सत्यमेव जयते
NITI Aayog

POSHAN Abhiyaan
PM's Overarching Scheme for Holistic Nourishment
सही पोषण - देश रोशन

TRANSFORMING NUTRITION IN INDIA: POSHAN ABHIYAAN

A PROGRESS REPORT

SEPTEMBER 2019

ABBREVIATIONS

ANM	Auxiliary Nurse Midwifery
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BRG	Block Resource Group
C2IQ	Coverage, Continuity, Intensity, Quality
CAS	Common Application Software
CAP	Convergence Action PLan
CBE	Community Based Event
CDPO	Child Development Project Officer
CHC	Community Health Center
CNNS	Comprehensive National Nutrition Survey
DAY- NRLM	Deendayal Antyodaya Yojana – National Rural Livelihoods Mission
DRG	District Resource Group
DWS	Drinking Water and Sanitation
EBF	Early Breast Feeding
H&FW	Health & Family Welfare
HR	Human Resource
ICDS	Integrated Child Development Scheme
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
IFPRI	International Food Policy Research Institute
ILA	Integrated Learning Approach
LBW	Low Birth Weight
LS	Lady Supervisor
MAM	Moderate Acute Malnutrition
NFHS	National Family Health Survey
NHM	National Health Mission
PFMS	Public Financial Management System
PHC	Primary Health Center
PMMVY	Pradhan Mantri MatruVandanaYojana
PMO	Prime Minister's Office
POSHAN	Prime Minister's Overarching Scheme for Holistic Nourishment
RD	Rural Development
SAM	Severe Acute Malnutrition
SBCC	Social and Behavioral Change Communication
SPMU	State Project Management Unit
SHG	Self Help Group
SNRC	State Nutrition Resource Centre
TSU	Technical Support Unit
UT	Union Territory
VHSND	Village Health Sanitation Nutrition Day
WCD	Women and Child Development

TABLE OF CONTENTS

LIST OF FIGURES

List of Tables

List of Boxes

EXECUTIVE SUMMARY

Background:

POSHAN Abhiyaan is an overarching umbrella scheme to improve the nutritional outcomes for children, pregnant women and lactating mothers by holistically addressing 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. It seeks to do so through an appropriate governance structure by leveraging and intensifying the implementation of existing programs across multiple Ministries while at the same time trying to rope in the expertise and energies of a whole range of other stakeholders – State Governments, Communities, Think tanks, Philanthropic Foundations and other Civil Society Actors. It aims to reduce child stunting, underweight and low birth weight by 2 percentage points per annum and anaemia among children (and young females) by 3 percentage points per annum. 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 programs and schemes:** ICDS, PMMVY, NHM (with its sub components such as JSY, MCP card, Anaemia Mukt Bharat, RBSK, IDCF, HBNC, HBYC, Take Home Rations), Swachh Bharat Mission, National Drinking water Mission, NRLM etc.
- **Leveraging technology (ICDS-CAS)** to empower the frontline worker with near real time information to ensure prompt and preventive action; rather than reactive one.
- **Jan Andolan:** Engaging the community in this Mission to ensure that it transcends the contours of being a mere Government programme into a peoples' movement inducing large scale behaviour change with the ownership of the efforts being vested in the community rather than government delivery mechanisms.

NITI Aayog is in the vanguard of shaping the contours of the POSHAN Abhiyaan – right from the conceptualization stage right up to the execution stage. Vice Chairman, NITI Aayog Chairs the National Council charged with the responsibility of steering the Abhiyaan. Moreover, as per the POSHAN Abhiyaan Guidelines NITI Aayog has been mandated with the responsibility of preparing bi-annual Reports to apprise the Hon'ble Prime Minister with the progress of the campaign. This is the Second Report on the status of implementation of the POSHAN Abhiyaan. Like the previous report, it assesses the readiness/ preparedness of the States and Union Territories to effectively implement the Abhiyaan. Two major departures from the last Report are worth noting: (1) that the preparedness of State Health Departments (weightage 35%) has been assessed in addition to the Women and Child Departments (weightage 65%) unlike last time when only WCD preparedness was assessed; and (2) We have made use of the Comprehensive National Nutrition Survey (CNNS) data to take stock of State wise coverage of key interventions as also look at the outcome variables of interest, viz. Stunting, Wasting, Underweight and Anaemia prevalence.

The sub-set of questions used in the State/ Ministry Response Forms was selected to ensure continuity with the previous report (Annexure 1a and b) while adding more information regarding additional aspects of the Abhiyaan.

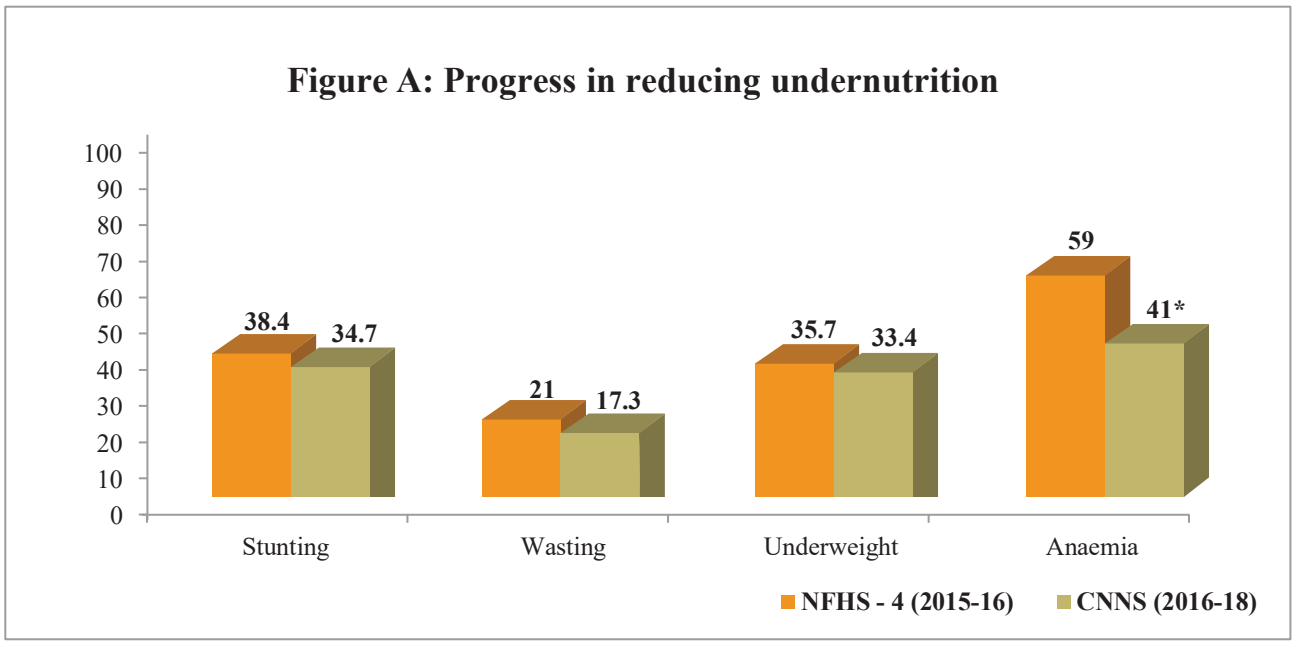
The Implementation Scores reflected in the present Report measures the readiness of the States/UTs to effectively implement and execute the POSHAN Abhiyaan. It is further grouped

under categories which are considered to be critical for the effective execution of the POSHAN Abhiyaan: 1. Governance and Institutional Mechanism; 2. Strategy and Planning; 3. Service Delivery and Capacities and 4. Programme Activities and Intervention Coverage. An overall composite score was created combining all the four themes to examine the implementation capabilities of States. Data provided by the States was digitized, post which weights were assigned to indicators chosen for the preparedness score in consultation with Experts. Once the weights were assigned, subtotals were computed for each domain. Finally, all the subtotals were summed up to create the final score. A detail of the rubric is placed at Annexure 2. It may also not be out of place to mention that the data reported was validated and the scores were subjected to a thorough peer review by our technical partners, International Food Policy Research Institute (IFPRI) to ensure the validity of the calculations arrived at by Technical Support Unit (TSU) of NITI Aayog.

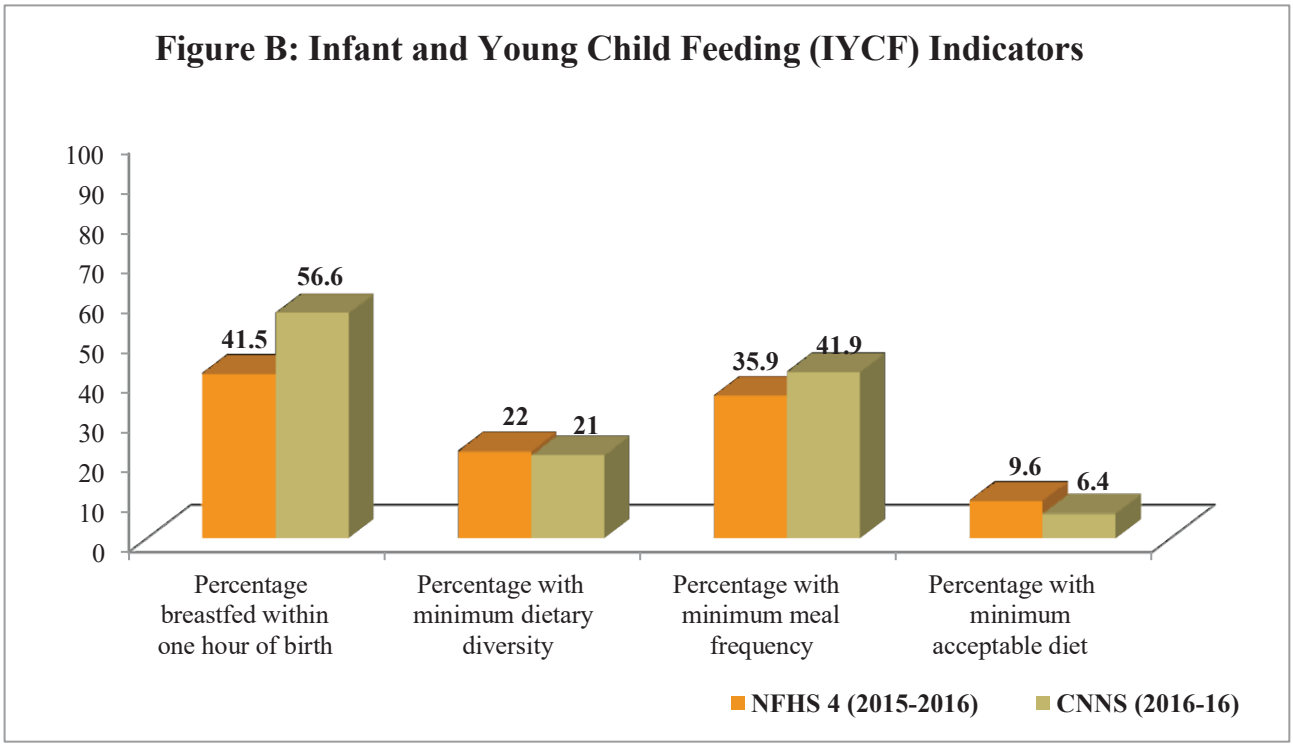
State of Implementation of the Abhiyaan in States:

Before we proceed to present our take on the status of implementation of POSHAN Abhiyaan in the States and UTs, it would be useful to take note of the outcome and coverage indicators of high priority interventions as revealed by the Comprehensive National Nutrition Survey (CNNS) conducted by MoHFW in association with UNICEF. **Admittedly the survey pre-dates the launch of the Abhiyaan,** none the less it holds important lessons for our strategy to implement this Mission. So far the latest survey data available regarding outcomes of interest (stunting, wasting, underweight & Anaemia prevalence) was NFHS-4 which carries information relating to the period 2015-16. Fortunately, we now have authoritative household level survey data representative at the State level from CNNS, conducted during the period 2016-18 and covering more than 110,000 households spread across the country. It provides the most updated data on the prevalence, coverage and continuity of a set of key nutrition and health interventions for India's States. We may consider this data as providing insight into baseline prevalence of the status of nutritional indicators that have a bearing upon the POSHAN Abhiyaan and can help States in finalizing their strategies for pacing their efforts in obtaining the desired outcomes as well as targets for intervention coverage.

Although can't strictly compare, but CNNS showed stunting decline has accelerated to 1.8 % points per annum which is almost double of the 0.9 % point per annum prevailing in the previous decade (2005-06 to 2015-16); (Figure A). This is perhaps due to a range of programmes implemented by the Government in the areas of health, nutrition and sanitation over the last few years. We are not comparing the Anaemia prevalence declines due to reasons mentioned in the note below Figure A. Overall, the story that emerges from the CNNS is that even before the launch of the POSHAN Abhiyaan we have nearly reached or exceeded the targets that we have set for ourselves in view of the multiple efforts by the Government of India under the NHM, ICDS and SBM campaigns.



[* Prevalence of anaemia was estimated from children in the age group 1-4 years measured using gold standard methods. The two figures are not comparable since they are arrived by using different methods of drawing blood samples to assess Hb levels]



Children need age-specific adequate nutrition of acceptable quality and quantity to prevent malnutrition, therefore, infant and young child feeding (IYCF) practices from CNNS data is also considered to provide the complete depiction. There is improvement in few indicators like the early initiation of breastfeeding, minimum meal frequency whereas, marginal decline is observed for minimum dietary diversity (Figure B).

It is now crucial that the momentum in reducing malnutrition is maintained and may perhaps be even accelerated given the unprecedented focus that POSHAN Abhiyaan has brought upon the multiple determinants of malnourishment among India's women and children. Additionally, it might be worth considering a possible upward revision of some of the targets given the notable levels of decline shown by CNNS data.

The other story that emerges from the CNNS data is not so positive and indicates the enormity of implementation challenge that we are confronted with on the coverage of a set of key nutrition and health interventions and policy initiatives in India's States and Union Territories. Figure C provides a snapshot of the coverage of the high-impact interventions at the National level and their State wise distribution. It is striking to note that in terms of the coverage levels, there is hardly any improvement in any State or in the relative position of the States when we compare these to NHFS-4 level. As would be seen, the highest level of coverage for receiving IFA is at about 70%. If we look at the co-coverage of all the required interventions (that is the percentage of mothers and children receiving all the required interventions) that figure would be at a very low one digit figure. This underlines the challenge for implementing agencies and the direction for future strategic shifts in our approach to the Abhiyaan. Another feature to be noted that CNNS finds substantial decline in malnutrition levels without the corresponding increase in coverage of interventions. We therefore need to the implementing agencies to place much greater emphasis in the POSHAN Abhiyaan on the quality of services provided to the beneficiaries.

Figure C: Coverage of selected set of health and nutrition interventions in India, CNNS (2016-18)

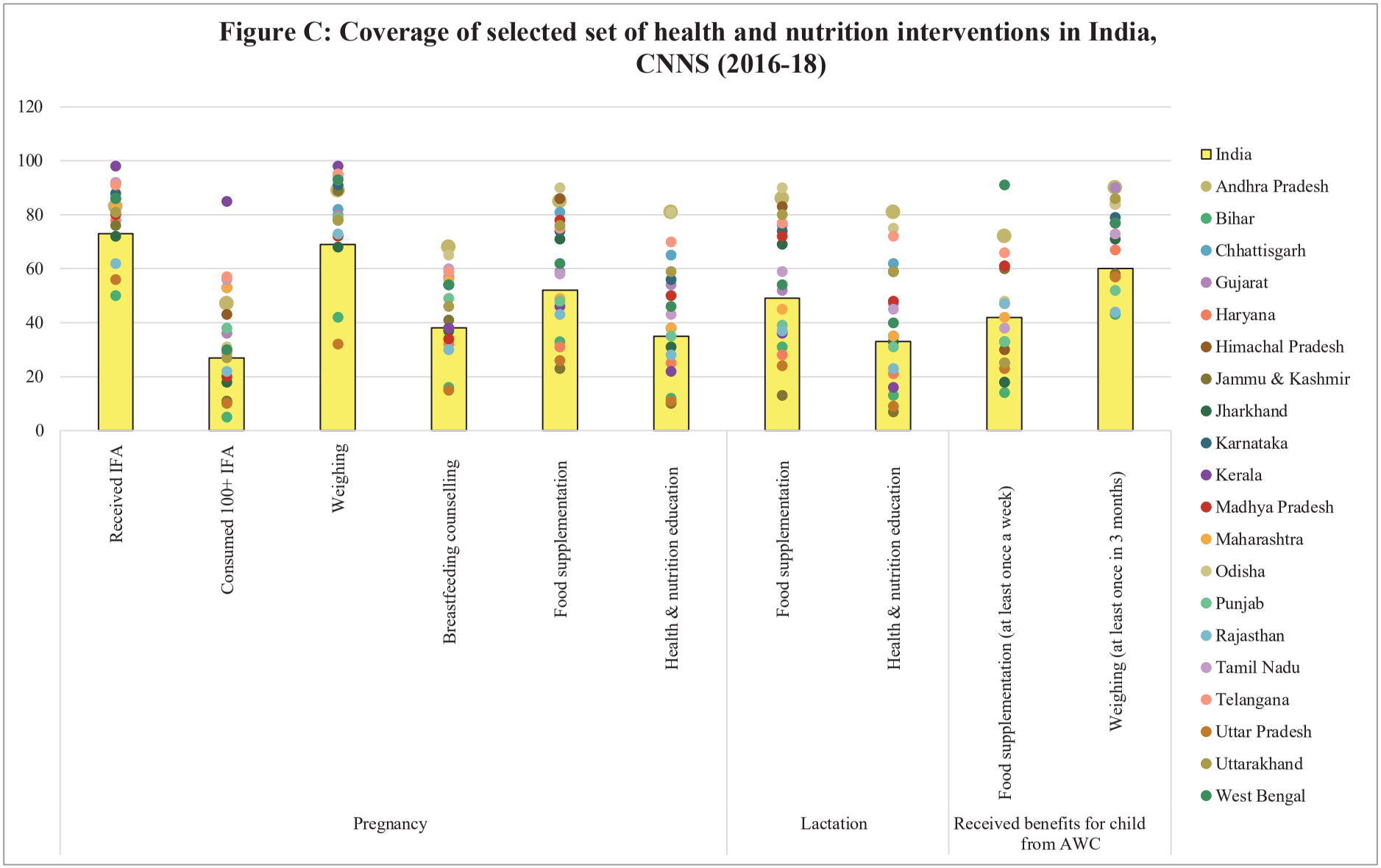
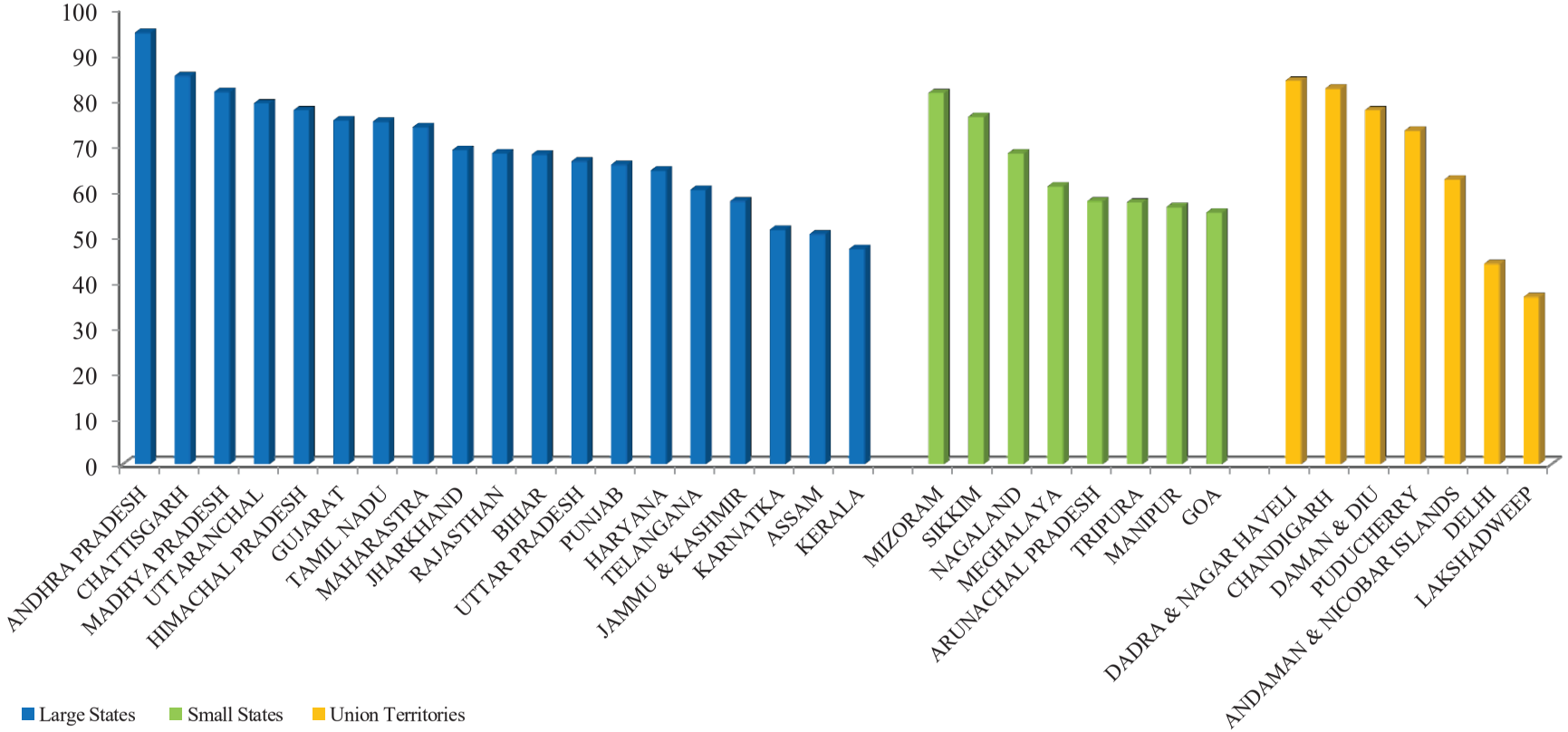


Figure D: Overall Implementaion Status-National Picture



Note: Status of Jammu& Kashmir refer to a date prior to bifurcation

We now present the inter-se ranking of the States and Union Territories (UTs) on the overall implementation status of the Mission (Figure D).

The scores for States and UTs are computed on the basis of data received from the WCD and Health Departments on four components with specific weights. Among the large States, Andhra Pradesh emerged as the top performing State and among the small States, Mizoram gets the top honours. Dadra and Nagar Haveli came out as the best in so far as UTs are concerned. We would like to point out a few issues that in our view are emerging as the key binding constraints in the implementation of the Abhiyaan:

1. ***Gaps in Human Resources, particularly at the supervisory level:***

   Overall across States, there are huge vacancies in supervisory cadre positions including that of Lady Supervisors, CDPOs, and DPOs. At a national level, the vacancy rates are in the range of 25% at both the CDPO and Lady Supervisor levels. This is the aggregated national scenario that varies from State to State; however, it is a clear indication of the relatively higher number of vacancies at the Supervisor level. For positions sanctioned under the POSHAN Abhiyaan, State Project Management Units (SPMUs) have not been established in two of the 19 large States (Punjab and Karnataka). Even where SPMUs have been established, 10 States have vacancy rates in the excess of 30%. In Uttar Pradesh and Haryana, less than 5% of the sanctioned posts have been filled up. Gujarat is the only large State where all SPMU positions have been filled up. The position in smaller States is even worse. With the exception of two States (Meghalaya & Mizoram), in the rest of the States either the SPMU has not been set up altogether or even where it has been set up all positions remain vacant due to non-completion of the recruitment process. The UTs are slightly better placed with four UTs having greater than 75 % of the SPMU posts filled up. None of the posts were filled in Puducherry and Delhi. Under the PMMVY scheme , against the provision of hiring 60 contractual staffs at State level and 1,434 contractual staffs at District level across the States and UTs, so far only 42% and 26% recruitments have been done at State and District levels respectively (as on 18 February 2019).

2. ***Procurement & ICDS-CAS:***

   There are significant challenges with the procurement and distribution of growth monitoring devices and smart phones. While there is a great emphasis in the Abhiyaan on the procurement of Smartphones and Growth Monitoring Devices, as per the last update only 27.6% of AWWs across the country have been provided with Smartphones and about 35% of AWWs have Growth Monitoring Devices (Infantometer, Stadiometer & Weighing Scales).

   Where real time growth monitoring data is available from the AWW centres, we need to ensure that the supervisory cadres are trained in their use. While a dashboard is available at the State Headquarters, we have not so far seen it being used for Monitoring and Evaluation purposes as well as a Decision Support Tool at the Block, District and State levels. In the absence of rigorous analytics, there is every likelihood of attrition in the quality of data collected through the ICDS-CAS. MoWCD and MoHFW currently use different applications for tracking the same beneficiaries leading to unnecessary duplication of efforts in data entry, besides lack of coordination in due-lists leading to a siloed approach to service delivery. Although significant resources have been dedicated to a pilot project to develop a common platform for the AAA functionaries and it has been in the works for some time now, we are yet to see a fruition of that effort. Another issue that needs to be addressed for smooth

functioning of the ICDS-CAS pertains to **internet con**nectivity in remote rural areas and also help-desk facilities for front line workers to help them navigate the software as first-time users. Only a few States like Maharashtra, Rajasthan, Sikkim, Andaman & Nicobar Islands, and Daman & Diu have established such helpdesks in all Districts.

3. ***Convergence:***

Convergence can be seen at two levels: (a) Governance level which creates institutional mechanism to ensure coherent response from multiple departments; and (b) Impact level where "effective convergence" implies successful reach of programs from relevant sectors that address the key determinants of undernutrition for the same household, same woman and same child. As has been pointed out earlier while discussing the CNNS results, our success in effective convergence of critical services at the household level has been fairly modest. Since the launch of POSHAN Abhiyaan, several coordinated policy announcements by concerned Ministries; strengthening the platforms of service deliveries such as VHSND and effective demand side push to drive behavioural change in health seeking behaviour of households through the high voltage Jan-Andolan campaign during the preceding year are likely to improve convergence as well as coverage of interventions, but in the absence of validated real time data we can only speculate. We would have a much clearer picture of this when NFHS 5 results are released later this year. However, early results in the Household Survey carried out by the NITI Aayog in the 27 Aspirational District in July 18 (Round1) and January 19 (Round 2) have shown over **15.7%** and **19.1%** increase in use of ORS and Zinc Treatment for Diarrhoea respectively; a **9.54%** increase in Early initiation of Breastfeeding and **3.47%** increase in ANC registration in the first trimester. This shows that it is possible to have big gains in coverage in relatively short periods of time with determined efforts. Along the lines of the recommendations stated in the earlier Report, we would like to reiterate that continued engagement with Chief Ministers and Chief Secretaries on issues that require cross-sectoral efforts and monitoring at the highest levels, must be ensured. We further need a renewed push towards the creation of **institutional mechanisms at the State, District, Block and Village** levels for accelerating convergent action required for the implementation of POSHAN Abhiyaan. Some of the learnings from existing State level convergence models which should be considered for scale up are listed below:

- Self Help Group federation of **JEEViKA model in the State of Bihar** created a promising platform for engaging the community through feeding demonstrations at the SHG meetings as a result of which **complementary feeding** which had remained stagnant for years showed more than a 2-fold improvement over a two-year period *(both in terms minimum acceptable diet and minimum dietary diversity).*
- **Government of Chhattisgarh** where convergence of various schemes like the State Rural Livelihood Mission in the District of Surguja, has helped to improve several indicators at the grass roots levels.
- Similarly, the Ajeevika initiative of the **Government of Jharkhand** where they engage the Sakhi Mandal members as Business Correspondent (BC). The gradual decline in prevalence of diseases on account of micronutrient deficiencies as well as reduced prevalence of stunting and wasting among under-5 children point towards a positive change
- In several **Aspirational Districts** the strengthening of Village Health Sanitation & Nutrition Days (VHSNDs) have been

demonstrably shown to be an efficient and effective platform of converged service delivery at the village level.

4. ***Fund Utilization:***

Utilization of funds for any program is one of the proxy indicators of its successful implementation. Variation in terms of utilization is observed across the country. The cumulative utilization rate is about 20% in the Large States; Small States and UTs have utilised on an average about 42% of the allocated funds. Haryana, Tamil Nadu, Punjab, Kerala, Delhi and Goa have a utilization rate of less than 5%. Even where funds have been released by the Government of India, tardiness in completing the procurement process of Growth Monitoring devices and Smart phones through the GeM portal precludes us from reaping the full benefit of scheme by the frontline workers and intended beneficiaries.

5. ***Jan Andolan:***

All the Ministries involved in the POSHAN Abhiyaan need to be complemented for giving a huge push and visibility to the Abhiyaan through Poshan Maah (September 2018) and Poshan Pakhwara (March 2019) where mobilization through community based events, door to door campaign and other related activities were organized with much greater degree of enthusiasm and effectiveness. However, it is imperative that this momentum has to be sustained and strengthened further to induce behaviour change at a massive scale. International evidence has shown that nutrition campaigns have never been successful without the campaign being owned and led by the community. To take the community ownership and involvement in the Mission to the next higher level the coming POSHAN Maah will focus upon the engagement with elected representatives at all levels – from the **Parliament to Panchayats.** Carefully designed material with appropriate messaging, content and media has been created to facilitate this engagement. We also need to leverage the SHGs and ensure that they can play a critical catalyzing role in enrolling the households to desired behavioural changes. Since lack of complementary feeding to children in the age group of 6-23 months has been major factor in the rampant prevalence of malnutrition, the upcoming Poshan Maah (September 2019) will focus on this theme. A sizeable workforce can be added in this campaign if we can successfully enroll the Panchayat representatives and the SHG members to our cause. A lot of preparatory work has been done but we need to sort out some minor budgetary issues to roll this out effectively.

6. ***Recommended priorities for the year 2019-20***

A successful campaign must prioritize the high impact interventions taking into consideration the capacities of our delivery system. Based on a careful consideration of the likely impact on outcomes of interest in the POSHAN Abhiyaan, the capacities of FLWs to deliver and our experiences from the Aspirational Districts, we would recommend that we should concentrate on the following action items as our key focus areas for the FY 2019-20

- ✓ Eliminate Diarrhoeal Deaths by focussing on prevention, rota virus vaccination, initiating timely treatment by giving ORS and Zinc and finally referral to a nearby health facility in case of complications.
- ✓ A huge campaign around improving complementary feeding practices
- ✓ Improve the quality of home visits through better implementation of the intensified and augmented Home-Based Newborn Care (HBNC) programme
- ✓ A very strong movement around ‘Anaemia Mukt Bharat’ Campaign.

- ✓ Taking the agenda of food fortification ahead.
- ✓ And lastly, fixing the delivery and supply logistics of the Take Home Rations (THR) to pregnant and lactating mothers and children. A recent study in 27 Aspirational Districts across 8 States showed that there are significant gaps in uptake and availability of THR to the eligible beneficiaries. We need to plug the gaps in the system to ensure that our Supplementary Nutrition Program is delivered more efficiently than what is in vogue today.
- ✓ In addition, we would also recommend that the gap in the guidelines for the management, treatment and follow up of Severely Acute Malnutrition (SAM) without medical complications OR Moderately Acute Malnourished (MAM) in the community should be plugged immediately. Other than the provision of double ration for SAM children in the Supplementary Nutrition Program, there is no other mechanism to follow up with them in the community. There are also no clear guidelines for community level frontline heath workers on this issue.

Conclusion

The present Report Implementation Score is a useful tool for systematic measurement of performance across States and UTs as far as their readiness to implement the Abhiyaan. It serves as an important aid in understanding the heterogeneity and complexity of the Nation's performance in nutritional indicators. Owing to the multiplicity of determinants that impact nutritional outcomes, BOTH WCD AND Health departments of States and UTs are contacted.

The erudition that have emerged during the process of development of the implementation score, will guide the States and UTs in directing their resources to improve the parameters where they are lagging behind. It further acts as an enabling mechanism to locate loop holes in the system and States/UTs can progress in a more procedural way to accomplish the target to combat malnutrition.

CHAPTER 1:
INTRODUCTION

1. INTRODUCTION

POSHAN Abhiyaan (National Nutrition Mission) is India's flagship programme to improve nutritional outcomes for children, pregnant women and lactating mothers. The programme aims to ensure service-delivery and interventions by use of technology, behavioural change through convergence and lays down specific targets to be achieved across different monitoring parameters over the next few years.

India embarked on an ambitious effort in 2018 – the Prime Minister's Overarching Scheme for Holistic Nourishment called POSHAN Abhiyaan -- to address multiple forms of malnutrition. Recognizing that malnutrition levels in India are high and have been slow to change over the last decade, this national nutrition mission attempts to address 5 key essential elements recognized to be critical in the fight against malnutrition –delivery of high impact interventions with adequate coverage, continuity, intensity and quality (C2IQ), including behaviour change communication at scale, multi-sectoral convergence to address the underlying drivers of malnutrition, adequate financing and monitoring to track the progress and learn, and committed leadership and an enabling environment. Impact on nutrition outcomes, such as stunting, wasting, anemia and low birth weight, can take some years but changes in these critical elements that can accelerate the progress on the path to good nutrition can be achieved in shorter timeframes.

The prominent features of POSHAN Abhiyaan are:

1. A high impact package of interventions with a focus on (but not limited to) the first 1000 days of a child's life.
2. Strengthening delivery of this high impact package of interventions through
    - o Remodelling of nutrition monitoring though the introduction of ICDS-CAS which leverages technology for management as well as monitoring.
    - o Improving capacities of frontline workers through the Incremental Learning Approach (ILA) mechanism.
    - o Emphasizing convergent actions among the frontline workforce, including through performance linked joint incentives for the 3As (ASHA, Anganwadi & ANM).
3. A focus on cross-sectoral convergence to emphasize the multidimensional nature of malnutrition, mapping of various Schemes contributing towards addressing malnutrition.
    - o Convergence committees at the state, district and block levels will support decentralized and convergent planning and implementation, supported by flexi-pool and innovation funds to encourage contextualized solutions.
4. Ramping up behaviour change communication and community mobilization through through Jan Andolan, a large-scale national nutrition behaviour change campaign that uses community-based events, mass media and other approaches.

The Abhiyaan focuses on strengthening policy implementation (at Central and State level) to improve targeting (identification of high burden Districts), enhance multi-sectoral convergence, develop innovative service delivery models and rejuvenate counselling and community-based monitoring. It aims to reduce child stunting, underweight and low birth weight by 2 percentage points per annum and anaemia among children (and young females) by 3 percentage points per annum (Figure 1).

