Program Progress Report

Eradicate Childhood Malnutrition Program
Madhya Pradesh, India
First Quarter – April – June 2014

Date:	Prepared by:
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I. Demographic Information

1. Districts and State:
Jhabua, Alirajpur, Khandwa, Barwani, Khargone districts in Madhya Pradesh, India

2. Organization:
Real Medicine Foundation, India (www.realmedicinefoundation.org)

3. Project Title:
"Eradicate Childhood Malnutrition"

4. Reporting Period:
April 1 – June 30, 2014

5. Project Location (region & city/town/village):
Southwestern Madhya Pradesh, India

6. Target Population:
Malnutrition support to approximately 100,000 children under age 5
Messages reach a population of over 500,000 people

II. Project Information

7. Project Goal:

To reduce the prevalence of underweight children under 5 years old and to reduce child mortality from malnutrition by strengthening communities and village level government facilities' capacity to identify, treat, and prevent malnutrition. This project aims to prove that a holistic, decentralized, community-based approach to malnutrition eradication will have better health outcomes, be more inclusive for children under 5 and will be more cost-effective in the long-run than centralized approaches, especially for rural, marginalized tribal communities.

This project empowers communities through health literacy and connects rural communities with the government health and nutrition services available.

RMF does not just act as a catalyst mobilizing communities to the resources available, but also works on a more intimate level with government health and nutrition workers and Village Health and Sanitation Committees to help build their capacity towards social mobilization, referrals, and provision of effective nutrition counseling. Throughout this year RMF is gradually transferring the responsibilities of our CNEs to government supervisors and Anganwadi workers, helping integrate RMF's work into the government framework to ensure long-term sustainability.

8. Project Objectives during this reporting period:

- Continue to identify new SAM and MAM cases, refer complicated cases to the NRC and provide home-based

counseling for all malnourished children
- Review all program data and make necessary changes in program reporting system
- Refer 1,000 SAM children to government centers for treatment with a 50% success rate
- Conduct 2,500 Community Nutrition Meetings
- Conduct 9,000 Individual Family Counseling Sessions
- Send CNEs to Nutrition Rehabilitation Centers (NRCs) to help counsel families present
- Continue to develop linkages with government health and nutrition services
- Continue pilot with Digital Green trust to produce and screen nutrition and health based videos in Khandwa, Madhya Pradesh
- Strengthen institutional capacity with support from World Bank's India Development Marketplace Award.

9. Summary of activities carried out during the reporting period under each project objective (note any changes from original plans):

- Paid salary and travel expenses to 60 Community Nutrition Educators and 6 District and Block Coordinators
- Printed weekly reporting sheets for the CNEs to compile indicators from their daily reports, including amount of SAM and MAM diagnosed, successful referrals, Family and Community Counseling sessions, and improved children

10. Results and/or accomplishments achieved during this reporting period:

Community Based Video Screening in Partnership with Digital Green

During the Second Quarter of 2014, RMF's Malnutrition Eradication Program continued to be a strong presence in Madhya Pradesh (MP).

After successful trainings of the CNEs in Khandwa District in September, RMF began full operations with videos in October, producing four videos per month and screening in 50 villages. From April through June, RMF's team completed more video production and also introduced new tools to verify adoptions and track the efficacy of the video in delivering health messages and knowledge in addtion to behavior.

In May 2014, a secondary training was held on dissemination and adoption verification to reinforce proper video screening and behavior change messaging as well as introduce new formats for knowledge recall adoption verification.

Since the introduction of these tools, RMF has seen the adoption rate quadruple in our target ares, with over 30% of viewers practicing promoted bahaviors either through direct practice or through increased awareness.

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RMF's new program focuses screenings on targeted populations of mothers and families with children under 5 years old in 3 district settings:

1) **Cluster Screenings** that target mothers in a small setting, usually 4-6 mothers, in their houses during the day.
2) **Evening Screenings** that target larger groups of 10-15 families and are screened when male family members can attend to increase their awareness of nutrition and health issues.
3) **Mangal Diwas Screenings** on Tuesdays at the Anganwadi Centre for ration distribution. By adding video screenings at the Anganwadi Centre on Mangal Diwas, RMF aims to both increase participation in ration distribution and also target at-risk families with health information.

