NITI Aayog

Nourishing India

NATIONAL NUTRITION STRATEGY,
GOVERNMENT OF INDIA.

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Glossary of Acronyms

AIIMS	All India Institute of Medical Sciences
ANC	Antenatal Care
APIPs	Annual Programme Implementation Plans
ARI	Acute Respiratory Infections
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWTC	Anganwadi Workers' Training Centre
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BMI	Body Mass Index
BPL	Below Poverty Line
BPNI	Breastfeeding Promotion Network of India
CEO	Chief Executive Officer
CGS	Child Growth Standards
CRM	Common Review Mission
DG	Director General
DLHS	District Level Household Survey
GMP	Growth Monitoring and Promotion
GOI	Government of India
HBNC	Home Based Newborn Care
HH	Households
HMIS	Health Management Information System
HRD	Human Resource Development
ICDS	Integrated Child Development Services Scheme
ICMR	Indian Council of Medical Research
IDA	Iron DeficiencyAnemia
IDD	Iodine Deficiency Disorders
IEC	Information, Education, Communication
IFA	Iron Folic Acid
IIPS	International Institute of Population Sciences
IPMS	Integrated Performance Management System
ISSNIP	ICDS Systems Strengthening & Nutrition Improvement Project
IVR	Interactive Voice Response

IYCF	Infant and Young Child Feeding
JE	Japanese Encephalitis
LBW	Low Birth Weight
M & E	Monitoring and Evaluation
MSY	Matritva Sahyog Yojana
MCPC	Mother and Child Protection Card (ICDS and NHM)
MCTS	Mother and Child Tracking System (NHM)
MIS	Management Information System
MLTC	Mid Level Training Centre
MDM	Mid Day Meal
MDWS	Ministry of Drinking Water and Sanitation
MHRD	Ministry of Human Resource Development
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MOHFW	Ministry of Health and Family Welfare
MRD	Ministry of Rural Development
MWCD	Ministry of Women and Child Development
NFI	Nutrition Foundation of India
NNM	National Nutrition Mission
NFHS	National Family Health Survey
NGOs	Non Government Organizations
NHM	National Health Mission
NHSRC	National Health Systems Resource Centre
NIHFW	National Institute of Health and Family Welfare
NIN	National Institute of Nutrition
NNM	National Nutrition Mission
NNMB	National Nutrition Monitoring Bureau
NNRC	National Nutrition Resource Centre
NSSO	National Sample Survey Organisation
ORS	Oral Rehydaration Salt
PMMVU	Pradhan Mantri Matru Vandana Yojana
PDS	Public Distribution System
PIPs	Programme Implementation Plans
PMO	Prime Minister’s Office
PRI	Panchayati Raj Institutions
RCH	Reproductive and Child Health

RMNCH +A	Reproductive, Maternal , Newborn, Child and Adolescent Health
SABLA	Rajiv Gandhi Scheme for Empowerment of Adolescent Girls
SAM	Severe Acute Malnutrition
SHG	Self Help Group
SIHFW	State Institute of Health and Family Welfare
SNP	Supplementary Nutrition Programme
SNRC	State Nutrition Resource Centre
TORs	Terms of Reference
THR	Take Home Ration
ULB	Urban Local Body
VAD	Vitamin A Deficiency
VHND	Village Health and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
WCD	Women and Child Development

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1 NUTRITIONAL SITUATION ANALYSIS

1.1 NUTRITION: CENTRE STAGE IN THE NATIONAL DEVELOPMENT AGENDA

The rationale for investing in Nutrition is globally well recognized – both as a critical development imperative, as well as crucial for the fulfillment of human rights- especially of the most vulnerable children, girls and women. It constitutes the foundation for human development, by reducing susceptibility to infections, related morbidity, disability and mortality burden, enhancing cumulative lifelong learning capacities and adult productivity. Nutrition is acknowledged as one of the most effective entry points for human development, poverty reduction and economic development, with high economic returns.

Undernutrition is both a consequence as well as a cause of perpetuating poverty, eroding human capital through irreversible and intergenerational effects on cognitive and physical development. This intergenerational cycle of undernutrition, manifest as low birth weight, is compounded by gender discrimination and social exclusion. Nutrition status of the most vulnerable age group of children is also a sensitive proxy indicator of human development and of the effectiveness of national socio economic development strategies. The Global Nutrition Report 2015 estimates that for investment in nutrition, there is a benefit cost ratio of 16:1 for 40 low and middle-income countries.

Nutrition is central to the achievement of other National and Global Sustainable Development Goals. It is critical to prevent undernutrition, as early as possible, across the life cycle, to avert irreversible cumulative growth and development deficits that compromise maternal and child health and survival; and undermine the achievement of optimal learning outcomes in elementary education, impairing adult productivity and undermining gender equality.

High levels of maternal and child undernutrition in India have persisted, despite strong Constitutional, legislative policy, plan and programme commitments. Legislations such as the National Food Security Act 2013 mandating food and nutrition entitlements for children, pregnant and breastfeeding mothers with maternity support and the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992, and Amendment Act 2003 provide a strong policy framework for protecting, supporting and promoting nutrition interventions – especially during periods of greatest vulnerability for children and women. The National Nutrition Policy 1993, complemented by other policies such as the National Health Policy 2002, the National Policy for Children, 2013 provides a strong foundation for addressing the immediate and the underlying determinants of undernutrition through both direct interventions and indirect interventions. The Twelfth Five Year Plan reinforced the commitment to preventing and reducing child undernutrition (underweight prevalence in children 0-3 years), articulated as one of its core Monitorable Targets, binding multiple sectors and States to collective action.

A wide spectrum of national programmes contribute to improved nutrition outcomes, addressing both the immediate and the underlying determinants of undernutrition through nutrition specific and nutrition sensitive interventions. These include the Integrated Child Development Services, National Health Mission- including RMNCH + A, Janani Suraksha Yojana, Swachh Bharat including Sanitation and the National Rural Drinking Water Programme, Matritva Sahyog Yojana, SABLA for adolescent girls, Mid Day Meals Scheme, Targeted Public Distribution System, National Food Security Mission, Mahatma Gandhi National Rural Employment Guarantee Scheme and the National Rural Livelihood Mission- among others.

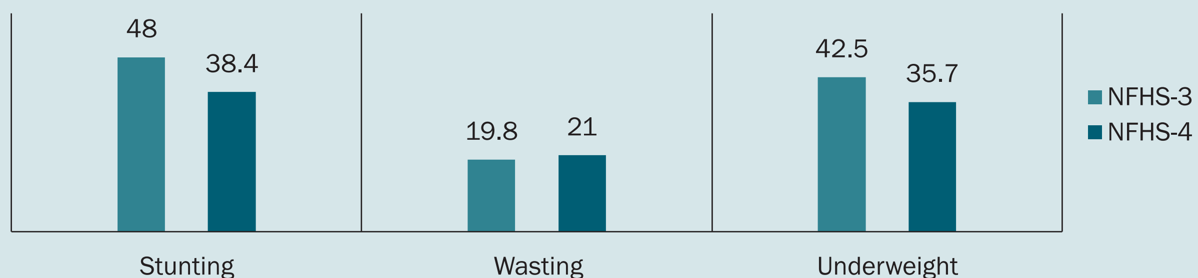
The policy commitment to preventing and reducing undernutrition was reaffirmed by the Budget 2014-15 speech of the Finance Minister, which stated that - “A national programme in Mission Mode is urgently required to halt the deteriorating malnutrition situation in India, as present interventions are not adequate. A comprehensive strategy including detailed methodology, costing, time lines and monitorable targets will be put in place within six months.” Guided by this policy direction, the Ministry of Women and Child Development also formulated a proposal for a National Nutrition Mission, building on the recommendations from a National Consultation, an Expert Advisory Group was constituted in 2014. This policy direction was reinforced by the PMO, mandating NITI Aayog to examine the emerging data on undernutrition and prepare, in consultation with the Ministries of WCD and Health, a specific strategy for poor performing states/districts. This has brought Nutrition center-stage on the National Development Agenda and is the policy context within which this National Nutrition Strategy has been been formulated, through a consultative processes.

1.2 CHILD UNDERNUTRITION

India is home to the largest number of children in the world. Nearly every fifth young child in the world lives in India. It is estimated that there are about 43 crore children in the age group of 0-18 years. Children and women together constitute around 70% of India’s people – representing not just the

Figure 1

Child Undernutrition



present human resource base – but also the future. This resource base is eroded by undernutrition - which undermines their survival, health, cumulative learning capacities and adult productivity and must be urgently addressed.

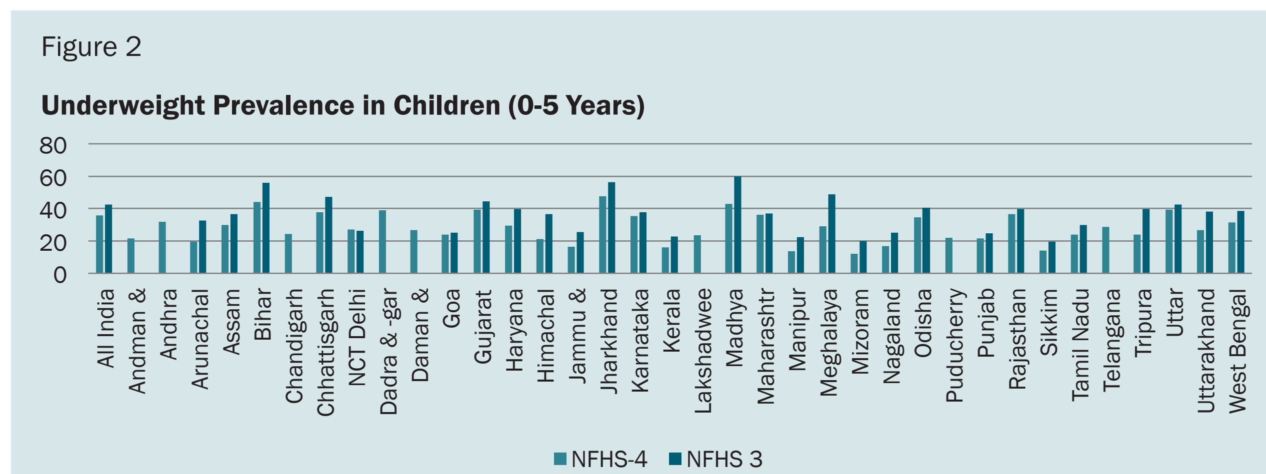
Child Undernutrition remains high, despite improvements over the last decade. Figure 1 compares the primary indicators of child undernutrition - stunting, wasting and underweight, for children below five years of age. As evident, while stunting and underweight prevalence has gone down, trends in wasting show an overall increase in the last decade. The decrease in stunting has been from 48% to 38.4%, that is, by 1 percentage point per year. Similarly, underweight prevalence has reduced by 0.68 percentage points from NFHS-3 to NFHS-4. Recent data, especially for challenging states is promising, suggestive of acceleration. However, the pace of reduction remains low and calls for focused interventions in the area for optimal results.

1.2.1 *Underweight Prevalence in Children*

In India, undernutrition levels have remained persistently high – especially in utero, in the early years of life, in adolescent girls and in women across the life cycle-especially in disadvantaged /excluded community groups and those living in areas or conditions of high nutritional vulnerability and multiple deprivations. National level estimates which have been used for drawing comparison are the NFHS-3 (2005-06) and NFHS-4 (2015-16).

Figure 2

Underweight Prevalence in Children (0-5 Years)



Overall, there has been a 16% decrease in the underweight prevalence among children below 5 years. Underweight prevalence in children under 5 years (composite indicator of acute and chronic undernutrition) has declined in all the States and UTs (except Delhi), although absolute levels are still high. Remarkable reductions are seen in Himachal Pradesh (by 41.9%), Meghalaya, Mizoram, Arunachal Pradesh (by 40%), Tripura (by 39%) and Manipur (by 37.8%); whereas Maharashtra, Goa, Karnataka, Uttar Pradesh and Rajasthan show near stagnation.

1.2.2 Stunting in Children

Recent findings from NFHS 4 (2015-16) highlight that stunting in children under 5 years has reduced in all the States, although absolute levels are still high in some States. This is as seen in Figure 3.

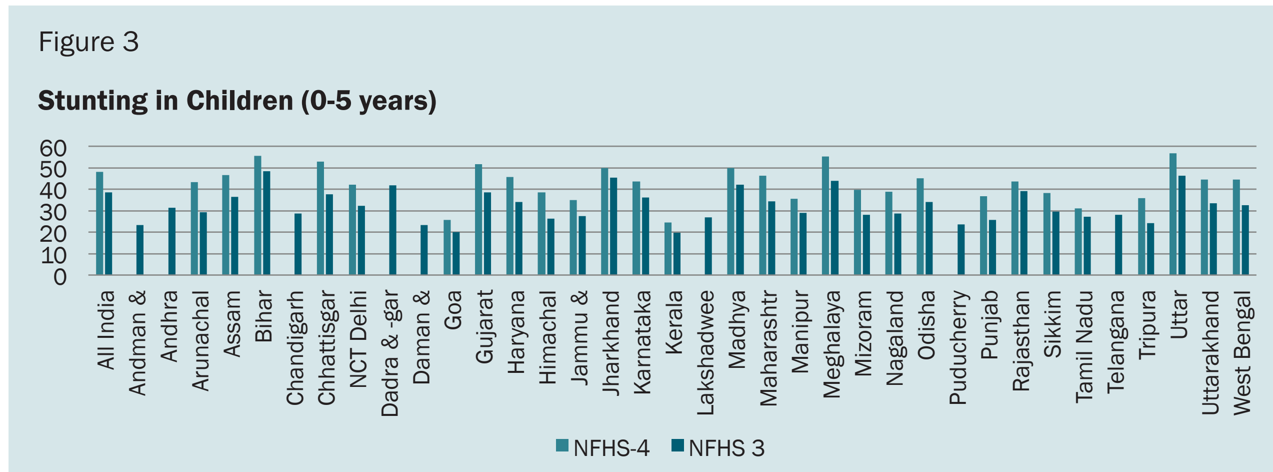


Figure 3

Stunting in Children (0-5 years)

Most significant reductions are seen in Arunachal Pradesh (by 32.10%), Tripura (by 31.92%), Himachal Pradesh (by 31.86%), Punjab (by 29.9%) and Mizoram (by 29.6%). Reductions by more than 25% are also seen in the case of Chhattisgarh, West Bengal, Nagaland, Maharashtra and Haryana, Gujarat. While the overall prevalence of stunting has gone down, in terms of absolute values, it continues to remain high in Bihar, Uttar Pradesh, Jharkhand, Meghalaya, Madhya Pradesh and Dadra & Nagar Haveli, where more than 40% of the children remain stunted.

1.2.3 Wasting in Children

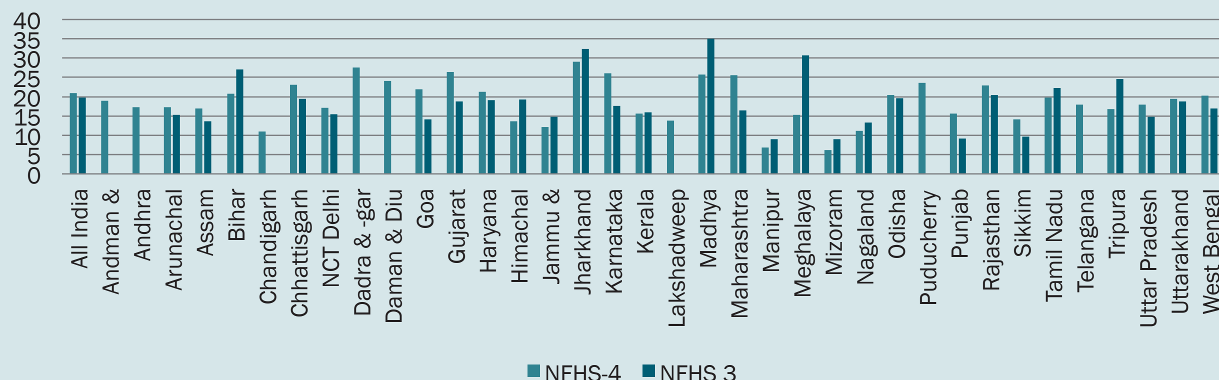
Findings from NFHS-4 (2015-16) highlight that wasting in children under 5 years (weight- for- height) or acute malnutrition is still high, as seen in Figure 4, with levels above 25 % in Jharkhand (29%), Dadra & Nagar Haveli (27.6%), Gujarat (26.4%), Karnataka (26.1%), Madhya Pradesh (25.8%) and Maharashtra (25.6%). Significant reductions are seen in Meghalaya (by 50%), Mizoram (by 32.33%), Tripura (by 31.7%), Himachal Pradesh (by 29.01%) and Madhya Pradesh (by 26.28%); although absolute values remain high. Sharp increase in the incidence of child wasting is seen in Punjab, Goa, Maharashtra, Karnataka and Sikkim.

As per NFHS-3, levels of severe wasting or severe acute malnutrition in children (0-5 years) were 6.4% for India. Data from NFHS-4 shows an overall increase in the levels of severe wasting to 7.5%. The level of severe wasting has increased in most of the States/ UTs and only 10 States/ UTs (Meghalaya, Madhya Pradesh, Tripura, Delhi, Himachal Pradesh, Bihar, Mizoram, Nagaland, Tamil Nadu and Jharkhand) have witnessed a decrease in the levels of severe stunting. States/UTs with the highest incidence of severe

wasting are Daman & Diu (11.9%), Jharkhand (11.4%), Dadra & Nagar Haveli (11.4%), Karnataka (10.5%), Gujarat (9.5%) and Goa (9.5%).

Figure 4

Wasting in Children (0-5 years)



1.3 UNDERNUTRITION IN WOMEN & GIRLS

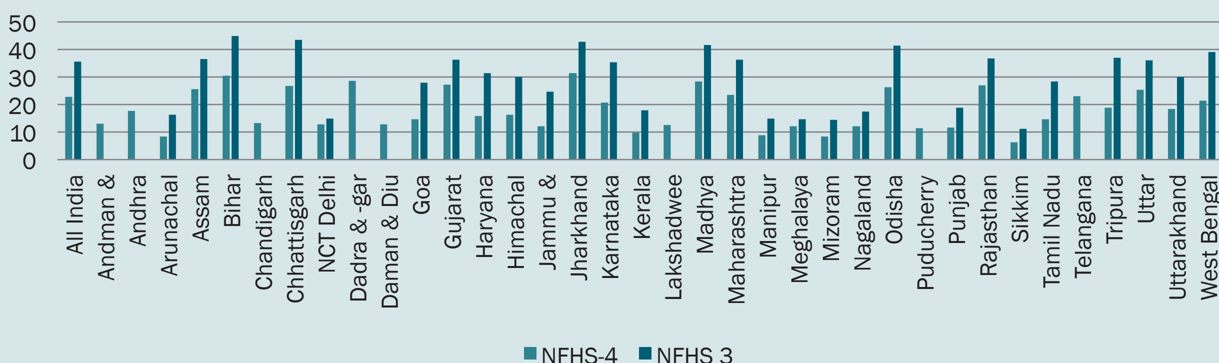
1.3.1 Women with Low BMI

As per NFHS 3, every third woman in India was undernourished (35.5 % with low Body Mass Index) and every second woman (15-49 years) was anemic (55.3%). About 15.8 % were moderately to severely thin, with BMI less than 17. Bihar (45%), Chhattisgarh (43%), Madhya Pradesh (42%) and Odisha (41%) were the states with the highest proportion of undernourished women.

In chronically undernourished women, pregnancy and lactation have an adverse effect on maternal nutritional status. Low pre pregnancy weight and low pregnancy weight gain are associated with low birth weight and all its attendant adverse consequences.

Figure 5

Percentage of Women with Low BMI



Recent findings from NFHS 4 (2015-16) highlight that nutritional status of women and girls (in the age group 15-49 years) has improved for all States, evident in figure 5. Overall, there has been a decrease from 35.5% (NFHS-3) to 22.9% (NFHS-4) in the prevalence of women with low BMI. The decrease has been by almost 50% in the states of Tripura, J&K, Haryana, Tamil Nadu and Kerala.

1.3.2 Anemia in Women

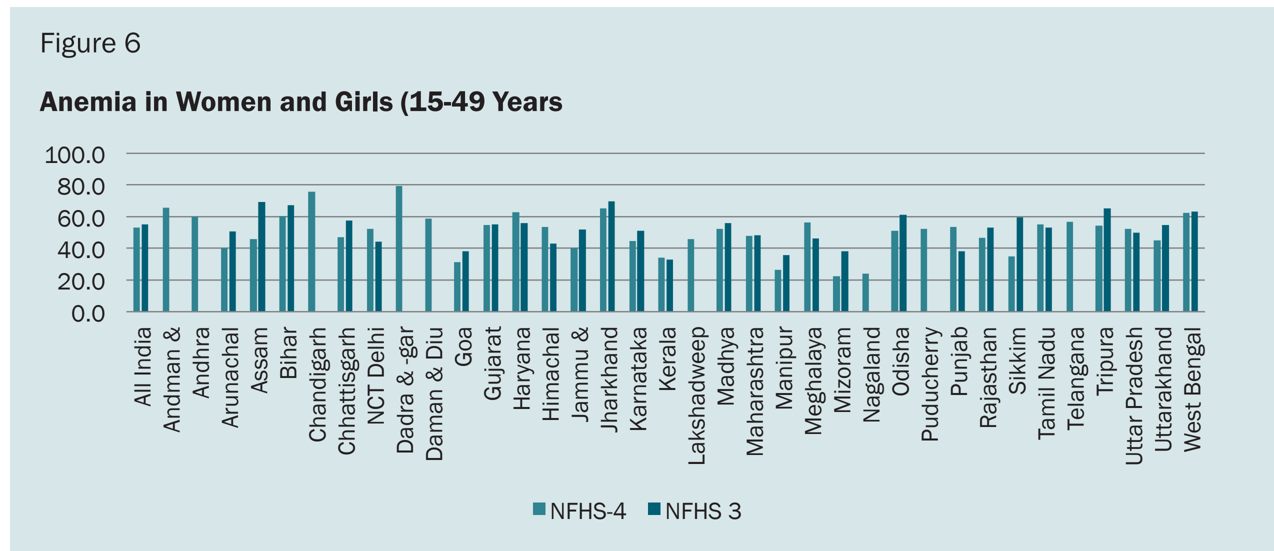


Figure 6

Anemia in Women and Girls (15-49 Years

Figure 6 presents the status of anemia among women and girls between 15-49 years of age. It is seen that overall, the levels of anemia among women and girls has stagnated over the last decade from 55.3% in NFHS-3 to 53% in NFHS-4. In terms of percentage points, States which have witnessed maximum decrease in the levels of anemia are- Sikkim (24.6), Assam (23.3), Mizoram (15.6), J&K (11.7), Tripura (10.6) and Chhattisgarh by 24.6 (10.5). Alternatively, 8 States/ UTs (Punjab, Himachal Pradesh, Meghalaya, Delhi, Haryana, Uttar Pradesh, Tamil Nadu and Kerala) have seen an increase in the prevalence of anemia.

