



PUSTIKAR DIWAS



1. Introduction

Severe malnutrition may act as a direct cause of death or an indirect cause by increasing dramatically the case fatality in children suffering from common childhood illnesses, such as, diarrhoea and pneumonia. Current estimates suggest that severely malnourished children have a 10 to 20 times higher risk of dying than well nourished children.

In the past, formal treatment of severe malnutrition was restricted to inpatient approaches which greatly limited coverage and impact. Exciting new evidences suggest that large numbers of severely malnourished children can be treated in the community and do not need to be admitted into a hospital. There is an urgent need to incorporate the community-based approach as an integral part of the management of children with malnutrition to reach out to the majority of children and address this important cause of childhood mortality.

To effectively combat the problems of malnutrition and to reduce malnutrition prevalence rate in Orissa (from 44% to 35% by 2012: NRHM Goal) "Pustikar Diwas" has been conceptualized. This activity is one of the strategic interventions by the joint efforts of Health & Family Welfare Department and Women & Child Development department. This is to be organized once on the 15th Day of every month, in the Block PHC/CHC. Children in the Grade II, III, IV or severely underweight (New WHO Growth Standards) or severely acutely malnourished (MUAC <115 mm) shall be referred by the AWW/ANM to the Block PHC/CHC for management & treatment. The Medical Officers shall undertake the treatment as per the standard clinical protocol.

At the Block, PHC/CHC Medical Officers are required to undertake detailed examination, possible investigation, diagnosis and treatment of referred children, as per the treatment protocol. AWW & ICDS Supervisor shall perform their roles as per this operational guideline and also educate the community on the objective of Pustikar Divas.

2. Objectives

The objectives of Pustikar Divas are:

- To reduce the risk of death and disease amongst (0-5 yrs) children due to malnutrition.
- To prevent malnutrition in early childhood through the promotion of improved child feeding, care giving, and care seeking practices at the facility, family and community levels
- To strengthen the convergence between Health & ICDS in order to improve the nutritional status of (0-5 yrs.) children; and
- To strengthen the capacity of individuals, families, communities and the health systems to effectively manage and prevent malnutrition.

3. Implementation guidelines

Organization of the Day

- Information about the Pustikar Diwas will be prominently displayed in the AWC / SC/ PHC/ CHC / in the form of fixation of Board.



- Prior information to community to be given by ASHA, AWW with the help of PRI representatives & NGOs.
- AWW must be present on the day. BEE / LHV / ICDS Supervisor / MO /AYUSH MO/ CDPO/BPO as per the plan will participate and supervise the activities.
- All required logistic must be made available at the site. Those are: IEC Materials, weighing machines, History taking formats, registers for enrollment and money disbursement, referral slips.

4. Pre-Activity

- AWW will identify the malnourished children after measuring MUAC & weighing all the children in the VHND/AWC.
- AWW will fill-up the referral slip prior to 15th & handover to the parents. In case the AWW is not able to accompany the identified undernourished children to the Pustikar Diwas site, she will inform the ASHA to complete the task. She will give detail information of the child to the ASHA.
- The ASHA will meet the parents & take the full information of the child. She will also finalize the time & mode of journey from village to PHC/CHC.
- On 15th ASHA will accompany the child (in the event of AWW not able to accompany) with the referral slip and MAA O SISHU SURAKHYA card will be attached with the referral slip (this will be utilized as a monitoring tool).
- The AWW will maintain the referral register & follow-up register.
- The ASHA/AWW shall explain the entitlements to be received to the parents of the child.
- Availability of one Medical Officer in the PHC/CHC on the “Pustikar Diwas” is a mandatory requirement for effective check up and management of malnourished children.
- In case the child admitted in the hospital, necessary funds can be availed form block RKS funds towards medicines & other expenses

5. Management Modalities

The treatment of malnourished children will be based on 2 phases

Phase1: Patients without an adequate appetite and/or a major medical complication are admitted to an in-patient facility (District/Sub-district Hospital) for Phase 1 treatment. Patients that are admitted are to be treated on a 24/24 hour basis, receiving the diet and full medical treatment of complications. For all in-patients, as soon as they regain their appetite and medical complications treated should be shifted to Phase 2 and should continue treatment as out-patients in Phase 2.

