HEALTH · HYGIENE · HOME

Nutrition India Programme

Annual Report 2019

Every child has a right to nutrition.

Implemented by
Plan International (India Chapter)

Preface

Gaurav Jain

Senior Vice President
RB-AMESA, Health

In India, where the public health system has expanded so quickly since 2005, and with such a large infrastructure and cadre in compliance we still witness severe acute malnutrition and deaths of children under two. This is because expanding and fortifying public health systems, while being absolutely crucial, aren't enough to deal with the multi-layered and complex challenges that affect the most vulnerable.

With the launch of the flagship **POSHAN Abhiyan**, India has shown immense commitment to ending world hunger - goal number 2 in the global Sustainable Development Goals (SDGs). The State Government of Maharashtra have also shown strong intent and have taken a considerably more aggressive stance in their campaign against malnutrition and under-five mortality. Gradually, a need for a multi-stakeholder partnerships to achieve the ambitious targets of 2030 emanated, echoing the core values of SDG 17.

Reckitt Benckiser, committed to a world where people live healthier and live better, have taken it upon themselves to work with the development sector, to create sustainable models of development, for some of India's most vulnerable populations.

We have conceptualised the Nutrition India Programme, which brings a mutuality, collective capacity and immediacy of action to work together, work with technology, work with communities and work with successful interventions accelerate and propagate solutions more rapidly onto the ground. The programme leverages the cumulative strength of creative research and learning, design, public health, implementation and evaluation to shape new strategies and calls to action. The programme is presently working to support the government to end malnutrition in Maharashtra, in the districts of Amravati and Nandurbar, the state's toughest regions. The project has started showing early trends, lives of about 6,500 under five children are saved in a span of 10 months, which is positive and encouraging. We see a ray of hope in working with multisector organisations and Government in servicing the deprived community better.

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The programme leverages the cumulative strength of creative research and learning, design, public health, implementation and evaluation to shape new strategies and calls to action.

Foreword

Patricia O' Hayer

External Relations & Strategic Partnerships Lead – Global RB

Child malnutrition has emerged as a silent national emergency and the greatest human development challenge that accounts for 68% of all infant mortality in India. The Comprehensive National Nutrition Survey (CNNS 2019), predicts that despite reduction in malnutrition during 1990-2017, India would miss the targets set by the National Nutrition Mission (NNM) for 2022 and WHO and UNICEF for 2030[1]

Currently, 1 in 40 babies die during childbirth and 1 in 25 children die before age 5. Most of these deaths are due to lack of access to clean water, pneumonia, diarrhoea and malaria. These diseases represent lack of sanitation and hygiene.

Malnutrition contributes significantly to high mortality and morbidity by reducing immunity and thereby increased infection. On the other hand, lack of sanitation causes gastrointestinal disorders like diarrhoea, which is a leading cause of death among children. Therefore, if nutrition and hygiene can begin in every household, a strong foundation for future health of society can be laid.

To develop a cost effective sustainable model, RB has developed an approach, focussed on bringing a transformational difference to the first 1000 days of a child's life, in two tribal districts of Maharashtra- Amravati and Nandurbar. This five year project aims to cover 1000 villages through digital and artificial intelligence based innovative training modules, strengthen the health, hygiene and nutrition status of pregnant women and children, targeting towards 40% reduction in the number of children under-5 who are stunted, reduce and maintain childhood wasting to less than 5%.

The social investment of RB is aimed towards demonstrating a cost effective scalable robust community centred model to address the challenge of malnutrition in a sustainable manner. The investment is part of larger effort spread over sectors like WASH, Health and Nutritional security on part of RB to contribute to the larger goal of national development.

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RB is aimed towards demonstrating a cost effective scalable robust community centred model to address the challenge of malnutrition in a sustainable manner.

[1]The burden of child and maternal malnutrition and trends in its indicators in the states of India: the Global Burden of Disease Study 1990–2017. https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(19)30273-1/fulltext

Editorial

Pragyal Singh

Partner, EY

The global healthcare landscape is currently focusing on formulating policies in alignment with the Sustainable Development Goals, indicative of a steady advancement towards SDG-2 and SDG-3, parallelly ensuring zero hunger and good health and well-being with a definitive target to build globally sustainable communities.

The healthcare timeline of India showcases an evolution in the quality and promotion of radical change for a dynamic ecosystem across the urban and rural capacities. A definitive emphasis on inclusive development for women and childcare, in addition to ensuring last mile accessibility to public healthcare services promotes equitable inclusivity and empowerment.

Emerging economies like India are steadfastly tackling major challenges of quality, affordability and accessibility in addition to creating awareness on the basic hygiene and sanitation practices in rural and urban areas. The prevalence of hunger and malnutrition specifically in the remote rural populations signals for immediate interventions that can be effectively implemented.

With a vision to leverage the aspects of collaborative partnerships and social investment, Reckitt Benckiser exemplifies the impact of transformational change through innovative initiatives that capture developmental change across 1000 villages Amravati and Nandurbar districts of Maharashtra.

The early stages of implementation of the Nutrition India programme showcase a significant change in the decline of number of fatalities caused due to malnourishment of mothers and children, highlighting the successful attributes of the programme.

The integration of new age technologies with modern medicine in such initiatives is substantially shaping the contours of sustainable communities that signifies the infallible advancement towards a health-oriented, sustainable future.

> **“A definitive emphasis on inclusive development for women and childcare, in addition to ensuring last mile accessibility to public healthcare services promotes equitable inclusivity and empowerment.**

Acknowledgement

Mohammed Asif

Executive Director, Plan India

Malnutrition is the underlying cause of 68 per cent of under five deaths, recent reports published by reputed organisations painted a gloomy picture of the country with every second under five child in India affected by some form of malnutrition.

Besides its immediate short term consequences, long term effects have profound implication on children's growth and cognitive abilities which may translate into reduced economic development of future generations. Fortunately, these losses are largely preventable if adequate investments in proven interventions are made, particularly those that focus on ensuring optimal nutrition in the critical 1000-day window between the start of a woman's pregnancy and her child's second birthday. Plan India, a nationally registered not for profit organisation striving to advance children's rights and equality for girls was looking for meaningful partnership to develop scalable model for eradication of child malnutrition in India.

In 2018-19, Plan India developed a partnership with RB and launched Nutrition India Programme to intervene on first 1000 days of life and transform the nutritional status of children & mothers. Intervention was done in Nandurbar and Amravati districts of Maharashtra.

Plan India would like to take this opportunity to express our gratitude to thank Reckitt Benckiser, specifically Mr. Ravi Bhatnagar, Director-External affairs and Partnerships, AMESA. This project wouldn't have been possible without his thought leadership.

We are thankful to the Officials from across the District Administration, Health Department and ICDS, Doctors, ANMs, AWWs, ASHAs, PRI members and community for supporting implementation of the project.

We would also like to express our special thanks to Padma Shri Dr. Indira Chakravarty, Dr. Raj Bhandari, Dr. Swati Maheshwari and Dr. Surajeet Patra, RB for their unconditional technical support in designing the project interventions

Plan India also acknowledges the generous contribution, expertise and hard work of project team and also ensuring that the Annual Report is ready and it meets recommendable standard.

Only 42% of children in the age group of 6-23 months are fed at adequate frequency[1]
Only 21% get an adequately diverse diet.

[1]National Family Health Survey 4

Messages

Ramnath Subramaniam

CEO, Village Social Transformation Foundation

The Maharashtra Government has embarked on a rural development journey to transform villages of Rural India in the state, worst-affected by social, economic, livelihood, connectivity and infrastructural challenges. The focus in is to create an inclusive growth model and transform them into model villages that are self-sustainable by collaborative and dedicated efforts. In order to create these model villages, Village Social Transformation Foundation, a not-for-profit (section 8) company institutionalized by the Rural Development Department.

The year 2019 - 20 has witnessed significant partnerships and collaborations across varied domains. One such notable achievement is our collaboration with Plan India for the Nutrition India programme to transform the nutritional status of children & mothers across **1000 villages in Nandurbar and Amravati districts** of Maharashtra – of which the programme as on date has presence across 204 villages.

The VSTF as a strategic partner provided expertise to liaise with all government agencies and departments for all statutory clearances, facilitated in Infrastructure development such as refurbishing a major Nutrition Rehabilitation Centre (NRC).

VSTF played an important role to facilitate the identification of villages through exhaustive research, and facilitated the development of a nutrition kit to spread awareness. Dr Raj Bhandari an advisor to VSTF (Advisor to NITI Aayog) is a member of the steering committee and has been the focal point for all stakeholders.

The Nutrition India programme envisages making a mother's journey through pregnancy (ensuring better nutritional care for her well-being and ensuring growth of the child in the mother's womb) and a child's journey from conception until the 2nd year, a holistic intervention for development and growth. This project has sole funding of Reckitt Benkiser.

I would also like to thank all our patrons whose support and guidance has seen VSTF scale newer heights and facilitate such transformation programs and look forward to their continued patronage to make our cause of giving back to society a larger mission.

The focus is to create an **inclusive growth model** and transform them into model villages that are **self-sustainable** by collaborative and dedicated efforts.

Messages

Sandra Hennessy

Global Social Impact and Partnerships manager
RB

Our company is inspired by the fight of making access to the highest quality hygiene, wellness and nourishment a right, not a privilege. Childhood sets the direction for the rest of life, and the first 1,000 days – from conception to a child's second birthday – are the most critical. Nutrition India Programme (NIP) focuses on the remote region of Maharashtra where malnutrition rates in children under five are 1.5 times the national average. We are fighting to change that.

Together with our partners we work directly with local communities to deliver simple and effective messaging around nutrition and hygiene with a goal of reducing malnutrition and stunting rates in those communities.

Padma Shri Dr. Indira Chakravarty

Public Health Specialist

The programme deploys technology in various forms across its interventions; from using real time data monitoring, blockchain to track and enable conditional cash transfers to women who travel to and complete the treatment cycle at the nutritional rehabilitation centres as well as verify service provision at every touch point. The social investment of RB is aimed towards demonstrating a cost effective scalable robust community centred model to address the challenge of malnutrition in a sustainable manner. The investment is part of a larger effort spread over sectors like WASH, Health, and Nutritional security. RB eventually aims to contribute to the larger goal of national development. It has been an extremely innovative step taken by the RB, as bringing such multiple stakeholders with varied objectives under the same umbrella is not only most difficult but also risky. I am delighted to see such a huge success this programme has achieved and how well the multiple agencies worked in total coordination and cooperation with each other lead by RB.

Dr. Surajeet Kumar Patra, MBBS,MD

Manager, Medical affairs
RB

The first 1,000 days of life is a unique period of opportunity when the foundations of optimum health, growth, and neurodevelopment across the lifespan are established. Nurturing care, including nutritional care during this early period is absolutely decisive for Early Childhood Development (ECD). Neuroscience offers compelling evidence on ECD as a critical opportunity to shape brain development and function. ECD is foundational for the SDGs. Nutrition during early life (Breast feeding being the Best) is essential for building better brains, building immunity & overall optimal growth & development.

Nutrition India programme is an excellent initiative & this project is looking after the nurturing care in first 1,000 days with multiple innovative approaches and strengthening the Early Childhood Development.

Messages

Dr. Raj Bhandari MBBS,MD

Member of the National Technical Board of Nutrition, NITI Aayog, GoI and Advisor to Maharashtra VSTF

Over the last few years, the healthcare system in India has evolved into an integrative model that is accommodative of innovative interventions. The current nutrition status in India highlights the importance of improving the qualitative and quantitative socioeconomic conditions of the rural population through effective implementation of the Poshan Abhiyan programme.

To complement the Poshan Abhiyaan, RB plans to cover 1000 villages through digital and artificial intelligence based innovative modules, strengthen the health, hygiene and nutrition status of pregnant women and children, targeting towards 40% reduction in the number of children under-5 who are stunted, reduce and maintain childhood wasting to less than 5%. The "Voucher scheme" is an innovative strategy based on cash transfers in which the beneficiaries are given cash benefits for transport, food expenses during stay in health facility and pay for loss of livelihood. It influenced the health seeking behaviour of the communities and saved lives of malnourished children.

Mr. Indranil Roy

Chief Executive Officer
Outlook Group

With an aim to create a platform that showcases the need for better and affordable healthcare in remote areas, Reckitt Benckiser has developed a consortium that caters to the primary healthcare development of women and children across 1000 villages in the districts of Amravati and Nandurbar in Maharashtra through the Nutrition India programme. The implementation model has been designed to create a sustainable and inclusive environment by engaging the local traditional healers as a part of the programme through capacity building and creating awareness on the aspects of health and nutrition.

Through the five year project, a multipurpose effort to reach out to the marginal communities to bridge the existing economic disparity and provide better standards of living to the communities with a collective goal to build a healthier and sustainable nation and world.

Dr. Swati Maheshwari, MBBS

Health Advisor, NIP

Nutrition India Programme is not just any run-of-the-mill programme targeting malnutrition and its root causes from all directions, it's actually a 360 degrees program in its approach, commitment as well as vision. The impacts will be far fetching and it will be a role model for others pursuing to empower, heal and nurture a society. Its been an enriching and motivational experience at every step be it developing behavioural change communication tools or being a part of the strategy and consulting team. As the programme metamorphosis into another year and takes on new challenges, it will surely bring in sustainable social improvement in lives of hundreds of thousands of communities who had actually given up on it.

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GOVERNMENT OF MAHARASHTRA
Biomedical Equipment Maintenance
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About the report

India is rapidly growing and is well on the path to become a global and economic power.

However, persistent problem of large scale malnutrition has the potential to derail this dream.

Addressing malnutrition has emerged as a national priority both for social and economic reasons. Reckitt Benckiser is investing in developing a robust cost effective model to address the challenge of malnutrition in two of the worst effected districts of Maharashtra viz. Amravati and Nandurbar.

Nutrition India Programme is an innovative digital and artificial intelligence based project, which aims to strengthen the health, hygiene and nutrition status of pregnant women and children.

The programme is conceptualised to Give Best Start in First 1000 days.

This document is the first of the annual implementation reports which highlights the wins, learnings, challenges, and the innovative practices which helped in averting the challenges. It also sets the foreground for the proposition of the coming year and the way forward.

Abbreviations

ADHO	Additional District Health Officer
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
BCC	Behaviour Change Communication
BMO	Block Medical Officer
CDR	Child Death Review
CDPO	Child Development Project Officer
CS	Civil Surgeon
CC	Cluster coordinator
CNW	Community Nutrition Worker
CPR	Couple Pretention Rate
CBR	Crude Birth Rate
CTC	Child Treatment Centre
DHO	District Health Officer
Dy. CEO	Deputy Chief Executive Officer
EIBF	Early Initiation of Breast Feeding
EBF	Exclusive Breast Feeding
EDD	Expected Date of Delivery
FADU	Frequency, Amount, Density, Utilization
IYCF	Infant and Young Child Feeding
IMR	Infant Mortality Rate
IEC	Information Education Communication
ICDS	Integrated Child Development Services
IQ	Intelligence Quotient
IDD	Iodine Deficiency Disorders
IDA	Iron Deficiency Anaemia
IFA	Iron Folic Acid
JSY	Janani Suraksha Yojana
KMC	Kangaroo Mother Care
LAMA	Leave Against Medical Advise
LBW	Low Birth Weight
NRC	Nutrition Rehabilitation Centre
MDR	Maternal Death Review
MMR	Maternal Mortality Rate
MO	Medical Officer
MOIC	Medical Officer In-Charge
NHM	National Health Mission
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
NRC	Nutrition Rehabilitation Centre
ORS	Oral Rehydration Solution
PRI	Panchayati Raj Institution
PHC	Primary Health Centre
PEM	Protein Energy Malnutrition
SAM	Severe Acute Malnutrition
THR	Take Home Ration
THO	Taluka Health Officer
TT	Tetanus Toxoid
VPD	Vaccine Preventable Disease
VHNSC	Village Health Sanitation and Nutrition Committee
VHSND	Village Health Sanitation and Nutrition Day
VAD	Vitamin A Deficiency

Currency conversion

1 pound sterling = 94.45 Indian Rupee

Our Purpose

Goal

To improve nutritional status during the first 1,000 days of life, with a goal of reducing stunting by 40% in children under 5 and keeping childhood wasting rates below 5%. **Over the next 5 years, NIP aims to reach 177,000 mothers of undernourished children across 1,000 villages.**

Our Strategy

Our strategies account for user needs and sensibilities, leverage positive health cultures inherent to this tribal group, target those that are most in need, and make innovative and efficient use of local resources.

Identification of high-risk groups

Periodic-follow ups and service delivery

BCC through audio-video nudges

Referral and treatment

Bolstering capacities

Our operating model

Our three-part model enabled us to cover a large group of beneficiaries across these 2 districts and made our interventions holistic:

Care of woman during first 270 days

Through immunization, hygiene and adequate diet

Care of mother and child for 2 years

Delivery, exclusive breastfeeding, diet diversity and immunization

Care on special conditions (SAM/MAM/SUW children, high-risk pregnant woman)

Therapeutic food at NRCs, management of lactation challenges

Our Output

Under-5 children

32,900

Under-5 children were reached by the interventions carried out under the programme

Treated under NIP

4,161

U5 (SAM,MAM and LBW) children were provided treatment under the programme

Pregnant Mothers

3,900

Out of 4,192 pregnant women identified under the programme, 3900 were provided support through multiple interventions

Institutional Deliveries

805

Out of 861 pregnant women due in 2020, 800 were provisioned with an institutional delivery through programme assistance

Nutritional Needs

1,268

Households were supported to grow kitchen gardens to assure adequate diet diversity among woman and children

Lactation Challenges

<10days

Pregnant women were assisted and lactation challenges were restored within less than 10 days

Executive Summary

India's efforts to acknowledge and tackle undernutrition dates back to the time of independence, with large number of policies addressing major areas of public health nutrition needs. The substantial focus was on "provision" and "supplementation" for masses.

However with innate trust on traditional healers the uptake for theses services was low by the communities. Another missing link has been the "policy coherence"—the contribution of other (non-nutrition) sectors and a convergent method of addressing the complex problem of undernutrition. Hence, there was a need for an intervention which is co-created with the community, health, nutrition and allied sector so that Nutrition is established as a Public Agenda.

Recognizing the fact that addressing malnutrition requires multi-sectoral efforts, Reckitt Benckiser (RB) is working with multiple partners having expertise in large scale implementation, design research firms, social technology agencies to develop scalable locally contextualized malnutrition programme, and to support the government, to end malnutrition amongst the most vulnerable population in Maharashtra.

The project is intervening in first 1000 days, utilising digital and artificial intelligence based innovative modules, strengthening the health, hygiene and nutrition status of pregnant women and children and targeting towards 40% reduction in the number of children under-5 who are stunted, reduce and maintain childhood wasting to less than 5%.

The project has worked with local communities to build up a workforce of travelling Community Nutrition Workers (CNWs), who are rigorously trained by a team of public health experts, paediatricians, gynaecologists and community development specialists. Going from village to village, the CNWs deliver simple and effective messaging around nutrition and hygiene to create behavioural nudges using specially designed games, nutrition kits, multimedia stimuli, and community festivals.

It has also employed a host of behavioral nudges, apps, games, nutrition kits, multimedia stimuli, and engaging social experiences to build community capacity around nutrition and hygiene. Technology has been deployed in various forms across the programme; from using real time data monitoring, blockchain to track and enable conditional cash transfers to women who travel to and complete the treatment cycle at a nutritional rehabilitation center as well as verify service provision at every touch point. Most importantly, the entire programme hinges on its synchronization with local health cultures and close collaboration with a network of traditional health providers and the communities who are not passive beneficiaries but key actors in the process of transformation. The project has started showing early trends, lives of about **6,500 under five children are saved** in a span of 10 months, which is positive and encouraging.