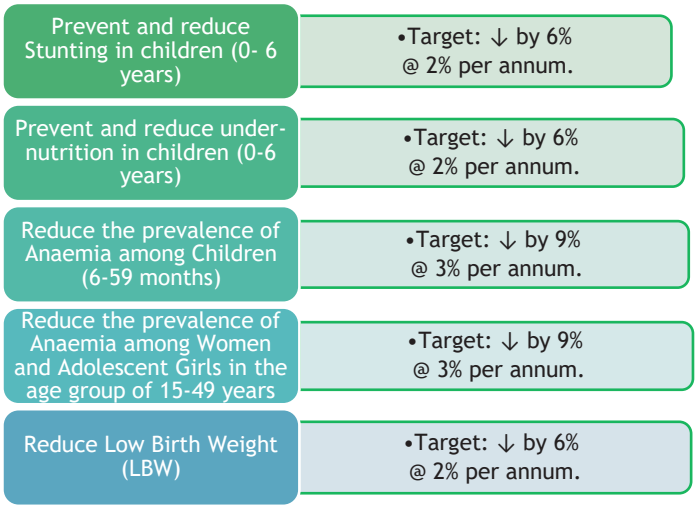


Figure 1: Targets of the POSHAN Abhiyaan

POSHAN Abhiyaan is an umbrella scheme which covers a host of program and services that target beneficiaries across 1000 day cycle with nutrition interventions. These include a take-home ration from Anganwadi centers; anaemia prevention and control under the Anaemia Mukt Bharat program; antenatal care services; dietary counselling through Village Health Sanitation and Nutrition Day (VHSND); and schemes such as Pradhan Mantri Surakshit Matrutva Abhiyaan that provide quality antenatal check-ups. Institutional Deliveries are promoted through conditional cash transfer schemes like Pradhan Mantri Matrtya Vandana Yojna (PMMVY) and Janani Suraksha Yojna (JSY) and free services for delivery and early neonatal care (Janani Shishu Suraksha Karyakram) and provide an important opportunity to support mothers in establishing good breastfeeding practices.

POSHAN Abhiyaan explicitly recognizes the need for convergence and coordination such that the benefits of multiple Government schemes and programs reach women and children in the first 1000 days. It aims to improve synergy through robust convergence mechanisms. The programme also aims to ensure service-delivery of key interventions supported by the use of technology, and behavioural change. It lays down specific targets to be achieved across different parameters over the next few years.

Through these targets, the programme is striving to reduce the levels of stunting, underweight, anaemia and low birth weight prevalence in babies. It also creates synergy among the Ministries and Departments, ensures better monitoring, issues alerts for timely action, and encourages States/UTs to perform, guide and supervise the line Ministries and States/UTs to achieve the targeted goals.

Under POSHAN Abhiyaan there is an ambition to ensure that every child and woman has access to quality services to address the malnutrition across the continuum of care. To achieve this, it is important to strengthen the pillars of the Abhiyaan in a targeted manner (Figure 2).

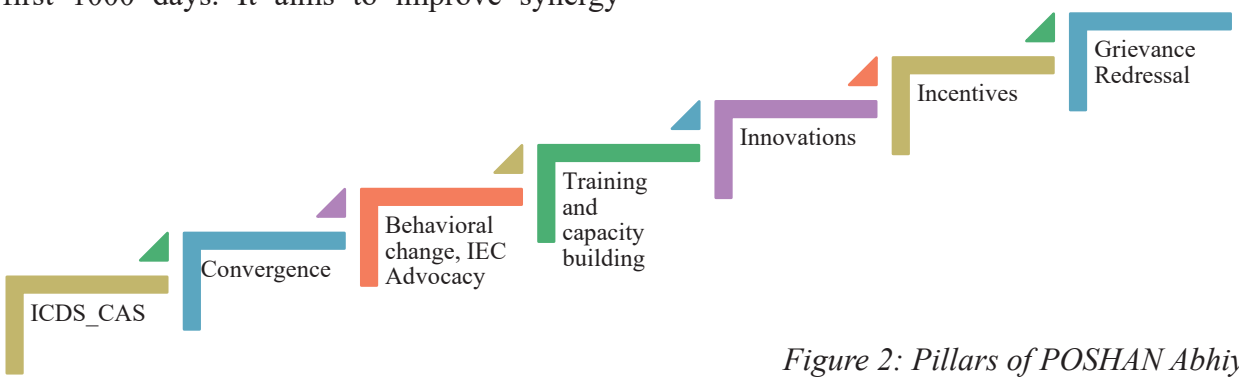
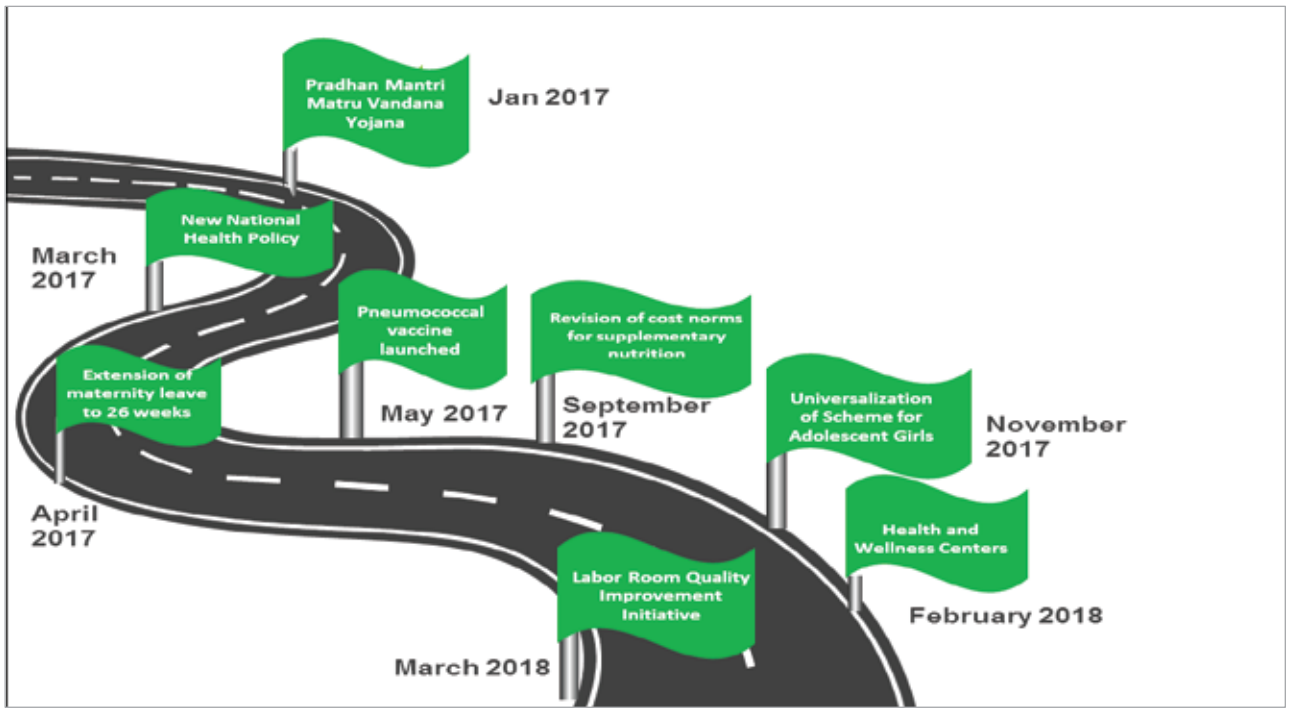


Figure 2: Pillars of POSHAN Abhiyaan

Policy initiatives in Nutrition and Allied Sectors

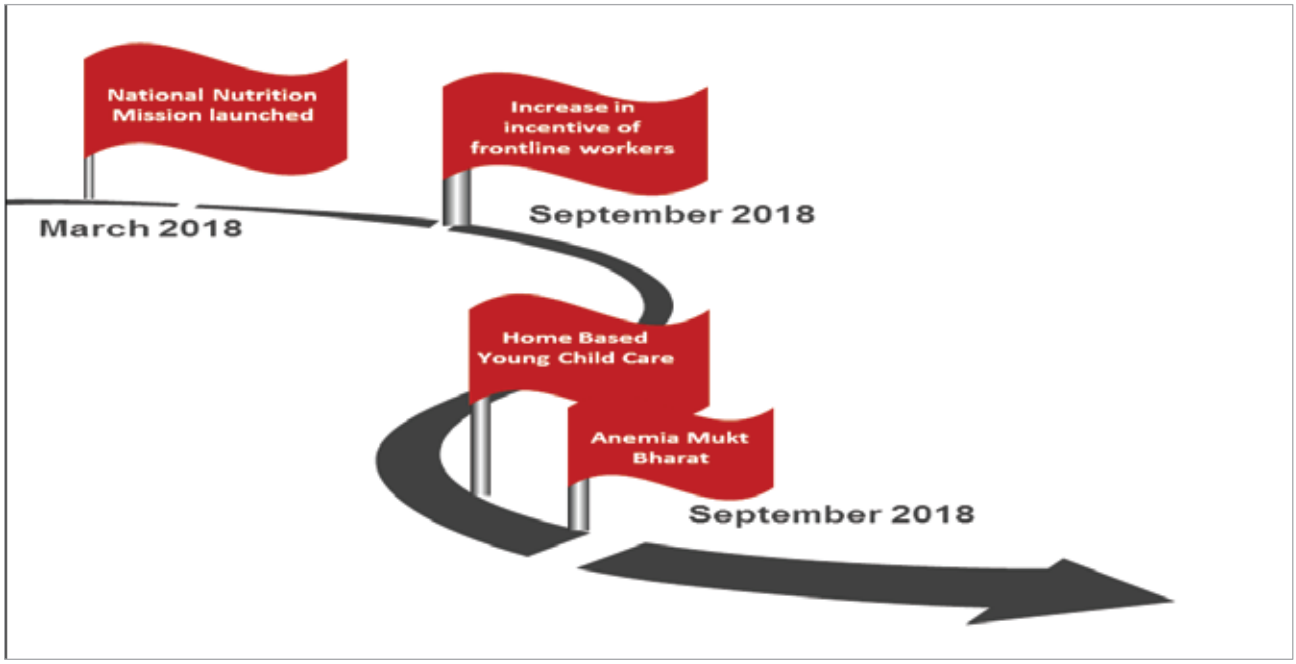
The launch of POSHAN Abhiyaan has been a watershed in the series of enhanced allocations, policy measures and advisories issued by the Government of India towards the goal of eradicating malnutrition in the country (Figure 4).

Figure 3: Key Government Initiatives in Nutrition and Allied sectors



The Abhiyaan has not only given momentum to existing programs, reoriented policy choices and aligned several sectors towards the common goal of eradication malnutrition from the country, it has also been instrumental in instigating a range of policy actions under its ambit within a short span of time (Figure 4).

Figure 4: Important Policy Actions under the ambit of POSHAN Abhiyaan



The above mentioned initiatives and policies of the Government are essential but the issue is of the coverage, continuity, intensity and quality of the services provided under the ambit of mentioned programs.

Pradhan Mantri Matru Vandana Yojana (PMMVY)

It is a Scheme which aims to improve health-seeking behaviour and nutrition among first-time pregnant women and lactating mothers (PW&LM) to reduce the effects of under-nutrition, the leanings from implementation is mentioned in details in this section of the Report.

It is a conditional maternity benefit scheme which provides Rs. 5,000 to pregnant women and lactating mothers in three instalments of Rs. 1,000, Rs. 2,000 and Rs. 2,000 respectively. The conditions for the payment of instalments are early registration of pregnancy, Antenatal Check-ups (ANC) and first cycle of immunization to the new born baby. Additionally, the women get her entitlement of around Rs. 1,000 under Janani Suraksha Yojana (JSY) after Institutional Delivery.

As per the mandate, NITI Aayog does quarterly concurrent monitoring of the scheme, for this the field studies are conducted by NITI team and Development Partners with an objective to understand Governance issues and get field level feedback.

I. Status of Implementation

The Scheme is being implemented with effect from 1st January, 2017; however it has started implementing on ground since October, 2017. Till 31st March, 2019, in total around 82.2 lakh Beneficiaries have been registered out of which around 83.5% of the eligible beneficiary have received 1st instalment with cumulative payment of Rs. 2,611 Crores. The average time taken in payment of 1st instalment from the date of registration is around 45 days, but when calculated with respect to the Last Menstrual Period (LMP) the average time taken is 234 days. Only 22% of the 1st instalments have been paid within 150 days with respect to the date of LMP. Analysing the method of payments, 66% of the total DBT transfers were made through Aadhaar based payments out of which 72% matched with the Bank Accounts provided by the Beneficiaries. The Scheme has been successful in registering around 19,000 beneficiaries per day in the quarter ending March, 2019. The trend in registration vis-à-vis payments of instalments and per day registration of new beneficiaries in the scheme can be seen in the below graphs:

In order to simplify the instalment payments and prevent delays, the Ministry has taken few corrective measures like- the beneficiary now can now submit the second claim application before 180 days of LMPs which will be automatically processed on compilation of 180 days of LMP. Also, Ministry had advised States/UTs to utilise the flexi funds for incentivising field personnel, data entry facilitator and for other innovative uses.

Figure 5: Trend in No. of Beneficiary Registration v/s Payments of Instalments-PMMVY

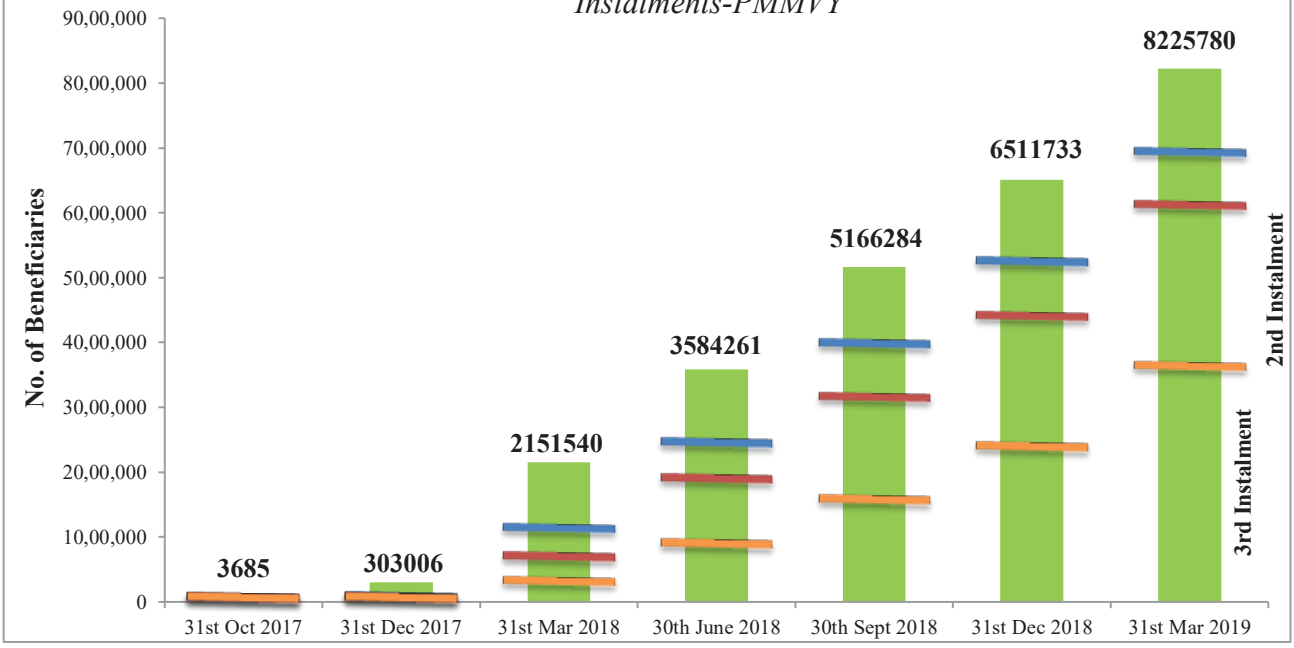
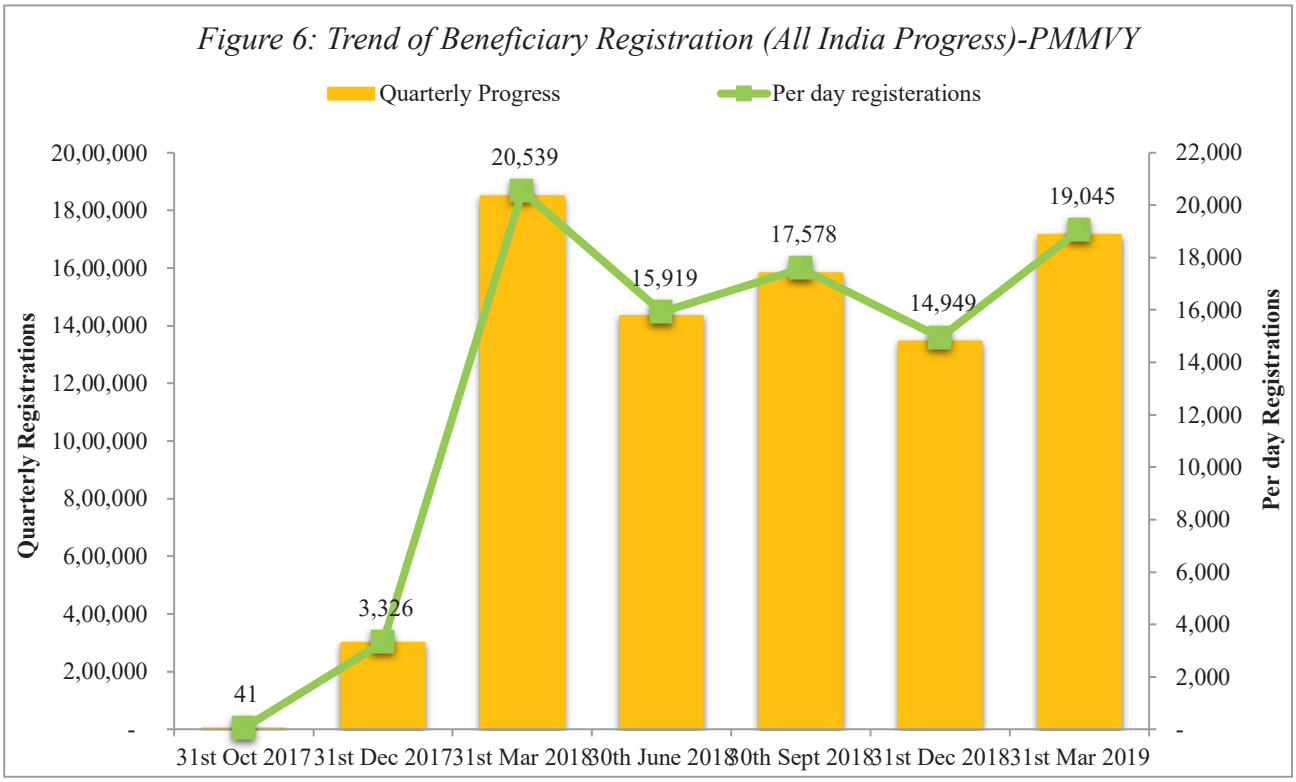


Figure 6: Trend of Beneficiary Registration (All India Progress)-PMMVY



II. Preliminary Findings

The survey conducted by Development Partners and field studies conducted during January 2019 by NITI team has shown in the following Figures 7 and 8:

Figure 7: Reported Utilization of Money (PPMVY)

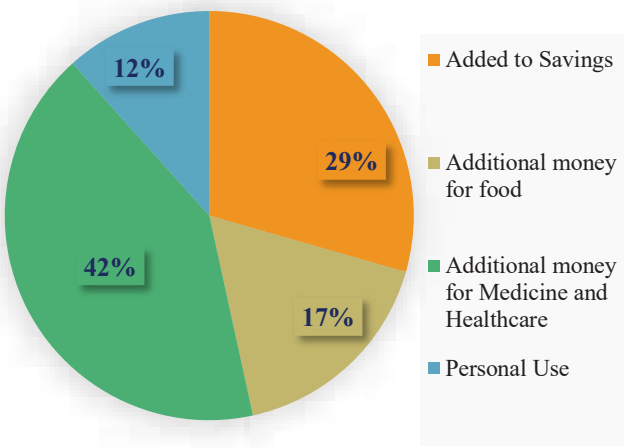
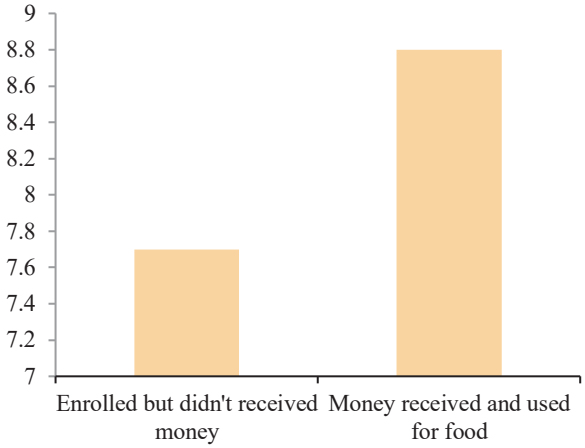


Figure 8: Average Minimum Dietary Diversity Score (PPMVY)



III. Remaining Challenges

The scheme has made impressive progress in a short duration after its launch and has been successful in reducing the delays in payments and enrolment of beneficiaries compared to its predecessor IGMSY, which was implemented in selected districts. This has been only possible because of the use of DBT mode of payments, constant monitoring and timely resolution of the identified bottlenecks in implementation of the scheme. However, there are still few challenges that need to be resolved to take the performance of the scheme to next level. These challenges are as follows:

- A substantial number of payments (28% cases of all Aadhaar based payments, i.e. in case of 31.29 lakh payments) are going to different Bank Accounts than what had been provided by the Beneficiaries. Sometimes these are even untraceable by beneficiaries and field functionaries. A telephonic survey of 5,525 beneficiaries was conducted by MoWCD which has revealed that only 60% were aware of both the receipt of the benefits and the bank account to which the money was reemitted. It is a prime cause of dissatisfaction amongst beneficiaries which needs to be addressed on urgent basis.
- There is need for simplification in documentation and operational rules. For example, the rule for completion of 180 days before processing 2nd instalment and mandatory requirement of Birth Certificate for 3rd instalment needs to be rationalized which are unnecessarily causing delays in payments.
- Incomplete MCP cards are another reason for delay in payments. ANMs needs to be trained and directed to properly fill MCP cards. Also, efforts needs to made to auto populate Heath Data (Pregnancy detection, ANC and Immunization) by linking PMMVY-CAS with Health Portal (RCH).
- Data Entry Operators (DEOs) at Block level is essential for timely entry of applications, processing of payments and timely resolving Correction Queues.
- For effective monitoring, there should be a dashboard at Block and District level providing information on critical indicators like beneficiaries registered against estimation, delay in payments w.r.t. LMP, status of beneficiaries eligible but not paid 2nd/3rd instalment etc. in a single window to encourage course correction.
- In order to minimize/eliminate exclusion, effective convergence (on sharing information on 1st pregnancy and counselling) is required among the AAAs so that all eligible beneficiaries could get enrolled in this scheme.

CHAPTER 2:
METHODOLOGY

This is the **Second Report** on the status of implementation of the POSHAN Abhiyaan. The focus of this Report is on assessing those aspects of POSHAN Abhiyaan which are crucial for effectively implementing the Abhiyaan. Various mechanisms and interventions utilised by the States/UTs to accelerate the implementation of the Abhiyaan are also analysed.

2.1 DATA COLLECTION:

Efforts were made to consolidate the multiple activities which are going on in different parts of the country under POSHAN Abhiyaan, by different set of stakeholders. For this purpose, a multi-pronged strategy for data collection was adopted where NITI Aayog reached out to several Cenral Government Ministries, States & UTs and development partners to collect information.

- **Ministries at the Central Level:** Information was sought from the key Ministries (Ministry of Women and Child Development (MWCD), Ministry of Health and Family Welfare (MoHFW), Ministry of Rural Development (MoRD), Ministry of Human Resource Development (MHRD) and Ministry of Panchayati Raj Institutions (MoPRI) at the Central level on their various initiatives launched within the ambit of POSHAN Abhiyaan focusing on first the 100 day interventions, from conception till 2 year of child' life.
- **States & UTs:** As mentioned above, for data from the States & UTs, a detailed format (Annexure 1a and b) was shared with their Women and Child Development and Health Departments to collect information. Details about indicators used in the templates is provided in the subsequent section of this chapter.
- **Development Partners:** Development partners with direct presence in the field were encouraged to collect new initiatives, stories of change, models which can be scaled-up and replicated and information about individuals who are doing exceptional and inspirational work at the ground level to change the status of nutrition in the country. Accordingly, these stories have been compiled and featured in this report.

While the first progress Report focused solely on preparedness related indicators of POSHAN Abhiyaan which were about modulation of systems in place so that work of Abhiyaan can get geared up, the second Report focuses on implementation of parameters covering both WCD schemes Health interventions at State and UT level and therefore, inputs/Data has been considered from both State WCD and Health Departments. A detailed framework of the indicators was formulated to analyse the data and information.

IMPLEMENTAION SCORE:

Broadly, Implementation Score measures the level of implementation of POSHAN Abhiyaan by the States and UTs. Since in many States and UTs the POSHAN Abhiyaan is effectively launched lately, briefly, the preparedness or readiness of the Sates/UTs for implementing the Abhiyaan is also captured.

The information received from the WCD and Health Departments of States/UTs was organized into the following categories which were considered to be crucial for generating the implementation score (Table 1)

Table 1: Implementation score themes for WCD and Health Department		
Implementation score themes	**WCD Department**	**Health Department**
Governance & Institutional Mechanism	• Fund Allocation • Constitution of Committees & Resource Groups	
Strategy and Planning	• Cross-sectional convergence	
Service Delivery & Capacities	• HR • Supplies [Mobile phones and growth Monitoring Devices] Training & capacity building	• Infrastructure • HR • Supplies(Stock out) Training & capacity building
Program activities and intervention coverage	• Program activities- ICDS	• Program activities

Each of these categories comprised a set of sub-themes, shown separately for WCD and Health Department (Table 1), which in turn had several indicators based on the information received (Annexure 1a and b). It must be noted that these indicators are proxy indicators reflecting at best intentions of the State and UTs with respect to each of these categories.

CATEGORIZATION:

For the purposes of inter-State comparison of only similar size/kind of States, this report categorizes the States and UTs into large States, small States and UTs (Table 2)

Table 2: Categorization of States		
Category*	**Number of States**	**List of States**
Large States	**21**	Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh, Uttarakhand, West Bengal
Small States	**8**	Arunachal Pradesh, Goa, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura
UTs	**7**	Andaman & Nicobar, Chandigarh, Dadra & Nagar Haveli, Daman & Diu, Delhi, Lakshadweep, Puducherry

* This categorization is similar to the one used for State Health Index Report

2.2 METHODOLOGY

COMPUTATION OF SCORES:

Implementation Score was created with a maximum score of 100. Maximum possible score allotted for WCD Departments was 65, whereas for Health it was 35. The sub-set questions were selected to ensure continuity with the prior report and were based on the previous questionnaire as well as administrative guidance from the Centre. These elements were common across all the States and UTs (Figure 9).

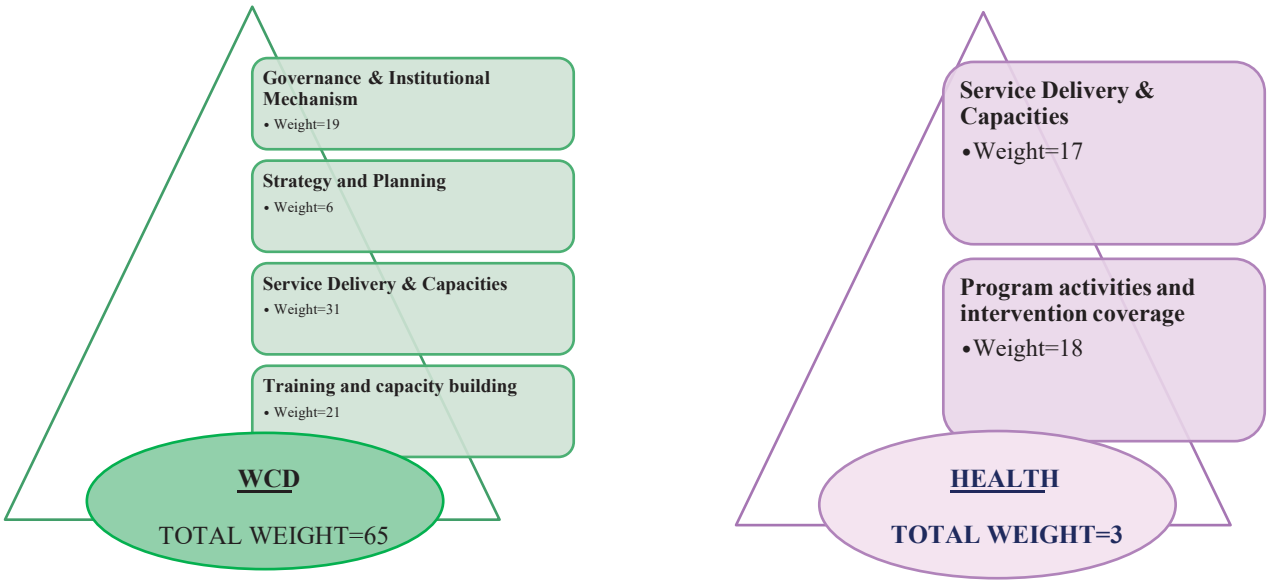


Figure: 9 Critical components for the evaluation implementation of the POSHAN Abhiyaan

For details on the process of generating the implementation score, please refer to Box 1.

Box 1: Steps to Generate Implementation Score

STEP 1. Developing assessment tool for States/UTs: NITI Aayog prepared two implementation assessment questionnaires (one for Health and one for WCD) that examined issues related to financing, multi stakeholder efforts, systems capacity and program implementation. These were finalized with inputs from several technical stakeholders (Annexure 1a and b).

STEP 2. Data collection at the State/UT level: The implementation assessment questionnaires were sent to officials in States in the departments of Women and Child Development and Health in April 2019. Officials in charge in the State gathered all the necessary information to complete the questionnaires and sent them back to NITI Aayog between April and May 2019.

STEP 3. Data Cleaning: Once the first round of data was received from the States, it was reviewed and manually cleaned to highlight inconsistencies in responses. These marked State templates were shared back with the States for revisions and clarifications [May 2019]

STEP 4. Data entry: The second round of data from the States were entered twice using the Survey CTO interface by 3 independent researchers. Double data entry was applied to ensure there were no data entry errors. All the discrepancies between the two rounds of data were corrected.

STEP 5. Data processing & analysis: Stata version 15 was used to conduct all logical checks and data analyses. Using the clean data, weights were assigned to variables chosen to construct the implementation score rubric and then summary scores were created for each State based on the implementation score rubric.

STEP 6 Data validation by States: Each State was then sent their initial scores and the weights of the elements used for that score. Comments were added and the States were requested to reconfirm data if there were any inconsistencies arising from logic checks. Video conferences were held with 18 large States on 6th-7th June 2019 and telephonic follow-up were done with the remaining small States and UTs. All the States were given an opportunity to provide any updates on their responses to the implementation assessment questionnaire. [*Limitation:* Only the data that were used to compute the rubric were validated by the States for accuracy. Validated data was received from all States except: WCD Department: Assam, Delhi and Kerala; Health Department: Andhra Pradesh, Arunanchal Pradesh, Bihar, Gujarat, Jharkhand and Meghalaya]

STEP 7 Data updation & final score calculation: States updated information as necessary in mid-June 2019. These data were then updated in the final dataset and the final scores were generated.

Process Validation

Technical Partner of the TSU established at NITI Aayog, International Food Policy Research Institute (IFPRI) was engaged to audit the entire process beginning from the data entry stage to the computation of the Implementation Scores.

Limitation

While all attempts were made to reach out to States and UTs and gather updated information, two States, namely, Odisha and West Bengal, have not been incorporated into this report due to unavailability of data from these States. For Lakshadweep, WCD Department had shared the required information, but Health Department has not provided the Data.

POSHAN Abhiyaan has been rolled out in phased manner in the Country, likewise the implementation has also moved in a phased manner. The availability of funds, supplies, ICDS-CAS roll out and other related indicators are dependent on the roll-out of the Abhiyaan in the State/UT. For the preparation of the present Report, all the States and UTs with their Districts are not distinguished as per the Phases in which the POSHAN Abhiyaan was rolled out.

For collating the data especially from the Health Department of all States and UTs, it was observed that for the indicators where information is not available in the HMIS, States/UTs found it difficult to compile and share any information. With respect to the responses/data shared by the States/UTs the health part of the rubric was given lesser weightage (35) as compared to the WCD part(65).

Standardizing denominator: To compute a few indicators of coverage, total number of 12-23 months old children was required. However, States provided information for a varied range of age categories e.g., 9 to 23 months, 6 to 23 months etc. Therefore, to construct the coverage indicator, the denominator was standardized to reflect the total number of children to be 12-23 months old. For example, if States provided information on total number of children for 9 to 59 months, then to standardize the total number of children to be in 12-23 months old group, that total number of children was divided by the difference between 9 and 59 months i.e., 51 months. The resulting number was multiplied with the number of months between 12-23 i.e., 12 months. This calculation assumes that equal number of children were born in each month.

Changing proportions that are greater than 100 percent to 100 percent: When computing indicators for coverage of interventions, where there were instances of greater than 100 percent coverage, the proportions were considered to be 100 percent. As the data from the States were from the health monitoring information system (HMIS) where the denominators are projection-based and not of the actual population, it is possible that the projected population is sometimes lower than the actual population receiving the services.

Brief Outline on the first POSHAN Abhiyaan Progress Report- (April - October, 2018)

POSHAN Abhiyaan's first progress report, submitted in December 2018, mainly highlighted its implementation status, from the time it was launched in March 2018. The report evaluated the Preparedness of the States and UTs for POSHAN Abhiyaan.

Data was collated from the WCD departments of the all the States and UTs (except West Bengal and Odisha). Further, Preparedness Score for each State and UT was calculated considering the information and data shared. The entire data set was organized into three categories:

- Governance and Institutional Mechanism
- Strategy and Planning
- Service Delivery Essentials

Taking into consideration the data for these categories, each State and UT was ranked on the Preparedness Score. For ease in comparison, the findings were presented separately for large States, small States and UTs.

Major findings of this report were that Chhattisgarh scored highest on the preparedness levels, while Assam was the least prepared to enter the implementation phase. Among the small States, Meghalaya scored the highest whereas Sikkim was at bottom of the preparedness level. As far as the UTs are concerned, Chandigarh was best prepared to implement the Abhiyaan, while Lakshadweep scored the lowest in terms of readiness.

Vital information was also provided by various line ministries at the central level on their initiatives launched within the ambit of POSHAN Abhiyaan to reduce malnutrition.

It was the first attempt at establishing a tool for measurement of preparedness across States and UTs on a variety of parameters within the three domains. Owing to the multiplicity of determinants that impact nutritional outcomes, some of these actions were outside the ambit of the WCD department.

The erudition that emerged during the process of developing the preparedness score, guided the States in identifying the gap areas and directing their resources to improve the parameters where they were lagging. It acted as an enabling mechanism to locate loopholes in the system to combat malnutrition. This detailed analysis presented in the first progress report of POSHAN Abhiyaan facilitated the States and UTs to get an overarching view and examine the factors leading onto the effective implementation of the Abhiyaan.