Phase2: Whenever patients have good appetite and no major medical complication they enter Phase 2, the patients are managed at home. Out-patient care, in the community, should also be organized from PHC/CHC. The patients attend on a monthly basis. Majority of patients can be managed entirely on an out-patient basis.

There needs to be a functioning communication and referral system between the PHC/CHC and DHH/SDH so that patients can be quickly and easily transferred from the in-patient facility to the out-patient



programme as they enter Phase 2 and those out-patients that fail to respond appropriately or who develop a complication can be admitted (temporarily) as in-patients.

6. Admission Criteria

PHC/CHC Out-patient Phase 2

- Any child 0-5 years of age in Grade II, III or IV malnutrition or Severe Underweight as per the new WHO Growth Standards.
- Any child 6 months - 5 years with MUAC of < 115 mm and/or presence of bilateral pitting edema
These are malnourished children who are alert, have a good appetite, are clinically well, and are not having generalized edema.

DHH/SDH In-patient Phase 1

- Any child 0-5 years of age with medical complications or severe loss of appetite.

A poor appetite means that the child has a significant infection or a major metabolic abnormality such as liver dysfunction, electrolyte imbalance, cell membrane damage or damaged biochemical pathways. These are the patients at immediate risk of death. Furthermore, a child with a poor appetite will not take the diet at home and will continue to deteriorate or die.

These complications include the following:

- Generalized bilateral pitting edema Grade 3 (+++)
- Severe vomiting/ intractable vomiting
- Hypothermia: axillary's temperature < 35°C or rectal < 35.5°C
- Fever > 39°C
- Number of breaths per minute:
 - ✎ 60 resps/ min for under 2 months
 - ✎ 50 resps/ minute from 2 to 12 months
 - ✎ >40 resps/minute from 1 to 5 years
 - ✎ 30 resps/minute for over 5 year-olds

Or

- Any chest in-drawing
- Extensive skin lesions/ infection
- Very weak, lethargic, unconscious
- Fitting/convulsions
- Severe dehydration based on history & clinical signs
- Any condition that requires an infusion or NG tube feeding.
- Very pale (severe anaemia)



- Jaundice
- Bleeding tendencies
- Other general signs the clinician thinks warrants transfer to the in-patient facility for assessment

7. Admission Procedure

Screen the patients in the community (weight for age plot on growth chart in the MOSS Card, MUAC and check for edema) during the Mamta Divas and refer the patients to the PHC/CHC on the Pustikar Divas if they fulfill the criteria. Every opportunity other than “Mamata Divas” should be taken to identify patients.

At the PHC/CHC, retake the anthropometric measurements (confirm the nutritional grade/MUAC at PHC/CHC) and check edema, errors during screening occur. There has to be feed-back to the community worker and possible retraining.

On arrival at the Pustikar Divas, obviously ill children and those that will clearly need in-patient or other medical treatment should immediately be given sugar water and “fast tracked” without having to wait for the rest of the patients to be seen. They have their anthropometry checked and are then referred directly to the DHH/SDH for in-patient management. Sugar water is approximately 10% sugar solution 10g of sugar per 100ml of water. If the in-patient facility (DHH/SDH) is a long way away the transport can lead to serious deterioration of the patient. Admit the patient to PHC/CHC, keep the patient quiet and start treatment pending the availability of transport.

For those that do not require “fast tracking” and fulfill the criteria should be examined and counseled on appropriate feeding and care practices. Families are advised to give frequent nutrient-dense foods, using locally available, culturally acceptable low-cost family foods, along with appropriate minerals and vitamins. Recipes of preparing energy and protein dense foods need to be shared with families. Treatment of young children should include support for breastfeeding and messages on appropriate feeding practices for infants and young children. Children under 6 months of age should not receive solid family foods. These children need milk-based diets, and their mothers need support to reestablish breast feeding.

