Working Towards Addressing Undernutrition in the State of Odisha

October 9, 2013
Bhubaneswar, Odisha

A Technical Session

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Background

On October 9, 2013, the Department of Women and Child Development (DWCD) of Government of Odisha organized a 1-day technical session at Bhubaneswar on *"working towards addressing undernutrition in Odisha"* with the support from a DFID-assisted Technical & Management Support Team (TMST). The International Food Policy Research Institute (IFPRI) facilitated this technical session, which was attended by state-level functionaries from the DWCD and Department of Health & Family Welfare (DHFW); Integrated Child Development Scheme (ICDS) functionaries from the district; leading development partners working on nutrition; and civil society representatives.

The objective of this technical session was to garner lessons learned from the experience of Odisha and wider India in addressing undernutrition and generate key action points to address undernutrition in the State of Odisha.

Department of Women and Child Development

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Inaugural Session	
Welcome and Introductions	**Ms. Aswathy S,** Director, Social Welfare, DWCD, Government of Odisha
Odisha's Commitment to Address Undernutrition	**Ms. Arti Ahuja,** Commissioner – cum - Secretary, DWCD, Government of Odisha

Technical Session - I	**Delivering Direct Nutrition Interventions to Improve Maternal and Child Nutrition in India**	
Expert Discussant	**Dr. Vandana Prasad**, Member of the National Commission on Protection of Child Rights, Government of India	
Moderator	**Ms. Arti Ahuja**, Government of Odisha	
Presentation 1	Delivering Evidence-based Interventions to Improve Maternal and Child Nutrition: Implications for Addressing Undernutrition in Odisha	**Dr. Rasmi Avula**, Post-doctoral Fellow, IFPRI
Presentation 2	Scaling-up Interventions to Improve Infant and Young Child Feeding: Implications for Odisha	**Dr. Purnima Menon**, Senior Research Fellow, IFPRI
Presentation 3	Addressing capacity gaps for improving IYCF in India	**Dr. Arun Gupta**, Regional Coordinator at IBFAN Asia/ Breastfeeding Promotion Network of India (BPNI)

Technical Session - II	**Role of Nutrition-Sensitive Interventions in Improving Maternal and Child Nutrition**	
Moderator	**Dr. Vandana Prasad**, Member of the National Commission on Protection of Child Rights, Government of India	
Presentation 1	Pathways to Improved Nutrition through Nutrition-Sensitive Interventions: The Role of Multisectoral Actions	**Dr. Suneetha Kadiyala**, Senior Lecturer, London School of Hygiene and Tropical Medicine
Presentation 2	National Food Security Bill: Implication for Odisha	**Mr. Biraj Patnaik**, Principal Adviser to the Commissioners of the Supreme Court
Q&A session		

Technical Session - III	**Mobilizing Stakeholders for Improving Nutrition**	
Moderator	**Dr. Purnima Menon**, Senior Research Fellow, IFPRI	
Presentation 1	Nutrition Agenda in Odisha: Perspective of the Stakeholders	**Ms. Mamata Pradhan**, Sr. KM Coordinator, IFPRI
Presentation 2	Role of Civil Society in setting Nutrition Agenda in Odisha	**Mr. Biraj Patnaik**, State Adviser to the Commissioners of the Supreme Court
Q&A session		

Closing Remarks	**Ms. Arti Ahuja**, Commissioner – cum - Secretary, DWCD, Government of Odisha

Inaugural Session

Welcome & Introductions

Ms. Aswathy S

Director, Social Welfare, DWCD, Government of Odisha

Ms. Aswathy, the Director of DWCD, extended a warm welcome to all the eminent experts, dignitaries, and other invitee participating in the workshop. She individually introduced all the dignitaries and experts present in the workshop namely Dr. Vandana Prasad, member of National Commission for Protection of Child Rights; Arti Ahuja, Commissioner cum Secretary, DWCD, and other subject-matter specialists who : Dr. Purnima Menon, Dr. Arun Gupta, Dr. Sunnetha Kadiyala, Dr. Rasmi Avula, Mr. Biraj Patnaik and Ms. Mamata Pradhan.

She also welcomed District Social Welfare Officers (DSWOs) and Child Development Project Officers (CDPOs) from different High-Burdened Districts (HBDs) of Odisha; staff of National Rural Health Mission (NRHM); members of Nutrition Operation Plan (NOP) team; members of Technical and Management Support Team (TMST); members of the IFPRI team; other leading development partners; and civil society representatives. She wished all the participants for a very fruitful discussion on addressing undernutrition in Odisha.

Inaugural Session .....

Odisha's Commitment to Address Undernutrition

Ms. Arti Ahuja

Commissioner - cum - Secretary,
DWCD, Government of Odisha

Greeting everyone with a cheerful welcome, Ms. Ahuja straightway came to her presentation stating, "Malnutrition is a national focus now, and I was reading in the newspaper couple of days back that the recent political debate gearing up on the issue of malnutrition in various states. So it is a very good opportunity for us to talk right now about this and bring it to the forefront and deliberate on how we can do better." She said that it would be more appropriate to know "what has been done so far, where we have reached and what are the gaps that need to be filled up." She said, "Odisha has a large area and large number of Anganwadi Centres (AWCs). Odisha reflected a highest decline of 10% in the under-three malnutrition between NFHS-II and III, but still the levels are very high, even though there is a decline. The concurrent monitoring also shows further reduction in the same. Odisha has been a good performer in ICDS, as evident from the various independent surveys."

ICDS At a Glance in Odisha
71,306 AWCs (10, 216 Mini-AWCs)
338 Projects (20 Urban Projects)
46.5 lakh beneficiaries (Approx.)

She briefly touched upon the five key strategies that are being taken-up by the state to address undernutrition in Odisha.

The key points that she focused under each strategy are as follows:

1) Strategy-I ICDS Strengthening

- In 2011, the Supplementary Nutrition Program (SNP) has been decentralized. Under this, the entire system is made known to people. The local villagers are involved in a big way not as recipients but as implementers of the program, which was a kind of shift in the way it was implemented. The women self-help groups (SHGs) are involved in procurement and preparation of Take Home Ration (THR). The cost norms have been revised, which is now Rs.6 for hot cooked meals for pre-school children, Rs.7 for THR for pregnant women and lactating mothers, and Rs.9 for severely malnourished children. While the allocation by Government of India (GoI) is for 15 districts only, the rest amount is provided by the state government to uniformly implement across all 30 districts of Odisha. Earlier one egg was given per week, which has been increased to three eggs per week. Similarly, in the THR also two eggs per week are given a DOTS-type strategy to pregnant women, lactating mothers, and children under 3 years old.

- A social audit of the SNP was done by a group of

NGOs, which said that it has resulted in an increase in the pre-school attendance and made more food available due to decentralization. The Commissioner of the Supreme Court has recommended it as a best practice.

- Under the strengthening of the preschool package named Nua Arunima, which is based on age-specific and theme-based syllabus, there are school

SNP Weekly Menu (as per revised cost norms)

Beneficiary	THR type	Hot Cooked Meal (3-6 years children)		Morning Snacks (3-6 years children)	
6 months–3 Years	Two boiled eggs per week + Chhatua one packet (Net 1.700 kg) every 15 days	Monday & Thursday	Rice and dalma (dal cooked with vegetables)	Monday & Thursday	Sprouted gram (Moong and sugar)
Pregnant women and lactating mother	Two boiled eggs per week + Chhatua one packet (Net 2.125 kg) every 15 days	Tuesday	Rice and soya chunk curry	Tuesday	Chuda Ladoo (Chuda + sugar / jaggery)
Severely malnourished children (6 months–3 years)	Two boiled eggs per week + One packet of Rasi Ladoo of 100 gms once in a month +Chhatua one packet (Net 2.550 kg) every 15 days	Wednesday, Friday & Saturday	Rice and egg curry	Wednesday , Friday & Saturday	Chuda Ladoo (Chuda + sugar / jaggery)
Severely malnourished children (3–6 years)	One packet of Rasi Ladoo of 100 gms once in a month + Chhatua one packet (Net 1.700 kg) every 15 days + HCM +MS	The revised ration cost is applicable to the entire State. The additional cost for 15 districts borne from the State Plan			

uniforms and new workbooks for AWW. All the training for the preschool package are prepared on CDs, which are linked to that month's lesson plan and uploaded in the departmental website. Many of the workers have also learned to download the song on their mobiles, which are then played by them at the AWCs. This Nua Arunima package has been developed in 10 tribal dialects.

- The other components of ICDS strengthening taken-up by the state include designing and rolling out a supervision checklist, provision of computers and broadband in every project office, additional staff to CDPOs, and training on leadership and financial management.

- The state has initiated the process of district planning with collectors. A dashboard tool is used, which has helped the collectors analyzing the trends of various outcome and process indicators and develop action plan for their district.

- Only 16,000 out of 71,000 AWCs have their own buildings. Therefore, as part of ICDS strengthening, the State is currently constructing 20,000 new AWC buildings.

2) Strategy-II Life Cycle Approach

- Weighing machines and newly improved hygiene kits have been supplied to AWCs, which have received very good feedback from the parents.

- Online training modules are now available for the supervisors. They can log onto these at any time.

- Various other initiatives are going on in convergence with the NRHM in the urban areas.

- Mother & Child Protection (MCP) card has been rolled-out throughout the state and is being used extensively under the eMamata scheme.

3) Strategy-III Focus on 1000 days

- The Mamata scheme was launched in 2011. On October 1, 2013, the state celebrated the coverage of 1 million beneficiaries under the Mamata scheme. The state has transferred about 371crore directly to the bank account in the names of the women beneficiaries. Since the launch of the scheme, the service coverage in the state has gone-up during last 2 years.

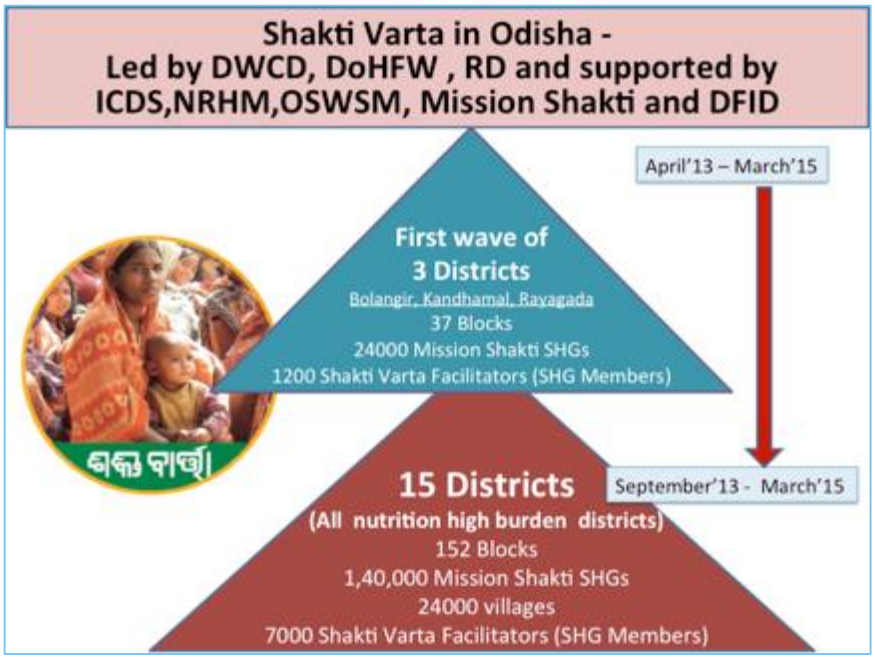
- The Jaanch committee and mothers' committee that have been created as part of the decentralization process are involved in the decentralized-feeding scheme and are very active in monitoring the scheme. Ms. Ahuja narrated an instance of a Jaanch committee member in a village in Sundargarh district, who is a retired headmaster and goes around the whole village to the AWCs on his own cycle delivering services.

- The state has started Arna-Prasanna to focus on the decline of stunting, which develops after the child is 6 month old. A *Katori* (bowl) with *Chammach* (spoon) is given to the beneficiaries at the AWCs where all the mothers are instructed in local recipes for the child and IYCF practices.

- A handbook is being given to the AWWs as a job aid to which they can refer back after the training.

4) Strategy-IV Community Engagement

- The State has recently launched Shakti Varta, a Participatory Learning Action Cycle (PLA) with SHGs in the high burden districts of Odisha. This is based on the EKJUT trial published in Lancet, where very good results were seen in the reduction of maternal and neonatal mortality through working with the women in the community. The state has customized it for ICDS. In this cycle, all the issues related to health, nutrition, water, and sanitation will be covered in 20 meetings. In Odisha, there is a very strong SHG movement with more than 500,000 SHGs in the state that have 5,000,000 female members. Among those SHGs, 140,000 will be involved in this PLA exercise.



- Social audit is another initiative regularly taken up by the state as part of the community engagement process.

5) Strategy-V Equity Focus

- There are significant gaps in equity and other indicators in the state. Economic deprivation is one of the major social determinants for inequity.
- One of the approaches adopted by the state is the Nutrition Operation Plan (NOP) funded by DFID.
- A special scheme for the Particularly Vulnerable Tribal Groups (PVGTs) has been developed. The state has around 13 PVTGs in 12 districts, where often there is no access to the AWCs due to physical distances. This scheme will track each child in those areas to make sure that none of them is malnourished.
- A pilot project is being initiated for the community management of acute malnutrition.

At the end of her deliberation, Ms. Ahuja shared an instance that was shared to her by the National Human Rights Commission (NHRC) rapporteur who visited the state few days back. She said, "The NHRC representative visited the state and was informed that the AWW is the person who most often responds to people in distress. He was also informed about a so-called starvation death in Nuapada district, where the person died and the first responder to that case was the AWW who gave him 4kgs of rice, not known from where, but the village people said to her don't do it or you will be caught. She did not listen to them and extended support. So, if we can make the community responsible, I am sure we can prevent many such things."

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Technical Session – I

Delivering Direct Nutrition Interventions to Improve Maternal and Child Nutrition in India

Presentation 1

Delivering Evidence-based Interventions to Improve Maternal and Child Nutrition: Implications for Addressing Undernutrition in Odisha

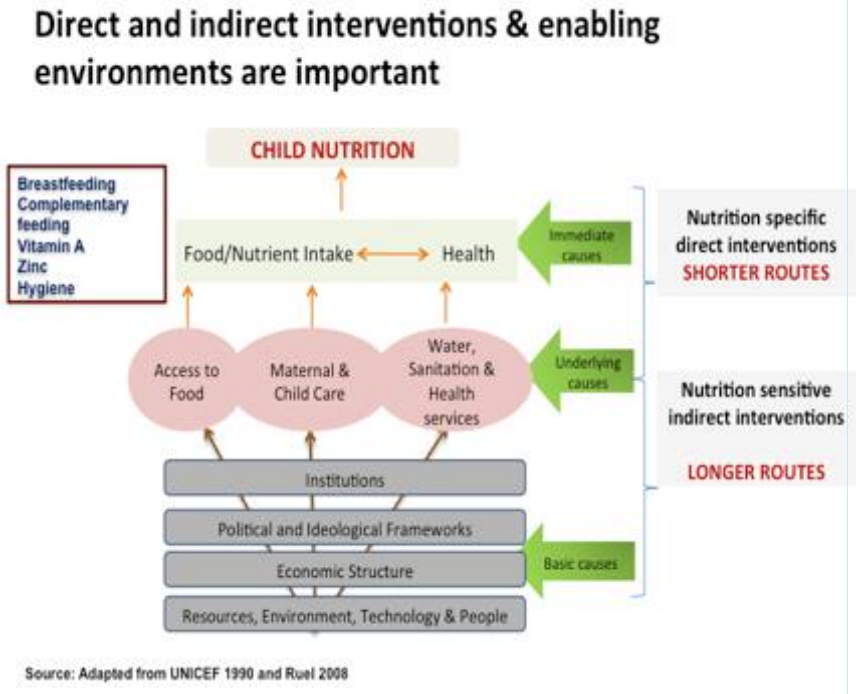
Dr. Rasmi Avula, PhD
Post-doctoral Fellow, IFPRI

After being introduced by Ms. Arti Ahuja, Dr. Rasmi briefly spoke about the POSHAN program evidence review on evidence-based interventions to improve maternal and child nutrition in India.

1) Conceptual Framework

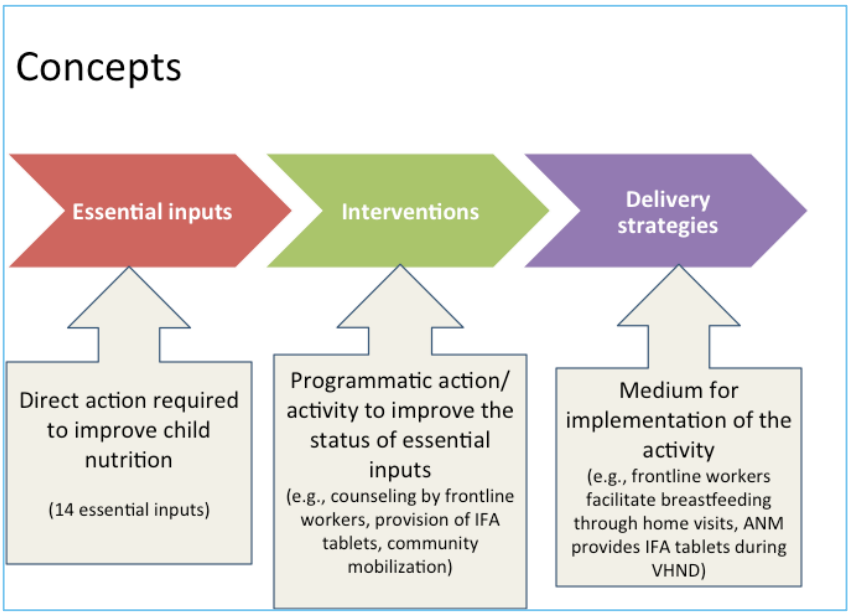
She said that UNICEF's conceptual framework shows the multiple influences on child nutrition. Child nutrition is influenced by the immediate causes, i.e., those that pertain to food and nutrient intake and health, which are in turn influenced by the underlying causes, such as access to food, maternal and childcare, water, and sanitation, and access to health services. All of these are influenced and operate within the confines of political and ideological frameworks and economic structures, known as the basic causes.

Addressing the basic and underlying causes through nutrition sensitive or what could be called indirect interventions (e.g., improving



access to food through homestead gardens, improving women's empowerment) takes a longer route but leads to creating an enabling environment that is needed to ensure that benefits are maintained over time and that will allow individuals and communities to move out of poverty, food insecurity, gender discrimination, poor health, and undernutrition in a sustainable way. Short-term gains can be achieved by addressing the immediate causes pertaining to food and nutrient intake and health. She said that the desk review conducted by them focused on the direct interventions to:

- Document the extent to which national and civil society / NGO programs in India reflect current technical recommendations for nutrition
- Assess the operational evidence base for implementing essential interventions for nutrition in the Indian context



Before she moved forward to next slides, she laid out some concepts that were used throughout the presentation made by her:

- **An essential input** is a direct action required to improve maternal and child nutrition—for example, exclusive breastfeeding in the first six months of life. It is usually an action undertaken by the child's caregiver or parent.
- **An intervention** is usually a programmatic action or activity intended to improve the status of the essential input—for example, counseling by lay health workers to promote exclusive breastfeeding.
- **Delivery strategies or platforms** are used to describe the programmatic approach through which interventions reach intended beneficiaries—for example, frontline workers or workers in health facilities may counsel mothers to enable them to exclusively breastfeed their infants. In the first case, the delivery strategy is one that is outreach-based and takes the intervention (counseling) to households using lay health workers. In the other, the delivery strategy is facility-based, and health workers at facilities offer counseling to parents who must come to the facility.

