Evaluation of Usage of Mother and Child Protection Card by ICDS and Health Functionaries

National Institute of Public Cooperation and Child Development
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A Report

National Institute of Public Cooperation and Child Development

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FOREWORD

The Mother and Child Protection Card (MCP Card) was introduced for functionaries of National Rural Health Mission (NRHM) and Integrated Child Development Service (ICDS) from 1 April 2010 to progressively replace the earlier *Jacchha Bacchha Card*. The new MCP Card is increasingly viewed as a critical tool for upkeep of maternal and child health in the expanded coverage of both, ICDS and NRHM.

The common MCP Card would enable the large network of Accredited Social Health Activists (ASHAs), Anganwadi Workers (AWWs) and Auxiliary Nurse Midwives (ANMs) to converge their efforts and utilise the critical contact opportunities more effectively during monthly Village Health and Nutrition Days and similar mass contact occasions. Being an entitlement card, it would ensure greater inclusion of unreached groups to demand and universalize access to key maternal and child care and health services.

The present study conducted by NIPCCD has been an attempt to (i) assess the awareness levels of ICDS beneficiaries about the MCP Card and importance in maternal and child care as well as knowledge and skills of AWWs, ANMs and ASHAs on appropriate usage of MCP Card and (ii) identify the problems and bottlenecks in effective utilization of MCP Card. The study has helped gain insights on the knowledge and skills of ASHA on issues relating to maternal and child health and nutrition. The report brings to fore valuable information about the existing interface between the ANM, AWW and ASHA as also the problems experienced in effective service delivery by the grassroots level workers. I am confident that this report would provide valuable inputs to planners, administrators, research scholars, extension personnel and other stakeholders working in the area of maternal and child health and nutrition, in bringing down the infant and maternal mortality in the country and achieving the Millennium Development Goals.

I appreciate the inputs provided by the Institutional Review Board in finalising the research design of the study. I like to place on record my appreciation for the contribution and guidance given by Dr. Ashok Kumar, Additional Director and Dr. Neelam Bhatia, Joint Director. I acknowledge the painstaking efforts of Smt. Shanta Gopalakrishnan, Assistant Director and In charge of the Project in successfully completing the project within the time frame with the able assistance of Ms. Priyanka Singh and Ms. Himani Nautiyal, Project Assistants. I extend my deep gratitude to Shri A.J. Kaul, Publication Officer for the layout and design of the report.

Dinesh Paul
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ABBREVIATIONS

ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCG	Bacillus Calmette Guerin
BP	Blood pressure
CCT	Conditional cash transfer
CDPO	Child Development Project Officer
CHC	Community Health Centre
DPT	Diphtheria, Pertussis and Tetanus
ECCSGD	Early Childhood Care for Survival, Growth and Development
EDD	Expected date of delivery
HBMR	Home based maternal record
ICDS	Integrated Child Development Services
ICMR	Indian Council of Medical Research
IFA	Iron and folic acid
IYCF	Infant and young child feeding
IGMSY	Indira Gandhi Matritva Sahyog Yojana
IMNCI	Integrated Management of Neonatal and Childhood Illness
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojna
LHV	Lady Health Visitor
LMP	Last menstrual period
MCH	Maternal and child health
MCPC	Mother and Child Protection Card
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MMR	Maternal Mortality Ratio
MWCD	Ministry of Women and Child Development
NHED	Nutrition and health education
NIPCCD	National Institute of Public Cooperation and Child Development
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
OPV	Oral polio vaccine
PHC	Primary Health Centre
SN	Supplementary nutrition
THR	Take home ration
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
VHND	Village Health and Nutrition Day
VHSNC	Village Health, Sanitation and Nutrition Committee
WHO-CGS	World Health Organization- Child Growth Standards

EXECUTIVE SUMMARY

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The Government of India introduced WHO-Child Growth Standards for growth monitoring of children less than five years, in both ICDS and NRHM, with effect from 15 August 2008, through a joint circular dated 6 August 2008. This initiative was complemented by another decision of both the Ministries- to universally introduce a common mother-held, Mother and Child Protection Card (MCP), which incorporates the WHO-CGS, in both ICDS and NRHM for strengthening the continuum of care from pregnancy till the child is three years old. The MCP Card is considered as an entitlement card and a counselling tool. The MCP Card was introduced in NRHM and ICDS with effect from April 1, 2010 vide a joint letter from Secretaries of both Ministries dated 25 March 2010. It was envisaged that this card would progressively replace the earlier Jacchha Bacchha Card and the earlier ICDS mother child card from 1st April, 2010.

With the increase in the outreach of ICDS, as well as, NRHM under which there are monthly fixed Village Health and Nutrition Days and Village Health and Sanitation Committees, the common Mother and Child Protection Card would enable the large network of ASHAs, AWWs and ANMs to converge their efforts and utilise the critical contact opportunities more effectively. Being an entitlement card, it would ensure greater inclusion of unreached groups to demand and universalise access to key maternal and child care and health services.

With the above in view, an attempt to evaluate the usage of the MCP Card by ICDS and health functionaries was undertaken. The objectives of the study were to: assess the knowledge and skills of AWWs, ANMs and ASHAs on appropriate usage of MCP Card; study the awareness of women (pregnant, lactating and mothers with children below 3 years) about the MCP card and its importance in maternal and child care; study the role perception of ICDS and Health functionaries with respect to MCP Card for better outreach of health and nutrition services; study the service utilization by the pregnant women and mothers with children below three years through the MCP Card; examine the existing interface between the ANMs, AWWs and ASHAs with regard to the usage of MCP Card; and identify the problems and bottlenecks in effective utilisation of MCP Card.

The study was conducted in six states, one each from East, West, North, South, Central and North-Eastern Region, namely, Jharkhand, Maharashtra, Haryana, Kerala, Madhya Pradesh and Assam. One district from each selected state was selected randomly. The data for the study has been collected through multi-stage stratified random sampling method. Perception of different stakeholders- ICDS (CDPOs, Supervisors and AWWs) and Health functionaries (MOs, LHVs, ANMs, ASHAs), community members/beneficiaries (pregnant women, mothers with children below six months and mothers with children between six months to three years; and family members of selected sample beneficiary) were ascertained through interviews and substantiated with observations. In all, the sample comprised 155 ICDS functionaries (12 CDPOs, 24 Supervisors and 119 AWWs); 45 health functionaries (11 Medical Officers, 12 LHVs, 22 ANMs); 116 ASHAs; 540 beneficiaries (240 pregnant women, 120 mothers with children less than six month and 180 mothers with children between six months and three years); and 60 family members of selected beneficiaries with children between six months and three years.

The major findings and conclusions of the study are presented in the following paragraphs.

5.1 Profile of the Respondents

- Majority of the beneficiaries were in the age group 20-24 years (54.8%), followed by 25-29 years (35.7%) and 30-34 years (8.2%), indicating that the fertility levels was higher in the age group 20-24 years. This is in line with the Sample Registration System (SRS) data of fertility levels being higher among 20-24 years age group.
- Over half of the family members of selected beneficiaries with children between 6 months and 3 years were above 40 years of age.
- The distribution of beneficiaries who had passed primary school, middle school, high school, intermediate, graduate and postgraduate level was 11.1 per cent , 18.0 per cent, 25.0 per cent , 23.0 per cent , 10.0 per cent and 2.0 per cent respectively. It may be mentioned that 10.9 per cent beneficiaries were illiterate among the respondents.

5.2 Procurement and Distribution of MCP Card by ICDS and Health Functionaries

- The procurement and distribution of the MCP Card in the sample states has been through the NRHM/Health department in Assam (100%), Jharkhand (100%); and

Maharashtra (100%). Both NRHM/Health department and ICDS department were involved in the distribution of the MCP Card in the sample states of Haryana, Kerala and Madhya Pradesh, as reported by the Medical Officers.

- As reported by the ICDS functionaries, namely CDPOs and Supervisors, the MCP Card has been distributed to over 90 per cent of AWCs and is being maintained properly in over 87 per cent of AWCs. Similarly, report from the health functionaries, namely MOs and LHVs, reveal that the MCP Card has been distributed to all Sub-centres and is being maintained properly in over 92 per cent of Sub-centres. Though the report of Supervisors and LHVs {Supervisors (90.8%) and LHVs (92.4%)} match on the proper maintenance of MCP Card, there is over reporting observed when the responses of CDPOs and MOs {CDPOs (87.1%) and MOs (96.4%)} are compared.
- The reasons given by the ICDS and health functionaries for the MCP Card not being maintained properly in the areas, has been the lack of training on the usage of the MCP Card; followed by lack of skills in using the MCP Card; indifferent attitude of beneficiaries; non- availability of the MCP Card; and losing/misplacing the MCP Card by the beneficiaries. The reasons expressed by both health and ICDS functionaries point towards the need for training.

5.3 Orientation Training on the MCP Card by ICDS and Health Functionaries

- Among the ICDS functionaries only 21.9 per cent of AWWs, 16.7 per cent of Supervisors and 58.3 per cent of CDPOs had received some kind of orientation training on the MCP Card. Among the health functionaries, 40.9 per cent of ANMs, 58.3 per cent of LHVs; 9.1 per cent of MOs and 20.7 per cent of ASHAs had received orientation training on the MCP Card, this is a serious lacuna which requires urgent remedial measures.
- The training was imparted mainly during the sectoral meetings or was integrated into other ongoing trainings (WHO-CGS; IYCF, etc.) . The duration of orientation training also varied across the respondents from half-a-day to five-day duration.

5.4 Awareness about MCP Card and its Maintenance among ICDS and Health Functionaries

- The awareness about the MCP Card among the grassroots level workers of ICDS and health systems, mainly AWWs, ANMs and ASHAs revealed that over 90 per cent of AWWs, ANMs and ASHAs, were aware about the MCP Card.
- Over 90 per cent of AWWs and ANMs and around 80 per cent of ASHAs responded that they had helped women in getting the MCP Card.
- In all, 82 per cent of AWWs; 90 per cent of ANMs and 76.7 per cent of ASHAs stated that the MCP Card is being maintained properly in their areas. Mother is mostly the custodian of the MCP Card.
- Among the beneficiaries, the awareness level was better among mothers with children between 6 months and 3 years (82.2%). Also, 67.2 per cent of mothers with children between 6 months and 3 years reported that they were explained about the MCP Card in contrast to pregnant women (59.6%), mothers with children below 6 months (60.8%) and family members (43.3%).
- The awareness of all beneficiaries and family members regarding the validity of the MCP Card was low.

5.5 Usage of MCP Card by ICDS and Health Functionaries

- About 95.8 per cent of AWWs; 87.5 per cent of Supervisors; 95.5 per cent of ANMs; 66.7 per cent of LHVs; and 90.5 per cent of ASHAs confirmed that they were using the MCP Card.
- The study reveals that the usage level has been low for functionaries at the supervisory level. The MCP Card has been used mainly with the pregnant women, during the ANC visits. Often, only the relevant section in the MCP Card was explained to the beneficiaries. This may be a hindering factor, as orienting about the MCP Card in totality may convey the benefits of the Card to the beneficiaries better.
- The purposes for using the Mother and Child Protection Card as reported by ICDS and health functionaries reveal that the MCP Card has been used by all the functionaries for explaining about – ANC services. As regards, explaining about preparation for delivery

the MCP Card was used more often by LHVs. Supervisors had used the MCP Card more for weighing, plotting and counselling after weighing; explaining about danger signs in newborn and for explaining about nutrition play and communication activities. The AWWs had used the MCP Card the most for explaining about the services available under ICDS.

5.6 Knowledge and Awareness about Maternal and Child Health Issues

- It was heartening to note that over three-fourth of ANMs were aware of the present minimum number of antenatal check-ups to be four. Regarding past obstetric history, their responses included anaemia (86.4%); pregnancy induced hypertension (81.8%); antepartum haemorrhage (77.3%); eclampsia (77.3%); post partum haemorrhage (77.3%); caesarean section (72.7%); and congenital abnormality (54.6%).
- The study revealed that recording of the chronic illnesses, such as tuberculosis, diabetes, asthma, etc. in the MCP Card by putting a tick mark was known to only 63.6 per cent of ANMs.
- The study also assessed the knowledge of ANMs regarding 'what' abdominal examinations reveal. The responses of ANMs included- checking of foetal movement (81.8%); baby's growth through checking the fundal height (77.3%); foetal heart rate per minute (77.3%); and lie/presentation of the baby (59.1%).
- The knowledge of AWWs and ASHAs on the danger signs during pregnancy and delivery needing referral revealed that the knowledge level of ASHAs was better than that of AWWs for the danger signs during pregnancy, namely, bleeding during pregnancy; excessive bleeding during and after delivery; and bursting of water bag without labour pain. The knowledge level of AWWs was better than that of ASHAs for danger signs namely, severe anaemia; high fever during pregnancy; high fever within 30 days of delivery; and headache, blurring of vision, fits and swelling all over the body.
- The awareness and practices of pregnant women regarding care during pregnancy exhibit that the awareness about the LMP and EDD was 97.5 per cent and 70.8 per cent respectively. The source of information about LMP and EDD was mainly ASHAs; followed by ANMs and AWWs.

- Though, over 96 per cent of pregnant women were registered at AWCs and out of them only 60 per cent of pregnant women got registered in their first trimester. Only 24 per cent of pregnant women had the requisite recommended four antenatal check-ups.
- As regards, the investigations done during pregnancy, over 80 per cent responded that their blood pressure, weight, blood and urine sample was checked; around 69 per cent mentioned that the abdominal examination was done; about 67 per cent stated that they had receive two doses of tetanus toxoid injections.
- It was encouraging to note that the pregnant women were aware about their BP levels. About 66.3 per cent of pregnant women stated that they were informed about their weight during the ANCs. Only one-third of pregnant women were informed about the findings of the abdominal examination. Only half of the pregnant women were aware of normal weight gain during pregnancy.
- As regards, the awareness about why abdominal examination is performed during pregnancy, the responses included- to see how the baby is growing (60.%); to check baby's position (47.9%); to check foetal movement (45.8%); and to check foetal heart rate (35.4%).
- The study revealed that 'red colour box or words written in red letter', as danger sign, was known to only 22.5 per cent of pregnant women and 43.3 per cent of family members. The awareness level of family members regarding danger signs during pregnancy needing referral though fair was better than that of the pregnant women. The major information source about danger signs during pregnancy needing referral was AWWs (38.3%), followed by ASHAs (35.0%) and ANMs (31.7%), reiterating the point that the grassroots level workers need to be oriented to the MCP Card for yielding better impact.
- Less than 10 per cent of pregnant women were referred to a higher facility during the present or previous pregnancy as reported by pregnant women. The referral source has been ASHAs; followed by AWWs; and ANMs. All the cases referred visited the higher health facility wherever referred; but only half of them mentioned that they are aware that the referral history was recorded in the MCP Card.
- Only 58.8 per cent pregnant women were aware about the recording of antenatal check-up in the MCP Card. The percentage of pregnant women who were able to show

correctly recording of weight, blood pressure, TT injection and quantity of iron and folic acid (IFA) tablets issued were 55 per cent , 49.6 per cent, 52.5 per cent and 40.4 per cent respectively.

- The percentage of pregnant women who were able to show correctly the section on rest, sleep and care during pregnancy and danger signs during pregnancy was 40.8 per cent and 37.5 per cent respectively.
- It is encouraging to note that over 90 per cent of ANMs could define preterm delivery. Recommended postnatal visit for a mother and child, in case of a normal delivery, and in low birth babies was known to only 50 per cent of ANMs.
- The knowledge of AWWs on the information to be filled in of the MCP Card revealed that over two-thirds of AWWs were aware about filling-in of the date and time of delivery; weight of the baby; sex of the baby; place of delivery; and type of delivery. However, the level of knowledge was not very encouraging as regards, the time of initiation of breastfeeding; term/ pre-term; about child's cry at the time of birth; about the complications; and period of stay post delivery. There is a dire need for orienting the AWWs on the above issues as other-wise, the purpose of MCP Card would be lost.
- It was heartening to note that about 70 per cent of deliveries were conducted in the government infrastructure.
- The requisite number of four postnatal visits after delivery was received only one-fourth of mothers with children below 6 months and one-third of mother with children between 6 months and 3 years.
- The responses on the components of monitoring newborn include fever (86.4%); urine passed (81.8%);diarrhoea (81.8%); vomiting (77.3%); stool passed (72.7%); jaundice (72.7%); chest in-drawing (68.2%) ; convulsions; sucking good or poor; (63.6 per cent each); condition of umbilical cord; activity monitoring (59.1 per cent each); and skin pustules–present or absent (54.6%).
- The knowledge of ANMs was better than that of AWWs and ASHAs for all danger signs in a newborn. The knowledge of AWWs was better than that of ASHAs as regards to danger signs, such as, baby unable to cry; baby having difficulty in breathing; yellow palm and soles; blood in stool; convulsions; and lethargic/unconscious. The knowledge of ASHAs was better than that of AWWs as

regards, weak sucking or refusal to breastfeed; and fever. As regards, the sign, ‘cold to touch’ both AWWs and ASHAs, exhibited similar level of knowledge.

- Only one-fourth of mothers with children below 6 months; half of mothers with children between 6 months and 3 years and two–fifth per cent of family members were aware about what is written in the MCP Card regarding the care of newborn. On the whole, the awareness regarding ‘danger signs in a newborn needing referral’ was better than for the ‘general care of newborn’. But words written in red letters denoting ‘danger’ and that the health worker needs to be contacted immediately, was known to less than one-fourth of mothers with children between 6 months and 3 years.
- The data also revealed that about one-fourth of mothers with children between 6 months and 3 years reported that they were referred to a higher health facility. ASHA has been the main source of information for such referral. Out of these, one-fifth had complied with the advice and very few mothers with children between 6 months and 3 years knew that the referral history was recorded in the MCP Card.
- The awareness level regarding the care of newborn among the other beneficiary groups, namely mothers with children below 6 months and the family members as regards these indicators was abysmally low, pointing towards the need for better orientation .
- The perception of family members on the provisions to be made in case of an emergency. related to women and children included saving up money for unexpected medical expenses (78%); identifying government/ private hospital (81%); making arrangements for transportation of women and children (73%); and remembering to take MCP Card along with them during referral (58%). The awareness levels among the functionaries, as well as the beneficiaries, could be improved for a better impact by stressing on the MCP Card as a referral tool.
- The knowledge of AWWs, ANMs and ASHAs on some of the parameters of feeding and care of young children were ascertained using some ’true and false’ statements revealed that on the whole, ASHAs had scored better than AWWs and ANMs for most of the parameters, such as, initiation of breastfeeding within an hour of birth; babies should be fed 8 to 10 times during day and night; and a child over one year need to be dewormed biannually. The knowledge level of ANM was better than that of ASHA and AWW for parameters, namely, breastfeeding can be continued upto 2 years or beyond;

and the vaccines given at birth are BCG, OPV and Hepatitis B. The knowledge level of all grassroots level workers need updating for parameters such as, child does not need water in summer along with breast milk in the first six months; breastfeeding should not be stopped during diarrhoeal episodes; and that iodised salt is good for health, as still 20-30 per cent of grassroots workers do not have the right knowledge.

- It was heartening to note that about 86 per cent of mothers with children below six months had initiated breastfeeding within an hour after birth. Awareness about exclusive breastfeeding for mothers with children between six months and three years was 93 per cent. However, there is a need to update mothers on all issues relating to breastfeeding and complementary feeding for yielding better results.
- As regards the knowledge and practices of AWWs on the steps in growth monitoring, it was heartening to note that majority of the AWWs were knowledgeable.
- About 91.6 per cent of mothers with children below 6 months and 96.1 per cent of mothers with children between 6 months and 3 years had got their child weighed at birth. The birth weight was known to 75.8 per cent of mother with children below 6 months and 74.4 per cent of mothers with children between 6 months and 3 years.
- Only 56.6 per cent mothers with children below 6 months and 67.2 per cent mothers with children between 6 months and 3 years knew that the child under six months needs to be weighed monthly.
- The awareness about the colour of the growth chart i.e. pink chart for girl was known to only 12.5 per cent of mothers below six months and 21.1 per cent mothers with children between 6 months and three years; and blue chart for boys was known to only 16.6 per cent of mothers with children below 6 months and 21.6 per cent of mothers with children between 6 months and three years. Only 31.6 per cent of mothers with children below 6 months and 45.5 per cent of mothers of children 6 months and 3 years confirmed that the AWWs had discussed the growth chart with them. This is a serious lacuna and needs to be addressed squarely.
- The timing of discussing the growth chart varied with only 25 per cent of mothers with children below 6 months and 40 per cent of mothers with children between 6 months and 3 years affirming that the AWWs discussed the growth chart with them immediately after weighing. Another stark finding was that there was gross over

reporting by the AWWs about the timing of discussing the growth chart, which was not corroborated by the beneficiaries.

- The ability of beneficiaries to show correctly in the MCP Card the recording of findings of check up of the child revealed that only 43 per cent of mothers with children below 6 months, 35 per cent of mothers with children between 6 months and 3 years and 23 per cent of family members were aware about the recording of findings about the child, made in the MCP Card.

5.7 Knowledge and Awareness about Feeding, Play and Communication

- The ability of mothers with children below 6 months was better than those of mothers with children between 6 months and 3 years, who showed better ability in showing correctly the section on 'feeding, playing and communicating with children'.
- The knowledge level of AWWs, ANMs and ASHAs on play and communication revealed that the knowledge level of ANMs was better than those of AWWs and ASHAs. The advice on combining play and communication activities during feeding, bathing, etc. was reported by 77.2 per cent of ANMs, 70.5 per cent of AWWs and 64.6 per cent ASHAs. Using any household objects that are clean and safe, in case a mother has no toys was reported by 81.8 per cent of ANMs, 76.7 per cent of ASHAs and 75.6 per cent of AWWs. The advice to be given to a mother in case a child seems slow as revealed from the study included asking the mother to spend more time interacting with the baby [AWWs (80.6%), ANMs (77.2%) and ASHAs (75.0%)]; checking whether the baby is able to see and hear [AWWs (58.8%) ANMs (63.6%) and ASHAs (45.6 %)]; and referring to special services if the child has difficulty in seeing or hearing [AWW (65.5%), ANM (77.2%) and ASHAs (52.6%)].
- The knowledge level of grassroots level workers on the developmental milestones in children for the various milestones revealed that the knowledge level needs to be enhanced for all the grassroots level workers.
- The ability of beneficiaries to understand clearly the messages in the MCP Card related to feeding children aged 6 months to 3 years was ascertained by showing the MCP Card to them and the responses thereby elicited revealed that only 46.6 to 57.7 per cent of beneficiaries could tell clearly, what is given in the MCP Card regarding the sections on

'feeding children aged 6 to 12 months; 'feeding children aged 1 to 2 years and 'feeding children aged 2 to 3 years'.

- Three-fourth of the mothers knew that a child upto 6 months can communicate and play with her. Less than half of them reported that they were explained about it by the functionaries. Majority of mother (85.8%) knew that a child under 6 months can smile in response. The awareness about the ability of a child to make a sound; holding head steady; tracking a ribbon bow; reaching out for objects; and turning to a voice was 74.2 per cent; 61.6 per cent; 55 per cent; 55.0 per cent; and 68.3 per cent.
- As regard, the awareness about how a mother can promote development of children below six months, about 50 per cent of mothers were aware about smiling, laughing, looking into child's eyes and talking to the child.
- The ability of mothers with children 6 months to 3 years to understand clearly the messages in the MCP Card related to playing and communicating with children 6 to 12 months was better than that of family members, for both, 'what a child aged 6-12 months can do', as well as, 'how we can promote development of children aged 6-12 months'. Only 48.3 to 57.2 per cent mothers with children between 6 months to 3 years were aware about what a child aged 6-12 months can do, in contrast to 28.3 to 38.3 per cent of family members. Similarly, the awareness about 'how to promote development of children aged 6-12 months' ranged between 50.5 to 56.1 per cent for mothers with children between 6 months to 3 years and 30.0 to 33.3 per cent of family members.
- The ability of mothers with children 6 months to 3 years to understand clearly the messages in the MCP Card related to playing and communicating with children 1 to 2 years was better than those of family members, with regard to what is given in the MCP Card regarding 'what a child 1 to 2 years can do' and 'what can be done to promote development of children 1 to 2 years'. Only 43.8 to 56.1 per cent mothers with children between 6 months to 3 years were aware about 'what a child aged 1 to 2 years can do', in contrast to 23.3 to 40.0 per cent of family members. Similarly, the awareness about 'how to promote development of children aged 1 to 2 years' ranged between 49.4 to 55.5 per cent for mothers with children between 6 months to 3 years and 31.6 to 38.3 per cent of family members.

- The ability of mothers with children 6 months to 3 years to understand clearly the messages in the MCP Card related to playing and communicating with children 2 to 3 years was better than those of family members as regards, what is given in the MCP Card regarding 'what a child 2 to 3 years can do' and 'what can be done to promote development of children 2 to 3 years. Only 46.1 to 56.1 per cent mothers with children between 6 months to 3 years were aware about 'what a child aged 2 to 3 years can do', in contrast to 30.0 to 41.6 per cent of family members. Similarly, the awareness about 'how to promote development of children aged 2 to 3 years' ranged between 47.7 to 52.2 per cent for mothers with children between 6 months to 3 years and 31.6 to 38.3 per cent of family members.
- It may be further mentioned that only 10.9 per cent of mothers were illiterate. These points to the fact that the beneficiaries need to be oriented about the MCP Card, for taking full advantage of the MCP Card.

5.8 Role Perception of ICDS and Health Functionaries with regard to MCP Card

- The efforts made by CDPOs and MOs for popularising and publicising the MCP Card include introducing the card during community growth monitoring and counselling session; during the regular field monitoring visits; during VHNDs; through the schemes such as JSY, IGMSY etc. and by giving publicity through Field Publicity Unit, local television channel/radio.
- The role perception and job performance of AWWs, ANMs and ASHAs such as 'recording of information only' and 'explaining/ counselling' with regard to various sections in the MCP Card was ascertained. The responses of AWWs, ANMs and ASHAs with regard to the role perceived by them, such as, 'recording of information only' and 'explaining/ counselling' for various sections in the MCP Card revealed that majority of AWWs have perceived 'recording of information' in the MCP Card as their main role with respect to growth monitoring and promotion (78.1%); family identification (60.5%); immunisation and vitamin A supplementation (50.4%); and playing and communicating with children (45.3%). The role perception of AWWs about their own role related to counselling and explaining to the beneficiaries about the various issues is grossly inadequate.

- The study revealed that the role perception and job performed by ANMs, with regard to the various sections in the MCP Card, as reported by them is very lucid. The role perceived and job performed by ANMs, herself focus mainly on 'recording of information' in the MCP Card related to regular check-ups during pregnancy (77.2%); danger signs during pregnancy (77.2%); postnatal record of mother (81.8%); record of newborn baby (81.8%); newborn care and danger signs in a newborn (59.0%); care during illness (63.6%) immunisation and vitamin A supplementation (68.1%). The role perception of ANMs about their own role related to counselling and explaining the beneficiaries about the various issues is grossly inadequate. However, it was encouraging to note that, though the ANMs do not perceive it their role to do growth monitoring and promotion, they identify with the role as a counsellor (59.0 %) in growth monitoring and promotion.
- The role perception and job performed by ASHAs with regard to the various sections in the MCP Card was moderate. The job perceived and performed by ASHAs as reported by her, focus mainly on 'explaining and counselling' for early initiation of breastfeeding (60.3%); family planning (56.0%); newborn care and danger signs in a newborn (50.8%); immunisation and vitamin A supplementation (47.4%); care during illness (53.4%); and feeding, playing and communicating with children (45.6%), which is close to the way her role has been perceived under the NRHM. The ASHAs mainly perceived their role, as a recorder of information with respect to only 'family identification'.

5.9 Support and Supervision with regard to MCP Card

- Almost all CDPOs (75%) and MOs (100%) affirmed that they monitored the usage of MCP Card. The nature of tasks monitored as reported by both CDPOs and MOs include monitoring the usage of the MCP Card; checking the availability of the MCP Card; monitoring the distribution of the MCP Card; educating about service entitlement during VHNDs; use of MCP Card for recording of services; usage of MCP Card as an entitlement Card under JSY; usage of MCP Card as an entitlement Card under IGMSY; usage of MCP Card as a counselling tool or not; and monitoring compliance of feedback during review meetings.

- Almost all the Supervisors (100%) and LHVs (75%) affirmed that they monitor the usage of the MCP Card. Mainly, check the availability of the MCP Card {Supervisors (83%) and LHVs (67%)}; and monitor distribution of the MCP Card {Supervisors (88%) and LHVs (67%)}; is monitored. The nature of other tasks monitored with regard to the MCP Card include monitoring the usage of the MCP Card foreducating about service entitlement during VHND {Supervisors (75%) and LHVs (58%)}; Recording of ANC in the MCP Card {Supervisors (63%) and LHVs (67 %)}; recording of PNC {Supervisors (54%) and LHVs (58%)}; recording of newborn care {Supervisors (63%) and LHVs (58%); recording of immunisation {Supervisors (83%) and LHV (67%)}; recording of weight of the child {Supervisors (75%) and LHVs (67%)}; recording of developmental delays {Supervisors (50%) and LHVs (58%)}; use of MCP Card as an entitlement under JSY {Supervisors (58%) and LHVs (50%)}; use of MCP Card as an entitlement tool under IGMSY {Supervisors (33%) and LHVs (8%)}; use of MCP Card as a counselling tool or not {Supervisors (54%) and LHVs (67%)} and monitoring compliance of feedback given during review meetings {Supervisors (54%) and LHVs (67%)}
- Supervisors' responses on the nature of supervision provided during the monitoring visits and responses of AWWs agreeing with it, revealed that supervision was done by giving verbal instructions{Supervisors (75%) and AWWs (85%)}; by demonstrating the usage of MCP Card {Supervisors (88%) and AWWs (62%)}; by providing guidance in recording of information {Supervisors (63%) and AWWs (54%); by providing hands-on training on counselling mothers after weighing the child {Supervisors (63%) and AWWs (45%)}; by explaining about various sections of the MCP Card {Supervisors (67%) and AWWs (48%)}; and by explaining about play and communication activities {Supervisors (67%) and AWWs (47%)}. The responses of AWWs reveal that there has been over reporting by Supervisors on the nature of supervision provided by them to AWWs.
- The responses of Supervisors on the supervision provided during GMP and responses of AWWs corroborating it include checking whether regular weighing of children is being carried out or not {Supervisors (54 %) and AWWs (56%)}; weight plotting is upto date or not {Supervisors (38%) and AWWs (44%)}; weights are plotted correctly or not

{Supervisors (46%) and AWWs (35%)}; weight points are joined to form the growth curve {Supervisor (46%) and AWWs (31%)}; and checking calculation of date of birth {Supervisor (38%) and AWWs (29%)}. The responses of Supervisors and AWWs showed that they are slightly in tune with each other.

- LHVs responses on the nature of supervision provided during the monitoring visits and the responses of ANMs confirming it, revealed that supervision was done mainly by giving verbal instructions {LHVs (92%) and ANMs (91%)}; by demonstrating the use of MCP Card {LHVs (75%) and ANMs (36%)}; providing guidance in recording information {LHVs (83%) and ANMs (55%)}; providing hands on training in recording of findings in the MCP Card {LHVs (33%) and ANMs (27%)}; explaining about various sections of the MCP Card {LHVs (67%) and ANMs (59%)}; explaining about play and communication activities {LHVs (58%) and ANMs (32%)}. The responses of ANMs reveal that there has been over reporting by LHVs on the nature of supervision provided by them to ANMs.
- The responses of LHVs on monitoring of problematic areas with regard to care of women and children and responses of ANMs corroborating it, include checking whether regular check-ups of children are being carried out or not {LHVs (58%) and ANMs (41%)}; recording of the findings of the check-ups are upto date or not {LHVs (50%) and ANMs (45%)}; early identification and referral of at-risk women and children are being carried out or not{LHVs (33%) and ANMs (45%)}; danger signs during pregnancy and in newborn are being explained using the MCP Card or not {LHVs (17%) and ANMs (50%)}; and MCP Card is being used effectively for counselling women or not {LHVs (33%) and ANMs (27%)}. The study revealed that there was a mismatch in the responses of LHVs and ANMs, with the ANMs not corroborating some of the responses of LHVs.
- The various ways in which the MCP Card has facilitated in supervision include better monitoring of AWWs/ ANMs; in better coordination among health and ICDS functionaries; in establishing a functional linkage among the workers; in recording of vital events; in serving as a reminder for delivery of services; in developing a functional referral system; by enhancing credibility in the community; by serving as discussion tool during supervisory visits; and in liasioning with other departments.

5.10 Perception about Contribution of MCP Card in Improving Interface between ICDS and Health Functionaries

- Over 78 per cent of ICDS and health functionaries opine that the MCP Card has contributed in improving the interface between ICDS and health functionaries. The ways in which the MCP Card has contributed leading to better interface include- facilitating in understanding each other's role; serving as a tool for educating the community; helped in building better rapport with the community by exhibiting a continuum in the care; facilitating in helping each other in a more systematic manner; reinforcing the messages has helped in uptake of services; and gaining credibility in the community by identifying and managing at-risk cases. The study revealed that CDPOs strongly affirm that the MCP Card has contributed in improving the interface between ICDS and health functionaries and that the MCP Card has facilitated the grassroots level workers in better understanding of each other's role.
- About 89 per cent of AWWs, 77 per cent of ANMs and 91 per cent of ASHAs reported that they conducted home visits alone and this has been confirmed by the beneficiaries. Joint home visits though mandated is very few and is not happening on a regular basis.
- The feedback of beneficiaries on the home visits by AWWs, ANMs and ASHAs was also ascertained to understand the existing interface between the grassroots level workers. The study revealed that 76.2 per cent of pregnant women; and 75 per cent of mothers with children below 6 months and 75 per cent mothers with children between six months and three years reported that the three grassroots level workers visited their home alone, pointing towards lack of interface between the grassroots level workers.

5.11 Contribution of MCP Card in Outreach and Utilisation of Health and ICDS Services

- The responses of ICDS and health functionaries on how MCP Card has contributed in better outreach and utilisation of ICDS and health services are that MCP card has facilitated in- improved access to services; better understanding of self care; better ANC; timely action, in case of at-risk cases; early risk identification and seeking timely treatment; saving life of women and children; and increased uptake of all services.

- It seems that benefits of the MCP Card have yet not been felt by the beneficiaries. However, around 50 per cent of pregnant women, mothers with children below 6 months and mother with children between six months and 3 years feel that the MCP Card has helped in better understanding about self care. Roughly, 40 per cent of all the beneficiaries expressed that the MCP Card has facilitated in better ANC and improved access to services.
- Roughly, 35 per cent beneficiaries reported that the MCP Card has helped in getting appropriate referral services. One-fourth of pregnant women reported that MCP Card holder are given preference over other the patients. One-third of all beneficiaries reported that the MCP Card helped in getting timely and right treatment.

5.12 Level of Satisfaction after the Usage of MCP Card

- In all, over 80.7 per cent of AWWs; 100 per cent of Supervisors, 90.9 per cent of ANMs; and 83.3 per cent of LHVs expressed their satisfaction with the use of MCP Card. The major reasons for satisfaction with the MCP Card have been that the Card is very informative as per all the functionaries; it is one record for all services; and has contributed in easy keeping of the record of the child and mother. The responses of ASHAs have been luke warm, probably because she is not directly involved in record keeping, *per se*.
- In all, 73 per cent of pregnant women; 80 per cent of mothers with children below 6 month and 66 per cent of mothers with children between 6 month and 3 years were satisfied with the MCP Card. Majority of the beneficiaries reported that the major reasons for satisfaction was that the MCP Card was very informative; it serves as a good reminder for seeking services; it serves as a complete record of health status of the child and the mother. About one third of beneficiaries also reported that MCP Card can help in monitoring child's development and in early identification of problems and also in seeking timely help.

5.13 Problems Encountered during the Usage of the MCP Card

- The CDPOs (58%) and MOs (36%) reported that workers are not recording in the MCP Card, as they see it as extra work. About 67 per cent of CDPOs and 45 per cent of MOs reported that the MCP Card is not being used for counselling women, as it should have

been. The other relevant problems encountered in usage of MCP Card include- women being illiterate; and incomprehensible illustrations in the MCP Card. Also, the MCP Card has not been a passport to easy care, as anticipated and even the inadequacy of referral support has not been felt by majority of functionaries, indicating that the potential of MCP Card has yet not been explored completely, yet. ASHAs did not report about the problems encountered as probably they are not using the MCP Card in the field areas.

5.14 Suggestions for Effective Utilisation of MCP Card

- The suggestions that have been expressed by both ICDS and health functionaries univocally is that there is a need for joint training of all the functionaries on the usage of MCP Card, to dispel any confusion, that may be there. The other suggestion that came forth include- popularising the MCP Card for its better usage; monitoring the usage of the Card in conditional cash transfer; need for more use of local words in the Card; and simplifying the MCP Card.

Recommendations

The major recommendations drawn, based on the findings of the present study are as follows:

- MCP Card printing as a part of APIP of ICDS and PIP of health has been a contributing factor in rolling out of the MCP Card in some states (UNICEF, 2012)[13]. This may be adhered to for speedy rolling out of the MCP Card in all States.
- Periodic supply reviews at district level should be carried out regularly and modalities to deal with shortage be worked out at the district level.
- There is a need to develop a mechanism to verify the reach of MCP Cards to all AWCs, apart from the data obtained from VHND monitoring format.
- Clubbing training on the MCP Card with other ongoing trainings should be encouraged so that all the functionaries are trained. Also, joint vertical trainings with NRHM by pooling budgets should be carried out wherever feasible, for better acceptance of the card at the community level.
- The essence of the MCP Card has not been captured by both health and ICDS functionaries, as per the findings of the study. It is intensely recommended that all

efforts should be made to uphold the potential of the MCP Card, so as to prevent loss of its true spirit.

- All efforts should be made to ensure that the functionaries explain the MCP Card in totality to the beneficiaries, so that they are better aware of the benefits of the Card.
- It is recommended that in the all the training of health and ICDS functionaries on the MCP Card, as also in all the advocacy campaign on the MCP Card, the Card has to be introduced as a 'family empowerment tool', so as to facilitate the families to be able to access the services they need to live life safely.
- There is a need to create strong linkages with Mother Child Tracking System, wherein all cards are being assigned a unique code, for enhancing MCP Card usage.
- Linkage of MCP Card with various CCT Schemes, such as the JSY, IGMSY, etc. has contributed in the use of MCP Card at the community level, which can be scaled up in some states.
- There is a need for intensive hands-on training of AWWs on growth monitoring and counselling, for yielding better results.
- Less than 40 per cent of beneficiaries were aware about the recording of findings about their child, made in the MCP Card. There is an urgent need for skill training of grassroots level workers on recording on the MCP Card, as also, on explaining the beneficiaries about the findings of the check-ups, to convey the total benefits of the MCP Card to the beneficiaries.
- The section on ''feeding, play and communication' in the MCP Card is an addition over the previous health/immunisation cards used in the health and ICDS sector. It was disheartening to note that the knowledge level of grassroots level workers on the developmental milestones in children was low. Also, the ability of mothers with children from birth to 3 years to understand clearly the messages in the MCP Card related to playing and communicating with children was also not encouraging. This point to need for an intensive orientation of all the functionaries of ICDS and health systems on this new section, so that the potential of the MCP Card is understood and it is utilised in totality, to accrue maximum benefits.
- The present study revealed that majority of AWWs have perceived only 'recording of information' in the MCP Card as their main role but their perception about their own

role related to counselling and explaining to the beneficiaries about the various issues is grossly inadequate. In order that grassroots level workers effectively counsel the beneficiaries for utilising services under ICDS/NRHM or for changing a certain behavior, they need to be trained in 'counselling', *per se*, in addition to the related subject.

- Since nutrition counseling is delineated as a service under the restructured ICDS, it is suggested that provisions for recording the services given under the component, be made in the MCP Card for each of the three grassroots level functionaries.
- It is also recommended that provisions should be made in the MCP Card for recording of services /counseling offered by each of the grassroots level workers during the stipulated home visits for postnatal and neonatal care, to improve accountability by each worker.
- In order to prevent and reduce undernutrition, special efforts have been made to introduce a new initiative 'Sneha Shivir' a community based care and nutrition counselling initiative for mothers/caregivers of under-threes in 200 high burden districts and endemic districts of Japanese Encephalitis (JE). It is recommended that provisions be made in the MCP Card for recording of services /counseling offered by each of the grassroots level workers under Sneha Shivir and Japanese Encephalitis (JE).
- There is a need to set up vigourous systems for field supervision of actual use of MCP Card by Supervisors.
- The ground use of MCP Card can be improved by including it as an agenda point in field monitoring and review meeting at state and district level. In Odisha, it is an agenda point in review meeting by district collector, which has given the needed impetus to the initiative of MCP Card.
- Supportive supervision is core to get optimum functioning of any programme. There is a need to showcase/document successful models for combined supportive supervision of AWWs, ANMs and ASHAs, as has been tried out in Valsad in Gujarat (UNICEF, 2011)[12].
- There is a need to develop a clear and defined, main responsibility/accountability of each in relation to the other for all major activities at the community level, so that she is fully aware of the roles and activities she must fulfill with regard to the MCP Card.

There is also greater need to ensure that the distinct roles and responsibilities are clearly communicated between the ASHA, ANM, and AWW, to avoid overlap and increase efficiency.

- Majority of beneficiaries of the present study reported that AWWs, ANMs and ASHAs conducted home visits alone. Home visits conducted alone, are missed opportunities for providing supportive supervision. This finding calls for a need for clear-cut guidelines on home visits by the health and ICDS functionaries, as also, role clarification on the same, to maximise health gain.
- There are many pointers from the study on the need for more advocacy in the state with respect to introduction of the MCP Card for taking full advantage of the MCP Card, to yield the desired results.
- The introduction of a common Mother and Child Protection Card for both ICDS and NRHM, to strengthen the continuum of care for pregnant mothers and children under-three years of age, incorporating the new WHO Child Growth Standards, warrants that a column be specified in the MCP Card for ASHAs, as well, to record the care given by them to women and children.

1
INTRODUCTION

INTRODUCTION

1.1 Determinants of Malnutrition

Malnutrition is the result of an imbalance of both macro- and micro-nutrients that may be due to inappropriate food intake. Poor feeding practices in infancy and early childhood, resulting in malnutrition, contribute to impaired cognitive and social development, poor school performance, and reduced productivity in later life. Malnutrition, therefore is a major threat to social and economic development as it is a formidable obstacle in the way to attaining and maintaining health of women and children. In order to address this, programmes such as the Integrated Child Development Services (ICDS) and National Rural Health Mission (NRHM) are implemented in the country.

Since its inception in 2005, the National Rural Health Mission endeavours for reduction of Under Five Mortality and has been developing and implementing unique strategies towards it. Malnutrition is attributed to more than one-third of these under-five deaths in the country. Childhood malnutrition rates are high in the country with 43 per cent children in India under-five years are reported to be underweight and 48 per cent are stunted. Trend of faltering growth in children begins in critical period of first two years of life and a major cause is due to faulty infant and young child feeding practices. One of the key reasons for undernutrition setting-in early in life is the faulty and sub-optimal infant and young child feeding practices, which is further compounded by factors such as repeated episodes of childhood illnesses and low birth weight.

As depicted in national data sets like the National Family Health Survey and District level surveys, poor infant and young child feeding practices are observed by caregivers. Dismal rates of early breastfeeding, stagnant rates of exclusive breastfeeding rates and poor rates of appropriate complementary feeding are cause of concern and would require focused attention of the health care system.