Treatment at home enables caregivers to continue with economic activities and family responsibilities including caring for other children. It also reduces the exposure of the patient to cross infections, common in health institutions and feeding centres.

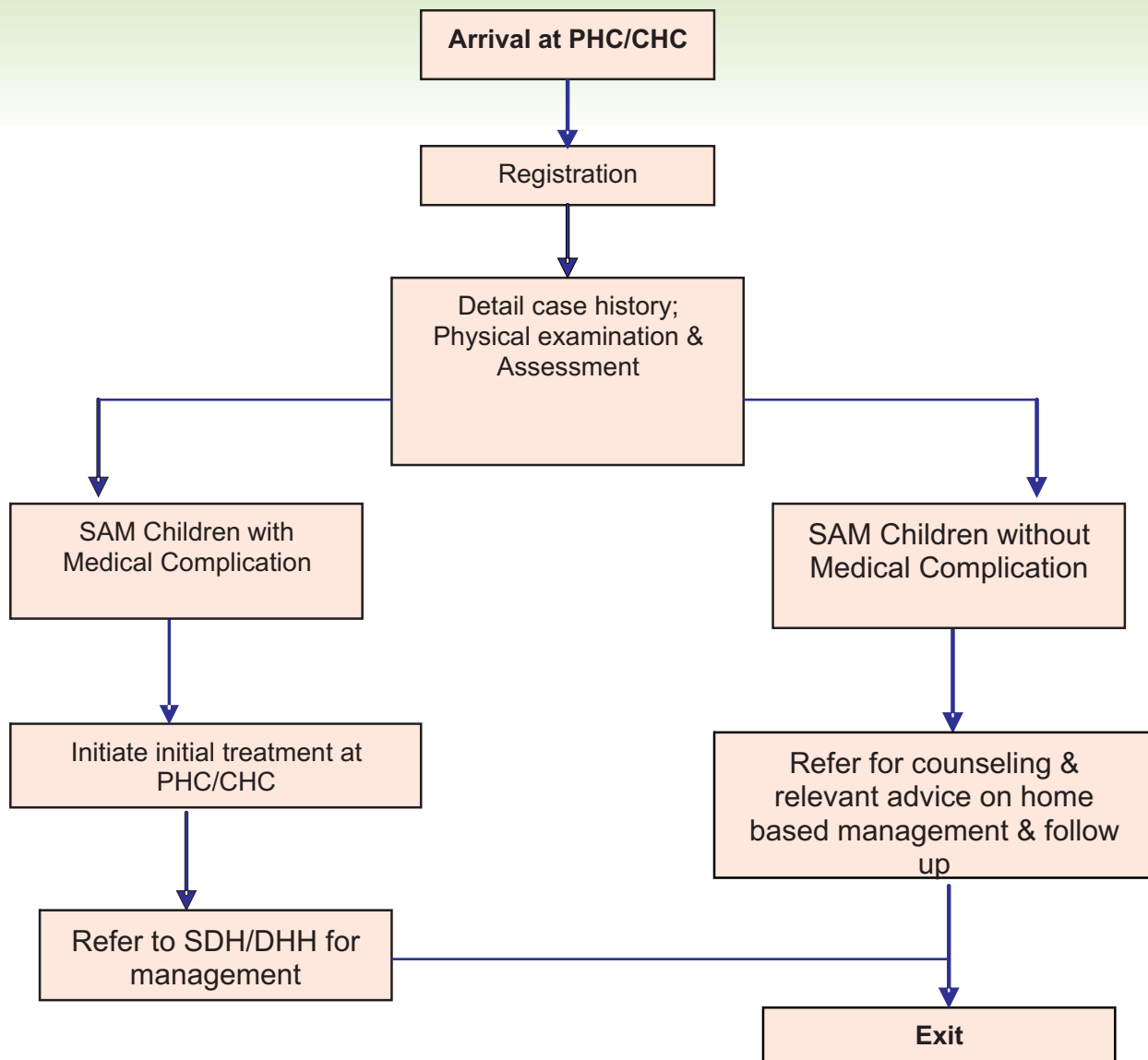
Success of out-patient management can be ensured by

- Advice being specific, clear, realistic and should not conflict with cultural beliefs
- Advice should be memorable and provide an opportunity to learn through supervised practice (Mamta Divas)
- Frequent meals
- Meals should be sufficiently energy and protein dense
- Timely management of infections and poor appetite, do not withhold food during illness

Fathers/other influential members should be involved: they often control families' finances.



