NATIONAL HEALTH MISSION
Medical, Health & Family Welfare Department
Government of Rajasthan

NATIONAL HEALTH MISSION

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POSHAN

Rajasthan POSHAN strategy -Proactive and Optimum zcare of children, through Social- Household Approach for Nutrition" for community based management of children with Severe Acute malnutritionSevere Acute malnutrition is the most dangerous form of malnutrition. Even after a decade of galloping economic growth, child malnutrition rates are worse in India than in many sub-Saharan African countries. India is the home to the largest pool of children with SAM in the world; we have around 80 lakh children which consist of 42 % of Global load of children with SAM. In Rajasthan we have around 638166 children with SAM as of 2012 (NFHS III- SAM Rajasthan 7.3%) and as per RSOC it is 2.9%.

Severe acute malnutrition is defined by very low weight-for-height/length (Z- score below -3SD of the median WHO child growth standards), a mid-upper arm circumference <115 mm, or by the presence of nutritional edema. SAM increases significantly the risk of death in children less than five years of age. It can be an indirect cause of child death by increasing the case fatality rate in children suffering from common illnesses such as diarrhea and pneumonia.

Children with Severe Acute Malnutrition (SAM) have nine times higher risk of dying than well-nourished children. In India, the prevalence of SAM in children remains high despite overall economic growth. The National Family Health Survey-3 revealed that 6.4 percent of all children under-five years of age are severely wasted. With appropriate nutritional and clinical management, many of the deaths due to severe wasting can be prevented.

It is proven by the NFHS data and confirmed by Ministry of Health and Family Welfare, GOI and also after the assessment of the Rajasthan data that the problem of children with SAM is mostly in most deprived populations like scheduled tribes, Primitive Tribes and in Scheduled Caste communities, children youngest- under 2 years and in girl children.

To prevent deaths due to severe acute malnutrition (SAM), specialized treatment and prevention interventions are required with strong food security and feeding drive. Programmatically, it is helpful to categorize children with SAM into 'complicated and uncomplicated' cases based on clinical criteria and can be managed through

- Facility/hospital-based care for SAM children and medical complications. (MTC)
- Home/community-based care for SAM children but without medical complications using Medical Nutrition Therapy (MNT)

Rajasthan initiative to treat and manage children with SAM –

Department of Health and Family welfare and UNICEF have jointly initiated facility based care for SAM children and complications. A total of 88 MTCs are fully operational and 59 are in the process of operationalisation. We have treated 9143 children with SAM in these facilities in the year 2014-15.
Now state has visualized community based strategy to manage SAM child without complications at Home/ community level. The strategy is discussed and consulted, with proposed frame and key features.

Success Rate -

Global experiences show that the community based programmes have a recovery rate about 80%. The mortality rate was found to be about 4%, default rate 11%, transfer to higher facility about 3% and non-recovery rate- 2%.

Risks involved-

Like any other pilot project, there are risks attached to this intervention

- Some children under the programme may die and media may highlight the deaths, although many of the SAM children are already dying without any intervention. But now, the deaths will assume more visibility and it may be attributed to the intervention, as we have seen in the case of polio, immunisation and vitamin-A programmes.
- Controversies (or misunderstandings) relating to therapeutic food will again surface, mostly fuelled by vested interests.

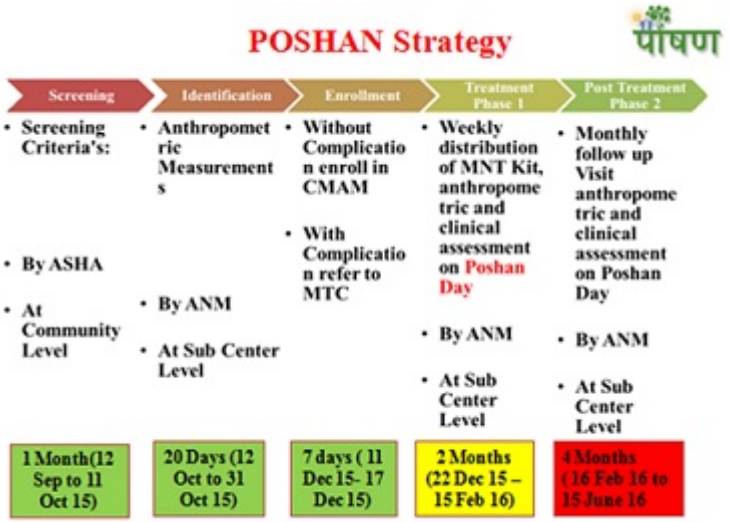
Geographical focus and case load– 10 HPDs and 3 Tribal District are the priority in first phase

