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

सत्यमेव जयते
NITI Aayog

PRESERVING PROGRESS ON NUTRITION IN INDIA: POSHAN ABHIYAAN IN PANDEMIC TIMES

JULY 21

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

सत्यमेव जयते
NITI Aayog

PRESERVING PROGRESS ON NUTRITION IN INDIA: POSHAN ABHIYAAN IN PANDEMIC TIMES

AUTHORS: This Report is prepared by a team at WCD Division, NITI Aayog (under guidance of Dr. Vinod K. Paul, Member (Health), led by Dr. Rakesh Sarwal, Additional Secretary (Health & Nutrition), Dr. Neena Bhatia (Senior Specialist), Dr. Supreet Kaur (Senior Consultant), Mr. Kumar Supravin (Senior Consultant), Ms. Prepsa Saini (Consultant) and Ms Parnika Singh (Intern) along with a team from the International Food Policy Research Institute (IFPRI) led by Dr. Purnima Menon (Senior Research Fellow), Rasmi Avula (Research Fellow), Phuong Hong Nguyen (Senior Research Fellow), Monika Walia (Data Manager), Esha Sarswat (Communications Specialist), Sattvika Ashok (Research Analyst), Shivani Kachwaha (Research Analyst), Anita Christopher (Research Analyst).

NITI Aayog acknowledges the contributions of the Ministry of Women and Child Development and Ministry of Health and Family Welfare and all State Governments for sharing the updated information to prepare the report.

Contents

List of Figures *v*
List of Tables *vii*
List of Boxes *vii*
Abbreviations *ix*

Executive Summary **1**
Introduction 1
Methodology 2
Findings 2
Key recommendations 5

1. Introduction **7**
1.1 Overview of POSHAN Abhiyaan 7
1.2 Objectives of POSHAN Abhiyaan IV Progress Report 11

2. Methodology **13**
2.1 Progress tracking framework 13
2.2 Data collection from states 14
2.3 Data collection from line Ministries 15
2.4 Data collection from development partners 15
2.5 Data analysis 15
2.6 Limitations 20

3. What progress have we made to date? **21**
3.1 What progress have States made on delivering POSHAN Abhiyaan? 21
3.2 Conclusion and Way Forward 40

4. Jan Andolan and Multi-Sectoral Interventions **43**
4.1 Background 43

4.2 Jan Andolan 43
4.3 Multi-sectoral involvement 48
4.4 Conclusion and Way Forward 54

5. Delivering POSHAN Abhiyaan Interventions during a Pandemic: How are States doing? 57

5.1 Women and child development services 57
5.2 Maternal and Child Health Services 69
5.3 Multi-sectoral involvement and policy action during COVID-19 88
5.4 Conclusion and Way Forward 92

6. Conclusions and Recommendations 95

7. Key Takeaways from POSHAN Abhiyaan 99

Lesson 1: POSHAN Abhiyaan has helped to bring a strong focus on improving nutrition outcomes during the first 1,000 days. 99
Lesson 2: POSHAN Abhiyaan has enabled a Nation-wide Jan Andolan catalysing nutrition related behaviour change at scale for positive impact on feeding and health care practices 101
Lesson 3: POSHAN Abhiyaan demonstrated that the processes for Inter-sectoral convergence are effectively operationalized through in place institutional mechanisms at multiple levels 102
Lesson 4: POSHAN Abhiyaan showed that Technology can be leveraged for real time monitoring of large scale health and nutrition programmes 103
Lesson 5: POSHAN Abhiyaan supported the resilience of health and nutrition systems during COVID-19 pandemic 104
Reflection on POSHAN Abhiyaan based on early results available for 22 states from NFHS-5 105

8. References 107

9. Annexures 109

Annexure 1a: State template-Women and Child Development 109
Annexure 1b: State Template-Health 115
Annexure 2: Rubric 119
Annexure 3: State score dashboard overall 125
Annexure 4: POSHAN Abhiyaan II Monitoring Report: Data Collection Form for MOWCD 134
Annexure 5: Concordance check between State Template Indicators and MPR/HMIS Data 164
Annexure 6: Top and bottom performing States/UTs based on Indicators used in Rubric 165

List of Figures

Figure 1:	Overall Implementation Status of POSHAN Abhiyaan at the National-Level in 2020	3
Figure 2:	Pillars of POSHAN Abhiyaan	8
Figure 3:	Targets of POSHAN Abhiyaan	9
Figure 4:	Critical components for examining the progress to date on rolling out POSHAN Abhiyaan in the WCD and Health departments	16
Figure 5:	Overall implementation status of POSHAN Abhiyaan* at the national-level in 2020	22
Figure 6:	State-wise scores for Government and Institutional Mechanism	23
Figure 7:	State-wise comparison of the Percentage Funds utilized up to FY 2018-19 and FY 2017-18 and up to FY 2019-20	25
Figure 8:	Constitution of committees: Comparison between 2019 and 2020	25
Figure 9:	Percentage of districts that have developed and submitted CAP for FY 2019-20 compared to FY 2020-21 at the national level	26
Figure 10:	State-wise scores for strategy and planning	27
Figure 11:	State-wise scores for Inputs for service delivery and capacity: Women and Child Development Department	29
Figure 12:	Distribution of supplies to districts: Comparison between 2019 and 2020	30
Figure 13:	Percentage of CDPOs trained on ICDS Dashboard/Mobile Phones: Comparison between 2019 and 2020	32
Figure 14:	State-wise scores for inputs for service delivery essentials: Health Department	33
Figure 15:	Percentage of functional health facilities: Comparison between 2019 and 2020	35
Figure 16:	Percentage of ANM positions filled: Comparison between 2019 and 2020	35
Figure 17:	State-wise scores for programme activities and intervention coverage – Women and Child Development Department	36
Figure 18:	State-wise scores for Programme activities and intervention coverage- Health Department	39
Figure 19:	Poshan Maah performance by participation across India, 2020	45
Figure 20:	Poshan Maah performance by participation: Comparison between 2019 and 2020	45
Figure 21:	Themes covered under POSHAN Maah, 2020	46

Figure 22: Policy guidance for implementation platforms and interventions across life stages 58

Figure 23: Changes in supplementary nutrition as per MPR data, October 2019 to December 2020 60

Figure 24: Disruption and restoration of supplementary nutrition among children 6 months to 6 years of age during the COVID-19 pandemic, MPR data, October 2019 to December 2020 61

Figure 25: Disruption and restoration of supplementary nutrition among pregnant and lactating women during pandemic, MPR data, October 2019 to December 2020 62

Figure 26: Policy guidance for interventions during pregnancy, postnatal and early childhood period 71