1.4 MATERNAL CARE

NFHS-4 findings reveal that there is better care for women during pregnancy and childbirth - contributing to reduction of maternal deaths and improved child survival. Almost all mothers have received antenatal care for their most recent pregnancy and increasing numbers of women are receiving the recommended four or more visits by the service providers. Overall, the Total Fertility Rate (TFR) or the average number of children per woman has also gone down from 2.7 in NFHS-3 to 2.2 in NFHS-4.

More and more women now give birth in health care facilities and rates have more than doubled in the

last decade in some States like Chhattisgarh (by as much as 390%), Jharkhand (by 238%), Uttar Pradesh (by 229%), Bihar (by 220%), Assam (by 215%), Madhya Pradesh (by 208%) and Rajasthan (by 183%). However, in terms of absolute values, institutional births continues to remain extremely low in Nagaland (32.8%), Meghalaya (51.4%), Arunachal Pradesh (52.3%), Jharkhand (61.9%) and Bihar (63.8%), which are the bottom five states with respect to institutional births.

Figure 7

Institutional Births

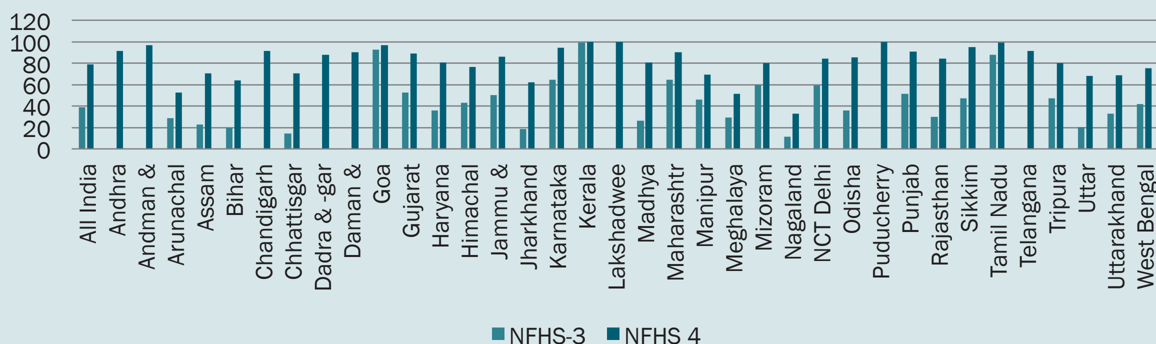
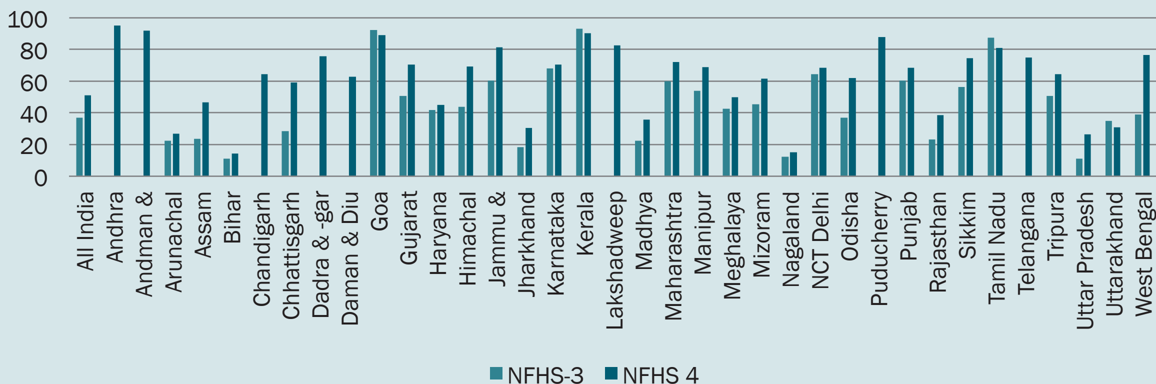


Figure 8

At Least 4 ANC Vists



Similarly, the number of pregnant women receiving more than 4 ANC visits has also gone up by 38.37% in the last decade, from 37% in NFHS-3 to 51.2% in NFHS-4. States which have shown remarkable improvement in providing ANC to pregnant women are Uttar Pradesh, Chhattisgarh, Assam, West Bengal, Odisha, Jharkhand and Rajasthan, although in terms of absolute values, the percentage of women receiving ANC continues to remain low. ANC visits have gone down in Uttarakhand, Tamil Nadu, Goa and Kerala over the last decade.

1.5 INFANT & YOUNG CHILD FEEDING PRACTICES

There has been improvement in the early initiation of breastfeeding rate, from 23.4% in NFHS-3 to 41.6% in NFHS-4. The figure varies from 73.3% in Goa to merely 25.2% in Uttar Pradesh. Similarly, there has been an overall improvement over NFHS 3 levels in children under six months who were exclusively breastfed, from 46.3% to 54.9%. States which have shown maximum improvements in terms of percentage point are Goa (by 43.2%), Himachal Pradesh (by 40%), Madhya Pradesh (by 36.6%), Tripura (by 34.6%), and Haryana (by 33.4%); while Kerala, Arunachal Pradesh, Karnataka, Chhattisgarh, West Bengal and Uttar Pradesh recorded a decrease in the percentage of children under six months who were exclusively breastfed.

Children aged between 6-8 months receiving solid or semi-solid food and breastmilk has gone down from 52.6% to 42.7%. In fact, most of the States/ UTs have witnessed a decrease in the percentage of children receiving solid or semi-solid food and breastmilk. States/ UTs that have recorded maximum dip are Kerala, Arunachal Pradesh, Bihar, Karnataka and Sikkim.

Recent new evidence on the health and economic benefits of breastfeeding (The LANCET 2016) indicates that the universalisation of optimal breastfeeding practices in India could reduce around 156,000 child deaths, mainly by protecting against diarrhea and pneumonia. It is also estimated that cognitive losses associated with not breastfeeding which impact upon earning potential could amount to a loss of Rs.4300 crores annually in India.

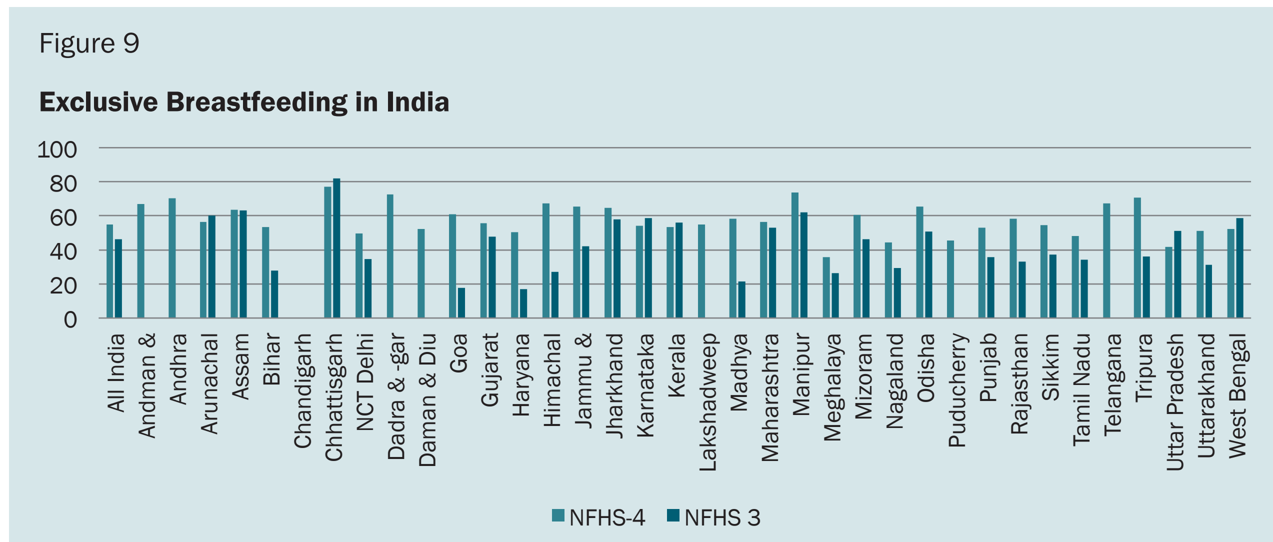


Figure 9

Exclusive Breastfeeding in India

Over earlier surveys, Infant and Young Child Feeding practices overall have remained sub optimal. Unfortunately, infant and young child feeding indicators have not shown a consistent rise over the years. This trend needs to be reversed. Major reasons include the aggressive promotion of baby foods by commercial interests, lack of support to women at family and work places-especially counseling, inadequate health care support and maternity protection.

1.6 INTERGENERATIONAL CYCLE OF UNDERNUTRITION

Nearly every third child in India is undernourished – underweight (35.7%) or stunted (38.4%) and 21% of children under five years are wasted as per NFHS 4 2015-16. Moreover, the NFHS-4 data indicates that every second child is anemic (58.4%).

An intergenerational cycle of undernutrition is often perpetuated, with a high incidence of babies born with low birth weight, more susceptible to infections, more likely to experience growth failure, reflected in high levels of child undernutrition and anemia.

This intergenerational cycle of undernutrition is accentuated by multiple deprivations related to poverty, social exclusion and gender discrimination. Nutrition vulnerabilities are compounded by differentials in socio economic status and vary by vulnerable community groups such as SC, ST, minorities and others.

1.7 THE GIRL CHILD

The girl child goes on to become an undernourished and anaemic adolescent girl, often deprived of adequate health care and nutritional support, educational opportunities, denied her right to be a child-married too early, with early child bearing and inadequate inter pregnancy recoupment. This perpetuates a vicious cycle of undernutrition and morbidity that erodes human capital through irreversible and intergenerational effects on cognitive and physical development. NFHS 4 findings reveal that around 26.8 per cent of currently married women in the age-group 20-24 years were married before attaining the age of 18 years.

1.8 MICRONUTRIENT DEFICIENCIES: VITAMIN & MINERAL DEFICIENCIES

Deficiencies of key vitamins and minerals such as Vitamin A, Iron, Iodine and Zinc continue to coexist and interact with protein and energy deficits and need to be addressed synergistically, through a multipronged approach.

- ***Vitamin A***

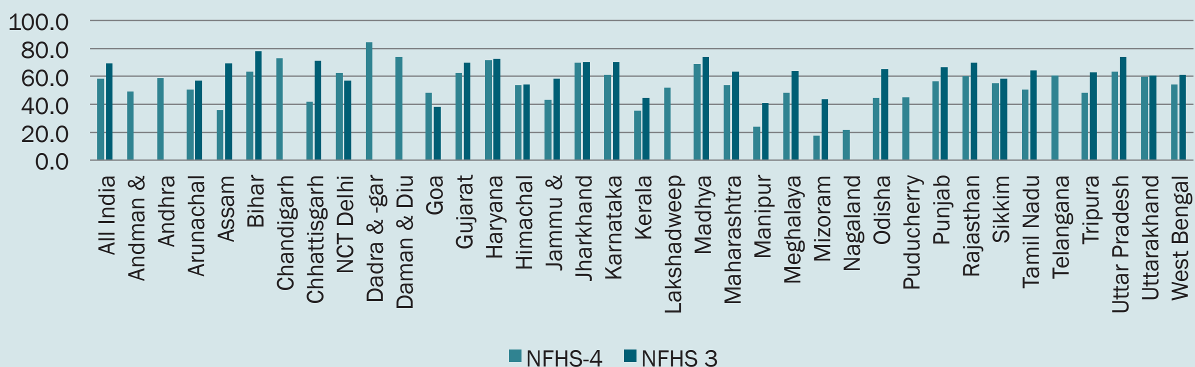
  Sub-clinical Vitamin A Deficiency (VAD) is a well-known cause of morbidity and mortality, especially among young children and pregnant women. Vitamin A deficiency limits the growth of young children, weakening their immunity and in cases of acute deficiency, leading to blindness and to increased mortality. Vitamin A supplementation has proven successful in reducing the incidence and severity of illness. It has been associated with an overall reduction in child mortality, especially from diarrhoea, measles and malaria. As per NFHS-4, 60.2% children aged 9-59 months received the six monthly Vitamin A supplement in the six months before the survey. However, inter-state variation in Vitamin A Supplementation for children aged 9-59 months continues with Goa at 89.5% and Nagaland at 27.1%.

► ***Iron***

Iron Deficiency Anemia (IDA) is common across all age groups, but highest among more vulnerable young children, adolescent girls, pregnant and lactating women. The consequences of IDA in pregnant women are increased risk of low birth weight or premature delivery, peri-natal and neonatal mortality, inadequate iron stores for the new-born, lowered physical activity, fatigue and increased risk of maternal morbidity. Iron deficiency impairs growth, cognitive development and immune function. It reduces the performance level of children in school and makes them less productive as adults.

Figure 10

Anemia in Children (6-59 months age)



India is among the countries with the highest prevalence of anemia in the world which needs to be addressed in a life cycle approach. Anemia is a major health problem affecting 53% of women (15-49 years) and 22.7% of men in India as per NFHS-4. 50.3% of pregnant women were found to be anaemic, as per NFHS-4. Anemia was found to be considerably higher in rural areas than urban areas, for disadvantaged groups (particularly scheduled tribes) and for children and women in households in the lower wealth quintiles.

► ***Iodine Deficiency Disorders***

IDD constitute the single largest cause of preventable brain damage worldwide, leading to learning disabilities and psychomotor impairment. As per NFHS 4, 93.1% households were using salt that was adequately iodized; others were using salt that was either inadequately iodized or was not iodized at all.

► ***Zinc***

Zinc deficiency results in the stunted growth of children. Zinc deficiency compromises the effectiveness of the immune system, increasing the incidence and severity of infections such as diarrhea disease and pneumonia. Therefore, as per MHFW guidelines, diarrhea management is

envisaged through ORS with zinc supplementation, which is used as a key indicator of programme interventions. As per NFHS 4, the percentage of children with diarrhea in the last 2 weeks preceding the survey who received zinc supplementation is found to be 20.3%. However, inter-state variation in the 'children with diarrhea in the last two weeks who received zinc' continues with Puducherry at 69.6% and Andaman and Nicobar Islands at 8.3%.

1.9 PREVENTION AND MANAGEMENT OF COMMON NEONATAL & CHILDHOOD ILLNESS

Maternal and Child Undernutrition is the attributable cause of nearly half (45%) of the mortality of children under five years (LANCET 2013), many of which are preventable through effective nutrition interventions. In India, annually, it is estimated (as on 2011) that about 1.45 million children die before completing their fifth birthday (MHFW). Currently the mortality rate in children under 5 years is 50, as per NFHS-4. The Infant Mortality Rate is 37 i.e. 37 out of 1000 infants die in the first year of life as reported in SRS Report 2015. Current trends highlight the need to accelerate reductions in neonatal mortality- as this constitutes around two thirds of infant mortality and around half of under-5 child mortality. Maternal mortality also needs to be addressed as maternal mortality continues to be high with MMR at 167 (SRS 2011-13, RGI Special Bulletin on Maternal Mortality 2013).

The prevention and management of common neonatal and childhood illnesses is critical for breaking the vicious cycle of malnutrition and infection, wherein infections such as diarrhea, acute respiratory infections and measles adversely impacting nutrition status and undernutrition increases susceptibility to infections, perpetuating this cycle. Effectively managing the onset of infections such as diarrhea and acute respiratory infections, adequate care and referral of severely undernourished and sick children remains a challenge.

NFHS 4 (2015-16) shows that there have been promising gains in child health care. The immunization rates have gone up. The number of children aged 12-23 months who were fully immunized (BCG, measles and 3 doses each of Polio and DPT) has gone up from 43.5% in NFHS-3 to 62% in NFHS-4. In terms of percentage points, maximum increase is seen in Punjab, Bihar, Meghalaya, Rajasthan and Uttar Pradesh. However, the number of children receiving full immunization has gone down in Tamil Nadu, Himachal Pradesh, Haryana, Maharashtra and Uttarakhand.

Similarly, prevalence of symptoms of Acute Respiratory Infection (ARI) has also gone down from 5.8% in NFHS-3 to 2.7% in NFHS-4. However, inter-state variation continues with Meghalaya at 5.8% and Sikkim at 0.3 with respect to the prevalence of ARI.

Occurrence of diarrhea among children has slightly increased over the last decade, from 9% in NFHS-3 to 9.2% in NFHS-4. Interstate variation in the prevalence of diarrhea continues with 17% in Uttarakhand to 1.8% in Sikkim. States which have shown maximum improvements in curbing diarrhea are Uttar Pradesh, Meghalaya, Uttarakhand and Chhattisgarh. However, in terms of absolute numbers, diarrhea

among children continues to remain a challenge in Uttarakhand, Uttar Pradesh, Puducherry and Meghalaya.

1.10 SAFE DRINKING WATER, SANITATION AND HYGIENE

World Health Organisation (WHO) estimates that 50% of malnutrition is associated with repeated diarrhoea or intestinal worm infections as a result of unsafe water, inadequate sanitation or insufficient hygiene. While there has been considerable progress in ensuring safe drinking water, ensuring universal access to sanitation and improving hygiene practices remains a key challenge. New initiatives are now being taken up to expand and intensify deworming interventions.

NFHS 4 (2015-16) shows that families are now more inclined to use improved water and sanitation facilities. Over two-thirds of households in every State/UT (except Manipur) have access to an improved source of drinking water, and more than 90% of households have access to an improved source of drinking water in 19 States/Union Territories. More than 50% of households have access to improved sanitation facilities in 26 States/Union Territories. Similarly, in 20 States/ UTs, more than 50% households use clean cooking fuel, which reduces the risk of respiratory illness and pollution.

1.10.1 *Safe Drinking Water*

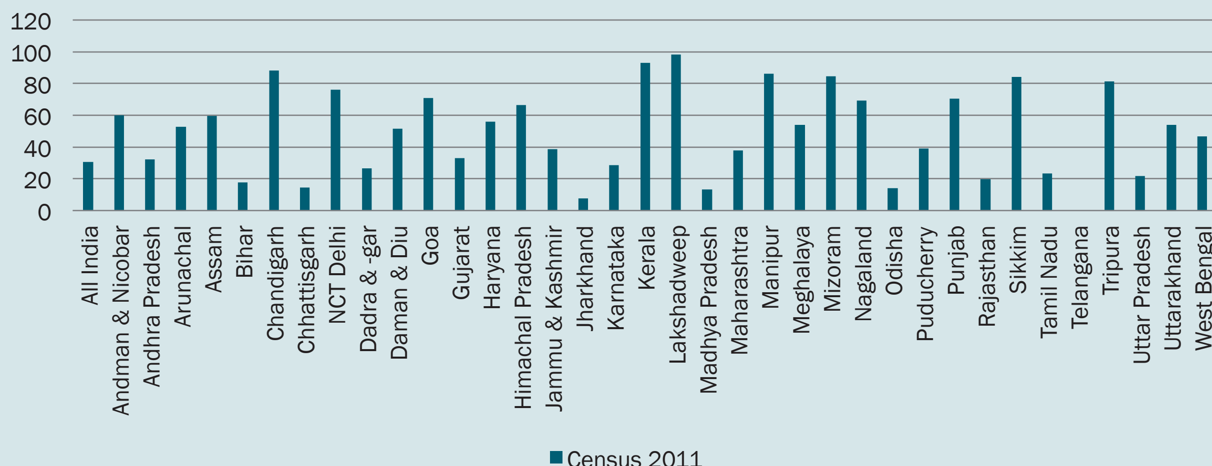
As per IMIS of Ministry of Drinking Water and Sanitation (MDWS), Govt. Of India, there are total 1696664 habitations in India, out of which 1249695 (73.66%) habitations are fully covered with >= 40 lpcd water supply facility, 368463 (21.71%) habitations are partially covered i.e. with < 40 lpcd water supply facility and 78506 (4.63%) habitations are quality affected as on 01.04.2014. There are still about 78506 quality affected habitations with water quality problem due to Arsenic, Fluoride, Iron Salinity and Nitrate.

1.10.2 *Sanitation & Hygiene*

Globally, due to inadequate and unsafe drinking water, poor sanitation and unhygienic practices, diarrhoea has emerged as one of the leading causes of child deaths under age of five, claiming nearly 11 percent of total deaths in the age group. Further it has been reported that a 10% increase in open defecation is associated with 0.7% increase in both stunting and severe stunting in children. Even today, it is estimated that 48% of India's population defecates in the open. Out of the total of one billion people defecating in the open across the world, an estimated 59.7% (597 million) reside in India (Report of the Sub Group of Chief Ministers on Swachh Bharat Abhiyan 2015).

Figure 11

Rural Households Toilets Coverage (%)



There is a wide disparity in rural and urban sanitation coverage in India. As per Census 2011, the rural household toilet coverage stands at 32.7% and urban household toilet coverage stands at 87.4%. Open defecation is linked to the presence or absence of household-level sanitation infrastructure and the absence of household toilet coverage is presumed to be the percentage of Open Defecation. (Report of the Sub Group of Chief Ministers on Swachh Bharat Abhiyan 2015).

As per Census 2011, 53.1% households did not have latrines as compared to 63.6 % households in Census 2001. The State wise rural household toilets coverage is indicated in Figure 12. As per the Base Line Survey conducted by MDWS in 2012, about 40.23% of Households were having Individual Household Latrines (IHHLs). Only 28002 (i.e. 11.19%) against total number of 250292 Gram Panchayats in the Country had achieved the status of Nirmal Gram, whereas the 12th Five Year Plan had aimed at ensuring that 50% of the Gram Panchayats attain Nirmal Gram status by the year 2017. The improvement of hygiene practices such as hand washing and safe disposal of waste remains a challenge, which is being addressed by Swachh Bharat.

The challenges in universalising access to sanitation and achieving open defecation free status within the next few years include inducing a behavioral change among people, developing sustainable revenue models for maintenance of community and public toilets, revival of dysfunctional toilets and the elimination of manual scavenging.

1.11 DIETARY INTAKE

Projected data from the surveys carried out by NNMB on nutrient intake in pre-school children between

1975 and 2006 has not shown any substantial improvement in their dietary intake. There has not been a major change in energy and protein intake of children. Time trends of the intra familial distribution of food indicate that the proportion of families where both the adults and preschool children have adequate food has declined from 30% to 22% over the last 30 years. The proportion of families where the preschool children receive inadequate intake while adults have adequate intake has increased to a greater extent. This data reinforces the need to strengthen infant and young child caring and feeding practices.

The ICMR Expert Committee revised the RDA for Indians (Nutrient Requirements and Recommended Dietary Allowances for Indians: A Report of the Expert Group of the Indian Council of Medical Research, 2010). In view of the revised RDAs, various food supplementation programs like SABLA, MDM and PMMVY will need to consider this while reviewing the nutritional norms of these programmes.

1.12 DUAL BURDEN OF MALNUTRITION

As indicated in the recently released Global Report on Nutrition 2016, obesity and overweight, rising in every region and nearly every country, are now becoming a global challenge. The number of children under 5 who are overweight is approaching the number who suffer from wasting. The number of overweight children under 5 years is increasing most rapidly in Asia.

NFHS 3 data also suggests that India is in the process of nutrition transition, where the dual burden of malnutrition – i.e. overnutrition and undernutrition is beginning to be seen in some groups. There is a relatively small, but increasing percentage of overweight children who are at greater risk for non-communicable diseases such as diabetes and cardio-vascular heart disease. These levels of overnutrition significantly compromise health and productivity. NFHS-4 reports that overweight/ obesity has affected almost 20.7% women and 18.6% men, mostly located in urban areas, in wealthier households and among older adults. It is seen that over nutrition is becoming an emerging issue, with Chandigarh and Lakshadweep indicating the prevalence of overweight women or obesity in women by more than 40%.