Events leading to undernutrition often predate the birth of the child; maternal undernutrition, adolescent pregnancy, less spacing between births and high birth order result in birth of low birth weight babies. Delayed initiation of breastfeeding and

inappropriate feeding practices in the new-born period and first year of life exacerbate under-nutrition in infants and children. Under the National Rural Health Mission, a 'life cycle approach' has been adopted for breaking the intergenerational cycle of undernutrition.

Promotion of optimal infant and young child feeding (IYCF) practices has been recognised as an important intervention not only for preventing undernutrition in children but also for improving child survival, as well as development. While interventions to prevent deaths due to common childhood illnesses in children with severe acute undernutrition have been included in the national health programme, it is equally important that high priority is accorded to preventive measures. This will ensure that new cases of undernutrition are not added to the already existing burden of child undernutrition in the country.

The reproductive, maternal, child and new born health services delivered through the public health system provide a number of contact opportunities with pregnant and lactating women, as well as, mothers of young children. It is extremely important that such opportunities are capitalised for counselling on infant and young child feeding practices and reinforcing the key messages in child care and nutrition.

One major initiative for accelerating reduction in maternal, neonatal and infant mortality and child undernutrition has been the adoption of WHO Child Growth Standards (WHO-CGS), with effect from 15 August 2008 in both ICDS and NRHM, through a joint circular dated 6 August 2008, issued by both the Secretaries of Women and Child Development and Health and Family Welfare, Government of India. This initiative has been enriched and complemented by yet another decision of both the ministries by introducing a common Mother and Child Protection Card (MCP Card) for both ICDS and NRHM, to strengthen the continuum of care for pregnant mothers and children under-three years of age, incorporating the new WHO Child Growth Standards (www.wcd.nic.in)[14].

The MCP Card is a maternal and child care entitlement card, a counselling and family empowerment tool which would ensure tracking of mother child cohort for health purposes.

It is unique in linking maternal, newborn and child care, and focuses on the child holistically by integrating health, nutrition and development. It links critical contact points for strengthening the continuum of care and improving utilisation of key ICDS and NRHM services, including immunisation, Indira Gandhi Matritva Sahyog Yojana (IGMSY) and Janani Suraksha Yojna (JSY). Besides, it is meant to promote key family care behaviours, highlights danger signs and links families to the referral system. The MCP Card would enable gender disaggregated tracking, to ensure optimal care of the girl child.

In number of States the Card has been in use for tracking nutritional status of children in ICDS, while the immunisation card has been used to track health status of pregnant women and children. The Ministries of Women and Child Development and Health and Family Welfare recognized the importance of a single universal card for tracking all pregnant women and children upto five years. In March 2010, the two Ministries took a policy decision to adopt the Mother and Child Protection Card as a ‘ Joint Card’ **(Annexure-I).** In view of this two new sections- antenatal and postnatal care were appended to include critical health parameters in the card. The New WHO Growth Standards for boys and girls has also been included in the card alongwith simple pictorial illustrations **(Annexure-II).**

1.2 Mother and Child Protection Card

1.2.1 Genesis

In accordance with Government of India’s strategy of Early Childhood Care for Survival, Growth and Development, National Institute of Public Cooperation and Child Development (NIPCCD) in collaboration with UNICEF and MWCD has developed Mother and Child Protection Card as a tool for communication. Early Childhood Care for Survival, Growth and Development (ECCSGD) framework endorses an integrated, holistic approach, within a rights perspective to ensure proper child care leading to survival, growth, full development and protection of the young child through child-centered, family-focused, and community-based intervention.

The card is in tune with ECCSGD principle, which emphasises that children are born with different capacities to learn and grow. But there are wide differences in how they develop, depending on what happens after birth. The quality of opportunities, the responsiveness of the environment, and all of the millions of interactions with it play a decisive role in development. Care, refers to the practices of the caregivers in the household

that day-by-day, attentively and warmly translate available resources (such as time, knowledge, food, health practices, psychological stimulation) into survival, growth and development of the child in early childhood-that is, between conception and eight years of age. The present MCP Card, however focuses on reaching out to children under-three.

1.2.2 The Concept

Home-based records have been in use for over three decades in most countries and proven to be a successful tool for health and nutrition promotion. They have been well accepted by the community health workers and the mothers and contributed to an active involvement of individuals and families in taking care of their own health and that of the children.

1.2.3 Purpose of the Card

Home–based records (child and maternal) provides and/ or pictorial information that can be retained by the families. The goal is to empower families to make decisions and take action for improved status of the health and nutrition of themselves and their children on a continual basis. The purpose of these records is to:

- Educate families on simple maternal and child and nutrition concepts;
- Help families to put the health and nutrition information into practice for growth and development of children;
- Access and utilise available health services;
- Remind families when to return to the health workers for follow up;
- Monitor health and nutrition status of children.

1.2.4 Home-based Records in Use in India

It was long realised that a combined mother and child care card would give greater dividends and improved maternal and child care because of the high profile immunisation programme. The two visits of the pregnant women's tetanus toxoid could have been utilised for antenatal care, detecting and treating anemia, and identifying any deviation from the normal and for giving her relevant advice regarding delivery. Similarly, the five visits of the child for immunisation could have been used for strengthening breastfeeding advice and timely addition of semisolids, prevention and management of common morbidities, etc. The Government of India introduced *Jachcha Bachcha* Card, Mother-Infant Immunisation Card,

which emphasises mostly on immunization, even though antenatal visits and iron tablets are mentioned (Ghosh, Shanti,1994)[2].

The Ministry of Health and Family Welfare has been using *Jaccha Baccha* Card, which helps in recording information of availed antenatal care, including Iron Folic Acid and Tetanus Toxoid and child's immunisation. The card is usually retained by the families with a detachable flap in the custody of the health workers. Growth charts used in the ICDS system have been institutional-based records and kept at the AWC/ hospitals. In the past, they have been considered of little value to the mother/ caregivers as the information is used for reporting and never shared with the mothers/caregivers. The private medical practitioners in urban areas use various kinds of home-based records (i.e. immunisation record, development chart etc.) for families.

1.2.5 UNICEF's Effort

UNICEF has been for actively involved in developing a home-based record prototype for number of years. A prototype was developed by Delhi office a few years ago and pilot-tested. It was further modified and adapted by Rajasthan, Bihar and Orissa to include State-specific change. In Rajasthan, known, as *Mamta* Card has been in use for the past few years. Bihar has modified the card to incorporate adolescent care in addition to the other parameters and is called the *Dular* card. The development and adaptation of the home-based cards has been a process of continuous evolution at the UNICEF (NIPCCD, 2005)[5].

1.2.6 Features of the Current Mother Protection Card

In order to address the Government of India's focus on Early Child Care for Survival, Growth and Development and reaching out to children under-3 years, the prototype of the Card developed by UNICEF was revisited. The Card was viewed as a part of communication strategy, comprising of the Card itself with an instruction Guidebook. The Guidebook was developed to strengthen the use and effectiveness of the card. The Card focuses on an integrated approach to maternal and child health and incorporates wide ranges of messages under pregnancy care and delivery, nutrition, child health and psychology, care and development. Key features include:

- Recording (and educational) format of antenatal care, immunisation and growth chart;
- Educational format for newborn care, care during illness, breastfeeding and complementary feeding and psychosocial care.

1.2.7 Important Aspects of the Card

The important aspects of the Card are as under:

- It educates families to identify danger signs during pregnancy, delivery and for the newborn. It also highlights the arrangements, which families should make in advance should these danger signs arise.
- It states recommendations for families for care and development. It also includes developmental milestones for children 0-3 years of age based on the norms developed from a cross-sectional study conducted on 13,000 children for assessment of psychosocial development, the study was conducted in 3 region (Chandigarh, Hyderabad and Jabalpur) of India under auspices of Indian Council of Medical Research (ICMR) and WHO and came up with age percentile values across a range of 5-95 per cent for milestones for 0-6 years old. Developmental milestone are presented in the card for 75 per cent age percentile values (NIPCCD, 2005)[5].
- The card necessitates improved coordination between ICDS and health for improved pregnancy outcomes and growth and development of the children,
- It promotes use of consistent message by all ICDS and health staff in the field.

The key objective of the card is to promote adoption of key care practice by the families as well as utilisation of services through the ICDS and NRHM.

1.2.8 Development of the Card

The card had been designed as a tool for families to learn, understand and follow positive practices to achieve good health of pregnant women, young mothers and children. It contains message and pictures related to psychological care and developmental milestones of children up to 3 years. It has been developed to improve the delivery of services through the ICDS and Health system. The MCP Card aims at preventive and developmental effort. It contains information about care during pregnancy, danger signs, preparation for home

delivery, newborn care, breastfeeding, details of immunisation, vitamin A, growth chart, and care during child illness, feeding, development and development milestones, key feeding problems and possible solution and finally cares for development problems and possible solution.

1.3 Different Sections of the MCP Card

1.3.1 Maternal Care

The various components under the maternal care include:

- Essential obstetric care: Essential obstetric care include registration of pregnancy, three antenatal check-ups, recording of blood pressure and weight, administering 2 doses of TT injection and consumption of IFA tablets, one tablet a day for atleast three months (100 days)
- Care during pregnancy: Care during pregnancy depicts message and illustrations related to nutritional needs, use of iodised salt and taking atleast two hours of rest during the day;
- Danger signs during pregnancy, child birth and after delivery: Danger signs during pregnancy, child birth and after delivery includes bleeding during pregnancy, excessive bleeding during delivery or after delivery severe anemia with or without breathlessness, high fever during pregnancy or within one month of delivery, convulsions or fits, blurring of vision, headache, vomiting, sudden swelling of feet, labour pain for more than 12 hours and bursting of water bag without labour pain;
- Preparation for home delivery: Preparation for home delivery depicts the 5Cs i.e. clean hands, clean surface and surroundings, clean blade, clean umbilical cord, clean thread to tie the cord; after delivery, adoption of family planning; and dealing with an emergency, arranging for transport, and identifying hospital in advance, for taking the mother in case of an emergency.

1.3.2 Child Care

The various components under the child care include:

- Newborn care: Messages on newborn care which include keeping the baby warm, starting breastfeeding immediately after birth and ensuring exclusive breastfeeding, not to bathe the child for 7 days, keeping the child away from people who are sick, weighing child at birth, and need for special care if the child is less than 2.5kg.

- Care during illness: Care during illness covers illnesses like diarrhea, fever and Acute Respiratory Infection.
- Danger signs in a child: Danger signs in a child that need immediate attention of health workers such as weak suck or refusal to breastfed; baby unable to cry/ difficult breathing; yellow palm and soles; cold to touch and convulsions.
- Immunisation schedule: Immunisation schedule of Bacillus Calmette Guerin (BCG), Diphtheria Pertussis and Tetanus (DPT), polio, measles and hepatitis B vaccine and administration of vitamin A solution.
- Growth chart: Growth chart of boy and girl child.

1.3.3 Development Milestones and Care Practices

- Care refers to the behavior and practices of caregivers (mothers, siblings, fathers and family members) that provide food, health care, stimulation, and emotional support necessary for children's health growth and development. These practices translate food and healthcare resources in good nutrition, responsive psychosocial care and adequate health for a child. Not only the practices themselves, but also the way they are performed – with affection, with responsiveness and consistency – are critical to children's survival, growth and development. The 'care aspect' is a new addition in this card, compared to the other existing cards in the health and ICDS system.
- The illustration and messages on developmental milestones and care practices have been classified age-wise i.e. 0-6 months (0-3 months, 3-6 months); 6-12 months, 1-2 years and 2-3 years. It has messages on 'feeding behaviour', 'what mothers can do to promote growth and development in their child to develop to his/her full potential and what most children can do tells, what milestones children reach in that particular age.

1.3.4 Utility of the Card

The Card has been designed for meeting multifarious needs. The utility varies according to the clientele. They are as follow:

A Family members (mothers, fathers, mother in law, adolescent's girls and others.)

- For gaining knowledge related to children's health, nutrition and development.
- For availing services.

- For practicing optimal care behaviors.
- For monitoring and promoting growth and development of children.

B Village group/ women (Mahila mandal) groups

- As a discussion tool in meetings.
- Monitoring effective service delivery in the area.

C ANM/AWW

- For educating families about optimal health, nutrition and care practices.
- For recording information on utilisation of services.
- For appropriate referrals.

D Health and ICDS Supervisors

- For ensuring that the Card reached the targeted families.
- Effective and efficient delivery of services to the target families.
- Use of the Card is properly explained to the families.

1.4 Guidebook on Mother and Child Protection Card

In order to maximise use of MCPC, a Guide Book has been developed which is a step wise manual with illustrations not only to inform mothers and family members but to enlist them as partners in promoting child survival, growth and development by using MCP Card as a tool to learn, understand and follow positive practices for achieving good health of pregnant women, young mothers and children. The Guide Book has been made user-friendly. It is hoped that the Guide Book would help in development of knowledge, understanding and skills required for effective use of MCP Card for promotion of child survival, growth and development. Role of AWW and ANM are well defined and focused in the Guide Book. The Guide Book is a useful reference and training material under ICDS and NRHM (NIPCCD, 2013)[7].

1.5 Rationale of the Study

The Ministries of Women and Child Development (MWCD) and Health and Family Welfare (MoHFW), Government of India in collaboration with WHO and UNICEF organised a national workshop on the adoption of the WHO-CGS, in February 2007. This workshop led to a national consensus on the countrywide adoption of WHO-CGS for child growth

monitoring, in ICDS and NRHM and on the operational modalities for its rollout. Subsequently, the Government of India introduced WHO-CGS for growth monitoring of children less than five years, in both ICDS and NRHM, with effect from 15 August 2008, through a joint circular dated 6 August 2008. In order to facilitate in the roll-out of new WHO-CGS, a manual has been developed (NIPCCD, 2010)[6].

The above mentioned initiative was complemented by another decision of both the Ministers- to universally introduce a common family- retained, Mother and Child Protection Card (MCPC), which incorporates the WHO-CGS , in both ICDS and NRHM for strengthening the continuum of care from pregnancy till the child is three years old. The MCP Card was considered as an entitlement card and a counselling tool given that- (i) it links and tracks maternal, newborn and child care services and (ii) it pictorially depicts the key family and childcare services, developmental milestones and danger signs of seeking referral at various stages and hence can be used for counselling at community and family level. This Card was introduced with effect from April 1, 2010 vide a joint letter from Secretaries of both Ministries dated 25 March 2010 **(Annexure-I).** It was envisaged that the MCP Card would progressively replace the earlier *Jacchha Bacchha Card* and the earlier ICDS Mother Child Card from 1st April, 2010.

With the increase in the outreach of ICDS, as well as, NRHM under which there are monthly fixed Village Health and Nutrition Days, innumerable Village Health and Sanitation Committees, the common Card would enable the large network of ASHAs, AWWs and ANMs to converge their efforts and utilise the critical contact opportunities more effectively. Being an entitlement card, it would ensure greater inclusion of unreached groups to demand and universalise access to key maternal and child care and health services. The present study is an attempt to evaluate the usage of the MCP Card by ICDS and health functionaries.

1.6 Objectives of the Study

The objectives of the study were to:

i. Assess the knowledge and skills of AWW, ANM and ASHA on appropriate usage of MCP Card;
ii. Study the awareness of women (pregnant, lactating and mothers with children below 3 years) about the MCP Card and its importance in maternal and child care;

iii. Study the role perception of ICDS and Health functionaries with respect to MCP Card for better outreach of health and nutrition services;

iv. Study the service utilisation by the pregnant women and mothers with children below three years through the MCP Card;

v. Examine the existing interface between the ANM, AWW and ASHA with regard to the usage of MCP Card;

vi. Identify the problems and bottlenecks in effective utilisation of MCP Card.

2
REVIEW OF LITERATURE

Review of Literature

The Ministries of Women and Child Development and Health and Family Welfare recognising the importance of a single universal card for tracking all pregnant women and children upto five years has adopted it in March 2010. A prototype of the MCP Card was provided to the States so that the States adapt it as it is or after incorporating in it some state-specific informations. Since, the MCP Card has been introduced recently into the health and ICDS system, there are very few studies done to assess its usage and impact on the overall service delivery and its utilisation. However, an attempt has been made to review studies which have focused on the MCP Card and the same has been presented in the following paragraphs.

2.1 Procurement and Distribution of MCP Card

2.1.1 Availability of MCP Card

UNICEF (2012)[12] carried out a study to assess the status of rollout of WHO–CGS and common MCP Card, in ICDS and NRHM in 13 States of India, namely, Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and West Bengal. The study found that the MCP Card was available at the community level in at least 75 per cent districts of most of the sample States except in Uttar Pradesh, Rajasthan, Madhya Pradesh and Maharashtra.

NIPCCD, Regional Centre, Bangalore (2014)[9] conducted a study in Andhra Pradesh and Kerala, with an objective to appraise the status of implementation of MCP Card and review the extent of functional convergence of the services provided for maternal and child health by different stakeholders. The data was gathered from all the categories, namely, pregnant women, lactating mothers and mothers with children 6 months to 3 years and found that the supply and distribution of the MCP Card was adequate in majority (81%) of AWCs in Andhra Pradesh and Kerala. As per the observations, all those who had received the MCP Card, were utilising the MCP Card to avail the services. Irrespective of the category, all mothers i.e. pregnant, lactating and mothers of children aged 6 months to 3 years children acknowledged the timely receipt of the MCP Card and also mentioned utilising the same (NIPCCD, Regional Centre, Bangalore, 2014)[9].

NIPCCD, Regional Centre, Bangalore (2014)[9] revealed that the MCP Card was distributed by AWWs in Kerala and in Andhra Pradesh it was by ANMs (100%). However, entry on the MCP Card was primarily made by AWWs in Kerala, whereas ANMs had taken the lead in entering the same in AP.

2.1.2 Printing and Distribution of MCP Card

UNICEF (2012)[13] found that MCP Card were printed and distributed to beneficiaries through the NRHM network in most States, namely Andhra Pradesh, Bihar, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Rajasthan and West Bengal. It was printed and distributed through ICDS in Maharashtra, Odisha and Chhattisgarh. The printing and distribution of the MCP Card was through both ICDS and NRHM in Uttar Pradesh. In Maharashtra, NRHM had not endorsed the use of MCP Card. In Assam, distribution of the MCP Card was done through pooling of budgets by both Departments.

2.1.3 Factors Facilitating Usage of MCP Card

The factors that have facilitated in the usage of the MCP Card, has been mainly, its availability; logistics available for distribution and use of MCP Card for recording of services; monitoring of MCP Card included in VHND monitoring; regular review of the MCP Card at State and district level; MCP Card being used as a means of verification for disbursement of cash benefits under the IGMSY; and where printing of MCP Card has been integrated under the Project Implementation Plan (PIP) of NRHM and ICDS (UNICEF, 2012)[13].

2.1.4 Barriers in the Rollout of MCP Card

The major barriers in the rollout of MCP Card has been poor joint planning, lack of pooling of budgets and lack of monitoring of supplies. These apart, other barriers included, when rolling out of MCP Card was not identified as a priority by both the departments, namely, Health and ICDS, as in Uttar Pradesh or by either departments, as by Health department in Maharashtra or by ICDS in Bihar and Madhya Pradesh (UNICEF, 2012)[13].

2.2 Training on the MCP Card

2.2.1 Modalities of Training

UNICEF,(2012)[13] found that excluding Bihar, in all other sample states training on MCP Card was incorporated in the job and refresher training of ICDS functionaries. Orientation of AWWs to MCP Card was done in sector meetings and also it was done through integrating it with other ongoing trainings. In Gujarat, Maharashtra and Jharkhand structured training was conducted at project level. Training was conducted jointly by NRHM and ICDS upto Supervisor level in Odisha, Gujarat, Rajasthan, Jharkhand and Madhya Pradesh.

2.2.2 Training Status

NIPCCD, Regional Centre, Bangalore (2014)[9] revealed that only 48 per cent of AWWs, 70 per cent of ANMs, 45 per cent of ASHAs, 50 per cent of ICDS Supervisor and 37 per cent of CDPOs had requisite training to carry out their responsibilities especially for implementation of MCP Card in the sample states.

2.3 Awareness about the MCP Card

In a study conducted by NIPCCD,(2013)[8] on the evaluation of functioning of ASHAs in ICDS related activities, found that almost all the ASHAs, ANMs and AWWs were aware about the MCP Card and had helped the mothers in procuring them. Mothers were the holders of the MCP Card in majority of the cases.

2.3.1 Source of Information about the MCP Card

NIPCCD, Regional Centre, Bangalore (2014)[9] revealed that initially whoever is the depot holder orients the beneficiaries on the importance and usage of MCP Card. Consequently, the concerned functionary who provides the services discussed its importance in that particular context. In general, all issues related to antenatal and postnatal issues vis-a-vis services required were oriented by ANM & ASHA. In particular, the growth monitoring, nutrition for mother and child, and for effective care practices, AWWs had taken the lead to orient the mothers, for which they are responsible.

2.3.2 Place of Receiving Information about the MCP Card

More importantly, during Nutrition and Health Education (NHED) session or while receiving Take Home Ration (THR), during home visits AWWs relied to some extent on the MCP Card to talk to the mothers for need and accessing the timely services. On the other

hand, ANMs and ASHAs made an effort to orient the mothers on immunisation day. Village Health Nutrition Day (VHND) is noted to be the catchment point for both the functionaries to provide services in the respective field which they also capitalised for orienting the beneficiaries. In particular, the VHND was used to promote key family care behaviour, caution them with danger sign/high risk cases which in itself point out the joint efforts of AWWs, ANMs & ASHAs at the same level (NIPCCD, Regional Centre, Bangalore, 2014)[9].

2.3.3 Purpose of Using the MCP Card

NIPCCD, (2013)[8] reported that the MCP Card was used for explaining about ANC services; danger signs during pregnancy; preparation for delivery; dangers in newborn; weighing, plotting and counselling after weighing; childhood illnesses; as also for advising about nutrition, immunisation, JSY, etc.

2.3.4 Acceptability of MCP Card/Home Based Maternal Card

An ICMR Task Force Study on Home Based Mothers Card found that the Home Based Mother Card was acceptable to the mothers, as well as, to the health workers, as a tool for improving the quality and coverage of Maternal and Child Health (MCH) services being rendered by the Primary Health Centre {Abraham S., et al., (1991)}[1].

Thirteen centres in eight countries (Egypt, India, Pakistan, Philippines, Senegal, Democratic Yemen and Zambia) participated in the WHO collaborative study to evaluate the home-based maternal record (HBMR). The evaluation showed that use of the HBMR contributed substantially to an increase in the quality and quantity of antenatal, postnatal and inter-pregnant care of mothers. It also provided better neonatal health care. It also improved the mother's knowledge about helpful practices, as well as early identification of risk factors during and after pregnancy, referral of high-risk mothers and infants. The HBMR had an impact on the continuity of care, more women started antenatal care and continued into the postnatal and inter-pregnancy periods in HBMR areas when compared with the baseline for these areas or with control areas. Mothers, Community Health Workers (CHWs) and health professionals at referral levels found the HMBR useful {Shah, P. M., et-al., (1993)}[11] .

2.3.5 Factors Affecting Retention of MCP Card

Pahari, D.P., et al., (2011)[10] conducted a study to know the factors affecting retention of child health card in 282 households with children between one to 36 months in a rural area of Nepal. The study revealed that only 45 per cent of the respondents who were issued child health card had retained it. Younger age group of the child, mothers living nearer to health facility, mothers with knowledge on use of child health card for recording immunisation and recording growth monitoring; and mothers who were explained child health card by health worker were found significantly higher odds of retaining it.

2.4 Awareness on Maternal and Child Health Issues

2.4.1 Expected Date of Delivery (EDD)

Majority of mothers in Andhra Pradesh (85%) and Kerala (88%) were aware about their last menstrual period date. However the knowledge on expected date to delivery (EDD), the awareness was slightly better among pregnant mothers of Kerala (85%) as compared to AP (72%) (NIPCCD, Regional Centre, Bangalore, 2014)[9].

2.4.2 Regular Check-ups

Almost all mothers were aware of need for registration in the AWCs for availing the services and the awareness was noted to be higher among the pregnant mothers in AP (98%) as compared to Kerala (91%). The study found that majority (82%) of pregnant mothers were aware of significance of antenatal check-ups. Majority of pregnant mothers were also aware that four antenatal check-ups are now mandatory. The percentage of pregnant mothers who got registered in the first trimester in AWCs was found to be satisfactory (84%) (NIPCCD, Regional Centre, Bangalore, 2014)[9].

2.4.3 Danger Signs during Pregnancy

As the MCP Card portrays 'high risk' cases pictorially, which enables for screening, the extent of awareness by the mothers on these vital issues was ascertained. Over 75 per cent of mothers were able to identify that bleeding during pregnancy is a danger sign during pregnancy. As regards anaemia, 76 per cent of pregnant mothers were aware of implications of severe anaemia. 79 per cent of mothers were aware of implications of high fever. Incidentally 78 per cent of pregnant mothers were able to recognize two to three symptoms

like blurring of vision, convulsion, headache, vomiting, swelling of foot, etc also as danger sign during pregnancy. About 73 per cent of the mothers were aware about bursting of amniotic sac without the labour pains as a complication. The respondents were able to relate these complications as it is pictorially depicted in the MCP Card. The description given by them although, was not technical, but the message was clear. This clearly indicated that the MCP Card has been able to generate interest among the mothers which enabled the functionaries to orient them to its content (NIPCCD, Regional Centre, Bangalore, 2014)[9].

2.4.4 Diet during Pregnancy

Majority of the respondents were aware of need for consumption of variety of food during pregnancy. Almost all respondents stated that they consumed iodised salt regularly. A majority (98%) of the pregnant mothers received Supplementary Nutrition (SN) from AWC and consumed the same. It was also noted that 93 per cent of the pregnant mothers received counselling about the diet during pregnancy either on VHND or while receiving other services like immunisation, take home ration, home visits, etc. (NIPCCD, Regional Centre, Bangalore, 2014)[9].

2.4.5 Rest and Sleep

Nearly eighty per cent of pregnant mothers had knowledge on need for taking intermittent and sufficient rest during pregnancy (NIPCCD, Regional Centre, Bangalore, 2014)[9].

2.4.6 Institutional Delivery

Almost all the lactating women and mothers of children between 6 months to 3 years mothers reported that they opted for institutional delivery consciously (NIPCCD, Regional Centre, Bangalore, 2014)[9].

2.4.7 Janani Suraksha Yojana (JSY)

Although, institutional delivery at Government Hospitals entitles for JSY benefits, the extent of its utilization was noted to be low, as only 52 percent of mothers had registered with JSY scheme and out of which only 32 percent received the benefits in the study area (NIPCCD, Regional Centre, Bangalore, 2014)[9].

2.4.8 Postnatal Visits at Home

Most of ASHAs reported carrying out postnatal home visits, followed by ANMs, and AWWs. The visits to a postnatal mother on the 1st day, 3rd day, 7th day, 21st day and 42nd day was 81 per cent, 84 per cent, 83 per cent, 48 per cent and 30 per cent by ASHAs, it was 40 per cent, 45 per cent, 30 per cent, 15 per cent and 20 per cent by ANMs; and 36 per cent, 36 per cent, 33 per cent, 11 per cent and 10 per cent by AWWs respectively (NIPCCD, 2013)[8].

2.4.9 Child Care Practices

NIPCCD, Regional Centre, Bangalore, (2014)[9] found that 70 per cent of mothers initiated breastfeeding within one hour of birth. Ninety seven per cent of mothers reported that they got their children were weighed regularly and also made use of all the information that was disseminated to them. The study however found that, their ability to link the child's growth with the supplementary nutrition, health check-up and referral services was inadequate and their understanding to detect early changes in the child's growth, requires consistent orientation.

2.5 Feeding, Playing and Communication

It is well established that active feeding, playing and communication with children are key enablers in age appropriate growth and development of children. The significance of which is indicated in the MCP Card to promote awareness of dependent relationship between children's physical and psychosocial needs. Accordingly the AWWs are expected to orient the mothers through the MCP Card on care practices to be followed for feeding and stimulation with respect to the age of the child.

2.5.1 Perception of Functionaries

Kalita, et al. (2006)[4] carried out a study in Shivpur district, Madhya Pradesh and found that child care was a shared responsibility among family members. Most of the functionaries directly related child care to health, and again referred to caring as ensuring that immunisations were completed and the child was well fed. The issue of psychosocial care was seldom raised in the interviews and focus group discussions.

2.5.2 Perception of Beneficiaries

Kalita, G., et al. (2006)[4] found that majority of mother respondents viewed child care primarily in practical terms of feeding, cleaning and protecting their children. Mother's

perceived cleanliness as having specific importance, as it prevented illness. Mother's related good care to immunisation and a few referred to the growth chart and the green area showing good health. Many of the mothers linked caring for their babies with the time they could spend with them and perceived themselves to be good caregivers when they or their mothers-in-law could be with the child at all times. None of the mothers associated the development milestone pictures with care unless prompted, at which point, many viewed this as an important part of child care. Family involvement was perceived as an integral part of child care with mothers-in-law assisting with this more than fathers.

2.5.3 Feeding

The data gathered from lactating mothers and mothers of 6 months to 3 years children revealed that almost all the mothers were knowledgeable related to breastfeeding which should start immediately after the birth and continue till six months without any liquids, introduce supplementary foods after six months. However, in practice only 60 per cent from Andhra Pradesh and 81 percent from Kerala had initiated breastfeeding within one hour after the delivery and only 60 to 70 per cent of mothers had introduced complementary feeding after six months in recommended proportion and quantity. After one year it was noted that whatever was being prepared for other family members, the same was fed to the child. Only 26 per cent of mothers reported that they continued breastfeeding till 2 years (NIPCCD, Regional Centre, Bangalore, 2014)[9].

2.5.4 Playing and Communication

The data was obtained from mothers on knowledge about developmental milestones of children and the role of parents in enabling these processes indicated that the mothers were knowledgeable on some of the developmental milestones of children like 3 to 6 months children can hold head steadily (38%); children can sit at 9 months (42%); and children can stand by one year (27%). They were also clear that the children start speaking by one and half year (43%), and at the age of 2 and ½ years the children can point 4 body parts (68%). However, the knowledge on the type of activities to be provided to stimulate children that compliments at attaining developmental milestones was lacking. Only 20 to 30 per cent of mothers were able to report that they enabled children to reach milestones. Although they had seen on the card the pictorial representation of the same but they were not able to concretise and link it with the development of children (NIPCCD, Regional Centre, Bangalore, 2014)[9].

2.6 Advantages of the MCP Card

Kalita, G., et al. (2006)[4] found that the majority of respondents at every level stated a preference for the MCP Card over other health cards in circulation. The co-existence of other health cards was perceived to be a limitation to the use of the MCP Card by all levels of respondents. It was also found that the simultaneous use of an immunisation card was deemed to cause confusion among primary service providers and mothers.

The significance of MCP Card as a means to strengthen the continuum of care was known to 80 per cent of the respondents and they were able to appreciate the benefits of MCP Card. NIPCCD, Regional Centre, Bangalore, (2014)[9] revealed that over 80 per cent pregnant mothers, lactating mothers and mothers of 6 months to 3 years children found that MCP Card is useful for her and her family in view of the information given on the card. They also opined that MCP Card led to improved health seeking behaviour of the mothers, as well as, monitoring of the child's growth.

UNICEF, (2012)[13] found that Odisha, Assam and West Bengal are top performers in rollout of both WHO-CGS and MCP Card. However, the use of the MCP Card even in these States is restricted to services recording. NIPCCD, Regional Centre, Bangalore, (2014)[9] also found that beneficiaries were yet to use it as a tool to demand services.

2.7 Recording of Services in the MCP Card

Although the initial entry in the card is made by the person who issues (ANM /AWW) the Card to the beneficiaries, the subsequent entries are crucial in linking with the services as also for follow up by the concerned functionary. In Andhra Pradesh even though ANM is the depot holder both ANM & AWW have taken equal responsibility in making entries in MCP Card, whereas in Kerala, AWW (85%) has taken lead to make entries in MCP Card as she is the depot holder of the MCP Card (NIPCCD, Regional Centre, Bangalore, 2014)[9].

2.8 Monitoring of MCP Card

UNICEF, (2012)[13] found that monitoring the use of MCP Card was done during the VHND field monitoring visits. Focus of MCP Card monitoring was mainly on its availability; logistics available for distribution and use of MCP Card for recording of services. The study found that counselling of women using the MCP Card is at a preliminary stage and so is its monitoring. The study found that overall MCP Card was limited to recording purposes alone. Hence, only MCP Card's availability is monitored.

NIPCCD, Regional Centre, Bangalore, (2014)[9] found that the entries in the card at the village / AWC level has although been adequately made by the ANM & AWW, but the verification of these entries in MCP Card are not consciously looked into it. However, at the time of disbursement of the cash under IGMSY scheme the Supervisor or CDPO refer the MCP Card to see whether the conditions are fulfilled for cash transactions.

The role of Supervisors and CDPOs in monitoring although crucial, it was noted that the time devoted to exclusively look into the facilitation of MCP Card by AWWs or ANM s was very limited. However, they deliberated on the compliance of the MCP Card and its management at the time of mothers meeting /VHND. The study noted that the supply chain management of MCP Card needs to be fine tuned and these issues needs to be consciously reflected in the monitoring system. The visibility on counselling of mothers in particular for psycho-social stimulation needs a strong emphasis and requires forceful steering for reaching the objective of MCP Card (NIPCCD, Regional Centre, Bangalore, 2014)[9].

2.9 Role Perception of ICDS and Health Functionaries

Haider, et al., (2008)[3], found that almost all the ANMs agreed that they got help from ASHA/ Sahiya in immunisation. Some also took help in identifying pregnant women and give ANC. Similarly, almost all the ASHA/ Sahiya reported that the ANMs helped them in replenishing the drugs, as also, in getting the immunisations done for their beneficiaries. It was found that in some areas, ANMs took assistance of ASHA/ Sahiya in home visits, health education and health programmes like malaria, pulse polio etc.

2.9.1 Nature of Support provided by ASHAs in AWC Activities

NIPCCD, (2013)[8] found that the activities of ASHAs agreed with by ANMs are ‘escorting during institutional delivery’; ‘assisting in immunisation of children and pregnant women’, and ‘assisting in village survey’. Similarly, the activities of ASHAs confirmed by AWWs include ‘assisting in organising Village Health and Nutrition Days’; and ‘conducting joint home visits’. ‘Assisting AWWs in weighing of children’ has been acknowledged by the AWWs.

2.9.2 Nature of Support provided to ASHAs

NIPCCD, (2013)[8] found that the extent of support provided by ANMs in the work of ASHAs is greater than the support provided by AWWs to ASHAs. The areas wherein the ANMs and AWWs are helping out ASHAs evenly, is mainly in the 'organisation of VHND'; 'holding of weekly meetings'; 'updating eligible couple register'; and 'in organizing health camps'.

2.9.3 Nature of Assistance provided by ANMs at AWCs

As regard the nature of assistance provided in the activities of AWCs, as reported by ANMs themselves, along with the feedback from AWWs on the same, the study revealed that it has been in the form of 'referral of malnourished/sick children'; 'conducting joint home visits'; 'providing health check-up of women and children'; and in 'organising immunisation sessions' (NIPCCD, 2013)[8].

2.10 Support and Supervision

All MOs, 90 per cent LHVs and 50 per cent ANMs reported that they were providing support and supervision to ASHAs. ICDS functionaries {(Supervisors (60%); CDPOs (50%); and AWWs (40%)} also reported providing support and supervision to ASHAs. About 90 per cent of MOs, 60 per cent of LHVs and 35 per cent ANMs reported that they help ASHAs in building rapport and motivation; reviewing and verification of work; providing training and refresh or update knowledge and skills; and providing support to manage health related problems encountered. (NIPCCD, 2013)[8].

2.11 Contribution of MCP Card in Improving Interface between ICDS and Health Functionaries

NIPCCD, Regional Centre, Bangalore, (2014)[9] observed that at the state level, NRHM in Andhra Pradesh and Department of Women and Child Development in Kerala had taken lead in logistics of implementation of MCP Card. Accordingly, the respective nodal departments and concerned officials like District Magistrate and Health Officer, MO, LHV, ANM from Health department and Project Director /Programme Officer, CDPO, Supervisor and AWW from DWCD at district, project/ block, and sector and village level have taken the responsibility for implementation. In Andhra Pradesh, both ANMs & AWWs equally (86%)

had taken the lead to personally inform each other. Whereas in Kerala only 50 per cent responded that they inform personally about the distribution of the Card.

2.11.1 Joint Home Visits

Home visits are an opportunity to provide preventive, promotive and curative care. NIPCCD, Regional Centre, Bangalore, (2014)[9] found that joint visits are conducted regularly by ANMs, AWWs and ASHAs in both the sample states, namely, Andhra Pradesh and Kerala.

However, NIPCCD, (2013)[8] found that there were some discrepancies in responses of ASHAs and AWWs with regard to joint home visits. On the one hand, 86 per cent of AWWs reported that ASHAs always accompany them during the home visits and on the other hand, only 28 per cent of ASHAs reported about conducting joint home visits with AWWs. Forty five per cent of ANMs reported that ASHAs rarely accompany them during home visits.

2.12 Satisfaction with regard to MCP Card

As the mothers had received the services of JSY, IGMSY and timely immunization, over 90 per cent of them expressed that they were satisfied with the MCP Card (NIPCCD, Regional Centre, Bangalore, 2014)[9].

3
METHODOLOGY

METHODOLOGY

3.1 Institutional Review Board

A Institutional Review Board comprising experts in the fields of community health, research methodology and statistics has been constituted by the Institute for seeking approval for the all the research studies undertaken by the Institute. The Committee offered its suggestions on the design and methodology of the study and the development of tools for data collection.

3.2 Methodology

The study was conducted in six states, one each from East, West, North, South, Central and North-Eastern Region, namely, Jharkhand, Maharashtra, Haryana, Kerala, Madhya Pradesh and Assam. One district from each selected state was selected randomly. The data for the study has been collected through multi-stage stratified random sampling method. Perception of different stakeholders- ICDS (CDPOs, Supervisors and AWWs) and Health functionaries (MOs, LHVs, ANMs, ASHAs), community members/beneficiaries (pregnant women, mothers with children below six months and mothers with children between six months to three years; and family members of selected sample beneficiary) were ascertained through interviews and substantiated with observations. In all, the sample comprised 155 ICDS functionaries (12 CDPOs, 24 Supervisors and 119 AWWs); 45 health functionaries (11 Medical Officers, 12 LHVs, 22 ANMs); 116 ASHAs; 540 beneficiaries (240 pregnant women, 120 mothers with children less than six month and 180 mothers with children between six months and three years); and 60 family members of selected beneficiaries with children between six months and three years.

3.2.1 Sample Selection

The sample size for the study was as given below:

States (N=6)	**Haryana**	**Jharkhand**	**Maharashtra**	**Kerala**	**Madhya Pradesh**	**Assam**
Districts (N=6)	Gurgaon	Ranchi	Wardha	Thiruvanantha-puram	Indore	Kamrup
Blocks (N=12)	Farrukhnagar	Kanke	Deoli	Nemon	Mhow	Uparhali
	Pataudi	Namkum	Arvi	Vellanad	Depalpur	Chhaygaon
Villages (N=60)	**Block-Farukhnagar**	**Block-Kanke**	**Block- Deoli**	**Block- Nemon**	**Block-Depalpur**	**Block-** Uparhali
	Budhera	Lalganj	Kajalsara	Vilappil	Chirakhun	Kumeria
		Khatanga	Tamba	Tholicode	Dhanawara	Karipara Nowapara
	Sultanpur	Pirtaul	Wabgaon	Malayadi	Dhannad	Kallapara
	Jodikhurd	Nayatoli	Babulgaon	Pallichal		Raibori Kalitapara
		Mesra	Lathapur	Vilavoorkkal	Manchal	Palasbari
			Bhidi	Maranalloor	Bagoda	
	Farukhnagar		Sawangi	Malayinkeezh		
	Sampta		Vijaygopal	Nemon		
			Husnapur			
	Block-Pataudi	**Block-Namkum**	**Block- Arvi**	**Block-Vellanad**	**Block- Mhow**	**Block-** Chhaygaon
	Noorpur	Singusarai	Kasarkheda	Vellanad	Kodariya	Majgumi
	Mirzapur	Kalinagar	Pimpalkhuta	Mannoorkara	Melandi	Upardhania
	Nareda	Bargama	Kachnur	Aryanad	Jameli	Bortari
	Ucha Majra	Tangartoli	Kharangna	Veerankavu	Kelod	Hahsori
	Pataudi	Sindwartoli	Morangna	Tholicode	Gawali	Phulguri Khalbakal
				Kuttichal		
				Parumkulam		
ICDS Functionaries						
AWW (N=119)	20	19	20	20	20	20
Supervisor (N=24)	4	4	4	4	4	4
CDPO (N=12)	2	2	2	2	2	2

Health Functionaries						
ANM (N=22)	4	4	2	4	4	4
LHV (N=12)	2	2	2	2	2	2
Medical Officer (N=11)	2	2	1	2	2	2
ASHA (N=116)	20	17	19	20	20	20
Pregnant Women (N=240)	40	40	40	40	40	40
ICDS Beneficiaries						
Mothers with children below 6 months (N=120)	20	20	20	20	20	20
Mothers With Children between 6 months and three years (N=180)	30	30	30	30	30	30
Family Members (of selected beneficiaries with children between 6 months and three years) (N=60)	10	10	10	10	10	10

3.2.2 Tools for the Study

The following research tools were used for collecting data for the study.

Sch. No.	Category	Method of data collection	Instrument used/Tools	Parameter
1-3	**ICDS Functionaries** (CDPO, Supervisor, AWW)	In-depth Interview Schedule	Interview Schedule	-Profile of the respondents -Training status -Procurement and distribution of MCP Card -Knowledge about the MCP Card: various sections, color codes, advantages, etc. -Role perception with regard to the MCP Card -Assess the knowledge and skills in recording information and in counselling - Contribution of MCP Card in outreach and utilization of health and ICDS services - Perception about the existing interface between the ANMs, AWWs and ASHAs through the usage of MCP Card - Problems encountered and suggestions for effective utilisation of MCP Card
4-6	**Health Functionaries** (MO, LHV, and ANM)	In-depth Interview Schedule	Interview Schedule	-Profile of the respondents -Training status -Procurement and distribution of MCP Card - Knowledge about the MCP Card: various sections, color codes, advantages, etc. -Role perception with regard to the MCP Card -Assess the knowledge and skills in recording information and in counselling -Contribution of MCP Card in outreach and utilization of health and ICDS services - Perception about the existing interface between the ANMs, AWWs and ASHAs through the usage of MCP Card - Problems encountered and suggestions for effective utilisation of MCP Card

7	ASHA	In-depth Interview	Interview Schedule	-Profile of the respondents -Training status - Knowledge about the MCP Card: various sections, color codes, advantages, etc. -Role perception with regard to the MCP Card -Assess the knowledge and skills in recording information and in counselling - Contribution of MCP Card in outreach and utilization of health and ICDS services - Perception about the existing interface between the ANMs, AWWs and ASHAs through the usage of MCP Card - Problems encountered and suggestions for effective utilisation of MCP Card
8-10	**ICDS Beneficiaries** • Pregnant Women • Mothers with children upto 6 months • Mothers with children between six months and two years	In-depth Interview Schedule	Interview Schedule	-Profile of the respondents - Awareness about the MCP Card: various sections, color codes, advantages, etc. -Knowledge and practice with regard to the relevant sections in the MCP Card - Changes perceived in the health, nutrition and care aspects of self and their children after the introduction of MCP card - Contribution of MCP Card in outreach and utilisation of health and ICDS services - Perception about the existing interface between the ANM, AWW and ASHA with regard to the usage of MCP Card - Problems encountered and suggestions for effective utilisation of MCP Card
11	**Family Members** (of selected beneficiaries- mothers with children between 6 months and three years)	In-depth Interview Schedule	Interview Schedule	-Profile of the respondents -Awareness about the MCP Card: various sections, color codes, advantages, etc. -Awareness with regard to the various sections in the MCP Card

3.3 Field Testing

The tools proposed to be used in the study were field tested before the study was undertaken. The data was collected after a brief training of the investigators which aimed at making them understand: situation of maternal and child health and nutrition in India/ State with special reference to Sample States; ICDS and NRHM and its components- JSY, Janani

Sishu Suraksha Karyakram (JSSK), Integrated Management of Neonatal and Childhood Illnesses (IMNCI), Infant and Young Child Feeding (IYCF), Nutrition Rehabilitation Centre (NRC), New WHO Child Growth Standards, IGMSY, etc.; Mother and Child Protection Card- need, users, target groups, color codes, advantages, etc.; roles and responsibilities of ICDS and Health functionaries with regard to the MCP Card; interface proposed between the health and ICDS functionaries on the use of MCP card, orientation to tools/ guidelines for collection of data; etc. Consent was obtained from all sample beneficiaries before seeking any personal information.