Figure 27: Changes in number of pregnant women received full course of 180 IFA tablets, 4 or more ANC check-ups from October 2019 to December 2020 72

Figure 28: Disruption and restoration of number of pregnant women who received 180+ IFA tablets, HMIS Data, October 2019-December 2020 73

Figure 29: Disruption and restoration of number of pregnant women who received four or more ANC visits, HMIS Data, October 2019-December 2020 75

Figure 30: Changes in the number of institutional deliveries conducted and the number of women receiving the first post-partum check-up between 48 hours and 14 days from October 2019 to December 2020 76

Figure 31: Disruption and restoration of number of institutional deliveries conducted (including C-section), HMIS Data October 2019-December 2020 77

Figure 32: Disruption and restoration of number of women who received postpartum check-ups between 48 hours and 14 days, HMIS Data, October 2019-December 2020 79

Figure 33: Changes in number of children who received fully immunized (9-11 months), 6 HBNC visits (newborns), and health check-up (severely underweighted children 0-5 years) from October 2019 to December 2020. 80

Figure 34: Disruption and restoration of number of children (9-11 months) fully immunised, HMIS Data, October 2019-December 2020 81

Figure 35: Disruption and restoration of number of newborns who received 6 HBNC visits after institutional delivery, HMIS Data October 2019-December 2020 83

Figure 36: Disruption and restoration of number of severely underweighted children (0-5 years) who received health check-ups, HMIS Data, October 2019- December 2020 84

List of Tables

Table 1:	Progress and implementation score themes for WCD and Health Departments	14
Table 2:	Categorisation of States	18
Table 3:	Service disruption and restoration definition and formulae	19
Table 4:	Utilization of funds: Comparison between FY 2017-18 to 2018-19 and FY 2017-18 to FY 2019-20	24
Table 5:	Key activities performed during Poshan Maah by Line Ministries	47
Table 6:	Summary of ICDS programme delivery innovations in the context of COVID-19, as reported by State Governments	63
Table 7:	Summary of health programme delivery innovations in the context of COVID-19, as reported by State Governments	85

List of Boxes

Box 1:	Brief outline of the first three POSHAN Abhiyaan progress reports	10
Box 2:	Steps to generate the progress and implementation score	17
Box 3:	Improving the micronutrient profile of the ICDS beneficiaries	54
Box 4:	Study to assess the THR production and distribution across 12 districts in Jharkhand and Rajasthan	67
Box 5:	Frontline health workers enable restoration of health and nutrition service delivery after early COVID-19 lockdown: Findings from a seven-state observational study	68

Abbreviations

A&T	—	Alive and Thrive
AMB	—	Anaemia Mukt Bharat
ANC	—	Antenatal Care
ANM	—	Auxiliary Nurse Midwife
ASHA	—	Accredited Social Health Activist
AWC	—	Anganwadi Centre
AWW	—	Anganwadi Worker
AYUSH	—	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
BRG	—	Block Resource Group
CAP	—	Convergence Action Plan
CAS	—	Common Application Software
CBE	—	Community-Based Event
CDPO	—	Child Development Project Officer
CIFF	—	Children's Investment Fund Foundation
CHC	—	Community Health Centre
CMAM	—	Community-based management of acute malnutrition
CNNS	—	Comprehensive National Nutrition Survey
CPMU	—	Central Programme Management Unit
DAY-NRLM	—	Deendayal Antyodaya Yojana – National Rural Livelihoods Mission
DMEO	—	Development Monitoring and Evaluation Office
DRG	—	District Resource Group
DWCD	—	Department of Women and Child Development
DPO	—	Development Project Officer
DWS	—	Drinking Water and Sanitation
EIBF	—	Early Initiation of Breastfeeding

FLW	—	Frontline Workers
FSSAI	—	Food Safety and Standards Authority of India
H&FW	—	Health & Family Welfare
HBNC	—	Home-Based Newborn Care
HBYC	—	Home-Based Care of Young Child
HMIS	—	Health Monitoring Information System
HR	—	Human Resource
HWC	—	Health and Wellness Centres
ICDS	—	Integrated Child Development Scheme
IDCF	—	Intensified Diarrhoea Control Fortnight
IEC	—	Information, Education and Communication
IFA	—	Iron and Folic Acid
ILA	—	Integrated Learning Approach
ISSNIP	—	Integrated Child Development Services (ICDS) Systems Strengthening and Nutrition Improvement Programme
IYCF	—	Infant and Young Child Feeding
JAS	—	Jan Arogya Samiti
JSSK	—	Janani Shishu Suraksha Karyakram
JSY	—	Janani Suraksha Yojana
LiST	—	Lived Saved Tool
LBW	—	Low Birth Weight
LS	—	Lady Supervisor
MAM	—	Moderate Acute Malnutrition
MAS	—	Mahila Arogya Samitis
MDMS	—	Mid-Day Meal Scheme
MGNREGS	—	Mahatma Gandhi National Rural Employment Guarantee Scheme
MHRD	—	Ministry of Human Resource Development
MoHFW	—	Ministry of Health and Family Welfare
MNREGA	—	Mahatma Gandhi National Rural Employment Guarantee Act
MoE	—	Ministry of Education
MoPRI	—	Ministry of Panchayati Raj Institutions
MoRD	—	Ministry of Rural Development
MPR	—	Monthly Progress Report
MTC	—	Malnutrition Treatment Centre
MoWCD	—	Ministry of Women and Child Development
NCoE-SAM	—	National Centre of Excellence for Management of SAM
NDD	—	National Deworming Day
NFHS	—	National Family Health Survey
NGO	—	Non-Governmental Organisation

NHM	—	National Health Mission
NRC	—	Nutritional Rehabilitation Centre
NREGA	—	National Rural Employment Guarantee Assurance
NRLM	—	National Rural Livelihood Mission
ODF	—	Open Defecation Free
ORS	—	Oral Rehydration Salts
PCV	—	Pneumococcal Conjugate Vaccine
PDS	—	Public Distribution System
PMMVY	—	Pradhan Mantri Matru Vandana Yojana
PMO	—	Prime Minister's Office
PRI	—	Panchayati Raj Institutions
PMSMA	—	Pradhan Mantri Surakshit Matrutva Abhiyaan
POSHAN	—	Prime Minister's Overarching Scheme for Holistic Nourishment
RBSK	—	Rashtriya Bal Swasthya Karyakram
RKSK	—	Rashtriya Kishori Swasthya Karyakram
RMNCH+A	—	Reproductive, Maternal, Newborn, Child, and Adolescent
RD	—	Rural Development
RVV	—	Rotavirus Vaccine
SAM	—	Severe Acute Malnutrition
SBCC	—	Social and Behavioural Change Communication
SBM	—	Swacch Bharat Mission
SCoE-SAM	—	State Centre of Excellences for Management of SAM
SHG	—	Self-Help Group
SNCU	—	Special Newborn Care Unit
SNP	—	Supplementary Nutrition Programme
SNRC	—	State Nutrition Resource Centre
THR	—	Take-Home Ration
TINI	—	The India Nutrition India
TPDS	—	Targeted Public Distribution System
UHSND	—	Urban Health Sanitation and Nutrition Day
ULB	—	Urban Local Body
UPHC	—	Urban Primary Health Care
UT	—	Union Territory
VHSND	—	Village Health Sanitation Nutrition Day
WCD	—	Women and Child Development
WFP	—	World Food Programme

Executive Summary

INTRODUCTION

In 2018, the Government of India launched its flagship programme, the POSHAN (Prime Minister's Overarching Scheme for Holistic Nourishment) Abhiyaan, to draw national attention to and take action against malnutrition, in a mission-mode.