2) Methods applied for the program evidence review

i) First, the team compiled a list of essential inputs from the *Lancet Series on Maternal and Child Undernutrition* (Bhutta et al., 2008) and compared these with the list of essential recommendations proposed in

List of essential inputs for child nutrition*

1. Timely initiation of breastfeeding within one hour of birth
2. Exclusive breastfeeding during the first six months of life
3. Timely introduction of complementary foods at six months
4. Age appropriate complementary feeding, adequate in terms of quality, quantity, and frequency for children 6-24 months
5. Prevention of anaemia
6. Safe handling of complementary foods and hygienic complementary feeding practices
7. Full immunization
8. Reducing vitamin A deficiency
9. Reducing burden of intestinal parasite
10. Prevention /Treatment of diarrhoea
11. Timely and quality therapeutic feeding and care for all children with severe acute malnutrition
12. Improved food and nutrition intake for adolescent girls particularly to prevent anaemia
13. Improved food and nutrients intake for adult women, including during pregnancy and lactation
14. Prevention /Treatment of malaria

Compiled based on recommendations from the Lancet Series on Maternal and Child Under-nutrition (2008); The Coalition for Nutrition Security in India Leadership Agenda for Action (2010); The Scaling Up Nutrition Framework (2011)

the *Leadership Agenda for Action by the Coalition for Sustainable Nutrition Security in India* (Coalition for Sustainable Nutrition Security in India 2010) and the *Scaling Up Nutrition Framework for Action* (2011). A list of 14 essential inputs for improving child nutrition was compiled.

ii) To identify evidence-informed interventions to address each of the essential inputs, a literature review was conducted through a search of Cochrane databases, the WHO Electronic Library (e-LENA), systematic reviews published by the International Initiative for Impact Evaluation (3ie), and the *Lancet Series on Maternal and Child Undernutrition*. Because this review was conducted prior to the release of *Lancet* 2013, the POSAHN team revisited the interventions and found that it was not different from what had been already identified to be important. The team also examined the WU6 recommendations for interventions and found them to be comparable to their list of interventions. WU6 group also recommends interventions such as crèches and maternity benefits.

iii) Followed the identification of interventions, the team reviewed programs for inputs and interventions. Since the ICDS and NRHM are national-level scaled-up programs, they were included in for review. Effort was also made to build on existing reviews, including the World Bank study and the Vistaar review. Since time has passed since these were written, to get the latest information, the team requested program information from 70 stakeholders. The desk review of programs was limited by the response rate and the extent of documentation available. Each of the programs was reviewed by examining components of the programs for inputs and interventions. Once interventions were identified for each of the inputs, the program documents were examined for the different essential inputs addressed, which interventions were used, and how they were delivered. Dr. Rasmi gave the example of the Reproductive and Child Health, Nutrition and AIDS (RACHNA) program implemented in nine states. While examining this program, a main challenge faced was that there were not enough details on the delivery of the program.

3) Results

i) **ICDS and NRHM**: By design, these two national programs together cover all the essential inputs for child nutrition. Where ICDS misses a given input, NRHM covers it, and vice versa. Furthermore, between both ICDS and NRHM, the essential inputs are largely addressed through evidence-based interventions by at least one of the programs. She gave an illustration of how ICDS and NRHM deliver similar interventions whereas for some inputs they play complementary role.

- Home visits by AWWs and ASHAs to counsel families, mobilizing of mothers and families for Village Health and Nutrition Days (VHNDs) for immunization, etc., are some delivery strategies used by ICDS and NRHM to implement the interventions. However, there is duplication between ICDS and NRHM in addressing inputs such as breastfeeding and complementary feeding, where by design AWWs and ASHAs are expected to counsel mothers. This could have positive implications for behavior change, if similar messages are promoted by both workers; however lack of role clarity and coordination could lead to confusion. Mixed messages could compromise effectiveness.

- Complementarity of ICDS and NRHM roles are evident in the example of vitamin A supplementation, where AWWs assist ANMs in implementing the supplementation.

- The ICDS and NRHM programs provide opportunities for combining bundles of interventions that are required to improve maternal and child nutrition. There is a huge potential for AWW and ASHA to be complementary.

- Proper coordination is important and needs to be looked at. Given the nature of roles that ICDS and NRHM personnel play in addressing pediatric anemia, diarrhea, immunization, and vitamin A supplementation, coordination becomes a critical ingredient for successful program implementation.

Operational guidelines for delivery of interventions highlight complementarities and reinforcements

Essential inputs	Interventions in ICDS Program	Delivery of ICDS interventions	Interventions in NRHM Program	Delivery of NRHM interventions
Exclusive breastfeeding for 6 months	BCC by AWWs	AWWs make regular home visits	ASHAs counsel mothers	ASHAs conduct scheduled home visits.
	Community mobilization	Facilitate VHND	Community mobilization	ASHAs discuss EBF on VHND.
Reducing vitamin A deficiency	Assist ANMs in Vitamin A supplementation	AWWs maintains stock of Vitamin A for ANM	ANM provides vitamin A	ANM provides vitamin A doses on VHND.

- Literature shows that there is implementation gap, as several inputs rely on home visits by AWWs and ASHAs. This is a major focus of ICDS restructuring.

ii) **Other Program Models**: In addition to the national programs, there are non-governmental (NGO) programs with a stated goal of addressing child undernutrition. Of the 22 NGO programs that were reviewed, a majority addressed breastfeeding and complementary feeding inputs. Only a few addressed pediatric anemia and severe acute malnutrition. The majority of interventions implemented to address the inputs in these program models were informed by evidence.

Some of the program models used innovative delivery strategies to implement interventions. For example, cell phones were used to send messages to promote breastfeeding. Nutrition cum day care centers was established to promote BCC as well as provide meals. Where ICDS and NRHM programs were used to implement the programs, convergence of frontline workers was achieved. Innovations in interventions and delivery strategies included:

- Use of cell phone technology
- Establishing nutrition cum day care centers
- Using community-based events such as village fairs, festivals, marriages etc., to interact with the community
- Organizing healthy mother and baby competitions

Additionally, prior to implementing interventions in these program models, system strengthening was achieved through the recruitment of a new cadre of health workers, training and mentoring, strengthening monitoring and supervision, etc.

iii) **Summary of Findings**:

- ICDS and NRHM incorporate all the essential inputs
  - Other NGO programs with the stated nutrition goals also address several inputs
  - The majority of the essential inputs are addressed through evidence-based interventions

- Individual and group counseling is a common evidence-based intervention used to address multiple inputs.

- Only a few program models address multiple essential inputs
  - Pediatric anemia, severe acute malnutrition, and prevention of malaria are the least addressed inputs

iv) **Gaps**:

- A key challenge is that not enough program models try to implement evidence-based interventions. For example, program guidelines indicate that IFA tablets should be given to 6 to 24-month old children to prevent pediatric anemia. However, there is very little documentation of programmatic evidence on how to provide IFA tablets. In addition, new evidence-based interventions such as the provision of micronutrient powders have not been tested through the existing delivery platforms such as ICDS or the NRHM in India. A similar gap exists with SAM, where community-based management approaches are slowly being tested to complement facility-based approaches.

- The inclusion of evidence-based interventions in most programs suggests that intervention designs have been largely sound. The gaps in coverage, however, raise a question: Are the delivery strategies used to implement the interventions operating at full potential? The review identified some key operational considerations that are important for the implementation of evidence-based interventions in India, but noted little or no operational evidence.

- There is the need to improve the delivery and effectiveness of all evidence-based interventions.
  - Convergence: There is a need for convergence between ICDS and Health/NRHM to ensure effective service delivery. There is little understanding, however, about how convergence can be most efficiently and effectively achieved.

4) Implications for Odisha

Dr. Rasmi presented the implications for Odisha using the NFHS-III data and where available, used concurrent monitoring survey data that was collected from 314 blocks from 30 districts in Odisha (2010-2011), which revealed that:

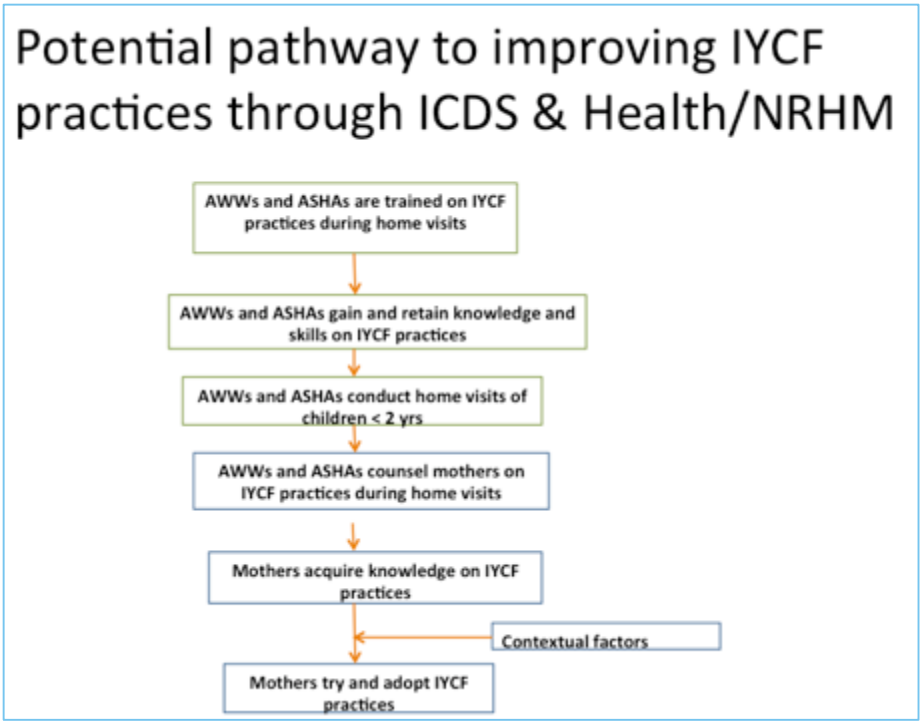
- There is a statistical association between stunting and coverage of 12 essential interventions

- Growth faltering starts at 6 months, which is when complementary feeding practices and hygiene practices have greatest implications. Research now establishes a strong link between open defecation and height.

- Although Odisha is performing better compared to India in terms of coverage of essential inputs, there is still long way to go.

- This review of programs suggests that there is little information on how to deliver interventions to improve complementary feeding practices both in NGO models and in government programs. The ICDS and NRHM require that AWWs and ASHA counsel mothers on improving Complementary Feeding (CF) practices. Based on the work

done in Bangladesh, the expected pathway to improve IYCF practices is laid out. This helps to understand what is expected to be delivered, how it is being implemented now, what can be improved, and what are the limitations.



5) Recommendations

- Orient current programs – ICDS and NRHM – more strongly on the prevention of undernutrition through a focus on optimal IYCF and hygiene practices.
- Strengthen frontline worker capacity to promote and support optimal IYCF practices and harmonize timing and messaging between the two cadres of workers
- Identify strategies to create enabling environments to facilitate maternal adoption of recommended IYCF practices (Odisha already has some of this in place with its Mamata scheme)
- Monitor WHO-recommended IYCF indicators in repeat surveys

Expert Comments by Dr. Vandana Prasad .....

Dr. Vandana started her deliberation appreciating the efforts made by Odisha in last five years working towards better nutrition for children. She said, "Odisha started from a very disadvantageous situation and is still able to reach that special place through its work, which means a lot." She discussed and brought out the following key points during her deliberation.

- There is already a lot of clarity that exists in the system. However, it is important to identify those peculiar and specific gaps and challenges from the collective experience of practitioners. More than any formal learning, there is a need to learn from the work or practice that we are doing.
- The list of 14 essential inputs for child nutrition mentioned by the presenter is neither the starting point nor the ending point. Starting with the macro details could be right but one needs to move to micro details. For example, in the training of AWWs and ASHAs, one might find that the frontline workers are not able to understand. Therefore, there is a need to take micro-level initiatives by simplifying the language of training. There is a need to develop tools that would help them to engage with people.
- The conceptual framework of UNICEF does not talk about the determinants of nutrition. Poverty or poor economic condition of people is one of the strong determinants for undernutrition, which would continue to remain so for

long even if we deal with this directly or through convergence mechanism. Women's right and women's empowerment is more important in India where women's literacy comes as a key determinant, which the UNICEF model does not include.

- There is no framework, which is absolute. It has to be dynamic and change contextually. For example when one talks about iron, people always speak about iron tablets. If one talks about the intake of iron to address malnutrition, it could be iron in the form of food, which the under-3 can take. The same thing could be applied in the intake of vitamin A. This remains to be a critical deficient area in the NRHM.

- Malnutrition is not a technical issue. It is primarily a political and socioeconomic issue with technical component; both are extremely important. One cannot afford to start with the larger understanding from the political socioeconomic component. One also need not have to do PhDs and Masters. It only requires technical learning of a minimum of 7 days to work on addressing malnutrition.

- There is a need to send out clear message to all people who are interested in saving the child from malnutrition that one need not confine to the state-jacketed program design or the jobs given to him. AWWs need to be given this message. For example, people should be given a simple message that when the weight of the baby goes down the growth falters. When the growth of the child starts to falter, there is a need to take a simple action immediately, i.e., giving extra feed or extra oil. This is a simple message and a simple practice, which is not costly in terms of human resources and funding.

- There is a need to shift to being orientated towards people. One may give 14 essential inputs but the child will still die. That 1 percent will keep the child well. If the child is not getting better, there has to be steps taken that are in the program guideline. It is given in the IYCF, if the child continues to be not being well, take further actions.

- The doctors and Nutrition Rehabilitation Centers (NRCs) need to do their jobs. Children in NRCs are discharged even when there is no weight gain or a 5–15 percent weight gain, which is not right. There is a clear guideline that if the child is not responding to the care given in the NRC then refer the child. The doctors and the NRCs need to do their job as caretakers of children.

- There is a need to track indicators like poverty and gender. Another important element, which is missing in the presentation, is community mobilization.

- Odisha has done a pilot intervention on malaria and malnutrition, which has not been discussed. There is a need to discuss and scale this up. The role of chronic malaria and TB in childhood needs attention as they are very poorly diagnosed and managed.

- Maternity entitlements and crèches are important ways to ensure exclusive breastfeeding and complementary feeding. Odisha is pioneering in this but more conditional cash transfers for immunization and exclusive breastfeeding needs to take place.

She ended her comments saying that there is a need to get into micro-details of the 14 essential inputs mentioned for improving child nutrition and need to look for a comprehensive model to address malnutrition.

Technical
Session – I

Delivering Direct Nutrition Interventions to Improve Maternal and Child Nutrition in India

Presentation 2

Scaling-up Interventions to Improve Infant and Young Child Feeding: Implications for Odisha

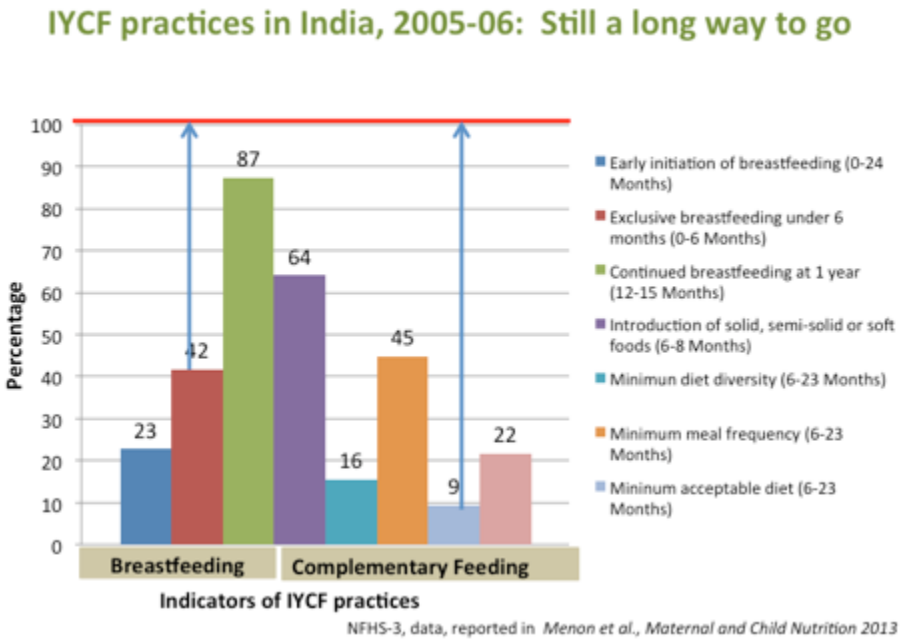
Dr. Purnima Menon
Senior Research Fellow, IFPRI

The moderator of the session, Ms. Arti Ahuja introduced Dr. Purnima Menon and invited her to make the presentation. Dr. Menon began her presentation stating that she agreed with Dr. Vandana and that it might have been ideal to discuss and understand some of the basic causes of undernutrition, equity, and gender issues, but assured her that these issues would be addressed in the second technical session on nutrition-sensitive interventions. Dr. Menon stated that she would speak about some of the evaluation work that POSHAN is doing on improving IYCF in Bangladesh and on IYCF practices in India. The key points that she raised are presented below.

- When thinking of IYCF practices, it is really useful to think about the whole continuum, remembering that babies need to be fed right from the day they are born to at least the day they are 2 years of age. The first 2 years of life is a critical period when the growth faltering starts, and that starts to settle in within this period. We know that once children are outside that period, there is very little scope to recover from some of the damages that happen due to growth faltering.

- It is highly useful to think about both the first 6 months and the 6–18 month period. In the first 6 months there has to be only exclusive breastfeeding, not even a drop of water or a drop of anything else fed to the baby. From 6 to 18 months, breastfeeding has to continue along with age-appropriate complementary feeding.

- Looking at the NHFS-III data from India, which is the most recent data available, there are quite significant gaps in all of the IYCF practices starting from Day 0 and then Hour 1, which is the initiation of breast-feeding. As for exclusive breastfeeding, less than half of children under 6 in India are exclusively breastfed. After 6 months, it further deteriorates when looking at complementary feeding.



- Typically, eight indicators are measured to gauge the quality of IYCF across the spectrum of the first 2 years of life. Three indicators capture breastfeeding—initiation of breastfeeding, exclusive breastfeeding, and continuation of breast feeding; and then five indicators relate to complementary feeding practices. Whether the child has received anything at all in the 6 to 8-month window shows whether complementary feeding started with the right food.

- Dietary diversity, frequency of feeding, consumption of iron rich foods, etc., all should be happening. Age-appropriate IYCF practices are extremely important for child nutrition outcomes.

- For stunting, it is really important to focus on IYCF, particularly in the age group of 6 to 24 months when there is the biggest slide in undernutrition rate.

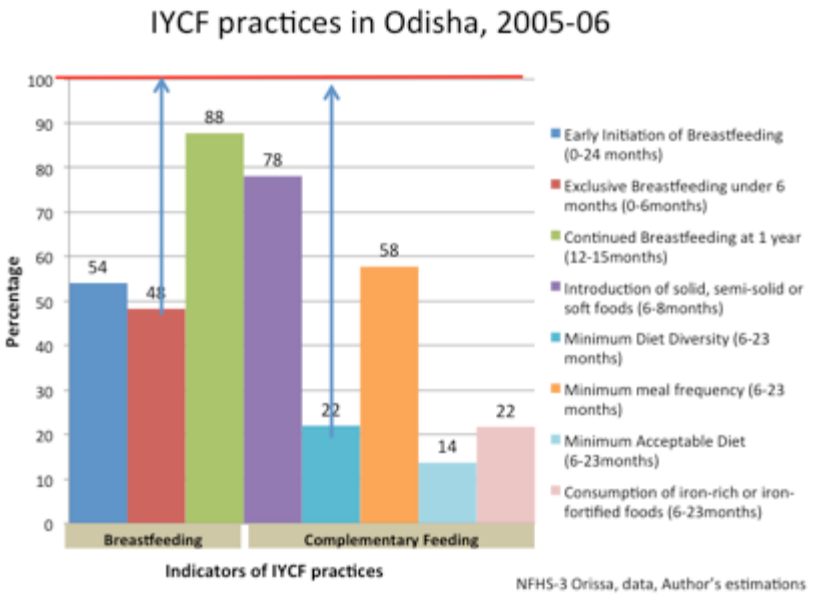
- The analysis of the NHFS-III data shows that consuming any solid food during the 6 to 8 months-period reduces the rate of underweight, and that improving dietary diversity in the 6 to 24-months period lowers the chances of stunting and underweight.

- As seen in other cross-sectional analyses, exclusive breastfeeding is not associated with nutritional status indicators but there are known links with child survival, which make it an essential practice.

- There are several other important determinants of child nutritional outcomes—water sanitation, maternal nutrition, poverty, maternal education, etc., which are very critical determinants of nutritional outcomes.

- None of the recent data including the CCM-2011 data (except the NFHS-III data of 2005-06) of Odisha brings out the status of core indicators to assess the quality of IYCF. The NFHS-III data of 2005-06 shows that many of these indicators for Odisha are much better than they are for India as a whole, particularly the percentage of early initiation of breastfeeding, children fed any complementary food in first 6 to 8 months, and minimum meal frequency. It is important that the right indicators be measured so that one can look at how these things are progressing. But there is a very significant gap in exclusive breastfeeding—less than half of the babies in Odisha are

exclusively breastfed—and there is a gap in the quality of complementary feeding. One needs to unpack and understand that better.