3.4 Execution of the Study

Six research teams were deployed for data collection in the six sample States. The data for the study was collected with the help of Consultants identified in five sample States, namely, Assam, Jharkhand, Kerala, Madhya Pradesh and Maharashtra, and by NIPCCD faculty in the State of Haryana for the study. The Consultants are heading the Preventive Medicine/ Community Medicine in Medical colleges in the sample States and some have also been identified for monitoring the ICDS Projects in their States. The Consultants coordinated the data collection through their research team and sent it to the institute. The List of Project Coordinators identified for data collection at the various sample states is placed at **Annexure-III**. The Consultants collected the data in the sample States with the help of local investigators hired for the purpose and sent it to the institute. For this, detailed Guidelines for Project Coordinators were evolved by the Institute **(Annexure-IV).**

The data was collected after a brief training of the investigators by the Consultants, which aimed at making them understand- situation of maternal and child health and nutrition in India/ State with special reference to Sample States; ICDS and NRHM and its components- JSY, JSSK, IMNCI, IYCF, etc.; Mother and Child Protection Card- need, users, target groups, color codes, advantages, etc.; roles and responsibilities of ICDS and Health functionaries with regard to the MCP Card; interface proposed between the health and ICDS functionaries on the use of MCP card, orientation to tools/ guidelines for collection of data; etc. The data thus obtained was analysed and a report was prepared.

4
RESULTS AND DISCUSSION

RESULTS AND DISCUSSIONS

The findings of the study have been presented in the following heads:

4. 1 Profile of Respondents

4.2 Procurement and Distribution of MCP Card by ICDS and Health Functionaries

4.3 Orientation Training on the MCP Card by ICDS and Health Functionaries

4. 4 Awareness about MCP Card and its Maintenance among ICDS and Health Functionaries

4.5 Usage of MCP Card by ICDS and Health Functionaries

4.6 Knowledge and Awareness about Maternal and Child Health Issues

4.7 Knowledge and Awareness about Feeding, Play and Communication

4.8 Role Perception of ICDS and Health Functionaries with regard to MCP Card

4.9 Support and Supervision with regard to MCP Card

4.10 Perception about Contribution of MCP Card in Improving Interface between ICDS and Health Functionaries

4.11 Contribution of MCP Card in Outreach and Utilisation of Health and ICDS Services

4.12 Level of Satisfaction after the Usage of MCP Card

4.13 Problems Encountered during the Usage of the MCP Card

4.14 Suggestions for Effective Utilisation of MCP Card

4. 1 Profile of Respondents

4.1.1 State-wise Distribution of Respondents

In all, the sample comprised 155 ICDS functionaries (12 Child Development Program Officers (CDPOs), 24 Supervisors and 119 Anganwadi Workers (AWWs); 45 health functionaries (11 Medical Officers, 12 Lady Health Visitors (LHVs), 22 Auxilary Nurse Midwives (ANMs); 116 ASHAs; 540 beneficiaries (240 pregnant women, 120 mothers with children less than six month and 180 mothers with children between six months and three years); and 60 family members of selected beneficiaries with children between six months and three years. The State-wise distribution of respondents is presented in **Table 1.**

Table 1: State-wise Distribution of Respondents

Category of Respondents	Haryana	Jharkhand	Maharashtra	Kerala	Madhya Pradesh	Assam
	No.	No.	No.	No.	No.	No.
ICDS Functionaries						
AWWs (N=119)	20	19	20	20	20	20
Supervisors (N=24)	4	4	4	4	4	4
CDPOs (N=12)	2	2	2	2	2	2
Health Functionaries						
ANMs (N=22)	4	4	2	4	4	4
LHVs (N=12)	2	2	2	2	2	2
Medical Officers (N=11)	2	2	1	2	2	2
ASHAs (N=116)	20	17	19	20	20	20
ICDS Beneficiaries						
Pregnant Women (N=240)	40	40	40	40	40	40
Mothers with children below 6 months (N=120)	20	20	20	20	20	20
Mothers with Children between 6 months and 3 years (N=180)	30	30	30	30	30	30
Family Members (of selected beneficiaries with children between 6 months and 3 years) (N=60)	10	10	10	10	10	10

4.1.2 Age-wise Distribution of Beneficiaries

4.1.2.1 Age-wise Distribution of Beneficiaries (Pregnant women, mothers with children below 6 months and mothers with children 6 month to 3 years)

Table 2 presents the age-wise distribution of beneficiaries including pregnant women, mothers with children below 6 months and mothers with children 6 month to 3 years. Majority of the beneficiaries were in the age group 20-24 years (54.8%), followed by 25-29 years (35.7%) and 30-34 years (8.2%), indicating that the fertility levels was higher in the age

group 20-24 years. This is in line with the Sample Registration System (SRS) data of fertility levels being higher among 20-24 years age group.

Table 2: Age-wise Distribution of Beneficiaries

Age-group	Haryana (n=90)		Jharkhand (n=90)		Maharashtra (n=90)		Kerala (n=90)		Madhya Pradesh (n=90)		Assam (n=90)		Total (n= 540)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
19 to 24 years	60	66.7	52	57.8	51	56.7	31	34.4	63	70.0	39	43.0	296	54.8
25 to 29 years	27	30.0	29	32.2	33	36.6	38	42.3	25	27.8	41	45.9	193	35.7
30 to 34 years	3	3.3	7	7.8	5	5.6	18	20.0	2	2.2	9	10.0	44	8.2
35 to 39 years	0	0.0	1	1.1	0	0.0	2	2.2	0	0.0	1	1.1	4	0.7
40 to 45 years	0	0.0	1	1.1	1	1.1	1	1.1	0	0.0	0	0.0	3	0.6

4.1.2.2 Age-wise Distribution of Family Members

Table 3 presents the age-wise distribution of family members of children who have been issued MCP Card. Over 58 per cent of the family members of selected beneficiaries with children between 6 months and 3 years were above 40 years of age.

Table 3: Age-wise Distribution of Family Members

Age-group	Haryana (n=10)		Jharkhand (n=10)		Maharashtra (n=10)		Kerala (n=10)		Madhya Pradesh (n=10)		Assam (n=10)		Total (n= 60)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
20 to 24 years	1	10.0	0	0.0	1	10.0	0	0.0	0	0.0	2	20.0	4	6.7
25 to 29 years	2	20.0	1	10.0	2	20.0	2	20.0	0	0.0	3	30.0	10	16.7
30 to 34 years	2	20.0	0	0.0	4	40.0	1	10.0	1	10.0	0	0.0	8	13.2
35 to 39 years	0	0.0	2	20.0	0	0.0	1	10.0	0	0.0	0	0.0	3	5.0
40 to 45 years	3	30.0	1	10.0	0	0.0	0	0.0	4	40.0	2	20.0	10	16.7
45 years and above	2	20.0	6	60.0	3	30.0	6	60.0	5	50.0	3	30.0	25	41.7

4.1.3 Distribution of Beneficiaries by Educational Status

4.1.3.1 Distribution of Beneficiaries(Pregnant women, mothers with children below 6 months and mothers with children 6 month to 3 years) by Educational Status

Table 4 gives the distribution of beneficiaries by educational status. The distribution of beneficiaries who had passed primary school, middle school, high school, intermediate, graduate and postgraduate level was 11.1 per cent, 18.0 per cent, 25.0 per cent, 23.0 per cent, 10.0 per cent and 2.0 per cent respectively. It may be mentioned that 10.9 per cent beneficiaries were illiterate among the respondents.

Table 4: Distribution of Beneficiaries by Educational Status

Educational Status	Haryana (n=90)		Jharkhand (n=90)		Maharashtra (n=90)		Kerala (n=90)		Madhya Pradesh (n=90)		Assam (n=90)		Total (n= 540)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Illiterate	5	5.6	18	20.0	2	2.2	0	0.0	17	18.9	21	23.4	59	10.9
Primary School	7	7.7	18	20.0	5	5.6	1	1.1	18	20.0	11	12.0	60	11.1
Middle School	15	16.7	12	13.5	17	18.9	0	0.0	38	42.2	13	14.0	95	18.0
High School	23	25.6	22	25.0	29	32.2	21	23.3	11	12.3	28	31.3	134	25.0
Intermediate	21	23.3	13	14.5	28	31.1	42	46.7	4	4.4	14	16.0	122	23.0
Graduate	14	15.5	6	7.0	8	8.9	22	24.5	1	1.1	3	3.3	54	10.0
Postgraduate	5	5.6	0	0.0	1	1.1	4	4.4	1	1.1	0	0.0	11	2.0

4.1.3.2 Distribution of Family Members by Educational Status

Table 5 gives the distribution of family members by educational status. Though 26.6 per cent of family members interviewed were illiterate, it was hearting to note that over 50 per cent of family members were literate. The distribution of family members who had passed primary school, middle school, high school, intermediate and graduation was 21.7 per cent, 18.3 per cent, 10.0 per cent, 1.7 per cent and 21.7 per cent respectively.

Table 5: Distribution of Family Members by Educational Status

Educational Status	Haryana (n=10)		Jharkhand(n=10)		Maharashtra (n=10)		Kerala (n=10)		Madhya Pradesh (n=10)		Assam (n=10)		Total (n= 60)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Illiterate	6	60.0	3	30.0	1	10.0	0	0.0	5	50.0	1	10.0	16	26.6
Primary School	0	0.0	2	20.0	2	20.0	2	20.0	2	20.0	5	50.0	13	21.7
Middle School	1	10.0	2	20.0	4	40.0	1	10.0	1	10.0	2	20.0	11	18.3
High School	1	10.0	2	20.0	0	0.0	1	10.0	0	0.0	2	20.0	6	10.0
Intermediate	1	10.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	1.7
Graduate	1	10.0	1	10.0	3	30.0	6	60.0	2	20.0	0	0.0	13	21.7
Postgraduate	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

4.1.4 Details of Family Member of Beneficiaries

Table 6 depicts the family members interviewed for the study and their relationship with the child. Over 55 per cent were grandparents and over 20 per cent were fathers. Half of the family members were responding in connection with children aged 2 to 3 years (50%), followed by 1 to 2 years (30%) and 6 months to 1 years(20%).

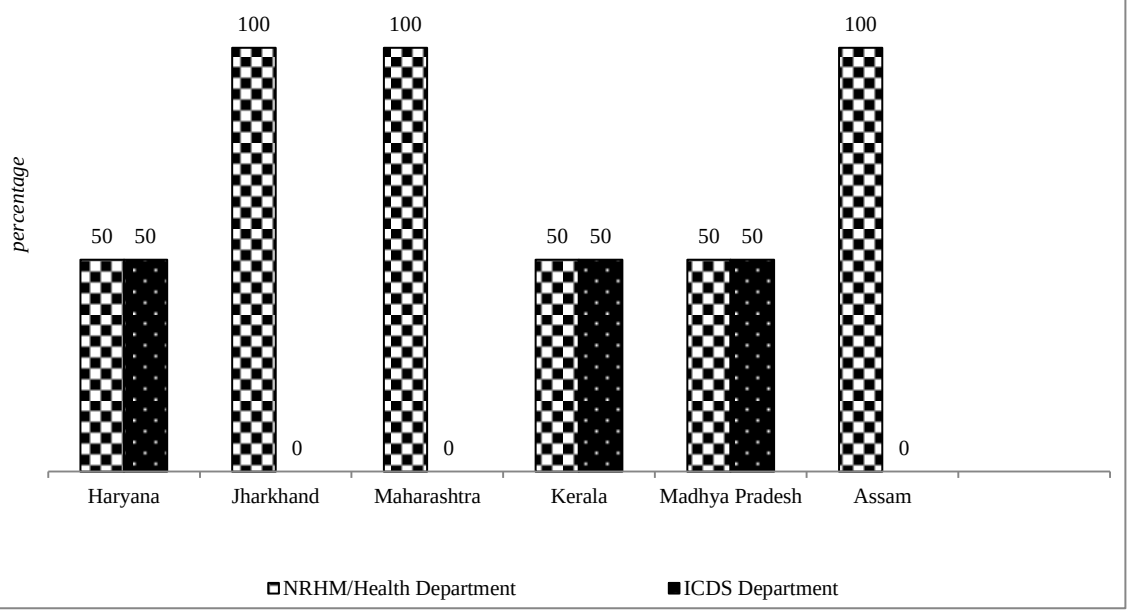
Table 6: Details of Family Members of Beneficiaries

Details of Family Members	Haryana (n=10)		Jharkhand (n=10)		Maharashtra (n=10)		Kerala (n=10)		Madhya Pradesh (n=10)		Assam (n=10)		Total (n=60)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Relationship with the child														
Father	1	10.0	3	30.0	7	70.0	1	10.0	1	10.0	0	0.0	13	21.7
Uncle/Aunt	4	40.0	0	0.0	0	0.0	3	30.0	0	0.0	0	0.0	7	11.6
Grandfather/ Grandmother	5	50.0	7	70.0	3	30.0	6	60.0	9	90.0	4	40.0	34	56.7
Niece/Nephew	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	6	60.0	6	10.0
Age of the child														
6 months to 1 year	0	0.0	0	0.0	2	20.0	0	0.0	4	40.0	6	60.0	12	20.0
1 to 2 years	0	0.0	4	40.0	8	80.0	0	0.0	4	40.0	2	20.0	18	30.0
2 to 3 years	10	100.0	6	60.0	0	0.0	10	100.0	2	20.0	2	20.0	30	50.0

4.2 Procurement and Distribution of MCP Card as Reported by Medical Officers

The procurement and distribution of the MCP Card in the sample states has been through the NRHM/Health department in Assam (100%), Jharkhand (100%); and Maharashtra (100%). Both NRHM/Health department and ICDS department were involved in the distribution of the MCP Card in the sample states of Haryana, Kerala and Madhya Pradesh, as reported by the Medical Officers (**Fig. 1).**

Fig. 1 Procurement and Distribution of MCP Card as Reported by Medical Officers



4.2.1 Distribution and Maintenance of MCP Card

4.2.1.1 As Reported by CDPOs, Medical Officers (MOs), Supervisors and Lady Health Visitors (LHVs)

Distribution and maintenance of MCP Card as reported by CDPOs and Medical Officers (MOs); Supervisors and LHVs is presented in the following **Table 7 & 8.** As reported by the ICDS functionaries, namely CDPOs and Supervisors, the MCP Card has been distributed to almost all the AWCs and is being maintained properly in over 87 per cent of AWCs. Similarly, report from the health functionaries, namely MOs and LHVs, reveal that the MCP Card has been distributed to all Sub-centres and is being maintained properly in over 92 per cent of Sub-centres. Though the report of Supervisors and LHVs {Supervisors (90.8) and LHVs (92.4)} match on the proper maintenance of MCP Card, there is over reporting observed when the responses of CDPOs and MOs {CDPOs (87.1) and MOs (96.4)} are compared.

Table 7: Distribution and Maintenance of MCP Card as Reported by CDPOs and Medical Officers (MOs)

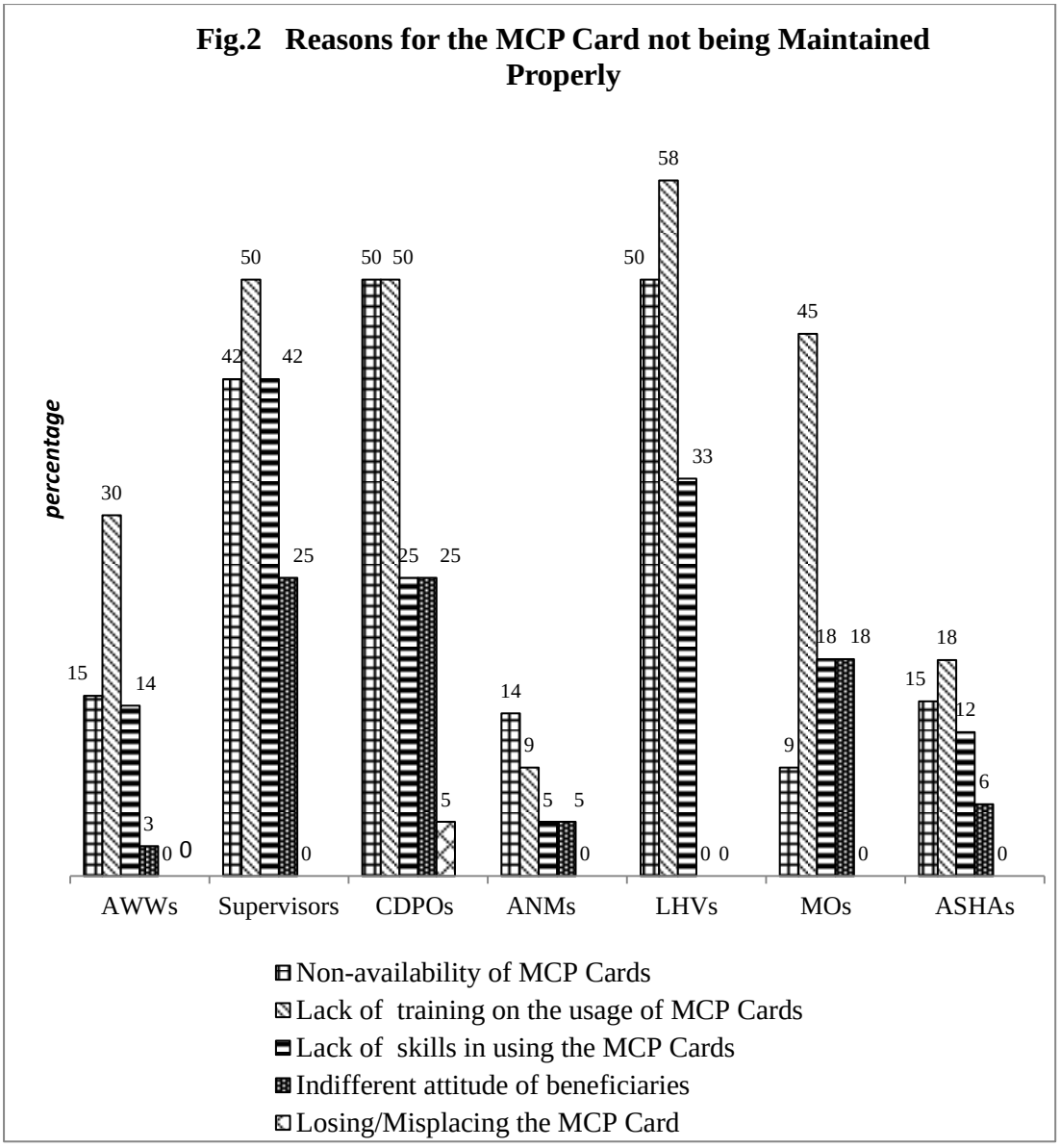
Distribution and Maintenance of MCP Card	As Reported by CDPOs (Total number of AWCs =1867)		As Reported by MOs (Total number of Subcentres=165)	
	No.	%	No.	%
Total number of AWCs/Subcentres in which MCP Cards have been distributed	1865	99.9	165	100.0
Number of AWCs/Subcentres where the MCP Cards are maintained properly	1627	87.1	159	96.4

Table 8: Distribution and Maintenance of MCP Card as Reported by Supervisors and Lady Health Visitors (LHVs)

Distribution and Maintenance of MCP Card	As Reported by Supervisors (Total number of AWCs =1076)		As Reported by LHVs (Total number of Subcentres=568)	
	No.	%	No.	%
Total number of AWCs/Subcentres in which MCP Cards have been distributed	1069	99.3	568	100.0
Number of AWCs/Subcentres where the MCP Cards are maintained properly	977	90.8	525	92.4

Fig. 2 presents the reasons given by the ICDS and health functionaries for the MCP Card not being maintained properly in the areas. The major reason for the MCP Card not being maintained properly has been the lack of training on the usage of the MCP Card (45.5%); followed by lack of skills in using the MCP Card (18.2%); indifferent attitude of beneficiaries (18.2%); non- availability of the MCP Card (18.2%); and losing/misplacing the MCP Card by the beneficiaries (9.1%).

Fig.2 Reasons for the MCP Card not being Maintained Properly



4.3 Orientation Training on the MCP Card by ICDS and Health Functionaries

Table 9 presents the information about the orientation training on MCP Card received by ICDS and health functionaries. Among the ICDS functionaries only 21.9 per cent of AWWs, 16.7 per cent of Supervisors and 58.3 per cent of CDPOs had received some kind of orientation training on the MCP Card. Among the health functionaries, 40.9 per cent of ANMs, 58.3 per cent of LHVs; 9.1 per cent of MOs and 20.7 per cent of ASHAs had received orientation training on the MCP Card, this is a serious lacuna needing urgent remedial measures. The training was imparted mainly during the sectoral meetings or was integrated into other regular trainings (WHO-CGS; IYCF, etc.). The duration of orientation training also varied across the respondents from half-a-day to five-day duration.

Table 9: Orientation Training on the MCP Card by ICDS and Health Functionaries

Orientation Training received on the MCP Card	ICDS Functionaries						Health Functionaries							
	AWWs n=119		Supervisors n=24		CDPOs n=12		ANMs n=22		LHVs n=12		MOs n=11		ASHAs n=116	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Received orientation training on the MCP Card	26	21.9	4	16.7	7	58.3	9	40.9	7	58.3	1	9.1	24	20.7
Nature of training received														
Job training	10	8.4	2	8.3	1	8.3	3	13.6	1	8.3	0	0.0	2	1.7
Refresher training	3	2.5	2	8.3	2	16.7	2	9.1	4	33.3	0	0.0	2	1.7
PHC/Sectoral meetings	20	16.8	1	4.2	2	16.7	8	36.4	4	33.3	1	9.1	22	19.0
Integrated into other training-(WHO-CGS; IYCF, etc.)	2	1.7	2	8.3	2	16.7	0	0.0	7	58.3	0	0.0	3	2.6
Duration of the training received														
Half a day	13	10.9	3	12.5	2	16.6	8	36.4	7	58.3	0	0.0	22	19.0
One day	13	10.9	3	12.5	5	41.7	4	18.2	3	25.0	1	9.1	0	0.0
Two day	2	1.7	0	0.0	0	0.0	0	0.0	2	16.7	0	0.0	0	0.0
Three day	3	2.5	1	4.2	0	0.0	0	0.0	0	0.0	0	0.0	1	0.9
Five day	2	1.7	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2	1.7

4. 4 Awareness about the MCP Card and its Benefits among ICDS and Health Functionaries and Beneficiaries

4.4.1 Awareness of Functionaries

The awareness about the MCP Card among the grassroots level workers of ICDS and health systems, mainly AWWs, ANMs and ASHAs revealed that over 90 per cent of AWWs, ANMs and ASHAs were aware about the MCP Card. About 91.6 per cent of AWWs and 95.5 per cent of ANMs and 81.9 per cent of ASHAs responded that they had helped women in getting the MCP Card. In all, 82 per cent of AWWs; 90 per cent of ANMs and 76.7 per cent of ASHAs stated that the MCP Card is being maintained properly in their areas. Mother

is mostly the custodian of the MCP Card as reported by 90.0 per cent of AWWs, 70.8 per cent of ANMs and 81.9 per cent of ASHAs **(Table 10).**

Table 10: Awareness about MCP Card among AWWs, ANMs and ASHAs

Awareness about the MCP Card	AWWs n=119		ANMs n=22		ASHAs n=116	
	No.	**%**	**No.**	**%**	**No.**	**%**
Awareness about the MCP Card	114	95.8	21	95.5	105	90.5
Helped women in getting the MCP Card	109	91.6	21	95.5	95	81.9
MCP Card is maintained properly in the area	98	82.4	20	91.0	89	76.7
Custodian of the MCP Card						
Mother	107	90.0	17	70.8	95	81.9
AWW	11	9.2	4	16.7	13	11.2

4.4.2 Awareness of Beneficiaries

The awareness about the MCP Card is presented in **Table 11**. Among the beneficiaries, the awareness level was better among mothers with children below 6 months (85.0%). Also, 67.2 per cent of mothers with children between 6 months and 3 years reported that they were explained about the MCP Card in contrast to pregnant women (59.6%), mothers with children below 6 months (60.8%) and family members (43.3%). In majority of cases, AWWs has been the source of information, followed by ASHAs. The awareness of all beneficiaries and family members regarding the validity of the MCP Card was low. About 78.8 per cent of pregnant women; 81.7 per cent of mothers with children below 6 months; 70.0 per cent of mothers with children between 6 months and 3 years; and 66.7 per cent of family members were confident about keeping the MCP Card safe. In all, 72.1 per cent of pregnant women; 73.3 per cent mothers with children below 6 months; 65.0 per cent mothers with children between 6 months and 3 years; and 51.7 per cent mothers informed that they carry the MCP Card along during their regular check-ups**.**

Table 11: Awareness of Beneficiaries and Family Members about the MCP Card

Awareness of Beneficiaries about the MCP Card	Pregnant Women N=240		Mothers with Children below 6 Months N=120		Mothers with Children between 6 Months and 3 Years N=180		Family Members N=60	
	No.	%	No.	%	No.	%	No.	%
Awareness about Mother and Child Protection Card								
Aware	193	80.4	102	85.0	148	82.2	44	73.3
Possess MCP Card								
Possess	190	79.2	98	81.7	144	80.0	43	71.7
Explained about MCP Card								
Explained	143	59.6	73	60.8	121	67.2	26	43.3
Source of information								
AWW	92	38.3	55	45.8	91	50.6	20	33.3
ANM	80	33.3	39	32.5	75	41.7	17	28.3
ASHA	82	34.2	48	40.0	80	44.4	14	23.3
Supervisor	5	2.1	2	1.7	9	5.0	2	3.3
LHV	2	0.8	3	2.5	6	3.3	2	3.3
Awareness about duration of validity of the MCP Card								
Till the child completes three years	87	36.3	40	33.3	70	38.9	14	23.3
Confident about keeping the MCP Card safe								
Confident	189	78.8	98	81.7	126	70.0	40	66.7
Take the MCP Card along during regular check-ups								
Take the MCP Card along	173	72.1	88	73.3	117	65.0	31	51.7

4.5 Usage of MCP Card by ICDS and Health Functionaries

Table 12 presents the responses of ICDS and health functionaries on the usage of MCP Card. About 95.8 per cent of AWWs and Supervisors; 95.5 per cent of ANMs; 83.3 per cent of LHVs; and 90.5 per cent of ASHAs confirmed that they were using the MCP Card. The study revealed that the usage level has been low for functionaries at the supervisory level. The MCP Card has been used mainly with the pregnant women, during the ANC visits. Often, only the relevant section in the MCP Card was explained to the beneficiaries. This may be a hindering factor, as orienting about the MCP Card in totality may convey the benefits of the Card to the beneficiaries better.

Table 12: Responses of ICDS and Health Functionaries on the Usage of MCP Card

Responses on the Usage of MCP Card	ICDS Functionaries				Health Functionaries					
	AWWs n=119		Supervisors n=24		ANMs n=22		LHVs n=12		ASHAs n=116	
	No.	%	No.	%	No.	%	No.	%	No.	%
Have used the Mother and Child Protection Card										
Yes	114	95.8	23	95.8	21	95.5	10	83.3	105	90.5
Clientele of the MCP Card										
Pregnant woman	108	90.7	22	91.7	21	95.5	9	75.0.	98	84.5
Mothers	63	52.9	14	58.3	10	45.5	4	33.3	62	53.5
Fathers	0	0.0	6	25.0	0	0.0	1	8.3	0	0.0
Both parents	9	7.6	3	12.5	3	13.6	2	16.7	15	12.9
Mother-in laws/Family members	12	10.1	7	29.2	2	9.1	1	8.3	5	4.3
When was the MCP Card used										
During ANC visits	97	81.5	19	79.2	18	81.8.	9	75.0	90	77.6
During home visits	68	57.1	13	54.2	14	63.6.	4	33.3	52	44.8
During growth monitoring sessions	50	42.0	11	45.8	8	36.4	4	33.3	34	29.3
During VHND sessions	55	46.2	14	58.3	12	54.5.	3	25.0	39	33.6
During Sectoral level meeting	44	37.0	13	54.2	8	36.4	4	33.3	27	23.3
SHG meeting	37	31.1	0	0.0	0	0.0.	0	0.0	0	0.0
Explained the relevant sections or all sections in the MCP Card										
Relevant sections	65	54.6	15	62.5	14	63.6.	8	66.7	69	59.5
All sections in the MCP Card	43	36.1	9	37.5	6	27.3	2	16.7	28	24.1
Advised to take the MCP Card during referral										
Yes	107	89.9	23	95.8	19	86.4	10	83.3	94	81.0
MCP Card helped in getting appropriate referral services										
Yes	89	74.8	23	95.8	17	77.3	10	83.3	88	75.9
Nature of help received during referrals with MCP Card										
MCP Card holder gets preference over other patients	54	45.4	15	62.5	9	40.9.	7	58.33	50	43.1
It helps in identification of complications	73	61.3	0	0.0	13	59.1	8	66.67	70	60.3
It helps in getting timely treatment	73	61.3	21	87.5	14	63.5	9	75.00	59	50.9
It helps in getting the right treatment	61	51.3	16	66.7	13	59.1	6	50.00	52	44.8
It helps in saving life	54	45.38	13	54.2	11	50.00	0	0.00	45	38.8

The purpose for using the Mother and Child Protection Card as reported by ICDS and health functionaries is presented in **Fig.3**. The MCP Card has been used by all the functionaries for explaining about – ANC services. As regards, explaining about preparation for delivery the MCP Card was used more often by LHVs. Supervisors had used the MCP Card more for weighing, plotting and counselling after weighing; explaining about danger signs in newborn and for explaining about nutrition play and communication activities. The AWWs had used the MCP Card the most for explaining about the services available under ICDS.

4.6 Knowledge and Awareness about Maternal and Child Health Issues

4.6.1 Care during Pregnancy

4.6.1.1 Knowledge of Functionaries

4.6.1.1.1 Knowledge of ANMs about Care during Pregnancy

Table 13 presents the knowledge of ANMs about care during pregnancy. It was heartening to note that over 77.3 per cent of ANMs were aware of the present minimum number of antenatal check – ups to be four. Regarding past obstetric history, the responses included anaemia (86.4%); pregnancy induced hypertension (81.8%); antepartum haemorrhage (77.3%); eclampsia (77.3%); post partum haemorrhage (77.3%); caesarean section (72.7%); and congenital abnormality (54.6%).

The knowledge of ANMs about history of chronic illnesses in the pregnant women ascertained during eliciting history include diabetes (86.4%); hypertension (81.8%); tuberculosis (68.2%); heart diseases (63.6%); other diseases such as malaria, asthma, etc. (59.1%). The study assessed the skills of ANMs on recording of findings in the MCP Card. The study revealed that recording of the illness in the MCP Card by putting a tick mark was known to only 63.6 per cent of ANMs.

The study also assessed the knowledge of ANMs regarding 'what' abdominal examinations reveal. The responses of ANMs include checking foetal movement (81.8%); baby's growth through checking the fundal height (77.3%); foetal heart rate per minute (77.3%); and lie/ presentation of the baby (59.1%).

Fig.3 Purposes for Using the Mother and Child Protection Card as Reported by ICDS and Health Functionaries

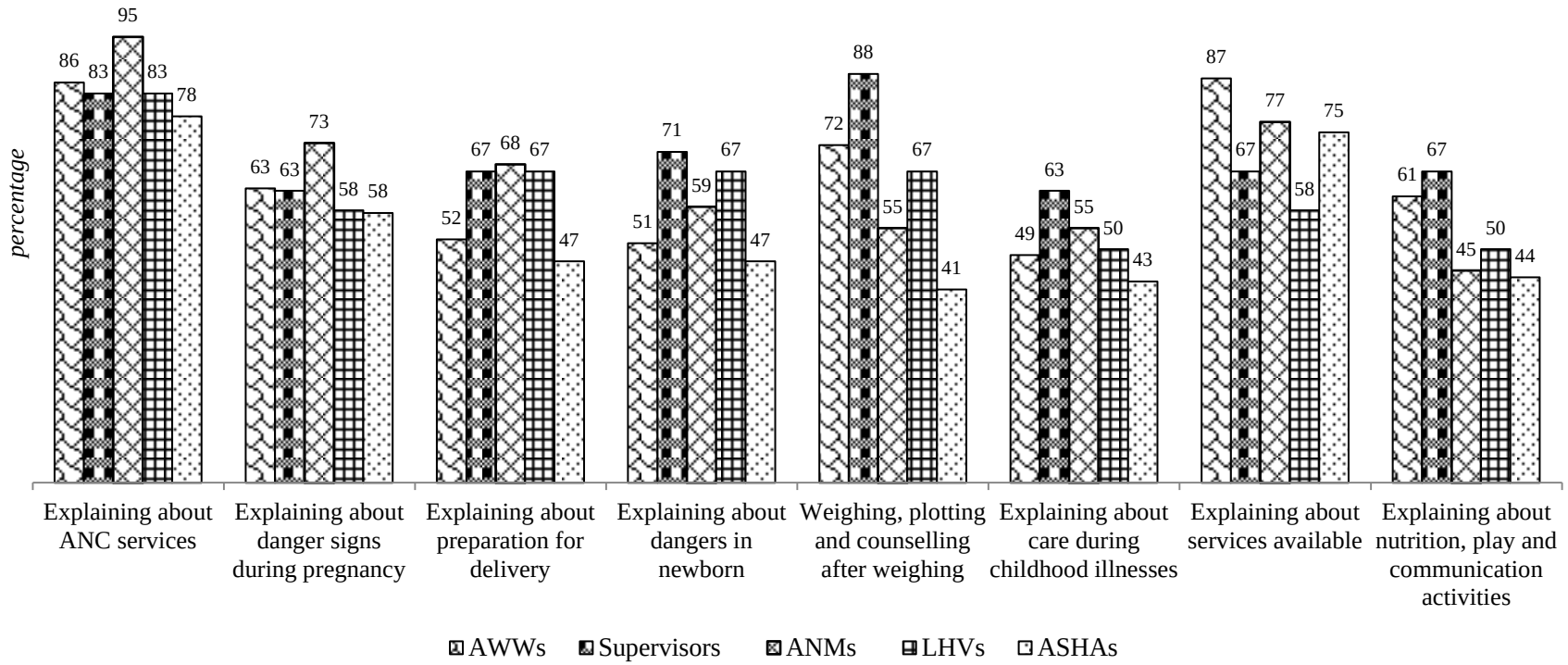


Table 13: Knowledge of ANMs about Care during Pregnancy

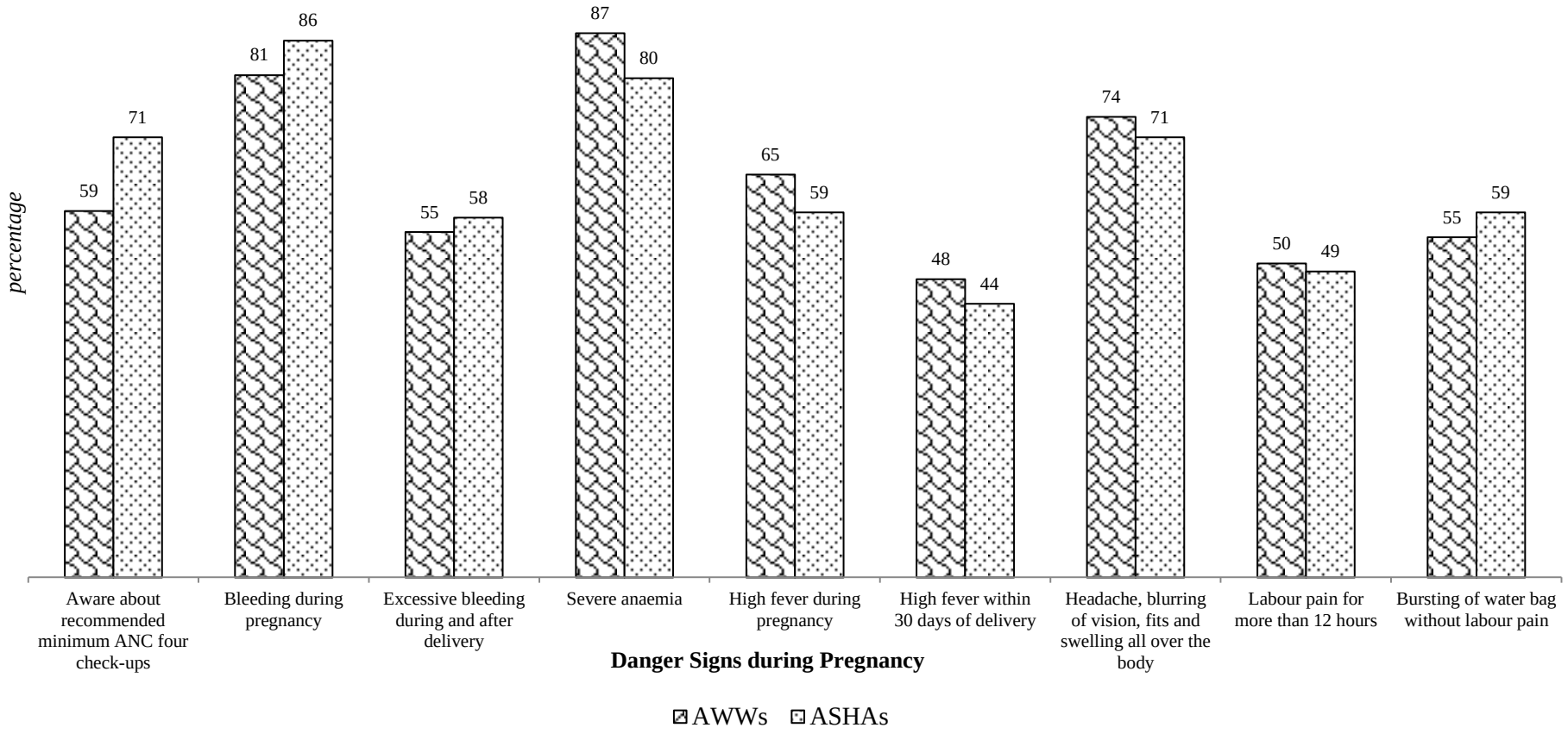
Knowledge of ANMs about Care during Pregnancy	Total (n=22)	
	No.	%
Minimum number of ANCs recommended		
Four check-ups	17	77.3
Past obstetric History		
Antepartum haemorrhage	17	77.3
Eclampsia	17	77.3
Pregnancy induced hypertension	18	81.8
Anaemia	19	86.4
Obstructed labour	13	59.1
Post partum haemorrhage	17	77.3
Caesarean section	16	72.7
Congenital abnormality	12	54.6
History of chronic illnesses		
Tuberculosis	15	68.2
Hypertension	18	81.8
Heart disease	14	63.6
Diabetes	19	86.4
Asthma, malaria, etc.	13	59.1
Recording the illnesses in the MCP Card		
By putting a tick mark	14	63.6
What does abdominal examination reveal		
Baby's growth/Fundal height	17	77.3
Lie/presentation	13	59.1
Foetal movement	18	81.8
Foetal heart rate per minute	17	77.3
Essential investigations during pregnancy		
Haemoglobin	21	95.5
Urine sugar	22	100.0
Urine albumin	19	86.4
Blood group	16	72.7
Rh typing	11	50.0
Others- HIV testing, Ultrasound, etc.	2	9.1
Recording the presence of sugar and albumin in the MCP Card		
By putting'+' or '-';	9	40.9

The knowledge of ANMs about essential investigations during pregnancy was better for checking the haemoglobin (95.5%); urine sugar (100.0%); urine albumin (86.4%) and testing blood group (72.7%). It was very low for Rh typing (50%) and other investigations, such as, HIV testing, ultrasound, etc. (9.1%). The knowledge of ANMs about recording the presence of sugar and albumin in the MCP Card was only 40.9 percent **(Table 13)**.

4.6.1.1.2 Knowledge of AWWs and ASHAs about Danger Signs during Pregnancy

Fig. 4 presents the knowledge of AWWs and ASHAs on the danger signs during pregnancy and delivery needing referral. The knowledge level of ASHAs was better than that of AWWs for the danger signs during pregnancy, namely, bleeding during pregnancy {ASHAs (86%) and AWWs (81%)}; excessive bleeding during and after delivery {ASHAs (58%) and AWWs (55%)}; and bursting of water bag without labour pain {ASHAs (59%) and AWWs (55%)}. The knowledge level of AWWs was better than that of ASHAs for danger signs namely, severe anaemia {AWWs (87%) and ASHAs (80%)}; high fever during pregnancy {AWWs (65%) and ASHAs (59%)}; high fever within 30 days of delivery {AWWs (48%) and ASHAs (44%)}; and headache, blurring of vision, fits and swelling all over the body {AWWs (74%) and ASHAs (71%)}.

Fig. 4 Knowledge of AWWs and ASHAs regarding Danger Signs during Pregnancy



4.6.1.2 Awareness and Practices of Beneficiaries

4.6.1.2.1 Awareness and Practices of Pregnant Women regarding Care during Pregnancy

Table 14 presents the awareness and practices of pregnant women regarding care during pregnancy, which is self explanatory. The awareness about Last Menstrual Period (LMP) and Expected Date of Delivery (EDD) was 97.5 per cent and 70.8 per cent respectively. The source of information about LMP and EDD was mainly ASHAs (35.4%); followed by ANMs (23.8%), AWWs (19.2%) and others including doctor, self acquired knowledge, mothers in law, etc. (6.7%). Amongst the pregnant women, roughly half were of first birth order. Majority (85%) were interviewed in their second or third trimester. Over 96 per cent of pregnant women were registered at AWCs and out of them only 60 per cent of pregnant women got registered in their first trimester. Only 24 per cent of pregnant women had the requisite recommended four antenatal check-ups. As regards, the investigations done during pregnancy, over 80 percent responded that their blood pressure, weight, blood and urine sample was checked; around 69 per cent mentioned that the abdominal examination was done; about 67 per cent stated that they had received two doses of tetanus toxoid. Only 62 per cent of pregnant women had declared that they had heard about anaemia; but 93 per cent of pregnant women were consuming iron folic acid (IFA) tablets regularly, without knowing about it. It was encouraging to note that the pregnant women were aware about their blood pressure (BP) levels. About 66.3 per cent of pregnant women stated that they were informed about their weight during the antenatal check-ups (ANCs). Only one-third pregnant women were apprised about the findings of the abdominal examination. Only half of the women were aware of normal weight gain during pregnancy.