1.13 DETERMINANTS OF UNDERNUTRITION

Undernutrition is the outcome of a complex interaction between insufficient dietary intake, absorption and inadequate prevention and management of disease/infections- these are the immediate determinants of undernutrition. Underlying determinants include the lack of access to health and child care services, safe drinking water, sanitation and hygienic environments, lack of access to household food security and livelihoods, and inadequate caring and feeding practices for children and women. Care practices are critical as they translate food and health resources into nutrition outcomes for

children and women. These include infant and young child feeding practices, health, hygiene, care for girls and women, psychosocial care and early learning. Direct or Nutrition specific interventions mostly focus on improving the immediate and underlying determinants of undernutrition, with impact visible over a shorter period of time.

Basic determinants include factors such as poverty, livelihoods, social protection safety nets, agriculture, public distribution systems, education and communication- especially female literacy and girls' education, women's empowerment and autonomy in decision making, control and use of resources (human, economic, natural), shaped by the macro socio- economic and political environments and the potential resource base. Indirect and/ or nutrition sensitive interventions mostly address these determinants, through multisectoral action and policy instruments with longer term impact. Recent findings over the last decade from Bangladesh, Brazil, Thailand, Senegal and Vietnam point to the fact that improvements in nutrition have come from interventions in multiple areas which include both direct nutrition interventions and indirect interventions focusing on underlying determinants. No single stand alone intervention has been able to lead to substantive, rapid and sustainable reductions in maternal and child undernutrition. A comprehensive approach is therefore called for which addresses multisectoral and inter related determinants of undernutrition across the life cycle, as also mandated by the National Nutrition Policy 1993 and reinforced two decades later by the call for addressing nutrition specific and nutrition sensitive interventions by The LANCET Series on Maternal and Child Nutrition, 2013.

1.14 REDUCTIONS IN MATERNAL & CHILD MORTALITY

These are possible through accelerated nutrition interventions as global evidence shows that –

— **One fifth of maternal mortality** can be averted by addressing maternal stunting and iron deficiency anemia. These increase the risk of death of the mother at delivery, accounting for at least 20 percent of maternal mortality- (LANCET 2008).

— **One fifth of neonatal mortality** can be prevented by ensuring the universal practice of early initiation of exclusive breastfeeding within the first hour of birth (22 % of neonatal mortality can be averted by this, as shown by evidence from West Africa and South Asia).

— **One fifth of child mortality (under 5 years)** in India can be prevented by ensuring universal exclusive breastfeeding for the first six months and appropriate complementary feeding practices after 6 months (along with continued breastfeeding till 2 years and beyond). Deaths of children under five years can be reduced globally by 13 % and in India by 16% - through the universal practice of exclusive breastfeeding for the first six months of life, and another 5 % through the universal practice of appropriate complementary feeding. (LANCET 2003, India analysis 2004).

Therefore, preventive early action – prenatally, in the neonatal period, early infancy- in the first hours, days, weeks, months and years of life is critical for addressing a vicious cycle of undernutrition, disease/infections, related mortality and risks to maternal and child survival and development.

2 IDENTIFICATION OF FOCUS DISTRICTS- INCLUDING POOR PERFORMING STATES AND DISTRICTS

The implementation of the National Nutrition Strategy will include representation from all States and UTs, while focusing on districts with high prevalence of malnutrition and /or performing poorly. There will also be some representation of best performing districts and good practices within States - along with poor performing ones, to encourage performance and create a demonstration or ripple effect within and across states.

In order to synergize impact - efforts will be made to cover districts already identified, such as the 184 High Priority Districts identified National Health Mission High Priority Districts (based on lowest 25 % districts on health related indicators), the 200 ICDS nutrition high burden districts (200) and 162 districts covered under ISSNIP, with flexibility to states in the finalization of districts.

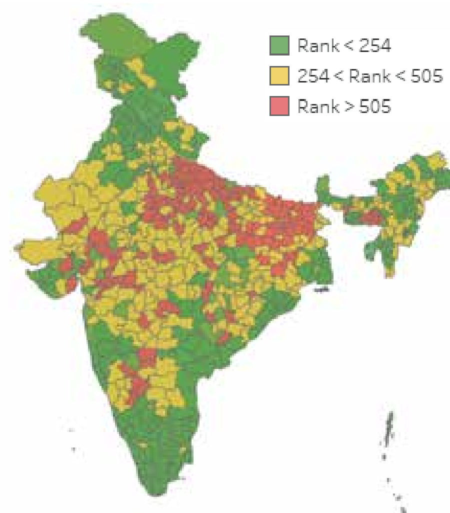


Figure 12

Districts Ranked based on Stunting of Children under 5 yrs

2.1 CRITERIA USED FOR IDENTIFICATION OF DISTRICTS:

- High prevalence of Child Undernutrition: Recent district level data on nutrition and health for the specific/ limited purpose of inter district comparison (or comparison within a cluster of states covered by the survey) is available in the recent NFHS-4 data. Figure 12 shows the district wise prevalence of stunting for children below five years, as given in NFHS-4.
- High/low prevalence districts identified across States, for which data is available, as well as within the State. The analysis of high/low prevalence across districts has been conducted using the parameters of women with low BMI and using anemia prevalence in children, adolescent girls and women, based on NFHS-4 data.

2.2 IDENTIFICATION OF FOCUS DISTRICTS

Currently, the focus areas/ high priority districts vary as per Ministries and their respective schemes. For example, out of the 184 High Priority Districts chalked out under the National Health Mission (NHM) implemented by the Ministry of Health & Family Welfare and the list of 200 High Burden Districts identified within the ICDS programand 162 Districts covered within the ISSNIP,both implemented by the

Ministry of Women and Child Development (MoWCD), only 39 districts are common (details in Annexure-II). As evident in Figure 13, there is a lack of synergy in the efforts made by MoWCD and MoH&FW to address the challenge of under nutrition. When we take other Ministries like Drinking Water and Sanitation, etc, the number of common high priority districts reduces further. The multidimensional nature of factors affecting nutrition calls for a coordinated and combined effort from all stakeholders to attain optimal outcomes.

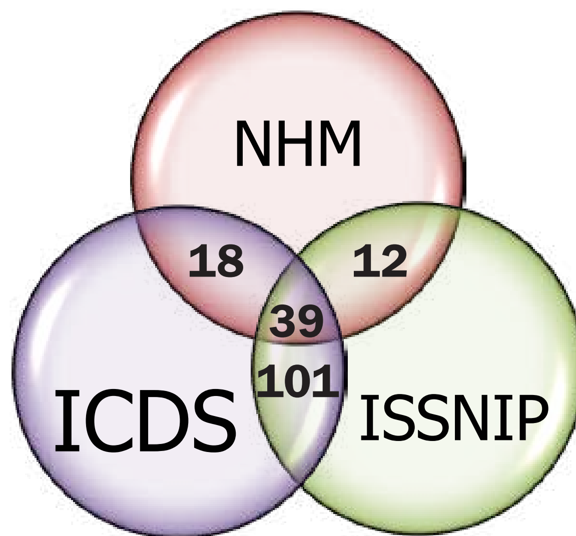
The recent NFHS-4 data presents the status of nutrition of women and children in details. Since national, state and district level data is available, it is important that different Ministries and States/ UTs work in close collaboration and converge their efforts to maximize the gains. Annexure- III presents a quick reference to the 100 worst performing districts with respect to stunting. Efforts can be made beginning from these poorly performing districts.

An alternative could be phasing of the roll out of the National Nutrition Strategy in harmony with the proposed National Nutrition Mission such that-

- Phase I (2017-18) covers 254 districts and identified urban areas;
- Phase II (2018-19) covers an additional 254 districts, i.e. a total of 508 districts; and
- Phase III (2019-20) cover the remaining districts based on needs assessment and performance.

Figure 13

High Burden/ Priority Districts of ICDS, NHM & ISSNIP



3 VISION 2022

The National Nutrition Strategy is committed to ensuring that every child, adolescent girl and woman attains optimal nutritional status- especially those from the most vulnerable communities. The focus is on preventing and reducing undernutrition across the life cycle- as early as possible, especially in the first three years of life. This commitment also builds on the recognition that the first few years of life are forever - the foundation for ensuring optimum physical growth, development, cognition and cumulative lifelong learning.

Figure 14

The Vision - "Kuposhan Mukt Bharat"

Free from malnutrition, across the life cycle.

This is elaborated as –

"Healthy, optimally nourished children, realizing their growth and development potential, active learning capacity and adult productivity;

Healthy, optimally nourished women realizing their social and economic development potential;

In protective, nurturing, gender sensitive and inclusive community environments –

That enhance human and national development in the present - and in the future.

4 GOALS, OBJECTIVES & KEY INDICATORS

It is widely recognized that Maternal and Child Undernutrition is the underlying cause of nearly half (45%) of the mortality of children under five years (Black RE et al, The LANCET 2013) and that one fifth of maternal mortality can be averted by addressing maternal stunting and iron deficiency anemia (LANCET 2008). The link between the vicious cycle of undernutrition, disease/infections and mortality has also been highlighted in the Nutrition Situation Analysis.

In this perspective, the National Nutrition Strategy will therefore contribute to key national development goals for more inclusive growth, such as the reduction of maternal, infant and young child mortality, through its focus on the following monitorable targets-

- To prevent and reduce undernutrition (underweight prevalence) in children (0- 3 years) by 3 percentage points per annum from NFHS 4 levels by 2022.
- To reduce the prevalence of anemia among young children, adolescent girls and women in the reproductive age group (15- 49 years) by one third of NFHS 4 levels by 2022.

The achievement of the above monitorable targets will contribute to improved learning outcomes in elementary education, improved adult productivity, women's empowerment and gender equality and the National Development Agenda. Achievement of these national development goals will also significantly shape progress towards global sustainable development goals.

In a longer term perspective, the strategy will also aim to progressively reduce all forms of undernutrition by 2030. The focus of this strategy over the next five years is on preventing and reducing child undernutrition. While undernutrition affects large segments of the population – the strategy accords priority to and focus on the most vulnerable and critical age groups, which also determine nutrition in later life and inter generationally.

Figure 15

Monitorable Outcomes

	Monitorable Outcomes	**Current status**	**Target 2022**	**Means of verification**
1.	Reduction in % age of underweight (Below-2SD) children below 5 years	35.7	20.7	NFHS
2.	Reduction in prevalence of anemia in children (6-59 months).	58.4	19.5	-do-
3.	Reduction in prevalence of anemia in women and girls (15-49 years).	53.1	17.7	-do-

The dual burden of malnutrition (undernutrition and over-nutrition) has been addressed in a longer term perspective, recognizing that over-nutrition constitutes an emerging issue, with an associated non-communicable disease burden.

The above goals will also contribute significantly to shaping the achievement of global Sustainable Development Goals related to ending hunger, achieving food security and improved nutrition, ending poverty, ensuring healthy lives, ensuring inclusive and equitable quality education, achieving gender equality and empowering women and girls. At least 12 of the 17 Sustainable Development Goals contain indicators that are relevant for nutrition, demonstrating that nutrition is the foundation for ensuring sustainable development. This will also contribute to achieving global nutrition targets endorsed in 2012, through the World Health Assembly Resolution 65.6, committing to a comprehensive implementation plan on maternal, infant and young child nutrition. This specified a set of six global nutrition targets for 2025 that aim to:

- Achieve a 40% reduction in the number of children under-5 who are stunted;
- Achieve a 50% reduction of anemia in women of reproductive age;
- Achieve a 30% reduction in low birth weight;
- Ensure that there is no increase in childhood overweight;
- Increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%;
- Reduce and maintain childhood wasting to less than 5%.

5 GUIDING PRINCIPLES

The implementation of the National Nutrition Strategy will be guided by the following key principles of action-

5.1 A LIFE CYCLE APPROACH

Recognizing that there is an intergenerational cycle of undernutrition, as described in the situation analysis, a life cycle approach will be adopted, with a focus on critical periods of nutritional vulnerability and opportunity for enhancing human development potential.

5.2 EARLY PREVENTIVE ACTION

Recognizing that growth and development deficits that compromise child health and survival and achievement of optimal learning outcomes are cumulative and largely irreversible – there will be emphasis on preventing under nutrition, as early as possible, across the life cycle.

5.3 INCLUSIVE AND GENDER SENSITIVE

It will be rooted in a rights based framework that seeks to promote the rights of women and children to survival, development, protection and participation – without discrimination. In this, strategies for ensuring social inclusion of marginalized community groups will be pursued- recognizing that nutritional vulnerability is compounded by multiple deprivations - based on socio economic status, high burden of disease, natural factors such as floods/droughts and/or other conditions such as lack of access to services. Efforts will focus on reaching the most vulnerable and deprived.

5.4 COMMUNITY EMPOWERMENT AND OWNERSHIP

Families and communities will be enabled for improved care behaviors and nutrition of children and women, to demand quality services, to contribute to increased service utilization and to participate in community based monitoring.

5.5 VALUING, RECOGNIZING AND ENHANCING THE CONTRIBUTION OF ANGANWADI WORKERS. HELPERS AND ASHAS

The approach will be to improve the working conditions, skills, development pathways and motivation of Anganwadi workers, helpers and also ASHAs - a frontline team of over 33 lakh women from the local community covering 13.42 lakh habitations across the country– recognizing that they are prime movers

of social change.

5.6 DECENTRALIZATION AND FLEXIBILITY

Contextually relevant, decentralized approaches will be promoted, with greater flexibility at State, district and local levels for greater and sustained programme effectiveness and impact, in harmony with the approach of cooperative federalism. This will also enable utilization of opportunities provided by the recommendations of the Fourteenth Finance Commission with greater devolution of resources to States- mobilizing and catalyzing state resources and action for Nutrition.

5.7 OWNERSHIP OF PANCHAYATI RAJ INSTITUTIONS AND URBAN LOCAL BODIES

Strengthening the ownership of Panchayati Raj Institutions and urban local bodies is a key principle – to ensure that local self governments own, promote, monitor and sustain nutrition initiatives – effecting convergence of action at the grass roots. This is essential as the subjects allocated in the 73rd Amendment include those addressing the immediate and underlying determinants of undernutrition such as Health and Sanitation, Family Welfare, Drinking Water, Women and Child Development, Public Distribution Systems, Agriculture, Education, Poverty Alleviation and Social Welfare, among others. This is even more relevant in the light of the Fourteenth Finance Commission Recommendations.

5.8 FOSTER INNOVATION

Innovation will be encouraged and recognized - including through quality circles which encourage a cluster of frontline teams to identify best practices and replicate the same – with a ripple effect and widening of the innovation. Best practices will be identified and local adaptation and replication or scaling up encouraged.

5.9 INFORMED BY SCIENCE AND EVIDENCE

Programme strategies will be evidence based, informed by the state of the science (as well as by the state of the practice) and updated as new evidence emerges related to nutrition, health and development.

5.10 ENSURE THAT THERE IS NO CONFLICT OF INTEREST

An underlying principle of action is that policy development and programme implementation must be transparent, open to public scrutiny and kept free from conflict of interest, with requisite safeguards. (This includes ensuring that representation on policy, technical advisory groups and various management committees at different levels is free from conflict of interest.)

6 NUTRITION INTERVENTIONS

Nutrition Interventions are well established and operational through flagship programmes such as ICDS, NHM -including RMNCH + A, Swachh Bharat and others such as PMMVY and SABLA. There is now a stronger global evidence base and programme implementation experience available. These may broadly be grouped as follows-

Figure 16

Nutrition Interventions

- Infant and Young Child Care and Nutrition
- Infant and Young Child Health
- Maternal Care, Nutrition and Health
- Adolescent Care, Nutrition and Health
- Addressing Micronutrient Deficiencies -including Anemia
- Community Nutrition (Interventions addressing the community)

The National Nutrition Strategy identifies key nutrition interventions that will be undertaken or WHAT will be done. The concept of direct and indirect interventions was envisaged in India's National Nutrition Policy 1993 and the proposed interventions include both direct or nutrition specific interventions and indirect or nutrition sensitive interventions. The next Chapter 7 elaborates HOW these interventions are to be operationalized, as these would be eliminates and promoted, relevant to the local context, by States and districts, through a flexible implementation framework, that enables strategic choices by States and districts.

The LANCET Series on Maternal and Child Undernutrition, 2008 highlighted that effective interventions are available to reduce stunting, micronutrient deficiencies and child deaths. Among the available interventions reviewed, breastfeeding counseling, appropriate complementary feeding and vitamin A and zinc supplementation have the greatest potential for reducing child deaths and future disease burden related to undernutrition. Interventions to reduce iron and iodine are important for maternal survival and child cognitive development, educability, and future economic productivity.

6.1 NUTRITION SPECIFIC AND NUTRITION SENSITIVE INTERVENTIONS

The global evidence was reviewed subsequently through the LANCET Series on Maternal and Child Nutrition 2013, which highlighted the need for both nutrition specific (direct) and nutrition sensitive (indirect) interventions. Some concerns were also voiced by the Indian scientific community on the study

design and findings, and these concerns have been factored in while firming up the proposed interventions under the National Nutrition Strategy.

The nutrition specific interventions highlighted in the recent LANCET series included adolescent and maternal nutrition, promotion of optimal breastfeeding and Infant and Young Child Feeding Practices, food and micronutrient supplementation programmes for young children and in pregnancy and lactation, prevention and management of severe acute malnutrition and disease prevention and management. Nutrition sensitive interventions reviewed included agriculture, social safety nets, early child development and schooling.

6.2 KEY NUTRITION INTERVENTIONS

In the above perspective, key nutrition interventions that would be promoted and supported are as follows-

i. Infant and Young Child Care & Nutrition

These interventions focus on the first three years of life, where there is the greatest vulnerability to undernutrition, infections and mortality and where a sound foundation is critical for improved nutrition and development outcomes across the life cycle. Growth and development potential is undermined by low birth weight and the sharp increase in undernutrition seen in this period, with leveling off in the third year.

Around two thirds of malnutrition related deaths are related to inappropriate caring and Infant and Young Child Feeding practices, and occur in the first year of life (WHO). Caring practices include infant and young child feeding, health, hygiene, psychosocial care and care for girls and women. Optimal Infant and Young Child Feeding practices including early initiation of breastfeeding within one hour of birth and feeding and exclusive breastfeeding for the first six months of life are especially critical for child survival and development. Breastfed children have at least six times greater chance of survival in the early months than non-breastfed children, as breastfeeding also drastically reduces deaths from acute respiratory infection and diarrhea, two major child killers (LANCET 2008). Optimal breastfeeding also enhances the infant mother bonding and benefits maternal health by reducing post partum hemorrhage and increasing birth intervals.

It is also important to ensure timely and appropriate complementary feeding after six months, (along with continued breastfeeding for two years or beyond) using family food resources. Optimal Infant and Young Child Feeding practices also include improved feeding during and after illness and/or during nutritional deprivation, which are essential for improved child health and nutrition outcomes.

Figure 17

Infant and Young Child Care and Nutrition

These interventions will focus on children under 3 years, through the promotion of -

- Universal early initiation (within 1 hour of birth) and exclusive breastfeeding for the first six months of life.
- Universal timely and appropriate complementary feeding after six months, along with continued breastfeeding for two years or beyond.
- Universal growth monitoring and promotion of young children-using WHO CGS with counseling of mothers/families using the Mother Child Protection Card.
- Universal access to infant and young child care (including ICDS, crèches, linkages with MGNREGA), with improved supplementary nutritional support/THR through ICDS.
- Enhanced care, improved feeding during and after illness, nutritional support, referrals and management of severely and acutely undernourished and/or sick children.

Child care services, linked to health care, supplementary nutritional support, regular tracking and promotion of child growth and counseling of mothers/families also contribute to reducing vulnerability to undernutrition and reducing risks to healthy child development - especially among more vulnerable community groups and in the context of enabling women's work and releasing girls from the burden of sibling care.

ii. Infant and Young Child Health

Almost half of childhood undernutrition is about fetal growth restriction and infections, preventing/ managing infections (including prevention through early and exclusive breastfeeding, complete immunization, micronutrient supplementation, safe drinking water, sanitation, hygiene practices such as hand washing) and not about food alone. Major infections that impact adversely upon child nutrition include diarrhoea, pneumonia and measles. There is also a need for malaria control measures in malaria endemic areas.

Figure 18

Infant and Young Child Health

The set of interventions related to Infant and Young Child Health therefore envisage the promotion of-

- Improved new born care and care of low birth weight babies.
- Bi annual vitamin A supplementation for children 9-59 months

- Universal, timely and complete immunization of infants against vaccine preventable diseases (and subsequent booster doses) with quality assurance.
- Ensuring that young children receive micronutrient supplementation and bi annual deworming as per MHFW guidelines. This includes-
- IFA supplementation for children 6-59 months.
- Bi annual deworming for children Over 1 year-59 months (linked to bi annual VAS rounds).
- Prevention and management of common neonatal and childhood illnesses such as diarrhoea (with ORS and zinc supplementation) and Acute Respiratory Infections (ARI) and severe acute malnutrition, at community and facility levels.

Diarrhoea, largely caused by a lack of water, sanitation and hygiene, is a leading cause of death in children under-five globally. Diarrhoea contributes to nutritional deficiencies, reduced resistance to infections and impaired growth and development. Research findings show that the proportion of child stunting attributed to 5 or more episodes of diarrhoea before 2 years was 25%. (Checkley 2008), reiterating that this is a major risk factor for undernutrition, along with other infections. Preventing and treating infections through increasing coverage and quality of primary and secondary health care must also be seen as an essential approach to reducing childhood undernutrition. Targeting intestinal parasitic worms among children (over 1 year) for India to achieve status of being 'Worm-free'is another element of the health strategy, covering all pre-school and school-age children (enrolled and non-enrolled) between the ages of 1-19 years, through the National Deworming Initiative.

Severe Acute Malnutrition increases significantly the risk of death in children under five years of age. It can be an indirect cause of child death by increasing the case fatality rate in children suffering from common illnesses such as diarrhoea and pneumonia. Using the new WHO Child Growth Standards in developing country situations results in a 2–4 times increase in the number of infants and children falling below -3 SD weight for height/length compared to using the former NCHS reference.

It needs to be reiterated that using the new standards increases the levels of malnourished children; however it also leads to earlier detection of malnutrition and in a less severe state; thereby providing an opportunity for faster recovery and lower case fatality rates (MHFW). Therefore interventions are needed for prevention, early identification and management of severe acute malnutrition (at community and facility levels).

iii. Maternal Care, Health and Nutrition

Evidence presented in the LANCET Series on Maternal and Child Nutrition 2013 reflects the importance of adolescent and maternal nutrition for the health of the adolescent, mother and for ensuring healthy

fetal growth and development. Meeting the increased nutrient requirements of women during pregnancy and lactation and controlling anemia is critical.