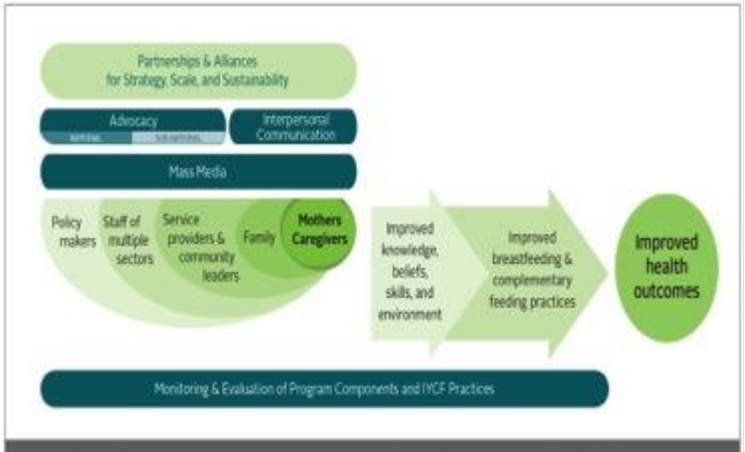
NFHS-3 Orissa, data, Author's estimations

- The published literature in India on how to improve infant feeding is very small. There is not a very strong published literature on what is working in different contexts in India, which is in complete contrast with a country like Bangladesh where for the last 25 years people have been experimenting with the best strategies to improve infant feeding. Therefore, we barely have a handful of studies in India either on breastfeeding or on complementary feeding in the published literature.

- The existing findings on program models that address IYCF also limit effective action. The interventions and delivery strategies adopted are mostly evidence-based (use of counseling by health workers, with some community mobilization) but there is little or almost no evidence on how to operationalize the same within the system. Barring INHP-II (2000-2009) implemented across nine states, very few programs have actually tackled the full spectrum of IYCF practices. Some focus only on the initiation of breastfeeding, some focus on exclusive breastfeeding, and some others focus on the initiation of complementary feeding. INHP-II is the only program, which has had a decent evaluation design (i.e., before-after, quasi-experimental design). However, the impact of INHP-II was very small. So, very little is known about the key constraining factors, implementation issues, and coverage issues. Lack of evidence is often due to poor documentation of models, poor evaluation designs or because material is not in the public domain. Operational research in India is important to put in place to understand this.

- Dr. Menon shared an example of an IYCF intervention at scale in Bangladesh. Alive & Thrive, which is a 6-year learning initiative funded by the Bill & Melinda Gates Foundation, is being implemented in Bangladesh, Vietnam, and Ethiopia. IFPRI is the evaluation partner for this initiative. The program strategy is focused on reducing undernutrition through prevention, IYCF practices, including hygiene during feeding.

- The target populations are the mothers and caregivers, and the core of the intervention is interpersonal communication. There is a large effort is around creating a more supportive environment for IYCF through advocacy and strategic use of mass media, through building partnerships and alliances at the national level to improve infant feeding. In Bangladesh, this community-based interpersonal communication is delivered by the nationwide NGO BRAC, which is the world's largest NGO. BRAC has 92,000 community health volunteers who cover all the



Alive & Thrive program components for improving infant and young child feeding (IYCF) practices

districts and sub-districts of the country. They have an integrated community-based approach to providing preventive health, variety of different health services, and a very large network of frontline workers.

- They have been experimenting on improving nutrition and feeding within the context of having a huge ground force who are not very skilled to improve nutrition, work with the community, and work with mothers to improve IYCF practices. BRAC established a training and performance improvement system to address the skills of the frontline volunteers and they put in place an additional skilled worker to be able to deal very specifically with problems and provide mental support to these large frontline force.

Areas of outreach, timing and # of contacts in Alive & Thrive, Bangladesh

A&T Community Team Member	Area of responsibility	# of households to visit	Target population for IYCF	Timing and recommended # of IYCF contacts
Community health volunteer (SS)	Neighborhood	All households (250-300)	35-40 children under 2 years of age	24 contacts (once a month in first 2 years)
Community health worker (SK)	Half a union	All households (2,500 – 3,000)	Approximately 120 pregnant women	3 contacts in third trimester of pregnancy
IYCF promoter (PK)	Half a union	Households with children 0-24 months of age (2500-3000 households or 300 children <2 years); 8-10 visits per day	100%	12 contacts: monthly during the first 8 months and one visit during months 9/10, 11/12, 15-18, and 23/24 months

Source: Alive & Thrive Operational Manual, Bangladesh

- They have specified the exact expectations of every worker in the system, clearly saying to them, you are the volunteer, this is your coverage area, here is the number of children you are expected to cover, and here is the number of contacts you are supposed to make with each of those children in a 2-year period. If you are a promoter to support this particular community, here is your coverage area, here is your target area, and here is exactly what you are expected to do. This is very well documented in the project website. Although these are very micro level things, these are clearly defined in there operational manual.

Very clearly defined roles of key staff involved in the Alive & Thrive interventions

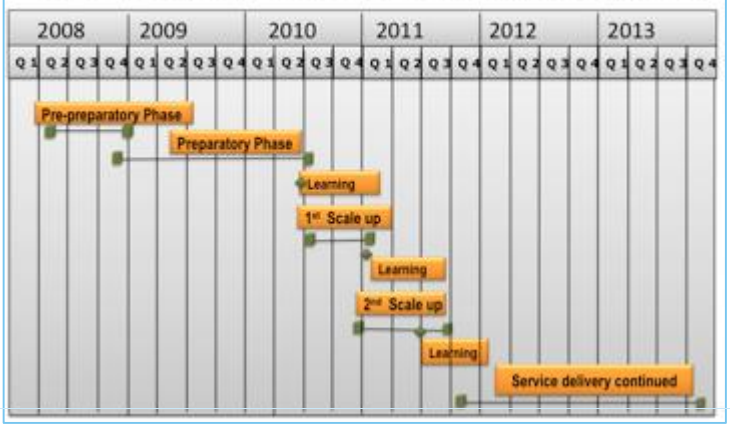
Shasthya Shebika (SS)	Shasthya Kormi (SK)	IYCF Promoter	A&T Program Organizer
1. Visit each pregnant woman and child below 12 months of age in her area at least once a month to ensure the following through counseling and demonstration: • initiation of breastfeeding within 1st hour of birth • Exclusive breast feeding for 1st 6 months • Appropriate amount and consistency of complementary foods and use of animal protein and oil according to age for children 7-12 months • Washing hands of mother and child before preparing meal and feeding child 2. Identify and solve IYCF-related difficult cases, request further management by IYCF promoter if needed, and continue follow-up. 3. Bring micronutrient powders to households	1. Identify and register pregnant women 2. Counsel pregnant women during ANC to initiate BF within 1st hour of birth and exclusively breastfeed for 1st 6 months 3. Support mothers during 1st PNC for proper attachment and positioning 4. Discuss recommended IYCF practices with mothers of children 0-24 months old attending health forums	1. Problem solve cases referred by SS, SK 2. Catalyze discussions on IYCF with family and community members 3. Counsel and demonstrate to mothers/family members age-specific IYCF practices during household visits for children 0-12 months old 4. Mentor SS 5. Link with the program organizer	1. Supervise SS, SK, and IYCF promoter and monitor activities 2. Conduct forums, follow up visits, and community meetings 3. Link with other BRAC program organizers and managers 4. Coordinate with local government bodies and health staff 5. Use monitoring data to solve performance issues 6. Prepare reports

Source: Alive & Thrive Operational Manual, Bangladesh

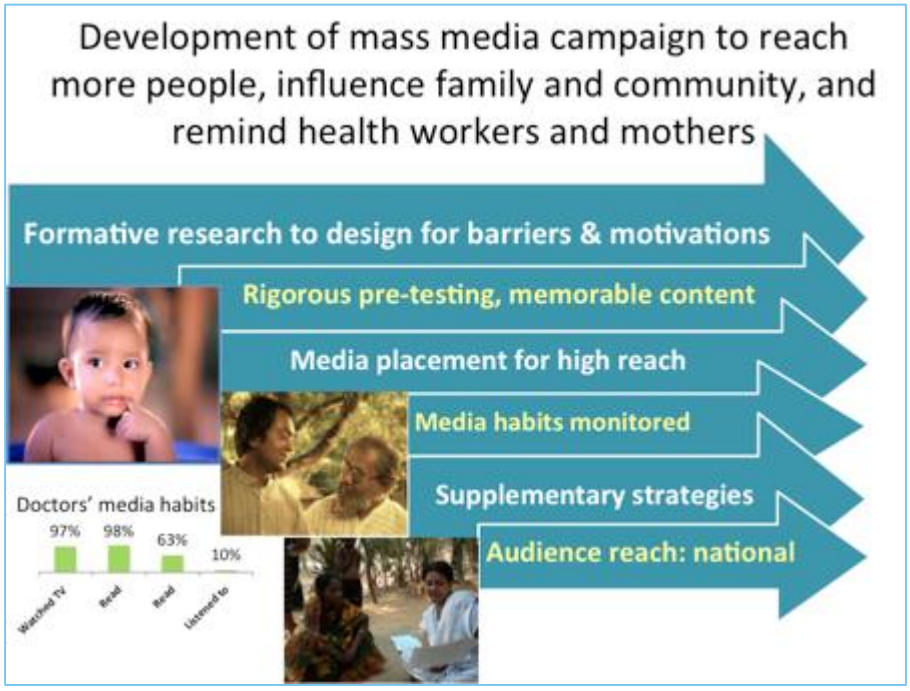
- They have very clearly defined roles of workers that help to deliver the interventions. It is that degree of specificity that helps everybody in the system to know what exactly their role is and what exactly they are supposed to do.

- The other thing that is important is that they follow a process that has learning and data embedded in in it from the beginning. So in the first 1 ½ of the program, there was a strong preparatory phase in that they did the formative research trying to understand the local constraints and developing and testing the counseling strategies. They also did a small test in a program area in four sub-districts, testing what kind of support health workers would need, what kind of material was needed, what kind

Phased scale-up of skilled counseling and support



of supervision was needed, etc. Once that learning was completed, they scaled up what they had learnt, which is an important lesson in program testing and roll out.

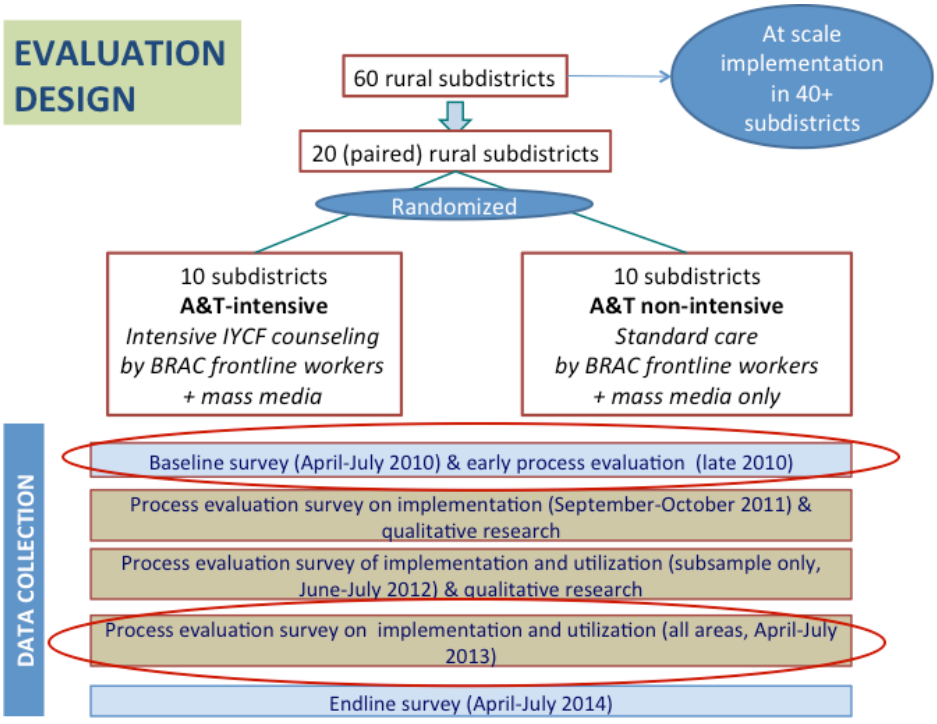


- With the continued learning, they have continued to scale up and then link their works with larger platforms. Linked with this was a very substantial national mass media campaign that was done with the alliance of key stakeholders who are interested in improving young child feeding in Bangladesh.

- Again, it is very well-designed mass media campaign done with formative research with pretesting in collaboration with people who know how to do mass media, such as advertising and media firms. This is also another important lesson for India. A simple public-driven announcement was not the strategy in Bangladesh. The videos produced can be seen on the website. The videos focus on key barriers and behaviors, e.g., the initiation of breastfeeding, when mothers perceive the insufficient milk and how the father is liable to bring different formulae. It is targeting that specific behavior and targeting the specificity of that context.

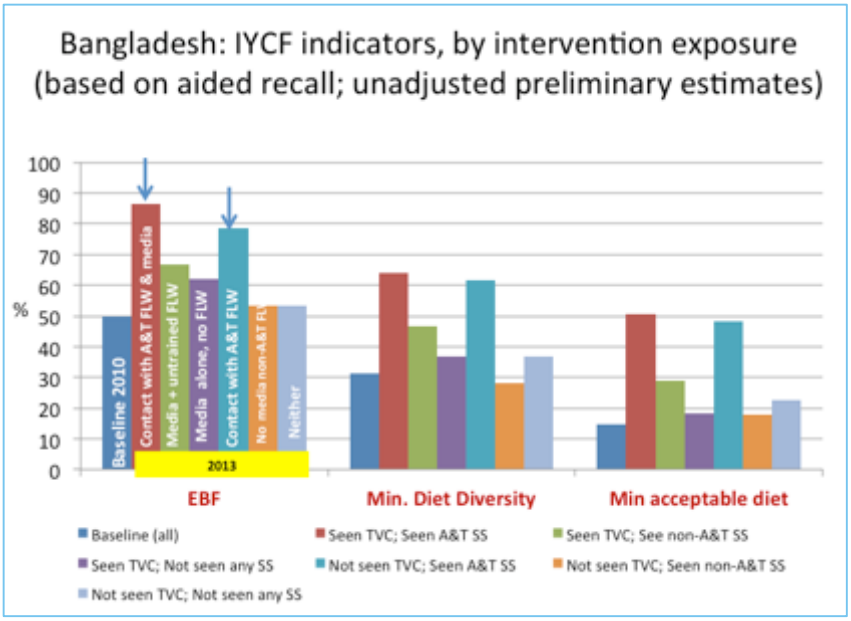
- IFPRI has been doing research with this program in each of these phases. Dr. Rasmi studied the preparatory phase, which has been recently published in the *Journal of Nutrition*. The data in this presentation are coming from the first scale-up phase.

- As mentioned, IFPRI's role in that is to do the evaluation. This did not constrain the program from going to scale and from IFPRI as evaluators in developing a rigorous design. IFPRI chose a subset of the areas in which the program was going to scale to do a cluster randomized evaluation design. The team randomized 20 sub districts into either the basic standard of care that has been delivered by the health workers and the mass media campaign and 10 districts into the approach of intensive interventions. A full

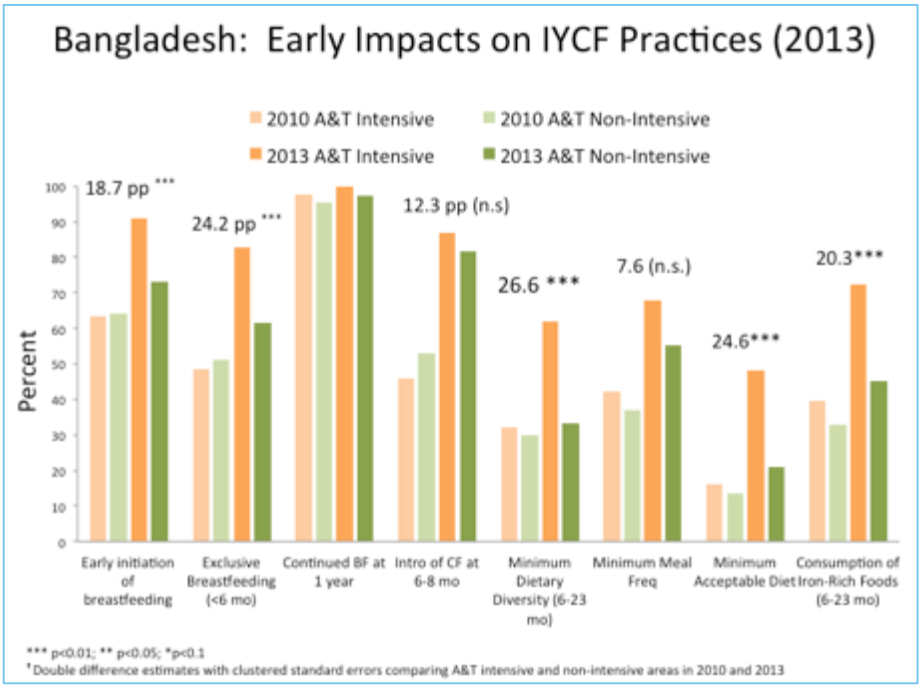


baseline survey was done in April-July 2010 and then an early process evaluation towards the end of that year. Then a process evaluation on the implementation was done in 2011. In 2012, the quality of and how the intervention is working in terms of reaching households was examined. In 2013, the baseline survey was repeated, and in 2014, the endline survey will look at the impact.

- Data from 2010 and 2013 shows some of the changes in eight IYCF indicators. The graph shows that there is a very substantial increase in all of those indicators except for continued breastfeeding, which was high already before the intervention. It also shows the critical role that counseling plays because the increase is much higher in the groups that are getting this intensive intervention. So for all IYCD practices, a very substantial increase was seen. It speaks to the focus of the intervention on addressing all of the local barriers that relate to each of those specific practices and making sure that the interventions are scaled up and reaching people. In this project, they reached over 90 percent of frontline workers.



- The data from 2013 shows that it is the counseling and contact with the frontline worker that make a very big difference. The arrows on the top of two bars on the exclusive breast feeding presented in the graph shows that the intensive groups who has contact with frontline workers (those who are delivering the counseling) are doing much better than the groups that have only been exposed to media. The groups that have not been exposed to either frontline workers or media are just the same as baseline, so really there is no change observed over the time.



- The same pattern is also seen in the case of minimum diet diversity and minimum acceptable diet. The findings really reinforces that the investment in frontline workers makes a very big difference. All of the investment in testing and developing these interventions has really paid off. Testing these interventions in a few different places and then scaling these up helps to improve these interventions.

- Comparing this with the IYCF practices in Odisha, there are some key lessons here, and there is a need to discuss how to orient the frontline

workers to what is already in the current programs through prevention and by working with families around how to make these behaviors happen. Part of it is understanding the context and the constraints at the local level and putting in place a system. A policy and program environment is needed where the elements of the system click, there is a mechanism to train the people, and a mechanism where additional food is brought in. In Bangladesh, there is no ICDS and no extra supplementary food yet that is also a poor country. Even then, many changes could happen due to focused and intensive interventions.

- The experience speaks to the need for focusing on a real strategic goal. Components like mass media, community mobilization, counseling by the frontline workers, and making sure that they reach the mother in law or household head in the family are important.

- In Odisha, there is potential for innovation by using SHGs, PLA approaches (experimental work currently going on), use of local media, etc. How can those innovations support behavior change is the question. What is really coming up from the findings from Bangladesh is that the one-on-one contact and working with the households is very important. There is a strategic conversation required on trying to figure out how to make that contact happen and making that happen in a way that supports behavioral change.

- The other important question is what kind of evidence is most useful in this context. Here more formative research is needed on what the constraints are around complementary feeding and the hygienic practices around exclusive breastfeeding (there are some gaps). Does the nutrition community in Odisha know why those gaps are there? Does it need to do some formative research? Does it need to do some operational research to understand what would help frontline workers, ASHA, AWWs, and ANMs actually support behavioral change of households? Does it need an impact evaluation?

- Does it need to do a costing study to estimate how much interventions cost? Currently, IFPRI is doing a costing study in Alive & Thrive and found that the interventions do not cost very much. However, you need to do the costing work to convince people.

Before completing her presentation, Dr. Purnima said, “I look forward to hearing Dr. Vandana’s comment and to discuss these issues.” She left the audience with the following questions:

i) How can one better orient current programs to prevent undernutrition through the support for optimal IYCF and hygiene practices?
ii) How can innovations like the use of media and/or women’s groups support behavior change?
iii) What roles can support schemes like Janani Surakhya Yozana (JSY), Mamata, and others play in improving IYCF?
iv) What kind of evidence is most useful?
    - Formative research?
    - Operations research?
    - Impact evaluations?
    - Costing studies?