There are 10 High priority districts and 3 Tribal Districts where Government and Partners are focussing its strategic step for all the maternal and Child health and Nutrition issues. So as the CMAM strategy is designed for 13 Districts (Jalor, Jaisalmer, Dungarpur, Rajsamand, Dholpur, Baran, Karuli, Udaipur, Sirohi, Pratapgarh, Banswada, Barmer and Bundi). As per NFHS III, out of the total under 5 population in the state, 7.3% population is SAM. The total case load of SAM for facility and Community is given in (Annexure 1)

Selection of Blocks (focus) within focus–

In first phase a total of 10000 children will be given treatment to standardize strategy, protocols and processes based on the need of the program. It is proposed–

- Based on criteria fixed, such as availability of MTC in the block, Staff, computer operator and No. of ASHAS working in the block. High priority blocks are identified in a consultative manner with DPMs, MTC in charges and RCHOs. Details attached in.(Annexure 2)



Screening and identification of Children with SAM at Village /community level –

Screening will take place in the community using MUAC and looking for bilateral pitting oedema. MUAC is a simple, accurate, low cost method that is easy to use by community-based workers and is accepted by WHO as fair and transparent method by the population. The screening comprises of active case finding along with self-referrals.

- **Active Case Finding (Screening) –** At village/ community level and all the hamlets surrounding the main village, the active case finding is through screening of all the Children of 6 to 59 months. The screening will be done by the ASHAs to find the cases. Children with SAM in the community will be identified through intensive house to house visit.
  The criteria of identification of children with SAM at community
  - MUAC< 115 mm
  - Looking for bilateral pitting oedema.
  - Parents of SAM Child without complication has refused to go to Facility based care for further screening

• **Self-referrals-** there are many cases of self-referrals by families or community, which is well sensitized; these can be taken into account for screening of children for identification of SAM.
• A line list of all the screened children with MUAC between 115-125 mm will be given to ICDS Department so that these children can be enrolled in the Supplementary Nutrition Program.
• A line list of all screened children with complication and oedema will be referred to MTC

Further assessment of identified children for enrolment in CMAM

After the assessment of children with SAM at community / village level by ASHA, the child further anthropometric assessment will be done at sub centre level by ANMs to confirm the SAM status and to identify the associated complications and conducting appetite test, so that we can segregate SAM child without complication and with complication.

This screening will be done on fixed day, fixed site approach by organising POSHAN DAY on weekly basis on a designated day at Sub-centre/ PHC/CHC. These POSHAN Days can further be used for providing MNT Kit (Energy dense Nutritional Supplement (EDNS), antibiotics and albendozole), monitoring of growth, counselling, identifying complications etc and taking timely decision of discharge or referral by ANM.

The SAM child with complication, having loss of appetite and pedal oedema will be referred for facility based care and SAM child without complications will be enrolled in CMAM programme. The enrolment criteria for children with SAM will be on basis of Z-Score.

Further assessment of identified SAM child with complication for confirmation after the findings of ANM, and referred to MTCs

This assessment will be done by respective MTC in-charges, who will confirm the findings of ANM and decide whether SAM child requires facility based care or may be cared at community level. The SAM child who doesn't require facility care will be referred back to POSHAN Day and will be enrolled for CMAM programme on priority basis.