Figure 19

Maternal Care, Health and Nutrition

Interventions for maternal care, health and nutrition therefore include the promotion of-

- Improved supplementary nutritional support during pregnancy and lactation (ICDS).
- Improved antenatal care - including health and nutrition counseling (also family support for extra diet and rest to ensure adequate weight gain), IFA supplementation, consumption of adequately iodized salt and screening /management of severe anemia.
- Enhanced maternity protection (through the effective implementation of PMMVY)
- Institutional deliveries, lactation management, improved post-natal and new born care.
- Promoting marriage at the right age, first pregnancy at the right age, inter pregnancy recoupment/ birth spacing and shared care/ parenting responsibilities.
- Promoting Women's Literacy and Empowerment.

The importance of addressing fetal growth restriction or being born small for gestational age is highlighted therein, indicating that around 20% of stunting is contributed to by fetal growth restriction. Fetal growth restriction is also a cause of more than a quarter of all neonatal deaths globally. Further, adverse nutritional status early in life, when coupled with rapid weight gain later in childhood, are important determinants of obesity and non-communicable diseases in adulthood. Addressing low birth weight is therefore critical for improved nutrition across the life cycle- while recognizing that improvements in birth outcomes call for a longer term inter-generational perspective.

iv. Adolescent Nutrition

Adolescence is a period of rapid growth and maturation from childhood to adulthood, with both vulnerability and opportunity. The rapid growth that occurs in adolescence creates increased demands for energy and nutrients. At the peak of the adolescent growth spurt, the nutritional requirements may be higher than the remaining period of adolescence. During puberty, body composition and biologic changes (e.g. menarche) emerge, which increase gender-specific nutrient needs of adolescent girls, and anemia control is a key priority. Girls especially need to be protected from discriminatory social practices that constrain their nutrition, health, education and development. This is also a time of opportunity to empower adolescents with life skills (including informed choices related to nutrition and health) for enabling them to achieve their development potential.

Figure 20

Adolescent Nutrition

The interventions here - especially for improving the nutrition status of adolescent girls- will focus on the promotion of-

- Equal care of the girl child at different stages of the life cycle- linked to the Beti Bachao Beti Padhao initiative.
- Improved access to health care, counseling support through school health programmes, ARSH and deworming as per MHFW National Deworming Initiative.
- Improved access to nutritional support through Mid-Day Meals in schools (MHRD) and through SABLA for out of school girls.
- Universal access of girls in school and girls out of school to IFA supplementation.
- Girls' education, skill development and female literacy.
- Changing gender constructs -Gender sensitization and life skills for adolescents.
- No Child Marriage- Marriage of young women after the age of 18 years.

The above will also have a positive inter-generational impact.

v. Control of Micronutrient Deficiencies or Vitamin and Mineral Deficiencies

Micronutrients are Vitamins and Minerals that humans need to consume in small amounts for optimal health and development. Micronutrient deficiencies often coexist with protein energy malnutrition and have independent and interacting effects on health, growth and immunocompetence. Vitamin A Deficiency, VAD, IDA and IDD are public health problems which need to be addressed through a comprehensive approach that includes promoting optimal Infant and Young Child Feeding Practices, Dietary Diversification, Nutrient Supplementation, Food Fortification, Public Health Measures and Horticultural interventions.

This group of interventions will therefore address the following-

a. Vitamin A Deficiency

Vitamin A Deficiency is the leading cause of preventable blindness in children. More significantly it increases the risk of disease and death from severe infections such as diarrhoeal disease, acute respiratory infections and measles. In pregnant women it causes night blindness and may increase the risk of maternal mortality. The interventions as already provided in the NHM RMNCH+ A National Programme for Control of Vitamin A Deficiency will be strengthened. These include-

- Breastfeeding: Promoting early initiation within the 1st hour of birth, eliminates feeding and exclusive breastfeeding for the first 6 months of life with appropriate complementary feeding

after 6 months, along with continued breastfeeding for 2 years or beyond.

- Dietary Diversification: Improving dietary intake of vitamin A through behavior change communication, increasing production and consumption of vitamin A rich foods such as carotene rich yellow/orange fruits and vegetables and others.
- Vitamin A Supplementation: as per MHFW guidelines and referred to in preceding sections.
- Public Health Interventions: Common public health interventions such as measles vaccination and control of diarrhoeal disease, through adequate access to safe water and sanitation.
- Integrated programme approaches.

b. Iron Deficiency Anemia

Iron Deficiency is the cause of more than 80% of anemia. Iron deficiency anemia impairs cognitive and motor development among children, increases their susceptibility to illness, and in adults reduces work capacity and productivity. In pregnancy, this contributes to high maternal and neonatal mortality, obstetrical risks, increased morbidities, impairment of fetal development, and low birth weight. As outlined in the NHM RMNCH+ A National Nutritional Anemia Prophylaxis and Control Programme, the major interventions will include the promotion of:

- Optimal Infant and Young Child Feeding Practices for young children.
- Dietary Diversification: Improving intake of iron and folate rich dark green leafy vegetables and vegetables and also those that promote iron absorption (rich in Vitamin C).
- IFA Supplementation: as per MHFW Iron Plus guidelines (as shown in Figure 4 and referred to in preceding sections).
- Biannual deworming: as per MHFW guidelines.
- Fortification -Introduction of iron and iodine-fortified salt, especially in ICDS and MDM, using lessons learnt from the IDD control programme.
  (Promotion of Conventional Plant Breeding & original research to develop indigenous varieties of food items with higher levels of micronutrients may also be explored).
- Health and nutrition education to promote optimal feeding practices- especially appropriate complementary feeding, consumption of iron and folate rich foods, also those that promote iron absorption (rich in Vitamin C) and use of iron fortified iodised salt.
- Screening, detection and management (Shown in Figure 4, as per MHFW guidelines)
- Iron and folic acid supplementation to vulnerable groups such as preschool children and adolescent girls.
- Screening for early detection of anemia among vulnerable groups (such as pregnant women).

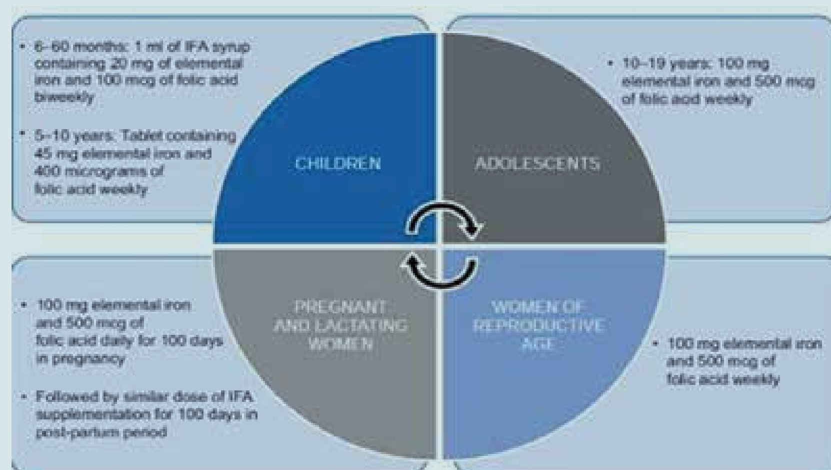
- Appropriate management of anemia depending upon its severity, chronicity, physiological status of the individual and the time available for correction of anemia
- Public health measures to improve hygiene and sanitation; reduce hook worm infestation and also measures for malaria control.

By 2022, this will enable progressive achievement of the following –

- Universal screening of pregnant women for anemia and appropriate treatment.
- Screening of children for anemia wherever possible and appropriate treatment of those found anemic.
- Reduction of the prevalence of moderate and severe anemia by one third in children, pregnant women and adolescent girls.

Figure 21

Guidelines for Control of Iron Deficiency Anemia, MHFW 2010



c. Iodine Deficiency Disorders

Iodine Deficiency is the leading cause of preventable brain damage worldwide, leading to learning disabilities and psychomotor impairment and a loss of 10-15 IQ points per child. Interventions under the NHM National Iodine Deficiency Disorders Control Programme will be strengthened. These include the promotion of –

- **Universal household consumption** of adequately iodised salt.
- **Special focus** on reaching pregnant women, young children and adolescent girls, through food supplementation programmes such as ICDS, MDM, SABLA and vulnerable community groups.
- **Health and nutrition education.**

- **Community based monitoring-** especially through salt testing in schools, health centres and panchayats.

Here the aim will be to achieve universal access to adequately iodised salt by 2018 and to reduce prevalence of iodine deficiency disorders in the country to less than 5 per cent by 2022.

d. Zinc Deficiency

As outlined in the NHM RMNCH+ A National Programme, the major interventions will be the use of ORS with zinc supplementation for diarrhoea management.

vi. Community Nutrition

The interventions grouped here address the community; include indirect nutrition interventions and are largely multisectoral. These seek to ensure a healthy, hygienic, caring and nutritionally secure environment, especially reaching the most nutritionally vulnerable community groups (such as SC, STs, minorities, others).

World Health Organisation (WHO) estimates that 50% of malnutrition is associated with repeated diarrhoea or intestinal worm infections as a result of unsafe water, inadequate sanitation or insufficient hygiene. Further, parasitic infections, such as soil-transmitted elminthes (worms), caused by a lack of sanitation and hygiene can also lead to anemia and impaired physical and cognitive development. This is also being addressed by the National Deworming initiative.

Figure 22

Community Nutrition

These interventions include, among others-

- **Ensuring universal access to safe drinking water, sanitation** and hygiene, in an open defecation free environment, through Swachh Bharat.
- **Prevention and treatment for malaria** through the –
  - Use of bed-nets and/or intermittent preventive therapy for malaria (as per MHFW protocols) in malaria-endemic areas
  - Facilitating mosquito control measures.

  Other relevant health /disease control measures specific for the state/district, relevant for improving nutrition at community levels - such as JE, kala azar etc.
- **Ensuring access to household food security**, social protection systems and safety nets.
- **Nutrition Education** to ensure that optimal feeding and caring practices, dietary diversity nutritious foods; sanitation and hygiene and healthy lifestyles are promoted-addressing

undernutrition and also the dual burden of malnutrition. (This includes Nutrition Education in the school curriculum and in colleges).

- **Focused Interventions** to reaching the most nutritionally vulnerable community groups (such as SC, STs, minorities, others) and address multiple nutritional vulnerabilities such as those related to seasonal distress, disease outbreaks, natural disasters (such as floods, drought, earthquakes) and other situations.
- **Flexible responses** to other State/district specific needs for improving nutrition at community levels.

7 Nutrition Strategy- HOW?

The Nutrition Strategy Framework envisages a Kuposhan Mukt Bharat - linked to Swachh Bharat and Swasth Bharat. The National Nutrition Strategy Mission will mobilize States to enable them to take up State/ District Action Plans for becoming Kuposhan Mukt with Kuposhan Mukt States/Districts/blocks/panchayats being recognized and rewarded. States will similarly encourage Districts and more decentralized planning processes for kuposhan mukt panchayats. This is especially relevant in view of enhanced resources to states, with greater flexibility to prioritise development interventions, with a greater role of panchayats and urban local bodies.

The resources for the Nutrition Strategy are envisaged as flowing from existing flagship programmes (especially from the 25 % flexi pool to be earmarked in Centrally Sponsored Schemes) and the upcoming National Nutrition Mission. Resources from States and PRIs, ULBs may also be catalysed- utilizing opportunities arising from the implementation of the Fourteenth Finance Commission recommendations.

In the above perspective, a flexible framework of implementation is envisaged that enables states with strategic choices for action, informed by best practices, through decentralized planning and local innovation- with accountability for nutrition outcomes.

The Nutrition Strategy Framework focuses on the core strategies outlined below.

Figure 23

Core Strategies - "HOW"

- **Governance Reform-** Nutrition Centre Stage and Public Accountability
- **Leading by Example-** Kuposhan Mukt States, districts and panchayats.
- **Convergence-** of State/ District Implementation Plans for ICDS, NHM and Swachh Bharat and others, addressing different determinants of undernutrition together.
- **Prioritize Action-** Reaching the most vulnerable communities in the districts/blocks with the highest levels of child undernutrition.
- **Counseling to Reach the Critical Age Group-** pregnant and lactating mothers, and children under 3 years, through skilled counselors, peer counselors and support groups.
- **Continuum of care-** across the life-cycle that includes preventive, promotive and curative care, linking families, communities, AWCs, health centers and health facilities.
- **Innovative Service Delivery Models-** demonstration and ripple effect, with evidence of impact.
- **Community Based Monitoring-** Making undernutrition visible to families, communities, tracking and informed action.

- **Enabling Actions-** Implementing innovative components of ICDS Restructuring; Crèches through MGNREGA; Extending SABLA and implementing Maternity Benifits through Pradhan Mantri Matru Vandana Yojana and Strengthening Nutrition within the Health System.

7.1 GOVERNANCE REFORM

India constituted a National Nutrition Mission in 2003, under the chairpersonship of the Prime Minister and subsequently some States constituted State Nutrition Missions with varied implementation experience. However, the National Nutrition Mission was never convened. The National Nutrition Mission was rescinded and in 2008, the Prime Minister's National Council on India's Nutrition Challenges was constituted for policy direction, review and effective coordination between ministries. The Council took four major decisions in end 2010, of which three were subsequently implemented. This included the Strengthening and Restructuring of ICDS in mission mode; launch of an IEC campaign against malnutrition and bringing Nutrition focus in relevant sectoral programmes, as reflected in the Twelfth Plan sectoral strategies and in the inclusion of Nutrition in the overarching Twelfth Plan Monitorable Targets. However, the multi-sectoral programme to address maternal and child undernutrition in selected 200 high-burden districts, although approved in September 2013, with 100 districts in the first phase- has not been rolled out. It is now subsumed in the proposed new National Nutrition Mission.

State Nutrition (or Nutrition related) Missions have been set up in several States- such as Atal Baal Mission in Madhya Pradesh, Baal Sukham in Gujarat and now Kuposhan Mukt Gujarat Maha Abhiyan, Rajmata Jijau Mission in Maharashtra, State Nutrition Missions in Uttar Pradesh, Karnataka and Jharkhand, Mission Manav Vikas in Bihar and Social Empowerment Mission in Andhra Pradesh, among others. These include some additionality of state resources in most cases and/or dependence on external resources in some instances.

The ICDS Mission has been functioning at national level, with states having established State ICDS Missions in most states. These may be subsumed under the proposed new National Nutrition Mission. Similarly the National Health Mission and Swachh Bharat have their own structures- including Mission Steering Groups for the coordination of multisectoral interventions and Inter Ministerial Coordination. However, the existing forums have not been very effective in converging multisectoral interventions across states, for accelerating nutrition outcomes.

The above highlights the emergent need to establish Nutrition as centre-stage in the National Development Agenda and rejuvenate the PM's National Council on India's Nutrition Challenges, as the overarching forum for policy guidance across multiple sectors and States. This also has oversight over the proposed new National Nutrition Mission.

Given the multi-sectoral nature of interventions and the need for convergence in action of a multiplicity

of agencies, an appropriate Governance mechanism is needed that would be able to establish Nutrition as the centre-piece in the National Development Agenda; while offering enough flexibility in operations and at the same time offering a platform for resolving issues relating to policy coordination, incentives and convergent action.

The following Governance structure and reform is therefore recommended-

- Convening of an expanded PM's National Council on India's Nutrition Challenges, to include representation from State Chief Ministers, in addition to Union Ministers and Vice Chairman of NITI Aayog (replacing Deputy Chairman of the erstwhile Planning Commission). This will serve as an overarching forum for policy guidance across multiple sectors and States with an oversight over the proposed NNM. The PM's Council will need a strong Policy Coordination Unit / Technical Secretariat for monitoring and evaluation of multisectoral interventions, to support the Council in effectively discharging its role.
- A Ministry of WCD led National Nutrition Mission; which will be the chief executive and implementing agency for the program, with appropriate governing structures that could mirror the ones approved for the National Health Mission (NHM). NNM will be accountable to the rejuvenated PM's National Council which could meet once in a year (or more) to take stock of the progress of the scheme.
- A Committee of Secretaries- MWCD, MHFW, MDWS, MFPD, MHRD, MRD, MPR, MOA, UD, MTA may also be constituted, chaired by CEO NITI Aayog. This is as requested by MWCD and needed to address and follow up multisectoral and inter-ministerial issues that also require coordination with states, as may emerge from programme implementation and deliberations of different Mission Steering Groups of relevant social sector flagship programmes such as NHM, Swachh Bharat, SSA, MDM, among others.
- Given that the mandate of NITI Aayog spans monitoring, evaluation, catalyzing change, ensuring policy coordination across sectors as well as to engage with the States (cooperative federalism), it would be appropriate to locate the Policy Coordination Unit /Technical Secretariat to the PM's Council at NITI Aayog. NITI Aayog can source required professional talent to be engaged in the Secretariat to ensure independent techno managerial inputs to the PM Council, Committee of Secretaries and the NNM.
- It is further recommended that the States/UTs would have parallel governance structure at the State/UT levels under the leadership of the Chief Ministers to drive the nutrition initiatives in their jurisdiction. The involvement of State Chief Ministers would strengthen the link between policy and its implementation at field level, as happened in Beti Bachao Beti Padhao through the Panipat consultation and launch. It is likely that the above measures will integrate and also give a boost to State Nutrition Missions and related initiatives.

- To ensure the success of the NNM, it is necessary to invest in building up an IT system. This should collect individual beneficiary level data that can be aggregated at village, block and district levels with appropriate dashboards for the District; State and National Dashboards that would act as a decision support system for the Program Managers. Ministry of WCD has already developed Software which has been piloted successfully in a few districts of Bihar. This has been demonstrated and could be a potentially game-changing intervention, provided it is Aadhar seeded to avoid duplication and can be integrated with the MHFW Mother and Child Tracking System (MCTS) and data collection on individual aspects relating to nutrition and health could be respectively assigned to the ANM and ASHA without a need for duplication of efforts or the tedium of maintaining multiple registers since it could easily be shared across electronic platforms.
- For improving public accountability, the existing commitments/provisions in ICDS Restructuring (2012) must be fulfilled/utilized -such as regular annual Common Review Missions conducted, as in NHM; community owned accreditation system; Jan Sunwais and Community Disclosure. These have not yet been operationalized.
- Nutrition Social Audits may also be conducted (as detailed in Chapter 8). At national and state levels, a website and necessary apps may be created. Field feedback on current nutrition initiatives may be provided there, with timely response.
- Another issue in improving public accountability is related to controlling large scale leakages in the ICDS Supplementary Nutrition Programme. A toll free number /help line in states may be provided for complaints and grievance redressal. Random checking/feedback may be enabled by greater publicity of / mapping of AWC locations on national/state web sites.
- A part of the problem could be addressed by implementing the UP model of improved monitoring through Cloud Telephony & IVRS based Daily Monitoring System for Hot Cooked Food in the AWCs The mobile phone based daily monitoring IVRS system, is a two-way direct communication system between the State headquarter and the AWWs. The software receives real time data on daily basis from the AWW regarding number of children being served Hot Cooked Meal and simultaneously makes it available on the web portal. The AWW by using her own mobile phone has to reply to the IVR calls for informing the number of children availing Hot Cooked Food on that day.
- Another approach could be uploading of photos to create public pressure for better governance and effective service delivery as has been experimented with in Swachh Bharat Mission. For nutrition, a possibility could be a virtual space for uploading photos of ICDS SNP feeding sessions and THR distribution at AWCs, randomly visited by a network of home science college/ training institutions/ student volunteers.

7.2 LEADING BY EXAMPLE: -ENABLING LEADERSHIP OF STATES, DISTRICTS AND PANCHAYATS

The Nutrition Strategy builds on the recognition of cooperative federalism and the appreciation of the leadership role of states in designing contextually relevant strategies to achieve state specific development goals, contributing to the National Development Agenda.

Leadership of States will be enabled by several measures. Identified States who are actively pursuing Nutrition initiatives will be represented on the PM's National Council, by rotation-leading by example. States will design their nutrition strategies, using the flexible Strategy Framework which provides a menu of strategic choices, which states may decide to take up. States would have accountability for achieving specified nutrition outcomes and policy reform within specified time frames, while having the flexibility to decide which strategic options are best suited to achieve the same. Inter State sharing and learning will be encouraged, sharing and adaptation of best practices will be promoted. The matrix of strategy choices will enable states to design and evolve their Annual Nutrition Implementation Plans, building on best practices and based on evidence of what works well.

Performance based incentives will be provided to States through a flexi pool innovation fund, which may be resourced from NNM. A component of the same can also be provided for innovation at the District level as the experience of Atal Bal Mission bears testimony to the success of a flexible approach to allow innovation at the local level, unbound by strait-jacketed flow of instructions on a top-down basis.

States may also evolve mechanisms for similarly enabling districts to develop their District Implementation Plans and by encouraging results at district, and block levels- recognizing and incentivizing malnutrition free districts, urban areas and panchayats. It is also proposed that awards may be instituted for Malnutrition Free States, Districts, urban areas and Panchayats - to recognize and motivate programme leaders, who will also be given enhanced sharing and learning opportunities.

7.3 CONVERGENCE

Convergence has to be considered from two perspectives - geographic and programmatic. As regards geographic convergence, it is seen that matching the list of 184 districts with high levels of child undernutrition, identified within th NHM, with the 200 ICDS high malnutrition burden districts, the 162 ICDS World Bank Assisted System Strengthening and Nutrition Improvement Project (ISSNIP) Districts and the 184 High focus districts of the NHM- there are only 39 districts where all three programmes are running concurrently. This implies that the geographic spread of programmes precludes concentration of efforts to get converted into high outcome or impacts.

Similarly, the programmatic guidelines indicate considerable overlap between the efforts of MHFW and MWCD. The same is the case with data gathering efforts of the two Ministries with a large degree of overlap in the data being captured at the village and the beneficiary levels leading to duplication of

efforts and inconsistencies. This fragmentation gets even more pronounced because of lack in synergies of the efforts of the two Ministries in the absence of appropriate Governance Structures to coordinate the policy and implementation. This has been addressed in the design of the Nutrition Strategy.

The State and District Nutrition Plan implemented through the Village Health and Nutrition Day shall constitute the core of the convergent action at the State, District and Village Panchayat levels. The success of the nutrition effort in other countries such as Thailand, Peru, Brazil and Zimbabwe have been predicated upon their ability to involve and sensitize local communities to take charge of this initiative and a similar approach shall be useful in India's context as well. The tools to achieve programmatic convergence at the field level, will include:

- Fixed Monthly Village Health, Sanitation and Nutrition Days to constitute the effective platform for convergence of services to the mother and child and a forum for growth promotion and behavioural change counseling.
- Joint Community Monitoring of nutrition status of children under 3 years at panchayat, village /AWC and health sub centres and in urban models and the IT enabled monitoring proposed by NNM.
- Joint Community Communication and Village Contact Drive by mapping and weighing of children, in front of the community- making undernutrition visible.
- Linking the concept of "kuposhan mukt panchayats" to the convergent gram panchayat plans being prepared through an intensive participatory planning exercise (IPPE) initiated by MRD in 2532 backward blocks (of which 967 are intensive blocks) for rural development. Trained panchayat members (especially women) and Women's SHGs mobilized under NRLM will play a key role in this.
- Strengthening of the Village Health Sanitation and Nutrition Committees (6.4 lakhs as per RHS 2014), recognized as sub committees of panchayats. Other convergence mechanisms in the state may be strengthened e.g. MAARPU in AP.
- Local gap filling and tapping of other resources in the district to strengthen ICDS, Health and Swachh Bharat infrastructure and services- as proposed in NNM.
- Joint planning, training and capacity development.