In the present Report, India's progress on the POSHAN Abhiyaan, focusing on efforts that commenced with the launch of the Nourishing India strategy in Sept 2017 is described. This Report highlights mainly on assessing the State of Governance and Institutional Mechanisms to support full-scale implementation of POSHAN Abhiyaan, convergence and delivery of high impact interventions, monitoring and learning, and the rollout of Jan Andolan, India's flagship behaviour change and community mobilization effort for malnutrition. It also looks at some of the challenges faced by the States and union territories (UTs) in the implementation of key health and nutrition interventions, and innovations developed by the States/UTs, and discusses the way forward for POSHAN Abhiyaan.

Focus of the Report is mainly on assessing the State of leadership and an enabling environment, convergence and delivery of high impact interventions, monitoring and learning, the rollout of the Jan Andolan, India's flagship behaviour change and community mobilization effort for malnutrition.

CHAPTER 3:
NUTRITION INTERVENTION COVERAGE AND OVERALL IMPLEMENTATION SCORES OF STATES AND UNION TERRITORIES FOR POSHAN ABHIYAAN

For assessing the progress of the POSHAN Abhiyaan, the most recent data on the prevalence, coverage and continuity of a set of key nutrition and health interventions for India's States is available from the **Comprehensive National Nutrition Survey (CNNS, 2016-18).** It collects the data from more than 1,12,000 children in the age group of birth to 19 years of age across India. The data also provides a benchmark to the status of nutritional indicators and can help States in setting targets for intervention coverage to achieve under POSHAN Abhiyaan.

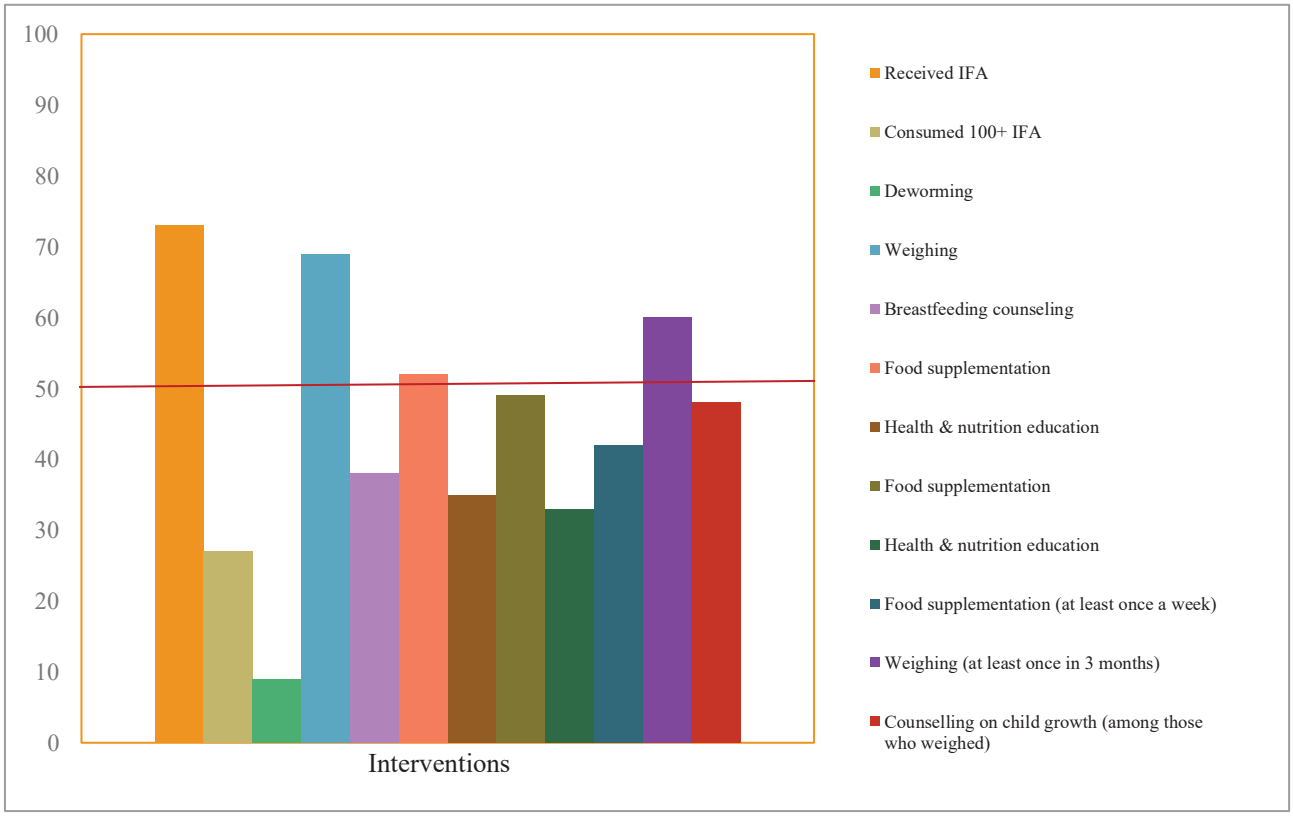
CNNS data surely reflects some progress in bringing down under nutrition levels (Figure A). Although this data acts as the baseline for the POSHAN Abhiyaan but it can be intended that the targets of POSHAN Abhiyaan will be well achieved with the reduction of stunting and anaemia in the coming years to come. CNNS also captures the prevalence of various micronutrient deficiencies for the children and adolescents in the age group of 10-18 years. Key findings are mentioned below:

- **Vitamin A deficiency** was 16-22% with geographical variations.
- **Vitamin B12 deficiency** ranged from 14% to 31% and it was found to be highest among adolescents.
- **Vitamin D** deficiency varied from 14% to 24%.
- Adequate Median Urinary Iodine level in all states indicating the success of Salt Iodization program

CNNS provided the vital information on the coverage and continuity of a set of key nutrition and health interventions and policy initiatives for India's States and Union Territories.

Figure 10 below shows that the highest level of coverage for key nutrition interventions is barely 70% (for receiving any IFA), and that for most interventions, coverage is just about 50%. This provides a clear set of coverage targets at the national level for these high impact interventions.

Figure 10 : Coverage of a selected set of nutrition interventions in India, CNNS (2016-18)



Keeping the CNNS findings in the backdrop data collated from all States and UTs for the present report is analysed and, it is observed that the coverage levels for interventions along the continuum of care vary tremendously by State and by intervention within and across States (Table3; Annexure 3). For example, for a majority of interventions during pregnancy including antenatal care (ANC) during the first trimester, receiving MCP card, IFA supplementation, weight monitoring, and food supplementation, the coverage levels are between medium to high (50 percent to 75 percent). Coverage is lower than 50 percent for 4 or more ANC, consumption of IFA supplements, breastfeeding counselling, and health and nutrition education. It is noticeable that the coverage is higher than 75 percent for any ANC and TT injection. The variable coverage is not platform-dependent i.e., the ICDS or the health platforms. In several large and small States, coverage for ANC during the first trimester, 4 or more ANC, IFA supplementation, and weight monitoring was found to be higher than the national average.

The rates of institutional delivery and presence of skilled-birth attendant at birth are high nationally (83 percent) and across several States. Coverage of institutional delivery is lower than 75 percent in a few States but the presence of skilled-birth attendant at birth is high in such instances except in Arunachal Pradesh, Jharkhand, and Manipur. Institutional delivery is particularly low in Nagaland and Meghalaya. At the national level, coverage of postnatal care for babies is only 62 percent but it is 90 percent or higher in several States including Goa, Jammu & Kashmir, Kerala, Maharashtra, Punjab, Tamil Nadu, and Telangana.

Nationally, coverage levels for food supplementation (49 percent) and exposure to health and nutrition education (33 percent) during lactation period are low. However, the coverage is highly variable for these interventions across States (Figure 10). While coverage of food supplementation is higher than 75 percent in some States including in Andhra Pradesh, Chhattisgarh, Goa, Himachal Pradesh, Odisha, Telangana, and Uttarakhand, it is lower than 25 percent (ranging from 9 percent to 24 percent) in some other States including in Arunachal Pradesh, Delhi, Jammu & Kashmir, Nagaland and Uttar Pradesh. In case of health and nutrition education intervention, coverage levels are much lower in several States compared to the national average.

Food supplementation during early childhood is low at 42 percent and is marked by high inter-State variability. The reach of food supplements is highest in West Bengal at 91 percent but there are only few States where reach is higher than 75 percent. Coverage was lower than 25 percent in ten States (Figure 10).

At the national level, weighing of children at least once in 3 months was only 60 percent and only 48 percent of mothers of children who were weighed received counselling. There is high variability in coverage for these two interventions across the States. In some States greater than 75 percent of children were weighed. However, in a majority of the States, 50 percent or lower proportion of mothers were counselled on growth after weighing.

The coverage data indicate huge gaps in the coverage and continuity across the continuum of care. Achieving full coverage of interventions for every woman and every child remains a significant challenge with significant coverage gaps for most interventions. It is of concern that coverage is low for several interventions across the States although implementation is through the same national platforms.

3. Overall Implementation Score Computed for the Second POSHAN Abhiyaan Report

   To assess the implementation level of POSHAN Abhiyaan in all the States and Union Territories (UTs), data were gathered using questionnaires from the State/UT Women and Child Development (WCD) and Health Departments on four key themes including:

1. Governance and Institutional Mechanism
2. Strategy and Planning
3. Service Delivery and Capacities
4. Programme Activities and Intervention Coverage.

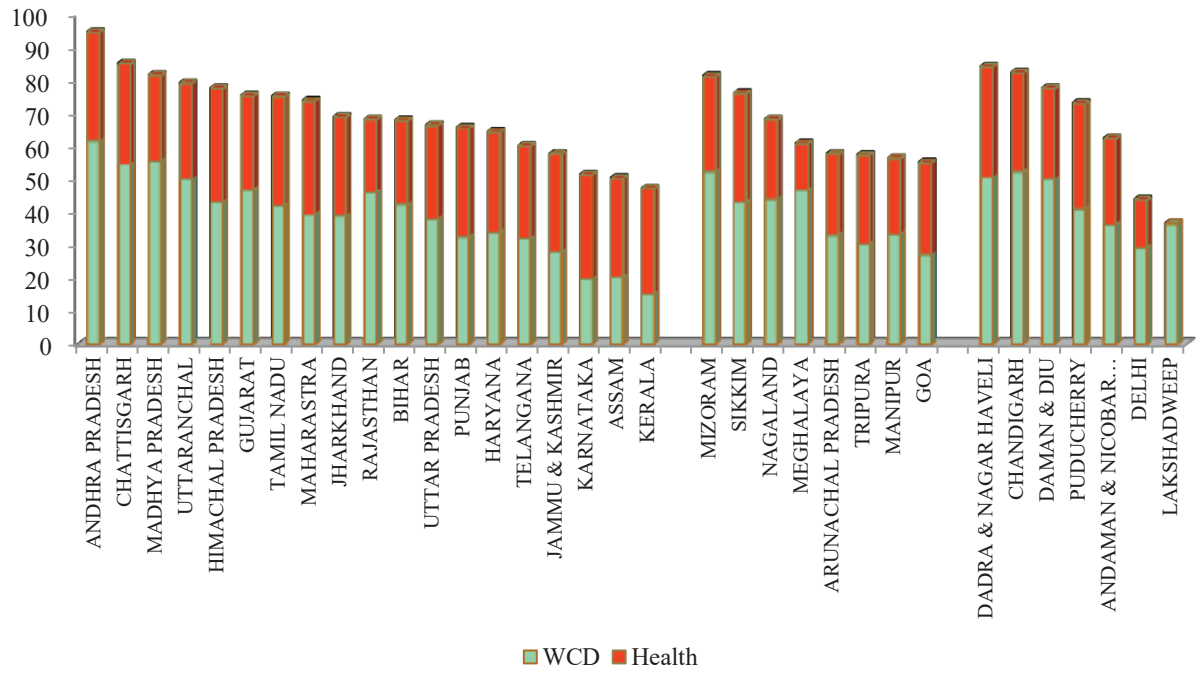
The process of data collection, compilation and computation of scores has been explained earlier in Chapter two. In this Chapter the scores of States and UTs for the implementation of POSHAN Abhiyaan, or their readiness for it, have been discussed.

An overall composite score was created combining all the four themes to examine preparedness and implementation capabilities of States and UTs. In terms of overall implementation in States and Union Territories (Figure 11), among the 19 **large States,** Andhra Pradesh, Chhattisgarh and Madhya Pradesh scored the topmost three ranks followed by Uttarakhand, Himachal Pradesh, Gujarat, Tamil Nadu and Maharashtra. Ten out of total 19 large States had an implementation score of over 70 percent. Karnataka, Assam and Kerala were at the bottom of the list, with an implementation lower than 55%.

Among the eight **small States,** Mizoram and Sikkim scored above 75 percent and were in the topmost position. Arunachal Pradesh, Tripura, Manipur and Goa were at the bottom of the list, with scores below 60%. However, all the small States had a score above 55%, displaying a fairly good level of readiness and implementation.

Four out of seven **UTs** had an implementation score of over 70 percent. Dadra and Nagar Haveli, Chandigarh, and Daman and Diu scored above 75 percent and were ranked among the top three UTs. Delhi, and Lakshadweep were at the bottom of the list, with implementation scores below 50 percent.

Figure 11: Overall Implementaion Status of POSHAN Abhiyaan- National Picture

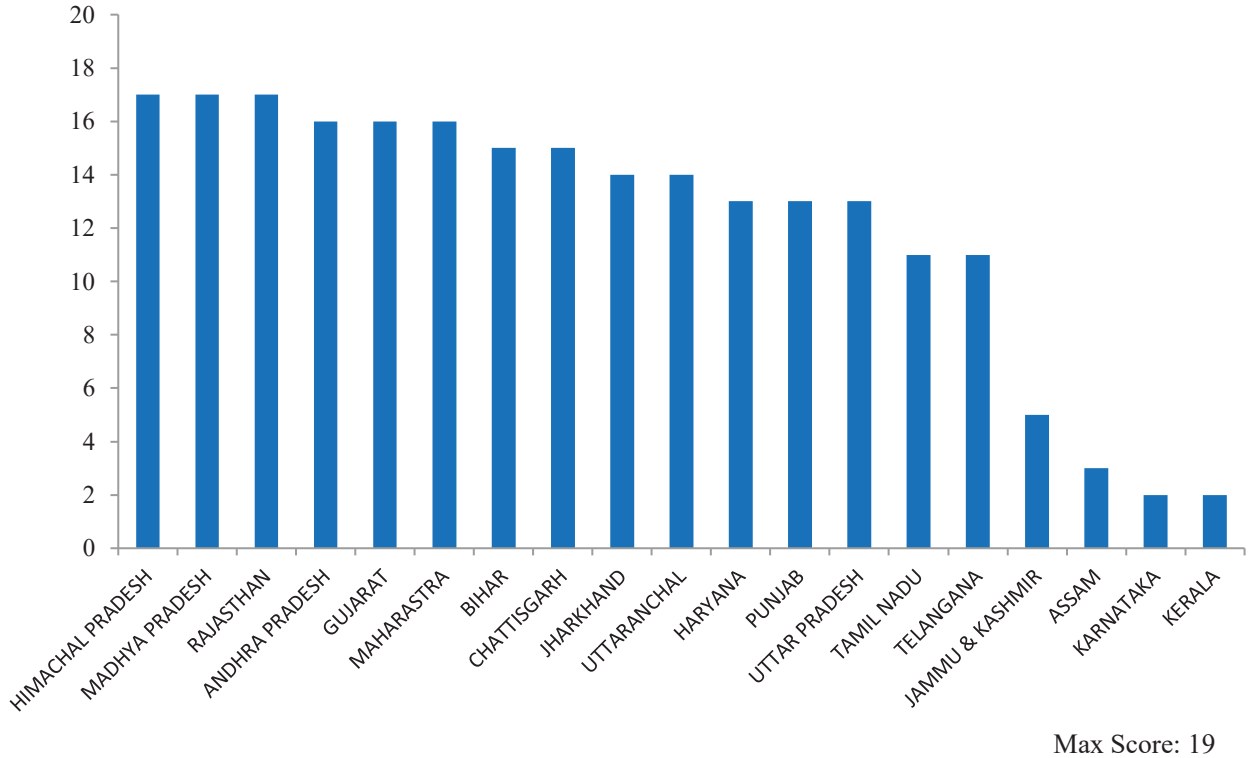


3.1 Governance and Institutional Mechanism

This theme captures the preparedness of States/UTs in terms of having the necessary Governance and Institutional structures in place, as envisaged under POSHAN Abhiyaan. One of the essential components of the Abhiyaan is fund utilization which acts as an interface to initiate effective implementation. All the large States have received funds from the Centre. Except Assam and Jammu & Kashmir, all large States, have earmarked funds to implement POSHAN Abhiyaan. Maharashtra has utilized maximum funds with close to 54.5 %. This is followed very closely by Karnataka and Bihar, with utilization rates of 40% and 35%, respectively. Similarly for small States all of them have received funds from Centre. Except Sikkim, Tripura and Manipur all other Small States have earmarked funds to implement POSHAN Abhiyaan. With respect to utilization of funds, Arunachal Pradesh, Meghalaya and Mizoram, have utilized maximum funds with more than 60%. This is followed very closely by Nagaland with utilization rate of 58%.

The Abhiyaan is fully funded in Union Territories without legislature (Andaman & Nicobar Islands, Chandigarh and Dadra & Nagar Haveli), implying that they do not need to earmark funds especially for this purpose. Therefore, for this particular parameter, they have given full scores. UTs with legislature (two out of seven- Puducherry and Delhi) have a cost sharing ratio of 60:40. For these UTs, earmarking of funds for the implementation of the Abhiyaan has been given a score on the basis of their affirmative response to the same. Findings suggest that all the UTs have received funds from the Centre. In terms of utilization of funds, Dadra & Nagar Haveli have utilized maximum funds with more than 60% utilization rate. This is followed very closely Chandigarh and Daman & Diu.

Figure 12:
Governance & Institutional Mechanism: Large States



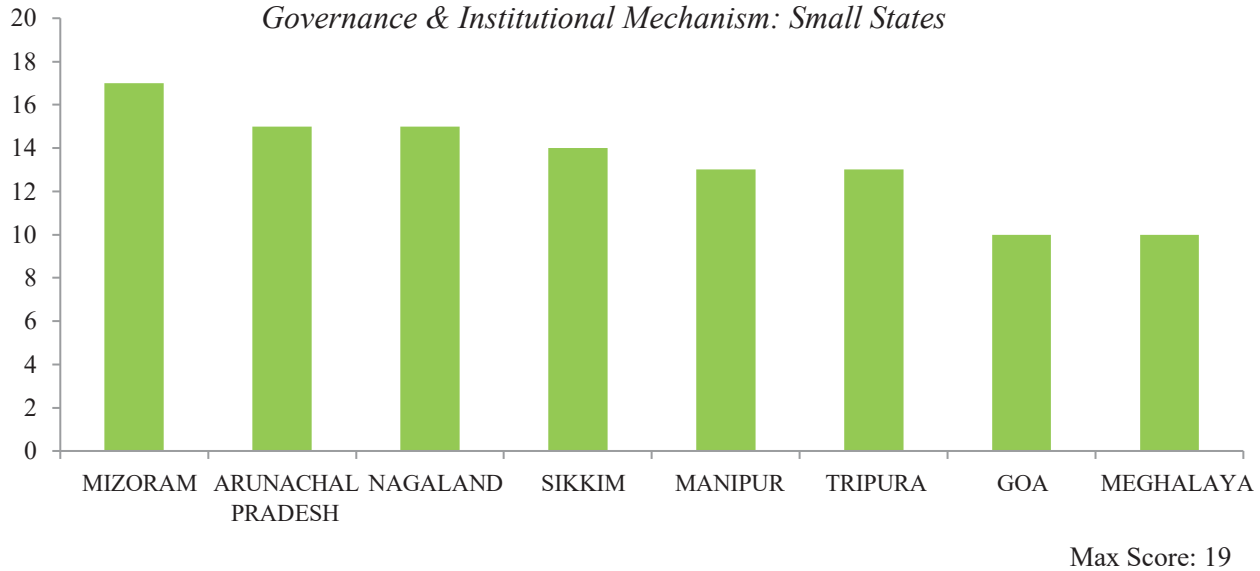
* Data collated only from WCD Departments of States and UTs

Another crucial institutional mechanism is convergent approach to ensure different inter-related schemes move from a siloed approach to a unified and convergent action to target malnutrition. For this, Convergence Committees are envisaged at the State, District and block levels to develop and follow Convergent Action Plans (CAPs).

Further under POSHAN Abhiyaan, Resource Groups are formed for Incremental Learning Approach (ILA) trainings at different levels to enhance the capacity of frontline workers. Finally, the Abhiyaan proposes a single unified technical set-up, i.e, Nutrition Resource Centre at National and State level to enhance and strengthen the quality of implementation and monitor and review the programme. These structures and processes are expected to provide overall direction, policy and guidance for timely, effective and smooth implementation of the Abhiyaan. Under the theme of Governance and Institutional mechanisms, overall, among the large States, Himachal Pradesh, Madhya Pradesh and Rajasthan are best prepared for implementation. These States are closely followed by Andhra Pradesh, Gujarat and Maharashtra (Figure 9). The States which were least prepared in Governance and Institutional mechanism included Kerala, Karnataka, Assam and Jammu & Kashmir, which scored five and below on a scale of 0 to 19.

Among the **small States,** Mizoram is the best prepared State in the area of Governance and Institutional mechanism closely followed by Nagaland and Arunachal Pradesh (Figure 13). Meghalaya and Goa are the least prepared States for the mentioned theme.

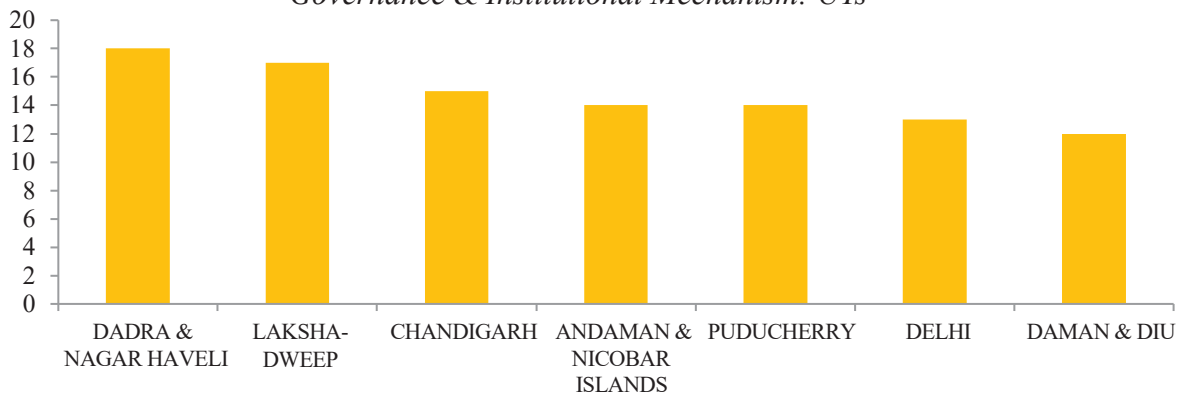
Figure 13:
Governance & Institutional Mechanism: Small States



*Data collated only from WCD Departments of States and UTs

Among the **UTs,** Dadra & Nagar Haveli followed by Lakshadweep are the best prepared UTs on Governance and Institutional mechanism (Figure 14). Daman and Diu scored the least in this area, closely followed by Delhi.

Figure : 14
Governance & Institutional Mechanism: UTs



Max Score: 19

*Data collated only from WCD Departments of States and UTs

Overall, in terms of Governance and Institutional mechanism, except a few large States including Kerala, Karnataka, Assam and Jammu & Kashmir most other States and UTs scored well demonstrating preparedness in Governance and Institutional mechanism.

3.2 Strategy and Planning

This theme examined the elements of cross-sectoral convergence and included two indicators-

1. whether a convergence action plan (CAP) has been submitted as part of the annual PIP;
2. a proportion of Districts with convergence action plans.

The score computed based on the information received from the State/UT WCD Department indicates that several States and UTs have not yet taken the initial steps toward cross-sectoral convergence.

On a scale of 0 to 6, only six large States ranked high on cross-sectoral convergence. These included Andhra Pradesh, Chhattisgarh, Madhya Pradesh, Uttaranchal, Uttar Pradesh and Punjab. States which scored a zero included Tamil Nadu, Maharashtra, Rajasthan, Bihar, Haryana, Telangana, Karnataka, Assam and Kerala. Remaining four States scored between 2 and 4 points.

From the eight small States, Sikkim and Nagaland were at the top of the list for cross-sectional convergence, closely followed by Meghalaya. All the others were least prepared for cross-sectional convergence, with a nil score.

Among the seven UTs, Chandigarh, Daman & Diu, and Andaman & Nicobar Islands ranked highest with a total score of 6. The remaining four UTs scored a zero on cross-sectoral convergence theme.

3.3 Service Delivery & Capacities

The theme of Service Delivery and Capacities was assessed using data from the State/UT WCD and Health Departments on human resources, supplies, and training and capacity building and information on infrastructure from State health departments.

Detailed indicator results of these components are discussed in Chapter 4. In this section the implementation scores for Service Delivery and Capacities theme have been analyzed.

The State scores on this theme, ranging from 0 to 31, based on the information from WCD State Departments indicate that several States need to create strengthened service delivery system for effective service delivery (Figure 15).

Figure 15: Service Delivery and Capacity: WCD Department

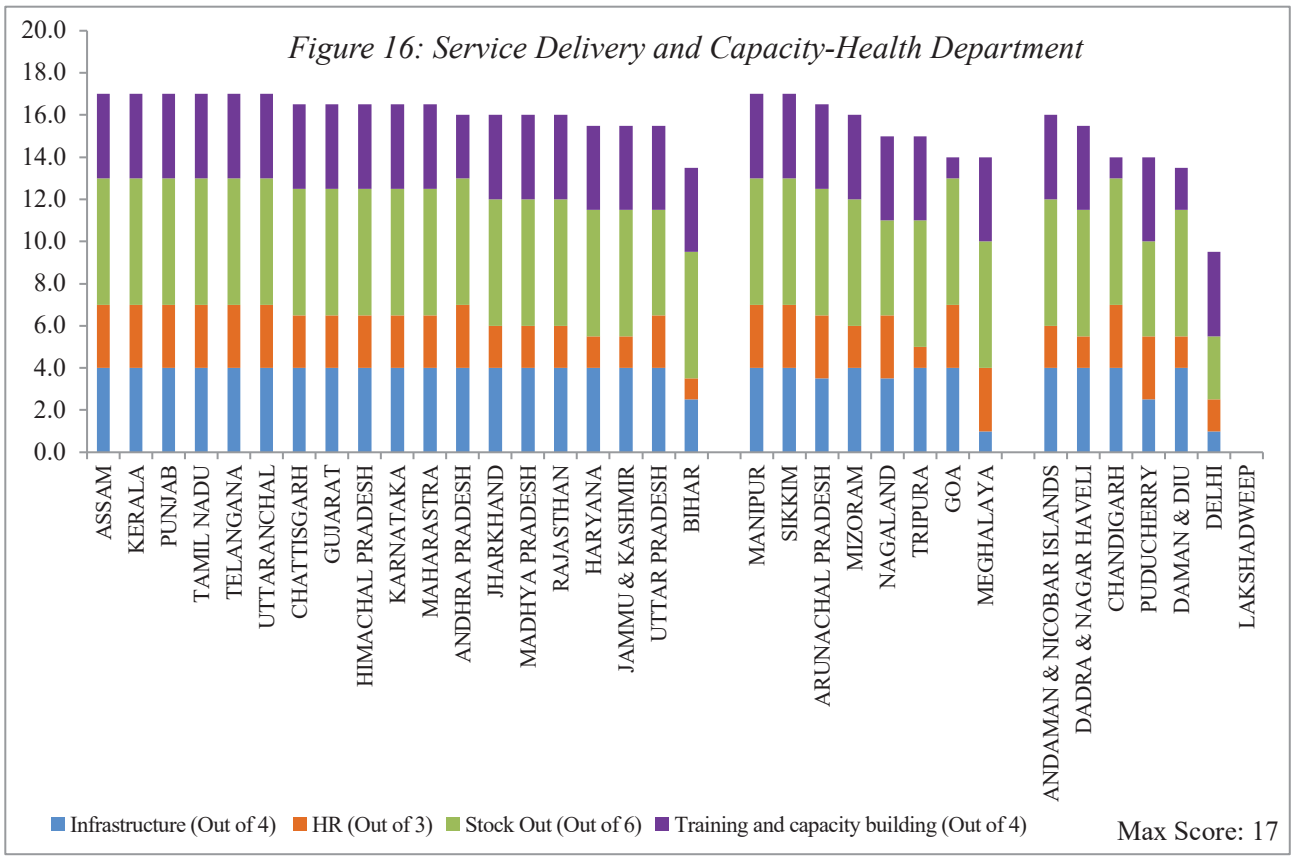
On a scale of 0 to 31, among **large States,** Andhra Pradesh scored the highest (30.7) followed by Tamil Nadu (28.2) and Chhattisgarh (24.7) on service delivery and capacities. Assam, Karnataka and Kerala were at the bottom of the list with a score 10 or less. Nine States that need to improve their service delivery and capacities include Himachal Pradesh, Maharashtra, Punjab, Haryana, Telangana, Jammu & Kashmir, Karnataka, Assam and Kerala.

In the case of **small States**, Mizoram, Meghalaya and Sikkim ranked high on service delivery and capacities. The remaining five small States scored less than 15 points and two of those States Tripura (8.5) and Arunachal Pradesh (9.2) scored less than 10 points.

Among the **UTs**, Dadra and Nagar Haveli, Chandigarh, and Daman & Diu scored the higher on service delivery and capacities. The remaining four UTs including Puducherry, Andaman & Nicobar Islands, Delhi and Lakshadweep scored less than 20 points.

Overall, most large and small States seemed to be doing fairly well in terms of health-related service delivery and capacities. Among **large States**, six States including Uttaranchal, Tamil Nadu, Punjab, Telangana, Assam and Kerala scored the highest possible score i.e., 17 points. Except Bihar all the large States scored above 15 points, which represented a good level of readiness and implementation in terms of health-related Service Delivery and Capacities (Figure 16).

Sikkim and Manipur were the two **small States** that scored the maximum possible points. Meghalaya and Goa were at the bottom of the list. Among the **UTs**, Andaman & Nicobar Islands was at the top of the list for health-related Service Delivery and Capacities. Delhi was at the bottom of the list and there was no information received from Lakshadweep.



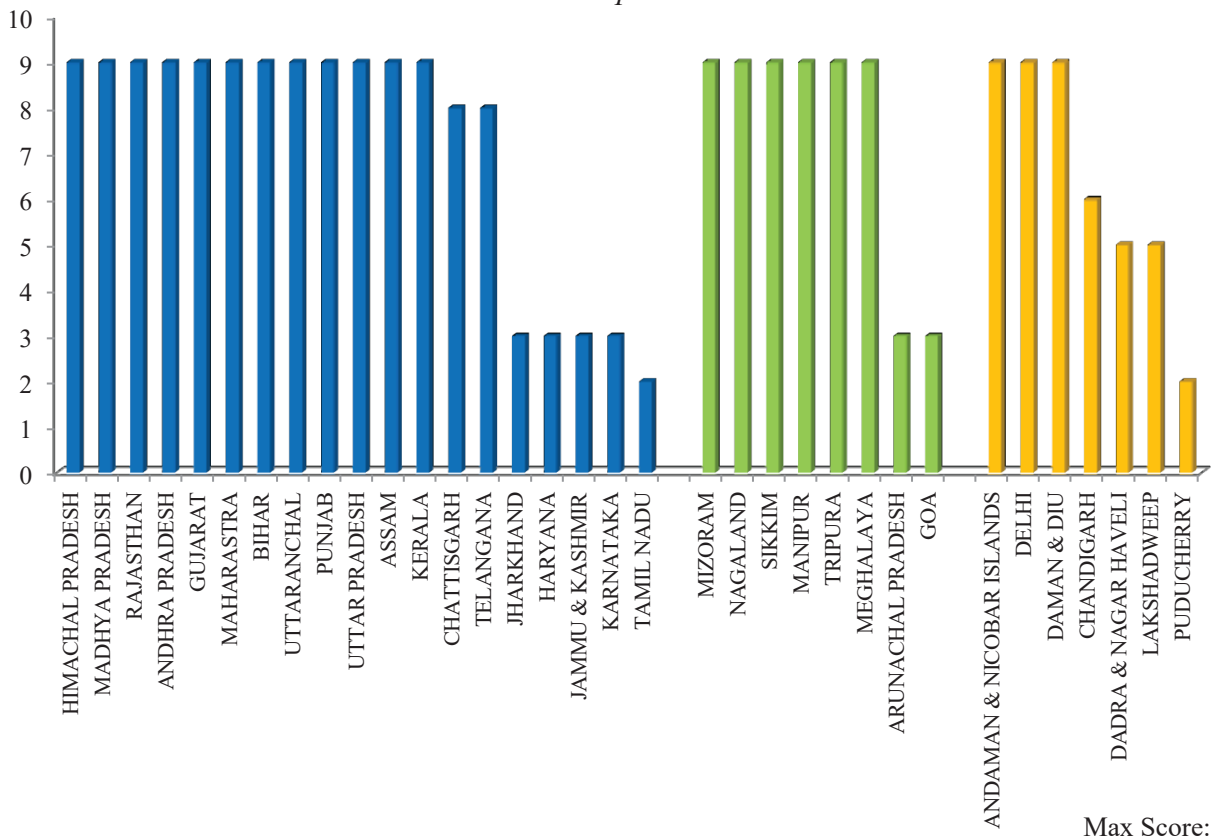
3.4 Program activities and intervention coverage

To assess the implementation score of States/UTs on programme activities and intervention coverage, information from States' WCD departments was received on a select set of interventions under ICDS, and from the health department on a select set of postnatal (children) and early childhood interventions. Detailed indicator results have been discussed in chapter 4. In this section, only implementation scores for programme activities and intervention coverage have been analyzed.

For **large States** on a scale of 0 to 9 points, 12 States scored the maximum score of 9 points and two States scored 8 points on the ICDS interventions. Four States including Tamil Nadu, Jharkhand, Uttar Pradesh, and Kerala scored 3 points while Punjab scored 2 points.

Other than Sikkim and Goa, all the other **small States** scored 9 points. Among the UTs, except Delhi, all other **UTs** scored 5 or more points on programme activities and intervention coverage pertaining to ICDS (Figure 17).