8. Operational Modalities





- The total cost of the management of the child will be paid on the spot. The BPO/BADA will keep advance amount for necessary payment and will be responsible for making the cash payment to the beneficiary

9. Discharge Criteria

Discharge form Phase 1 (DDH/SDH)

- Child has recovered fully from medical complication
- Return of good appetite, child well and alert
- Major loss or disappearance of edema

Discharge form Phase 2 (PHC/CHC)

- MUAC > 115 mm for children 6months-5 years of age
- Absence of bi-lateral edema for more than 10 days
- Clinically well and alert

10. Roles and Responsibilities

ADMO (FW) will be the Nodal Officer of 'Pustikar Diwas' at District level and MO i/c of the Block PHC will be responsible for 'Pustikar Diwas' at Block level

To facilitate the Pustikar Divas more effective for the management of severe malnourished children the roles & responsibilities of both ICDS & Health are clearly defined

ICDS	Health
<p>Roles of AWW (at AWC level)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anthropometric measurements (weighing, MUAC) <input type="checkbox"/> Malnutrition grading (plotting of growth chart) <p>Role of Supervisor</p> <ul style="list-style-type: none"> <input type="checkbox"/> Counseling and advice on relevant issues through growth monitoring card and other IEC materials 	<p>Roles of MO / AYUSH MO / LHV / SN / ANM</p> <ul style="list-style-type: none"> <input type="checkbox"/> Registration <input type="checkbox"/> History taking in detail (refer to History taking format) <input type="checkbox"/> Anthropometry (MUAC & Weight) <input type="checkbox"/> Physical examination <input type="checkbox"/> Screening of cases with and without acute symptoms of severe malnutrition <input type="checkbox"/> Refer SAM children without medical complications for counseling to ICDS supervisors after providing follow up advice <input type="checkbox"/> Initiate initial management of SAM children with medical complications <input type="checkbox"/> Refer SAM children with medical complications to higher centre (SDH/DHH)



11. Other responsibilities

CDMO & DSWO

- ✓ CDMO & DSWO will be responsible to orient the MOs & the CDPOs on the guideline
- ✓ CDMO to ensure that all PHCs to observe and monitor Pustikar Diwas.
- ✓ The CDMO, ADMO (FW), DPM & DSWO will supervise every month in the district
- ✓ DPM & BPO will coordinate the activities and report every month from district to the State
- ✓ BPO will maintain the registers of enrollment & money disbursement

12. Training and Orientation

There is provision of combined training of functionaries on VHND and Pustikar Diwas, as described under VHND Training Strategy. There will be one day training for State, District and mid-level managers; and half-day training for ANM, AWW and ASHAs. The main focus would be to orient them on management of malnutrition, clinical protocols & follow-up activities.

13. Follow-up

- On 16th ASHA, mother/ parents & AWW will meet & they will discuss about the instruction given by the MO. If the child is admitted in the DDH/SDH, ASHA will inform to the AWW.
- The follow-up activities at the household level would be done by ASHA & supervised by the AWW; Surprise visit will be done by the respective Supervisor.
- AWW/ ASHA will visit the home of the child, guide and counsel the mother on feeding, personal hygiene & child care practices.
- There should be at least three home visits in the first week and thereafter from second week onwards, one visit at every 7 days interval. The two-fold objectives of such visits is a) to assist the mothers in practicing new skills of infant and young child feeding preparation; and b) and to ensure treatment compliance as advised.
- During Mamta Diwas the ASHA & AWW will meet the Village Health & Nutrition committee, SHGs & other family members in a meeting within the community & discuss about malnutrition & referral.
- For supervision activity the CDPO will visit the houses at random and review the referrals at sector/ project level respectively.