From October 2013 to June 2014, RMF's program with Digital Green in Khandwa has:

- Produced **36 Videos** on Immunizations, Sanitation and Hygiene Practices, Management of Diarrhea, Locally available Nutrition Diet, and Immunizations, Government Services for Nutrition and Health under NRHM and ICDS, and Acute Malnutrition, how to identify it, and how to treat
- Conducted a total of **2,771 disseminations** in 100 villages, reaching **10,839 households**
- Recorded **2,963 practice adoptions** directly resulting from our videos.

During this quarter the Malnutrition Eradication program:

- Identified **707** children suffering from SAM and gave counseling to the caregivers of each of these children
- Saw an improvement from SAM to MAM in **402** children

- Identified **1,633** new children with MAM and provided one-on-one counseling to the caregivers of these children
- Saw an improvement from MAM to normal in **1,112** children
- Successfully ensured the 14-day treatment of **209** of the most serious cases at local Nutrition Rehabilitation Centers
- Conducted **2,293** village nutrition training sessions, with over **15,398** people in attendance
- Conducted **15,143** family counseling sessions

11. Impact this project has on the community (who is benefiting and how):

Since our program began in 2010 this program directly impacted:

- **2,858** children who have received lifesaving treatment
- **33,889** children who have improved directly through our intervention
- **427,409** individuals from rural villages who have received training on malnutrition awareness and prevention in their villages
- The families of the **66** women RMF employs as part of this initiative, many of whom are from the intervention villages themselves and use their salary from RMF to support their children's education and to improve the lives of their families.

12. Number served/number of direct project beneficiaries (for example, average number treated per day or month and if possible, per health condition):

Month	APRIL	MAY	JUNE	Q2 TOTAL
Severely Acute Malnourished (SAM) Children				
New SAM Children Identified	179	298	230	**707**
Total Number of SAM Children ever reached	13872	14170	14400	**14400**
Old SAM Children Visited	995	1155	1266	**3416**
% of SAM Children Visited	7%	8%	9%	**23.72%**
SAM Children Improved (to MAM)	120	129	153	**402**
SAM Children ever improved	9444	9573	9726	**9726**
Improvement Rate (%)	68.08%	67.56%	67.54%	**67.54%**
Moderately Acute Malnourished (MAM) Children				
New MAM Children Identified (New Case + SAM to MAM)	439	700	494	**1633**
Total Number of MAM Children ever reached	33221	33921	34415	**34415**
Old MAM Children Visited	2976	3385	3547	**9908**
% of MAM Children Visited	9%	10%	10%	**29%**
MAM Children Improved (to Normal)	418	315	379	**1112**
MAM Children ever improved	23469	23784	24163	**24163**
Improvement Rate (%)	70.65%	70.12%	70.21%	**70.21%**
NRC Referrals				
Children Referred to NRC (Parents Counseled and Referral Slips Issued)	156	266	221	**643**
Children that got admitted in NRC	37	73	99	**209**
Success Rate of NRC Admissions after Counseling Parents	0.00%	0.00%	44.80%	**32.50%**
Total Number of Children Ever Admitted to the NRC	2686	2759	2858	**2858**
Follow Up of the Child at the Village (ever admitted to NRC)	77	114	176	**367**
Follow Up of the Child at NRC (ever admitted to NRC)	25	34	53	**112**

Family Counseling Sessions				
Family Counseling Session- Total Numbers	4385	5449	5309	**15143**
Total Number of individuals present for a session	7836	9651	9317	**26804**
Community Group Sessions				
Community Group Session- Total Numbers	612	810	871	**2293**
Total Number of individuals present for a session	4371	5900	5127	**15398**
Average attendees in the Community Group Session	7	7	6	**7**
Other Activities done by the CNEs				
Cooking Demonstration	317	250	361	**928**
Meeting with Anganwadi workers	160	443	688	**1291**
Meeting with other stakeholders in the village	13	78	141	**232**
Meeting with SHG members in the Village	0	0	0	**0**

