -1 Widowed- 2 Divorced-3 Separated-4 Unmarried-5	
4	Religion	Hindu -1 Muslim -2 Christian -3 Sikh -4 Other (specify)-5	
5	Caste	SC- 1 ST-2 OBC-3 General-4 Others-5	
6	Type of family	Nuclear-1 Joint family-2 Single parent family-3	
General in formations			
7	How long have you worked as an AWW?	<5 yrs -1 5 -10 yr-2 11- 15yrs-3 16-20 yrs-4 21-25 yrs-5 ➢ 26 yrs-6	
8	Are you staying within the same area where anganwadi centre is located?	Yes – 1 No-2	
9	Income: Rs_____/m	<1000 Rs-1	

		1,001 to 2,000rs- 2 2,001 to 3,000rs- 3 3,001 to 4,000rs- 4 ➢ 4,001-5	
10	Have you undergone training?	Yes-1 No- 2	
	If yes	When, Where	
11	Have you undergone refresher training?	Yes-1 No-2	
	If yes, how many years back?	1 yr 2yr 3 yr 4 yr 5 yr	
12	During training, did you receive enough practical experience?	Yes 1 No 2	
	Husband‘s occupation	Working Not working	
13	Children enrolled at the AWCs are- Less than10- 1 10-20- 2 20-30-3 >30 -4		
14	Are all these children coming to AWCs regularly? Yes 1 No 2		
	If not, What are the reasons?		
15	What are the problems faced by you? (Don’t read options, only mark relevant options) • Inadequate salary • Discontinue of salary • Infrastructure related • Work overload • Excessive record maintenance • Lack of community support • Logistic supply related • Inadequate supervision • Others (specify)		
16	How many times do you arrange the meetings with mothers? -Weekly -Once in 15 days -Once in a month -More than 1 month		
17	What type of survey you have conducted? -Population -Ration card survey -Children survey -Pregnant mother surveys -All		

Section B- Awareness regarding role and responsibilities

S no	What are the responsibilities of you as an AWW? (Don't read options, only mark relevant options)	Remarks
	✓ Caring of children (0-6yrs) ✓ Growth monitoring(0-6 yrs) ✓ Distribution of supplementary food to children (0-6 Yrs) ✓ Distribution of supplementary food to children, pregnant and lactating mothers ✓ Distribution of supplementary food to adolescent girls ✓ Distribution of Iron and folic acid to mother and adolescent girls ✓ Health check up ✓ Treatment of minor ailments ✓ Participation in immunization ✓ Preschool education to children ✓ Community survey ✓ Arranging mother's meeting ✓ Arranging and organizing VHND ✓ Attending VHSC meeting ✓ Education of an adolescent girl	

Section C – Knowledge assessment

Knowledge assessment scale for AWWs

S no	Questions	Correct Answer (1)	Wrong Answer (0)
1	How frequently you have to check the weight of children? -Once in a month -Once in 2 months -Once in a 3 month -No idea		
2	At least how many times the weight of pregnant lady checked? 3 times 2 times 1 times 4 times		
3	What is the average height of one-year-old child? -30 inches -32 inches -34 inches -36 inches		
4	What is the right time to starting breastfeeding to be new born? Just after delivery After 1 HR After 1 day After 2 days		
5	What is the right time to start weaning in infants? ? -After 6 months		

	-After 8 months -After 10 months -After 1 yr		
6	What is the correct time up to exclusive breastfeeding? 4 months 6 months 8 months 10 months		
7	What is the average weight of new born? 2kg 2.5 kg 3 kg 3.5 kg		
8	Good ,food stuff with maximum iron content? -Jaggery -Green leafy vegetables -All of above		
9	A disease caused by vitamin A deficiency in children? -Xeropthalmia - Beriberi -Scurvy		
10	What is the correct time for administration of vitamin A to children? -Once in a month -Once in a six month -Once in a year		
11	What is the right time for expectant mother to receive immunization against tetanus? TT 1 dose- • First trimester • Second trimester		
12	TT 2 dose - • After 4 weeks, followed by 1 dose • As soon as possible		
13	What we have to do when a child is ill? - Stop breast feeding - Continue breast feeding		
14	The disease against BCG vaccination provides protection? -Tuberculosis -Measles' -Diphtheria		
15	DPT stands for- Diphtheria, pertussis, Tetanus Diphtheria, polio, Typhoid		
16	Diseases prevent by DPT are- -Two -Three		
17	Polio immunization schedule- -Opv-0,6wk,10 wk, 14 wk, 15-18 month, 5 yrs - OPV-0, 9 months, 5 yrs -OPV- 1 month, 9 months, 5 years		
18	Treatment for round worm infestation is-		

	-Mebendazole -1 -Albendazole - 2 -Piparazine - 3 -All of above -4		
19	Sign and symptom of severe dehydration is /are- Extreme thirst-1 Very dry mouth,skin and mucous membrane -2 In infants – sunken fontanels -3 Rapid breathing and heartbeat- 4 No tears when crying – 5 All of the above – 6		
20	Immediate treatment of diarrhea is- -ORS -Lemon water+ salt+ sugar -Coconut water -Rice water		
21	Amount of supplementary nutrition to be given to a severely malnourished child is- -800 kcal and 20-25 gm protein -500 kacl and 30 gm protein -800 kacl and 30 gm protein -500 kacl and 20-25 gm protein		
22	Amount of supplementary nutrition to be given to pregnant and lactating mothers is- -600 kcal and 20-25 gm protein -500 kcal and 30 gm protein		
23	If a child is severely malnourish what action do you take- -Refer to SC -Refer to PHC -Refer to CHC -Refer to NRC		
24	If a child has high fever and vomiting with convulsion what action do you take- -Treat the child by yourself -Refer to the PHC / CHC -No idea		

Section D: Skill assessments Rating scale for AWW

S no	Steps	1	2	3	4	5
1	Bringing the pointer to zero.					
2	Removal of clothes and shoes					
3	Suspend the weighing pants from the lower hook of the scale and readjust the scale to zero					
4	No part of the body should touch the wall or the ground					
5	No one should touch the child while weighing					
6	Record the reading correctly					
Total						

*Poor- <10 (<33%) *Average – 10-20 (33-66%) *Good- > 20 (> 66%)

Interview – AWW

1. VHND (Village health and nutrition day)

(A) Immunization-

(a) On the day of Immunization /VHND ANM supposed to come with immunization material and performed immunization. What is your experience during immunization?
(b) ANM prepare the list of children who required immunization and tally with you? What's your opinion?
(c) According to you, how will ASHA keep track of children those required immunization and for those who missed? Share your opinion?
(d) What do you think ASHA visit the families and talk to them and accompany them to the immunization session?

(B) Antenatal and postnatal checkup

(a) In your opinion, what type of services ANM is provided to the pregnant mother during the antenatal checkup?
(b) If a pregnant lady comes with the any danger signs of pregnancy, then how she will take care of the lady? Share your experience?
(c) (i) Did ANM workers make home visits once in the first week of delivery?
(ii)Along with the post-natal care, what are the contents of the health education?
(iii) Does she cover the importance of breast feeding along with the weaning diet? Share your experience?
(d) What do you think ASHA encourage and escorts pregnant ladies for institutional delivery?
(e) In your view, how does ASHA tracks and promote antenatal care?
(f) What do you think, ASHA make visiting and ensure essential newborn care?
(g) Share your experience regarding ASHA established breastfeeding within one hour and promote exclusive breastfeeding?
(h) What do you think, ASHA able to counsel and gives correct information to family members especially for mothers regarding weaning?

(2) Referral

(a)When you tell ANM about the referral cases, then what she will do?

(b)What do you think ASHA worker able to find the danger sign of pregnancy and refer cases to SC/PHC/CHC?

(3) Health and hygiene education

(a)What are the contents of health and hygiene education provided by ANM to the beneficiaries?

(b)On which component ANM is focused more during health and hygiene education?

(c)How does ASHA worker assist you in health and hygiene education to the beneficiaries?

(4) Health services

(a)Express your view on -You are working as a depot holder of medicine /contraceptives for ASHA?

(b) Does ASHA worker come to you for receiving medicine kit/Contraceptives in the village?

(c)What's your opinion does ASHA available 24 hours with basic drug kits?

(5) Drug administration

(a) After the health checkup, ANM administered the drugs as specified by the medical officer?

(b)Do you think ASHA worker administered selected drugs (Albendazole, paracetamol) and distributed ORS/IFA tablets to the beneficiaries?

(6) Maintenance of records

(a)What is the experience during maintenance of records? Share your view?

(b)Does ASHA worker help you for maintaining records on pregnant women, eligible couple and birth and death of children?

(**7) Delivery services**

(a)How does ANM guide /counsel women on institutional delivery? Please share experience?

(b)What is the role of ASHA as an escort for institutional delivery? Please share your experience?

(8) Nutrition and health education

(a)When a malnourished child comes for VHND than what type of advices ANM gives to the family members to improve the health condition of a malnourished child?

(b) What types of common health problems do you observe when ANM conduct health checkup and how does she treat it? Share your experience?

(c) Whenever you inform about the grade III & a grade IV child to the ANM then what she will do? Share your experience?