Expert Comments by Dr. Vandana Prasad ……

Before giving her expert comments on the presentation, she wanted to know what population norm was used and what the frequency of household visits was. Dr. Menon replied that the population norms were actually not that different from what are followed in India. The community health volunteer is the first visitor who covers 250 to 300 households, which is almost the same as an AWW in India (an AWW covers a population of 1,000, which translates to approximately 250 households). In the first 2 years of life, the total number of contacts made is 24 and they are timed differently. There are more intensive contacts around the first 8–9 months and after that, normal contacts are made. The nutrition promoters support 10 community health volunteers and 2,500 to 3,000 households each, which translates to approximately 300 children under 2years. The workers make 12 contacts with each of these 300 cases. Dr. Vandana shared the following comments on the presentation:

- Interpersonal communications is very vital to IYCF. What blocks IYCF or exclusive breastfeeding or complementary feeding is the interpersonal relationships in the community or human relationships. It would be, for example, somebody's husband, mother-in-law, or elders in the family, etc., who tells a woman what to do and not do. These are the power relations that eventually lead to the outcome of a woman doing or not doing something. So after one understands that human relationship, they then can change that equation to make something happen.
- In our grassroots work and our practice on malnutrition in communities is that having a research eye to programs is very important. It is a very empowering thing for the people who are engaged in the program.
- Our frontline workers have to feel that they are party to the full program cycle. Particularly, data sent by them should be used at every level. However, the AWWs and AHSAs hardly ever do any data analysis to make any programmatic interventions. It is very challenging for semiliterate village women to do data analysis; it requires handholding, supervision, training, and capacity building, which are very important. Once someone's capacity is built, he or she does not need anyone to tell him or her what to do. They know and understand the whole cycle and they know that they are responsible for the whole cycle.
- There are tools at the community level that promote research. For example, growth monitoring gives very simple data and can be analyzed simply. However, this data is not used effectively, which is a concern. For the completion of the programmatic cycle, the analysis has to lead into actions that workers can understand and do at their level.
- There are strong practitioners who believe that interpersonal communication is the only thing, some feel that household visit is the only thing, and some others believe that group work is the only thing. However, all are required. EKJUT believes, that Participatory Learning Action (PLA) in-group can bring improvement in nutritional status of children. As they are working more and more on malnutrition, they are also realizing that other things are needed. The ASHA program has not yet engaged with in-groups. At the policy level, there is a gap. The ASHA and the AWW is supposed to do intensive home visits. However, what we need is a combination of both, i.e. working in groups as well as working at the individual household level.
- Just IYCF will not shift exclusive breastfeeding. More women are engaged with economic activities in India, so giving the time up while they work is a concern. Therefore, without maternity crèches, exclusive breastfeeding and complementary feeding is unlikely to go up.

She finished her comments by saying that operation research reveals which interventions and strategies are most appropriate. It helps to understand very soft issues relating to operations.

Technical Session – I

Delivering Direct Nutrition Interventions to Improve Maternal and Child Nutrition in India

Presentation 3

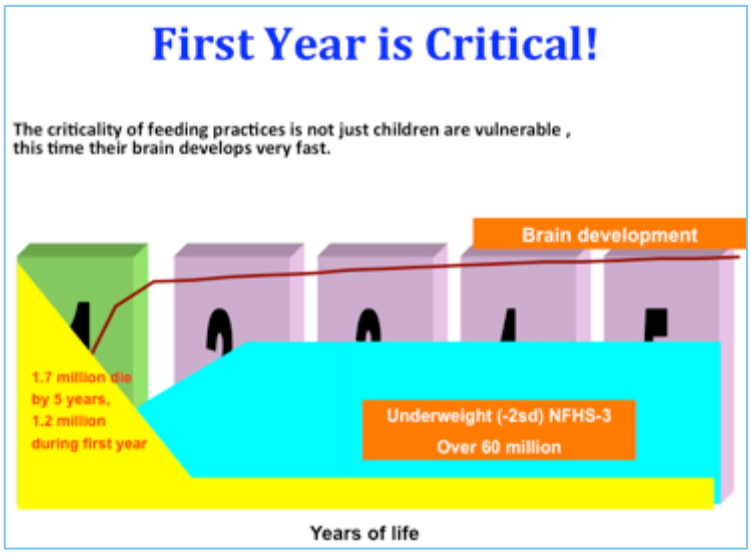
Addressing Capacity Gaps for Improving IYCF in India

Dr. Arun Gupta
Regional Coordinator at IBFAN Asia / Breastfeeding Promotion Network of India (BPNI)

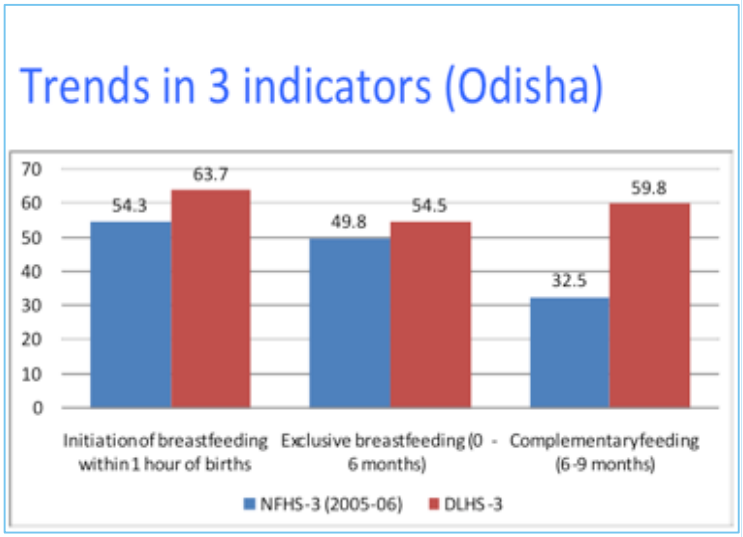
Dr. Arun Gupta thanked the Government of Odisha for inviting him to make his presentation and said that he fully agrees with what Dr. Vandana said during her presentations about the need for focusing on the basics of IYCF practices. He made the following main points during his presentation:

- There are three practices requiring focus under IYCF, among which, exclusively breastfeeding for the first 6 months stands out due to its value and benefits, which has been demonstrated globally. All three practices up to the age of 3 years require protection, promotion, and support. These are the three elements that were recognized as early as 1979 by the first formal global meeting of WHO, UNICEF, civil society, industry, baby food industry, etc. This meeting led to the development of a breastfeeding substitute.
  - The first element is to provide protection to children. It is important that the children should be protected from the commercial sector (e.g. children under 6 month should be protected from the commercially produced milk powders). It is also important to include the protection of children from the commercial sectors in the list of essential inputs for nutrition that are presented in the first technical presentation.
  - The second element is promotion, which includes messaging and information on what is normally being practiced. It includes skill counseling, one-to-one counseling, media, any other behavior change communication, etc. Just passing the information to women about the breastfeeding, complementary feeding, etc. would not be enough to bring behavior change.
  - The third element is support, which is the most critical. If, for example, we gain exclusive breastfeeding over 2 years by an increase of 10 points or 20 points and there is no systematic change in place, it is likely to fall off. Very recently, some new analysis also showed that in countries where the systems are put in place that it took about two to three decades to set a sustainable motion towards increasing these practices than in countries where they were not put in place.

- Mostly, people talk about under-five but the first 2 year of life is very important and the focus can be further narrowed down to first year of life as shown in the diagram. For example, among the approximately 2 million child deaths in India, most of the babies die within the first year of life and then in the first month of life. That is an important thing to note.

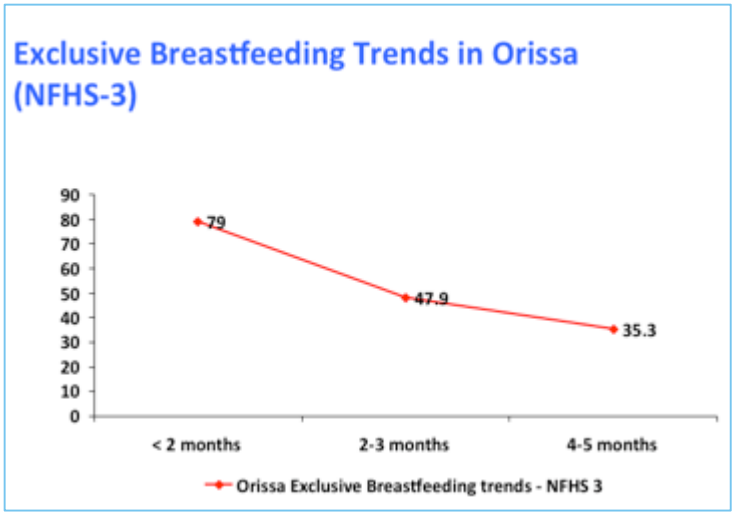


- The growth faltering starts during 3-4 months and then it progresses and remains static after 1 ½-years (might differ from state to state). The point is that the damage is already done in the first year itself. Therefore, the first year of life and even the growth during pregnancy is important for better nutritional status.



- During this period of life, 70 percent of the brain development takes place, though a lot of it happens during the pregnancy part. However, after 2 years, only 4- 5 percent of the brain develops, which is a fundamental to why we work.

- Following are the four national norms of infant and young child feeding, which are known to everybody.
  - Initiation of breastfeeding within 1 hour of birth
  - Exclusive breastfeeding for the first 6 months
  - Timely and appropriate complementary feeding after 6 months along with continued breastfeeding till 2 years or beyond



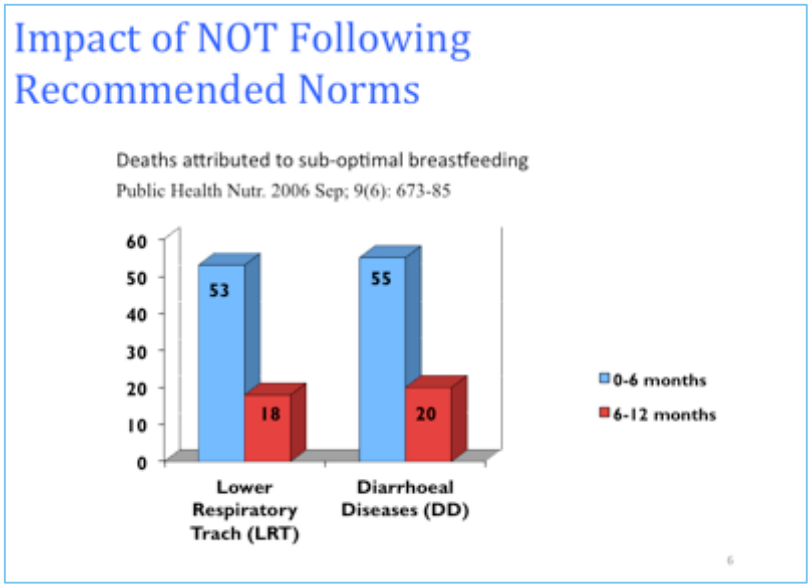
- These indicators have not shown huge progress barring a couple of data points that Dr. Menon showed. Since DLHS data is not available after 2008, a comparison between the NFHS-III conducted in 2005-06 and DLHS conducted in 2008 presented in the graph alongside the text here shows only marginal change in different indicators.

- There is 80 percent exclusive breastfeeding at 2 months, which then rapidly goes down to 20-25 percent nationally and to about 30-35 percent in Odisha when the child is 4-5 months. This might have changed (the data presented here is from NFHS-III, which was released more than 8 years ago).

- Therefore, the whole system has to increase the percentage of exclusive breastfeeding during 4-5 months to the same level as it is during 1-2 months.

- Since the exclusive breastfeeding rate is based on 6-12 months of recall data, there is no certainty about the real exclusive breastfeeding rate of any state within or outside India. If it were counted on a daily basis, longitudinally from Day 1 to Month 6, it would not be surprising if the figure were just 10 percent.

- We are living in a world of mixed-fed populations and all our babies are mixed fed most of the times. Therefore, that is the reality, which we should keep in mind when we talk about capacity. If we are serious about increasing breastfeeding or complementary feeding rates in the country, state, district, block, or village, where only two children are born every month, it is important to not to shift to the harmful norm of more formula feeding but to work towards a norm of exclusive breastfeeding.



- Everybody knows that diarrhea, pneumonia, and newborn infection increase if exclusivity is broken or if formula is given to the baby. These are the three major killers of infants in India; still we fail to invest in increasing the rate of practices that end up saving the babies.

- A very recent analysis by WHO (2013) on IQs, which was updated from 2007, clearly shows that an increase in IQ development from 3.5 to 7 is possible. This is particularly important in terms of giving a start to education, preparing children to learn better, taking up productive activity, and preventing diabetes, non-communicable diseases, etc. The contribution of exclusive breast-feeding in all of these is essential among infant feeding practices.

Dr. Gupta asked the following questions of participants:

Q. What is the current level of initiation of breastfeeding within 1 hour of birth in Odisha?
A. 71 percent

Q. What is the delivery rate in health facility?
A. 81 percent

Dr. Gupta commented saying that there is a 10 percent gap between institutional delivery and initiation of breastfeeding within 1 hour, and the health system needs to address this.

Q. Has exclusive breastfeeding for the first six months increased in Odisha?
A. First two months it increases. Annual Health Survey (AHS) shows 24.8 percent of exclusive breastfeeding.

Dr. Gupta noted that this figure might be disputed, but there is a need to be serious about improving the rate.

Q. What is the common reason for women to adopt other feeding methods?
A. Insufficient milk. Indigestion.

Q. What is the most common reason for not giving adequate foods after 6months?
A. Ignorance about the time of complementary feeding, no knowledge about why it should be given, and unavailability of enough foods.

- It is important to know that there are two types of hormones—prolactin and oxytocin—that help mothers get adequate milk and in the secretion of milk to feed the baby. The prolactin helps to get adequate milk and oxytocin helps to release the milk. Even if the mother has adequate breast milk, it would not be released due to low oxytocin. Oxytocin is dependent on the psychological condition of the mother. Lack of oxytocin happens if the mother is low in confidence or she has any anxiety or suffering from any pain. If the doctor or anyone else tells the mother that she does not have adequate milk, she starts believing them, which affects her oxytocin, and then she cannot release breast milk. Then, due to advice or pressure from doctors, health workers, family members, etc., the mother starts giving formula. This further undermines her confidence and the secretion of breast milk almost stops. Therefore, the more the child is given breast milk, the more it helps in the secretion of the same.

- Industry people want their products to be sold, so they undermine the confidence of mothers so that she starts giving powder milk to the child. There are also health workers, who tell mothers to take outside milk, as they do not have required knowledge and skill to guide her. Family members also tell the same thing, citing their own and others examples.

- Therefore, it is not the research issue here. Everywhere you go, 90 percent of mothers feel that they do not have enough milk for their babies, which is the main reason for supplementing during the exclusive breastfeeding period. Therefore, this is a serious issue for which the capacity of mothers needs to be developed. If she does not get confidence, breast milk flow will be reduced and there will be a feeling of not enough milk and that will continue.

- Now in India, many companies promote their bottle milk. They also promote it on the Internet through advertisements that say, “You give this bottle milk after 4 months and it will be better for your baby.”

- So the question here is what are the solutions to address these challenges? How to increase the capacity at different levels? Building confidence is not a small thing that one can do by spreading a message. It requires listening, talking, giving support and requires accurate information. We are giving accurate information and the government is also giving information. We have also started appreciating (e.g., appreciation of growth monitoring done by mothers). We are also doing negotiation, demonstration, and persuasion through counseling.

- The context should be kept in mind for the counseling. It is not like delivery of a message or a vaccine but it requires a well-trained caring and supportive worker. It has been done and demonstrated in India. It is possible, but requires a lot of hard work.

- The next question is who will do this. We always load more work on the AWWs and ASHAs. If we have to increase the capacity of mothers then we have to enhance the capacity of these facility-based workers, outreach workers, etc. There should be also some system with the AWWs to address issues faced by mothers. For example, when mothers say that they are feeling pain during breastfeeding (around 10-15 percent complain about pain on the nipple so they give outside milk), the AWWs should know that this is preventable and treatable; and there should be a referral system so that AWWs can refer to the higher health facilities. It would not only require enhancing the capacity of AWWs but also require strengthening the capacity of the specialists who would deal such cases. The capacity building can be done through training. If needed, Breast Feeding Promotion Network of India (BPNI) would help in developing and undertaking the training. It requires development of trainers, which are at the level of Child Development Project Officers (CDPOs), supervisors, nurses, etc., who can be developed into trainers. These trainers can train 30 frontline workers in 1 week. For handling the basics at the family level, a minimum of 4 days training is required to touch upon breastfeeding, complementary feeding, and growth monitoring.

- If there were one improvement the government could make, it would be in reporting. How many children rise up or fall down the growth curve in the past month should be reported and must be analyzed at the block level. Therefore, the capacity of supervisors working at the block level must be developed to analyze the growth charts. The capacity of AWWs should be also developed so that they can identify how many children have fallen down the curve at 3 months.

- The next question is whether our system is fully capable to handle all that is needed at the district and block level, including action plans, human resources, etc. In this regard, the state needs analyze its own program and policies in support of breastfeeding and complementary feeding.

- Dr. Arun Gupta made the following suggestions:

  - Commission a study of policies and programs
  - Document gaps and develop an action plan
  - Establish a line item for breastfeeding and IYCF actions
  - Ensure adequate training of counselors and their visits
  - Develop and disseminate informational booklets on breastfeeding and complementary feeding for mothers (local language, local context given out during Months 6-7 of pregnancy)

- Appoint nodal officers at the district and state levels through Government Order (GO) on Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992 (IMS Act)
- Organize awareness seminars for health workers and people at the district and block levels
- Set up a committee for state and district coordination mechanisms to supervise and monitor an action plan

Expert Comments by Dr. Vandana Prasad .....

The important point made by Dr. Gupta is the protection from commercialization. He also discussed the systems and capacities at different levels.

- One of the gap areas in addressing malnutrition is that there is no program for community-based management of malnutrition and the lack of therapeutic food. These issues have been discussed across the country. Both commercial and community-based approaches have been discussed and debated in India because of the Supreme Court judgment, the recent food security bill, and the practice and understanding of the value of community-based production of therapeutic food, which requires roasting and grinding. In the Odisha context where SHGs are flourishing, we should be going for community-based production of Ready-to-use Therapeutic Food (RUTF) though SHGs, which would also empower women's group.

- In some states, commercial RUTF was considered very strongly. Jharkhand is the recent example. There was quite a furor in the country in response to the use of commercial RUTH. It is likely that Jharkhand will also reconsider its plan. It seems they have withdrawn the tender to the company producing easy paste as a substitute or an analog of plumy nut, the French product. In contrast, in many programs we have been using community-based RUTF. The ministry at the center has also given out guidelines on what kind of food can be produced in the community, which can be used for therapeutic feeding. Therefore, the issue of commercial interest and involvement in therapeutic feeding has to be kept in mind along with breast milk substitutes.

- Another important point generally missing in our discussion on IYCF is feeding during sickness. Children routinely suffer many bouts of diarrhea, infections, etc., and if they are not fed properly during that period then that becomes dangerous.

- Now the AHS data is providing district-level figures, which is helpful in comparing districts. The data show one district performing remarkably well and one district performing abysmally. Similarly, from our experience in working in a district, we find a big difference among blocks within a district. Even in states that are doing very well in terms of implementation, there are still wide gaps in certain subareas. In Gujarat, for example, which is claiming implementation up to 80-90 percent, there are still some pockets that are being left out and have 0 percent coverage. Therefore, it is important to target neglected areas. It could be areas with typically migrant population, tribes with peculiar characteristics, populations that face social discrimination, or areas that are geographically difficult. So the mapping of neglected blocks or areas should be the starting point rather than focusing on broad programmatic areas. We have to actively look for neglected areas, map them, and then do programmatic planning for those areas.

- Dr. Prasad questioned how breastfeeding could have a positive impact on IQ development. She questioned how one would even measure whether a child could have an increase or decrease of three IQ points due to breastfeeding.

- The rates for institutional delivery and initiation of breastfeeding seem to be same 71 percent, But if both the indicators are put in a Venn diagram, it would not neatly overlap as some children delivered in health institutions were not initiated breastfeeding within 1hr of birth. Dr. Arun Gupta mentioned, we should not miss the opportunity to ensure that within 1 hour of institutional birth the child is breastfed. It is important that we must recognize the missed opportunity to immunize. When a sick child comes to the hospital, the pediatrician does not actually bother to look at the grow chart of that child. Therefore, we are missing of a huge amount of opportunities within the system between ICDS and NRHM under different interventions. Again, because of that, we are following a very straightjacketed kind of narrow approach rather than the comprehensive approach of keeping children well. Therefore, the pediatrician community can remind themselves about their training on this. They need to do just a simple piece of research by disaggregating the data to look at all the institutional deliveries and see whether these had early initiation. One can easily capitalize on this one opportunity.