As regards, the awareness about why abdominal examination is performed during pregnancy, the responses included- to see how the baby is growing (60.0%); to check baby's position (47.9%); to check foetal movement (45.8%); and to check foetal heart rate (35.4%).

Table 14 : Awareness and Practice of Pregnant Woman regarding Care during Pregnancy

Awareness and Practice regarding Care during Pregnancy	Haryana (n=40)		Jharkhand (n=40)		Maharashtra (n=40)		Kerala (n=40)		Madhya Pradesh (n=40)		Assam (n=40)		Total (n=240)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Awareness about LMP	36	90.0	38	95.0	40	100.0	40	100.0	40	100.0	40	100.0	234	97.5
Awareness about EDD	18	45.0	27	67.5	27	67.5	38	95.0	34	85.0	26	65.0	170	70.8
Source of information														
ASHA	3	7.5	10	25.0	1	2.5	11	28.0	21	52.5	39	97.5	85	35.4
ANM	2	5.0	7	17.5	20	50.0	5	13.0	21	52.5	2	5.0	57	23.8

AWW	1	2.5	4	10.0	3	7.5	13	33.0	20	50.0	5	12.5	46	19.2
Mother-in-law, etc.	2	5.0	10	25.0	0	0.0	0	0.0	3	7.5	1	2.5	16	6.7
Order of pregnancy														
First	30	75.0	17	42.5	18	45.0	18	45.0	16	40.0	18	45.0	117	48.8
Second	5	13.0	13	32.5	19	47.5	13	33.0	18	45.0	17	42.5	85	35.4
Third	4	10.0	8	20.0	3	7.5	9	23.0	3	7.5	3	7.5	30	12.5
Fourth	0	0.0	1	2.5	0	0.0	0	0.0	2	5.0	2	5.0	5	2.1
Fifth and more	1	2.5	1	2.5	0	0.0	0	0.0	1	2.5	0	0.0	3	1.3
Stage of pregnancy														
First Trimester (0-3 months)	1	2.5	6	15.0	2	5.0	13	33.0	6	15.0	7	17.5	35	14.6
Second Trimester (4-6 months)	19	48.0	15	37.5	16	40.0	24	60.0	12	30.0	10	25.0	96	40.0
Third Trimester (7-9 months)	20	50.0	19	47.5	22	55.0	3	7.5	22	55.0	23	57.5	109	45.4
Registered at the AWC	40	100.0	38	95.0	39	97.5	35	88.0	39	97.5	40	100.0	231	96.3
Timing of registration at the AWC														
First Trimester (0-3 months)	27	68.0	26	65.0	26	65.0	23	58.0	24	60.0	17	42.5	143	59.6
Second Trimester (4-6 months)	10	25.0	12	30.0	13	32.5	10	25.0	13	32.5	17	42.5	75	31.3
Third Trimester (7-9 months)	3	7.5	0	0.0	0	0.0	2	5.0	3	7.5	6	15.0	13	5.4
Number of check-ups done														
One	5	13/0	8	20.0	6	15.0	2	5.0	0	0.0	1	2.5	22	9.2
Two	15	38.0	14	35.0	10	25.0	3	7.5	7	17.5	4	10.0	53	22.1
Three	11	28.0	7	17.5	9	22.5	7	18.0	19	47.5	9	22.5	62	25.8
Four	9	23.0	5	12.5	5	12.5	7	18.0	8	20.0	25	62.5	59	24.6
More than four	0	0.0	4	10.0	10	25.0	21	53.0	5	12.5	1	2.5	41	17.1
Investigations done during pregnancy														
Blood pressure	29	73.0	34	85.0	36	90.0	39	98.0	37	92.5	36	90.0	211	87.9
Checking weight	26	65.0	35	87.5	35	87.5	40	100.0	37	92.5	35	87.5	208	86.7
Abdominal examinations	20	50.0	26	65.0	25	62.5	38	95.0	37	92.5	20	50.0	166	69.2
Urine test	32	80.0	34	85.0	30	75.0	40	100.0	38	95.0	37	92.5	211	87.9
Blood test	32	80.0	29	72.5	29	72.5	40	100.0	39	97.5	28	70.0	197	82.1
Ultrasound	16	40.0	19	47.5	18	45.0	40	100.0	34	85.0	7	17.5	134	55.8
Number of TT doses to be given during pregnancy														
One	2	5.0	4	10.0	27	67.5	3	7.5	5	12.5	4	10.0	45	18.8
Two	32	80.0	29	72.5	2	5.0	32	80.0	35	87.5	32	80.0	162	67.5
Three or more	6	15.0	2	5.0	4	10.0	4	10.0	0	0.0	0	0.0	16	6.7

Number of TTdoses given														
One	14	35.0	13	32.5	11	27.5	14	35.0	12	30.0	9	22.5	72	30.0
Two	26	65.0	24	60.0	26	65.0	26	65.0	27	67.5	25	62.5	154	64.2
Awareness about anaemia during Pregnancy														
Had heard about anemia	35	88.0	27	67.5	9	22.5	36	90.0	37	92.5	6	15.0	150	62.5
Given IFA tablets	40	100.0	35	87.5	33	82.5	40	100.0	37	92.5	39	97.5	223	93.0
Consumed IFA tablets regularly	40	100.0	35	87.5	33	82.5	40	100.0	36	90.0	39	97.5	223	92.9
Awareness about blood pressure (BP)														
Awareness about BP being normal or not	38	95.0	30	75.0	27	67.5	39	98.0	30	75.0	39	97.5	203	84.6
Normal weight gain during pregnancy														
10 to 12 kg	20	50.0	8	20.0	7	17.5	33	83.0	18	45.0	34	85.0	120	50.0
Weight taken during antenatal check up	40	100.0	37	92.5	40	100.0	40	100.0	36	90.0	40	100.0	233	97.1
Informed about the weight gain	16	40.0	23	57.5	28	70.0	24	60.0	28	70.0	40	100.0	159	66.3
Awareness about pre-pregnancy weight	30	75.0	16	40.0	35	87.5	28	70.0	23	57.5	39	97.5	171	71.3
Awareness about the abdominal examination done during pregnancy														
To see how the baby is growing	29	73.0	28	70.0	18	45.0	33	83.0	28	70.0	8	20.0	144	60.0
To check the baby's position	24	60.0	16	40.0	4	10.0	33	83.0	28	70.0	10	25.0	115	47.9
To check foetal movement	14	35.0	19	47.5	9	22.5	33	83.0	28	70.0	7	17.5	110	45.8
To check foetal heart rate	12	30.0	12	30.0	5	12.5	25	63.0	25	62.5	6	15.0	85	35.4
Abdominal examination done during pregnancy														
ANM shared the findings of abdominal examination	10	25.0	18	45.0	11	27.5	10	25.0	22	55.0	10	25.0	81	33.8

4.6.1.2.2 Awareness and Practices of Beneficiaries regarding Danger Signs during Pregnancy Needing Referral

Table 15 presents the awareness level of pregnant women and family members regarding danger signs during pregnancy needing referral. The study revealed that 'red colour box or words written in red letter', as danger sign, was known to only 22.5 per cent of pregnant women and 43.3 per cent of family members. The awareness level of family members regarding danger signs during pregnancy needing referral though fair, was better than that of the pregnant women. The major information source about danger signs during pregnancy needing referral was AWWs (38.3%), followed by ASHAs (35.0%) and ANMs

(31.7%) reiterating the point that the grassroots level workers need to be orientated to the MCP Card for yielding better impact.

Less than 10 per cent were referred to a higher facility during the present or previous pregnancy as reported by pregnant women. The referral source has been ASHAs (4.6%); followed by AWWs (2.5%); and ANMs (1.7%). All the cases referred visited the higher health facility wherever referred; but only 5.4 per cent out of them mentioned that they are aware that the referral history was recorded in the MCP Card.

Table 15: Awareness and Practices of Beneficiaries regarding Danger Signs during Pregnancy Needing Referral

Awareness and Practices regarding Care and Danger Signs during Pregnancy	**Pregnant Women N=240**		**Family Member N=60**	
	No.	**%**	**No.**	**%**
Awareness about 'red color box or words written in red letter				
Red denotes danger and to contact ANMs/AWWs/ASHA s immediately	54	22.5	26	43.3
Awareness about danger signs during pregnancy when ASHAs/AWWs/ANMs should be consulted				
Bleeding during pregnancy or delivery	106	44.2	26	43.3
Severe anaemia with or without breathlessness	98	40.8	25	41.7
High fever during pregnancy or within one month of delivery	84	35.0	24	40.0
Convulsions or fits	74	30.8	24	40.0
Blurring of vision	66	27.5	27	45.0
Severe headache	65	27.1	27	45.0
Sudden swelling of feet	70	29.2	26	43.3
Labour pain for more than 12 hours	68	28.3	32	53.3
Bursting of water bag without labour pain	68	28.3	29	48.3
Awareness about the MCP Card regarding the care during pregnancy				
Aware	110	45.8	26	43.3
Information source about danger signs needing Referral				
ASHA	51	21.3	21	35.0
ANM	36	15.0	19	31.7
AWW	41	17.1	23	38.3
Supervisor	4	1.7	3	5.0
LHV	5	2.1	2	3.3
Referred to a higher health facility during this or your previous pregnancies				
Referred to a higher health facility	21	8.8	3	5.0
Referral Source				

ASHA	11	4.6	1	1.7
ANM	4	1.7	1	1.7
AWW	6	2.5	1	1.7
Visited the higher facility wherever referred				
Visited the higher facility wherever referred	21	8.8	3	5.0
Referral history recorded in the MCP Card				
Recorded	13	5.4	0	0.0

4.6.1.2.3 Awareness of Pregnant Women regarding Recording of Findings of Antenatal Check-ups in the MCP Card.

Table 16 present the awareness of pregnant women regarding recording of antenatal check-ups in the MCP Card. Only 58.8 per cent pregnant women were aware about the recording of antenatal check-up in the MCP Card. The percentage of pregnant women who were able to show correctly recording of weight, blood pressure, *tetanus toxoid* (TT) injection and quantity of iron and folic acid (IFA) tablets issued were 55 per cent , 49.6 per cent, 52.5 per cent and 40.4 per cent respectively. The percentage of pregnant women who were able to show correctly the section on rest, sleep and care during pregnancy and danger signs during pregnancy was 40.8 per cent and 37.5 per cent respectively. The awareness level of pregnant women regarding recording of antenatal check-ups in the MCP Card of Kerala was better than of other sample states. The awareness level of pregnant women was found to be very low compared to the other sample states.

Table 16: Awareness of Pregnant Women about Recording of Findings of Antenatal Check-ups in the MCP Card

Awareness about recording of AN check-up	Haryana (n=40)		Jharkhand (n=40)		Maharashtra (n=40)		Kerala (n=40)		Madhya Pradesh (n=40)		Assam (n=40)		Total (n=240)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Awareness about recording of antenatal check-ups in the MCP Card														
Aware	34	85.0	14	35.0	3	7.5	35	88.0	24	60	31	77.5	141	58.8
Able to show correctly in the MCP Card the recording of findings of antenatal check-ups														
Weight	34	85.0	10	25.0	2	5.0	33	83.0	22	55.0	31	77.5	132	55
Blood pressure	27	68.0	10	25.0	2	5.0	28	70.0	22	55.0	30	75.0	119	49.6
Date when TT injection was administered	33	83.0	11	27.5	2	5.0	28	70.0	23	57.5	29	72.5	126	52.5
IFA Tablets issued	23	58.0	8	20.0	2	5.0	31	78.0	21	52.5	12	30.0	97	40.4

About diet and rest during pregnancy	23	58.0	8	20.0	2	5.0	32	80.0	22	55.0	11	27.5	98	40.8
Danger signs during pregnancy	19	48.0	7	17.5	2	5.0	32	80.0	21	52.5	9	22.5	90	37.5

4.6.2 Care during Delivery and Post Partum Period

4.6.2.1 Knowledge and Practices of Functionaries

4.6.2.1.1 Knowledge of ANMs about Delivery and Post Partum Care

The knowledge of ANMs regarding care during delivery and post partum period is presented in **Table 17**. It was encouraging to note that over 90 per cent of ANMs could define preterm delivery. Recommended postnatal visit for a mother and child, in case of a normal delivery, and in low birth babies was known to only 50 per cent of ANMs. The knowledge level of ANMs in Jharkhand and Maharashtra was much better than the other sample states, followed by Assam, Maharashtra and Haryana, where the knowledge about components of postnatal care among ANMs needs updating, if we want to bring down the MMR (Maternal Mortality Ratio) in the country.

Table 17: Knowledge of ANMs about Care during Delivery and Post Partum Period

Knowledge of ANMs	Total (n=22)	
	No.	%
Preterm delivery		
Delivery before 37 week	20	90.9
Recommended postnatal visits to mother and newborn baby		
Four visits	11	50.0
Recommended extra postnatal visits to low birth weight baby		
Three visits	12	54.5
Components of postnatal care		
Pallor	15	68.2
Pulse	16	72.7
Blood pressure	19	86.4
Temperature	20	90.9
Breast feeding	18	81.8
Nipple	16	72.7
Uterus tenderness	12	54.5
Bleeding per vagina	16	72.7
Lochia	13	59.1
Episiotomy	14	63.6
Convulsion	13	59.1

Loss of conscious	10	45.5

4.6.2.1.2 Knowledge of AWWs

Table 18 depicts the knowledge of AWWs on information to be filled in the MCP Card after delivery. The knowledge of AWWs on the information to be filled in the MCP Card revealed that majority were aware about filling-in of the date and time of delivery (79.0%); weight of the baby (78.2%); sex of the baby (70.6%); place of delivery (68.9%); and type of delivery (62.2%). However, the level of knowledge was not very encouraging as regards, the time of initiation of breastfeeding (48.7%); term/ pre-term (42.9%); about child's cry at the time of birth (38.7%); about the complications (34.5%); and period of stay post delivery (27.7%). There is a dire need for orienting the AWWs on the above issues as other-wise, the purpose of MCP Card would be lost.

Table 18: Knowledge of AWWs on Information to be Filled-in the MCP Card after Delivery

Knowledge of AWWs	Haryana (n=20)		Jharkhand (n=19)		Maharashtra (n=20)		Kerala (n=20)		Madhya Pradesh (n=20)		Assam (n=20)		Total (n=119)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Date and time of delivery	9	45.0	17	89.5	9	45.0	19	95.0	20	100.0	20	100.0	94	79.0
Place of delivery	11	55.0	18	94.7	6	30.0	18	90.0	17	85.0	12	60.0	82	68.9
Type of delivery	8	40.0	15	79.0	5	25.0	16	80.0	16	80.0	14	70.0	74	62.2
Term/preterm	4	20.0	14	73.7	2	10.0	15	75.0	13	65.0	3	15.0	51	42.9
Period of stay post delivery	2	10.0	5	26.3	2	10.0	11	55.0	11	55.0	2	10.0	33	27.7
Complications, if any	3	15.0	8	42.1	4	20.0	16	80.0	10	50.0	0	0.0	41	34.5
Sex of the baby	9	45.0	17	89.5	5	25.0	15	75.0	19	95.0	19	95.0	84	70.6
Weight of the baby	7	35.0	18	94.7	9	45.0	20	100.0	19	95.0	20	100.0	93	78.2
Child's cry immediately after birth	2	10.0	4	21.1	0	0.0	13	65.0	11	55.0	16	80.0	46	38.7
Time of initiation of breastfeeds	1	5.0	10	52.6	4	20.0	15	75.0	14	70.0	14	70.0	58	48.7

4.6.2.2 Responses of Beneficiaries

4.6.2.2.1 Responses of Beneficiaries regarding Care after Delivery

Table 19 present the responses of mothers with children below 6 months and mothers with children 6 months and 3 years, on the care received after delivery. It was heartening to

note that about 70 per cent of deliveries were conducted in the government infrastructure. Roughly half of the beneficiaries were registered under Janani Suraksha Yojana (JSY) and the cash assistance was received by nearly 40 per cent. About 67.5 per cent of mothers with children below six months and 72.2 per cent of mothers with children between 6 months and 3 years responded that ASHAs had frequented them at home, after delivery. The requisite number of four postnatal visits after delivery was received by only by 23.3 per cent of mothers with children below 6 months and 36.1 per cent of mother with children between 6 months and 3 years.

Table 19: Awareness and Practices of Beneficiaries regarding Care after Delivery

Awareness and Practice regarding Care after Delivery	Mothers with Children below 6 Months N=120		Mothers with Children between 6 Months and 3 Years N=180	
	No.	%	No.	%
Place of delivery				
Home	8	6.7	13	7.2
Govt. hospital/PHC/CHC	83	69.2	128	71.1
Private institution	29	24.2	39	21.7
Registered under JSY				
Registered under JSY	63	52.5	84	46.7
Received cash assistance under JSY				
Cash assistance received	49	40.8	73	40.6
Workers visited you and your child at home after childbirth				
ANM	50	41.7	74	41.1
AWW	71	59.2	92	51.1
ASHA	81	67.5	130	72.2
LHV	7	5.8	10	5.6
Supervisor	1	0.8	6	3.3
Number of times you were visited after delivery				
Four times	28	23.3	65	36.1
Seven times	11	9.2	2	1.1

4.6.3 Newborn Care

4.6.3.1 Knowledge and Practices of Functionaries

4.6.3.1.1 Knowledge of ANMs about Newborn Care

Table 20 depicts the knowledge of ANMs about newborn care. The responses on the components of monitoring newborn include fever (86.4%); urine passed (81.8%);diarrhoea (81.8%); vomiting (77.3%); stool passed (72.7%); jaundice (72.7%); chest in-drawing (68.2%) ; convulsions; sucking good or poor; (63.6 per cent each); condition of umbilical cord; activity monitoring (59.1 per cent each); and skin pustules–present or absent (54.6%).

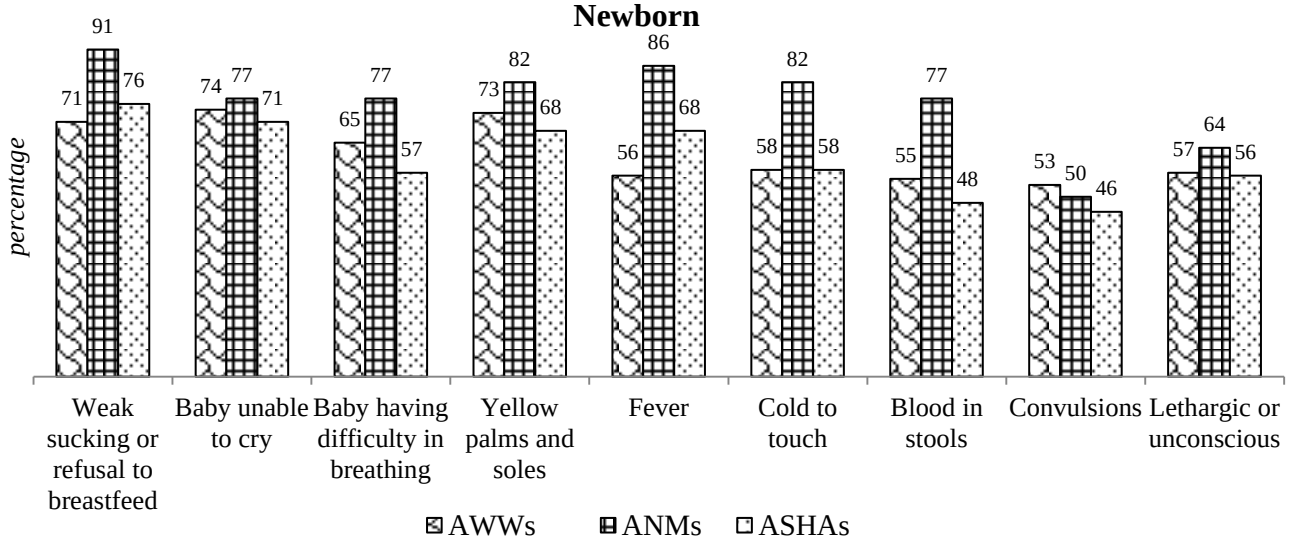
Table 20: Knowledge of ANMs about Newborn Care

Knowledge of ANMs about Newborn Care	Total (n=22)	
	No.	%
Components of monitoring newborn		
Urine passed	18	81.8
Stool passed	16	72.7
Diarrhoea	18	81.8
Vomiting	17	77.3
Convulsions	14	63.6
Activity-good/lethargic	13	59.1
Sucking good/poor	14	63.6
Chest indrawing	15	68.2
Temperature	19	86.4
Jaundice	16	72.7
Condition of umbilical stump	13	59.1
Skin pustules present/absent	12	54.6
Others-weight checking	1	4.6

4.6.3.1.2 Knowledge of AWWs, ANMs and ASHAs about Danger Signs in a Newborn

Fig.5 presents the knowledge of AWWs, ANMs and ASHAs on the danger signs in a newborn. The knowledge of ANMs was better than that of AWWs and ASHAs for all danger signs in a newborn. The knowledge of ANMs was better than that of AWWs and ASHAs as regards to danger signs, such as, baby unable to cry {ANMs (77%), AWWs (74 %) and ASHAs (71%)}; baby having difficulty in breathing {ANMs (77%), AWWs (65 %) and ASHAs (57%)}; yellow palm and soles { ANMs (82%), AWWs (73%) and ASHAs (68%)}; blood in stools {ANMs (77%), AWWs (55%) and ASHAs (48%)}; convulsions {ANMs (50%), AWWs (53%) and ASHAs (46%)}; and lethargic/unconscious {ANMs (64%), AWWs (57%) and ASHAs (56%)}; fever {ANMs (86%), ASHAs (68%) and AWWs (56%)}; weak sucking or refusal to breastfeed {ANMs (91%), ASHAs (76%) and AWWs, (71%)} and cold to touch both {ANMs (82%), AWWs (58%) and ASHAs (58%)}.

Fig 5. Knowledge of AWWs, ANMs and ASHAs about Danger Signs in a Newborn



4.6.4.1 Awareness and Practices of Beneficiaries

The awareness and practices of mothers with children below 6 months; mother with children between 6 months and 3 years; and family members regarding care of newborn is presented in **Table 21.** Only 25.8 per cent of mothers with children below 6 months; 50.6 per cent of mothers with children between 6 months and 3 years and 40 per cent of family members were aware about what is written in the MCP Card regarding the care of newborn. On the whole, the awareness of beneficiaries regarding 'danger signs in a newborn needing referral' was better than for the 'general care of newborn'. But red letters denoting 'danger' and that health worker needs to be contacted immediately was known to less than 26.1 per cent of mothers with children between 6 months and 3 years. The data also revealed that about 28.3 per cent of mothers with children between 6 months and 3 years reported that they were referred to a higher health facility. ASHA has been the main source of information for such referral. Out of these, 20.5 per cent had complied with the advice and 18.8 per cent of mothers with children between 6 months and 3 years knew that the referral history was recorded in the MCP Card. The awareness level among the other beneficiary groups, namely mothers with children below 6 months and the family members as regards these indicators was abysmally low, pointing towards the need for better orientation.

4.6.3.4.1 Awareness and Practices of Beneficiaries regarding Care of Newborn

Table 21: Awareness and Practices of Beneficiaries regarding Care of Newborn

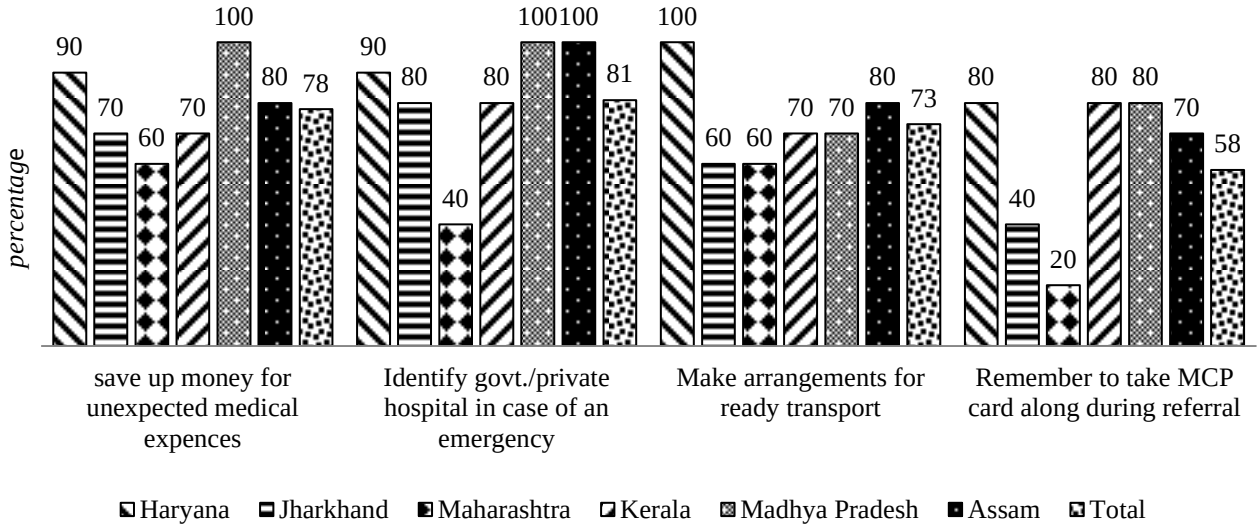
Awareness and Practices regarding Care of Newborn	Mothers with Children below 6 Months N=120		Mothers with Children between 6 Months and 3 Years N=180		Family Members N=60	
	No.	%	No.	%	No.	%
Awareness about what is written in the MCP Card regarding the care of a newborn baby						
Aware	31	25.8	91	50.6	24	40.0
Knowledge about newborn care						
Keep the child warm	28	23.3	87	48.3	25	41.6
Start breastfeeding within one hour of birth	29	24.2	86	47.8	25	41.6
Exclusive breastfeeding for the first 6 months	27	22.5	85	47.2	24	40.0
Do not bathe the child for the first 48 hours	14	11.7	64	35.6	16	26.6
Keep the cord dry	15	12.5	65	36.1	18	30.0
Keep the child away from people who are sick	18	15.0	62	34.4	18	30.0
Weigh the child at birth	18	15.0	59	32.8	15	25.0
Give special care if child weighs less than 2.5 kgs. at birth	14	11.7	55	30.6	11	18.3
Awareness about red color box or words written in red letters mean						
Red denotes danger and to contact ANM/AWW/ASHA immediately	12	10.0	47	26.1	10	16.6
Awareness about danger signs in a newborn needing referral						
Weak suck or refuses to breastfeed	33	27.5	110	61.1	39	65.0
Baby unable to cry/difficult breathing	29	24.2	107	59.4	44	73.3
Yellow palms and soles	27	22.5	105	58.3	41	68.3
Fever/cold to touch	14	11.7	109	60.5	34	56.6
Blood in stools	15	12.5	87	48.3	33	55.0
Convulsions	18	15.0	83	46.1	29	48.3
Lethargic or unconscious	18	15.0	61	33.8	30	50.0
Referred to a higher health facility						
Referred	11	9.2	51	28.3	3	5.0
Source of information about danger signs in newborn needing referral						
ASHA	13	10.8	68	37.7	1	1.6

ANM	9	7.5	59	32.7	1	1.6
AWW	12	10.0	50	27.7	1	1.6
Supervisor	0	0.0	4	2.2	0	0.0
LHV	0	0.0	4	2.2	0	0.0
Visited the higher facility wherever referred						
Visited the higher facility wherever referred	9	7.5	37	20.5	3	5.0
Referral history recorded in the MCP Card						
Recorded	5	4.1	34	18.8	0	0.0

4.6.3.4.2 Perception of Family Members on the Provisions to be made in Case of Emergency

One of the measures under the NRHM for reducing the maternal deaths has been to reduce the delay on the part of the family members to take the women and children to the higher health facility, in case of an emergency. **Fig. 6** depicts the perception of family members on the provisions to be made in case of an emergency. The provisions to be made in case of an emergency related to women and children included saving up money for unexpected medical expenses (78%); identifying government/ private hospital (81%); making arrangements for transportation of women and children (73%); and remembering to take MCP Card along with them during referral (58%). The awareness levels among the functionaries, as well as the beneficiaries, could be improved for a better impact by stressing on the MCP Card as a referral tool.

Fig. 6 Perception of Family Members on the Provisions to be made in Case of an Emergency



4.6.4 Child Care

4.6.4.1 Knowledge and Practices of Functionaries

4.6.4.1.1 Knowledge of AWWs, ANMs and ASHAs on Feeding and Care of Young Children

The knowledge of AWWs, ANMs and ASHAs on some of the parameters of feeding and care of young children were ascertained using some 'true and false' statements. The result of the same is presented in **Table 22**. On the whole, ASHAs had scored better than AWWs and ANMs for most of the parameters, such as, initiation of breastfeeding within an hour of birth {ASHAs (93.9%), AWWs (91.6%) and ANMs (87.5%)}; babies should be fed 8 to 10 times during day and night {ASHAs (93.9%), AWWs (86.5%) and ANMs (83.3%)}; and a child over one year need to be dewormed biannually (ASHAs (78.4%), ANMs (75.0%) and AWWs (74.7%). The knowledge level of ANM was better than that of ASHAs and AWWs for parameters, namely, breastfeeding can be continued upto 2 years or beyond {ANMs (83.3%), ASHAs (79.3%) and AWWs (74.7%)}; and the vaccines given at birth are Bacillus Calmette Guerin (BCG), Oral Polio Vaccine (OPV) and Hepatitis B {ANMs (91.6%), ASHAs (81.9%) and AWWs (75.6%)}. The knowledge level of all grassroots level workers need updating for parameters such as, child does not need water in summer along with breast milk in the first six months; breastfeeding should not be stopped during diarrhoeal episodes; and that iodised salt is good for health, as still 20-30 per cent of grassroots workers do not have right knowledge.

Table 22: Knowledge of AWWs, ANMs and ASHAs on Feeding and Care of Young Children

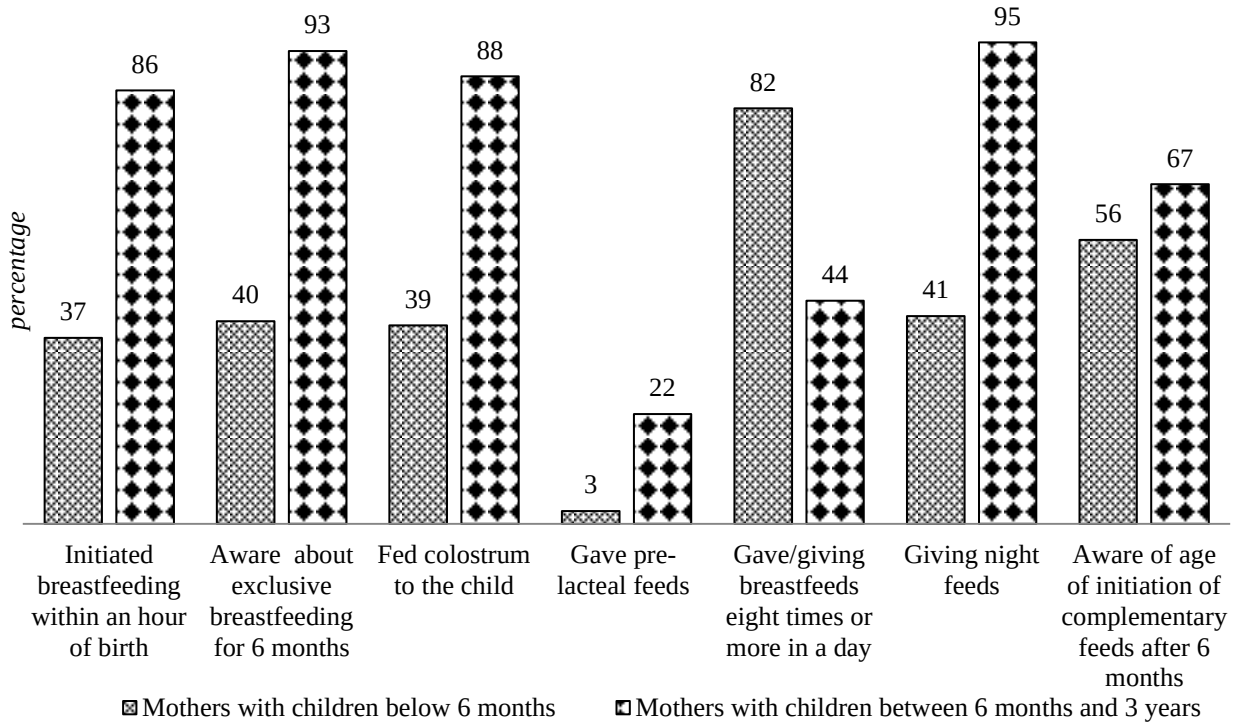
Knowledge of AWWs, ANMs and ASHAs on Feeding and Care of Young Children	AWWs N=119		ANMs N=24		ASHAs n=116	
	No.	%	No.	%	No.	%
Breastfeeding to be initiated as early as possible within one hour.	109	91.6	21	87.5	109	93.9
A child needs water in summers along with breast milk in the first six months.	29	24.3	7	29.1	32	27.5
Babies should be breastfed 8-10 times during day and night.	103	86.5	20	83.3	109	93.9
Breastfeeding should be stopped during diarrhoea.	21	17.6	7	29.1	35	30.1
Child needs extra food after illness.	83	69.7	15	62.5	73	62.9
Iodised salt is not good for health.	32	26.8	2	8.3	39	33.6
A child between 2 and 3 years should be fed at least 5 times a day.	107	89.9	21	87.5	93	80.1
Breastfeeding can be continued upto 2 years or beyond.	89	74.7	20	83.3	92	79.3
The vaccines given at birth are the vaccines are BCG, OPV and Hepatitis B.	90	75.6	22	91.6	95	81.9
A child over one year need to be dewormed biannually (twice in a year)	89	74.7	18	75.0	91	78.4

4.6.4.2 Awareness and Practices of Beneficiaries

4.6.4.2.1 Awareness and Practices of Beneficiaries regarding Breastfeeding and Complementary Feeding

The awareness and practices of mothers with children below six months and mothers with children between six months and three years was ascertained regarding breastfeeding and complementary feeding **(Fig. 7).** It was heartening to note that about 86.0 per cent of mothers with children below six months had initiated breastfeeding within an hour after birth. Awareness about exclusive breastfeeding for mothers with children between six months and three years was 93.0 per cent. The study revealed that the practice of giving pre–lacteal feeds; feeding colostrum; breastfeeding eight times or more; giving feeds at night; and introduction of complementary feeds after six months as reported by mothers with children between six months and three years was 22.0 per cent; 88.0 per cent; 44.0 per cent; 95.0 per cent; and 68.0 per cent respectively. There is a need to update mothers on all issues relating to breastfeeding and complementary feeding for yielding better results.

Fig. 7 Awareness and Practices of Beneficiaries regarding Breastfeeding and Complementary Feeding



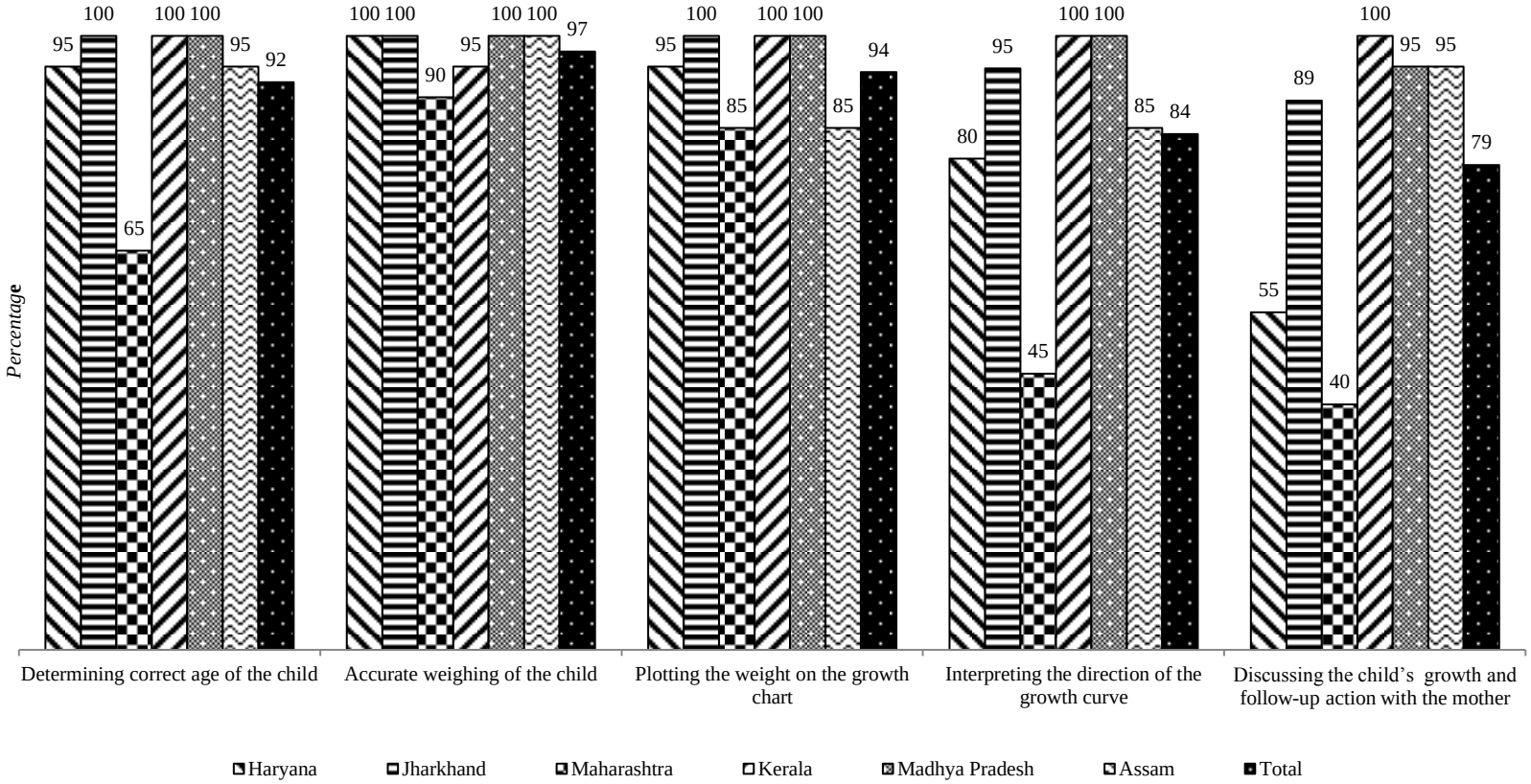
4.6.5 Growth Monitoring and Promotion

4.6.5.1 Knowledge and Practices of Functionaries

4.6.5.1.1 Knowledge and Practices of AWWs on Growth Monitoring and Promotion

As regards the knowledge and practices of AWWs on the steps in growth monitoring, it was heartening to note that majority of the AWWs were knowledgeable as regards determining the correct age of the child (92%); accurate weighing of the child (97%); plotting the weight on growth chart (94%); interpreting the direction of the growth curve (84%); and discussing the child; growth and follow up actions with the mother (79%) **(Fig. 8).**

Fig. 8 Knowledge and Practices of AWWs on Growth Monitoring and Promotion



4.6.5.2 Perception of Beneficiaries

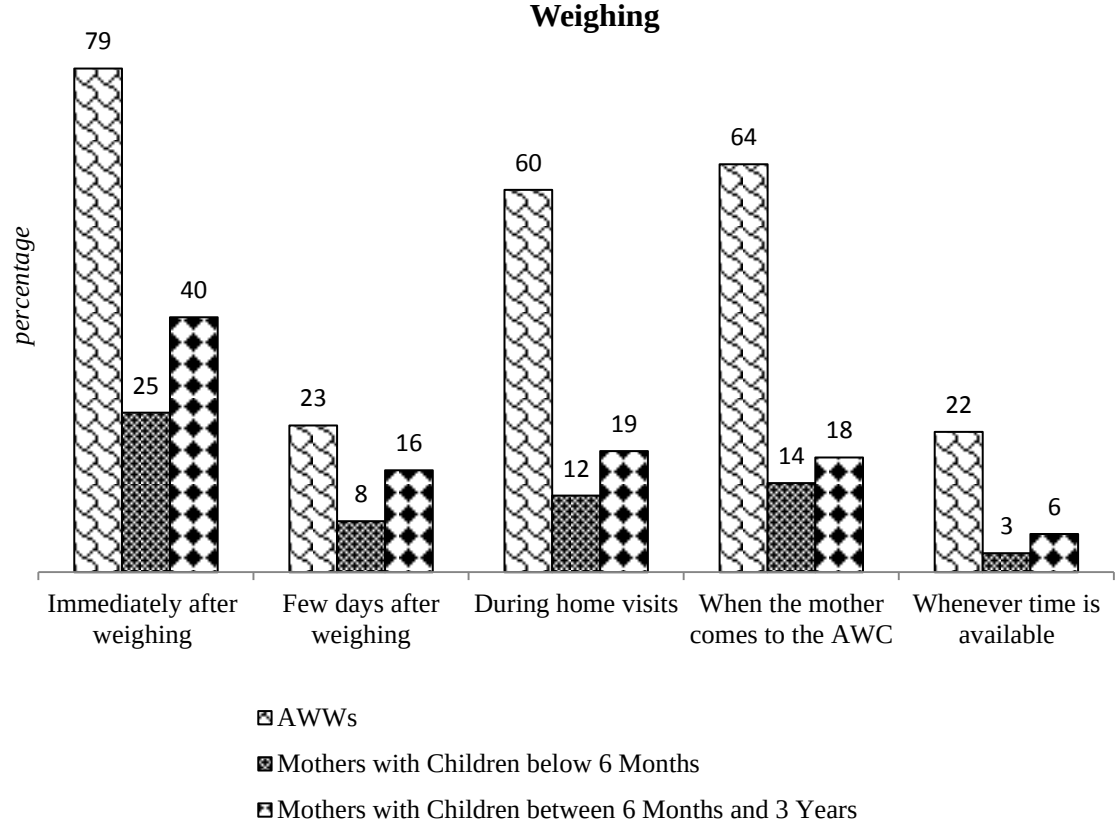
4.6.5.2.1 Perception of Beneficiaries regarding Growth Monitoring and Promotion

Table 23 presents the awareness and practices of beneficiaries on growth monitoring and promotion. About 91.6 per cent of mothers with children below 6 months and 96.1 per cent of mothers with children between 6 months and 3 years had got their child weighed at birth. The birth weight was known to 75.8 per cent of mother with children below 6 months and 74.4 per cent of mothers with children between 6 months and 3 years. Roughly 24 per cent of babies were of low birth weight, i.e. weighing less than 2500 gms. Only 56.6 per cent mothers with children below 6 months and 67.2 per cent mothers with children between 6 months and 3 years knew that the child under six months needs to be weighed monthly. The awareness about the colour of the growth chart i.e. pink chart for girl was known to only 12.5 per cent of mothers below six months and 21.1 per cent mothers with children between 6 months and three years; and blue chart for boys was known to only 16.6 per cent of mothers with children below 6 months and 21.6 per cent of mothers with children between 6 months and three years. This is a serious lacuna and needs to be addressed squarely. Further, only 31.6 per cent of mothers with children below 6 months and 45.5 per cent of mothers of children 6 months and 3 years confirmed that the AWWs had discussed the growth chart with them.