(d)In your opinion, ASHA is able to counsel family members for health and nutrition education?

(e)What do you think, dose ASHA ensure children to attend VHND?

(9) Records of village

(a) Does ANM counter, check the available information with you and the ASHA worker before the share with the village registrar?

(b)ASHA ensures the registration of all births and deaths of mothers and children and shared with you and ANM before submitting to the village registrar?

(10) Constraints

(a) What is the constraints you face during the work? Share your experience? (Service delivery, coordination with ASHA and ANM, VHSC, PRIs, supervisory level, supplies, workload, maintenance of records, etc.)

(11) Work experience and suggestions

(a)What do you think about the overall work experience with the ANM and ASHA?

(b)According to you, how will we improve the health and nutrition status of the children? Share your opinion?

(c)Gives some suggestions, how to improve work quality and reduced role conflicts between you and ASHA worker?

Annexure-XI

(State level)

Directorate of Health and Family Welfare- (DOHFW)

1. Please express your view regarding child malnutrition and maternal health in reference to the Madhya Pradesh State?

2. Health & family welfare and Women and child health departments are working Parallel to each other for a reduction in child malnutrition and mortality-
   a. Did your department to get any support from the Women and child health department?
   b. If yes, what type of support you get from them?
3. Is there any combine strategy to work together for cure of child malnutrition?

4. What are the major contribution of your department's for a reduction in child malnutrition and improve maternal health?
5. What are the hurdles /Problems faced by your department's during work?

   (Budget problem, manpower level, planning level etc.)

6. What are the future plans to improve the health status of children and mothers?
7. Yours suggestions?

Directorate of Women and Child development - (DWCD)

1. Please express your view regarding child malnutrition and maternal health in reference to the Madhya Pradesh State?
2. Health & family welfare and Women and child health departments are working Parallel to each other for a reduction in child malnutrition and mortality-
   a. Did your department to get any support from the health department?
   b. If yes, what type of support you get from them?

3. Is there any combine strategy to work together for cure of child malnutrition?
4. What are the major contribution of your department's for a reduction in child malnutrition and improve maternal health?

5. What are the hurdles /Problems faced by your department's during work?
   (Budget problem, manpower level, planning level etc.)
6. What are the future plans to improve the health status of children and mothers?
7. Yours suggestions?

Annexure-XII

(Village level)

Questionnaire for the PRIs/VHSC

1 . What is the socio demographic profile of the people in your village?

2.a. What are the various types of health services provided in your village?

b. What do you think these services beneficial for the community people (specially-mother & Child)?

3. You have the untied fund?

a. Is this money regularly supplied and sufficient for the activities?

B What types of problems do you face during the utilization of this money?

c. You are using money, mainly in which activity?

4. a. How frequently you organized the meeting with health personnel's?

b. During the meeting on which topic you usually discuss?

b(i)Does it is mainly based on the primary health care infrastructure, then why?

(ii)Does it is based on health status of mother and child?

5. The VHND arranged at the AWCs. How did you help during the VHND?

6.a. You used which type of media and methods for publicity of VHND?

b. After using all these efforts, why some people do not want to attain the VHND. What will be the possible reasons?

c. How did you counsel them?

7. Children from your village suffering from the malnutrition problem. What are the possible reasons of malnutrition in your area?

8. What do you think NRCs (nutrition, rehabilitation centres) are really helpful for sought out the malnutrition problem in your area?

9 Instead of this facility, some people don't want to go to NRC, Why? What would be possible reasons?

10. Do you think ANM/ASHA/AWW all these functionaries fulfilling their duties properly to fight from the malnutrition problem?

Annexure-XIII

(District level)

DPM- District Program Manager

1. As an administrator, how will you monitor managerial, administrative and financial aspect of the NRHM program in the district?

2. As an overall in charge of the of district level, what are the job responsibilities?

3. What are the common problems you faced during coordination with other consultant of NRHM program at central/ state/district level?

4. How do you provide logistic support to the contractual and field staff for implementation of NRHM program?

5. What are the common cause of delay in release of funds and propose corrective actions?

6. How will you take appropriate actions in relation to feedback provided by medical officers/program officers of the district?

7. During the preparation of the annual budget, what are the important points you have to be more concerned?

8. What are the strategies of co-ordination with other departments (like –women and child health department) for successful implementation of the project?

9. How will you provide necessary guidance to technical consultants appointed at state and field level during their field visits?

10. What will be the corrective measures for improving output?

DPO- District Program Officer

1. As an administrator, how will you monitor the scheme implemented by the ICDS department?

2. What are the common problems you faced as an administrator?

3. As an overall charge of district programs (ICDS cell), what are the job responsibilities?

4. What are the strategies of co-ordination with other departments (like –Health Department) for successful implementation of ICDS project?

5. What is the basis of the submission of proposals to the Directorate in respect of the ICDS scheme?

6. During the preparation of the annual budget, what are the important points you have to be more concerned?

7. What are the common cause of delay in release of funds and proposed correct actions?

8. What are the common problems you observed during coordination with other consultant of ICDS program at central/ state/district level?

9. How do you provide logistic support to the CDPOs and field staff for implementation of the ICDS program?

10. What will be the corrective measures for improving output?

Annexure-XIV

(Block level)

Interview schedule for Block Medical officer

General in formations-

1. Mostly people from which background comes to CHC? For what reasons they come to CHC?

2. What kind of special services provided to women & child at the CHC in compare to others? What are the situations and reasons?

Disease management-

3. How does CHC manage Child suffering from severe diarrhea/dysentery /ARI /pneumonia? Which protocol/ guideline is you using to treat the child?

4. In case of emergency what kind of special services available at the CHC for treatment of the child?

Health Service delivery, utilization, supervision and management-

5 Did you face staff crisis /Problem /role & responsibilities while distribution of work, especially for emergency services (like – Delivery) at the CHC? Please share your experience?

6. How frequently do you have meetings with the Frontline workers for necessary clinical and community setting guidance?

7. What do you think, most women come to the CHC for institutional deliveries? Share your experience?

8 .What is the status of Immunization in your area?

Malnutrition-

9. What are the possible causes of malnutrition in your area? Please elaborate the cause, according to the situations?

Suggestions

10. Do you think services available at the CHC are efficient and sufficient to the beneficiaries? How we will improve it?

11 . What will the main focus areas for solving the problem of malnutrition?

Child development project officer

1. You are principal executive functions of the ICDS team at the project level.

How will you hold the responsibility of implementing the program and supervision of day- today administration?

2. How will you allocate monthly and yearly budgets for running of the ICDS program?

3. What are the necessary steps for supervising and guide the work of the entire team specially AWWs and their supervisors?

4. How will you inspect the records at the project and Anganwadi centre level?

5. What is the process to maintain necessary links with district and state officials for the arrangement of the transportation, storage and distribution of supplies for the ICDS program?

6. How will you ensure the use and maintenance of equipment and material supplies for the smooth running of the ICDS program?

7. What are the essential steps to ensure a co-ordinated implementation of the ICDS program at project level?

8. How do you organize an educational program like nutrition and hygiene demonstrations for the field workers?

9. How do you initiate and guide the Anganwadi workers in a quick survey of the project village to identify children, pregnant women and nursing mothers?

10. How do you ensure the necessary arrangements for transportation, storing and distributing supplies to the Anganwadi centres?

Annexure-XV

(Supervisory level)

Questionnaire for ASHA facilitator

1. How will you have to support ASHA worker to improve their functionality?

(Specially – ASHA who is poor in a task or remain absent during VHND)

2. In what way you accompany ASHA during the home visit in the community?

3. How will you support ASHA in mobilizing women and children to attend VHND and ensure she convey the health messages to the women?

4. Do you regularly check the content of drug kit and ensure requisitions of supplies when stocks have decreased?

5. How do you organize monthly meetings with ASHA and review performance and planning?

6. You have to go to field visit and maintain a monthly tour diary. How will you maintain all the records?

7. You have to attain monthly meeting at the block level conducted by BMO. Generally, what is the discussion agenda during the meeting?

8. How do you ensure that ASHA gets the prescribed incentives on time every month?

9. (a) What is your responsibility during the training of ASHA?

(b) Do you organize need based ASHA training with the consultation of BMO? If yes then how?

10. As an important task, how will you enable ASHA to reach poorest and marginalized people? (Families at distant hamlets, women whose husband outside etc.)

Questionnaire for LHV / ANM Supervisor

1. How will you supervise and guide the ANM in the delivery of health care services?

2. What are the necessary steps to help and guidance of ANM in relation to Anganwadi centre?

3. How will you ensure visits to ANM centre? (At least once a week on fixed day)

4. (a) How frequently you conduct staff meetings of ANMs?

(b) How will you inspect the maintenance of records of ANM especially under the ICDS?

5. What are the essential steps to promote teamwork among the health workers and Coordinating activities with ICDS supervisors?

6. What are your responsibilities to conduct MCH & family planning clinics?

7. How do you manage cases referred by ANM and Anganwadi workers?

8. How frequently you organize and conducting training for traditional birth attendants with the help of ANMs?

9. What is your participation level in mass immunization and health check-up campaigns, family planning and health and nutrition education in your operational area?