- There are some technical issues in measuring exclusive breastfeeding. As per the NFHS protocol, by probing for just 5 to 10 minutes, it would not be possible to get correct data on exclusive breastfeeding. Whether it is NFHS or AHS, often we find that the data comparison between prelatic and exclusive breastfeeding never match. By definition, if 80 percent are prelatic that means exclusive breastfeeding can only be less than 20 percent. The technical and research community needs to look at such technical flaws in the data.

- Another issue discussed is involving supervisory cadre in the programmatic activity. If a time use analysis were done on what supervisors do, one would find that they are mostly engaged in financial management and administration. There is less involvement of supervisory cadre in program activities. In every Anganwadi, there would not be more than two or three red-flagged children. It should be part of the checklist of the supervisory cadre to ensure that they are tracking these children who are not doing well. Although the status of these children would differ in each visit to the AWC, we have to give firm programming tasks to supervisors with the capacities and tools to actually address these rather than just working on finance and management, which will make a big difference to the program on the ground.

- Another issue is the need for tracking trends rather than state indicators. The trend analysis would help to know whether growth is becoming better or worse and whether it is showing upward or downward rather than focusing on flat cutoffs of number of children in severe underweight, mildly or moderately underweight. There is a need to start tracking trends rather tracking indicators. More important is introducing a child tracking system.

- We need a seamless continuum of care. That means between ICDS and NRHM, joint protocols are putout, for example, matching criteria for referral, admission, discharge, admission, and community-based management. In terms of operations, when a child visits any facility whether it is PHC, sub-center, CHC, district hospital, or any ICDS center, that child has to be registered there and all referrals should be made regardless of where he or she was admitted. They have to be registered at that first point of contact, whatever first level of care can be given at that point of contact has to be given, and then the child has to be referred through the system. There should not be any verbal referral but a three-slip referral system. There is also a need for transport, primary, and subsequent level of care. In maternal death, these components make a critical difference so it could do the same for child nutrition and mortality.

Question & Answer Session
(Technical Session I)

Questions / Comments from the Participants

- How will it be possible to ensure IYCF practices when the state government (in Tamil Nadu) gives tax exemption on the selling of pre-lacteals?
- Under the Nirmal Bharat Abhiyan program, the government has fund provision to provide water and sanitation facility at the AWCs. So, why can't there be convergence between the department of RD and the departments of WCD & Health for effectively using that allocated fund for the same?
- There is a need to give special attention to low birth weight babies and adolescent girls while promoting IYCF practices, which will have a positive and sustainable impact.
- The Rashtriya Bala Swasthya Karyakarm is a new scheme recently introduced by the government, which focuses on 4D model—care and treatment of children with disease, disability, deformity, and developmental errors. Children detected under these four categories will be actively tracked until they are cured. Each child will be assigned an ID for proper tracking and will be taken-up at tertiary health institutions.
- The health department of Odisha is interested to know the kind of counseling model developed by BPNI to promote IYCF practices. This would help the department in Odisha to plan and introduce the IYCF and WHO growth monitoring during pre-service training at Auxiliary Nurse Midwife Training Centers (ANMTCs) and General Nursing Midwife Training Centers (GNMTCs).
- We have very limited data sources related to nutrition. When we refer to any sort of nutrition data, we always refer the NFHS, which was done 8 years ago. So, why don't we raise this at the national level forums on the need for collecting nutrition data on a more frequent basis? The AHS provides very limited data related to nutrition. It does not provide data on complementary feeding.
- The AHS data shows only 25 percent exclusive breastfeeding in Odisha but the earlier data collected under NFHS and DLHS (conducted earlier) show much higher percentages. Therefore, which source of data should one believe and use for planning?
- What sort of policy decisions are needed to take under MAMATA scheme so that we can effectively address the issue of early marriage and its adverse consequences in terms of mother giving birth to low-weight babies, still birth, and maternal deaths?
- Safe drinking water sources should be provided at every AWC.
- The construction work of AWC buildings should be given to the respective AWW. At present, the quality of construction is found to be very poor causing water leakages during the rainy season.

- What sort of BCC / IEC strategy do we require to address the issues of IYCF, left-outs / dropouts, and what sort of BCC strategy do we adopt for the tribe who have their own cultural and traditional norms?

- If we look at the current AHS data with all the caveats in mind, we find the neonatal mortality is much lower in tribal districts than some of the coastal districts of Odisha. In addition, the breastfeeding practices both early initiation and exclusive breastfeeding, are higher in tribal areas. So, are some of our policies overriding the tribal customs that are actually protective? What would be our BCC strategy for this?

- We have lot of nutritional data collected through the MIS of departments on regular basis but there are issues around data quality, over reporting of data and data mismatch between health and ICDS. Can we have a system of data validity by health and ICDS so that there is no mismatch and that we get good quality data?

Responses to the questions / comments

- On data mismatching, Ms. Arti Ahuja said that this issue has been raised at the national level forums in terms of sharing mother and child tracking data with ICDS. However, since this is encrypted with a very secret code by NIC, the source code cannot be shared with ICDS. Therefore, unless the source code is shared, it is not possible to include the AWC data in that. Therefore, MCTS needs to share that code with ICDS for including the AWC data.

- In 1992, the IMS law was passed o prohibiting pre-lacteals for babies. In 2003, this law was further strengthened by not allowing the promotion of pre-lacteals for children less than 2 years. However, this law was not implemented at the national level or by the states. Few individuals and agencies implement this. So, both health and ICDS need to agree and implement it. As for giving benefits to companies, there are efforts being made, e.g., public-private partnership to benefit corporations. The IMS law does not forbid the government to give incentives for producing pre-lacteals. It only bans the promotion, e.g., advertisement, reaching mothers directly, sponsoring the meeting of doctors, giving research funds, etc. The law does not stop production of items / baby food. It only bans promotion.

- Regarding IYCF training modules, BPNI has developed modules based on ones developed by WHO and other agencies. The training module address breastfeeding, complementary feeding, and HIV. They are organized into a 4-day session for Frontline Worker (FLW), 7-days session for trainers, and 7-day session for specialized workers (HIV). A 3-day draft-training module is being prepared for pre-service training on IYCF in consultation with different stakeholders. Dr. Gupta said that all these modules would be shared with the Government of Odisha.

- Regarding data, there is a very strong data gap. It would take another 2 years to get NFHS-IV data, which will be probably available after the MDG period. In Odisha, TMST and UNICEF are doing some large-scale surveys. However, the review of concurrent monitoring data shows that core IYCF indicators are not covered. They are not difficult to integrate with the surveillance system.

- There are some issues around exclusive breastfeeding data. However, it is important to understand that the exclusive breastfeeding data is not collected for the entire 6-month period. It is exclusively breastfed in the last 24 hours, which gives us some indication or some sense of the practice of exclusive breastfeeding. The complementary feeding indicators have gone through much more validation process than the exclusive breastfeeding indicator. If one is interested to know how the state is doing for these indicators, there is a need to apply the same methodology to measure any changes / progress. The methodology cannot be changed from study

to study. It is important to use the same validated indicator in each study. Dr. Menon said that IFPRI could support the Concurrent Monitoring (CCM) in integrating validated indicators.

- On the issue of beliefs and customs, Dr. Menon said that beliefs are normative practices and some beliefs have come into place because of the circumstances in which certain populations have found themselves for a very long time. However, they are not necessarily unchangeable. That is where the skill of the very good behavior change management comes in to address those beliefs. The caring group of Ekjut has already done some work to address beliefs on feeding practices. It is worth looking at the findings of this trial. One needs to identify the critical constraints for each behavior, which we want to change. If the belief is the constraint then the behavior change strategy has to address that belief. However, if maternal diet or food insecurity or maternal entitlement is the constraint to a specific behavior then the strategy for changing that behavior has to hit that particular constraint. Formative research is essential to understand the driving factors behind a particular practice or behavior that one wants to change. One has to be extremely focused on understanding what is that one should try to change. There are plenty of experiences, methodologies, and groups of people who know how to do this but we need to bring these things in.

- On addressing the myths and beliefs, Dr. Vandana said that we have to have our processes right. The processes have to start dialogues with communities. It should not be a top down approach by developing messages and then looking at what is working or not working. Many beliefs are protective but finally it depends on negotiation. Therefore, human skills are very important to address these.

Responding to the issue of early marriage, Dr. Vandana said that the law prohibits marriage before 18 years. But the law also says that once the girl is married under 18 years of age and pregnant, one cannot penalize the girl and the child delivered by her. In our system, we cannot deny such cases at least from the angle of human rights and health rights. If a child at the age of 14 is pregnant and approaches a doctor, the doctor cannot deny her treatment because she is underage. She even requires more support than others do. Efforts are being made at various levels to stop early marriage. But, the people working in health and nutrition sector need to provide services to such cases and there is a need to have continuous dialogues with the community to prevent such cases. It has to be dealt through continuous persuasion and support. If that support is there to the family, the parents will never do something that is wrong for their child. So benefits under Indira Gandhi Matritva Sahyog Yojana (IGMSY) should also be opened to such cases because.

- On the need of convergence with the RD department, one of the participants from the health department mentioned that the department has already constituted an equity task force, of which RD is part.

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Technical Session – II

Role of Nutrition-Sensitive Interventions in Improving Maternal and Child Nutrition

Presentation 1

Pathways to Improved Nutrition Through Nutrition-Sensitive Interventions: The Role of Multisectoral Actions

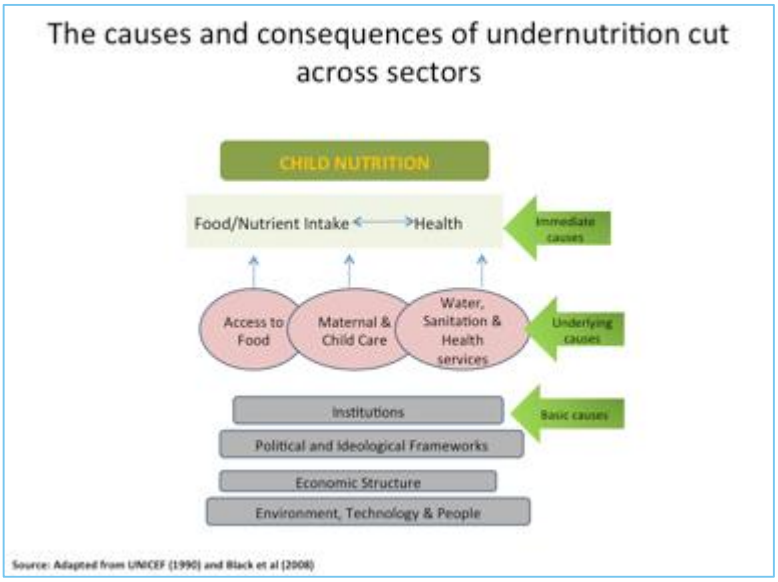
Dr. Suneetha Kadiyala

Senior Lecturer, London School of Hygiene and Tropical Medicine

Dr. Kadiyala stated that her presentation would directly address some of the issues that Dr. Vandana Prasad raised about the macro factors as well as poverty, access to income and food, and other important underlying determinants of undernutrition. She briefly outlined India's development status according to key indicators (with the assumption that Odisha is at India's average if not slightly higher for some of the indicators):

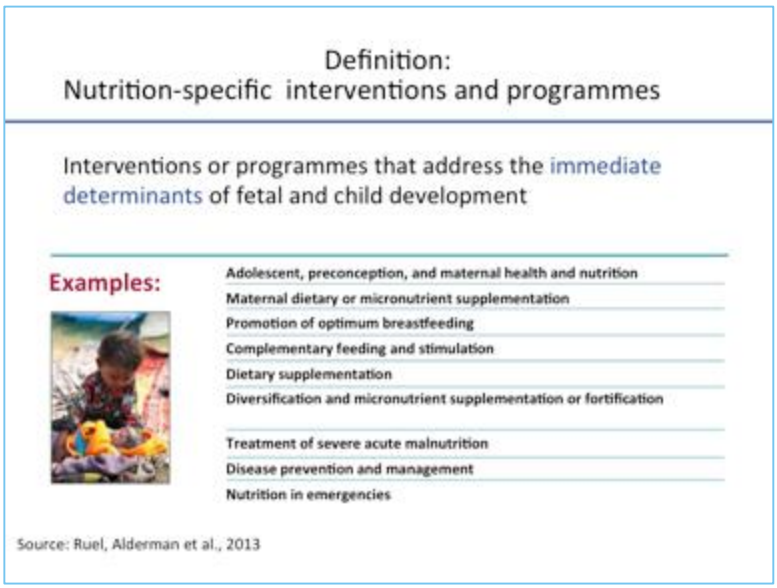
i) There is steady decline in poverty rates, but 42 percent of people still live below $1.25 per day.
ii) Food constitutes over one-half of household expenditures.
iii) Agriculture sector performance is below the target 4 percent growth rate.
iv) There is discouraging progress in human development
- Human Development Index: 134/187
- Gender Gap Index: 113/135
- Global Hunger Index: 67/81

v) There is glacial progress in nutrition
   - 1 in 2 children stunted
   - 80 percent children anemic
   - One-third of women underweight
   - Double-burden of malnutrition (10 percent adults are overweight)



Dr. Kadiyala then deliberated on the need for multisectoral approaches:

- The causes and consequences of undernutrition cut across several sectors, e.g., nutrition, health and agriculture, women empowerment, water sanitation, etc.



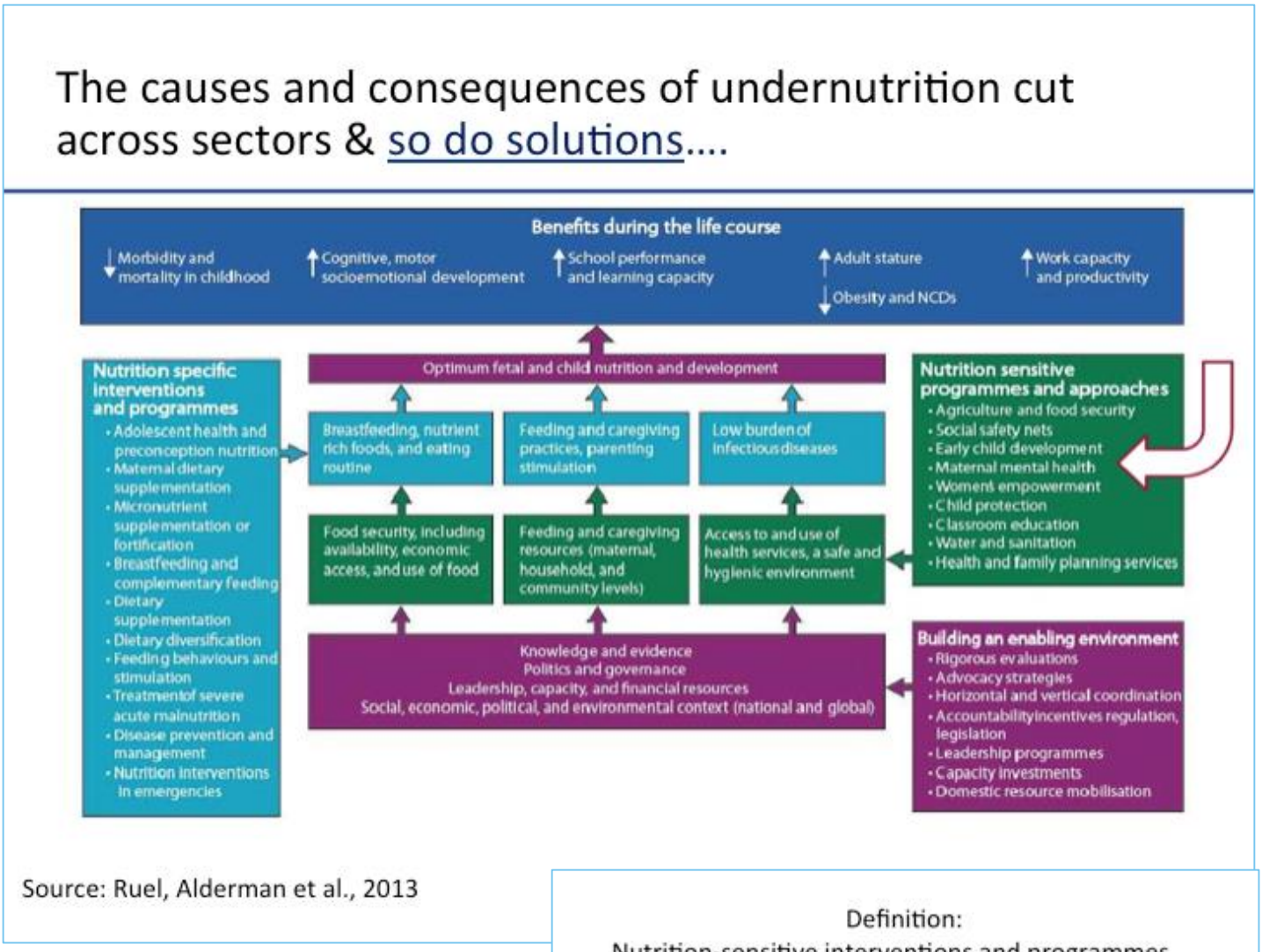
- In the nutrition jargon and in the development nomenclature, we have something called nutrition-specific interventions (presented by Dr. Rasmi earlier) which are the programs or interventions that address the immediate determinants of undernutrition like the determinants of food intake and issues related to food intake and health of children (see box on this page).

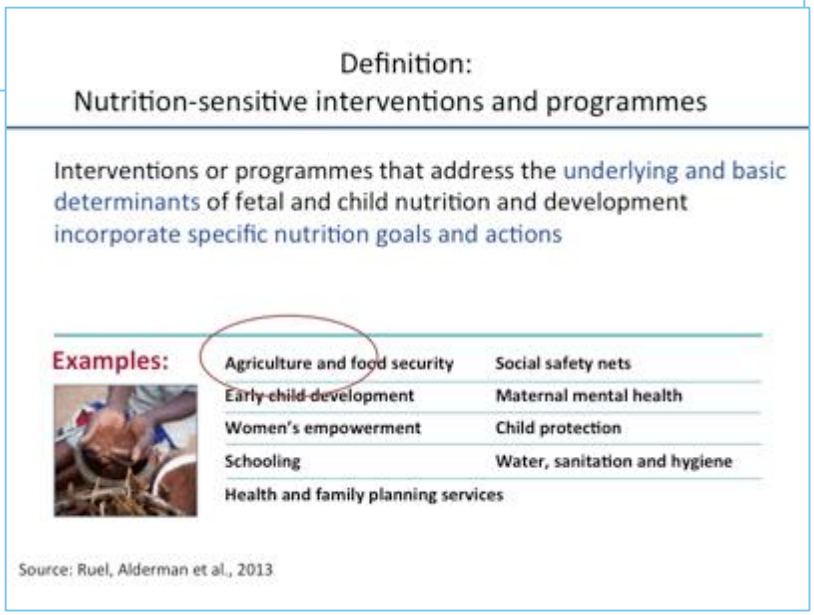
- Effective health and nutrition specific interventions are essential, but they are not enough. According to the latest estimates (*Lancet* 2013), by improving the coverage of 90 percent of nutrition-specific interventions, we will be only able to reduce undernutrition by 20 percent. Since we are far away from the 90 percent mark on several of these interventions, a lot needs to be done first to improve the nutrition-specific interventions and to reduce the undernutrition burden by 20 percent. We do not have choice of not doing that. We have to do them regardless of how tough they are and how expensive they are.

- However, what we also need is the interventions that tackle underlying and basic causes to address the rest of the 80 percent of the undernutrition burden, which can improve the coverage and efficiency of nutrition-specific interventions. However, of course, it has to be along with the nutrition-specific interventions.

- We need investments to understand how to make development interventions nutrition sensitive. For example bringing improvement in women's empowerment would also help to make the choices and actually implement the choices that make an impact on infant and young child feeding practices, ANC, PNC, etc. Investments need to be made to make these broader interventions and development interventions nutrition sensitive.

- It is also important to understand that nutrition-sensitive interventions are important because we know the causes and consequences are multisectoral and so are the solutions. A latest framework on this (see below), which is a much-improved version of UNICEF framework. In the left side of this framework, there are nutrition-specific interventions and on the right side, there are the nutrition-sensitive interventions addressing issues like food and care giving, food security and access to health and sanitation services. Not only the domains like food access, women's care, and water sanitation are on this but it also includes some of the examples and actions and interventions that can be put in place to address undernutrition. To improve the underlying basic causes of undernutrition, we need an enabling environment and governance system that is accountable and responsible, for example, there has to be a political will necessary for an enabling environment.