14. Reporting System

Reporting will be undertaken every month from Block level on the day of 1st sector meeting in the prescribed format. These reports will be compiled by the BPO at Block level. The Block MO will submit the report of PHC and supervisory report to the district by 7th of every month. The CDMO after consolidating the PHC reports will submit the same to State Maternal & Child Survival Cell under Directorate of Family Welfare with a copy to Mission Director, NRHM, by 10th day every month. Various formats have been developed and attached in the Guideline for ready reference, as:



1. History Taking Format
2. Monthly Block Reporting Format
3. Monthly District Reporting Format
4. Enrollment Register
5. Financial Support Register
6. Referral Slips

15. Monitoring and Evaluation

The quality of services offered & available during Pustikar Diwas will depend on the quality of the supervision and leadership. The MOs and the District level Supervisors should jointly visit the centers submit their reports on a regular basis, which will be discussed at the monthly meeting convened by the CDMO. During the supervisory visits, special attention should be given to the following elements:

- How many children from vulnerable communities availed the services?
- Whether or not the Doctor was available at the Centre?
- Whether or not all resources (human resources and materials) in place?
- Whether there is any compromise on the quality of the services?

Moreover, issues related to the client satisfaction should be addressed as and when felt appropriate.

Below given are the Performance and output indicators for the management of malnutrition in Phase 1 and Phase 2, per time period:

- Number and percentage of PHC/CHC conducting Pustikar Diwas
- Number of registered patients (new admissions)
- Number of discharge
- Number and percentage cured
- Number and percentage died
- Number of referrals to inpatient care
- Number admitted from PHC/CHC

Number of staff (e.g. health care providers, community health workers [ANMs. AWWs], volunteers) trained

16. Financial Guidelines

Financial Guidelines

Sl no	Item	Cost estimate per Session	Source of Fund
1	Referral Transportation Cost(1 st & 2 nd)	Rs 150/200/-	NRHM
2		Rs 250	NRHM



Conditions for Payment

1. Transportation cost (both 1st & 2nd referral) @ Rs 150/- (for a distance of less than equal to 10 Kms and Rs 200/- (for more than 10 Kms) respectively, will be paid to the beneficiaries. The cost incurred on this head will be booked under Pustikar Diwas account.
2. Payment will be made at referral institution where the patient underwent treatment. BADA/BPO at Block level and Hospital Manager at DHH & Programme Manager at SDH will do necessary processing to reimburse the payment with the permission of the Head of the Institutions.
3. Grade III & Grade IV children along with Grade II children having medical complications will be referred to Pustikar Diwas
4. AWW will accompany cases to the Hospital for treatment on Pustikar Diwas. In the absence of AWW, ASHA of the same AWC shall accompany the cases to the Pustikar Diwas site.
5. Sick children requiring treatment on emergency should be referred to hospital on any day. In such cases, referral transportation cost for the beneficiaries escot to ASHA, drugs & investigation cost, if required may be charged from the Sub Centre Untied Fund.
6. No payment shall be made from Pustikar Diwas if cases are not referred from VHND session (carrying 1st referral Card)
7. There is no provision of 3rd referral transportation cost under Pustikar Diwas.
8. Escort Cost @ Rs 100/- per trip only once a month, either as 1st referral or as 2nd referral will be provided to AWW/ASHA who has accompanied cases to Pustikar Diwas and this cost will be charged from OHSP fund.
9. Provisions on drugs, investigation, under Pustikar Diwas should be spent as per the recommendation of the treating physician, subject to maximum of Rs 250/- per child(that includes costs of drugs and investigation)
10. Benefits (referral transport cost to beneficiary and Escort cost to AWW/ASHA will be paid at referral institutions where the patient is treated and on the day of OPD treatment. BADA at block level and District Accountant at DHH and Asst. Programme Manager at SDH will do necessary processing to reimburse the payment to be made at JSY payment counter and by the same person handling JSY. A board highlighting the Pustikar Diwas payment should be placed at the counter.
11. Investigation may be done at empanelled pathological clinics, if the required facilities are not available at respective hospitals. Empanelment of agency/cies to be ensured by the concerned MO(i/c) with the support of the DPMU.



