

Documentation of Rajmata Jijau Mother-Child Health and Nutrition Mission in Maharashtra

Pushing the Nutrition Agenda Forward

October 2016



Process documentation of State Nutrition Mission by Results for Development and Amaltas



RESULTS FOR
DEVELOPMENT

AMALTAS

Acknowledgements

This report is part of a series of three papers: Documentation of the Rajmata Jijau Mother-Child Health and Nutrition Mission in Maharashtra, Documentation of the State Nutrition Mission in Uttar Pradesh and Policy Brief: Lessons from the State Nutrition Missions of Maharashtra and Uttar Pradesh.

This study was funded by UNICEF India. This report was written by Mary D'Alimonte and Jack Clift from Results for Development, Suneeta Singh and Kriti Kaushal from Amaltas, and James Levinson. The authors would like to thank Saba Mebrahtu, Gayatri Singh, Rajilakshmi Nair and Richa Singh Pandey of UNICEF for their support and guidance. The team would also like to express its gratitude to the Governments of Uttar Pradesh for its support of this report. In particular, we would like to thank the Director General and Director of the State Nutrition Mission in Uttar Pradesh, Mr Kamran Rizvi and Mr Amitabh Prakash (respectively). The authors would also like to thank all of the experts and stakeholders interviewed for this report, who contributed their time and inputs to the study. The names of experts and stakeholders interviewed for this report are listed in Appendix C. In addition, the authors would like to thank Hilary Rogers and Kusum Hachhethu for their invaluable contributions to the field work and analysis. A number of Results for Development Institute (R4D) staff provided support and peer review in the preparation of this report: the authors would like to particularly thank Daniel Arias and Yashodhara Rana for their contributions.

Documentation of Rajmata
Jijau Mother-Child
Health and Nutrition
Mission in Maharashtra

Pushing the Nutrition Agenda Forward

October 2016



Content

Abbreviations and Acronyms	07
Executive Summary	09
Chapter 1: Introduction	12
Chapter 2: Methods	20
Chapter 3: History of RJMCHN Mission	24
3.1. Genesis of the Mission: the Marathwada Initiative (2001-2004)	25
3.2. RJMCHN Mission Phase 1	27
3.3. RJMCHN Mission Phase 2	28
3.4. RJMCHN Mission Phase 3	29
Chapter 4: Key Factors Influencing RJMCHN Mission	30
4.1. Assessment of Critical Enablers and Mission Resources	31
4.2. Key Activities of the Mission	34
Chapter 5: Budget Analysis	46
5.1. Nutrition Budget Analysis Across All Departments	47
5.2. Nutrition Investments in the Public Health Department	50
Chapter 6: Conclusions	52
Annex A: Nutrition-relevant Public Programmes in India	56
Annex B: Basic Health and Nutrition Indicators in Maharashtra	57
Annex C: Key Informant Interviews	59
Annex D: Nutrition-relevant Programmes Included in the Budget Analysis	61
Annex E: Considerations for Future SNM Strategy Development: Multi-sectoral Nutrition Convergence in Targeted Vulnerable Blocks	62



Abbreviations and Acronyms

AAA	AWWs, ASHAs and ANMs
ACDPO	Assistant Child Development Project Officer
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BPL	Below Poverty Line
BPNI	Breastfeeding Promotion Network of India
CDC	Child Development Centre
CDNC	Child Development Nutrition Centre
CDPO	Child Development Project Officer
CMAM	Community Management of Severe Acute Malnutrition
CNSM	Comprehensive Nutrition Survey in Maharashtra
CSR	Corporate Social Responsibility
DG	Director General
DoPH	Department of Public Health
FLW	Frontline Worker
GSDP	Gross State Domestic Product
IAP	Indian Academy of Paediatrics
ICDS	Integrated Child Development Services
IDS	Institute of Development Studies
IIPS	International Institute of Population Sciences
IMR	Infant Mortality Rate
ISO	International Organisation for Standardisation
IYCF	Infant and Young Child Feeding
JSSK	Janani-Shishu Suraksha Karyakram
MAM	Moderate Acute Malnutrition
MMR	Maternal Mortality Rate
MUAC	Mid-Upper Arm Circumference
MO	Medical Officer
NFHS	National Family Health Survey
NHM	National Health Mission
NIDDCP	National Iodine Deficiency Disorders Control Programme
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PIP	Programme Implementation Plan (PIP)
RJMCHN	Rajmata Jijau Mother-Child Health and Nutrition Mission
RUTF	Ready-to-Use Therapeutic Foods
SAM	Severe Acute Malnutrition
SEARCH	Society for Education, Action and Research in Community Health
SNM	State Nutrition Missions
SNP	Supplementary Nutrition Programme
SUN	Scaling Up Nutrition
TDD	Tribal Development Department
VCDC	Village Child Development Centre
WASH	Water, Sanitation and Hygiene
WCD	Women and Child Development
WIFS	Weekly Iron and Folic Acid Supplementation



Executive Summary

Maharashtra experienced an impressive 15 percentage-point decline in stunting among children under 2 years of age between 2005 and 2012.¹ In 2005, the Rajmata Jijau Mother-Child Health and Nutrition Mission (RJMCHN Mission) was set up as the first-ever State Nutrition Mission in India. Supported by UNICEF, RJMCHN Mission acts as a multi-sectoral coordinating body within the government with the objective to improve nutrition programming across sectors, especially within Integrated Child Development Services (ICDS) and the National Health Mission (NHM). RJMCHN Mission has gone through two phases in its lifespan and is currently about to enter Phase 3 with a new transformative approach.

While the macro-level factors that contributed to the state's stunting decline have been analysed, the literature has not assessed the role that RJMCHN Mission played in improving nutrition programming during the same time period. The main objective of this report is to document the evolution of the Mission, its current governance structure, core activities, successes and challenges. The impact of government-delivered nutrition services on nutrition outcomes was not evaluated. A budget analysis for nutrition was also conducted to assess nutrition-specific and -sensitive budget allocations across departments in Maharashtra.

Assessing Enabling Factors of the Mission and Key Mission Activities

A research team conducted secondary research and key informant interviews at the state level and in three districts that were purposefully selected to capture information pertinent to the Mission's activities and influence. The research team interviewed personnel from UNICEF, RJMCHN Mission staff, state and district government officials, development partners, frontline workers and beneficiaries. Core thematic areas were analysed, including critical enabling factors that have led to the success of the Mission and the Mission's key activities.

The key enabling factors and resources that have contributed to the Mission's achievements to-date include: strong programme leadership at the Director General level throughout both phases, political support across sectors (including Women and Child Development and Public Health departments), encouraged by personal relationships and dedication to pushing the nutrition agenda forward, policy and programme advocacy enabled by access to data and linkages with civil society and advocacy efforts to raise awareness for nutrition through media and other population-based sources and strong technical support provided by UNICEF and other partners throughout its lifecycle.

¹ Haddad, L.; Nisbett, N.; Barnett, I. and Valli, E. (2014) Maharashtra's Child Stunting Declines: What is Driving Them? Findings of a Multidisciplinary Analysis, Brighton: IDS

The report documents some of the key activities of RJMCHN Mission. The Mission has fostered innovative and adaptive solutions to implementation challenges. Examples of these innovations include the establishment of Village Child Development Centres – which was an innovation to treat severe acute malnutrition at Anganwadi Centres and an example of collaboration between ICDS and NHM – and the recent initiatives to leverage funds for nutrition through corporate social responsibility. The Mission developed training programmes for frontline workers to not only improve their technical skills, but to also encourage leadership, ownership and motivation among them. These trainings led to innovations in the way frontline workers communicated with mothers and encouraged them to engage with communities. The trainings also helped to create the first-ever Anganwadi centre that meets the standards of International Organisation for Standardisation (ISO).

The Mission has collaborated with partners from civil society, the private sector and academia. For example, the Bhavishya Alliance was a network of partners during Phase 1 of the Mission with members in the public and private sectors that came together to coordinate nutrition activities. The Mission has used a dual convergence strategy by focusing on convergence between officials (state high-level government officials as well as village and district officials) and on convergence of frontline workers within ICDS and NHM. Finally, the Mission has made efforts to generate data and incorporate it into evidence-based decision making, exemplified by the Mission's fact-finding visits as well as the Comprehensive Nutrition Survey in Maharashtra.

One of the challenges of RJMCHN Mission has been to boost and maintain ownership and accountability for nutrition within ICDS and NHM. This has been one of the core objectives of the Mission from its inception, and continues to be important today. Key informants provided recommendations for how RJMCHN Mission can continue to work towards this objective, which are aligned with the transformation plan set out for its third Phase.

Budget Analysis for Nutrition

A descriptive budget analysis for nutrition was conducted to assess nutrition-specific and nutrition-sensitive budget allocations across departments. RJMCHN Mission considered the following departments to have nutrition-specific and -sensitive investments: Women and Child Development, Public Health, Education, Tribal Development, Food and Civil Supplies, Water Supply and Sanitation, Irrigation Department and Rural Development. Budget allocations for nutrition-sensitive programmes as a share of the total departmental budget ranged from 3 per cent in education department to 89 per cent in the irrigation department.

NHM Programme Implementation Plans for 2013-14 and 2014-15 showed there was an overall increase in the budget for nutrition-specific interventions over the two years, growing to the proposed budget of Rs 250 crore in 2015-16 (US \$40 million). Budget allocations for the treatment of acute malnutrition increased by about 20 per cent between 2013-14 and 2015-16. The proposed budget for the treatment of acute malnutrition in 2015-16 is about 60 per cent higher than the approved budget in 2014-15. Although this large increase is in the proposed budget and not the approved budget, the increase could suggest that these interventions have been prioritised in the planning and budget management cycle.

This analysis is a first step towards mapping resources dedicated to nutrition-relevant programmes in the state in an effort to generate data to build a case for investment in nutrition. Future analyses can explore the programmatic components that are counted towards nutrition within each nutrition-relevant department, and assess where and how they can be made more nutrition-sensitive. Ultimately, this resource mapping information could help assess how departmental budgets could be leveraged for nutrition (or made more nutrition-sensitive), and help build the case for investment in nutrition, needed to influence the policy and budget management cycle for nutrition, across sectors on an annual basis.

Conclusions

The establishment of RJMCHN Mission represents one of the most significant efforts to-date to improve the governance and coordination of nutrition services across sectors in India. While the historic decline in stunting has eased some of the undernutrition burden in the state, the prevalence of stunting among 2-year-old children is still high at 24%² and the prevalence of stunting among children under five is even higher at 34%.³ This makes it clear that enhanced, targeted efforts to combat malnutrition are needed in the state. As things stand now, the second phase of RJMCHN Mission has ended and a proposal for the next phase has been submitted to the state Cabinet for approval. Now more than ever the state needs a new and improved State Nutrition Mission to help reverse these trends and the expected transformation of RJMCHN Mission during its third phase could make that possible. The proposed components for the third phase of the Mission are described in Chapter 3 of this report.

² International Institute for Population Sciences (IIPS) and UNICEF. (2012). Comprehensive Nutrition Survey in Maharashtra. Retrieved from Mother and Child Nutrition: <http://motherchildnutrition.org/india/pdf/IIPS-CNSM-Survey-Report.pdf>

³ International Institute for Population Sciences (IIPS). (2015). National Family Health Survey (NFHS-4) Maharashtra fact sheet. Retrieved from RCIIIPS: <http://rchiips.org/nfhs/pdf/NFHS4/Maharashtra.pdf>

Chapter



Introduction

The burden of undernutrition

India is home to about a third of all global cases of chronic undernutrition. Almost 40 per cent of children under the age of five exhibit stunted growth.⁴ Although as a whole India's rates of undernutrition have improved significantly – rates of stunting declined from 48 to 39 per cent from 2005-06 to 2013-15 – the country still lags behind in terms of achieving the World Health Assembly's targets for stunting.⁵ Across India, there is wide variability in nutrition outcomes; state-level analyses are critical to understand the complexities of undernutrition in the country.⁶



⁴ Rapid Survey on Children (2013-2014). (2016, April). Ministry of Women and Child Development, Government of India.

⁵ Raykar, N., & Menon, P. (2016). "State Nutrition Missions in India: Doing Poorly on Target Setting." Global Nutrition Report, 29-30.

⁶ Ibid.

Maharashtra is the second largest state in India, with a population of more than 112 million. A large percentage of its population lives in urban areas (45.2%) and slum areas (10.5%).⁷ Maharashtra is one of the more economically successful states in India, contributing 23.2 per cent of India's total Gross Domestic Product (GDP). The per capita GDP in the state is US \$1,818, which is higher than the national average of US \$1,503.⁸ The literacy rate in Maharashtra is 82.3 per cent, which is higher than the national average of 74 per cent. Similarly, the female literacy rate of 75.9 per cent is higher than the national average of 64.46 per cent.¹ See Table 1.1 for a summary of demographic indicators in the state.

Maharashtra, while economically booming, is burdened with both chronic and acute undernutrition. About 35 per cent of children under five in the state exhibit stunted linear growth, which is only slightly lower than the Indian average of 39 per cent prevalence of stunting.⁹ The prevalence of wasting among children under five in the state is 26 per cent; roughly 2.5 million children, or a quarter of all children under five, suffer from wasting and as a result face severe health, development, and mortality risks due to acute undernutrition.¹⁰ Nearly one in six cases of children affected by wasting across India lives in Maharashtra.¹¹



⁷ Maharashtra Population Census data 2011. (n.d.). Retrieved June 28, 2016, from Census 2011: <http://www.census2011.co.in/census/state/maharashtra.html>

⁸ India's top 25 states with highest GDP. (n.d.). Retrieved June 28, 2016, from rediff : <http://www.rediff.com/money/slide-show/slide-show-1-top-25-states-with-highest-gdp/20120223.htm> - 2

⁹ Rapid Survey on Children (2013-2014). (2016, April). Ministry of Women and Child Development, Government of India.

¹⁰ International Institute for Population Sciences (IIPS). (2015). National Family Health Survey (NFHS-4) Maharashtra fact sheet. Retrieved from RCIIIPS: <http://rchiips.org/nfhs/pdf/NFHS4/Maharashtra.pdf>

¹¹ Based on Global Nutrition Report. (2015). 2015 Nutrition Country Profile: India. Retrieved from IFPRI: <http://ebrary.ifpri.org/utills/get le/collection/p15738coll2/id/129813/ lename/130024.pdf>, NFHS4, and UNICEF & Government of Maharashtra (Eds.). (n.d.). Children in Maharashtra: An Atlas of Social Indicators.