Admission/ enrolment is proposed as follows -

Category	Criteria (any of the following)
Enrolment of Children 6-59 months in CMAM	MUAC < 11.5 cm or WHZ <-3SD with good appetite and no medical complications
Other reasons for POSHAN Sub center enrolment	
Transfer from MTCs	Child referred to POSHAN after initial treatment at the MTCs Children transferred to POSHAN from MTC will be provided EDNS on Sunday at Poshan Center ; the quality will be sufficient to meet the requirements of the child till the next regular Poshan Diwas
Return after default***	Children who return after default continue their treatment if they still fulfill the enrolment criteria for Poshan sub center Return after default: Children who return after defaulting (absent for 2 or more consecutive visits). Returning defaulters are readmitted if they still fulfill the admission criteria.

Confirmation and review of screening process by block BCMOs and MOICs–

each block BCMO and MOIC will move in the field to cross check the screening process in 50% cases and will provide the computerised report in software on the screening monitoring.

CMAM enrolment for the MTC discharge children –

It is proposed that apart from newly identified children with SAM, who have been screened for the programme children with SAM discharged from MTC (coming in the selected area of implementation) who have no medical complication will also be enrolled in the programme. Following need to be checked.

- Appetite returned
- Medical treatment completed
- Medical complications controlled
- Weight gain

Incentives to ASHAs for screening-

Each ASHA will get Rs 100/ for child identified as SAM by them. The incentive will be transferred through District Health Society.

Treatment protocols at community level –

The treatment protocol is divided in 2 Phases, Treatment Phase I start from enrolment to 2 months and Post Treatment Phase II from 3rd month to 6th month. The treatment phase I for 2 months by using medical nutrition therapy (MNT) Kit which consists of EDNS, Antibiotics and De-worming tablet. After the child is enrolled, we will provide a kit to family/ mother consisting of pictorial guide for the care of the SAM child at home with enrolment card. The Post Treatment Phase II for 4 months after completion of Treatment Phase I

Incentives to Poshan Prahari for Treatment Phase I-

From enrollment to 2 months, the daily home visit to be done by POSHAN Prahari to supervise EDNS feeding of SAM Child to review his/her appetite, general health and hygiene & care practices and incentives of Rs 250/ child after completing first month and Rs 500/ child after completing second month will be given by District Health Society of respective districts.

Medical Nutrition Treatment Schedule for 8 weeks (Treatment Phase 1)

Week	Treatment	Day-1	Day-2	Day-3	Day-4	Day-5	Day-6	Day-7
1st Week	Antibiotics- Amoxicillin	☑	☑	☑	☑	☑	☑	☑
	Albendazole							☑
	Energy Dense Nutritional Supplement	☑	☑	☑	☑	☑	☑	☑
	Home visit by Poshan Prahari	☑	☑	☑	☑	☑	☑	☑
2nd Week	Energy Dense Nutritional Supplement	☑	☑	☑	☑	☑	☑	☑
	Home visit by Poshan Prahari	☑	☑	☑	☑	☑	☑	☑
3rd Week	Energy Dense Nutritional Supplement	☑	☑	☑	☑	☑	☑	☑
	Home visit by Poshan Prahari	☑	☑	☑	☑	☑	☑	☑
4th Week	Energy Dense Nutritional Supplement	☑	☑	☑	☑	☑	☑	☑
	Home visit by Poshan Prahari	☑	☑	☑	☑	☑	☑	☑
5th Week	Energy Dense Nutritional Supplement	☑	☑	☑	☑	☑	☑	☑
	Home visit by Poshan Prahari	☑	☑	☑	☑	☑	☑	☑
6th week	Energy Dense Nutritional Supplement	☑	☑	☑	☑	☑	☑	☑
	Home visit by Poshan Prahari	☑	☑	☑	☑	☑	☑	☑
7th Week	Energy Dense Nutritional Supplement	☑	☑	☑	☑	☑	☑	☑
	Home visit by Poshan Prahari	☑	☑	☑	☑	☑	☑	☑
8th Week	Energy Dense Nutritional Supplement	☑	☑	☑	☑	☑	☑	☑
	Home visit by Poshan Prahari	☑	☑	☑	☑	☑	☑	☑

Home Visit schedule for Treatment Phase (from enrolment to 2 months)

Daily home visits for the first 2 months after enrolment in the program will be conducted by ASHA /Poshan Praharis as per schedule (above) and on every visit she will review appetite, consumption EDNS , maintenance of general and food hygiene and status of child.