As per an independent evaluation done on the Social Return on Investment (SROI) of the project, **every ₹1 invested in the institution of Nutrition India Programme delivers ₹36.90 of social value.**

Mr. Ravi Bhatnagar

Director- External Affairs and Partnerships, AMESA
RB Health

Social Return on Investment Evaluation (2019-20)

An Independent evaluation by Sustainable Square

For Nutrition India Programme

Impact

Beneficiaries

- Increased status of women in community
- Increased trust in institutions due to CNWs
- Increased in awareness of hygiene practices
- Decrease in pregnancy related anxiety
- Increased knowledge
- Increased usage of child measurement chart
- Reduction in Childhood Mortality (Estimated)
- Increased institutional delivery
- Reduction in visit to health facilities Increased perception of government effectiveness
- Reduction in SAM and MAM
- children
- Increased nutrition of mothers and pregnant women
- Reduction in pregnancy and birth related economic burden

CNWs

- Increased community trust
- Increased influencing capacity towards community

ANMs

- Increased enthusiasm
- Increased identification of critical cases

AWWs

- Increased identification of critical cases

ASHAs

- Reduced disease prevalence
- Increased identification of HRPW

Total social value creation

₹ 397.7 crores

SROI ratio

1:37

Results of SROI

Change for Community Nutrition Workers (CNWs)

Increased abilities of CNWs (Technical and Soft), leading to beneficiaries accepting their advise

92% — Beneficiaries observed increase in confidence among CNWs in their operations

89% — Increased community trust towards CNWs

84% — Increased beneficiaries trust towards CNWs

74% — Increase CNWs technical skills

66% — Beneficiaries hold effective communication with CNWs

34% — Beneficiaries hold effective communication with Government workers

CNWs being able to communicate with ease among beneficiaries

Beneficiaries' improved perception on CNWs and their work

97% — Due to CNWs, beneficiaries are more aware of the NIP

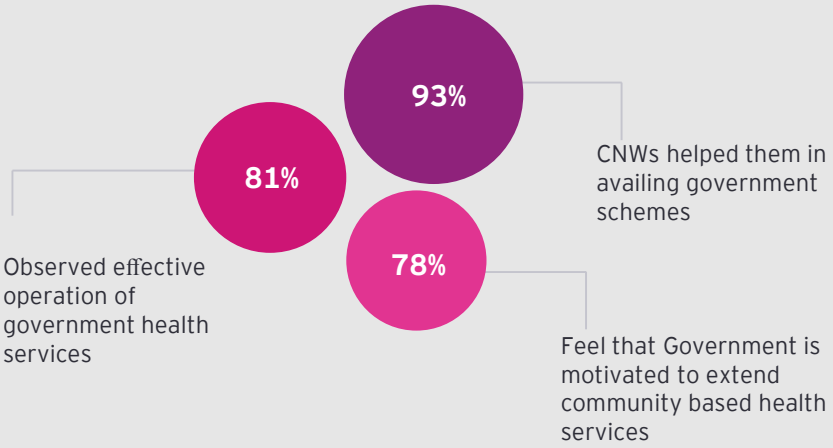
95% — CNWs are better able to influence the community

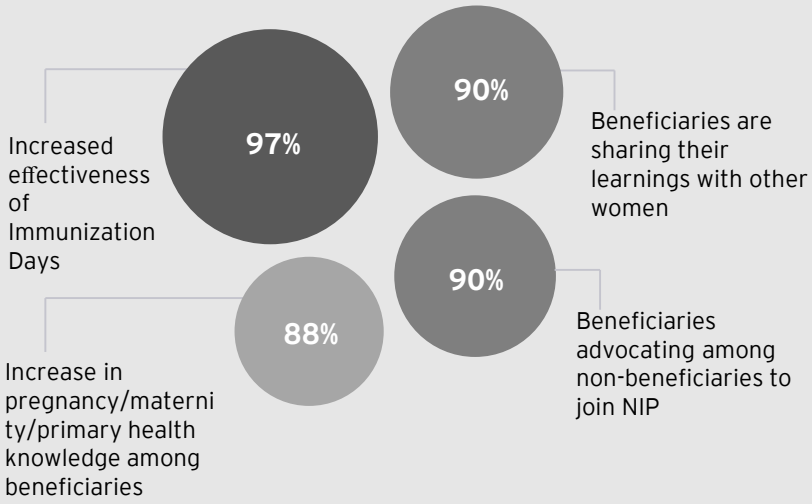
84% — Increased respect by the community towards CNWs

Change for Beneficiaries

(Pregnant women and mothers in rural Maharashtra)

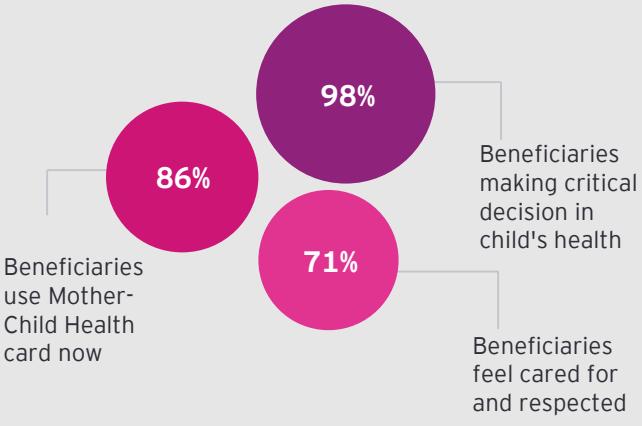
Change in government health services functioning due to CNWs influence according to beneficiaries



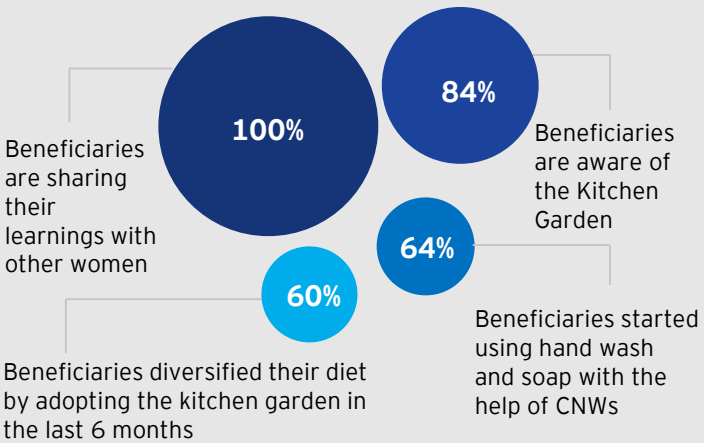


Beneficiaries increasing knowledge with the help of Behavioural Change Interventions and become change leaders by advocacy

Mother's taking ownership and feels their contribution is valued



Beneficiaries adopting new WASH practices and environmental dietary modifications



Impact Values

Every **₹1** invested in the institution of Nutrition India Programme delivers **₹36.90** of social value.

₹1 ₹37

₹107,805,000
Total cost leveraged through all partners

₹3,977,885,332
Total social value created

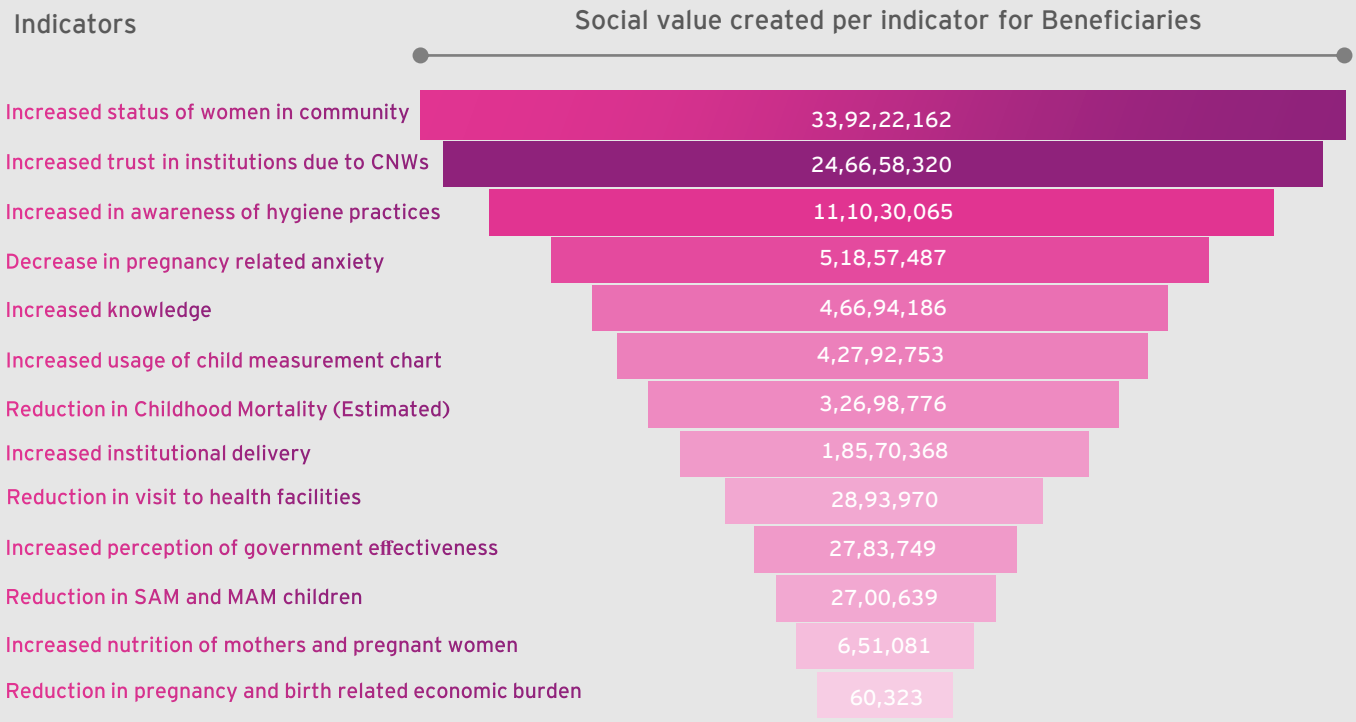
Sensitivity Analysis

A Lower / higher range of sensitivity indicated above is between 1:33.58-1:39.22. Undertaking a sensitivity analysis is important to ensure that results have not been subject to bias and the assumptions are not unreasonable. The validation looks into the percentages determined for the deadweight, displacement, attribution and drop off of the programme, in addition to the duration.

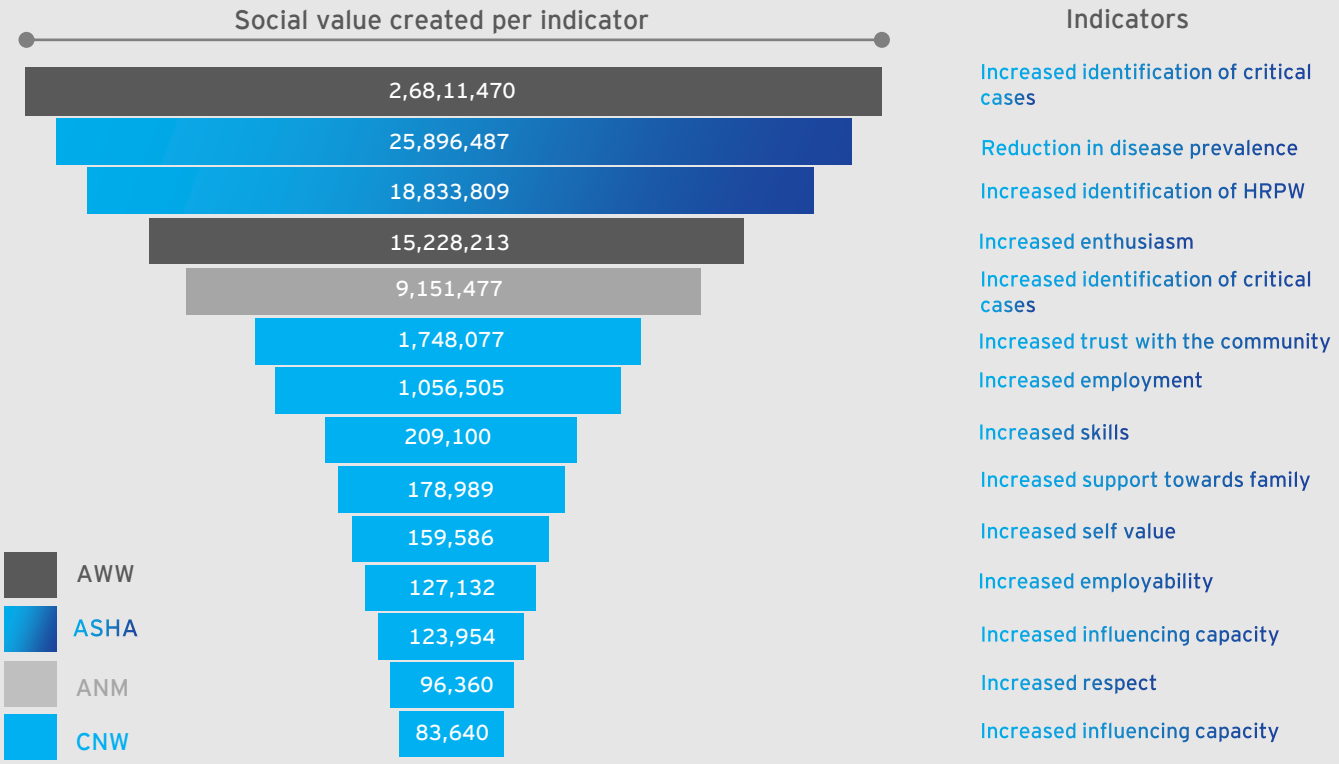
A further breakdown of SROI findings indicates that the programme is extremely robust and beneficial to the institutions (i.e. a small investment in institutional trust, infrastructure, capacity building, Community Nutrition Workers, field presence and connects and thus results in a 37x return).

Indicators and Valuations

For beneficiaries



For CNWs, ASHAs, ANMs and AWWs



Social Impact Investment

We invest for life.

Good health.
Proper hygiene.
Adequate nutrition.

All of these should be within everyone's reach

Our social impact strategy focuses on investing in areas where we can make the most impact as a business, and where we identify the greatest unmet needs.

Through our programmes we promise to help empower communities with products, education and skills they can use to change their everyday lives – to spark progress not measured year-on-year, but over lifetimes.

Our vision

We seek to empower local communities to drive their change and own their programmes.

Our approach is not to impose solutions from above; it's to understand problems and alleviate them from the ground up. When people – especially women and girls – have access to good health, hygiene and sanitation services, the whole community benefits in the long run. That's how we invest for life.

Our social impact strategy

Our social impact strategy focuses on the areas of unmet needs where we can create the most impact as a business. These focus areas align with the UN Sustainable Development Goals (SDGs). For the Nutrition India Programme, we have supported **Sustainable Development Goal 2- Zero Hunger**.

Plan International (India Chapter)

Plan International's on-ground expertise helped to shape the impact to better fit a community.

This is why we work with NGOs, community experts, governments, and even local vendors, to co-create the best possible solutions to local issues.

NUTRITION INDIA PROGRAMME
Nourishing Healthier Communities
Breast Milk is the best Nutrition for Infants
PLAN INTERNATIONAL
www.planindia.org

About NIP

The programme focuses on the remote region of Maharashtra, India, where malnutrition rates in children under five are 1.5 times the national average. NIP works with local communities to develop a workforce of travelling Community Nutrition Workers (CNWs), who are rigorously trained by public health experts, paediatricians, gynaecologists and community development specialists.

The CNWs deliver simple and effective messaging around nutrition and hygiene using specially designed games, nutrition kits, multimedia stimuli, and community festivals. Today, the programme has 41 CNWs, reaching out to 204 communities across the Maharashtra region.

Some statistics from 2019

200,000

Individuals reached through distribution of soap

36,800

Pregnant women and young children reached by programme from various nutrition intervention

20,000

people reached with nutrition and hygiene messaging through events

46,000

more people regularly washing their hands with soap after defecation

Our Impact Portfolio

Kaushaliya's story

Kaushaliya Pawara works as a Community Nutrition Worker, as a part of the Nutrition India Programme (NIP). She decided to join the programme after witnessing the impact of malnutrition in her own village.

Through NIP, Kaushaliya has developed new skills and a livelihood that also empowers her and others like her to make a real difference to her community and to a whole generation of local children that represent their future.

> "I have seen many village women not able to feed their child, and as a result many children died. I am very happy to work for a project where I am restoring lactation to the mothers and saving the life of a child who has just seen the light of life."
>
> Kaushaliya Pawara
> Nutrition India Programme

RB's Pledge on breastfeeding

***We** commit to help prevent malnourishment and undernutrition, estimated to be associated with 2.7 million child deaths annually. In-line with the WHO Global Targets 2025, we believe that quality infant and child nutrition is key to improving child survival and promoting healthy growth and development, as well as reducing levels of stunting.*

***We** support the WHO Code recommendation for exclusive breastfeeding in the first six months of life, and encourage continued breastfeeding for up to two years and beyond. We support the introduction of safe and appropriate Complementary Foods from six months of age. We commit to actively support breastfeeding for all families and we will work across our supply chain, with our partners, employees and consumers to promote the best start in life and optimal nutrition for the first 1000 days.*

***Globally, we** commit to respecting all legislation implementing the WHO Code. In Higher-Risk countries, we respect whichever are the stricter requirements relating to BMS Marketing- be that local legislation or our own BMS Marketing Policy, which applies to all Infant Formulas, Follow-On Formulas, Delivery Products and Complementary Foods for Infants under six months of age.*

***We** commit to improve women's empowerment in the communities where we live and work, and to diversity across our organisation. We have a particular focus on improving the lives of mothers and infants. We commit to improve health, access to clean water and sanitation, because these are the foundations of good health and nutrition.*

***We** commit to continuous improvement and transparency. Our Pledge will evolve as we seek guidance from key stakeholders, conduct internal and external verifications, and changes in the external environment. The CEO has responsibility for this Pledge and we will ensure all updates will be public and that we engage meaningfully with stakeholders to demonstrate progress.*

***We** commit as a key player in science based infant and child nutrition, to continue our scientific and medical research to provide the highest quality infant nutrition, so that children can achieve their full potential.*

Problem Statement

Malnutrition refers to deficiencies, excesses or imbalances in a person's intake of energy and/or nutrients. The term malnutrition covers '**undernutrition**'- which includes stunting (low height for age), wasting (low weight for height), underweight (low weight for age), micronutrient deficiencies or insufficiencies and overweight, obesity and diet-related non-communicable diseases (such as heart disease, stroke, diabetes and cancer).

Despite sustained efforts, India's success in combating malnutrition has been modest and slower than other countries with comparable socio-economic indicators. **For instance, from 2005-06 to 2015-16, stunting among under 5 children declined only by 1% per year while yearly decline in the proportion of underweight children as low as 0.68%[1].**

Child malnutrition has emerged as a silent national emergency and the greatest human development challenge that accounts for[2]-

- **68%** of the total under-5 mortality, and
- **17.3%** of the total disability-adjusted life years (DALYs)

Malnutrition in a complex situation, more of a social and political challenge, than medical, is attributed by various SDGs, including water & sanitation, health, education, food systems and gender equality etc. Similarly it is essential for the success of various other SDGs, encouraging result of investment in nutrition ($16 return of each $1 investment) has been indicated by various studies.

Catalysing transformational change in a diverse country like India is strenuous task, and it needs a multi-layered staggered approach, and there is no single solution exists. Inadequate feeding and child care practices, especially during the first two years of life and insufficient antenatal care and dietary intake in pregnant women are some of the major factors contributing to malnutrition.

First 1000 days of life

Undernutrition occurs at all ages, but when it occurs early in life, it has its most devastating and profound effects that last well into the lifespan, as well as into the next generations. **The first 1000 days of a child's life, including 9 months of pregnancy, and 24 months of postnatal life, are critical when designing interventions that address malnutrition in all its forms.** The nutrition provided in the period between conception and the child's second birthday is critical for optimum cognitive and physical development of the child.

Maharashtra being the second most populous state of India is not far behind the national average in terms of maternal and child health indicators.

However, some districts like Nandurbar and Amravati show substantial variations in these indicators where many remain significantly lower than the state and national average.

The right nutrition during this 1,000 day window can have an enormous impact on a child's ability to **grow, learn, and rise out of poverty**[3].

[1]National Family Health Survey 4
[2]The burden of child and maternal malnutrition and trends in its indicators in the states of India: Lancet
[3]United Nations

Breastfeeding: The numbers

Only 41.6%

of babies in India are **breastfed** within an hour of birth[5]

Only 54.9%

of babies in India are exclusively **breastfed**[3]

Over 51.4%

of women in reproductive ages are anaemic in India. Maternal anaemia has a direct impact on children's nutrition[4]

RB believes breast-milk provides the best nutrition for infants to achieve optimal growth and development. NIP advocates early initiation of breastfeeding and exclusive breastfeeding.

Other facts and figures

1/3rd

India's contribution to the global burden of undernutrition[1]

$46b

may be lost by India to malnutrition by 2030[1]

69%

of U5 deaths in 2019 in India were due to malnutrition[2]

3/10

of stunted children in the world are from India (46.6m)[2]

50%

of the global wasting burden is shared by India, 25.5 million children out of 50.5 million globally[1]

>1m

overweight children in India[1]

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[1]The Global Nutrition Report 2018, World Health Organization
[2]The United Nations Children's Fund
[3]National Family Health Survey 4
[4]United Nations
[5] UNICEF

Programme Flow

- **Overview** of existing policies on malnutrition
- **Food consumption and Ethnographic** research
- **Designing** the programme for hard-to-reach communities
- **Approach** of the programme
- **Results** of the programme
- **Outlook Poshan** awards and media coverage
- **Way** forward

Overview of existing policies on malnutrition

A commitment to tackle undernutrition is reflected in India's policy realm which became specific, prioritised and intensified with time. Systematic efforts to improve the nutrition situation in India can be traced even before Independence. In late 1940s, there was a shift in programme strategy. Food production became the central focus and an emphasis on protein or protein crisis was considered the most critical solution for reducing undernutrition.

By the late 1970s, the emphasis shifted from addressing the protein gap to the calorie gap. National Health Policy (NHP) came in 1983, which brought a policy framework to deliver quality health services, encompassing preventive, promotive, curative, palliative and rehabilitative .

Multisectoral action and macro policy environment is missing:

NHP focussed on tackling malnutrition like a public health challenge. The policy had minimal convergent vision, which could be seen in several programmes and the Five Year Plans of the country committing to action.

Overlapping but active revision of Policies

The National Health Policy of MoHFW came in 2002 followed by Policy on Infant and Young Child Feeding (2004), Policy on Control of Anaemia (MoHFW 2004) and Policy on Micronutrient Vitamin A (MoHFW). Some policies like IYCF and Anaemia control have been actively revised and integrated with existing programmes at scale without demarcating the end goal.

Continuous policy formulation without adequate documentation of past processes has resulted in several policies with overlapping goals and targets.

Many policies and many formats

Varied policy formats were followed with lacking consistency in policy structure. Some were complex that went into complete detail about the issue (such as the 1993 NNP) while others were closer to merely a set of guidelines. All of them tried to address need of public health nutrition. However, stress on individual and community behaviours varied.

This variability on individual and community behaviours acted as a barrier to systematic policy-driven action and diluted the real definition of the policy.

Gap in evidence of policy implementation

The Indian policy landscape has also been responsive to various international and national issues with limited inclusion of learnings/evidences from past experiences of implementing age old schemes and programmes. For instance, after International Conference on Nutrition in 1992, India, adopted its National Nutrition Policy (NNP) in 1993, The Nutrition Council, which was recommended in 1993 but was established only in 2011.

Lack of integration of evidence in policy formulation

Although, indirect actions are seen to be the key in having an impact on the nutrition landscape with some stress on convergence (e.g., economic empowerment of women, food security, strengthening of India's PDS, improving access to primary healthcare), operational details are still not provided.

Need to strengthen institutional mechanisms within the policy formulation environment

The National Health Policy of MoHFW, 2002 focussed on tackling malnutrition like a needed public health intervention. There are differing levels of commitment, governance, and supply-side issues, as well as operational gaps in the understanding of how these programmes can best reach out to those who need them most. The substantial focus was on "provision" and "supplementation" for masses. However, the ground was not ready for acceptance and desired level of utilisation of these services naturally.. Another missing link is "policy coherence"- the contribution of other (non-nutrition) sectors and a convergent method of addressing the complex problem of undernutrition, but its integration in the larger Five Year Plans of the country had minimal convergent vision.

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Ray of hope: POSHAN Abhiyan

The National Nutrition Mission i.e. POSHAN Abhiyaan is an overarching umbrella scheme to improve the nutritional outcomes for children, pregnant women and lactating mothers. The programme holistically addresses the multiple determinants of malnutrition and attempts to prioritize the efforts of all stakeholders on a comprehensive package of intervention and services targeted on the first 1000 days of a child's life. With an holistic approach combining the available resources and enhancing the delivery mechanism through robust monitoring aims to address the shortcomings of the existing policies.

It is based on 4 pillars:

- Ensuring access to quality services across the continuum of care to every woman and child; particularly during the first 1000 days of the child's life.
- Ensuring convergence of multiple programmes and schemes
- Leveraging technology (ICDS-CAS)
- Jan Andolan

A study on food consumption of mother and children

- Weekly provisioning data revealed that the households consumed cereals (wheat, rice, jowar, bajra, maize), pulses (red gram and green gram), tubers (potato and onion) and vegetables (brinjal and tomato)
- Additional varieties of vegetables (lady's finger and pumpkin) were consumed during rainy and winter seasons only and consumption of additional cereal like jowar (*Sorghum vulgare*) reduced from **79%** **during rainy and winter seasons to** **47%** **during summer**
- Green leafy vegetables (spinach, fenugreek and cabbage) which were consumed by **80%** **households during rainy and winter seasons decreased to** **37%** **during summer**
- The percent of households that consumed more than 2 types of green leafy vegetables reduced from **65%** **in rainy and winter seasons to** **19%** **in summer**
- Fruits were consumed by **87%** **and** **76%** **households during rainy and winter seasons and summer respectively** with majority consuming only 1 variety- Banana. Since Banana was cheap and readily available perennially
- Analysis indicates the consumption of **all food categories** by almost all households during both seasons; however the variety **reduced** during summer
- **Pregnant women mostly rely on carbohydrate rich food**

Farming practices

Agrarian Society- Source of irrigation is mostly rainwater, and river streams

Most of the families have kitchen garden. However, these gardens are seasonal and rainfall dependent. **Brinjal, chillies, pumpkin, tomato, methi are common vegetables** grown in the kitchen garden.