Figure 17: Program activities and intervention coverage-WCD Department



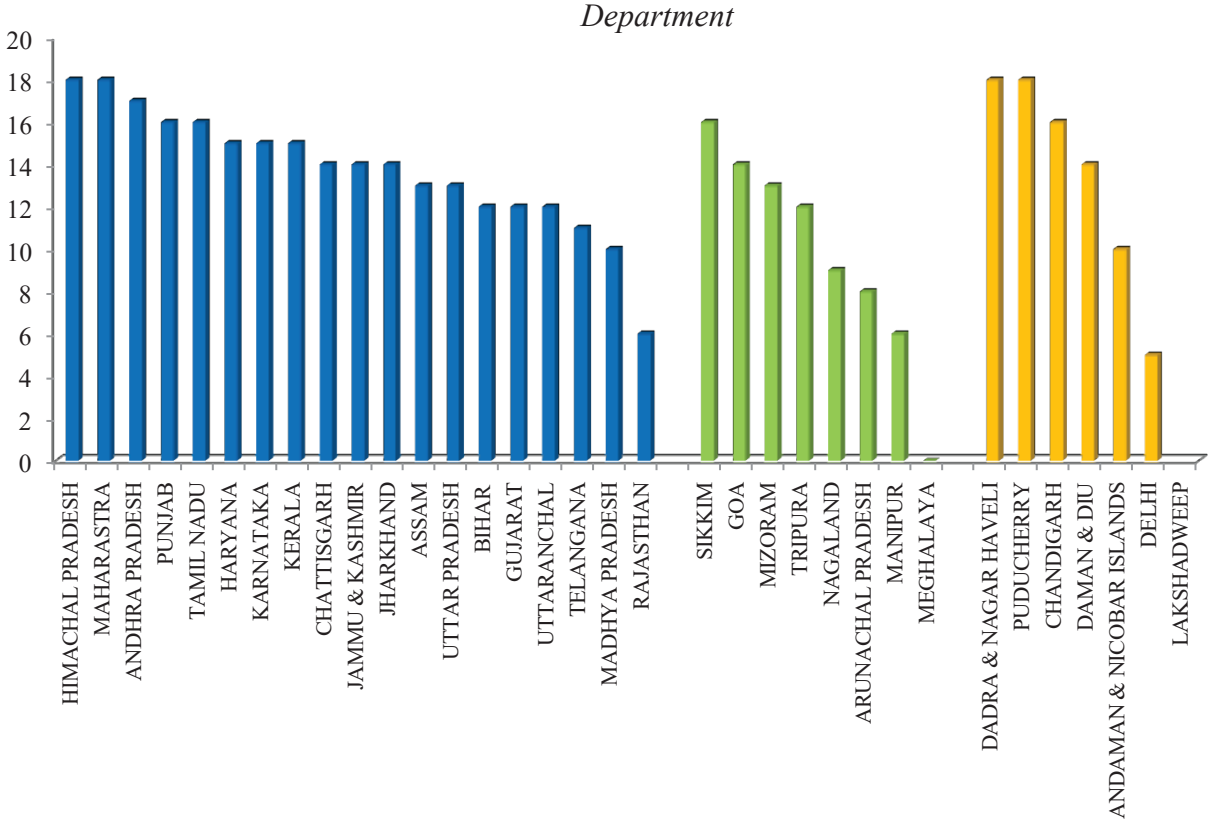
Based on information received from the State/UT health departments on a selected set of postnatal (children) and early childhood interventions, States/UTs were assessed on a scale of maximum 18 points (Figure 18).

Among the **large States**, Himachal Pradesh and Maharashtra scored the highest i.e., 18 points on the health-related programme activities and intervention coverage. . Andhra Pradesh, Tamil Nadu and Punjab followed closely. Rajasthan was at the bottom of the list scoring only 6 points.

Among the **small States**, Sikkim ranked the highest scoring 16 points, followed closely by Goa, Mizoram and Tripura. Meghalaya was at the bottom of the list with a nil score.

All the **UTs**, except Delhi and Lakshadweep scored high on the list of health-related programme activities and intervention coverage. There was no information received from Lakshadweep.

Figure 18: Program activities and intervention coverage-Health Department



CHAPTER 4:

SCALING UP POSHAN ABHIYAAN BY DELIVERING CORE INTERVENTIONS AT SCALE TO ENSURE COVERAGE, CONTINUITY, INTENSITY AND QUALITY - C^2IQ

4.1 Background:

POSHAN Abhiyaan aims to reduce stunting, anemia, and low birthweight across high malnutrition burden Districts. It recognizes the need for convergence and coordination such that the benefits of government schemes and programs reach women and children in the first 1000 days. The POSHAN Abhiyaan lays out targeted determinants of nutritional outcomes that exist in various schemes and programs. These include maternal nutrition, newborn care practices, infant feeding and care practices and underlying determinants, such as age at marriage, age at first birth and sanitation (Figure 16).

To achieve the ambition of a malnutrition-free India, it is imperative to ensure that the package of programmatic interventions is implemented with adequate coverage, continuity, intensity and quality (C2IQ). High impact interventions need to be implemented such that they cover 80-90 percent of eligible populations in a C2IQ framework and are monitored on a quarterly basis. The mission-mode approach provides an impetus to strengthen not just the implementation but also the monitoring and measurement of progress.

Interventions for POSHAN Abhiyan

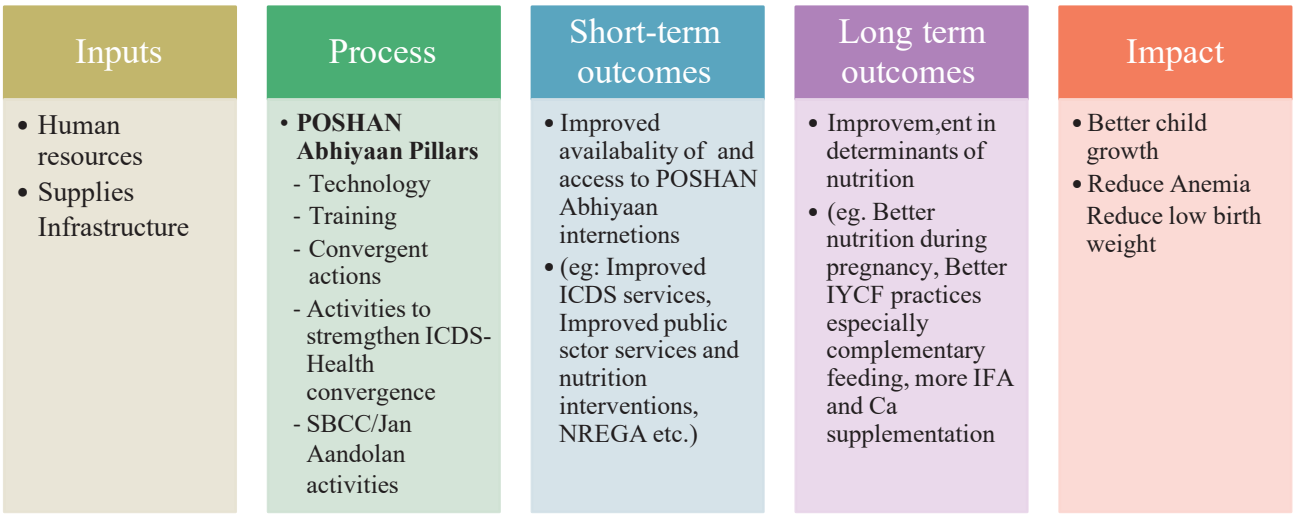
Girl / adolescent / woman	Newborn and child	Swachh

• Care and education of the girl child: Beti bachao, beti padao
• Adolescent girl care: Food , micronutients, healthcare, life style, preparation as adult
• Right age for child birth: Marriage after 18 years, childbirth after 20 years
• Pre-pregnancy care: Food, micronutrients, contraception
• Birth sapcing: Gap between births more than 2-3 years
• Antenatal care: checks for complication detection, food, iron-folic acid, tetanus immunization, birth preparedness, treatment of complications
• Skilled birth attendance and emergency obstetric care: Facility birth, emergency obstetric care
	• Newborn care:
	  • Care at birth, hygiene, cord care
	  • Breast feeding: within one hour, exclusive for six months, cpntinuling for 2 years or more
	  • Extra care of low birth weight baby
	  • Kangaroo mother care
	  • Care of the sick and small neonate
	• Complete immunization: Including rotavirus and pneumococcal Vaccines
	• Breast feeding upto 2 years and more
	• Complementary feeding: From 6 months onward; culturally appropriate recupes, hygienc, increaing amount, adequate in nutrition
	• Growth monitoring
	• Care of the undernourished child
	• Care in severe acute malnutrion
	• Early stimulation and child development
	• Early detection and care of illness: For diarrhea (including ORS and zinc), pneumonia (including antibiotics) and other illnesses; referral
	• Supplements:
	  • Supplementary nutrition
	  • Iron-folic acid
	  • Vitamic A supplementation
	• Deworming
		• Swachh: Sanitation, safe water, hand washing, toilet use (mother) and safe disposal of feces

Figure 19: Interventions in POSHAN Abhiyaan

Although a majority of these interventions are part of the national health and nutrition programs in India, the coverage of these interventions is highly variable - by life stage, by intervention, by State, and by District.

4.2 Theory of Change for POSHAN Abhiyaan:



The efforts behind scaling up POSHAN Abhiyaan interventions are based on several assumptions that map to the key pillars of POSHAN Abhiyaan (using technology, improving capacities, the convergence of multiple programs and behaviour change communication).

- First, it assumes that a set of core POSHAN Abhiyaan pillars (technology, training, processes to support convergence, and Jan Andolan) will trigger a series of changes that improve the availability and quality of nutrition interventions in the ICDS and health system, and interventions to address underlying challenges of gender, sanitation, and poverty.
- Second, it assumes that putting these interventions in place will address both the immediate and underlying determinants of poor nutritional outcomes. These determinants include dietary practices for women and children, use of micronutrient supplements and food supplements, sanitation practices and more.
- Finally, the theory of change assumes that these will lead to improved outcomes such as child growth, reduction in anemia and other targets of the nutrition mission.

In this chapter, we focus on the status of the core programmatic platform inputs, the roll-out of the POSHAN Abhiyaan pillars and the coverage of POSHAN Abhiyaan interventions. In describing these, we use a combination of data provided by the State Governments (for inputs and program roll-out) and from surveys (for program coverage). In all the results, we present findings separately for the 19 large States, the 8 small States and the 7 Union Territories (UTs).

4.3 INPUTS

Program inputs related to the ICDS and health platforms are critical for functioning of POSHAN Abhiyaan pillars. These **include funding, human resources, supplies,** and **infrastructure**. Below, we describe the status of these, using data provided by the State Governments and data compiled for other programs under the ambit of POSHAN Abhiyaan.

a. Fund allocation & utilization

Funds are critical to initiate, implement, and sustain processes required for delivering interventions including staffing, supplies and infrastructure. From the information shared by the States/UTs, it is evident that all the large States have received funds from the Centre. Except Assam and Jammu & Kashmir, all **large States**, have earmarked funds for POSHAN Abhiyaan. With respect to the utilization of funds, Maharashtra has utilized the maximum amount, close to 55 percent, followed by Karnataka (40 percent) and Bihar (35

percent). In Punjab, Kerala, Haryana, and Jharkhand the utilization level of funds has been 5 percent or less; in Chhattisgarh and Uttar Pradesh, it was less than 10 percent. In the remaining large States, fund utilization ranged between 19 and 33 percent.

All the small States reported receiving funds from the Centre. Except Sikkim, Tripura and Manipur, all other **small States**, have earmarked funds for POSHAN Abhiyaan. With respect to utilization of funds, Arunachal Pradesh, Meghalaya and Mizoram, utilized more than 60 percent of funds followed by Nagaland (58 percent). In the remaining small States, fund utilization ranged between 20 and 44 percent. None of the funds were utilized in Goa.

In **UTs** where there is no State legislature including Andaman & Nicobar Islands, Chandigarh, Dadra & Nagar Haveli, Daman & Diu, and Lakshadweep, POSHAN Abhiyaan is fully funded, implying that they do not need to earmark funds. UTs with legislature including Puducherry and Delhi have a cost sharing ratio of 60:40 with the Center. All the UTs reported receiving funds from the Centre. Dadra & Nagar Haveli utilized more than 60 percent of funds followed by Chandigarh (58 percent) and Daman & Diu (56 percent). Funds utilization level was lowest in Delhi at 4 percent. In the remaining UTs, funds utilization was lower than 40 percent.

Low level of fund utilization is a matter of concern in most States and UTs. None of the large States, except Maharashtra, has utilized more than 50 percent funds. Only four out of eight small States, and three out of seven UTs have reached a utilization level of more than 50 percent.

b. Human Resources

Human resources are critical for implementation of any of the interventions. Here we describe the status of staffing at multiple levels in the ICDS and health systems as reported by the States. The expected steps to ensure overall convergence at the State/UT level are to establish State Project Management Units (SPMUs), set up Convergence Action Plan (CAP) committees at State, District, block levels and develop convergent action plans at these administrative levels. This indicator is mentioned under Convergence Section of the Report, however it is critical indicator to be discussed under HR related issues as well.

- ***District Program Officers (DPO), Child Development Project Officers (CDPOs), Lady Supervisors (LS), Anaganwadi Workers (AWWs) and Anganwadi Helper (AWHs) positions***

  In eight of the 19 **large States**, all the DPO positions were filled. Only in Assam, less than 50 percent of DPO positions were filled. In five of the small States, all the CDPO positions were filled. More than 90 percent of LS positions were filled in five large States (Assam, Gujarat, Kerala, Madhya Pradesh) and less than 60 percent of LS positions were filled in three large States (Bihar, Rajasthan, Uttar Pradesh). Between 61 percent to 85 percent of LS positions were filled in the remaining large States. More than 90 percent of AWW and AWH positions were filled in a majority of the large States. Only in Bihar (82 percent) and Uttar Pradesh (89 percent) less than 90 percent of AWH positions were filled.

  In case of **small States**, except in Manipur and Tripura, all the CDPO positions were filled. In a majority of small States, all the DPO positions are filled. Similarly, in five States (Arunachal Pradesh, Goa, Manipur, Meghalaya, Sikkim) all LS positions were filled. In Mizoram and Nagaland more than 80 percent of LS positions were filled. In Tripura, only 52 percent of LS positions

were filled. Nearly all small States had all AWW and AWH positions filled.

- ***Lady Health Visitor (LHV) & ANM positions***

  Among the **large States**, in 14 States, more than 75 percent of ANM positions were filled and a similar situation was observed for LHV positions in 10 States. In 4 of the small States, more than 90 percent of ANM posts were filled; in Arunachal Pradesh all ANM positions were filled. In Mizoram, only 32 percent of LHV positions were filled and information was not available for Tripura. In the remining **small States** more than 85 percent of LHV positions were filled. In 4 **UTs,** more than 95 percent ANM posts were filled.

  Adequate staffing is important to ensure reach of interventions with quality and intensity. Therefore, there is an urgent need to close gaps in human resources to facilitate implementation. The gaps in supervisory positions particularly impede delivery of interventions with quality.

- **Establishment of State Project Management Unit (SPMU)**

  In many States and UTs, State Project Management Units (SPMUs) were established. However, the level at which posts were filled in these SPMUs varied greatly. SPMUs were established in 17 large States (except Punjab and Karnataka). In four large States more than 80 percent of the SPMU posts were filled while in three States more than 70 percent posts were filled. Only in Gujarat 100 percent of the posts were filled. In Uttar Pradesh and Haryana, less than 5 percent of the posts are filled. In the remaining large States less than 50 percent SPMU posts have been filled.

  Among the 8 **small States**, the SPMUs were established in 6 States (except Manipur and Goa). In Mizoram 73 percent of the SPMU posts were filled while in Meghalaya only 25 percent posts were filled. In the remaining small States none of the posts were filled. In four UTs more than 75 percent of the SPMU posts were filled. None of the posts were filled in Puducherry and Delhi.

- **Pradhan Mantri Matru Vandana Yojana (PMMVY)**

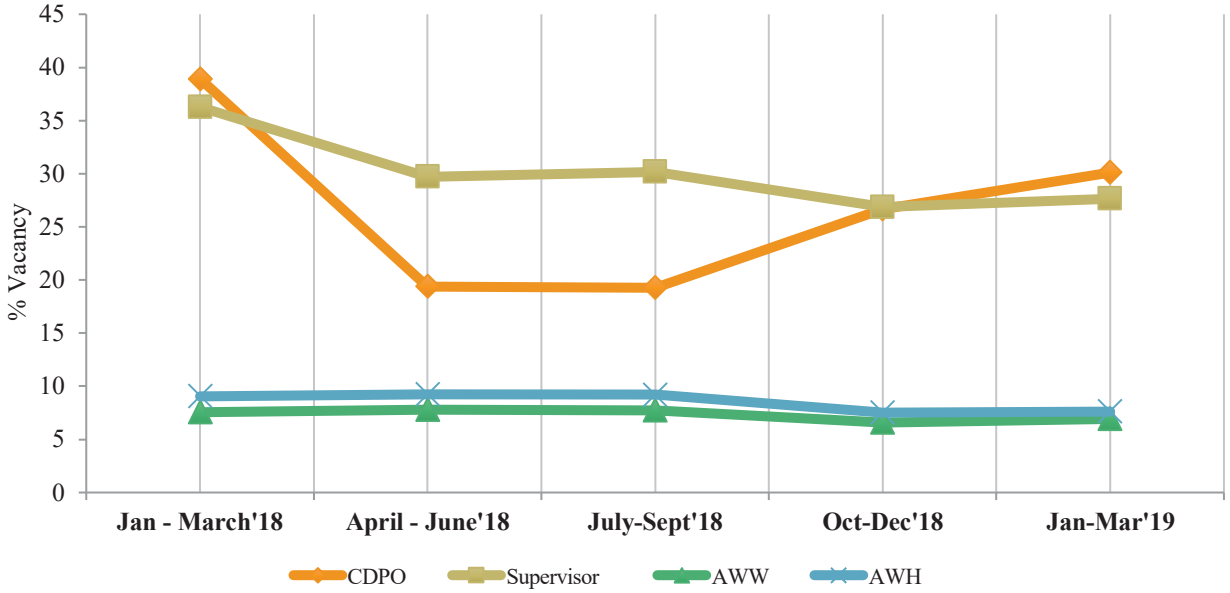
  In the Pradhan Mantri Matru Vandana Yojana (PMMVY) of MoWCD, against the provision of hiring 60 contractual staffs at State level and 1,434 contractual staffs at District level across the States and UTs, so far 42% and 26% recruitments have been done at State and District levels respectively (MoWCD data as on 18 February 2019).

Trend in year 2018-19

Analysis of the trend of vacancy at these levels under ICDS in last one year reveals that progress has been made to fill-up the vacant positions. The below figure 20 presents the trend, wherein it is evident that around 10% decline in the vacancy of CDPOs and Supervisors has been observed in last one year. The vacancies of Supervisors are on constant decline whereas CDPO vacancy has increased in the last quarter.

The current position of human resource deployment against the sanctioned position under ICDS, POSHAN Abhiyaan and PMMVY has been analysed and few feasible measures have been suggested that are in conformity with Guidelines of these Schemes.

Figure 20: Trend of HR vacancy at different levels under ICDS in the last one year



MoWCD, Data as on 31st March 2019

Measures suggested for improving the vacancy status

The Ministry of Women and Child Development has been communicating with the States and UTs on the need for filling-up the vacancies under the ICDS/PMMVY/POSHAN Abhiyaan. It has suggested several measures to provide flexibility so that they could speed-up their recruitment process:-

i) In the letter addressed to all Secretaries dealing with ICDS dated 15th Sept., 2015, the Ministry had communicated that "50% of vacancies in the posts of Supervisors would be filled up by promotion from amongst AWWs with 10 years of experience as AWWs and having the prescribed educational qualification as per the Recruitment Rules for the post of Supervisor".

On mere implementation of the above Order (subject to adherence of qualification and education norms), the **Lady Supervisory level vacancy will reduce by 50%**, whereas vacancy at AWW level will increase only by 0.5%. Also, this will enhance work efficiency amongst the AWWs to perform better to graduate to the higher level.

ii) In order to fast track the filling of vacant position of CDPOs, the Ministry in its letter to all Chief Secretaries of States and UTs dated 06th Feb, 2019 has allowed to recruit the afore mentioned personnel "on contract basis till such time the vacancies are filled on regular basis". The selection procedure and salary norm for such contractual appointment has also been provided in the said letter. With this measure, **all CDPO level vacancies may be filed within 3-6 months timeline on contract basis.**

iii) In the above mentioned letter dated 06th Feb, 2019, the Ministry has also mentioned about its previous Order where the District Magistrates has been authorised to recruit the AWWs and Supervisors at his/her level. **By implementing this measure, the remaining 50% vacancy at the Supervisor level and all vacancies at AWW level may be filled within 3 months.**

For newly launched Schemes of PMMVY and POSHAN Abhiyaan, MoWCD needs to persuade the States and UTs to fill-up contractual positions at State, District and Block levels so that the Schemes could perform well. Also, MoWCD should monitor HR vacancy status under these Schemes constantly and communicate to the States/UTs raising the concerns at the highest levels.

*c. **Supplies***

- **Growth monitoring devices**

  The distribution levels of growth monitoring devices including weighing scales for infants and adults, and height measuring instruments - infantometers, and stadiometers varied across the States and UTs. Among the **large States**, 9 States reported not distributing any of the infant or adult weighing instruments. Three States distributed 50 percent or fewer scales. Among the **small States**, three of them distributed 100 percent of the required weighing scales while 4 others did not distribute any weighing scales. In four out of seven **UTs**, 100 percent of the required weighing scales were distributed (Table 5; Annexure 3).

  In eight **large States** and four **small States** and in one **UT**, none of the height measurement instruments were distributed. In three large States, and in four small States and UTs, 100 percent of the required height measuring devices were distributed. As availability of a measuring instrument is the first step in ensuring that measurement takes place, this huge gap in lack of instruments at the AWCs needs immediate attention.

- ***Stock-out of IFA red tablets, TT injections, and albendazole in the month of Feb 2019***

  For an effective implementation of some pre-pregnancy and postnatal interventions, it is essential to have an adequate level of stocks of IFA red tablets, TT injections, and albendazole. Most of the States and UTs seemed to have a good level of stocks of these supplies.

  None of the **States and UTs** reported stock-out of IFA red tablets in Feb 2019, except Nagaland (100 percent stockout), Uttar Pradesh (1 percent stockout) and Delhi (82 percent stockout). No information was received from Lakshadweep.

  None of the States and UTs reported stock-out of TT injections in Feb 2019, except Uttar Pradesh (23 percent). No information was received from Lakshadweep.

  None of the States and UTs reported stock-out of albendazole in Feb 2019, except Madhya Pradesh (11 percent), Uttar Pradesh (67 percent) and Delhi (100 percent). No information was received from Lakshadweep.

*d. **Infrastructure***

For some of the health interventions to be delivered, it is essential to have functional Community Health Centres (CHCs) and sub-centres. In nearly all **large States**, 100 percent of CHCs were reported to be functional, except in Bihar (33 percent), Punjab (99 percent), and Uttar Pradesh (87 percent). Similarly, in a majority of large States all sub-centers were reported to be functional except in Assam (97 percent), Bihar (60 percent), Jammu & Kashmir (96 percent), Jharkhand (92 percent), and Rajasthan (94 percent).

In nearly all **small States** 100 percent of CHCs were functional, except in Meghalaya (information unavailable) and Tripura (88 percent). Only in 4 small States 100 percent of sub-centers were functional. In all UTs, except in Delhi and Lakshadweep, 100 percent of CHCs and sub-centers were reported to be functional. No information was received from Delhi and Lakshadweep.

What's working well	What needs attention
• Most AWW and helper positions and ANM positions are filled across States. This is encouraging as they are the key personnel to ensure the delivery of interventions. • *Growth monitoring* devices procurement and distribution is high. • *Low levels* stock-out of supplies across States is encouraging. • *All* CHCs and sub-centres are functional in a majority of the States.	• Low levels of fund utilization across State and UTs is a matter of concern. It is important to identify the reasons for low fund utilization and identify opportunities to improve it. • Supervisory cadre positions need to be filled. These are critical to ensure that the frontline functionaries are supported to deliver services. • Attention is needed to close gaps in procurement and distribution of growth monitoring devices in some States. • Remaining State-level supply gaps for IFA, TT, and albendazole tablets need to be closed. Attention is needed to ensure that distribution further down the chain is not hampered. • Infrastructure challenges linger in some States and need attention, especially in high burden States like Bihar.

BOX 2: Challenges reported by State/UT Governments on strengthening inputs needed to implement POSHAN Abhiyaan actions

Human Resources

Human resource gaps at different levels were identified as an impediment by 11 States including Assam, Bihar, Chhattisgarh, Jammu & Kashmir, Haryana, Madhya Pradesh, Maharashtra, Nagaland, Puducherry, Punjab and Uttarakhand. In the case of Haryana, vacancies could not be filled due to the imposition of the Model Code of Conduct.

- With preparation for 2019 General Elections underway, many skilled personnel were engaged in election duties in Bihar and Telangana.
- Bihar reported that in addition to election duties, personnel were also involved in invigilating exams.
- Assam mentioned that ICDS field-level officials and AWWs were engaged in work related to the National Register of Citizens.
- Tamil Nadu faced several challenges with the Commcare App which does not allow for data to be edited or elaborate information of beneficiaries to be entered which would prevent duplication and exclusion.
- Uttarakhand specified engagement of resource group members in other departmental work because of which rollout was delayed.
- Maharashtra also mentioned delays in overall rollout of POSHAN Abhiyaan because of delays in lack of HR personnel, and imposition of the Model Code of Conduct, resulting in long administrative processes.

Supplies

Three States/UTs including Andaman and Nicobar Islands, Chhattisgarh and Jammu & Kashmir faced issues related to the distribution and maintenance of growth monitoring devices. Andaman and Nicobar Islands faced procurement issues, while Chhattisgarh cited challenges in maintaining machines as well as the need to develop the skills necessary to correctly use them. In Jammu & Kashmir, hilly terrain has led to slow distribution of devices to AWCs. Maharashtra also reported challenges related to procuring and distribution of devices.

Infrastructure

None of the States reported explicit challenges related to infrastructure.

Source: Data provided by the State/UT governments in response to questionnaires sent out by NITI Aayog, May 2019

4.4 TECHNOLOGY

The ICDS-CAS application functions through a mobile application at the level of AWW and LS and through a dashboard at the higher levels. The application digitizes 10 of the 11 registers of the AWWs, provides a supervisory application to the LS, and a dashboard application to CDPOs, DPOs as well as to officials at the State and at the central level to be able to monitor Anganwadi Center (AWC) activities.

We examine four major technology-related implementation components, by State. These include the **availability of mobile devices, the establishment of technology support, training of functionaries at multiple levels and the availability/training in the use of the dashboard.**

The data used to assess these is based on responses from the State governments to the questionnaire sent out by NITI Aayog in May 2019.

a. Mobile phone devices

The first step in ICDS-CAS functionality is availability of the mobile devices. The distribution level of mobile phones varied in States and UTs. Among **large States**, only in Andhra Pradesh mobile phones were distributed to all Districts. In ten large States, the distribution levels were between 19 and 39 percent Districts. Mobile phones were not distributed to any of the Districts in Assam, Gujarat, Haryana, Karnataka, Kerala, Punjab, and Maharashtra. In Jammu & Kashmir, phones were distributed to only 2 percent of the Districts.

Among **small States** In Goa and Meghalaya mobile phones were distributed to all the Districts. In Mizoram, phones were distributed to nearly 62 percent of the Districts. In the remaining five States, mobile phones were not distributed to any of the Districts. In four UTs mobile phones were distributed to more than 85 percent of the Districts, and in the remaining three UTs, phones were not distributed to any of the Districts (Table 6; Annexure 3).

b. Technology support

Establishing a helpdesk provides the technology support required for the smooth implementation of ICDS-CAS. Among the **large States**, in Gujarat, Maharashtra and Rajasthan, helpdesks have been established in almost all the Districts. Of the remaining 16 large States, helpdesks have been established in less than 50 percent of the Districts in seven States and in none of the Districts in nine States. Among the small States, helpdesks have only been established in Mizoram and Sikkim. Among the seven UTs, helpdesks have only been established in Andaman & Nicobar Islands and Daman & Diu (Table 6; Annexure 3).

Access to ICDS-CAS dashboard and training in the use of the ICDS-CAS dashboard

Data from the ICDS-CAS goes into the State nutrition dashboards, providing an overall snapshot for monitoring. Among the large States, 11 States have access to this ICDS-CAS dashboard. Only four small States and four UTs have this access. Much also needs to be done to complete the training of field functionaries on the use of the dashboard in ICDS-CAS in the States and UTs (Table 7; Annexure 3).

More than 75 percent of DPOs and CDPOs were trained on using ICDS-CAS dashboard only in three of the large States (Andhra Pradesh, Tamil Nadu, Jharkhand). None of the DPOs were trained in seven small States except in Meghalaya where only 20 percent of the DPOs were trained. In case of CDPOs training, among small States, all the CDPOs in Mizoram, 64 percent in Goa, and 28 percent in Meghalaya were trained in the use of the dashboard. None of the CDPOs in the remaining five States were trained. Among the UTs, only in Puducherry all the DPOs were trained. Only in Dadra & Naga Haveli, Daman & Diu, and Chandigarh all the

CDPOs were trained in the use of dashboard.

More than 75 percent of LS were trained only in two large States (Andhra Pradesh, Tamil Nadu). Among small States, only in Goa all the LS were trained on using the ICDS-CAS dashboard or mobile. None of the LS received training in Arunachal Pradesh, Manipur, Tripura, Nagaland and in the remaining small States between 50 to 62 percent of LS were trained. In Dadra & Nagar Haveli, Chandigarh, and Daman & Diu, all LS were trained in ICDS-CAS dashboard use. Overall, a high proportion of ICDS functionaries remain untrained on ICDS-CAS dashboard/mobile and this requires immediate attention of the States and UTs.

BOX 3: State-level challenges related to strengthening technology in the context of POSHAN Abhiyaan

Connectivity, procurement and device-related challenges are the most common problems reported by the States in rolling out ICDS-CAS.

Connectivity issues

Poor connectivity is cited as the most common impediment to mobile phone functioning at ground level. This was reported by States such as Bihar, Chhattisgarh, Mizoram and Nagaland. While Bihar, Chhattisgarh and Nagaland face these issues in remote areas, Mizoram attributes this connectivity issue to its geographical terrain. Other States/UTs that report network connectivity issue hampering the implementation of ICDS-CAS include Jharkhand, Lakshadweep, Madhya Pradesh, Meghalaya, and Puducherry.

Procurement and device-related problems

In Haryana, Jammu & Kashmir, Maharashtra and Punjab, the implementation of ICDS-CAS has been hampered by delays in training and procurement. Punjab mentions pending bids as a problem to the smooth functioning of mobile phones because of which mobile phones have not even reached 16 Districts. Issues related to app and device performance and usability are reported by Chandigarh, Daman and Diu, Madhya Pradesh, and Tamil Nadu. Tamil Nadu has encountered storage issues where the app on the mobile phone does not allow for recording of details once the count of beneficiaries crosses 200.

Other State-specific issues

Punjab and Rajasthan face budget constraints, while in Maharashtra, vacancies posed a significant challenge for the implementation of ICDS-CAS. In Himachal Pradesh, ICDS-CAS is not linked with PMMVVY, leading to the exclusion of some beneficiary groups. And in Uttarakhand, discrepancies in paperwork have led to issues in data collection and phone configuration.

Source: Responses provided by State governments to questionnaires sent by NITI Aayog, May 2019

Summary

What's working well	**What needs attention**
Mobile phone procurement and distribution is moving well with variable achievement of reach of procurement and distribution across States.	- *Helpdesk set-up* needs attention across the board as it is critical for frontline worker support in using ICDS-CAS - *Dashboard access* needs to expand across all States. - Immediate attention is needed for training ICDS functionaries on the use of dashboard and mobiles. - Connectivity challenges need to be addressed to ensure ICDS-CAS functioning at the village level.

4.5 TRAINING

Training is an integral component of POSHAN Abhiyaan. It is intended to strengthen the capacity of frontline workers (FLWs) to deliver services in a timely, efficient and effective manner. Twenty-one Incremental Learning Approach (ILA) modules were developed and launched to train FLWs to improve their knowledge and skills in an ongoing and incremental manner. Key capacity building related components to roll out this training include the establishment of resource groups for training, and the actual training of frontline providers.

a. Establishment of training resource groups

- **State-level resource group for ILA training established**

  The State-level resource groups for ILA training were established in all States and UTs, except in Karnataka.

- **District-level Resource Group (DRG) for ILA training established**

  Nearly all large States have established all the required DRGs for ILA training, except in Assam, Karnataka, Kerala and Jammu & Kashmir. Jammu & Kashmir had the lowest proportion of established DRGs at 41 percent. All small States have established DRGs except in Arunachal Pradesh (84 percent). Except in Daman & Diu, all the DRGs were established in the UTs.

- **ILA training for District Resource Groups (DRGs)**

  In most States and UTs, ILA training for DRGs has been initiated. Except in Telangana, Jammu & Kashmir, Karnataka, Assam and Kerala, ILA training has been initiated for DRGs in 14 large States. In 11 of the States, more than 75 percent of DRG members have been trained, and in three States between 50 and 75 percent of DRG members have been trained.

  Except in Tripura and Goa, ILA training has been initiated for DRGs in six small States. Of these, in four States, more than 75 percent of DRG members were trained. Except Daman and Diu, and Lakshadweep, ILA training has been initiated for DRGs in five UTs. Of these, in four UTs, more than 75 percent DRG members have been trained

- **Block-level Resource Group (BRG) for ILA training established**

  Nearly all large States have established all the required BRGs, except in Assam, Karnataka, and Kerala. Jammu & Kashmir had the lowest proportion of BRGs established BRGs (49 percent).

  All small States have established BRGs, except in Goa. As there are no blocks in Andaman & Nicobar and in Chandigarh, BRGs cannot be established. Except in Daman & Diu, BRGs were established in the rest of the UTs.

b. Training of ICDS and MoHFW functionaries

- Lady Supervisors (LS) and Anganwadi Workers (AWW) trained in six or more ILA modules

  Data on the training of LS and AWW in six or more ILA modules show that much is still desired. The number of LS that were trained on at least 6 ILA modules was higher than 75 percent in nine large States, 3 small States and 4 UTs. In the case of AWWs, this was true in only six large States, two small States and four UTs (Table 7; Annexure 3).

- **Training of ASHAs**

  Out of 34 States and UTs, 17 States and UTs have a plan to provide ILA training to ASHAs. Of the 19 large States, seven have a plan to provide ILA training to ASHAs. Four small States, and all except one UT plan for ILA training for ASHAs. In

subsequent reporting, we will assess roll-out of the ILA training to ASHAs.

Aside from the ILA modules, the sixth and seventh modules of the Home-based Newborn Care (HBNC) training for ASHAs cover areas related to nutrition. Most States and UTs are doing well on this training for ASHAs. More than 75 percent of the ASHAs were trained on HBNC modules six and seven in all large and small States, except in Andhra Pradesh (69 percent). Among UTs, all ASHAs were trained in Andaman & Nicobar Islands and Puducherry while more than 90 percent ASHAs were trained in Dadra & Nagar Haveli and Delhi. There was no information available for Goa, Chandigarh and Lakshadweep.