Home Visit Scheduled by Poshan Prahari for follow up Phase (from 3rd month to 6th month)

Poshan Prahari will monitor the diet and health and hygiene practices of the child during home visit in the follow up Phase which will be as per the schedule mentioned below:

Month	Schedule	Number of Visit
3rd	Once/week	4
4th	Fortnightly	2
5th	Fortnightly	2
6th	By the end of month	1

Follow up schedule of POSHAN Days during the Treatment Phase 1

After enrolment of children with SAM, ANM will be available at sub centre on a fixed day of week to organise POSHAN day. She will enrol referred cases and follow up the enrolled cases on these days. During follow up ANM will review each case very carefully and will have the following activities-

- MUAC assessment and entering in report card
- Assessment of weight by carefully weighing each child with efficient weighing machine
- Will conduct assessment of Weigh for height for conforming Z-Score through look up tables.
- Check up on both feet to asses status of oedema
- Review and conduct assessment to identify sign of any complications
- Conduct Appetite test
- Discussions with family/ mother to understand Medical history (illness in the previous week)
- Maintain records – in standard registers/ formats and in the enrolment- treatment card
- Counselling on Breast Feeding, hand washing ,drinking water, general hygiene of baby and preventive topics to be given to her in BCC package

By doing these assessment, she will decide whether child should be continued with the CMAM programme or has to be referred for facility based care. ANM will get incentives to organise POSHAN days efficiently.
Note- ANM will be given skill training and equipment's to facilitate the same. Anthropometric Kit , Counselling cards, Posters, MNT guide etc.
Weight gains during the treatment phase:

Week	Weight Gain	Action
First 2 weeks from enrolment	8-10gm/kg/day	If minimum weight gain is achieved the progress is acceptable else child will be referred to MTC
After completion of 2 weeks from enrolment	3-4gm/kg/day	If minimum weight gain is achieved the progress is acceptable else child will be referred to MTC

Discharge criterion from CMAM – Discharge criteria for POSHAN is as follows -

- MUAC ≥ 12.5cm
- Z-score ≥ -2 SD
- Alert and clinically well

Different outcome of CMAM

Discharged	**Discharged Recovered**	Z-score =-2SD or MUAC = 12.5cm and child is "clinically well"
	Discharged Not Recovered	Children who do not meet discharge criteria after 12 weeks when all investigation and treatment options have been carried out.
Defaulted		Children who left the program before reaching the discharge criteria or those who were absent for two consecutive visits **or** medical referrals who do not return.
Died		Died while in treatment in POSHAN
Moved out to other POSHAN		Child has moved to other POSHAN sub center for further management

Follow-up after Discharge from CMAM Program

Children discharged from the CMAM program will be referred to the Supplementary Nutrition Program (SNP) of the ICDS and monitor their growth monthly; children who have not recovered (not met the discharge criteria) after 12 weeks in the program will be referred to MTC for medical examination and a detailed work-up before being sent to the SNP and classified as Discharged not recovered.

Referral to MTCs in different critical conditions – ANM and ASHAs/ PoshanPrahari will ensure the referral from CMAM to MTC in the following conditions

- No weight gain for two continuous visits ( )
- Any medical complication or anorexia or development of oedema.
- Unexplained Weight loss between any visit
- Non recovery after three months

Capacity building strategy – All the teams from District to community level need to be given a systematic skill training/ program orientation- Following are some of the trainings Proposed –

- State level sensitization of District collectors as the lead to oversee the program. State level orientation of Regional training cum resource centres including mentors-
- Divisional orientation of Block CMHOs, District teams on CMAM-The 13 districts will be divided in to 5 zones for organising orientation of district and block teams . State level team will go to these zones to organize one day orientation. The division of zones is as follows –