Table 23: Awareness and Practices of Beneficiaries regarding Growth Monitoring and Promotion

Awareness and Practices regarding Growth Monitoring and Promotion	Mothers with Children below 6 Months N=120		Mothers with Children between 6 Months and 3 Years N=180	
	No.	%	No.	%
Child weighed at birth	110	91.6	173	96.1
Awareness about weight of the child at birth				
Less than 2500gms	29	24.1	43	23.8
More than 2500gms	91	75.8	134	74.4
Awareness about how often should a child under 6 months be weighed				
Every month	68	56.6	121	67.2
Knowledge about Color of the Growth Chart to be Used for Boys and Girls				
Pink chart for girls	15	12.5	38	21.1
Blue chart for boys boys	20	16.6	39	21.6
AWW discussed the growth chart	38	31.6	82	45.5

Fig. 9 Responses of AWWs and Beneficiaries on Timing of Discussing the Growth Curve of the Child with the Mother after Weighing



Responses of AWWs on timing of discussing the growth curve of the child with the mother after weighing include, immediately after weighing (79%); when mother comes to the AWCs (64%); during home visits (60%); few days after weighing (23%); and whenever time is available (22%). The growth curve if not discussed immediately loses its importance and timely action. This issue has to be taken up during the supervisory visits by the Supervisors

The timing of discussing the growth chart varied with only 25 per cent of mothers with children below 6 months and 40 per cent of mothers with children between 6 months and 3 years affirming that the AWWs discussed the growth chart with them immediately after weighing. The other responses, namely, discussing the growth chart after few days of weighing; during home visits; when the mother comes to the AWCs and whenever AWWs finds time, are quite worrisome, as the essence of growth monitoring and promotion is lost with such practices. Another stark finding was that there was gross over reporting by the AWWs about the timing of discussing the growth chart, which was not corroborated by the beneficiaries. **(Fig. 9).**

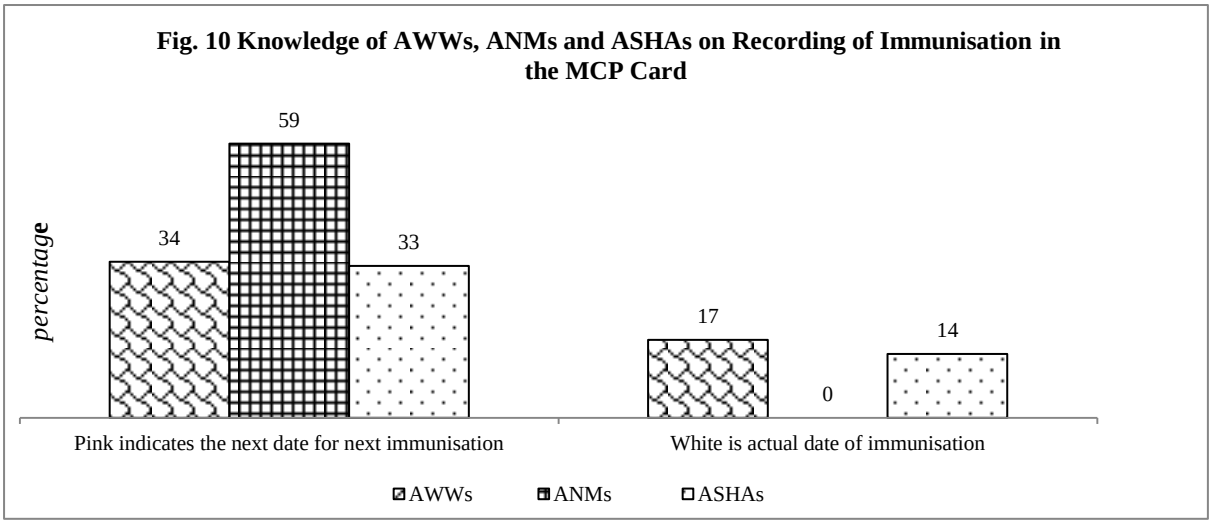
4.6.6 Immunisation

4.6.6.1 Awareness of Functionaries

4.6.6.1.1 Awareness of AWWs, ANMs and ASHAs regarding Immunisation in the MCP Card

The skill of AWWs, ANMs and ASHAs related to recording of immunisation in the MCP Card was assessed. Only 34 per cent of AWWs, 59 per cent of ANMs and 33 per cent of ASHAs could mention that pink colour indicate the next date of immunisation. White colour representing the actual date when the child is immunised was known to only to few functionaries. The low awareness level of the grassroots level workers can be attributed to the fact that the MCP Card used in State not having such colour demarcation, as in the prototype MCP Card provided to the States **(Fig. 10).**

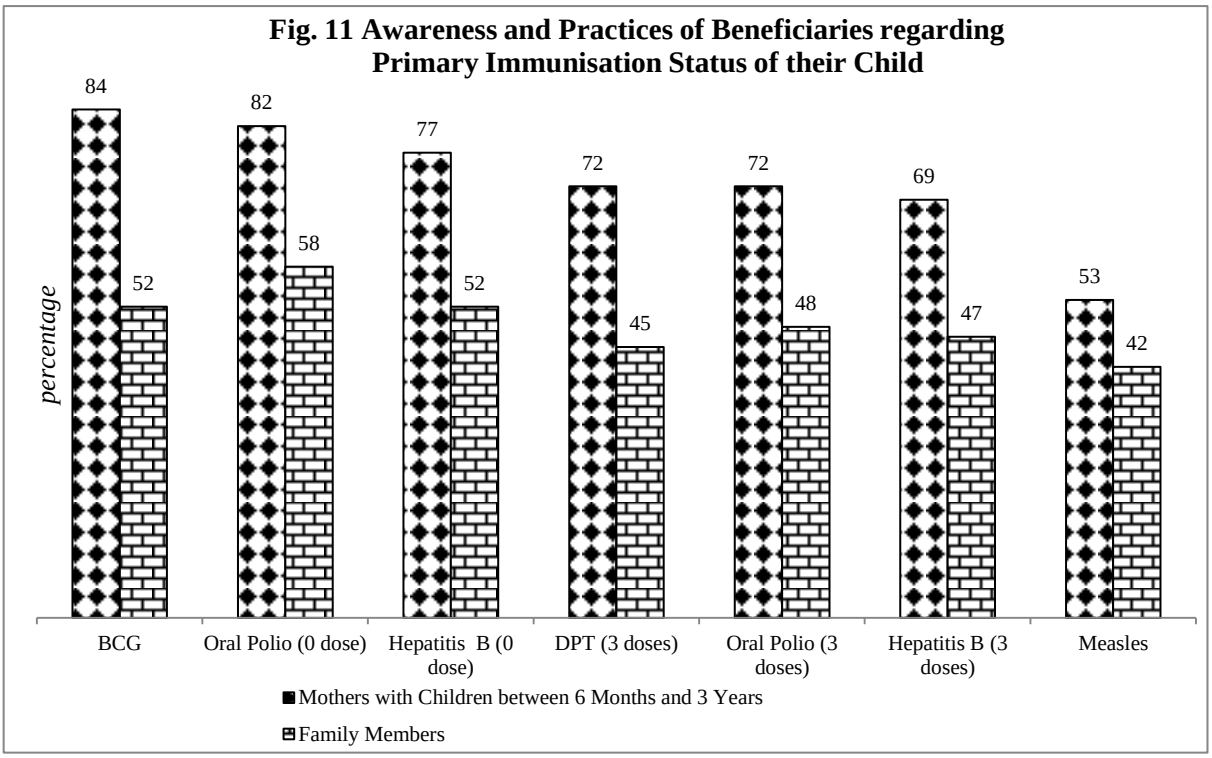
Fig. 10 Knowledge of AWWs, ANMs and ASHAs on Recording of Immunisation in the MCP Card



4.6.6.2 Awareness and Practices of Beneficiaries

4.6.6.2.1 Awareness and Practice of Beneficiaries regarding Immunisation

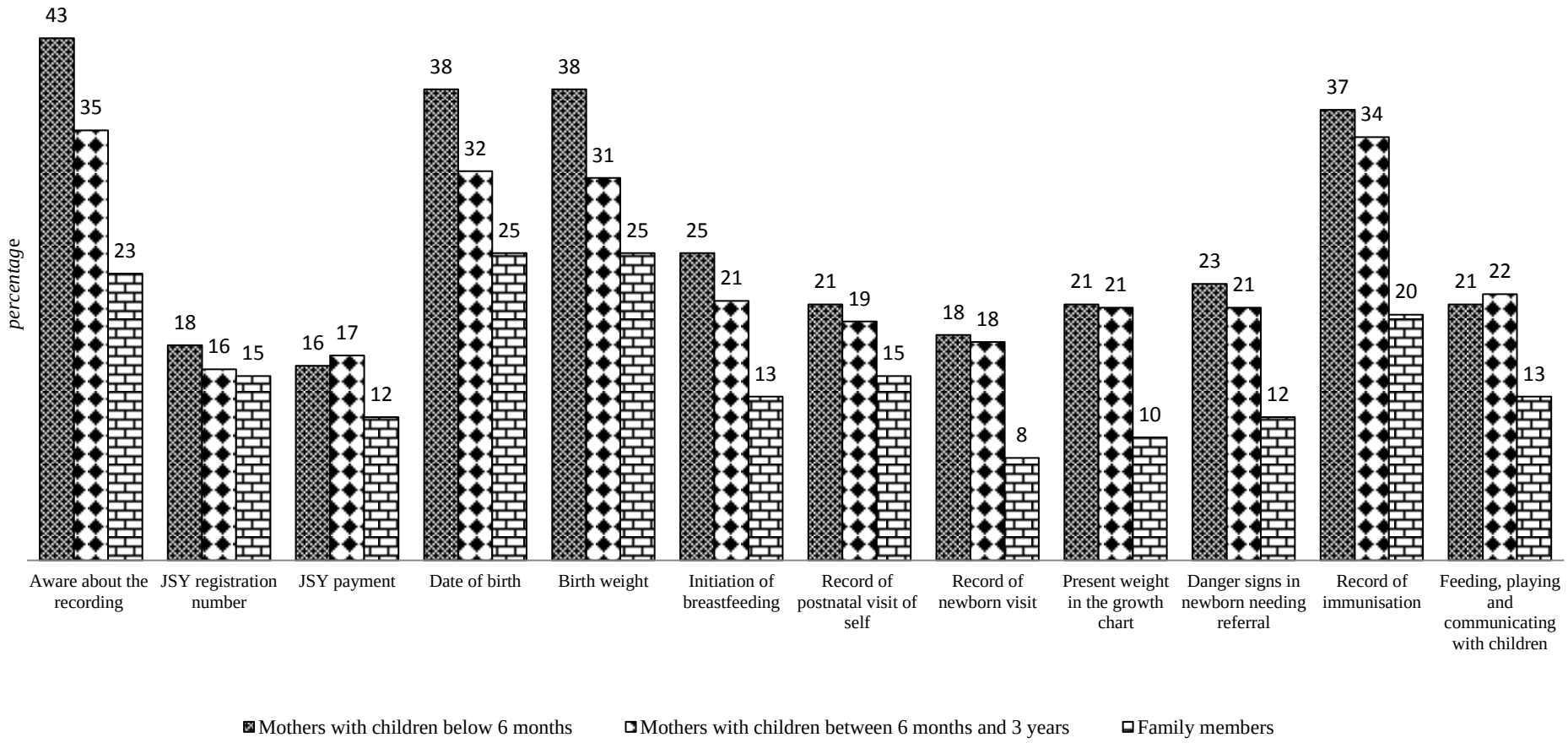
The awareness of mothers with children between 6 months and 3 years and family members on immunisation status of the child is presented in **Fig.11**. The awareness level of mothers on the immunisation status of the child was much better than that of family members. It was encouraging that over 40.0 per cent of family members were aware of immunisation status of their child, which can be improved by judicious use of MCP Card, for educating all the members of the community.



4.6.6.2.2 Awareness of Beneficiaries regarding Recording about the Child in the MCP Card

The ability of beneficiaries to show correctly in the MCP Card, the recording of findings of check up of the child is presented in **Fig. 12**. Only 43.0 per cent of mothers with children below 6 months, 35.0 per cent of mothers with children between 6 months and 3 years and 23.0 per cent of family members were aware about the recording of findings about the child, made in the MCP Card. The ability of mothers with children below 6 months to show correctly in the MCP Card the JSY registration number; JSY payment; date of birth of the child; birth weight; initiation of breastfeeding; record of postnatal visit of self; record of newborn visit; present weight in the growth chart; danger signs in newborn needing referral, record of immunisation; and feeding, playing should communicating with children was 18.0 per cent ; 16.0 per cent; 38.0 per cent; 38.0 per cent ; 25.0 per cent ; 21.0 per cent ; 18.0 per cent , 21.0 per cent, 23.0 per cent, 37.0 per cent and 21.0 per cent respectively. The ability of mothers with children below 6 months was better than those of mothers with children between 6 months and 3 years, who showed better ability in showing correctly the section on 'feeding, playing and communicating with children'.

Fig. 12 Ability to Show the Recording of Findings of Check-up of the Child in MCP Card



4.7 Knowledge and Awareness about Feeding, Play and Communication

4.7.1 Knowledge of Functionaries regarding Feeding, Play and Communication

4.7.1.1 Knowledge of AWWs, ANMs and ASHAs regarding Play and Communication

The knowledge level of AWWs, ANMs and ASHAs on play and communication is presented in **Table 24**. The knowledge level of ANMs was better than those of AWWs and ASHAs. The advice on combining play and communication activities during feeding, bathing, etc. was reported by 77.2 per cent of ANMs, 70.5 per cent of AWWs and 64.6 per cent ASHAs. Using any household objects that are clean and safe, in case a mother has no toys was reported by 81.8 per cent of ANMs, 76.7 per cent of ASHAs and 75.6 per cent of AWWs. The advice to be given to a mother in case a child seems slow, as revealed from the study included asking the mother to spend more time interacting with the baby [AWWs (80.6%), ANMs (77.2%) and ASHAs (75.0%)]; checking whether the baby is able to see and hear [AWWs (58.8%) ANMs (63.6%) and ASHAs (45.6 %)]; and referring to special services if the child has difficulty in seeing or hearing {AWWs (65.5%), ANMs (77.2%) and ASHAs (52.6%)}.

Table 24: Knowledge of AWWs, ANMs and ASHAs regarding Play and Communication

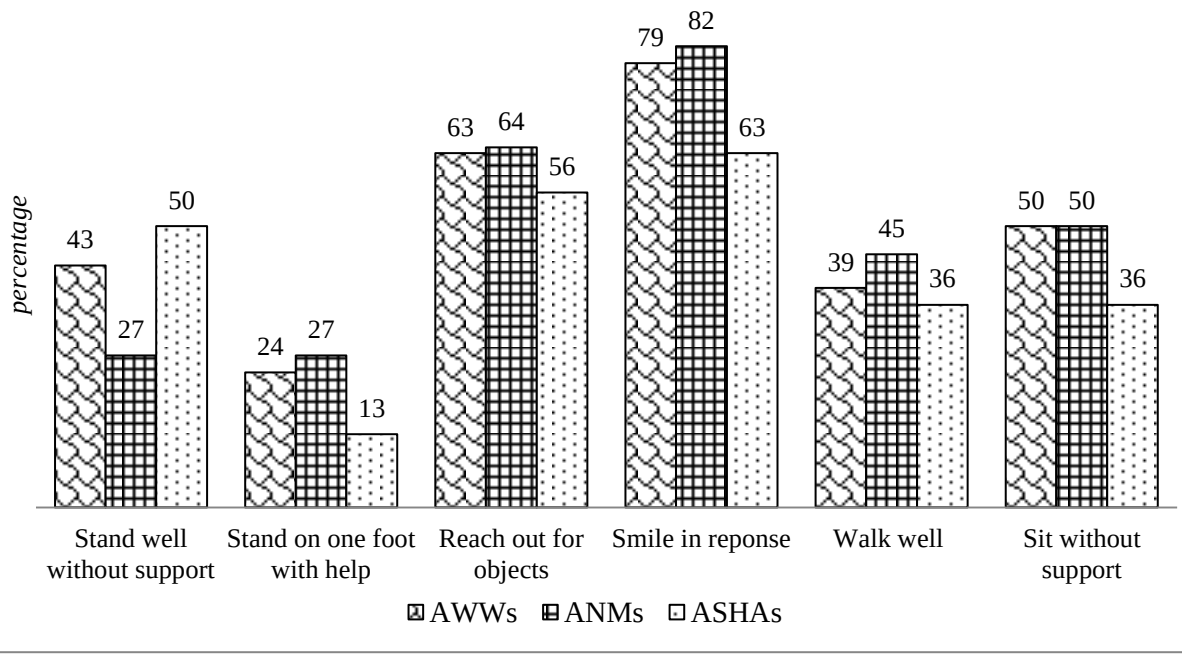
Knowledge of AWWs, ANMs and ASHAs on Play and Communication	AWWs N=119		ANMs N=22		ASHAs n=116	
	No.	%	No.	%	No.	%
Advice given to a mother in case she does not have enough time to provide care for development, play and communication						
Combine playing and communicating activities during feeding, bathing, dressing or other	84	70.5	17	77.2	75	64.6
Ask other family members to help/ provide care for development	94	78.9	19	86.3	89	76.7
Help her with other tasks	38	31.9	11	50.0	43	37.0
Advice given to a mother in case she no toy for the child to play						
Use any household objects that are clean and safe	90	75.6	18	81.8	89	76.7
Make simple toys	70	58.8	17	77.2	77	66.3
To play with the child and the child will learn to play with her and others	54	45.3	16	72.7	52	44.8
Advice given to a mother in case her child seems slow						

Encourage the mother to spend more time interacting with the baby	96	80.6	17	77.2	87	75.0
Check whether the baby is able to see and hear	70	58.8	14	63.6	53	45.6
Refer to special services, if the child has difficulty in seeing or hearing	78	65.5	17	77.2	61	52.6
Encourage the mother and other family members to play and communicate with the child through touch and movement	80	67.2	16	72.7	75	64.6

4.7.1.2 Knowledge about Developmental Milestones in Children among AWWs, ANMs and ASHAs

The knowledge level of grassroots level workers about the developmental milestones in children for the various milestones are presented in **Fig.13,** namely, stand well without support [AWWs (43%), ANMs (27%) and ASHAs (50%)]; stand on one foot with help [AWWs (24%), ANMs (27%) and ASHAs (13)]; reach out for objects{AWWs (63%), ANMs (64%) and ASHAs (56%)]; smile in response [AWWs (79%) , ANMs (82%) and ASHAs (63%)]; walk well [AWWs (39) , ANMs (45%) and ASHAs (36%)] ; and sit without support [AWWs (50%), ANMs (50%) and ASHAs (36%)]. Overall, the knowledge level needs to be enhanced for all the grassroots level workers.

Fig. 13 Knowledge about Developmental Milestones in Children among AWWs, ANMs and ASHAs



4.7.2 Knowledge of Beneficiaries regarding Feeding, Play and Communication

4.7.2.1 Feeding Children Aged 6 months to 3 years

4.7.2.1.1 Ability of Beneficiaries to Understand the Messages in the MCP Card regarding Feeding Children

The ability of beneficiaries to understand clearly the messages in the MCP Card related to feeding children aged 6 months to 3 years was ascertained by showing the MCP Card to them and the responses thereby elicited are presented in **Table 25**. Only 46.6 to 57.7 per cent of beneficiaries could tell clearly, what is given in the MCP Card regarding the sections on 'feeding children aged 6 to 12 months; 'feeding children aged 1 to 2 years and 'feeding children aged 2 to 3 years'. It may be further mentioned that only 10.9 per cent of mothers were illiterate. This points to the fact that the beneficiaries need to be oriented about the MCP Card, for taking full advantage of the MCP Card.

Table 25: Ability of Beneficiaries to Understand Clearly the Messages in the MCP Card regarding Feeding Children

Perception of Beneficiaries about Feeding Children Aged 6 Months to 3 Years	**Mothers with Children between 6 Months and 3 Years N=180**	
	No.	**%**
Awareness about what you should feed a child aged 6 to 12 months		
Start with small amount of soft mashed cereal, dal, vegetable and fruits	104	57.7
Increase the quality of the food	96	53.3
Increase the frequency of the food	98	54.4
Increase the thickness of the food	93	51.6
Understand the child's signals for hunger and respond	87	48.3
Feed the child 4-5 times a day with continued breastfeeding	85	47.2
Awareness about what you should feed a child aged 1 to 2 years		
Offer a variety of family foods such as rice, chappati, dal, vegetables	102	56.6
Feed the child at least 5 times a day	99	55.0
Feed from a separate bowl and monitor how much the child eats	94	52.2
Sit with the child and help her finish the serving	89	49.4
Continue breastfeeding up to 2 years or beyond	84	46.6
Awareness about what you should feed a child aged 2 to 3 years		
Continue to feed family foods 5 times a day	100	55.5
Help the child feed herself/himself	94	52.2
Supervise child's feeding	98	54.4
Ensure hand washing with soap before feeding	84	46.6

4.7.2.2 Communication and Play with Children below 6 Months

4.7.2.2.1 Awareness and Practice of Beneficiaries regarding Communicating and Playing with a Child below 6 Months

The ability of beneficiaries regarding communicating and playing with a child below 6 months is presented in **Table 26.** About 87 per cent of the mothers knew that a child upto

6 months can communicate and play with her. Less than half of them (45%) reported that they were explained about it by the functionaries. Majority of mother (85.8%) knew that a child under 6 months can smile in response. The awareness about the ability of a child to make a sound; holding head steady; tracking a ribbon bow; reaching out for objects; and turning to a voice was 74.1 per cent; 61.6 per cent; 55 per cent; 55.0 per cent; and 68.3 per cent. As regard, the awareness about how a mother can promote development of children below six months, about 50 per cent of mothers were aware about smiling, laughing, looking into child's eyes and talking to the child.

Table 26: Awareness and Practices of Beneficiaries regarding Communicating and Playing with a Child below 6 Months

Awareness and Practices regarding Communicating and Playing with a Child below 6 Months	Haryana n=20		Jharkhand n=20		Maharashtra n=20		Kerala n=20		Madhya Pradesh n=20		Assam n=20		Total n= 120	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Do you feel a child up to 6 months can communicate and play with you														
Yes	19	95.0	19	95.0	16	80.0	20	100.0	19	95.0	11	55.0	104	86.6
Explained about how you can play and communicate with your child														
Explained	3	15.0	12	60.0	6	30.0	18	90.0	9	45.0	6	30.0	54	45.0
Awareness about what a child under six months can do														
Smile in response	19	95.0	19	95.0	16	80.0	20	100.0	19	95.0	10	50.0	103	85.8
Track a ribbon bow	14	70.0	14	70.0	4	20.0	14	70.0	15	75.0	5	25.0	66	55.0
Begin to make sound	18	90.0	18	90.0	11	55.0	18	90.0	18	90.0	6	30.0	89	74.1
Hold head steady when help upright	11	55.0	18	90.0	7	35.0	19	95.0	17	85.0	2	10.0	74	61.6
Reach out for objects	10	50.0	17	85.0	8	40.0	16	80.0	15	75.0	0	0.0	66	55.0
Turn to a voice	13	65.0	19	95.0	13	65.0	18	90.0	17	85.0	2	10.0	82	68.3
Awareness about how you can promote development of children below six months														
Smile and laugh at your child, look into child's eyes and talk to	4	20.0	15	75.0	6	30.0	20	100.0	10	50.0	6	30.0	61	50.8

your child														
Provide ways for the child to see, hear, feel and move	1	5.0	15	75.0	3	15.0	18	90.0	11	55.0	5	25.0	53	44.1
Have large colourful objects for your child to see and to reach for	1	5.0	15	75.0	6	30.0	17	85.0	11	55.0	3	15.0	53	44.1
Talk to and respond to your child	1	5.0	15	75.0	5	25.0	18	90.0	10	50.0	1	5.0	50	41.6
Respond to the child with sounds and gestures	0	0.0	15	75.0	4	20.0	18	90.0	8	40.0	1	5.0	46	38.3

4.7.2.3 Playing and Communicating with Children 6 Months to 12 Months

4.7.2.3.1 Abilities of Beneficiaries to Understand the Messages of MCP Card regarding Playing and Communicating with Children 6 to 12 months

The ability of beneficiaries to understand the messages in the MCP Card related to playing and communicating with children 6 to 12 months is presented in **Table 27.** The ability of mothers with children 6 months to 3 years to understand clearly the messages in the MCP Card related to playing and communicating with children 6 to 12 months was better than that of family members, for both, 'what a child aged 6-12 months can do', as well as, 'how we can promote development of children aged 6-12 months'. Only 48.3 to 57.2 per cent mothers with children between 6 months to 3 years were aware about what a child aged 6-12 months can do, in contrast to 28.3 to 38.3 per cent of family members. Similarly, the awareness about how to promote development of children aged 6-12 months ranged between 50.5 to 56.1 per cent for mothers with children between 6 months to 3 years and 30.0 to 33.3 per cent of family members.

Table 27: Abilities of Beneficiaries to Understand the Messages of MCP Card regarding Playing and Communicating with Children 6 to 12 Months

Ability of Beneficiaries to Understand the Messages of MCP Card regarding Playing and Communicating with Children 6 to 12 Months	Mothers with Children between 6 Months and 3 Years N=180		Family Members N=60	
	No.	**%**	No.	**%**
Awareness about what a child aged 6-12 months can do				
Sit up from lying position	103	57.2	23	38.3
Pick up with thumb and finger	100	55.5	23	38.3
Sit without support	99	55.0	21	35.0
Stand well without support	93	51.6	20	33.3
Wave out to people	90	50.0	17	28.3
Say papa/mama	87	48.3	17	28.3
Awareness about how you can promote development of children aged 6-12 months				
Give child clean safe items to handle and things to make sounds with	99	55.0	18	30.0
Play games like peek-a-boo, etc.	101	56.1	20	33.3
Tell the child names of things and people	91	50.5	19	31.6

4.7.2.4 Playing and Communicating with Children 1-2 Years

4.7.2.4.1 Abilities of Beneficiaries to Understand the Messages of MCP Card regarding Playing and Communicating with Children 1 to 2 Years

The ability of beneficiaries to understand clearly the messages in the MCP Card related to playing and communicating with children 1 to 2 years is presented in **Table 28**. The ability of mothers with children 6 months to 3 years to understand clearly the messages in the MCP Card related to playing and communicating with children 1 to 2 years was better than those of family members, with regard to what is given in the MCP Card regarding 'what a child 1 to 2 years can do' and 'what can be done to promote development of children 1 to 2 years'. Only 43.8 to 56.1 per cent mothers with children between 6 months to 3 years were aware about what a child aged 1 to 2 years can do, in contrast to 23.3 to 40.0 per cent of family members. Similarly, the awareness about how to promote development of children aged 1 to 2 years ranged between 49.4 to 55.5 per cent for mothers with children between 6 months to 3 years and 31.6 to 38.3 per cent of family members.

Table 28: Abilities of Beneficiaries to Understand the Messages of MCP Card regarding Playing and Communicating with Children 1 to 2 Years

Perception of Beneficiaries about Play and Communication for Children Aged 1-2 Years	Mothers with Children between 6 Months and 3 Years N=180		Family Members N=60	
	No.	**%**	No.	**%**
Awareness about what a child aged 1to 2 years can do				
Express wants	100	55.5	18	30.0
Put three pebbles in a cup	95	52.7	14	23.3
Walk well	101	56.1	24	40.0
Stand on one foot with help	93	51.6	22	36.6
Say one other word	91	50.5	22	36.6
Imitate household work	79	43.8	20	33.3
Awareness about how you can promote development of children aged 1 to 2 Years				
Give child things to stack up and to put into containers and take out	96	53.3	20	33.3
Ask simple questions	100	55.5	23	38.3
Respond to child's attempt to talk	89	49.4	19	31.6

4.7.2.5 Playing and Communicating with Children 2-3 Years

4.7.2.5.1 Abilities of Beneficiaries to Understand the Messages of MCP Card regarding Playing and Communicating with Children 2 to 3 Years

The ability of beneficiaries to understand clearly the messages in the MCP Card related to playing and communicating with children 2 to 3 years is presented in **Table 29**. The ability of mothers with children 6 months to 3 years to understand clearly the messages in the MCP Card related to playing and communicating with children 2 to 3 years was better than those of family members as regards, what is given in the MCP Card regarding 'what a child 2 to 3 years can do' and 'what can be done to promote development of children 2 to 3 years. Only 46.1 to 56.1 per cent mothers with children between 6 months to 3 years were aware about what a child aged 2 to 3 years can do, in contrast to 30.0 to 41.6 per cent of family members. Similarly, the awareness about how to promote development of children aged 2 to 3 years ranged between 47.7 to 52.2 per cent for mothers with children between 6 months to 3 years and 31.6 to 38.3 per cent of family members.

Table 29: Abilities of Beneficiaries to Understand the Messages of MCP Card regarding Playing and Communicating with Children 2 to 3 Years

Abilities of Beneficiaries to Understand the Messages of MCP Card regarding Playing and Communicating with Children 2 to 3 Years	Mothers with Children between 6 Months and 3 Years N=180		Family Members N=60	
	No.	**%**	No.	**%**
Point to four body parts	98	54.4	22	36.6
Feed self, spilling little	101	56.1	23	38.3
Name one colour correctly	97	53.8	25	41.6
Copy and draw straight line	91	50.5	20	33.3
Wash hands by herself	90	50.0	20	33.3
Name 3 out of 4 objects	83	46.1	18	30.0
Awareness about how you can promote development of children aged 2 to 3 Years				
Help child count and compare things	94	52.2	20	33.3
Make simple toys for child	94	52.2	23	38.3
Encourage child to talk and respond to child's questions	93	51.6	19	31.6
Teach child stories, songs, and games	86	47.7	19	31.6

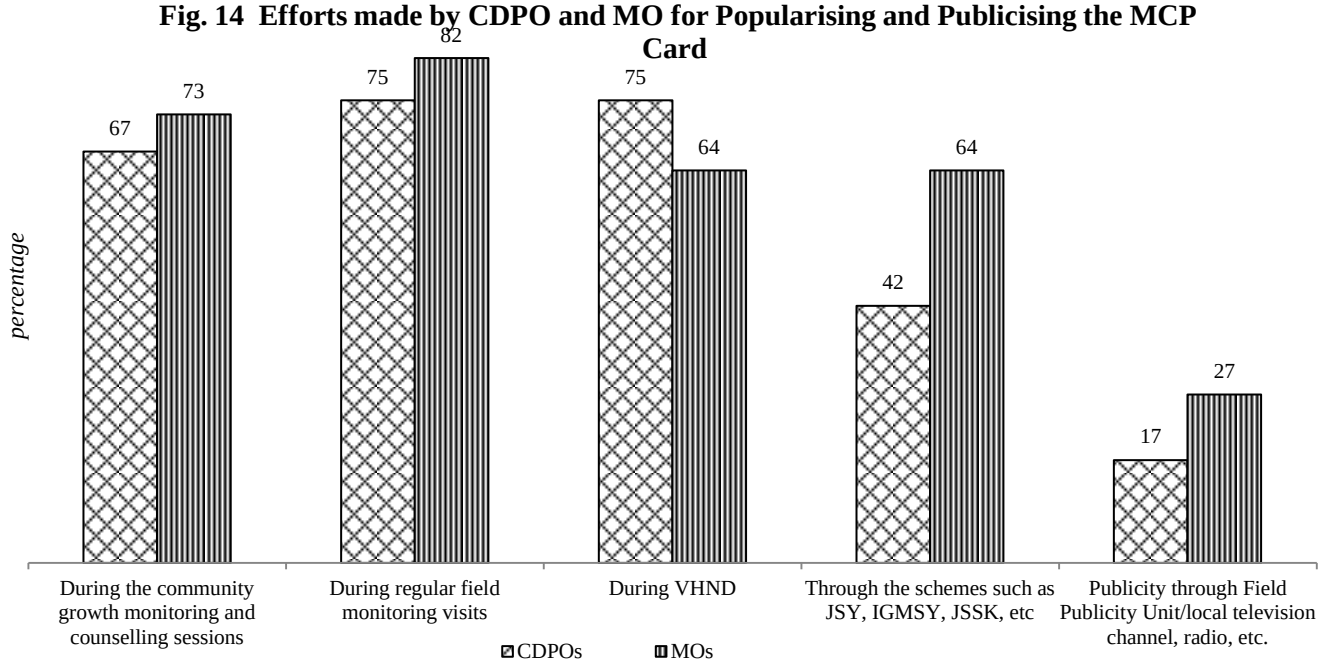
4.8 Role Perception of ICDS and Health Functionaries with regard to MCP Card

4.8.1 Role of CDPOs and MOs

4.8.1.1 Efforts made by CDPOs and Medical Officers for Popularising and Publicising the MCP Card

Fig. 14 presents the efforts made by CDPOs and MOs for popularising and publicising the MCP Card. They include introducing the Card during community growth monitoring and counselling session {CDPOs (67%) and MOs (73%)}; during the regular field monitoring visits {CDPOs (75%) and MOs 82%)}; during VHNDs {CDPO (75%) and MOs (64%)}; through the schemes such as JSY, IGMSY etc. {CDPOs (42%) and MOs (64%)} and by giving publicity through Field Publicity Unit, local television channel/radio {CDPOs (17%) and MOs (27%)}.

Fig. 14 Efforts made by CDPO and MO for Popularising and Publicising the MCP Card



4.8.2 Role Perception and Job Performance of ICDS and Health Functionaries with respect to MCP Card

4.8.2.1 Role Perception and Job Performance of AWWs, ANMs and ASHAs

The role perception and job performance of AWWs, ANMs and ASHAs such as 'recording of information only' and 'explaining/ counselling' with regard to various sections in the MCP Card was ascertained. The responses of AWWs, ANMs and ASHAs with regard to the role perceived by them, such as, 'recording of information only' and 'explaining/ counselling' for various sections in the MCP Card is presented in the **Table 30**.

Majority of AWWs have perceived 'recording of information' in the M CP Card as their main role with respect to growth monitoring and promotion (78.1%); family identification (60.5%); immunisation and vitamin A supplementation (50.4%); and playing and communicating with children (45.3%). The role perception of AWWs about their own role related to counselling and explaining to the beneficiaries about the various issues is grossly inadequate.

The study revealed that the role perception and job performed by ANMs, with regard to the various sections in the MCP Card, as reported by them is very lucid. The role perceived and job performed by ANMs, herself focus mainly on 'recording of information' in the MCP Card related to regular check-ups during pregnancy (77.2%); danger signs during pregnancy (77.2%); postnatal record of mother (81.8%); record of newborn baby (81.8%); newborn care and danger signs in a newborn (59.0%); care during illness (63.6%) immunisation and vitamin A supplementation (68.1%). The role perception of ANMs about their own role

related to counselling and explaining the beneficiaries about the various issues was grossly inadequate. However, it was encouraging to note that, though the ANMs do not perceive it their role to do growth monitoring and promotion, they identified themselves with the role as a counsellor (59.0 %) in growth monitoring and promotion.

The study revealed that the role perception and job performed by ASHAs with regard to the various sections in the MCP Card was moderate. The job perceived and performed by ASHAs as reported by her, focus mainly on 'explaining and counselling' for early initiation of breastfeeding (60.3%); family planning (56.0%); newborn care and danger signs in a newborn (50.8%); immunisation and vitamin A supplementation (47.4%); care during illness (53.4%); and feeding, playing and communicating with children (45.6%), which is close to the way her role has been perceived under the NRHM. The ASHAs mainly perceived their role, as a recorder of information with respect to only 'family identification'.

Table 30: Role Perception and Job Performance with respect to MCP Card as Reported by AWWs, ANMs and ASHAs

Self-Perception of Role of AWWs, ANMs and ASHAs with respect MCP Card	AWWs n=119		ANMs n=22		ASHAs n=116	
	No.	%	No.	%	No.	%
Family identification						
Recording of Information	72	60.5	6	27.2	72	62.0
Explaining/ counselling	29	24.3	9	40.9	37	31.9
Regular check-ups during pregnancy						
Recording of Information	29	24.3	17	77.2	31	26.7
Explaining/ counselling	48	40.3	3	13.6	39	33.6
Danger signs during pregnancy						
Recording of Information	23	19.3	17	77.2	25	21.5
Explaining/ counselling	64	53.7	5	22.7	58	50.0
Institutional delivery & preparations in case of home delivery						
Recording of Information	24	20.1	9	40.9	32	27.5
Explaining/ counselling	55	46.2	7	31.8	65	56.0
After delivery early initiation of breastfeeding						
Recording of Information	29	24.3	12	54.5	26	22.4
Explaining/ counselling	71	59.6	7	31.8	70	60.3
Family planning						
Recording of Information	22	18.4	11	50.0	30	25.8

Explaining/ counselling	77	64.7	9	40.9	65	56.0
Post natal care record of mother						
Recording of Information	30	25.2	18	81.8	23	19.8
Explaining/ counselling	52	43.7	3	13.6	47	40.5
Post natal care record of baby						
Recording of Information	33	27.7	18	81.8	21	18.1
Explaining/ counselling	53	44.5	3	13.6	49	42.2
Newborn care & danger signs in a newborn						
Recording of Information	34	28.5	13	59.0	22	18.9
Explaining/ counselling	59	49.5	8	36.3	59	50.8
Immunization and vitamin A supplementation						
Recording of Information	60	50.4	15	68.1	38	32.7
Explaining/ counselling	41	34.4	5	22.7	55	47.4
Feeding, playing and communicating with children						
Recording of Information	54	45.3	3	13.6	11	9.4
Explaining/ counselling	54	45.3	13	59.0	53	45.6
Growth monitoring and promotion						
Recording of Information	93	78.1	2	9.0	10	8.6
Explaining/ counselling	23	19.3	13	59.0	40	34.4
Care during illness (diarrhoea, ARI & fever)						
Recording of Information	39	32.7	14	63.6	25	21.5
Explaining/ counselling	50	42.0	7	31.8	62	53.4

4.9 Support and Supervision with regard to the MCP Card

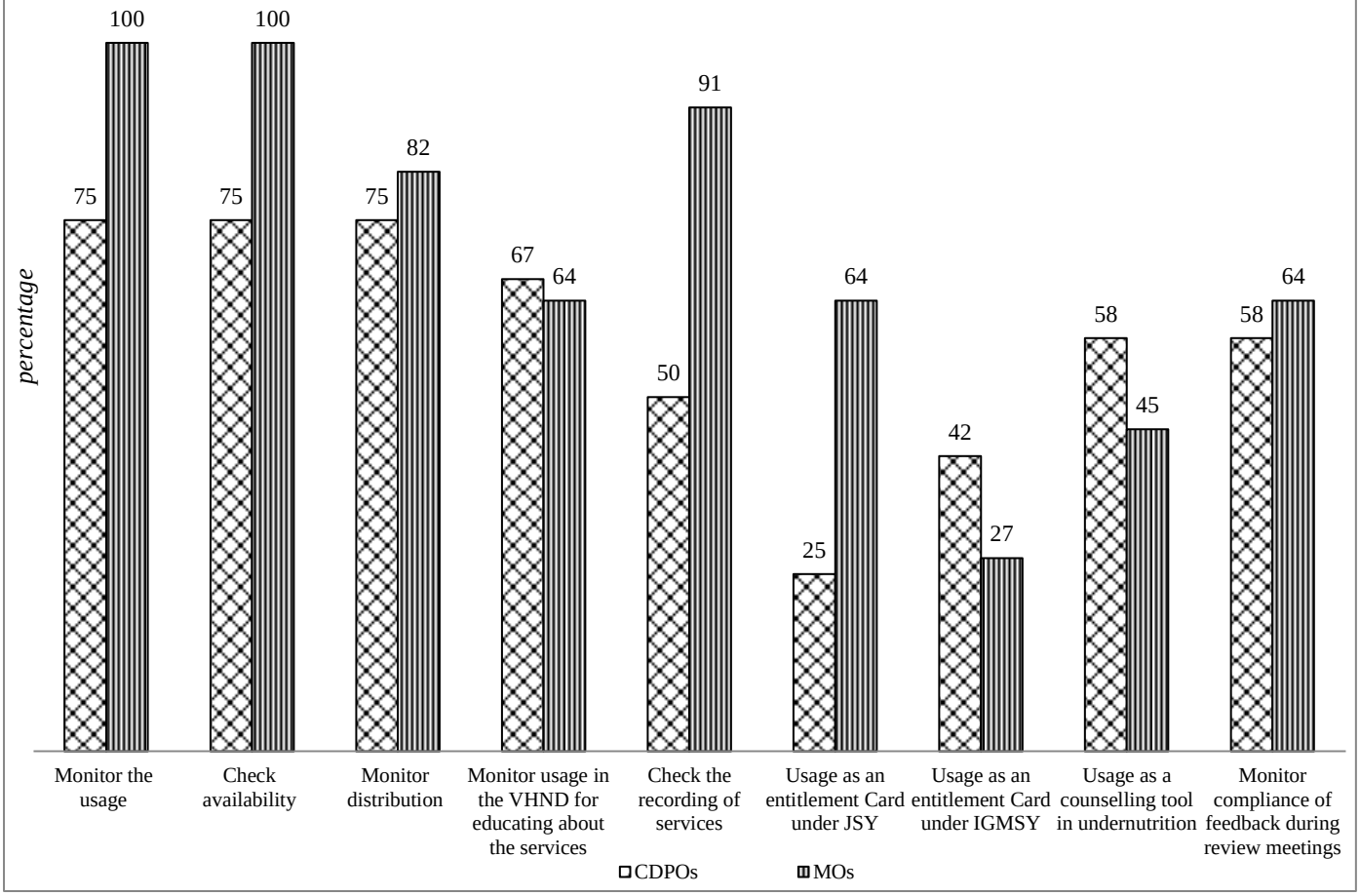
4.9.1 CDPOs and Medical Officers

4.9.1.1 Nature of Task Monitored by CDPOs and Medical Officers with regard to MCP Card

Almost all CDPOs (75%) and MOs (100%) affirmed that they monitored the usage of MCP Card. The nature of tasks monitored as reported by both CDPOs and MOs include monitoring the usage of the MCP Card {CDPOs (75.0%) and MOs (100%)}; checking the availability of the MCP Card {CDPOs (75%) and MOs (100%)}; monitoring the distribution of the MCP Card {CDPOs (75%) and MOs (82%)}; educating about service entitlement during VHNDs {CDPOs (67%) and MOs (64%)}; use of MCP Card for recording of services; usage of MCP Card as on entitlement Card under JSY {CDPOs (25%) and MOs (64%)}; usage of MCP Card as an entitlement Card under IGMSY {CDPOs (42%) and MOs

(27%)}; usage of MCP Card as a counselling tool or not{CDPOs (58%) and MOs (45%} and monitoring compliance of feedback during review meetings{CDPOs (58%) and MOs (64%)}**(Fig. 15).**

Fig. 15 Nature of Tasks Monitored by CDPOs and MOs with regard to the MCP Card



4.9.2 Supervisors and LHVs

4.9.2.1 Role Perception of Supervisors and LHVs with regard to Monitoring

Almost all the Supervisors (100%) and LHVs (75%) affirmed that they monitor the usage of the MCP Card. Mainly, check the availability of the MCP Card {Supervisors (83%) and LHVs (67%)}; and monitor distribution of the MCP Card {Supervisors (88%) and LHVs (67%)}. The nature of other tasks monitored with regard to the MCP Card include monitoring the usage of the MCP Card for educating about service entitlement during VHND {Supervisors (75%) and LHVs (58%)}; Recording of ANC in the MCP Card {Supervisors (63%) and LHVs (67 %)}; recording of PNC {Supervisors (54%) and LHVs (58%)}; recording of newborn care {Supervisors (63%) and LHVs (58%); recording of immunisation {Supervisors (83%) and LHV (67%)}; recording of weight of the child {Supervisors (75%)

and LHVs (67%)}; recording of developmental delays {Supervisors (50%) and LHVs (58%)}; use of MCP Card as an entitlement under JSY {Supervisors (58%) and LHVs (50%)}; use of MCP Card as an entitlement tool under IGMSY {Supervisors (33%) and LHVs (8%)}; use of MCP Card as a counselling tool or not {Supervisors (54%) and LHVs (67%)} and monitoring compliance of feedback given during review meetings {Supervisors (54%) and LHVs (67%)} **(Fig. 16).**

4.9.3 Supervisors and AWWs

4.9.3.1 Responses of Supervisors and AWWs on the Mode of Supervision provided during Monitoring Visits

Responses of Supervisors and AWWs on the mode of supervision provided during the monitoring visits are presented in **Fig. 17**. Supervisors' responses on the nature of supervision provided during the monitoring visits and responses of AWWs agreeing with it, revealed that supervision was done by giving verbal instructions{Supervisors (75%) and AWWs (85%)}; by demonstrating the usage of MCP Card {Supervisors (88%) and AWWs (62%)}; by providing guidance in recording of information {Supervisors (63%) and AWWs (54%); by providing hands-on training on counselling mothers after weighing the child {Supervisors (63%) and AWWs (45%)}; by explaining about various sections of the MCP Card {Supervisors (67%) and AWWs (48%)}; and by explaining about play and communication activities {Supervisors (67%) and AWWs (47%)}. The responses of AWWs reveal that there has been over reporting by Supervisors on the nature of supervision provided by them to AWWs.