Major crops grown are jowar, bajra, maize, urad & moong dal, cotton, sugarcane and soya bean

Cooking and feeding practices

Cooking is done in earthenware and steel containers.

Staple food include jowar roti, rice, pulses.

Consumption of predominantly a carbohydrate -rich diet. Have three meals a day on an average. Fruit and vegetable consumption is relatively less.

Ethnographic research

Nourishing hard to reach communities

It involves **interactive engagement** with the community vis-à-vis documenting material, home and diet cultures, thereby developing an in-depth understanding

Recognizing the fact that the alleviation of malnutrition for vulnerable populations represents an extraordinarily complex and multi-layered challenge, **an exploratory approach was adopted to understand the gaps, needs and on-ground realities of the lives of the families.** Ethnographic research involved engaging with the range of stakeholders including community while designing the programme to enhance adoptability and social acceptability.

Ethnographic research is a qualitative method predicated on the diversity of culture within the cultural ecosystem. The research explored extensively observing community life and visually documenting material, home and food cultures, and came up with rich narratives and deep understandings around the complexity of malnutrition.

The study helped the team conceptualizing the project to understand the living experience, cultures, and multi-layered challenges of these hard to reach populations. The research identified critical gaps that remain unaddressed even after intense development work, and identified unique opportunities and strategic directions for new interventions that can actually redress behaviours around malnutrition.

The result of the study was interpreted to explore the correlation between access to agricultural and forest produce, seasonal migration and malnutrition in Nandurbar and Amravati.

Human centric design

A human centred design (HCD) approach was employed to gather information and insights about cultural systems and beliefs around health and nutrition within these tribal communities.

Human Centred Design, or human centred research, gathers and works on from the end user's point of view. In an ideal HCD-driven project, researchers employ qualitative and design research methods that put the subjective and the user experience forward, at all times.

Snapshot

Amravati and Nandurbar

Focused ethnographies and participant observation with young mothers, family members, and members of the village community who were a part of the local health systems were conducted.

The other stakeholders, such as extended family members, ASHAs and officials in the public health system, were engaged using a combination of focus group discussions, in- depth interviews and key informant interviews.

Implementation protocols:

1. Context setting

Evidence Review: Review of secondary literature relating to health and nutrition, and related practices.

Implementation Review: Review of interventions, best practices and models on community based interventions related to under-nutrition and child health.

Stakeholder mapping exercise was done to determine the key list of stakeholders who would be at the core of the research.

Introductory Field Visit to Nandurbar and Amravati districts was done to understand practices with respect to health, nutrition, explore local knowledge

2. Research Sprint

A purposive sampling technique to select 18 villages in Nandurbar and Amravati. These villages were selected with the support of our field partner- VSTF.

An equal proportion of VSTF and non-VSTF villages were selected using the following criteria:

- Health indicators of the villages
- Road connectivity to villages
- Presence of field partner VSTF
- Villages with cluster migration

Once the villages were identified, the respective FLWs were involved in drawing out a social maps of the villages

Findings from the ethnographic study

State suffers from poor health indicators and large number of cases of undernutrition

"Mainstreaming" of malnourishment happens in both districts

Tribal people mostly only speak local language

Increased soil and forest degradation and regional climate has degraded

Low diversity in produce and diet, rain-fed agriculture

Migrant parents work on farms and children eat stale food and drink contaminated water

First touch points for health seeking behaviour are traditional healers- Bhumkaas

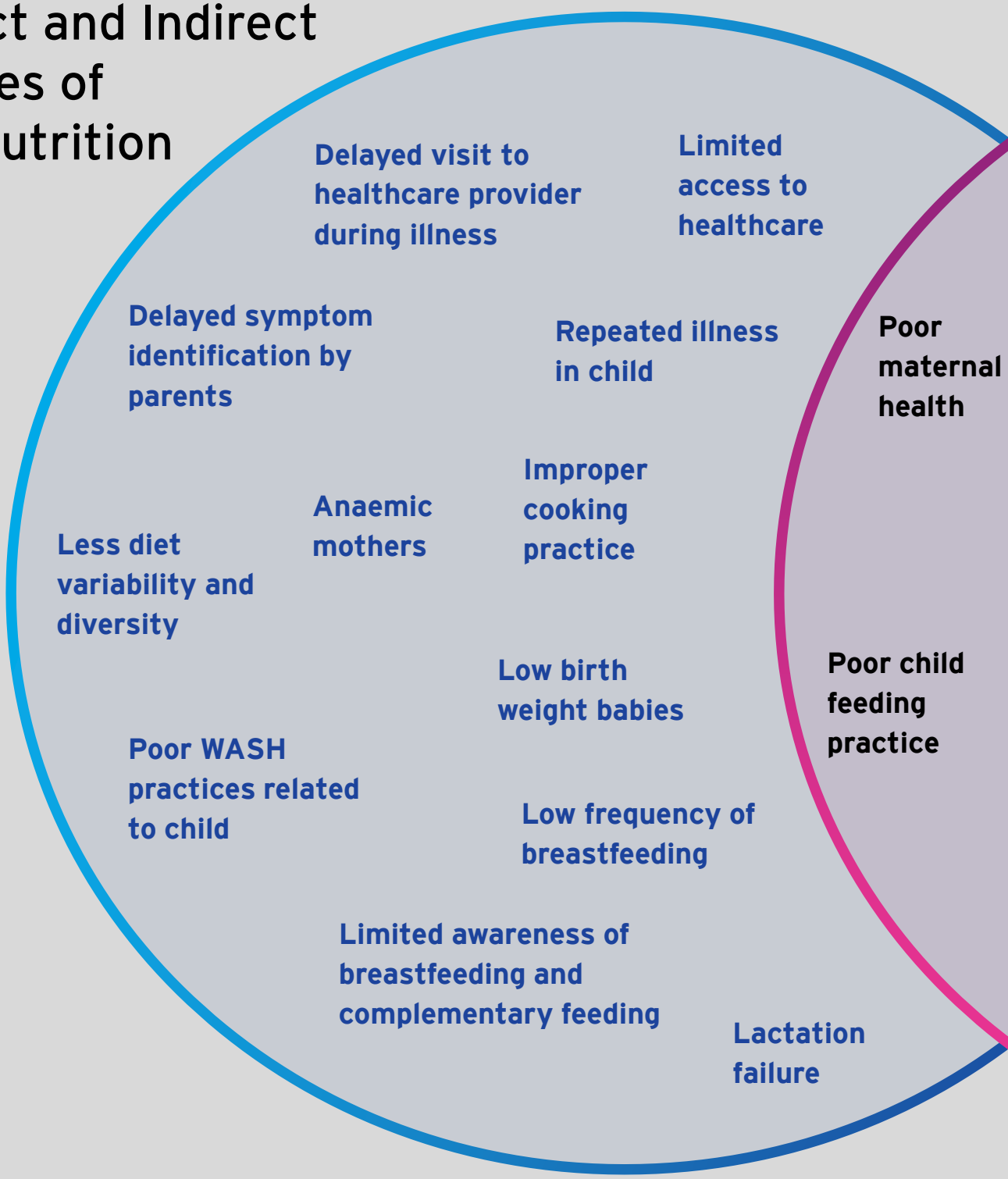
The traditional birth assistant, or dai, is integral to the process of bringing life into the world

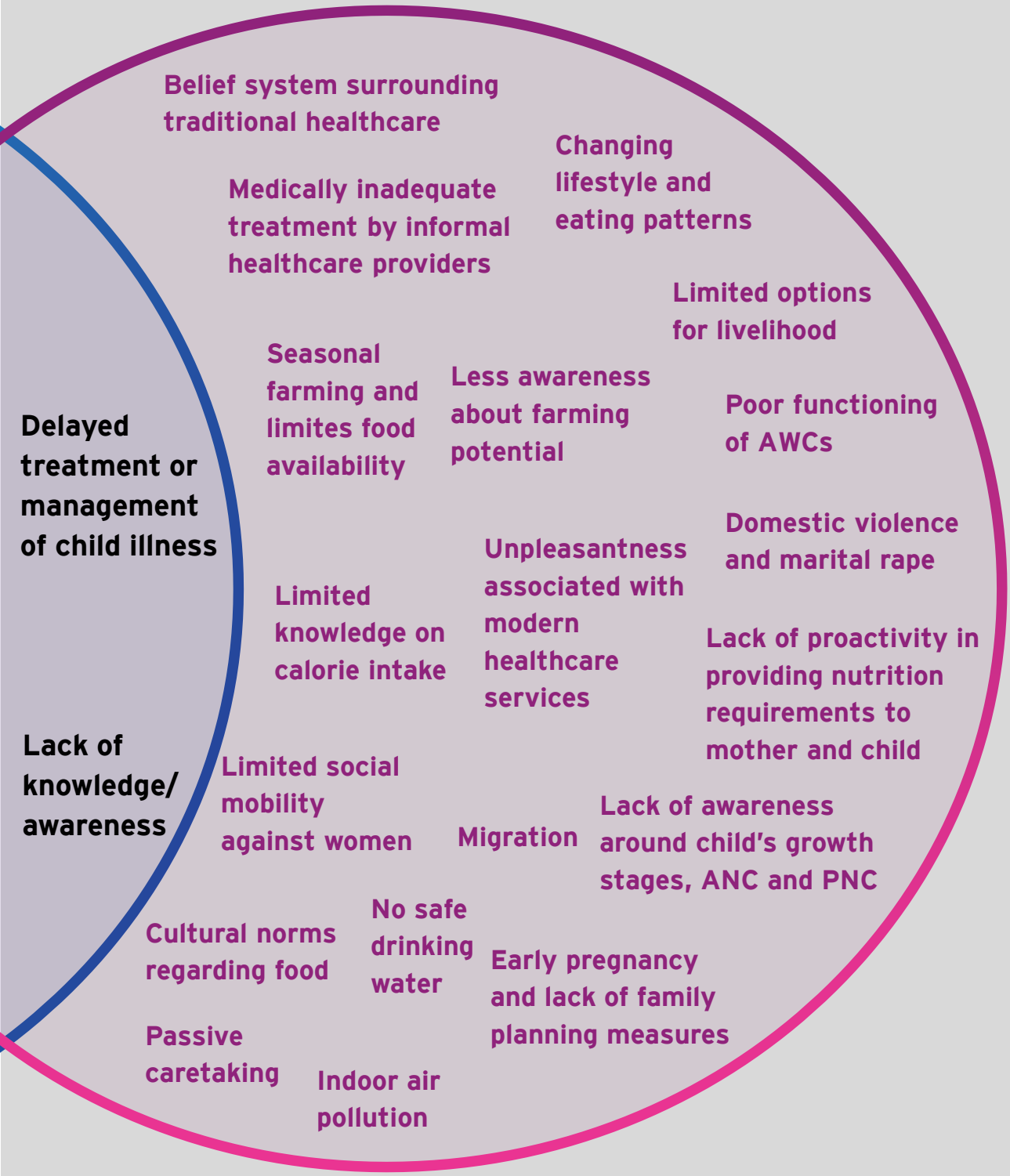
Replication of urban popular cuisine cultures and increased uptake of processed food instead of fruits or leafy vegetables

NIP has conducted a first of its kind ethnographic research to design the programme interventions.

Circles of influence

Direct and Indirect causes of malnutrition

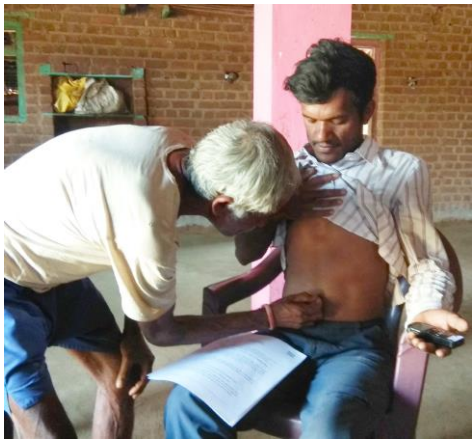




Indirect causes

Findings from the ethnographic study

1.Malnourishment in the state



"Mulga ani mulgi aatun vaaltat ahey" – in Marathi, this translates to 'the boy, or girl, is drying up from the inside'.

In some districts of Maharashtra, which suffer from poor health indicators, the above phrasing is used frequently. Despite the number interventions that have been implemented to fight malnutrition in the state. Malnutrition deaths are a perennial feature in Maharashtra.

As per the state government, nearly 94,000 **children are severely malnourished** in the state.

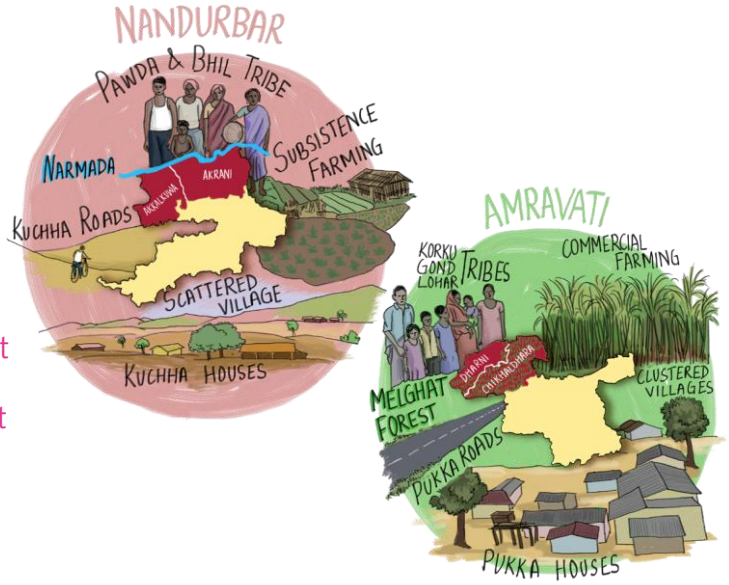
In 2017-18 more than 900 **children died** as a result of complications from malnutrition, stunting and wasting.

2.Amravati and Nandurbar

Nandurbar and Amaravati are both predominantly tribal and hilly, remote districts on the edges of northern Maharashtra.

When compared, some aspects of Nandurbar and Amravati demonstrate a binary dynamic nature- specifically in terms of their agriculture and infrastructure.

However both districts are home to significant numbers of malnourished children. At the core of their malnutrition woes is the fact that both districts are, increasingly, **'mainstreaming'.**



3.Language

In the Pawra and Bhil tribes in Nandurbar speak Bhil while tribe in Amravati speak a combination of Gondi and Hindi dialects.

Therefore, engaging with ASHAs, Anganwadi workers, doctors and nurses at CHCS, comprehensively becomes taxing.

The problematic effects of linguistic barriers are manifest in state with the appointed caregivers as well. Public health system actors who aren't a part of the community and have little or no knowledge of the local tribal language, aren't able to respond to patient's needs.

Findings from the ethnographic study

4.Relationship with forest

In both districts, malnourishment appears to be a result of the fallout of the community's relationship with its green cover. Forests offered villagers refuge, shade, sources of food, income and fuel, at the very least. As a living, dynamic entity, the forest is a lifeline – unobtrusive, yet integral to the tribal routine.

But with increased soil and forest degradation, the regional climate has degraded, and the numbers and variety of food sources that forests offer have reduced.

Increased degradation and human mismanagement of the forest will only further increase malnutrition among the tribals in the future.

5.Agrarian society

Communities here grow jowar, rice, urad and toor dals, banti, maize, soy bean, and peanuts for their own consumption. There is a systemic dependence on rain-fed agriculture, and a negligible use of irrigation systems, that invariably leads to low diversity in produce and diet.

Such growth and consumption patterns directly impacts not only diet diversity, but also income and food security when looked at through the forest degradation and climate change lens.

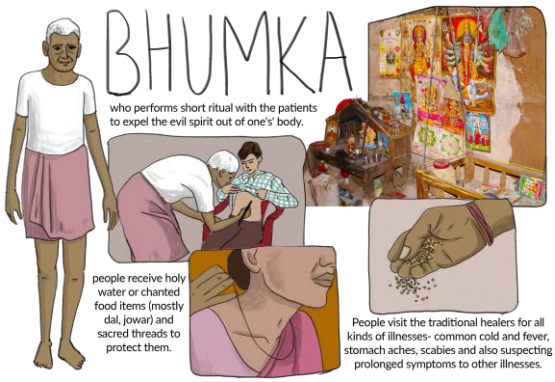
6.Migration, Transient life and Liminality

The heavy dependence on monsoon Kharif crop alone for economic security makes the tribal people extremely vulnerable. This necessitates a need for men in the tribal regions to migrate to the neighbouring states of Gujarat and MP in search of work during the months of November to March. Some move with families, others move alone, leaving wives, children and other dependents behind.

To get a job on a large farm, a man must take his wife with him. If a woman is to travel with her husband, she is likely to take her children with her - especially if they are under the age of two. For the already vulnerable baby, the displacement into such an unrelenting environment can be devastating, leading her or him directly down a path from moderate to severe and then acute malnourishment.

Findings from the ethnographic study

7.Health cultures and Bhumkas

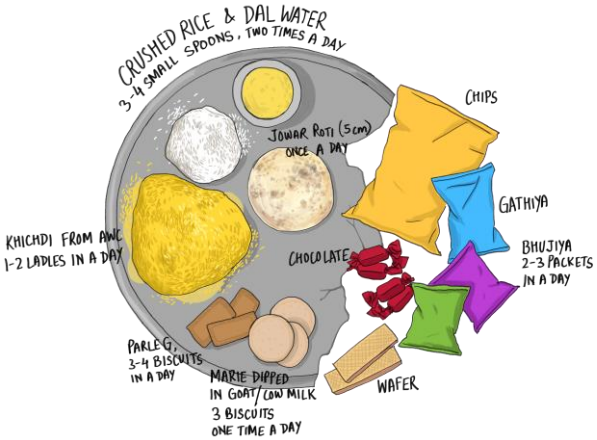


The culture of health seeking here is based on a complex layering of notions, around the severity of the symptoms a patient presents; accessibility (convenience), and the perceived efficacy of a treatment. There is some consensus that private, modern health care is most effective when it comes to treating severe conditions. However, despite its reliability, first touch points for health seeking behaviour are nearly traditional healers. Culturally, poor health is a sign of something 'evil', that needs chasing away. For this, the customary thing to do is to turn to practitioners in the hierarchical traditional health system, namely, bhumkas and bhagats, whose repertoire and understanding of symptoms is questionable.

8.Dai

The traditional birth assistant, or dai, is integral to the process of bringing life into the world. Dais bring knowledge and comfort to the pregnant and lactating women's homes, assuring them respect and privacy. In contrast, ASHAs, ANMs and doctors at the health centres require pregnant patients to come to them, and their brusque and impersonal manner is further alienating. The extent and depth of the dai's presence in these communities is demonstrated by the rituals and ceremonies that are centred around her (blessing event of mother and child, songs and dance).

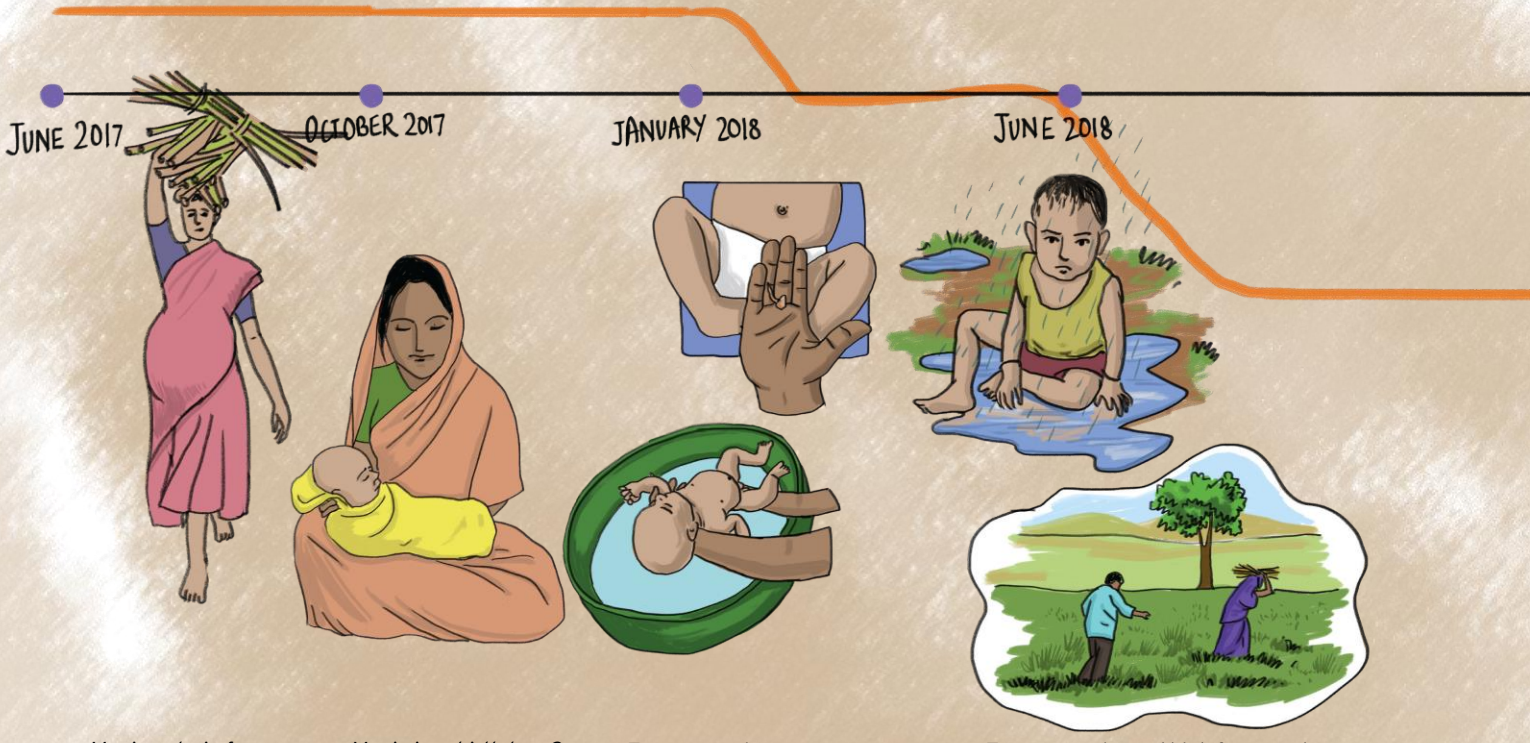
9.Culture, Diet and Cuisine



The growing presence of junk or fast food, even in remote villages in Nandurbar and Amravati, threatens the life of the local, more nutritious cuisine in these parts. Traditionally consumers of tubers, leafy green vegetables, wild grain and fish, tribal communities here have replaced the local, cruciferous items on their plates with increasing amounts of processed food.