10. Do you arrange the group meeting with community leaders and involving them in spreading the message for various health programs including those organized under ICDS?

Questionnaire for Anganwadi worker supervisor

1. As a AWWs supervisor, which type of job guidance you provide to AWW?

2. (a) How frequently you visit the AWC?

(b) How will you manage visit to AWCs which is located at a distance of more than 5kms?

3. During your visit, how you help the Anganwadi workers to identify "at risk" mother and children and refer them to PHC?

4. How will you guide AWW for the management and rehabilitation of severely malnourished child?

5. Do you ascertain the number of un-immunized children and report to the CDPO?

6. (a) Do you organize monthly meetings of AWWs in your circle?

(b) What will you discuss during the meeting AWWs? (Review of work done in previous months, Plan for next month, Preparation of weekly time table, continuing education –diarrhea management, growth monitoring etc.)

7. How do you maintain a diary of record on the work done during visit to AWCs?

8. How do you ensure timely submission of monthly progress reports of Anganwadi to the CDPO and also check the accuracy of the reports?

9. During the monthly meeting at project headquarters, how will you assist CDPO?

(Honoraria of AWWs in circle, alternative arrangement of Anganwadi workers, information about any special event or problem or achievement in her circle)

11. How do you find out the personal and work related problems of Anganwadi workers and provide the necessary guidance for them to cope with problems?

Annexure-XVI

Hindi Tools

डी0पी0एम0 जिला कार्यक्रम प्रबंधक

1. एक प्रशासक के तौर पर, आप कैसे एन0आर0एच0एम0 के प्रबंधकीय, प्रशासनीय और वित्तीय पहलुओं को जिले में देख रेख करते है ?

2. जिले के संपूर्ण रूप से प्रभारी के तौर पर, आप की क्या जिम्मेदारियों है ?

3. सेंट्रल/राज्य/जिले स्तर पर, एन0आर0एच0एम0 के अन्य सलाहकार के साथ ताल मेल बैठाने में आप को किन दिक्कतों का सामना करना पड़ता है ?

4. एन0आर0एच0एम0 कार्यक्रम का कार्यान्वयन करने के लिये आप ठेके और फील्ड स्टॉफ को किस प्रकार का संभार तंत्र साथ देते है ?

5. फंड को देर से रिलीज और संशोधनात्मक प्रस्तावित कार्य को देर से करने के सामान्यतः क्या कारण है ?

6. जिले के स्वास्थ्य अधिकारी/कार्यक्रम अधिकारी जानकारी देने के संदर्भ में आप क्या यथा योग्य कार्य करते है ?

7. वार्षिक बजट बनाने के दौरान, किन महत्वपूर्ण बिंदुओं पर आप ज्यादा महत्व देते हैं ?

8. प्रोजेक्ट के सफल कार्यान्वयन के लिये, दूसरे विभाग (जैसे–महिला एवं बाल विकास) के साथ तालमेल बैठाने में कूटनीतियां हैं ?

9.फील्ड विजिट के दौरान नियुक्त तकनीकी अधिकारी को आप कैसे जरूरी मार्ग दर्शन देते है?

10. बेहतर आउट पुट के लिये क्या संशोधनात्मक उपाय हो सकते ह

डी0पी0ओ0–जिला कार्यक्रम अधिकारी

1. एक प्रशासक के तौर पर आप किस तरह आई0सी0डी0एस0 विभाग की योजना के कार्यान्वयन को देखते हैं ?

2. एक प्रबंधक के तौर पर सामन्यतः आप को किन मुसीबतों का सामना करना पड़ता है ?

3. (आई0सी0डी0एस0सेल) कार्यक्रम के जिले के संपूर्ण प्रभारी के तौर पर, आप की क्या जिम्मेदारियां है ?

4. आई0सी0डी0एस0 प्रोजेक्ट के सफल कार्यान्वयन के लिये दूसरे विभाग (जैसे स्वास्थ्य विभाग) के साथ ताल मेल बैठाने में क्या कूटनीतियां है ?

5. आई0सी0डी0एस0 योजना के संदर्भ में निर्देशालय को प्रस्ताव देने के क्या आधार है ?

6. वार्षिक नजर बनाने के दौरान किन महत्वपूर्ण बिंदुओं पर आप ज्यादा महत्व देते है ?

7. फंड को देर से रिलीज और प्रस्तावित संशोधनात्मक कार्य को देर से करने के सामान्यतः क्या कारण है ?

8. सेंट्रल/राज्य/जिले स्तर पर आई0सी0डी0एस0 कार्यक्रम के अन्य सलाहकार के साथ तालमेल बैठाने में आपको किन दिक्कतों का सामना करना पड़ता है ?

9. आई0सी0डी0एस0 कार्यक्रम के कार्यान्वयन के लिये आप कैसे सी0डी0पी0ओ0 और फील्ड स्टाफ को संभारतंत्र सहायता देते है ?

10. बेहतर आउटपुट के लिये क्या संशोधनात्मक उपाय हो सकते है ?

प्रश्नावली आशा फेसिलिटेटर के लिये

1. आशा कार्यकर्ता की कार्यशीलता को बढाने केलिये आप कैसे सहायता करते है ? (खासतौर पर –आशा नियत कार्य को करने में कमजोर और वी0एच0एन0डी0 के दौरान अनुपस्थित हो)

2. कम्युनिस्टि में होम–विजिट के दौरान आप आशा को किस तरह से साथ देती है ?

3. वी0एच0एम0डी0 पर आप किस तरह आशा को महिलाओं एवं बच्चों को उपस्थित होने के लिये तैयार करने में सहायता करती हैं और महिलाओं को स्वास्थ्य संदेश पहुंचाने में सुनिश्चित करती है ?

4. क्या आप नियमित तौरे से दवाइयों की विषय सूची जांचती हैं और भंडार कम होने पर संभरक की मांग को सुनिश्चित करती है ?

5. आशा के साथ मासिक बैठक आप कैसे आयोजित करती हैं और प्रदर्शन पर पुनः विचार और योजना बनाती हैं ?

6. आप को फील्ड निरीक्षण के लिये जाना और मासिक टूर डायरी बनानी होती है। आप कैसे सभी लेखाबद्ध करती हैं ?

7. ब्लॉक स्तर पर बी0एम0ओ0 द्वारा संचालित मासिक बैठक में आपको जाना होता है। बैठक के दौरान सामान्य तौर पर वाद–विवाद की विषय सूची क्या होती है ?

8. हर महीने आशा को मिलने वाली निर्धारित प्रेरणादायक को आप कैसे सुनिश्चित करते हैं ?

9. अ. आशा के प्रशिक्षण के दौरान आपकी क्या जिम्मेदारियां होती है ?

ब. आप आशा की जरूरत पर आधारित प्रशिक्षण को बी0एम0ओ0 के साथ परामर्श करके आयोजित करती है, यदि हां तो कैसे ?

10. एक खास कार्य की तरह आप कैसे आशा को बहुत गरीब और अधिकार हीन लोगों तक पहुंचने में सक्षम बनाती है ? (परिवार जो सुदूरवर्ती उपग्राम में है, महिलाएं जिनके पति बाहर है आदि)

प्रश्नावली एल0एच0बी0/ए0एन0एम0 सुपर वाइजर के लिये

1. स्वास्थ्य सुविधाओं के वितरण के लिये आप कैसे ए0एन0एम0 का निरीक्षण एवं अगुवाई करती है ?

2. आंगनबाड़ी केंद्र से जुड़ी मदद और अगुवाई के लिये आप क्या जरूरी कदम लेती है ?

3. आप ए0एन0एम0 सेंटर पर दौरे को कैसे सुनिश्चित करती है ? (कम से कम हफते में एक बार सुनिश्चित दिन पर)

4. अ. प्रायः आप ए0एन0एम0 के साथ स्टॉफ बैठक संचालित करती है ?

5. ब. खासातौर पर आई0सी0डी0एस0 के अंतर्गत आप कैसे रिकार्ड को जांचती एवं रख रखाव करती है ?

6. स्वास्थ्य कार्यकर्ता और आई0सी0डी0एस0 सुपरवाइजर के बीच में समन्वयीकरण गतिविधियों को सम्मिलित रूप से सहायता करने के लिये क्या जरूरी कदम है ?

7. ए0एन0एम0 एवं आंगनवाड़ी कार्यकर्ता द्वारा भेजे गए केसेस की आप कैसे व्यवस्था करती है?

8.पारंपरिक बर्थ परिचालक के लिये ए0एन0एम0 के साथ प्रायः आप कैसे प्रशिक्षण आयोजित एवं संचालित करती है ?

9. आप के क्षेत्र में परिवार नियोजन और स्वास्थ्य और पोषण शिक्षा और ढेर टीकाकरण एवं स्वास्थ्य जांच अभियान के लिये आप का सहयोग स्तर क्या है ?

10. कम्युनिटी लीडर के साथ क्या आप सामुहिक बैठक तय करती है और विविध स्वास्थ्य कार्यक्रमों के लिये संदेश फैलाव जो आई0सी0डी0एस0 के अंतर्गत संगठित हैं शामिल करती है ?

