PROJECT SPOTLIGHT

Implementation strategy
Integrated Child Development Services System Strengthening and Community Mobilization Initiative in Maharashtra

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

TATA TRUSTS

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CONTENTS

"My most visible goal is to do something in nutrition to children and pregnant mothers in India. Because that would change the mental and physical health of our population in years to come."

Shri. Ratan N Tata
Chairman, Tata Trusts

ABOUT US

Tata Trusts is amongst India's oldest philanthropic organisations that works in a multitude of community development initiatives.

The philanthropic work can be traced to its founder Jamsetji Nusserwanji Tata, who was a pioneer, patriot and philanthropist. In 1892, he set up India's first scholarship for higher studies. The JN Tata Endowment was the first of the Trusts, marking the beginning of 128 years of nation-building and community welfare.

Successive generations of the family have followed in his footsteps, pledging vast amounts of their personal wealth to notable causes, education and research, healthcare and art amongst others. Today the several Trusts, founded by different generations, operate under the umbrella of the Tata Trusts.

Through the century, the Tata Trusts have constantly endeavoured to achieve societal and economic development for attaining self-sustained growth relevant to the nation. We have helped build some of India's most exceptional institutions, among them the Tata Institute of Social Sciences, Tata Memorial Centre, Tata Institute of Fundamental Research and the National Centre of the Performing Arts.

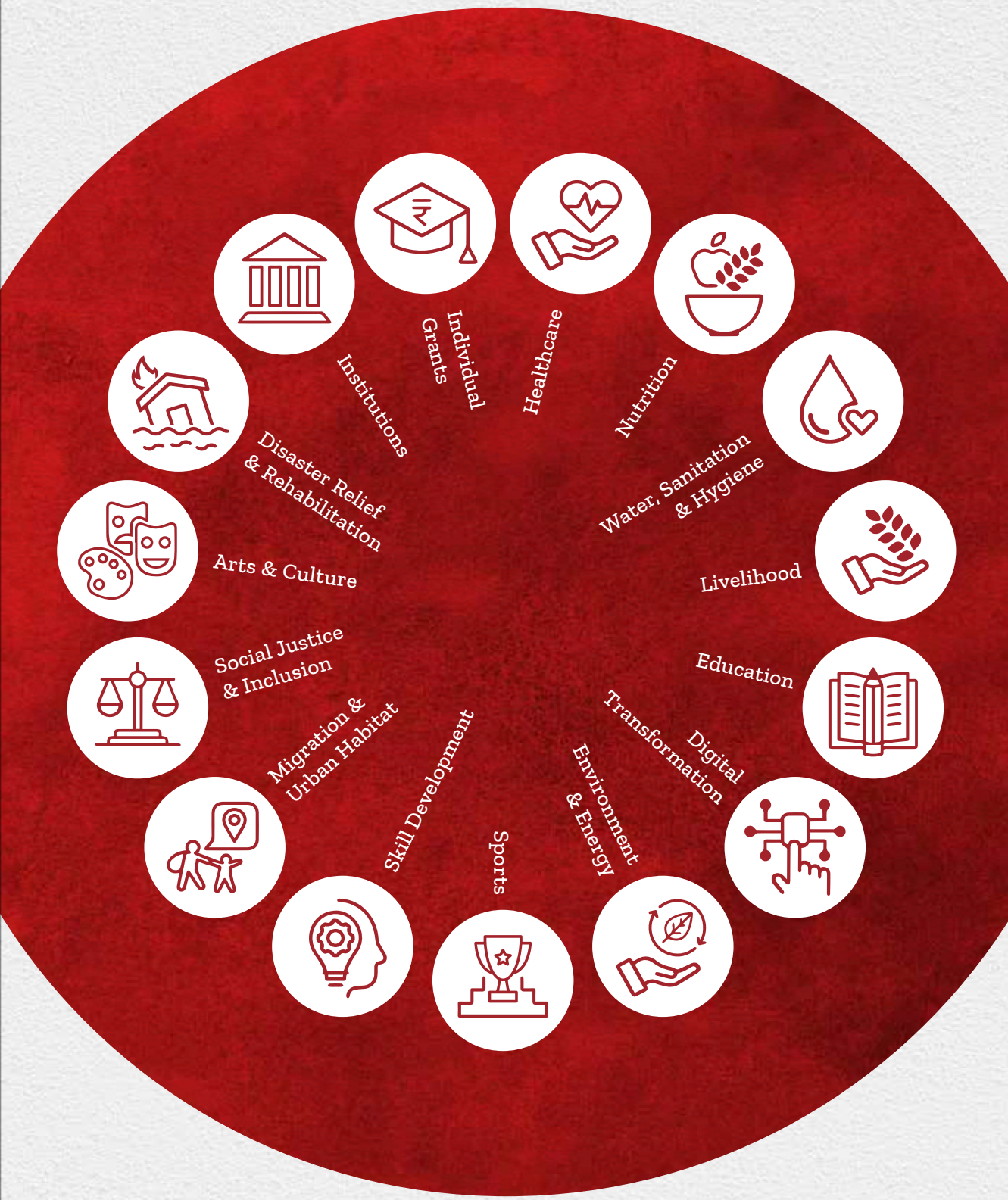
The one common tenet has been our commitment to improving the quality of life for India and its people, especially those on the margins.

Using multi-pronged strategies of direct implementation, co-partnership and grant making, the Trusts support and drive innovation towards an assortment of causes such as health, nutrition, education, water and sanitation, livelihoods, social justice and inclusion, skilling, migration and urbanisation, environment, digital literacy, sports, arts, craft and culture, and disaster management to name a few.

Tata Trusts seek to empower, enable and transform communities across India, while improving the quality of life of the tribal, underserved, underprivileged, backward and minority sections, and laying special emphasis on women and children.

TATA TRUSTS

Our Areas of Engagement


Individual Grants
Healthcare
Nutrition
Water, Sanitation & Hygiene
Livelihood
Education
Digital Transformation
Environment & Energy
Sports
Skill Development
Migration & Urban Habitat
Social Justice & Inclusion
Arts & Culture
Disaster Relief & Rehabilitation
Institutions

Theme:

Nutrition

Malnutrition remains a leading healthcare challenge across the globe. Malnutrition under its definition encompasses both over-nutrition and undernutrition, which also includes micronutrient malnutrition. Multiple indicators to measure and describe malnutrition and food insecurity exists, however nutritional failures are usually understood with the severity of anthropometric failures such as stunting, wasting and underweight.

Nutrition practices including exclusive breastfeeding, introduction of complimentary foods, iron-folate supplementation in pregnant and lactating women, and behaviour change communication to educate mothers and families on appropriate nutrition practices are critical foundations. Yet, despite these initiatives, less than 10% children have diets with adequate nutrition and nearly 60% of children and 50% of pregnant women are anaemic across India (IIPS, 2016).

Biased focus on anthropometric failure indicators as the outcome improvement indicators largely misses out on process indicators of the program. Failure of any of the combinations above can have detrimental effects in the growth of children and can keep them in the vicious cycle of malnutrition.

Malnutrition has both human and economic consequences, which include poor health outcomes, reduced economic productivity and lower educational attainment, which have been increasingly recognized by policy makers (ID, 2017).

Our goal is aligned towards the United Nations (UN) Sustainable Development Goal 2 of ending hunger, helping the country achieve food security and improved nutrition, and promoting sustainable agriculture.

The Tata Trusts' strategy for combating malnutrition is an integrated approach that focuses on three foundational pillars: **Products, Platforms** and **Policy**.

Products - Development and use of innovative products to mitigate health risks related to undernutrition among population. Some of these products include, salt, rice, milk, wheat and oil, pulse-based snacks fortified with iron, folate, vitamin B12, A and D as well as android based applications like m-Khushalli.

Platforms - are the gateway of program delivery at scale. With a special focus on strengthening existing social safety net programs, activities were designed to improve coverage by delivering quality services. These programs included Integrated Child Development Services (ICDS), National Rural Health Mission (NRHM) and Public Distribution System (PDS) amongst others.

Policy - Evidence based advocacy with policy makers and various stakeholders for scaling up of products through various platforms. Providing data analytics support to help understand and tackle challenges in meeting nutrition goals of the country.

Augmenting Platforms

Integrated Child Development Services and National Health Mission

ICDS is India's response to malnutrition amongst children.

Started in 1975, it expanded post 2005 and is one of the largest community nutrition programs in the world today.

It is well designed to address the proximate and distal determinants of malnutrition, the intergenerational cycle of malnutrition and covers the 'one thousand days' window as well.

The ICDS and National Health Mission (NHM) coverage has an unmatched reach and are intended to serve the most vulnerable populations. They are structured together to deliver the essential nutrition and health inputs required to improve the health and nutrition status of the population.

Growth monitoring of children is the most integral component of ICDS. It lays the foundation to detect growth faltering early on and bring children back to the normal growth path as soon as possible.

Effectiveness of ICDS in the Indian context in improving service delivery is largely a function of program management and not about resources.

A comprehensive nutrition program that includes nutrition specific and nutrition sensitive interventions, combined with household practises to improve mother, infant and young child nutrition and utilization of ICDS and NHM services will result in sustained improvement in nutritional status and contribute significantly to reduce stunting.

Project Spotlight: ICDS System Strengthening & Community Mobilization

The 'Project Spotlight' initiative was our spirited attempt to make a lasting impact on the status of nutrition in selected geographies viz. Andhra Pradesh, Rajasthan (as Making it Happen) and Maharashtra. It aimed to use as scaffolding, the ICDS which is India's response to malnutrition and is one of the largest community nutrition programs in the world. Over the years, the program has grown in scale and its potential to reach beneficiaries has been truly impressive, and is difficult to match. Aligning ourselves with the vision and thematic strategy of the ICDS program, 'Project Spotlight' strives to strengthen the existing delivery system and mobilize the community with an array of carefully planned activities in the three districts of Maharashtra viz. Chandrapur, Gadchiroli and Palghar. Our activities primarily included refurbishing Anganwadi Centres, building capacities of frontline workers by helping them converge with other delivery stakeholders, improving infant and young child feeding practices, and working with communities and Panchayati Raj Institutions to generate awareness on the causes and consequences of malnutrition in their area.

Project Spotlight is being implemented in three districts and **thirteen blocks** as below-

Palghar: Jwahar, Mokhada, Vikramgad, Talassari, Palghar, Dahanu, Wada, Vasai
Chandrapur: Mul, Pombhurna, Jiwati
Gadchiroli: Bhamragad, Kurkheda

4114
anganwadi

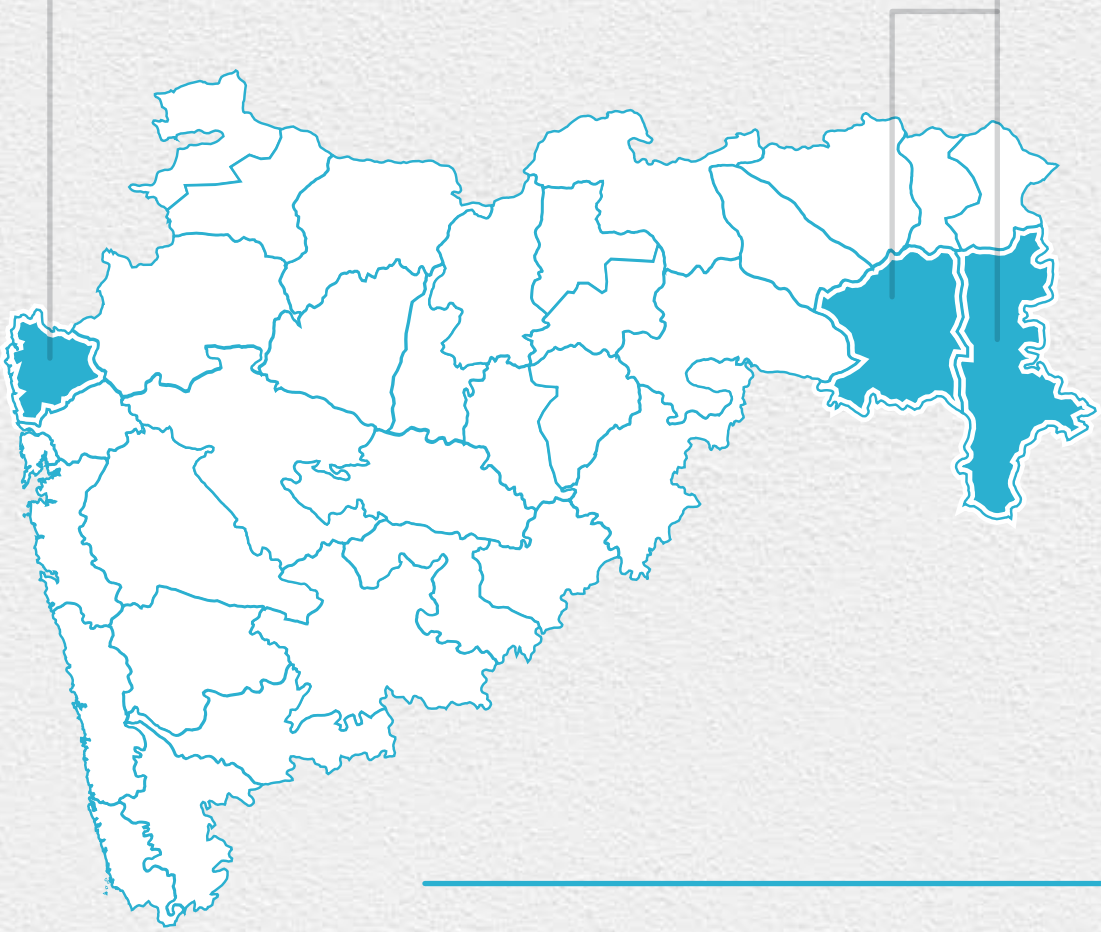
MAHARASHTRA (3 Districts)