13. Number of indirect project beneficiaries (geographic coverage):

Approximately 500,000

14. If applicable, please list the medical services provided:

Referrals to Nutrition Rehabilitation Centers for children with Severe Acute Malnutrition
Referrals to public health centers and community health centers for MAM children with suspected complications
Hospital referrals for children who need advanced care

15. Please list the five most common health problems observed within your region.

Malnutrition, Gastroenteritis, Diarrhea, Respiratory Tract Infections, Malaria, Tuberculosis

16. Notable project challenges and obstacles:

NRC Referrals

One of the largest challenges facing our CNEs, and the treatment of SAM in MP in general, is getting children requiring treatment to the NRC. Even after successful referrals, the rate of defaulters is very high as many of the mothers cannot stay with their children for the full 14-day course of the treatment. Each child must have a caretaker stay with them for the entire course of treatment. However, many of the women are not able to stay that long, or even go to the NRC with their child at all because of family pressure, household responsibilities such as cooking or agricultural work, or the presence of other small children in the household with no other caretaker.

Our CNEs and coordinators try to solve this with a variety of techniques, including:

- Increased counseling in the field about the NRC treatment and why it is important;
- Follow up with successful referrals by our coordinators;
- Coordination with NRC workers by our coordinators to address problems specific to our referrals;
- Follow up with defaulters in the field by our CNEs;
- Suggestions for other caretakers, such as grandparents or siblings;
- Increased communication about the need and specifics of treatment, such as why it takes fourteen days.

With the introduction of CMAM, many SAM children can be treated in the community, circumventing the need for trips to the NRC. Since referral to NRCs is the largest hurdle to our program's success, RMF expects that this new protocol will change the way malnutrition is treated in India.

17. Success story(s) highlighting project impact

On Aprll 4th, 2014, RMF's Khargone District Coordinator, Auntim Gupta, alerted the RMF team about a severe case of malnutrition in Galtar village of Jirnia block, Khargone. RMF's CNE, Neelofar Mirza, had been working with a family of four for months, and both parents were unwilling to take the children to a hospital for care. Despite all of her efforts, the family was insistent that they could not take their child to the NRC, both due to constraints at home but also, more alarmingly, because they did not trust the care provided by the government system.

Both of the children, Prateek (5 years and 11 months old) and Savan (34 months) were suffering from SAM and an undiagnosed respiratory infection. Their parents, Bahadur and Munni, were aware of the gravity of the situation, and had consulted many of the local medical practitioners, including a traditional healer and an unliscensed medical provider. They had spent significant money trying to improve their children's conditions. The medical practitioner had given the children vitamin supplements, and the traditional healer had performed a ceremony sacrificing livestock in an attempt to cure the children. Clearly, the family was willing to work towards the impovement of the children, but not willing to travel the two hours to Khargone to spend 14 days in the NRC. It's a story RMF's CNEs are very familiar with.