POSHAN Abhiyaan is the Government of India's flagship programme to improve nutritional outcomes for children, pregnant women and lactating mothers, and adolescents. The Abhiyaan is a multi-ministerial convergence mission with the vision to accelerate India's progress on malnutrition, in a time bound manner with fixed target. Specifically, the mission attempts to (1) deliver a high impact package of interventions in the first 1,000 days of a child's life; (2) strengthen the delivery of these interventions through technology and management; (3) improve the capacity of frontline workers (FLWs); (4) facilitate cross-sectoral convergence to address the multi-dimensional nature of malnutrition; and (5) enhance behaviour change and community mobilization.

Although progress towards improving nutrition outcomes, such as stunting, wasting, anaemia and low birth weight (LBW), requires a long-term commitment, changes in critical implementation elements, programme coverage and household behaviours to *accelerate* nutritional improvements can be achieved in shorter timeframes.

This fourth progress report on POSHAN Abhiyaan (1) assesses the progress of POSHAN Abhiyaan implementation (2) analyses the impact of the COVID-19 pandemic on nutrition and health services; and (3) provides insights on service delivery restorations and adaptations and other related needs across India. This report presents key recommendations to deepen India's efforts to tackle malnutrition, especially in the context of COVID-19. Lastly, the report highlights five key lessons learned by the implementation of POSHAN Abhiyaan over the last three years, including following the onset of the coronavirus pandemic.

METHODOLOGY

Various data sources were used to generate the findings in this report. NITI Aayog collected information from State and Union Territories (UTs) using two questionnaires to assess progress and implementation capabilities on infrastructure, human resources, training and capacity building, convergence, programme and output activities, service delivery by FLWs during COVID-19 and the status of innovation and the flexi-plan for March and July 2020 (Annexure 1). A progress and implementation score framework was developed to assess the progress and capabilities of State and UTs using the data collected.

NITI Aayog also sought information from key ministries on their initiatives launched under the auspices of POSHAN Abhiyaan, focusing on interventions during the first 1,000 days. Furthermore, field-level development partners were encouraged to collect information on new initiatives, stories of change and models that can be scaled-up and replicated, and inspiring anecdotes of exceptional individuals working towards improving nutritional outcomes at the ground-level in the country. NITI Aayog collected this information to align with the strategic pillars of POSHAN Abhiyaan—namely, convergence, training and capacity building, Integrated Child Development Services – Common Application Software (ICDS-CAS) (now POSHAN Tracker Tool), innovations, and behaviour change and IEC advocacy.

In addition, multiple data sources were used to assess policy guidance, adaptations and changes in the coverage of key health and nutrition services during the pandemic. State-level policy guidance from March until October 2020 was examined for 13 States (***Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Rajasthan, Uttar Pradesh and West Bengal)*** using the available state policy documents in the *POSHAN COVID-19 Monitoring report. Data* from the state templates were used to track the service delivery adaptations and innovations made during the pandemic.

Finally, Health Monitoring Information System (HMIS) data and monthly progress report (MPR) data from Anganwadi Centres (AWC) from October 2019 to December 2020 were analysed to examine changes in the coverage of health interventions over the course of the pandemic.

FINDINGS

This report assesses the implementation of the Mission. A rubric was designed and scores for states and UTs were tabulated based on their performance in governance, strategy and planning, availability of inputs, and coverage of key programme activities under Women and Child Development (WCD) and Health. Figure 1 highlights the performance of states and UTs based on these scores.

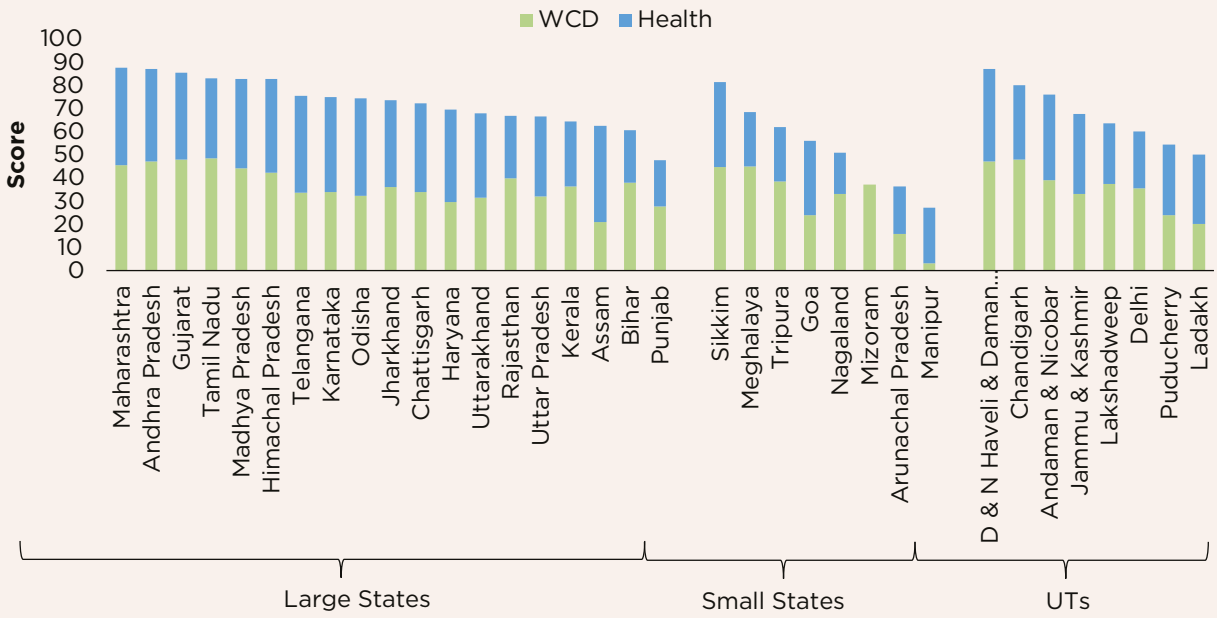

Figure 1: Overall Implementation Status of POSHAN Abhiyaan at the National-Level in 2020

Maximum Score: 100

First, on a positive note, system readiness and capabilities to deliver POSHAN Abhiyaan interventions improved from previous POSHAN Abhiyaan progress reports. The coverage of service delivery is also acceptable for many WCD and health activities. Efforts to prioritize systems preparedness and expand the coverage of key interventions between 2018 and 2020 have likely contributed to the achievements observed during this period.