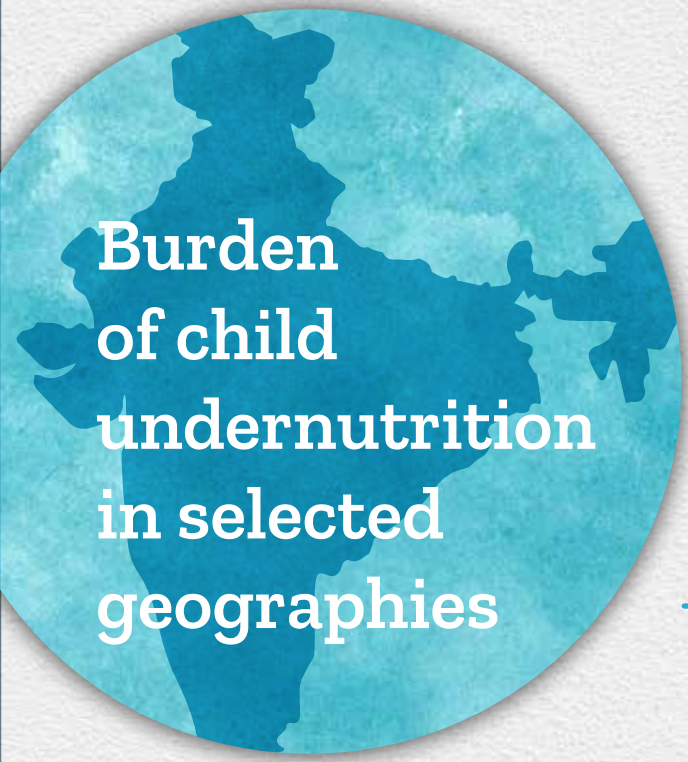
Palghar

April 2017 – March 2021

Chandrapur & Gadchiroli

December 2018 – March 2021





Burden of child undernutrition in selected geographies

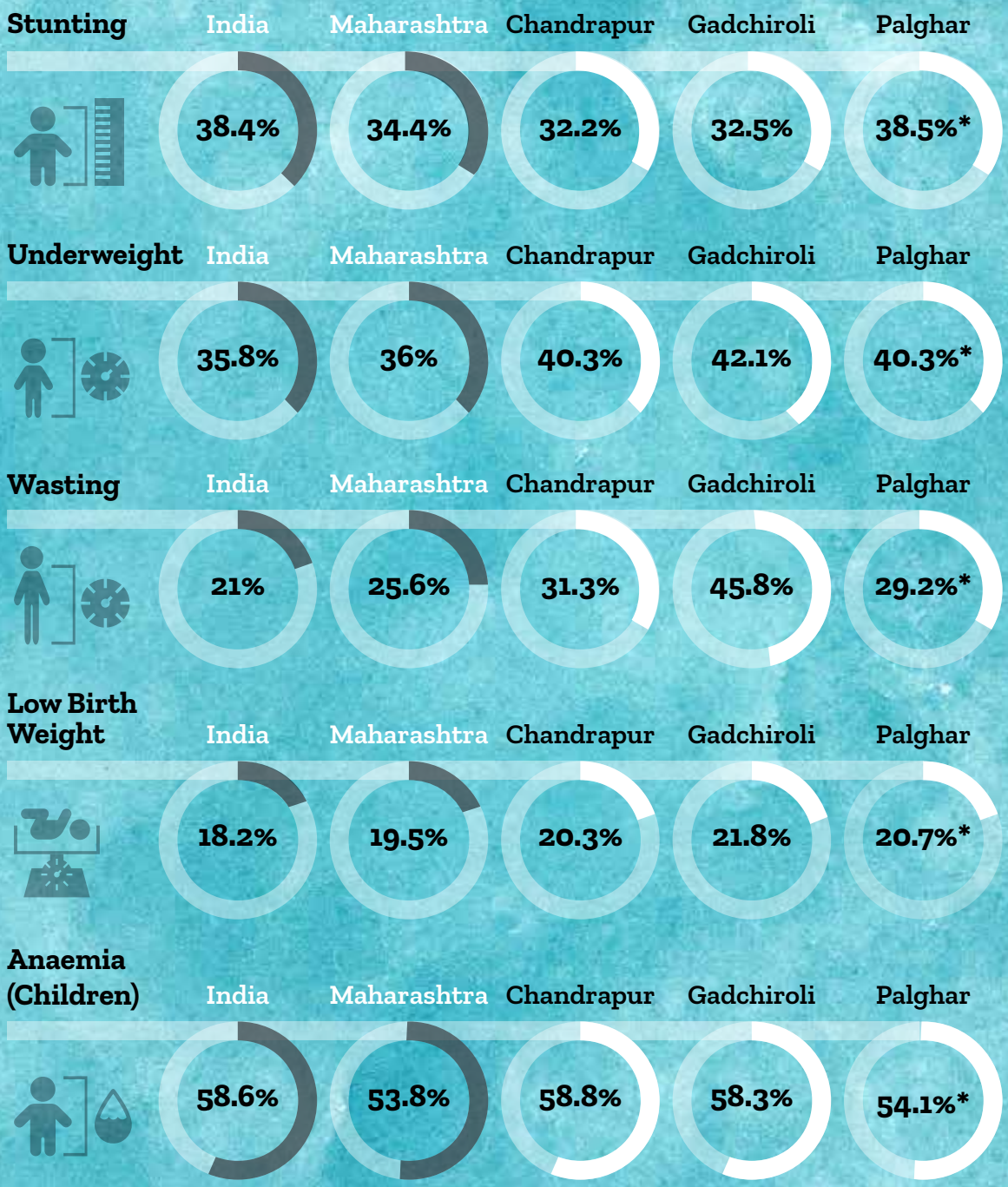
Under optimal environmental conditions, following the normalized World Health Organization (WHO) growth chart for height, weight and age; only 2.5% children would fall below two standard deviations to be referred to as stunting, underweight or wasting respectively (WHO MGRS 2006). In India, which shares the most burden in the South Asia region; prevalence of stunting, underweight and wasting amongst children under 5 years in 2016 were 38%, 35.8% and 21% respectively. Therefore and rightly so, governments and UN agencies prioritized and tracked malnutrition prevalence amongst children using these anthropometry failures viz. stunting, underweight and wasting.

The Prime Minister's Overarching Scheme for Holistic Nutrition (POSHAN) Abhiyaan scheme of Government of India aimed to reduce anthropometric failures gradually over a period of time. Though the findings of National Family Health Survey (NFHS) 5 are not very encouraging, it further underscores the importance of understanding the causes of malnutrition and their relationship with the outcomes of interest. The burden of child malnutrition in Maharahstra (expressed in terms of stunting, wasting and underweight) is alarming and calls for strategic solutions. Palghar, Chandrapur and Gadchiroli being tribal and rural districts, presented a huge burden for anthropometric failures as well as anaemia in the 2016 NFHS survey. Though Palghar is a newly carved out district from Thane, its fifth round of survey findings can be reasonably compared with those from fourth round of NFHS, as argued by Wang et al, 2020 in their publication. The district has done fairly well on all three anthropometric failures when compared to NFHS 4, especially when the State average has not moved or gone up. The survey timelines of fourth and fifth series also closely matches our project timelines. While in Gadchiroli, underweight and stunting has declined, Chandrapur's figures with regards to all three failures have worsened. Anaemia levels have surprisingly shot up across the board.

WHO Multicentre Growth Reference Study Group (2006). Assessment of differences in linear growth among populations in the WHO Multicentre Growth Reference Study. Acta Paediatrica 450, 56–65.

Indicator
NFHS 4

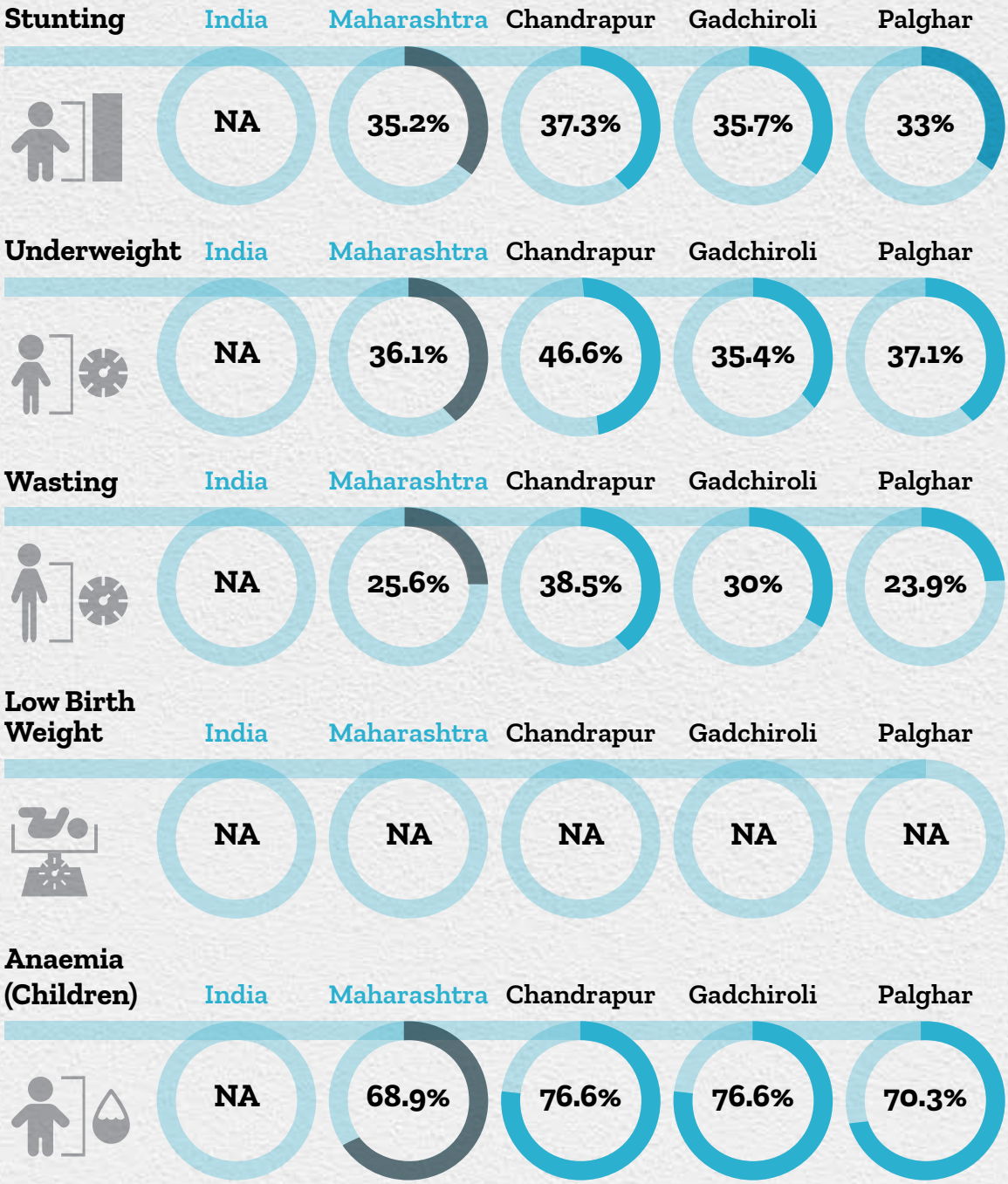
Burden of child malnutrit
Comparison of findings



* 'Wang W, Zhang W and Subramanian SV. Prevalence of Anaemia, Underweight and Stunting in 342 districts of India. Harvard Dataverse V4 (2020)'

ion in selected geographies: from NFHS 4 and NFHS 5

Indicator NFHS 5



Source: National Family Health Survey (NFHS)- 4 (2015-2016) and 5 (2019-2020)

Five important determinants of action to address child undernutrition

The conceptual model of child undernutrition as proposed by United Nations Children Fund (UNICEF)[1] identifies various underlying nutrition sensitive and nutrition specific indicators. Of these, in a study by Kim et al (2019)[2], 23 robust variables were scientifically identified from the NFHS-4 database and evaluated for their association with child undernutrition in Indian context.

Most strong associations were found with household factors that reflect nutrition specific and nutrition sensitive variables which are discussed in the this section.[2]

1. Parental Nutritional Status
2. Children's Dietary Intake
3. Household Socio-economic Status
4. Household Environment
5. Health and Nutrition Services

1 Reference: *Improving Child Nutrition: The achievable imperative for global progress. United Nations Children's Fund. p.4. (2013)*

2 Reference: *Kim R, Rajpal S, Joe W, Corsi DJ, Sankar R, Kumar A, Subramanian SV. Assessing associational strength of 23 correlates of child anthropometric failure: An econometric analysis of the 2015-2016 National Family Health Survey, India. Social Science and Medicine 2019(238):112374*

1.