An enabling environment will be provided by the National and the State Nutrition Missions to encourage convergence of decentralized joint State/ District Implementation Plans with village based planning for Nutrition (ICDS), Health and Swachh Bharat – addressing different determinants of undernutrition together. The geographical aspect of achieving convergence will be achieved by urging all concerned Departments to prioritize their efforts on districts facing high burden of malnutrition, as detailed below.

7.4 PRIORITSE ACTION IN DISTRICTS/ BLOCKS WITH THE HIGHEST LEVEL OF CHILD MALNUTRITION

There are wide disparities in nutrition status across states, districts, blocks and different community groups, and with districts/blocks with very high levels of maternal and child undernutrition and related mortality. In order to significantly reduce child undernutrition at an aggregate level at a faster pace and for more inclusive development- it will be important to have focused interventions for these districts/ blocks and community groups, with high levels of child undernutrition. Even if a few districts are taken up in a state, these become important demonstration models which show that it is possible to reduce child undernutrition, at a faster pace- even under challenging conditions, thereby motivating other districts to take up such initiatives. This focus is integral to the Nutrition strategy- for faster, more significant and sustainable reduction in child undernutrition and more inclusive growth.

The NFHS-4 data should be used for effective geographic convergence. Subsequent NFHS rounds will be used for tracking mid-term and endline progress.

7.5 BREAKING THE VICIOUS CYCLE OF UNDERNUTRITION AND INTENSIFICATION OF COUNSELING TO REACH THE CRITICAL AGE GROUP (CHILDREN UNDER 3 YEARS, PREGNANT AND LACTATING MOTHERS)

The need for a life cycle approach has been highlighted, synergising health, nutrition, care and maternity protection interventions. This calls for preventive early action in the most vulnerable period– prenatally, at birth, in the neonatal period, early infancy- in the first hours, days, weeks, months and years of life, because it is critical for addressing a vicious cycle of undernutrition, disease/infections, related mortality and risks to maternal and young child survival and development.

Reforming Take Home Rations (THR) under the ICDS Scheme: Under the current ICDS scheme, the pregnant mother and the new born child is entitled to receive THR worth Rs 7125/- over a 45 month period, or averaging out it works out to Rs 158 per month1. It may be noted that this is based on 2011-12 prices and have not been revised since. It is recommended that the MWCD suggestion for an indexation of the THR entitlement to the Consumer Price Index [CPI] on lines of the Mid-Day Meal Scheme may be supported. The THR scheme has been plagued with complaints of leakages, poor quality food supplement and vested interests and needs to be looked afresh. As has evolved from various deliberations, after consultation with State Governments, pilots may be initiated in a few districts to test the efficacy of implementing the ICDS supplementary nutrition component through a cash transfer/ conditional cash transfer route, (to be transferred directly in the Jan- Dhan account of the mother), aligned to the framework of the National Food Security Act 2013. It may be considered to pilot some of the cash transfers testing it in States which opt to try out such options.

However, it must be emphasized that cash transfer alone is unlikely to be a magic bullet. It must be accompanied by enabling conditions; service guarantees; an improvement in complementary State Services (particularly primary health, nutrition and food security) and a Behavioural Change Communication (BCC) Plan. Issues that would need to be factored in include banking outreach /effectiveness, women's autonomy; actual availability/ non availability of low cost locally acceptable, nutritious, age appropriate complementary foods in all areas, especially in times of distress, drought, floods; care and feeding practices; differing patterns of women's work and time; less regular group contact with mothers as ICDS THR distribution will no longer be a weekly/fortnightly nutrition counseling contact point, need to adjust cash transfer amount to monthly child nutrition status (higher provision for severely undernourished) and offsetting the effects of inflation. NFSA 2013 and various Supreme Court Directives mandate universal nutrition entitlements for children of this age group and the design /testing of conditionalities (especially when beyond the span of control of the mother/family) needs to be formulated in this perspective.

ICDS Restructuring was intended to introduce Care counseling with prioritized home visiting by AWWs, as a service. This needs to be operationalised.

- States may have flexibility to use different approaches for home based counseling and tracking of pregnant, lactating mothers, children under 3 years.
- Use of Nava Jatan (Chhattisgarh) type of arrangement with community level Suposhan volunteers assigned to look after a group of undernourished children. This could also be modified to assign volunteers to a group of young children so that while currently undernourished children are attended to, other children with growth faltering are not left out to later become undernourished.
- Use of earlier Dular (Bihar) type of arrangement with women community level volunteers /local resource persons each taking responsibility for 15-20 families with young children, counseling and linking them with ICDS and related health services.
- Use of positive role model mothers whose children are growing well, mothers' support groups, as tried out in Positive Deviance (West Bengal, Odisha) to counsel mothers of undernourished children, with demonstrated spot feeding sessions (for 12 days), followed by home based practice sessions (18 days) and follow up and repeat cycles.
- Utilizing provisions for the second anganwadi worker / link workers, as already provided under ICDS Restructuring and being used by some states, such as Gujarat.
- Incentivizing teams of ASHAs and /or Anganwadi workers and ANMs.
- Use health contact points (pregnant /lactating mothers, healthy newborn infant /child and sick newborn infant/ child) for nutrition counseling- including Fixed Monthly Village Health and Nutrition Days.

- Strengthen Baby Friendly health facilities - linking with baby friendly communities.
- Communication for changing care behaviours, such as observing Mangal Diwas Gode Bharai, Janam Diwas Samaroh. Anna Parashan and Kishori Balika Samaroh, addressing key stages of the life cycle (as in MP).

Other supportive measures for reaching this critical age group may include-

- Cash transfers given under the Pradhan Mantri Matru Vandana Yojana including through state initiatives such as MAMTA in Odisha. NFSA 2013 mandates progressive universalisation.
- Accelerated implementation of the provision for 5% AWCs cum crèches under ICDS Restructuring, especially in the districts with high prevalence of child undenutrition.
- Crèches, infant care support as locally required and also linked to MGNREGA provisions.
- Resource centres and provisions for technical capacity development of skilled counselors for IYCF to be provided in NNM and enhanced in ICDS and NHM.
- Improvement in the quality of ICDS THR/SNP; controlling and progressively eliminating the high percentage of leakages through improved governance, public accountability and community based monitoring, while increasing the participation of local communities, women's SHGs and mothers' committees.

7.6 CONTINUUM OF CARE

The Strategy will ensure a continuum of care- across the life cycle; that includes preventive, promotive and curative care; and that links families, communities, AWCs, health centres and health facilities. A holistic continuum of care is envisaged that is seamless across-

- The life cycle stages - adolescence, pregnancy, child birth, neonate, infant and young child.
- The nature of care - preventive, promotive, curative and rehabilitative.
- The site for care - family, crèche, AWC, health centre and referral hospital.
- The range of interventions- synergising health, nutrition, care and maternity protection.

This will be done by enabling convergence of relevant programmes being implemented by different Ministries for pregnant and lactating mothers and children (0-3 years) and by using some of the approaches described below, as may be found contextually relevant by States.

- SNEHA SHIVIRS may be taken up/ extended which use the Positive Deviance approach and includes enhanced care and nutritional support, community based management of moderately and severely

undernourished children, along with further screening at health sub centre levels and health referrals of severely and acutely undernourished children.

- Gujarat approach with 3 levels of management in Mission Baal Sukham may be adapted.
  - The Village Child Nutrition Center as “Bal Shaktim Kendra” at Anganwadi centers for malnourished children without any medical needs.
  - The Child Malnutrition Treatment Center as “Bal Sewa Kendra” at PHC/CHC/ Sub District level for malnourished children needing some medical care.
  - Nutrition Rehabilitation Center as “Bal Sanjeevani Kendra” at District Hospital/ Medical College for malnourished children requiring significant medical care.
- Maharashtra model of Village Child Development Centres may also be adapted.
- Strengthen health referral chain support for management of common neonatal and childhood illnesses such as diarrhoea and acute respiratory infections and also for severe acute malnutrition.
- Increase the network of Nutrition Rehabilitation Centres in the health system - with stronger community and health centre linkages and follow up.
- Both ministries may issue joint guidance for prevention, community and facility based management of severe acute malnutrition, detailing roles of AWWs, ASHAs, ANMs, supervisors, CDPOs, Mos in the same, with greater community involvement.

7.7 INNOVATIVE SERVICE DELIVERY MODELS

The Nutrition Strategy will build on innovative service delivery models / experiences in Odisha (Ami Bhi Paribu), Madhya Pradesh (Suposhan and Sneha Shivirs), West Bengal (Keno Parbo Na- Positive Deviance); Chhattisgarh (Nava Jatan) and Maharashtra in using growth monitoring and promotion as the trigger for ensuring universal coverage, making undernutrition visible and enabling early preventive action.

Different views emerge on the need to first study / pilot cash transfers- including the need for evidence of sustained impact on young child nutrition in different contexts. This has also to be viewed in the perspective of entitlements guaranteed by the National Food Security Act 2013 and various Supreme Court orders States such as Odisha have opted for a model with decentralisaton of ICDS SNP, which may be an illustrative model for other states. Piloting of cash transfers for ICDS THR would be another approach that will be tested, in states wishing to exercise this strategy option.

Another innovative approach that could be tested is SNEHA (Synergistic Nutrition Education and Health Action) -a unified set of health, nutrition, care and maternity support interventions for pregnant and breastfeeding mothers, infants and young children under 3 years- pulling together schematic inputs

from programmes such as RMNCH +A, JSY, JSSK, RBSK, PMMVY, ICDS, crèches and others. This will include a strong community mobilization and behavior change component that changes deeply entrenched societal norms that deny women and girls equal care and compromise health and nutrition outcomes over the life cycle, through practices such as early marriage and child bearing, sex selective elimination, inadequate health care seeking etc.

7.8 COMMUNITY BASED MONITORING

A major challenge is that mothers, families and communities are often not aware that the young infant is slipping into malnutrition- growth has started to falter. The problem is often recognized only after the child has become visibly undernourished, becomes listless, does not feed well, becomes more prone to infections and becomes severely undernourished. Regular growth monitoring, tracked on the family retained card, and on the web enabled MIS, is a powerful communication tool that makes undernutrition visible to workers, mothers and families- enabling counseling and early preventive action, improved care and feeding so that the child does not slip into malnutrition. Therefore the following will be promoted -

- The nutrition strategy would be launched by initiating a joint Intensive Village Community Contact Drive (ICDS, NHM, Swachh Bharat) that brings in unreached mothers and young children – going beyond ICDS.
- Child Weighing would be done in front of the community, to create awareness and mobilize support- like Chhattisgarh "Wajan Tyohar".
- Ensuring 100 % Weighment Efficiency, to ensure universal reach of services and that no child is missed.
- Growth faltering will be used as the trigger to ensure early action to prevent undernutrition from setting in- through counseling and improved services.
- Growth Monitoring and Promotion will be critical- using the ICDS NHM Mother Child Protection Card as an Entitlement Card for accessing key health, maternity and ICDS services, focusing on children under three years.
- Nutrition status of children under 3 years will be positioned as a lead progress indicator at national, state, district, block and village levels.
- Equal care for the young girl child will also be tracked.
- This will enable community level monitoring and action for sustained improvement in nutrition status.

Community processes such as Village Contact Drives, Community weighment sessions and mapping of nutrition status, monitoring through VHSNCs will also contribute to improved community monitoring - so

that these move towards becoming kuposhan mukt.

In the above perspective, it is envisaged that enabling actions will be needed to effectively reinforce the Nutrition Strategy. These are outlined in the table below:

Figure 24

Enabling Actions

	Enabling Actions	Rationale
1	Expansion of Matritva Sahayog Yojana	Ensuring maternity protection in high prevalence districts
2	Expansion of SABLA for adolescent girls	Improved nutrition of adolescent girls- especially those out of school
3	National/ State Plans of Action for Infant and Young Child Feeding with time bound monitorable outcomes	Improved IYCF practices
4	Ensure availability of adequate resources for roll out of NFSA 2013	Improved access to household food security
5	Enabling compliance with Supreme Court orders on ICDS SNP	Efficient delivery of ICDS SNP
6	Ensuring Human Resources for Health	Improved Health Services.

The Nutrition Strategy envisages that the following components will be supported, as per operational guidelines that will be developed by the National/State Nutrition Missions, aligned to existing programmes-

i. Nutrition Centric Planning

ii. Community Mobilization

iii. Training and Capacity Development

iv. Service Delivery

v. Communication and Changing Care Behaviours

vi. Innovation and Gap filling flexi funds

vii. Incentivisation of performance and awards

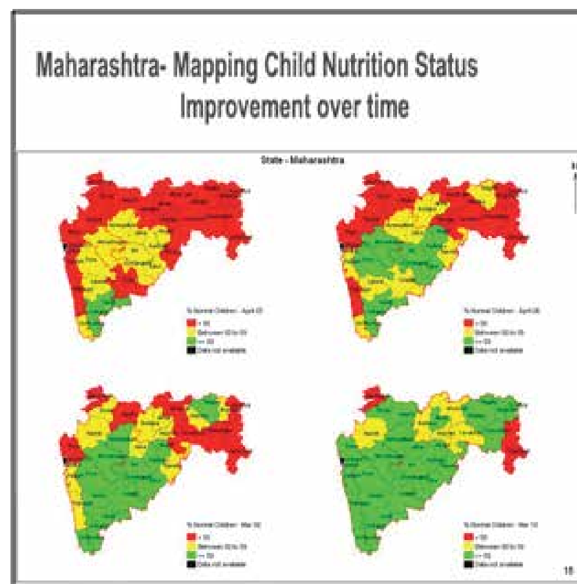
viii. ICT enabled Monitoring, Research &Evaluation (as detailed in the next section).

8 MONITORING, TRACKING AND RECOGNIZING PROGRESS

8.1 MONITORING & REVIEWS

8.1.1 *Monitoring Systems- ICT Enabled Monitoring through NNM*

A web enabled Nutrition Information System will be established to monitor the Nutrition Strategy (proposed under NNM - linking revamped MIS of ICDS, NHM /MCTS and data from Swachh Bharat).



This will provide child specific real time data on child nutrition status for States, districts, urban areas, blocks, panchayats and villages- focusing on the districts covered by the Strategy in different phases. This would also generate score cards, a 6 tier dashboard and trend analysis to facilitate performance assessment of states, districts, blocks, panchayats, villages with identification and replication of good practices and recognition of malnutrition free districts, blocks, panchayats.

- **Digitalization of ICDS MPR data:** The web-based software for the revised MIS in ICDS will generate key process data relating to child nutrition, viz., weighing efficiency of 3 years old children; supplementary food feeding efficiency; observance of VHSNDs at the AWCs; full immunization of one year old children; referrals and status of various degrees of undernourishment among children.
- **Revamping of the existing ICDS MIS** to make it more Nutrition outcome oriented, triggered by mapping of weighment efficiency and nutrition status of children under three years.
- **Integration of child nutrition status monitoring within the Health MIS and the NHM Mother Child Tracking System-** linked to the revamped ICDS MIS, using the same family based record - ICDS NHM Mother Child Protection Card.

The integration of nutrition status of young children in the NHM MCTS will ensure that this is regularly monitored by the National Health Mission and health functionaries at different levels across the country- in conjunction with other related indicators- so that necessary corrective action can be taken, closer to the level at which data is generated.

- **Name-based tracking of severely undernourished children:** The monitoring system will have special focus on tracking and monitoring of severely undernourished children, - including severely and acutely undernourished children. The girl child will also be given priority.

- **Use of Mother & Child Protection Card (MCPC):** The ICDS NHM joint Mother & Child Protection Card (MCPC) will also serve as an entitlement card for health ,maternity support and nutrition - in ensuring services to the unreached (such as migrants) and in mother child cohort based tracking. The use of the card will be enhanced, exploring use of Unique Identification Number (UID) of the mother as reference number of the card for ensuring universal access and in linking other services for the mother and child, such as Matritva Sahyog Yojana cash transfers.

- **Name-based tracking of severely undernourished children:** The monitoring system will have special focus on tracking and monitoring of severely undernourished children, - including severely and acutely undernourished children. The girl child will also be given priority.

8.1.2 *Reviews of the Nutrition Strategy*

Reviews of nutrition related components of different schemes will be held regularly at national, state, district, block, urban area, panchayat and village levels, through NNM committees/sub committees.

Further Nutrition will be included as an agenda item in other reviews convened at State, Divisional and District level, such as District Collectors' meetings chaired by Chief Ministers/ Chief Secretaries/Development Commissioners, Divisional Commissioners for the division and District reviews chaired by District Magistrates/CEOs Zila Parishads- as may be specified by States/UTs.

8.1.3 *Common Review Missions*

NHM and ICDS missions have provided for review by a Common Review Mission (CRM) on an annual basis. Joint CRMs for NNM and a review of the Nutrition Strategy would be planned, linked to ICDS and NHM CRMs.

Additionally the Nutrition component would also be a part of structured reviews of the three flagship programmes - ICDS, NHM and Swachh Bharat at national/state and district levels. The annual NNM joint Common Review Mission will provide feedback on strategy design and implementation will suggest corrective actions for its improvement at national, state and district levels and monitor compliance of the same.

8.2 TRACKING & RECOGNIZING PROGRESS

The new Nutrition Monitoring System will enable tracking of progress at different levels and identification of states/ districts/blocks/ AWCs that are performing well and those that are lagging behind, using lead indicators and tools such as dashboards and score cards, with wide dissemination of the same, including display on the relevant websites of the Ministry/State government department/district.

This will be reviewed regularly by the proposed NNM Mission Steering Groups at National/ state levels and by NNM District Committees, with corrective actions suggested.

8.2.1 *Appropriate Mechanisms*

Appropriate mechanisms will also be developed for benchmarking of progress for the identification and recognition of malnutrition free districts/blocks/urban areas. Such benchmarking will be done by a State team- in addition to tracking done by the VHSNC and panchayats themselves.

8.3 EXTERNAL TEAM ASSESSMENT & COMMUNITY VALIDATION

The process for assessing achievement would include external team assessment as well as half yearly/quarterly community based processes for validating child nutrition status and key indicators, using Fixed Monthly Village Health and Nutrition Days and community tracking and display of lead indicators at AWCs, panchayats, health centres etc.

8.3.1 *National/ State Mentoring Group*

A group of National/State Mentors may be identified (consisting of experts, practitioners) and teams of 2-3 Mentors assigned to mentor identified States/Districts, especially those with a higher burden of maternal and child undernutrition. The teams would undertake intensive field visits and field oriented consultations. The Mentors' team will enable state/district teams to undertake problem analysis, share /learn from best practices and work out contextually relevant solutions. The team would also help advocate for greater priority and enhanced resources for State/District Nutrition Action Plans and related multisectoral interventions, benefitting from the larger share of resources allocated to States from the Central Divisible Pool (Fourteenth Finance Commission).

8.4 THE COMPREHENSIVE REPORT OF THE NATIONAL MENTORING GROUP

The report will be presented to the NMSG, highlighting action recommendations for accelerating

progress, in addition to individual reports shared with concerned States. Similarly the report of the State Mentoring Group will be presented to the State Mission Steering Group, in addition to individual reports shared with concerned districts.

8.5 INCENTIVIZING STATES, DISTRICTS & PANCHAYATS

The National Nutrition Mission intends to annually monetarily incentivize those States/UTs which achieve the goals in improving the nutritional status of the targeted beneficiaries. The incentives proposed may be grouped based on the population of the State (Census: 2011) and performance to be assessed on the basis of data collected in surveys conducted from time to time.

- In addition to the above, it is proposed that Kuposhan Mukt Districts /Blocks/Urban areas and Panchayats may be incentivized.
- The norms for the same may be worked out by the NNM Committees at State levels, to be met from the 25 % State flexipool fund provided for in Centrally Sponsored Schemes.
- The incentives for districts/blocks/panchayats may be financial &/or non financial - including awards and recognition at district/state/national levels. The incentives may also be in the form of additional resources for local innovation, additional opportunities for sharing and learning in neighbouring districts/states, additional resources for local service quality improvement and institutional development.
- The incentives would be based on a set of lead indicators, rewarding both high absolute levels of achievement, as well as positive changes in key indicators.
- The above would enable a positive demonstration effect or ripple effect of a widening quality circle.

8.6 NATIONAL NUTRITION SURVEILLANCE SYSTEM

A National Nutrition Surveillance System should be set up, building on previous experience in states such as Andhra Pradesh. This will include an early warning system for increase in nutritional vulnerabilities, through assessment and analysis with trigger points for timely corrective action, through development programmes and safety nets. The use of sentinel sites will be pursued and multiple vulnerabilities tracked such as those related to socio-economic deprivation, agrarian distress, seasonal migration, distress, seasonal migration, disruptions in access to services, lack of access to social protection measures, disease outbreaks, endemic disease areas, natural disasters etc.

Mapping of undernourished endemic zones of the country in terms of identifying ‘high risk and vulnerable districts’ for the rest of districts, cases of severe undernutrition in children should be included in the routine disease reporting system. The surveillance system will also enable

epidemiological investigation of ‘malnutrition clusters’ and traditional endemic zones, using verbal autopsy to determine the underlying causes of deaths, besides the immediate cause.

The nutrition surveillance system will be GIS (Geographic Information System) based for tracking severely undernourished children, families and communities in the long run. This will not only ensure child-wise tracking, appropriate care, feeding and medical interventions for severely undernourished children- but also help link the families of severely undernourished children with social protection measures, food security measures and to access employment through MGNREGA/ other livelihood options.

As required, linkages will also be established with the National Integrated Disease Surveillance System, as a significant proportion of under 5 child deaths reflect the vicious cycle of severe undernutrition and disease/infections. The design of the proposed National Nutrition Surveillance System will be developed subsequently by the National Nutrition Mission, with support from National Institute of Nutrition.

9 RESEARCH & EVALUATION

9.1 NUTRITION SURVEY

The Nutrition Strategy will use a systematic population sample based survey to assess baseline, mid term and final evaluation of Nutrition outcomes and overall progress of the key monitorable targets, nutrition outcomes, related nutrition and health process indicators. This will include anthropometric indices as related to maternal and child nutrition, as well as assessment of anemia prevalence. Data from service providers (ICDS, NHM) will be used for regular programmatic monitoring for improved programme effectiveness and efficiency.

NFHS 4 data will therefore be used as the baseline and to benchmark progress of the Nutrition Strategy at national, state and district levels. This will also enable an evidence based approach for convergent district planning, intervention and monitoring (addressing maternal and child undernutrition and anemia).

Since the periodicity of NFHS rounds is proposed to be 3 years, the next round of NFHS will provide insights for the Mid-term Evaluation of the Nutrition Strategy. Similarly the successive NFHS round will provide data for endline assessment. This periodicity must be maintained- more so as in future AHS and DLHS will be subsumed in NFHS. Ad hoc Nutrition surveys may not be encouraged, as they do not provide comprehensive, fully comparable and robust data.

If so required, States may complement NHFS and the National Nutrition Surveillance System data with other state specific surveys that provide deeper district/block level analysis. This would be planned with the support of technical Institutions like NIN, Medical Colleges and Home Science Colleges. Policy guidance on Nutrition Surveys may be given by the National Nutrition Mission Advisory Group.

9.2 SOCIAL NUTRITION AUDITS

Social nutrition audits would be need-specific and linked to/ based on nutrition surveillance data. As suggested by NNM, assistance may also be taken from Social Audit Units set up under MGNREGA.