Training load of Zonal/ District Level Trainings:

				Participants					
S.No	Zones	Districts	Blocks	MOIC	CDPO	BHS	MTC(CHC)	Training load District wise	Zone wise Training Load
1	Sirohi	Jalore	3	30	3	3	3	39	70
		Sirohi	3	20	4	4	3	31	
2	Barmer	Barmer	3	49	4	4	3	60	80
		Jaisalmer	2	14	2	2	2	20	
3	Udaipur	Udaipur	6	64	7	7	5	83	214
		Dungarpur	3	34	3	3	2	42	
		Rajsamand	3	26	3	3	3	35	
		Banswara	4	15	4	4	3	26	
		Pratapgarh	3	20	3	3	2	28	
4	Kota	Bundi	2	14	2	2	2	20	42
		Baran	2	10	2	2	8	22	
5	Dholpur	Dholpur	3	21	3	3	3	30	75
		Karoli	4	34	4	4	3	45	
		Total	41	351	41	41	42		

- Training of trainers (district trainers) at the regional training cum resource centres- 130 trainers 10 persons per district
- District/ block level skill training of ANMs- 38 batched across in 13 districts
- District/ block level skill training of PoshanPrahri and ASHAS– 10000 to be trained in 200 batched in 13 districts
- Skill training of Block data entry operators at regional training centres.

Separate detailed plan will be developed. Separate training module will be developed for ASHA/PP and ANMs

Data and knowledge management of treatment progress –

The monitoring, data management and supportive supervision will be conducted by a team of District and block health officials with clear role and monitoring frequency. Following are some of the proposed strategies -

- Data entry operator at block level especially taken for CMAM program will be compiling the information at block level based on the data sheets he/she will receive from Poshan sub centre. DPM will use the block data to review the progress every month and visit 50% children under treatment.
- Each District have DPM of NUHM, they will be the nodal of CMAM in respective district. He will be taking progress from data entry operators for organising monthly review meetings.

State and District level review mechanizem –

Each district will have a monthly meeting mechanizem under the leadership of collector to review the progress. At state level quarterly meetings are proposed with all the district and block officials. Partners meeting at state level will

be organised every two month.
Budget and financial implications – The Budget is enclosed for reference at Annexure 6. UNICEF and GAIN will share the cost as per the need. Annexure 1

Proportionate division of 10,000 children in 10 HPD and 3 Tribal Districts of Rajasthan

S.no	High Priority District	Child population (0-5)	SAM Estimated	SAM for Facility based care	SAM for CMAM	Distribution of State Target in proportion to Estimated SAM Population
1	Banswara	274307	20024	2002	18022	1000
2	Barmer	434561	31723	3172	28551	1550
3	Bundi	127986	9343	934	8409	450
4	Dhaulpur	178494	13030	1303	11727	650
5	Dungarpur	201741	14727	1473	13254	750
6	Jaisalmer	114101	8329	833	7496	400
7	Jalor	262190	19140	1914	17226	950
8	Karauli	197364	14408	1441	12967	700
9	Rajsamand	143666	10488	1049	9439	500
10	Udaipur	427262	31190	3119	28071	1550
	Total	2361671	172402	17240	155162	8500

S.no	Tribal District	Child population (0-5)	SAM Estimated	SAM for Facility based care	SAM for CMAM	Distribution of State Target in proportion to Estimated SAM Population
1	Baran	147219	10747	1075	9672	500
2	Sirohi	143775	10496	1050	9446	500
3	Pratapgarh*	125556	9166	917	8249	500
	Total	416549	30408	3041	27367	1500