Parental Nutritional Status

Short parental stature and poor nutritional health have some of the strongest associations with child undernutrition.

In the light of new scientific evidence, there is an urgent need to move beyond maternal perspective in addressing child undernutrition to address socio-economic vulnerabilities.

Burden of low Body Mass Index (BMI) among men is almost as low as BMI among women. Since the paternal data was restricted to the representation of the state Chandrapur and Gadchiroli showed higher levels of low maternal BMI than the country average.

Short maternal stature

India **11%**
Maharashtra **9.3%**
Chandrapur **8.7%**
Gadchiroli **9.7%**
Palghar **8.5%***

Low maternal BMI

India **22.1%**
Maharashtra **22.5%**
Chandrapur **29.3%**
Gadchiroli **27.1%**
Palghar **20.7%***

Low BMI of men

India **20.2%**
Maharashtra **19.1%**
Chandrapur **NA**
Gadchiroli **NA**
Palghar **NA**

The data for the indicators related to men was available at the State level. The district level sample is therefore unavailable for district level estimations.

Source: National Family Health Survey (NFHS)- 4 (2015-2016)

* 'Wang W, Zhang W and Subramanian SV. Prevalence of Anaemia, Underweight and Stunting in 342 districts of India. Harvard Dataverse V4 (2020)'

2.

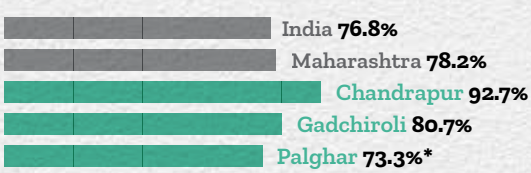
Children's Dietary Intake

Dietary diversity is positively associated with the quality of diet, micronutrient intake and better nutritional status of young children and household food security.

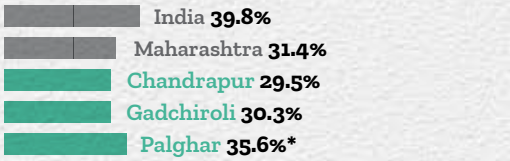
Dietary diversity of children in India is highly inadequate with only 23% meeting the minimum criteria. Moreover, only 13% children of 6 – 23 months of age, reported consuming legumes and nuts in last 24hrs depicting gross protein deficiency.

Dietary inadequacy indicators for Maharashtra are higher than the country average, while Chandrapur and Gadchiroli districts fared worse. These grave figures of dietary intake need urgent attention especially when put in context with its association with child undernutrition.

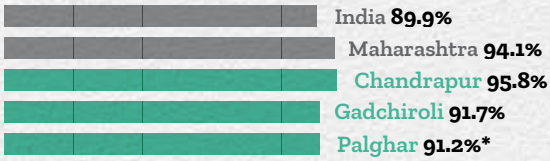
Poor dietary diversity



No Vit A supplementation



Inadequate diet



Source: National Family Health Survey (NFHS)- 4 (2015-2016)

Reference: *'Agarwal S, Kim R, Gausman J, Sharma S, Sankar R, Subramanian SV. Socio-economic patterning of food consumption and dietary diversity among Indian children: evidence from NFHS-4. European Journal of Clinical Nutrition 2019(73):1361-1372'*

* 'Wang W, Zhang W and Subramanian SV. Prevalence of Anaemia, Underweight and Stunting in 342 districts of India. Harvard Dataverse V4 (2020)'

3.

Household Socio-economic Status

Poverty and illiteracy are basic drivers of several forms of deprivation including child undernutrition, with particularly high concentration across backward districts. According to a recent study by Agarwal et al, 2019, maternal education and household wealth status significantly influences the dietary consumption of patterns of Indian children.

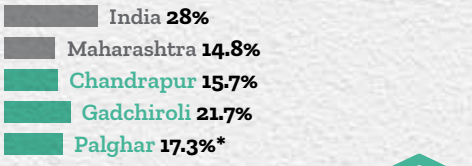
Children in the wealthiest families consumed dairy three times more than children from poorest households.

Children of highly educated mothers had significantly higher odds of consuming all of the seven food groups.

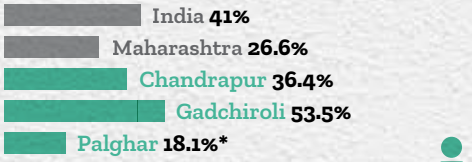
Maharashtra fared well on no maternal (14.8%) and paternal education (9%) as well as poor household wealth status (26.6%) compared to country average. However, the state has a long way to go to improve its household socio-economic status.

To address undernutrition, authors Kim et al (2019) suggest a focus on multiple household socio-economic factors to address undernutrition than intensively focusing on single risk factors.

No maternal education



Poor household wealth



No paternal education

The data for the indicators related to men was available at the State level. The district level sample is therefore unavailable for district level estimations.

Source: National Family Health Survey (NFHS)- 4 (2015-2016)

Reference: *'Agarwal S, Kim R, Gausman J, Sharma S, Sankar R, Subramanian SV. Socio-economic patterning of food consumption and dietary diversity among Indian children: evidence from NFHS-4. European Journal of Clinical Nutrition 2019(73):1361-1372'*

* 'Wang W, Zhang W and Subramanian SV. Prevalence of Anaemia, Underweight and Stunting in 342 districts of India. Harvard Dataverse V4 (2020)'

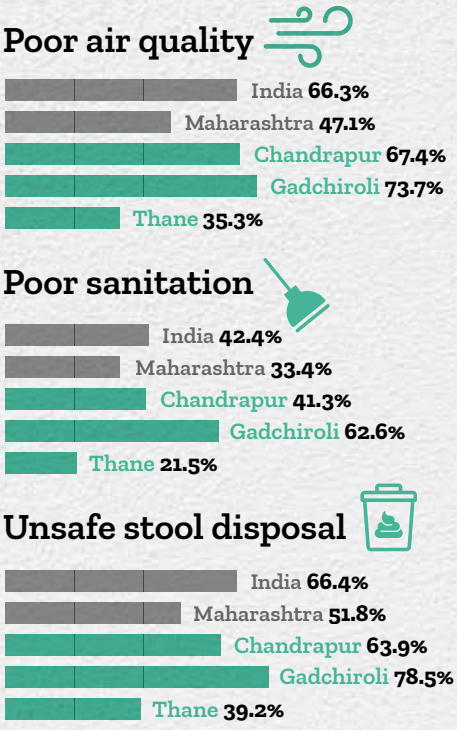
4.

Household Environment

Contextual factors such as improved sanitation, safe stool disposal and improved air quality are hitherto neglected aspects in child undernutrition particularly in rural areas.

This is evident in the high prevalence of unsafe stool disposal in rural districts, with 64% in Chandrapur and 78.5% in Gadchiroli districts respectively.

The outcome of intra-state wealth disparity on child undernutrition generates evidence for states to actively support developmental policies that bring about improvements in household socio-economic status and environment.



Source: National Family Health Survey (NFHS)- 4 (2015-2016)

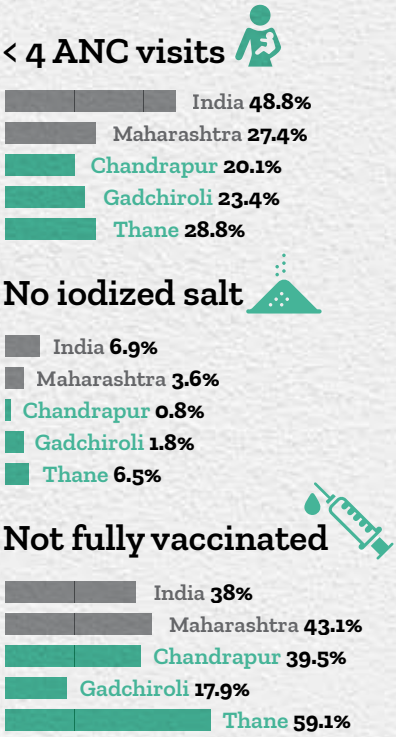
Reference: *'Rajpal S, Kim R, Sankar R, Kumar A, Joe W, Subramanian SV.Frequently asked questions on child anthropometric failures in India. Economic and Political Weekly 2020(6):59-64'*

5.

Health and Nutrition Services

ICDS and NHM are instrumental for improving continuum of care and for addressing the high burden of maternal and child undernutrition in India. Such programs can potentially bridge the equity gaps in health and nutrition outcomes among children, particularly in challenging geographies and socio-economic inequalities.

To achieve life-saving potential that Ante-natal care (ANC) services promises for mother and child, at least four visits during pregnancy are considered to be essential. Maharashtra has performed well with only 27.4% women receiving less than 4 ANC visits. Prevalence is less worse in rural districts with Chandrapur and Gadchiroli districts recording less than 20% and 23% respectively.



Source: National Family Health Survey (NFHS)- 4 (2015-2016)

Reference: *'Rajpal S, Joe W, Subramanayam M, Sankar R, Sharma S, Kumar A, Kim R, Subramanian SV. Utilization of Integrated Child Development Services in India: Programmatic insights from National Family Health Survey, 2016. Int J Environ Res Public Health 2020(17) :3197.*

Greater contribution in reducing child undernutrition prevalence can come from low-performing states and/or districts as they have considerable scope for rapid improvements.

Increasing public investments in educating and empowering women can accelerate improvements in nutritional outcomes with utilization of health services to play a key role.

The above findings clearly depict a role of individual socio-economic status, household factors, diversified dietary intakes with a special focus on rural pockets for improvement in child undernutrition.

Reference: *Rajpal S, Kim R, Sankar R, Kumar A, Joe W, Subramanian SV.Frequently asked questions on child anthropometric failures in India. Economic and Political Weekly 2020(6):59-64.*

Project Spotlight: Goals and Objectives

Goal
Women of reproductive age and children achieve sustainable improvement in their nutrition and health status. With a special focus on most vulnerable populations and families, reduction in stunting and anaemia will be the key impact indicators of improved nutritional status of the population.

Objectives
To improve the quality and coverage of services in the ICDS and NHM by focusing on trainings, demand generation, monitoring and a management information system that helps in managing the process.

To improve nutritional practices and seek behavioural change of the communities at individual, family and community level for improved nutritional status of population.

Coverage

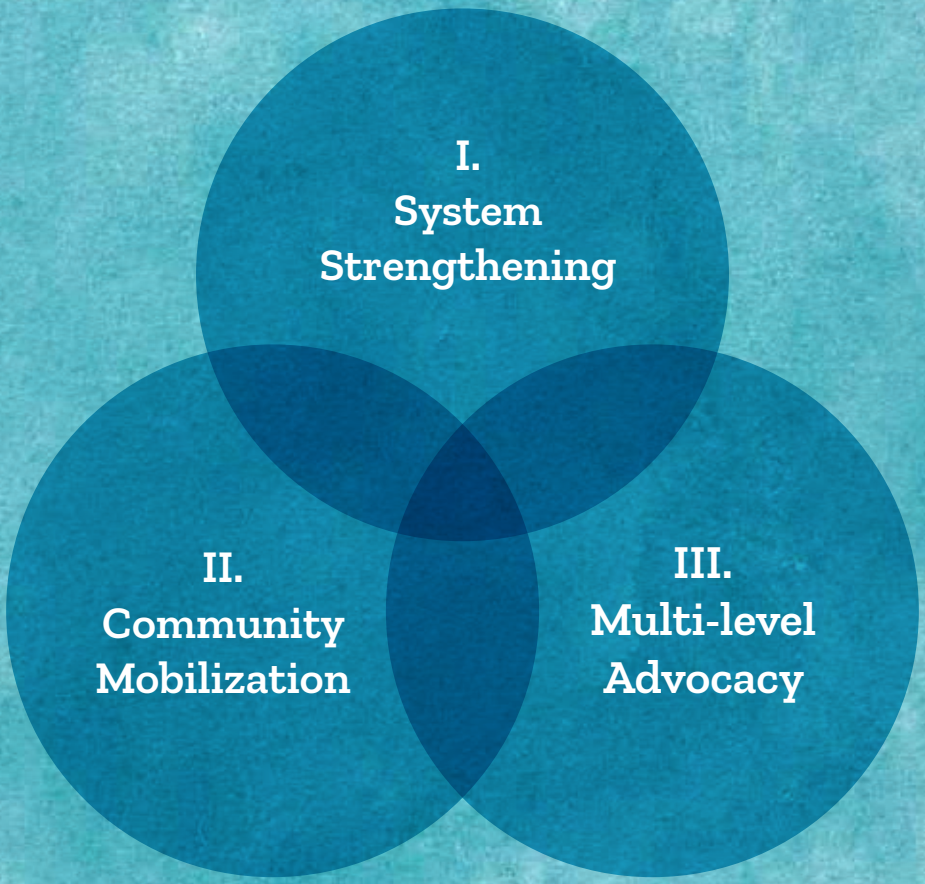
State
Maharashtra

Districts
Chandrapur, Gadchiroli and Palghar

No. of Anganwadis
4,114

Total Population
28,39,726

A three-pronged implementation approach



*__AAA - AWW, ASHA, ANM__, __DM__- District Magistrate, __ANM__- Auxillary Nurse Midwife, __AWC__- Anganwadi Centre, __ASHA__- Accredited Social Health Assistant, __AWW__- Anganwadi worker, __BDO__- Block Development Officer, __CEO__- Chief Executive Officer, __CDPO__- Child Development Project Officer, __DHO__- District Health Officer, __DPO__- District Program Officer, __DWCD-__ Department of Women and Child Development, __FLW__- Frontline workers, __MO__- Medical Officer, __LHV__ - Lady Health Visitor, __PRI__ – Panchayati Raj Institution, __VHRC__- Village Health Report Card

I. System Strengthening

When a mammoth framework to address malnutrition in India - the country-wide implemented ICDS - already exists, it was imperative to focus on a series of initiatives to strengthen this scheme. The ICDS scheme offers a package of six services at the last mile, and has in-built convergence with NRHM and Panchayati Raj schemes. These six services implemented at Anganwadi Centres (AWC) through Anganwadi workers (AWW), include: Supplementary nutrition - for children below 6 years, pregnant and lactating mothers; Immunization - for children below 6 years, pregnant and lactating women; Health Check-up - children below 6 years; Referral Services; Pre-school education and Nutrition and Health Education.