Nutrition Social Audit teams, consisting of a mixed group representing officials (National, State and District level (from different districts), community members /organsiations, Panchayati Raj Institutions, voluntary agencies, experts and technical institutions would visit a defined sample of hot-spots / areas repeatedly reporting higher prevalence of severe undernutrition. Through public interaction, focused group discussion (FGDs) with members of families and communities and programme functionaries and a study of child /women nutrition status and relevant parameters on the spot, as well as available data, these teams would carry out qualitative analysis of interventions, gaps and further measures required for improving nutrition outcomes and impact.

The teams would prepare a Social Nutrition Audit Report with recommendations for action. This would be discussed with the District team and State/ National Mission Steering Group/s and action taken would be put out for public information on the MWCD/ NNM website.

9.3 PUBLIC ACCOUNTABILITY

An appropriate application will also be developed for enabling members of the public to give feedback and suggestions on Nutrition interventions and strategy, which will be examined and followed up by the NNM committees

9.4 EVALUATION

The Nutrition Strategy will be evaluated, linked to the third party baseline, mid term and end point evaluation of NNM, that is envisaged. This will also be harmonized with NFHS rounds. This will be a comprehensive evaluation to assess the effectiveness of the programme design, strategic interventions, implementation efficiency, as well the overall impact of those interventions on the outcome indicators, especially as related to the nutritional status of children under three years of age.

9.5 OPERATIONS RESEARCH

The Operations Research component of the Nutrition Strategy will address questions of both efficacy and effectiveness of programme interventions - thereby developing a menu of strategic options for states/districts to select from - informed by the evidence of what works well in different programme settings. . Piloting of new nutrition related interventions will be backed up by operations research. Alternative and innovative service delivery mechanisms will be assessed to inform programme choices. States will be enabled to plan and implement operations research for the evaluation and refinement of state level nutrition related programmes, with wide dissemination of the findings. The Operations Research component will be anchored by the proposed National Nutrition Mission Resource Centre.

10 CONVERGENCE OF MULTISECTORAL INTERVENTIONS

The causal framework for Nutrition highlights the immediate and underlying determinants of nutrition, calling for both direct (nutrition specific) and indirect (nutrition sensitive) interventions, as envisaged in the National Nutrition Policy 1993. These involve several sectors such as women and child development, health, food and public distribution, sanitation, drinking water, rural development, livelihoods, education and agriculture, among others. Indirect multi sectoral nutrition interventions are also designed to have a longer term impact – even inter generationally – such as girls' education.

The major programmes and concerned sectors /Ministries which address various determinants of nutrition include the following-

Figure 25

Major Programmes & Concerned Departments

Sr. No	Determinants of Nutrition	Ministry	Major Programmes
1	Access to Maternal and Child Care	MWCD	- Integrated Child Development Services (ICDS) - Pradhan Mantri Matru Vandana Yojana (PMMVY) - Creches - Rajiv Gandhi Scheme for the Empowerment of Adolescent Girls- SABLA
2	Access to Healthcare	MHFW	- National Health Mission - Includes RMNCH+A encompassing programmes for the control of Micronutrient Deficiencies (VAD, Nutritional Anemia, IDD)
3	Access to Drinking Water	MWDS	- Swachh Bharat Mission - National Rural Drinking Water Programme
4	Access to Household Food Security (& food supplementation)	MCAFPD MA MHRD	- Targeted Public Distribution System - National Food Security Mission - Agriculture - Mid Day Meals Scheme (Food Supplementation)
5	Access to Livelihoods Security and Poverty Alleviation	MSD MRD	- Skill Development - NRLM - MGNREGA
6	Girls' Education, Literacy & Empowerment	MHRD MWCD	- Sarva Shiksha Abhiyan - Sakshar Bharat - Beti Bachao Beti Padhao

7	Information Communication & Social Mobilization	MI&B MPR MUD MYAS	- Information Campaigns - Training of PRIs - Training of Urban Local Bodies - Youth Initiatives
8	Interventions for Vulnerable Community Groups	MTA MSJE MMA	- Focussed Interventions for vulnerable community groups (Scheduled Tribes, Scheduled Castes) - Multi Sectoral Development Programme (Minorities)
9	Key Determinants	MWCD	- NNM/ Nutrition Programme in High Burden Districts

The roles and responsibilities of different sectors / ministries need to be defined in this perspective, with accountability for monitorable outcomes. Indicative action points for convergence as related to the roles of different ministries/sectors are accordingly highlighted in the matrix below, on the premise that these will be contextualized, relevant to specific state/district contexts.

Figure 26

'Convergence'- Role of Different Ministries

MINISTRY/ SECTOR	**INDICATIVE ACTION POINTS FOR CONVERGENCE**
Objective 1: Ensure universal access to Maternal and Child Care (including supplementation of dietary intake)	
Ministry of Women and Child Development	- Leadership; policy direction multisectoral coordination as the nodal Ministry for Nutrition. - Ensure Nutrition commitments are in the National Development Agenda, Results - Framework Documents and Five year Strategic Plans of concerned ministries. - Ensure universal reach of quality maternal and child care services through ICDS Restructuring (and progressively Matritva Sahyog Yojana) including key nutrition intervention/practices. - Ensure inclusion of the most vulnerable and deprived communities, women and children - such as SC, ST, particularly vulnerable tribal groups and minorities. - Implement new components of ICDS Restructuring –especially those focused on reaching the younger child under 3 years such as second

worker, crèches, Infant and Young Child

- Feeding Counseling, Growth Monitoring and Promotion, improved care behaviours-(including health, hygiene, feeding, psychosocial, care of girls and women), prevention, care, community based management of severely undernourished children and referrals.
- Improve the quality and delivery of SNP esp.THR in ICDS with greater decentralization, community participation and involvement of PRIs, women's SHGs, mothers' committees.
- Extend a redesigned Matritva Sahyog Yojana for progressive universal coverage.
- Extend the provisions for infant and child care / Crèches through existing and revamped
- schemes, linkages with MGNREGA- based on local needs assessment.
- Promote nutrition of adolescent girls out of school through SABLA, strengthen and expand
- Enable development, implementation and monitoring of National, State and district level nutrition action plans- initially in 200 high prevalence districts- focusing on linking ICDS, NHM and Swachh Bharat plans.
- Universalise use of the new common Mother Child Card with new WHO child growth standards in ICDS, NHM.
- Enhance institutional capacity for Nutrition at different levels.
- Strengthen partnerships between government sectors, civil society, panchayati raj institutions, families and communities for fulfilling nutrition rights.
- Institute mechanisms to ensure that infant and young child feeding and nutritional support interventions are free from commercial influence and conflict of interest
- Develop, strengthen and integrate Nutrition monitoring through revamping ICDS MIS, integrating Nutrition status monitoring in NHM MCTS and developing a National Nutrition Surveillance System.
- Ensure that periodic Nutrition Surveys – linked to Health Surveys are conducted regularly for assessing monitorable outcomes at National, State and district levels.
- Promote Women's Empowerment through ongoing initiatives – NMEW. NRLM etc.

Objective 2: Ensure Universal Access to Quality Health Care Services	
Ministry of Health and Family Welfare	- Link NHM District Implementation Plans with ICDS, Swachh Bharat District Plans for better nutrition outcomes - Strengthen its Nutrition components especially in 200 high prevalence districts /184 NHM high priority districts - Specify redefined roles of frontline worker team (AWWs/ ASHAs/ ANMs) and also at other levels with a focus on Nutrition - Ensure universal use of Mother Child Protection Card with WHO child growth standards in ICDS and NHM by trained functionaries - Ensure regularity and reach of Fixed Monthly Village Health and Nutrition Days, effective use of contact points for nutrition counseling and service delivery - Strengthen Village Health Sanitation and Nutrition Committees - Integrate reporting of nutrition status of under 3s in NHM MCTS - Position nutrition status of children under 3s as a lead progress indicator of NHM - Improve maternal care and ensure safe institutional delivery, ensuring a seamless continuum of maternity support, health, nutrition and care during pregnancy, lactation, early infancy. - Improve newborn care – including care of low birth weight babies - Strengthen skilled counseling support for Infant and Young Child Feeding early and exclusive breastfeeding, appropriate - 53 -complementary feeding) - Progressively make all maternity facilities baby friendly. - Ensure timely and full/ complete immunization. - Strengthen programmes for the control of Micronutrient deficiencies – Vitamin A, Anemia and Iodine Deficiency Disorders and ensure micronutrient supplementation, deworming - Ensure improved management of neonatal, infant and childhood illnesses at community and facility levels – - Diarrhea management with ORS and zinc supplementation - Management of ARI - Ensure improved care, referrals and facility based management of severe acute malnutrition- linking with community based management at AWC level - Improve adolescent health and nutrition – reaching girls in and out of school with health check-ups, IFA supplementation, deworming, health and nutrition counseling and screening through RBSK

Objective 3: Ensure Universal Access To Safe Drinking Water, Hygiene And Sanitation	
Ministry of Drinking Water & Sanitation	- Link District Implementation Plans with ICDS, NHM – for better nutrition outcomes - Progressively ensure provision of toilets and safe drinking water supply in all AWCs. HSCs and schools and at community and household levels. - Reduce open defecation. - Focus on improving hygiene practices – handwashing, safe disposal of child stools and waste etc. - AWCs, schools and health centres to be strengthened as the hubs for demonstrating and changing hygiene practices. - Swachhta Doots and community mobilisation activities under Swachh Bharat- NHM and ICDS to be linked. - Common core training and communication packages to be developed and widely used. - Linking with Village Water and Sanitation Committees.

Objective 4: Ensure Universal Access to Household Food Security	
Ministry of Consumer Affairs, Food & Public Distribution	- Monitor effective implementation of the National Food Security Act 2013, including its enabling provisions and formulation of rules by concerned sectors/states. - Ensure food & nutrition security at the household level by making the essential food grains (rice, wheat, and coarse grains), edible oils and sugar available through the Targeted Public Distribution System. - Effective implementation of TPDS along with reform measures, tools strengthened monitoring, on an ongoing basis. - Provide Social safety nets especially in times of nutritional vulnerability, seasonal distress and natural calamities. - Support for piloting of community grain banks in high burden districts, based on district plans in identified states
Ministry of Food Processing Industries	- Promote processing of locally available nutritious foods through training of women's SHGs/Federations (564 FPTCs in 2010-11) and use this for nutrition communication - Cater to cluster development for nutritious food preparation
Ministry of Agriculture	- Strengthen convergence of Rashtriya Krishi Vikas Yojana with other schemes such as MGNREGA for improving livelihood and food security of nutritionally vulnerable groups

	- Strengthen improvement in food and nutrition security through National Food Security Mission, National Horticulture Mission (NHM)and Horticulture Mission for North East and Himalayan States (HMNEH) - Provide support for kitchen gardens in AWCs as village demonstration sites - Strengthen cereal productivity & strengthen production diversity – including the production of coarse cereals such as millets, ragi etc - Integrate household food and nutrition security considerations into the design of cropping and farming systems for large and small farmers - Invest in strengthening systems for the supply of high nutrient value foods (vegetables, fruits, milk, eggs, etc.) - Stabilize prices of cereals, pulses and high value foods such as dairy, eggs, vegetables and fruits
Objective 5: Ensure Livelihoods Security and Alleviate Poverty	
Ministry of Rural Development	- Improve livelihood security of the most vulnerable and accelerate poverty alleviation efforts in high undernutrition districts. - Integrate concept of malnutrition free panchayats in gram panchayat plans underway under IPPE in 2532 backward blocks (of which 967 are intensive blocks). - Strengthen implementation of the enabling provisions for women and child care / crèches in MGNREGA, with piloting in remote and tribal areas. - Use amended MGNREGA guidelines to increase percentage of constructed AWCs, with better provisions for health check-ups and care of mothers at AWC; hygienic food storage and cooking, safe drinking water and sanitation. - Encourage use of MRD funds for strengthening nutrition interventions, AWC and HSC construction with better provisions for drinking water and sanitation. - Link Women's SHGs, NRLM with provision of SNP in ICDS, where locally feasible.
Ministry of Skill Development	- Provide opportunities for skill development to young women-especially in nutritionally vulnerable community groups and areas. - Provide opportunities for skill development – linked to older out of school adolescent girls reached by SABLA.

Objective 6: Promote Girls' Education and Women's Literacy	

Ministry of Human Resource Development	- Promote female literacy and girls' education (including secondary and higher education) also linking with Beti Bachao Beti Padhao.
	- Use schools as a contact point for reaching in school and linking with SABLA) for:
	  - Nutrition and health counselling and check-ups- linking with RBSK
	  - Anemia control through supervised weekly IFA supplementation (WIFs) deworming
	  - Second chance/ alternative education for out of school girls
	  - Retaining girls in education and eliminating child marriage
	- Strengthening of nutrition, health and sanitation education component in school curriculum and through Sakshar Bharat- with activity based learning sessions. .
	- Use schools as village hubs for demonstrating and changing hygiene practices in community.
	
	Food supplementation- as linked to Objective IV:
	- Improve nutrient value, quality and community based monitoring of Mid Day Meals in schools and usage of iron fortified iodised salt (double fortified salt).
	- Use SSA flexi funds for kitchen gardens in/around school premises- contributing to addition of local /seasonal vegetables and fruits in MDM.
	- Strengthen linkages between MDM / ICDS SNP where locally needed, specific piloting of community kitchens in innovative models.
	- Address overlap of children 5-6 years old in ICDS SNP and MDM.
	- Strengthen ICDS convergence and linkages with timings / location of AWCs, where locally needed- releasing girls from the burden of sibling care to participate in education.

Objective 7: Information Communication and Social mobilization for Nutrition	
Ministry of Information and Broadcasting	- Facilitate a nationwide IEC and intensive media campaign on Nutrition, with State adaptations and support. - Conduct competitions with crowd sourcing for designing media campaigns. Allocate free time for communicating nutrition messages during the prime time on Doordarshan.

	- Consider making it mandatory for the private satellite television channels to carry advertisements/public messages on Nutrition in the public interest. - Facilitate use of Community Radio Services for awareness creation on health & nutrition - Strengthen capacity of State media units through orientation/training for communicating - Nutrition issues, reporting best practices such as malnutrition free panchayats and encouraging local solutions.

Ministry of Panchayati Raj	- Mainstream Nutrition in the training of PRIs –for malnutrition free panchayats, earmarking certain wards to them - especially women members
	- Support the development of innovative district models with PRIs leadership in 200 NNM districts
	- Share best practices to support the devolution of powers related to nutrition - to PRIs in other states
	- A special Gram Sabha meeting dedicated to Nutrition in every gram sabha every year.
	- Recognition and incentivisation of malnutrition free panchayats.
	- Especially in disturbed and other special areas-
	  - Gram panchayat should be the actual delivery agency for PDS of food grains
	  - Ward Sabha and Ward members should take up issues of absentee AWWs, health workers, school teachers and missing children-including girls.
	  - Supervision and monitoring to be led by gram panchayat or its sub committee

Ministry of Youth Affairs	- Mobilise youth groups for nutrition communication campaign (IEC). - Strengthen youth groups through training /orientation - for supporting and /or adopting malnutrition free panchayats/communities.
Objective 8: Enable Focused Interventions for Vulnerable Community Groups	
Ministry of Tribal Affairs	- Nutrition interventions for Tribal Areas to be reflected as a part of Tribal Sub Plan – especially in identified high priority districts. - Special focus to be given to PTGs (particularly vulnerable tribal groups).

	- Construction of AWCs as a comprehensive mother and child care centre, and HSCs to be funded from Tribal Sub Plan - especially in difficult areas with large infrastructure gaps - Improvement in the quality and nutritional value of foods being provided under relevant programmes/ institutions.
Ministry of Social Justice and Empowerment	- Nutrition interventions to be reflected in identified high priority districts. - Improvement in the quality and nutritional value of foods being provided under relevant programmes/ institutions.
Ministry of Minority Affairs	- Nutrition interventions to be integrated in MSDP. - Construction of physical infrastructure for Anganwadi services and Health care services under MSDP. - Improvement in the quality and nutritional value of foods being provided through relevant institutions.

A societal movement for improved nutrition outcomes: The National Nutrition Strategy will create a nationwide societal movement for improved nutrition outcomes - a momentum for social change which calls for strengthened and extended partnerships in action. While the above matrix highlights partnerships of different ministries and sectors, many other partnerships with voluntary agencies, professional bodies and technical resource institutions etc. are also envisaged. Such partnerships need to be aligned to the national policy framework, be free from the conflict of interest and not undermined by commercial influence. Clear memorandums of understanding will be developed- open to public scrutiny and with accountability for committed monitorable outcomes.

The objectives of partnerships with voluntary agencies, professional bodies and technical resource institutions may be related to any of the following themes – and would need to be specified-

- More inclusive service delivery: Reaching unreached and vulnerable communities.
- Improved service quality.
- Improved technical and managerial capacity.
- Improved behavior change communication.
- Strengthened community processes and ownership.
- Improved monitoring systems.
- Evaluation and Operations Research.
- Social Audits/Nutrition Audits.

The range of partners may include the following, as illustrative examples-

- Other ministries/sectors.
- States, districts and local self Governments.
- National and State Technical Resource and Training Institutions such as ICMR. NIN, NHSRC, NIHFW /SIHFWs, NIPCCD/MLTCs/AWTCs, AIIMS etc.
- National/State Academic Institutes, Universities and Colleges- Medical, Nursing and Home Science Colleges- such as IIPS, TISS etc.
- Professional bodies and networks such as BPNI, IAP, FOGSI etc.
- Development partners working in this field.
- Voluntary Agencies and community based organizations.
- Community/ Women's / youth and adolescent girls' groups.
- Parents, Families and Communities.

Different partnership models will emerge in the state/district specific contexts and would be developed at national/ state levels.

11 THE ROLE OF PANCHAYATI RAJ INSTITUTIONS AND URBAN LOCAL BODIES

Subjects allocated in the 73rd Amendments to PRIs include those addressing the immediate and underlying determinants of undernutrition such as Health and Sanitation, Family Welfare, Drinking Water, Women and Child Development, Public Distribution Systems, Agriculture, Education, Poverty Alleviation and Social Welfare, among others. There is a need to revisit how these are specified in the 74th Amendment, in respect of ULBs. Therefore it is essential that local self governments own, promote, monitor and sustain nutrition initiatives - effecting convergence of action at the grass roots. This is even more relevant in the light of the implementation of the Fourteenth Finance Commission Recommendations, with greater devolution of resources to States and also to PRIs and ULBs.

11.1 "KUPOSHAN MUKT" PANCHAYATS AND URBAN AREAS

Resources also need to be prioritized and mobilized for progressively creating "malnutrition free panchayats" or "kuposhan mukt panchayats"- encouraging a demonstration or ripple effect for wider replication. This approach will be contextualized- specific to the state/district or urban area contexts, including in malnutrition free cities/wards. The active involvement of panchayats is seen to be a key factor in changing societal norms and entrenched behavior patterns in campaigns such as Swachh Bharat, Beti Bachao Beti Padhao and also as related to examples from different states.

11.2 LINKING WITH GRAM PANCHAYAT PLANS AND WOMEN'S SHGS

It is essential to link nutrition interventions with poverty alleviation initiatives, as poverty is an underlying cause of undernutrition, as well as a manifestation of poor nutrition. In this regard, the interlinkages of MGNREGA, NRLM, RMK, ICDS and NNM are relevant for improving livelihoods, food security, reducing poverty and undernutrition.

The approach of malnutrition free panchayats will need to be linked with the ongoing initiative of the Ministry of Rural Development, which is going to be used for planning for utilisation of resources devolved as per the recommendations of the Fourteenth Finance Commission. Under the MRD comprehensive initiative, an intensive participatory planning exercise has been initiated in 2532 backward blocks (of which 967 are intensive blocks) for rural development. Linking with this initiative will enable gram panchayats to integrate the concept of "malnutrition free panchayats" in the gram panchayat plans being prepared. This would build on the Maharashtra Dashutri experience, where community plans are linked with other dimensions of poverty and deprivation and envision "Malnutrition Free SHGs/ Open Defecation Free SHGs".

Trained panchayat members (especially women) and Women's SHGs mobilized under NRLM will play a

key role in catalyzing this approach. The gram panchayat plan can include a set of simple indicators to enable, track, recognise, and incentivise malnutrition free panchayats. (These could be displayed at community level; in AWCs, health centres, schools and panchayats/urban local bodies).

11.3 MOBILIZATION OF COMMUNITY ACTION

Active leadership of panchayati raj institutions and urban local bodies is critical for the effective mobilization of community action for Nutrition. Greater community ownership would (i) enhance nutrition and health awareness (ii) help improve family care behaviors (iii) expand community outreach to the most vulnerable (iv) enable effective program implementation at the grassroots level and (v) strengthen community based monitoring. Therefore training and capacity development of panchayats and urban local bodies will need to be emphasized.

11.4 VILLAGE HEALTH, SANITATION & NUTRITION COMMITTEES

At community level, around 6.4 lakh Village Health Sanitation and Nutrition Committees (RHS 2014), recognized as Sub-Committees of Panchayats, provide a platform for convergence at field level between NHM, ICDS and Swachh Bharat for addressing different determinants of undernutrition synergistically. These need to be mobilized and empowered for community action for nutrition- deepening and extending the outreach of panchayats. The flexi funds provided under NHM to VHSNCs and under ICDS/NNM can be used for local innovation and gap filling, linked to real time name based tracking of undernourished children, counseling and community based monitoring.

12 INSTITUTIONAL ARRANGEMENTS

The broad contours of Governance Reform have been spelt out in Chapter 8. Following from this, the preferred option for Institutional Arrangements emerges, as outlined below:

12.1 NNM PLUS

A National Nutrition Mission to be set up, along the lines of the National Health Mission structure-anchored in the existing ICDS Mission, for enabling multisectoral convergence, especially with NHM and Swachh Bharat and integrating nutrition interventions across the life cycle, including those related to MWCD such as PMMVY(maternity support), SABLA (adolescent girls), crèches etc. The arrangements would promote decentralization and flexibility, enabling leadership for nutrition at state/district and local levels. A flexible framework of implementation is envisaged that enables states/districts with strategic choices for action, informed by best practices, through decentralized planning and local innovation- with accountability for nutrition outcomes. This would imply the following-

- PM's Nutrition Council may be expanded to include representation from State Chief Ministers.
- The existing ICDS Mission structures would be redefined /expanded to become the National Nutrition Mission, to avoid duplication and an overload of structures at different levels, as several states have already constituted ICDS mission structures after ICDS Restructuring in end 2012. Human resources and technical support already approved therein may be effectively utilized, with some additionality, if/ as may be required.
- To ensure that this arrangement is more effective, better linked to states and more multisectoral in nature, the proposed Mission structure must be more organically linked to the overarching PM's Nutrition Council. This will be done by constituting a Committee of concerned Secretaries chaired by CEO NITI Aayog, supported by a Policy Coordination Unit in NITI Aayog.
- To ensure better synergy and continuum of interventions across the life cycle, the new National Nutrition Mission would also be the umbrella structure for oversight of PMMVY, SABLA, crèches etc. and other such nutrition related schemes of MWCD.
- This arrangement would build on and include existing State Nutrition Mission initiatives and encourage mobilization of state resources for nutrition - not substitution.
- The expanded mandate of the National Nutrition Mission would be as follows-
  - Under the guidance of PM's National Council on India's Nutrition Challenges, to function as an Apex body for nutrition related policies and programmes.