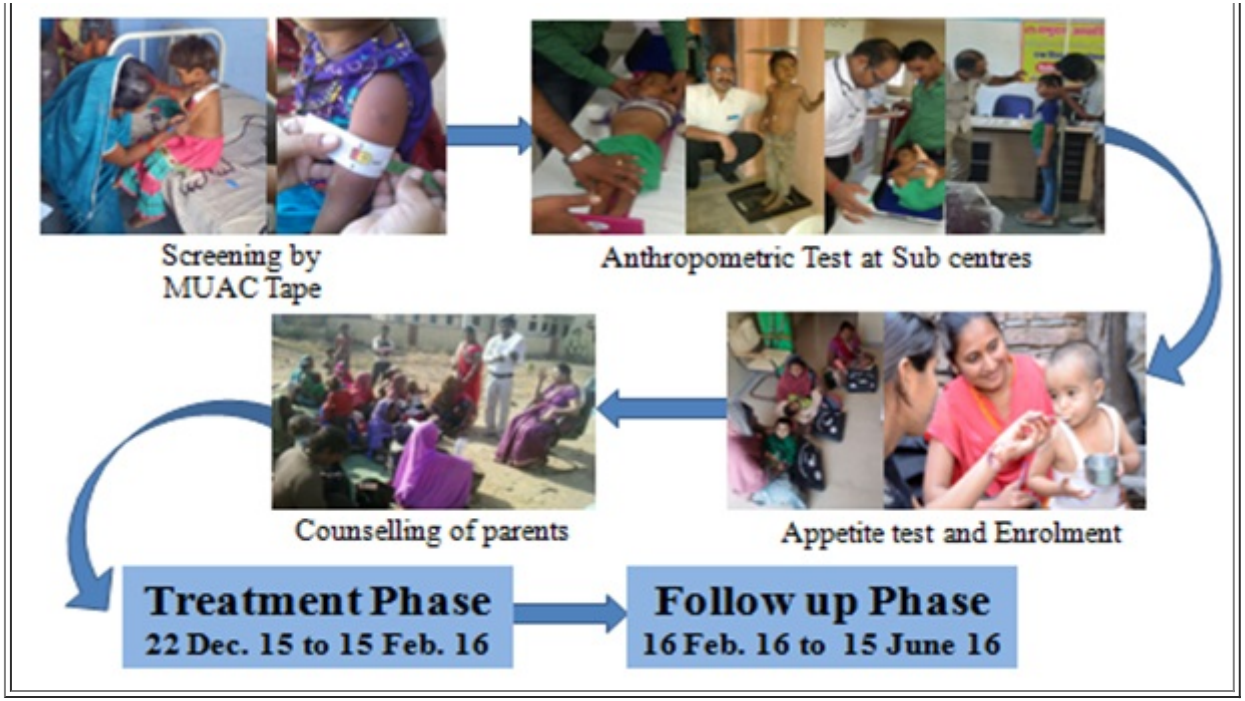
Implementation status of POSHAN

S. No.	District	No. of Blocks	No. of SCs	No. of Villages	Screened	As SAM in Anthro. Examination (By MUAC & Z-Score both)	No. of Pohan Prahari	Children Referred to MTC	Children referred to AWC
1	Banswara	4	65	223	27959	1392	295	115	1080
2	Baran	2	24	57	8064	537	118	58	1093
3	Barmer	3	86	158	38588	1339	348	14	1391
4	Bundi	2	25	61	7199	480	125	11	88
5	Dholpur	3	30	88	9568	316	90	36	724
6	Dungarpur	3	50	150	22325	596	172	125	3148
7	Jaisalmer	2	25	45	7340	183	41	2	295
8	Jalore	3	48	72	18210	762	179	7	1179
9	Karauli	4	35	130	16497	749	172	20	114
10	Rajsamand	3	25	81	8780	550	122	42	131
11	Pratapgarh	3	26	98	10602	317	111	5	471
12	Sirohi	3	56	116	24815	582	184	22	733
13	Udaipur	6	60	341	34457	1726	371	149	2207
	Total	**41**	**555**	**1620**	**234404**	**9529**	**2328**	**606 ***	**12654 ***

Pictures:

Tripartite MoU signing Ceremony between NHM, UNICEF and GAIN

2. Implementation of POSHAN



3. Pre-Launch Partners experience sharing meet

4. Launch of Poshan on 22nd December 2016