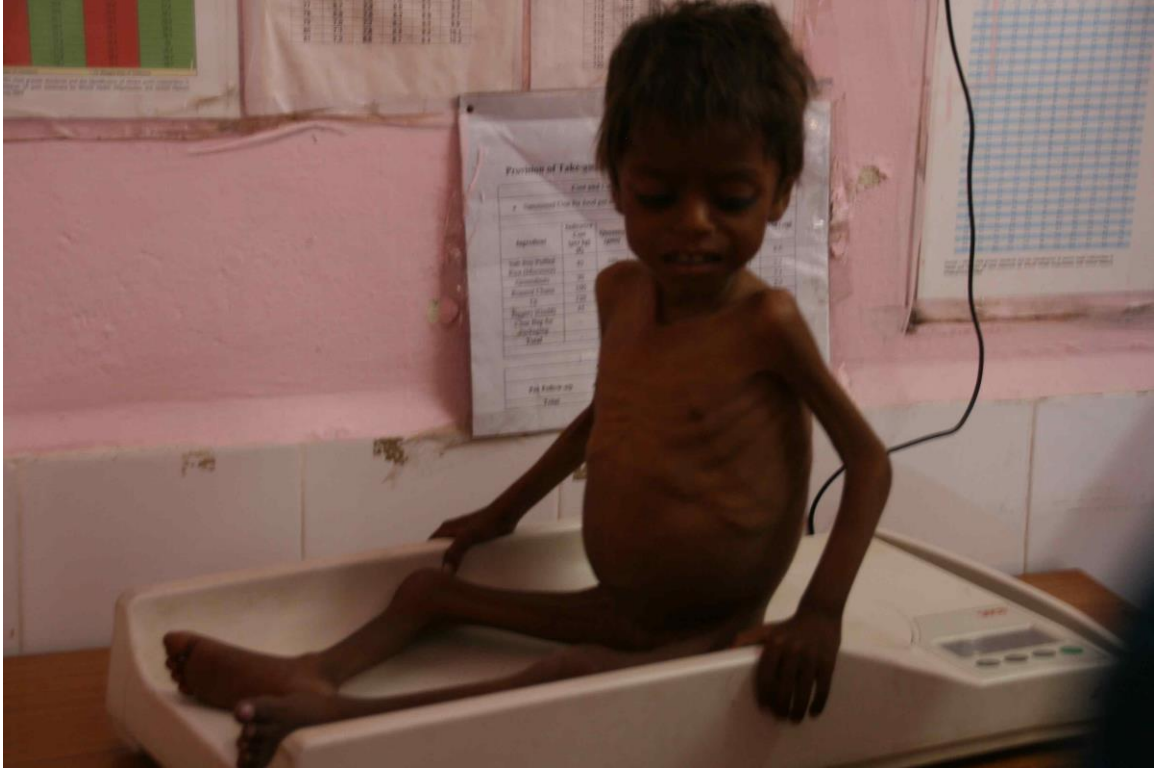
Auntim was not willing to let this matter rest, however. Together with senior staff, Auntim met with the Chief Medical and Health Officer (CMHO) of the district to mobilize government health staff. After sharing photos and the details of the children, the CMHO dispatched a local help supervisor and ambulance to Galtar to meet the family. The RMF team was not far behind.

Upon arriving in the village, the magnitude of the children's malnutrition became apparent. With a MUAC of 7.0 and weighing just 5.48 kg, Savan was one of the most severe cases of SAM ever identified by RMF CNEs. His brother, also SAM with a MUAC of 10.7, was suffering from severe acute malnutrition for a second time. When speaking to the parents about Prateek, it became clear why they refused to go to the NRC: on every trip to the district hospital, the family had been mistreated, ignored, or even chastised for the state of the family, and they had no desire to return to a facility that not only failed to treat their son, but also cost them time, comfort, and took them away from their support structure.

After sitting with the family, Neelofar was able to make progress. Prateek had been one of her first referrals, and now, armed with 3 years of experience, she was able to confidently address all of the families concerns. Auntim, now familiar with the entire district health setup and all of the hospital staff, assured the family that their previous experience was an anomaly. After several hours of counseling, the family reluctantly agreed to go to the NRC.

Once in the Khargone district hospital, the staff of the new NRC immediately rose to the occasion. The new pediatrician immediately visited the family and calmly diagnosed both children, attributing their severe malnutrition to Tuberculosis, one of the more common malnutrition co-infections in Madhya Pradesh. He counseled the family, informing them of the duration of the treatment required, the protocol they needed to follow to treat their TB, the side-effects, and a detailed explanation of every treatment the NRC was providing. Although this seems basic, overburdened health staff often do not have the time to provide this standard of care. In addition, Auntim and Neelofar worked out a schedule to visit the family twice a day to provide them psychosocial support, address their concerns, shop for them in the local market, or communicate updates back to their family in their village.

Two weeks later, both children were stabilized and discharged from the NRC after achieving their target weight gain. Once back in their homes, both the children were regularly visited by the Anganwadi worker to monitor their weight gain and report and problems to both RMF and the local government health staff. The family is adhering to their TB treatment and, although they have a long way to go, both children are on the road to healthy lives.



Savan on Admission to the NRC

Four Months Later, Savan Recovering at Home