प्रश्नावली आंगनवाड़ी कार्यकर्ता सुपरवाइजर के लिये

1. आंगनवाड़ी कार्यकर्ता सुपरवाइजर के तौर पर किस प्रकार का कार्य मार्गदर्शन आप आंगनवाड़ी कार्यकर्ता को देती है ?

2. अ. बहुधा आप कितना आंगनवाड़ी निरीक्षण के लिये जाती है ?

ब. आंगनवाड़ी केंद्र जो कि पांच कि0मी0 से ज्यादा दूरी पर स्थित है, आप कैसे निरीक्षण की व्यवस्था करती है।

3.आप के निरीक्षण के दौरान, आंगनवाड़ी कार्यकर्ता के ''खतरे में'' आने वाली महिलाओं और बच्चों का पता लगाने में आप कैसे मदद करती है और उन्हें पी0एच0सी0 भेजती है ?

4.अधिक कुपोषित बच्चे के प्रबंधन एवं बहाली के लिये आप कैसे आंगनवाड़ी कार्यकर्ता को दिशा निर्देश देती है ?

5. क्या आप अटीकाकरणीत बच्चों को जांच कर पता लगाती हैं और सी0डी0पी0ओ0 को सूचना देती है ?

6.अ. क्या आप आपके के क्षेत्राधिकार में आने वाली आंगनवाड़ी कार्यकर्ता की मासिक बैठक आयोजित करती है ?

ब. बैठक के दौरान आप आंगनवाड़ी कार्यकर्ताओं के साथ आप क्या चर्चा करती है ? पिछले महीने में हुए कार्य का पुनः परीक्षण, अगले महीने के लिये योजना, साप्ताहिक समय सारणी बनाना, जारी शिक्षा–दस्त प्रबंधन, विकास अनुश्रवण आदि।

7. आंगनवाड़ी केंद्र निरीक्षा के दौरान किए हुए कार्य की लेखाबद्ध डायरी को आप कैसे कायम करती है ?

8. आप कैसे सी0डी0पी0ओ0 को आंगनवाड़ी के विकास का मासिक रिकार्ड जमा करना सुनिश्चित करती हैं और रिपोर्ट का खरापन जांचती है ?

9. मुख्यालय पर परियोजना की मासिक बैठक के दौरान आप सी0डी0पी0ओ0 को कैसे सहायता देती है ?

(क्षेत्राधिकार के आंगनवाड़ी कार्यकर्ताओं का मानदेय, वैकल्पिक आंगनवाडी कार्यकर्ता की व्यवस्था, क्षेत्राधिकार में कोई खास कार्यक्रम और दिक्कत और उपलब्धि की जानकारी।

10. आंगनवाड़ी कार्यकर्ता की व्यक्तिगत और कार्य से जुड़ी समस्याओं का आप कैसे पता लगाते हैं और उन्हें मुसीबतों का सामना करने के लिये जरूरी सलाह देती है ?

बाल विकास परियोजना अधिकारी

1. आप परियोजना स्तर पर, आई0सी0डी0एस0 दल के प्रधान पदाधिकारी है।

कार्यक्रम के दिन प्रतिदिन प्रशासन का निरीक्षण और कार्यान्वहन में आप कैसे जिम्मेदारियों को संभाले रखते हैं ?

2. आई0सी0डी0एस0 कार्यक्रम के संचालन के लिये आप कैसे मासिक और वार्षिक बजट निर्धारित करते है ?

3. पूरे समूह के कार्य का निरीक्षण और अगुवाई खासतौर पर आंगनवाड़ी कार्यकर्ता और उनके सुपरवाइजर के लिये क्या जरूरी कदम उठाते है ?

4. परियोजना और आंगनवाड़ी केंद्र स्तर पर आप कैसे रिकार्ड की जांच करते है ?

5. आई0सी0डी0एस0 कार्यक्रम के लिये यातायात प्रबंधन, भंडारण और संभारण के वितरण के लिये जिले और राज्य अधिकारियों के साथ जरूरी कड़ी तैयार की विधि क्या है ?

6. आई0सी0डी0एस0 कार्यक्रम को सुचारू रूप से चलाने के लिये उपकरण और सामग्री संभारण को कैसे सुनिश्चित करते हैं ?

7. आई0सी0डी0एस0 कार्यक्रम को तालमेल के साथ कार्यान्वित करने के लिये क्या जरूरी कदमों को आप सुनिश्चित करते हैं ?

8. आप शिक्षा कार्यक्रम कैसे आयोजित करते हैं जैसे पोषण और स्वास्थ्य प्रदर्शन फील्ड कार्यकर्ताओं के लिये।

9. परियोजना गांव में बच्चों गर्भवती महिलाओं और धानी महिलाओं का पता लगाने के लिये तीव्र सर्वेक्षण में आंगनवाड़ी कार्यकर्ताओं को आप कैसे दीक्षित और अगुवाई करते हैं ?

10. आंगनवाड़ी केंद्र पर आप परिवहन भंडारण और संभारण के वितरण में लिये जरूरी व्यवस्था को कैसे सुनिश्चित करते है ?

ब्लॉक स्वास्थ्य अधिकारी के लिये साक्षात्कार

सामान्य जानकारी

1. प्रायः किस पृष्ठभूमि के लोग सी0एच0सी0 आते है ? किस कारण से वे सी0एच0सी0 आते है ?

2. दूसरों की तुलना में महिलाओं और बच्चों को किस प्रकार की खास सुविधाएं दी जाती है ? क्या स्थितियां और कारण है ?

बीमारी प्रबंधन

3. अत्याधिक दस्त/पेचिश/ए0आर0आई0/न्यूमोनिया से ग्रसित बच्चों का सी0एच0सी0 पर प्रबंधन कैसे करते है ? कौन सा प्रोटोकाल /मार्गदर्शन बच्चो के इलाज में काम में ले रहे है ?

4. आपातकालीन स्थिति में किस प्रकार की खास सुविधाएं बच्चे के इलाज के लिये सी0एच0सी0 पर उपलब्ध है ?

स्वास्थ्य सुविधा वितरण/उपयोग/निरीक्षण/प्रबंधन–

5. सी0एच0सी0 पर क्या आपने स्टॉफ संकट/मुसीबत/कर्तव्य और जिम्मेदारियों का खास तौर पर आपातकालीन सुविधाओं (जैसे–डिलेवरी) का सामना किया है ? कृपया उस स्थिति के बारे में बताइये ?

6. जरूरी चिकित्सीय और कम्युनिटी सेंटिग सलाह के लिए फ्रन्ट लाइन कार्यकर्ता के साथ आप प्रायः बैठक लेते है ?

7. आप क्या सोचते हैं प्रायः महिलाएं संस्थागत प्रसव के लिये सी0एच0सी0 आती है ? अपना अनुभव बताइये ?

8. टीकाकरण को आपके क्षेत्र में क्या स्थिति है?

कुपोषण–

9. आप के क्षेत्र में कुपोषण के क्या संभावित कारण हो सकते है ? कृपया स्थिति के अनुसार विस्तार से बताइये ?

सुझाव

9. आप क्या सोचते हैं लाभार्थियों के लिये सी0एच0सी0 पर उपलब्ध सुविधाएं प्रभावशाली और पर्याप्त है ? हम कैसे उसमें सुधार कर सकते हैं ?

10. कुपोषण की समस्या के समाधान के लिये क्या खास ध्यान केंद्रित करने वाला क्षेत्र है ?

Annexure: XVII

Survey Photograph

No 1: Mamta corner situated at the Primary Health centre

No 2: RBSK team doing the Health checkup of school children

No 3: AWW giving the pre-school education at the AWC

No 4: ANM giving the Immunization to the children at the Sub-centre

No 5: ANM providing Immunization service during VHND

No 6: Children's taking hot cooked food in the AWC premises

No 7: Sanwer block NRC situated in the Community Health centre

No 8: Anganwadi workers busy in preparing reports at AWC in Indore slums

जाँच–सूची आँगनवाड़ी केंद्र के लिये

क्रमांक	स्थान	
1	जिला	
2	ब्लॉक	इंदौर–1 सॉवेर–2
3	सामुदायिक स्वास्थ्य केंद्र	
4	प्राथमिक स्वास्थ्य केंद्र	
5	सब सेंटर	
6	गाँव का नाम	
7	प्रतिभागी का नाम	

क्रमांक	प्रश्न	प्रतिक्रिया	
1	स्थापना का वर्ष		
2	अ. गाँव के अंदर स्थित	हाँ–1	यदि 1, तो
		ना–2	छोड़कर 3
	ब. गाँव से दूरी	एक कि.मी. 1	
		दो कि.मी. 2	
		तीन कि.मी. 3	
		से ज्यादा	
3	आँगनवाड़ी केंद्र आसानी से अहितकारी लोगों के लिए उपलब्ध है।	हाँ 1	टिप्पणी
		ना 2	
		यदि नहीं तो	
		स्पष्ट कीजिए	