Table 1.1: : Demographic Indicators in Maharashtra and India

Indicator	Maharashtra	India
Population (2011) ^a	112,374,333	1,210,854,977
Rural	55%	69%
Urban	45%	31%
Minority population (2011) ^a		
Scheduled Tribes	9.4% (10,510,213)	8.6% (104,281,034)
Scheduled Castes	12% (13,275,898)	17% (201,378,086)
GSDP (Rupee in crore) 2013-14 ^b	1,476,233	10,472,807
GSDP growth (annual) 2013-14 ^c	11.52%	11.54%
Poverty Headcount Ratio (< \$1.25/day PPP) ^d	30.7%	27.5%
Rural	29.6%	28.3%
Urban	32.2%	25.7%
India State Hunger Index ^d	22.80	23.30
IMR (2012) ^e	25	42
MMR (2012) ^e	87	178

^a Indian Census 2011 (http://www.censusindia.gov.in/2011census/PCA/PCA_Highlights/pca_highlights_le/India/5Figures_at_glance.pdf, http://www.censusindia.gov.in/2011census/hlo/pca/PCA_pdf/PCA-CRC-2700.pdf)

^b Gross State Domestic Product (GSDP) at Current Prices (as on 31-10-2014) http://planningcommission.gov.in/data/datatable/data_2312/DatabookDec2014%20156.pdf

^c Growth Rate - GSDP % (current prices) as per CSO Data 1997-98 onwards (as on 30-11-2014), Data for Planning Commission, 2014. http://planningcommission.gov.in/data/datatable/data_2312/DatabookDec2014%20163.pdf

^d Percentage of population below poverty line by states & UTs for 61st (2004-05) rounds, Data for Planning Commission, 2014. <http://planningcommission.gov.in/data/datatable/index.php?data=datatab> http://planningcommission.gov.in/data/datatable/data_2312/DatabookDec2014%20105.pdf

^e Infant, Child and maternal Mortality Rate. Ministry of Health and Family Welfare, Government of India, July 11 2014. <http://pib.nic.in/newsite/PrintRelease.aspx?relid=106438>

While the current nutritional profile of Maharashtra still has a lot of room for improvement, the state's rate of chronic undernutrition has declined impressively. Between 2005 and 2012 the prevalence of stunting among children aged 0 to 2 years declined from 39 to 24 per cent, representing an impressive 15 percentage point decrease.^{12,13,14} Among children under five years, stunting declined from 46 per cent to 34 per cent from 2005-06 to 2014-15; the trend in wasting, though, shows an opposite picture – it has risen from 16 per cent in 2005-6 (NFHS-3) to 26 per cent in 2014-15 (NFHS-4¹⁵). A note of caution, however. While wasting increases in humanitarian emergencies are vitally important as an

¹² Haddad, L.; Nisbett, N.; Barnett, I. and Valli, E. (2014) Maharashtra's Child Stunting Declines: What is Driving Them? Findings of a Multidisciplinary Analysis, Brighton: IDS

¹³ NFHS-3 - International Institute for Population Sciences (IIPS) and Macro International. (2007). National Family Health Survey (NFHS-3), 2005-06 India: Volume II. Mumbai: IIPS

¹⁴ International Institute for Population Sciences (IIPS) and UNICEF. (2012). Comprehensive Nutrition Survey in Maharashtra. Retrieved from Mother and Child Nutrition: <http://motherchildnutrition.org/india/pdf/IIPS-CNSM-Survey-Report.pdf>

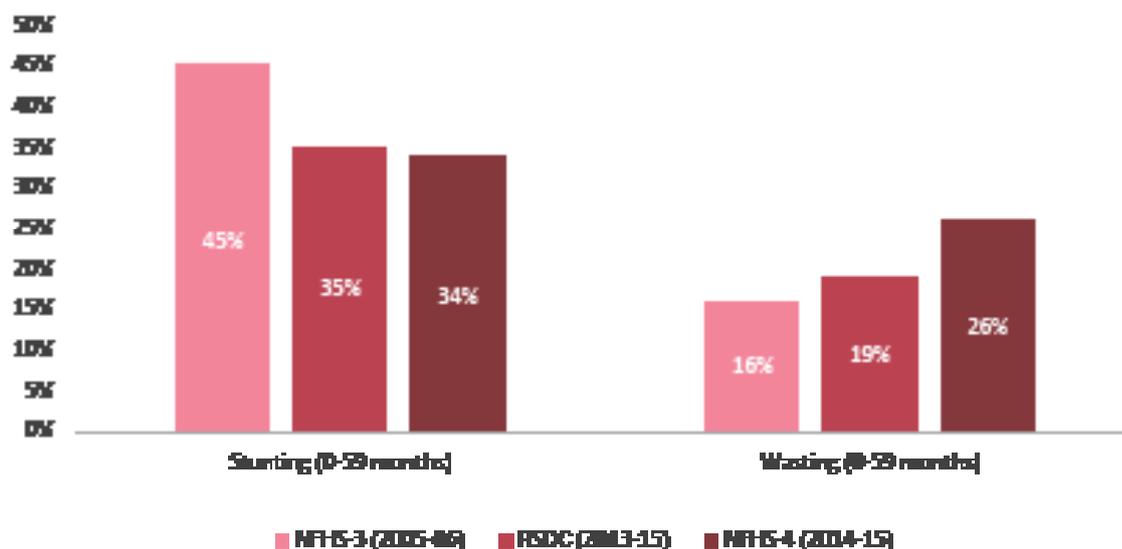
¹⁵ International Institute for Population Sciences (IIPS). (2015). National Family Health Survey (NFHS-4) Maharashtra fact sheet. Retrieved from RCIIPS: <http://rchiips.org/nfhs/pdf/NFHS4/Maharashtra.pdf>

indication of short-term/recent undernutrition, increases in moderate wasting in situations of chronic undernutrition where both stunting and underweight reductions are taking place, may indicate simply that length/height is increasing at a faster rate than weight. Figure 1.1 outlines the trends in two core nutrition indicators in the state.

Due to the recent declines in stunting in Maharashtra, researchers have studied the impact of the state’s social, economic, and political environment on childhood nutrition. The Institute of Development Studies (IDS)¹⁶ assessed macro-level factors that contributed to the decline in stunting in the state through a three-part synthesis study, comprising literature review, quantitative survey and qualitative survey. The report found that a favourable enabling environment – including stronger economic performance, governance and social determinants of health, and improvements in the commitment to nutrition spending and interventions – helped contribute to a decline in stunting. The report further noted that interviewed stakeholders believed that the Nutrition Mission demonstrated leadership and signalled the government’s commitment to ending undernutrition.

A recent study by Aguayo, Nair, Badgaiyan and Krishna¹⁷ has further helped identify factors most significantly associated with child stunting in Maharashtra. Using a representative sample of over 2,500 children (0-23 months old), Aguayo and colleagues conducted a multivariate regression analysis to determine predictors of stunting and poor linear growth. The researchers found that children’s birthweight and feeding practices were clear predictors of undernutrition. However, the team also noted that women’s nutrition and status and broader factors – such as household sanitation and poverty – were among the most significant factors that predicted stunting and poor linear growth.

Figure 1.1: Nutrition indicators in Maharashtra



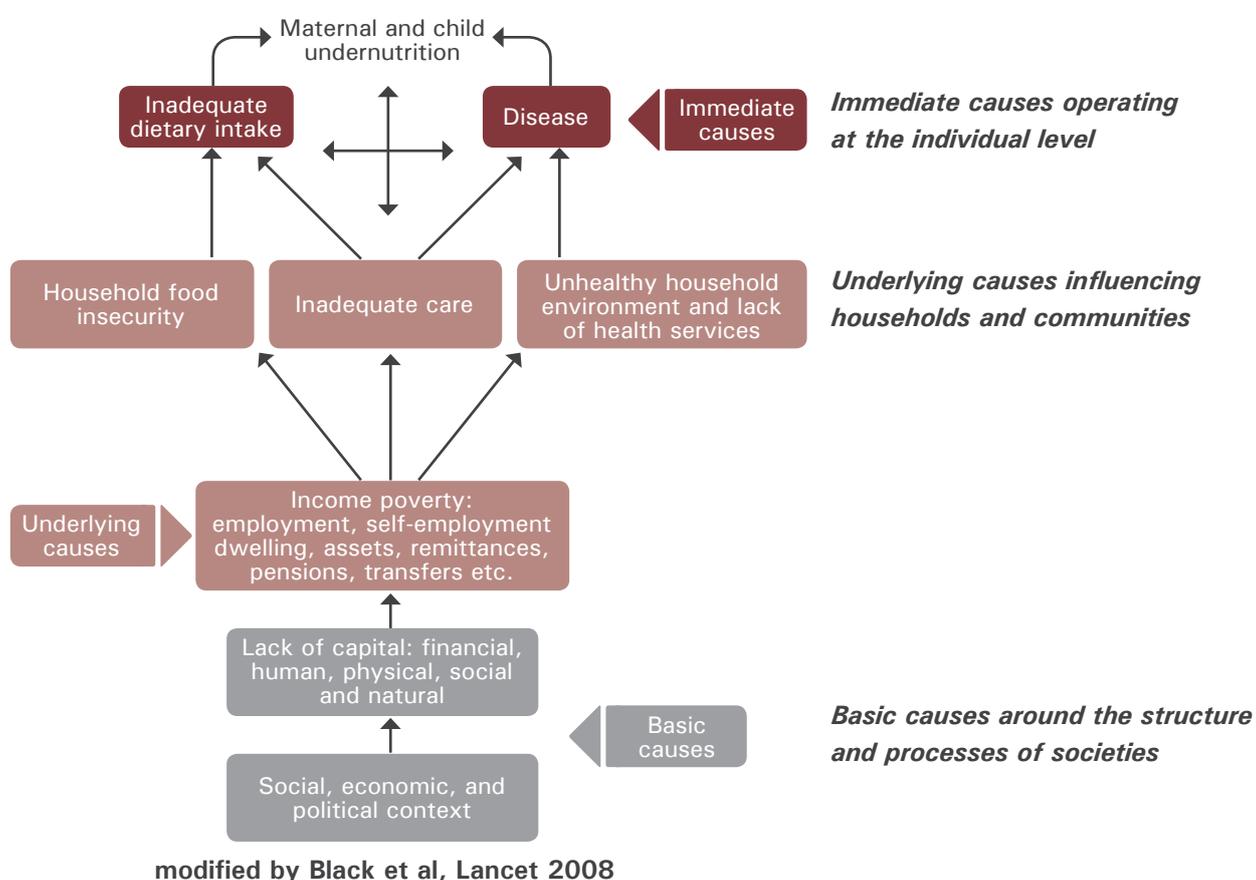
¹⁶Haddad, L.; Nisbett, N.; Barnett, I. and Valli, E. (2014) Maharashtra’s Child Stunting Declines: What is Driving Them? Findings of a Multidisciplinary Analysis, Brighton: IDS

¹⁷Aguayo, V. M., Nair, R., Badgaiyan, N., & Krishna, V. (2016). Determinants of stunting and poor linear growth in children under 2 years of age in India: An in-depth analysis of Maharashtra’s comprehensive nutrition survey. *Maternal & Child Nutrition*, 12, 121-140. doi:10.1111/mcn.12259

Interventions to address undernutrition in Maharashtra and India

The causes and consequences of undernutrition are multi-faceted and intergenerational. The UNICEF conceptual framework for undernutrition highlights the immediate, underlying and basic causes of undernutrition (see Figure 1.2).¹⁸ To break the cycle of intergenerational undernutrition, global experts recommend that governments adopt a multi-faceted approach that includes 1) developing a multi-sectoral nutrition plan that includes nutrition-sensitive components and 2) scaling up a core package of high impact nutrition-specific interventions.^{19,20}

Figure 1.2: UNICEF conceptual framework for undernutrition²¹



¹⁸ Based on UNICEF. (n.d.) Multi-sectoral Approaches to Nutrition: Nutrition-Specific And Nutrition-Sensitive Interventions To Accelerate Progress. Retrieved from http://www.unicef.org/eapro/Brief_Nutrition_Overview.pdf and UNICEF conceptual framework (see Figure 1.2)

¹⁹ Ruel, M. T., & Alderman, H. (2013). Nutrition-sensitive interventions and programmes: How can they help to accelerate progress in improving maternal and child nutrition? *The Lancet*, 382(9891), 536-551. doi:10.1016/s0140-6736(13)60843-0

²⁰ Bhutta, Z. A., Das, J. K., Rizvi, A., Gaffey, M. F., Walker, N., Horton, S., Black, R. E. (2013). Evidence-based interventions for improvement of maternal and child nutrition: What can be done and at what cost? *The Lancet*, 382(9890), 452-477. doi:10.1016/s0140-6736(13)60996-4

²¹ UNICEF. (2008). UNICEF Conceptual Framework. Retrieved from <http://www.unicef.org/nutrition/training/2.5/4.html>

A recent analysis by Aguayo and Menon shows that the major causes of stunting in South Asia include poor diet of pregnant women (which increase the likelihood of their infants being born with low birthweight and subsequently undernourished), inadequate food and nutrient intake of young children and poor sanitation practices.²² Improving nutrition, therefore, requires a multitude of interventions, including dietary diversification that ensures greater consumption of nutrient-rich foods by women, the timely introduction of nutrient-dense complementary feeding, the provision of nutrient fortified foods, greater access to micronutrient supplementation and better access to improved sanitation.

Recognising that undernutrition is a massive public health and development problem across India, the Government of India has implemented several major programmes and policy initiatives to reduce the alarming rate of undernutrition in the country.²³ Annex A includes a list of public departments and agencies in India concerned with nutrition-specific and nutrition-sensitive interventions.

The Integrated Child Development Services (ICDS) and National Health Mission (NHM) are two centrally sponsored programmes that the central government funds and the states implement (adhering to the 14th Finance Commission involves a change in the cost sharing pattern of centrally sponsored schemes). Both programmes have a broad scope and nutrition is only one of several areas of focus.

ICDS, launched in 1975, is the government's largest maternal and child health and nutrition programme and, arguably, the largest in the world.²⁴ Run by the Ministry of Women and Child Development (WCD), the programme has six essential interventions, including immunisation, supplementary nutrition, health check-ups, referral services, pre-school education and nutrition and health education.

The National Health Mission (NHM), launched in 2005 as the National Rural Health Mission, is another centrally sponsored scheme housed in the Ministry of Health and Family Welfare. NHM delivers high impact nutrition-specific interventions through the health sector.

Although these programmes have been around for some time, only 75 per cent of children below the age of six were covered by an Anganwadi Centre (AWC) in 2005 in Maharashtra.²⁵ Currently, just 56 per cent of the children in Maharashtra receive supplementary food from an AWC through ICDS and mothers of only 40 per cent of these children received any counselling after their child was weighed.^{26,27} While coverage of basic health care services has mostly risen in the state (See Annex B, Figure B.1: coverage rates

²² Aguayo, Victor and Purnima Menon. (2016). "Stop stunting: improving child feeding, women's nutrition and household sanitation in South Asia." *Maternal & Child Nutrition*, 12 (Suppl. 1). Pp. 3-11.

²³ Kapil, Umesh, S. Chaturvedi, and D. Nayar. National Nutrition Supplementation Programmes (1992). Retrieved June 28, 2016 from: <http://www.indianpediatrics.net/dec1992/1601.pdf>

²⁴ Ministry of Women and Child Development, Government of India . (n.d.). INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) SCHEME. Retrieved April 27, 2016, from Ministry of Women and Child Development, Government of India : <http://icds-wcd.nic.in/icds/icds.aspx>

²⁵ NFHS-3 - International Institute for Population Sciences (IIPS) and Macro International. (2007). National Family Health Survey (NFHS-3), 2005 06 India:Volume II. Mumbai: IIPS

²⁶ Rapid Survey on Children (2013-2014). (2016, April). Ministry of Women and Child Development, Government of India.