Identifying Anganwadis as the focal point for service delivery as well as convergence, a string of initiatives to strengthen the system were designed and implemented.

These initiatives are listed as below:

A **Civil upgradations of Anganwadi Centres**

B **Upgrading Anganwadi Centres with need based equipment**

C **Capacity building of ICDS and NHM staff and particularly, AAA (AWW-ASHA-ANM) on convergence matrix**

D **Capacity building of Panchayati Raj Institution's representatives on their roles and responsibilities by converging with Anganwadis**

E **Capacity building of Anganwadi workers on Mother, Infant and Young Child Nutrition (MIYCN)**

F **Capacity building of Anganwadi workers on conducting community based events and Jan Andolan initiatives**

II. Community Mobilization

Behaviour, a complex phenomenon, is influenced by factors within the individual and beyond. Social and Behaviour Change Communication (SBCC) has been used for decades to promote changes in knowledge, attitudes, norms, beliefs and behaviours. Grounded in theory and backed by evidence, SBCC encompasses coordination of messages and activities across a variety of channels to reach multiple levels of society, including the individual, the community, services and policy[1]. In India, polio eradication is an exemplar success of a strategy wherein SBCC was a part of core strategy.

Understanding the importance of mobilizing communities to avail services offered at Anganwadis, a number of thoughtful initiatives were implemented to further complement the efforts taken to strengthen the system.

These included:

A **Conducting Community Based Events to support and scale up POSHAN Abhiyaan**

B **Periodic conduct of mass communication events (or commonly known as Jan Andolan events) on a variety of topics. Dietary diversity amongst children and women, different types of breastfeeding positions for young mothers, early child education and play, ANC services and pre-natal services were some of the areas some areas covered through these mass mobilization events**

C **Conducting community MIYCN trainings with an attempt to make mothers, mother-in laws and community influencers Master Trainers themselves on young child nutrition practises**

D **Facilitating joint household visits of frontline workers to homes with pregnant and lactating mothers**

E **Organizing multiple felicitation events to recognize the efforts of frontline workers in their fight against malnutrition**

1 Reference: *sbccimplementationkits.org*

III. Multi-level Advocacy

Advocacy is a combination of individual and societal actions designed to gain political commitment, policy support and social acceptance for a particular health goal or program. It is an action directed at changing the policies, positions or programmes of any type of institution. It puts a problem on the agenda, provides a solution to that problem and builds support for acting both on the problem and solution. However, advocacy has to operate in a world of multi-level governance. Following the hierarchy of implementation of Government schemes, programs are executed with transfer of power from State Government to District and further Block Administration to the last unit of administration at Village, known as Panchayati Raj Institution.

Advocacy, when closely follows the Government's line of hierarchy, thereby applying the principles of advocacy at various levels, is known as Multi-Level Advocacy. Although, not very well explored and executed by program implementers, it holds the key to successful uptake of program objectives. It is enabled by focusing way and beyond Secretariats; on the government system as a whole, and by communicating the same programme messages at multiple levels.

To achieve this, some of the initiatives taken up were as below:

A **State level advocacy to scale up convergence matrix and smart anganwadis with Principal Secretary and ICDS Comissioner, DWCD, Govt. of Maharashtra on a half-yearly basis**

B **District level advocacy jointly with DM, CEO Zilla Parishad, DPO, DHO, PRI members to discuss progress and seek joint monitoring support on a quarterly basis**

C **Block level advocacy jointly with BDO, CDPO, MO and PRI members to discuss progress and seek joint monitoring support on a monthly frequency**

D **Village level advocacy jointly with Lady Supervisor, LHV, AWW, ASHA, ANM and PRI members to seek programmatic support on a monthly frequency**

Project Spotlight: Accomplishments

Typical *Anganwadis* before and after refurbishment

I. System Strengthening

Civil Upgradation of Anganwadi Centres

Dilapidated Anaganwadis were upgraded by way of infrastructure repairs and fixes which included: repair of roof to provide protection from rains, repair of walls to prevent seepage, addressed uneven flooring, kitchen upgradation for organized and clean cooking practises, pivoting for safe and secured entrance, construction of toilet wherever possible, upgradation of existing toilets, water proof painting of walls with specially designed Information, Education and Communication messages.

- **100** dilapidated Anganwadi Centres in Palghar and **5** in Gadchiroli were refurbished and transformed to develop model Anganwadi Centres

- Technical support to Chandrapur District Administration for refurbishing 49 Anganwadi Centres

- Through systematic and convergent approach of refurbishing Anganwadis (for details please refer to SOP on Refurbishment of Anganwadi Centres), all 105 transformed AWCs received support from respective Gram Panchayat. This included provision of tables, chairs, fans, tube lights, school uniforms etc depending on the requirements. Moreover, 39 such AWCs also got electrified with the support of the Gram Panchayat.

- Refurbished and Transformed Anganwadis handed over to District Administration in Palghar by former Hon'ble Chief Minister of Maharashtra Shri Devendra Fadnavis

Need based upgradation of Anganwadis

To enable Anganwadis to deliver most essential and basic services, they should be well-equipped with the most basic and essential instruments. To ensure seamless delivery of core components of ICDS services, district wide survey to assess the status of availability of various equipments within AWC were conducted in Chandrapur, Palghar and Gadchiroli, Maharashtra.

After careful consideration from the findings of survey, **3183** Anganwadis across Palghar district were upgraded with need-based equipment. They were provided with the following items:

- **1 Stadiometer**
- **1 Infantometer**
- **1 Weighing Machine**
- **1 Water Purifier**
- **4 Plastic Mats**
- **12 Posters on Nutrition and Early Child Education**
- **13 Educative play material**
- **20 Nutrition Booklets on Mother Infant and Young Child Feeding**

Capacity building of Mother Infant and Young Child Feeding Nutrition (MIYCN)

Equal importance was laid on disseminating in-depth subject matter knowledge on nutrition and health through practical sessions. Special focus was on training one and all with same rigor instead of cascading approach.

Under POSHAN Abhiyaan, AWWs have been trained in a cascade fashion, on a number of topics to improve quality of service delivery. To supplement the extensive exercise of Goverment of India, we built capacities of frontline workers on practical insights of MIYCN practices.

Through a 3-day residential training program, the curriculum was delivered through video presentations and hand-held lessons on 49 positions of successful breastfeeding, deep-dive knowledge on essential nutrients and its low-cost food sources, initiation of complementary feeding of a 6 months old young child, along with cooking demonstrations to prepare low-cost nutritious recipes for 'young children'.

~ 3100 frontline workers trained on MIYCN across Chandrapur, Gadchiroli and Palghar districts

Capacity Building of Frontline Workers and Panchayati Raj Institution members on Convergence Matrix

With 6.49 lakh villages across the country, India proudly lives in its villages! The AWW, ASHA, ANM and Gram Sevaks spread across these villages are the warriors fighting malnutrition across country. Bringing them together and building their capacities on key aspects of nutrition and health, will go a long way in improving service delivery. The understanding that working in tandem with these department results in a common outcome, led us to develop and implement the 'econometrics of convergence'.

The underlying focus of 'econometrics of convergence' was *measuring* convergence. Simply put, for convergence to count, we must count convergence! Building on this, through extensive trial and errors, tools to measure convergence were developed and successfully implemented across three districts. These tools were namely, 'AAA Report Card' for ICDS and NHM convergence and 'Village Health Report Card' (VHRC) for ICDS and PRI convergence. Frontline warriors were trained on working in convergence through the mandatorily use of tools approved by all three District Authorities.

Convergence of services offered by Anganwadi- ASHA- ANM (AAA):

With the objective to enable convergence of services under ICDS and NHM, a joint Government Resolution (GR) was released from DWCD and Department of Public Health, Maharashtra. This GR offered detailed guidelines on the five-point implementation process of convergence of services provided by ICDS and NHM. In addition to this, district orders were taken out to mandate tools as measures of convergence.

~ 7,000 workers were trained through **640+** trainings in Chandrapur, Gadchiroli and Palghar districts

Convergence of services offered by ICDS-PRI Members:

Anganwadis are an integral part of a village and a responsibility of Sarpanch. An oversight on its functioning and identification of high-risk beneficiaries can go a long way in defining village's health status. Building on this with an objective to form a bridge of information through convergence, PRI members and officials of ICDS Deptt. were trained on use of VHRC.

~ 884 : Sarpanch, Gram Sewaks, CDPO, Lady Supervisors were trained on econometrics of convergence in Palghar, Chandrapur and Gadchiroli While AWWs were handheld to activate the system, periodic efforts were made to ensure Gram Sewaks and Lady Supervisor jointly submit VHRC to Sarpanch, CDPO and Block Extension Officer

Building capacities of Anganwadi Workers on Community Based Events

Community Based Event (CBE), an excellent initiative under POSHAN Abhiyaan wherein AWWs are mandated to celebrate events designed to alter the behavior of communities around maternal and child nutrition. Per guidelines, themes identified to conduct CBEs include: *Goud Bharai* (Inviting women during the first/second trimester of pregnancy), *Annaprashan diwas* (marking initiation of complementary feeding), *Suposhan Diwas* (Focused on orienting husbands), *Celebrating coming of age* – getting ready for preschool at AWC and messages related to public health for improvement of *nutrition and to reduce illness* (such as Handwashing, Clean drinking water, Sanitation, Deworming).

Implementation of POSHAN Abhiyaan scheme was phased out across the country. Palghar, a newly formed district was identified in Phase II of implementation plan of this scheme. Recognizing the importance of CBE initiative in spreading awareness systematically, it was considered imperative to bring up-to speed one of the infamous districts with soaring child malnutrition indicators. Thereby AWWs were handheld to implement CBE following the guidelines mentioned under the scheme before its official roll out. The first step in this was to train AWWs and LS on understanding CBE process under the scheme and its guidelines along with handholding support in conducting the same.

1,486 Anganwadi workers trained on ways of conducting Community Based Events

II.Community Mobilization

Celebrating Community Based Events

Community based events (CBE) are innovatively designed by Ministry of Women and Child Development (MWCD), Government of India (GOI) under POSHAN Abhiyaan scheme. Since the scheme was thrust upon phase wise across districts in India, Palghar particularly, being a part of Thane district at the time, did not figure in the first round of implementation. Recognizing the importance of CBE in generating awareness sustainably through ICDS system, Palghar district was chosen to bring up-to speed with POSHAN Abhiyaan scheme. Following GOIs guidelines of CBE implementation, AWWs were trained, hand-held and accordingly compensated for celebrating these events for an interim period of 8 months by Tata Trusts. This special focus on Palghar by way of celebrating 20, 000 events in 8 months, garnered state and district government support, trust of AWWs as well successfully mobilized communities on extent of child malnutrition.

~ 20,000 Community Based Events conducted directly before POSHAN : Abhiyaan subsumed in Palghar district in a span of six months

~ 9,000 Community Based Events supported in Chandrapur and Gadchiroli

Periodic conduct of mass communication events (popularly known as *Jan Andolan* events)

Jan Andolan events in project spotlight aspire to motivate multiple sectors and communities on malnutrition, its various forms and need for consumption nutritious food by tapping into people's inherent goals. When communities instead of individuals begin to identify it as their problem, perception changes and ownership follows soon. However, these movements when defined on a particular day, week or month loses the strength of 'mass perception change', especially on long drawn issues of malnutrition.

An attempt therefore was made of bringing periodicity to mass behaviour change initiatives under this project. Moreover, various aspects of addressing child nutrition failure were taken up in multiple separate sessions. This allowed us to bring about small yet immediate knowledge based behaviour alterations. Some of the areas addressed included: household dietary diversity, low-cost nutritious food sources, types of breastfeeding positions, early child education and play through inter-anganwadi sports competitions, ante-natal services, pre-natal services.

1284 Jan Andolan events conducted across Chandrapur, Gadchiroli and Palghar districts, well-distributed throughout project period

Community Trainings on Infant and Young Child Feeding practises

The ultimate beneficiary whose behaviour we aspire to alter through knowledge dissemination are the *households* with a special focus on mothers. While there are multiple channels to reach out and impact knowledge, attitude and eventually practises, the most common approach tends to be creating master trainers and cascading it further. These communication campaigns have its own pros and cons for implementation at scale. Under Project Spotlight, we believed in the power of reaching out to the last mile with perseverance. Underscoring the importance of quality of knowledge dissemination at the village level, we trained communities on addressing malnutrition through nutrition. Hence, capacity building activities were thoughtfully included under the SBCC initiative of this project.