- We need to understand what we mean by nutrition-sensitive interventions. The

interventions and programs that address the underlying and the basic determinants of fetal and child nutrition and development and incorporate specific nutrition goals and actions are termed as nutrition sensitive.

- Increasing incomes, as we have seen in India, do not necessarily bring improved nutritional status. If there are more specific goals and actions around nutrition starting from an understanding of the problem and then addressing specific peculiar challenging issues, this will help to improve nutrition. Even poverty reduction is unlikely to be nutrition sensitive and seen in many states, districts, and blocks in India. Examples about some of the scope for certain domains and sectors to become nutrition sensitive are presented (see box).

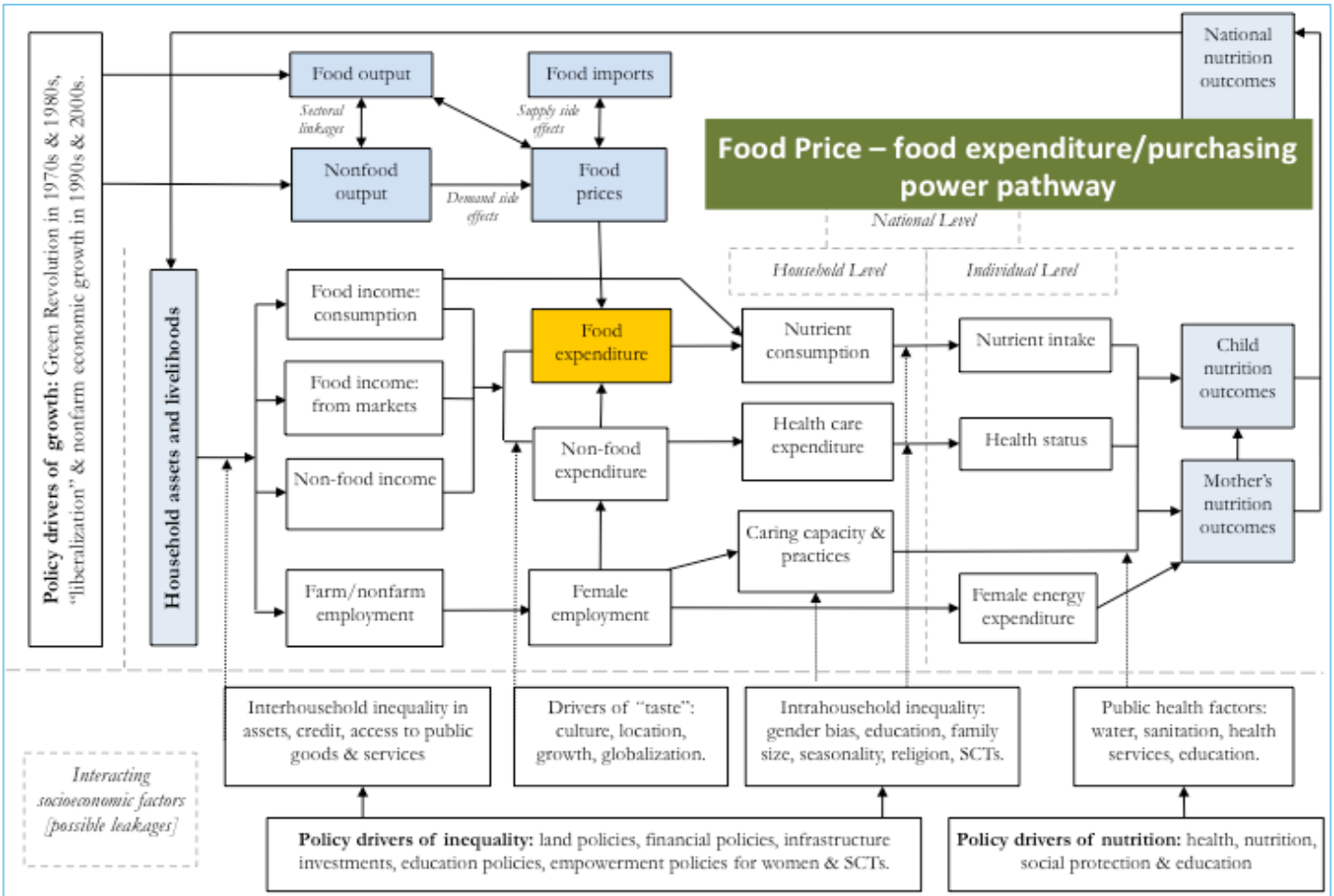
- After a quick deliberation on what is nutrition specific and nutrition sensitive interventions, Dr. Kadiyala focused on nutrition from sectoral perspectives, in specific reference to the agriculture-nutrition linkage in India. She presented the following points to justify why agriculture is important:
  - Agriculture employs 58 percent of Indians.
  - Agriculture employs 83 percent of rural female workforce in India.
  - Agriculture generates over 55 percent of rural income.
  - Agriculture is fundamental in bringing in a more inclusive and sustainable structural transformation.
  - The potential for agriculture to influence nutrition outcomes at scale is large.
  - Agriculture growth predicts reductions in stunting in several countries, but not in India.

- There is no other sector that reaches and engages so many people than the agriculture sector. The global evidence shows that agriculture growth is actually more nutrition sensitive but it is not so in India, so clearly there is something happening in India that there is a disconnect between agriculture, how agriculture sector is developing, and the leakages that it has along the nutrition pipeline. There can be quite a lot of work that can be done in actually minimizing those leakages.

- The next question is what are some of the agriculture nutrition linkages at the macro household and individual levels. Through an initiative called *Tackling the Agriculture and Nutrition Disconnect in India*, between 2010-2011, several stakeholders came together to really understand to address some of these questions on what are the potential conceptual links between agriculture and nutrition and to generate some learning around what is happening and not happening in India. It is known that agriculture is a key driver of poverty reduction but pathways to nutrition are diverse and interconnected.

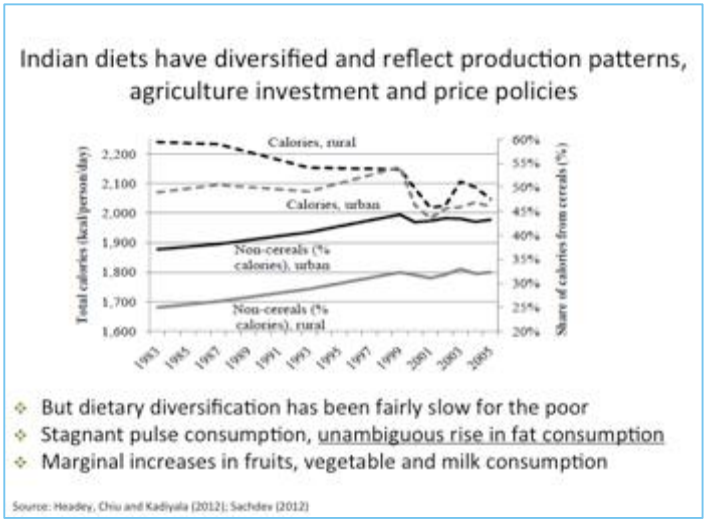
- Agriculture is a source of food, income, and expenditures. The gender dimensions in agriculture are also very strong in terms of women's status and intra-household decisions and resource allocation; women's ability to manage young children; women's own nutritional status; etc. The majority, 83 percent, of the female labor force in India is already in agriculture, which has implications about their control of income and household resource allocation, their ability to manage young children, and their own nutrition status which has implications for the intergeneration cycle of undernutrition.

- A conceptual framework is given hereunder to map each of those pathways. The pathways include one micro and a household-level one. The highlighted portion in the framework shows the implications for food prices and food expenditure pathways in India.

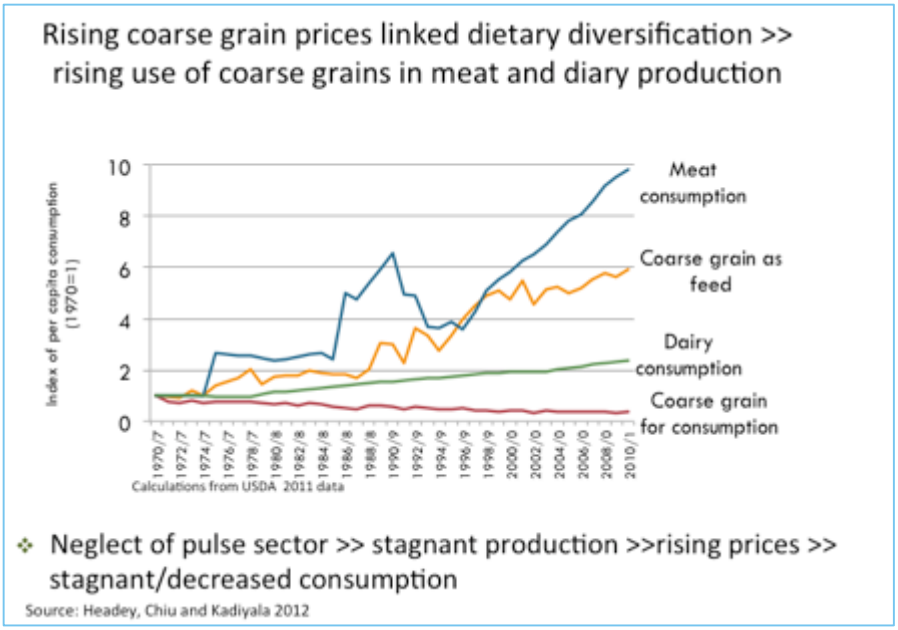


Source: Headey, Chiu and Kadiyala (2011)

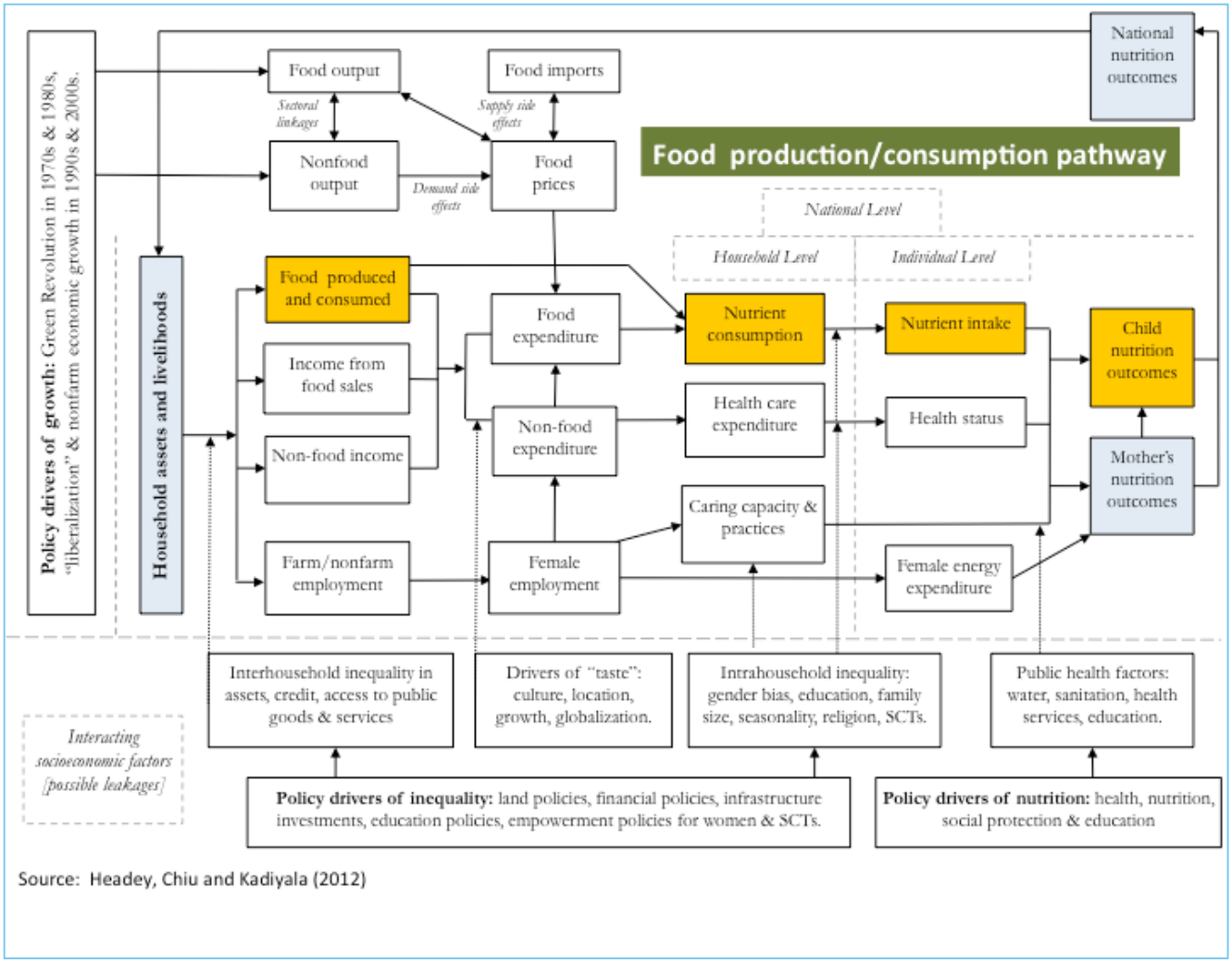
- As shown in the graph, Indian diets overall have been diversifying and reflect the macro changes in agriculture investment. India has invested a lot in cereals and therefore there is less of a calorie deficit now than before. The overall diets are also diversified. The non-cereal share is an indicator of the total expenditure of food share and dietary diversity. The dark solid lines at the bottom in the graph show an upward slope from 1983 to 2000 but then taper off a bit. Overall, we find that our production patterns are reflected in stagnant pulse consumptions and in marginal increases in fruits and vegetables.



- We also see that more of the coarse grains are used in meat and dairy production due to increased consumption of meet. We also see that coarse grain prices go up because their consumption goes down. So clearly, there are linkages among all these, which are playing a major role.



- We also see the growing of various crops and having livestock are important at the household level for dietary diversification. So there is a clear link with agriculture policy in terms of improving crop production, diversified crop production, enhancing livestock production, etc. This is one of the examples to understand in terms of how one can think about nutrition-sensitive interventions.



- The next one is the women's empowerment. The *Lancet* series, which has done a systematic review, shows that empowering women have many beneficial impacts and can affect nutrition. There is evidence that men and women allocate food and other resources differently. Evidence shows that there are positive impacts of cash transfers and agricultural programs on measures of women's empowerment and negative association between disempowerment (e.g., domestic violence) and child nutrition outcomes.

- Dr. Kadiyala then discussed India's experiences with multisectoral approaches to nutrition. She explained the operational definition of working multisectorally, which focuses on how to work more comprehensively to bring the policies, programs, resources, and actions to bear at the same time and place on the same child.

- Since 1993 up to the *12th Five-year plan*, India has attempted, at least mentioning in various policy documents, the idea or the notion around a comprehensive nutrition policy drawing on various sectors. However, there has been some disconnect and lack of coherence in how that has been articulated and taken forward. But, right now, there is a new dawn in terms of the multisectoral nutrition plan in the 200 high-burden districts, which is now finalized.

- Several states have also initiated multisectoral initiatives. For example, states like Karnataka, MP, Gujarat, and Maharashtra in their own ways have set-up certain nutrition missions and AP has passed a government act in which elimination of poverty has been focused. Now, the community mobilization strategy using self-help groups is going through almost national scale in some form or the other in various countries including Odisha.

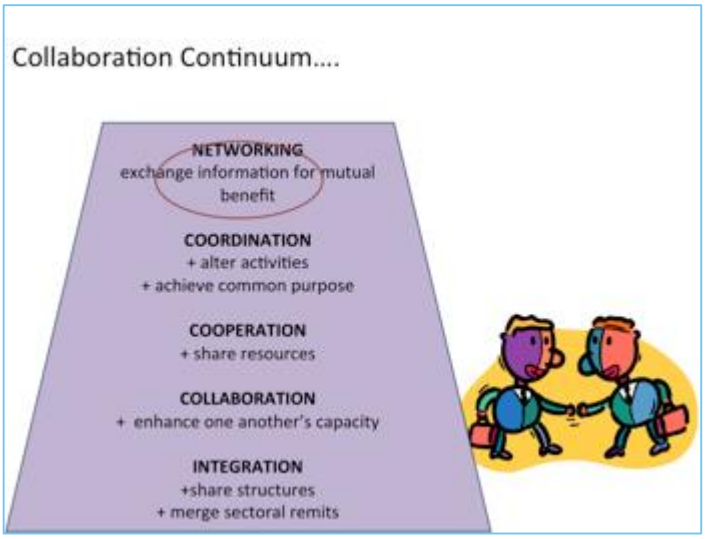
- As Dr. Vanadana Prasad said, Odisha is already conceptually there and operationally it has already started several safety net programs, which are being led by various departments. Ms. Arti Ahuja mentioned about the institutional linkages and mechanisms at state, district, block, Grama Panchayat, and community level. There are several schemes like Mamata, Sabla and the Malaria & Malnutrition, use of Janch committees, and SHG's to improve service monitoring and accountability. This is one of the mechanisms to improve nutrition of adults and girls, vocational training, lifecycle training, and mainstreaming for out-of-school adults and girls. There are four different departments involved in this scheme. So, several things are already happening in Odisha.

- Overall, in India, we see that the policy direction is gaining much more momentum now on the multisectoral approaches than ever before. But, there are several gaps in operational guidelines and question include, How it is designed and implemented? How does the states' nutrition missions set up? How do they relate to the multisectoral plan? All these still need to be resolved and a lot needs to be done.

- So the next question before us is how do we make all these nutrition safety net programs and mechanisms really work for each child and each mother at the time that they are required. That is the question we need to think about.

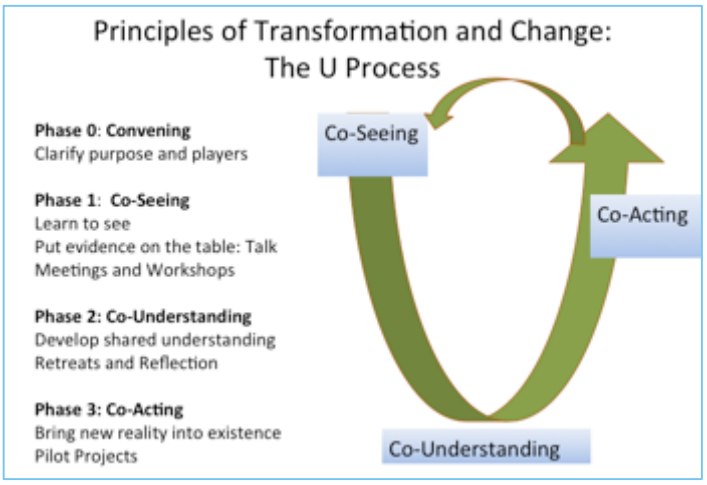
- A colleague of mine, James Granet, has conducted a global review on experiences of several countries like Colombia, Senegal, Brazil, etc., on how have these countries tackled undernutrition by drawing various sectors. This review tells different ways of how they collaborated in terms of networking, coordination, collaboration, and integration.

- In India or any of the states in India, we are still in the networking phase but at least we need to get into the cooperation phase in the next 2-3 years.



- Malnutrition needs to be given top priority though it important to get political space but this also requires the space in bureaucracy. We need a common language, identifying solutions, and institutionalizing coordination within and across sectors. Again all key actors need to agree on what to do. It is not enough to just obviously network and share problems but we all need to agree on what to do. As mentioned by Dr. Menon, in her Alive & Thrive presentation, everyone's role and responsibility has to be very clear. Capacities can be built even when they are pulled, but there needs to be certain kind of mechanisms put in place for that.

- There are several tools used in different countries for this. In Colombia, they used a management tool called a 'U' process where sectors come together for clear purpose, then co-see the problem or learn to identify the problem, then talk and agree to work, then co/share-understand the problem, and then a co-act. All these can be put under one box, i.e., co-learning.



- We also need a strong data system unlike a conventional big database system in SPSS. As Dr. Vandana pointed out, the system has to be seamless and enables discussion and verification across sectors, so information does not get lost.

- It is not the time to talk about how we achieve impact but more about how do we even start. First, we need to develop the rational. For example, the rationale for why the agriculture sector should be engaged. We need to develop and hypothesize pathways on why a certain sector will change nutrition outcomes or contribute to the change and how. Then, there is a need to invest in evidence building and show the effects of the work, which will offer learning and keep the momentum going. Of course, in the context of changing political parties and changing bureaucratic authorities, we need to inoculate these programs against political and bureaucratic change and then nurture lateral leadership.