क्रमांक	प्रश्न	प्रतिक्रिया
4	आंगनवाड़ी केंद्र का प्रकार?	मुख्य आंगनवाड़ी केंद्र–1 छोटी आंगनवाड़ी केंद्र–2
5	आंगनवाड़ी केंद्र चलता हैं? – – – –	खुद के भवन में–1 किराये के भवन में–2 आंगनवाड़ी कार्यकर्त्ता के घर–3 पंचायत भवन में अन्य (उल्लिखित कीजिए)
6	आंगनवाडी केंद्र पर नामांकित बच्चों की संख्या और उनकी उपस्थिति	
	(अ) कुल –	6 महीने से 3 साल 3 साल से 6 साल
	(ब) नामांकित	6 महीने से 3 साल 3 साल से 6 साल
	(स) औसत उपस्थिति/सप्ताह	6 महीने से 3 साल 3 साल से 6 साल

7	आंगनवाड़ी केंद्र में सुविधाएं	हॉ –1 नहीं–2	क्या हालत है? अच्छी–1 ठीक–2 बुरी–3 बहुत बुरी–4 नहीं देखा–5	टिप्पणी
	क. बिजली			
	ख. बिजली का पंखा			
	ग. टेलीफोन			
	घ. परिसर में साफ पीने का पानी			
	ङ. शौच सुविधा			
	च. पूर्व स्कूली बच्चों के लिए भीतरी कार्यक्लाप के लिये जगह			
	छ. खाना बनाने की जगह			
	ज. खाने के लिये भंडारण व्यवस्था			

झ. उपकरण के लिये भजरण व्यवस्था
ञ. वी.एच.एल.डी./टीकाकरण/स्वास्थ्य जाँच के लिये जगह

8 आंगनवाड़ी की स्थिति

हॉ–1
नहीं–2
अस्पष्ट–3

क. आंगनवाडी मरमम्त की जरूरत
ख. पर्याप्त हवादार आंगनवाड़ी केंद्र
ग. पर्याप्त रोशनी
घ. आंगनवाड़ी की चार दीवार

9	क्या आंगनवाड़ी केंद्रों पर उपकरण की पर्याप्त संख्या और संतोषजनक गुणवत्ता हैं?	यह उपस्थित है हाँ 1 ना 2	क्या हालत है अच्छी 1 ठीक 2 बुरी 3 बहुत बुरी 4	टिप्पणी

क. दवाईयों की किट
ख. प्राथमिक उपचार बॉक्स
ग. बच्चों के वजन का स्केल
घ. व्यस्क वजन मशीन
ङ. खाना बनाने के बर्तन
च. भीतर खेलने के बर्तन ,
छ. भीतर खेलने के उपकरण
ज. पीने के पानी के भंडारण का बर्तन
झ. गर्म पका हुआ खाना बॉटने के बर्तन
ञ. बच्चों के बैठने के लिए दरी
ट. वृद्धि चार्ट (लड़के और ल़ड़कियों के लिए अलग)
ठ. पोस्टर/आई.ई.सी सामग्री
ड. टेक होम राशन का भंडारण
ढ. रिकार्ड रखने का रजिस्टर

10	दवाईयों की सुविधा	हाँ 1 नहीं 2	बार–बार उपयोग किया 1 कभी नहीं किया 2	टिप्पणी यदि कोई

(क) आयरन कॉलिक एसिड
(गर्भवती महिलाओं के लिये)
(ख) आयरन कॉलिक एसिड
(किशोर लड़कियों के लिए)
(ग) अलबेन्डा जॉल टेबलैट
(घ) बच्चों के लिए अलबेन्डाजॉल
टेबलेट
(ङ) ओ आर एस पैकेट
(च) पेरासीटामोल टेबलेट
(छ) एन्टीसेपटीक ऑइन्टमेन्ट/लोशन
(ज) थर्मामीटर
(झ) कॉटन/बेंन्डेज
(ञ) क्लोरोक्वीन टेबलेट
(ट) अन्य, उल्लेख कीजिए

जाँच–सूची पोषण पुर्णवास केंद्र के लिए

(क) सामान्य जानकारी :

ब्लॉक का नाम :

सामुदायिक केंद्र का नाम :

बिस्तरों की संख्या :

10 बिस्तर –

20 बिस्तर –

क्रमांक	सूचक	आखिरी विकास में संख्या	दर
1	दाखिला		
2	पुनर्लाभ बच्चे		
3	पूर्वावस्था प्राप्ति		
4	मृत्यु		
5	चूककर्ता		

मासिक रिकॉर्ड

क्रमांक	सूचक	लड़का	लड़की	कुल
1.	**दाखिला**			
	एस.सी.			
	एस.टी.			
	पिछड़ी जाति			
	सामान्य जाति			
2.	**दाखिले का मानदंड**			
	1) –3 एस.डी.			
	2) एम.यू.ए.सी >11.5एम.एम.			
	3) बाई बेटरल पीटिंग एडिमा			

3. रेफर बॉय

फ्रन्ट लाईन कार्यकर्त्ता–

ए.एन.एम.

आशा कार्यकर्ता

आंगनवाड़ी कार्यकर्ता

आर.बी.एस. कैंप

पिडियाट्रिक ओ.पी.डी.

4. रुकने का कार्यकाल

7 दिन

7 से 12 दिन

7 से 15 दिन

5. हांसिल लक्ष्य वजन (15) वजन प्राप्त

एन.आर.सी. से छुट्टी

चूककर्ता गैर प्रत्युत्तर मृत्यु

बच्चे जो आगे की कार्यवाही से बचे हैं

आगे की कार्यवाही के समय मृत्यु पूर्वावस्था

(ख) एन.आर.सी. पर स्टॉफ

क्रमांक	**स्टॉफ**	**पोजिशन पर**	**खाली**
1	मेडिकल ऑफिसर (पेडीट्रक)		
2	नर्सिंग स्टॉफ		
3	पोषण काउन्सलर		
4	कुक कम केयर टेकर		
5	क्लीनर		

(ग) जरूरी वॉर्ड उपकरण

क्रमांक	**चीज**	**हाँ**	**नहीं**	**स्थिति** अच्छी–1 ठीक–2 बुरी–3 बहुत बुरी–4
1	ग्लुकोमीटर 1			
2	थर्मामीटर 2			
3	वजन स्केल 3			
4	इन्फेन्टोमीटर 1			
5	स्टेडियोमीटर 1			
6	रिससीटेशन उपकरण			
7	स्कशन उपकरण (कम प्रेशर)			

(घ) अन्य वॉर्ड उपकरण

क्रमांक	चीज	हाँ	नहीं	स्थिति अच्छी–1 ठीक–2 बुरी–3 बहुत बुरी–4
1	आई 1 बी स्टैण्ड			
2	रूम हिटर			
3	आई.ई.सी–ऑडियो–विडियो सामग्री			
4	खिलौने			
5	घड़ी			
6	कैलकुलेटर			
7	फ्रीज			

(ङ) स्टॉफ की ट्रेंनिग

क्रमांक	**कर्मी**	**द्वारा प्रशिक्षण**	**कार्यकाल (कम से कम 3 दिन)**	ट्रेंनिग का स्थान
	मेडिकल ऑफिसर	सिनियर पिडियाट्रिशियन	1 दिन	एन.सी.आर पर
	नर्स	(मेडिकल कॉलेज के)	2 दिन	जिला अस्पताल पर
	पोषण		3 दिन	सामुदयिक केंद्र पर
	काउन्सलर			मेडिकल कॉलेज हॉस्पीटल पर

(च) किचन उपकरण

क्रमांक	**चीज**	**हाँ**	**ना**	**स्थिति** अच्छी–1 ठीक–2 बुरी–3 बहुत बुरी–4
1	खाना बनाने की गैस			
2	ठाइट्री स्केल			
3	मेजर्सिंग जार			
4	वॉटर फिलटर			
5	फ्रिज			
6	बर्तन			
	– बड़ा बर्तन			
	– खाना बनाने के बर्तन			
	– फिटिंग कप			
	– स्पून			
	– गिलास			
	– प्लेट्स			
	– जार			

7 किचन आपूर्ति अनुमानित लागत महीना

- सूखा दूध
- पूरा दूध
- स्कीम्ड मिल्क
- दाल
- चावल
- वेजीटेवल ऑयल

(छ) फार्मेसी आपूर्ति

क्रमांक	चीज	हॉ	नहीं	अनुमानित लागत महीना

1. एन्टीवायोटिक

- श्ग्पीसिलिन/एगोवसी/ बेन्जाइल पेनिसिलिन
- क्लोमफेनिकोल
- क्लोट्रिगोजॉल
- ट्रेटासाइकलिन/क्लोमफेनिकोल आई ड्रॉप

2. सामान्य दवाईयॉ

- ओ.आर.एस. पैकेट
- पोटेशियम क्लोराइड
- मेगनिशयम क्लोराइड/सल्फेट
- आयरन सीरप
- मल्टी विटामिन टेबलेट
- फॉलिक एसिड टेबलेट
- विटामिन ए सीरप
- ज़िक सल्फेट/डिसपरसिबल ज़िक टेबलेट
- ग्लुकोज़ (और सुक्रोज)
- आई/वी फ्लुड
- रिगर लेकटेट साल मुशन विथ S-1 ग्लुकोज़
- नार्मल सलाइन