At the village level, observers find increasing numbers of village shops that sell junk food, and are easily accessible, particularly to young children who prefer the latest flavour of chips and fried cornflour based snacks.

10. Health journey of 1.5 year old boy Tarun who was diagnosed malnourished in January 2019 (as reported by his mother, Mani)

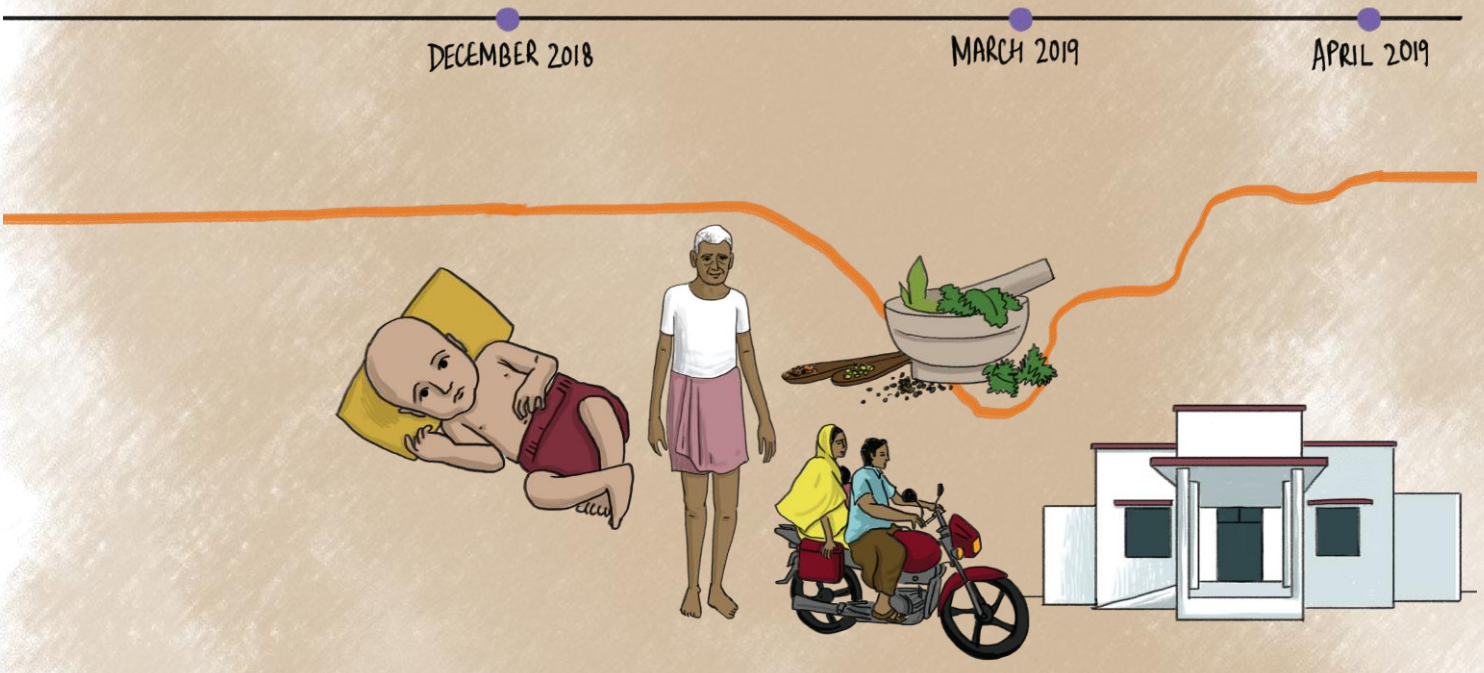


Mani works in farm while she is 6 months pregnant with her fourth child. Her ANC test reveals that she is anaemic.

Mani gives birth to a 2 kilo baby boy at home, her mother in law assists as the dai of their village. After the navel cord dries and falls off, they name the baby Tarun.

Tarun experiences minor symptoms of cold. Mani and the family chooses to not seek treatment, hoping they will go away.

Tarun experienced high fever and symptoms of cold. Mani believes this illness occurred in the monsoon season. As she was busy working at her rain-fed farm, she could not pay active attention to Tarun. He remained wet and cold.



The family member visited their village Bhumka. They also visited PHC Horafali 5 times and PHC Helamba 1 time. They consulted with 2-3 renowned bhumka. But, there was no improvement in his health.

Mani reports that Tarun's appetite is low. His complimentary feeding also began at 8-9th month of age. Treatment: Ayurvedic medication were given to Tarun in the hope to cure cold symptoms.

All the recurring illness and running around for treatment has caused another severe sickness episode for Tarun. This time his condition is extremely critical, when he fell unconscious the family chose to take him to a Private Hospital

Designing for hard to reach communities

Behavioural nudges and interventions

The project is first of many such research-led design efforts. Ethnography underlined that health seeking behaviour in these villages is based on a complex layering of notions.

The Nutrition India Programme proposes strategic directions, based on barriers and opportunities identified from the research undertaken in Nandurbar and Amravati. The ethnography-forward design approach has been based on the findings on vulnerability indicators, critical challenges around nutrition, social and environmental risks, local health perceptions, organic health networks, resources, deeply rooted health behaviours and rituals.

The strategies build account for user needs and sensibilities, leverage positive health cultures inherent to this cultural group, target those that have the most need, and make innovative and efficient use of local resources.

The directions offered here propose interventions at different levels-

- **Improving the efficiency of referrals and timeliness of critical care**
- **Build resilience of these beneficiaries, enabling healthful and preventive behaviours, building better caregiving capacity and vigilance toward danger signs**

The call to action therefore included-

1. Creation of community nutrition cadre to mobilize, monitor and coach
2. Build trust and a shared glossary of health knowledge
3. Incentivize access to critical Care and Rehabilitation tor the malnourished
4. Port health across native and migratory settlements
5. Sync with local cultures of health
6. Revitalize food cultures for nutrition security

Use of behavioural nudges

The project also employed a host of behavioural nudges in the form of mobile apps, games, nutrition kits, multimedia stimuli, and new kinds of resilience rituals, community festivals and engaging social experiences to build community capacity around nutrition and hygiene.

Community nutrition workers (CNWs)

This workforce of travelling Community Nutrition Workers (CNWs), is rigorously trained by a team of public health experts, paediatricians, gynaecologists and community development specialists.

Going from village to village, the CNWs are delivering a range of screening, referral, mobilization, monitoring, and nutritional and social behaviour change communication activities and care-giver coaching within their communities.

Community Nutrition Workers

Our Nutrition Warriors.

An informal community nutrition cadre comprising of **41 young women** from the local communities

The National Rural Health Mission (NRHM), introduced the accredited social health activist (ASHA) system in 2005, to create a vast cadre of village-level female community health workers, with a target of full public health implementation across all villages in India in 2012. Research studies and literature on ASHAs point at extreme workload, lack of or too much of training, inadequate and delayed monetary incentives as some of the broad challenges they face. It was observed that ASHAs' motivation levels are low and their competencies are not always enough to cater to their communities.

As major part of Nutrition India Programme, an informal community nutrition cadre comprising of women from the local regions will be trained and deployed across Nandurbar and Amravati. This cadre is essential to mediate between the community and health care providers in order to promote positive health care behaviours and to facilitate sustainable adoption of health practices. Through this programme an all women **volunteer** network of nutrition cadre is established.

The technical team developed a bespoke training manual detailing basics of first 1000 days, the programme interventions as well as protocols of imparting the training to the project team.

Trust building by the community Nutrition workers

The tireless efforts of the CNW have led to an increased trust of the community on the modern health care system. This is reflected in the increased admission of SAM children with medical complications to NRC/CTC.

Out of the 197 SAM children with oedema, 190 were admitted in NRC/ CTC and 180 completed the mandated treatment and recovered.

Built capacities of 984 frontline health workers to increase convergence of ASHAs, AWWs with newly appointed CNWs

The training was aimed at increasing the convergence among ANM, ASHA, AWW and CNW and for regular organisation of the VHNDs and improved delivery of services.

Recruitment, workflow and MIS for CNWs

Recruitment criteria of CNWs

CNWs are local women in the age group 25 – 35 Outreach workers had to be from their local community. In addition, as much as possible, they were chosen from women who were poor, but whose children were nevertheless well nourished. Before they even began nutrition counselling, they were proof to the community that poverty need not be an impediment to good nutrition

Work routines

These were clearly defined on a daily, weekly, and monthly basis. One major task of the CNW is to ensure regular organisation of the VHSND in partnership with AWW, ANM and ASHA. This ensures that growth monitoring, is conducted on the same day every month, so women knew when to bring their children to the aganwadi centres.

Supervision and trainings

There is a Cluster Coordinator (CC) for every 10 community workers. The team of CC and CNW is supervised by the District lead. The CC, holds a weekly meeting with the CNW on every Monday and a district level review meeting is organised in the last week of the month. The meetings provide an opportunity to the CNWs share experiences and learnings, review their achievements and also list out areas of support needed. The district level monthly meeting also provides scope for conducting knowledge sessions as per the requirement of the CNWs. Government officials are also engaged for these knowledge sessions.

Mobile based MIS and Counselling app:

The programme has developed an APP which helps the CNW capture the programme data in an easy manner. The data related to target beneficiary and services provided through home visits and mother's group meeting are captured. The App has also integrated the counselling videos which enables CNW to communicate the right messages to the beneficiaries. In the monthly meeting the data for all the CNWs are analysed and CNWs performing not up to the mark are identified for special attention by the supervisors.

Strengthening convergence through district level support

CNWs are also strengthening the convergence of activities by proactively engaging the ANM, AWW and ASHA in the organisation of Village Health Sanitation and Nutrition Day (VHSND). This has resulted in increased community participation and better targeting of SAM/MAM children and High Risk pregnant women. Regular district and block level co-ordination review meetings are organised on a monthly basis to identify and address the challenges and identify solutions.

Community Nutrition Workers have emerged as a beacon of hope and pillar of trust for the community in the programme villages. The hard work and dedication has saved many lives of severely malnourished children and high risk pregnant women. Many stories of courage and sincerity abound and they have played a role in motivating number of parents and pregnant women to access health care services. The efforts have been praised by government officials and community. CNW plays a crucial role in identification, counselling and referral of SAM and HRG pregnant women. They are also playing a crucial role in bringing together the ASHA, AWW and ANM together.

Training of Community Nutrition Workers

The programme adopted an Integrated multi sectoral approach and a Human centred design (HCD)

A total 41 CNWs, 4 Cluster Coordinators are deployed to undertake operations to ensure standard home based interventions, tailor made for the programme

A bespoke training manual detailing the programme interventions as well as protocols was developed by the technical team of the project to impart training to the CNWs. In this regard, a 6-day, residential training programme was organised in Amravati from 12-17 May, 2019, to build capacities of newly inducted team (CCs and CNWs).

The pre assessment of trainees was done three days before actual start of the training. The six day training covered the following components:

1 Introduction, Background, Ethnographic Research

On day 1, the inauguration was done by Hon. Shailesh Nawal, IAS, District Collector, Amravati, Dr. Raj Bhandari, Member National Technical Board of Health & Nutrition, NITI Aayog, Mr Ravi Bhatnagar, Director External Affairs and Partnerships at RB, Mr. Sanjay Bahekar – Director, Prabodhini, Mr. Prafull Rangari – Mission Manager, VSTF, Ms. Padma Raghavan – Head of corporate affairs, Plan India.

Background of the project and details on the **interventions** to be made along with pre-assessment results was discussed.

Session on **ethnographic research** shared information about beneficiary's knowledge, current practices, and underlying myths around child and maternal health. It also spoke about the issues, ground knowledge, possible hot spots, community norms, practices and call to action. The next session on **enhancing skills of CNWs with special focus on communications** guided the participants on service coordination to enhance knowledge base and interpersonal communication skills.

2 Skill based technical know-how of Health, Nutrition and WASH interventions

Day 2 started with session focussed on discussion around technicalities of nutrition and what drives a normal child to the vicious cycle of malnutrition. Specific attention was provided with a **hands on practice session on detection of SAM/MAM** – Z score, growth charts, Wasting Stunting and Underweight and nutritional recipes. A session on **care of adolescent girls and newlyweds** was facilitated using series of case studies and group exercises on early marriage, conception and its adverse effects, family planning and child spacing. The next session on **care during pregnancy** specifically highlighted the danger signs during pregnancy .

The session continued with an explanation of Breastfeeding, Institutional delivery, postnatal care, wherein apart from presentations and group exercise.. A session on **target intervention** helped the participants to understand the need of multipronged intervention, level of preparations required. The last session explained **principles of care at birth**, including breath, neonatal asphyxia hypothermia, early initiation of breastfeeding and Infections danger signs. A specific demonstration was provided on **Kangaroo Mother Care (KMC)** as well.

3 Breastfeeding and other key interventions of the programme

A discussion on **exclusive breastfeeding** and its advantages was organized on day 3. The session was followed by **impact of water borne diseases** on children i.e. diarrhoea and its management using Oral Rehydration Solution (ORS), Zinc supplement, appropriate feeding and other home fluids.
The session stressed on the importance for CNWs to identify the signs and initiate early management of the problem. It further focussed on how care during the **first 1000 days of life**- affecting economic productivity, the **Golden Rules** to minimise undernutrition. The programme approach of having both **preventive and curative aspect** and specifically designed interventions for each target group was also explained.
The discussion was followed by hands on practice session on step wise intervention, including village entry, mapping of target groups, activities at Village Health and Sanitation days, creating women sub groups. The day concluded with a session on **timely initiation of complementary feeding** to overcome nutritional gap.

4 Exposure visit, Use of Nutrition Kit & Swachhta Chakra

All the participants visited Nutrition Rehabilitation Centre (NRC) at Amravati district to understand the processes followed, get hands on experience of conducting anthropometric measurements and also assess case history of MAM children .

The day was followed with 2 sessions on familiarising with the use of Nutrition Kit and Swachhta Chakra app and water testing using H2S vial using water samples brought from their villages.

5 Assessment of CNWs & training on Data Management

The day started with post assessment test of CNWs The result of post assessment showed significant increase of knowledge among the trainees. **(indicated below)**
The next session was on hands on practice of use of tablets and filling of forms. CNWs were trained in each and every aspect of using tablets including entering the data in the tablet using various forms, locating the data at the dashboard for follow up and after registration services.

6 Field Visit

The teams were prepared and oriented on their activities at the VHSND and household visit. Team visited village Shendola Khurd in Amravati district and observed the VHND and filled their observation in the tablets. During interaction they identified the specific Target Group of children, which was Moderately Acute Malnourished. Each team visited one MAM household, registered the child and extended service and created track record of the child using real time tracking system.
After field visit, CNWs provided feedback on issues faced during field day, each of the issues were discussed in detail and sorted.

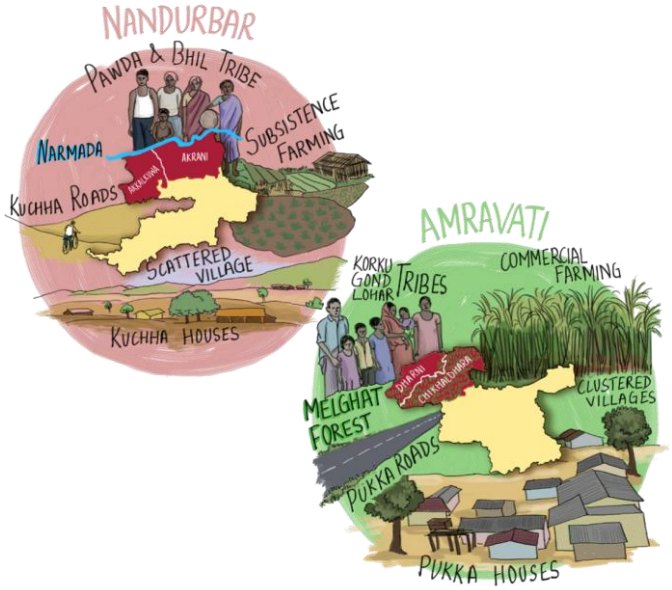
Valedictory function

The valedictory function was planned with Dr. Indira Chakraborty, Chair, Nutrition India Programme.
She also facilitated a session on the importance of water, sanitation and hygiene in nutrition and presented case studies. She put emphasis on use of safe water and clean environment for the reduction of worm infestation, diarrhoea and anaemia.

Evaluation	Pre-test Number of CNW	Post test Number of CNW	Pre-test % of CNW	Post test % of CNW	% change
Red	20	2	48.78%	5%	~90%
Yellow	13	13	31.71%	33%	0%
Green	8	25	19.51%	33%	21.3%

Behavioural nudges

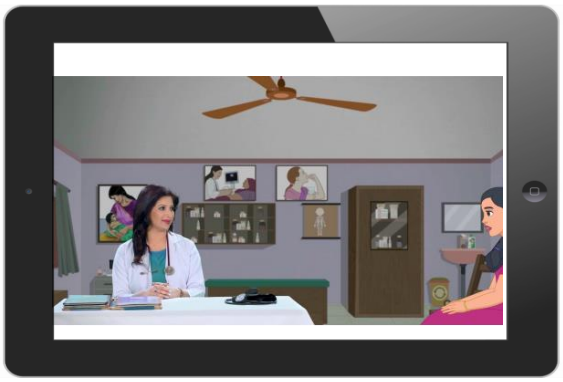
The programme employs a host of behavioural nudges, apps, games, nutrition kits, multimedia stimuli, new kinds of resilience rituals, community festivals and engaging social experiences to build community capacity around nutrition and hygiene.



Ethnography study was performed to capture the social norms, cultures, stratification, migration and transient life, health seeking behaviours, diet and language.

Based on these findings appropriate nudges were designed to make people aware about the issue of under-nutrition and to change the situation.

1. Interactive curriculum for CNWs by doctors



CNWs representing the community and their queries to a doctor

Developed in 4 local languages- Bhil, Pawra, Hindi & Marathi

Counselling around safe and proper breastfeeding practices

Counselling around hygiene practices like hand washing before feeding a child

Counselling around diet diversity during pregnancy

Counselling around required Immunizations for a child

Through an **interactive and detailed curriculum with multiple training modules**, these nutrition workers are trained by experts and doctors on understanding malnutrition, care of adolescents and young mothers, care during pregnancy, birth preparedness, antenatal and postnatal care, diet diversity, breast feeding practices, health and hygiene practices and so on.

2. Driving hygiene through digital practices: Swachhta Chakra

Swachhta Chakra is an interactive android game designed for frontline workers to create awareness on personal and environmental hygiene like sanitation practices among the community members especially mothers, caregivers etc.

It consists of a set of multiple choice questions around situations and decisions undertaken by an individual pertaining to hygiene and sanitation in daily life.

This quiz helps in monitoring the change in knowledge and increase in the understanding of player/s about hygiene and sanitation practices. Moreover, it helps in building connection with frontline workers and motivates the player/s to adopt or improve WASH practices as a part of their daily routine.

3. Nutrition kits

A Nutrition Kit targeted towards increasing knowledge, building awareness and practices around healthy nutrition practices and health seeking behaviours among expectant mothers, children (aged 3-5 and 6-10) and front-line health workers was designed. This kit has been designed mindfully and incorporates various tools and games catering towards the above mentioned groups through social and behaviour change communication strategies. The proposed modules in this kit are the following: good and bad eating habits during the first 1000 days of life, education on nutritional values of food items, hygiene practices and slides demonstrating best practices during and pre and post-natal stages.

Components of Nutrition Kit:

First 1000 days of child

An interactive board game which focusses on do's and don'ts for taking care of a baby during first 1000 days of baby's life. In the game, the mother follows the good habits and avoids the bad habits to get a healthy baby.

First phase- first 9 months

Second Phase- Birth to 6 months

3rd Phase- 6 month to 24 months

Nutrition mania

What is the colour of your food today?

Through these colour-coded plates a message of how the people are lacking in essential vitamins and nutrition was conveyed. All the food is locally available and locally grown, in kitchen gardens. Since the food is available, all they need to be told about is eating right kind of food.

What is the colour of the food on your plate today? Does it have all the colours – white, for milk and milk products, green, for vegetables, orange, for carrots and tomatoes, or does it always have the brown colour of chappatis?

This innovative colour-coded plate is helping to spread awareness about nutrition among women Amravati and Nandurbar, giving a big push to the government's Poshan Abhiyaan.

With these make your own meal plates, the project has reached out to 3,000 women – pregnant women, lactating mothers, and women planning pregnancy – in Amravati and Nandurbar. It aims to reach out to 1,75,000 such women.

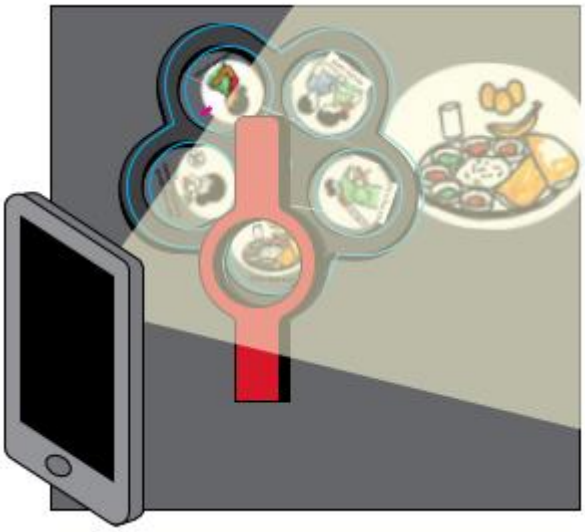
There are five colours in the plate –white, brown, orange, green, violet. In conversations with the mothers, the kind of food consumed was mapped for 2 weeks and it was observed that green, orange, white, violet are missing and only browns are there. Brown is basically chapattis, of wheat, jowar or bajra.
The women were communicated that they need to have various colours in their plate daily, so that they get the vitamins, minerals, iron in order to have adequate calorie intake.

Food for infants

This tool shows the adequate food for infants from birth till 2 years of age.

Glitter game

In this game, some glitter is put on the hands of the children and they are asked to shake hands with others – to show how germs are spread. The children are then asked to first wash hands with plain water, in which some of the glitter washes off, but most of it sticks. This shows how plain water does not help to wash off the germs. Then they wash with soap, and the glitter is completely gone. This has proved to be an effective way to tell them about the benefits of handwashing with soap.