Fig. 16 Nature of Tasks Monitored by Supervisors and AWWs with regard to MCP Card

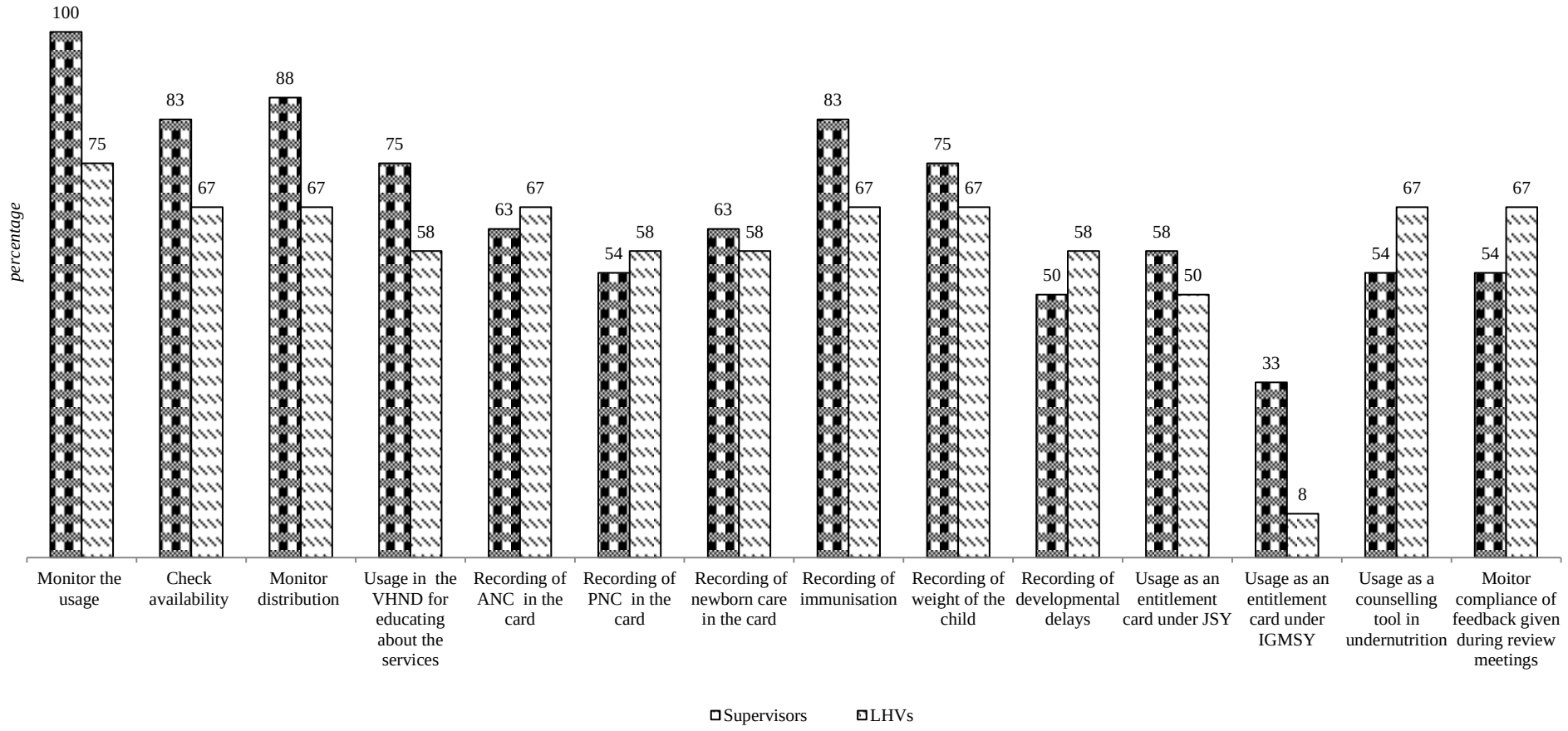
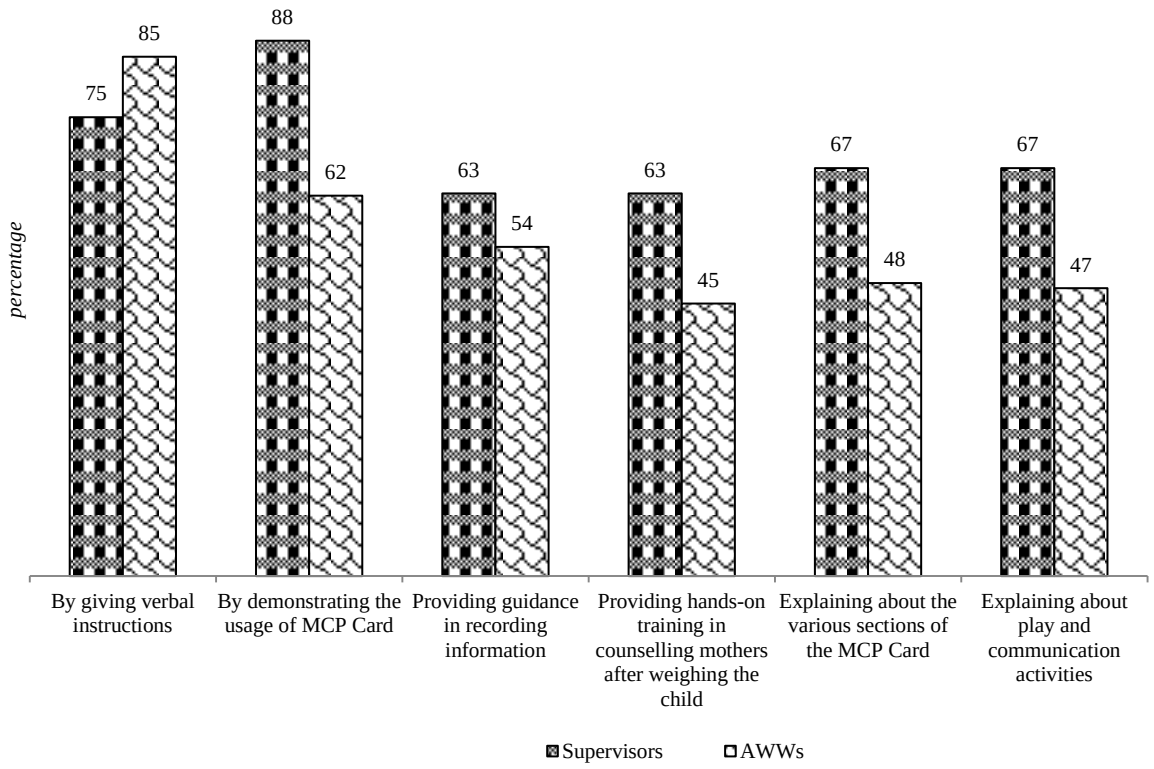


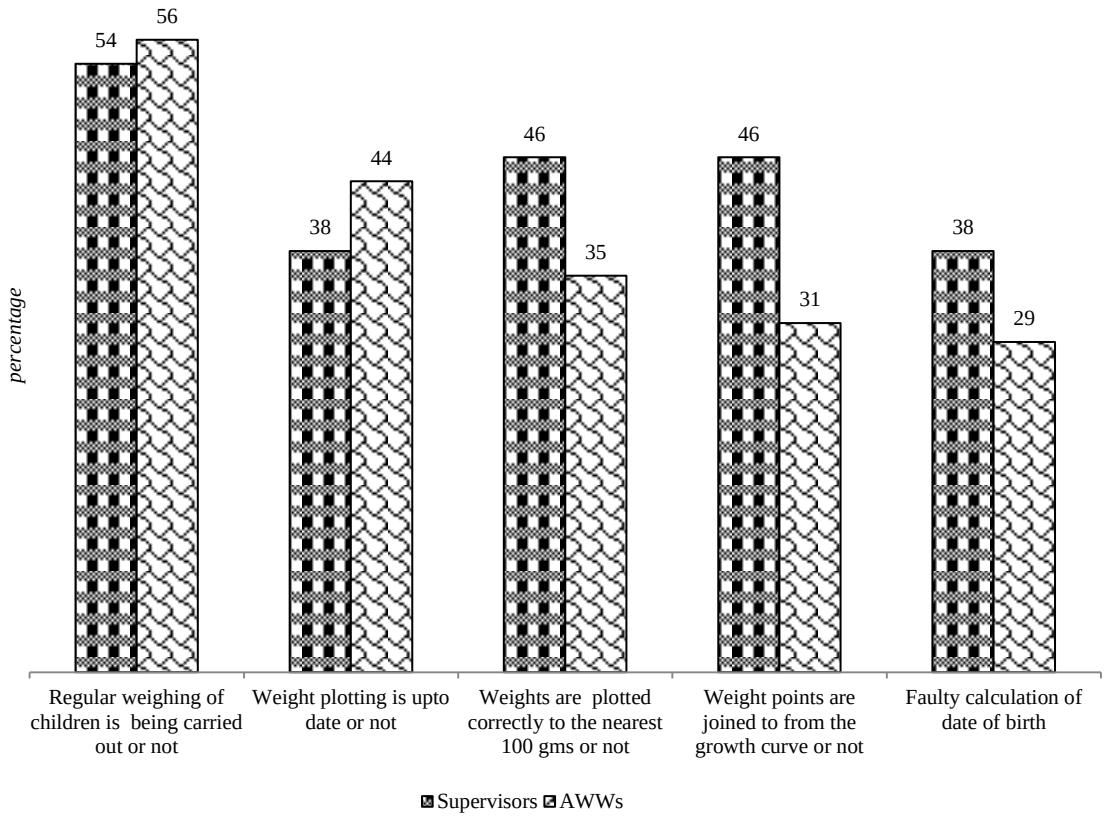
Fig. 17 Perception of Supervisors and AWWs on the Nature of Supervision Provided during Monitoring Visits



4.9.3.2 Responses of Supervisors and AWWs on the Nature of Supervision provided with regard to Growth Monitoring and Promotion (GMP)

The responses of Supervisors and AWWs on the nature of supervision provided with regard to growth monitoring and promotion is presented in **Fig. 18**. The responses of Supervisors on the supervision provided during GMP and responses of AWWs corroborating it include checking whether regular weighing of children is being carried out or not {Supervisors (54 %) and AWWs (56%)}; weight plotting is upto date or not {Supervisors (38%) and AWWs (44%)}; weights are plotted correctly or not {Supervisors (46%) and AWWs (35%)}; weight points are joined to form the growth curve {Supervisor (46%) and AWWs (31%)}; and checking calculation of date of birth {Supervisor (38%) and AWWs (29%)}. The responses of Supervisors and AWWs showed that they are slightly in tune with each other.

Fig. 18 Responses of Supervisors and AWWs on the Nature of Supervision Provided with regard to Growth Monitoring and Promotion

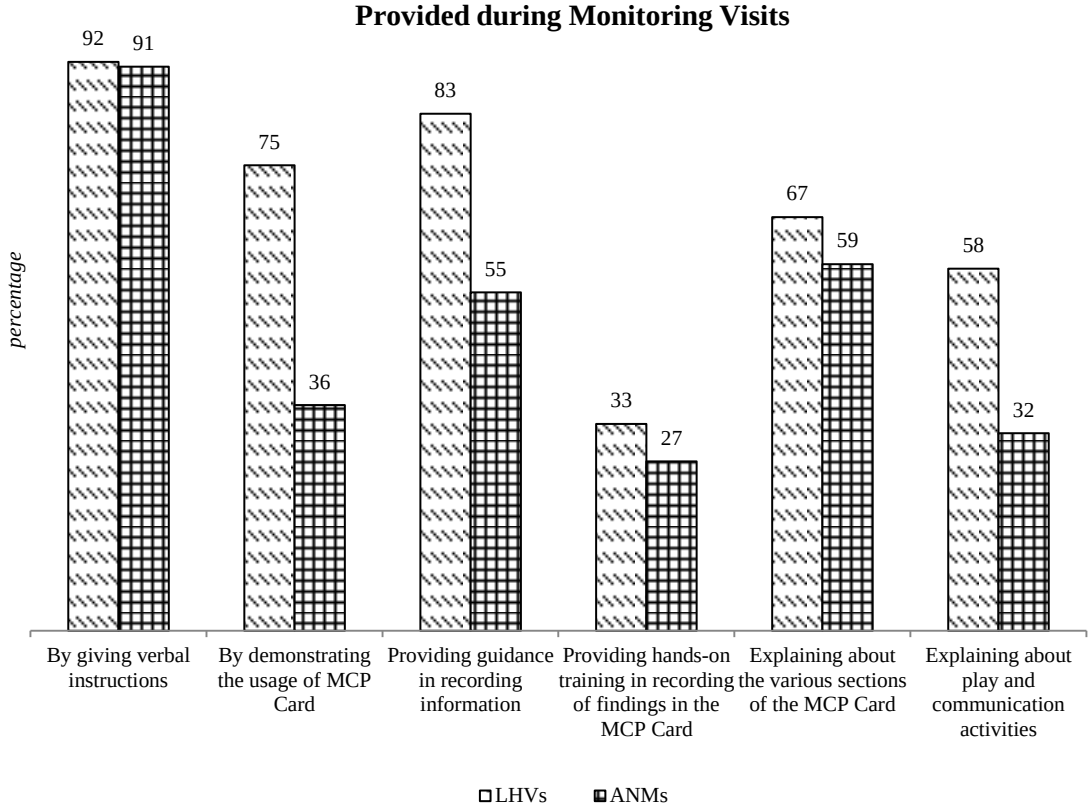


4.9.4 LHVs and ANMs

4.9.4.1 Responses of LHVs and ANMs on the Mode of Supervision provided during Monitoring Visits

Responses of LHVs and ANMs on the nature of supervision provided during the monitoring visits are presented in **Fig. 19.** LHVs responses on the nature of supervision provided during the monitoring visits and the responses of ANMs confirming it, reveal that supervision was given done by giving verbal instructions {LHVs (92%) and ANMs (91%)}; by demonstrating the use of MCP Card {LHVs (75%) and ANMs (36%)}; providing guidance in recording information {LHVs (83%) and ANMs (55%)}; providing hands on training in recording of findings in the MCP Card {LHVs (33%) and ANMs (27%)}; explaining about various sections of the MCP Card {LHVs (67%) and ANMs (59%)}; explaining about play and communication activities {LHVs (58%) and ANMs (32%)}. The responses of ANMs reveal that there has been over reporting by LHVs on the nature of supervision provided by them to ANMs.

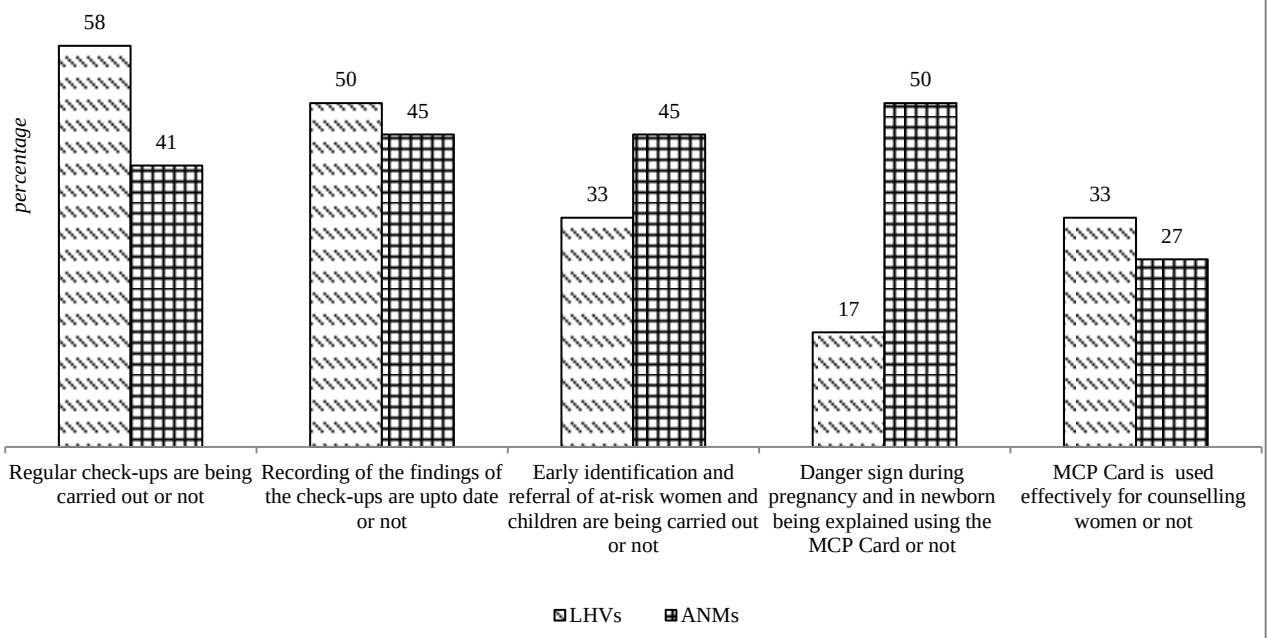
Fig. 19 Responses of LHV and ANMs on the Nature of Supervision Provided during Monitoring Visits



4.9.4.2 Perception of LHVs and ANMs on Monitoring of Problematic Areas with regard to Care of Women and Children

Responses of LHVs and ANMs on monitoring of problematic areas with regard to care of women and children are presented in **Fig 20.** The responses of LHVs on monitoring of problematic areas with regard to care of women and children and responses of ANMs corroborating it, include checking whether regular check-ups of children are being carried out or not {LHVs (58%) and ANMs (41%)}; recording of the findings of the check-ups are upto date or not {LHVs (50%) and ANMs (45%)}; early identification and referral of at-risk women and children are being carried out or not{LHVs (33%) and ANMs (45%)}; danger signs during pregnancy and in newborn are being explained using the MCP Card or not {LHVs (17%) and ANMs (50%)}; and MCP Card is being used effectively for counselling women or not {LHVs (33%) and ANMs (27%)}. The study revealed that there is a mismatch in the responses of LHVs and ANMs, with the ANMs not corroborating some of the responses of LHVs.

Fig. 20 Responses of LHVs and ANMs on Monitoring of Problematic Areas with regard to Care of Women and Children

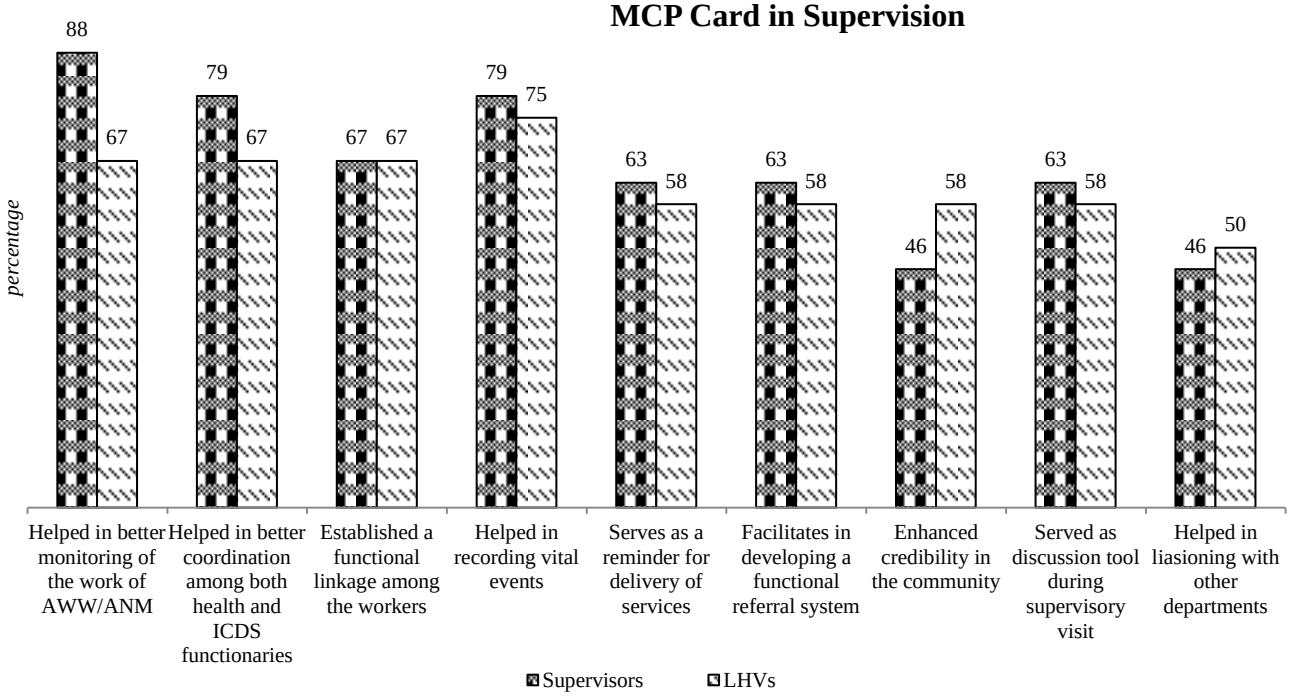


4.9.5 Supervisors and LHVs

4.9.5.1 Perception of Supervisors and LHVs on Nature of Help provided by the MCP Card in Supervision

The perception of Supervisors and LHVs on the nature of help provided by the MCP Card in supervision of grassroots level workers is presented in **Fig**. **21**. The various ways in which the MCP Card has facilitated in supervision include better monitoring of AWWs/ ANMs {Supervisors (88%) and LHVs (67%)}; better coordination among health and ICDS functionaries{Supervisors (79%) and LHVs (67%)}; in establishing a functional linkage among the workers {Supervisors (67%) and LHVs (67%)}; in recording of vital events {Supervisors (79%) and LHVs (75%)}; in serving as a reminder for delivery of services {Supervisors (63%) and LHVs (58%)}; in developing a functional referral system {Supervisors (63%) and LHVs (58%)}; by enhancing credibility in the community {Supervisors (46%) and LHVs (58%)}; by serving as discussion tool during supervisory visits {Supervisors (63%) and LHVs (58%)} and in liaisoning with other departments {Supervisors (46%) and LHVs (50%)}.

Fig. 21 Perception of Supervisor and LHV on Nature of Help Provided by the MCP Card in Supervision



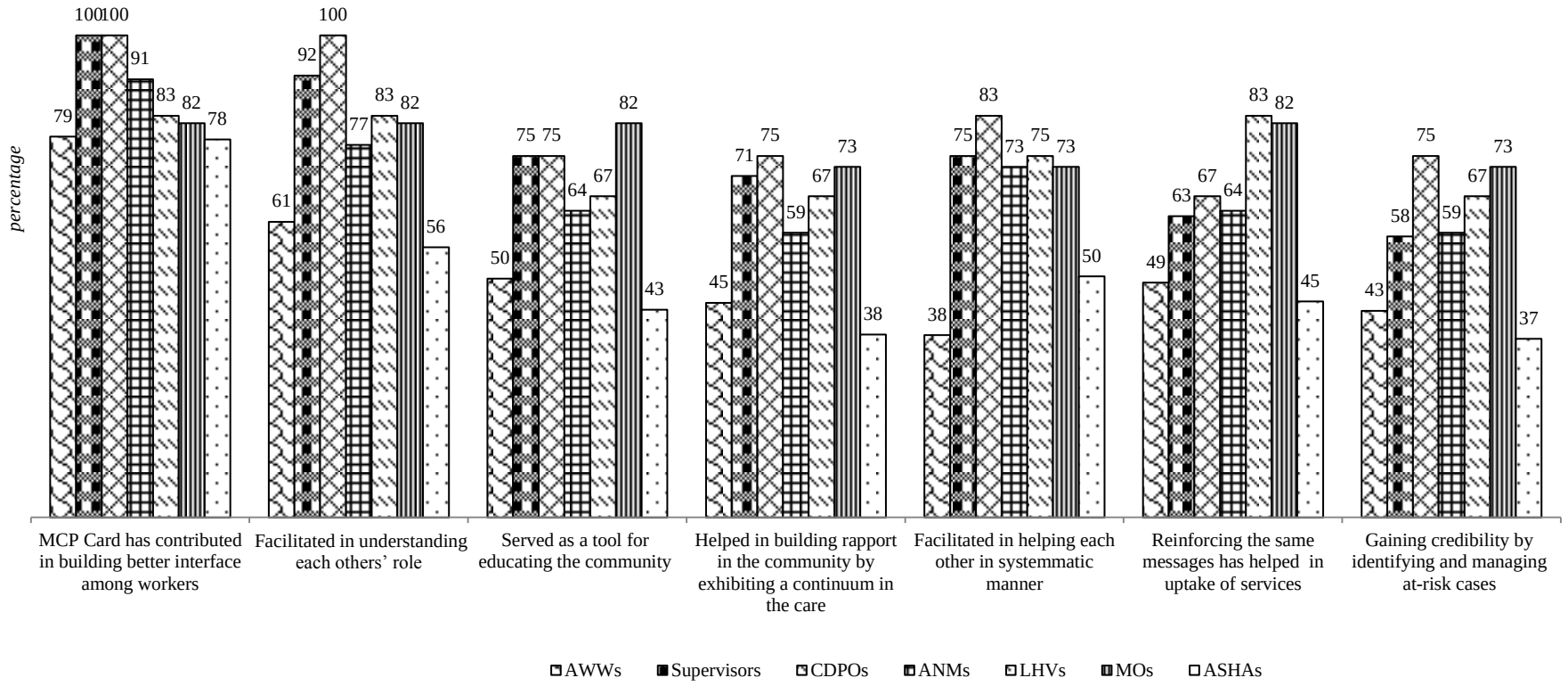
4.10 Perception about Contribution of MCP Card in Improving Interface between ICDS and Health Functionaries

4.10.1 Perception of Functionaries

4.10.1.1 Perception of ICDS and Health Functionaries on the Contribution of MCP Card

Fig. 22 presents the perception of ICDS and health functionaries on contribution of MCP Card in improving the interface between AWW, ANM and ASHA. Over 78 per cent of ICDS and health functionaries opine that the MCP Card has contributed in improving the interface between ICDS and health functionaries. The ways in which the MCP Card has contributed leading to better interface include- facilitating in understanding each other's role; serving as a tool for educating the community; helped in building better rapport with the community by exhibiting a continuum in the care; facilitating in helping each other in a more systematic manner; reinforcing the messages has helped in uptake of services; and gaining credibility in the community by identifying and managing at-risk cases. The study revealed that CDPOs strongly affirm that the MCP Card has contributed in improving the interface between ICDS and health functionaries and that the MCP Card has facilitated the grassroots level workers in better understanding of each other's role.

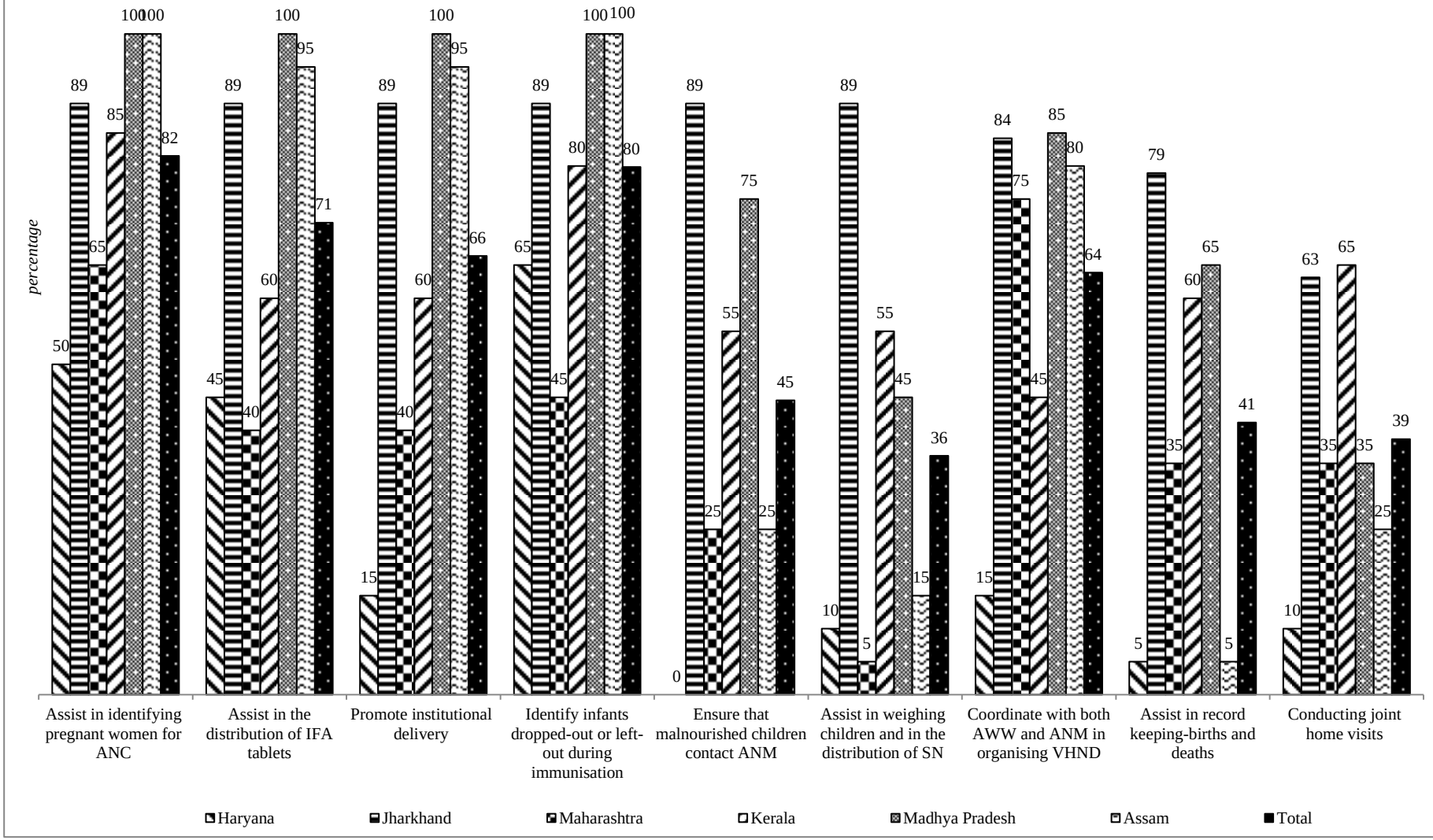
Fig. 22 Perception of ICDS and Health Functionaries on Contribution of MCP Card in Interface between AWW, ANM and ASHA



4.10.1.2 Responses of AWWs on the Nature of Support provided by ASHAs in Delivery of Services at AWCs

Fig. 23 depicts the responses of AWWs in the present study, on the support provided by ASHAs in the AWC activities. According to AWWs, the maximum support provided by ASHAs in AWC activities include assisting in identifying pregnant women for ANCs (82%); followed by identifying dropout or left out children for immunisation (80%); assisting in the distribution of IFA tablet (71%); promoting institutional delivery (66%); coordinating with AWWs and ANMs in organising VHNDs (64%); ensuring that malnourished children come for consultation with ANMs (45%); assisting in record keeping of births and deaths (41%); conducting joint home visits (39%); and assisting in weighing children and in the distribution of supplementary nutrition (SN) (36%).

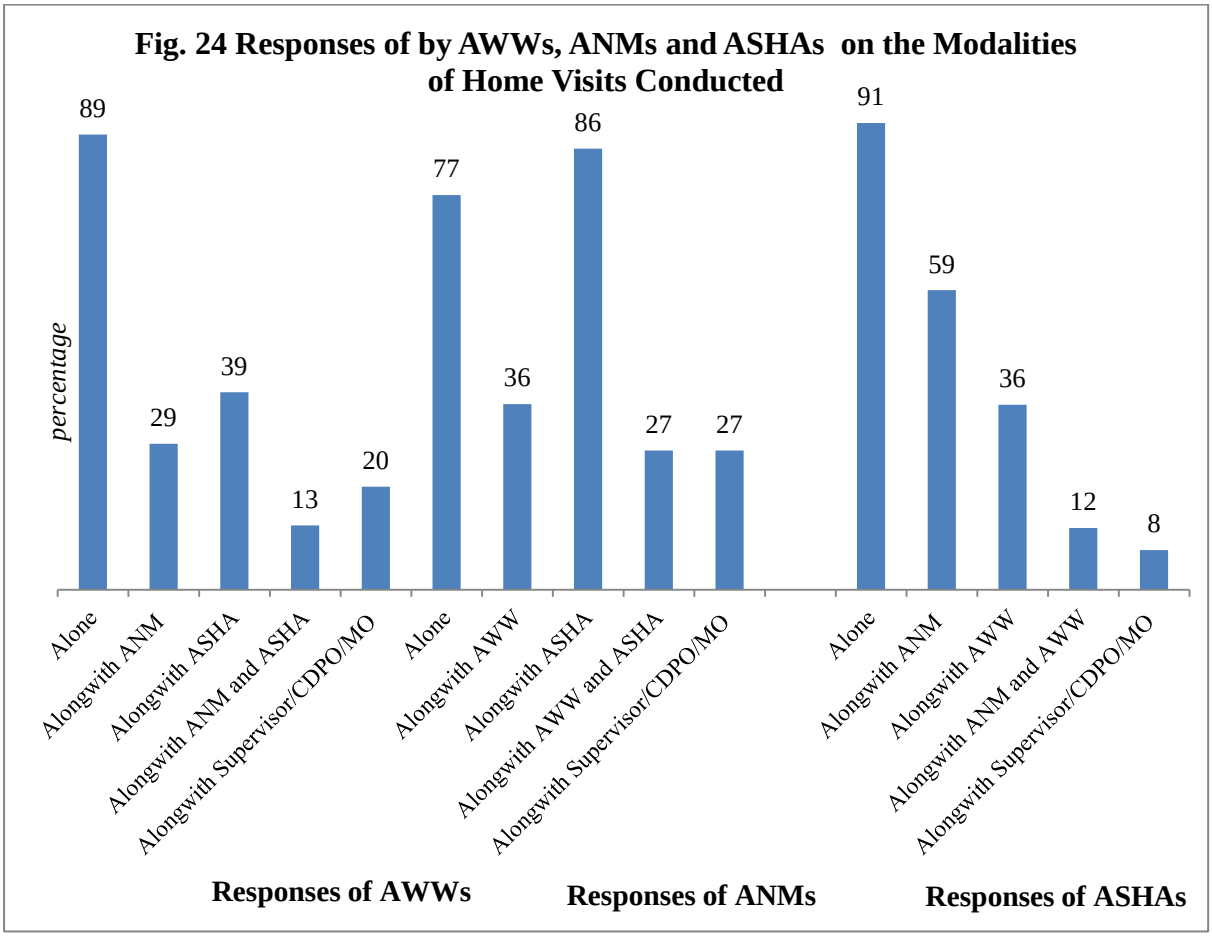
Fig. 23 Responses of AWWs on the Nature of Support Provided by ASHAs in AWC Activities



4.10.1.3 Modalities of Home Visits Conducted by AWWs, ANMs and ASHAs

4.10.1.3.1 Perception of Functionaries

The responses of the grassroots level workers on the modalities of home visits conducted by them are presented in **Fig. 24.** About 89 per cent of AWWs, 77 per cent of ANMs and 91 per cent of ASHAs reported that they conducted home visits alone. Joint home visits though mandated is very few and is not happening on a regular basis.



4.10.3.1.2 Perception of Beneficiaries

Source of information on VHND as reported by beneficiaries was ASHAs followed by AWWs, ANMs and AWHs (NIPCCD, 2013)[8]. **Table 31** presents perception of the beneficiaries on the existing interface between AWWs, ANMs, and ASHAs in organising VHND, one of the initiatives under the NRHM. The awareness of the beneficiaries about the Village Health and Nutrition Days (VHNDs) organised in coordination with the three grassroots level workers was ascertained. The study revealed that 73.9 per cent of mothers with children between six months and three years; 62.5 per cent of pregnant women and 62.5 per cent of mothers with children below 6 months were aware of VHNDs. The main source of information about VHND for pregnant women was ASHAs (37.9%); followed by AWWs (34.1%); Anganwadi Helper (AWHs) (16.2%); and ANMs (10.4%). The source of

information was similar for mothers with children below 6 months with majority of information coming from ASHAs (44.1%); followed by AWWs (38.3%); AWHs (13.3%); and ANMs (11.6%). The responses of mothers with children between 6 months and 3 years revealed that the main information source was AWWs (48.3%) followed by ASHAs (44.4%); AWHs (21.6%) and ANMs (18.3%).

The feedback of beneficiaries on the home visits by AWWs, ANMs and ASHAs was also ascertained to understand the existing interface between the grassroots level workers. The study revealed that 76.2 per cent of pregnant women; and 75 per cent of mothers with children below 6 months and 75 per cent mothers with children between six months and three years reported that the three grassroots level workers visited their home alone, pointing towards lack of interface between the grassroots level workers.

Table 31: Perception of Beneficiaries on Existing Interface between AWWs, ANMs and ASHAs

Perception of Beneficiaries on Existing Interface between AWW, ANM and ASHA	Pregnant Women N=240		Mothers with Children below 6 Months N=120		Mothers with Children between 6 Months and 3 Years n=180	
	No.	%	No.	%	No.	%
Awareness about VHND						
Yes	150	62.5	75	62.5	133	73.8
Information Source about VHND						
AWW	82	34.1	46	38.3	87	48.3
ANM	25	10.4	14	11.6	33	18.3
ASHA	91	37.9	53	44.1	80	44.4
AWH	39	16.2	16	13.3	39	21.6
Modalities of Home Visit						
Alone	183	76.2	90	75.0	135	75.0
With ANM	53	22.0	32	26.6	54	30.0
With AWW	49	20.4	22	18.3	47	26.1
With ANM and AWW	16	6.6	8	6.6	23	12.7

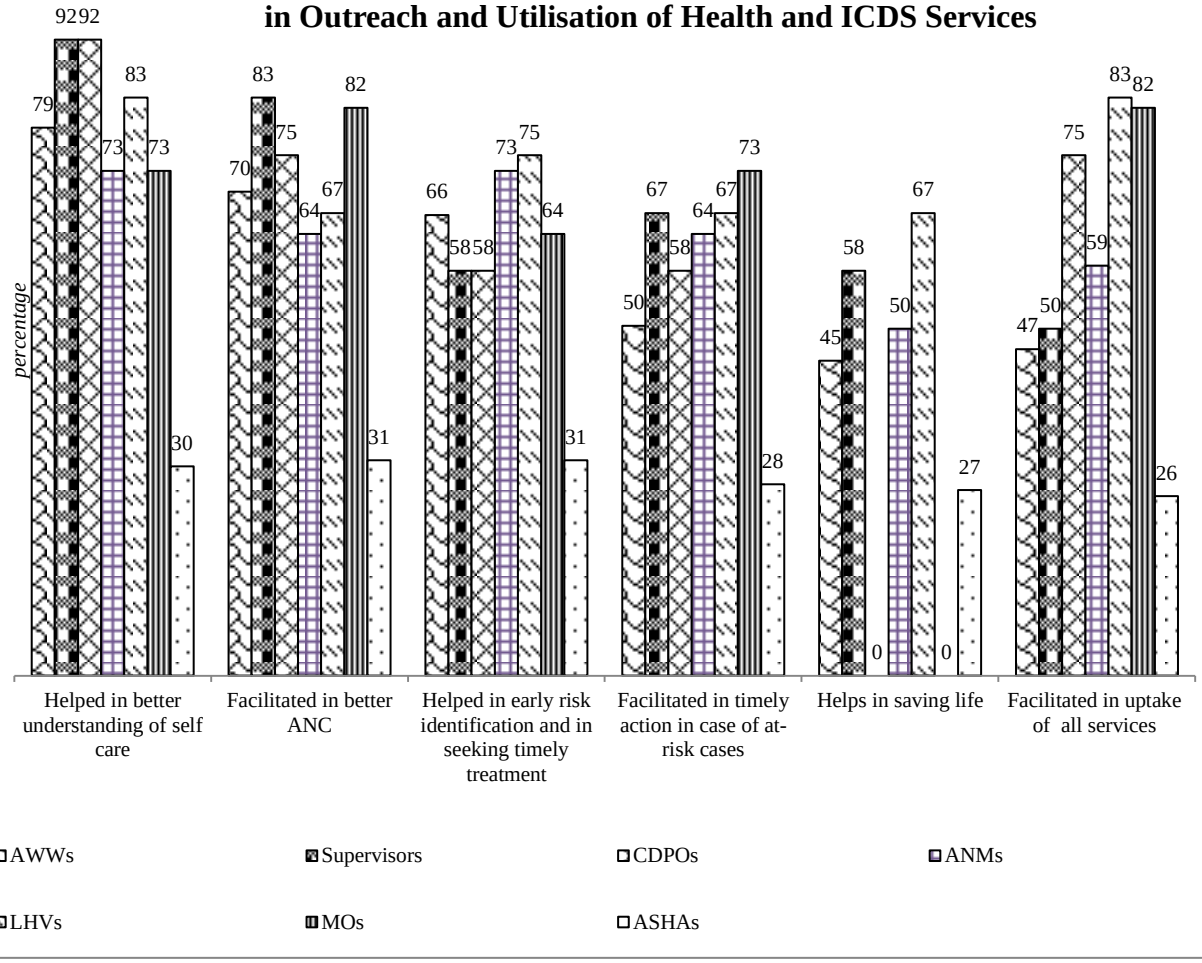
4.11 Contribution of MCP Card in Outreach and Utilisation of Health and ICDS Services

4.11.1 Perception of Functionaries

Fig 25 presents the responses of ICDS and health functionaries on how MCP Card has contributed in better outreach and utilisation of ICDS and health services. The various responses are that MCP Card has facilitated in- better understanding of self care; better understanding of self care; better ANC; timely action, in case of at-risk cases; early risk

identification and seeking timely treatment; saving life of women and children; and increased uptake of all services.