Summary

What's working well	What needs attention
• Establishment of *State-level resource groups for ILA training* is nearly complete across States. • ILA training for District-*level resource groups (DRGs)* has been initiated. • Nearly all States and UTs have established required block-level *resource groups.*	• Training is not complete across the DRGs. • Huge gaps in ILA training of LS and AWWs across States.

BOX 4: Challenges reported by States in relation to strengthening training for POSHAN Abhiyaan

Twelve States faced delays or challenges in implementing the Incremental Learning Approach (ILA) at different levels. Low attendance, difficulties in record-keeping, insufficient funds, rough terrain, unavailability of training materials or equipment, lack of trainers and low quality of training were variously noted by Chandigarh, Gujarat, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Maharashtra, Meghalaya, Punjab and Uttarakhand. Madhya Pradesh noted that the e-ILA app is too heavy for most mobile phones. The State of Assam has not yet been able to implement training, though plans are in place. In Himachal Pradesh, training has been pushed back due to delays in smartphone procurement.

Source: Responses provided by State governments to questionnaires sent by NITI Aayog, May 2019

4.6 CONVERGENCE

Convergence is a key pillar within the framework of POSHAN Abhiyaan. The goal of convergence is to ensure that all nutrition-related programmes converge on households with mothers and children in the first 1,000 days. The expected steps to ensure overall convergence at the State/UT level are to establish State Project Management Units (SPMUs), set up Convergence Action Plan (CAP) committees at State, District, block levels and develop convergent action plans at these administrative levels. Village Health, Sanitation & Nutrition Day (VHSND) is considered as a convergence platform at the village-level.

Under convergence, the CAP committees together with the departments implementing programmes are expected to: (i) develop a convergent action plan; (ii) conduct periodic reviews; (iii) monitor and track progress of the actions in the plan; and (iv) facilitate efforts to achieve the targets.

Below, we describe the status of the establishment of the committees and development of plans, using data provided by the State governments. In subsequent reporting, we will assess roll-out of reviews and monitoring efforts.

a. Establishment of State Project Management Unit (SPMU)

(Already discussed in HR related issues in the earlier section of this Chapter).

b. Convergence Action Plan (CAP) committee

In most States and UTs, CAP committees were established (except Karnataka and Meghalaya). The CAP committees were formed in all the Districts in nearly all large and small States and UTs, except in Madhya Pradesh (99 percent), Gujarat (79 percent), Tamil Nadu (34 percent), Telangana (3 percent), Jammu & Kashmir (41 percent), Arunachal Pradesh (84 percent), Delhi (90 percent). The CAP committees were not formed in any of the Districts in Assam and Kerala (Table 9; Annexure 3).

c. Convergence Action Plan (CAP) developed and submitted

Overall, in 21 States and UTs, CAPs were developed. Among the **large States**, CAPs were developed in 14 States. The five large States where these were not developed include Assam, Haryana, Karnataka, Tamil Nadu, and Telangana. In the case of **small States**, CAPs were developed in just three States. These were not developed in Arunachal Pradesh, Goa, Manipur, Mizoram, and Tripura. In four out of the seven UTs, CAPs were developed. Delhi, Lakshadweep, and Puducherry were the only three **UTs** where these were not developed.

Even in States and UTs where a CAP was developed, it was not submitted as part of the Annual PIP for the year 2019-20, in all the cases. Nine of the **large States**, three of the **small States**, and three of the **UTs** submitted their CAPs as part of the Annual PIP for the year 2019-20. These included Andhra Pradesh, Chhattisgarh, Madhya Pradesh, Uttarakhand, Himachal Pradesh, Gujarat, Uttar Pradesh, Punjab, Jammu & Kashmir, Sikkim, Nagaland, Meghalaya, Chandigarh, Daman and Diu, and Andaman and Nicobar Islands.

While the convergent action plan efforts are important for facilitating convergence-related processes, their purpose can only be fully realized when such processes trigger the within- and across-sector actions that lead to effective reach of an agreed upon core set of interventions to all households in the 1,000-day period (Box 5).

Summary

What's working well	What needs attention
• *State project management units (SPMUs)* have been established in nearly all States and in all UTs. o *Karnataka, Punjab, Manipur and Goa do not have SPMUs* • *Convergence Action Plan committees* established in nearly all States and UTs. • *Convergence Action Plans (CAPs)* developed in several but not all States and UTs.	• SPMUs staffing gaps exist across several States. • Development of CAPs needs attention at the State and District levels. • Operationalizing the convergence action plans in a way that the interventions reach the first 1000-day households.

BOX 5: Challenges reported by States related to establishing processes related to convergent action planning

Convergence planning gaps are evident at the State, District and block levels. For achieving convergence, unfilled vacancies are a challenge in both Chhattisgarh and Puducherry, while budget constraints and the lack of a digital platform are mentioned by Chhattisgarh and Rajasthan. In Jammu & Kashmir, many Districts are yet to receive the Convergence Plan, delaying State-level convergence planning. Himachal Pradesh, Maharashtra, Madhya Pradesh and Meghalaya also reported a lack of cooperation or participation, manifesting in data sharing issues, difficulties organizing timely meetings, and preparing plans with allied departments. This could be because the implementation of POSHAN Abhiyaan is viewed as the domain of WCD, as noted by Himachal Pradesh. Gujarat noted that as compared to State and District-level convergence, block-level convergence is more difficult to implement, as is convergence further down the line.

Source: Responses provided by State/UT governments to questionnaires sent by NITI Aayog, May 2019

4.7 JAN ANDOLAN (Community mobilization)

Poshan Abhiyaan is thus envisioned to be a "*Jan Andolan*" and a "*Janbhagidaari*" meaning "People's Movement". The goal of Jan Andolan is to build recognition across sectors for nutrition and to build knowledge among communities and facilitate intent to improve nutrition practices to improve maternal and child nutrition. Multiple platforms are engaged to facilitate Jan Andolan including community-based events (CBEs), social media, mass media, frontline workers, influencers and celebrities. Here we describe CBEs

As part of Jan Andolan, community-based events (CBEs) are routinely organized across the AWCs in the country. The purpose of these events is to raise awareness among the communities and to influence behaviour changes for better nutrition health. The first anniversary of POSHAN Abhiyaan was marked with the celebration of 'Poshan Pakhwada' from 8-22 March 2019. Most States and UTs organized various CBEs. Further details received from Central Ministries is mentioned in Chapter 6.

In the month of March 2019, either all or most AWCs organized such events in twelve of the large States. Similarly, more than 75 percent of AWCs in five small States organized the events. All AWCs organized the CBEs in all the UTs other than in Andaman & Nicobar.

More than 75 percent villages provided all the activities mandated under VHSND in 14 of the 19 large States. In 5 of the 8 small States, more than 75 percent villages provided all the activities mandated under VHSND. In all UTs, except Chandigarh, all the villages provided all activities mandated under VHSND.

Summary

What's working well	
• There is an enthusiastic response to *Jan Andolan* and the community-based events are being organized across States •	• Ensuring continuity of behaviour change communication throughout the year and beyond the designated months and events is critical for facilitating behaviour change. • Strengthen existing Village Health, Sanitation, and Nutrition day platform for the delivery of interventions.

BOX 6: Challenges reported by the States in relation to Jan Andolan

Several States, including Chhattisgarh, Himachal Pradesh, Jharkhand, Madhya Pradesh, Maharashtra and Meghalaya provided insights into issues faced in organizing community-based events (CBEs). Chhattisgarh noted that in the absence of a digital platform, delays in reporting, tracking and monitoring such events are inevitable. In Himachal Pradesh, frequent CBEs pose logistical problems because of rough terrain. Organizing CBEs also hampered routine work in some States, like Jharkhand noted that CBEs affected home visits and day-to-day activities in AWCs, and Madhya Pradesh identified them as an increased burden at the block-level. Maharashtra reported that implementation was affected by CDPO vacancies. Meghalaya mentioned low participation by the community, particularly husbands of beneficiaries.

Source: Responses provided by State/UT governments to questionnaires sent by NITI Aayog, May 2019

The Government of India is commited to improving the nutritional status of children and women through POSHAN Abhiyaan. The mission mode approach provides the impetus to strengthen implementation and its monitoring. To achieve malnutrition-free India, implementation of health and nutrition interventions need to be strengthened in accordance with the C2IQ framework.

A set of POSHAN Abhiyaan pillars (technology, training, processes to support convergence, and Jan Andolan) have been identified under the assumption that efforts put forth in strengthening these pillars will trigger a series of changes that improve the availability and quality of nutrition interventions in the ICDS and health system. There are core programmatic inputs including funding, human resources, supplies, and infrastructure that are critical to functioning of these POSHAN Abhiyaan pillars. Overall across the States, there are gaps that require immediate attention to strengthen the inputs and the pillars of POSHAN Abhiyaan.

CHAPTER 5:
MULTI-SECTORAL CONVERGENCE AND POLICY ACTION

5. Multi-sectoral convergence and Policy action- At National Level

Nutrition is fundamental to human survival and development and is an essential foundation of National development. While POSHAN Abhiyaan in itself has an earmarked three year budget of Rs.9046.17 crore commencing from 2017-18, it really is an overarching framework that seeks to leverage funds, functionaries, technical resources and IEC activities from existing programs and schemes such as the Integrated Child Development Services (ICDS), Pradhan Mantri Matru Vandan Yojana (PMMVY), National Heath Mission (NHM), Swacch Bharat Mission (SBM),National Rural Livelihood Mission (NRLM) , National Rural Employment Guarantee Assurance (NREGA) and the Public Distribution System (PDS). The idea is to align the efforts of every stakeholder in a direction that could positively impact nutrition outcomes.

Over the past few months the involvement of key partner Ministries in work related to the POSHAN Abhiyaanhas been quite evident. And same was quite pronounced during the celebration of *Poshan Maah* and *Poshan Pakhwada.*

5.1 Specific actions across the multiple Ministries and Line Departments supporting POSHAN Abhiyaan

A. Ministry of Women and Child Development (MWCD)

Ministry of Women and Child Development (MoWCD), the Nodal Ministry, for POSHAN Abhiyan is implementing it across the country. The Abhiyaan was rolled out in phased manner, as per notification released by the Ministry, the Abhiyaan is launched in all the Districts w.e.f December 2018.

The MWCD shared updates like, **Fund utilization** which indicates that on an average, States/UT have utilized only 15.6% of the funds sanctioned to them since the inception of the POSHAN Abhiyaan (2017-2019). No fund utilization is there for the States of Goa, Jharkhand and Karnataka. For the **Procurements of Growth Monitoring Devices (GMD) and smart phones/tablets:** 11 States/UTs have met the requirements with regards to the equipment procured. States namely, Andhra Pradesh, Assam, Gujarat, Haryana, Jharkhand, Karnataka, Kerala, Manipur, Meghalaya, Orissa, Punjab, Sikkim, Tripura and West Bengal haven't procured any smartphones under the scheme yet. Another important component of POSHAN Abhiyaan is **ILA training** which has been rolled out in most the States and UTs. Tamil Nadu has completed 13 modules, the maximum for any State.

Utilising technology for effective implementation of POSHAN Abhiyaan is done with the help of ICDS-CAS software. It is notified by the Ministry that ICDS-CAS has completed in 16 States and more than 2 Lakh AWCs are working with ICDS-CAS facility. Also there is a provision of **Flexi funds** given to the States/UTs to conduct some pilot studies or test new interventions that help in meeting the objectives of the Abhiyaan. States like Rajasthan, Tamil Nadu, Mizoram, Maharashtra, Jharkhand, Daman and Diu, Jammu and Kashmir are under process of constituting State Level Sanctioning Committee. Chhattisgarh on the other hand has decided to use its Flexi Fund for filling gaps in existing components rather than to utilize it for other pilots.

- **Convergent activities jointly by Line Ministries to support POSHAN Abhiyaan**
  - Executive Committee: Series of Executive Committee have been held in the time period of last six months under the Chairmanship of Secretary WCD. Sixth executive committee of POSHAN Abhiyaan was held on 29th March 2019. Three meetings in the month of December 2018, January and March

2019 was organised by the Ministry. These meetings have been an important mechanism for understanding State and field level challenges and resolving them in timely manner.

- National Council: The 3rd and 4th National Council meeting have been held in the month of November 2018 and February 2019 to review the progress of POSHAN Abhiyaan. Various issues on utilization of funds under POSHAN Abhiyaan, procurement of devices, rice fortification roll out were discussed in detail.
- Optima Workshop: Workshop was organized with the objective to orient on the mechanisms to optimize the planning and financing for nutrition. It was held from 18-20 Feburary, 2019 at Goa. Representatives of the NITI Aayog, key Central Ministries from each of the 36 States/UTs of India participated in the workshop.
- Lighthouse India Workshop: MWCD in collaboration with the World Bank had organized an international knowledge exchange event – titled "Lighthouse India: A Drive to Fight Undernutrition" during 1-5 February, 2019.
- Agri-Nutrition Conference: MoWCD had organized a one day Agri-Nutrition Conference on 15th March 2019 to develop an Agri-Nutrition convergence action plan to accelerate the progress towards improving nutrition indicators. The conference was aimed at deciding the Agri-Nutrition action plan in India with policy recommendations.

► **Details regarding Supplementary Nutrition**

Almost all States/UTs are doing fairly well with regards to Supplementary Nutrition. With regards to Hot Cooked Meals and THR, most States prepare a mix of regional dishes and staple food. Some States offer sweets like kheer, while others resort to offering a stipulated amount of dry snacks with meals.

► **IEC/SBCC Mass Media Campaigns (1st October 2018 to 31st March 2019)**

Promotion of POSHAN Abhiyaan and awareness of healthy behaviour is promoted and communicated through print media which includes the advertisement in 87 newspapers in 16 States of the country on 9th March 2019. Pan India mass communication was planned by the MoWCD for Poshan Abhiyaan during the month of March 2019 as part of Poshan Pakhwada. However due to model code of conduct the approval of PMO was not given for other mass media campaign.

Promotion of PMMVY scheme is promoted through Doordarshan and other private channels. The scheme was promoted on 251 channels across the country. The video in addition to promotion of scheme also included message on positive health behavior.

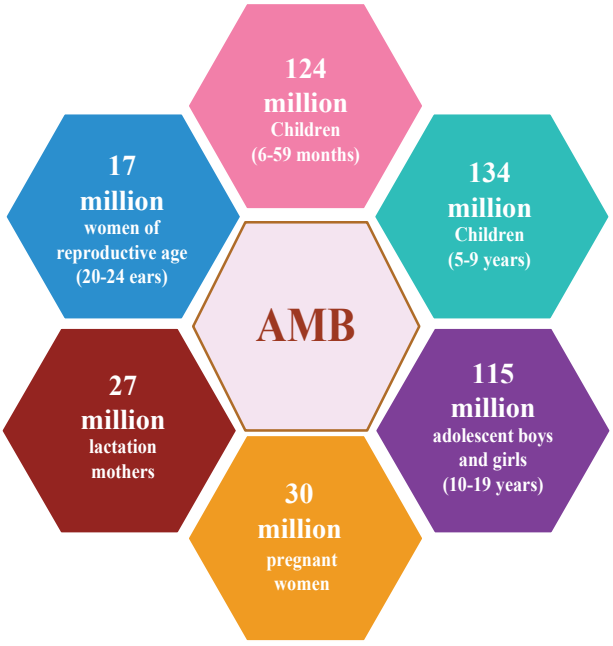
Challenges:

The level of participation in the National Council and Executive Committee Meetings of POSHAN Abhiyaan was very low. Odisha and West Bengal have not started rolling out the scheme. States have not performed well on procurement of devices and filling up the manpower. The fund utilization by States/UTs has been inefficient.

B. Ministry of Health and Family Welfare

National Health Mission (NHM) under MoHFW plays a vital role in the success of POSHAN Abhiyaan as both the missions share similar goals like reduction of undernutrition, anemia and prevalence of low birth weight. Various health sector interventions which are instrumental in the success of POSHAN Abhiyaan:

- Working and strengthning Home Based Care of Young Children, Home Based New-born Care, Anemia Mukt Bharat, National De-worming Days (NDDs), Universal Immunisation, Promotion of IYCF at Health Facility and Community (Mother's Absolute Affection (MAA) Programme), Control of Childhood Diarrhoea (IDCF), nutritional deficiency screening among children, nutrition counselling and education at schools and villages, food fortification, and Nutrition Rehabilitation Centres
- Home Based Care of Young Children- HBYC programme involves additional home visits over and above the existing Home Based Newborn care (HBNC) visits for nutrition promotion. Ministry of Health and Family welfare has sanctioned around Rs 218 crore to cover 240 Districts including 115 Aspirational Districts for the HBYC initiative in 2019-20. As far as capacity building of frontline workers is concerned, 24 States have completed training of trainers and 9 States have initiated ASHA/ANM training. More than 12,000 frontline workers are trained covering 23 districts in these 9 States.



- Home Based New-born Care (HBNC)- 1.29 Crore newborns have received home visits by ASHAs in 2018- 19 and 5.3 Lakhs new-born referred during the year 2018-19. lt is worth mentioning that there is more than 100% point increased in sick newborn referral rate from the last financial year. For the year 2019-20, Rs.462 Crore has been sanctioned for this program. Funds were also approved for Smartphone for 1.24 Lakh ASHA/ ASHA Facilitators for Supportive supervision. Around 686 trainers and 16391 ASHAs/ASHA Facilitators have been certified.
- Anaemia Mukt Bharat- Approximately Rs.414 crore has been sanctioned for implementation of Anemia Mukt Bharat (AMB) in all the 36 States/UTs in 2019-20. Three resource institutions namely, AIIMS, lnstitute of Economic Growth and Tarang Hub-New Concepts Centre for Development Communication have been identified to provide technical support at the national level. AMB has been launched in 9 states so far- Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Maharashtra, Meghalaya, Punjab, Uttar Pradesh, Rajasthan and 5 States are likely to launch the programme soon. These states are Haryana. Goa, Odisha, Gujarat and Kerala.

  More than 2 lakh participants including District and Block nodal officers, teachers and AWWs have been oriented on the programme.
- National Deworming Day (NDD) and Universal Immunisation Programme - 93% (22.12 crore) children were covered during the 8th round of NDD conducted in February 2019 in 33 States and UTs. For Mission Indradhanush, a total of 3.39 crore children and 87.2 lakh pregnant women were vaccinated. New vaccines such as Pneumococcal Conjugate Vaccine (PCV) is introduced in 5 States whereas, Rota Virus Vaccine (RVV) was introduced in all 36

States and UTs on September 6, 2019. By the end of year 2018 under Intensified Diarrhoea Control Fortnight (IDCF), 8.7 crore under-five children were covered (78%).

- Integration of ICDS-CAS and Reproductive Child Health (RCH) portal - A platform would be created by MoHFW to develop a common beneficiary registration system to facilitate exchange of data between RCH portal and ICDS-CAS. This platform is likely to be completed in the next three months including pilot in 1 District of Haryana/Uttar Pradesh.
- Fortification- MoHFW is actively supporting pilot scheme of both rice fortification and milk fortification meant for addressing micronutrient deficiencies and improve the nutrient quality of diet.
- Mothers' Absolute Affection (MAA)- to improve breastfeeding practices, around 4 lakh ASHAs and 82 thousands health staffs were sensitized for breastfeeding promotion strategies under this programme.
- Early Childhood Development (ECD) with focus on 1000 days- MCP card is updated with developmental milestones. Emphasis on early childhood development has been identified a priority component of HBYC programme. Funds for ECD call

C. Ministry of Human Resource Development (MHRD)

Through the Mid Day Meal (MDM) scheme, Ministry of Human Resource Development ensures an effective convergence with the Ministry of Women and Child Development to support the objectives of POSHAN Abhiyaan.

This scheme aims at the enhancement of school enrolment, retention and attendance and simultaneously improving nutritional levels among children. It covers all the children studying in government, local body and government-aided primary and upper primary schools and the Education Guarantee Scheme (EGS)/ Alternative Innovative Education (AIE) centres including Madarsa and Maqtabs supported under Sarva Shiksha Abhiyan (SSA) of all the States across the country.

The **fund utilization** information shared by the ministry indicates that most of the States have utilised more than 80% of funds earmarked for MDM and are left with a small proportion of unspent balance ranging between 3-20%. On the other hand, States/UTs like Jharkhand (75%), Puducherry (75%) and West Bengal (63%) have utilised much lesser than 80% of the funds for MDM and are left with 25-37% of unspent balance.

- **Tithi Bhojan** –A community participation programme was initiated by the State Government of Gujarat in mid-day meal programme by relying on the traditional practise of providing food to large number of people on special occasions such as festivals, days of national importance etc. Members of the community provide nutritious and healthy food to the children as an additional food item or full meal on such special occasions/festivals.

  As per the information provided, by MHRD, a concept similar to Tithi Bhojan, with the same name or a different nomenclature, has been adopted by 12 States/UTs which include Assam (Sampriti Bhojan), Andhra Pradesh (Vindhu Bhojanam), Chandigarh (Tithi Bhojan), Daman & Diu (Pravesh Utsav), Haryana (Beti ka Janamdin), Karnataka (Shalegagi Navo-Nivo), Madhya Pradesh (Sneh Bhojan), Maharashtra (Sneh Bhojan), Punjab (Priti bhojan), Puducherry (Anna Dhanam), Tamil Nadu (Nal Virundhu) and Uttarakhand (Tithi Bhojan). In addition, States/UT like Jharkhand, Dadra & Nagar Haveli and Tripura occasionally give special food items like sweets and chicken to children.
- **Provision of good quality proteins in MDM:**

As many as 23 States/UTs are making an effort to enrich the protein quality of the mid-day meal by providing either **egg or milk to children**. Both eggs and milk are a source of good quality protein which helps in improving the overall health. In most cases, egg and milk are provided alternatively and the frequency varies from once a week to six times a week. In Tamil Nadu, eggs are provided on all working days and Rajasthan provides milk six times a week. Some of the States/UTs also give seasonal fruits interchangeably with milk/egg to children. In Delhi, milk is distributed by Mother Dairy on a pilot basis to children in schools that come under the Directorate of Education

► **Fortification:**

- **Double fortified salt (DFS)-** One of the objectives of POSHAN Abhiyaan is to reduce the prevalence of anemia among both children (6-59m) and women (15-49 years) by 9% @ 3% p.a. One cost effective way of increasing the intake of iron is fortification of salt with iron in addition to iodine. Ministry of Health and Family Welfare has prescribed the legal standards for DFS.

  MHRD had written to all the States/UTs encouraging them to use DFS in MDM to correct the iron deficiency among children and improve their learning and concentration in school. However, only half of the States/UTs (18 out of 36) are using DFS in preparation of MDM.

  This needs to be scaled up as the States which have reported high prevalence of anaemia among children, like Bihar, Chhattisgarh, Jharkhand, and Uttar Pradesh are not using DFS in MDM for children.

► Fortification of commonly consumed commodities like **wheat flour, rice, milk and edible oil** - The MHRD has communicated to the States the mandate of using fortified food items to address the problem of malnutrition in the country. As per the information received, only Chandigarh is providing **both fortified rice and wheat flour** in MDM. These staples are fortified with nutrients-Iron, Folic acid and Vitamin B12 which play an important role in restoring the iron levels and correct all forms of anaemia. The State of Haryana and UT of Dadra and Nagar Haveli are providing **fortified wheat flour** to prepare MDMs. Haryana was the first State in the country to take up this initiative in March 2018, on a pilot basis and gradually expanded it to the whole State. Haryana also provides edible oil fortified with fat soluble vitamins A and D.

As far as the status of fortified rice is concerned, 100% of the MDMs are being prepared **with fortified rice** in Nagaland, whereas in Karnataka, Odisha and Uttar Pradesh it is being done in 5, 2 and 1 Districts, respectively. Eleven out of 36 States/UTs are providing **edible oil fortified with Vitamin A & D.** Rajasthan is the only State which provides fortified milk (with vitamin A and D) under MDM and the frequency of milk distribution to children is also highest in this State, 6 times a week.

► **Kitchen Gardens:** Kitchen garden is an excellent opportunity to provide freshly grown vegetables rich in vitamins and minerals to children and help address micronutrient deficiency in them, also commonly known as “hidden hunger”. Involvement of children in kitchen garden can be an educative learning for them and a medium to teach them cooperation and teamwork & give them a sense of ownership. In Assam 87% of the schools have developed kitchen gardens whose produce is being used in preparation of MDMs. This is followed by Dadra & Nagar Haveli and Nagaland where 80% & 56% of the schools have developed kitchen

gardens, respectively. In rest of the States/UTs, less than 25% of the schools have developed kitchen which ranges from 2% in Bihar to 25% in Odisha. While, MHRD is making an effort in encouraging States/UTs to develop kitchen gardens but very little change is seen at the ground level.

- **Involvement of mothers in supervision committee:** Mothers are the decision makers of availability and accessibility of food to children among other caregiving practices. MDM guidelines encourage mothers to oversee the preparation and feeding of the children, thus ensuring quality and regularity of the meal. This intervention also results in community involvement which is very crucial for the success of any welfare programme. Only 10 out of the 36 States/UTs involved mothers as part of supervision committee to monitor and supervise preparation and serving of MDM and within these 10 States/UTs, 100% of the schools involved mothers. Dadra and Nagar Haveli reported about 20-30% of the mother's involvement in supervision commitee.
- LPG usage for preparing MDM: Liquefied Petroleum Gas (L.P.G.) is considered to be safe, economic, time-saving and smoke-free fuel for cooking Mid-day Meal in school. The MHRD insists on the use of LPG under Cooked Mid-day Meal Programme (CMDMP). The information received indicates that in 20 out of 36 States/UTs, the LPG usage is 80% and more. In 4 States usage ranges between 40-80% and in 9 States/UTs it is less than 40%. Out of these 9 States/UTs 3 States i.e. Arunachal Pradesh, Chhatisgarh and Manipur have reported LPG usage in less than 10% of schools. An effort should be made to find out the reason behind the low usage of LPG and necessary steps may be taken to replace firewood and smokeless chulla with LPG as these pose a threat to the health of the cook, children who are around, and also pollute the environment.

Coverage of children under MDM

Almost all the States and UTs reported that 80% and above children are being covered under MDM as beneficiaries. The coverage period was from 1st October 2018-31st March 2019. States like Assam, Mizoram, West Bengal and Delhi have reported 100% coverage. Twenty-two States/UTs out of 36 reported 90% and above coverage. The State of Uttarakhand reported frequent changes in enrolment and coverage of beneficiaries. Similarly, in Chandigarh, a 42% reduction in beneficiaries' coverage was seen between February and March 2019. An effort should be made to find out the reason behind this and also tap the eligible beneficiaries who are currently excluded.

Services under School Health Programme

- **Referral and healthcare facilities:** Almost all the States/UTs are screening children and providing them **referral and healthcare facilities**. In States/UTs like Chhattisgarh, Tamil Nadu, Andaman and Nicobar Islands, Chandigarh, Dadra and Nagar Haveli, Daman & Diu, Lakshadweep and Puducherry all the schools are providing this service. 19 out of 36 States/UTs have reported that more than 80% of the schools are providing this service to children. It is a matter of concern that in the State of Uttarakhand only 3% of the schools are providing this service.
- Except in Tripura and Andaman and Nicobar Islands, none of the schools are providing **immunisation services** to children.
- **Iron and Folic Acid supplementation** - Anemia is a serious public health challenge in India with more than 50% prevalence among young children. Thus, it becomes imperative to provide iron supplementation to this vulnerable group. Under the anemia control programmes run by the Government

of India, children are provided iron supplementation.

As per the information shared, in 11 States/UTs all the schools are providing micronutrient supplementation to children. In 6 States less than 40% of the schools provide micronutrient supplementation, with the access to service being as low as 13% in West Bengal. Even in a State like Kerala, which is doing well in the implementation of most welfare programmes, the administration of micronutrient supplementation is in only 28% of schools. Bihar and Jharkhand are providing micronutrient supplementation to children in just about 35% of schools.

- **Deworming-** The National Deworming Day is a single fixed-day approach which is conducted bi-annually to administer Albendazole to all children aged 1-19 years. This intervention is a convergence between MHRD and Ministry of Health and Family Welfare. In 23 out of 36 States/UTs, Albendazole tablets are provided bi-annually in more than 80% of the schools. Almost half of these 23 States/UTs run deworming programme in all the schools within the State/UT. In West Bengal, the administration of Albendazole tablet is reported to be low - only in 14% of the schools.

D. Ministry of Rural Development:

After the launch of POSHAN Abhiyaan, MoPR has geared up the communities for nutrition related activities by organizing Gram Sabhas. Through Deendayal Antodaya Yojana - National Rural Livelihood Mission (DAY-NRLM), they ensure women's participation through self-help group (SHG) platforms. As on March 2019, DAY-NRLM has mobilised 592 lakh households into more than 52 lakh SHGs covering 5,330 blocks in ALL States/UTs. It has developed more than 2 lakh community resource persons under various components including Food, Nutrition, Health and WASH (FNHW). At the policy level, NRLM has adopted a 'Dashasutra' strategy, i.e. it has layered FNHW interventions over its institution building interventions and issued necessary circulars and advisories to State Rural Livelihoods Missions (SRLM), for an active participation during Poshan Maah.

The State Missions, in convergence with the line departments, conducted several activities under POSHAN Abhiyaan, viz. collaboration with Swachh Bharat Mission, Lohia Awas Yojana (PMAY), etc. The key actions areas are highlighted below:

- Collaborated with Swachh Bharat Mission, Lohia Awas Yojana (PMAY), in Bihar.
- Mobilized SHG women and promoted awareness on VHSND in most of the States, supported ASHA and Anganwadi workers in mobilizing women for availing services like Take Home Rations (THR), distribution of Iron Folic Acid (IFA) tablet, immunization etc. in Madhya Pradesh.
- Promoted household level agri-nutri gardens and nutrition sensitive livelihoods for year-round supply of nutritive fruits and vegetables in convergence with the thematic livelihoods team and department of agriculture, in Bihar, Chhattisgarh, Odisha, Jharkhand, Madhya Pradesh etc.
- Involved ANMs and Sahiyyas (ASHA workers) from Health Department in the capacity building of VO/SHG members, in Jharkhand.
- Convergence with the Drinking Water and Sanitation Department for collaborative initiatives on Rani Mistri (Women Mason) training, construction of IHHL, behaviour change communication of hand washing, use of toilets, access to clean drinking water, in Jharkhand.
- Developed backyard poultry and goatery etc. across the States.
- Convergence with the Health Department,

under which demonstrative feeding programme was implemented with the aim of providing quality nutrition and supplementary food to all the children, lactating mothers and pregnant women and created livelihood opportunities for the SHGs member. In Gujarat, there are 2,564 villages in which demonstrative feeding programme was conducted and 48,577 pregnant women and 39,373 lactating mothers have been benefitted till now.

- Collaborated with the line departments on nutrition and nutrition linked livelihoods, e.g. in Assam the State mission has organized a State level convergence workshop with 6 line department on Nutrition and Nutrition Linked livelihoods in collaboration with UNICEF Assam.

Activities planned for POSHAN Abhiyaan from 1st October 2018 to 31st March 2019 along with State-wise data:

State wise activities were planned for POSHAN Abhiyan from "1st October, 2018 to 31" March, 2019. The Dashasutra strategy has been adopted by all State Missions and FNHW agenda has been integrated in the institutional structure across all levels. Most of the States have dedicated one SHG meeting in a month to discuss FNHW issues. Modalities to capture information of meetings held etc. exclusively on FNHW is not been captured in MIS as of now, the work is in progress. Hence, consolidated numbers of the meeting etc. is not available at this stage. However, few States have evolved systems for recording such data.

Several States reported high numbers of Meetings and workshops- Bihar reported 327,051 SHG meetings, 556 CLF meetings, 29,404 VO meetings and 420 workshops/trainings. This was followed by Jharkhand and Madhya Pradesh. While the same was least in Haryana- 47,703 SHG meetings, 118 CLF meetings, 2913 VO meetings and 135 workshops; followed by Uttar Pradesh. Apart from this, platforms like VHSNDs, rallies, and trainings were used in collaboration with line department workers with high community participation. Maharashtra conducted 10,253 rallies, celebrated 10,359 VHNDs and prepared layouts of 9508 individual and 1005 community nutri-gardens which is a big achievement. In Miozoram, SHG members collected their kitchen gardens products and sold them at the local market, under anaemia campaign, 10 activities were conducted at the school where experts like Doctors, nutrition experts had discussions with school students.

State/UT wise initiatives in training SHGs/VOs/CLFs on health and nutrition:

Apart from this, MoRD also took initiatives in training SHGs/VOs/CLFs on health and nutrition, viz. FNHW modules are being developed by State Missions on the importance of breastfeeding, complementary feeding, maternal, infant, young child nutrition for integration in trainings at all levels. Orientation for State, District and block level staff is being conducted on FNHW including the above-mentioned topics.

States like **Jharkhand** are conducting cascade training for members of Vos and Social Action Committee (SAC) through the flipbook titled "Samuh Varta". Few States have undertaken training of trainers (TOT), e.g. **Bihar** reported to have conducted trainings in 1,29,361 SHGs on nutrition module.

Few States are involved in ICDS Supplementary Nutrition Programme (SNP) at Aanganwadi Centre and schools. **Bihar** reported to have five Food Fortification Units running in 3 different Districts viz., Gaya, Khagaria and Muzaffarpur. Take Home Ration is supplied to 898 Anganwadi Centres under an MoU with respective blocks ICDS projects. Similarly, Mid-Day Meal (MDM) programme is running in two blocks of two Districts viz., Muraul (Muzaffarpur) and Ghosi (Jehanabaad) by VOs. A total of 162 MDM programmes are being monitored by 162 VOs where around 35,000 school children are benefitted.

In **Madhya Pradesh**, a total of 12,030 SHGs are involved in Supplementary Nutrition Programme. Uttar Pradesh reported to have 18,347 SHGs involved in SNP during Poshan Pakhwada. Total 13,121 SHGs helped Anganwadi Workers to organize the recipe demonstration event in which different types of recipes made of THR (Nutrient Packets) where shown to mothers and pregnant women. In Gujarat, two THR units have been set up in Vadiya and Babra block of Amreli District. **Haryana** reported involvement of around 850 SHGs in THR preparation.

New initiatives by SRLMs that can be scaled for strengthening POSHAN Abhiyaan in all States/UTs:

Creation of trained resource pool for FNHW: Some State Missions have identified community resource person (CRPs) from among the SHG members for taking forward FNHW issues with the community. These identified CRPs are trained periodically on various FNHW issues. These CRPs are paid by the community institutions based on the service they provide, like organizing meetings, mobilizing women to VHSND, etc.