²⁷ NFHS-3 - International Institute for Population Sciences (IIPS) and Macro International. (2007). National Family Health Survey (NFHS-3), 2005 06 India:Volume II. Mumbai: IIPS

of key nutrition interventions), vitamin A supplementation among children is still at just 71 per cent of the population, only 41 per cent pregnant women consume iron and folic acid supplements, just 57 per cent children are exclusively breastfed and a mere 52 per cent households have improved sanitation.²⁸

State Nutrition Missions – entering “Mission mode” to improve multi-sectoral nutrition

Because of India’s limited success in remedying the high rates of undernutrition across the country, several states have set up State Nutrition Missions (SNM) to reduce undernutrition among women and children. An SNM is a multi-sectoral coordinating body within the government with the objective of improving nutrition programming across sectors, especially within ICDS and NHM.²⁹ The model is similar to multi-sectoral governance bodies for nutrition that have been used in other countries to help develop a supportive environment for nutrition governance and stewardship.^{30,31}

SNMs go beyond departmental activities and the nutrition-specific areas of NHM and ICDS. They elevate the profile and importance of nutrition at the state level and help to endorse nutrition-specific and nutrition-sensitive policies and strategies to reduce undernutrition using an integrated and multi-sectoral approach. They provide the formal structure needed to prioritise the issue within each sector.

Maharashtra established Rajmata Jijau Mother-Child Health and Nutrition Mission (RJMCHN Mission) in 2005, the first ever SNM in India. It has run through two phases till date and is now entering the third. The main objective of the Mission, beginning in phase 2, was:

To reduce the proportion of malnourished pregnant women and children up to 2 years of age covered under ICDS. The Mission will converge with all departments through its steering committee for providing programme direction.³²

²⁸ Rapid Survey on Children (2013-2014). (2016, April). Ministry of Women and Child Development, Government of India.

²⁹ Maharashtra, R. J.-C. (n.d.). FAQs on Setting up a Nutrition Mission in a State - Why and How. Retrieved 4 26, 2016, from Maharashtra Health and Nutrition Mission: http://www.mahnm.in/Pdf/Why_Nutrition_Mission.pdf

³⁰ Levinson, J. and Balarajan, Y. (2013). "Addressing Malnutrition Multisectorally: What have we learned from recent international experience?"

³¹ Acosta, A.M. and Fanzo, J. (2012). "Fighting Maternal and Child Malnutrition: Analysing the political and institutional determinants of delivering a national multisectoral response in six countries." IDS Synthesis paper

³² Government of Maharashtra; Women and Child Development Dept.; Govt. Resolution No. ICD-2010/C.No. 145/-5

After Maharashtra, Uttar Pradesh, Gujarat, Jharkhand, Karnataka, and Madhya Pradesh have all established nutrition missions; Andhra Pradesh announced in June 2016 its plans to set up an SNM. The establishment of SNMs across India represents one of the largest and most significant efforts to improve the governance and coordination of nutrition services across sectors in India.

Purpose of this report

While studies before this have examined the burden of undernutrition in Maharashtra and the decline in stunting – at the level of the state and the level of a single child – these did not assess what was happening at the ground-level of service delivery or the role the RJMCHN Mission played in improving service delivery, which may have contributed to the decline.

This report documents the history and trajectory of RJMCHN Mission in Maharashtra – the evolution, the current governance structure including coordination between sectors, core activities including its influence on programmatic activity at state and district levels and successes and challenges. This report does not formally evaluate or assess the SNM. Rather, the qualitative information presented here is descriptive and identifies a set of key issues that policy-makers may wish to consider further. It is hoped this information will be useful to the government as it strengthens the SNM and identifies components that work and/or processes that may be useful in initiating SNMs in other states in India.

The chapters that follow describe the methods used to document RJMCHN Mission, provide a historical review from Phase 1 up to now, describe enabling factors that have helped to shape the SNM and some of its key activities and present a budget analysis for nutrition.

Chapter 2

Methods

Documentation of the State Nutrition Mission

The documentation involved secondary research and primary qualitative data collection through key informant interviews. The first step was a desk review of available literature related to core policy and research documents on child undernutrition; the review was carried out set the context and develop a framework for interviews. A five-person research team then visited Maharashtra to conduct key informant interviews and focus group discussions to gather information on the evolution and current conduct of the Mission.³³ The research team interviewed stakeholders, including



³³ Interviews took place over a two-week period in May 2016.

personnel from UNICEF, RJMCHN Mission staff, state and district government officials, development partners, frontline workers – including Anganwadi Workers, Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs) – and beneficiaries (see Annex C for a list of key informants). Three districts were selected purposefully based on consultation with UNICEF and RJMCHN Mission leadership to ensure that the information captured came from a broad and diverse array of sources. The research team conducted field work during a two-week period.

The research team communicated regularly with UNICEF and the RJMCHN Mission staff while it collected data to present preliminary findings. The research team generated emergent themes to represent the Mission through an iterative process while consulting with key stakeholders to ensure the accuracy of reporting. The team’s process was important because many of the Mission’s key events and efforts, carried out earlier, had not been documented.

The research team’s documentation efforts sought to answer the following core questions:

1. Who or what factors influenced the development of RJMCHN Mission?
2. What changes in nutrition programming resulted from the RJMCHN Mission’s activities?

The research team selected districts in Maharashtra purposefully to capture information on the Mission’s core developments and processes, as indicated in Annex C.

Qualitative analysis

The research team analysed the Mission’s core themes, including critical enabling factors and resources that have led to the success of the Mission, and the key activities that have contributed to the Mission achieving its objectives. These core aspects of the Mission help improve service delivery across departments, which ultimately have an impact on nutrition. An analytical framework was developed to summarise these core themes, as they emerged from key informant interviews, depicted in Figure 2.1.





The five critical enablers and Mission resources required for the SNM to carry out its work comprise (i) political support; (ii) programme leadership; (iii) oversight mechanisms; (iv) policy and programme advocacy and (v) technical support.

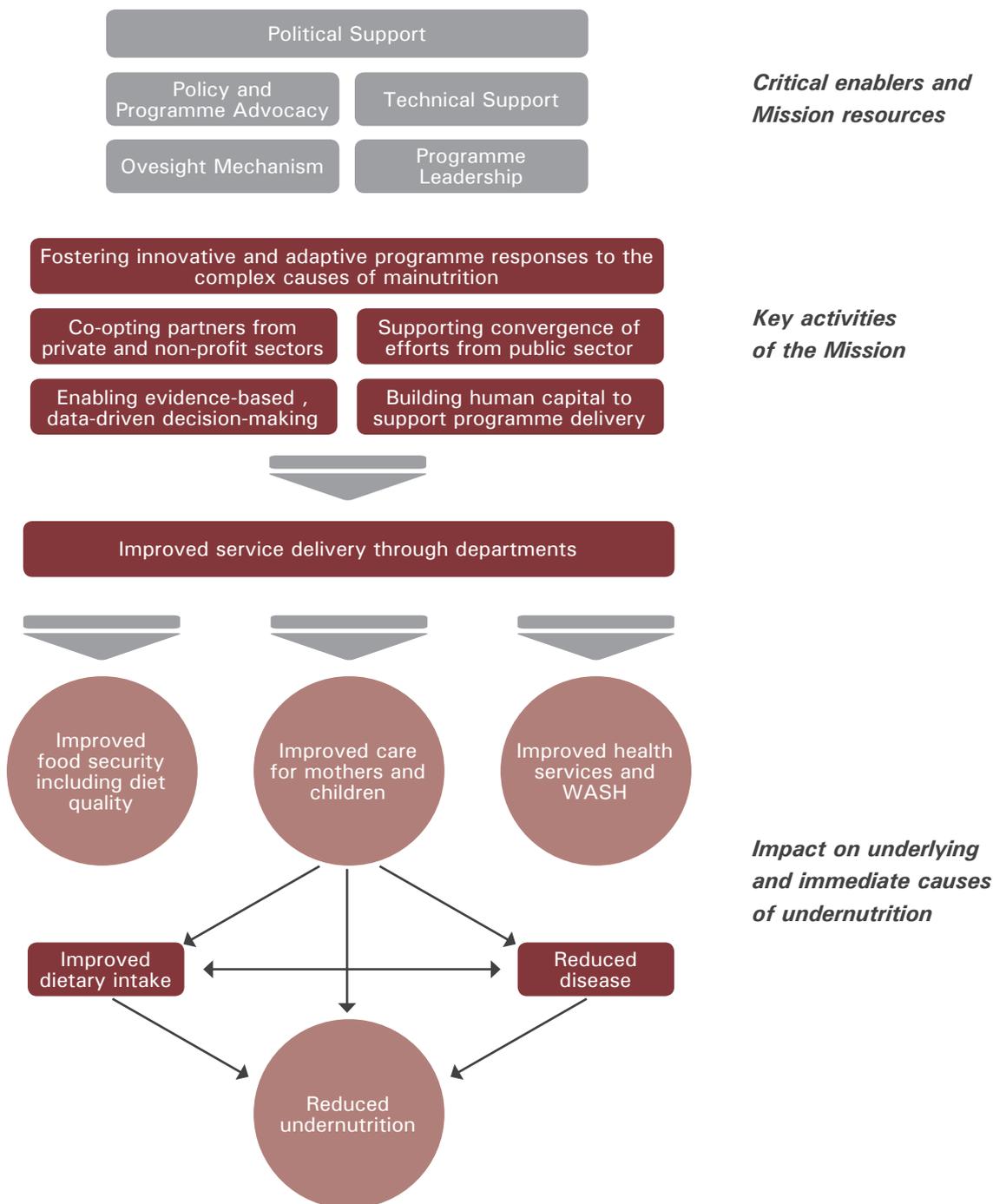
The team also aimed to capture key activities undertaken by the Mission, including (i) innovative thinking; (ii) co-option of partners; (iii) convergence of efforts between public sectors; (iv) evidence-based, data-driven decision making and (v) building human capital to support programme delivery.

Chapter 4 describes each of these areas based on information from key informant interviews. The impact of government-delivered nutrition services on nutrition outcomes was not evaluated.

Budget analysis

A descriptive budget analysis for nutrition was conducted with RJMHCN Mission and UNICEF. Chapter 6 gives a description of the data and the approach to budget analysis for nutrition across sectors.

Figure 2.1: Analytical framework of State Nutrition Mission’s influence on the delivery of nutrition services across departments³⁴



³⁴ WASH: water, sanitation and hygiene; Underlying and immediate causes of undernutrition adapted from UNICEF conceptual framework: UNICEF. (2008). UNICEF Conceptual Framework. Retrieved from <http://www.unicef.org/nutrition/training/2.5/4.html>

Chapter

3

History of RJMCHN Mission

RJMCHN Mission has gone through phases since its inception in 2005. Phase 1 lasted from 2005 to 2010 and Phase 2 from 2010 to 2015. This summary of the history of Phase 1 and of events that led to the inception of RJMCHN Mission by the Marathwada Initiative is based on V. Ramani's paper, "The Maharashtra State Nutrition Mission: Learning By Doing," and provides the context for the sections that follow. This section is meant to touch on core activities within each phase; Chapter 5 presents more details on some activities, particularly key factors Influencing RJMCHN Mission. Figure 3.1 presents a timeline of events related to Mission activities.



3.1. Genesis of RJMCHN: the Marathwada Initiative (2001-2004)

In the late 1990s and early 2000s, Maharashtra's children suffered from poor health and nutrition. Civil society and social activists reported on and drew media attention to numerous child deaths due to undernutrition in the villages of Aurangabad district. At the same time, children in Aurangabad had limited access to basic health and nutrition services through ICDS: only 67 per cent children under six registered in Anganwadi Centres, and only 52 per cent of those who registered were weighed.³⁵ Civil society held the government accountable for the dual problem of poor childhood nutrition and limited access to health services, and the government began to respond.

In 2002, the Malnutrition Eradication Campaign was launched in Aurangabad to increase the registration of children at Anganwadi Centres and the number of children weighed, in order to identify cases of undernutrition that required special attention. The government, by way of the campaign, identified two major problems immediately: (1) a shortage of functional weighing scales and (2) limited resources to build the capacity of ICDS staff at the supervisory and Anganwadi Worker (AWW) levels. To address these problems, UNICEF provided scales and initiated intensive training to motivate, monitor, and supervise staff. After the staff overcame the initial deficiencies, the Anganwadi workers weighed almost twice the number of children under six between 2001 and 2004, and the number of Grade III and IV undernourished children³⁶ declined nine-fold, from a high of 10,705 in July 2002 to 1,251 children in December 2004.

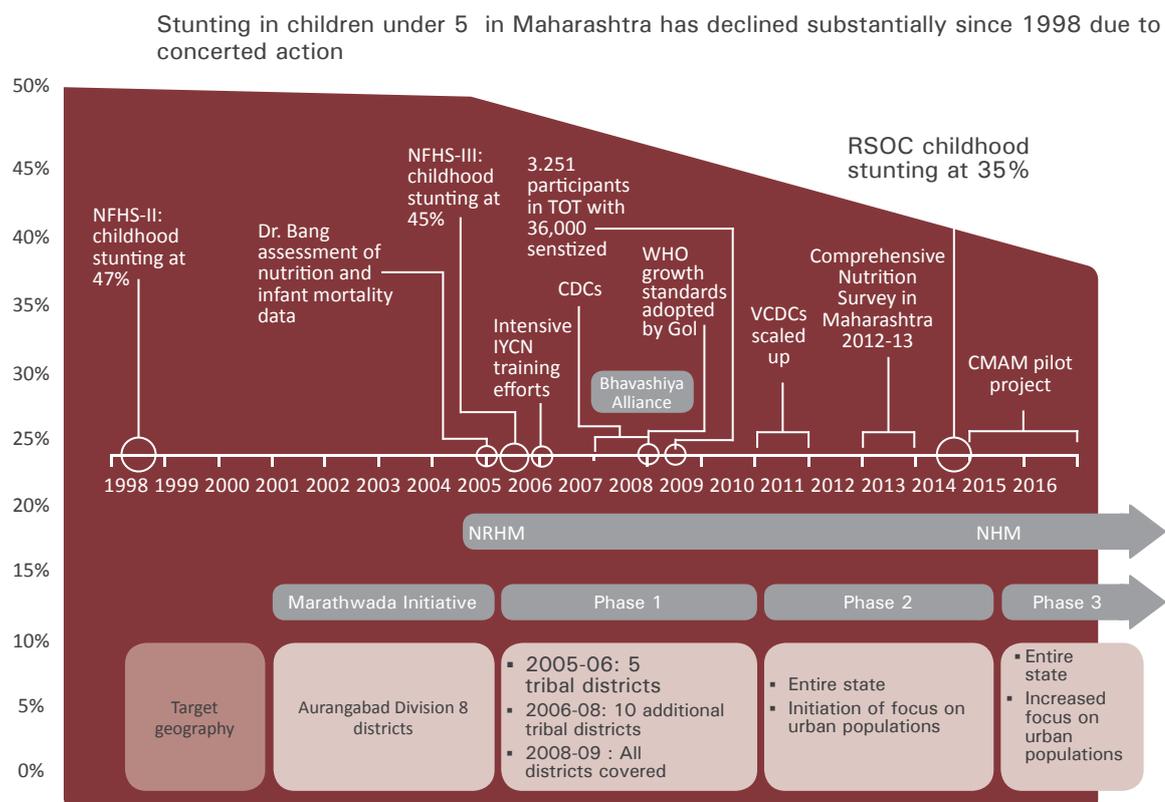
By 2004, with the media increasingly focusing attention on undernutrition and child deaths in tribal areas like Nandurbar district, the government was held accountable for inequitable access to public services. However, it unclear which government department was responsible for attending to undernutrition: the health department considered undernutrition to be the domain of ICDS while the WCD department viewed child mortality and its causes as a health sector problem. This challenge of ownership illustrated the need for advocacy and political support to encourage the two sectors to converge and collaborate.