Fig.25 Perception of Functionaries on the Contribution of MCP Card in Outreach and Utilisation of Health and ICDS Services

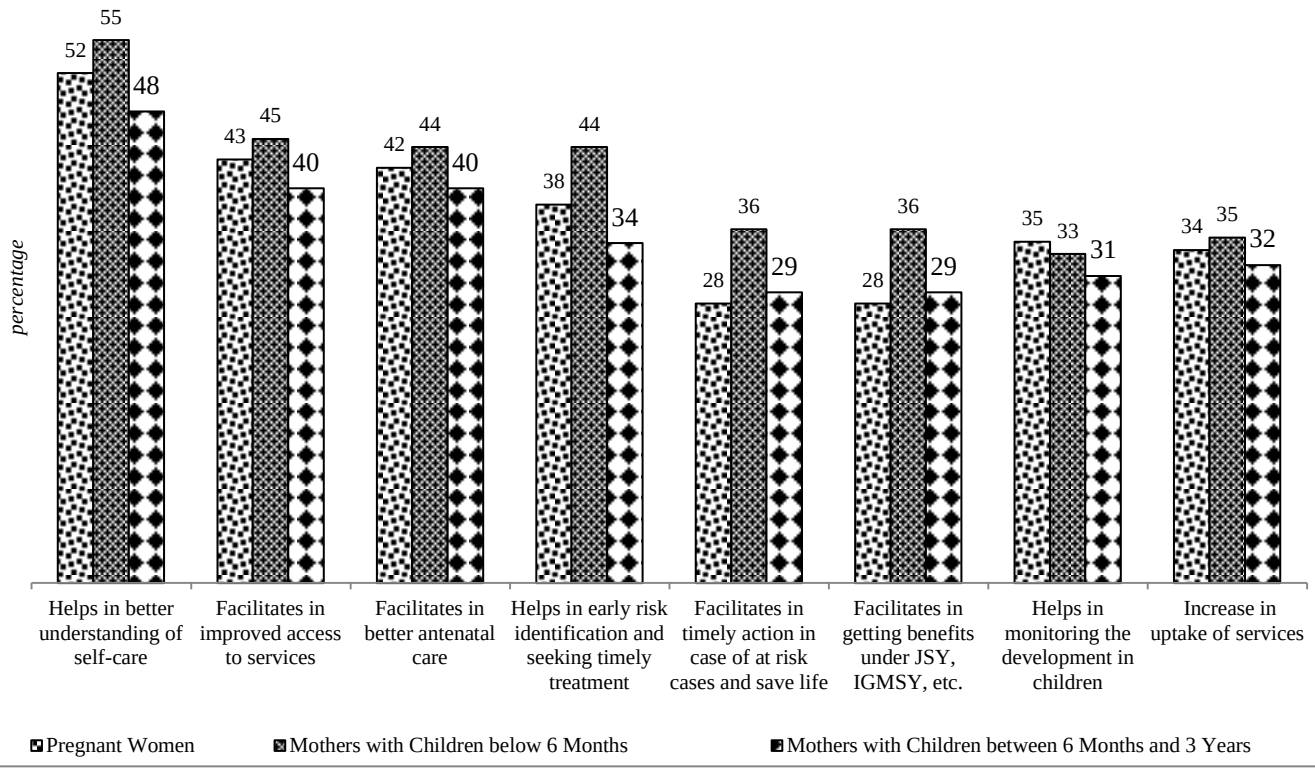


4.11.2 Perception of Beneficiaries

4.11.2.1 Perception of Beneficiaries on the Contribution of MCP Card in Outreach and Utilisation of Health and ICDS Services

The response of beneficiaries on the contribution of MCP Card in outreach and utilisation of ICDS and health services is presented in **Fig. 26.** It seems that benefits of the MCP Card have yet not been felt by the beneficiaries. However, around 50 per cent of pregnant women, mothers with children below 6 months and mother with children between six months and 3 years feel that the MCP Card has helped in better understanding about self care. Roughly, 40 per cent of all the beneficiaries expressed that the MCP Card has facilitated in better ANC and improved access to services.

Fig. 26 Perception of Beneficiaries on the Contribution of MCP Card in Outreach and Utilisation of Health & ICDS Services



4.11.2.2 Perception of Beneficiaries about the Changes in the Health, Nutrition and Care Aspect of Self and their Children after the Introduction of MCP Card

Response of beneficiaries on the changes MCP Card has brought in the health, nutrition and care aspects of self is presented in **Table 32**. Roughly, 35 per cent beneficiaries reported that the MCP Card has helped in getting appropriate referral services. One-fourth of pregnant women reported that MCP Card holder are given preference over other the patients. One-third of all beneficiaries reported that the MCP Card helped in getting timely and right treatment.

One-third of beneficiaries had gone through the MCP Card mainly to understand how to look after oneself; to know about danger signs; and to check when the next immunisation is due. Roughly two-fifth of beneficiaries felt that the MCP Card has helped in identification of risk factors in women and children by encouraging families and communities in self care. Over one-third of beneficiaries felt that the present MCP Card is better than the earlier *Jachcha Bachcha Card*. The advantage of the present MCP Card over the earlier *Jachcha Bachcha Card* is the illustrations, which has helped is creating better awareness.

Table 32: Perception of Beneficiaries about the Changes in the Health, Nutrition and Care aspects of Self and their Children after the Introduction of MCP Card

Perception of Beneficiaries about the Changes after the Introduction of MCP Card	Pregnant Women N=240		Mothers with Children below 6 Months N=120		Mothers with Children between 6 Months and 3 Years n=180	
	No.	%	No.	%	No.	%
MCP Card helped in getting appropriate referral services	90	37.5	47	39.1	62	34.4
Modality of referral with MCP Card						
MCP Card holders are given preference over other patients	59	24.5	22	18.3	39	21.6
It helps in getting timely treatment	75	31.2	45	37.5	56	31.1
It helps in getting the right treatment	74	30.8	43	35.8	51	28.3
It helps in saving life of mother and the baby	53	22.0	33	27.5	48	26.6
It helps in saving money	41	17.0	23	19.1	37	20.5
Read the MCP Card	95	39.5	48	40.0	73	40.5
Reasons for reading the MCP Card						
To understand how to look after myself	89	37.0	44	36.6	54	30.0
In care of newborn baby	0	0.0	35	29.1	51	28.3
In growth monitoring of the child	0	0.0	25	20.8	45	25.0
To see when the next check- up/immunisation is due	95	39.5	40	33.3	63	35.0
To know more about the danger signs for timely action	73	30.4	31	25.8	43	23.8
To know how to play with my child	54	22.5	26	21.6	43	23.8
To know what and how much to feed my child	58	24.1	27	22.5	38	21.1
MCP Card has helped in identification of risk factors in women and children	93	38.7	53	44.1	61	33.8
How has the MCP Card helped in identification of risk factors in women and children						
By encouraging families and communities in self care	75	31.2	42	35.0	49	27.2

As a help in referring a case to higher facility	75	31.2	41	34.1	47	26.1
Helping to achieve continuity of care during pregnancy and in post partum period	71	29.5	39	32.5	46	25.5
MCP Card is better than the Jaacha Baacha Card or other Card in use	81	33.7	34	28.3	63	35.0
Illustrations/pictures in the MCP Card helped in creating awareness	116	48.3	63	52.5	78	43.3

4.12 Level of Satisfaction after the Usage of MCP Card

4.12.1 Perception of Functionaries

4.12.1.1 Perception of ICDS and Health Functionaries on the Level of Satisfaction after the Usage of MCP Card

Table 33 presents the level of satisfaction of ICDS and health functionaries after the usage of MCP Card. In all, over 80.7 per cent of AWWs; 100 per cent of Supervisors, 90.9 per cent of ANMs; and 83.3 per cent of LHVs expressed their satisfaction with the use of MCP Card. The major reasons for satisfaction with the MCP Card have been that the card is very informative as per all the functionaries; it is one record for all services; and has contributed in easy keeping of the record of the child and mother. The major reasons for dissatisfaction with the MCP Card have been that the card is too lengthy, heavily loaded with information, not able to maintain the regular records at the AWC, etc. The responses of ASHAs has been half hearted, probably because she is not directly involved in record keeping, *per se*.

Table 33: Perception of ICDS and Health Functionaries on the Level of Satisfaction after the Usage of MCP Card

Perception of ICDS and Health Functionaries on the Usage of MCP Card	ICDS Functionaries				Health Functionaries					
	AWWs n=119		Supervisors n=24		ANMs n=22		LHVs n=12		ASHAs n=116	
	No.	%	No.	%	No.	%	No.	%	No.	%
Satisfied	96	80.7	24	100.0	20	90.9	10	83.3	34	29.3
Reasons for the satisfaction										
Very informative	105	88.2	23	95.8	20	90.9	10	83.3	34	29.3
One record for all services	81	68.1	20	83.3	14	63.6	8	66.7	31	26.7
Easy to handle	57	47.9	12	50.0	9	40.9	5	41.7	30	25.8
Easy to keep the record of the child and the mother	85	71.4	22	91.6	15	68.2	9	75.0	33	28.4
Reasons for the dissatisfaction										
Too lengthy	1	0.8	0	0.0	0	0.0	2	16.7	4	3.4
Too complicated	2	1.6	0	0.0	2	9.0	2	16.7	1	0.8
Too much information in one	1	0.8	0	0.0	2	9.0	0	0.0	3	2.5

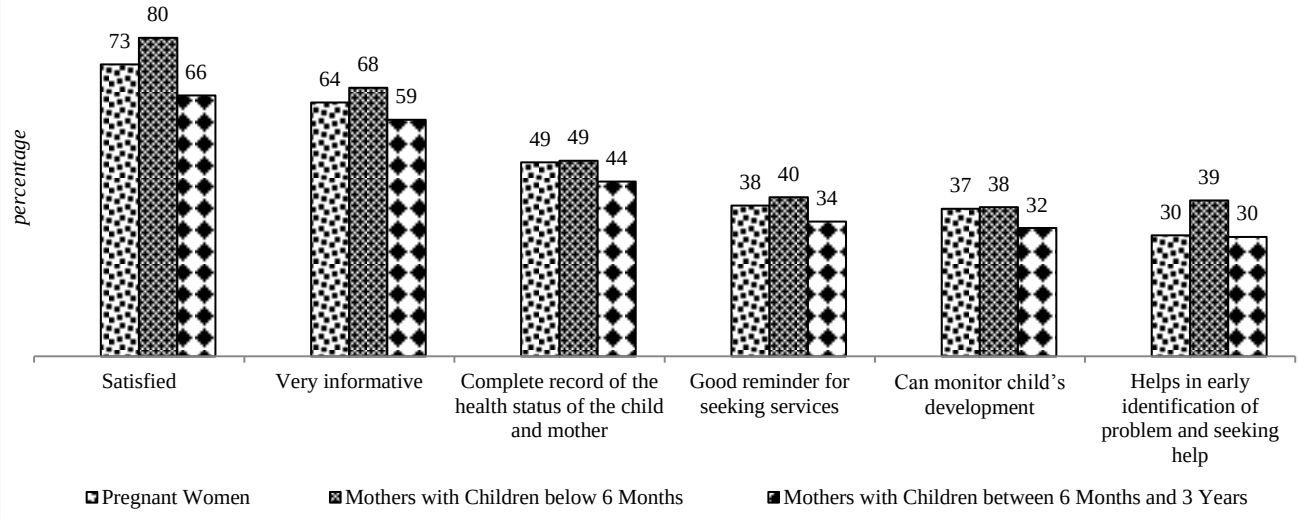
Cannot be handled by mother	3	2.5	0	0.0	1	4.5	1	8.3	2	1.7
Not able to maintain the ANC/PNC, immunization records properly at the AWC	2	1.6	0	0.0	0	0.0	0	0.0	0	0.0

4.12.2 Opinion of Beneficiaries

4.12.2.1 Opinions of Beneficiaries on the Level of Satisfaction after the Usage of MCP Card

The opinions of beneficiaries after the usage of MCP Card are presented in **Fig. 27**. In all, 73 per cent of pregnant women; 80 per cent of mothers with children below 6 months and 66 per cent of mothers with children between 6 month and 3 years were satisfied with the MCP Card. Majority of the beneficiaries reported that the major reasons for satisfaction was that the MCP Card was very informative; it served as a good reminder for seeking services; it serves as a complete record of health status of the child and the mother. About one third of beneficiaries also reported that MCP Card can help in monitoring child's development and in early identification of problems and also in seeking timely help.

Fig. 27 Opinions of Beneficiaries on the Level of Satisfaction after the Usage of MCP Card



4.13 Problems Encountered during the Usage of the MCP Card

4.13.1 Responses of ICDS and Health Functionaries regarding Problems Encountered during the Usage of the MCP Card

The problems encountered while using the MCP Card is presented in **Table 35**. The CDPOs (58%) and MOs (36%) reported that workers are not recording the findings of check-ups in the MCP Card, as they see it as extra work. About 67 per cent of CDPOs and 45 per cent of MOs reported that the MCP Card is not being used for counselling women, as it should have been. The other relevant problems encountered in usage of MCP Card include- women being illiterate; and incomprehensible illustrations in the MCP Card. Also, The MCP

Card has not been a passport to easy care, as anticipated and even the inadequacy of referral support has not been felt by majority of functionaries, indicating that the potential of MCP Card has not been explored completely, yet. Most of the ASHAs did not report about the problems encountered, as probably they are not using the MCP Card directly in the field areas.

Table 35: Responses of ICDS and Health Functionaries regarding Problems Encountered during the Usage of the MCP Card

Problems Encountered on the Usage of MCP Card	ICDS Functionaries						Health Functionaries						ASHAs n=116	
	AWWs n=119		Supervisors n=24		CDPOs n=12		ANMs n=22		LHVs n=12		MOs n=11			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Workers are not recording in the MCP Card as it is extra work	19	16.0	5	21.0	7	58.0	5	22.7	4	33.0	4	36.0	5	4.3
Women are losing/ misplacing the Card	24	20.2	10	42.0	4	33.0	8	36.4	4	33.0	5	45.0	14	12.1
Card is not used for counselling women	16	13.4	5	21.0	8	67.0	1	4.5	0	0.0	5	45.0	1	0.8
Card has not been a passport to easy care as anticipated	10	8.4	5	21.0	3	25.0	3	13.6	1	8.0	1	9.1	2	1.7
Referral support is inadequate	9	7.5	6	25.0	4	33.0	3	13.6	0	0.0	1	9.1	5	4.3
Card has not reached all the beneficiaries	14	11.8	4	17.0	3	25.0	4	18.2	1	8.0	1	9.1	4	3.4
Most of the women are illiterate	29	24.4	12	50.0	4	33.0	9	40.9	4	33.0	4	36.0	14	12.1
Not able to understand the illustrations in the MCP Card	21	17.6	10	42.0	5	42.0	3	13.6	3	25.0	3	27.0	8	6.9
Incomplete information recorded in the Card as it is with the mother and not at the AWC	4	3.3	3	13.0	3	25.0	1	4.5	3	25.0	4	36.0	1	0.8
Problems in coordinating with other services	4	3.3	2	8.3	2	17.0	2	9.0	0	0.0	5	45.0	4	3.4

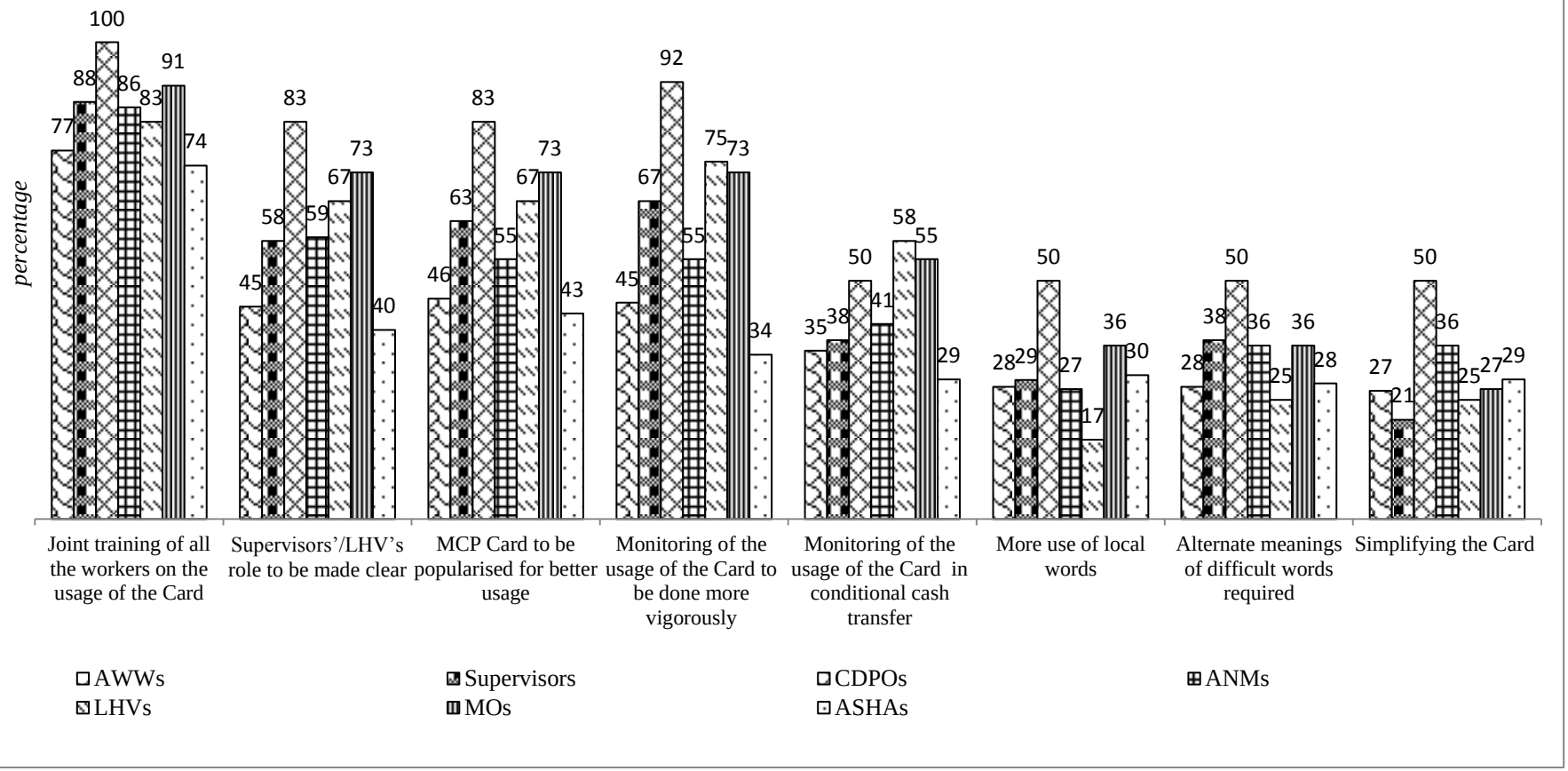
4.14 Suggestions for Effective Utilisation of MCP Card

4.14.1 Suggestions of Functionaries

4.14.1.1 Suggestions of ICDS and Health Functionaries for Effective Utilisation of MCP Card

The suggestions of ICDS and health functionaries for effective utilisation of MCP Card are presented in **Fig. 28**. The suggestions that has been expressed by both ICDS and health functionaries univocally is that there is a need for joint training of all the functionaries on the usage of MCP Card, to dispel any confusion, that may be there. Majority of CDPOs (83%) and MOs (73%) felt that the Supervisors /LHVs role in monitoring of the MCP Card needs to be made clear. Regular and proper monitoring of MCP Card has been a major suggestion from CDPOs (92%) and MOs (73%). The other suggestion that came forth include- popularising the MCP Card for its better usage; monitoring the usage of the Card in conditional cash transfer; need for more use of local words in the Card; simplifying the MCP Card, etc.

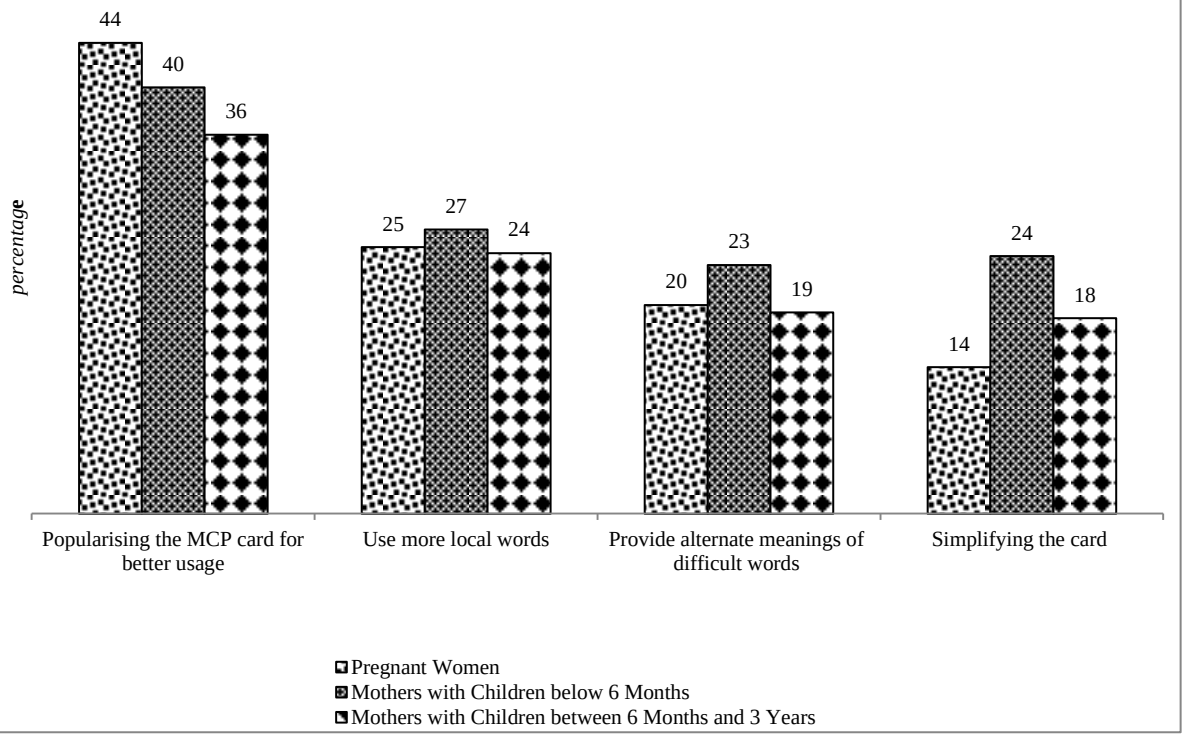
Fig. 28 Suggestions of ICDS and Health Functionaries for Effective Utilisation of MCP Card



4.14.2 Suggestions of Beneficiaries

The suggestions of beneficiaries on the MCP Card include popularising the Card for better usage; use of more local words in the MCP Card; simplifying the Card; and providing alternate meaning of difficult words **(Fig. 29).**

Fig. 29 Suggestions of Beneficiaries for Better Utilisation of the MCP Card



5
CONCLUSIONS

CONCLUSIONS

The major findings of the study are presented in the following section.

5.1 Profile of the Respondents

- Majority of the beneficiaries were in the age group 20-24 years (54.8%), followed by 25-29 years (35.7%) and 30-34 years (8.2%), indicating that the fertility levels was higher in the age group 20-24 years. This is in line with the Sample Registration System (SRS) data of fertility levels being higher among 20-24 years age group.
- Over half of the family members of selected beneficiaries with children between 6 months and 3 years were above 40 years of age.
- The distribution of beneficiaries who had passed primary school, middle school, high school, intermediate, graduate and postgraduate level was 11.1 per cent , 18.0 per cent, 25.0 per cent , 23.0 per cent , 10.0 per cent and 2.0 per cent respectively. It may be mentioned that 10.9 per cent beneficiaries were illiterate among the respondents.

5.2 Procurement and Distribution of MCP Card by ICDS and Health Functionaries

- The procurement and distribution of the MCP Card in the sample states has been through the NRHM/Health department in Assam (100%), Jharkhand (100%); and Maharashtra (100%). Both NRHM/Health department and ICDS department were involved in the distribution of the MCP Card in the sample states of Haryana, Kerala and Madhya Pradesh, as reported by the Medical Officers.
- As reported by the ICDS functionaries, namely CDPOs and Supervisors, the MCP Card has been distributed to over 90 per cent of AWCs and is being maintained properly in over 87 per cent. Similarly, report from the health functionaries, namely MOs and LHVs, reveal that the MCP Card has been distributed to all Sub-centres and is being maintained properly in over 92 per cent. Though the report of Supervisors and LHVs {Supervisors (90.8%) and LHVs (92.4%)} match on the proper maintenance of MCP Card, there is over reporting observed when the responses of CDPOs and MOs {CDPOs (87.1%) and MOs (96.4%)} are compared.

- The reasons given by the ICDS and health functionaries for the MCP Card not being maintained properly in the areas, has been the lack of training on the usage of the MCP Card; followed by lack of skills in using the MCP Card; indifferent attitude of beneficiaries; non- availability of the MCP Card; and losing/misplacing the MCP

Card by the beneficiaries. The reasons expressed by both health and ICDS functionaries point towards the need for training.

5.3 Orientation Training on the MCP Card by ICDS and Health Functionaries

- Among the ICDS functionaries only 21.9 per cent of AWWs, 16.7 per cent of Supervisors and 58.3 per cent of CDPOs had received some kind of orientation training on the MCP Card. Among the health functionaries, 40.9 per cent of ANMs, 58.3 per cent of LHVs; 9.1 per cent of MOs and 20.7 per cent of ASHAs had received orientation training on the MCP Card, this is a serious lacuna needing urgent remedial measures.
- The training was imparted mainly during the sectoral meetings or was integrated into other ongoing trainings. The duration of orientation training also varied across the respondents.

5.4 Awareness about MCP Card and its Maintenance among ICDS and Health Functionaries

- The awareness about the MCP Card among the grassroots level workers of ICDS and health systems, mainly AWWs, ANMs and ASHAs revealed that over 90 per cent of AWWs, ANMs and ASHAs, were aware about the MCP Card.
- Over 90 per cent of AWWs and ANMs and around 80 per cent of ASHAs responded that they had helped women in getting the MCP Card.
- In all, 82 per cent of AWWs; 90 per cent of ANMs and 76.7 per cent of ASHAs stated that the MCP Card is being maintained properly in their areas. Mother is mostly the custodian of the MCP Card.
- Among the beneficiaries, the awareness level was better among mothers with children between 6 months and 3 years (82.2%). Also, 67.2 per cent of mothers with children between 6 months and 3 years reported that they were explained about the MCP Card in contrast to pregnant women (59.6%), mothers with children below 6 months (60.8%) and family members (43.3%).
- The awareness of all beneficiaries and family members regarding the validity of the MCP Card was low.

5.5 Usage of MCP Card by ICDS and Health Functionaries

- About 95.8 per cent of AWWs; 87.5 per cent of Supervisors; 95.5 per cent of ANMs; 66.7 per cent of LHVs; and 90.5 per cent of ASHAs confirmed that they were using the MCP Card.
- The study reveals that the usage level has been low for functionaries at the supervisory level. The MCP Card has been used mainly with the pregnant women, during the ANC visits. Often, only the relevant section in the MCP Card was explained to the beneficiaries. This may be a hindering factor, as orienting about the MCP Card in totality may convey the benefits of the Card to the beneficiaries better.
- The purposes for using the Mother and Child Protection Card as reported by ICDS and health functionaries reveal that the MCP Card has been used by all the functionaries for explaining about – ANC services. As regards, explaining about preparation for delivery the MCP Card was used more often by LHVs. Supervisors had used the MCP Card more for weighing, plotting and counselling after weighing; explaining about danger signs in newborn and for explaining about nutrition play and communication activities. The AWWs had used the MCP Card the most for explaining about the services available under ICDS.

5.6 Knowledge and Awareness about Maternal and Child Health Issues

- It is heartening to note that over three-fourth of ANMs were aware of the present minimum number of antenatal check-ups to be four. Regarding past obstetric history, their responses included anaemia (86.4%); pregnancy included hypertension (81.8%); antepartum haemorrhage (77.3%); eclampsia (77.3%); post partum haemorrhage (77.3%); caesarean section (72.7%); and congenital abnormality (54.6%).
- The study revealed that recording of the chronic illnesss in the MCP Card by putting a tick mark was known to only 63.6 per cent of ANMs.
- The study also assessed the knowledge of ANMs regarding ‘what’ abdominal examinations reveal. The responses of ANMs included- checking foetal movement (81.8%); baby’s growth through checking the fundal height (77.3%); foetal heart rate per minute (77.3%); and lie/presentation of the baby (59.1%).

- The knowledge of AWWs and ASHAs on the danger signs during pregnancy and delivery needing referral revealed that the knowledge level of ASHAs was better than that of AWWs for the danger signs during pregnancy, namely, bleeding during

pregnancy; excessive bleeding during and after delivery; and bursting of water bag without labour pain. The knowledge level of AWWs was better than that of ASHAs for danger signs namely, severe anaemia; high fever during pregnancy; high fever within 30 days of delivery; and headache, blurring of vision, fits and swelling all over the body.

- The awareness and practices of pregnant women regarding care during pregnancy exhibit that the awareness about the LMP and EDD was 97.5 per cent and 70.8 per cent respectively. The source of information about LMP and EDD was mainly ASHAs; followed by ANMs and AWWs.
- Though, over 96 per cent of pregnant women were registered at AWCs and out of them only 60 per cent of pregnant women got registered in their first trimester. Only 24 per cent of pregnant women had the requisite recommended four antenatal check-ups.
- As regards, the investigations done during pregnancy, over 80 per cent responded that their blood pressure, weight, blood and urine sample was checked; around 69 per cent mentioned that the abdominal examination was done; about 67 per cent stated that they had receive two doses of tetanus toxoid injections.
- It was encouraging to note that the pregnant women were aware about their BP levels. About 66.3 per cent of pregnant women stated that they were informed about their weight during the ANCs. Only one-third of pregnant women were informed about the findings of the abdominal examination. Only half of the pregnant women were aware of normal weight gain during pregnancy.
- As regards, the awareness about why abdominal examination is performed during pregnancy, the responses included- to see how the baby is growing (60.%); to check baby's position (47.9%); to check foetal movement (45.8%); and to check foetal heart rate (35.4%).
- The study revealed that 'red colour box or words written in red letter', as danger sign, was known to only 22.5 per cent of pregnant women and 43.3 per cent of family members. The awareness level of family members regarding danger signs during pregnancy needing referral though fair was better than that of the pregnant women. The major information source about danger signs during pregnancy needing referral was AWWs (38.3%), followed by ASHAs (35.0%) and ANMs (31.7%), reiterating

the point that the grassroots level workers need to be oriented to the MCP Card for yielding better impact.

- Less than 10 per cent of pregnant women were referred to a higher facility during the present or previous pregnancy as reported by pregnant women. The referral source has been ASHAs; followed by AWWs; and ANMs. All the cases referred visited the higher health facility wherever referred; but only half of them mentioned that they are aware that the referral history was recorded in the MCP Card.
- Only 58.8 per cent pregnant women were aware about the recording of antenatal check-up in the MCP Card. The percentage of pregnant women who were able to show correctly recording of weight, blood pressure, TT injection and quantity of iron and folic acid (IFA) tablets issued were 55 per cent , 49.6 per cent, 52.5 per cent and 40.4 per cent respectively.
- The percentage of pregnant women who were able to show correctly the section on rest, sleep and care during pregnancy and danger signs during pregnancy was 40.8 per cent and 37.5 per cent respectively.
- It was encouraging to note that over 90 per cent of ANMs could define preterm delivery. Recommended postnatal visit for a mother and child, in case of a normal delivery, and in low birth babies was known to only 50 per cent of ANMs.
- The knowledge of AWWs on the information to be filled in of the MCP Card revealed that over two-thirds of AWWs were aware about filling-in of the date and time of delivery; weight of the baby; sex of the baby; place of delivery; and type of delivery. However, the level of knowledge was not very encouraging as regards, the time of initiation of breastfeeding; term/ pre-term; about child's cry at the time of birth; about the complications; and period of stay post delivery. There is a dire need for orienting the AWWs on the above issues as other-wise, the purpose of MCP Card would be lost.
- It was heartening to note that about 70 per cent of deliveries were conducted in the government infrastructure.
- The requisite number of four postnatal visits after delivery was received only one-fourth of mothers with children below 6 months and one-third of mother with children between 6 months and 3 years.
- The responses on the components of monitoring newborn include fever (86.4%); urine passed (81.8%);diarrhoea (81.8%); vomiting (77.3%); stool passed (72.7%); jaundice

(72.7%); chest in-drawing (68.2%) ; convulsions; sucking good or poor; (63.6 per cent each); condition of umbilical cord; activity monitoring (59.1 per cent each); and skin pustules–present or absent (54.6%).

- The knowledge of ANMs was better than that of AWWs and ASHAs for all danger signs in a newborn. The knowledge of AWWs was better than that of ASHAs as regards to danger signs, such as, baby unable to cry; baby having difficulty in breathing; yellow palm and soles; blood in stools; convulsions; and lethargic/unconscious. The knowledge of ASHAs was better than that of AWWs as regards, weak sucking or refusal to breastfeed; and fever. As regards, the sign, 'cold to touch' both AWWs and ASHAs, exhibited similar level of knowledge.
- Only one-fourth of mothers with children below 6 months; half of mothers with children between 6 months and 3 years and two–fifth per cent of family members were aware about what is written in the MCP Card regarding the care of newborn. On the whole, the awareness regarding 'danger signs in a newborn needing referral' was better than for the 'general care of newborn'. But words written in red letters denoting 'danger' and that the health worker needs to be contacted immediately, was known to less than one-fourth of mothers with children between 6 months and 3 years.
- The data also revealed that about one-fourth of mothers with children between 6 months and 3 years reported that they were referred to a higher health facility. ASHA has been the main source of information for such referral. Out of these, one-fifth had complied with the advice and very few mothers with children between 6 months and 3 years knew that the referral history was recorded in the MCP Card.
- The awareness level regarding the care of newborn among the other beneficiary groups, namely mothers with children below 6 months and the family members as regards these indicators was abysmally low, pointing towards the need for better orientation .
- The perception of family members on the provisions to be made in case of an emergency. related to women and children included saving up money for unexpected medical expenses (78%); identifying government/ private hospital (81%); making arrangements for transportation of women and children (73%); and remembering to take MCP Card along with them during referral (58%). The awareness levels among

the functionaries, as well as the beneficiaries, could be improved for a better impact by stressing on the MCP Card as a referral tool.

- The knowledge of AWWs, ANMs and ASHAs on some of the parameters of feeding and care of young children were ascertained using some 'true and false' statements revealed that on the whole, ASHAs had scored better than AWWs and ANMs for most of the parameters, such as, initiation of breastfeeding within an hour of birth; babies should be fed 8 to 10 times during day and night and ANM; and a child over one year need to be dewormed biannually. The knowledge level of ANM was better than that of ASHA and AWW for parameters, namely, breastfeeding can be continued upto 2 years or beyond; and the vaccines given at birth are BCG, OPV and Hepatitis B. The knowledge level of all grassroots level workers need updating for parameters such as, child does not need water in summer along with breast milk in the first six months; breastfeeding should not be stopped during diarrhoeal episodes; and that iodised salt is good for health, as still 20-30 per cent of grassroots workers do not have right knowledge.
- It was heartening to note that about 86 per cent of mothers with children below six months had initiated breastfeeding within an hour after birth. Awareness about exclusive breastfeeding for mothers with children between six months and three years was 93 per cent. However, there is a need to update mothers on all issues relating to regarding breastfeeding and complementary feeding for yielding better results.
- As regards the knowledge and practices of AWWs on the steps in growth monitoring, it was heartening to note that majority of the AWWs were knowledgeable.
- About 91.6 per cent of mothers with children below 6 months and 96.1 per cent of mothers with children between 6 months and 3 years had got their child weighed at birth. The birth weight was known to 75.8 per cent of mother with children below 6 months and 74.4 per cent of mothers with children between 6 months and 3 years.
- Only 56.6 per cent mothers with children below 6 months and 67.2 per cent mothers with children between 6 months and 3 years knew that the child under six months needs to be weighed monthly.
- The awareness about the colour of the growth chart i.e. pink chart for girl was known to only 12.5 per cent of mothers below six months and 21.1 per cent mothers with children between 6 months and three years; and blue chart for boys was known to only 16.6 per cent of mothers with children below 6 months and 21.6 per cent of

mothers with children between 6 months and three years. Only 31.6 per cent of mothers with children below 6 months and 45.5 per cent of mothers of children 6 months and 3 years confirmed that the AWWs had discussed the growth chart with them. This is a serious lacuna and needs to be addressed squarely.

- The timing of discussing the growth chart varied with only 25 per cent of mothers with children below 6 months and 40 per cent of mothers with children between 6 months and 3 years affirming that the AWWs discussed the growth chart with them immediately after weighing. Another stark finding was that there was gross over reporting by the AWWs about the timing of discussing the growth chart, which was not corroborated by the beneficiaries.
- The ability of beneficiaries to show correctly in the MCP Card the recording of findings of check up of the child revealed that only 43 per cent of mothers with children below 6 months, 35 per cent of mothers with children between 6 months and 3 years and 23 per cent of family members were aware about the recording of findings about the child, made in the MCP Card.

5.7 Knowledge and Awareness about Feeding, Play and Communication

- The ability of mothers with children below 6 months was better than those of mothers with children between 6 months and 3 years, who showed better ability in showing correctly the section on 'feeding, playing and communicating with children'.
- The knowledge level of AWWs, ANMs and ASHAs on play and communication revealed that the knowledge level of ANMs was better than those of AWWs and ASHAs. The advice on combining play and communication activities during feeding, bathing, etc. was reported by 77.2 per cent of ANMs, 70.5 per cent of AWWs and 64.6 per cent ASHAs. Using any household objects that are clean and safe, in case a mother has no toys was reported by 81.8 per cent of ANMs, 76.7 per cent of ASHAs and 75.6 per cent of AWWs. The advice to be given to a mother in case a child seems slow as revealed from the study included asking the mother to spend more time interacting with the baby [AWWs (80.6%), ANMs (77.2%) and ASHAs (75.0%)]; checking whether the baby is able to see and hear [AWWs (58.8%) ANMs (63.6%) and ASHAs (45.6 %)]; and referring to special services if the child has difficulty in seeing or hearing {AWW (65.5%), ANM (77.2%) and ASHAs (52.6%)}.

- The knowledge level of grassroots level workers on the developmental milestones in children for the various milestones revealed that the knowledge level needs to be enhanced for all the grassroots level workers.
- The ability of beneficiaries to understand clearly the messages in the MCP Card related to feeding children aged 6 months to 3 years was ascertained by showing the MCP Card to them and the responses thereby elicited revealed that only 46.6 to 57.7 per cent of beneficiaries could tell clearly, what is given in the MCP Card regarding the sections on 'feeding children aged 6 to 12 months; 'feeding children aged 1 to 2 years and 'feeding children aged 2 to 3 years'.
- Three-fourth of the mother knew that a child upto 6 months can communicate and play with her. Less than half of them reported that they were explained about it by the functionaries. Majority of mother (85.8%) knew that a child under 6 months can smile in response. The awareness about the ability of a child to make a sound; holding head steady; tracking a ribbon bow; reaching out for objects; and turning to a voice was 74.2 per cent; 61.6 per cent; 55 per cent; 55.0 per cent; and 68.3 per cent.
- As regard, the awareness about how a mother can promote development of children below six months, about 50 per cent of mothers were aware about smiling, laughing, looking into child's eyes and talking to the child.
- The ability of mothers with children 6 months to 3 years to understand clearly the messages in the MCP Card related to playing and communicating with children 6 to 12 months was better than that of family members, for both, 'what a child aged 6-12 months can do', as well as, 'how we can promote development of children aged 6-12 months'. Only 48.3 to 57.2 per cent mothers with children between 6 months to 3 years were aware about what a child aged 6-12 months can do, in contrast to 28.3 to 38.3 per cent of family members. Similarly, the awareness about 'how to promote development of children aged 6-12 months' ranged between 50.5 to 56.1 per cent for mothers with children between 6 months to 3 years and 30.0 to 33.3 per cent of family members.
- The ability of mothers with children 6 months to 3 years to understand clearly the messages in the MCP Card related to playing and communicating with children 1 to 2 years was better than those of family members, with regard to what is given in the MCP Card regarding 'what a child 1 to 2 years can do' and 'what can be done to promote development of children 1 to 2 years'. Only 43.8 to 56.1 per cent mothers

with children between 6 months to 3 years were aware about 'what a child aged 1 to 2 years can do', in contrast to 23.3 to 40.0 per cent of family members. Similarly, the awareness about 'how to promote development of children aged 1 to 2 years' ranged between 49.4 to 55.5 per cent for mothers with children between 6 months to 3 years and 31.6 to 38.3 per cent of family members.

- The ability of mothers with children 6 months to 3 years to understand clearly the messages in the MCP Card related to playing and communicating with children 2 to 3 years was better than those of family members as regards, what is given in the MCP Card regarding 'what a child 2 to 3 years can do' and 'what can be done to promote development of children 2 to 3 years. Only 46.1 to 56.1 per cent mothers with children between 6 months to 3 years were aware about 'what a child aged 2 to 3 years can do', in contrast to 30.0 to 41.6 per cent of family members. Similarly, the awareness about 'how to promote development of children aged 2 to 3 years' ranged between 47.7 to 52.2 per cent for mothers with children between 6 months to 3 years and 31.6 to 38.3 per cent of family members.
- It may be further mentioned that only 10.9 per cent of mothers were illiterate. This point to the fact that the beneficiaries need to be oriented about the MCP Card, for taking full advantage of the MCP Card.

5.8 Role Perception of ICDS and Health Functionaries with regard to MCP Card

- The efforts made by CDPOs and MOs for popularising and publicising the MCP Card include introducing the card during community growth monitoring and counselling session; during the regular field monitoring visits; during VHNDs; through the schemes such as JSY, IGMSY etc. and by giving publicity through Field Publicity Unit, local television channel/radio.
- The role perception and job performance of AWWs, ANMs and ASHAs such as 'recording of information only' and 'explaining/ counselling' with regard to various sections in the MCP Card was ascertained. The responses of AWWs, ANMs and ASHAs with regard to the role perceived by them, such as, 'recording of information only' and 'explaining/ counselling' for various sections in the MCP Card revealed that majority of AWWs have perceived 'recording of information' in the MCP Card as their main role with respect to growth monitoring and promotion (78.1%); family identification (60.5%); immunisation and vitamin A supplementation (50.4%); and playing and communicating with children (45.3%). The role perception of AWWs

about their own role related to counselling and explaining to the beneficiaries about the various issues is grossly inadequate.

- The study revealed that the role perception and job performed by ANMs, with regard to the various sections in the MCP Card, as reported by them is very lucid. The role perceived and job performed by ANMs, herself focus mainly on 'recording of information' in the MCP Card related to regular check-ups during pregnancy (77.2%); danger signs during pregnancy (77.2%); postnatal record of mother (81.8%); record of newborn baby (81.8%); newborn care and danger signs in a newborn (59.0%); care during illness (63.6%) immunisation and vitamin A supplementation (68.1%). The role perception of ANMs about their own role related to counselling and explaining the beneficiaries about the various issues is grossly inadequate. However, it was encouraging to note that, though the ANMs do not perceive it their role to do growth monitoring and promotion, they identify with the role as a counsellor (59.0 %) in growth monitoring and promotion.
- The role perception and job performed by ASHAs with regard to the various sections in the MCP Card was moderate. The job perceived and performed by ASHAs as reported by her, focus mainly on 'explaining and counselling' for early initiation of breastfeeding (60.3%); family planning (56.0%); newborn care and danger signs in a newborn (50.8%); immunisation and vitamin A supplementation (47.4%); care during illness (53.4%); and feeding, playing and communicating with children (45.6%), which is close to the way her role has been perceived under the NRHM. The ASHAs mainly perceived their role, as a recorder of information with respect to only 'family identification'.