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Technical Session – II

Role of Nutrition-Sensitive Interventions in Improving Maternal and Child Nutrition

Presentation 2

National Food Security Bill: Implication for Odisha

Mr. Biraj Patnaik

Principal Adviser to the Commissioners of the Supreme Court

Mr. Biraj Patnaik presented the following key points regarding the national food security bill and its implications for Odisha:

- The macro situation in the food and nutrition bill has some positives and some negatives. One big positive, which has happened due to campaigns, case in the Supreme Court, activism, and research findings is that food and nutrition is very much at the center of policy discourse in India today as compared to 15 years ago.

- The amount of space given in media to food and nutrition is far more today than we had before, which is great to see.

- On the flip side, this awareness come at a time when we had two major economic downfalls in very quick succession—one in 2008 and the other is now in India. This has led to the government making a commitment and legislating. But the big question is on whether we will find the money to fulfill such commitments. Therefore, the discussion on the food bill should have been entirely on the kind of interventions that we should do or on evidence-backed interventions. Whether we focus more on access or availability or more on absorption are discussed as side things. The main debate was on the fiscal consideration and whether we have the money or not. Even in those discussions, 99 percent of were around the public distribution system.

- The first positive thing is that we have now the National Food Security Act. It is now a law and it has to be implemented. We have to see what is the best thing that we can make out of it. The biggest takeaway from the bill, which has not been commented on publicly at all, is the universal unconditional maternity benefit that has found its way in the act. Mr. Biraj said that it was a big struggle to get in there. Now every single pregnant and

nursing mother in the country would be getting financial benefit, which is budgeted about 18,000 crores for the whole country. It is good to see that there has not been a single comment on this. The government did not look at the amount, which is a huge commitment from the government in the fiscal term, and is actually the single largest additional component in the entire food security bill. The public distribution system is not that big compared to this entitlement in fiscal terms. Starting from no commitment to making a commitment of something of 18,000 crores is huge.

- The second positive thing in the bill is that at least one component of the ICDS, supplementary nutrition, found its way into the bill despite opposition from the Ministry of Women and Child Development in Delhi, whose basic position was that having the ICDS in food security bill would mean that they would become accountable. For this, they are not yet ready to become accountable. It would take them 5 years or more to become accountable. One thing that needs to be added to the bill is supplementary nutrition not just for children 6 months to 36 months old and 36 months to 72 months old but also for the pregnant and lactating mothers.

- Lastly, this is the first time we have the piece of legislation that has two things: one it creates, recognizes, and acknowledges the right to food, and second, it places and gives importance to programs like '1000 days' in a rights-based approach. Although there are so many things that need to be done, this is the small step in the right direction.

- The flip side of course is that none of the other key social returns particularly pertaining to water and sanitation, access to quality health care, etc., are there, which is in my view, is the biggest single barrier and the biggest single challenge in India. At present 52 percent of all open defecation in the world is in India. According to Census, almost close to 70 percent of households do not have access to private toilets. None of the countries with the problem of malnutrition has a similar situation of sanitation. That is going to be the single and biggest disadvantage for India.

- The other challenges are from the farming sector, where 250,000 farmers (a quarter of farmers) have committed suicide since 1996. This is the largest record of mass suicide. Talking about food security and not doing anything about that is one of the biggest flipsides.

- In the bill, there is no provision of pulses, quality food, and proteins either in the public distribution system or in the facility. There is no intervention for children with severe acute malnutrition, children with moderate malnutrition, or for people in the emergencies like disasters. All of these are proposed by the multinational advisory committee.

- Lastly, there is nothing for the urban poor in the bill. Brazil has brilliant program of public canteens that are successfully run. Tamil Nadu, Maharashtra, and Chhattisgarh have programs as well those are run very well. However, these are not in the bill. Cost wise, e.g., providing subsidized food or free food is not high. These are some of the other sides of the bill.

- Not all these flip sides mean that the bill does not address issues in nutrition. So on the contrary, there are positive externalities linked to nutrition. First, the fact is that the government is providing subsidized cereal to poor households, particularly, who are living in the lowest wealth quintiles and who have up to 60% of their household income is spent on food, which enables the households to save money on the same and spend on other food items. When we say food for the bottom two-wealth quintiles, more than 80 percent consumes only basic cereals because they do not have access to food. The government is providing the subsidized food where 60 percent of

household income is spent on food, which means a significant part of it is subsidized and that allows saving, which potentially can be used for other food items such as proteins, vegetables, pulses, etc. That is the largest positive externality.

- The second externality is that there is national recognition of what Odisha in terms of decentralizing the entire delivery mechanism for supplementary nutrition. In the bill, not just for the ICDS but also for the public distribution system, there is a proposal to remove private intermediaries and replace them with public bodies.

- As far as ICDS and MDM are concerned, in the last minute, some strict specifications were added to Schedule 2 insisting that the Food Safety and Standards Authority (FSSAI) standards be followed for supplementary nutrition (e.g., it should be micronutrient fortified), which needed to be specified in the rules but were not discussed.

- The national food security act is the central legislation and there is the bill. How can we leverage the national food security bill for better nutrition outcomes in the state? There are four schemes / entitlements in Odisha—ICDS, MDM, PDS, and maternal benefit schemes. Two of them, ICDS and maternal entitlement schemes, are under DWCD. Within the ICDS, there are SNP component and other components. The good news is that the bill allows state governments to do anything related to any of these schemes or introduce any additional measures that they feel fit in addition to what the national food security act provides. This means that the national food security act has become the basic minimum. Beyond that, states can do what is permitted.

- There are two main things that Odisha can do and take a lead in which other states have not yet done. Every act needs rules. Neither the central government nor the states have framed the rules. All the additions that have been provided and that the Odisha government is currently providing need to be inoculated against future political and bureaucratic actions by explicitly mentioning the rules. The rules should be there to raise the bar from what the act has provided. However, these rules cannot be framed by DWCD. It has to be framed by the food department. The DWCD can frame the rules for the components pertaining to them and then give these to the food department.

- If Odisha can take a lead in framing the rules for maternity entitlement, this would provide clear guidelines and directions. Again, this is central law but the state can do more than what is done centrally. One of the examples is the pension department. The state government has done three times more than what the Government of India is doing on pension, which is now a nationally recognized action that other states can replicate.

- The act in terms of grievance redressal provides for two kinds of mechanisms.
  - One mechanism is, which is given in a single clause, that the departments or state governments must have their own internal grievance redressal mechanism like a helpline, call center, etc. It is a great opportunity for Odisha to create a demand for a grievance redressal mechanism. Most of our programs, even in Odisha, do not have very robust and accessible internal grievance redressal systems (internal to the department). If helplines can work very well in PDS, there is no reason why a telephone helpline cannot work in ICDS. However, a lot of backend work needs to be done to ensure that the grievance redressal processing actually happens in terms of complaints are received and actually addressed. This is one area where DWCD can work.
  - The second area is the external grievance redressal mechanism, which the bill provides, but again no state or the Government of India has created a Grievance Redressal mechanism in the bill. Every district has to have a District Grievance Redressal Officer (DGRO) who has the power and authority to address the complaints at the district level. Every state has to have a State Commission comprising of five members, chairperson, and

member secretary who is no less than the rank of a joint secretary to the Government of India. It is not a perfect system. It should have been much more like Right to Information (RTI) for instance. There is no penal provision in this. The essential commodities act makes offences cognizable and non-bailable. But these things have not been incorporated in the national food security bill. As a first step here, DWCD and HRD should get together to decide on how to frame the rules and get the ball rolling on that. Again, when the rules are being framed, the next question is how you would introduce it because much of the grievance redressal handled by the food ministry is on PDS, which makes the focus on child nutrition lost. Therefore, the challenge is to see how Odisha can take a lead and set an example by building a grievance redressal system that recognizes the needs of children under the age of 6 years and pregnant and lactating mothers.

Mr. Biraj concluded his deliberation saying, "We are here to support on all these areas if the department takes the lead."

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Expert Comments .....

Dr. Vandana Prasad: The term malnutrition is completely not in the act. Thus, we do not have any legal underpinning for guaranteed services for malnutrition. There is also no right to health, though Mr. Biraj said that the act gives the scope to frame rules by the states. The nutrition policy is not in sync with the programs. There is no policy to direct the stakeholders and players both at the national and state level. It would be highly useful if the state could take a lead on this, which would really help and sort out many of the coordination difficulties found with the donor agencies and multiple kinds of programs, some of which thrown out hurriedly. A good, well-debated, state-level nutrition policy for a state like Odisha would certainly help the sector a great deal, something that can be done quite easily and will have quite high impact. Overall, advocacy is required to have the right to child health and within that an up-to -date nutrition policy would really help.

On the grievance redressal, the children's right to food is a very specific issue, which is not coming out in the national food security act in India. We have tried to position the State Commissions Act and the National Commission for Protection of Child Rights, Children's Right to Food and Grievance Redressal Act but these were rejected. However, it is not to say that we cannot continue doing that if we have the capacity.

Dr. Purnima Menon: Odisha is really trying to do some good work. But it is important to see how this becomes a model-driven exercise for things that need to happen with much larger skills. It is important to have a strategy and look at which are those things absolutely required. It is important to review what things have worked well in nutrition and identify which multisectoral processes would work for nutrition in Odisha.

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Technical Session – III

Mobilizing Stakeholders for Improving Nutrition

Presentation 1

Nutrition Agenda in Odisha: Perspective of the Stakeholders

Ms. Mamata Pradhan
Sr. KM Coordinator, IFPRI

Thanking Dr. Purnima for introducing her, Ms. Mamata Pradhan, being an Odia, expressed her immense pleasure to present for the first time in her home state in her 14-years career. Ms. Mamata said that the policies, programs, resources, and actions (also shared by Dr. Suneetha in her presentation) are really needed for better nutrition outcomes. But one important thing missing is the stakeholders and actors to influence those policies and programs for better resource allocations, better actions, and better nutrition outcomes. She outlined her presentation, which included: the rational for mapping the stakeholder landscape nationally and in Odisha, the mapping method, the mapping process, and findings and recommendations for the state government. She made the following points:

- Understanding the stakeholder landscape is very important. Nutrition policy literature shows the importance of actors and actor powers, as they are very important in shaping how issues rise to prominence (Shiffman 2010). Research on nutrition policy processes identifies many societal conditions, catalytic events, structural factors, and most importantly, the behavior of actors as key shapers of the policy process (Pelletier et al., 2011).

- The Odisha Government requested IFPRI to do the mapping exercise. IFPRI has done stakeholder mapping at the national level and in Uttar Pradesh and Madhya Pradesh. The nutrition policy space in Odisha has diverse stakeholders. There is the government departments, donors, non-government actors, development partners, etc. These stakeholders in Odisha are both engaged in the funding of nutrition programs and also engaged in facilitating and supporting technical actions. But what is little known about these stakeholders is how they interact amongst themselves.

- The objective behind this exercise was to develop an understanding of how the stakeholders are interacting with each other to achieve nutrition outcomes and to enable the strengthening of this interaction. The method used for undertaking this exercise is called the 'Netmap' methodology (http://netmap.wordpress.com/about/).

- The method is a participatory interview technique, which actually combines social network analysis, stakeholder mapping, and power mapping. It helps to understand and visualize the landscape. This method is very unique in that it examines the power goals, perspective of the stakeholders, and stakeholders' interactions with each other. It reveals how each actor is influential in developing the policy or the plan and looks at ways to improve that process. It also provides deep insight on how things are actually done as opposed to what is written in the formal documents. Those are the actual insights of the people who are there and who are the part of the process and who know the insight of the process.

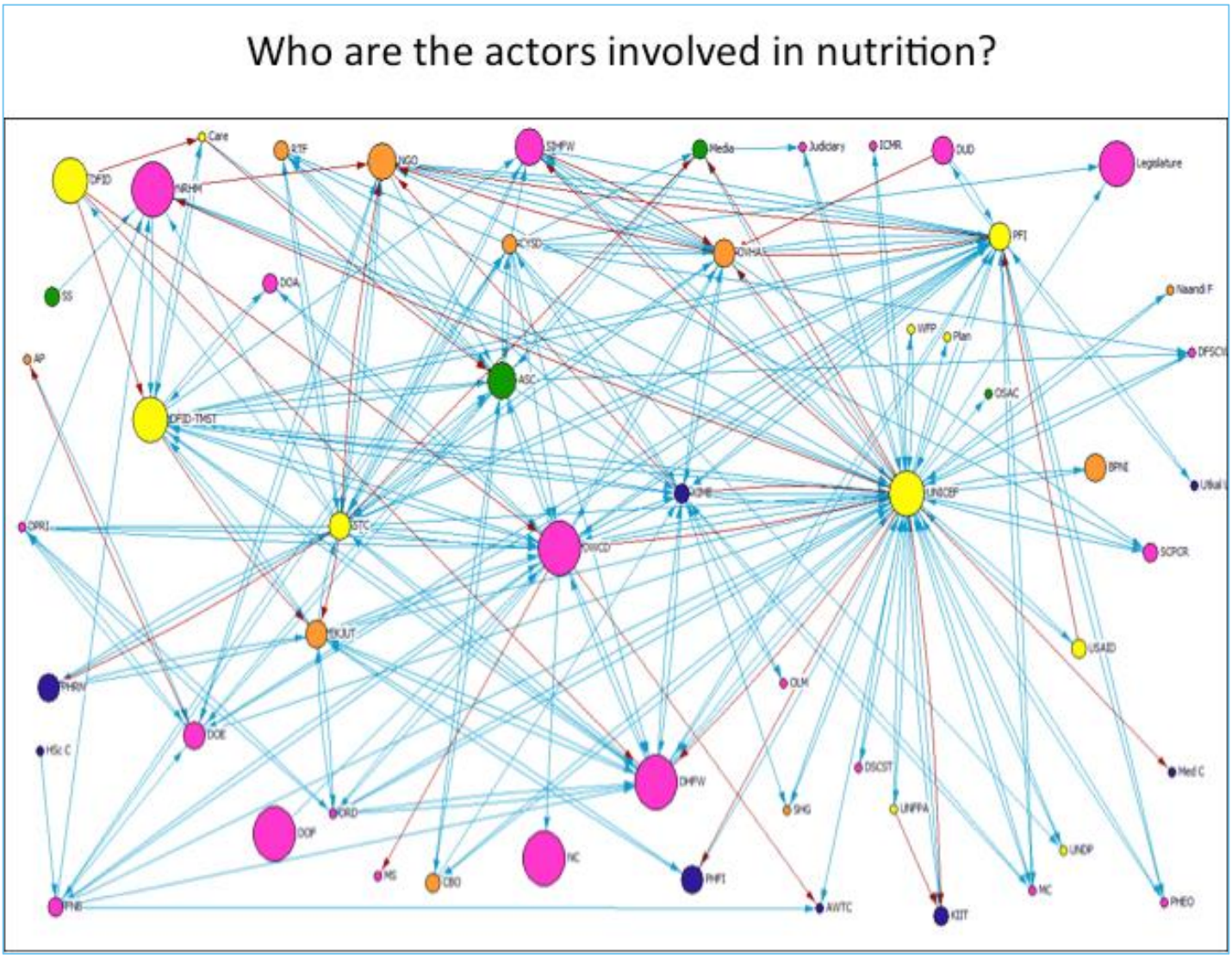
  In Odisha, IFPRI led a participatory, 1-day meeting with 10 people who were knowledgeable and part of the process of influencing policy and programs. Participants were asked the overarching question, "Who is influential in shaping nutrition related policy and program decisions in the state of Orissa?" Using their responses, a map resulted of the critical actors, how they are connected, and their relative influence over each other.

The Net Map Methodology

- Answers to the question also determined the types of links that stakeholder had with each other, whether in terms of technical information or funding flows. A "Technical information" link was defined as when any stakeholder either provides information in the form of technical assistance or support to another organization or generates information in the form of research and provides research-based information to another. A "Funding" link was defined as a links between the two organizations that involved funding of any type and magnitude between the two.

- IFPRI then compiled the data from the map and analyzed it using social network analysis software. Data from notes taken during the exercise were analyzed separately.

- The map shows the complex landscape of stakeholders involved in shaping nutrition policy and program decisions in the state of Odisha. Each circle on the map reflects stakeholders named by the interview participants, and the lines in between stakeholders depict the links related to *technical information* and *funding.* She explained that the blue lines are the exchange of the technical information and the red ones are the funding links amongst stakeholders. The size of the circle for each stakeholder maps depicts their influence or potential influence in relation to policy and program decisions about nutrition. The stakeholders in the network include the government,



as well as development partners, civil society/NGOs, academia, development partners, and others (such as media) who shape and influence the discourse related to nutrition in Odisha. The categorization of stakeholders into these broad categories was also based in consultation with the participants of the interview.

Stakeholders who are highly linked and viewed as being in an influential position

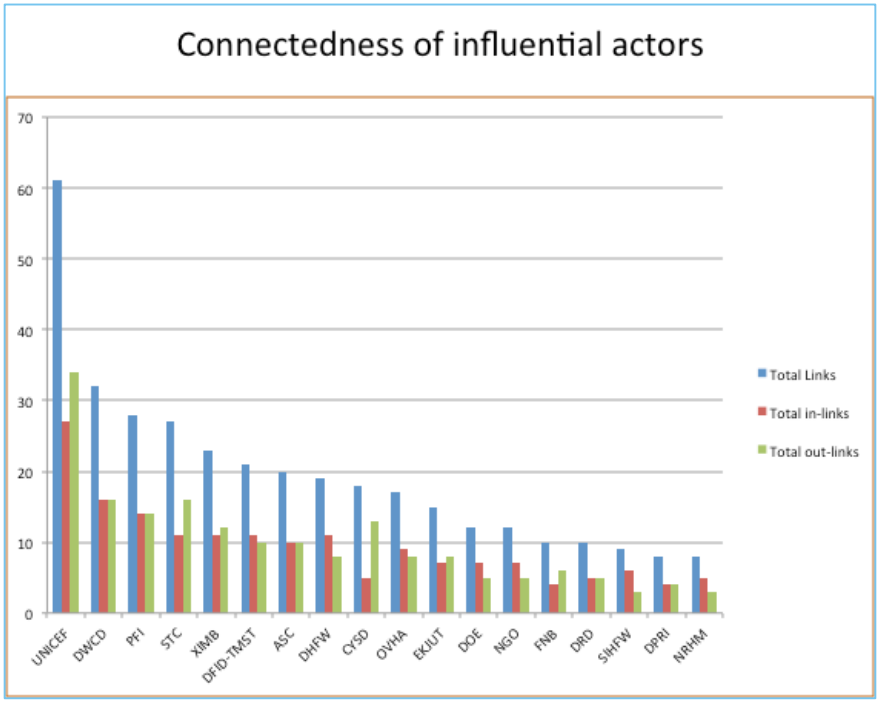
Stakeholder	Total Links	Total in-links	Total out-links	Influence (Score: 1-5)
UNICEF	61	27	34	4
DWCD	32	16	16	5
PFI	28	14	14	2
STC	27	11	16	2
XIMB	23	11	12	1
DFID-TMST	21	11	10	4
ASC	20	10	10	3
DHFW	19	11	8	5
CYSD	18	5	13	1
OVHA	17	9	8	2
EKJUT	15	7	8	2
DOE	12	7	5	2
NGO	12	7	5	3
FNB	10	4	6	1
DRD	10	5	5	-
SIHFW	9	6	3	3
DPRI	8	4	4	-
NRHM	8	5	3	5

- The stakeholders who were identified to be highly linked have the most influential positions. These stakeholders are UNICEF, DWCD, PFI, Save the Children, XIMB, DFID-TMST, Advisor to Supreme Court, and DHFW. The number of total links that is going to each of these organizations is quite high. It is also important to note that the number of in-links for any one organizations means the number of organizations reaching out to the

organization, and the number of out-links means the number of organizations that the organizations reaches out to.

- A positive finding is that the most influential stakeholders on the map are either supportive or very highly supportive of the nutrition agenda. However, some of those stakeholders working on the right to food issue and supportive of the nutrition agenda (academic institutions, State Advisors to the Supreme Court, State Institute of Health & Family Welfare (SIHFW), NGOs, and civil society organizations) are not that influential at the state level. DFID-TMST and UNICEF emerged as the co-funders of nutrition initiatives. UNICEF has a high number of technical links and is investing a lot of money in nutrition programs. So the general interest among stakeholders to work together to move the nutrition agenda is very positive.