- **Nutrition Sensitive Integrated Farming System (NSIFS) for diet diversity:** For improving dietary diversity at the household level and ensuring various kinds of food availability through-out the year, nutrition sensitive integrated farming is being encouraged in many State Missions.
- **Micro planning on FNHW for community ownership, SRLM:** SRLMs like Bihar, Chhattisgarh, Jharkhand and Odisha are developing micro plans for improving health and nutrition status of the community. These plans are developed and monitored by the communities. This helps in encouraging community ownership and making collective efforts for improving the nutrition status.
- **Home visits by SRLM members in Bihar, Chhattisgarh, and Odisha:** Home visits are being made regularly to the households identified to be at "nutritional risk". Counselling is provided and families are mobilized for participating in VHSNDs and accessing services and entitlements.
- **Navratan Tool, developed by State Mission, Bihar:** Navratan tool for awarding the "Champions", i.e. best performing mother. First 1000 days' life has been categorized into 9 indicators called Navratna. Out of 9 Ratnas, 7 are on health and nutrition and 2 are for sanitation indicators. These include institutional delivery, maternal diet diversity, breastfeeding, complementary feeding, immunization, nutri-gardens, family diet diversity, hand washing and ORS use and usage of toilet.
- **Sensitization of Gram Sabha, State Mission, Madhya Pradesh:** Gram Sabhas were sensitized on issues of malnutrition, community volunteering, community-based malnutrition management, PDS, linking Severe Acute Malnourished children with Nutrition Rehabilitation Centre, competition on various nutrition issues, demonstrations and awareness camps.
- **Newlywed couples' Meeting, State Mission, Odisha:** In the tribal dominated areas, under-18 marriage is still common, resulting in a vicious circle of malnutrition. To avoid 'Too Early, Too Soon & Too Many' Pregnancies, newly-wed couples' meetings are being organized where the couples are counselled on family planning measures.
- **Mushroom development project, State Mission, Assam:** In order to meet the nutritional deficits and provide livelihood opportunities to the SHG members, State Missions have taken up Mushroom Development Project with 200 SHG members.
- **Implementation of Food and Feeding Demonstration sessions at AWCs using**

local food compendium in Odisha: Four mothers' meetings were conducted in each month on different aspects of complementary feeding. Recipe demonstration sessions were conducted at AWCs using local food compendium, counselling flip books and videos.

- **Health Camps in Odisha:** In spite of the various schemes implemented by health department, still there are some hard to reach areas where organizing VHSND is also not possible at a regular interval. Keeping those areas in consideration, cluster level health camps were organized in Odisha where basic health services were being provided to the target beneficiaries.
- **Multi-sectoral FNHW intervention: Swabhimaan Programme, State Mission, Chhattisgarh:** SRLM partnered with UNICEF, Chhattisgarh, to initiate the Swabhimaan Programme (named as 'Mocho Mangun' in the State) with an aim to improve the nutritional status of adolescent girls, pregnant women and mothers of children under two years in Bastar block of Bastar District, by increasing the coverage of five essential nutrition (specific and sensitive) interventions. It is being implemented in coordination with the Departments of Health & Family Welfare, Civil Supplies, Panchayat & Rural Development, Women & Child Development, Agriculture, Horticulture and Public Health Engineering.

Challenges faced:

Some of the challenges faced by SRLMs included incomplete coverage of target beneficiaries due to migration, and misconceptions prevalent in the communities. There were challenges related to continued reinforcement of messages and retaining good practices. There were problems in tracking behaviour change and issues with uploading data on POSHAN Abhiyaan MIS portal.

E. Ministry of Panchayati Raj:

MoPR plays an important role in providing logistics support and facilitating observance of the POSHAN Abhiyaan activities that are planned, conceived and implemented by various Ministries like MoWCD, MoHFW, MHRD, MoDWS and MoA&FW; and their counterpart departments in States/UTs. Convergence of line ministries at the grassroot levels with PRIs is crucial for the success of respective activities. These departments are the appropriate agencies to identify convergent activities for PRI and their participation in POSHAN Abhiyaan.

During POSHAN Maah, MoPR was earmarked to conduct Prabhat Pheris and Special Gram Sabha, which turned out to be very successful. Besides, the Ministry is advising States/UTs separately for observing VHSNDs optimally in all the villages. This is done in compliance to the guidelines issued by MoWCD, where PRIs are given specific tasks to be performed on every VHSND that takes place at least once in a month. Also, PR departments in the States/UTs are continuing to organize one Prabhat Pheri every month with appropriate messages related to POSHAN Abhiyaan. A record of these activities is also being maintained.

PRIs are also suggested to organise one special Gram Sabha on POSHAN Abhiyaan every six months of which one must be on 2nd October. Convergence of PRI is an essential component for the implementation of POSHAN Abhiyaan.

F. Ministry of Consumer Affairs & Public Distribution- Department of Food & Public Distribution:

Government of India has approved the centrally sponsored pilot scheme on 'Fortification of Rice and its Distribution under PDS' for a period of three years beginning 2019-20 with a total budget outlay of Rs. 147.61 crores. It would be funded in the ratio of 90:10 in respect to North Eastern, Hilly and Island States and 75:25 in

respect to the rest of the country. To begin with, the pilot scheme will focus on 15 Districts, preferably 1 District per State.

The decentralized model of fortification with blending at the milling stage has been approved by States/UTs in the pilot scheme. So far eight State governments, i.e. Andhra Pradesh, Kerala, Karnataka, Maharashtra, Odisha, Gujarat, Uttar Pradesh and Assam have consented and identified their respective District (s) for implementation of the pilot scheme.

FSSAI had issued official letters to Food Secretaries of all the States and union territories to take steps to promote the use of fortified edible oils in all their welfare schemes from 1st October 2018 onwards.

Challenges: The department is insisting all States/UTs to implement the pilot scheme "Fortification of Rice and its Distribution under Public Distribution System". So far only 8 States have identified their Districts. Further, regarding distribution of fortified wheat flour through PDS, despite advisories from this department, it is being distributed only in 2 States/UTs.

5.2 Multi-sectoral convergence and Policy action- At State Level

With the launch of POSHAN Abhiyaan last year, the States/UTs WCD and Health departments have geared up to tackle the battle of malnutrition. Many States/UTs have initiated measures to improve the health and nutrition outcomes of mothers and children. This section highlights various initiatives taken by the States/UTs which focuses on first 1000 days (from a period of conception to child' first two years of life) to improve the health and nutrition status of women and children under the following heads: Convergence, Community Based Events/ Community Mobilization, Behavior Change Communication and Other Initiatives like technology etc. by States/UTs.

A. Convergence

✓ In **Andhra Pradesh** the State Government has taken a few important steps to operationalize convergence between ICDS and PRI. They are described in detail in the following section.

- At the village level under *Mahila Shishu Darshini* for increased accountability. At the village level, both the ICDS and Panchayat Raj Institutions (PRI) are responsible for the well-being of the people. In each District, monthly review meetings are convened by District Collector. During these meetings, ICDS and Health staff reports their reviewed outcomes, and any gaps which were assessed.
- Gram Panchayats in Andhra Pradesh, recently agreed to provide Rs. 5000/- to all AWCs from their Annual GPs budget.
- Another Initiative taken up by State Government is **Memu Saitham:** Tapping the goodness of community through a donor-driven initiative. Given the focus of POSHAN Abhiyaan on Convergence the State Government has decided to include donors who can contribute in terms of infrastructural support, this will improve the quality of AWCs. It is worth noting that more than 950 donors contribute to POSHAN Abhiyaan in the State. The support is provided in the form of nutritious food (Raagi, Bajra, Millets, Ground Nuts, Jaggery, Fruits) and infrastructure items (tables, chairs, utensils etc.)
- Initiative for Tribal Population named **Chandranna Giri POSHANA Kendra** is also started by Women Development and Child Welfare department by providing hot cooked meals to the children and women of hill top and remote habitations in tribal areas. The

meals are provided daily at the community level with help of persons identified in the community to serve the meals. More than 14,000 pregnant & lactating women and about 10 thousand children from 6 months to 6 years are covered in this scheme.

- ✓ In **Tamil Nadu,** as part of convergence, Department of transportation along with WCD Department established separate feeding rooms in 352 Bus stands and Terminals to enable the feeding mothers to breast feed their new born child in a safe enclosed room.
- ✓ **Karnataka** has initiated interventions on Child Health which has resulted in significant reduction in the quantum of child deaths and the State is making sincere efforts made to achieve Sustainable Development Goal. Karnataka also has 41 Special Newborn Care Units (SNCU) to manage sick newborns, of which 22 SNCUs are with Ventilator. A total 61529 annual admission of which 76.4% newborns were successfully discharged by Dec 2018. Adjunct to all SNCUs, Kangaroo Mother Care Wards & Lactation Clinics are established to improve the survival of low birth weight babies and also provide support to mothers in optimal feeding of newborns.

  Karnataka Government has also signed an MoU with National Neonatology Forum (NNF) to improve the quality of care in SNCUs by SNCU & NBSU mentoring. State resource center for Facility Based Newborn Care (FBNC) is established at IGICH Bangalore to have sustainable mechanism of capacity building, technical support & mentoring of FBNC across the State. Basic Newborn Care & Resuscitation Program (IAP-NNF-NRP- FGM) to build the capacity of staff nurses & medical officers of all delivery points across the State to reduce morbidity & mortality related to birth asphyxia. State specific, strategic and time bound Karnataka Newborn Action Plan has been drafted with monitoring and evaluation framework and targets in response to India Newborn Action plan to accelerate Karnataka's effort toward achieving SDG of single digit NMR by 2025, 5 year ahead of Global target. Thus, Karnataka is setting an example for other States/UTs to follow.
- ✓ In Rajasthan, Department of WCD, Health and TAD (Tribal Area Development Department) were brought under the umbrella of PUKAR. ANMs, ASHAs, AWWs and *Swasthyakarmi* contractual workers) were given specific roles. Household are divided among AWWs, ASHAs and Swasthyakarmi according to hamlets/colony for better monitoring, supervision and updating mother and child health indices along with nutrition. Block level workshops were organised to sensitize all about the roles and responsibilities. These workers were given printed registers to list such beneficiaries.
- ✓ The State of **Madhya Pradesh** has initiated many interventions to ensure best health and nutrition outcomes. Maternal Nutrition intervention is being pilot tested in Vidisha District and District Hospital Ujjain. The objectives of Maternal Nutrition intervention is to assess the Nutritional Status of Pregnant women based on which Nutritional Care will be targeted, to improve provision of Maternal Nutrition services at Community & Health facility Level and to facilitate health care providers & other stakeholders to engage in Interpersonal Nutrition & Education Counseling.
- ✓ The State has taken ownership for Tracking of High Risk Pregnancies. Identification of every pregnant woman is done by ANM at Community Level and by Medical Officer/

Specialist; fortnightly follow up is done by multidisciplinary team including sector MO, CDPO and counselor.

✓ The State Health department of **Jammu & Kashmir** in convergence with the ICDS Department is providing hot meals to pregnant women. The State is also providing *Dakshata* Training for improving skills of the staff in labour room, to improve antenatal and perinatal care during and after delivery.

B Community Based Events

✓ In **Bihar**, in order to mobilize people for celebration of **Annaprashan Diwas,** the field functionaries of ICDS had developed a "**CBE Invitation Card**" for the mother of the child whose Annaprashan is scheduled and are being invited through this pictorial invitation card. Further, to established the complementary feeding and making it as a habit for the care giver, **a follow up card** has been developed and being implemented in one District- Sitamarhi as a pilot basis.

✓ In **Daman & Diu** an effective use of platforms like "*Gram Sabha*", "Construction Sites", "*Otalni Varta*" with SHGs member to create awareness about POSHAN ABHIYAAN has been done. This has created awareness among citizens, beneficiaries and students about the benefits, importance and objectives of POSHAN Abhiyaan and Umbrella ICDS Scheme. Also they have been sensitized about correct nutrition and hygiene practices. This has resulted in increase of number of beneficiaries by almost 10% in last one year.

✓ Rajasthan as mentioned in the earlier section also, the State has made efforts for Community Partnership under a State initiate called *PUKAR*. Each Wednesday, in each of the panchayat, , Pukar meetings are held where ANM, ASHA, AWW AND SWASTHYAKARMI sit at some pregnant woman's house and read them a document about how to take care of health & nutrition from conception to the time baby turns to 2 year's age. Importance of the supplementary food from ICDS is also being highlighted in these meetings. Around 50 beneficiaries attend a meeting and every week 346 meetings are held in a District benefitting around 15 thousand pregnant women & lactating women.

✓ The State of **Haryana** has set an example in Community Mobilization around Immunization. Recognizing the limitations of community mobilization through ASHAs and to resolve the disruptive campaigns against Routine Immunization, Haryana has roped in Community Mobilization Volunteer (CMVs) for better Community Mobilization and awareness generation to improve the Routine Immunization coverage in Mewat & Hathin block of the District Palwal.

Further, in a first, as pilot project to improve Immunization coverage in Urban areas under NUHM, Haryana has introduced a new intervention called E-Rickshaw for Urban ANM mobilization, in District Panchkula to ensure 100% immunization coverage in Urban areas. One E-Rickshaw is hired for alternate Vaccine delivery system, including mobility support for ANMs to session sites from Cold Chain Points and vice-versa. The replication of the project is also proposed in other four Districts in FY 2019-20 i.e. Ambala, Kurukshetra, Karnal and Jhajjar.

✓ The State of **Sikkim** has initiated Proud Mothers Scheme to ensure that every pregnant woman (during her first and second live birth) and her newborn (up to the age of six years) receive monetary assistance so that they can avail of better healthcare facilities and greater support during and after delivery. The overall aim of the scheme is to greatly reduce Maternal deaths and the Infant Mortality Rate

prevailing in the State. The long term aim of the Scheme is to improve the Total Fertility Rate as well as Child Sex Ratio and the overall health status of all women and children in the State.

✓ The State of **Himachal Pradesh** has started many initiatives to promote healthy pregnancy which deserves to be highlighted. The State has launched for the first time in India "Community Based distribution of Misoprostol to prevent postpartum Hemorrhage (PPH)" where the inaccessible pockets which have high home delivery rate were provided with Misoprostol tablets to prevent PPH. The pilot was recognized both nationally and internationally and now has been scaled up to another 11 blocks which is going a long way in preventing maternal deaths and thereby decreasing MMR. The State has for the first time in the country started a protocol to identify, monitor, and treat High Risk Pregnancies in one of the remote blocks of the State.

The initial results are encouraging and there are plans to scale up. In addition to this, continuous review of every reported maternal death and a constitution of State level Committee has enabled the State to fix responsibility in cases of gross negligence. The State has also put in a mechanism to back track cases of Severe Anemia reporting in the tertiary institutes which would ensure early detection of Anemia during the ante natal period and decrease in maternal mortality. Finally, it has put in a mechanism for audit of un-necessary referrals to tertiary institutions. This would lead to un-necessary congestion and better treatment of complicated pregnancies leading to decrease in maternal deaths.

C. Behavior Change Communication

✓ The State of **Assam** has devised Jan Andolan Strategy for Behavior Change Communication. The State initiated meetings with Doordashan Kendra – Guwahati, One community radio station (Radio luit), Big FM and Pratidin time (Local News Channel) etc. for various community awareness programme on POSHAN Abhiyaan on a regular basis.

Other activities carried out for Jan Andolan in the State are: Community based awareness meetings, Poshan rallies, Prabhat Phery on Malnutrition and anemia, Street play on Child marriage, ethnic food melas etc, celebration of *Pratham Aahar day and Matri Amrit day* are also undertaken.

✓ The State of **Bihar** has nominated Goodwill Ambassador for POSHAN Abhiyan- Bihar (Ms. Shreyasi Singh, Indian shooter, Arjun Awardee). She is promoting key health and nutrition messages to community for the improvement of nutrition status of State.

✓ Several innovative approaches and campaigns are playing a vital role in connecting communities across the State of **Chhattisgarh**. An initiative named 'Every Festival, Poshan Festival' is one initiative which has been appreciated by Hon'ble Prime Minister Narendra Modi. Messages and activities related to awareness on Malnutrition issues were incorporated through local festivals and rituals. The local popular festivals like Rakhi, Kamarchhat, Pola Utsav, Ganesh Puja, Holi etc. was dovetailed with malnutrition messages.

✓ In **Rajasthan**, Community Awareness activity is done each Wednesday, in each of the panchayat, in one revenue village of that panchayat, Pukar meetings are held where ANM, ASHA, AWW AND SWASTHYAKARMI sit at some pregnant woman's house. Videos relating to mother and child health care are shown to beneficiaries through the mobiles of ANMs.

D. Technology

✓ The State of **Jharkhand** has launched *Sahiya Sang*i portal to provide an IT

infrastructure, to track the progress of HBNC (Home Based Newborn Care). This Real time monitoring will enable to take swift actions on the most impacted areas, and decisions can be made based on the reports. This Dashboard will rank the Districts on various parameters which will showcase the best performing Districts while inspire the lower performing Districts at the same time. The portal provides Real Time tracking of monthly/yearly expenditure District/Block Wise. The portal also defines accountability for STTs, DPCs, Sahiyas to get better results. Finally, Real Time SMS to parents/*sahiya* for SNCU visits will improve the discipline for timely visits. The State has also initiated services for high risk babies which involve step by step tracking of the high risk babies from the data, such as weight on the visit dates. This system not only tracks the high risk babies but also reminds Sahiyas about the visit dates of a child via text SMS and emails.

✓ **Goa** has initiated measures to improve health outcomes of pregnant mothers and newborns. It has launched new born screening test launched in the month of August 2018 to detect errors of metabolism in new born. In order to identify high risk pregnancies, printed color coded sticker to stick on MCP cards according to their criteria. The State has also taken several initiatives to improve communication and awareness of health of mothers and children. For instance, it has provided TV sets/ LED boards in five delivery points to display IEC material; posters on ANC/ Breastfeeding/immunization etc.to display in all health centers and motherhood and Anaemia booklets to all ANC.

E. Other Initiatives

✓ **Bihar** has introduced the provision of 150 ml Milk once in a week to all registered children of age group 3-6 years at AWC. Also, eggs are being provided twice in a week to pregnant women and children registered with AWC. Double fortified salt (DFS) has been introduced in hot cook meal of ICDS and MDM currently in Tirhut division of State. The same may be scalded up throughout the State.

To ensure the capacity building of ICDS and Health field functionaries, incremental learning approach is implemented at Health Sub Centre (HSC) platform, which is a unique and one of its kind in country .

✓ The Government of Tamil Nadu is implementing *Dr. Muthulakshmi Reddy Maternity Benefit Scheme (MRMBS)* with the noble objective of providing assistance to poor pregnant women / mothers to meet the expenses on nutritious diet and to compensate them for the loss of income during the delivery period, so as to prevent low birth weight in newborn babies. The State Government has already enhanced the assistance from Rs.12,000/ to Rs.18,000/- per beneficiary.

Under 'Amma Baby Care Kit', the Government of Tamil Nadu is providing baby kits containing 16 materials for about 6.7 lakh children born annually in the Government Hospitals to mothers for improving the hygiene of the post-natal mothers and newborn babies. The State Government has also established Breast Milk Banks in 25 Government Medical College Hospitals and District Headquarters Hospitals.

✓ In **Telangana** Incentives are been given to Anganwadi Teachers for enrolling SAM Children to NRCs. The District Administration, has taken an innovative approach to bring more number of SAM children to get enrolled to NRCs located at Utnoor and Adilabad through incentivizing the efforts of Anganwadi teachers @ Rs.200 for each SAM Child who was enrolled by the respective AWTs. With this small

intervention, access to the NRCs increased by the community, CDPOs, Supervisors and AWTs are taking special interest to bring the SAM children to NRCs to fight against the under-nutrition in interior tribal tracts of Adilabad District.

- ✓ The State of Uttarakhand has proposed fortified Milk along with Cooked food twice in a week in convergence with Milk Federation- URJA. Provided to all SAM/MAM children throughout the State through Self Help Groups. The results are positive because of high nutritive value.
- ✓ Maharashtra on the other hand has developed and initiated a comprehensive training program for hospital based counselors which includes RCH component and other Disease control programmes. It is also training ASHA workers in tribal blocks for sepsis, pneumonia and diarrhea for early identification of high risk newborns, treatment and timely referral.
- ✓ **Uttar Pradesh** has initiated Mentoring of specialist (Gynecologist, Anesthetist & Pediatrician) through Regional Resource training working with Eight medical colleges. In order to reduce mortality related indicators. UP Technical Support Unit envisages to develop selected area-specific medical colleges as Regional Resource and Training Centers (RRTCs) to facilitate area-based teamwork for Maternal, Neonatal and Child Health care through continued medical education, mentoring, and regular supportive supervision ensuring effective continuum of care. These RRTCs will in turn, mentor the key personnel within the District Hospitals (DH) and identified CHC FRIJs namely obstetrician, pediatricians, anesthetist and general surgeons to improve the quality of service delivery system for maternal, newborn and child health outcomes.

UP TSU Project has aimed to scale up this mentoring program in the First Referral Units (FRU) of Northern Uttar Pradesh with an objective to complement the existing community and PHC interventions and maximize the health outcomes in the region. The FRU intervention is designed based on the learning and experience of the CHC/PHC nurse mentoring program in 25 High Priority Districts (HPDs) of Uttar Pradesh during 2014-17. The main goal of the intervention is to improve the quality of essential and emergency obstetric and newborn care in 50 identified FRUs of the region with a focus on improving provider preparedness, facility systems and client aspects for quality of care. The intervention have major focus on the management of maternal complications i.e. Hemorrhage, Hypertensive disorders during Pregnancy and sepsis among women and low birth weight, birth asphyxia and sepsis among the newborn. The project aims to cover 87 FRUs (25 DHs and 62 CHC FRUs) of 25 HPDs out of 286 FRUs in the entire State. This had a **positive impact** as the initial results demonstrate increase in the use of iron sucrose to manage moderate and severe anemia.

Uttar Pradesh -TSU initiative on Nurse Mentoring

Government of Uttar Pradesh with support from UP-TSU undertook an initiative to mentor and train staff nurses and ANMs in mini-skill labs as well as conducting emergency drills and use of case sheets as job aids in 200 blocks of 25 High Priority Districts (HPDs) of UP. The main objective is to improve the quality of critical clinical care practices during labour and immediate postpartum period and the quality of systems in public health facilities and to improve the identification, management, follow-up and referral of maternal and newborn complications.

Major components of the program are:

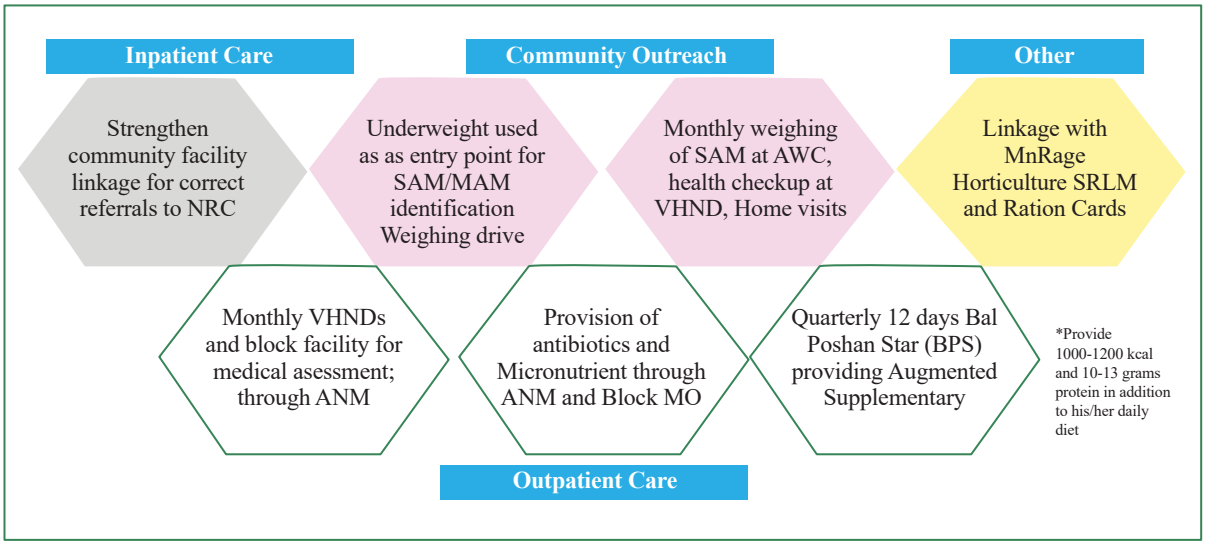
Improving Clinical Competencies of Staff Nurse and ANMs:	Quality Improvement of services in facilities	Referral Strengthening
Mentoring of ANMs in mini skill labs Outreach support to ANMs in VHNDs and sub-centers to improve the quality of RMNCH+A service	Conducting facility assessment through Self-assessment process Preparation of Facility Action Plan through root cause analysis by nurse mentors	A common platform called Vertical Integration meetings has been established for improving referral mechanisms. Referral whatsapp groups have also been made functional to improve communication of referred cases between lower and higher level facilities.

A total of 2021 staff nurses and ANMs were mentored on various skill stations from November 2017 to October 2018. Based on the success of Nurse Mentoring Program in 200 blocks of 25 HPDs, Government of UP has scaled up the nurse mentoring program across 620 blocks of the entire State to bring about substantial improvements in quality of services in the high load delivery points and to affect faster declines in maternal and newborn morbidities and mortalities across Uttar Pradesh.

Uttar Pradesh - Community Based Management of Acute Malnutrition (CMAM)

Government of Uttar Pradesh in collaboration with UNICEF, Abhyuday Sanathan and Kalawati Saran Children's Hospital, undertook a pilot of an integrated model for prevention and management of severe acute malnutrition (SAM) and moderately acute malnutrition (MAM) through community based demonstration session in Banda District of Uttar Pradesh. The duration of the pilot is from December, 2017 to March, 2020.

The approach of the Pilot is explained diagramatically below:



Pilot Results

Till now, the outcomes of Pilot have been measured in two phases.

	Phase I	Phase II	Combined Phase I and III
Total Children Weighed	5607	4675	10282
Identified Underweight Children	435	353	788
Identified SAM Cases	87 (1.5%)	66 (1.4%)	148
Treatment Outcomes			
Cured	33(39%)	24(36%)	57(38%)

CHAPTER 6:
JAN ANDOLAN

6.1 Jan Andolan

The Honourable Prime Minister intended that the POSHAN Abhiyaan be converted into a Jan Andolan for effective outreach and implementation. The Mission strives in preventing and reducing undernutrition, low birth weight, and stunting across the life cycle, but as early as possible, especially in the first three years of life and with interventions up to the age of 6 years. Several programmes across Ministries and Departments have been making serious effort to tackle the issues of malnutrition and anemia in the country. POSHAN Abhiyaan on one hand looks to synergise all these efforts by Converging to achieve the desired goals and on the other, intends to convert Awareness level at community level into a *Jan Andolan*.

Objectives: Jan Andolan is geared towards achieving the following objectives:

- Build recognition across sectors in the country on impact of malnutrition and 'call to action' for each sector's contribution to reducing malnutrition.
- To mobilize multiple sectors and communities in the country on the impact of malnutrition and contribute to reducing malnutrition.
- To generate massive awareness to build knowledge, attitudes and behavioural change to consume nutrient-rich food, practice optimal breastfeeding, complementary feeding, maternal nutrition and adolescent nutrition practices to prevent malnutrition, including SAM and anemia.

During the month of September 2018, POSHAN Maah has demonstrated the power of convergent outreach. It garnered 26 crore participation across 22.5 lakh activities across the country. As directed by the PMO on 02 February 2019, in an effort to bolster Jan Andolan and mark the first anniversary of POSHAN Abhiyaan, Poshan Pakhwada was launched on International Women's Day. Poshan Pakhada was celebrated on a pattern similar to Poshan Maah but was enhanced by Poshan Maah's learning and knowledge for increasing its efficacy amongst its audience and the overall system.

There was a tremendous enthusiasm across the country and impressive participation in various activities was witnessed. It is imperative to mention that compared to Poshan Maah, Poshan Pakhwada covered 2.7 times more people (reaching out to overall 44.8 crore people) by undertaking 3.7 times more activities (82.75 lakh activities) in half the time. Using its learning from Poshan Maah, Poshan Pakhwada also saw an approximate 280% increase in male participation across all activities, reaching out to approximately 8.53 crore men in the Pakhwada compared to 3.8 crore men during Maah.

The activities were logged in on the Jan Andolan Dashboard at the Block level. It served as a useful tool to keep track of activities under community engagement eve during Poshan Pakhwada. The total number of activities recorded on the dashboard were 1.63 crores and the population reach was 96.09 crore. These figures are too high compared to the Poshan Maah (22.5 lakh activities and 25.4 crore reach). In order to check the authenticity, veracity and data quality of the records, an extensive data cleaning exercise was conducted in field.

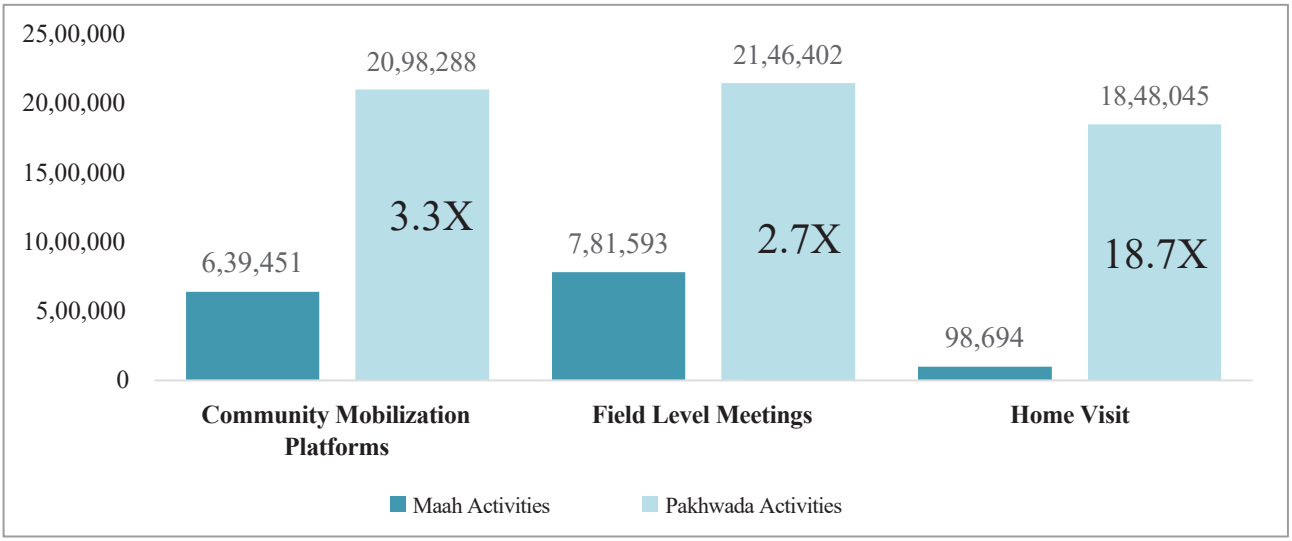


Figure: 21 Participation of the Community during Poshan Maah and Poshan Pakhwada

Figure 21 shows how Poshan Pakhwada used the learning from Poshan Maah and prioritized its top three message dissemination platforms of community mobilization, field-level meetings, and home visits. Poshan Pakhwada engaged a greater number of field level health workers for community mobilization, 20.9 lakh activities reached out to 13.5 crore people; 3.3 times than Poshan Maah. 21.5 lakh Field-level meetings reached 12.9 crore people; 2.7 times more than in Poshan Maah; 18.6 lakh Home visits were carried out, which was 18.7 times more than Poshan Maah.

Poshan Pakhwada also saw an increase in mobilization of youth and peer groups for undertaking dissemination of nutrition-based messages. These groups included School-Based peer groups -2.85 lakh groups reached out to 1.81 crore students and teachers; Self-Help Groups - over 77 thousand groups reached 47.2 lakh people; Youth Groups - over 2 lakh groups reached out to 1.2 crore people. This is noteworthy not only for the sheer numbers but also because this is one of the few opportunities where family members such as the mother-in-law and husband, usually the decision makers of the family, engaged in a dialogue for better nutrition which can lead to a permanent change for better nutrition-based behavior for the family. For the first time, 'Anemia Camps' were a focus activity in an effort to educate young girls and women about Anemia. During the Pakhwada, 2.85 lakh Anemia Camps reached out to 2.0 crore people.

Approaches:

Convergence for Jan Andolan:

Various Line Ministries like Ministry of Health & Family Welfare, Drinking Water & Sanitation, Rural Development, Human Resource & Development, Information & Broadcasting, Panchayati Raj, Tribal Affairs, Housing and Urban Affairs, Electronics and Information Technology, Minority Affairs, AYUSH, Sports & Youths Affairs, Social Justice and Empowerment, Ministry of Agriculture Cooperation and Farmers Welfare and Ministry of Consumer Affairs, Food & Public Distribution partnered with Ministry of Women and Child Development during the Poshan Pakhwada. At the grass root level platform like Gram Sabhas, SHGs, and Field functionaries across various Ministries & Schemes were used for optimum spread and coverage.

Ministry	Activities
Ministry of Women and Child Development (MoWCD)	Poshan Pakhwada, on the lines of Poshan Maah, was celebrated across the country as a part of Jan Andolan under POSHAN Abhiyaan from the 8th to 22nd March 2019. • Total 82.75 lakh activities conducted (3.6 times of Poshan Maah) with a participation of 44.8 crore (1.76 times of Poshan Maah) including 8,90,44,852 male population and 14,99,33,490 female population. • Focus was on interpersonal communication and home visits. • States like Rajasthan, Madhya Pradesh, Gujarat, Maharashtra, Chhattisgarh, Punjab, Bihar, Andhra Pradesh, and Tamil Nadu performed above average whereas Telangana performed at an average level and the rest below average (Criteria - performance by activities). • On the participatory grounds, Uttar Pradesh, Maharashtra, Rajasthan, Andhra Pradesh, Tamil Nadu, Chhattisgarh, Bihar, Gujarat, and Madhya Pradesh performed well. • Various activities undertaken were: Nukkad natak/ folk shows, Poshan Melas, cycle rally – on nutrition, home visits – AWW and mass media campaign. • Pan India mass communication was planned by the MoWCD for POSHAN Abhiyaan during the month of March 2019 as part of Poshan Pakhwada. However due to model code of conduct, the approval of PMO was not given for mass media campaign.
Ministry of Health and Family Welfare (MoHFW)	• A total of 48 lakhs children covered by home visits during Poshan Pakhwada against a target of 10 lakhs. • 1.96 lakhs "Test, Treat and Talks (T-3)" Anaemia camps organized during Poshan Pakhwada and 1.65 crore beneficiaries covered against a target of 1 crore. • Counselling on nutrition rich food and the importance of dietary diversity etc. was given at the camps along with creating awareness on various interventions under Anemia Mukt Bharat strategy.
Ministry of Rural Development/ (MoRD)	Self Help Group meetings, Haat Bazaar activities and mass media campaign.
Ministry of Housing and Urban Affairs (H&UA)	Cooperative/Federation meetings, urban SHG mela, counselling camps.
Ministry of Drinking Water and Sanitation (MoDWS)	Swachhata Jagaran, cycle rally – on hygiene and mass media campaign.
Ministry of Panchayati Raj (MoPR)	Panchayat meetings, Poshan walks, Prabhat Pheree and mass media campaign.
Ministry of Human Resource Development and Department of Education (MHRD, DoE)	School-based activities, awareness campaign for adolescent girls and mass media campaigns.
Ministry of Agriculture and Farmers' Welfare (MoAFW)	Farmer club meeting, fruits & vegetable exhibition.
Ministry of Youth Affairs and Sports (MoYAS)	Poshan rally and youth group meeting.
District and Block Admin with Support from Department of Women and Child Development/Social Welfare + Ministry of Health and Family Welfare (MoWCD + MoHFW)	Community radio activities and mass media campaign.