Participants of these training sessions included pregnant and lactating mothers, husbands, mothers-in laws, women of the village, young girls and village influencers. The curriculum of these training sessions included role of nutrients in our body, local low-cost food sources of essential nutrients, dietary diversity, effective breastfeeding positions through role-play and video sessions, initiation of complementary feeding, cooking demonstration for young child feeding and role of hygiene and sanitation. Since such elaborate sessions require approximately 3-4 hours, participants were offered nutritious lunch which also seemed to improved attendance.

400 individual Community Trainings on IYCF conducted in Chandrapur and Gadchiroli districts

Joint household visits by frontline workers

Having access to the right information at the right time at the right place can be the difference between success and failure. ICDS scheme currently operational at a ratio of 1 Anganwadi Centre per 1000 population, is structured to serve the purpose of providing timely quality information and services to young mothers and children. Household visits are an integral yet often overlooked aspect of the six services offered by ICDS. Vast knowledge and experience of *frontline* workers can be a boon to pregnant or lactating women or young children when they need it the most, and will be most effective when it breaks the barriers of myths and misconceptions and are given *at their home*.

Under Project Spotlight, since AAA's worked in tandem, we further underscored their convergence by focusing on *'Joint Household Visits'* of all three frontline workers. Like any other initiative, AAA's were hand held initially from coordinating calendars to visiting beneficiaries' houses together. Soon, the accolades and commendation received from household members, village panchayat members as well as the positive change seen in the mothers' behaviours motivated the frontline workers to scale up the initiative.

~25,000 household visits by frontline workers across three districts has been our best foot forward in sensitizing both THE communities as well as the system, thereby enabling and bringing alive successful initiative of SBCC of this project.

Felicitating the efforts of frontline workers

More often than not, organizations take frontline workers for granted undermining their existing knowledge and experience. A fair amount of funds are expended on training frontline workers teaching what they preach. The biggest barrier in behaviour change is not the lack of skill and expertise of frontline workers, unfortunately it is the lack of trust in frontline workers, both of organizations and communities!

Therefore, under Project Spotlight, we made a deliberate attempt to recognize the hard work of AAA's at various levels. Various events on Poshan theme were organized at the Sector, Block and District level wherein best performing AAA's were felicitated to boost their self-confidence.

III. Multi-Level Advocacy

Technical Support Units (TSU) established at State, District, Blocks and Village were key to facilitate the At the State, the focus of the TSU was to set up review meetings with the Principal Secretary and the ICDS Commissioner. At District, The District Magistrate, CEO-Zilla Parishad, Deputy CEO, ICDS and Health Officer were the most instrumental officials to allow implementation in respective districts.

At Block, the Block Development Officer, CDPO, Taluka Health Officer and Extension Officer were the facilitators of project implementation and focus of the TSU. At village, the Sarpanch, Gram Sevak and AAA were the real foot soldiers to bring the project alive.

All the TSUs throughout were in sync to push, support and scale up ideas in a timely and effective manner. Documenting the minutes of advocacy meetings and prompt release of official communications enabled through the TSUs played the most instrumental role in efficient program delivery.

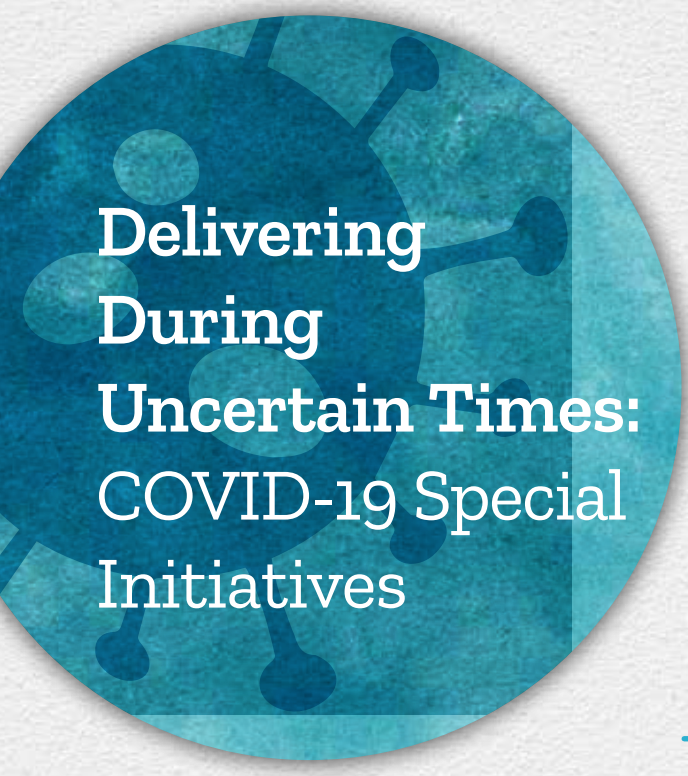
~9241 such advocacy meetings were held under project spotlight across all TSU

State Level Advocacy


District Level Advocacy


Block Level Advocacy


Village Level Advocacy



Delivering During Uncertain Times: COVID-19 Special Initiatives

India declared a nationwide lockdown on the 24th of March 2020 in response to the global SARS – CoV 2, better known as the COVID 19 pandemic. Initially planned for a period of twenty-one days, it was extended multiple times to counter the surge of increasing cases. A direct consequence of such a measure was the slowing down of almost all other activities apart from essential Covid and health related ones.

With the lockdown extended beyond the initial twenty-one days, it dawned upon us that things would probably not return to normalcy in the near future. This in turn meant that we would have to rethink our engagement with the government in terms of ensuring continued success and implementation.

This was an opportunity for us to pivot to a new way of working – virtually – while at the same time ensuring that focus on the program implementation on the ground did not falter. Over the course of the next few months, we adapted to a dynamic and fluid environment and succeeded in positively engaging with the beneficiaries of the ICDS program as well as the government functionaries on the ground. What follows below is a brief snapshot of how we adapted, and some of our learnings that could be adopted by anyone who wishes to learn from our experience.

Effect of Lockdown

With the country under lockdown, it was no surprise that restrictions were imposed on the way Anganwadis functioned. This meant that both the beneficiary and the AWW were physically apart from each other. As time went by, it became apparent that this status quo could not be maintained for long. There were mothers and malnourished children who needed attention.

Impact on our work

Prior to the lockdown we had leads for each of the three districts, and within

those districts we had a number of field functionaries. These field functionaries were instrumental in implementing the project activities by connecting with the frontline staff of the government, such as the AWW, health workers, Lady Supervisors, and the beneficiaries themselves. In particular, they were important in keeping a watch over specific cases of interest such as pregnant mothers with health complications, children categorised as severely underweight, severely wasted, and moderately malnourished. Their active engagement as a pivot between the beneficiaries and the service providers helped to streamline the focus areas and improve outcomes.

However, the imposition of lockdown meant that this crucial pivot was also impacted. We needed to find a way to maintain momentum and at the same time ensure progress toward the outcomes envisioned under the ICDS. After a short period of considered deliberation we decided to utilize the virtual world to the fullest and test for ourselves whether the efforts and service delivery could be sustained despite the lack of physical presence on the ground.

We were pleasantly surprised to learn that despite some initial hiccups on getting used to the virtual way, overall, the field team worked in harmony with the government functionaries on the ground to sustain progress under the program.

It is pertinent to note here that the lockdown strategy varied across the districts in the state. Ultimately, it was left to the district administrations to decide what level of activity would be permitted. Consequently, some districts that were not carrying significant covid caseloads, started opening up much earlier that others, which continue to be in some state of lockdown. As a result,

Gadchirolli, June 2020: Pregnant mother counselled on ANC care along with Lady Supervisor and Medical Officer

Palghar, June 2020: Pregnant mother counselled on ANC care along with Lady Supervisor and Medical Officer

while Anganwadis in some district have opened up, they remain closed in others. Regardless, learnings from this experience are not restricted to three districts alone. Across India, and within Maharashtra as well, it appears that for some time to come, social distancing measures would need to be maintained. Given this, we are certain that our experience can add value to such efforts across the country.

Adapting our work

As COVID 19 forced many organizations to adapt, a complex problem needed to be addressed: How do we get essential work done when in fact we are alone and separated. To be successful in a socially distanced environment, teams require the ability to communicate effectively. Along with a communication strategy, teams also require that decision making be delegated and decentralised. Ensuring this meant utilizing data to inform our approach.

Prior to the lockdowns, our field facilitators and district coordinators would meet with various stakeholders on ground, and solve problems with people usually gathered in a centralised space. This was no longer an option for us. As we moved to the virtual space, we had to plan all parts of the decision-making process. This is all the more important because by the nature of the medium, virtual work is mostly asynchronous. Things such as body language, nonverbal agreement, interpersonal connections etc which might be noticed in a physical set up, need a different sort of attention when we move to remote work.

To help our transition we created a simple yet effective data tracker, which covered various aspects of program delivery as pertaining to the ICDS. As smart mobile phones have attained unparalleled ubiquity in India, WhatsApp, the messaging and video communication application became an invaluable tool for the team to reach out to the stakeholders. We thus created dedicated WhatsApp groups for each of the blocks within the three districts that we were present in. Further, such groups were also formed at the state level.

We utilised the application to conduct regular audio and video phone calls with different stakeholders including beneficiaries, the triple A triumvirate AAA, Lady Superviors and the Child Development Project Officer. Initially, to understand the functioning on ground, we focused on the Severely wasted and Malnourished children (SAM, and MAM). We strove to track them and follow-up with help and guidance using frontline workers. The reason was simple - High Risk beneficiaries are most vulnerable in such unprecedented scenarios.

Tracking of this information and data was done on a weekly basis by the district coordinators which enabled them to contextualize their decision making. Decision making was encouraged to be devolved to the field functionaries, thereby increasing their motivation and dedication. Another key aspect was the trust that was fostered across the spectrum. Our work was regularly shared with the block level government functionaries thereby increasing transparency. Doing so also encouraged a free flow of feedback and inputs from their end which was assimilated in a virtuous feedback loop.

Palghar, Aug 2020: Young mother provided hand holding support during Annaprashan

Chandrapur, June 2020: Virtually monitoring and counselling health of infant to ensure delivery of services.

Gadchiroli, July 2020: High Risk pregnant mother referred to nearest Primary Health Hospital

Under the Virtual world, we were able to:

467 WhatsApp groups with district and block officials ICDS officials

11,489 AAA workers were trained and supported to operate in virtual setting

4655 Pregnant and lactating mothers were counselled virtually

1,223 Village Health Sanitation and Nutrition Days were conducted virtually to operate within the realms of COVID-19 norms

831 High risk pregnant mothers were identified, counselled and followed up virtually

869 High risk children were identified and followed up virtually

525 Severely Acute Malnourished children were identified and provided necessary support through the system

1,814 Advocacy convergence meetings held virtually to focus on work resumption

591 Virtual Feedback received from mothers and Anganwadi workers

Survey and Findings

Project Spotlight aimed to strengthen ICDS service delivery and impact behaviour of communities through various mechanisms. Therefore, both baseline and endline surveys were designed to ascertain the impact of project activities on coverage of services and knowledge, attitude and practises of communities.

With a sample size of 640 beneficiaries from 80 Anganwadis, and interviewing 200 Anganwadi Workers; preliminary findings from Palghar district were very encouraging and promising.

Some of the key results are presented below:

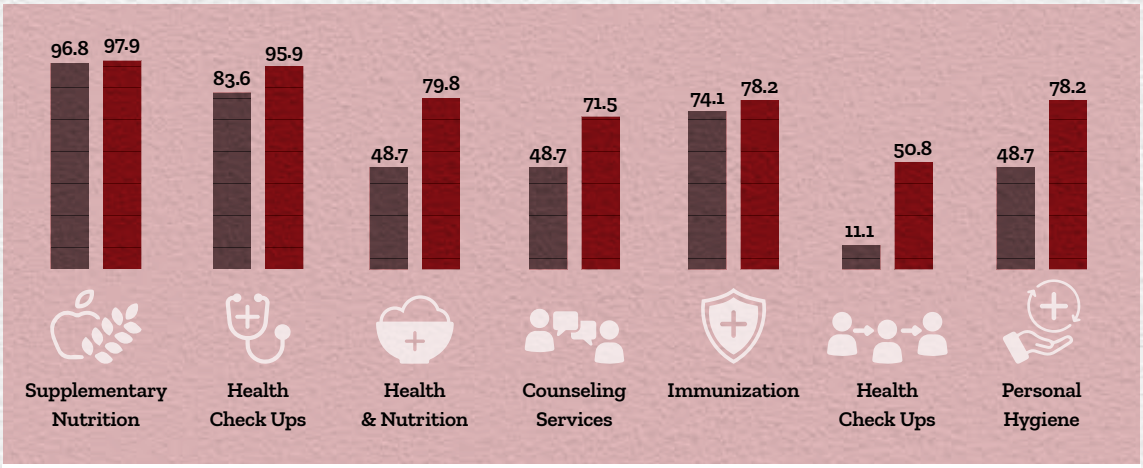


Fig 1. Coverage of services amongst pregnant women from baseline to endline

Coverage of ICDS services availed by pregnant women went up for all of the six services provided in Palghar. The most significant difference was seen for referral services, which could be an outcome of convergence activities especially household visits, an activity which enabled identification of high risk beneficiaries.