Second, there is mixed progress across multiple indicators on delivering POSHAN Abhiyaan between States. Overall, fund utilization is low, with less than half of funds utilised in 23 States and UTs. Notably, fund utilization is lower in States and UTs with a low distribution of mobile phones and growth monitoring devices. There are also gaps in the occupation of HR positions. The constitution of district- and block-level convergence action plan committees is not uniform across States and UTs, which has implications for preparing convergence action plans—the roadmap for achieving convergence.

State scores varied across service delivery indicators, including HR, infrastructure, supplies, training, and capacity building. To continue progress under POSHAN Abhiyaan, gaps in HR positions must be closed, particularly in States where less than half of the required positions are filled. There is also a need to close supply gaps in some States. In addition, several States are underperforming in staff training on e-ILA modules; therefore, identifying and tackling the determinants for these gaps in training is crucial.

In terms of WCD programme coverage, many States and UTs have distributed take-home rations (THR) to all beneficiaries. However, coverage remains low in Bihar (65% pregnant women, 62% lactating women, and 52% children), Punjab (78% pregnant women, 76% lactating women, and 65% children), Sikkim (84% pregnant women, 84% lactating women, and 77% children),and Jammu and Kashmir (49% pregnant women, 51% lactating women, and 54% children). In addition, the percentage of under-five children weighed at AWCs is still low in many States and UTs.

There are also prevailing gaps in programme activities conducted by health departments. While the coverage of indicators like early initiation of breastfeeding (EIBF), 180 days of iron and folic acid (IFA) received by pregnant women and tetanus toxoid (TT2)/ boosters received by pregnant women is acceptable in most States and UTs, the coverage is relatively low for pregnant women who received albendazole tablets after the first trimester, lactating women who received IFA, and children who received iron and folic acid (IFA) syrup. Thus, service delivery across anaemia interventions must be strengthened. Additionally, States like Bihar, Jharkhand, Kerala, Punjab, Rajasthan, Telangana, Uttarakhand, North-eastern States and UTs must focus on child immunisation, antenatal care (ANC) check-ups, and the use of oral rehydration solution (ORS) for treating diarrhoea.

Overall, there is scope to improve the coverage of interventions during the first 1,000 days. In particular, low coverage of THR, growth monitoring, and IFA supplements across the life stages need special attention. To this end, challenges on the supply- and demand-side should be assessed to improve intervention coverage during this critical window of opportunity.

This report analyses the impacts of the COVID-19 pandemic on the delivery of key essential services and the actions taken by various line Ministries, State Health Departments and State WCD Departments to deliver the services despite the pandemic.

Third, the analysis of service disruptions, drawing primarily from publicly available administrative data, highlights substantial disruptions in the immediate months following the onset of the pandemic. Encouragingly, by mid-2020, many services had been restored, and by December 2020, a similar level of service delivery had been achieved as in December 2019.

Fourth, the findings on early restorations and adaptations to service delivery are promising and highlight a commitment across policy, implementation and frontline toward restoring essential services in health, nutrition and social safety nets. Various adaptations to service delivery were observed across platforms and interventions, which have contributed to recovery in service provision.

Although there are encouraging signs of recovery, the pandemic has already set in motion negative impacts on the education of adolescent girls. Evidence shows that education is critical to prevent early marriage, which, in turn, contributes to preventing early childbearing in India. The potential risks of early marriage in the context of the pandemic are higher, but little is known about the extent of the challenge.

This report highlights five key lessons learned from the implementation of the POSHAN Abhiyaan over the past three years, including amid the COVID-19 pandemic. First, POSHAN Abhiyaan has prioritised improving nutrition outcomes during the first 1,000 days and has expanded the focus of nutrition programmes from merely distributing food supplements to actively engaging supply- and demand-side stakeholders. Second, POSHAN Abhiyaan created a nationwide *Jan Andolan* to influence behaviour change, and has galvanized active participation of all stakeholders. Third, POSHAN Abhiyaan has demonstrated that intersectoral convergence is possible through in-place institutional mechanisms, and has

provided various health and nutrition services across the same beneficiaries. Fourth, the Abhiyaan has demonstrated that technology can be leveraged for real-time monitoring of large-scale health and nutrition programmes. Fifth, the Abhiyaan has highlighted the resilience of health and nutrition systems during the COVID-19 pandemic.

KEY RECOMMENDATIONS

- Expand coverage and improve quality of essential health and nutrition interventions by continuing to strengthen the ICDS and health platforms
  - Strengthen governance and institutional mechanisms that trigger effective implementation processes. Assess and close gaps in fund utilization and expedite the constitution of committees and groups to ensure preparation and execution of effective Convergence Action Plans (CAPs).
  - Operationalize the CAPs so that the convergence is outcome-oriented and interventions across sectors reach the target beneficiaries. For this, it is important to train the field staff on sharing information and data among themselves.
  - To close the gaps on procurement of smartphones, the Anganwadi Workers (AWWs) can be incentivized for data entry on online application or providing monthly allowance for rental/usage for using their own devices, as an alternative.
  - Close gaps in HR, infrastructure, supplies, and staff training to strengthen service delivery across ICDS and health programmes. Among the ICDS services, the priority areas for capacity building includes strengthening of growth monitoring and home-based counselling.
  - To address the gaps on coverage of programme activities, Panchayati Raj Institutions (PRIs) should be involved in community engagement, Village Health Sanitation Nutrition Day (VHSNDs) in rural areas and Urban Health Sanitation Nutrition Day (UHSNDs), Urban Local Bodies (ULBs), Mahila Arogya Samiti (MAS), and Urban Primary Health Care (UPHCs) in urban areas should be involved in explaining programmatic benefits. Additionally, it is recommended that a separate interface within POSHAN Tracker application should be formed which would enable two-way communication system to address the gaps and challenges at the implementation level.
  - Identify reasons for low coverage of certain health and nutrition services, including assessment of supply- and demand-side factors.
- Services that will need particular attention in the restoration of services will be screening and monitoring of growth of all children, active support towards early initiation of breastfeeding (EIBF) and even greater efforts to support complementary feeding.
- Convergence-related efforts will need maximum effort in the coming years – targeting and focusing all efforts to be sharply goal-focused – we must achieve

the stated goal of household convergence of key programmes, especially those addressing the determinants that have seen slow movement or have been affected sharply in 2020.