Nutrition talkies

Another game is like a kaleidoscope, that can be used with a mobile torch, to project on a large screen different messages – on the benefits of breast milk, steps to be taken during diarrhoea, on the food pyramid, steps to be taken during delivery, during pregnancy, preventive undernutrition.

Other than this, seven videos are also created on the first 1,000 days of a child's life. **The videos, in Marathi, are done in a dialogue format, using a mother and child from the community shown on VHNDs**

Nutri-mania

Nutrition mania is a card game designed to spread the message about nutrition among children in an interactive, interesting way.

This is a trump card game to explore the relative nutrition value across different food items. The game has 2 levels covering a variety of food items across food groups.

Our Impact Portfolio

Dewanshu's story |

Dewanshu Mongya Tandilkar, a severely malnourished child was diagnosed with pneumonia during a regular home visit by the CNW. Despite several counselling sessions by the various NIP members, Dewanshu's parents were reluctant to admit him at the local Primary Health Centre.

After many attempts, the parents admitted Dewanshu at a hospital and attempted to flee due to the fear of losing their child. Dewanshu was later admitted at Nagpur Super Speciality Hospital and soon recovered. The story is an indicative of the importance of providing support to the family during such critical times.

> "Bacha marvega toh jimidari hamara". The parents of the child speak their heart out when they say anything that happens to their child is their responsibility.
>
> Dewanshu's parents
>
> Nutrition India Programme

A girl child from Dharni |

This girl child was delivered at Rural Hospital Dharni and weighed 1 kg and 950 grams. She was under the care of the hospital for seven days, after which she was sent home. The child lost 700 grams due to inadequate breastfeeding.

The CNW counselled the parents of the child, after which the child was admitted in the hospital after which she attained 2200 grams. The child has recovered and has gained substantial weight within a timeline of three months.

Approach of the programme

Nourishing Hard to reach Communities

Technology is deployed in various forms across the programme- from using real time data monitoring, blockchain to track and enable conditional cash transfers

The project focusing on **1000 days** intends to demonstrate scalable innovative models involving partnership between government, private and civil society, leading to substantial reduction in malnutrition and also increasing the capacity of existing system through capacity building and system strengthening.

With the help of the ethnographic study, it was underlined that health seeking behaviour in Amravati and Nandurbar is based on a complex layering of notions, and depends upon the severity of the symptoms, accessibility (convenience), and the perceived efficacy of a treatment.

Based on this, a design-led approach was adopted under the programme. The project employed a new cadre of female Community Nutrition Workers, to mobilize the community and promote positive health care behaviours. Through these activities, the cadre helps generate awareness on feeding practices, symptoms of malnutrition and common childhood diseases, while also implementing measures that would allow vulnerable pregnant women and children to get the timely and critical health care they need.

At the same time, project also has a targeted focus on identifying, addressing and surveilling the most vulnerable and malnourished pregnant women and children under two, it balances these efforts with innovations and initiatives that aim to build resilience and nutrition capacity across communities. The project also employed a host of behavioural nudges, apps, games, nutrition kits, multimedia stimuli, and new kinds of resilience rituals, community festivals and engaging social experiences to build community capacity around nutrition and hygiene.

Innovations under the programme

The project operates with a wide range of service delivery spectrum including identification of high-risk children and mothers, BCC, periodic follow-ups, referral and treatment and capacity building.

This was coupled with a range of programme innovations like Blockchain enabled voucher scheme, breastfeeding pods, mobile nutrition units and mobile BCC units.

Snapshot

Service delivery spectrum

- Identification of high risk groups and enrolment
- Periodic follow up and service delivery
- Behaviour change and communication
- Referrals and treatment
- Bolstering capacity of district and block level actors and resources

Special emphasis on the vulnerable target groups

Care of woman during first 270 days

Through immunization, hygiene and adequate diet

Care of mother and child for 2 years

Delivery, exclusive breastfeeding, diet diversity and immunization

Care on special conditions (SAM/MAM/SUW children, high-risk pregnant woman)

Therapeutic food at NRCs, management of lactation challenges

Innovations under the programme

Blockchain enabled voucher scheme

conditional cash transfer to enable the families to use services offered by the public health system

Breastfeeding pods

Equipped with relevant amenities for lactating mothers while also focussing on their security and health

Mobile Nutrition Kits

Specifically designed to aid in social BCC and support nutrition workers and expectant mothers

Mobile BCC units

To make communities aware about malnutrition, health journey of a child and importance of adequate diet

Snapshot

Blockchain enabled voucher scheme

Incentivize access to critical care & rehabilitation for the malnourished

Aim

Accelerate timely care through self-identification, networked referrals, incentives to complete care and post illness care counselling

Current challenges and deterrents

- Low recognition of danger signs
- Lack of urgency to address early signs
- No referral system connecting the traditional and public healthcare
- Expensive travel and long duration stays at nutrition rehabilitation centres

As a result..

- Majority of malnourished children either do not reach NRCs to receive timely and critical care or leave the NRC before the prescribed treatment course
- In addition, a deep faith and preference of traditional healers often precipitates a gap in the treatment
- Parents only address the superficial symptoms by seeking out to traditional healers
- Children are only brought to the local ASHA or FLW's attention once her/his condition has worsened significantly

NIP's voucher scheme allows:

1. Families to self-identify and self-mobilize
2. Traditional care providers and health functionaries to screen and refer malnourished children
3. Nutrition rehabilitation practitioners receive and provide critical care to acutely malnourished children
4. For a tribal migrant population, with a life on the move 5-6 months of the year, a voucher with danger signs for health is an extremely powerful tool to identify health threats and take corrective steps to overcome them. It can:
    1. Mobilize families to seek appropriate medical attention for their children
    2. Illustrate the danger signs that require care
    3. Detail the care pathways
    4. Emphasize the requisite incentive structures that can cover the cost of their travel and stay at the NRC

Timely and Critical Care received at the NRC

Money transferred through conditional cash transfers

Completion of a 14 day treatment period

Motivation to the family and feasible treatment

Build faith in public healthcare facilities and doctors

Economic support to families

Use of blockchain in voucher scheme

To strengthen the referral and incentive system, blockchain technology increases transparency of information, efficiency of processes, promotes evidence-based actions and collaboration amongst the stakeholders like health functionaries, nutrition rehabilitation practitioners, patients (mother and child), community based entrepreneurs (CBE) like ASHA, AWW etc.

i. The CBE or CNW issue the voucher to the target audience (mother) and scan the coupon code. The coupon code is stored in blockchain, with owner as the CBE.

ii. The mother can redeem the voucher for services/NRC. The service provider/NRC scans the voucher which will change the corresponding coupon state as "redeemed" (first tranche on the admission and second tranche after the completion of the treatment) on the blockchain and the owner as the NRC.

iii. At any point in time the CBE/ CNW/ NRC will be able to view the details of any coupon transaction on blockchain.

iv. The blockchain solution enables traceability of coupons, transparency on usage of coupons and provide indicator on the efficiency of coupon processing and thereby the programme.

Our progress in the first year

A pilot of the voucher scheme was run in the first year of the programme i.e. 2019, with the initial plan to distribute only 50 vouchers. **However, because of the demand in the community, 152 vouchers were distributed.**

It has benefited **36 SAM children** and **75 high risk pregnant women**

- Of the 36 admitted to the NRCs, 34 were discharged, all of them stayed there for 14 days, recovered and now in the MAM category
- Of 75 pregnant women, 7 got C-section remaining 71 deliveries were normal

Value of the vouchers:

For SAM Children: INR 4500
For High risk pregnant women: INR 1700

Cost includes transportation, food and wage loss cover

Target for 2020:

Distribution of 600 vouchers amongst the identified SAM children and pregnant women

Target audience and service deliveries

Woman during first 270 days

1. Immunization, complete ANC
2. Hygiene, safe drinking water, sanitation
3. Adequate nutrients, diet diversity (locally grown food), care, rest, preparation for delivery

Mother and child for 2 years

1. Institutional delivery, initiation of breastfeeding within 1 hour of birth, complete pre-natal care
2. Exclusive breastfeeding for 6 months, timely introduction of complementary feeding and age appropriate food till 2 years
3. Diet diversity for lactating mother and child (locally grown food)
4. Complete immunization, Vitamin A supplement, deworming and development milestones

Special conditions (SAM/MAM/SUW children, high-risk pregnant woman)

1. Appropriate care and feeding during illness
2. Therapeutic food and care at NRCs
3. Support for high risk pregnant women, management of lactation challenges

Identification of high risk groups and enrolment and periodic follow-ups

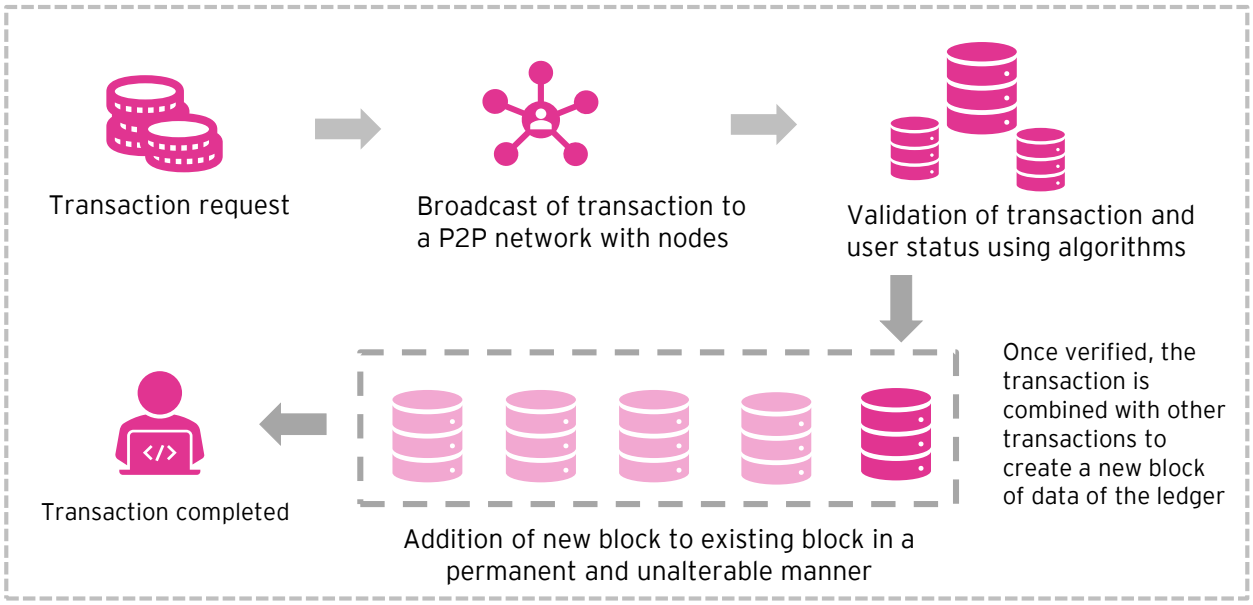
Targeting malnourished children and ensuring their timely care is imperative to improved nutritional outcomes among under 5 children. The nutrition workers will be equipped and trained on identification parameters of SAM/MAM/ SUW children. Thus, early identification and referrals to NRC can be initiated. The workers will begin with mapping village households and identifying the SAM/ MAM children. Such children will be registered and will be monitored to check for their health progress to ensure their timely care. Mothers and family members of severely undernourished children will be counselled at the household level using videos which would be vital to enabling better understanding of nutritional challenges.

It is crucial to ensure monitoring of intervention activities to enable in follow up and to escalate emergency health cases. Prompt identification and treatment of severely under-nourished children and their admission into the closest Nutrition Rehabilitation centre is critical to the child's health. The nutrition workers will assure the monitoring of the admitted children who will be followed up on post their treatment period at the Centre.

Blockchain enabled voucher scheme

Blockchain technology overview

A blockchain is a decentralized, distributed, public digital ledger that is used to record transactions between parties efficiently, securely, and in a verifiable manner. Each transaction is stored as a unique block which holds information of the previous bock, the transaction data, along with a timestamp. Once recorded, the transactions cannot be edited without alteration of all existing blocks, which requires consensus of all participants on the blockchain network. The democratized system facilitates execution of smart contracts/transactions on a blockchain-enabled network in real-time which is secure, transparent, and unalterable.



What is Voucher scheme?

The proposed Voucher Scheme as a part of the Nutrition India Programme is a mean to enable and facilitate the targeted beneficiaries to accrue services from the available public health system. It also proposes to enable beneficiaries to purchase services (hygiene products and SBCC tools) from the knowledge providers within the programme.

Nutrition India Programme will also advocate with the government functionaries to ensure enhanced access to safe drinking water, sanitation and hygienic environment in the public health institutions.

Who is eligible?

Mother of SAM children who are referred to Child Treatment Centre (CTC)/Nutrition Rehabilitation Centre (NRC)

High-risk Pregnant Woman

Blockchain-based voucher validation & transaction monitoring

The blockchain enabled digital voucher scheme aims to increase the transparency and security of the disbursal process through the evidence based voucher disbursement mechanism.

The blockchain serves as a tamper proof data processing mechanism, thereby eliminating data redundancies and duplication for effective evaluation of the scheme progress

Other key advantages of the integrated voucher-blockchain system:

Sample voucher for SAM children

Transparent | Secure | Immutable | Trusted transaction | Process automation | Real-time tracking

The blockchain network can be **further extended** to other parties like manufactures of products, government institutions and even banks who would like to participate in the network so as to provide better services to target beneficiaries.

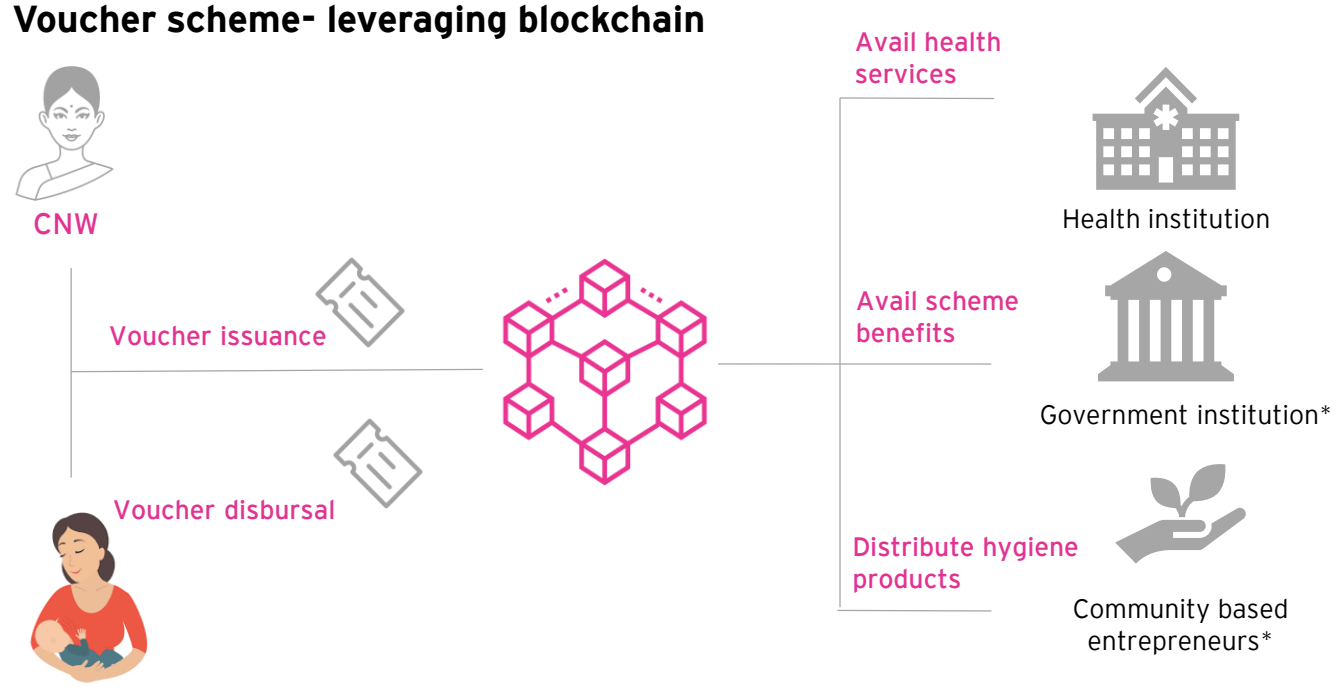
Voucher scheme- leveraging blockchain

The voucher scheme will leverage blockchain technology to improve validation & traceability of vouchers and hence ensure their intended usage. Blockchain will enable different participants like target beneficiaries, Community Nutrition Worker (CNW), Cluster Coordinator (CC) and the overall NIP to seamlessly transact services and commodities using vouchers which will be identified, validated and tracked using blockchain's immutable ledger.

Voucher Validation:

- Access to authorised participants
- Digitisation of voucher to a cryptographic asset on the blockchain
- Transaction verification by blockchain
- Secure transaction database recorded by the blockchain

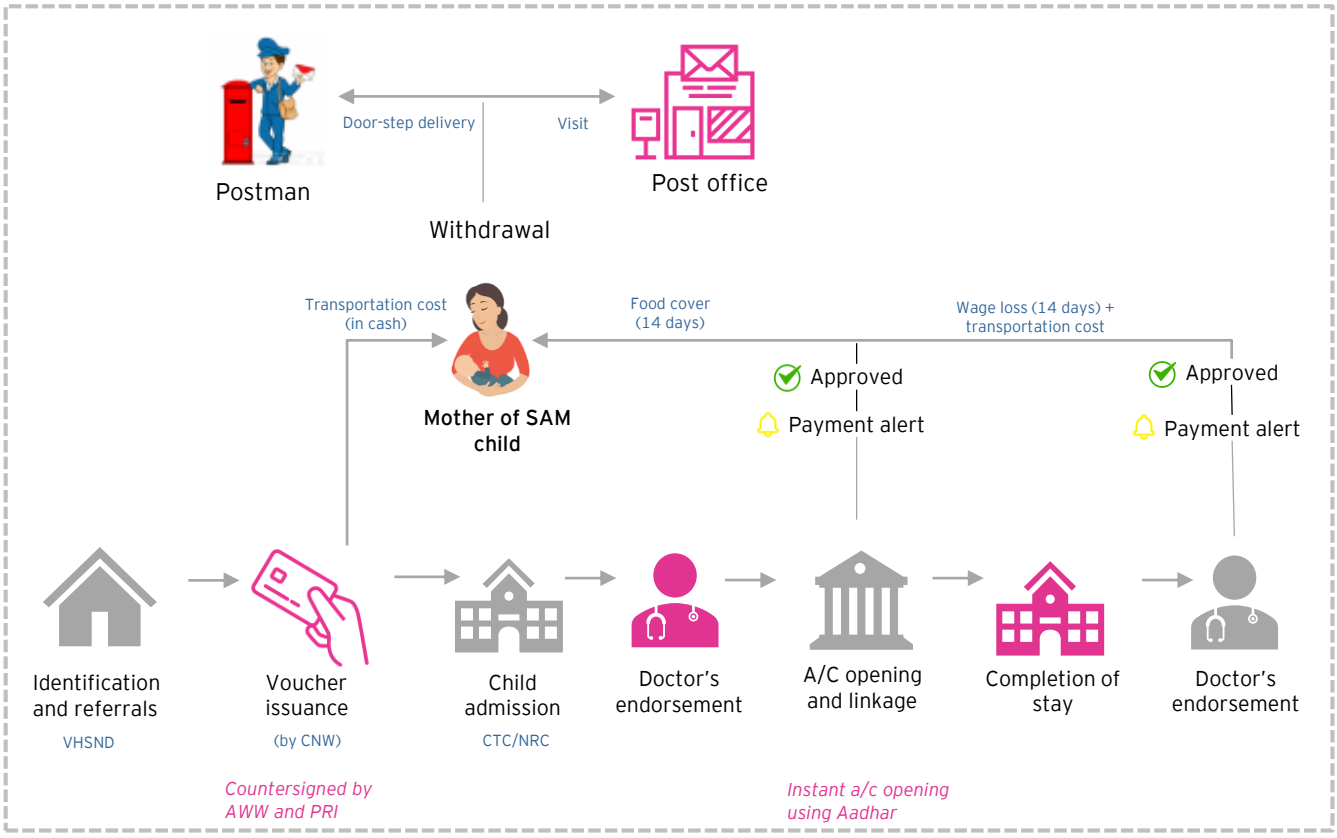
Voucher scheme- leveraging blockchain



*To be introduced post roll-out of voucher scheme for availing health services

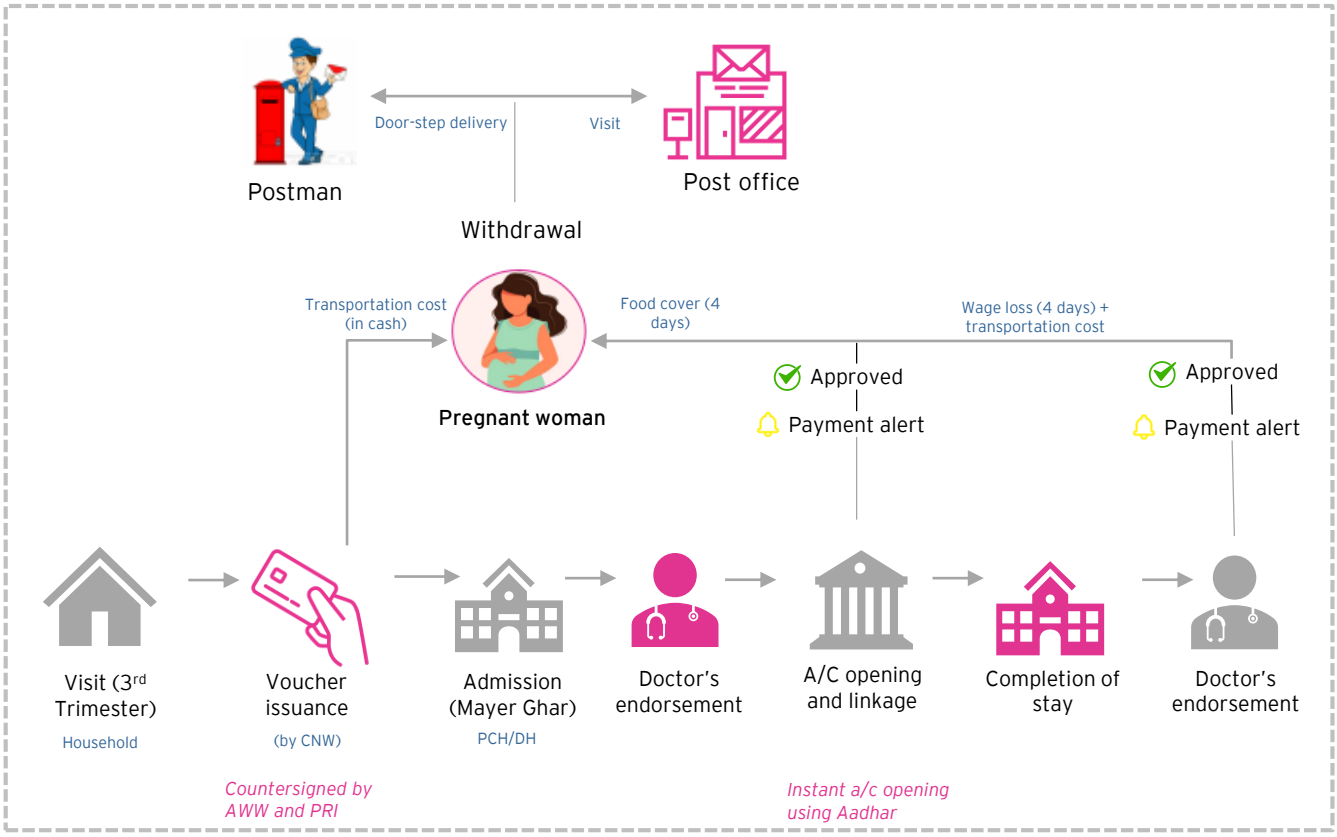
Journey of a SAM child for availing a voucher

The voucher scheme for SAM children enables the referred SAM child to reach NRC, complete a minimum 14-day stay and undertake **4 follow-up visits**. The journey of the mother of a SAM child is indicated:



Journey of a high risk pregnant woman for availing a voucher

The voucher scheme for high risk pregnant women will enable her to reach the district hospital 3 days before delivery and avail benefits under the Mayer Ghar government scheme



Facilitating communities in availing healthcare services

The health of a woman pre, during and post pregnancy plays a crucial role in determining the health of the child. Hence, identification of high-risk pregnancy women, those with lactating issues, those suffering with health severities in the journey of giving birth will be identified and counselled.