Significant increase in service uptake was seen in descending order for personal hygiene, health and nutrition services, counselling services, health-check ups and immunization services (Fig 1). A significant increase in satisfaction from the services availed by pregnant women compared to the baseline was observed. It jumped from

39% to 63% on a likert scale of satisfactory and 23% to 31.5% for highly satisfactory. This could be the effect of coordination and convergent action as beneficiaries tend to retain the most when counselled by AAAs together. It was also evident in the women's knowledge levels and subsequent behaviour change, wherein a significant increase in awareness around danger signs during pregnancy was observed. Moreover,

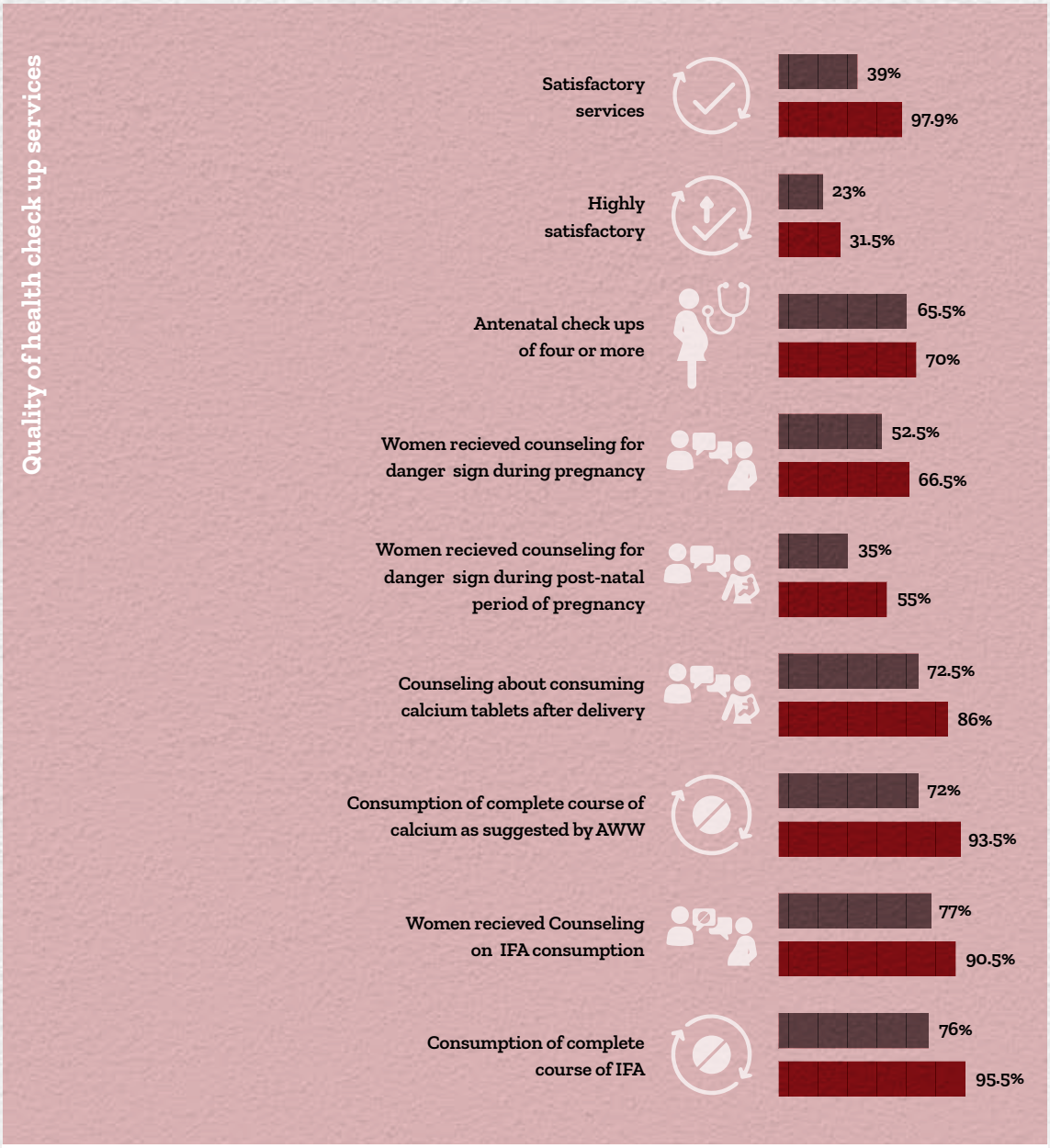


Fig 2. Knowledge of pregnant women on quality of ante-natal services

a higher number of pregnant women were aware of the importance of Calcium and Iron Folic as well as significantly more women consumed the same (Fig 2).

Similar findings were observed as in Fig 3, for service utilization; knowledge, attitude and practises of nursing mothers and mothers with young children. A huge significant jump was observed in referral