- Efforts to increase household demand for services are also going to be central to achieving coverage; therefore, demand creation to access and use of health and ICDS services should be a key focus of the social and behavioural change component (SBCC) pillar of POSHAN Abhiyaan in 2021.
- The efforts for convergence with key sectors, especially food and civil supplies via the public distribution system (PDS) and rural development via the National Rural Employment Guarantee Act (NREGA) will be essential for strengthening social protection to vulnerable families. This will also ensure that the social protection programmes reach families in the first 1,000 days. Furthermore, by incorporating nutri-cereals, fortified rice, and other nutritious foods into social safety nets will help to make these provisions nutrition-sensitive.
- State- and District-focused diagnostic work, with the support of development partners and academic institutions, are required to understand the nature of the determinants of poor nutrition and to diagnose and close gaps in systems implementation challenges. One size will not fit all States or even all Districts within a State, but the data will help diagnose areas for improvement and prioritise targeted actions.
- Evidence has accumulated that education is critical to prevent early marriage, which in turn is critical to prevent early childbearing in India. The risks of increasing early marriage in the context of the pandemic are higher, but little is known about the extent of the challenge. Community engagement to ensure adolescent girls can return to school and that early marriages are prevented will, therefore, also need sharp focus in 2021. Additionally, RKSK may mobilize community to prevent early marriage of adolescent girls with the help of FLWs.

In closing, this report and the analysis therein demonstrate that POSHAN Abhiyaan's efforts have settled into the political and programmatic fabric of India. Continued emphasis is needed to deepen the commitment, be strategic and geographically focused in strengthening the systems to deliver essential nutrition interventions and to strengthen the available programmes to induce changes in key social determinants of malnutrition. The progress on improving programme coverage, breastfeeding and complementary feeding and key determinants of malnutrition such as sanitation coverage shows that results are attainable. This report provides directions for every State to embrace the mission fully, address their specific systems and population-level challenges, and contribute to helping India achieve national and global targets for malnutrition.

1 Introduction

1.1 OVERVIEW OF POSHAN ABHIYAAN

Launched by the Prime Minister on International Women's Day on March 8, 2018 in Jhunjhunu, Rajasthan, POSHAN (the Prime Minister's Overarching Scheme for Holistic Nutrition) Abhiyaan aims to prioritize addressing malnutrition in India. Malnutrition can have life-long, irreversible impacts, currently affecting one in every three children and half of all women in India.[1]

POSHAN Abhiyaan (previously called the National Nutrition Mission) is the Government of India's flagship programme to improve nutritional outcomes for children, pregnant women and lactating mothers. It is a multi-ministerial convergence mission, which aims to eliminate malnutrition in India by 2022.

Recognizing that malnutrition levels in India are high, POSHAN Abhiyaan attempts to deliver the following features to fight against malnutrition:

1. A high impact package of interventions, focusing on (but not limited to) the first 1,000 days of a child's life
2. Strengthening the delivery of a high impact package of interventions through:
   - Remodelling nutrition monitoring by leveraging technology and management through the Integrated Child Development Services Common Application Software (ICDS-CAS) (now POSHAN Tracker Tool);
   - Improving capacities of frontline workers through the incremental learning approach (ILA) mechanism;
   - Emphasising convergent actions among the frontline workforce.
3. A focus on cross-sectoral convergence to emphasise the multi-dimensional nature of malnutrition, mapping of various schemes contributing towards addressing malnutrition.

1 Global Nutrition Report, 2018

- ➲ Convergence committees at the state, district and block levels will support decentralized and convergent planning and implementation, supported by flexi-pool and innovation funds to encourage contextualised solutions.

4. Ramping up behaviour change communication and community mobilisation through **Jan Andolan**, a national nutrition behaviour change campaign that uses community-based events, mass media and other approaches.

The Abhiyaan focuses on strengthening policy implementation (at the Central- and State-levels) to improve targeting (identification of high burden Districts), enhance multi-sectoral convergence, develop innovative service delivery models and rejuvenate counselling and community-based monitoring. In addition, the mission acknowledges the need for robust convergence mechanisms and coordination to help multiple government schemes and programmes reach women and children during the first 1,000 days of life. The programme also aims to ensure service delivery of key interventions supported by the use of technology and behavioural change. Figure 2 depicts the key pillars of POSHAN Abhiyaan that have been proposed to facilitate the objective of the mission.

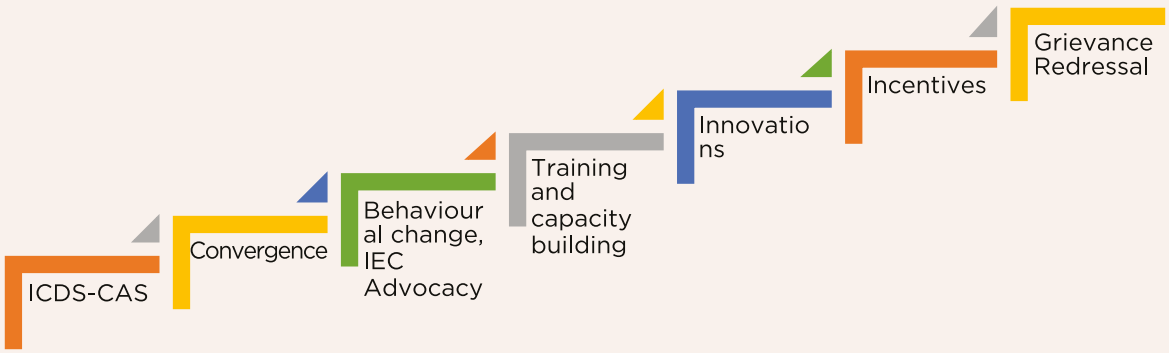

Figure 2: Pillars of POSHAN Abhiyaan

POSHAN Abhiyaan was first rolled out in 315 priority (high burden) Districts as part of Phase I (2017-18), 267 Districts as part of Phase II (2018-19), and in the remaining 136 Districts as part of Phase III (2019-20). The Abhiyaan has specific targets to be achieved across different parameters over the next few years (Figure 3).