Women in critical conditions will be immediately referred for timely care and health assessment to protect the health of the mother and the unborn child. Women, suffering from health severities during pregnancy (such as high risk pregnancies, anaemia and so on) will be identified and monitored for their health progress.

Women will be made aware of best eating practices during pre and postnatal stages through the use of the games in the Nutrition Kit.

Our Impact Portfolio

Story of a single high risk pregnant woman |

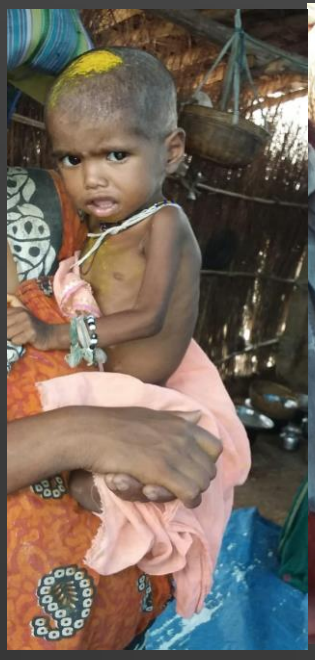
A single woman, became pregnant at the age of 16. The family came to know of the pregnancy in the third month and they insisted on getting the child aborted. The girl is administered abortion pill, however, pill was unsuccessful due to the advance stage of pregnancy. CNW came to know about the pregnancy and visits the family to register the girl. She counselled them on the diet and the need to take the woman to hospital for ANC. The weight of the woman is 32 kg and she was severely anaemic (HB 5).

At the hospital the woman was identified as severe and was administered two units of blood. The CNW visited the woman on regular basis. The woman started to gain weight but her HB level remains alarming. The CNW advised the parents for institutional delivery as the condition of the woman was severe. The parents agree for institutional delivery. The woman safely delivered a healthy baby weighing 2.5 kg.

> “The efforts of the CNW have till now identified 1569 High Risk category pregnant women and have been able to ensure that almost 50% High Risk Group pregnant women opt for institutional delivery.”

A SAM child from Tembhala |

Before



After

A SAM child was identified and counselled for NRC admission, but the family was relying on the local Bhumka/Bhagat and was not willing to admit the child in the NRC.

The conditions grew further adverse when the father was willing to kill the child than take the risk of admitting him at the NRC. The CNW team counselled the family multiple times and admitted the child at Dhadgaon NRC. The child recovered post 15 days of admission and a gradual increase in weight from 4 kilograms to 4.7 kilo grams was reported.

Exclusive Breastfeeding

Managing lactation failures

Why breastfeeding?

Breastfeeding is advised because human milk is a species-specific nourishment for the baby. This milk produces optimum growth and development, and provides substantial protection from illness. Along with the baby, lactation is also beneficial to mother's health and biologically fosters a special mother-baby relationship.

Advocating early initiation of breastfeeding

The first milk produced by mothers after delivery is colostrum, which is rich in immunological components such as secretory IgA, lactoferrin, leukocytes and helps the baby combating diseases.

Brain of a breastfed child is more developed because the breast milk contains essential fatty acids required for baby's growing brain.

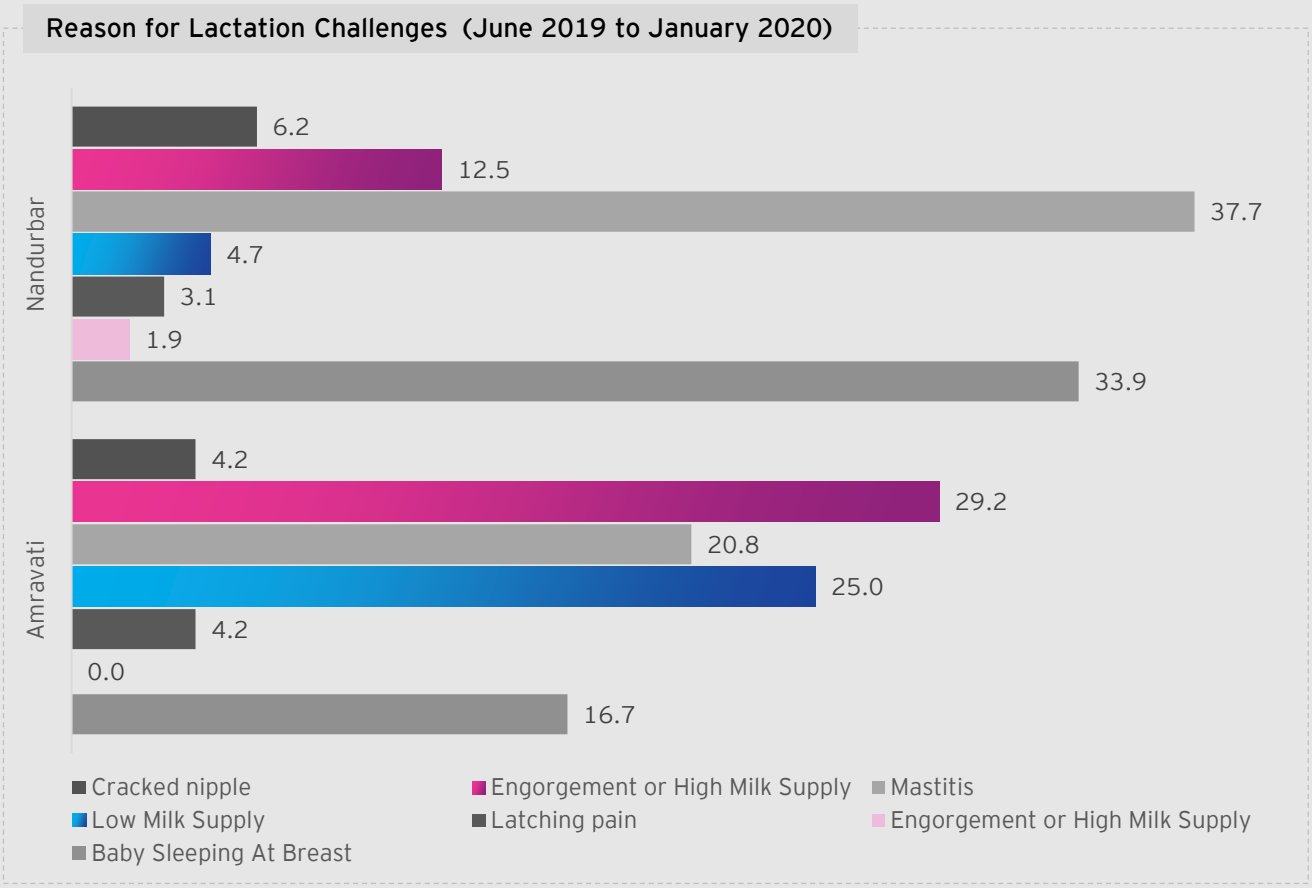
The project is advocating early initiation of breastfeeding within 1 hour of birth and exclusive breastfeeding till 6 months of age.

Lactation Challenges in Nandurbar and Amravati

Perceived insufficient milk supply was found common among postpartum women who delivered for the first time and was a major reason for early weaning. In Amravati and Nandurbar, few mothers complained of insufficient breast milk and believed this to be due to poor health, anaemia and not eating enough nourishing foods.

281 mothers **complained of breast conditions like mastitis, engorgement and sore nipples which resulted in feeding difficulties - this was perceived by mothers as** "lactation failure".

Identified reasons for lactation challenges:



Support extended through the programme

These mothers were supported and counselled by our workers for proper positioning, attachment and expression of breast milk which resulted in continuity of breastfeeding.

To ensure that the child was receiving adequate breast milk, the parameters of adequate weight gain and urine passage for at least 6 times a day were followed.

For optimal breastfeeding practices, special emphasis was laid on building confidence of mother, continued breastfeeding on demand, feeding at night, personal hygiene etc. They were also shown the videos specifically designed to portray advantages of breast milk and optimal breastfeeding practices.

<10 days

With the support extended in the Programme, most mothers were able to overcome these challenges within 10 days of intervention. In case any medical intervention was required, they were referred to the public health facility for treatment.

Celebration of World Breastfeeding Week in the programme

A total of 11,300 women participated in the World Breast feeding Week organized by Nutrition India Programme

Breastfeeding is a fairly common practice among new mothers in both the districts.

Seasonal migration, poor food habits, severe anaemia, sickle cell disease, stress due to work in households or farm fields and lack of understanding of importance of breastfeeding are few factors posing hindrances to proper breastfeeding. Women in these tribal communities usually do not face lactating problems but are majorly unaware of best breastfeeding practices and are not proactive in seeking care. This leads to under nourishment of babies under 1000 days, resulting in extreme malnutrition and stunted growth.

World Breastfeeding Week (August 1-7) highlights the importance of giving children the best start in life through breastfeeding, and draws attention to the vital need for optimal nutrition for mothers and infants.

Promoted in more than 120 countries worldwide, the objectives of the week are to inform people about the link between breastfeeding and good nutrition, food security and poverty reduction, and to inspire action to advance breastfeeding rates.

Breastfeeding week was celebrated during 1st week of August, 2019 in all the **204 villages** covering **417 Anganwadis**.

Following activities undertaken in the celebration includes,

- Screening of informative videos on positive impact of breastfeeding for both mothers and infants
- Group meetings of mothers to initiate discussions on risks that an infant might face due to lack of breastfeeding
- Rallies to demonstrate collective strength

Focus on Exclusive Breastfeeding and installation of Breastfeeding pods (*Hirkani Kaksha)*

Security, health and safety are the mandatory protocols followed at the *Hirkani Kaksh* Breastfeeding Pods.

Under the Nutrition India programme, special attention is paid to breastfeeding and proper breastfeeding practices. Early and exclusive breastfeeding helps children survive and also supports healthy brain development, improves cognitive performance and is associated with better educational achievement at age 5. Breastfeeding is the foundation of good nutrition and protects children against diseases. This project will ensure that breastfeeding practices taught by the community nutrition workers are in alignment with the UN's breastfeeding conduct.

Breastfeeding pods called the "Hirkani Kaksha", are being installed throughout the intervention areas, to ensure comfortable and private space for breastfeeding. Hirkani Kaksha serves the following objectives-

- Promotion and sensitization about breastfeeding in public spaces.
- Social awareness about breastfeeding and its benefits.
- Develop Hirkani Kaksha social enterpriser model through social sensitization and sustainability by generating revenue.

Along with breastfeeding, focus is also laid on a host of other facilities. Some of them are indicated:

Facilities reserved for women-

- 3 x Breastfeeding Pods / nursing rooms
- Induction stove and utensils for heating food/ water
- Breast pumps, warmers, ORS powder sachets and hot water bag
- Water dispenser - free drinking water up to 250 ml
- Dustbins-dustbin, towels, hand sanitizer, folding table for supporting child for change in nappies, toys
- Handwashing station, dryers and communication of steps of handwashing
- Fire extinguisher, LED lighting, fans, provision for cooler

Other purchasable items include-

- Chilled water and milk for sale
- Ready to eat upma/oats/poha sachets, biscuits, fruits for women
- Sanitary pad vending machine

Outside Hirkani Kaksh-

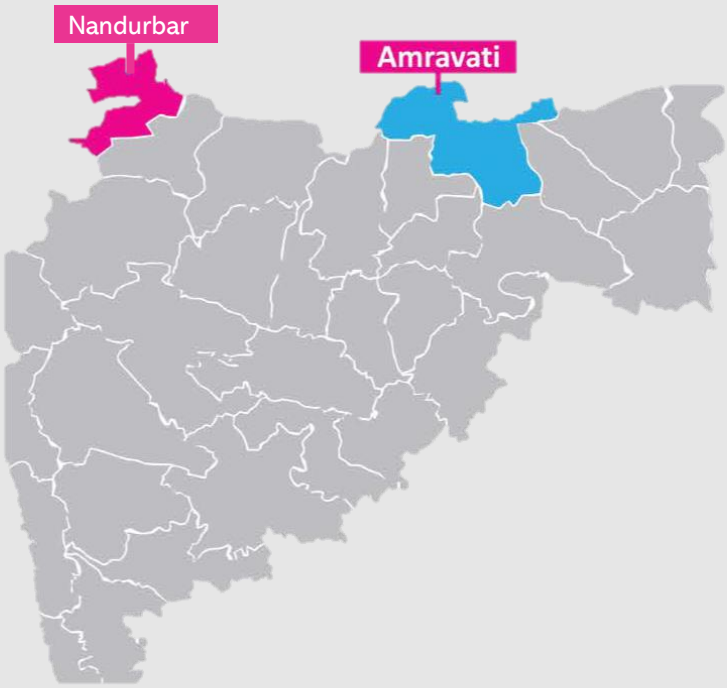
- Water ATM dispenser (open for all)
- Waiting Area- sitting capacity at the waiting area is also available

IEC

- Cabins- Breast feeding positions (WHO)
- Gallery/waiting area – steps of Breastfeeding (hand wash, cleaning of breast area, three positions of feeding), children friendly tribal art

Results of the programme

The Nutrition India Programme (NIP) has been implemented in 204 villages spread across four most deprived administrative blocks named Akkalkuwa & Akrani of Nandurbar district and Chikaldhara & Dharni blocks of Amravati district in the state of Maharashtra.



Along with the interventions elaborated in the report, health system strengthening measures were also implemented, which included-

- Improving implementation of village health sanitation and nutrition days
- Capacity building of the service providers
- Enhancing delivery of services at health institutions
- Enhancing implementation of existing schemes

Coverage of the programme

Total number of villages
204

Total number of hamlets
395

Total number of Anganwadis
417

Total number of PHCs
14

Total number of sub-centres
61

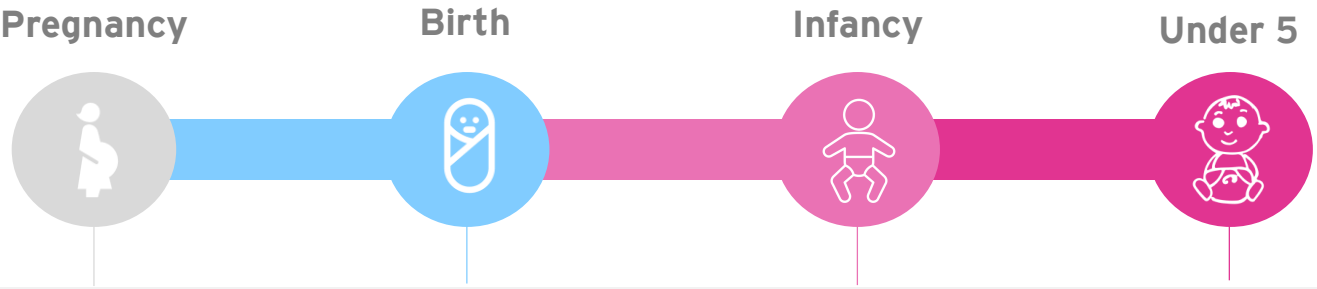
Total number of NRCs
08

Public Health Impact of the programme

At the on-set of the programme, the below targets were set. Results for the year 2019, corresponding to these targets are indicated further in the report-

40% Reduction in the number of children under 5 who are stunted

<5% Reduce and maintain childhood wasting to less than 5



	Pregnancy	Birth	Infancy	Under 5
2020 Targets	• 50% increase in full ANC coverage • 50% increase of pregnant women who gained appropriate weight during pregnancy (10-12 kg) • 50% reduction in pregnant women with anemia	• 50% increment in exclusive breastfeeding up to 6 months of age • 50% increment in timely initiation of complementary feeding • 50% increment in initiation of breastfeeding-within 1 hour of birth • 30% increment in diet diversity of pregnant and lactating women	• 50% reduction of undernutrition among 24 months children	• 10% reduction in stunting • 40% reduction in childhood wasting
2019 Achievements	• 7% Increase in proportion of pregnant women with Complete ANC Coverage • 22.35% Increase in proportion of pregnant women consumption of 100 IFA tablets • 23% Reduction in pregnant women with anemia	• 59% increase in Institutional birth at public facility • 56% Reduction in proportion of low birth weight babies • 37% increase in proportion of child with breast feeding initiated within 1 hour of birth* • 11.6% increase in proportion of lactating women whose diet diversity is ensured*	• 13.9% increase in proportion of child with exclusive breastfeeding up to 6 months • 71% increase in proportion of child with timely initiation of complementary feeding *	• 7.4% reduction in proportion of severely Acute Malnourished children *
Baseline	• Only 47% of pregnant women had complete ANC coverage • 46% of pregnant women consumed 100 IFA tablets • 58% pregnant women are anemic	• Only 52.5% institutional births are at public facilities • 63.35% breastfeeding initiated within 1 hour of birth	• 64.4% exclusive breastfeeding • 4.7% infants – timely initiation of complementary feeding	• 11.2% children with Severe Acute Malnutrition • 42.1% children stunted • 40.4% children with wasting

1. Identification of high-risk groups

Identified

U5 Children: 41,091

Pregnant Woman: 4,192

Under five children who are either acute malnourished (severe acute, moderately acute) or severe underweight and women (high risk pregnant, mothers facing challenge in lactation) are denoted as the **high risk group** for the project, targeted intervention for them is under implementation.

The project collected village level universe of under five children from the zonal survey carried out by the ICDS Department, the same was crosschecked from figures of village level census 2011. Number of pregnant women was estimated adding number of births + number of abortions + estimated total fetal losses for the district.

Reached

U5 Children: 32,900

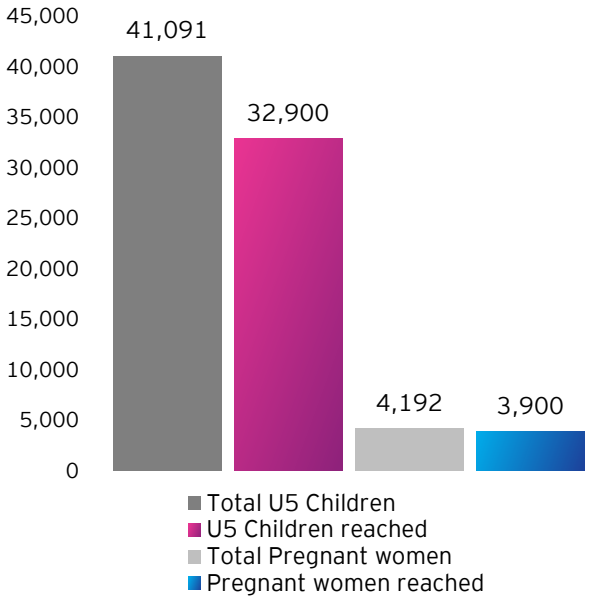
Pregnant Woman: 3,900

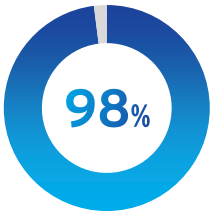
In all, **41,091 U5** children (Nandurbar-26,020, Amravati-15,071) and **4,192 pregnant women** (Nandurbar-2,462, Amravati-1,730) were found in 204 project villages.

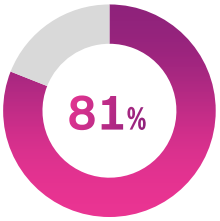
Of which, **32,900 Under 5 children** (mothers of U5 children) and **3,900 pregnant women** were contacted under various interventions from June 2019 to January 2020, while 2936 registered.

While, 89 per cent pregnant women and 80 per cent under five child available in the project villages of Nandurbar under various intervention and access benefits of various Government schemes pertaining to curb malnutrition

High risk group reached in the project area







The project has been able to mobilise 98% of available pregnant women and about 81% mothers of available under five child in the project villages of Amravati and Nandurbar.

District wise breakup

Under-5 children reached:	Pregnant woman reached:
Amravati: 80.7%	**Amravati: 98.3%**
Nandurbar: 79.7%	**Nandurbar: 89.4%**

2. Identification of Under-5 malnourished children

Registered

Amravati: 2,596
Nandurbar: 1,565

MAM: 2624
SAM: 622
LBW: 915

In June 2019, the field intervention was launched, trained community nutrition workers started traveling to the villages, and they are covering 4-5 villages, each month they spare 4 days for a village.

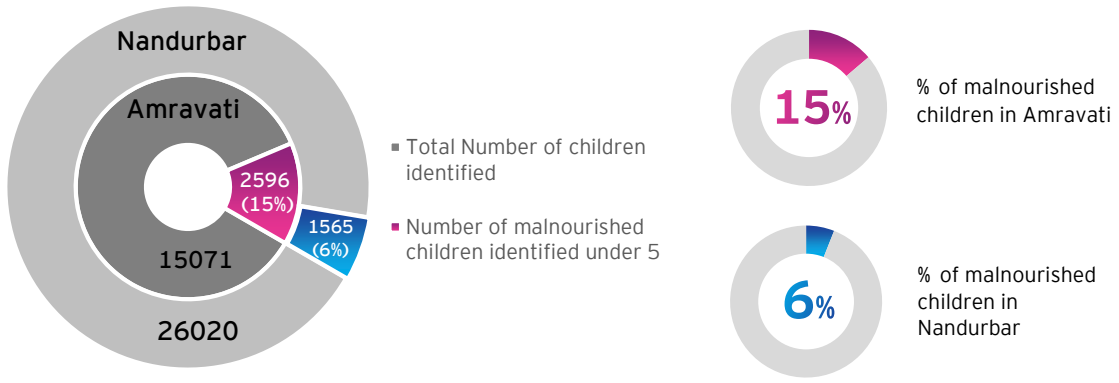
Village entry and mapping exercise was carried out in the beginning, this helped in creation of village level maps, which is dynamic by nature and denotes areas where high risk groups stayed in the village. The mapping help CNWs to identify the number of U5 children in the village, a total **41,091 U5 children were found in 204 villages**, of which, 15,071 are in district Amravati and 26,020 in Nandurbar.