Under the Chairmanship of Member, Health & Nutrition, NITI Aayog, series of meetings were conducted to build the synergy between the Ministries to participate, organize and accelerate the nutrition awareness level at grassroots level. Poshan Pakhwada saw an increase in inter-ministerial convergence for implementation of activities, collaboration for greater coordination and reducing duplication of efforts. Overall, 14 Ministries undertook 17 lakh joint activities during Poshan Pakhwada. Following the trend of Poshan Maah, Poshan Pakhwada showed better results in human-centered, group activities that supported demonstration of the positive behavior. The top performing States are as shown in figure 22.

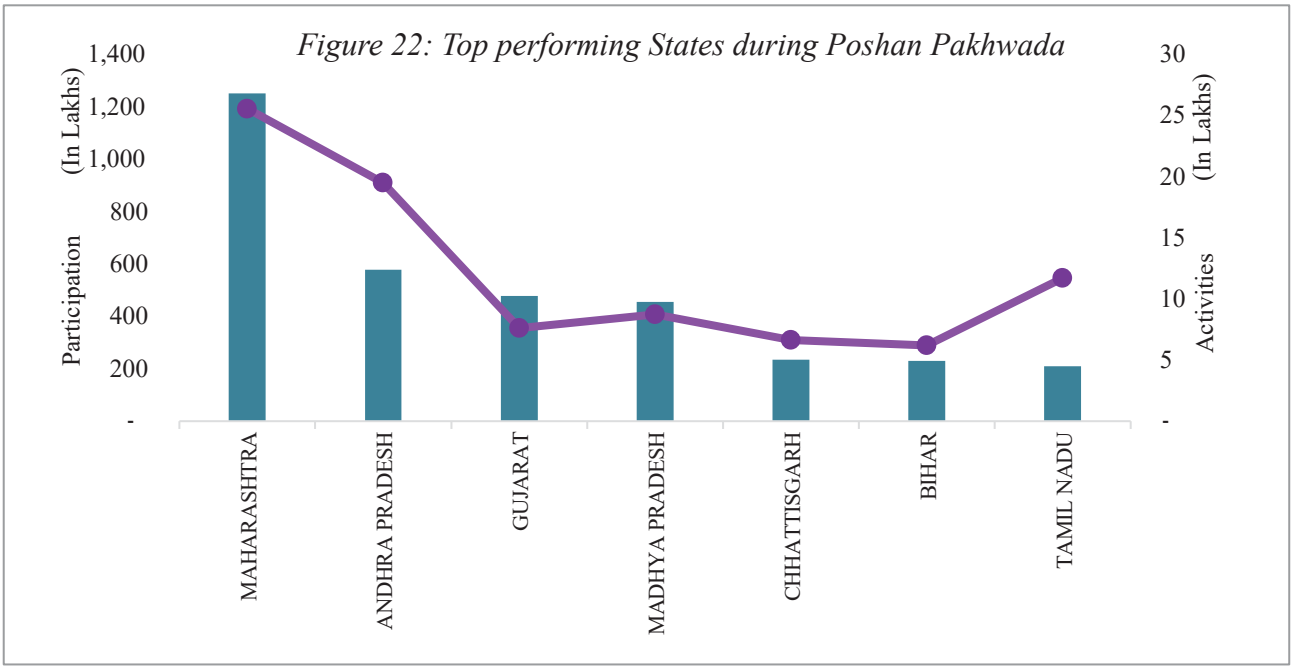


Figure 22: Top performing States during Poshan Pakhwada

6.3 Community based Events for Jan Andolan:

Community Based Events (CBEs) are being conducted for awareness generation on issues like care during pregnancy, infant and young child feeding practices, maternal nutrition etc. During the third Meeting of National Council on India's Nutrition Challenges in November 2018, it was inter alia decided to conduct two CBEs each month. In this light, all States/UTs are organizing CBEs on a regular basis, especially Godbharaai and Annaprasaan. State-wise percentage of CBEs conducted during April 2018-April 2019 is mentioned in Figure 23.

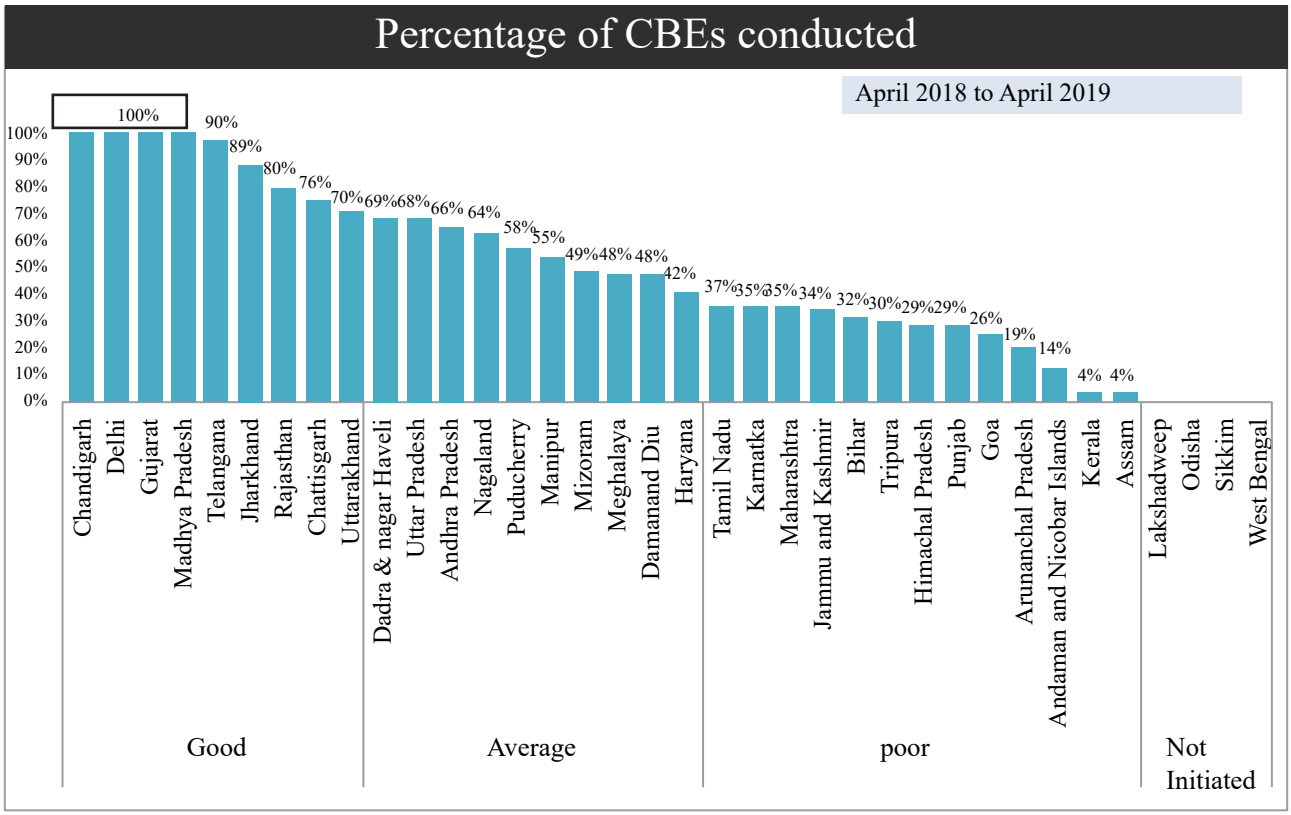


Figure 23: percentage of CBEs conducted

- Chandigarh, Delhi, Gujarat, Madhya Pradesh, Telangana, Jharkhand, Rajasthan, Chhattisgarh and Uttarakhand performed well. States/UTs like Tamil Nadu, Karnataka, Maharahstra, Jammu & Kashmir, Himachal Pradesh, Punjab, Goa, Arunachal Pradesh, Kerala, Andaman & Nicobar Islands and Assam need to improve in planning and organising theme based community based event to optimise the awareness level at targeted beneficiaries level.
- In addition to this, many States/UTs conducted various IEC/SBCC/mass media campaigns on issues like maternal health and nutrition, infant and young child feeding practices and menstrual hygiene, sanitation and hygiene. Jharkhand developed IEC materials in the form of posters, leaflets etc. VOs participated in VHSND, SBM-G and conducted Nukkad Nataks. Short clip videos on essential health and nutrition intervention like family planning, 1000 days window, ANC check-ups, IFA consumption, institutional delivery, exclusive breastfeeding, complementary feeding etc. were developed. Bihar reported to have distributed total 20,000 (two pager) leaflets in 400 blocks and 500 banners, and flip charts to 35,000 SHGs and conducted campaign on family dietary diversity among pregnant and lactating mothers during the given period. Madhya Pradesh organized various IEC/SBCC/mass media campaigns on the promotion of breastfeeding practices, tiranga thali for diet diversity, Ratri Chaupal, and radio messages etc. Uttar Pradesh reported taking Suposhan Shapath (pledge on nutrition by children, adolescents and women), disseminated messages on 'Sahi Poshan Desh Roshan', conducted rangoli designs specimens on nutrition and sanitation for SHGs and short films.

Conclusion: NITI Aayog has been consistently providing technical support to MoWCD and other line Ministries to leverage their existing platforms and campaigns to accelerate POSHAN Abhiyaan. Poshan Maah and Pakhwada celebrations in the country have set a positive momentum to make this mission into a Jan Andolan. It has made an attempt to change the way people look at nutrition and make it an intrinsic part of their lives. Many central government and State government schemes, such as Swachh Bharat Abhiyaan, DAY-NRLM, WASH, MAA, Beti Padhao Beti Bachao etc. played a crucial aspect during Poshan Pakhwada. This special campaign on POSHAN Abhiyaan succeeded in creating a special buzz at all levels, from the national level down to the village level.

CHAPTER 7: RECOMMENDATIONS

7. Recommendations:

The Government of India is committed to improving the nutritional status of children and women through POSHAN Abhiyaan. It prioritise on the first 1000 days which is a critical window of opportunity to eradicate malnutrition. The journey of first 1000 days starts from woman's pregnancy to her child's second birthday. It is critical that they receive essential services for improved nutrition of mother and child. Under POSHAN Abhiyaan Government of India is committed to improve the coverage and quality of the evidence based, most critical and effective interventions which are discussed in this Report in detail in Chapter 4.

To achieve malnutrition-free India, implementation of health and nutrition interventions needs to be strengthened. Context specific solutions to prevent children from developing malnutrition must be the priority. These solutions should be grounded in an understanding of the specific cause and drivers that lead to malnutrition. The high prevalence of underweight and wasting in India suggests the need to improve the nutritional status of women before or during pregnancy and ensure mothers to have skilled support to promote the early, exclusive breastfeeding and continued breastfeeding. These interventions are already part of existing health and nutrition schemes and programs, but not reaching children and women with desired Coverage, Continuity, Intensity and Quality (C2IQ).

A set of POSHAN Abhiyaan pillars (technology, training, processes to support convergence, and Jan Andolan) have been identified under the assumption that efforts put forth in strengthening these pillars will trigger a series of changes that improve the availability and quality of nutrition interventions in the ICDS and health system. There are core programmatic inputs including funding, human resources, supplies, and infrastructure that are critical to functioning of these POSHAN Abhiyaan pillars. Overall across the States, there are gaps that require immediate attention to strengthen the inputs and the pillars of POSHAN Abhiyaan.

Given that nutritional outcomes are impacted by multi-dimensional factors, successfully tackling malnutrition requires a systems approach wherein multiple agents align their actions through cross-sectoral convergence. It requires setting up Governance structures that enable contextualized planning at each level of implementation process and information flows that enable real time feedback to continuously improve supply side responses. It also requires taking a realistic view of the capabilities of the delivery systems; and prioritize and sequence the interventions accordingly. After one year of the launch of the Abhiyaan, we have taken stock of its progress (or the lack of it) on multiple fronts. On the basis of our assessment, we would recommend the following course of action to be prioritized by the Central and the State Governments, District Administrations and the Development Partners to synchronize our efforts to accelerate the effectiveness of POSHAN Abhiyaan in the coming time to come:

- ***Human Resource:***

  Overall across States, there are few gaps in the frontline worker positions in the ICDS and health systems, but gaps exist in supervisory cadre positions including LS, CDPOs, and DPOs. At a national level, the vacancy rates are in the range of 25% at both the CDPO and Lady Supervisor levels. This is the aggregated national scenario that varies from State to State; however, it is a clear indication of the relatively higher number of vacancies at the Supervisor level. For positions sanctioned under the POSHAN Abhiyaan, State Project Management Units (SPMUs) have not been established in two of the 19 large States (Punjab and Karnataka). Even where SPMUs have been established, 10 States have vacancy rates in the excess of 30%. In Uttar Pradesh and Haryana, less than 5% of the sanctioned posts have been filled up. Gujarat is the only large State where all

SPMU positions have been filled up. The position in smaller States is even worse. With the exception of two States (Meghalaya & Mizoram), in the rest of the States either the SPMU has not been set up altogether or even where it has been set up all positions remain vacant due to non-completion of the recruitment process. The UTs are slightly better placed with four UTs having greater than 75 % of the SPMU posts filled up. None of the posts were filled in Puducherry and Delhi. Thus, it is recommended that these gaps need to be closed at the earliest and they are critical to ensuring support to the frontline workers.

For few other schemes like PMMVY, it is recommended to fill-up contractual positions at State, District and Block levels so that the Schemes could perform well. So far only 42% and 26% recruitments have been done at State and District levels respectively Also, MoWCD should monitor HR vacancy status under these Schemes constantly and communicate to the States/UTs raising the concerns at the highest levels.

Convergence action plan committees have been established in nearly all States and UTs but CAPs have not been developed in all States and UTs. Gujarat is the only state where all the SPMU staff positions were filled. Development of these plans needs attention. More importantly, focus is needed on operationalizing the convergence action plans in a way that the interventions across sectors reach the same mother, same child, and same households in the first 1000-days.

- ***Technology and Procurement:***

  There are huge gaps in the procurement and distribution of growth monitoring devices. As per the last update only **27.6%** of AWWs across the country have been provided with Smartphones and about **35%** of AWWs have Growth Monitoring Devices (Infantometer, Stadiometer & Weighing Scales). Given that growth monitoring is one of the key activities under POSHAN Abhiyaan and it is being closely monitored at multiple administrative levels across the country, it is imperative to ensure that the basic equipment required to conduct growth monitoring is procured and distributed urgently. There is variability in coverage and reach. States and **UTs** including Assam, Gujarat, Haryana, Karnataka, Kerala, Punjab, Maharashtra, Jammu & Kashmir, Manipur, Tripura, Nagaland, Sikkim, Arunachal Pradesh, Andaman & Nicobar, Chandigarh, and Delhi need to close the distribution gaps urgently.

  While a Dashboard is available at the State Headquarters, we have not so far seen it being used for Monitoring and Evaluation purposes as well as a Decision Support Tool at the Block, District and State levels. In the absence of rigorous analytics, there is every likelihood of attrition in the quality of data collected through the ICDS-CAS.

  MoWCD and MoHFW currently use different applications for tracking the same beneficiaries leading to unnecessary duplication of efforts in data entry, besides lack of coordination in due-lists leading to a siloed approach to service delivery. Although significant resources have been dedicated to a pilot project to develop a common platform for the AAA functionaries and it has been in the works for some time now, we are yet to see a fruition of that effort.

  Data Monitoring: For improved Service Delivery and Effective Monitoring POSHAN Abhiyaan thrust is on Integrated Child Development Services (ICDS)-Common Application Services (CAS) application. Within the provided limited procurement of the Smart phones, the data collated by Anganwadi Worker is required to be monitored closely at highest level. It is recommended that the raw Data should be made available for Monitoring and Evaluation purposes. Also, exploring innovative ways to support data use for decision making will be key especially at

Block, District and State levels.

MoWCD and MoHFW currently use different approaches to track common beneficiary. Although the pilot project is under consideration where common platform can be designed and utilised by all the frontline health workers at ground level. It is required to fasten the process so as to ensure stronger service delivery convergence.

It's an urgent need to address challenges pertaining to connectivity and the software issues to ensure ICDS-CAS operations function smoothly. Only few States like Maharashtra, Rajasthan, Sikkim, Andaman & Nicobar Islands, and Daman & Diu have established helpdesks in all the Districts.

Currently the whole spectrum of energy of Abhiyaan is towards the procurement of Smartphones. On the other hand, essential component of quality of training and assessment of capabilities of AWW is not focused upon. It is highly recommended that, the aforesaid critical issues to be escalated at highest level to ensure the quality and reliability of data collected.

Nearly all States report that they are well-equipped with the **basic stocks** of IFA, TT injections, and albendazole. There are some exceptions including Nagaland, Delhi, Madhya Pradesh, Uttar Pradesh, which report stockouts of either IFA or albendazole. An urgent investigation is needed to examine the reasons for such high levels of stockouts in some States and actions are needed to close these gaps. IFA and albendazole are critical preventive approaches to anemia and stockouts of these drugs cannot be ignored.

- ***Convergence:***

  Convergence can be seen at two levels: (a) Governance level which creates institutional mechanism to ensure coherent response from multiple departments; and (b) Impact level where "effective convergence" implies successful reach of programs from relevant sectors that address the key determinants of undernutrition for the same household, same woman and same child.

  As has been pointed out earlier while discussing the CNNS results, our success in effective convergence of critical services at the household level has been fairly modest. Since the launch of POSHAN Abhiyaan, several coordinated policy announcements by concerned Ministries; strengthening the platforms of service deliveries such as VHSND and effective demand side push to drive behavioural change in health seeking behaviour of households through the high voltage Jan-Andolan campaign during the preceding year are likely to improve convergence as well as coverage of interventions, but in the absence of validated real time data we can only speculate. We would have a much clearer picture of this when NFHS 5 results are released later this year. However, early results in the Household Survey carried out by the NITI Aayog in the 27 Aspirational District in July 18 (Round1) and January 19 (Round 2) have shown over **15.7%** and **19.1%** increase in use of ORS and Zinc Treatment for Diarrhoea respectively; a **9.54%** increase in Early initiation of Breastfeeding and **3.47%** increase in ANC registration in the first trimester. This shows that it is possible to have big gains in coverage in relatively short periods of time with determined efforts. Along the lines of the recommendations stated in the earlier Report, we would like to reiterate that continued engagement with Chief Ministers and Chief Secretaries on issues that require cross-sectoral efforts and monitoring at the highest levels, must be ensured. We further need a renewed push for creation of **institutional mechanisms at the State, District, Block and Village** levels to accelerate convergent action required for the implementation of POSHAN Abhiyaan. We

would need to ensure that as a team to implement them effectively at the ground level; keeping in mind the capacities for delivery of those services.

Leanings from the existing State level convergence models should be considered to scale up should. For eg: Self Help Group federation of **JEEViKA model in the State of Bihar** created a promising platform for reaching the community. Around 8.5 lakh SHGs are created to reach more than 1 Crore households. JEEViKA's Health, Nutrition and Sanitation Strategy focuses on the most critical period i.e 1000 day life cycle approach. They impact evaluation of the project revealed that in the matter of 2 years the indicator of **complimentary feeding** which remained stagnant for years showed more than 2 fold improvement *(both in minimal acceptable diet and minimum dietary diversity).*

Another model shown by **Government of Chhattisgarh** where convergence of various schemes by like State Rural Livelihood Mission in the District of Surguja showed an enhancement of many indicators at grass root levels. It showed a decline of about 23% in malnutrition rates from 12.7%; functional utilization from 61% to 100% are some of the achievements of this model.

Similarly, Ajeevika initiative of **Government of Jharkhand** where engagement of the Sakhi Mandal members as Business Correspondent (BC) Sakhi is done. Currently, the practice of Poshan Vatika is prominently being observed in three districts of Jharkhand, namely Hazaribagh, Ramgarh and East Singhbhum. Members of Sakhi Mandals are being provided special trainings focused on "Importance of Nutrition Garden and Cultivation Techniques". The food plates of the rural families in these regions contain nutrient rich foods. Further, the gradual decline in terms of deficiency prone diseases as well as less number of cases of stunting and wasting among under-5 children point towards positive change. It is recommended to consider these interventions for scaling-up at higher levels.

In several Aspirational Districts the strengthening of Village Health Sanitation & Nutrition Days (VHSNDs) have been demonstrably proved to be an efficient platform of converged service delivery at the village level. As per our assessment, a large number of services comprising the package of interventions can be delivered through the VHSND and it would also help streamline the due lists of the ASHA, Anganwadi, ANM trio. We need to scale it up and ensure that high quality service delivery can happen through these VHSNDs. We also need to expedite issue of Guidelines relating to the disbursal of joint incentives for the frontline line workers.

- ***Coverage and Quality of Nutrition Related Interventions:***

  For the implementation of health and nutrition interventions to be strengthened, in accordance with the C^2IQ framework, it is important that the gap areas identified under each of the four POSHAN Abhiyaan pillars are adequately addressed. The key elements of these four pillars need to be strengthened to facilitate implementation of interventions with full coverage, continuity, intensity and quality.

  As per the data from latest **Comprehensive National Nutrition Survey (CNNS)**-discussed in detail in the earlier sections, the current coverage of interventions is sub-optimal. Given that there are national platforms available to deliver all the interventions under POSHAN Abhiyaan, the potential for reach of these interventions is 100 percent. However, the current coverage rates are lower than 55 percent for several interventions. In addition, there is a high variability across States for the coverage of various interventions.

The supplementary nutrition program (SNP) is one of the six services provided under the Integrated Child Development Services (ICDS), Within this, the **Take Home Rations** (THR), provided to pregnant and lactating mothers and children (7 months-3 years) is a crucial component and covers a substantial proportion of the ICDS budgetary allocation. As identified in recent research efforts and program experiences, several challenges remain in ensuring that the ICDS-THR is effective in its quality, reach and impact. Also, in Aspirational District Program, it is observed that the uptake of THR is as low as 6% in some Districts. These challenges are suggested to review for the composition and nutritional quality of THR; Production and Distribution model of THR and Coverage and Consumption of THR.

To make POSHAN Abhiyaan reach out to the most unreachable, it is utmost important at this stage to improve the coverage of nutritional interventions with quality, intensity and continuity.

- ***Fund Utilization:***

  Utilization of funds for any program is one of the proxy indicators of its successful implementation. Variation in terms of utilization is observed across the country. The cumulative utilization rate is about 20% in the Large States; Small States and UTs have utilised on an average about 42% of the allocated funds. Haryana, Tamil Nadu, Punjab, Kerala, Delhi and Goa have a utilization rate of less than 5%. Even where funds have been released by the Government of India, tardiness in completing the procurement process of Growth Monitoring devices and Smart phones through the GeM portal precludes us from reaping the full benefit of scheme by the frontline workers and intended beneficiaries.

- ***Jan Andolan:***

  While the Jan Andolan activities are being organized with great enthusiasm, it is imperative that such enthusiasm continues throughout the years and beyond the designated months to ensure behaviour change. The spirit of Poshan Maah was continued to be visible in Poshan Pakhwada held in the month of March 2019.

  Marking the annual event of POSHAN Maah, the enthusiasm should be maintained and the efforts are required to reach the masses with information and importance of nutrition through various events and activities. The upcoming Poshan Maah will be celebrated with a theme **'Complementary Feeding'**. There is an urgent need to improve the behaviour which can lead to better complementary feeding practices. Standardised messages which can be adopted specific to the region and language should be developed so that it can reach the beneficiaries in accurate manner.

  As a next phase of community engagement, the engagement with elected representatives at all levels – from the **Parliament to the Panchayats** is already initiated. It is critical at this stage is to carefully design the appropriate messaging, content and media from the already existing resources to facilitate this engagement. MWCD, MoRD and Ministry of Panchayati Raj are working closely together to jointly plan this campaign. Development Partners and NITI Aayog can be used as facilitators to develop a sustained movement around this work stream. This could also be used a platform to engage with the SHGs to ensure that they can be roped in to play a role in the Abhiyaan.

- ***Training:***

  It is not complete across all the DRGs and there are huge gaps in ILA training of LS and AWWs across multiple States and UTs. Without training, the frontline functionaries are not adequately equipped to deliver services. Therefore, there is an urgent need to pay attention to State-specific challenges

pertaining to low attendance at trainings, insufficient funds, unavailability of training materials or equipment, lack of trainers and low quality of training. Only few States and UTs where all LS and AWWs have been trained on 6 or more ILA modules are Andhra Pradesh, Tamil Nadu, Mizoram, Chandigarh, Dadra & Nagar Haveli, and Daman & Diu.

- ***Infrastructure:***
  State like Bihar, which are high-burden States that are lagging behind in several health and nutrition indicators are also facing lingering issues pertaining to infrastructure including availability of functional CHCs and sub enters. It is important that such States are prioritized in building the required infrastructure.
  The setting up and recruitment of personnel of State and District Nutrition Management units needs to be expedite since they will make a difference to the quality and speed of program implementation.

ANNEXURES

ANNEXURE 1A:
Second POSHAN Abhiyaan Monitoring Report: Data Collection Form

WCD TEMPLATE
[Kindly fill information as on 31st March, 2019 and share latest by 20th April, 2019]

1. Name of the State/UT:

2. Total number of Districts in the State:

3. Total number of Blocks in the State:

4. Total number of Villages in the State:

5. Total number of Anganwadi Centers in the State/UT:

6. If UT, does the UT have a State Legislature? Yes || No

SECTION I: GOVERNANCE AND INSTITUTIONAL MECHANISMS

SN	INFORMATION REQUIRED	RESPONSE	
A	**UTILIZATION OF FUNDS under POSHAN Abhiyaan (2018 - 19)**		
1.1	a) Amount of Funds received from GoI (in lakhs)		
	b) Funds Earmarked by the State/UT (in lakhs)		
	c) Funds utilized at the State/UT level (in lakhs; as on 31st March 2019) – *Note: Can specify unaudited funds also*		
	d) % of funds utilised		
1.2	If any of the above figures is "zero", give reasons		
1.3	**Utilization of Funds under other related Schemes (2018 - 2019)**		
	Amount of Funds available from (2018 - 19):	Central Govt Share (in *Lakhs*)	State Govt Share (in *Lakhs*)
	a. ICDS Scheme		

SN	INFORMATION REQUIRED	RESPONSE	
	b. *Pradhan Mantri Matryu Vandana Yojna* (PMMVY)		
1.4	**Provide the amount and % fund utilization for (2018-19):**		
	a. ICDS Scheme		
	b. *Pradhan Mantri Matryu Vandana Yojna* (PMMVY)		
1. 5	Applied for flexi funds for innovations and pilot	Yes || No || Not Aware about flexi - funds	
B	**CONSTITUTION OF COMMITTEES AND RESOURCE GROUPS**		
1. 6	Has the State /UT Project Management Unit been established?	Yes || No	
1. 7	If yes, staff details	No. of posts sanctioned	
		No. of posts filled	
1. 8	Has a Convergence Action Plan Committee been formed at State /UT level?	Yes || No || In process	
1. 9	Provide details.	No. of District s in which Convergence Action Plan Committee has been formed	
		No. of Blocks in which Convergence Action Plan Committee has been formed	
1. 10	Has State /UT l evel Resource Group for ILAtraining been established?	Yes || No	
1. 11	Have District level Resource Groups (DRGs) for ILA training been established?	Yes || No	
	If yes, provide details	No. of DRGs required	
		No. of DRGs established	
1.1 2	Have Block l evel Resource Groups (BRGs) for ILA training been established?	Yes || No	
	If yes, provide details	No. of BRGs required	

SN	INFORMATION REQUIRED	RESPONSE	
		No. of BRGs established	
1.1 3	a) Number of District s in which the help desks have been established at District level ?		
	b) Number of District s in which the help desks have been established at Block level ?		

SECTION II: STRATEGY AND PLANNING

SN	INFORMATION REQUIRED	RESPONSE	
A	**CROSS-SECTORAL CONVERGENCE**		
2.1	Has the State /UT level Convergence action plan been developed?	Yes || No	
2.2	Has the State /UT level Convergence action plan been submitted as part of the Annual PIP for the year **2019 - 20**	Yes || No	
	If yes, provide details	No. of Districts which have developed District Convergence action plan	
		No. of Blocks which have developed Block Convergence action plan	

SECTION III: SERVICE DELIVERY INPUTS

SN	INFORMATION REQUIRED	RESPONSE	
A	**HUMAN RESOURCE: Provide following details**		
3.1	a) DPO	No. of posts sanctioned	
		No. of posts filled	
3.2	b) CDPO	No. of posts sanctioned	
		No. of posts filled	
3.3	c) Lady Supervisor	No. of posts sanctioned	
		No. of posts filled	
3.4	d) AWW	No. of posts sanctioned	
		No. of posts filled	
3.5	e) AWH	No. of posts sanctioned	
		No. of posts filled	
B	**SUPPLIES**		
3.6	a) Mobile phones	No. required	
		No. procured	
		No. configured	
		No. distributed to Districts	
		No. functional at ground level	
3.7	b) SIM cards for mobile phones	No. required	
		No. procured	
3.8	c) Data connectivity plans	No. of data plans required	
		No. of data plans activated	
3.9	Please specify the concerns related to mobile phone functioning at ground level (If any)		

SN	INFORMATION REQUIRED	RESPONSE		
	Kindly attach it as an annexure			
3.10	**Growth Monitoring Devices**	**No. required**	**No. procured**	**No. distributed**
	a) Weighing Scale (Infant)			
	b) Weighing Scale (adult)			
	c) Infantometer			
	d) Stadiometer			
C	**TRAINING AND CAPACITY BUILDING**			
3.11	Has ILA training has been initiated for State /UT Resource group?	Yes || No		
3.12	Has the ILA training been initiated for the District Resource groups	Yes || No		
3.13	If yes, provide the details	No. of DRG members to be trained		
		No. of DRG members trained		
3.14	**Provide the details of the ILA training**	No. of Modules	No. of LS trained	No. of AWW trained
		Less than 5		
		6-10		
		More than 10		
3.15	Has State /UT translated the ILA modules to **ALL** the State languages other than Hindi and English?	Yes || No || NA		
3.16	Has State /UT printed the ILA modules as per the guidelines and specification given by MWCD?	Yes || No		
3.17	Is the State /UT planning to provide ILA trainings to ASHA workers?	Yes || No		
3.18	If yes, specify no. of ASHAs trained till 31st March, 2019	No. of ASHAs to be trained		
		No. of ASHAs trained		
3.19	Does the State /UTs have access to ICDS - CAS Dashboard?	Yes || No		

SN	INFORMATION REQUIRED	RESPONSE		
3.20	Who at the State /UT level is authorized to review and use ICDS-CAS dashboard?			
3.21	**Staff trained on ICDS-CAS Dashboard/Mobile**	Personnel	No. t o be trained	No. Trained
		DPOs		
		CDPOs		
		LSs		
		AWWs		

SECTION IV: PROGRAM ACTIVITIES AND INTERVENTION COVERAGE

A	PROGRAM ACTIVITES -ICDS		
4.1	Total number of beneficiaries from **1st April 2018 to 31 st March 2019.**	Pregnant women	
		Lactating women	
		Children 6 to <36 months of age	
		Children 3 -6 years of age	
4.2	**Data Entry in ICDS-CAS**		
	a) No. of District s where ICDS-CAS is functional		
	b) No. of AWWs who have started entry in ICDS -CAS		
	c) No. of AWWs who have completed beneficiary data in ICDS-CAS		
	d) No. of AWWs who have used ICDS -CAS to submit their Monthly Progress Report through CAS in the previous month.		
4.3	Has State /UT started the process of providing Incentives to AWW/AWH as per the MWCD Guidelines?	Yes || No	
4. 4	**If yes, provide the following details**		
	a) Number of workers who received	No. of AWW	

	Incentives (till **31st March 2019)**	No. of AWH	
	b) Number of District s received award for the best performance in the year 2018-19	No. of District s	
4. 5	**Details of Community Based Events under POSHAN Abhiyaan (held in the month of March 2019):**		
	a) Percentage of AWCs in State /UTs that organised community based events in the month of **March 2019**		
	b) Average number of participants per event		
	c) Themes covered		
4. 6	**Details on VHSND organised in the Month of March 2019**		
	a) Total no. of VHSND organized in the State /UT events in the month of **March 2019**	No. of VHSNDs planned	
		No. of VHSNDs organized	
	b) % of villages in State /UT provide ALL the activities mandated under VHSND namely: *Antenatal Check -up; Growth Monitoring of children upto 2 yrs; Immunization; Supplementary nutrition; Health and Nutritional Counselling and Referral*		
4. 7	**Take Home Rations/ Food Supplementation under ICDS Program**		
	What is the State /UT policy on frequency and amount of THR to be distributed per month per beneficiary (please provide details as attachment if space is insufficient)	Pregnant Women	
		Lactating Women	
		Children 6 - 36 months of age	
4. 8	No. of beneficiaries who received mandated THR from **1st April 2018 to 31 st March 2019** .	**Beneficiary**	**No. of beneficiaries who received THR as mandated**
		Pregnant Women	
		Lactating	

		Women			
		Children 6 - 36 months of age			
4. 9	Does fortified foods being used in preparation of hot cooked meals? (eg: Oil, Salt, Rice, wheat products)	YES || NO			
		If yes, in how many AWCs			
4. 10	**Growth Surveillance and Management: 1st April 2018 to 31st March 2019**				
	a) No. of beneficiaries who were weighed:	No. of pregnant women			
		No. of children 6 - <36 months			
		No. of children 3 -6 years of age			
	b) No. of children from 6-59 months who are	**Children**	**Identified**	**Referred**	**Treated**
		Severely Acute Malnourished Children (SAM)			
		Moderately Acute Malnourished Children (MAM)			
	c) No. of malnourished children who received increased Supplementary Nutrition .	Severely Acute Malnourished Children (SAM)			
		Moderately Acute Malnourished Children (MAM)			
B	**HOME VISITS by AWW**				
4.1 1	Out of the mandated number of home visits (as per the home visit planner, or the home visit scheduler in CAS), the % of home visits made by AWWs during the month of **March 2019**				
4.12	%of home visits to household with pregnant mothers to counsel on appropriate practices during pregnancy during the month of **March 2019**				
4.13	PMMVY scheme during the month of till **March 2019**	No. of pregnant women targeted		No. of pregnant women benefited as per the entitlement	
4.14	%of home visits to household with **young infant (less than 1 month)** to counsel on				