- NNM will act through NNM Steering Group headed by Minister, WCD and will report to the Prime Minister.
- Provide policy and programmatic guidance on Nutrition to concerned sectors and States.
- Facilitate multi-sectoral and multi state planning, coordination, monitoring and review of nutrition components/interventions.
- Finalize and monitor commitments, milestones of progress for nutrition related programmes of different Ministries/sectors and States/UTs.
- Enable states' leadership and decentralization through a flexible implementation framework.
- Catalyse resource mobilization for Nutrition, identify and provide gap filling support to nutrition related schemes.
- Enhance institutional and technical capacity development for Nutrition.
- Enable social and community mobilization for Nutrition, promoting optimal family care and infant feeding practices.
- Develop a National Nutrition Surveillance system, with quick response in vulnerable hot spots.
- Institute ICT enabled Real Time Monitoring, with ICDS-MCTS/RCH integration.
- Enable supportive action in lagging States and high burden districts with mentoring support.

12.2 INSTITUTIONAL ARRANGEMENTS- NATIONAL LEVEL

The National Nutrition Mission will thus be constituted to provide policy support and guidance to the states, with an empowered structure called the National Nutrition Mission Steering Group (NNMSG) and the Empowered Programme Committee (EPC) respectively under the chairpersonship of Minister of Women and Children and the Secretary, Ministry of Women and Child Development. The institutional arrangements at the national level are elaborated below:

12.2.1 *The National Nutrition Mission Steering Group (NNMSG)*

It will be the key body for providing direction, policy and guidance for implementation of various programmes/schemes under the NNM and will have the following composition:

1	Minister of Women and Child Development	Chairperson
2	Ministers of 5 Regions by Rotation from States having High Burden Districts	Member
3	CEO NITI Aayog	Member
4	Secretary, Ministry of WCD	Member
5	Secretary, Expensiture, Ministry of Finance	Member
6	Secretaries of Line Ministries/ Departments such as Health & Family Welfare, Panchayati Raj, Rural Development, Drinking Water Supply & Food	Member
7	Chief Secretaries of 5 regions by Rotation (from states having high burden districts) in the field of child development and nutrition	Member
8	Representatives from Medical/Home Science colleges/NGOs/eminent institutions in the field of child development and nutrition	Member
9	Experts (5) – to be co-opted	Member
10	Mission Director (Additional Secretary)	Member Secretary & Convener

12.2.2 *The National Nutrition Mission Steering Group (NNMSG)*

It will meet once in six months and will be responsible for following functions:

- Approval of policies and programmes for the Schemes covered under the NNM;
- Ensure effective convergence of policy and programmes among the various Departments;
- Advise the Empowered Programme Committee of the NNM on policies and oversee programme implementation;
- Review the outcomes and suggest mid course corrections that may be required in the policy design;
- Assess and catalyse resource mobilization as required;
- Initiate measures for institutional and technical capacity development; constitute mentoring groups, advisory/working groups as required.
- Appraise recommendations of the EPC related to proposals and schemes and approve them based on the broad normative framework;

- Appraise and approve recommendations of the EPC on hiring of experts and functionaries on a contractual basis for carrying out the activities under the NNM;
- Carry out any such modifications in operational modalities as may be warranted, from time to time, for effective implementation of the NNM;
- Any other matter with policy implications affecting target group of the Mission.

12.2.3 *The Empowered Programme Committee (EPC)*

Headed by the Secretary, Ministry of Women and Child Development would be the highest technical body for planning, supervising and monitoring the effective implementation of NNM. The composition of the EPC will be as under:

1	Secretary, Ministry of Women and Child Development	Member
2	Principal /Senior Advisor WCD, NITI Aayog	Member
3	Joint Secretary, Department of Expenditure, Ministry of Finance	Member
4	Joint Secretary& FA, Ministry of WCD	Member
5	Representatives of line Ministries / Departments, such as Health & Family Welfare, Human Resource Development, Drinking Water & Sanitation, Panchayati Raj, Food, Rural Development	Member
6	Director, NIPCCD /National Nutrition Resource Centre	Member
7	Joint Secretaries (Incharge) ICDS, ISSNIP SABLA, PMMVY	Member
8	State WCD Secretaries (with HBD districts) from five regions by rotation	Member
9	Director, NIN	Member
10	Experts/ Representatives from Medical/Home Science colleges/NGOs/eminent institutions in the field of child development	Member
11	Mission Director (Additional Secretary)	Convener

The Chairperson of the EPC may co-opt other members to assist the Committee in its task or invite to the meetings as special invitees such persons as may be deemed necessary. For effective functioning, the EPC would be empowered on the lines of empowerment already provided in SSA and the NHM. The EPC will meet once in every quarter (three months) and will be responsible for the following functions:

- Plan, and monitor Mission activities and programmes, to achieve stated goals and objectives.
- Frame rules and procedures and place the same before the NNMSG for approval.
- Facilitate planning, implementing and monitoring State/District plans.
- Approve Annual plans as well as make modifications of norms of approved schemes / items of expenditure, within the overall budget of respective scheme covered under the NNM.
- Carry out any such modifications in operational modalities as may be warranted, from time to time, for effective implementation of NNM.
- Track progress on key outcomes with an analysis of lagging states and supportive action.
- Make recommendations regarding programmes, personnel and budget etc. for approval of the NNMSG.
- Exercise executive and financial powers to implement the Schemes under NNM.
- Approve the plans under the broad approved framework.
- Approval of proposals on training, advocacy and IEC, monitoring including MIS and evaluation.
- Mentor and support State EPCs for effective decentralized functioning
- Any other relevant tasks assigned by the NNMSG.

12.2.4 *The National Nutrition Mission Directorate*

In order to carry out the functions mandated by the NNMSG / EPC, National ICDS Mission Directorate already existing under ICDS would be converted into National Nutrition Mission Directorate headed by the Mission Director. The concerned Joint Secretary/Bureau Heads dealing with the specific scheme under the NNM would be responsible for their respective schemes such as ICDS, SABLA, PMMVY etc. Similar to NHM, where AS and MD is vested with appropriate executive and financial powers, the National Nutrition AS and Mission Director will be vested with appropriate executive and financial powers as approved by the NNMSG, to enable him/her to function in effective manner to achieve the goals of the NNM. The overall structure of the National Nutrition Mission Directorate would be along the lines as approved under the ICDS Mission, with some additionality.

The **specific roles** and responsibilities of the National Nutrition Mission Directorate will include:

- Operationalise planning, implementation and monitoring of the Mission activities;
- Planning and effective implementation of the ICDS Scheme. Concerned JS/Bureau head would be responsible for implementation of their respective scheme.
- Track progress on key outcomes- with an analysis of lagging states/ high burden districts and supportive action;
- Exercise the executive and financial powers as may be approved/delegated by the National Nutrition Mission Steering Group/Empowered Programme Committee;
- Facilitate evaluation, operations research, independent studies to assess progress and ensure mid - course correction as needed;
- Ensure effective operational coordination and linkages with key sectoral ministries /programmes such as NRHM, SSA, TSC, MGNREGS, ICDS, SABLA, ISSNIP, PMMVY, FNB, NIPCCD for effective implementation of scheme as well as management of supplies, infrastructural inputs and other resources;
- Appraise and process the State Plans under NNM for approval from NNMSG / EPC. Concerned JS/Bureau head would be responsible for implementation of their respective scheme plans.
- Work closely with States / UT Administrations to improve their capacity to plan and implement programmes as well as provide mentoring support to the State Nutrition Mission Directorates;
- Ensure advocacy and public education (IEC) with a view to achieve the enunciated objectives of NNM;
- Review the work of FNB & NIPCCD administration through concerned Joint Secretary;
- Develop parameters and tools for effective monitoring and supervision of NNM throughout the country;
- Carry out monitoring, supervision and evaluation of the programme from time to time;
- Facilitate training and capacity building of functionaries with the help of National Nutrition Mission Resource Centre, NIPCCD & its regional Centres, FNB and other relevant training institution at national, state and district level;
- Enable institutional capacity Development, supervise and review the functioning of the National Nutrition Mission Resource Centre;
- Provide regular feedback to EPC on any outstanding issues that need to be resolved or referred to the NNMSG;
- Any other task (s) assigned by the NNMSG / EPC / Ministry of Women and Child Development, Government of India.

12.2.5 *The National Nutrition Mission Resource Centre:*

The National ICDS Mission Resource Centre already sanctioned would be converted into National Nutrition Mission Resource Centre, to be located in NIPCCD to serve as an apex body for technical assistance, dissemination and for functioning as a Centre of Excellence for facilitating the National and State Nutrition Mission Directorates in all issues concerning implementation, supervision and monitoring of Nutrition related schemes. This resource centre would be patterned on the NHSRC in NHM and would provide necessary technical assistance to the Mission Directorate. Besides having experts in the areas such as nutrition (Maternal, Young Child and Adolescent Nutrition, Infant and Young Child Feeding, Community Nutrition, Micronutrients), gender and child care, early learning, communication (social mobilisation and advocacy) and nutrition surveillance, monitoring and evaluation, it would be assisted by four to five thematic groups such as IYCF, communication for changing care and feeding practices, child care and early learning, nutrition surveillance, monitoring and evaluation, etc. These groups, involving different professionals, institutions, voluntary agencies would assist in developing strategies and capacity- building activities.

The National Nutrition Mission Resource Centre would draw up on resources from and link with other national institutions to respond to requests from states and districts for technical support in planning and implementation of the programme. Besides facilitating programme implementation, it would also improve the quality and relevance of work done in these institutions. National institutions would also catalyse the creation of a network of state, district resource institutions to promote local capacity development.

12.3 INSTITUTIONAL CAPACITY DEVELOPMENT

The Mission and its Resource Centre will also seek to strengthen the techno managerial capacity of programme managers and mid level functionaries of the major sectors contributing to improved nutrition outcomes. Representatives of PRIs and ULBs, who have an enabling leadership role will be actively engaged.

A four pronged approach will be evolved, relevant to the local context of States and Districts. This would include the following:

- **Creation of new institutions:** Setting up of a National and State Nutrition Resource Centres, based on state requirements, as well as District Nutrition Resource Centres/Units, which will enable technical nutrition capacity development for concerned sectors-ICDS,NHM, Swachh Bharat, HRD and others.
- **Creation of living universities:** This would be by identifying well performing malnutrition free blocks as learning centres, where others can learn from. Learning could also be through field based

practice. This would also create a ripple effect, encouraging other /neighbouring blocks/districts.

- **Strengthening of nutrition capacity of existing institutions in health, ICDS:** This may include strengthening technical nutrition capacity in existing institutions such as SIHFWs, MLTCs etc.
- **Creating a nutrition resource network** of technical and academic institutions such as Medical Colleges, Home Science Colleges etc. This may include partnerships with civil society and knowledge organizations, as outlined in Chapter 11, related to partnerships.

12.4 INSTITUTIONAL ARRANGEMENTS - AT STATE LEVEL

In order to provide policy support and guidance for effective implementation in the State/UT, a State Nutrition Mission would be constituted, the State Council of which would be led by the State Chief Minister/ Lt. Governor/Chief Administrator. Similar to NHM, an empowered structure called the State Mission Steering Group (SMSG) and the State Empowered Programme Committee (SEPC) respectively under the chairpersonship of the Minister in-charge of the WCD Department of the State / UT and the Secretary of the WCD Department of the State / UT would be constituted, subsuming/ integrating the existing State ICDS Mission /State Nutrition structures. The State Mission would mobilize and provide additional resources to the States /UTs to enable them meet the diverse nutrition needs -especially of young children, adolescent girls and women. The functions under the State Nutrition Mission would be carried out through the State Nutrition Society that will be headed by a State Mission Director. The State Mission Director would be vested with appropriate executive and financial powers as approved by the SMSG to enable him/her to function in effective manner to achieve the goals of the Mission.

12.5 INSTITUTIONAL ARRANGEMENTS- DISTRICT LEVEL

Every district would have a District Nutrition Mission headed by the District Magistrate / Collector and/or the Chairperson of its Zila Parishad of the concerned district (co- chaired by either of the two) as may be decided in the state specific context. A District level officer, as decided in the state specific context / District Programme Officer ICDS would function as the nodal officer / Director of the District Nutrition Mission. The Mission would include public representatives such as Members of Parliament (MP), MLAs, MLCs from the concerned district, chairpersons of the Standing Committees of Zila Parishad, chairpersons of Panchayat Samitis and district Programme Managers from relevant departments as official representatives, state representatives, representatives of NGOs and experts. The District Mission would serve as the District Unit of the State Nutrition Society, to effectively discharge all relevant roles and responsibilities of the Mission in the respective districts.

12.6 INSTITUTIONAL ARRANGEMENTS- BLOCK LEVEL

At the Block / Project level, each Block would have a Block Mission Committee headed by the SDM or the Chairperson of the concerned Panchayat Samiti. The Block Development Officer (BDO) of the concerned Block would function as the co-chairperson and Child Development Project Officer (CDPO) as the convenor of this Committee. Other members would include public representatives such as from the block, members of Panchayat and Block-Level Officers from relevant departments, such as Block Medical Officer, Block Education Officer, Extension Officer, Water and Sanitation, two or three ICDS Supervisors (on rotation), NGOs, two or three practitioners.

12.7 INSTITUTIONAL ARRANGEMENTS AT PANCHAYAT AND VILLAGE /WARD LEVELS

12.7.1 Village Health Sanitation and Nutrition Committee (VHSNC)

Atprovide the platform for converging local resources and innovation and for community base the village/ward (urban areas) level, the VHSNC would be responsible for coordinating nutrition related activities. VHSNCs are recognized as sub-committees of the panchayat and would monitor nutrition outcomes. Flexi funds for NHM are channelized through VHSNCs and the same pattern may be extended for nutrition.

12.7.2 Anganwadi Centres

AWCs would remain the hub for promoting maternal and child health, nutrition and development activities at village habitation level, also providing a critical link with and outreach extension of health, water and sanitation services. AWCs also will provide a platform at village habitation level for convergent services across the life cycle continuum such as ICDS, PMMVY, SABLA, nutrition education etc. Fixed monthly Village Health and Nutrition Days at AWCs will provide the basis for strengthening health and sanitation interventions. AWCs will also anchor ASHAs (as/where locally needed) and strengthen teamwork of ASHAs, AWWs and ANMs though joint training and supportive work schedules. A critical element will be the use of the common Mother Child Protection Card by ICDS, NHM and maternity support programmes. At the AWC level, the existing ALMC would be responsible for management and supportive supervision.

13 ESTIMATED RESOURCE REQUIREMENT

It may be assumed that the Strategy will be implemented using resources of the major flagship programmes involved - NHM, ICDS, Swachh Bharat and resources earmarked for the upcoming National Nutrition Mission (including ICT enabled monitoring and a Nutrition Surveillance System). The increased provision of 25 % of flexi funds for States in Centrally sponsored schemes and the enhanced resources devolved to States, panchayats and urban local bodies would also be catalyzed for the purpose.

Additional resources would be needed for flexible responses at district level (as in MP), local innovation, gap filling and incentivisation of good performance.

Annexure I:

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Annexure – II: District Analysis

Sr No	State	District	ICDS High Burden Districts	NHM High Priority Districts	ISSNIP Districts	Common Districts
1	Andaman & Nicobar Island	Nicobar				
2	Andaman & Nicobar Island	North & Middle Andaman				
3	Andaman & Nicobar Island	South Andaman				
4	Andhra Pradesh	Anantapur				
5	Andhra Pradesh	Chittoor				
6	Andhra Pradesh	East Godavari				
7	Andhra Pradesh	Guntur				
8	Andhra Pradesh	Krishna				
9	Andhra Pradesh	Kurnool				
10	Andhra Pradesh	Prakasam				
11	Andhra Pradesh	Sri Potti Sriramulu Nellore				
12	Andhra Pradesh	Srikakulam				
13	Andhra Pradesh	Visakhapatnam				
14	Andhra Pradesh	Vizianagaram				
15	Andhra Pradesh	West Godavari				
16	Andhra Pradesh	Y.S.R.(Cuddapah)				
17	Arunachal Pradesh	Anjaw				
18	Arunachal Pradesh	Changlang				
19	Arunachal Pradesh	Dibang Valley				
20	Arunachal Pradesh	East Kameng				
21	Arunachal Pradesh	East Siang				

22	Arunachal Pradesh	Kurung Kumey				
23	Arunachal Pradesh	Lohit				
24	Arunachal Pradesh	Lower Dibang Valley				
25	Arunachal Pradesh	Lower Subansiri				
26	Arunachal Pradesh	Papum Pare				
27	Arunachal Pradesh	Tawang				
28	Arunachal Pradesh	Tirap				
29	Arunachal Pradesh	Upper Siang				
30	Arunachal Pradesh	Upper Subansiri				
31	Arunachal Pradesh	West Kameng				
32	Arunachal Pradesh	West Siang				
33	Assam	Baksa				
34	Assam	Barpeta				
35	Assam	Bongaigaon				
36	Assam	Cachar				
37	Assam	Chirang				
38	Assam	Darrang				
39	Assam	Dhemaji				
40	Assam	Dhubri				
41	Assam	Dibrugarh				
42	Assam	Dima Hasao				
43	Assam	Goalpara				
44	Assam	Golaghat				
45	Assam	Hailakandi				
46	Assam	Jorhat				
47	Assam	Kamrup				
48	Assam	Kamrup Metropolitan				

49	Assam	Karbi Anglong				
50	Assam	Karimganj				
51	Assam	Kokrajhar				
52	Assam	Lakhimpur				
53	Assam	Morigaon				
54	Assam	Nagaon				
55	Assam	Nalbari				
56	Assam	Sivasagar				
57	Assam	Sonitpur				
58	Assam	Tinsukia				
59	Assam	Udalguri				
60	Bihar	Araria				
61	Bihar	Arwal				
62	Bihar	Aurangabad				
63	Bihar	Banka				
64	Bihar	Begusarai				
65	Bihar	Bhagalpur				
66	Bihar	Bhojpur				
67	Bihar	Buxar				
68	Bihar	Darbhanga				
69	Bihar	Gaya				
70	Bihar	Gopalganj				
71	Bihar	Jamui				
72	Bihar	Jehanabad				
73	Bihar	Kaimur (Bhabua)				
74	Bihar	Katihar				
75	Bihar	Khagaria				

76	Bihar	Kishanganj				
77	Bihar	Lakhisarai				
78	Bihar	Madhepura				
79	Bihar	Madhubani				
80	Bihar	Munger				
81	Bihar	Muzaffarpur				
82	Bihar	Nalanda				
83	Bihar	Nawada				
84	Bihar	Pashchim Champaran				
85	Bihar	Patna				
86	Bihar	Purba Champaran				
87	Bihar	Purnia				
88	Bihar	Rohtas				
89	Bihar	Saharsa				
90	Bihar	Samastipur				
91	Bihar	Saran				
92	Bihar	Sheikhpura				
93	Bihar	Sheohar				
94	Bihar	Sitamarhi				
95	Bihar	Siwan				
96	Bihar	Supaul				
97	Bihar	Vaishali				
98	Chandigarh	Chandigarh				
99	Chattisgarh	Bastar				
100	Chattisgarh	Bijapur				
101	Chattisgarh	Bilaspur				

102	Chattisgarh	Dakshin Bastar Dantewada				
103	Chattisgarh	Dhamtari				
104	Chattisgarh	Durg				
105	Chattisgarh	Janjgir Champa				
106	Chattisgarh	Jashpur				
107	Chattisgarh	Kabirdham				
108	Chattisgarh	Korba				
109	Chattisgarh	Koriya				
110	Chattisgarh	Mahasamund				
111	Chattisgarh	Narayanpur				
112	Chattisgarh	Raigarh				
113	Chattisgarh	Raipur				
114	Chattisgarh	Rajnandgaon				
115	Chattisgarh	Surguja				
116	Chattisgarh	Uttar Bastar Kanker				
117	Dadra and Nagar Haveli	Dadra and Nagar Haveli				
118	Daman and Diu	Daman				
119	Daman and Diu	Diu				
120	Goa	South Goa				
121	Goa	North Goa				
122	Gujarat	Ahmadabad				
123	Gujarat	Amreli				
124	Gujarat	Anand				
125	Gujarat	Banaskantha				
126	Gujarat	Bharuch				

127	Gujarat	Bhavnagar				
128	Gujarat	Dohad				
129	Gujarat	Gandhinagar				
130	Gujarat	Jamnagar				
131	Gujarat	Junagarh				
132	Gujarat	Kachchh				
133	Gujarat	Kheda				
134	Gujarat	Mahesena				
135	Gujarat	Narmada				
136	Gujarat	Navsari				
137	Gujarat	Panchmahal				
138	Gujarat	Patan				
139	Gujarat	Porbandar				
140	Gujarat	Rajkot				
141	Gujarat	Sabarkantha				
142	Gujarat	Surat				
143	Gujarat	Surendranagar				
144	Gujarat	Tapi				
145	Gujarat	The Dangs				
146	Gujarat	Vadodara				
147	Gujarat	Valsad				
148	Haryana	Ambala				
149	Haryana	Bhiwani				
150	Haryana	Faridabad				
151	Haryana	Fatehabad				
152	Haryana	Gurgaon				
153	Haryana	Hisar				

154	Haryana	Jhajjar				
155	Haryana	Jind				
156	Haryana	Kaithal				
157	Haryana	Karnal				
158	Haryana	Kurukshetra				
159	Haryana	Mahendragarh				
160	Haryana	Mewat				
161	Haryana	Palwal				
162	Haryana	Panchkula				
163	Haryana	Panipat				
164	Haryana	Rewari				
165	Haryana	Rohtak				
166	Haryana	Sirsa				
167	Haryana	Sonipat				
168	Haryana	Yamunanagar				
169	Himachal Pradesh	Bilaspur				
170	Himachal Pradesh	Chamba				
171	Himachal Pradesh	Hamirpur				
172	Himachal Pradesh	Kangra				
173	Himachal Pradesh	Kinnaur				
174	Himachal Pradesh	Kullu				
175	Himachal Pradesh	Lahul and Spiti				
176	Himachal Pradesh	Mandi				
177	Himachal Pradesh	Shimla				
178	Himachal Pradesh	Sirmaur				
179	Himachal Pradesh	Solan				
180	Himachal Pradesh	Una				

181	Jammu & Kashmir	Anantnag				
182	Jammu & Kashmir	Badgam				
183	Jammu & Kashmir	Bandipore				
184	Jammu & Kashmir	Baramula				
185	Jammu & Kashmir	Data Not Available				
186	Jammu & Kashmir	Doda				
187	Jammu & Kashmir	Ganderbal				
188	Jammu & Kashmir	Jammu				
189	Jammu & Kashmir	Kargil				
190	Jammu & Kashmir	Kathua				
191	Jammu & Kashmir	Kishtwar				
192	Jammu & Kashmir	Kulgam				
193	Jammu & Kashmir	Kupwara				
194	Jammu & Kashmir	Leh(Ladakh)				
195	Jammu & Kashmir	Pulwama				
196	Jammu & Kashmir	Punch				
197	Jammu & Kashmir	Rajouri				
198	Jammu & Kashmir	Ramban				
199	Jammu & Kashmir	Reasi				
200	Jammu & Kashmir	Samba				
201	Jammu & Kashmir	Shupiyan				
202	Jammu & Kashmir	Srinagar				
203	Jammu & Kashmir	Udhampur				
204	Jharkhand	Bokaro				
205	Jharkhand	Chatra				
206	Jharkhand	Deoghar				
207	Jharkhand	Dhanbad				
208	Jharkhand	Dumka				
209	Jharkhand	Garhwa				