Out of these, number of **malnourished children** identified in **Amravati** were **2,596**.

And, number of **malnourished children** identified in **Nandurbar** were **1,565**. The figures are indicated in the graph below.

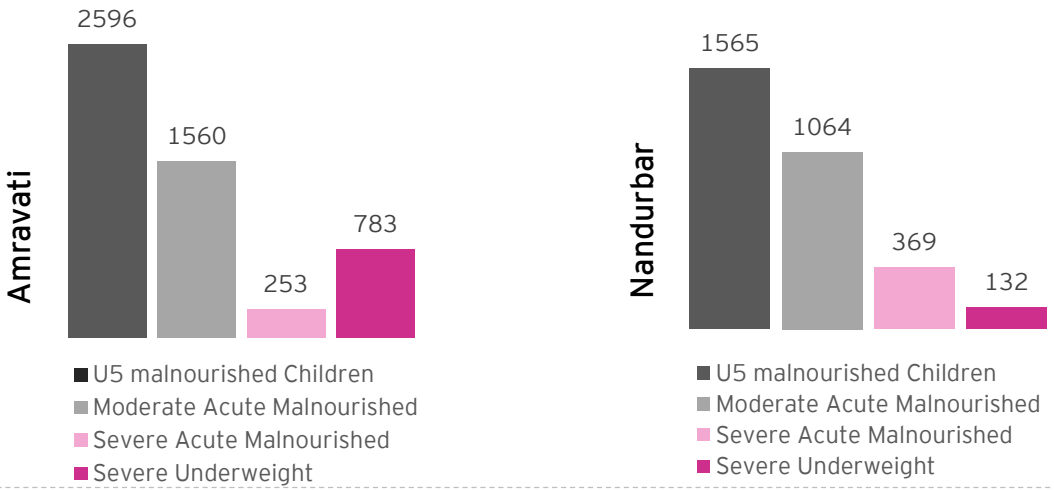
The mapping also helped the project to register high risk children, acute malnourished (severe acute, moderately acute) or severe underweight, **of the total U5 children, 4,161 were registered, 2,596 in Amravati and 1565 in Nandurbar**.

Number of malnourished U5 children identified (June 2019 to January 2020)



Of the total registered, 2,624 were moderate acute malnourished, 622 severe acute malnourished and 915 severe underweight.

Number & Type of malnourished U5 children identified (June 2019 to January 2020)



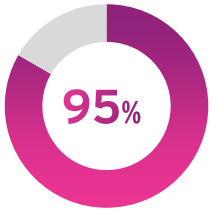
3. Under-5 SAM children supported to recover from malnutrition

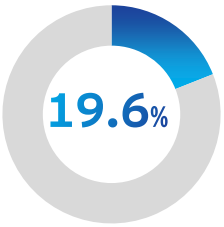
Of the total, 622 severe acute malnourished children (Nandurbar-369, Amravati-263), 197 had oedema (medical complications). 190 of them were taken to the NRCs and CTCs and 180 recovered in the NRCs which is 95% of the total.

Further, another **122** improved to Moderately Acute Malnourished (MAM) (**19.6%**).

Further, 80 **(12.8%)** of these severely malnourished children recovered to normal.

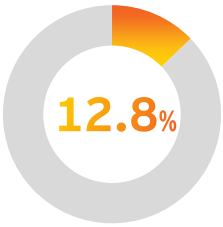
% of registered SAM children taken to NRCs recovered to normal in NRCs because of NIP assistance



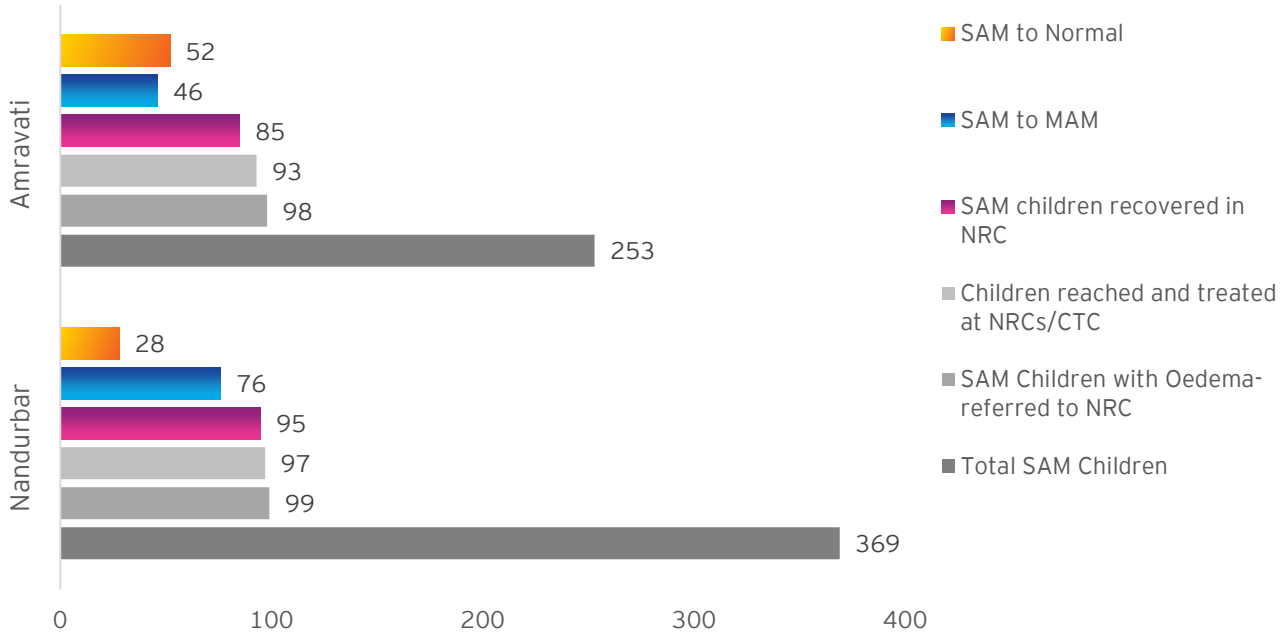


% of total registered SAM children converted to MAM because of NIP assistance

% of total registered SAM children recovered to Normal because of NIP assistance



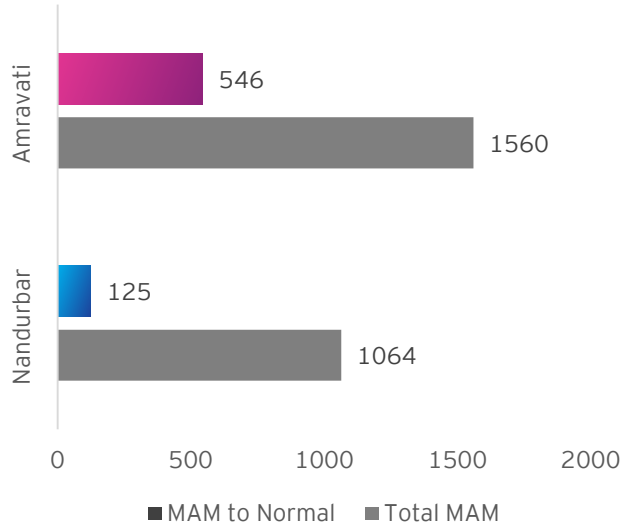
U5 SAM children supported to recover from malnutrition (June 2019 to January 2020)



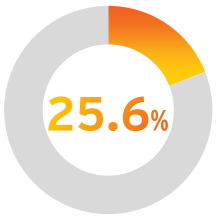
4. Under-5 MAM children supported to recover from malnutrition

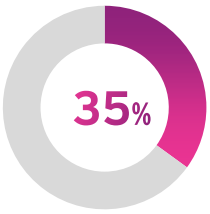
In addition, **2,624 U5 children** who were identified as moderate acute malnourished, treated at the Anganwadis, **671 (25.6%) of them recovered to normal.**

U5 MAM children supported through NIP



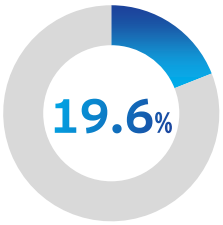
% of identified MAM children recovered to Normal because of NIP assistance





% of identified MAM children recovered at anganwadis at Amravati

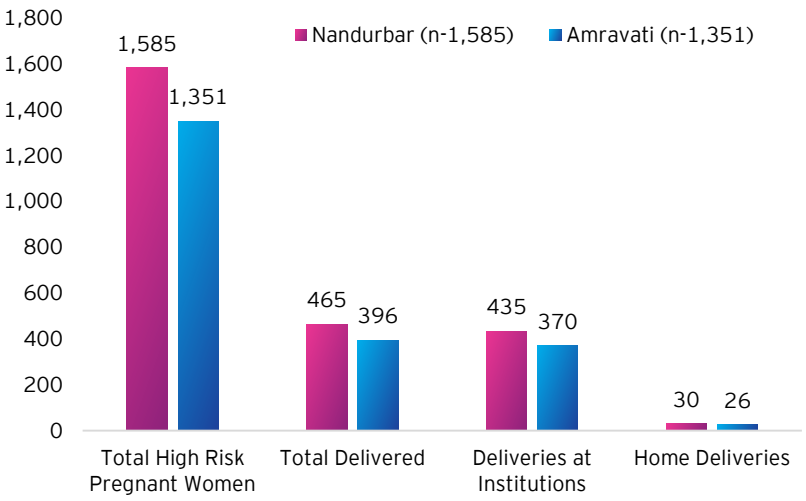
% of identified MAM children recovered at anganwadis at Nandurbar



5. High risk pregnant women identified and supported

% of registered high risk pregnant women who under went institutional deliveries through NIP assistance

Institutional deliveries assisted through NIP



A total of 2,936 high risk pregnant women were registered with the programme, counselled and served.

Till January 2020, out of these women who were registered, 861 pregnant women were delivered, out of which 805 delivered in institutions (public facilities), which is 93%.

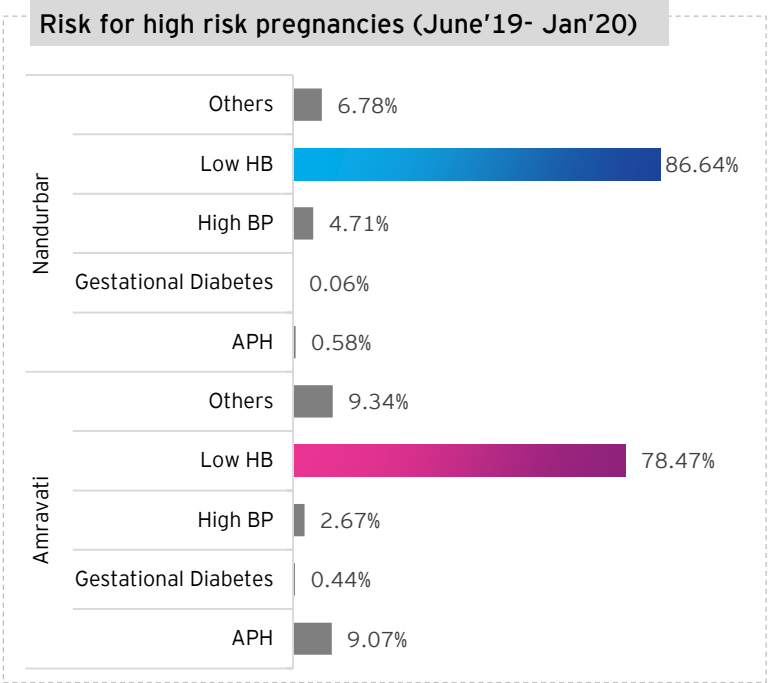
Institutional delivery for Amravati has significantly increased to 93.54% compared to 63.3% in NFHS-4.

For Nandurbar as well, it has increased to **93.43%** from 41.7% in NFHS-4.

significantly higher than the NFHS-4 which is 41.7 per cent for Nandurbar rural and 63.3 per cent for Amravati.

6. Identifying the reasons for high risk pregnancies

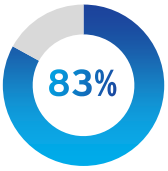
Reasons for high risk pregnancies:



It is essential to mention that out of **2,936** high risk pregnant women registered with the programme, most (83%) of the women were high risk because of **low haemoglobin level.**

This is further worse in Nandurbar district where about 87 per cent women had low haemoglobin.

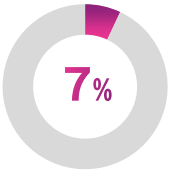
Status of other risks related to high risk pregnancies are indicated.



of pregnant women were high risk because of low haemoglobin level

Reduction in anaemia prevalence due to NIP assistance

While calculating anaemia prevalence of pregnant women for the project villages, it was found that there has been a **slight reduction in Nandurbar**, as NFHS-4 data for the district was 66.2% and the project data is 59.2% . While, the project data of district Amravati (51.2%) found higher proportion of pregnant women suffering from anaemia than NFHS-4 (49.7 %).



reduction in the rate of prevalence of anaemia amongst pregnant woman in Nandurbar due to NIP assistance

The project is covering Melghat region of Amravati, studies showed a gloomy picture with an anaemia prevalence rate of 91%, justifying higher deprivation for the region.

7. Ensuring safe drinking water and hygiene

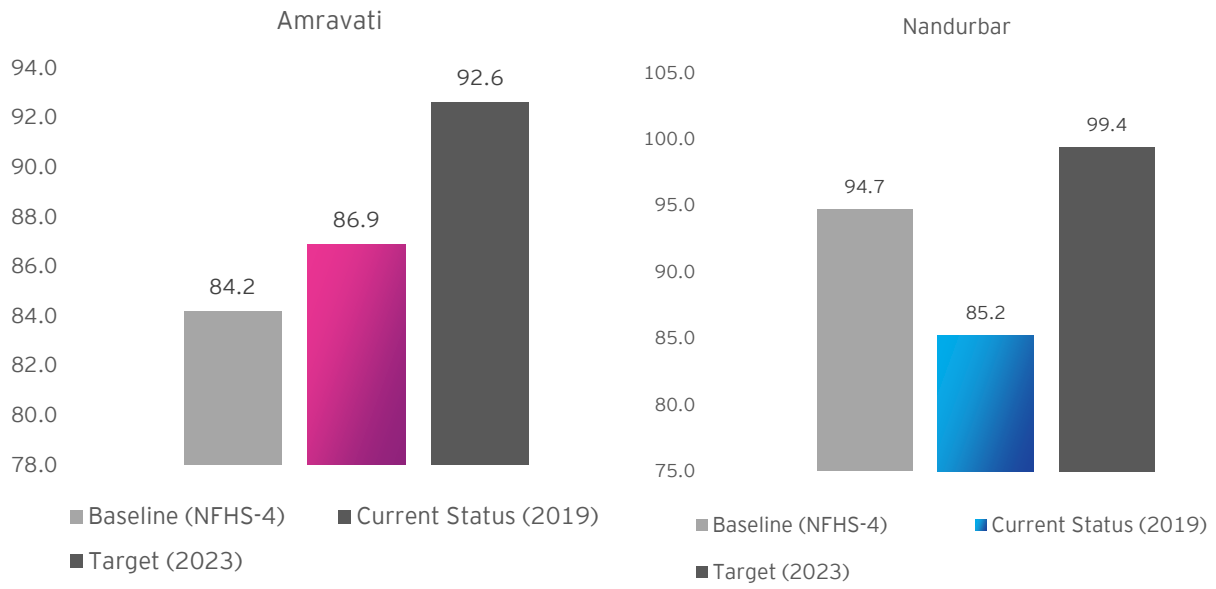
The programme is also promoting clean hygiene and WASH practices, kitchen garden, zinc and ORS for diarrhoea management, increased access to health care services by regular organisation of the VHSND.

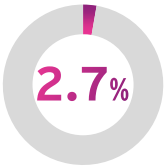
Hygiene promotion is one of the key focus of the programme. The programme team is using **Swachhta Chakra** an interactive android game designed for frontline workers to create awareness on personal and environmental hygiene like sanitation practices among the community members especially mothers, caregivers etc.

Moreover, it helps in developing a connection with frontline workers which motivates the player/s to adopt or improve WASH practices as a part of their daily routine. The efforts have yielded encouraging trends.

There has been increase in proportion of women who reported collecting drinking water from safe sources, which could be result of mass scale awareness campaigns organised under clean village drive, further details could be referred in exhibit below.

Women reported collecting drinking water from safe sources





Increase in proportion of women who reported collecting drinking water from safe sources.

The programme is also promoting zinc and ORS for diarrhoea management, increased access to health care services by regular organisation of the VHSND.

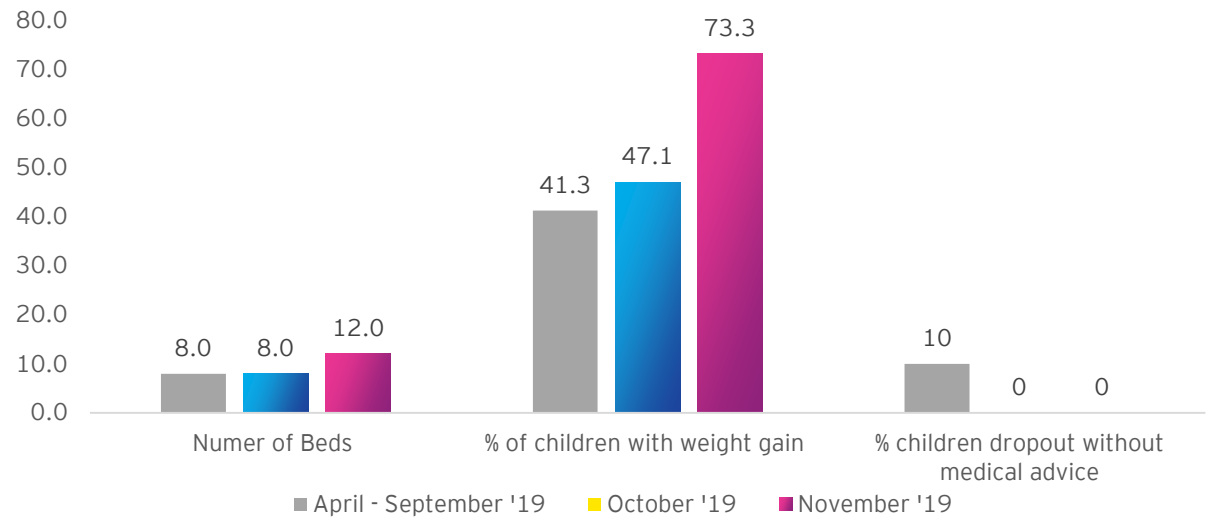
8. Refurbishing of NRCs

While through the other interventions under the programme, children were referred to the Nutrition Rehabilitation centres for treatment, NIP also assured cleanliness and hygiene within the NRC and PHC premises.

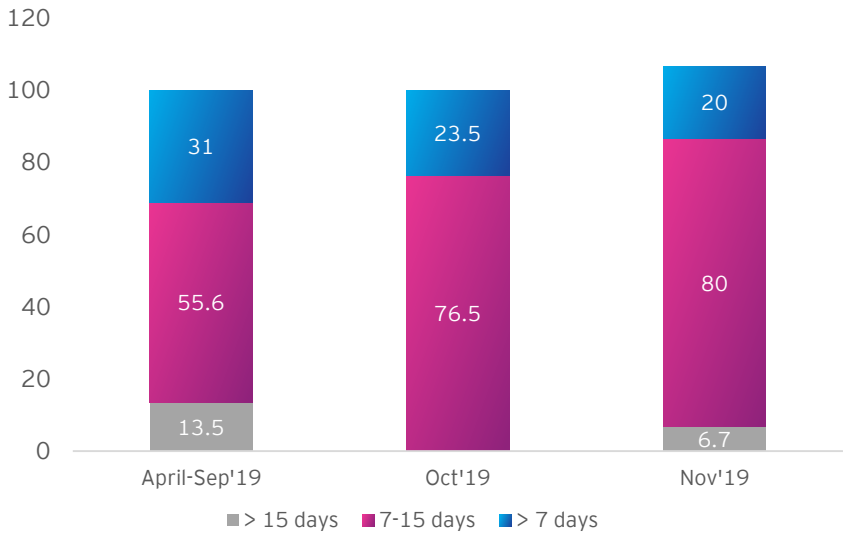
The clean environment of the NRC, hygienic toilet and child friendly atmosphere helped the children to complete their stay.

Hence, through NIP assistance, **the average number of days of stay increased, this impacted the weight gain of children positively and also curbed the issue of patient dropout.**

Performance of NRC in Amravati after NIP distance



Proportion of children completed stay for number of days



66.6%

Increase in the number of beds

26.2%

Children reported a weight gain

0

Dropouts without medical advice

Refurbishing of NRCs

Before

After

Clean environment, hygienic toilets, handwashing basins and availability of soaps along with other mother and child friendly facilities were positioned at these health centres. As a result, the average number of days of stay at these centres increased.

MD, National Health Mission Maharashtra and District Magistrate of Amravati reviewing renovated NRC

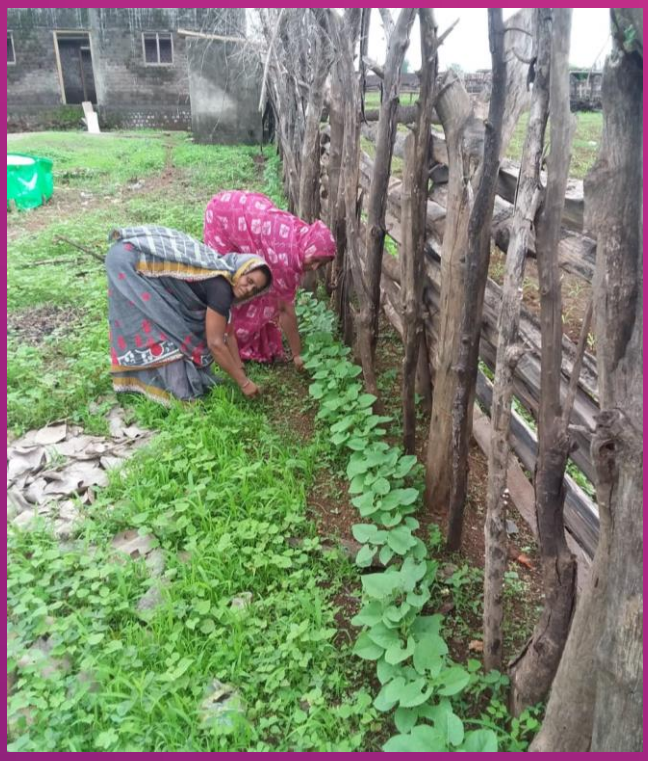
Kitchen Gardens

In a population that relies heavily on subsistence farming, it is imperative for nutrition to reach them through their own farms.