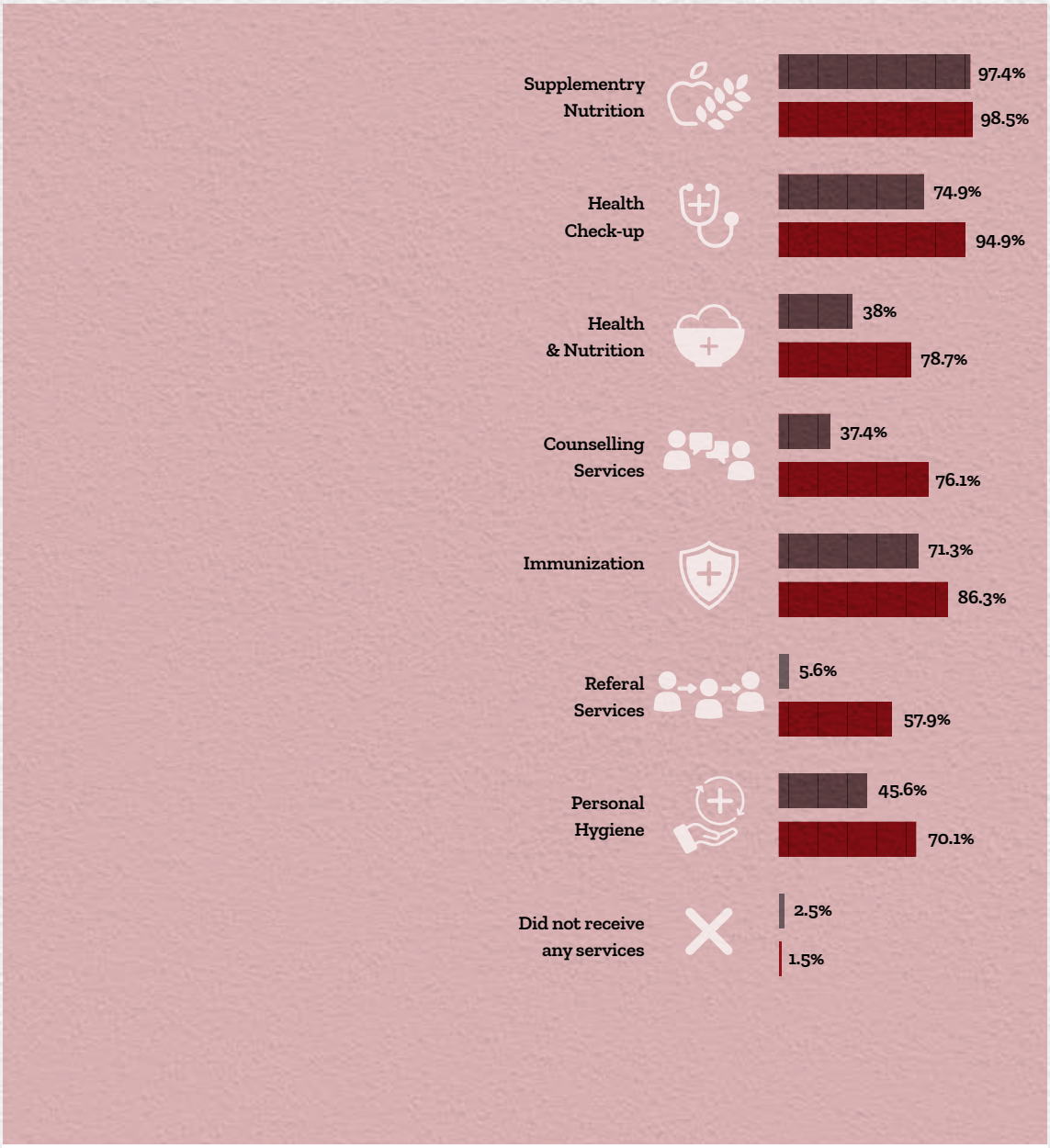


Fig 3. Coverage of services amongst mothers of young children

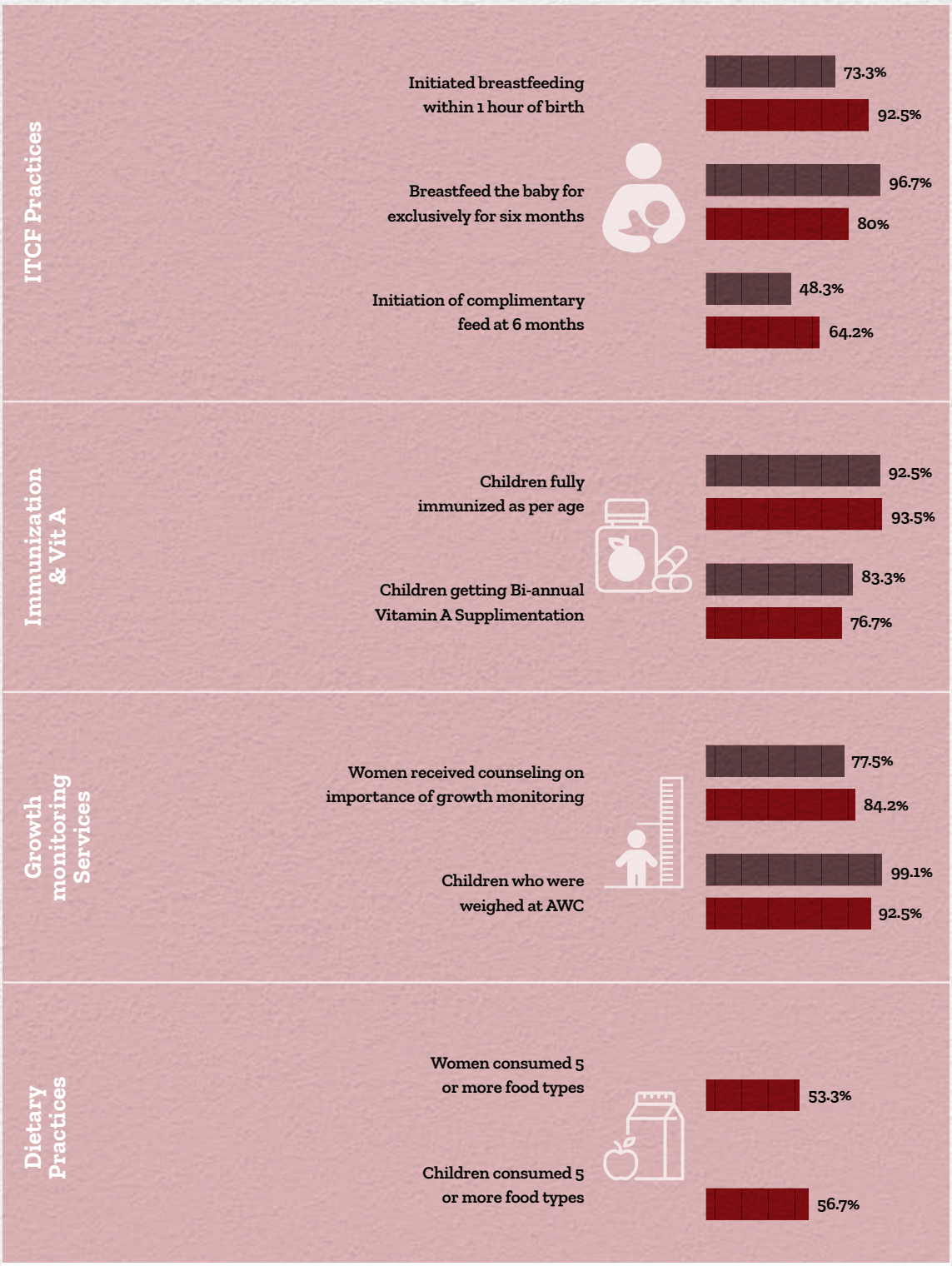


Fig 4. Knowledge and attitude of mothers of young children

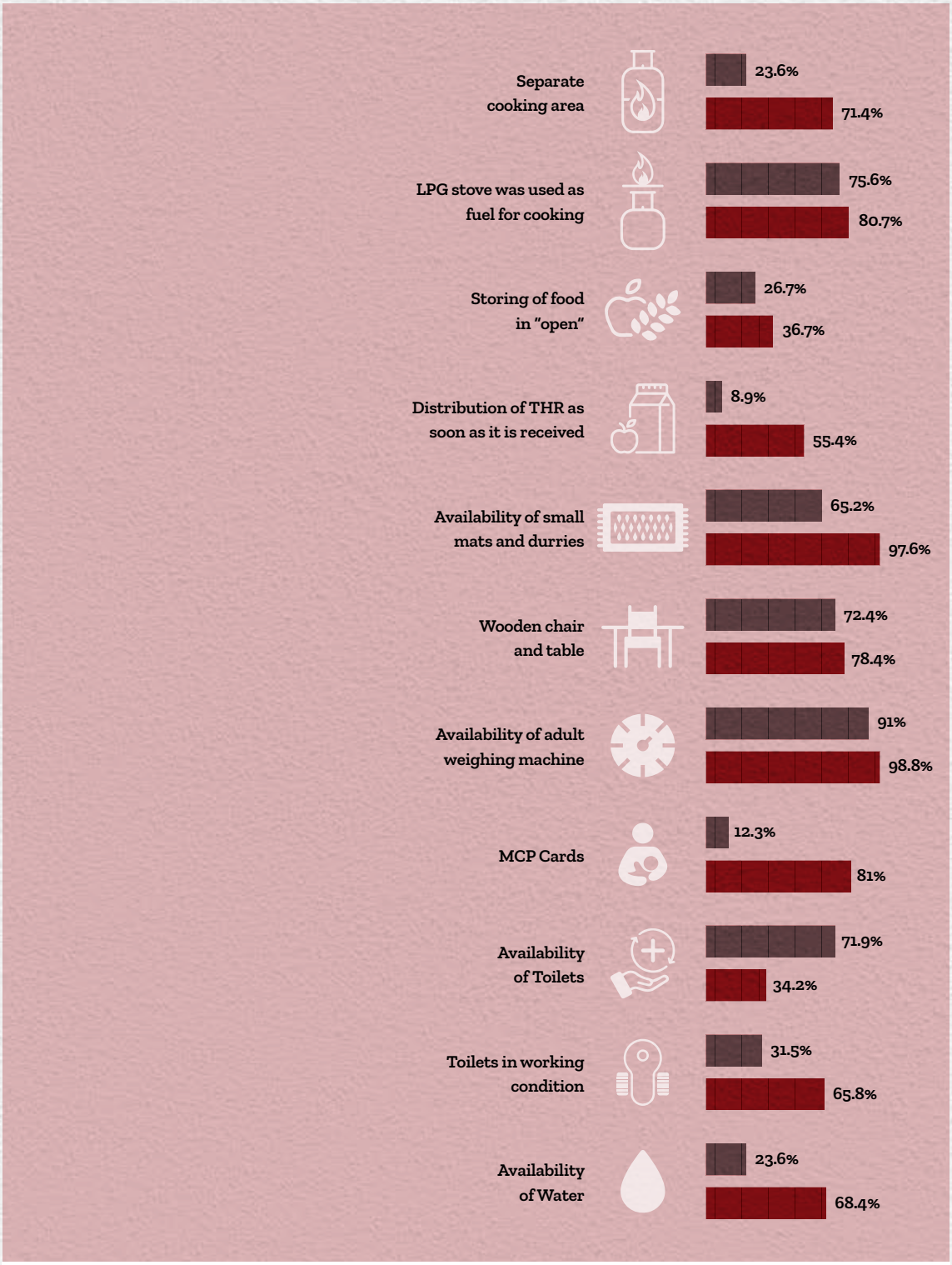


Fig 5. Status of Anganwadi infrastructure at baseline and endline

services, counselling services as well as health and nutrition services amongst others.

Improvements were also observed for infant and young child feeding practises, indicators with significant increase in initiation of complementary feeding at 6 months of age as well as breastfeeding within one hour of birth. However, a slight reduction was seen in bi-annual vitamin A supplementation and exclusive breastfeeding for six months figures as well.

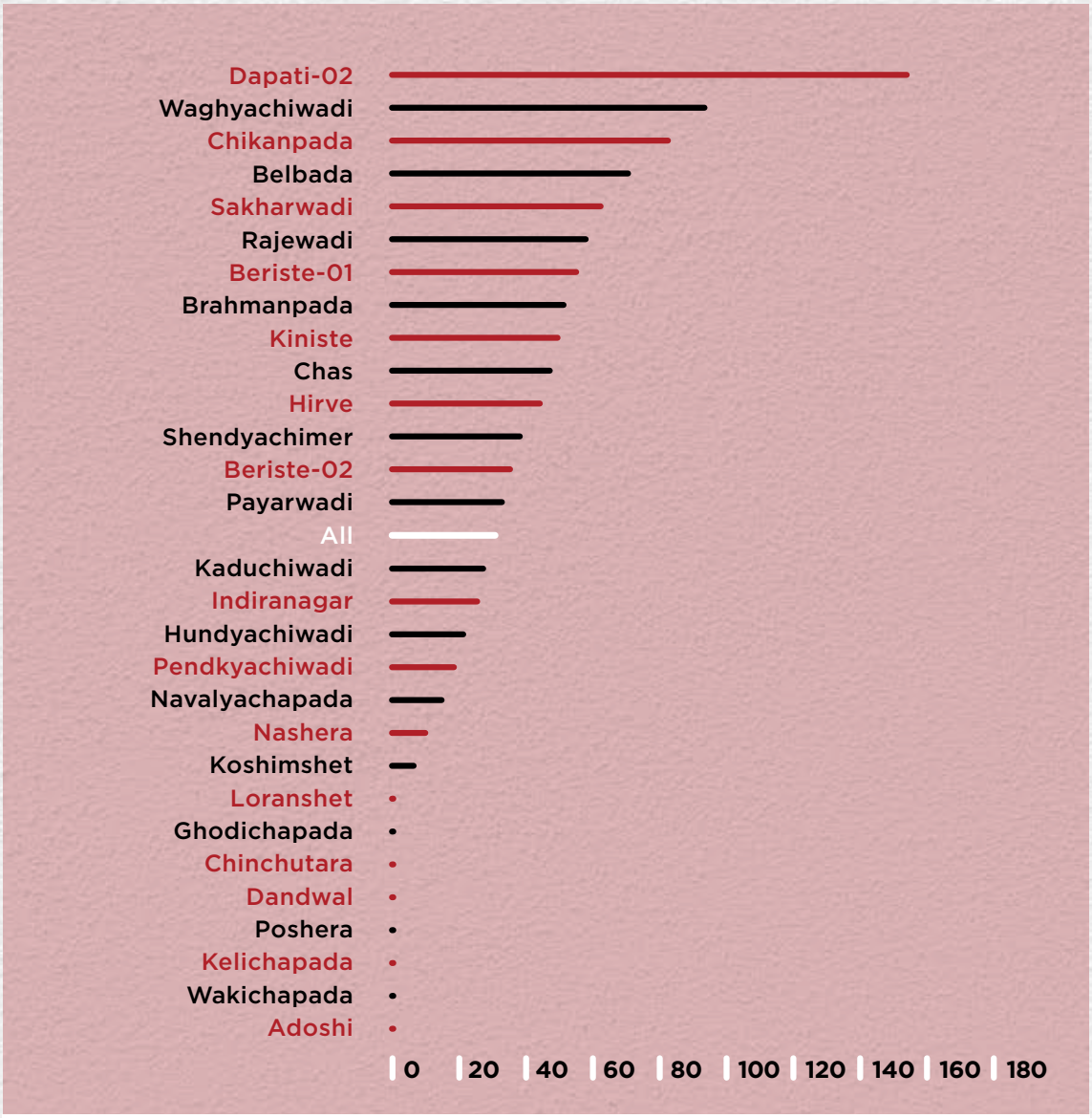


Fig 6. A sample of 30 Anganwadi Centres undergone refurbishment, depicting attendance of children before and after one month of refurbishment in Palghar, Maharashtra. Source: Standard Operating Procedure on Refurbishment of Anganwadi Centres.

With regards to Anganwadi Infrastructure in Palghar, a significant improvement was observed as under separate cooking area, practises of storing food in open, availability of mats, weighing machines, mother child protection card, toilets in working condition, water availability, amongst others (Fig 5). In addition, a quick survey before and after refurbishment demonstrated increased footfall of children visiting AWCs. The average number of children availing primary education service increased by 31.5% from a total of 485 to 638 children across the thirty sampled Anganwadis. Nearly two-thirds of the centres reported an increase in attendance of 20% or more.

What do Tribals in Maharashtra eat ?

CASE STUDY

The before

While frontline functionaries such as Anganwadi Workers (AWW), Accredited Social Health Activists (ASHA) and Auxiliary Nurse Midwives (ANM) (collectively AAA) work in the same village, they are not similarly acquainted with their beneficiaries. They work in silos and usually collaborate monthly, no Village Health, Sanitation and Nutrition Days which are mostly focused on antenatal check-ups. So, there exists a scope for synchronising instances of collective counselling of common beneficiaries by the AAA.

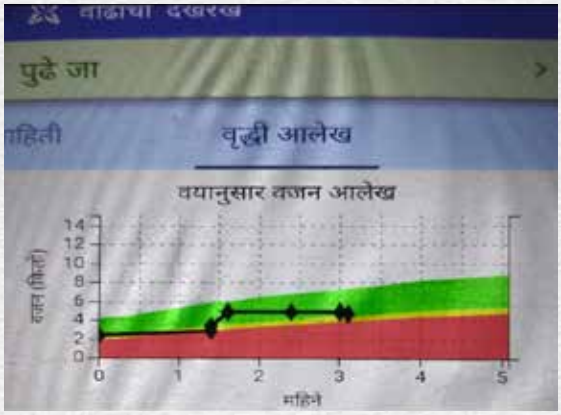


Fig 2. Pallavi's growth chart from CAS mobile

The intervention

Under Project Spotlight, Tata Trusts trained the frontline workers on step-wise guidelines on convergence of the two departments – Health and Family Welfare, and Women and Child Development, in Palghar district in Maharashtra. Through extensive cascade trainings, a skeleton of extensive follow-up mechanism and focus on joint household visits of AAA, significant synergy in activities was generated. This AAA group began to motivate communities when they started making visits jointly, with beneficiaries quickly realising that health and nutrition outcomes are closely related.


Fig 1. Pallavi being weighed at home by AAA group

The after: The Story of Pallavi

In Sapane village of Wada, one-month old Pallavi, the third daughter of the family was identified as Severely Acute Malnourished (SAM) by the AAA group during a growth monitoring session in January 2020. Upon learning this, the frontline workers went into action and counselled her mother, Yashoda, on effective breastfeeding practises. Anganwadi sewika Ms. Pranali Kale also contributed by demonstrating good nutrition practices through videos on Common Application Software (CAS) - the digital tool is the digital tool launched by Government of India to enable frontline

workers improve nutrition service delivery by better monitoring and intervention. Since Pallavi was born premature and weighed low at birth, Yashoda was alerted to watch out for any early warning signs. The AAA group categorised Pallavi's case as a high- risk household visit. At the visit, it was observed that Pallavi was experiencing fever and cough. She was immediately referred to the hospital, but both Yashoda and her husband were reluctant. However, the AAAs persisted for over two hours, where they emphasised upon the urgency of this step. They eventually ensured that Pallavi received adequate medical care.

Fig 3. Well informed mother with now recovered healthy Pallavi

The visits by the AAA continued. With counselling, medication for underlying problem and support, Pallavi's weight started improving, and she moved up into the 'normal weight' category in only a short span of 22 days! The frontline workers continued to diligently monitor Pallavi's situation and she remained in the 'normal weight' category in every subsequent visit too.

"I wish such attention was paid to Pallavi's older siblings when they were growing up! I was reluctant initially as I thought it was normal like my other kids, but it was only through the insistence of Anganwadi, ASHA and ANM Didi that I understood how severe the problem was."

- Yashoda

Fig 4. Pallavi's growth story was a huge success and was discussed amongst other AAA groups.

01 ANNEXURE

Convergence Matrix of Panchayat Raj Institution (PRI) members with Integrated Child Development Services (ICDS) representatives through the use of 'Village Health Report Card'

'आमचं गाव आमचा विकास'

प्रति, दिनांक:

मा.सरपंच / ग्रामसेवक,

ग्रामपंचायत कार्यालय ----------,

संदर्भ: १. महाराष्ट्र शासन, ग्राम विकास विभाग, शासन निर्णय क्रमांक झेडपिए २०१३/प्र.क्र. ७६, पंरा-१ दि. २४ जानेवारी २०१४

२. महाराष्ट्र शासन, ग्राम विकास विभाग, शासन निर्णय क्रमांक जीपीडीपी २०१७/प्र.क्र. ५२/पं.राज ६, दि. २ फेब्रुवारी २०१८

३. महाराष्ट्र शासन, ग्राम विकास विभाग, शासन निर्णय क्रमांक जीपीडीपी जीपीडीपी २०१९/प्र.क्र.३८/पंरा-६, दि. २८ मे २०१९

विषय: अंगणवाडी प्रगती अहवाल सादर करून आदर्श अंगणवाडी केंद्र आणि कुपोषण मुक्त गाव बनविण्याकरिता अपेक्षित मदत मिळणेबाबत.

महोदय,

उपरोक्त संदर्भीय विषयान्वेय आपणास कळविण्यात येते की, मी आपल्या गावात मागील …….. वर्षांपासून अंगणवाडी कार्यकर्ती या पदावर कार्यरत आहे. आज पर्यन्त आपण करीत असलेल्या सहकार्यची मला माझ्या कार्यात मदत होत आहे. आजच्या ग्राम/मासिक सभा निमित्याने मी माझ्या अंगणवाडीचा प्रगती अहवाल सादर करीत आहे तथा खालील मागण्याची पूर्तता करण्यासाठी आपल्याला विनंती करीत आहे.