³⁵ Based on 2001 Decennial Census and reported in "The Maharashtra State Nutrition Mission: Learning By Doing" by V. Ramani

³⁶ At that time, was Grade III & IV based on previous IAP classifications, which have now been revised.

Figure 3.1: Evolution and core activities of RJMCHN Mission during Phase 1 and Phase 2



In 2004 and 2005, Dr Abhay Bang of the Society for Education, Action and Research in Community Health (SEARCH) issued an assessment of infant mortality in Maharashtra based on long years of research in Gadchiroli district, which is predominantly tribal. This research identified a gross discrepancy between (a) ICDS-reported data on child undernutrition and mortality rates and (b) SEARCH survey data. In Melghat, the SEARCH study, which was verified by the government, found an infant mortality rate (IMR) of 96 per 1,000 live births and a Severe Acute Malnutrition (SAM) prevalence of 9.6 per cent whereas ICDS data recorded IMR at 31 and SAM at 1.2 percent.³⁷ The government and UNICEF verified this discrepancy; the government could not ignore this more reliable SEARCH survey data as it generated more attention to combating undernutrition in the state, especially in the tribal districts.

This attention, coupled with evidence that the Malnutrition Eradication Campaign was improving the nutrition status, led to the establishment of RJMCHN Mission in 2005. The Cabinet approved the Mission in February 2005 and it was constituted by a WCD Government Resolution.

The experience of the Marathwada Initiative highlights two important factors that fed into RJMCHN Mission: the use of data to improve and monitor service delivery and the use of data – that is paired with strong social activism messages – to influence policy.

³⁷ Reported by Dr. Ashish Satav from MAHAN Trust

3.2. RJMCHN Mission Phase 1

RJMCHN Mission was established as the first state government coordinating body for nutrition with the aim to raise nutrition higher on the political agenda across sectors. In 2005, Mr V. Ramani was appointed Director General (DG) of the Mission. The Mission established its headquarters in Aurangabad to remain close to the high burden tribal districts in need of attention and to continue building on the work of the Marathwada Initiative. RJMCHN Mission's strategy for expansion was as follows:

- **Phase 1.1 (2005-06):** Covered five tribal districts: Thane, Nashik, Nandurbar, Amravati, and Gadchiroli
- **Phase 1.2 (2006-08):** Covered an additional 10 tribal districts
- **Phase 1.3 (2008-10):** Included rural areas in the state and began to focus on urban areas

In Phase 1.1, the Mission aimed to achieve universal coverage of ICDS and the complete registration of children under six years, pregnant women and lactating mothers through Anganwadi Centres. A major focus area from the start of the Mission was on convergence between health and ICDS functionaries at the ground level. At the time, RJMCHN Mission officials were concerned that the majority of severely underweight children were not being medically examined. There was a gap in the referral system to health facilities and Anganwadi Workers had not been taught to identify children who needed medical attention.

RJMCHN Mission provided training to ICDS and health functionaries in the five districts, including Assistant Child Development Officers (ACDPOs), Medical Officers (MOs), and Anganwadi Supervisors and focused on behaviour change communication for optimal Infant and Young Child Feeding (IYCF) practices. The Mission partnered with Breastfeeding Promotion Network of India (BPNI), Maharashtra chapter, to ensure that breastfeeding and complementary feeding education were prominent components of the training. The training emphasised complementary feeding because NFHS-3 figures showed that less than half the infants, aged between six and eight months, received solid or semi-solid complementary foods.³⁸ The training programme also included strategies for healthcare workers to communicate behavioural change messages and took on a "training of trainers" model.

RJMCHN Mission staff also conducted fact-finding visits to AWCs and Primary Health Centres (PHCs) to identify the causes behind gaps in service delivery. The staff identified two immediate, critical concerns: too many vacancies in key field personnel positions and low levels of motivation and skills among field functionaries.

Anganwadi Workers (AWWs) were overtasked, undertrained, and, at the same time, blamed for high undernutrition rates in their areas. RJMCHN Mission thus focused its training efforts on developing enthusiasm, commitment and leadership among frontline workers. RJMCHN Mission also initiated a "star competition" to provide incentives to and recognition of AWWs, and, in turn, improve their performance. The Mission's intensive IYCF training and motivation efforts in partnership with BPNI continued through 2009 and later mainstreamed through the NHM, as described by key informants and former Mission staff.

³⁸ International Institute for Population Sciences (IIPS). (2006). National Family Health Survey (NFHS-3) Maharashtra fact sheet. Retrieved from RCIPS: <http://rchiips.org/nfhs/pdf/Maharashtra.pdf>

3.3. RJMCHN Mission Phase 2

Despite progress, undernutrition remained a major problem at the end of Phase 1. The Chief Minister endorsed Phase 2 of RJMCHN Mission on September 10, 2010 for another five-year period, and requested that UNICEF again partner with the Mission and provide technical and financial support. Unfortunately, there was a gap of nearly nine months prior to this endorsement during which the Mission was in limbo.

In Phase 2, the Mission continued to advance core lessons from Phase 1 and pursue new initiatives. With international attention now focused on “the first 1,000 days” – the time period from conception to a child’s second birthday – RJMCHN Mission also adopted this targeted focus. This, however, created a dilemma, which has not been fully resolved, on how to reconcile this focus with that of ICDS, which is still disproportionately focused on pre-school age children between three and six years of age.

RJMCHN Mission was also involved in the Comprehensive Nutrition Survey in Maharashtra during this time period, a statewide effort carried out through the International Institute of Population Sciences (IIPS). This survey involved collection and documentation of data on nutrition indicators and risk factors. The government’s involvement in this effort showed its commitment towards data-driven decision making and problem solving.

During Phase 2, Maharashtra joined the Scaling Up Nutrition Movement (SUN), which till date includes 57 countries. Until 2016, when Uttar Pradesh and Jharkhand joined, Maharashtra was the only state in India that was part of SUN. The SUN country/state alliance provides access to technical support, key networks and acts as a repository for global policy recommendations.

In 2014, RJMCHN Mission, jointly with the Department of Women and Child Development and the Public Health Department initiated a landmark pilot project for Community Management of Severe Acute Malnutrition (CMAM) in Nandurbar district, for which UNICEF provided technical support and the Tata Trusts provided financial support. This pilot programme is the first CMAM programme implemented in Maharashtra and among the first in India to be operated as a government programme.

Recognising a training gap that was impeding the nutritional programmes in the health sector, RJMCHN Mission increased efforts throughout Phase 2 to include nutrition in medical curricula through the Public Health department, as described by Mission staff.

3.4. RJMCHN Mission Phase 3

RJMCHN Mission is currently in a transitional period, similar to that which existed between Phases 1 and 2. The proposal for Phase 3 – which was developed by government staff, the current and former Directors General and UNICEF – is awaiting clearance from the Government of Maharashtra at the time of writing.

The proposal for Phase 3 outlines a new approach for the Mission including the following suggestions:

- » Set targets for reducing child malnutrition using low birthweight and stunting among children under two as indicators.
- » Focus on the first 1,000 days of life, but expand the Mission's focus to include adolescent girls and women of reproductive age.
- » Expand the Mission's focus to include nutrition-sensitive approaches by collaborating with departments/agencies carrying out activities in their respective areas of child nutrition, child protection, women's empowerment, health, drinking water, sanitation and hygiene, education, skill development and livelihoods.
- » Focus on geographical areas with the highest burden of child malnutrition and use ICDS monthly reports to monitor progress in those areas.
- » Structure the Mission as a society under the Societies Registration Act and the Public Trust Act, which will open up access to funding from an array of sources.
- » Restructure the oversight mechanism to have the Chief Secretary of Maharashtra chair the Governing Council of the Mission. The Governing Council would include Secretaries from all relevant departments, a representative of UNICEF, and three non-official experts from health, nutrition and development sectors. The Steering Committee would be chaired by the Chief Minister (to meet annually) and the Executive Committee to be chaired by the Secretary of WCD (to meet once every two months).
- » New roles for the Mission are outlined, including increased focus on monitoring and accountability, financial reporting and on leveraging funding for nutrition from various departments.

Chapter

4

Key Factors Influencing RJMCHN Mission

This chapter describes key themes that emerged from interviews and field visits across the three sample districts that were part of the documentation exercise. The findings are categorised into two broad thematic areas: enabling factors that influenced RJMCHN Mission and its role and implementing factors that illustrate key activities of the Mission, as defined in Chapter 2.



4.1. Assessment of Critical Enablers and Mission Resources

Programme Leadership

RJMCHN Mission benefits from strong leadership at the Director General (DG) level, which helps to motivate the staff and raise the Mission higher, politically.

Key informants described Mr Ramani, DG during Phase 1 of the Mission, as a strong leader and champion for nutrition; he was enthusiastic about effecting change during the Marathwada Initiative, at the inception of the Mission, and even now. His enthusiasm for his work was reportedly contagious among the Mission staff.

The current DG of Phase 2, Ms Vandana Krishna, has also shown strong leadership skills while heading RJMCHN Mission. They have each shown commitment to the Mission through collaborations with local officials, UNICEF staff and civil society partners, and even through engagement with frontline workers.

Key informants explained that the role of DG, and importantly the individual who assumes the position of DG, bears a lot of influence on the activities and actions taken by the Mission. If that person is committed and knowledgeable about improving nutrition, the “sky’s the limit”, but if not, the Mission will not sustain or gain the political momentum it needs to be a strong governing body. The leadership of the DG influences the Mission staff as well as, by offshoot, their interactions with officials and functionaries across sectors; so it is important that the Mission continues to build leadership capacity within this role.

Political Support

Strong political support has played a critical role in RJMCHN Mission’s successes till date. Nutrition champions across ICDS and NHM helped bolster political support of the Mission in each sector, encouraging multi-sectoral convergence at a high level of governance.

When Mr V. Ramani helped launch RJMCHN Mission in Aurangabad he and his team received considerable support from then Chief Minister, Mr Vilasrao Deshmukh, as well as from members of his cabinet and other senior bureaucrats. Support from UNICEF,



particularly from Mr Cecilio Adorna, then India representative, and Dr Werner Schultink, then Chief of Nutrition, was instrumental in the Mission's successful launch.

The Mission has benefited from key relationships built between Mission staff and high-level governmental counterparts across sectors. Principal Secretaries of the departments concerned, including Women and Child Development, Public Health and Tribal Development, facilitated the Mission's efforts in its early years. Ms Vandana Krishna, who assumed leadership of the Mission in Phase 2, continued to work closely with these departments, her role facilitated by her former role as Secretary of the WCD, when she worked closely with the Mission.

However, more than a decade after inception the RJMCHN Mission faces several challenges in sustaining the political support needed for success.

Key informants suggest that the Mission faced, and may continue to face, the following challenges in gaining and strengthening political support:

1. The Mission has had difficulty defining ownership and accountability for nutrition outcomes across sectors, especially within ICDS and NHM. Multiple officials referred to an absence of continuous dialogue and cooperation among the primary sectors involved in nutrition, which resulted in mixed feelings about which sector is responsible for the high nutrition burden. (We discuss ownership and accountability further below.)
2. Key stakeholders perceived that the Mission has become redundant, that the key sectors are capable of achieving desired nutrition-related results with or without mutual cooperation, and that beyond its initial role in training and eliciting local cooperation (acknowledged by virtually all to have been important), the Mission no longer serves an essential, definable purpose. While there was enthusiasm that the Mission continue, key informants requested that the Mission and ICDS clarify and deepen their distinctive roles in coming years as it enters Phase 3. The transformation proposed by the Mission, described in Chapter 3, will help mitigate these challenges.
3. Stakeholders noted that the following issues are problematic: (a) turnover among government officials and lack of continuity in key Mission staff, (b) the lengthy gaps between Phases (contributing to the issue of continuity among Mission staff), and (c) questions about the DG's level of authority vis-à-vis sectoral counterparts. These questions loom particularly large at present with the transfer of the Phase 2 DG and the resulting leadership vacuum.

To sustain political support in the future, the Mission will have to transform and adapt in Phase 3, and the proposed changes for Phase 3 are a starting point.

Phases 1 and 2 helped to establish RJMCHN Mission as a governance and coordinating structure across sectors. Some of the factors that enabled it to grow and expand into what it is today – as described in this chapter – were effective. However, some key informants indicated that the current phase of the Mission requires that the Mission transform its strategy and priority areas. This call for transformation seems to be built upon the healthy need for continual adaptation of the Mission in order to support sectors that are constantly changing as they develop. Recommendations for the Mission from stakeholders included, for

example: act as a repository of information and knowledge from which other sectors can draw (being a member of the SUN Movement provides access to global recommendations and evidence), make enhanced connections with civil society to strengthen advocacy efforts, participate in drafting proposals for departments to increase or enhance nutrition services, possibly helping to develop a financial needs assessment for those proposals, and strengthen available technology not only to collect process and outcome data for nutrition, but also to analyse the data (perhaps through a third party initiative).

As RJMCHN Mission plans to enter Phase 3, as described in Chapter 3, a primary objective of the Mission continues to be to bolster continued support among political champions across departments in order to push the nutrition agenda further. Informants who were aware of the proposed transformation in Phase 3 agreed with the plan and informants who were not aware of the details of the plan had recommendations to make that aligned with what was being proposed.

Oversight Mechanisms

An oversight structure of was established to ensure continuous and timely review of core Mission activities and to execute key decisions when needed. However, it is unclear how frequently the oversight committees meet and whether this enabling factor may need to be strengthened further.

The official oversight mechanism for the RJMCHN Mission consists of three committees: the Steering Committee, chaired by the Chief Minister, the Monitoring Committee, chaired by the Minister of WCD and the Advisory Committee, chaired by the Additional Chief Secretary of Public Health.³⁹

There was indication from key informant interviews that the routine oversight meetings are not being conducted regularly. This makes oversight less effective and reduces the momentum for coordinated action. This is especially true when the difficult task at hand is convening two sectors – ICDS and NHM – which have different perspectives on which department is responsible for nutrition outcomes and deaths due to undernutrition, which requires oversight at the highest level.

Policy and Programme Advocacy

Civil society and social activism played a significant role in increasing awareness about nutrition in the state, both at senior levels of government and – through media attention – among the general population. This attention to nutrition helped fuel RJMCHN Mission.

As described above, one of the most critical factors in the inception of RJMCHN Mission was civil society organisations' advocacy for governmental intervention to reverse the high rate of child deaths due to undernutrition.

³⁹ Government of Maharashtra; Women and Child Development Dept.; Govt. Resolution No. ICD-2010/C.No. 145/5

Beginning in the 1990s, social activist groups, including Khoj and MAHAN, disseminated information about the high number of child deaths that resulted from undernutrition in Melghat and similar “high burden” areas of the state. Their advocacy efforts, along with those of other members of civil society, resulted in government action, which led to the creation of the Mission, as well as increased demand on the ground for public services among marginalised populations. These groups are still highly active today and continue to advocate for improved public services among the most vulnerable tribal groups. One of the strongest tools that armed these advocacy efforts is data – data showing the high burden, as well as, at times, showing what can be done to reverse the damage.

Technical Support

UNICEF has provided valuable technical and financial support to RJMCHN Mission throughout its lifecycle.

Nutrition has always been a core focus of UNICEF in Maharashtra. UNICEF has been a key partner of the government throughout the journey of RJMCHN Mission, from the Marathwada Initiative to the beginning of RJMCHN Mission in 2005.