Micronutrient deficiency such as Vitamin A, iron and iodine, is common among pregnant women, lactating mothers and under five children. This impacts on disease immunity, illness and health in general. People living in remote villages often pay a higher price for vegetables and fruits, if not grown locally.

Kitchen garden therefore has a potential to impact on Vitamin A intake (and in a lesser way iron intake), provide support for malnourished and sick children and potentially provide nutritional diversity to support complementary feeding.

Kitchen gardens thereby provide and supplement subsistence requirements and generate secondary direct or indirect income.



To promote diet diversity and adequate nutrition to the mother and child, Kitchen gardens were promoted during the programme.

Kitchen gardens are a common sight, especially in Amravati, when attached to well-constructed housing. In Nandurbar, naturalists believe in the local nutritious recipes to alleviate malnutrition.

Training in partnership with Krishi Vikas Kendras

To promote the kitchen gardens, the programme has partnered with the local district Krishi Vikas Kendras. Training programs for CNW, ANM and AWW in kitchen garden are being organised. The training programme has both a class room session along with a demo session. After the training, seeds are also provided for further distribution to the beneficiaries.

In the two districts, till now, a total of 1,268 kitchen gardens have been promoted in the programme region.

Major Focus:

The major focus was on vegetables such as carrot, dill (Shepu), beat, bottle gourd, tomato, chillies, bitter gourd, onion, garlic, and other varieties of dark green leafy vegetables, spinach, radish, brinjal, coriander; as they take shorter time to grow and to harvest and can bring faster returns. Some other crops selected were beans, papaya, and drumstick.

Impact

As per the Anganwadi workers of Nandurbar -"*earlier women of our village could cook vegetables only when they have visited the market or some vendor has come to sell (in the village). Now that they are growing vegetables at home, they are cooking different vegetables every day. Some of them also sell vegetables to the villagers*".

These gardens are rightly promoting diet diversity which would uplift the nutritional status of mothers and children.

M&E for the programme

Evidence based integrated approach for nutrition management

The MIS ensures service delivery across care continuum, use of evidence to support nutrition management and real time data visualization.

To support mother and child journey through care continuum, a real time monitoring mechanism has been developed by for this project. The key features of this mechanism are to ensure service delivery across the care continuum, use of evidence to support nutrition management and real time data visualization and analysis for intervention refinement.

Nutrition workers, post registration of identified mothers and children, are able to track them during various stages of health check ups. Through this dashboard, nutrition workers are able to set a task list and check for alerts for immediate attention towards mothers and children in need of critical care. Such evidence based prioritization helps the nutrition workers in catering to their assigned villages efficiently. The data generated from this dashboard is utilized to generate data analysis insights and interactive maps to identify individual, village level and block level status quo of identified mothers and children. This real time data analysis and visualization helps in immediate intervention refinement.

Access points like VHNDs and sanitation and nutrition days not only allow for the initiation of timely referrals for children and women to the closest health care centres but also allow for an opportunity to mobilize and to disseminate information regarding health (ANC, Immunization) and sanitation on the Village Health, Sanitation and Nutrition day (VHSND). Since VHSND presents a platform to engage with the community, the nutrition workers would leverage this platform to ensure dissemination of nutrition related practices.

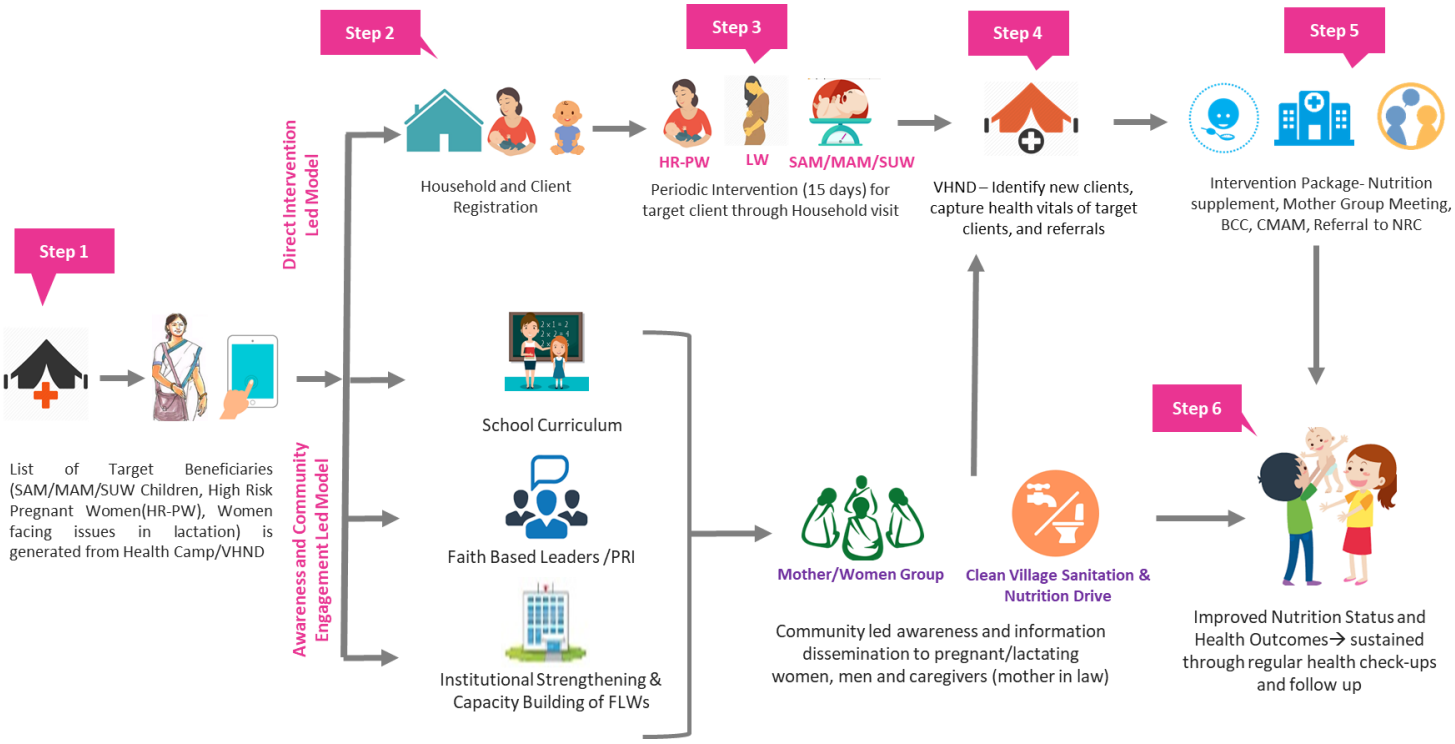
Mobilizing communities

Village Health sanitation and nutrition days serve as vital access points to interact with women in villages.

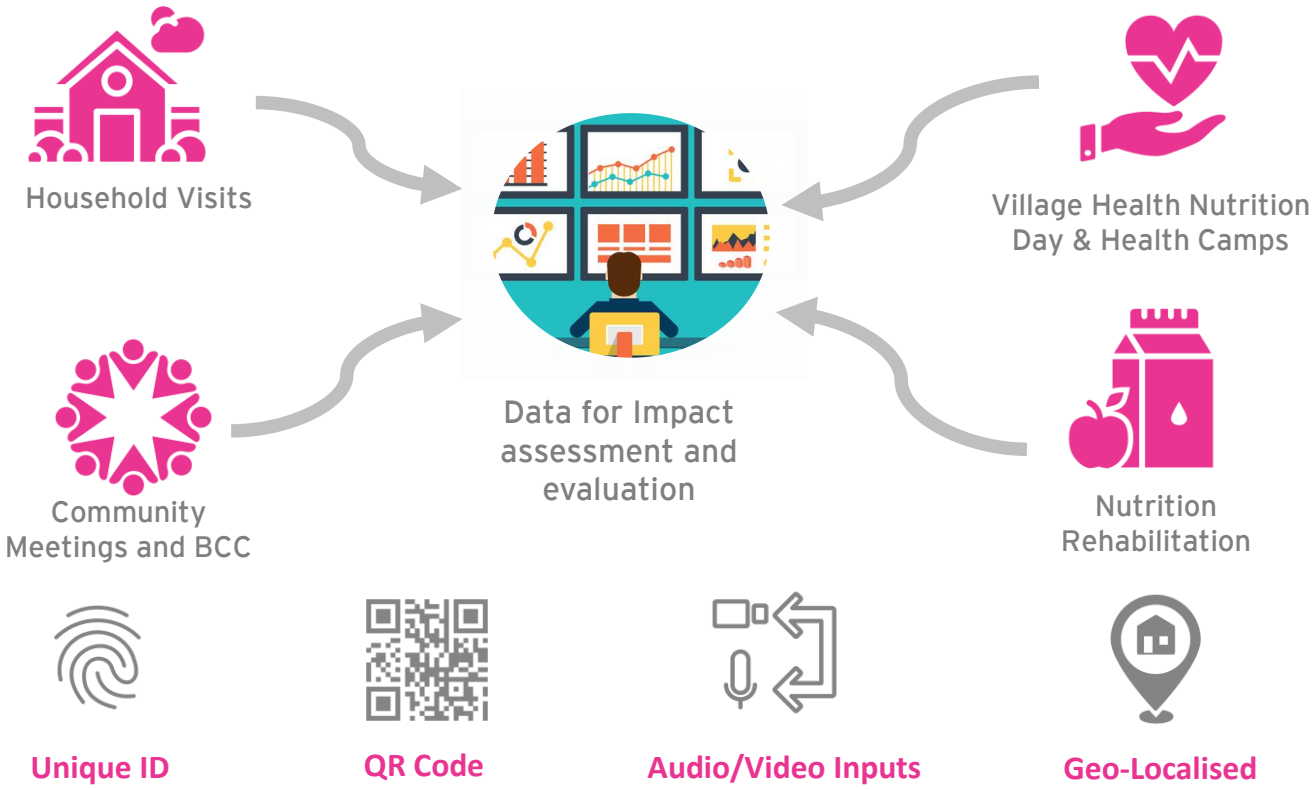
Since VHSND presents a platform to engage with the community, the nutrition workers would leverage this platform to ensure dissemination of nutrition related practices.

Sub-women groups are also formed at the MATA samiti to provide a forum for discussion and knowledge dissemination.

Step-wise programme workflow



MIS Framework



Data capturing and reporting

Data capture and intervention

Community Nutrition Workers (CNW) capturing and tracking at each stages

UIC/Client Registration ID

Evidence based data capture for activities at each stage

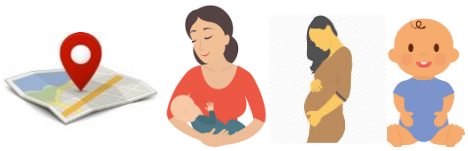
CNW Dashboard and task list, alerts and decision making

Data analytics and planning

Cluster Coordinator/ District Coordinator/M&E Manager/Donor

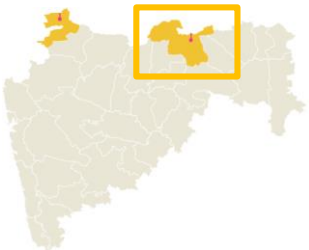
VHND Follow-up
Service uptake follow-up
Monthly visit follow-up

Alerts and Highlights



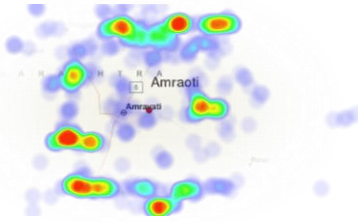
Mapping of Target Clients and evidence based prioritization

Interactive maps and Individual level data analysis

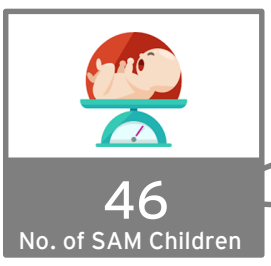


District Level View

Block Level View



Village Heat Map
(Showing prevalence of SAM children)

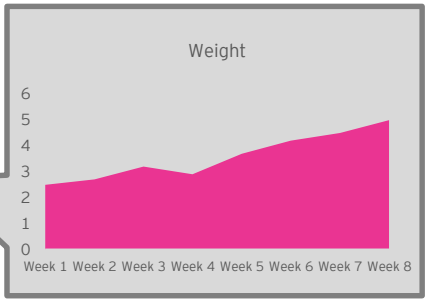


Aggregated View

List of SAM Children

UIC	Caregiver Name	Mobile	Z Score
9739487	Shital Kale	+919008010095	-2
398758	Madhubala Dave	+987008017645	-2.5
845833	Kanta Bai	+917808010095	-1.8
749784	Rajashree Pawar	+919578010087	-3.7

SAM Line List



Individual SAM Profile

"Nutrition India programme is an innovative programme where experts from various fields in both the private sector and the public sector came together to work towards a common goal of saving lives. The programme has a 360 degree approach and is complimenting the government's efforts. With the aim of using technology in voucher schemes, to ensure that families are incentivised to go through the complete care programme and introducing blockchain to bring in transparency of transactions, RB and Plan India have shown great commitment and a futuristic view point of enhancing operational efficiencies and accountability. It has been an honour to be part of one of the most passionately run programmes."

- Mr. Vipin Yadav

CEO, Dure Technologies

Outlook Poshan Awards 2019

Making Nutrition a Jan Andolan

Powered by RB and the Nutrition India Programme, the Outlook Poshan Awards is a forum by the outlook group, which celebrates the exemplary efforts of individuals and institutions in the field of nutrition.

The forum stresses upon initiation of discussions on issues like malnutrition and stunting and not just treating these issues like a problem of the poor.

As part of its commitment to making good nutrition an agenda for every household, Outlook aims to bring about a transformative change in the nutrition sector and make those changes visible at the ground level. RB India has been a key enabler of this initiative. Through its Nutrition India Programme under the health portfolio of RB Healthcare has a mandate of providing better nutrition support to 177,000 mothers in the next 5 years. Innovation and consistency in delivery of quality intervention makes RB one of the few companies working for Health in totality.

To acknowledge the exemplary efforts of individuals and institutions in the field of nutrition, Outlook Poshan Innovation Awards-2019 were conducted in August 2019. The categories of awards were:

- Safe and Nutritious Food
- Policy and Governance
- Urban Nutrition
- Social Enterprise
- Science and Technology
- Nutrition Warriors
- Living Legend

The awards aim to recognize the outstanding work of individuals/professionals and institutions in providing innovative solutions to tackling the scourge of malnutrition in India.

The awards were presented at a national event with key stakeholders from the field of nutrition to acknowledge the contributions of unsung heroes and institutions who have made substantial and meaningful impact in the field of nutrition using innovative, localized, ethical and sustainable approaches/models. The objective was also to capture the untold success stories that need to be given recognition and the limelight they deserve.

Outlook Group in partnership with Project Concern International (PCI)/India (its knowledge partner) also launched a web platform 'Outlook Poshan': All About Nutrition' - the first of its kind initiative in the field of nutrition. It is believed that good nutrition has the potential to transform the Sustainable Development agenda and unleash India's human capital potential ,giving the much-needed fillip to growth and productivity.

The space is regularly updated with recent updates, findings, precautions related but limited to nutrition. With a special focus on the child and maternal health, informative audio-content is made available for better reach of developments. The portal has reached a wide audience concerned over the country's status on malnutrition, pre & post natal care and development in Government provisions.

The event was attended by Hon'ble Vice President Mr. M. Venkaiah Naidu and other senior policy makers

Hon'ble Vice President of India with the Jury

Hon'ble Vice President of India marking his presence at the event

Mr. Gaurav Jain, Senior Vice-President , AMESA ,RB talking about RB's role in ensuring safe nutrition of 1000 days

Union women and child development minister Smriti Irani with Elangbam Valentina Devi, 9, Manipur's Green Ambassador

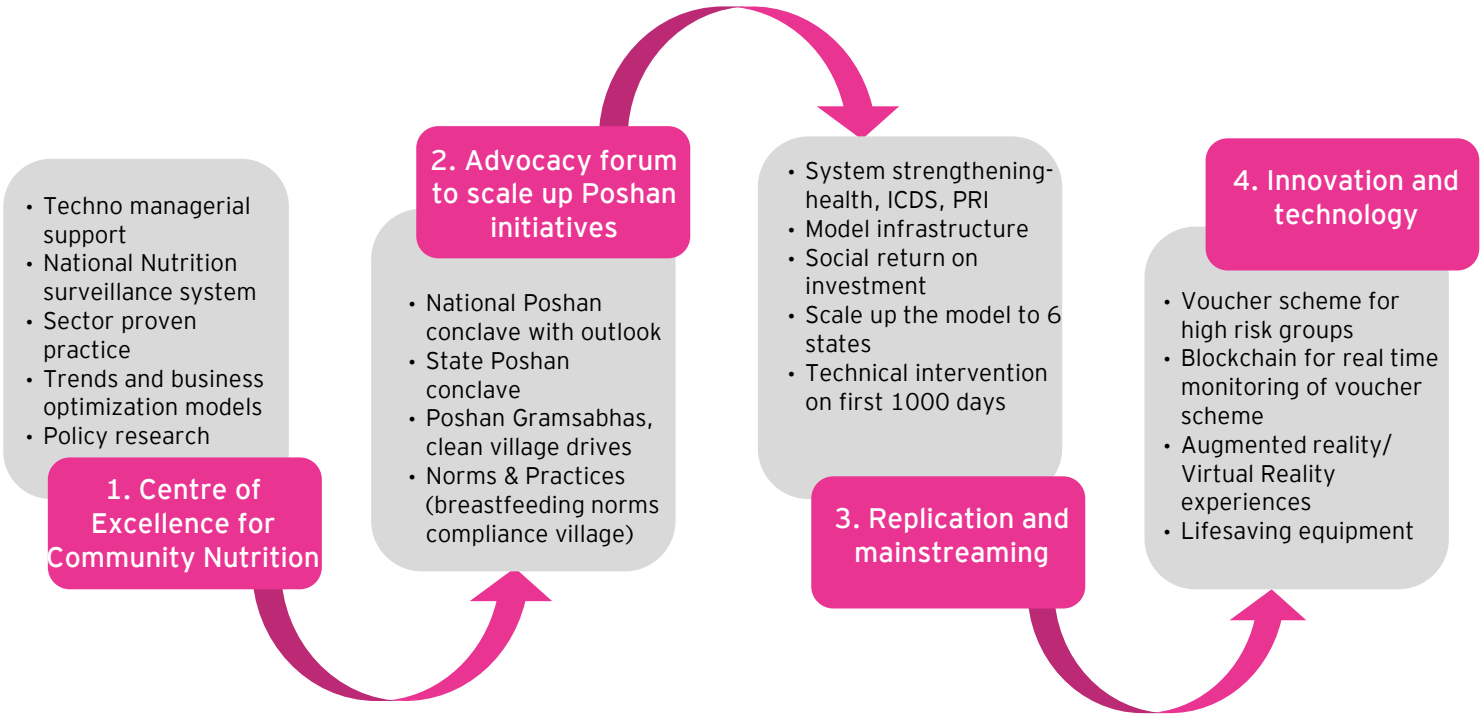
Mr. Ravi Bhatnagar, Director- External Affairs & Partnerships, AMESA,RB Health talking about the importance of Ethnographic study

Way forward

Analysis represented in the above section show an early trend of progress from the baseline figures. A momentum has to be build towards rapid reduction of malnutrition in the project area, with more efforts to ensure increased institutional deliveries, exclusive breastfeeding, initiation of age appropriate complementary feeding and anaemia reduction.

In nutshell, a multi-layered approach both in strategy and level of intervention could help in ensuring long term sustainability, based on which following foundation pillars are chosen:

- Centre of Excellence for Community Nutrition
- Advocacy Forum to Scale up Poshan Initiatives
- Replication & Mainstreaming
- Innovation & Technology



Centre of excellence (CoE) for community nutrition

The Centre of Excellence will function as an apex body for the state Maharashtra, look at the sanitation, nutrition, health and early childhood development holistically with a view to ensure the following for cleaner, healthier and happier life:

Techno managerial support for transforming the nutrition sector would include-

- National Nutrition Surveillance System
- Sector-proven Practices
- Trends Business Process Optimization
- Policy research

COE will be housed within the State Nutrition Mission and would generate resources by offering technical support services in planning and implementation to the states and districts of India

Advocacy forum to scale up Poshan initiatives

The advocacy forum will have a mandate to establish Poshan , a public agenda and scale up Poshan initiative. This part of activity will follow two major pathways, of which the first part shall deepen the community level on ground initiative and the second part shall celebrate the Poshan Festival, where it will engage with global leaders, community champions, policymakers, development workers, grassroots activists, entrepreneurs and beyond.

The Community level initiatives include:

- Norms and practices
- Clean Village Drive
- Nukad natak
- Celebrate Champions of Change
- Poshan Gram Sabhas

Innovation and technology

Following innovations are planned in second year of intervention

- Voucher scheme
- Strategy to ensure safe childbirth
- Community based entrepreneurships
- Introduction of mobile application based digital weighing and measurement machine
- Bempu Hypothermia alert device
- Lucky iron fish/iron bindis
- Breastfeeding pods at local markets

Replication and mainstreaming

The model will be implemented by the Community Nutrition Workers in 204 villages spread across four blocks named Dharni and Chikaldhara of district Amravati and Akrani, Akkalkuwa of Nandurbar, Maharashtra.

The model will have following interventions

- System strengthening-Health, ICDS , PRI
- Model infrastructure
- Social Return of Investment
- Model infrastructure
- Technical interventions of 1000 Days
- Model scale up across 6 states

Community Based Entrepreneurs

Community Nutrition workers identify, mobilize and nurture 1 Community Based Entrepreneur for 100-200 HH.

The Community Based Entrepreneurs are selected basis an eligibility criteria of basic education, HH penetration, entrepreneurship qualities and can be birth attendants/traditional healers

The CBEs are responsible for NRC referrals, initiation of breastfeeding, hygiene, immunization and habit formation, supply of discount coupons to mothers and caregivers, which are reimbursed by margin money and also to sell products from their health basket through which the CBEs shall make an income of Rs.2.5 per coupon., a total of Rs 1500 per month.

Flow of programme outcome and conversion to social benefits

Inputs	Output	Outcome	Outcome incidences	Deduct	Impact
Money Invested	Number of stakeholders	Changes created by activities	Indicators representative outcomes	Deadweight indicators	Social Benefit
Volunteer time spent			Financial proxies outcome indicators	Multiply attribution rate	

Notes

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