POSHAN Abhiyaan is a scheme under ICDS umbrella which converge with other programs and service delivering nutrition interventions during the first 1000-days period. These include take-home rations (THR) from Anganwadi Centres (AWC); anaemia prevention and control under the Anaemia Mukt Bharat (AMB) programme; antenatal care (ANC) services; dietary counselling on the Village Health Sanitation and Nutrition Day (VHSND); and schemes such as Pradhan Mantri Surakshit Matrutva Abhiyaan (PMSMA) and Pradhan Mantri Matrtya Vandana Yojana (PMMVY) that provide quality antenatal check-ups. Schemes like Janani Suraksha Yojana (JSY) are promoting institutional deliveries through cash transfers, and free services for delivery and early neonatal care are available through the Janani Shishu Suraksha Karyakram (JSSK) scheme, which supports mothers in establishing appropriate breastfeeding and nutrition practices.

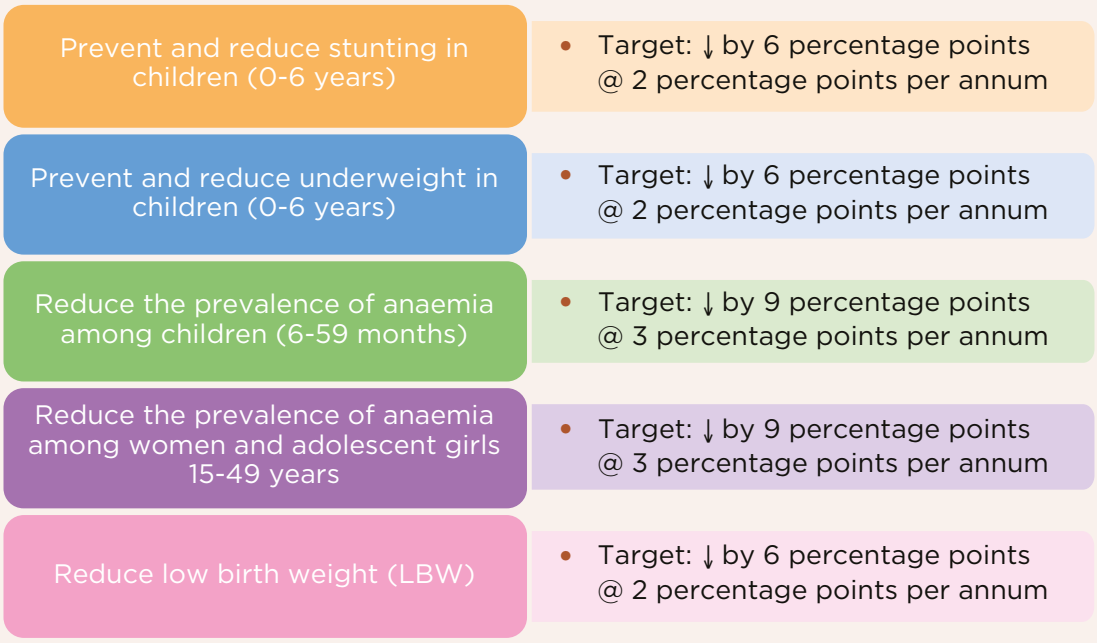

Figure 3: Targets of POSHAN Abhiyaan

Baseline–NFHS 4 (2015-16)

POSHAN Abhiyaan aims to ensure that every child under 6 years of age, every pregnant and lactating woman, and adolescent girl has access to quality services to address malnutrition across the continuum of care. This requires a cost-effective, integrated and sustainable approach that successfully prevents malnutrition and provides care to those who are malnourished. To achieve this, it is important to strengthen the pillars of the Abhiyaan in a targeted manner.

Considering the importance of pillars of POSHAN Abhiyaan, the bi-annual POSHAN Abhiyaan progress reports have been designed to capture the mission's progress on convergence, training and capacity building, ICDS-CAS, innovations and implementation of programme activities conducted by the Women and Child Development (WCD) and Health Departments. The first POSHAN Abhiyaan Progress Report evaluated the preparedness of the States/UTs with regards to the mission, the second report evaluated the implementation of the pillars, whereas the third report provided the status of field-level roll-out. Building upon the first three reports, this fourth report assesses the implementation of the key inputs and services. Box 1 outlines the objective and content of the previous reports.

BOX 1: BRIEF OUTLINE OF THE FIRST THREE POSHAN ABHIYAAN PROGRESS REPORTS

i. POSHAN Abhiyaan's First Progress Report, submitted in December 2018, evaluated the preparedness of States and UTs for POSHAN Abhiyaan. The report focused on understanding which systems were in place for the work to be carried out from March 2018.

   Data were obtained from WCD Departments for all States and UTs (except for West Bengal and Odisha). A preparedness score was assigned to each State and UT considering the information and data shared. The entire dataset was organized into three categories:

   - Governance and institutional mechanism
   - Strategy and planning
   - Service delivery essentials

The State-level preparedness scores helped States identify gaps and inform where to direct their resources to improve the parameters where they were lagging to combat malnutrition. This detailed analysis, presented in the first progress report of POSHAN Abhiyaan, helped States and UTs establish an overarching view and examine the factors leading onto the effective implementation of the Abhiyaan.

ii. POSHAN Abhiyaan's Second Progress Report, submitted in September 2019, focused on implementation of parameters covering WCD schemes and Health interventions at the State- and UT-levels (*except West Bengal and Odisha*) and therefore, inputs/data have been considered from both State WCD and Health Departments. The entire dataset was organized into four categories:

   - Governance and institutional mechanism
   - Strategy and planning
   - Service delivery and capacities
   - Programme activities and intervention coverage

iii. POSHAN Abhiyaan's Third Progress Report, submitted in July 2020, took stock of the roll-out status in the field and implementation challenges encountered at various levels using secondary data from the National Family and Health Survey (NHFS-4) and Comprehensive National Nutrition Survey (CNNS). A modelling analysis was conducted using the Lived Saved Tool (LiST) to predict the trends in decline of stunting, wasting and anaemia, and assess how POSHAN Abhiyaan can scale up coverage of key interventions to accelerate the decline in malnutrition.

1.2 OBJECTIVES OF POSHAN ABHIYAAN IV PROGRESS REPORT

This report outlines India's progress on the POSHAN Abhiyaan, focusing on preserving nutrition progress during the COVID-19 pandemic. The objectives of this report include:

1. Examine the progress to date on rolling out all POSHAN Abhiyaan interventions using relevant data;
2. Discuss the importance of preserving progress on the nutrition agenda in the context of the COVID-19 pandemic; and
3. Recommend key actions to accelerate progress towards India's nutrition goals.

2 Methodology

This chapter elaborates on the information collected and the methodology for analysing data. We examined the progress of States and UTs on implementing POSHAN Abhiyaan using multiple data sources, including data from semi-structured questionnaires/templates collected by the States &UTs (Annexure 1), monitoring information systems from the health department and the ICDS, and additional information from the Ministries. We analysed progress between 2019 to 2020 using data from the second progress report as the reference point for 2019. Administrative data, including monthly progress report (MPR) data of ICDS and Health Management Information System (HMIS) data of the Ministry of Health and Family Welfare (MoHFW), were utilized to evaluate changes in service delivery during the COVID-19 pandemic.