UNICEF is the only UN agency working on nutrition in the state. Since RJMCHN Mission’s inception, UNICEF has served as an implementing partner and has worked alongside governmental staff to strategise and build relationships amongst partners. Committed UNICEF staff travelled back and forth to Aurangabad during the Mission’s initial phase. UNICEF also has ensured that the Mission’s agenda was completely driven by the government and the government has grown to rely on critical UNICEF resources, including its financial and technical support, and importantly, global and national programmatic experience. UNICEF fosters relationships down to the village level and has been a valuable partner in the Mission’s efforts to improve the nutrition status. Partnering with UNICEF has been integral to the success of the Mission throughout its multi-phase lifespan.

4.2. Key Activities of the Mission

Innovative and adaptive thinking

One of the core factors that has helped RJMCHN Mission succeed in its role as a coordinating body across sectors is its ability to foster innovative and adaptive programmes in response to complex challenges of implementation.

Two examples include developing Village Child Development Centres (VCDCs) and leveraging corporate social responsibility (CSR) funding for nutrition as new, non-traditional sources of funding.

Development of village child development centres (VCDCs)

The concept of Child Development Centres (CDCs) began in 2007 after fact finding visits made by RJMCHN Mission staff to nutritional rehabilitation centres (NRCs) found that while treatment of acute malnutrition was effective at NRCs, there was no emphasis on

the prevention of undernutrition. Thus NRCs did not get to the root of the problem (which was often suboptimal IYCF behaviours). Upon discussion and consultation with UNICEF, the Mission established CDCs as facility-based treatment centres at Primary Health Centres for children who had severe acute malnutrition. This initiative sought to improve coordination and monitoring between ICDS and health teams. RJMCHN Mission developed protocols to run the CDCs and trained ICDS and health staff to include a core educational component on IYCF behaviour change in the treatment of malnourished children.

The CDCs were a success. About 60 per cent children showed enhanced nutrition status after 21-day stays at the CDC.⁴⁰ On top of that, the children's nutritional status improved in the six months after they were discharged: 76 per cent of children with severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) cases improved six months after discharge.⁴¹ The focus of the CDC on behaviour change and caregiving at home helped reverse previous relapse rates that were detrimental to improving nutrition. The Mission monitored follow-up data in partnership with an IT company.

In 2008, Government of India adopted the WHO growth standards, which replaced the Indian Academy of Paediatrics' (IAP) metric to define acute malnutrition. Based on the new technical definitions of malnutrition, RJMCHN Mission, along with ICDS and NHM partners, recognised that the number of children who qualified for CDC admission would dramatically rise based on the new definitions alone. As such, the Mission and its partners estimated that monthly costs for CDCs would increase about tenfold if they continued to be implemented at Primary Health Centres and logistics and capacity would restrict a large number of children from actually being admitted. This presented a huge implementation problem.

The RJMCHN Mission responded by implementing an adaptive community-based model known as the village child development centre (VCDC). The VCDC was the first point of service to tackle undernutrition. The VCDC was located at the AWC where the mother received education from the AWW. This was a comfortable move, since it was found during implementation of the CDCs that 80-85 per cent of the cases did not have medical complications.⁴²

The Government issued a resolution, jointly signed by WCD and Public Health departments on January 1, 2010 that provided detailed instructions on how to run CDCs and VCDCs. The resolution affirmed that both sectors were responsible for addressing undernutrition. The Public Health Department's NHM budget provided funding for VCDCs (although funding was ultimately cut at the central level; see Chapter 6).⁴³

While the VCDC approach is generally thought of as a success, there have been few quantitative evaluations on the interventions. One study in Gadchiroli found that 76 per cent of the children with severe or moderate acute malnutrition, admitted to a VCDC, improved.⁴⁴

⁴⁰ Ramani, V. (2011). The Maharashtra State Nutrition Mission: Learning By Doing.

⁴¹ Ramani, V. (2011). The Maharashtra State Nutrition Mission: Learning By Doing.

⁴² See VCDC Models document from Rajmata Jijau-Mother Child Health and Nutrition Mission at http://www.mahnm.in/Pdf/VCDC_Models.pdf

⁴³ While VCDCs represents a strong example of convergence between sectors they were implemented through WCG and funded through NHM funding for VCDCs was ultimately cut because it remained outside the mandate of NHM. Currently, funding for VCDCs is sought from the Tribal Development Department (TDD) and elsewhere.

⁴⁴ Samal, J., & Meshram, F. A. (2014). A Study on "Village Child Development Centre (VCDC)" and its Role in Redressing Malnutrition Problem in Gadchiroli District, Maharashtra, India. *Indian Journal of Public Health Research & Development Ind. Jour. of Publ. Health Rese. & Develop.*, 5(2), 162. doi:10.5958/j.0976-5506.5.2.096

Leveraging CSR funding

Budget restrictions and financial deficiencies commonly limit the implementation or scale-up of core nutrition interventions. RJMCHN Mission has shown leadership among the nutrition community and other SUN member states by conducting budgetary analyses to assess investments in nutrition, multi-sectorally (described in Chapter 6). One key realisation that emerged through this work was the need for additional sources of funding for nutrition.⁴⁵

RJMCHN Mission is working with UNICEF and other partners to unlock new sources of financing for nutrition through the 2014 Government of India corporate social responsibility (CSR) mandate that requires companies to spend two per cent of their profits on social development. RJMCHN Mission identified this as a key opportunity to leverage new funding for nutrition and tap into money for required expenditures that the government is less likely to finance. UNICEF has helped by acting as a partner convener; the RJMCHN Mission has leveraged this new Government of India bill to establish multiple partnerships. This could be a significant source of funding for nutrition moving forward and will be important to monitor.

Building human capital to support programme delivery

The RJMCHN Mission has emphasised building the capacity of frontline workers (FLWs), particularly ICDS staff, through trainings that were not only technical, but also helped to encourage ownership, leadership, and motivation among FLWs.

From the beginning of Phase 1, RJMCHN Mission worked to build the capacity of frontline workers and recognised this investment as critical to improve service delivery. The Mission and its partners designed, organised and conducted several training modules focused on nutrition. Mission-led trainings focused on increasing knowledge and also the skill and motivational levels of the trainees, particularly frontline workers and their supervisors. RJMCHN Mission designed and delivered training modules in collaboration with UNICEF consultants and BPNI.

The trainings improved AWWs' technical capabilities. Based on interviews, both AWW supervisors and AWWs reported that their capacity for technical tasks, including weighing children; entering and reporting of data increased as a result of IYCF trainings. The trainings also aimed to motivate frontline workers and build a sense of dedication to their important work – one strategy for this was by giving recognition to their hard work. RJMCHN held a “star competition” among ICDS and health department functionaries to promote healthy rivalry, offer rewards, and motivate frontline workers to do their best. The star competition was on a five-point scale and stars were awarded based on performance (with a rating of 5 being outstanding).⁴⁶

⁴⁵ Menon, Purnima; McDonald, Christine M.; and Chakrabarti, Suman. 2016. Estimating the cost of delivering direct nutrition interventions at scale: National and subnational level insights from India. *Maternal & Child Nutrition* 12 (Suppl. 1), pp. 169-185. <http://dx.doi.org/10.1111/mcn.12257>

⁴⁶ Ramani, V. (2011). *The Maharashtra State Nutrition Mission: Learning By Doing*.

In some areas, stakeholders indicated that coordination for nutrition improved with the trainings and better understanding of the undernutrition issue. One stakeholder claimed that “RJMCHN Mission has ignited the minds of people.” These stakeholders also indicated that through joint trainings, the Mission improved coordination among AWWs, ASHAs, ANMs and the local government at the community level.

RJMCHN Mission-led trainings encouraged frontline workers to use innovative strategies to improve communication about behavioural change.

The trainings encouraged AWWs to think “outside of the box” with new innovative ideas to encourage behavioural change and raised their levels of self-esteem and motivation. RJMCHN Mission’s strategy was to increase capacity of FLWs and encourage them to initiate solutions to local-level challenges in service delivery and uptake. The Mission came up with a number of innovative approaches to promote nutrition at the village level. The following examples highlight some of the Mission’s suggestions for frontline workers to implement at the grassroots level:

- » Have a *Bal kopro*, or food corner, in the home for toddlers, which encourages mothers to keep nutritious finger food in places that are physically accessible to the child to increase the frequency with which children eat, resulting in improved food intake of good quality and diverse food items.
- » In some areas, deeply held social beliefs were causing some parents to delay starting their children on complementary foods until long after the recommended age of six months. The Mission responded by asking AWWs to modify the traditional practice of Annaprashan to a celebration of the half-yearly birthday when the child turns six months old. Annaprashan is a ceremony that marks an infant’s first intake of solid food, which in some villages might traditionally take place at eight or nine months. The half-yearly Annaprashan also provides an opportunity to counsel the mother on the importance of timely introduction of nutrient-rich complementary feeding and of continuing to breastfeed.
- » The Mission acknowledged the difficult time frontline workers were having at successfully communicating behaviour change messages, especially among tribal populations, and recommended communicating messages in a way the mother will understand. An AWW described an analogy she uses to help explain a community growth chart to mothers in a way that she knows they will understand: with adequate nourishment and water, plants will be green (therefore, normal weight children are found in the green section of the chart), but with less water they become dry (i.e., children on the growth chart move to the yellow), and if further neglected they become deprived (i.e., they move into the red).

Mission-led trainings not only increased self-respect among FLWs, but also resulted in the villagers taking them more seriously, and treating them with more respect. The documentation team was impressed with the extent to which FLWs now think of ways to reach mothers so these they can understand and, increasingly, make home visits to counsel the in-laws and husbands of pregnant women.

The Mission carried out most of this training during Phase 1. It conducted fewer trainings in the last five years.

Stemming from the support given by RJMCHN Mission to frontline workers, the first ever “gold standard” ISO-standard AWC was born in Aurangabad, driven by the efforts of one frontline worker.

Many key informants narrated an impressive success story of an ICDS supervisor, who is credited with the first-ever ISO-standard AWC in Aurangabad. It meets high quality cleanliness and core functioning standards to qualify for ISO certification. The motivation to raise the bar and turn AWCs into high quality centres was, in part, a result of the nurturing, training and support RJMCHN Mission gave to the supervisor and other FLWs. See Box 1 for the supervisor’s story, which describes how she developed these ISO-standard AWCs.

RJMCHN Mission influenced FLW activities by encouraging community engagement and solidarity, especially with regard to raising funds from the community to improve the AWC.

Local governments in Maharashtra have increased their participation in and contribution to efforts to improve maternal and child health and nutrition. However, these efforts have been limited by inadequate budgets. In response, AWWs and their helpers in many villages have sought contributions from families to fund some of the AWCs’ work, including their nutrition-related activities, improving cleanliness and overall appearance and contributing to ISO certification. This has been one more manifestation of the increased empowerment of these workers that resulted, at least in part, from the Mission’s training and encouragement. Some AWCs have boards that list the names of village contributors and the amounts contributed as a way of showing gratitude.

Co-opting partners from private and non-profit sectors

As the Mission evolved, so did partnerships joining forces to advocate for better nutrition. The Bhavishya Alliance – a coalition of partners from the government, civil society and the private sector – worked to increase communication and collaboration among stakeholders.

Stakeholders reported that the Mission played an important role in forming the Bhavishya Alliance, which provided the platform to develop a more cohesive response to child undernutrition with help from various partners. RJMCHN Mission's leadership helped convene this group, and, in its early years, helped to maintain the momentum among the partners. The Alliance met once a month in Mumbai. The meeting gave stakeholders an opportunity to discuss their work, learn about other initiatives, identify common interests and join forces in advocacy efforts. Additionally, the Alliance initiated pilot projects designed to reduce the prevalence of undernutrition.

The Alliance was a successful collaborative model of nutrition-related interest groups: the Mission and UNICEF provided technical support, corporate members provided the technology and finances, civil society organisations provided advocacy and government partners worked on the delivery of services. The Bhavishya Alliance subsequently dissolved after Phase 1. During their interviews informants deemed the network useful to drive policy, identify interested partners and bring diverse actors together with a common goal. Informants recommended revitalisation and transformation of this group to re-establish a network among civil society groups, government and other partners. The Mission continues to build and strengthen public and private partnerships, such as with the CMAM pilot project described next.

Manisha is an ICDS supervisor who has 20 years of experience. She currently supervises 40 AWCs in Aurangabad district, where the Rajmata Jijau Mother-Child Health and Nutrition Mission first started. She became one of the nutrition pioneers in the district by working to improve the condition of the AWCs under her supervision and to make her villages “malnutrition free.” She also has been instrumental in getting her Anganwadi Centres to meet ISO standards by becoming “cleaner, more beautiful, and better functioning.” All 40 of the AWCs that she supervises are now considered “ideal” and 29 are ISO-standard adherent.

Early in her career, Manisha recognised the level of effort, time and resources needed to enhance the cleanliness, appearance and overall functioning of AWCs in her charge. She divided the many AWCs she supervised into Grades A, B and C based on their condition and cleanliness. This helped target her efforts.

Manisha focused on upgrading grade B and C AWCs by routinely cleaning the centres, putting up educational posters and charts, putting up curtains and having AWWs arrange for uniforms for the children. These changes attracted children and made parents more willing to send them to the AWC. As the first batch of lower grade AWCs graduated to grade A, Manisha asked AWWs of centres that still remained in grades B and C to visit the newly improved centres so that they could see first-hand the transformation that was possible with modest resources. This peer learning process encouraged AWWs to make the positive changes they saw were working so well elsewhere.

After Manisha saw the improved cleanliness and overall functioning of the AWCs, she made efforts to gain ISO-certification. This certification enabled the community to be proud of its AWC, and it also attracted more families to it.

Manisha’s focus on maternal and child nutrition, encouraged by the Mission, enabled her to attract yet more attention to her agenda and to experiment with creative interventions. She uses, for example, the concept of the tri-coloured flag of India to inform girls and pregnant women that all the colours of the flag should be represented on the plate for a fully nutritious diet – encouraging dietary diversity.

News of Manisha’s ISO-standard compliant AWCs spread through the media and other platforms to other Anganwadi supervisors interested in improving their own AWCs. RJMCHN Mission and UNICEF have recognised Manisha for her accomplishments. She is viewed as a role model and has been invited to participate in trainings for frontline workers across the state, and more recently, even outside of the state.

The RJMCHN Mission serves as a coordinating body between partners, as was exemplified by a recent community-based management of acute malnutrition (CMAM) programme piloted through the ICDS machinery.

The CMAM pilot project in Nandurbar is underway to assess the feasibility and effectiveness of such a programme to treat children with acute malnutrition. This pilot programme is novel in India, as it operates out of the ICDS machinery (i.e., at the AWC) – this is much more of an integrated approach compared to the NGO-run model of other CMAM programmes that may have a shorter lifespan. Nandurbar was the district selected for this pilot project because it has a high burden of acute malnutrition with 15 per cent of under five population suffering severe acute malnutrition and also because it has a large tribal population.

This CMAM pilot project is a public-private partnership with RJMCHN Mission, UNICEF and Tata Trusts as partners. The Mission's role in this partnership has been to provide training programmes for health and ICDS staff. UNICEF provides technical support helps with monitoring along with the Mission. Tata Trusts provide financial support; The Tatas were also instrumental in negotiating the licence fees to use Ready-to-Use Therapeutic Foods (RUTF) from Nutriset. All three partners were necessary to get the pilot programme off the ground.

Previously in the state, medical curricula did not include maternal and child nutrition – RJMCHN Mission worked with the Department of Public Health (DoPH) and champions among medical officers to adapt the curriculum in order to begin training health professionals on nutrition.