- i. WHO Growth Standards
- ii. Referral slips
- iii. Register for enrollment
- iv. History taking format
- v. Register for financial support
- vi. Monthly Block Reporting format
- vii. Monthly District Reporting format

Annexure I: WHO Growth Standards

What are the WHO Child Growth Standards?

The World Health Organization has launched new global Child Growth Standards for infants and children up to the age of five. These have been accepted by the Govt. of India, plans are being drawn up on training of the community workers on the use of these growth charts. Until now the 1977 National Center for Health Statistics (NCHS) were used.

The new WHO Child Growth Standards confirm that children born anywhere in the world and given the optimum start in life have the potential to develop to within the same range of height and weight. The new standards prove that differences in children's growth to age five are more influenced by nutrition, feeding practices, environment, and healthcare than genetics or ethnicity.

WHO and its principal partner, the United Nations University, undertook the Multi-centre Growth Reference Study (MGRS) which was a community-based, multi-country project involving more than eight thousand children from Brazil, Ghana, India, Norway, Oman, and the United States of America.

The new growth charts include growth indicators such as weight-for-age, length/height-for-age, and weight-for-length/height. For the first time, there now exists a Body Mass Index (BMI) standard for children up to age five, as well as the Windows of Achievement standard for six key motor development milestones. With these new WHO Child Growth Standards it is now possible to show how children *should* grow.

Current growth reference

Until recently National Centre for Health Statistics (NCHS) standards were used for assessment of nutritional status of preschool children. These NCHS standards have the following limitations:

- The standards were based on formula fed children from a single community in the USA; growth pattern of breast fed infants is different from that of formula fed infants
- Children were measured once every three months, which is not adequate to describe the rapid and changing rate of growth in early infancy.



- There were shortcomings inherent in the statistical methods available at that time which led to inappropriate modeling of growth patterns.

Differences between the new WHO standards and NCHS references

The growth charts based on the new WHO standards differ from the existing standards in many innovative ways. They describe 'how children should grow', which is a prescriptive approach, not just a descriptive one.

The pooled sample from the six participating countries creates a truly international standard, in contrast to the previous growth reference based on children from a single country.

A key characteristic of the new standard is that it makes breastfeeding the biological “norm” and establishes the breastfed infant as the normative growth model. The previous reference was based on the growth of artificially-fed children.

There are charts for boys and for girls, and for infants to one year, and for children up to five years.

In the growth charts used in our country, underweight children were classified as Grade I, II, III and IV, the new growth chart will classify underweight children as Moderately Underweight and Severely Underweight.

Additionally, the new Child Growth Standards also include *Windows of Achievement* describing the range and timeline for six key motor development milestones for children, such as sitting without support, crawling, standing with assistance, walking with assistance, standing alone and walking alone. This provides a unique link between physical growth and motor development.

As expected, there are important differences between the new WHO standards and NCHS references. However, these vary by age, sex, anthropometric measure. Differences are particularly important in infancy.

Computed under-nutrition rates in the critical 0-6 month age group with new WHO standard are higher as compared to under-nutrition rates derived from NCHS standards. This should be viewed as a correction of a historical fallacy and not as alarming rise in under weight rates in 0-6 age group.

In the 1-5 year age group the computed undernutrition rates using the new WHO standards are substantially lower as compared to those computed from NCHS standards. This should not be allowed to generate a sense of complacency that undernutrition rates are falling

A notable effect is that stunting will be greater throughout childhood when assessed using the new WHO standards compared to the previous international reference.

For wasting, the main difference between the new standards and the old reference is during infancy, up to about 70 cm length, when wasting rates will be substantially higher using the new WHO standards.