2.1 PROGRESS TRACKING FRAMEWORK

Tracking progress on nutrition helps identify strengths, areas for improvement, and inform options for how to most effectively achieve targets within a proposed timeframe. Between 2019 and 2020, NITI Aayog and development partners jointly developed a framework of indicators[2] to track progress on nutrition in India. The framework is based on conceptual and programmatic frameworks for nutrition, as well as programmatic and biological temporality on how change occurs for various nutrition outcomes. First, in relation to monitoring progress on the nutrition mission, the team recommended that an assessment of progress follows the ***programmatic theory of change, as well as programme and biological temporality.*** Second, the team advised that early progress tracking for the nutrition mission should initially focus on system preparedness and readiness, and then assess progress on coverage of interventions. Thereafter, the focus may shift to assessing changes in determinants and outcomes that are relevant to the programme roll-out. The team also outlined which kinds of data to use to track progress on different parts of the monitoring framework, focusing on population-level surveys to track progress on

2 Menon et al. 2020

outcomes and determinants, and using both population-based surveys and administrative data to track progress on intervention coverage.

This report covers the period January to December 2020, which mostly coincides with the active implementation of mission activities, following a long period of aligning actions across multiple ministries, development partners, states, districts and communities. Information on themes covering key elements of the pillars of the mission—namely, Convergence, Training and capacity building, ICDS-CAS (now POSHAN Tracker Tool), and programme activities—was collected from the Department of Women and Child Development (DWCD) and Department of Health of States/UTs. Additionally, information on **Jan Andolan** and interventions undertaken by various line ministries was collected to glean insights on behavioural change and IEC advocacy. To this end, the data collected for this progress report are aligned with the pillars of POSHAN Abhiyaan.

Information on the data collected for the progress and implementation score framework and the methodology for computation of the scores has been described in the subsequent sections.

2.2 DATA COLLECTION FROM STATES

Information on the multiple activities which are being conducted by different stakeholders across the country under POSHAN Abhiyaan was consolidated using the semi-structured questionnaires/templates. For this purpose, a multi-pronged strategy for data collection was adopted where NITI Aayog reached out to several central government Ministries, States & UTs, and development partners to collect the relevant information.

NITI Aayog prepared two assessment questionnaires that captured information related to infrastructure, HR, training and capacity building, convergence, programme and output activities, service delivery by FLWs (during the COVID-19 pandemic), and status of innovation and flexi-plan for March and July 2020 (Annexure 1).

A progress and implementation score framework was developed to assess the information received from the States and UTs. Broadly, this score measures State and UT implementation capabilities and progress on the roll-out of POSHAN Abhiyaan. Table 1 summarises the information that was received from the Women and Child Development (WCD) and Health Departments of States/UTs under four themes.

Table 1: Progress and implementation score themes for WCD and Health Departments

Theme	WCD Department	Health Department
Governance and Institutional Mechanism	• Fund Allocation • Constitution of Committees and Resource Groups	
Strategy and Planning	• Developed and submitted convergence action plan (CAP)	

Theme	WCD Department	Health Department
Inputs for Service Delivery & Capacities	• HR • Supplies • Training and Capacity Building	Infrastructure HR
Programme activities and intervention coverage	• Programme activities-ICDS	Programme activities AMB strategy

Each of the four themes in Table 1 comprised a different set of sub-themes for the WCD and Health Departments. A total of 40 indicators–22 on WCD and 18 on health were included in the framework. These indicators are proxy indicators that intend to reflect the progress and implementation status of the States and UTs for each of these categories.

The data collected from the States and UTs also underwent a series of data validation processes to verify that the data are logically correct. For this, multiple rounds of video conferencing with States/UTs for resolving issues with the data, followed by feedback of the States and UTs on the calculated scores and agreement on the same, were carried out.

2.3 DATA COLLECTION FROM LINE MINISTRIES

Central-level information was sought from key Ministries–that is, Ministry of Women and Child Development (MoWCD), Ministry of Health and Family Welfare (MoHFW), Ministry of Rural Development (MoRD), Ministry of Human Resource Development (now Ministry of Education, MoE) and Ministry of Panchayati Raj Institutions (MoPRI)–on their various initiatives launched under the auspices of POSHAN Abhiyaan, focusing on interventions during the first 1,000 days of life.

2.4 DATA COLLECTION FROM DEVELOPMENT PARTNERS

Development partners with direct presence in the field were encouraged to collect information on new initiatives, stories of change, models that can be scaled-up and replicated and on individuals who are conducting exceptional and inspirational work at the grassroot-level to improve nutrition outcomes in India. These stories have been compiled and are featured in this report.

2.5 DATA ANALYSIS

2.5.1 Analysis of data from States on system readiness and service delivery

Computation of State/UT scores

A score was computed and assigned to States and UTs to assess their progress on the implementation of POSHAN Abhiyaan.

The progress score is comprised of two sub-scores: one for the WCD Department and one for the Health Department, both of which have a maximum possible score of 50. Overall, the maximum possible progress score was 100.

The questions under each theme and sub-theme were based on previous questionnaires and were selected to ensure comparability with the prior report. The questions selected for each theme aim to ascertain the progress of states and UTs on the roll-out of POSHAN Abhiyaan, as per the administrative guidance from the Centre. These elements were common across all States and UTs (Figure 4).