अ) ग्राम आरोग्य अहवाल (Village Health Report)

सूचक	एकूण संख्या	तपशील
मागील महिण्यात नोंद केलेल्या एकूण गर्भवती महिलांची संख्या		
मागील महिण्यात लोह व कॅल्शिअम प्राप्त केलेल्या एकूण गर्भवती महिलांची संख्या		
मागील महिण्यात नोंद केलेल्या एकूण जोखमीच्या गर्भवती महिलांची संख्या		
मागील महिण्यात नोंद केलेल्या एकूण स्तनदा महिलांची संख्या		
मागील महिण्यात लोह व कॅल्शिअम प्राप्त केलेल्या एकूण स्तनदा महिलांची संख्या		
मागील महिण्यात नोंद केलेल्या एकूण जोखमीच्या स्तनदा महिलांची संख्या		
मागील महिन्यात एकूण बाल मृत्यु संख्या (० ते ५ वर्ष)		

सूचक	० ते ३ वर्ष	३ ते ५ वर्ष	एकूण संख्या
० ते ५ वर्ष पूर्ण केलेल्या बालकांची संख्या			
मागील महिन्यात ० ते ५ वर्ष बालकांची वजन घेतलेल्या संख्या			
सामान्य मुलांची संख्या (Normal)			
मध्यम तिव्र कमी वजनाची बालकांची संख्या (MUW)			
अतितिव्र कमी वजनाची बालकांची संख्या (SUW)			

ब) ग्राम पंचायत कार्यालयास (महिला व बाल विकास विभाग, पेसा तथा इतर उपलब्ध निधीतून) मदतीसाठी विनंती ….

1. ----------
2. ----------
3. ----------
4. ----------
5. ----------

सही *(अंगणवाडी कार्यकर्ती)*

अंगणवाडी कार्यकर्तीचे नाव: - ---------- अंगणवाडी केंद्र ----------प्रकल्प:---------- जिल्हा पालघर

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आमचं गाव आमचा विकास

प्रपत्र २

प्रति, दिनांक:

बालविकास प्रकल्प अधिकारी,

एकात्मिक बालविकास सेवा योजना प्रकल्प.....

मुख्य सेविका यांच्या कार्यक्षेत्रात असलेले एकूण बिट ची संख्या ---------- एकूण अंगणवाडी केंद्र ----------अंगणवाडी सेविके मार्फत ग्रामपंचायतीला माहे ---------२०२० मध्ये सादर केलेल्या अंगणवाडी प्रगती अहवाल (प्रपत्र १) तपशील पुढीलप्रमाणे

मुख्य सेविका यांच्या कार्यक्षेत्रात असलेल्या एकूण ग्रामपंचायतीची संख्या ?	अंगणवाडी सेविके मार्फत ग्रामपंचायतीला सादर केलेले एकूण अंगणवाडी प्रगती अहवालाची संख्या (प्रपत्र १)	ग्रामपंचायत मार्फत अंगणवाडी प्रगती अहवाल (प्रपत्र १) नुसार एकूण अंगणवाडी केंद्रांना केलेली मदत	शेरा

आपल्या माहितीकरिता सादर.

मुख्य सेविका,

एकात्मिक बालविकास सेवा योजना प्रकल्प..... .....

आमचं गाव आमचा विकास

प्रपत्र ३

प्रति, दिनांक:

जिल्हा कार्यक्रम अधिकारी

(महिला व बालकल्याण विभाग)

जिल्हा परिषद, पालघर

अंगणवाडी सेविके मार्फत ग्रामपंचायतीला माहे ---------२०२० मध्ये सादर केलेल्या अंगणवाडी प्रगती अहवाल (प्रपत्र १) तपशील पुढीलप्रमाणे

प्रकल्पाअंतर्गत असलेल्या एकूण ग्रामपंचायतीची संख्या ?	अंगणवाडी सेविके मार्फत ग्रामपंचायतीला सादर केलेले एकूण अंगणवाडी प्रगती अहवालाची संख्या (प्रपत्र १)	ग्रामपंचायत मार्फत अंगणवाडी प्रगती अहवाल (प्रपत्र १) नुसार एकूण अंगणवाडी केंद्रांना केलेली मदत	शेरा

आपल्या माहितीकरिता सादर.

बाल विकास प्रकल्प अधिकारी,

एकात्मिक बालविकास सेवा योजना प्रकल्प..... .....

विस्तार अधिकारी (ग्रामपंचायत)

पंचायत समिती .....

आमचं गाव आमचा विकास

प्रपत्र २

प्रति, दिनांक:

बालविकास प्रकल्प अधिकारी,

एकात्मिक बालविकास सेवा योजना प्रकल्प.....

मुख्य सेविका यांच्या कार्यक्षेत्रात असलेले एकूण बिट ची संख्या ---------- एकूण अंगणवाडी केंद्र ----------अंगणवाडी सेविके मार्फत ग्रामपंचायतीला माहे ---------२०२० मध्ये सादर केलेल्या अंगणवाडी प्रगती अहवाल (प्रपत्र १) तपशील पुढीलप्रमाणे

मुख्य सेविका यांच्या कार्यक्षेत्रात असलेल्या एकूण ग्रामपंचायतीची संख्या ?	अंगणवाडी सेविके मार्फत ग्रामपंचायतीला सादर केलेले एकूण अंगणवाडी प्रगती अहवालाची संख्या (प्रपत्र १)	ग्रामपंचायत मार्फत अंगणवाडी प्रगती अहवाल (प्रपत्र १) नुसार एकूण अंगणवाडी केंद्रांना केलेली मदत	शेरा

आपल्या माहितीकरिता सादर.

मुख्य सेविका,

एकात्मिक बालविकास सेवा योजना प्रकल्प..... .....

02 ANNEXURE

Convergence Matrix of National Rural Health Mission (NRHM) and Integrated Child Development Services (ICDS) representatives through the use of AAA Card

प्रपत्र ?: AAA Management tool

	आरोग्यसेविकाचे नाव:	आरोग्य उपकेंद्राचे नाव:				Reporting महिना:		2020
	VHSND सत्र आयोजित केलेल्या अंगणवाडी/केंद्रा चे नाव:							
	दिनांक :	...../...../2020	...../...../2020	...../...../2020	...../...../2020	...../...../2020	...../...../2020	
A	**AAA समन्वयाची (Coordination) ची स्थिती**							**Total**
1	AAA बैठकीमध्ये उपस्थित आशा, अंगणवाडी कार्यकर्ती आणि आरोग्यसेविका यांची एकूण संख्या							
2	आशा स्वयंसेविका आणि अंगणवाडी कार्यकर्ती यांनी एकत्रितपणे कार्यक्षेत्राचा नकाशा तयार/अद्ययावत केलेला आढळला का ?							
3	आशा स्वयंसेविका आणि अंगणवाडी कार्यकर्ती यांनी एकत्रितपणे गृहभेटीचे नियोजन तयार केलेले आढळले का ?							
4	यादीत नोंदविण्यात आढळलेल्या एकूण अतिजोखमीच्या गरोदर आणि स्तनदा मातांची संख्या							
5	एकूण आढळलेल्या अतिजोखमीच्या गरोदर/ स्तनदा मातांपैकी किती कुटुंबाना AAA यांनी एकत्रितपणे गृहभेटी देऊन समुपदेशन केले आहे							
B	**वृद्धी संनियंत्रण (Growth Monitoring) ची स्थिती**							
1	VHSND दिवशी वजन केलेल्या ३ वर्षाखालील मुलांची एकूण संख्या							
2	VHSND दिवशी माता बाल संरक्षण (MCP) कार्ड मध्ये असणाऱ्या वृद्धिआलेखामध्ये (Growth Chart) नोंद केलेल्या ३ वर्षाखालील बालकांची एकूण संख्या							
C	**० ते ६ वयोगटातील बालकांच्या कुपोषणाची ची स्थिती**							
1	एकूण SAM बालके							
2	एकूण MAM बालके							
3	एकूण आढळलेल्या SAM/MAM तसेच आजारी बालकांपैकी किती कुटुंबाना AAA यांनी एकत्रितपणे गृहभेटी देऊन समुपदेशन केले आहे							
4	AA/AAA यांनी एकूण रेफर केलेल्या अतिजोखमीच्या (SAM/MAM तसेच आजारी) बालकांची संख्या							
D	**लसीकरणाची (Immunization) स्थिती**							
1	पूर्ण लसीकरण झालेल्या एकूण बालकांची संख्या (९ महिने पूर्ण ते १ वर्ष)							
2	९ महिने पूर्ण ते १ वर्ष नव असणाऱ्या बालकांची एकूण संख्या							
E	**स्थलांतराची (Migration) स्थिती**							
1	बाहेरून स्थलांतरित होऊन आलेल्या एकूण गरोदर माता							
2	बाहेरून स्थलांतरित होऊन आलेल्या एकूण स्तनदा माता							
3	कार्यक्षेत्रातून बाहेर स्थलांतरित झालेल्या एकूण गरोदर माता							
4	कार्यक्षेत्रातून बाहेर स्थलांतरित झालेल्या एकूण स्तनदा माता							
A	आशा स्वयंसेविका सही							
A	अंगणवाडी कार्यकर्ती सही							
A	आरोग्यसेविका सही							

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प्रपत्र २: आरोग्य उप केंद्र (Health Sub Center) ठिकाणी पार पडलेल्या मासिक AAA बैठकीचे इतिवृत्त

	प्राथमिक आरोग्य केंद्राचे नाव:					दिनांक:	
अ. क्र.	उपकेंद्राचे नाव	एकूण नियोजित ग्राम आरोग्य पोषण दिन (VHSND)	एकूण पार पाडलेले ग्राम आरोग्य पोषण दिन (VHSND)	VHSND दिवशी एकूण पार पाडलेल्या AAA आढावा बैठकी	AAA Management Tool (प्रपत्र १) जमा केलेले आहे का?	आढावा घेतलेले प्रमुख विषय: 1 AAA समन्वयामध्ये येणाऱ्या समस्या 2 गावपातळीवरील आढळलेल्या आरोग्य-पोषण समस्या 3 आरोग्य-पोषणाच्या सेवा देताना येणाऱ्या अडचणी 4 आढावा घेतलेले इतर विषय व सूचना	प्राथमिक आरोग्य केंद्र स्तरावरून अपेक्षित मदत
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
	एकूण =						

*सदर प्रपत्र उपकेंद्र [illegible] अथवा प्रा. आ. केंद्र स्तरावर आरोग्य सहाय्यिका/सहाय्यक [illegible] प्रपत्र १ [illegible] मासिक आढावा बैठकी [illegible]

मुख्य सेविका (ए. बा. वि. से. यो.), बिट/सेक्टर: वैद्यकीय अधिकारी

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प्रपत्र ३: प्राथमिक आरोग्य केंद्र (Primary Health Center) स्तरावर पार पडलेल्या AAA बैठकीचे इतिवृत्त

प्राथमिक आरोग्य केंद्राचे नाव:			दिनांक:	
तालुक्याचे नाव:				
एकूण उपकेंद्र संख्या	आरोग्य उपकेंद्र (HSC) ठिकाणी पार पाडलेल्या एकूण मासिक AAA आढावा बैठकीची संख्या	एकूण जमा केलेल्या AAA Management Tool (प्रपत्र १) ची संख्या	प्राथमिक आरोग्य केंद्र स्तरावर घेण्यात आलेल्या AAA आढावा बैठकीमधील प्रमुख विषय	तालुका / जिल्हा स्तरावरून अपेक्षित मदत
			2. गावपातळीवरील आढळलेल्या आरोग्य-पोषण समस्या व उपाय: 3. आरोग्य-पोषणाच्या सेवा देताना येणाऱ्या अडचणी व उपाय: 4. आढावा घेतलेले इतर विषय व सूचना:	
1. AAA समन्वयामध्ये येणाऱ्या समस्या व उपाय:				

मुख्य सेविका (ए. बा. वि. से. यो.), बिट/सेक्टर: वैद्यकीय अधिकारी

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प्रपत्र ८: तालुका स्तरावर (Block Level) चार पडलेल्या AAA बैठकीचे इतिवृत्त

तालुक्याचे नाव:		दिनांक:	
एकूण प्राथमिक आरोग्य केंद्रांची संख्या	प्राथमिक आरोग्य केंद्र स्तरावर चार पडलेल्या एकूण AAA आढावा बैठकी	तालुका स्तरावर घेण्यात आलेल्या AAA आढावा बैठकीमधील प्रमुख विषय	जिल्हा स्तरावरून अपेक्षित मदत
		2. मागणीकृत आढावलेल्या आरोग्य योजना संख्या व उपाय:	
1. AAA संकल्पनेमागे घेतलेल्या संकल्पना व उपाय:		3. आरोग्य योजनांच्या योजना देताना येणाऱ्या अडचणी व उपाय:	
		4. आढावा घेतलेले इतर विषय व मुद्दे:	

बाल विकास प्रकल्प अधिकारी

तालुका आरोग्य अधिकारी

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"What advances a nation or a community is not so much to prop up its weakest and most helpless members, but to lift up the best and the most gifted, so as to make them of the greatest service to the country."

Jamsetji Tata

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Dr. Smriti Sharma
ssharma@tatatrusts.org

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