210	Jharkhand	Giridih				
211	Jharkhand	Godda				
212	Jharkhand	Gumla				
213	Jharkhand	Hazaribagh				
214	Jharkhand	Jamtara				
215	Jharkhand	Khunti				
216	Jharkhand	Kodarma				
217	Jharkhand	Latehar				
218	Jharkhand	Lohardaga				
219	Jharkhand	Pakur				
220	Jharkhand	Palamu				
221	Jharkhand	Pashchimi Singhbhum				
222	Jharkhand	Purbi Singhbhum				
223	Jharkhand	Ramgarh				
224	Jharkhand	Ranchi				
225	Jharkhand	Sahibganj				
226	Jharkhand	Saraikela Kharsawan				
227	Jharkhand	Simdega				
228	Karnataka	Bagalkot				
229	Karnataka	Bangalore				
230	Karnataka	Bangalore Rural				
231	Karnataka	Belgaum				
232	Karnataka	Bellary				
233	Karnataka	Bidar				
234	Karnataka	Bijapur				
235	Karnataka	Chamarajanagar				

236	Karnataka	Chikkaballapura				
237	Karnataka	Chikmagalur				
238	Karnataka	Chitradurga				
239	Karnataka	Dakshina Kannada				
240	Karnataka	Davanagere				
241	Karnataka	Dharwad				
242	Karnataka	Gadag				
243	Karnataka	Gulbarga				
244	Karnataka	Hassan				
245	Karnataka	Haveri				
246	Karnataka	Kodagu				
247	Karnataka	Kolar				
248	Karnataka	Koppal				
249	Karnataka	Mandya				
250	Karnataka	Mysore				
251	Karnataka	Raichur				
252	Karnataka	Ramanagara				
253	Karnataka	Shimoga				
254	Karnataka	Tumkur				
255	Karnataka	Udupi				
256	Karnataka	Uttara Kannada				
257	Karnataka	Yadgir				
258	Kerala	Alappuzha				
259	Kerala	Ernakulam				
260	Kerala	Idukki				
261	Kerala	Kannur				
262	Kerala	Kasaragod				

263	Kerala	Kollam				
264	Kerala	Kottayam				
265	Kerala	Kozhikode				
266	Kerala	Malappuram				
267	Kerala	Palakkad				
268	Kerala	Pathanamthitta				
269	Kerala	Thiruvananthapuram				
270	Kerala	Thrissur				
271	Kerala	Wayanad				
272	Lakshadweep	Lakshadweep				
273	Madhya Pradesh	Alirajpur				
274	Madhya Pradesh	Anuppur				
275	Madhya Pradesh	Ashoknagar				
276	Madhya Pradesh	Balaghat				
277	Madhya Pradesh	Barwani				
278	Madhya Pradesh	Betul				
279	Madhya Pradesh	Bhind				
280	Madhya Pradesh	Bhopal				
281	Madhya Pradesh	Burhanpur				
282	Madhya Pradesh	Chhattarpur				
283	Madhya Pradesh	Chhindwara				
284	Madhya Pradesh	Damoh				
285	Madhya Pradesh	Datia				
286	Madhya Pradesh	Dewas				
287	Madhya Pradesh	Dhar				
288	Madhya Pradesh	Dindori				
289	Madhya Pradesh	Guna				

290	Madhya Pradesh	Gwalior				
291	Madhya Pradesh	Harda				
292	Madhya Pradesh	Hoshangabad				
293	Madhya Pradesh	Indore				
294	Madhya Pradesh	Jabalpur				
295	Madhya Pradesh	Jhabua				
296	Madhya Pradesh	Katni				
297	Madhya Pradesh	Khandwa (East Nimar)				
298	Madhya Pradesh	Khargone (West Nimar)				
299	Madhya Pradesh	Mandla				
300	Madhya Pradesh	Mandsaur				
301	Madhya Pradesh	Morena				
302	Madhya Pradesh	Narsimhapur				
303	Madhya Pradesh	Neemuch				
304	Madhya Pradesh	Panna				
305	Madhya Pradesh	Raisen				
306	Madhya Pradesh	Rajgarh				
307	Madhya Pradesh	Ratlam				
308	Madhya Pradesh	Rewa				
309	Madhya Pradesh	Sagar				
310	Madhya Pradesh	Satna				
311	Madhya Pradesh	Sehore				
312	Madhya Pradesh	Seoni				
313	Madhya Pradesh	Shahdol				
314	Madhya Pradesh	Shajapur				
315	Madhya Pradesh	Sheopur				

316	Madhya Pradesh	Shivpuri				
317	Madhya Pradesh	Sidhi				
318	Madhya Pradesh	Singrauli				
319	Madhya Pradesh	Tikamgarh				
320	Madhya Pradesh	Ujjain				
321	Madhya Pradesh	Umaria				
322	Madhya Pradesh	Vidisha				
323	Maharashtra	Ahmadnagar				
324	Maharashtra	Akola				
325	Maharashtra	Amravati				
326	Maharashtra	Aurangabad				
327	Maharashtra	Bhandara				
328	Maharashtra	Bid				
329	Maharashtra	Buldana				
330	Maharashtra	Chandrapur				
331	Maharashtra	Dhule				
332	Maharashtra	Gadchiroli				
333	Maharashtra	Gondiya				
334	Maharashtra	Hingoli				
335	Maharashtra	Jalgaon				
336	Maharashtra	Jalna				
337	Maharashtra	Kolhapur				
338	Maharashtra	Latur				
339	Maharashtra	Mumbai				
340	Maharashtra	Mumbai Suburban				
341	Maharashtra	Nagpur				
342	Maharashtra	Nanded				

343	Maharashtra	Nandurbar				
344	Maharashtra	Nashik				
345	Maharashtra	Osmanabad				
346	Maharashtra	Parbhani				
347	Maharashtra	Pune				
348	Maharashtra	Raigarh				
349	Maharashtra	Ratnagiri				
350	Maharashtra	Sangli				
351	Maharashtra	Satara				
352	Maharashtra	Sindhudurg				
353	Maharashtra	Solapur				
354	Maharashtra	Thane				
355	Maharashtra	Wardha				
356	Maharashtra	Washim				
357	Maharashtra	Yavatmal				
358	Manipur	Bishnupur				
359	Manipur	Chandel				
360	Manipur	Churachandpur				
361	Manipur	Imphal East				
362	Manipur	Imphal West				
363	Manipur	Senapati				
364	Manipur	Tamenglong				
365	Manipur	Thoubal				
366	Manipur	Ukhrul				
367	Meghalaya	East Garo Hills				
368	Meghalaya	East Khasi Hills				
369	Meghalaya	Jaintia Hills				

370	Meghalaya	Ri Bhoi				
371	Meghalaya	South Garo Hills				
372	Meghalaya	West Garo Hills				
373	Meghalaya	West Khasi Hills				
374	Mizoram	Aizawl				
375	Mizoram	Champhai				
376	Mizoram	Kolasib				
377	Mizoram	Lawangtlai				
378	Mizoram	Lunglei				
379	Mizoram	Mamit				
380	Mizoram	Saiha				
381	Mizoram	Serchhip				
382	Nagaland	Dimapur				
383	Nagaland	Kiphire				
384	Nagaland	Kohima				
385	Nagaland	Longleng				
386	Nagaland	Mokokchung				
387	Nagaland	Mon				
388	Nagaland	Peren				
389	Nagaland	Phek				
390	Nagaland	Tuensang				
391	Nagaland	Wokha				
392	Nagaland	Zunheboto				
393	NCT of Delhi	Central				
394	NCT of Delhi	East				
395	NCT of Delhi	New Delhi				
396	NCT of Delhi	North				

397	NCT of Delhi	North East				
398	NCT of Delhi	North West				
399	NCT of Delhi	South				
400	NCT of Delhi	South West				
401	NCT of Delhi	West				
402	Odisha	Anugul				
403	Odisha	Balangir				
404	Odisha	Baleshwar				
405	Odisha	Bargarh				
406	Odisha	Baudh				
407	Odisha	Bhadrak				
408	Odisha	Cuttack				
409	Odisha	Debagarh				
410	Odisha	Dhenkanal				
411	Odisha	Gajapati				
412	Odisha	Ganjam				
413	Odisha	Jagatsinghapur				
414	Odisha	Jajapur				
415	Odisha	Jharsuguda				
416	Odisha	Kalahandi				
417	Odisha	Kandhamal				
418	Odisha	Kendrapara				
419	Odisha	Kendujhar				
420	Odisha	Khordha				
421	Odisha	Koraput				
422	Odisha	Malkangiri				
423	Odisha	Mayurbhanj				

424	Odisha	Nabarangapur				
425	Odisha	Nayagarh				
426	Odisha	Nuapada				
427	Odisha	Puri				
428	Odisha	Rayagada				
429	Odisha	Sambalpur				
430	Odisha	Subarnapur				
431	Odisha	Sundargarh				
432	Puducherry	Karaikal				
433	Puducherry	Mahe				
434	Puducherry	Puducherry				
435	Puducherry	Yanam				
436	Punjab	Amritsar				
437	Punjab	Barnala				
438	Punjab	Bathinda				
439	Punjab	Faridkot				
440	Punjab	Fatehgarh Sahib				
441	Punjab	Firozpur				
442	Punjab	Gurdaspur				
443	Punjab	Hoshiarpur				
444	Punjab	Jalandhar				
445	Punjab	Kapurthala				
446	Punjab	Ludhiana				
447	Punjab	Mansa				
448	Punjab	Moga				
449	Punjab	Muktsar				
450	Punjab	Patiala				

451	Punjab	Rupnagar				
452	Punjab	Sahibzada Ajit Singh Nagar				
453	Punjab	Sangrur				
454	Punjab	Shahid Bhagat Singh Nagar				
455	Punjab	Tarn Taran				
456	Rajasthan	Ajmer				
457	Rajasthan	Alwar				
458	Rajasthan	Banswara				
459	Rajasthan	Baran				
460	Rajasthan	Barmer				
461	Rajasthan	Bharatpur				
462	Rajasthan	Bhilwara				
463	Rajasthan	Bikaner				
464	Rajasthan	Bundi				
465	Rajasthan	Chittaurgarh				
466	Rajasthan	Churu				
467	Rajasthan	Dausa				
468	Rajasthan	Dhaulpur				
469	Rajasthan	Dungarpur				
470	Rajasthan	Ganganagar				
471	Rajasthan	Hanumangarh				
472	Rajasthan	Jaipur				
473	Rajasthan	Jaisalmer				
474	Rajasthan	Jalor				
475	Rajasthan	Jhalawar				
476	Rajasthan	Jhunjhunun				

477	Rajasthan	Jodhpur				
478	Rajasthan	Karauli				
479	Rajasthan	Kota				
480	Rajasthan	Nagaur				
481	Rajasthan	Pali				
482	Rajasthan	Pratapgarh				
483	Rajasthan	Rajsamand				
484	Rajasthan	Sawai Madhopur				
485	Rajasthan	Sikar				
486	Rajasthan	Sirohi				
487	Rajasthan	Tonk				
488	Rajasthan	Udaipur				
489	Sikkim	East District				
490	Sikkim	North Sikkim				
491	Sikkim	South Sikkim				
492	Sikkim	West Sikkim				
493	Tamil Nadu	Ariyalur				
494	Tamil Nadu	Chennai				
495	Tamil Nadu	Coimbatore				
496	Tamil Nadu	Cuddalore				
497	Tamil Nadu	Dharmapuri				
498	Tamil Nadu	Dindigul				
499	Tamil Nadu	Erode				
500	Tamil Nadu	Kancheepuram				
501	Tamil Nadu	Kanniyakumari				
502	Tamil Nadu	Karur				

503	Tamil Nadu	Krishnagiri				
504	Tamil Nadu	Madurai				
505	Tamil Nadu	Nagappattinam				
506	Tamil Nadu	Namakkal				
507	Tamil Nadu	Perambalur				
508	Tamil Nadu	Pudukkottai				
509	Tamil Nadu	Ramanathapuram				
510	Tamil Nadu	Salem				
511	Tamil Nadu	Sivaganga				
512	Tamil Nadu	Thanjavur				
513	Tamil Nadu	The Nilgiris				
514	Tamil Nadu	Theni				
515	Tamil Nadu	Thiruvallur				
516	Tamil Nadu	Thiruvarur				
517	Tamil Nadu	Thoothukkudi				
518	Tamil Nadu	Tiruchirappalli				
519	Tamil Nadu	Tirunelveli				
520	Tamil Nadu	Tiruppur				
521	Tamil Nadu	Tiruvannamalai				
522	Tamil Nadu	Vellore				
523	Tamil Nadu	Viluppuram				
524	Tamil Nadu	Virudhunagar				
525	Telangana	Adilabad				
526	Telangana	Hyderabad				
527	Telangana	Karimnagar				
528	Telangana	Khammam				
529	Telangana	Mahbubnagar				

530	Telangana	Medak				
531	Telangana	Nalgonda				
532	Telangana	Nizamabad				
533	Telangana	Rangareddy				
534	Telangana	Warangal				
535	Tripura	Dhalai				
536	Tripura	North Tripura				
537	Tripura	South Tripura				
538	Tripura	West Tripura				
539	Uttar Pradesh	Agra				
540	Uttar Pradesh	Aligarh				
541	Uttar Pradesh	Allahabad				
542	Uttar Pradesh	Ambedkar Nagar				
543	Uttar Pradesh	Auraiya				
544	Uttar Pradesh	Azamgarh				
545	Uttar Pradesh	Baghpat				
546	Uttar Pradesh	Bahraich				
547	Uttar Pradesh	Ballia				
548	Uttar Pradesh	Balrampur				
549	Uttar Pradesh	Banda				
550	Uttar Pradesh	Bara Banki				
551	Uttar Pradesh	Bareilly				
552	Uttar Pradesh	Basti				
553	Uttar Pradesh	Bijnor				
554	Uttar Pradesh	Budaun				
555	Uttar Pradesh	Bulandshahr				
556	Uttar Pradesh	Chandauli				

557	Uttar Pradesh	Chitrakoot				
558	Uttar Pradesh	Deoria				
559	Uttar Pradesh	Etah				
560	Uttar Pradesh	Etawah				
561	Uttar Pradesh	Faizabad				
562	Uttar Pradesh	Farrukhabad				
563	Uttar Pradesh	Fatehpur				
564	Uttar Pradesh	Firozabad				
565	Uttar Pradesh	Gautam Buddha Nagar				
566	Uttar Pradesh	Ghaziabad				
567	Uttar Pradesh	Ghazipur				
568	Uttar Pradesh	Gonda				
569	Uttar Pradesh	Gorakhpur				
570	Uttar Pradesh	Hamirpur				
571	Uttar Pradesh	Hardoi				
572	Uttar Pradesh	Jalaun				
573	Uttar Pradesh	Jaunpur				
574	Uttar Pradesh	Jhansi				
575	Uttar Pradesh	Jyotiba Phule Nagar				
576	Uttar Pradesh	Kannauj				
577	Uttar Pradesh	Kanpur Dehat				
578	Uttar Pradesh	Kanpur Nagar				
579	Uttar Pradesh	Kanshiram Nagar				
580	Uttar Pradesh	Kaushambi				
581	Uttar Pradesh	Kheri				
582	Uttar Pradesh	Kushinagar				

583	Uttar Pradesh	Lalitpur				
584	Uttar Pradesh	Lucknow				
585	Uttar Pradesh	Mahamaya Nagar				
586	Uttar Pradesh	Maharajganj				
587	Uttar Pradesh	Mahoba				
588	Uttar Pradesh	Mainpuri				
589	Uttar Pradesh	Mathura				
590	Uttar Pradesh	Mau				
591	Uttar Pradesh	Meerut				
592	Uttar Pradesh	Mirzapur				
593	Uttar Pradesh	Moradabad				
594	Uttar Pradesh	Muzaffarnagar				
595	Uttar Pradesh	Pilibhit				
596	Uttar Pradesh	Pratapgarh				
597	Uttar Pradesh	Rae Bareli				
598	Uttar Pradesh	Rampur				
599	Uttar Pradesh	Saharanpur				
600	Uttar Pradesh	Sant Kabir Nagar				
601	Uttar Pradesh	Sant Ravidas Nagar				
602	Uttar Pradesh	Shahjahanpur				
603	Uttar Pradesh	Shrawasti				
604	Uttar Pradesh	Siddharthnagar				
605	Uttar Pradesh	Sitapur				
606	Uttar Pradesh	Sonbhadra				
607	Uttar Pradesh	Sultanpur				
608	Uttar Pradesh	Unnao				
609	Uttar Pradesh	Varanasi				

610	Uttarakhand	Almora				
611	Uttarakhand	Bageshwar				
612	Uttarakhand	Chamoli				
613	Uttarakhand	Champawat				
614	Uttarakhand	Dehradun				
615	Uttarakhand	Haridwar				
616	Uttarakhand	Nainital				
617	Uttarakhand	Pauri Garhwal				
618	Uttarakhand	Pithoragarh				
619	Uttarakhand	Rudraprayag				
620	Uttarakhand	Tehri Garhwal				
621	Uttarakhand	Udham Singh Nagar				
622	Uttarakhand	Uttarkashi				
623	West Bengal	Bankura				
624	West Bengal	Barddhaman				
625	West Bengal	Birbhum				
626	West Bengal	Dakshin Dinajpur				
627	West Bengal	Darjiling				
628	West Bengal	Haora				
629	West Bengal	Hugli				
630	West Bengal	Jalpaiguri				
631	West Bengal	Koch Bihar				
632	West Bengal	Kolkata				
633	West Bengal	Maldah				
634	West Bengal	Murshidabad				
635	West Bengal	Nadia				

636	West Bengal	North Twenty Four Parganas				
637	West Bengal	Paschin Medinipur				
638	West Bengal	Purba Medinipur				
639	West Bengal	Puruliya				
640	West Bengal	South Twenty Four Parganas				
641	West Bengal	Uttar Dinajpur				

Annexure III: 100 Poor Performing Districts in terms of Stunting

1	Uttar Pradesh	Bahraich	65.1
2	Uttar Pradesh	Shrawasti	63.5
3	Uttar Pradesh	Balrampur	62.8
4	Jharkhand	Pashchimi Singhbhum	59.4
5	Uttar Pradesh	Siddharthnagar	57.9
6	Bihar	Sitamarhi	57.3
7	Uttar Pradesh	Gonda	56.9
8	Uttar Pradesh	Sitapur	56.4
9	Karnataka	Koppal	55.8
10	Karnataka	Yadgir	55.5
11	Uttar Pradesh	Budaun	55.1
12	Rajasthan	Dhaulpur	54.3
13	Bihar	Nalanda	54.1
14	Jharkhand	Godda	54
15	Uttar Pradesh	Kheri	53.9
16	Bihar	Kaimur (Bhabua)	53.8
17	Bihar	Vaishali	53.7
18	Uttar Pradesh	Maharajganj	53.3
19	Uttar Pradesh	Etawah	53.2
20	Bihar	Sheohar	53
21	Bihar	Gaya	52.9
22	Uttar Pradesh	Fatehpur	52.4
23	Haryana	Mewat	52.3
24	Karnataka	Gulbarga	52.2
25	Madhya Pradesh	Sheopur	52.1
26	Bihar	Jehanabad	52.1
27	Bihar	Purnia	52.1

28	Madhya Pradesh	Barwani	52
29	Jharkhand	Pakur	51.8
30	Bihar	Madhepura	51.8
31	Bihar	Madhubani	51.8
32	Meghalaya	Ri Bhoi	51.6
33	Uttar Pradesh	Bara Banki	51.5
34	Uttar Pradesh	Pilibhit	51.5
35	Uttar Pradesh	Kanshiram Nagar	51.5
36	Uttar Pradesh	Sant Ravidas Nagar	51.4
37	Meghalaya	West Khasi Hills	51.1
38	Uttar Pradesh	Etah	51
39	Uttar Pradesh	Chitrakoot	50.9
40	Meghalaya	Jaintia Hills	50.8
41	Gujarat	Sabarkantha	50.6
42	Bihar	Lakhisarai	50.6
43	Uttar Pradesh	Sant Kabir Nagar	50.5
44	Uttar Pradesh	Hardoi	50.5
45	Uttar Pradesh	Kannauj	50.4
46	Jharkhand	Sahibganj	50.2
47	Bihar	Arwal	50.2
48	Uttar Pradesh	Kaushambi	50.1
49	Rajasthan	Banswara	50
50	Madhya Pradesh	Burhanpur	50
51	Uttar Pradesh	Faizabad	49.9
52	Bihar	Khagaria	49.8
53	Madhya Pradesh	Tikamgarh	49.7
54	Jharkhand	Chatra	49.6
55	Bihar	Banka	49.6
56	Karnataka	Bellary	49.5
57	Jharkhand	Hazaribagh	49.3

58	Uttar Pradesh	Shahjahanpur	49.3
59	Bihar	Samastipur	49.2
60	Bihar	Katihar	49.2
61	Uttar Pradesh	Aligarh	49.1
62	Uttar Pradesh	Mirzapur	49.1
63	Uttar Pradesh	Farrukhabad	49.1
64	Bihar	Darbhanga	49
65	Chattisgarh	Narayanpur	49
66	Madhya Pradesh	Datia	48.9
67	Uttar Pradesh	Basti	48.9
68	Chattisgarh	Rajnandgaon	48.8
69	Madhya Pradesh	Sidhi	48.7
70	Madhya Pradesh	Shivpuri	48.6
71	Madhya Pradesh	Alirajpur	48.6
72	Bihar	Rohtas	48.5
73	Meghalaya	East Khasi Hills	48.5
74	Bihar	Nawada	48.4
75	Gujarat	Bhavnagar	48.4
76	Bihar	Araria	48.4
77	Bihar	Aurangabad	48.3
78	Madhya Pradesh	Khargone (West Nimar)	48.3
79	Chattisgarh	Bijapur	48.2
80	Gujarat	Anand	48.2
81	Bihar	Supaul	48.1
82	Gujarat	The Dangs	48.1
83	Madhya Pradesh	Shajapur	48.1
84	Uttar Pradesh	Jaunpur	48
85	Bihar	Muzaffarpur	47.9
86	Madhya Pradesh	Morena	47.7

87	Maharashtra	Nandurbar	47.6
88	Madhya Pradesh	Bhopal	47.6
89	Madhya Pradesh	Bhind	47.6
90	Rajasthan	Bharatpur	47.6
91	Odisha	Subarnapur	47.5
92	Rajasthan	Udaipur	47.5
93	Gujarat	Narmada	47.4
94	Maharashtra	Yavatmal	47.4
95	Assam	Dhubri	47.4
96	Karnataka	Bagalkot	47.3
97	Bihar	Purba Champaran	47.2
98	Bihar	Kishanganj	46.9
99	Rajasthan	Dungarpur	46.8
100	Uttar Pradesh	Banda	46.7