The Mission worked closely with a highly qualified medical doctor, who also served as advisor to DoPH, to incorporate nutrition into the medical curricula in the state. RJMCHN Mission, DoPH and UNICEF worked together to develop a medical curriculum to train medical school personnel, including deans, professors and other medical personnel (both pre-service and post-service), on nutrition. Stakeholders noted the initial resistance to such training – DoPH argued that preventive nutrition was not part of its agenda – and attributed the success of this collaboration to the Mission.

Supporting convergence of efforts within the public sector

High-level interdepartmental coordination

RJMCHN Mission has advanced its objective of high-level convergence between ICDS and NHM, albeit with some challenges and slow movement at times (as described above).

One of the mandates of the first two phases of the RJMCHN Mission was to facilitate convergence between NHM and ICDS. Despite challenges, several stakeholders indicated that the Mission achieved some success in facilitating this collaboration, and that convergence has improved somewhat over the last decade. During Phase 1 the DG worked closely with the Principal Secretary of WCD (who became the DG of the RJMCHN Mission

in Phase 2) and also played an active role in seeking to incorporate nutrition into the health sector's agenda.⁴⁷ The VCDC initiative was an example of such convergence. It was implemented through ICDS machinery but funded through NHM; however, the initiative has now been defunded.^{48,49}

We would have not been able to make significant headway without the support of the ICDS commissioner. NHM also played an important role by funding the VCDC and RJMCHN Mission provided the technical support. The Tribal Department is playing an important role in mothers' health.

State Government Officer

The Mission's mandate did not include multi-sectoral convergence beyond ICDS and NHM in its first two phases, though collaboration with the Tribal Development Department has been increasing significantly. The Mission paid relatively little attention to convergence with other departments; however, in instances in which the Mission has reached out to other departments, it achieved the following noteworthy results:

- The State Transport Department established breastfeeding rooms (Hirkani Kaksh) at 250 bus stops across Maharashtra at the request of RJMCHN Mission.
- WCD, with the Mission's encouragement, collaborated with the Department of Animal Husbandry for backyard poultry and with the Department of Horticulture for kitchen gardens.
- The Mission is in pursuit of collaborations with the Tribal Development Department (TDD).
- The Mission collaborated with the Office of the Governor of Maharashtra in its tribal focus.

Accountability and ownership for nutrition in ICDS and NHM was sometimes unclear among key informants at the state level, suggesting that continued efforts are needed as RJMCHN Mission evolves in Phase 3.

At the state level, government has not taken ownership of and accountability for nutrition outcomes. The Mission has continually been confronted with the question of which department should be accountable for nutrition. The question of "whose baby is nutrition?" was often raised among key informants – ICDS is focused on prevention of undernutrition while NHM's focus is on the medical, curative aspect of nutrition; but it is unclear if either department will take ownership. This issue of accountability and ownership has been a core focus of the Mission since it was established. While some progress has been made in this regard, refereeing between ICDS and NHM continues to be a strong reason for the continuation of the Mission.

⁴⁷ The first budget of health for nutrition came in for IYCF feeding in 2008.

⁴⁸ In some areas, the district collectors have been using District Planning funds to support the VCDC. The Tribal Department might be supporting the VCDC in the tribal districts.

⁴⁹ One stakeholder expressed considerable concern that the ICDS commissioner and the DG of the Mission are both at the same government level, making collaboration more difficult.

That RJMCHN Mission is housed in the WCD may impede NHM's genuine sense of ownership of nutrition, despite its responsibility for an array of preventive services, including the distribution of iron and folic acid tablets, Vitamin A supplementation and immunisation. As indicated above, NHM initially funded the VCDCs but then budget cuts coming from the central level cut funding for them – the research team was told that this was because the VCDCs, which operated out of AWCs, were outside of the mandate of NHM. This is while VCDCs were helping treat children with acute malnutrition, reducing the number of children admitted to NRCs (and thereby reducing costs).

Health did not want to take the ownership of VCDC; they said 'why should we fund it?' Health says that nutrition has nothing to do with health.

District Government Stakeholder

District and local interdepartmental coordination

RJMCHN Mission's activities at the local level have encouraged village and district officials to advance the nutrition agenda.

RJMCHN Mission's outreach and advocacy efforts have sensitised local government bodies to the importance of mother and child nutrition, and, in turn, encouraged them to take on the challenge of making their villages undernutrition free. In districts such as Nandurbar, community growth chart demonstrations have been displayed at the Gram Sabha to sensitise the entire village to the problem of undernutrition and, in turn, provide means of addressing it. During these demonstrations, children of three nutritional status categories are placed on the community growth chart under the different colour category bands of red, yellow, and green, to highlight undernutrition in the community and teach mothers how to identify malnourished children, how to intervene and how to prevent undernutrition.

Key informants explained the RJMCHN Mission's efforts to engage with the local government through open dialogue and regular meetings. In some communities these efforts paid off with the gram panchayat and sewaks actively supporting community initiatives for nutrition from their budgets. For example, in one area, the local government's budget provided funding to the community AWC to enhance its cleanliness and functionality.

In some districts, such as Aurangabad, local panchayat leaders, i.e., the Sarpanch, became champions and helped to raise community awareness of maternal and child nutrition. In Jogeshwari village, the Sarpanch has actively supported maternal and child health and nutrition programmes and dedicated resources to them to improve their functionality.

Key informants indicated that further collaboration with these leaders, including emphasising the importance of maternal and child nutrition and ways to prevent undernutrition, might be valuable in Phase 3 of RJMCHN Mission, and may yield further benefit for these communities.

The RJMCHN Mission has supported convergence and coordination between ICDS and NHM at the frontline. The high level of interaction between Health and ICDS functionaries makes this important for service delivery.

At the district level, stakeholders from Health and ICDS reported reasonably good coordination with the RJMCHN Mission on the ground and appreciation for the Mission's technical support. One stakeholder referred to the linkages as a "family-like relationship." Through efforts like VCDCs and joint trainings between Health and ICDS, the Mission has encouraged camaraderie among frontline workers.

The mission has given us technical support which we needed, and will need in the future as well. We call UNICEF consultants in case of any problems, and receive endless support from them. We are well coordinated with the Mission; we have a family-like relationship.

District Government Stakeholder

Some key informants mentioned that now that the Mission undergoing a gap between Phases 2 and 3, its field presence is noticeably absent.

Enabling evidence-based, data-driven decision-making

The village-level fact-finding visits of RJMCHN Mission gave the Mission staff the information needed to identify challenges in service delivery and possible solutions.

RJMCHN Mission initiated efforts to monitor the performance of ICDS and to strengthen the existing monitoring system by building the capacity of ICDS to report and manage data. In Phase 1 the Mission conducted fact-finding visits using monthly ICDS reports to monitor districts. Mission officials clarified that these visits were not intended to find fault with the programme or with FLWs, but rather were meant to monitor progress and identify knowledge gaps and possible solutions. This was an important aspect of the visits in terms of maintaining strong relationships with personnel. The birth of CDCs and their eventual transformation to VCDCs is due in part to these fact-finding visits that tried to identify challenges and propose solutions.

The Mission helped conduct the independent Comprehensive Nutrition Survey in Maharashtra (CNSM), showing commitment to the importance of data collection and monitoring.

CNSM was the result of a partnership between ICDS, NHM, RJMCHN Mission, UNICEF and the International Institute for Population Sciences. Survey data showed the impressive reduction in the prevalence of stunting among children under age two over a six-year period, from 39 per cent in 2005-06 to 25 per cent by 2012-13.⁵⁰ This study was critical as it helped to generate evidence for interventions that could improve maternal and child nutrition in the state.

⁵⁰ International Institute for Population Sciences (IIPS). (2013). Comprehensive Nutrition Survey in Maharashtra. Retrieved from IIPS: http://iipsindia.org/cnsm_report.htm

The Mission laid some groundwork for better decision-making and policy based on data, with some success, but much more could be possible in the future with a stronger focus on data convergence between ICDS and Health.

The focus on data collection and data-driven decision-making has increased in Maharashtra. Several non-government stakeholders indicated that officials who work on nutrition talk increasingly in terms of data, which is a huge achievement. Similarly, social advocates more frequently use data to achieve their objectives, recognising that the government “cannot ignore the numbers.”

ICDS’s monthly reports, particularly on child weighing, which are disaggregated by block and district, have enormous potential to influence timely decision-making. However, the influence of such reports continues to be hampered because ICDS submits reports late or without data, or submits data that are inaccurate. Several stakeholders reported that ICDS’s data are not yet reliable because they contain considerable amounts of false reporting; one stakeholder estimated reliability at 60-65 per cent. There is a common impression that government officials, frightened of the potentially politically damaging effect of unfavourable numbers and trends on key indicators, intentionally misrepresent the findings. “Departments don’t like to publish data – it increases accountability and they feel that if the data are not good it shows that they are not doing well.” – State Government Stakeholder

The planned chain of ICDS data validation involves supervisors checking data from AWWs and Child Development Project Officers (CDPOs) verifying data from the supervisors. Several stakeholders indicated that this system is not working well and suggested that data could be manipulated as it goes up the chain.

The Mission has undertaken efforts to improve data collection and management. During Phase 1 of the Mission, graduate students were trained to carry out ICDS-validation surveys (using cluster sampling) in selected clusters. This process identified discrepancies in ICDS reported data and validation survey data up to tenfold, indicating the need for improved data collection and data transparency efforts to prevent reporting error or falsification.

To increase accuracy in data collection, the Mission, with UNICEF’s support, has provided length boards and mid-upper arm circumference (MUAC) tapes to Anganwadi Centres and has trained AWWs on how to use them. The Mission also trained frontline workers to report data accurately.

Frontline workers were always accused of reporting wrong data and not delivering well, but the idea that frontline workers cannot deliver was defeated by the Jijau Mission. It’s about how you build their capacity.

State Non-government Stakeholder.

Chapter 5

Budget Analysis

This Chapter provides a descriptive analysis on nutrition-specific and -sensitive budget allocations across departments (Section 5.1) and on nutrition-specific interventions specifically within NHM (Section 5.2).

This analysis represents a high-level look into funding available for nutrition and is an essential first step towards mapping resources dedicated to nutrition-relevant programmes. However, more work in this area is needed to effectively map nutrition-relevant resources across departments. Ultimately, intervention and programme-level resource mapping information could help assess how departmental budgets could be leveraged for nutrition (or made more nutrition-sensitive), and help build an investment case for nutrition across



sectors. Specifically, this information can be used to influence the departmental budget cycle through which funds are released (i.e., in the financial component of proposals to increase or enhance nutrition services through departments that are sent for approval to the Chief Minister). As Phase 3 of RJMCHN Mission evolves, part of the Mission's activities could include working with departments to develop these proposals for the implementation of innovative nutrition services.

5.1. Nutrition Budget Analysis Across All Departments

As part of Maharashtra's membership with the SUN Movement, RJMCHN Mission and UNICEF participate in various global events and conferences. The SUN Movement Secretariat provides technical guidance on budget analysis and financial tracking for nutrition to SUN members; accordingly, budget analysis and financial tracking have become a core focus for member countries and states. Maharashtra used the 3-Step Approach⁵¹ to conduct a budget analysis for nutrition in 2016. The findings are summarised here.

RJMCHN Mission considered the following departments to have nutrition-specific and -sensitive investments in this exercise: Women and Child Development, Public Health, Education, Tribal Development, Food and Civil Supplies, Water Supply and Sanitation, Irrigation Department and Rural Development. All departments have nutrition-sensitive investments while only three departments have nutrition-specific activities, which include Women and Child Development,⁵² Public Health and Tribal Development. Annex D provides a list of nutrition-relevant programmes and activities included in this analysis.



⁵¹ Fracassi, P., & Picanyol, C. (2016). Tracking government investments for nutrition at country level.

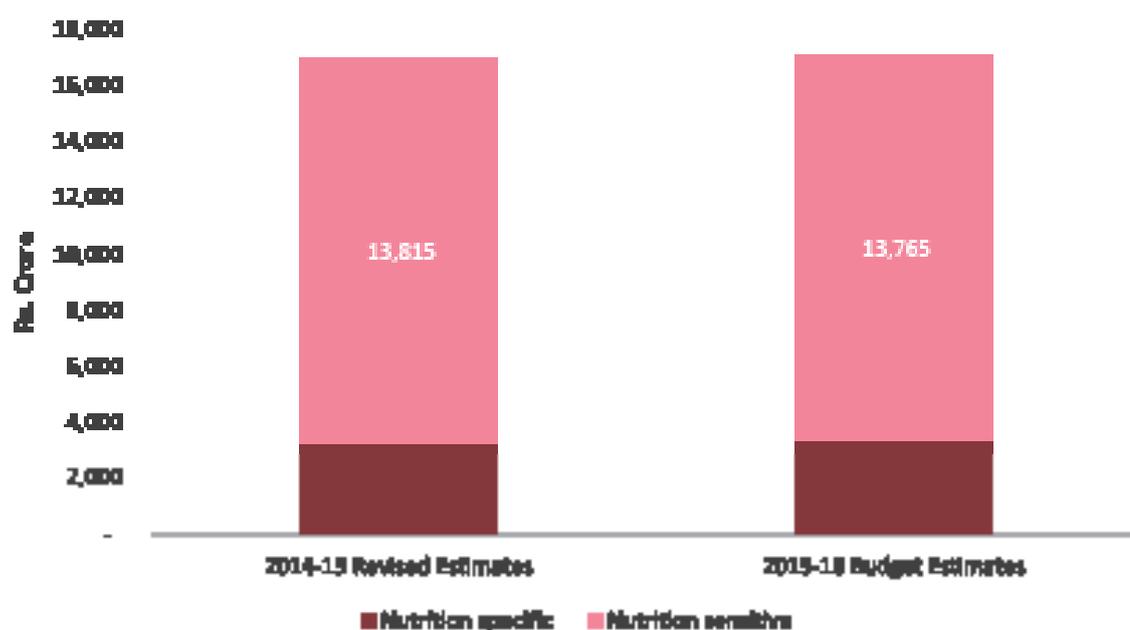
⁵² As part of this exercise, the total WCD budget was considered by the Mission as nutrition-related: 69 percent was counted as nutrition-specific and 31 percent counted as nutrition-sensitive.

This budget analysis has not applied percentage allocations – or “weights” as they are commonly referred to in the field of nutrition – to nutrition-sensitive programming.⁵³ Instead, the full programme activity costs are presented (See Annex D). This was done in order to assess the total contributions available for nutrition-sensitive programming. Future analysis is needed to understand the particular components currently aimed at improving nutrition within each nutrition-sensitive programme. This information is necessary in order to advocate for enhanced nutrition-sensitive programming across departments.

Figure 5.1 shows funding contributions for nutrition-specific and nutrition-sensitive interventions within departmental plans for the fiscal year 2014-15; the figure shows revised budget estimates for 2014-15 and proposed budget for the following year, 2015-16.⁵⁴ Although these data points cannot be directly compared to show a trend over time, comparing the current budget with the proposed budget could indicate where and when departments are aspiring to grow.

Across all of these departments, proposed budget allocations for nutrition-specific investments in 2015-16 was estimated to be about Rs 3,292 crore (US \$531 million)⁵⁵ and for nutrition-sensitive investments about Rs 13,765 crore (US \$2.2 billion).

Figure 5.1: Nutrition investments across all departments included in the analysis



⁵³ Fracassi, P., & Picanyol, C. (2016). Tracking government investments for nutrition at country level.