5.9 Support and Supervision with regard to MCP Card

- Almost all CDPOs (75%) and MOs (100%) affirmed that they monitored the usage of MCP Card. The nature of tasks monitored as reported by both CDPOs and MOs include monitoring the usage of the MCP Card; checking the availability of the MCP Card; monitoring the distribution of the MCP Card; educating about service entitlement during VHNDs; use of MCP Card for recording of services; usage of MCP Card as on entitlement Card under JSY; usage of MCP Card as an entitlement Card under IGMSY; usage of MCP Card as a counselling tool or not; and monitoring compliance of feedback during review meetings.

- Almost all the Supervisors (100%) and LHVs (75%) affirmed that they monitor the usage of the MCP Card. Mainly, check the availability of the MCP Card {Supervisors (83%) and LHVs (67%)}; and monitor distribution of the MCP Card {Supervisors (88%) and LHVs (67%)}; is monitored. The nature of other tasks monitored with regard to the MCP Card include monitoring the usage of the MCP Card foreducating about service entitlement during VHND {Supervisors (75%) and LHVs (58%)}; Recording of ANC in the MCP Card {Supervisors (63%) and LHVs (67 %)}; recording of PNC {Supervisors (54%) and LHVs (58%)}; recording of newborn care {Supervisors (63%) and LHVs (58%); recording of immunisation {Supervisors (83%) and LHV (67%)}; recording of weight of the child {Supervisors (75%) and LHVs (67%)}; recording of developmental delays {Supervisors (50%) and LHVs (58%)}; use of MCP Card as an entitlement under JSY {Supervisors (58%) and LHVs (50%)}; use of MCP Card as an entitlement tool under IGMSY {Supervisors (33%) and LHVs (8%)}; use of MCP Card as a counselling tool or not {Supervisors (54%) and LHVs (67%)} and monitoring compliance of feedback given during review meetings {Supervisors (54%) and LHVs (67%)}
- Supervisors' responses on the nature of supervision provided during the monitoring visits and responses of AWWs agreeing with it, revealed that supervision was done by giving verbal instructions{Supervisors (75%) and AWWs (85%)}; by demonstrating the usage of MCP Card {Supervisors (88%) and AWWs (62%)}; by providing guidance in recording of information {Supervisors (63%) and AWWs (54%); by providing hands-on training on counselling mothers after weighing the child {Supervisors (63%) and AWWs (45%)}; by explaining about various sections of the MCP Card {Supervisors (67%) and AWWs (48%)}; and by explaining about play and communication activities {Supervisors (67%) and AWWs (47%)}. The responses of AWWs reveal that there has been over reporting by Supervisors on the nature of supervision provided by them to AWWs.
- The responses of Supervisors on the supervision provided during GMP and responses of AWWs corroborating it include checking whether regular weighing of children is being carried out or not {Supervisors (54 %) and AWWs (56%)}; weight plotting is upto date or not {Supervisors (38%) and AWWs (44%)}; weights are plotted correctly or not {Supervisors (46%) and AWWs (35%)}; weight points are joined to form the growth curve {Supervisor (46%) and AWWs (31%)}; and checking calculation of date

of birth {Supervisor (38%) and AWWs (29%)}. The responses of Supervisors and AWWs showed that they are slightly in tune with each other.

- LHVs responses on the nature of supervision provided during the monitoring visits and the responses of ANMs confirming it, reveal that supervision was given mainly by verbal instruction {LHVs (92%) and ANMs (91%)}; by demonstrating the use of MCP Card {LHVs (75%) and ANMs (36%)}; providing guidance in recording information {LHVs (83%) and ANMs (55%)}; providing hands on training in recording of findings in the MCP Card {LHVs (33%) and ANMs (27%)}; explaining about various sections of the MCP Card {LHVs (67%) and ANMs (59%)}; explaining about play and communication activities {LHVs (58%) and ANMs (32%)}. The responses of ANMs reveal that there has been over reporting by LHVs on the nature of supervision provided by them to ANMs.
- The responses of LHVs on monitoring of problematic areas with regard to care of women and children and responses of ANMs corroborating it, include checking whether regular check-ups of children are being carried out or not {LHVs (58%) and ANMs (41%)}; recording of the findings of the check-ups are upto date or not {LHVs (50%) and ANMs (45%)}; early identification and referral of at-risk women and children are being carried out or not{LHVs (33%) and ANMs (45%)}; danger signs during pregnancy and in newborn are being explained using the MCP Card or not {LHVs (17%) and ANMs (50%)}; and MCP Card is being used effectively for counselling women or not {LHVs (33%) and ANMs (27%)}. The study revealed that there is a mismatch in the responses of LHVs and ANMs, with the ANMs not corroborating some of the responses of LHVs.
- The various ways in which the MCP Card has facilitated in supervision include better monitoring of AWWs/ ANMs; in better coordination among health and ICDS for functionaries; in establishing a functional linkage among the workers; in recording of vital events; in serving as a reminder for delivery of services; in developing a functional referral system; by enhancing credibility in the community; by serving as discussion tool during supervisory visits; and in liasioning with other departments.

5.10 Perception about Contribution of MCP Card in Improving Interface between ICDS and Health Functionaries

- Over 78 per cent of ICDS and health functionaries opine that the MCP Card has contributed in improving the interface between ICDS and health functionaries. The ways in which the MCP Card has contributed leading to better interface include- facilitating in understanding each other's role; serving as a tool for educating the community; helped in building better rapport with the community by exhibiting a continuum in the care; facilitating in helping each other in a more systematic manner; reinforcing the messages has helped in uptake of services; and gaining credibility in the community by identifying and managing at-risk cases. The study revealed that CDPOs strongly affirm that the MCP Card has contributed in improving the interface between ICDS and health functionaries and that the MCP Card has facilitated the grassroots level workers in better understanding of each other's role.
- About 89 per cent of AWWs, 77 per cent of ANMs and 91 per cent of ASHAs reported that they conducted home visits alone and this has been confirmed by the beneficiaries. Joint home visits though mandated is very few and is not happening on a regular basis.
- The feedback of beneficiaries on the home visits by AWWs, ANMs and ASHAs was also ascertained to understand the existing interface between the grassroots level workers. The study revealed that 76.2 per cent of pregnant women; and 75 per cent of mothers with children below 6 months and 75 per cent mothers with children between six months and three years reported that the three grassroots level workers visited their home alone, pointing towards lack of interface between the grassroots level workers.

5.11 Contribution of MCP Card in Outreach and Utilisation of Health and ICDS Services

- The responses of ICDS and health functionaries on how MCP Card has contributed in better outreach and utilisation of ICDS and health services are that MCP card has facilitated in- improved access to services; better understanding of self care; better ANC; timely action, in case of at-risk cases; early risk identification and seeking timely treatment; saving life of women and children; and increased uptake of all services.
- It seems that benefits of the MCP Card have yet not been felt by the beneficiaries. However, around 50 per cent of pregnant women, mothers with children below 6 months and mother with children between six months and 3 years feel that the MCP

Card has helped in better understanding about self care. Roughly, 40 per cent of all the beneficiaries expressed that the MCP Card has facilitated in better ANC and improved access to services.

- Roughly, 35 per cent beneficiaries reported that the MCP Card has helped in getting appropriate referral services. One-fourth of pregnant women reported that MCP Card holder are given preference over other the patients. One-third of all beneficiaries reported that the MCP Card helped in getting timely and right treatment.

5.12 Level of Satisfaction after the Usage of MCP Card

- In all, over 80.7 per cent of AWWs; 100 per cent of Supervisors, 90.9 per cent of ANMs; and 83.3 per cent of LHVs expressed their satisfaction with the use of MCP Card. The major reasons for satisfaction with the MCP Card have been that the Card is very informative as per all the functionaries; it is one record for all services; and has contributed in easy keeping of the record of the child and mother. The responses of ASHAs have been luke warm, probably because she is not directly involved in record keeping, *per se*.
- In all, 73 per cent of pregnant women; 80 per cent of mothers with children below 6 month and 66 per cent of mothers with children between 6 month and 3 years were satisfied with the MCP Card. Majority of the beneficiaries reported that the major reasons for satisfaction was that the MCP Card was very informative; it serves as a good reminder for seeking services; it serves as a complete record of health status of the child and the mother. About one third of beneficiaries also reported that MCP Card can help in monitoring child's development and in early identification of problems and also in seeking timely help.

5.13 Problems Encountered during the Usage of the MCP Card

- The CDPOs (58%) and MOs (36%) reported that workers are not recording in the MCP Card, as they see it as extra work. About 67 per cent of CDPOs and 45 per cent of MOs reported that the MCP Card is not being used for counselling women, as it should have been. The other relevant problems encountered in usage of MCP Card include- women being illiterate; and incomprehensible illustrations in the MCP Card. Also, the MCP Card has not been a passport to easy care, as anticipated and even the inadequacy of referral support has not been felt by majority of functionaries, indicating that the potential of MCP Card has yet not been explored completely, yet.

Also ASHAs did not report about the problems encountered as probably they are not using the MCP Card in the field areas.

5.14 Suggestions for Effective Utilisation of MCP Card

- The suggestions that has been expressed by both ICDS and health functionaries univocally is that there is a need for joint training of all the functionaries on the usage of MCP Card, to dispel any confusion, that may be there. The other suggestion that came forth include- popularising the MCP Card for its better usage; monitoring the usage of the Card in conditional cash transfer; need for more use of local words in the Card; and simplifying the MCP Card.

6
RECOMMENDATIONS

RECOMMENDATIONS

The major recommendations drawn, based on the findings of the present study are as follows:

- MCP Card printing as a part of APIP of ICDS and PIP of health has been a contributing factor in rolling out of the MCP Card in some states (UNICEF, 2012)[13]. This may be adhered to for speedy rolling out of the MCP Card in all States.
- Periodic supply reviews at district level should be carried out regularly and modalities to deal with shortage be worked out at the district level.
- There is a need to develop a mechanism to verify the reach of MCP Cards to all AWCs, apart from the data obtained from VHND monitoring format.
- Clubbing training on the MCP Card with other ongoing trainings should be encouraged so that all the functionaries are trained. Also, joint vertical trainings with NRHM by pooling budgets should be carried out wherever feasible, for better acceptance of the card at the community level.
- The essence of the MCP Card has not been captured by both health and ICDS functionaries, as per the findings of the study. It is intensely recommended that all efforts should be made to uphold the potential of the MCP Card, so as to prevent loss of its true spirit.
- All efforts should be made to ensure that the functionaries explain the MCP Card in totality to the beneficiaries, so that they are better aware of the benefits of the Card.
- It is recommended that in the all the training of health and ICDS functionaries on the MCP Card, as also in all the advocacy campaign on the MCP Card, the Card has to be introduced as a 'family empowerment tool', so as to facilitate the families to be able to access the services they need to live life safely.
- There is a need to create strong linkages with Mother Child Tracking System, wherein all cards are being assigned a unique code, for enhancing MCP Card usage.
- Linkage of MCP Card with various CCT Schemes, such as the JSY, IGMSY, etc. has contributed in the use of MCP Card at the community level, which can be scaled up in some states.
- There is a need for intensive hands-on training of AWWs on growth monitoring and counselling, for yielding better results.
- Less than 40 per cent of beneficiaries were aware about the recording of findings about their child, made in the MCP Card. There is an urgent need for skill training of grassroots level workers on recording on the MCP Card, as also, on explaining the

beneficiaries about the findings of the check-ups, to convey the total benefits of the MCP Card to the beneficiaries.

- The section on ‘’feeding, play and communication’ in the MCP Card is an addition over the previous health/immunisation cards used in the health and ICDS sector. It was disheartening to note that the knowledge level of grassroots level workers on the developmental milestones in children was low. Also, the ability of mothers with children from birth to 3 years to understand clearly the messages in the MCP Card related to playing and communicating with children was also not encouraging. This point to need for an intensive orientation of all the functionaries of ICDS and health systems on this new section, so that the potential of the MCP Card is understood and it is utilised in totality, to accrue maximum benefits.
- The present study revealed that majority of AWWs have perceived only ‘recording of information’ in the MCP Card as their main role but their perception about their own role related to counselling and explaining to the beneficiaries about the various issues is grossly inadequate. In order that grassroots level workers effectively counsel the beneficiaries for utilising services under ICDS/NRHM or for changing a certain behavior, they need to be trained in ‘counselling’, *per se*, in addition to the related subject.
- Since nutrition counseling is delineated as a service under the restructured ICDS, it is suggested that provisions for recording the services given under the component, be made in the MCP Card for each of the three grassroots level functionaries.
- It is also recommended that provisions should be made in the MCP Card for recording of services /counseling offered by each of the grassroots level workers during the stipulated home visits for postnatal and neonatal care, to improve accountability by each worker.
- In order to prevent and reduce undernutrition, special efforts have been made to introduce a new initiative ‘Sneha Shivir’ a community based care and nutrition counselling initiative for mothers/caregivers of under-threes in 200 high burden districts and endemic districts of Japanese Encephalitis (JE). It is recommended that provisions be made in the MCP Card for recording of services /counseling offered by each of the grassroots level workers under Sneha Shivir and Japanese Encephalitis (JE).

- There is a need to set up vigourous systems for field supervision of actual use of MCP Card by Supervisors.
- The ground use of MCP Card can be improved by including it as an agenda point in field monitoring and review meeting at state and district level. In Odisha, it is an agenda point in review meeting by district collector, which has given the needed impetus to the initiative of MCP Card.
- Supportive supervision is core to get optimum functioning of any programme. There is a need to showcase/document successful models for combined supportive supervision of AWWs, ANMs and ASHAs, as has been tried out in Valsad in Gujarat (UNICEF, 2011)[12].
- There is a need to develop a clear and defined, main responsibility/accountability of each in relation to the other for all major activities at the community level, so that she is fully aware of the roles and activities she must fulfill with regard to the MCP Card. There is also greater need to ensure that the distinct roles and responsibilities are clearly communicated between the ASHA, ANM, and AWW, to avoid overlap and increase efficiency.
- Majority of beneficiaries of the present study reported that AWWs, ANMs and ASHAs conducted home visits alone. Home visits conducted alone, are missed opportunities for providing supportive supervision. This finding calls for a need for clear-cut guidelines on home visits by the health and ICDS functionaries, as also, role clarification on the same, to maximise health gain.
- There are many pointers from the study on the need for more advocacy in the state with respect to introduction of the MCP Card for taking full advantage of the MCP Card, to yield the desired results.
- The introduction of a common Mother and Child Protection Card for both ICDS and NRHM, to strengthen the continuum of care for pregnant mothers and children under-three years of age, incorporating the new WHO Child Growth Standards, warrants that a column be specified in the MCP Card for ASHAs, as well, to record the care given by them to women and children.

REFERENCES

REFERENCES

1. Abraham, S., et al., (1991). Indian Experience of Home Based Mothers Card: ICMR Task Force Study. *Indian Pediatrics*, Nov. - Dec., 58 (6): 795-804.

2. Ghosh, Shanti (1994). Combined Mother and Child Card. *Indian Pediatrics*, 31: 726-727

3. Haider, S., et al., (2008). A Rapid Appraisal of Sahiya (ASHA) in Jharkhand. *Journal of Health and Population*, 2008, Vol. 31 (2), pp.80-84

4. Kalita, G., Snowden, H and Ghosh, S. (2006). The Effectiveness of the Mother and Child Protection Card as a Community Management Tool : A Case Study. Indore, NIPCCD Regional Centre. *49 p*.

5. National Institute of Public Cooperation and Development, New Delhi. (2005). Report of Pre-Test Study: Mother and Child Protection Card. New Delhi: NIPCCD. 121 p.

6. National Institute of Public Cooperation and Development, New Delhi. (2010). Growth Monitoring Manual. New Delhi. 179 p.

7. National Institute of Public Cooperation and Development, New Delhi. (2013). Guide Book: Mother and Child Protection Card. New Delhi. 125 p.

8. National Institute of Public Cooperation and Development, New Delhi. (2013). Evaluation of Functioning of Accredited Social Health Activists (ASHAs) in ICDS Related Activities. New Delhi. 182 p.

9. National Institute of Public Cooperation and Development, Regional Centre, Bangalore. (2014). Status of Implementation of MCP Card for Ante-Natal, Natal and Child Care Services- A Study. Bangalore. 100 p.

10. Pahari, D.P., Bastola S.P., Paudel, R., (2011). Factors Affecting Retention of Child Health Card in a Rural Area. *Journal of Nepal Health Resource Council*, Oct; 9(2): pp 154-8.

11. Shah, P. M., et-al., (1993). Evaluation of the Home-Based Maternal Record: A WHO *collaborative Study. Bulletin of the World Health Organization, 71(5): p. 535-54*

12. UNICEF, 2011. Mamta Abhiyan: Delivering Convergent Services for Improved Maternal and Child Health. *Briefing Paper Series 7: Innovations, Lessons and Good Practices*, pp.1-20

13. UNICEF (2012). Rollout of the WHO Child Growth and Development Standards and the Family Retained Mother and Child Protection Card in 13 States of India. New Delhi.42 p.

14. www.wcd.nic.in. Mother and Child Protection Card under ICDS and MRHM. Secretary's Letter. 2010, March. 2 pgs

ANNEXURES

Annexure-I

Joint Letter Dated 25-03-2010 Issued from Ministries of Women and Child Development and Health and Family Welfare for Introduction of MCPC under ICDS and NRHM

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Secretary to the Government of India
Ministry of Women & Child Development
Shastri Bhawan
New Delhi
Tel.: 23383586
Fax:23381495

K. Sujatha Rao
Secretary to the Government of India
Ministry of Health & Family Welfare
Nirman Bhawan
New Delhi
Tel.:23063221/23061863
Fax:23061252

As you may be aware that the Ministries of Health Family Welfare and the Women and Child Development have been taking initiatives through the National Rural Health Mission and ICDS with an idea for accelerating reduction in maternal, neonatal and infant mortality and child under nutrition. The ICDS currently provides the crucial community based outreach system with an outreach of 10.79 lakh AWCs to 150 lakh pregnant and lactating mothers and 688 lakh young children under 6 years, it links them with over 7.31 lakh ASHAs (Accredited Social Health Activists), around 1.46 Lakh Health sub centres, 23, 458 primary health centres and 4276 community health centres, FRUs and hospital facilities at different levels. With the universalisation, ICDS would reach out to 14 lakh habitations in 7076 projects in the country.

2. One major joint initiative in fact has been the adoption of WHO Child Growth Standards, with effect from 15 August 2008 in both ICDS and NRHM, through a joint circular dated 6 August 2008, issued by both the Secretaries of Women and Child Development and Health and Family Welfare, Government of India. This was based on the recommendations of a joint National Workshop in 2007. This initiative is being enriched and complemented by another decision of both the ministries to introduce a common Mother and Child Protection Card for both ICDS and NRHM, to strengthen the continuum of care for pregnant mothers and children under three years of age, incorporating the new WHO child growth and development standards. A copy of the Card is annexed.

3. The Mother and Child Protection Card is a maternal and child care entitlement card, a counseling and family empowerment tool which would ensure tracking of mother child cohort for health purposes. It is unique in linking maternal, newborn and child care, and focuses on the child holistically by integrating health, nutrition and development. It links critical contact points for strengthening the continuum of care and improving utilization of key ICDS, NRHM services, including immunization and Janani Suraksha Yojna. Besides, it is meant to promote key family care behaviours, highlights danger signs, and links families to the health referral system. The card would enable gender disaggregated tracking, to ensure optimal care for the girl child. The card includes the JSY and birth registration numbers.

4. With the increase in the outreach of ICDS as well as NRHM under which there are monthly fixed Village Health and Nutrition Days, and more than 4.28 lakh Village Health and Sanitation Committees, the common card would enable the large network of ASHAs, AWWs and ANMs to converge their efforts and utilize the critical contact opportunities more effectively. Being and entitlement card, it would ensure greater inclusion of unreached groups to demand and universalize access to key maternal and child care and health services.

5. We propose that the common Mother and Child Protection Card will be introduced both in ICDS and NRHM with effect from 1st April 2010. The sample copies of the card in Hindi and English will be shared with you by 25th March 2010, along with the Camera Ready Copy (CRC) on CDs for printing the same locally by the States. The States shall undertake a transliteration of the text into state official language and make only such adaptation as are essentially required. While doing so, the States shall ensure that the card does not alter in size and the font size is such that entries in each row and columns are easily readable. ICDS Mother Child Protection Card having state specific adaptations and transliterations were previously available in Urdu, Oriya, Bengali, Assamese, Gujarati, Marathi, Tamil, Teulgu and Kannada. This can be made use of. Financial resources for printing and dissemination of the cards will be provided from the State NRHM PIPs and/or ICDS. From 1st April 2010 onwards, the common Mother and Child Protection Card will progressively replace the earlier MHFW Jachcha Bachcha Card and the earlier ICDS mother child card.

6. Comprehensive training is proposed to be undertaken jointly by both the ministries for disseminating the card, using resource teams from NIHFW, NIPCCD, NIN, UNICEF and WHO. This training would be suitably integrated with regular training under ICDS and NRHM. A network of more than 800 national/state core trainers developed on the new WHO child growth standards and the Mother Child Protection Card would be roped in for this endeavour. Separate budget for the training would be provided through NRHM PIPs and ICDS.

7. We are confident that our shared commitment and synergistic action will help enhance maternal and child survival, their nutrition and development and thus assure the young children a good start to life.

With best wishes,

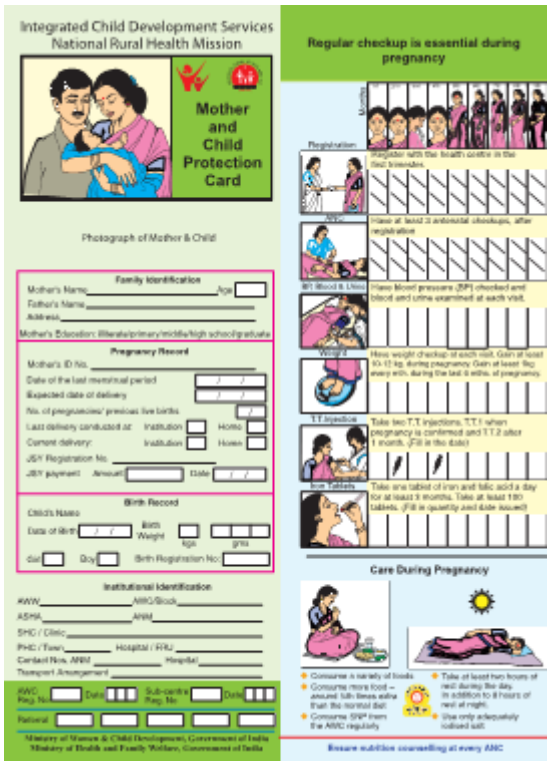
Yours sincerely

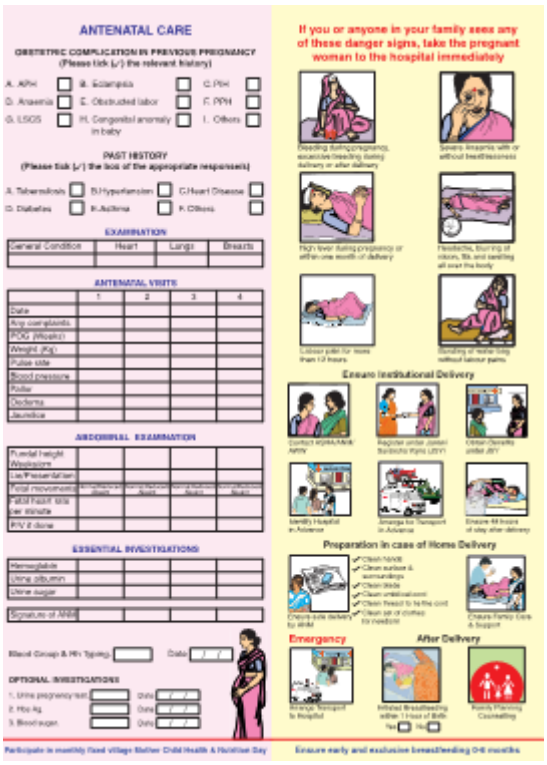
(D.K.Sikri) **(K. Sujatha Rao)**

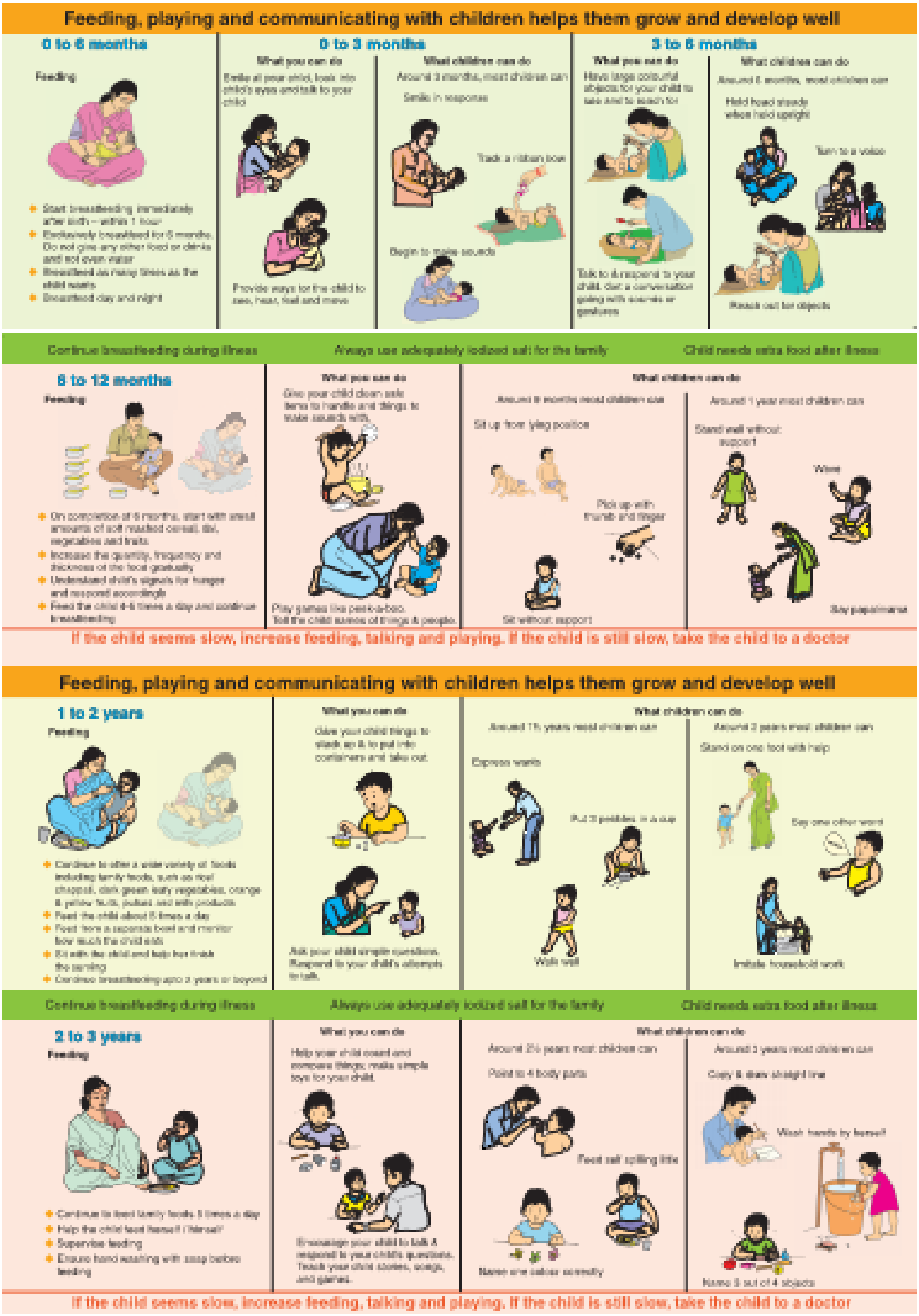
State Secretaries Health and Family Welfare
State Secretaries Women and Child Development

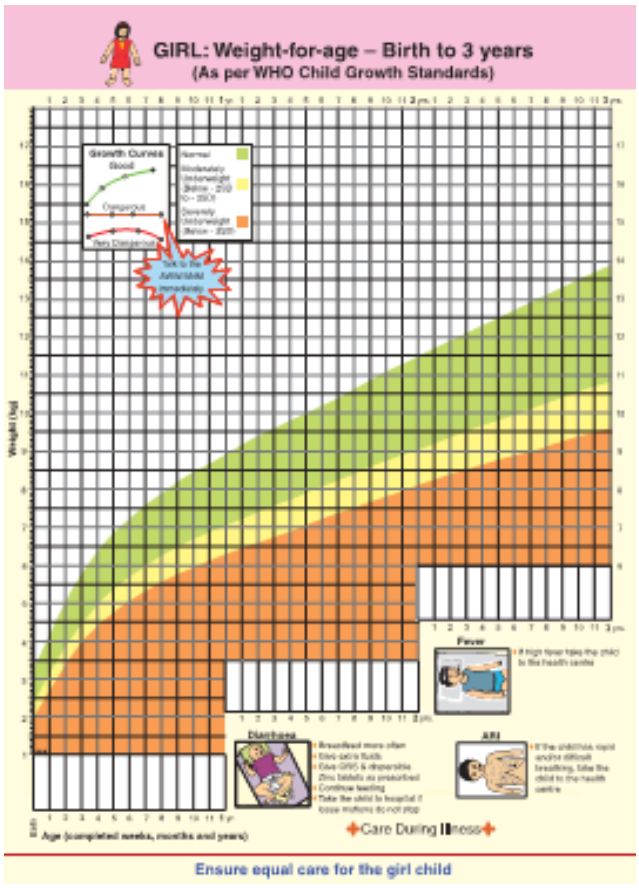
Annexure-II

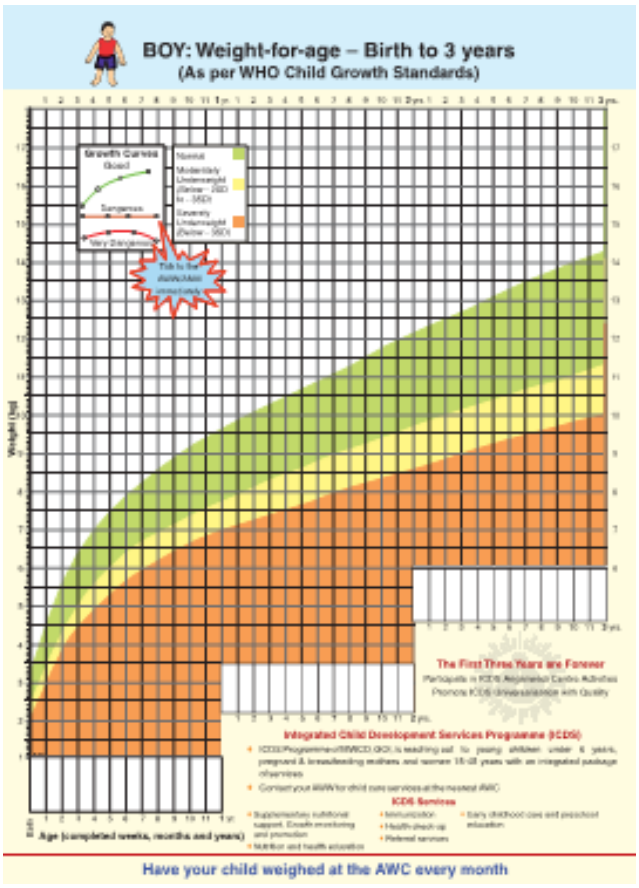
Mother and Child Protection Card






Feeding, playing and communicating with children helps them grow and develop well
0 to 6 months
Feeding
Start breastfeeding immediately after birth – within 1 hour
Exclusively breastfeed for 6 months. Do not give any other food or drink and not even water
Breastfeed as many times as the child wants
Breastfeed day and night
0 to 3 months
What you can do
Smile at your child, look into child's eyes and talk to your child
Provide ways for the child to see, hear, feel and move
What children can do
Around 3 months, most children can
Smile in response
Track a ribbon toon
Begin to make sounds
3 to 6 months
What you can do
Have large colourful objects for your child to see and to reach for
Talk to & respond to your child. Start a conversation going with sounds or gestures
What children can do
Around 6 months, most children can
Hold head steady when held upright
Turn to a voice
Reach out for objects
Continue breastfeeding during illness
Always use adequately iodized salt for the family
Child needs extra food after illness
6 to 12 months
Feeding
On completion of 6 months, start with small amounts of soft mashed cereal, rice, vegetables and fruits
Increase the quantity, frequency and thickness of the food gradually
Understand child's signals for hunger and respond accordingly
Feed the child 4-6 times a day and continue breastfeeding
What you can do
Give your child clean safe items to handle and things to make sounds with.
Play games like peek-a-boo. Tell the child names of things & people.
What children can do
Around 9 months most children can
Sit up from lying position
Pick up with thumb and finger
Sit without support
Around 1 year most children can
Stand well without support
Wave
Say papa/mama
If the child seems slow, increase feeding, talking and playing. If the child is still slow, take the child to a doctor
Feeding, playing and communicating with children helps them grow and develop well
1 to 2 years
Feeding
Continue to offer a wide variety of foods including family foods, such as rice/chapati, dark green leafy vegetables, orange & yellow fruits, pulses and milk products
Feed the child about 5 times a day
Feed from a separate bowl and monitor how much the child eats
Sit with the child and help but finish the learning
Continue breastfeeding upto 2 years or beyond
What you can do
Give your child things to stack up & to put into containers and take out.
Ask your child simple questions. Respond to your child's attempts to talk.
What children can do
Around 1½ years most children can
Express wants
Put 3 pebbles in a cup
Walk well
Around 2 years most children can
Stand on one foot with help
Say one other word
Imitate household work
Continue breastfeeding during illness
Always use adequately iodized salt for the family
Child needs extra food after illness
2 to 3 years
Feeding
Continue to feed family foods 5 times a day
Help the child feed herself / himself
Supervise feeding
Ensure hand washing with soap before feeding
What you can do
Help your child count and compare things; make simple toys for your child.
Encourage your child to talk & respond to your child's questions. Teach your child stories, songs, and games.
What children can do
Around 2½ years most children can
Point to 4 body parts
Feed self spilling little
Name one colour correctly
Around 3 years most children can
Copy & draw straight line
Wash hands by herself
Name 3 out of 4 objects
If the child seems slow, increase feeding, talking and playing. If the child is still slow, take the child to a doctor


GIRL: Weight-for-age – Birth to 3 years
(As per WHO Child Growth Standards)
Growth Curves
Good
Dangerous
Very Dangerous
Normal
Moderately Underweight (Below - 2SD to -3SD)
Severely Underweight (Below - 3SD)
Talk to the Anganwadi immediately
Fever
Diarrhoea
ARI
Age (completed weeks, months and years)
Care During Illness
Ensure equal care for the girl child


BOY: Weight-for-age – Birth to 3 years
(As per WHO Child Growth Standards)
Growth Curves
Good
Dangerous
Very Dangerous
Normal
Moderately Underweight (Below - 2SD to -3SD)
Severely Underweight (Below - 3SD)
Talk to the Anganwadi immediately
The First Three Years are Forever
Integrated Child Development Services Programme (ICDS)
ICDS Services
Age (completed weeks, months and years)
Have your child weighed at the AWC every month

Annexure-III

List of Project Coordinators at Various Sample States

S.No.	Sample State	District	Name, Designation and Address of the Project Coordinators
1	Assam	Kamrup	Dr. Achyut Kumar Baishya Director Regional Resource Centre, NE Assam Medical Council Bhawan (SIHFW Complex) G.S. Road, Khanapara Guwahati-22
2	Jharkhand	Ranchi	Dr. S. Haider Professor & Head Department of PSM, Rajendra Institute of Medical Sciences Ranchi, - 834009, Jharkhand
3	Kerala	Thiruvananthapuram	Dr. K. Vijayakumar Professor & Head Department of Community Medicine Medical College Thiruvananthapuram, Kerala
4	Madhya Pradesh	Indore	Dr. Sanjay Dixit Professor & Head Department of Community Medicine, MGM Medical College Indore, Madhya Pradesh
5	Maharashtra	Wardha	Dr. B. S. Garg Director, Professor & Head, DSNSPH Deptt. of Community Medicine Mahatma Gandhi Institute of Medical Sciences, Sewagram – 442102, Wardha, Maharashtra

Annexure-IV

Evaluation of Usage of Mother and Child Protection Card by ICDS and Health Functionaries

Guidelines for Project Coordinators

Data Collection

Six research teams will be deployed for data collection in the six identified sample States. The data for the study would be collected with the help of by NIPCCD faculty/ project staff in Haryana from the Northern region and with the help of Consultants / Experts in the other five Sample States, namely, Jharkhand from the Eastern region; Madhya Pradesh from the Central region; Maharashtra from the Western region; Kerala from the Southern region; and Assam from the North Eastern region. The Consultants are heading either the Department of Social and Preventive Medicine/ Community Medicine in Medical colleges or the Regional Resource Centre under the NRHM and have been identified for monitoring the ICDS Projects in their States. The Consultants / Experts will coordinate data collection through their research team and send it to the Institute. The data thus obtained will be analysed and a report would be prepared.

Specific Responsibilities of Coordinator (Consultants / Experts)

i) Selection of District
ii) Selection of Block
iii) Selection of Villages
iv) Orientation of the interviewers
v) Liaisoning with the MO, LHV, ANM, CDPO, Supervisor, AWWs and Beneficiaries at the village level
vi) Organizing data collection so as to finish the required number of interviews in each village within the stipulated time
vii) Checking of filled in schedules.

Orientation of Interviewers/Investigators

The **Coordinator (Consultants / Experts**) would be responsible for planning and orientation of the interviewers as well as covering of the following contents:

a) Orientation of the interviewers on situation of maternal and child health and nutrition in India/ State with special reference to sample States; ICDS and NRHM and its components- JSY, JSSK, IMNCI, IYCF, NRC, New WHO Child Growth Standards, IGMSY, etc.; Mother and Child Protection Card- need, users, target groups, color codes, advantages, etc.; roles and responsibilities of ICDS and Health functionaries with regard to the MCP Card; interface proposed between the health and ICDS functionaries on the use of MCP card, orientation to tools/ guidelines for collection of data; etc..

b) The investigators should be instructed to do physical verification of the MCP Card, wherever necessary.

c) The investigators should also be instructed to observe and make note of things/situations that may add value to the study;

d) Filling up of schedules

e) Techniques of interviewing and practical hands-on experience on filling-up of schedules.

Selection of Sample (ASHAs, Functionaries & Beneficiaries)

- Coordinator (Consultants / Experts) should make it a point to select District where ICDS has been operational and MCP Card have been in use.
- From each District two Blocks should be selected randomly. From each District two Blocks should be selected randomly.
- From each Block, five villages should be selected randomly.
- Medical Officer associated with procurement and distribution of MCP Card may be selected.
- The Coordinator (Consultants /Experts) should ensure that the LHV and ANM selected are using the MCP Card and are being monitored and supervised.
- The selection of AWW should be from selected villages where the MCP Card is being used and the Supervisor from the circles of selected villages.
- Coordinator (Consultants / Experts) should ensure that the ICDS beneficiaries are from selected villages where the MCP Card is in use.

- Further, pregnant women, Mothers with children upto 6 months and Mothers with children between six months and three years should be selected from selected villages where the MCP Card is in use.
- The Family Member should also be of selected beneficiaries with children between 6 months and three years.
- The following respondents from different categories of sample groups/functionaries will be included in the study from each State:

S. No.	Category	Number per State	Sampling Method	Sample	Total No.
ICDS Functionaries					
1.	AWW	2/ village	From selected villages	2x10	20
2.	Supervisor	2/Block	Two from each block	2x2	4
3.	CDPO	1/Block	One from each Block	1x2	2
Health Functionaries					
4.	ASHA	2/village	From selected villages	2x10	20
5.	ANM	2/Block	Two from each Block	2x2	4
6.	LHV	1/Block	One from each Block	1x2	2
7.	Medical Officer	1/Block	One from each Block	1x2	2
ICDS Beneficiaries					
8.	Pregnant Women	4/ Village	random	4x10	40
9.	Lactating Mothers with children below 6 months	2/village	-do-	2x10	20
10	Mothers with children between six months and three years	3/ Village	-do-	3x10	30
Others					
11	Family Members (of selected beneficiaries with children between 6 months and three years)	1/village	Family members of sample beneficiary	1x10	10
				GRAND TOTAL	**154**

Logistics

- As far as possible, the members of the research team (interviewers) should travel together for data collection.

- Rapport and introduction of the team should be made with the functionaries of the Health/ ICDS project, ASHAs and beneficiaries before initiating data collection.
- **A sample of MCP Card being used in the State may be sent along with the filled-in Schedules.**

Filling-up of Schedules

i) Questions need to be asked in the same order as given in the schedule.

ii) The responses should be put neatly against the questions.

iii) In open-ended questions, the responses should be filled neatly and legibly.

iv) All the questions should be asked and no question should be left unattended or incomplete. **Do not leave any box vacant/empty.** The **universal coding system** has to be followed which will run across all schedules as follows:

Code 0 – to be used for '**no response' (NR)**

Code 8 – To be used/filled for '**Do not know' (DK)**

Code 9 – To be used for '**Not applicable' (N.A)**

Wherever **actual no.** is to be filled, the boxes have to be filled in the following manner. For example, if the no. is 6

In case of two boxes | | | fill | 0 | 6 |

v) In **multiple choice questions** whatever response is given by the respondent should be considered as 1 (i.e., 'yes') and the other responses choices/blank boxes should be filled as 0 (i.e., 'no response'). Otherwise for each question/item, the code to be filled as specified against the question itself.

vi) In multiple choice questions, try to fit the responses in one of the answers given. In case one is not able to do so, write the remarks/answers received on the side. **Do not increase or make any box on your own.**

vii) While filling schedules, interviewers may be cautioned to assess if respondents are giving socially desirable answers. They may probe carefully to solicit the correct information. This would require all interviewers to be alert and observant so as to record valid and realistic replies only.

viii) Biases and prejudices is in no way should creep in while administering the schedules.

ix) Interviewers should be able to ask questions in local dialect/language without distorting their meanings. These responses would be recorded as per the format given in schedule and in English language only.

x) In no way, the interviewer should disapprove the statements made by the respondents and as far as possible should also avoid evaluative gestures or comments

xi) The filled-in schedules should be duly checked by the Coordinator (Consultants / Experts).

xii) The unfilled portion if any checked by the Coordinator should be filled-in the next day.

Stacking/Packing of Schedules

i) Arrange and bundle complete set of schedules for each State

ii) Each packet would have identification slip as follows:

1. Name of the State _____
2. Name of the District_____
3. Name of the Block_____
4. No. of Schedules in each category_____
5. Name & Signature of (Consultants / Experts) _____

Time Schedule for Data Collection

Data collection work in ICDS project should be completed within 30 days with the help of interviewers who should be Post-graduate/PG students from respective College/University.