(ज) स्वच्छता

क्रमांक	हाथ धोना	हाँ	नहीं	टिप्पियाँ
1	एन.आर.बी. पर हाथ धोने की सुविधा है।			
2	क्या स्टॉफ अच्छे से हाथ धोता है?			
3	क्या स्टॉफ पेशेंट को छूने से पहले और बाद में हाथ धोते हैं?			
4	क्या वे खाना देने से पहल हाथ धोते है?			
	माँ की स्वच्छता			
5	माँ के नहाने के लिये स्थान है?			
6	क्या माँ बच्चे को खिलाने से पहले हाथ धोती है?			
7	क्या माताएँ शौच के बाद साबुन से हाथ धोती हैं?			
	सामान्य स्वच्छता			
8	क्या बेडशीट रोज बदली जाती है?			
9	बाथरूम में गरम–पानी की सुविधा है?			
10	क्या फर्श रोज साफ होता है?			
11	क्या टॉयलेट रोज साफ होता है?			
12	क्या प्लेट्स रोज साफ होती हैं?			
	खाना खिलाना			
13	क्या सही खाना सही समय और सही मात्रा में खिलाया जाता है?			
14	क्या बच्चों को खाने के लिये प्रोत्साहित किया जाता है?			
15	बच्चा हुआ खाना सही से रिकॉर्ड किया जाता है?			
	वजन लेना			
16	क्या वजन मशीन सही से काम कर रही है?			
17	क्या एक ही समय में बच्चों का वजन लिया जाता है?			
18	क्या वजन लेने से पहले स्टाफ स्केल को शून्य तक लाते है ?			

19 क्या बच्चों को कपड़े उतार कर वजन लिया जाता है ?

20 क्या स्टॉक सही से पढ़ते है?

21 क्या सही से वजन को वजन चॉर्ट में बनाया जाता है?

एन्टीबायोटिक्स देना

22 क्या एन्टीबायोटिक्स निधारित समय पर दिया जाता है?

23 क्या फॉलिक एसिड रोज दिया जाता है?

24 क्या मल्टीबिटामिन रोज दिया जाता है?

25 क्या ऑयरन टेबलेट रोज दिया जाता है?

26 क्या बिटामिन 'ए' सारणी के अनुसार दिया जाता है?

भौतिक सुविधाएं

27 क्या एन.आर.सी. पर बिना रुकावट 24 घण्टे बिजली की आपूर्ति होती है?

28 क्या एन.आर.सी में 24 घण्टे पानी रहता है?

29 पर्याप्त प्रकाश और हवा उपस्थित रहती है एन.आर.सी. पर?

30 क्या खिड़कियाँ मच्छर स्कीन से ढकी हुई हैं?

जाँच सूची समुदायिक स्वस्थ्य केंद्र के लिये

सामान्य जानकारी

ब्लॉक का नाम –
सी.एच.सी. का नाम –
सी.एच.सी. के अंतर्गत पी.एच.सी. की संख्या –
पी.एच.सी. के अंतर्गत सब सेन्टर की संख्या –
समाविष्ट गाँवों की संख्या –
समाविष्ट लोगों की संख्या –
जिला स्वस्थ्य सुरक्षा सुविधाओं से दूरी –

क्रमांक	स्टॉफ	स्थान पर	खाली
1	ब्लॉक मेडिकल ऑफिसर/मेडिक सुपरिटेन्डेन्ट–1		
2	पब्लिक हेल्थ स्पेशलिस्ट–1		
3	पब्लिक हेल्थ नर्स–1		
खास सुविधाएँ			
4	जनरल सर्जन–1		
5	जनरल ड्यूटी मेडिकल ऑफिसर–2		
6	मेडिकल ऑफिसर आयुष–1		
नर्स और पेरामिकल			
7	स्टॉफ नर्स–1		
8	फॉर्मासिस्ट–1		
9	फॉर्मासिस्ट आयुष–1		
10	लेब टेकनीशियन–2		
11	रेडियो ग्राफर–1		
12	डाईटिशियन–1		
13	आपथेलमिक असिस्टेन्ट–1		
14	डेंटल असिस्टेन्ट–1		
15	कॉल्ड चेन और वेकसीन लोजिसटिक्स असिस्टेन्ट–1		
16	ओ.टी. टेकनीशियन–1		
17	मल्टी रिहेबिलिटेशन वर्कर–1		

प्रबंधक स्टॉफ

18 रजिस्ट्रेशन क्लर्क–1

19 स्टेटिकल असिस्टेन्ट/डेटा ऐन्ट्री ऑपरेटर–2

20 अकाउन्ट असिस्टेन्ट–1

21 एडमिनिस्ट्रेशन असिस्टेन्ट–1

सरह डी स्टॉफ

22 ड्रेसर–1

वॉर्ड बॉय/नर्सिंग अर्दली–1

ड्रायवर–1

कुल –33

क्रमांक	**सुविधाएँ**	**अस्थित हाँ/नहीं**	**टिप्पणी**
1	समाविष्ट जनसंख्या		
2	अस्थित खास सुविधाएँ		
3	दवाईयॉ		
4	सर्जरी		
5	ओ.बी.जी		
6	पिडियाट्रिवस		
7	नेशनल हेल्थ प्रोग्राम सर्विसेस (एन.एच.के.)		
8	इमरजेन्सी सर्विसेस		
9	लेबोट्री		
10	ब्लड स्टोरेज सर्विसेस		
	आधारिक संरचना		
11	बिलिडिंग का क्षेत्र		
12	ओ.पी.डी. रूम		
13	वेंटिग रूम मरीजों के लिये		
14	बिस्तरों की संख्या–पुरुष		
15	बिस्तरों की संख्या–स्त्री		
16	ऑपरेशन थियेटर		
17	लेबर रूम		
18	लेबोट्री		

19 एक्सरे रूम
20 ब्लड स्टोरेज
21 फार्मेसी
22 वॉटर सप्लाई
23 इलेक्ट्रीसिटी
24 गार्डन
25 ट्रांसपोर्ट सुविधा

सुविधा उपयोग

क्रमांक	**ओ.पी.डी. प्रश्न**	**प्रतिक्रिया** हाँ/नहीं
1	कुल मरीजो की संख्या (त्रैमासिक)	
	पुरुष	
	महिला	
	बच्चे	
	कुल डेलिवरी केसेस–	
	कुल बीमार बच्चे	
	मृत्यु अगर है तो	
	महिला	
	बच्चे	
2	समाविष्ट जनसंख्या	
	एस.सी.	
	एस.टी.	
	बैक वर्ड क्लॉस	
	जिनेरा	
	बी.पी.एल. कॉर्ड होल्डर	

खास दवाईयों की आपूर्ति

3 क्या एन्टीरेविज़ वेक्सीन सी.एच.सी. पर उपलब्ध है?
4 क्या मलेरिया की दवाई सी.एच.सी. पर उपलब्ध है?
5 क्या ए.आर.टी. ड्रग और सुविधाएँ सी.एच.सी. पर उपलब्ध है?
6 क्या ट्यूबर के लिये सी.एच.सी. पर दवाई उपलब्ध है?
7 क्या लेप्रसी की दवाई सी.एच.सी. पर उपलब्ध है?

8 क्या आयुष दवाईयाँ सी.एच.सी. पर उपलब्ध है?

9 क्या होमियोपैथिक दवाईयाँ सी.एच.सी. पर उपलब्ध है?

10 क्या सभी दवाईयाँ सी.एच.सी. पर मुफ्त में उपलब्ध है?

हाँ / नहीं

कुछ दवाईयाँ दी जाती हैं और कुछ मेडिकल स्टोर से खरीदनी होती है–3

ज्यादातर हम मेडिकल स्टोर से खरीदते है–4

नही पता–5

रिप्रोडक्टिव और चाइल्ड हेल्थ सर्विसेस

11 क्या एन्टीनेटल क्लीनिक्स सी.एच.सी. पर आयोजित किया जाता है?

12 डिलेवरी सर्विसेस सी.एच.सी. पर 24 घण्टे उपलब्ध है?

डिलेवरी की कुल संख्या–

एस.सी.–

एस.टी.–

बैकवर्ड क्लॉस–

जनरल–

बी.पी.एल. कार्ड होल्डर–

ऐमरजेन्सी केस रेफर्ड–

13 क्या वे सही से एन्टीसेप्टिक टेकनीक का उपयोग करते हैं (5 सफाई)?

14 गायनोकोलॉजिक निरीक्षण के लिये सुविधाएँ उपलब्ध हैं?

15 गायनोकोलॉजिक विकारों के लिये उपचार उपलब्ध है?

16 परिवार नियोजन विधियों के लियं सुविधा उपलब्ध है।

- गर्भनिरोधक गोलियाँ
- कॉनडम
- आई.यू.डी. इन्सरसन
- इस्टरलाईजेशन

17 क्या एम.टी.पी. के लिये सी.एच.सी. पर मुफ्त में सुविधा उपलब्ध है?

18 कम वजन वाले बच्चों के लिए सुविधा उपलब्ध है?

19 क्या निमोनिया के लिये उपचार की सुविधा उपलब्ध है?

20 क्या बच्चे जो दस्त, पेचीस और बुखार के ग्रसित हैं, उनका प्रबन्ध किया जाता है?

लेबोट्री सुविधायें

21 क्या ब्लड परीक्षण की सुविधा उपलब्ध है?