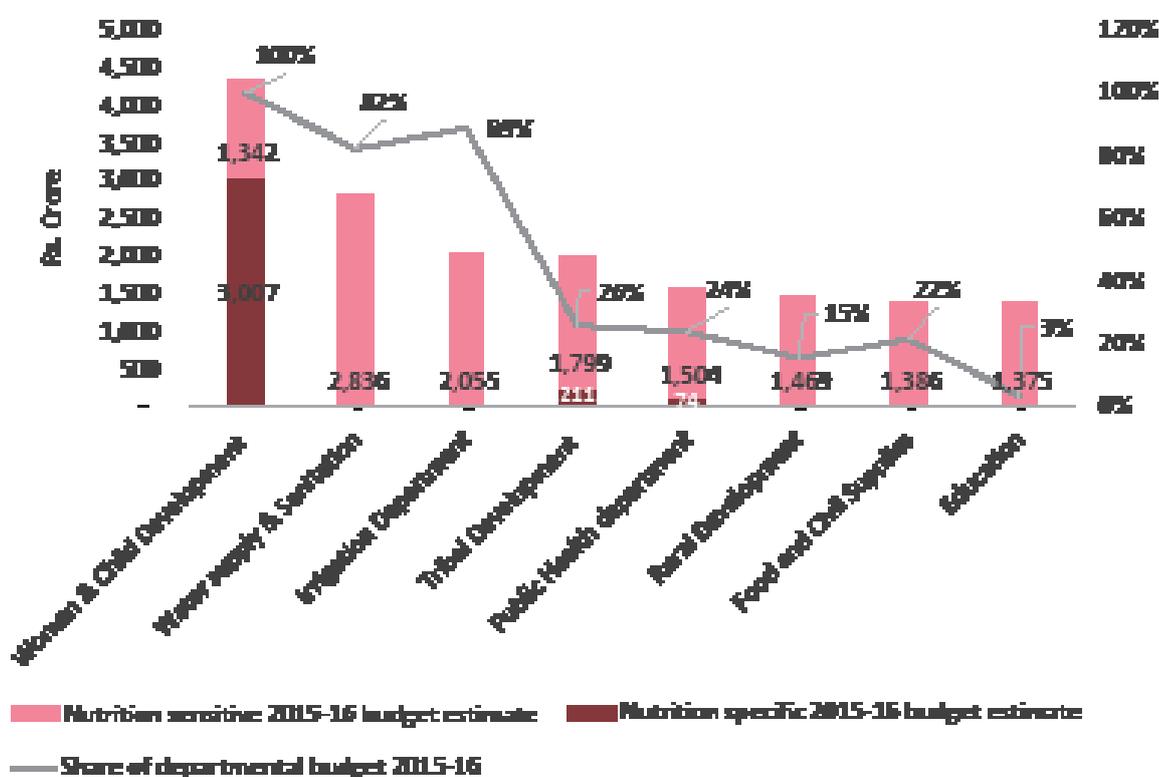
⁵⁴ Departmental plans report three financial data points actual expenditures showing what was disbursed and spent the year prior, revised budget estimates for the current year, and proposed budget estimates for the following year.

⁵⁵ The conversion rate used by the government was applied for this Chapter (1 USD = 62 INR).

Figure 5.2 shows total nutrition-relevant proposed budget allocations by department for 2015-16. WCD contributes the highest amount towards nutrition as all of its budget was deemed nutrition-relevant. The Supplementary Nutrition Programme (SNP) represents the majority of WCD’s contributions and was considered nutrition-specific. The Water Supply and Sanitation sector was considered as contributing the highest absolute amount to nutrition-sensitive programmes in 2015-16, representing about 82 per cent of the departmental budget. Note that there was a wide range in how much each department contributed to nutrition-sensitive activities as a share of their total departmental budgets, from 3 per cent in Education to 89 per cent in Irrigation Department.

Future analysis can explore the programmatic components within each department that are counted as nutrition-sensitive and assess where and how they can be made more nutrition-sensitive.

Figure 5.2: Total nutrition-relevant budget allocations in 2015-16 by department



⁵⁶While SNP is considered nutrition-specific in this analysis, the ICDS age range of 0-6 years does not match the recommended 0-2 year target age range for most nutrition-specific interventions to focus on the first 1,000 days.

5.2. Nutrition Investments in the Public Health Department

A budget analysis for nutrition within the NHM was conducted in order to determine whether the Mission's nutrition advocacy activities helped to leverage funding from NHM and increase the amount of resources going to nutrition. The hypothesis was that if the Mission's advocacy efforts were successful, there would have been increased funding allocations for nutrition interventions in NHM budgets in recent years.

Maharashtra NHM Programme Implementation Plan (PIP) budgets for 2014-15 and 2015-16 were analysed to identify budget lines relevant for nutrition at the intervention level.⁵⁷ NHM implemented the following nutrition-specific interventions each with its own budget line item: Janani-Shishu Suraksha Karyakram (JSSK), care of sick children and severe malnutrition through NRCs, Child Development Nutrition Centres (CDNCs) and community-based programmes (i.e., VDCDCs), Weekly Iron and Folic Acid Supplementation (WIFS), IYCF training and the National Iodine Deficiency Disorders Control Programme (NIDDCP).⁵⁸

Figure 5.3 shows approved budget allocations for these nutrition-specific interventions within the NHM service delivery platform for fiscal years 2013-14 and 2014-15 and proposed budget allocations for 2015-16. The total approved budget allocations for nutrition grew by 10 per cent between 2013-14 and 2014-15, from Rs 179 crore (US \$29 million) to Rs 196 crore (US \$32 million), respectively. The total proposed budget for 2015-16 is even higher, at Rs 250 crore (US \$40 million).⁵⁹ The data show that budget allocations for nutrition increased over the three-year period both in total and for each individual intervention.

In order to assess this change in funding with more granularity, budgets were explored to identify contributions made specifically to VDCDCs, which stand as a good example of increased funding contribution by NHM as a result of the Mission's efforts. As described in previous chapters, WCD implemented VDCDCs, but NHM funded them. Within NHM PIPs, VDCDCs were funded under budget line A.2.5 "Facility Based Newborn Care (SNCU, NBSU, NBCC) and Management of children with SAM (NRC, CDNC, Community Based Programme) – including Human Resources, Training, and New Construction)."

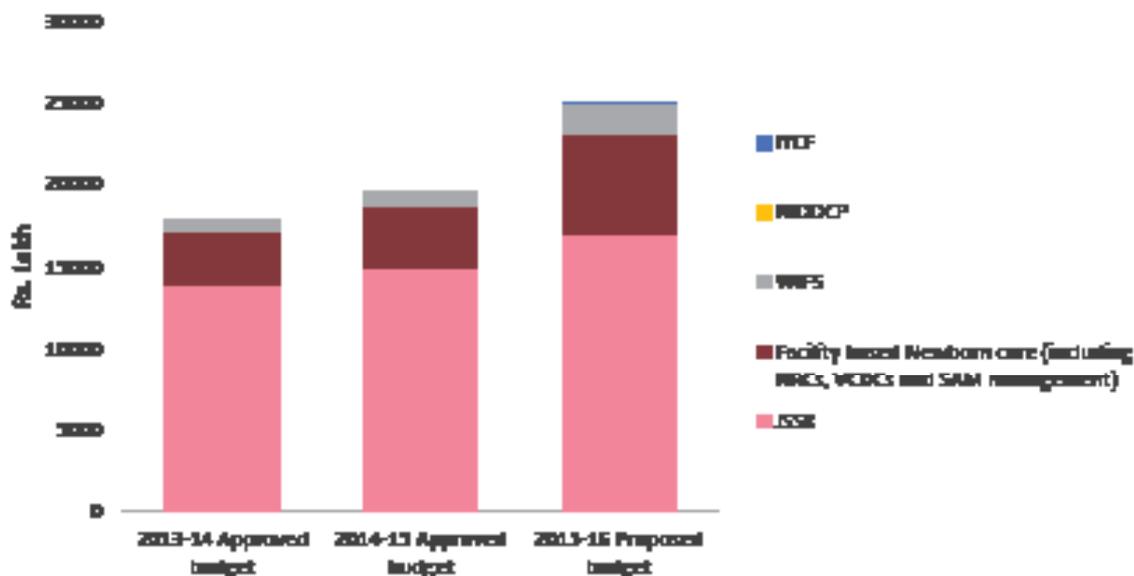
From this analysis, it appears as though NHM has been increasing funding for the treatment of acute malnutrition. Approved budget allocations for the treatment of acute malnutrition through budget line A.2.5 (mentioned above) increased by about 20 per cent between 2013-14 and 2014-15; and the proposed budget in 2015-16 is about 60 per cent higher than the approved budget in 2014-15. This increase could indicate prioritisation of the treatment of acute malnutrition.

⁵⁷ National Health Mission data were gathered from State Programme Implementation Plans (PIPs) downloaded from <http://nrhm.gov.in/nrhm-in-state.html>. Review of budget annexes "Part I: NRHM + RMNCH plus A* Flexipool" identified nutrition-specific investments.

⁵⁸ Monthly Village and Child Health Days was not included as its budget line was blank for all years included.

⁵⁹ Approved and proposed budget allocations cannot be directly compared. However, this does indicate some expansion within the department. The conversion rate used by the government was applied (1 US\$ = 62 INR).

Figure 5.3: Nutrition-specific spending within the Public Health Department by intervention



Despite the overall increase in nutrition budgeting for the treatment of acute malnutrition in the NHM budget, there is indication of reduced planning efforts specifically for VCDCs. Because this budget line is aggregated to include multiple initiatives, it was not possible to tell how much was specifically intended for VCDCs – but it is possible to assess the reach. The 2014-15 approved budget supported VCDC care for 80,000 SAM children for 30 days at Anganwadi Centres at a cost of Rs 1200 (US \$19) per child.⁶⁰ The 2015-16 plan budgeted for 65,990 SAM children, representing a 20 per cent reduction in reach. The indication of budget restrictions for VCDCs is consistent with what stakeholders said. Stakeholders explained that the cut in funding resulted from the ongoing question of accountability for nutrition; funding was not approved at the central level because the Public Health Department did not view nutrition in general, and perhaps community-based treatment of acute malnutrition in particular, as within its mandate. However, as indicated above, the overall budget for the treatment of acute malnutrition did appear to increase.

⁶⁰ As indicated in PIP Annex A.2.5

Chapter

6

Conclusions

The preceding chapters provided an overview of the history of RJMCHN Mission, documented enabling factors that have helped to shape the Mission, described some of the key activities of the Mission and presented a descriptive budget analysis for nutrition. Here, we summarise the main results.



The key enabling factors and resources that have contributed to the Mission's achievements till date include:

- » Strong programme leadership at the Director General level through both phases;
- » Political support across sectors, encouraged by personal relationships and dedication to pushing the nutrition agenda forward;
- » Linkages with civil society and advocacy efforts to raise awareness for nutrition through media and other population-based sources;
- » Strong technical support provided by UNICEF and other partners throughout its lifecycle.

The key activities of the Mission include:

- » Fostering innovative and adaptive solutions to implementation challenges, such as through the establishment of VDCs or leveraging funds from the corporations through corporate social responsibility (CSR);
- » Developing and delivering training programmes for frontline workers that improve technical skills as well as encourage leadership, ownership, and motivation among them – these trainings led to innovations in the way AWWs communicated with mothers, helped to create the first-ever ISO-standard AWC and encouraged AWWs to engage with the community to raise contributions from the village;
- » Co-opting partners from civil society, the private sector, and academia;
- » Using a dual convergence strategy by focusing both on convergence between officials (state high-level government officials as well as village and district officials) as well as convergence of frontline workers within ICDS and NHM; and
- » Focusing on evidence-based, data-driven decision making, exemplified by the Mission's fact-finding visits as well as the support of the Comprehensive Nutrition Survey in Maharashtra.



However, some challenges were noted. While RJMCHN Mission worked hard on its core objective to improve collaboration between ICDS and NHM and had some success, it proved difficult to maintain political support, ownership, and accountability for nutrition across these sectors. The fact that there are still questions about defining accountability for nutrition outcomes in ICDS and NHM – two sectors that have clear supportive roles within the conceptual framework of undernutrition – points to the ongoing need to bolster advocacy efforts to raise nutrition higher on the development agenda and for a stronger RJMCHN Mission in Phase 3. Linked to the question of sustainable political support, it appears that the Mission’s high-level Steering Committee, chaired by the Chief Minister, has not met in three years. Finally, while the Mission has given attention to converging data between ICDS and NHM, little progress has been made to operationalise data convergence. There appears to be a core focus on monitoring and evaluation moving forward.

As RJMCHN Mission enters a transformative Phase 3, it has the opportunity to build on past successes, learn from previous challenges and continue to raise nutrition higher on the development agenda in Maharashtra. While recommendations for strategy development of the Mission was beyond the scope of this documentation exercise, Annex E provides some considerations for future strategy development and refinement.

An important component of the Phase 3 proposal is the recommendation for the Mission to incorporate data-driven budgetary and financial analyses into its advocacy efforts across departments. This begins with a landscape assessment of what is currently being spent across departments on nutrition-specific and sensitive interventions (a descriptive analysis is presented in Chapter 6 which represents the preliminary step) and is followed by an assessment of what could be changed or improved in order to leverage funding across departments and increase the nutrition-sensitivity of programmes. Generating data to influence the budget management cycle across departments may be the critical step towards enhancing convergence in the state.

The establishment of RJMCHN Mission represents one of the significant efforts to improve the governance and coordination of nutrition services across sectors in India. While the historic decline in stunting has eased some of the malnutrition burden, the prevalence of stunting among children aged two is still high at 24 per cent⁶¹ – and the prevalence of stunting among children under five even higher at 34 per cent⁶² – making it clear that enhanced, targeted efforts to combating malnutrition are needed in the state.

⁶¹ International Institute for Population Sciences (IIPS) and UNICEF. (2012). Comprehensive Nutrition Survey in Maharashtra. Retrieved from Mother and Child Nutrition: <http://motherchildnutrition.org/india/pdf/IIPS-CNSM-Survey-Report.pdf>

⁶² International Institute for Population Sciences (IIPS). (2015). National Family Health Survey (NFHS-4) Maharashtra fact sheet. Retrieved from RCIIIPS: <http://rchiips.org/nfhs/pdf/NFHS4/Maharashtra.pdf>

To provide the environment necessary for RJMCHN Mission to be a success, policy-makers must ensure that critical enablers and resources are in place and sustained over time. For the Mission to succeed in improving the multi-sectoral response to undernutrition, it must continue to bring a spirit of innovation and adaptation to combat undernutrition, enlist a broad coalition of government and non-governmental actors to support the state's nutrition goals and ensure that both evidence and human capacity are strengthened to support improved decision-making and frontline service delivery.

The experience and lessons learned from RJMCHN Mission can also be used to inform other states interested in establishing a State Nutrition Mission. The policy brief in this documentation series describes overarching themes and policy recommendations that emerged from documenting the Maharashtra and Uttar Pradesh experiences.⁶³ These policy recommendations could apply more broadly to states looking to set up a State Nutrition Mission or to strengthen their existing Mission.