	Importance of immediate breastfeeding **March 2019**	
4.15	%of home visits to household with **infants (5-6 months of age)** to counsel on Importance of initiation of complementary feeding and continued breastfeeding **March 2019**	

SECTION V: ADDITIONAL INFORMATION

SN	INFORMATION REQUIRED
5.1	Specify the main challenges faced in implementation of POSHAN Abhiyaan at State /UT level with respect to: (Provide details as attachment) (i) ICDS_CAS (ii) ILA (iii) HR (iv) Growth Monitoring Devices (v) Convergence (vi) Jan Aandolan/Community based events (vii) Any other
5.2	Specify the good practices or innovations State /UT has done in the year 2018-19 to improve the nutrition indicators during the first 1000 days life cycle : (Provide details as attachment)

ANNEXURE 1B:
Second POSHAN Abhiyaan Monitoring Report: Data Collection Form

HEALTH TEMPLATE
[Kindly fill information as on 28th February, 2019 and share latest by 20th April, 2019]

1. Name of the State/UT:

2. Total number of Districts in the State:

3. Total number of Blocks in the State:

4. Total number of Villages in the State:

5. Total number of Anganwadi Centers in the State/UT:

6. If UT, does the UT have a State Legislature? **Yes** || **No**

SECTION I: SERVICE DELIVERY ESSENTIALS

SN	INFORMATION REQUIRED	RESPONSE	
A	**INFRASTRUCTURE**		
1.1	**Number of Health Facilities in the State/UT**		
	a) CHCs	No. sanctioned	
		No. functional	
		No. functional as FRU	
	b) PHCs	No. sanctioned	
		No. functional	
	c) Additional PHCs	No. sanctioned	
		No. functional	
	d) Sub Centres	No. sanctioned	
		No. functional	
	e) Health and Wellness Centres	No. sanctioned	
		No. functional	
1.2	**Provide details for Health and Wellness Centres (HWCs)**		
	a) Total no. HWCs p lanned		
	b) No. of HWCs operational		
	c) No. of HWCs providing ALL the proposed services		

B	**HUMAN RESOURCES**		
1.3	Lady Health Visitor (LHV)	No. of posts sanctioned	
		No. of LHVs in position	
	ANM	No. of posts sanctioned	
		No. of ANMs in position	
	ASHA Facilitators	Total no. in State /UT	
		No. of ASHAs per facilitator	
	ASHA	Total no. of ASHAs working in State /UTs	
		No. of villages with one ASHA	
		No. of villages with two or more ASHA	
		No. of villages without ASHA	
C	**SUPPLIES INFORMATION FOR THE MONTH OF FEB 2019 (Feb 1 to Feb 28, 2019)**		
1.4	**Number of Districts which reported STOCK-OUT of the following for the month of Feb 2019 (Feb 1 to Feb 28, 2019):**		
	a) IFA Red tablets (adult)		
	b) Pregnancy detection kit		
	c) IFA syrup		
	d) Calcium tablets		
	e) Albendazole tablets		
	f) TT injections		
	g) Any modern contraceptives (OCPs, condoms etc.)	No. of District s reporting stock -out	
		Specify which items were stock -out	
	h) Consumables for a naemia detection kits		
	i) Iron-Sucrose injections		
	j) Oxytocin		
	k) Oral Misoprostol		
	l) ORS packets/sachets		
	m) Zinc syrup/tablets		

	n) MCP Card		
D	**TRAINING AND CAPACITY BUILDING**		
1. 5	Provide the details of the ASHAs trained in module 6 and 7 which pertain to Home Based New Born Care (HBNC) till **28 th Feb 2019**	No. of ASHAs targeted	
		No. of ASHA trained	
1. 6	In which year was the last round of HBNC training conducted in the State /UT		
1. 7	Provide details for the Skilled Birth Attendant (SBA) trainings for ANMs.	No. who have received SBA training	
		No. who have received **refresher** SBA training	
		No. of SBA trainings conducted from 1st April 2018 to 28th Feb 2019	

SECTION II: PROGRAM ACTIVITES AND INTERVENTION COVERAGE
Information is required for ONE YEAR (1st April 2018 to 28th Feb 2019)

SN	INFORMATION REQUIRED	RESPONSE		
A	**PROGRAM ACTIVITES- NHM**			
2.1	Total number of beneficiaries registered **(for the period of 1st April 2018 to 28th Feb 2019)**	Pregnant women registered for ANC	**I trimester**	
			II trimester	
			III trimester	
		Children 0-59 months of age	**0-6 month**	
			6-59 month	
		Children 12 - 23 months of age		
2. 2	Health interventions in first 1000 days **(Provide data for the period of 1st April 2018 to 28th Feb 2019)**			
	a) No. of registered pregnant women who	Received MCP cards		
		Had MCP cards filled		
	b) No. of pregnant women who registered for ANC in the first trimester (i.e. in the first 12 weeks of pregnancy)			

	c) No. of pregnant women who received 4 or more ANC check-ups		
	d) No. of pregnant women given 180 IFA tablets		
	e) No. of pregnant women who had their weight gain monitored during pregnancy		
	f) No. of pregnant women with adequate weight gain (9-12 kg) during pregnancy		
	g) No. of pregnant women given TT2/booster		
	h) No. of pregnant women given one Albendazole tablet after first trimester		
	i) No. of pregnant women who received counselling on birth preparedness and complication readiness during pregnancy		
	j) No. of pregnant women **tested** for Haemoglobin 4 or more times during pregnancy		
	k) No. of pregnant women **detected** to have severe anemia (Hb level <7 gm%) in any trimester		
	l) No. of pregnant women detected with severe anaemia treated		
	m) No. of high risk pregnancies **identified**		
	n) No. of high risk pregnancies **referred**		
2.3	**Total number of reported deliveries for the period of 1st April 2018 to 28th Feb 2019**		
	a) No. of home deliveries attended by Skilled Birth Attendant (SBA)		
	b) No. of home deliveries attended by non-SBA/ Trained Birth Attendant (TBA)		
	c) No. of institutional deliveries	**Normal**	
		C-section	
2.4	**Provide details of live births for the period of 1st April 2018 to 28th Feb 2019**		
	a) Total no. of live births		

	b) No. of newborns weighed at birth		
	c) No. of newborns with weight less than 2.5 kg at birth		
	d) No. of new borns breastfed within one hour of birth		
	e) No. of newborns who received mandated Home Based Newborn Care (HBNC) visits by ASHA*	6 in case of institutional deliveries	
		7 in case of home deliveries	
2.5	**Provided the following details for children 12-59 months of age for the period of 1st April 2018 to 28th Feb 2019**		
	a) No. of children 12-23 months completely immunized		
	b) No. of children 12-23 months who were provided at least 8 doses of IFA syrup per month		
	c) No. of children 12-23 months who have received at least one dose of Vitamin A		
	d) % of children 12-23 months who received at least one dose of Albendazole		
2.6	**Provide the following information for the period of 1st April 2018 to 28th Feb 2019**		
	a) No. of diarrhea episodes reported in children 0 to 59 months of age		
	b) No. of diarrhea episodes reported in children 0 to 59 months of age where only ORS was given		
	c) No. of diarrhea episodes reported in children 0 to 59 months of age where both ORS and zinc were given		

SECTION III: ADDITIONAL INFORMATION

SN	INFORMATION REQUIRED	RESPONSE
3.1	Specify the good practices or innovations State/UT has done in the year 2018-19 to improve the health indicators during the first 1000 days life cycle: (Provide details as attachment)	

Annexure 2: Implementation Score Rubric

Rubric						
	Theme	**Sub- Theme**	**Sub Sub-Theme**	**Indicators (as per Template)**	**Type**	**Weights (TOTAL- 100)**
	WCD template TOTAL-65					
1	**Governance & Institutional Mechanism**					**19**
	1.1	**Fund Allocation**				**4**
				% utilized by the State/ UT (as on 31st March 2019 – **A. Q1.1 d**	%	1 if <25% 2 if 25%-<50% 3 if 50%-<75% 4 if ≥ 75%
	1.2	**Constitution of Committees and Resource Groups**				**15**
				% of posts filled in the SPMU – **B.Q1.7 (No. of posts filled/No. of posts sanctioned)**	%	0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of districts where the convergence action plan committees have been formed - **B Q.1.9/Total number of districts**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of blocks where the convergence action plan committees have been formed - **B Q.1.9/Total number of blocks**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of districts where DRGs have been formed – **Q1.11 No. of DRGs established/ No. of DRGs required**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of blocks where BRGs have been formed **- Q1.12 No. of BRGs established/ No. of BRGs required**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%

Rubric						
	Theme	**Sub- Theme**	**Sub Sub-Theme**	**Indicators (as per Template)**	**Type**	**Weights (TOTAL- 100)**
2	**Strategy and Planning**					**6**
	2.1	**Cross-sectional convergence**				**6**
				Has the State/UT level Convergence action plan been submitted as part of the Annual PIP for the year 2019-20- Q2.2	Y/N	3 if YES; 0 if NO
				% of districts that developed CAP - Q2.2/ Total number of districts	%	0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
3		**Service Delivery & Capacities**				**31**
	3.1	**HR**				**5**
				% of DPO positions filled – Q3.1 – No. of DPO positions filled/No. of DPO positions sanctioned	%	0.25 if <25% 0.5 if 25%-<50% 0.75 if 50%-<75% 1 if ≥ 75%
				% of CDPO positions filled - Q3.2 – No. of CDPO positions filled/No. of CDPO positions sanctioned		0.25 if <25% 0.5 if 25%-<50% 0.75 if 50%-<75% 1 if ≥ 75%
				% of LS positions filled - Q3.3 – No. of LS positions filled/No. of LS positions sanctioned		0.25 if <25% 0.5 if 25%-<50% 0.75 if 50%-<75% 1 if ≥ 75%
				% of AWW positions filled- Q3.4 – No. of AWW positions filled/No. of AWW positions sanctioned		0.25 if <25% 0.5 if 25%-<50% 0.75 if 50%-<75% 1 if ≥ 75%
				% of AWH positions filled - Q3.5 – No. of AWH positions filled/No. of AWH positions sanctioned		0.25 if <25% 0.5 if 25%-<50% 0.75 if 50%-<75% 1 if ≥ 75%

Rubric						
	Theme	**Sub- Theme**	**Sub Sub-Theme**	**Indicators (as per Template)**	**Type**	**Weights (TOTAL- 100)**
	3.2	**Supplies**				**5**
		Mobile phones		% of mobile phones distributed to districts **- Q3.6 – No. of mobile phones distributed /No. of mobile phones required**		0.25 if <25% 0.5 if 25%-<50% 0.75 if 50%-<75% 1 if ≥ 75%
		Growth monitoring devices	Weighing scale- infant	% distributed to districts- **Q3.10 a– No. of weighing scales-infant distributed /No. of weighing scales-infant required**		0.25 if <25% 0.5 if 25%-<50% 0.75 if 50%-<75% 1 if ≥ 75%
			Weighing scale- adult	% distributed to districts **Q3.10 b – No. of weighing scales-adult distributed /No. of weighing scales-adult required**		0.25 if <25% 0.5 if 25%-<50% 0.75 if 50%-<75% 1 if ≥ 75%
			Infantometer	% distributed to districts **Q3.10c – No. of infantometers distributed /No. of infantometers required**		0.25 if <25% 0.5 if 25%-<50% 0.75 if 50%-<75% 1 if ≥ 75%
			Stadiometer	% distributed to districts **Q3.10 d – No. of stadiometers distributed /No. of stadiometers required**		0.25 if <25% 0.5 if 25%-<50% 0.75 if 50%-<75% 1 if ≥ 75%
	3.3	**Training and capacity building**				**21**
				% DRGs trained in ILA **Q3.13 – No. of DRGs trained /No. of DRGs to be trained**		1 if <25% 2 if 25%-<50% 3 if 50%-<75% 4 if ≥ 75%
				% of LS trained on 6 or more modules **Q3.14 – (No. of LS trained on 6-10 modules + No. of LS trained on 10 or more modules)/ No. of LS posts filled (Q3.3c)**		1 if <25% 2 if 25%-<50% 3 if 50%-<75% 4 if ≥ 75%
				% of AWW trained on 6 or more modules **Q3.14 – (No. of AWW trained on 6-10**		1 if <25% 2 if 25%-<50%

Rubric						
	Theme	**Sub- Theme**	**Sub Sub-Theme**	**Indicators (as per Template)**	**Type**	**Weights (TOTAL- 100)**
				modules + No. of AWW trained on 10 or more modules)/ No. of AWW posts filled (Q3.3d)		3 if 50%-<75% 4 if ≥ 75%
				% DPOs trained on ICDS-CAS Dashboard/Mobile **Q3.21 – (No. of DPOs trained on ICDS-CAS/ No. of DPO posts filled (Q3.1a)**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% CDPOs trained on ICDS-CAS Dashboard/Mobile **Q3.21 – (No. of CDPOs trained on ICDS-CAS/ No. of CDPO posts filled (Q3.1b)**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% LS trained on ICDS-CAS Dashboard/Mobile **Q3.21 – (No. of CDPOs trained on ICDS-CAS/ No. of CDPO posts filled (Q3.1c)**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
4	**Program activities and intervention coverage**					**9**
	4.1	**Program activities- ICDS**				**9**
				% of pregnant women who received THR **Q4.8 – No. of pregnant women received THR/ Q4.1 Total number of pregnant women**	%	0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of lactating women who received THR **Q4.8 – No. of lactating women received THR/ Q4.1 Total number of lactating women**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of children 6-36 months who received THR **Q4.8 – No. of 6-36 mo children received THR/ Q4.1 Total number of 6-36 mo children**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
	Health template TOTAL-35					

Rubric						
	Theme	**Sub- Theme**	**Sub Sub-Theme**	**Indicators (as per Template)**	**Type**	**Weights (TOTAL- 100)**
1	**Service delivery essentials**					**17**
	1.1	**Infrastructure**				**4**
				% of sub-centres functional -**Q1.1 d No. of sub-centers functional/No. of sub-centers sanctioned**		0.5 if <25% 1 if 25%-<50% 1.5 if 50%-<75% 2 if ≥ 75%
				% of CHCs functional--**Q1.1 a No. of CHCs functional/No. of CHCs sanctioned**		0.5 if <25% 1 if 25%-<50% 1.5 if 50%-<75% 2 if ≥ 75%
	1.2	**Human Resource**				**3**
				% of LHV posts filled -**Q1.3 No. of LHVs in position/No. of LHV posts sanctioned**		0 if <25% 0.5 if 25%-<50% 1 if 50%-<75% 1.5 if ≥ 75%
				% of ANM posts filled- **Q1.3 No. of ANMs in position/No. of ANM posts sanctioned**		0 if <25% 0.5 if 25%-<50% 1 if 50%-<75% 1.5 if ≥ 75%
	1.3	**Stock out**				**6**
				% districts that reported stock-out of IFA red tablets in the month of Feb 2019 - **Q1.4 a No. of IFA tablets stock-out districts/Total number of districts in the state (Q2)**		2 if <25% 1.5 if 25%-<50% 1 if 50%-<75% 0.5 if ≥ 75%
				% districts that reported stock-out of TT injections in the month of Feb 2019-- **Q1.4 f No. of TT injection stock-out districts/Total number of districts in the state (Q2)**		2 if <25% 1.5 if 25%-<50% 1 if 50%-<75% 0.5 if ≥ 75%
				% districts that reported stock-out of albendazole in the month of Feb 2019 -- **Q1.4 e No. of albendazole stock-out**		2 if <25% 1.5 if 25%-<50% 1 if 50%-<75%

Rubric						
	Theme	**Sub- Theme**	**Sub Sub-Theme**	**Indicators (as per Template)**	**Type**	**Weights (TOTAL- 100)**
				districts/Total number of districts in the state (Q2)		0.5 if ≥ 75%
	1.4	**Training and capacity building**				**4**
				% of ASHAs training on HBNC modules 6 and 7-- **Q1.5 No. of ASHAs trained/Total number of ASHAs in the state (QB1.3)**		1 if <25% 2 if 25%-<50% 3 if 50%-<75% 4 if ≥ 75%
2	**Program activities and intervention coverage**					**18**
	2.1	**Program activities**				**18**
				% of newborns weighed at birth – **Q2.4b No. of newborns weighed at birth/Total number of live births (Q2.4a)**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of newborns breastfed within one hour of birth- **Q2.4d No. of newborns breastfed immediately after birth/Total number of live births (Q2.4a)**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of children (12-23 mo old) fully immunized- **Q2.5a No. of children 12-23 months completely immunized /Total number of 12-23 mo old children (Q2.1)**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of children (12-23 mo old) who were provided at least 8 IFA syrup per month-- **Q2.5b No. of children 12-23 months who were provided at least 8 doses of IFA syrup per month /Total number of 12-23 mo old children (Q2.1)**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of children (12-23 mo old) who have received at least one dose of Vitamin A-- **Q2.5c No. of children 12-23 months who have received at least one dose of Vitamin A /Total number of 12-23 mo**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%

Rubric						
	Theme	**Sub- Theme**	**Sub Sub-Theme**	**Indicators (as per Template)**	**Type**	**Weights (TOTAL- 100)**
				old children (Q2.1)		
				% of children (12-23) who have received at least one dose of Albendazole -- **Q2.5d**		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%

	Health template					TOTAL-35
1	Service delivery essentials					17
	1.1	Infrastructure				4
				% of sub-centres functional - **Q1.1 d No. of sub-centers functional/No. of sub- centers sanctioned**		0.5 if <25% 1 if 25%-<50% 1.5 if 50%-<75% 2 if ≥ 75%
				% of CHCs functional - **Q1.1 a No. of CHCs functional/No. of CHCs sanctioned**		0.5 if <25% 1 if 25%-<50% 1.5 if 50%-<75% 2 if ≥ 75%
	1.2	Human Resource				3
				% of LHV posts filled - **Q1.3 No. of LHVs in position/No. of LHV posts sanctioned**		0.25 if <25% 0.5 if 25%-<50% 0.75 if 50%-<75% 1 if ≥ 75%
				% of ANM posts filled **Q1.3 No. of ANMs in position/No. of ANM posts sanctioned**		0.25 if <25% 0.5 if 25%-<50% 0.75 if 50%-<75% 1 if ≥ 75%
				% of villages with ASHA posts vacant **Q1.3 No. of villages without ASHA/ Q4 Total number of villages in theState**		1 if < 25% 0.75 if 25%-<50% 0.5 if 50%-<75% 0.25 if ≥ 75%
	1.3	Stock out				6
				%Districts that reported stock -out of IFA red tablets in the month of Feb 2019 - **Q1.4 a No. of IFA tablets stock out Districts/Total number of Districts in the State (Q2)**		2 if <25% 1.5 if 25%-<50% 1 if 50%-<75% 0.5 if ≥ 75%
				%Districts that reported stock -out of TT injections in the month of Feb 2019 -- **Q1.4 f No. of TT injection stock-out Districts/Total number of Districts in the State (Q2)**		2 if <25% 1.5 if 25%-<50% 1 if 50%-<75% 0.5 if ≥ 75%
				%Districts that reported stock -out of albendazole in the month of Feb 2019 -- **Q1.4 e No. of albendazole stock-out Districts/Total number of Districts in the State (Q2)**		2 if <25% 1.5 if 25%-<50% 1 if 50%-<75% 0.5 if ≥ 75%

	1.4	Training and capacity building				4
				% of ASHAs training on HBNC modules 6 and 7-- Q1.5 No. of ASHAs trained/Total number of ASHAs in theState (QB1.3)		1 if <25% 2 if 25%-<50% 3 if 50%-<75% 4 if ≥ 75%
2	Program activities and intervention coverage					18
	2.1	Program activities				18
				% of newborns weighed at birth – Q2.4b No. of newborns weighed at birth/Total number of live births (Q2.4a)		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of newborns breastfed within one hour of birth- Q2.4d No. of newborns breastfed immediately after birth/Total number of live births (Q2.4a)		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of children (12-23 mo old) fully immunized- Q2.5a No. of children 12-23 months completely immunized /Total number of 12 - 23 mo old children (Q2.1)		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of children (12-23 mo old) who were provided at least 8 IFA syrup per month-- Q2.5b No. of children 12-23 months who were provided at least 8 doses of IFA syrup per month /Total number of 12-23 mo old children (Q2.1)		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of children (12-23 mo old) who have received at least one dose of Vitamin A-- Q2.5c No. of children 12-23 months who have received at least one dose of Vitamin A /Total number of 12-23 mo old children (Q2.1)		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%
				% of children(12 -23) who have received at least one dose of Albendazole -- Q2.5d		0 if <25% 1 if 25%-<50% 2 if 50%-<75% 3 if ≥ 75%

Annexure 3

Table 3: Coverage of health interventions during pregnancy and delivery-CNNS Data

<25%	25-<50%	50-<75%	≥75%

State	Pregnancy									Delivery & Postnatal		
	Any ANC	ANC in 1st trimester	4 or more ANC	Received MCP card	Blood pressure measured	Urine sample taken	Blood sample taken	Abdomen examined	TT injection	Institutional birth	Skilled birth attendant	Postnatal care for babies
India	81	58	47	72	67	67	67	67	87	80	83	62
Andhra Pradesh	89	75	48	85	88	88	88	88	88	83	86	87
Arunachal Pradesh	70	40	32	61	66	63	63	56	77	62	64	55
Assam	86	60	36	85	85	81	82	80	83	73	76	86
Bihar	68	42	20	54	35	37	36	37	91	69	76	28
Chhattisgarh	86	63	56	80	81	77	79	80	91	72	77	75
Delhi	93	72	72	61	90	88	88	90	94	83	86	73
Goa	97	89	92	84	96	96	95	95	98	97	99	95
Gujarat	82	70	69	85	80	78	80	80	90	94	95	89
Haryana	81	60	45	75	78	77	77	77	89	78	81	73
Himachal Pradesh	94	81	66	85	91	90	90	91	94	75	80	82
Jammu & Kashmir	95	85	81	85	92	94	93	92	87	87	89	90
Jharkhand	83	60	33	69	57	56	51	54	90	63	72	40
Karnataka	94	81	87	76	92	91	91	91	91	94	91	88
Kerala	99	95	95	58	99	98	98	99	96	99	100	97
Madhya Pradesh	84	53	38	75	70	64	71	64	90	76	80	40
Maharashtra	94	78	83	87	93	92	92	93	95	89	94	95
Manipur	82	68	59	30	80	77	78	77	85	62	67	60

State	Pregnancy									Delivery & Postnatal		
	Any ANC	ANC in 1st trimester	4 or more ANC	Received MCP card	Blood pressure measured	Urine sample taken	Blood sample taken	Abdomen examined	TT injection	Institutional birth	Skilled birth attendant	Postnatal care for babies
Meghalaya	81	48	46	74	77	75	74	77	80	44	50	63
Mizoram	85	54	53	73	82	68	79	79	83	81	83	71
Nagaland	55	28	14	26	40	35	38	45	68	32	46	27
Odisha	96	70	70	90	92	87	89	86	95	83	87	86
Punjab	81	76	46	74	80	80	80	79	90	90	95	91
Rajasthan	79	52	40	71	72	73	73	74	87	85	88	71
Sikkim	93	72	50	89	91	92	91	88	95	95	96	89
Tamil Nadu	95	82	84	87	94	94	94	94	75	98	99	92
Telangana	96	87	67	84	95	95	95	95	91	93	96	98
Tripura	66	42	54	52	63	64	63	60	87	80	84	74
Uttar Pradesh	62	35	16	59	33	34	34	37	79	72	75	34
Uttarakhand	95	77	49	82	78	81	81	86	92	76	78	60
West Bengal	94	54	74	86	93	92	91	87	87	89	90	82

Source: Comprehensive National Nutrition Survey, 2016-18.

Table 4: Coverage of health and nutrition interventions during pregnancy, lactation, and early childhood-CNNS Data

<25%	25-<50%	50-<75%	≥75%

State	Pregnancy						Lactation		Received benefits for child from AWC		
	Received IFA	Consumed 100+ IFA	Weighing	Breastfeeding counselling	Food supplementation	Health & nutrition education	Food supplementation	Health & nutrition education	Food supplementation (at least once a	Weighing (at least once in 3 months)	Counselling on child growth (among those who weighed)
India	73	27	69	38	52	35	49	33	42	60	48
Andhra Pradesh	83	47	89	68	85	81	86	81	72	90	51
Arunachal Pradesh	70	12	65	9	9	3	9	2	24	27	31
Assam	86	24	86	65	58	31	63	31	15	72	32
Bihar	50	5	42	16	33	12	31	13	14	43	44
Chhattisgarh	86	30	82	54	81	65	76	62	61	90	54
Delhi	87	47	89	41	18	16	15	12	61	43	43
Goa	94	75	96	55	81	55	82	54	23	77	42
Gujarat	84	36	80	57	59	54	52	47	18	90	55
Haryana	78	29	78	32	31	25	28	21	47	67	30
Himachal Pradesh	92	43	89	38	86	38	83	35	30	57	32
Jammu & Kashmir	76	11	89	41	23	10	13	7	60	58	41
Jharkhand	72	18	68	37	71	31	69	33	18	71	45
Karnataka	88	53	91	54	74	56	74	59	33	79	36
Kerala	98	85	98	38	46	22	36	16	25	77	32

State	Pregnancy						Lactation		Received benefits for child from AWC		
	Received IFA	Consumed 100+ IFA	Weighing	Breastfeeding counselling	Food supplementation	Health & nutrition education	Food supplementation	Health & nutrition education	Food supplementation (at least once a week)	Weighing (at least once in 3 months)	Counselling on child growth (among those who weighed)
Madhya Pradesh	80	20	72	34	78	50	72	48	61	84	62
Maharashtra	84	53	93	56	49	38	45	35	42	85	47
Manipur	73	24	80	10	32	3	29	2	4	13	20
Meghalaya	74	40	78	44	61	43	58	40	55	68	48
Mizoram	77	50	82	32	68	43	62	40	79	71	23
Nagaland	39	2	38	7	13	1	9	0	2	10	13
Odisha	92	31	95	65	90	81	90	75	48	84	58
Punjab	86	38	79	49	48	35	39	31	33	52	48
Rajasthan	62	22	73	30	43	28	37	23	47	44	42
Sikkim	90	48	91	56	47	38	45	36	17	77	72
Tamil Nadu	92	56	94	60	58	43	59	45	38	73	43
Telangana	91	57	95	59	75	70	77	72	66	77	51
Tripura	83	19	64	42	65	43	58	41	85	60	36
Uttar Pradesh	56	10	32	15	26	11	24	9	23	57	41
Uttarakhand	81	27	78	46	76	59	80	59	25	86	61
West Bengal	86	Dewormin	93	54	62	46	54	40	91	77	48

Source: Comprehensive National Nutrition Survey, 2016-18.

Table 5: Availability of growth monitoring instruments at *Anganwadi* centers across States

<25%	25-<50%	50-<75%	≥75%

State/UT	% of infant weighing scales distributed	% of adult weighing scales distributed	% of infantometers distributed	% of stadiometers distributed
Large States				
Andhra Pradesh	100	100	100	100
Assam	0	0	0	0
Bihar	87	80	26	86
Chhattisgarh	47	49	1	8
Gujarat	0	0	0	0
Haryana	0	0	0	0
Himachal Pradesh	42	42	42	42
Jammu & Kashmir	93	93	93	93
Jharkhand	51	51	51	51
Karnataka	0	0	0	0
Kerala	0	0	0	0
Madhya Pradesh	0	100	100	100
Maharashtra	73	77	82	78
Punjab	0	0	0	0
Rajasthan	0	35	51	51
Tamil Nadu	34	34	34	34
Telangana	0	0	0	0
Uttar Pradesh	0	0	0	0
Uttarakhand	100	100	100	100
Small States				
Arunachal Pradesh	0	0	0	0
Goa	0	0	0	0
Manipur	0	0	0	0
Meghalaya	100	100	100	100
Mizoram	100	68	100	100
Nagaland	100	100	100	100
Sikkim	0	0	0	0
Tripura	13	13	13	13
Union Territories				
Andaman & Nicobar	0	0	0	0
Chandigarh	100	100	100	100
Dadra & Nagar Haveli	100	100	100	100
Daman & Diu	100	100	100	100
Delhi	0	--	--	--
Lakshadweep	0	0	0	100
Puducherry	100	100	100	100

Source: Responses provided by State/UT governments to questionnaires sent by NITI Aayog, May 2019

Table 6: Availability of mobile devices and technology support across States

<25%	25-<50%	50-<75%	≥75%

State	Mobile Hardware		Technology support	
	Procurement (%)	Distribution (%)	District helpdesk (%)	Block helpdesk (%)
Large States				
Andhra Pradesh	100	100	23	2
Assam	0	0	0	0
Bihar	38	38	16	1
Chhattisgarh	52	19	44	5
Gujarat	0	0	97	99
Haryana	0	0	19	0
Himachal Pradesh	39	39	0	0
Jammu & Kashmir	2	2	0	0
Jharkhand	30	28	29	4
Karnataka	0	0	0	0
Kerala	0	0	0	0
Madhya Pradesh	29	29	29	38
Maharashtra	23	0	100	7
Punjab	0	0	0	0
Rajasthan	34	33	100	11
Tamil Nadu	34	32	34	34
Telangana	29	29	0	0
Uttar Pradesh	31	30	0	0
Uttarakhand	100	35	0	0
Small States				
Arunachal Pradesh	0	0	0	0
Goa	100	100	0	0
Manipur	22	0	0	--
Meghalaya	100	100	0	0
Mizoram	95	62	63	70
Nagaland	100	0	0	0
Sikkim	61	0	100	100
Tripura	0	0	0	0
Union Territories				
Andaman & Nicobar	100	0	100	60
Chandigarh	100	0	0	0
Dadra & Nagar Haveli	100	92	0	0
Daman & Diu	100	90	100	0
Delhi	96	0	0	0
Lakshadweep	86	86	0	0
Puducherry	91	91	0	0

Source : Responses provided by State governments to questionnaires sent by NITI Aayog, May 2019

Table 7: Training of ICDS functionaries on ICDS-CAS dashboard/mobile use

<25%	25-<50%	50-<75%	≥75%

State	% of DPOs trained	% of CDPOs trained	% of LS trained	% of AWWs trained
Large States				
Andhra Pradesh	77	76	100	88
Assam	6	1	0	0
Bihar	18	22	15	12
Chhattisgarh	58	71	57	23
Gujarat	0	0	0	0
Haryana	0	0	0	0
Himachal Pradesh	0	0	6	--
Jammu & Kashmir	0	0	0	0
Jharkhand	100	100	16	17
Karnataka	0	0	0	0
Kerala	29	0	1	0
Madhya Pradesh	30	27	28	29
Maharashtra	0	0	0	0
Punjab	--	6	1	--
Rajasthan	27	59	16	32
Tamil Nadu	100	100	100	100
Telangana	32	32	29	31
Uttar Pradesh	42	38	--	8
Uttarakhand	0	0	43	2
Small States				
Arunachal Pradesh	0	0	0	0
Goa	NA	64	100	0
Manipur	0	0	0	0
Meghalaya	20	28	50	0
Mizoram	0	100	63	68
Nagaland	0	0	0	0
Sikkim	0	0	60	63
Tripura	0	0	0	0
Union Territories				
Andaman & Nicobar	NA	**0**	**8**	**0**
Chandigarh	NA	**100**	**100**	**100**
Dadra & Nagar Haveli	NA	**100**	**100**	**100**
Daman & Diu	NA	**100**	**100**	**100**
Delhi	--	--	--	--
Lakshadweep	**0**	**0**	**0**	**0**
Puducherry	**100**	**0**	NA	**100**

Source : Responses provided by State governments to questionnaires sent by NITI Aayog, May 2019

Table 8: Training of ICDS supervisors and frontline workers on incremental learning approach modules

<25%	25-<50%	50-<75%	≥75%

State	% of Lady Supervisors trained on 6 or more ILA modules	% of Anganwadi workers trained on 6 or more ILA modules
Large States		
ANDHRA PRADESH	100	100
ASSAM	0	0
BIHAR	84	64
CHATTISGARH	98	100
GUJARAT	80	83
HARYANA	0	0
HIMACHAL PRADESH	24	16
JAMMU & KASHMIR	0	0
JHARKHAND	0	0
KARNATAKA	0	0
KERALA	0	0
MADHYA PRADESH	100	98
MAHARASTRA	0	0
PUNJAB	0	0
RAJASTHAN	100	99
TAMIL NADU	100	100
TELANGANA	0	0
UTTAR PRADESH	87	
UTTARANCHAL	90	57
Small States		
ARUNACHAL PRADESH	0	0
GOA	0	0
MANIPUR	0	0
MEGHALAYA	100	64
MIZORAM	100	100
NAGALAND	0	0
SIKKIM	90	100
TRIPURA	0	0
Union Territories		
ANDAMAN & NICOBAR ISLANDS	0	0
CHANDIGARH	100	100
DADRA &NAGAR HAVELI	100	100
DAMAN & DIU	100	100
DELHI	95	100
LAKSHADWEEP	0	0
PUDUCHERRY		0

***Source**: Responses provided by State governments to questionnaires sent by NITI Aayog, May 2019*

Table 9: Convergence-related activities by State

<25%	25-<50%	50-<75%	≥75%

State	% of Districts with convergence action plan committees	% of blocks with convergence action plan committees	% of Districts with convergence action plans	% of blocks with convergence action plans
Large States				
ANDHRA PRADESH	100	100	77	79
ASSAM	0	0		--
BIHAR	100	100		--
CHATTISGARH	100	100	100	100
GUJARAT	79	82	27	0
HARYANA	100	100		--
HIMACHAL PRADESH	100	100	42	44
JAMMU & KASHMIR	41	49	23	21
JHARKHAND	100	86	67	34
KARNATAKA				--
KERALA	0	0		--
MADHYA PRADESH	98	100	98	100
MAHARASTRA	100	100		--
PUNJAB	100	100	100	100
RAJASTHAN	100	100	0	--
TAMIL NADU	34	34	0	--
TELANGANA	3	0		--
UTTAR PRADESH	100	100	100	100
UTTARANCHAL	100	100	100	100
Small States				
ARUNACHAL PRADESH	84	100		--
GOA	100	100		--
MANIPUR	100	61		--
MEGHALAYA			27	89
MIZORAM	100	100		4
NAGALAND	100	81	100	81
SIKKIM	100	100	100	100
TRIPURA	100	97		--
Union Territories				
ANDAMAN & NICOBAR ISLANDS	100	100	100	100
CHANDIGARH	100	100	100	0
DADRA & NAGAR HAVELI	100	100		100

State	% of Districts with convergence action plan committees	% of blocks with convergence action plan committees	% of Districts with convergence action plans	% of blocks with convergence action plans
DAMAN & DIU	100	100	100	0
DELHI	91	100		--
LAKSHADWEEP	100	100		--
PUDUCHERRY	100	100		--

***Source**: Responses provided by State governments to questionnaires sent by NITI Aayog, May 2019*

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