22 क्या सी.एच.सी.पर मलेरिया पेरासाईट का पता लगाने की सुविधा उपलब्ध है?

23 क्या सी.एच.सी. पर स्पूटम किया जाता है?

24 क्या सी.एच.सी. पर गर्भवती महिलाओं की पेशाब की जाँच की जाती है ?

25 क्या सी.एच.सी. पर सुविधाओं के लिए अलग से पैसे देने का भ्रष्टाचार है?

26 क्या लोगों के द्धारा भेदभाव का सामना हुआ? (एस.टी/एस.सी./ओ.बी.सी./माइनोरिटी पिपल

उपकरण और जाँच किट

क्रमांक	चीज	क्या उपलब्ध है हाँ	नहीं	स्थिति अच्छी–1 ठीक–2 बुरी–3 नहीं देखा–4	टिप्पणी
1	सामान्य डिलीवरी किट				
2	असिटेड वैक्यूम डिलेवरी उपकरण				
3	न्यूनेटल और न्यूबॉर्न के लिए उपकरण				
4	आई.यू.सी.डी. इन्सरसन किट				
5	रेफ्रीजरेटर				
6	आई.एल.आर. (छोटा) वोलटेज, स्टेपलाईजर के साथ				
7	बेंकसीन केरियर 4 आईस पैक के साथ				
8	स्पेइयर आईस पैक बॉक्स–8				
9	कंप्यूटर नेट के साथ				
10	नवजात के लिए रेडियन्ट वॉरमर				
11	व्यस्क वजन स्केल				
12	बेबी वजन स्केल				
13	हाईट मापक स्केल				

14 फोटो थेरेपी यूनिट
15 सेल्फ इनफेलेटिंग बैग और मॉस्क न्यू नेटल के लिए
16 ग्यूक्स इक्सट्रेक्टर
17 फीडिंग ट्यूब फॉर बेबी

लेबर रूम

18 सक्शन मशीन
19 डिलीवरी टेबल
20 इस्टरलाइजेशन फॉर इक्यूपमेंट
21 24 घण्टे बहता पानी
22 24 घण्टे लाइट
23 टॉयलेट जुड़ा हुआ
24 टॉर्च
25 अम्ब (बेन्टलेटरी) बैग और फेस मॉस्क
26 पोंछने, सुखाने और कवर करने के लिए टावल
27 बेबी को गरम रखने का स्रोत (बल्व/बेबी वॉरमर)
28 बेबी वेइंग मशीन
29 ड्रेसिंग ड्रम
30 हिमोग्लोबिनोमीटर साहीली
31 बी.पी. उपकरण
32 बेसिन स्टैंड
33 बेडशीट
34 मेकिंनटोश शीट
35 आई.वी. स्टैन्ड
36 ए.डी. सिरिंज
37 आई.एफ.ए.
38 टी.टी. शॉट
39 स्थेतोस्कॉप
40 फिटोस्कॉप
41 हब निडिल डिस्ट्रोयर
42 ऑक्सीजन एडमिनिशट्रेशन उपकरण
43 केली हिमोस्टेट फारसेप
44 कुसको स्पेक्यूलम

45 सिम स्पेक्यूलम
46 चिटिल फॉरसेप
47 यूथ फेस सेप
48 पेलन फॉर सेप
49 किडनी ट्रे
50 वाइल ऑपनर
51 बैक्सीन केरियर

एमेरजेन्सी दवाईयाँ

52 मिसोप्रिसटोल पत्रसेप
53 इन्ज, ऑक्सीटोक्सीन
54 इन्ज, डाईजीपाम
55 इन्ज, मेफिडेपिन
56 इन्ज, मैगनेशियम सल्फेट
57 लिग्नोकेन हाईड्रो क्लोरिन
58 वाइल ओपनर

सामान्य दवाई

58 आईब्रूफेन
59 पेरासिटामोल
60 एम्पीसिलीन
61 बेन्जाईल पेनसिलीन
62 सिफेलिक्सीन
63 जेन्टामाइसीन
64 मेबेन्डाजॉल
65 बिटामिन ए

लेबोट्री सुविधा

66 रियेजेन्ट ऑफ सियानमेन्थ फॉर हब
67 यूटोसट्रीक फॉर यूरिन एलबूयमिन
68 ए.बी.ओ. और आर.एच.
69 ग्राम सेन्टन
70 आर.पी.आर. टेस्ट सिफलिएकिट
71 स्वाब और स्वाब स्टीक

बेहोशी के लिए उपकरण

72 कफ फॉर इन्ड्रोट्रेकीयल केथेटर

73 लेरिजो स्कोप

74 ब्रिपिंग ट्यूब

75 वेपोराइज़र

76 निडिल, स्पानल, स्टेनलेस–4

किटफॉर ब्लड ट्रान्सफ्यूजन

77 बेवारन एलल्यूमिन 20% टेस्टींग एजेंट

78 सेन्ट्रीफ्यूज़

79 पिपेट

80 सी.पी.डी.एस. काम्यूलेन्ट

जाँच सूची प्राथमिक स्वस्थ्य केंद्र

क. सामान्य जानकारी

ब्लॉक का नाम –
सी.एच.सी. का नाम –
पी.एच.सी. का नाम –
प्राईमरी स्वास्थ्य केंद्र का प्रकार –
प्रकार 'क'
प्रकार 'ख'
(प्रकार 'क' पी.एच.सी. 20 डिलिवरी कम भार के साथ और 20 डिलिवरी तक एक महीने में)
(प्रकार 'ख' पी.एच.सी. 20 डिलिवरी लोड के साथ और महीने में 20 से ज्यादा डिलिवरी)
भारतीय पब्लिक स्वास्थ्य मानक (आई.पी.एच.एस.)

- सीएचसी. से पूरी
- समाविष्ट जनसंख्या पी.एच.सी. के द्वारा
- समाविष्ट एस.सी. की संख्या परी.एच.सी. के द्वारा
- कुल जनसंख्या
- गावों की संख्या

ख. पी.एच.सी. पर स्टॉफ

क्रमांक	**स्टॉफ**	**प्रकार 'क'** स्थिति पर खाली	**प्रकार 'ख'** स्थिति पर खाली
1	मेडिकल ऑफिसर एम.बी.बी.एस.–1		
2	मेडिकल आफिसर आयुष–1		
3	डाटा एन्ट्री ऑपरेटर–1		
4	फार्मासिस्ट–1		
5	फार्मासिस्ट, आयुष–1		
6	नर्स मिडवाईफ (स्टॉफ नर्स)–3		
7	हेल्थ वर्कर, फीमेल–1		
8	हेल्ड असिस्टेंट, मेल–1		
9	हेल्ड असिस्टेंट फीमेल/लेडी हेल्थ विजिअर–1		

10 हेल्थ ऐजुकेटर–1

11 लैब टेक्नीशियन–1

12 कोल्डचेन और बैक्सीन लॉजिस्टिक असिस्टेंट–1

13 मल्टीस्कील्ड ग्रुप 'डी' कार्यकर्ता–1

14 सेनिटरी वर्कर कम वॉयमैन–1

कुल – 16

ख. सुविधा उपयोगिता

क्रमांक	**प्रश्न**	**प्रतिक्रिया**
		हाँ–1 नहीं–2
1	कुल बाह्य मरीजों की संख्या (त्रैमासिक)	
	एस.सी.	
	एस.टी.	
	बैकवर्ड क्लॉस	
	जनरल	
	कुल महिलाओं की संख्या	
	कुल बच्चों की संख्या	
	बी.पी.एल. कार्ड होल्डर	

खास दवाइयों की उपलब्धता

2 क्या एन्टीरेबिज टीकाकरण पी.एच.सी. पर उपलब्ध है?

3 क्या मलेरिया की दवाई पी.एच.सी. पर उपलब्ध है?

4 क्या ट्युबरक्लोसिस की दवाई पी.एच.सी. पर उपलब्ध है?

5 क्या लेप्रेसी के लिये पी.एच.सी. पर दवाई उपलब्ध है?

6 क्या आयुष दवाइयाँ पी.एच.सी.पर उपलब्ध हैं?

7 क्या होमियोपैथिक दवाई पी.एच.सी. पर उपलब्ध है?

8. क्या दवाइयाँ पी.एच.सी. मुफ्त में दी जाती हैं?

हाँ–1

नहीं–2

कुछ दवाईयाँ दी जाती हैं और कुछ मेडिकल स्टोर से खरीदना होता है–3

ज्यादातर हमें मेडिकल स्टोर से खरीदना होता है–4

नहीं पता

रोग निवारक सुविधाएँ

9 क्या घाव का प्राथमिक प्रबंधन पी.एच.सी.पर किया जाता है?

10 क्या छोटी सर्जरी पी.एच.सी. पर होती है?

11 क्या जले का प्राथमिक प्रबंधन पी.एच.सी. पर होता है?

प्रजनन और चाइल्ड स्वास्थ्य सुविधाएँ

12 क्या एनटीनेटल क्लीनिक पी.एच.सी. पर संगठित किया जाता है?

13. डिलिवरी सर्विसेस 24 घंटे पी.एच.सी. पर उपलब्ध है?

कुल डिलिवरी की संख्या –

एस.सी.