⁶³ R4D. (2016). POLICY BRIEF: Lessons from the State Nutrition Missions of Maharashtra and Uttar Pradesh

Annex A

Nutrition-relevant Public Programmes in India

Table A.1: Key Nutrition-Specific and Nutrition-Sensitive Schemes and Programmes and Associated Departments⁶⁴

Scheme/Programme	Abbreviation	Relevant Department
National Food Security Mission	NFSM	Agriculture and Farmers' Welfare
Public Distribution System	PDS	Food and Public Distribution
Mahatma Gandhi National Rural Employment Guarantee Act	MNREGA, MGNREGA or NREGA	Gram Panchayat
National Health Mission	NHM	Health and Family Welfare
Mid-Day Meals	MDM	Human Resource Development
Swachh Bharat Abhiyan	SBA	Ministry of Urban Development
Integrated Child Development Services	ICDS	Women and Child Development
Indira Gandhi Matritva Sahyog Yojana	IGMSY	Women and Child Development
Rajiv Gandhi Scheme for Empowerment of Adolescent Girls	RGSEAG –Sabla	Women and Child Development

⁶⁴ Mahbub, Rifaiyat et al. (2016). Tracking Nutrition Financing in Rajasthan. Retrieved from: http://www.r4d.org/sites/resultsfordevelopment.org/files/v3_R4D_NF%20in%20Rajasthan_ExecSummaryPg.pdf

Basic Health and Nutrition Indicators in Maharashtra

Table B.1 Health and nutrition programme coverage Indicators

	NFHS 3	RSOC	NFHS 4
Vitamin A (NFHS: 9-69 months)	23%	62%	71%
Consumed 100 or more IFA tablets/syrup during pregnancy (90 for NFHS 3)	19%	29%	41%
Institutional births	65%	90%	90%
Mothers who had at least four antenatal care visits for their last birth (three or more for NFHS 3)	60%	52%	72%
Children under six months exclusively breastfed	53%	73%	57%
Supplementary Nutrition Programme (SNP) for children	42%	56%	NA
SNP for lactating mothers	18%	42%	NA
SNP for pregnant women	26%	47%	NA
Salt iodisation	74%	77%	96%
Improved drinking water source	93%	95%	92%
Households using improved sanitation	32%	44%	52%

Table B.2 Nutrition Indicators

	NFHS 3	RSOC	NFHS 4
Stunting	46%	35%	34%
Wasting	17%	19%	26%
Low birthweight (0-35 months) (birthweight less than 2.5 kg)	22%	20%	NA
Anaemia among pregnant women	58%	NA	49%

NA = not available

Figure B.1: Trends in coverage rates of key nutrition-sensitive and nutrition-specific interventions in Maharashtra

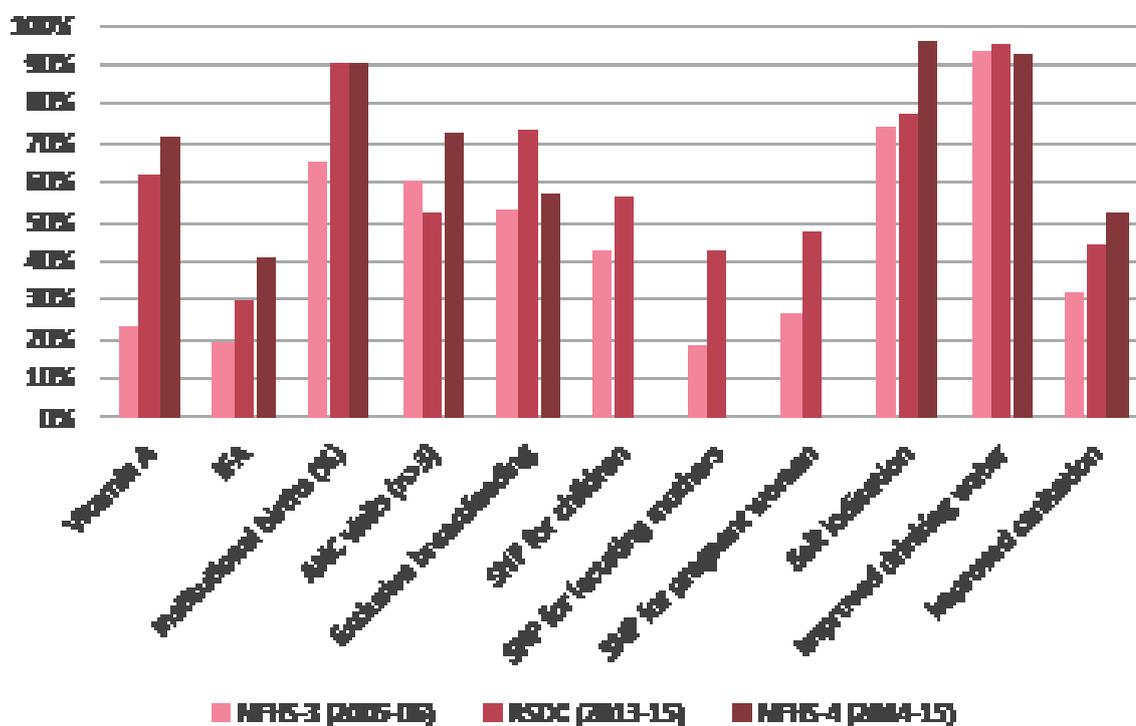
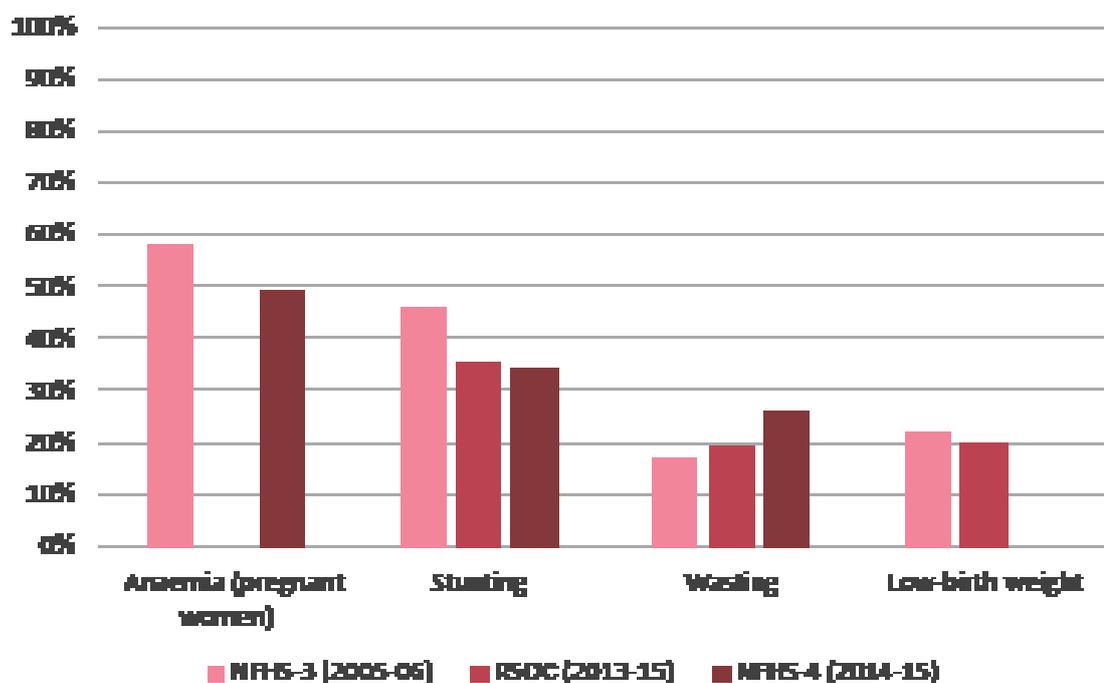


Figure B.2: Trends in nutrition indicators in Maharashtra



Key Informant Interviews

Table C.1: List of key informants interviewed in Maharashtra

Level	Organization	Interviewees	
		Name	Position
State	Public Health and Family Planning	Sujata Saunik	Principal Secretary
	Women and Child Development Department	Sanjay Kumar	Principal Secretary
	Director	Suprabha Agarwal	RJMCHN Mission
	Governor's office	Parimal Singh	Deputy Secretary to Governor of Maharashtra
	RJMCHN Mission	V. Ramani	Former Director General of RJMCHN Mission
	RJMCHN Mission	Vandana Krishna	Director General of RJMCHN Mission
	RJMCHN Mission	Suprabha Agarwal	Director of RJMCHN Mission
	UNICEF / RJMCHN Mission	Pandurang Sudame	IYCF Consultant
	UNICEF/TDD	Devika Deshmukh	UNICEF consultant
	UNICEF	Rajlakshmi Nair	Nutrition Specialist
	Tata Trusts	R. Venkataramanan	Executive Trustee
District and village	ICDS	Manisha S. Kadam	Anganwadi Supervisor
3 Districts: Aurangabad Nandurbar Amravati	Health	Dr Nagar	DHO
	ICDS	Mr Pardeshi	Deputy CEO
	Khoj	Purnima Upadhya	Founder and Director
	MAHAN Trust	Ashish Satav	Founder and Director
Interviewees from the districts and villages also included:			
<ul style="list-style-type: none"> ▪ District/Civil Hospital and NRC staff <ul style="list-style-type: none"> » AWC supervisors ▪ AWWs, ASHAs, and ANMs (AAAs) <ul style="list-style-type: none"> » Gram Sewaks ▪ Beneficiaries: pregnant women with young children, adolescent girls 			

Table C.2: Field visit locations and main reasons for capturing information pertaining to RJMCHN Mission

Location	Who was interviewed	Main reason to visit
State Level	<ul style="list-style-type: none"> ▪ UNICEF team ▪ Nutrition Mission Director ▪ Former DG Mr V. Ramani (Bengaluru) ▪ Vandana Krishna ▪ P. Secretary NHM ▪ Tata Trust ▪ Governor's office ▪ Neerja Chaudhury 	<ul style="list-style-type: none"> ▪ Understand activities undertaken in the mission ▪ Assess the governance structure of the Nutrition Mission at state level ▪ Identify key contextual factors in setting up the Mission
Kumbephal and Jogeshwari, Aurangabad district	<ul style="list-style-type: none"> ▪ Former Nutrition Mission staff (now UNICEF consultants) ▪ FLWs and supervisors ▪ Village Sarpanch 	<ul style="list-style-type: none"> ▪ Visit AWC (ISO) ▪ Document local level governance structure
Nandurbar district	<ul style="list-style-type: none"> ▪ District/Civil Hospital and NRC ▪ Deputy CEO, ICDS ▪ District Health Officer 	<ul style="list-style-type: none"> ▪ Visit NRC ▪ Document the collaboration / convergence among NHM, ICDS and RJMCHN Mission
Nandurbar district	<ul style="list-style-type: none"> ▪ Anganwadi Workers ▪ Anganwadi Supervisors 	<ul style="list-style-type: none"> ▪ Visit AWC (non-ISO)
Melghat, Amravati district	<ul style="list-style-type: none"> ▪ MAHAN ▪ Khoj 	<ul style="list-style-type: none"> ▪ Document Bhavishya Alliance and civil society's engagement with the Mission

Nutrition-relevant Programmes Included in the Budget Analysis

Department	Program/Activity	Classification
Women & Child Development	SNP, Sabla, KSY, IGMSY	Specific
Public Health department	Maternal & Child Health (including JSSK, WIFS, NIPI, VAS DW, ORS Zinc, Rehabilitation of malnourished children in 3 tier system - VCDC, CTC & NRC)	Specific
Tribal Development	Ashram schools diet, nutrition & APJ Abdul Kalam Amrut Aahar Yojna	Specific
Women & Child Development	Other activities for child development	Sensitive
Public Health department	NHM	Sensitive
Education	Mid-Day Meal/School Nutrition Programme	Sensitive
Tribal Development	Social security scheme (Tribal welfare), Rural employment, Animal, Crop husbandry, Fisheries	Sensitive
Food and Civil Supplies	Food grain purchase, ware house, storage and supply	Sensitive
Water supply & Sanitation	Water supply and sanitation, Irrigation	Sensitive
Irrigation Department	Soil conservation, Irrigation	Sensitive
Rural Development	Agricultural research, rural employment, irrigation, soil & water conservation, social security	Sensitive

Considerations for Future SNM Strategy Development: Multi-sectoral Nutrition Convergence in Targeted Vulnerable Blocks

In its Phase 3, the Nutrition Mission could pursue multi-sectoral nutrition convergence, a cutting edge international approach, which has resulted in remarkable reductions in stunting in Peru, Brazil, and part of Bangladesh (4.5 percentage point reductions per year).

This approach will require the Mission to identify particularly vulnerable blocks and provide inputs from key sectors in each village of these blocks. These inputs will include both those from the health sector that address malnutrition directly, the so-called “nutrition-specific” interventions, and those that address the underlying determinants of malnutrition, the “nutrition-sensitive interventions.” International experience suggests that providing these multiple services has synergistic effects in generating reductions in stunting (e.g. $1 + 1 + 1 = 5$).

In this targeted multi-sectoral nutrition convergence, the Mission must pay special attention to the limiting factors that are most likely to constrain continued reductions in stunting in the state. Careful analysis in Maharashtra has identified the following factors:

- Inadequate young child feeding, particularly delays in introducing complementary food, and inadequate nutrient density and dietary diversity;
- Poor nutritional status of women, including adolescent girls, which results in infants with low birthweight and inadequate women’s empowerment;
- Inadequate household sanitation;
- Household poverty and household food insecurity.⁶⁵

⁶⁵ Aguayo, V.M., Nair, R., Badgaiyan, N., Krishna, V. (2016, May). Determinants of stunting and poor linear growth in children under 2 years of age in India: An in-depth analysis of Maharashtra’s comprehensive nutrition survey. *Matern Child Nutr*, 12 (Suppl 1), 121-40.<http://dx.doi.org/10.1111/mcn.12259>.

To address these limiting factors, the Mission's nutrition-specific interventions should include activities that currently are being pursued by ICDS and by the NHM with significantly increased attention to pregnant women and adolescent girls.

The Mission's nutrition-sensitive interventions should include the following:

In the Agriculture and Livelihoods Sectors (to address household food insecurity, poverty and inadequate dietary diversity):

- Provide women in BPL rural households with their choice of:
 - » Homestead garden: seeds and seedlings, fencing, other necessary inputs and extension, or
 - » Small livestock: animals, vaccinations, access to quality feed and other extension services
- Work to improve dietary diversity by mapping, by region and by season, those food groups not adequately available, or that are too expensive, and those that are readily available but inadequately consumed. Address these problems through production intensification/extension/research and through consumer-focused behaviour change communication.

In the WASH Sector (to address the sanitation constraints):

- Increase construction and maintenance of sanitation facilities
- Elicit full cooperation of local leaders and institutions in latrine utilisation
- Provide financial incentives for villages that attain Total Open Defecation Free status and maintain it for one year

In the Education Sector (to increase women's knowledge and empowerment, delay age of marriage, and, in turn, improve infants' birthweights):

- Intensify efforts to increase school enrollment and attendance of school-age girls through 10th standard
- Assure latrines for girls at all schools to facilitate the above
- Introduce or intensify counselling of adolescent girls (in and out of school) in health and nutrition, reproductive health and life skills
- Consider annual incentives for BPL girls necessary to assure (a) 100 per cent completion of primary school and (b) 50 per cent completion of 10 years of school by 2020 in these targeted blocks.

The primary guiding principles of multi-sectoral nutrition convergence are the following:

- Plan multi-sectorally
- Implement sectorally
- Review multi-sectorally

The Mission will facilitate the monitoring and evaluation of this convergence effort by recruiting a full time external (to the programme) M&E entity to review data, facilitate its local utilisation, identify and carry out necessary operations research and conduct baseline, midterm and endline evaluations.