- The graph shows how influential actors are connected to each other particularly the top few actors. Among the influential stakeholders, DWCD came up with the highest number of links. DHFW has significant number of links and are highly influential. UNICEF, which is linked to the majority of the map, is influential. DFID-TMST is very reasonably linked and they are as influential as UNICEF. While NGOs like Center for Youth & Social Development (CYSD), Odisha Voluntary Health Association (OVHA), and Ekjut in particular are significantly linked, they are not very influential. It is interesting that the legislature, which was identified to be influential, was not significantly linked. Media, which came out as having a very potential for high influence, is currently not very influential except that some eminent writers who write on the subject of nutrition and publish but they don't seem to be very significantly linked with the other stakeholders.



- So the role of the government in the development partners around nutrition in Orissa is very strong. NGOs also play an important role in exchanging nutrition-related technical information with other stakeholders. Development partners are influential through both their financial and technical supports for the implementation of the nutrition policy in the state.

- Overall, the nutrition stakeholder landscape in Odisha appears to be very much with positive energy behind it. Most of the stakeholders are supportive of the nutrition agenda in the state and they seem to support each other to move the nutrition agenda in the state.

- This continued support and encouragement of these diverse and stakeholders in the nutrition space, the positive energy, and support to nutrition amongst the direct stakeholders in the state will likely to continue to prove positive benefits.

- The recommendations that come out from this exercise are:

  - Create a common platform for all nutrition stakeholders to come together to discuss nutrition-related data and issues, and to identify ways in which diverse stakeholders may best converge efforts in addressing nutritional challenges in the state.
  - With high levels of influence and support for nutrition, the two nodal departments that address nutrition interventions, namely the Department of Women and Child Development, and the Department of Health and Family Welfare, should continue to sustain their support for nutrition and to act as conveners for a nutrition network.
  - Creating spaces for supportive, albeit less influential, actors to engage with the nutrition discourse will help to amplify overall support for nutrition in the state.
  - Strengthening media interest in, and capacity for, reporting on nutrition could also help in bringing more attention to how nutrition is improving within the state.
  - The capacity of some state-level academic institutions could be effectively examined and strengthened so that they may continue to be a technical resource for the government and other stakeholders.

At the end of her presentation, Ms. Mamata said, the links amongst stakeholders are very productive. So all we have to do is to continue to support those links to push the nutrition agenda in Odisha.

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Technical Session – III

Mobilizing Stakeholders for Improving Nutrition

Presentation 2

Role of Civil Society in Setting the Nutrition Agenda in Odisha

Mr. Biraj Patnaik

State Adviser to the Commissioners of the Supreme Court

Mr. Patnaik before starting his deliberation on the topic asked the participants to share their experiences on what they perceive as the successes and challenges in working with civil society.

Responses / Feedbacks of the Participants on Civil Society Engagement

- Overall, positive support comes from the NGOs like CYSD, Pradan, etc. Unlike the people working in government, NGOs devote more time with the people to address their problems. They also extend support to ICDS functionaries. They support more when the funds are directly given to them. However, when the funds are disbursed after the work is complete, NGOs offer less support as compared to when the funds are directly given to them.

- Although, the NGOs are working well and extending support, they are always collecting more data from the AWW.

- An enormous number of NGOs are contracted in the DFID-TMST program, in multiple different areas of our works, including the extensive work in nutrition. It is important to be sensitive to the fact that NGOs are contracted to deliver something in particular, and not necessarily their own product, which can be a potential conflict for the NGO.

- NGOs are doing well in implementation. However, there are also some gaps in their planning and implementation. Many a times, the relationship with NGOs is limited to data collection only.

- There is a need of system and mobility support for effective community mobilization and monitoring.

- In DWCD, many NGOs are involved in programs such as AWW Training, SABLA, etc. Some of the NGOs are good in implementation. However, there are some gaps in the programs implemented by the NGOs. For example, in case of implementation of SABLA, the NGOs do not implement in the way that is expected. They document the activities very well but hardly any outcome-level changes are observed.

- It is quite challenging for the NGOs while working with community and dealing with systems. Many of the challenges are systemic in nature, particularly, if the issues are around infrastructures. Although, there are institutions in the community who raise these issues, the NGOs find difficulty in addressing the same.

- NGOs are weaker in documentation and analytical skills than in implementation.

- They take the side of the most vulnerable. The role of civil society is standing-up for people without showing power. Power is the people. To speak truth to power remains a very important function. Can the state commission play that kind of role and how much do they understand their role? Do they have the capacity to play that kind of role and have the space in the government to play that role? The State commission should actually monitor the government. It is important for the government to encourage them to play that role. There is a need that somebody who speak-up on behalf of the poor people and address their grievances. The tool like Jan Sunwai is very good to address grievances and the state can provide resources to introduce Jan Sunwai. These are the ways where civil society should play a role apart from implementations done by them.

Discussions by Mr. Biraj Patnaik

One of the key challenges for organizations in Odisha, particularly those working on the ground, is that they still do not have (within the civil society) an institutional understanding of the facets of nutrition. As far as the Right to Food or other campaigns are concerned, whether campaigns or network, they always operate from the pressure from below. The pressure from the below is always hunger. People understand hunger much better than the malnutrition. This is the reason why the organization's role responds less to the challenge of malnutrition. There is no pressure on malnutrition or there is no pressure from the community on malnutrition. But people understand hunger, which is articulated more vocally by the community. Therefore, they create pressure on groups and these pressures have been articulated further as a campaign.

That is perhaps the reason why issues like water and sanitation have never been at the core of right to food campaign. The children right to food campaign came above because of people from within and because of the contributions of people from health care background who are much more aware of the social determinants of malnutrition than the groups working on hunger issues. Therefore, the national food security bill is more of a zero hunger bill than of a zero malnutrition bill. This understanding even within the government is weak. The intersectorality issue with malnutrition is weak at the levels of the central ministry as well as state governments. Sanitation has come up very recently within government. Within the system, there is no pressure to have that intersectorality.

In other states, groups have worked far more cohesively on the issue of malnutrition. For instance in Madhya Pradesh, in generating public pressure to make malnutrition a political discourse. That pressure does not happen in Odisha. In Odisha, the pressure has always been on judicial action, action by the national human rights commission, and actions

centered on the starvation deaths particularly in 80s and 90s. The most comprehensive action by any human rights commission anywhere in the world was in Odisha. The human rights commission personally managed the feeding program in the KBK districts of Odisha for 21 years. Over the last 8 to 10 years, it has also been the factor of responsiveness of the administrations, which is responsive to the demand of civil society. It is good that the demand is redressed but at the same time, it is also bad because it has not become the public discourse, as it is in Madhya Pradesh, Tamil Nadu, and Kerala.

In Odisha, you had a tradition where the line between where you cooperate and where you resist is more black and white than in other states. For instance, the most active and articulate are the ones who fight the state on displacement, mining, and land acquisition. On the other hand, the groups, which are working on health care reforms or education or health are not vocal or articulate as compared to national scenario.

In many states, going with the Brazilian model, the state governments are increasingly trying to find ways of creating institutional platforms and mechanisms where there is formal interaction between the state and civil society. For instance, the state has a resource center, where the constitution of the board includes a chairperson from the civil society. 51 percent of the members are from the civil society and 49 percent of the members are from the government. In both Madhya Pradesh and Gujarat, which are going into creating of mission, e.g. the Atal Bal Mission in MP, from top to bottom in the institutional structures and in the governance arrangements, they have ensured that NGOs are present. That is a good move. This is what you would find in Brazil. The Consea in Brazil has two-thirds employees from the civil society and one-third from the Government that from the highest level (President of Republic, important cabinet ministers, etc.). This is seen more and more in other states. Also what governments are doing is that they are not only creating spaces for NGOs in implementation but also giving them space in governance, keeping aside some of the vested groups.

In some way Odisha, simple things like joint review and joint monitoring can be started. In the Government of India, the ministry of HRD every year does the joint review mission, which is headed by somebody from the Government of India and it has somebody represented from the state governments of Joint Secretary level who spend 10 to 15 days in the field looking at the implementation of the MDM in one particular state. In that body, it is mandated in the circular that a representative from the office of Supreme Court Commissioner and someone from UNICEF have to be there. That is the institutional mechanism and they keep receiving feedback from that. The NRHM has successfully done this. The Mission Steering Group formed under NRHM is an example. Every single technical resource group for NRHM has institutional mechanism. The community-based monitoring that the NRHM has now was piloted by civil society organizations. Both in governance and operational structures, there is engagement of NGOs across NRHM at all levels e.g. at the center, state, district, and block levels. It is the state, which has to take leadership and initiative and Odisha can pioneer some of these initiatives.

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Closing Comments by Ms. Arti Ahuja

Commissioner cum Secretary, DW&CD, GoO

Ms. Ahuja shared her closing comments mentioning, "The whole day I got the feeling what one of my professors used to say that to a man with the hammer everything looks like a nail. And today while sitting here I was reminded of that because eventually when we are talking on nutrition, there is just so much and each and every activity we can think of gets related to that. It's very difficult to pick and choose; and to a person who is passionate about nutrition as most of you in this room are it becomes as I said in the beginning very difficult to prioritize, which nail to hit and when. Anyway, couple of recommendations from the workshop, very useful, I have personally learnt a lot siting here today. So many things need to be done. So much that remains to be done. So many convergences have to be happened. So much more are to be done. I just tried to pick out couple of points, which I think I would like to communicate to my team here on what is that we need to do now?"

i) "We need to look now at some kind of a protocol where we identify what are the critical net flags, what are the responses, who are the responders, kind of a framework so that there is clarity across board. It was really well put in one of the presentations that it is possible that the Secretary and Joint Secretary may have acknowledged, but it may not translate down. So one kind of a protocol or one kind of a simple technical document, which is the same across the board for everybody even a family. Anybody reading it should be able to understand. It should not become so technical, so convoluted, or complex that it is only known to the frontline workers and to the managers. What I said in the morning, it is not that the families want their children to be malnourished. Firstly, they may not be aware that their child is malnourished. Secondly, they may not know what to do in case the child is malnourished. So as a State, we have to do that thing and we have to do that quickly."

ii) "The other is about the mapping. Recently we did a mapping with UNFPA across all departments of all women issues. We took the lifecycle approach. So, we have 37 departments in Odisha and for each of those departments we did a detailed analysis for about 14 points. For each of those points, what are the responses of departments, what programs and policies they have that we mapped. From that, we drew the conceptual framework. We also identified the gaps. We have formed a task force on girl child recently and we had the first meeting for that and we presented to all the departments. It was very interesting that they had some very small interventions, which can make a lot of difference. It is just that we have never thought about it systematically. Once we did that analysis

those things came to light. Just to give a small example that many girls are not appearing for matriculation or even higher because of the examination fees, which is a very small amount, Rs.1000/- or Rs.1200/-. But many parents are unwilling to send their daughters for that reason or may be because the uniforms are not given after the primary schooling. These are small things, which are very low cost and can be done at the state level. Even things like cervical cancer for example. Women present themselves when it is absolutely beyond repair because of obvious reasons. The screening of cervical cancer is a very low cost thing. So we got these kind of things which are very critical gaps but not being met or not being addressed simply because we have not mapped it out before. Although we knew, we did not know what the importance of these things before. So I suggest that for our state we must do a similar mapping for nutrition like we did for women issues. Conducting mapping not just in the sense of identifying who is important. Of course, everybody is important in his or her own way but what is it across government departments that is lacking in nutrition and where they can influence. If we do this exercise, I am sure you will come up of with some startling results as we came up with this."

iii) "Again for mapping, we were talking about civil society and what is their importance. I just tried to mention, in Odisha, specially, the activists have been a great support. The social audit that was done by group of NGOs and they did it across seven districts, actually they did it without informing us. They were more pleasantly surprised than we were by the results of the social audit. It is in fact they, who then published what has happened in the decentralization. They continue to do the social audit. We are now asking them to do the social audit for pensions. So the civil society has been very constructive and positive partner for us. Sure, they tell us things that are going wrong. But it is not a confrontational thing to that extent. Yes, we can systematize that. We have been going for all the public hearings, junction wise that have been organized by them."

iv) "We have also created a state management unit for ICDS, which meets once in 2 months or in 3 months where all agencies represent. We have civil society, partner agencies, donor agencies and health department member of that management unit. So I think when we do this kind of mapping exercise we need to take into account all these factors."

v) "The next thing that we need to do immediately is that what Biraj suggested to form rules for SNP and we have the conditional scheme i.e. MAMATA, which is IGMSY + one installment. So sure we will do that. I think we will need the help of Biraj for framing those rules, for at least helping us frame those rules. But we will do that and sent as our contribution to the food and civil supplies department."

vi) "The issue of grievance redressal mechanism, which is very important and we will take it up. We have a toll free help line already for SNP. It needs to be activated. The onus is with us to do that. It is functional but it has to be more functional."

vii) "CMAM is the community management of acute malnutrition. Based on the experiment or success of that experiment of decentralization of SNP where we involve the community, using that platform we have gone ahead with number of things involving the community and CMAM is one part of that."

viii) "We are taking up a pilot in Kandhamal with 3 arms where one arm is a kind of RUTF, not really RUTF. We have decided not to go for RUTF. We will be going in for energy dense food manufactured by self-help groups. One arm of hot cooked meal throughout the day in a Crèche kind of setting and one arm where it will be take home ration we give. It needs to be modified up to that extent. The emphasis is on the first two words, community and

management, not on the product. So we are making guidelines, but still some elaboration we are working on that to make sure to put in those elements of community monitoring and management of malnutrition. That is about CMAM."

ix) "After we do this mapping exercise across all departments and stakeholders, ideally we should come-up with the nutrition policy. But my experience as a policy maker has been that very often policies remain just on the shells; and there is very little follow-up of policies. So, may be even it would be better to come up with an action plan with very clear timelines and responsibilities. Because in my experience, when you do that and you monitor that at the central level the work get started. Policy often becomes more like wish list or statements or desire. Probably, we need to come up with a nutrition action plan. It may not be very ambitious. We have to take up few things but we have to definitely do that."

x) "We have done some kind of exercise like that already for nutrition council headed by the Chief Minister for different departments and what is it that they can do and we have very clear timelines for that too. But I think that needs little bit of elaboration and based on this mapping exercise we may be able to do."

xi) "Lastly in our State, we have been doing many things but I tell you frankly those 5 strategies that I showed you are more of after thoughts after we put that. It is not we started up with as they are five golden rules and we are going to do according to our plan and that is what we are going to do. As we went along, we kept doing things. As and when things came to us we did that. But now I think we have reached a stage, having done all that, we need to tie-up all together, and we need to put it in a prospective and say ok, we have reached this level. After this level now what next? Now it is the time for that quantum jump. The platform is there, and the foundation is there and we have to now build upon that. I feel if we do this kind of exercise, we do that priority setting and we do this kind of putting nutrition on the agenda and following it up through a mechanism, it is not that we need additional resources for that. Within the given constraint and within the given structure also we can make things go. I think in Odisha we have been doing that, without any additional or huge resources. So, within this system how we can work, I think that is what we need to look at now. I am sure with the wonderful team we have in Odisha, we will able to do these things in pretty short time."

After the closing comments by Ms. Ahuja, the workshop come to an end with vote of thanks offered by Ms. Aswathy S, Director, DWCD to everybody for participating and sharing their valuable thoughts in the discussion.

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LIST OF PARTICIPANTS			
SL. NO.	**FULL NAME**	**DESIGNATION**	**ORGANISATION/INSTITUTION**
1	Caroline Haworth	TL - TMST	TMST
2	Jyoti Kanungo	AD cum Under Secretary	W&CD Department
3	B.N.Mohanty	Deputy Director SC&ST.	SSD Department
4	Ms.Arti Ahuja	Commissioner cum Secretary	W&CD Department
5	Ms.Aswathy.S	Director Social Welfare	W&CD Department
6	Ms.Rasmita Panda	Under Secretary	W&CD Department
7	Dr.Rasmi Avula	Post Doctoral Fellow	IFPRI
8	Dr.Purnima Menon		IFPRI
9	Dr.Suneetha Kadiyala		IFPRI
10	Ms.Biraj laxmi Sarangi		TMST
11	Ms.Mamata Pradhan		IFPRI
12	Suchintita Mohanty	Documentation	DCOR
13	Priya Lenka	Documentation	TMST
14	Prakriti Kanchan	Proj. Associate	TMST
15	Sanghamitra Mahapatra	DSWO	Kandhamal
16	Padmini Bakshi	CDPO	BMC-II (BBSR)
17	Bharati Patel	DSWO	Sundergarh
18	Ramachandra Sahoo	SSWO	Gajapati
19	Snehalata Padhi	M&E Manager, NOP	Rayagada
20	Ashok Kumar Das	SI, DWCD	W&CD Department
21	Swarna Manjari Nayak	CDPO	W&CD Department
22	S.N.Pattanayak	Program Coordinator	PHRN
23	Pushpa Awasthy	Nutrition Officer	UNICEF
24	Dr. Anita Anasuya	Sector Lead, Health	TMST
25	Prativa Kumari Barik	DSWO, Malkangiri	W&CD Department
26	Rajkumari Dei	PO, Bolangir	W&CD Department
27	Smarajit Chakrabarty	Project Director	PFI
28	Basanti Hembram	DSWO, Koraput	W&CD Department
29	Padmini Sahu	CDPO, Ullunda	W&CD Department
30	Gokul Chandra Jena	AD, Statistic	W&CD Department
31	Pragnya Sikha Gour	M&E Specilist, NOP	W&CD Department
32	Sanjeev Kumar	Nutrition Specialist, TMST	TMST
33	Dr. Soumya Mishra	Program Codinator	Save the Children
34	Ashalata Mohanty	CDPO, Khaira	W&CD Department
35	Swati Pradhan	CDPO, Daspalla	W&CD Department
36	Baishnab Charan Rath	State training Manager, NOP	W&CD Department
37	Satyanarayan Mohanty	Field Research Expert	TMST
38	Himanshu Pradhan	Senior Program Manager	TMST
39	Prativa Ranjan Maharana	Manager, A & F, NOP	MVSN

LIST OF PARTICIPANTS			
SL. NO.	**FULL NAME**	**DESIGNATION**	**ORGANISATION/INSTITUTION**
40	Nandita Nayak	SPM, NOP	W&CD Department
41	Sitansu Singh	M&E Manager, NOP	W&CD Department
42	Biraj Patanaik	Principal Advisor	Supreme Court Commissioner office
43	Rabi N. Parhi	Policy & Planning Expert	TMST
44	Suraj Shakti Pradhan	Documentation	DCOR
45	Asutosh Dash	Project Coordinator	CYSD
46	Dr. D.K.Panda	TL, SHSRC	NHRM
47	Fr. Renny Abraham	Project Officer	CENDERET, XIMB, BBSR
48	Dr. J. C. Reddy.M	DGM, Naandi	Naandi Foundation
49	Kamalakara Bhatta	DM, Nandi	Naandi Foundation
50	Namita Dash	CDPO, Kuliana	W&CD Department
51	Matilda Dungdung	DSWO, Jharsuguda	W&CD Department
52	Akash Ch. Baboo	Account Assistant	MVSN, NOP
53	Bijaya Mohanty	DSWO, Bhadrak	W&CD Department
54	Dr. Banani Samal	Equity Advisor - NRHM	NRHM
55	Anasuya Sahu	Program Manager, Keonjhar	W&CD Department
56	Urmila Dehuri	CDPO, Dhenkanal	W&CD Department
57	Sandhyarani Devi	CDPO Biridi	W&CD Department
58	Pradip Kumar Mishra	National Coordinator	Save the Children
59	Diptimayee Patanaik	Account Assistant	W&CD Department
60	Santosh Panda	Communication Manager	W&CD Department
61	Jeetendra Patnaik	MIS Expert	TMST
62	Nihar Mishra	M&E Expert	TMST
63	Hrudananda Rout	Trg. Coordinator	NRHM
64	Prof. B. Mohapatra	Director	SIHFW
65	Dr. BB Das	Dy. Director	SIHFW
66	P. Tripathy		
67	Krupasindhu Nayak	DSWO, Angul	W&CD Department
68	Dhaneswar Kerketta	SO, ICDS	W&CD Department
69	Gangadhar Marandi	ASO, ICDS	W&CD Department
70	B. S. Mohapatra	ASO, ICDS	W&CD Department
71	Srikanta Sundar Panda	ASO, ICDS	W&CD Department
72	Laxmidhar Digal	W&CD Department	W&CD Department
73	Sripati Samantaray	W&CD Department	W&CD Department
74	Manoranjan Mishra	W&CD Department	W&CD Department
75	Dr. Arun Gupta	BPNI Coordinator	BPNI
76	Dr. Vandana Prasad	Member NCPCR	NCPCR
77	Aditya Kumar Jena	Manager	EKJUT
78	G. Sahoo	SNO/MDG	S&ME

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Bhubaneswar, Odisha

Web: http://dcorconsult.com Email: info@dcorconsult.com