एस.टी.

बैकवर्ड क्लॉस

जनरल

बी.पी.एल. कार्ड होल्डर

इमरजेन्सी केस रेफर

14 क्या वे गहरी सेपटीक टेक्नीक का प्रयोग करते हैं (5 सफाई)?

15 क्या गाइनोकॉलोजिक परीक्षण के लिये सुविधा उपलब्ध है?

16 क्या गाइनोकॉलोजिकल विकार के लिये उपचार उपलब्ध है?

17 परिवार नियोजन विधियों की सुविधा उपलब्ध है?

- गर्भ निरोधक दवाएँ
- कॉन्डम
- आई.यू.डी. इनसरसन
- स्टरलाइजेशन

18 क्या एम.टी.पी. की सुविधा पी.एच.सी. पर उपलब्ध है?

19 क्या कम वजन वाले बेबीज के लिये सुविधा उपलब्ध है?

20 न्यूमोनिया के लिये उपचार उपलब्ध है?

21 क्या बच्चे जो दस्त, पेचिश और बुखार से ग्रसित हैं उनका प्रबंधन पी.एच.सी. पर उपलब्ध है?

लेबोट्री सुविधा

22 क्या ब्लड परीक्षण की सुविधा उपलब्ध है?

23 क्या मलेरिया पेरासाइट का पता लगाने का कार्य पी.एच.सी. पर होता है?

24 क्या स्पूटम की जाँच पी.एच.सी. पर होती है?

25 क्या गर्भवती महिलाओं की जाँच पी.एच.सी. पर होती है?

26 क्या पी.एच.सी. पर भ्रष्टाचार उपस्थित है? (अलग से सुविधाओं के लिये पैसे)

27 क्या लोगों द्वारा भेदभाव का सामना हुआ है? (एस.सी./एस.टी., ओ.बी.सी, माइनॉरिटी)

ग. आधारिक संरचना

क्रमांक	प्रश्न	प्रतिक्रिया	
		हाँ	नहीं
1	क्या पी.एच.सी. सरकारी भवन से पदगमित हैं यदि नहीं, क्या प्रकार है, भवन का किराये पर पंचायत द्वारा अन्य, उल्लेख कीजिए		
2	क्या पी.एच.सी. चाहरदीवार गेट के साथ उपस्थित है?		
3	क्या क्लीनिक रूप पी.एच.सी.पर उपलब्ध है?		
4	क) क्या लेबररूम पी.एच.सी. पर है?		
	ख) क्या डिलिवरी लेबररूम में की जाती है?		
	ग) सुविधाएँ, लेबररूम में उपस्थित		
	1. लेबररूम टेबल, गद्दे, तकिये के साथ		
	2. मेकिंगटॉश शीट		
	3. शक्शन मशीन		
	4. ऑक्सीजन देने के लिये सुविधा		
	5. इस्टरलाईजेशन उपकरण		
	6. 24 घंटे बहता पानी		
	7. बिजली आपूर्ति बैकअप के साथ (जनरेटर)		
	8. जुड़ी हुई शौच व्यवस्था		
	9. नवजात कॉरनर		
	– रिससिरेशन		
	– गर्म रखने की व्यवस्था		
	– वजन मशीन नवजात		

आपातकालीन दवाईयाँ

इन्ज. ऑक्सीपेसीन

इन्ज. मेगनेशियम सल्फेट

इन्ज. मिथाइल अरगोमेइट्रिन मेईलेट

घ) अलग लेबररूम डिलिवरी के काम में नहीं आ रहा है तो, क्या संभावित कारण हो सकते हैं?

– लेबररूम की बुरी स्थिति

– लेबररूम में कोई भी पॉवर सप्लाई नहीं है

– स्टॉफ की अनुपलब्धता

– अन्य कोई कारण

5 क्या परीक्षण कमरा पी.एच.सी. पर उपलब्ध है?

6 क्या पी.एच.सी. पर निरंतर पानी की सुविधा है?

7 क्या पी.एच.सी. पर निरंतर बिजली की सुविधा है?

8 क्या पी.एच.सी. पर सही से कमरे के विवरण का सिस्टम है?

9 पी.एच.सी. पर संचार की सुविधा है?

मोबाइल जुड़ाव–1

लैण्डलाइन जुड़ाव–2

10 पी.एच.सी. पर परिवहन सुविधा है?

वह करीबी पब्लिक स्वास्थ्य सुविधा से कितनी दूरी पर है?

11 क) रहने की सुविधा स्टॉफ के लिये उपलब्ध है –

1. एम.बी.बी.एस. डॉक्टर
2. स्वास्थ्य कार्यकर्ता महिला
3. स्वास्थ्य कार्यकर्ता पुरुष
4. हेल्थ विजिटर
5. स्टॉफ नर्स

ख) यदि हाँ, क्या डॉक्टर पी.एच.सी. पर रहते हैं?

एक एम.बी.बी.एस. पी.एच.सी. पर रहती है?

हेल्थ वर्कर पी.एच.सी. पर रहते हैं?

स्टॉफ नर्स पी.एच.सी. पर रहती है?

ग) कमरों की पी.एच.सी. पर क्या स्थिति है?

सुधार की जरूरत है।

पर्याप्त हवादार है।

प्रकाश की कमी है।

12 शौचालय की सुविधा पी.एच.सी. पर उपलब्ध है?
स्टॉफ के लिए
सामान्य लोगों के लिए

उपकरण, फर्नीचर, परीक्षण किट

क्रमांक	चीज	क्या उपलब्ध है हाँ नहीं	स्थिति अच्छी–1 ठीक–2 बुरी–3 नहीं देखा–4	टिप्पणी
1	सामान्य डिलीवरी किट			
2	असिटेड वैक्यूम डिलेवरी के लिये उपकरण			
3	नियोनेटर और नवजात के लिए उपकरण			
4	आई.यू.सी.डी. इन्सरसन किट			
5	रेफ्रीजरेटर			
6	आई.एल.आर. (छोटा) वोलटेज, स्टेपलाईजर के साथ			
7	बेंकसीन केरियर 4 आइस पैक के साथ			
8	अलग से आइस पैक बॉक्स के साथ–8			
9	कंप्यूटर नेट के साथ			
10	रेडियन्ट वॉरमर नवजात के लिए			
11	व्यस्क वजन स्केल			
12	बेबी वजन स्केल			
13	लम्बाई मापक स्केल			
14	फोटो थेरेपी यूनिट			
15	सेल्फ इनफेलेटिंग बैग और मॉस्क नियोनेट के लिए			
16	ग्यूक्स इक्सट्रेक्टर			
17	फीडिंग ट्यूब बेबी के लिए			

लेबर रूम

18	सक्शन मशीन			
19	डिलेवरी टेबल			
20	इस्टरलाइजेशन उपकरण के लिये			
21	24 घण्टे बहता पानी			

22 24 घण्टे लाइट
23 शौचालय जुड़ा हुआ
24 टॉर्च
25 अम्बू (बेंटीलेटर) बैग और फेस मॉस्क
26 पोंछने, सुखाने और ढकने के लिए टॉवल
27 बेबी को गरम रखने का स्रोत (बल्व/बेबी वॉरमर)
28 बेबी वजन मशीन
29 ड्रेसिंग ड्रम
30 हिमोग्लोबिनोमीटर साहिली
31 बी.पी. उपकरण
32 बेसिन स्टैंड
33 बेडशीट
34 मेकिंन टॉश शीट
35 आई.वी. स्टैन्ड
36 ए.डी. सिरिंज
37 आई.एफ.ए.
38 टी.टी. शॉट
39 स्थेतोस्कॉप
40 फिटोस्कॉप
41 हब और निडिल डिस्ट्रायर
42 ऑक्सीजन एडमिनिशट्रेशन उपकरण
43 केली हिमोस्टेट फारसेप
44 कउसको स्पेक्यूलम
45 सिमस स्पेक्यूलम
46 चिरेल फॉरसेप
47 यूथ फेससेप
48 पिलेन फॉरसेप
49 किडनी ट्रे
50 वाइल ऑपनर
51 बैक्सीन केरियर

आपातकालीन दवाईयाँ

52 मिजोप्रिसटॉल (टेबलेट)

53 इन्ज, ऑक्सीटोक्सीन

54 इन्ज, डाईजीपाम

55 इन्ज, मेफिडिपीन

56 इन्ज, मैगनेशियम सल्फेट

57 लिग्नोकेन हाईड्रोक्योलाइड

58 वाइल ओपनर

सामान्य दवाएँ

58 आईब्रूफेन

59 पेरासिटामॉल

60 एम्पीसिलीन

61 बेनजाईल पेनसिलीन

62 सिफेलिक्सीन

63 जेन्टामाइसीन

64 मेबेन्डाजॉल

65 बिटामिन ए

लेबोट्री सुविधाएँ

66 रियेजेन्ट ऑफ साइनमेथ फॉर एच.बी.

67 यूटीसट्रीक्स पेशाब एलबूयमिन के लिए

68 ए.बी.ओ. और आर.एच.

69 ग्राह्म स्टेन

70 आर.पी.आर. टेस्ट सिफलिएकिट

71 स्वॉब और स्वॉब स्टीक