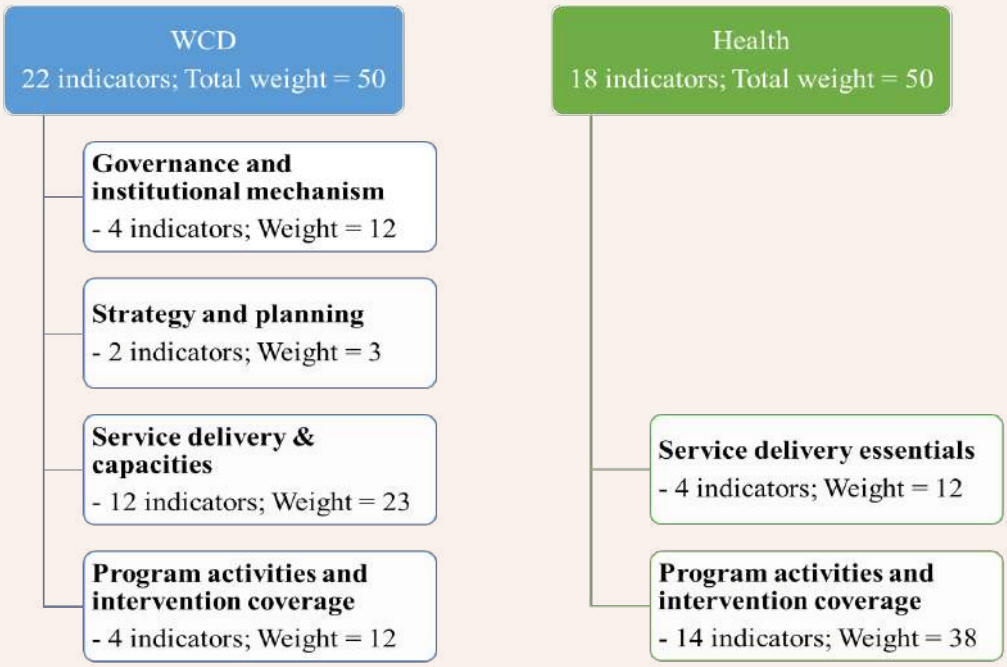

Figure 4: Critical components for examining the progress to date on rolling out POSHAN Abhiyaan in the WCD and Health departments

Weights were assigned to the selected indicators for the progress and implementation score in consultation with experts. For indicators that assessed the status of implementation or roll-out, a range of weights were used that assigned full credit for completed work and partial credit for work in progress. For indicators that were measured as proportions, credit was assigned according to predetermined ranges. Once the weights were assigned, scores were computed for each theme. Finally, all the theme scores were summed to compute the overall progress score. Annexure 2 provides the details of the rubric/scoring framework. Box 2 elaborates on the process for generating the score.

BOX 2: STEPS TO GENERATE THE PROGRESS AND IMPLEMENTATION SCORE

STEP 1. Developing an assessment tool for States/UTs: NITI Aayog prepared two implementation assessment questionnaires (one for Health and one for WCD), which captured information on infrastructure, HR, training and capacity building, convergence, program and output activities, service delivery by FLW during the COVID-19 pandemic and the status of innovation and flexi-plan. These were finalized with inputs from several technical stakeholders (Annexure 1).

STEP 2. Data collection at the State/UT-level: The implementation assessment questionnaires were sent to State/UT officials in the WCD and Health Departments in September 2020. Officials in charge gathered the necessary information to complete the questionnaires and returned them to NITI Aayog between October and November 2020. Simultaneously, data entry programs were developed in CSPro version 6.4. Appropriate skip and logic checks were built into the program to identify any data quality issues.

STEP 3. Data cleaning and round 1 entry: Upon receiving the completed questionnaires from States and UTs, three independent researchers carried out a first round of data entry to identify inconsistencies in the responses. Feedback sheets for every State/UT were developed and shared back with the States/UTs for revisions and clarifications in November 2020.

STEP 4. Data correction and round 2 entry: Between November 11 and 25, 2020, video conferences were held with States/UTs to discuss issues identified in the data. Based on these discussions, corrections were made and information was revised in the State/UT templates. These corrections were documented and data entered in the first round were corrected. After all issues were corrected, the second round of data entry took place. This double data entry approach was applied to ensure higher data quality. All discrepancies between the two rounds of data were identified and corrected.

STEP 5. Data processing and analysis: Stata version 16 was used to compare and analyse data from both rounds. The clean and validated data were used to create indicators in the scoring framework and assign weights to the scores. Scores for relevant indicators were then summed to compute the scores for each theme, which were further summed to obtain the progress and implementation score for each State/UT based on the scoring framework/rubric.

STEP 6. Data validation by States: All States/UTs were sent their scores and the estimates of key indicators used for scoring. Video conferences were held with States/UTs between January 8 and 19, 2021, during which all States/UTs were able to provide any updates on their responses to the assessment questionnaire and review the scores. Only data that were validated by States/UTs were used to compute the scores.

STEP 7. Concordance checks with MPR and HMIS data: The data on some of the program activities conducted by DWCD and Department of Health were comparable to MPR data of ICDS (MoWCD) and HMIS data (MoHFW). If data from State/UT templates and MPR/HMIS differed by more than 10%, these States and UTs were contacted to verify the data in April 2021. All discrepancies were then addressed and corrected. Annexure 5 shows the concordance between the State template data and MPR/HMIS data.

STEP 8. Data update & final score calculation: Data were revised based on the revisions provided by the States/UTs and the final scores were generated.

Categorisation of States

This report categorises States and UTs into large States, small States, and UTs to enable fair comparisons (Table 2).

Table 2: Categorisation of States

Category	Number of States/UTs	List of States/UTs
Large States	19	Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh, Uttarakhand
Small States	8	Arunachal Pradesh, Goa, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura
UTs	8	Andaman & Nicobar, Chandigarh, D & N Haveli & Daman & Diu, Delhi, Jammu & Kashmir, Ladakh, Lakshadweep, Puducherry

* *Categorization of States/UTs is consistent with previous reports that followed the State Health Index Report. Findings from Dadra & Nagar Haveli and Daman & Diu have been presented jointly.*

Stata version 16 was used to analyse data across survey rounds. All 40 indicators in the scoring framework/rubric were measured and assigned weights, as per the defined criteria. The individual scores on the 40 indicators were summed to compute the scores for each of the themes. Theme scores were then summed as per the scoring framework/rubric to obtain State/UT progress scores under the WCD and Health Departments.

A set of common indicators between the Second POSHAN Abhiyaan Monitoring Report and this report were identified to assess progress between 2019 to 2020 using a percentage change formula.

2.5.2 Analysis of administrative data to assess impact of COVID-19

ICDS Monthly Progress Report (MPR)

AWWs prepare the MPR data based on their service registers, which include the details of service delivery. The centre-level data are compiled and aggregated to the sector-,

block-, district- and state-levels and become part of the monitoring information system for the ICDS programme. We examined the coverage of supplementary nutrition during the pandemic using MPR data between October 2019 and December 2020.

We used State/UT-wise quarterly data for five quarters i.e., from October-December 2019 to October-December 2020 on two indicators: 1) the number of children from 6 months to 6 years old who received supplementary nutrition and 2) the number of pregnant and lactating women who received supplementary nutrition. The number of beneficiaries at the national-level for each quarter was calculated by adding the number of beneficiaries for all States and UTs.

Service disruption and restoration using MPR data were defined and calculated using the approach adopted for HMIS data. Table 3 provides the details on definitions and formulae used.

Table 3: Service disruption and restoration definition and formulae

Indicator	Definition and formula
Service disruption	Percentage of beneficiaries receiving service during lockdown i.e., between April-June 2020 (T1) compared with the pre-pandemic period i.e. between October–December 2019 (T0) $\left(\frac{\text{Number of beneficiaries during T1}}{\text{Number of beneficiaries during T0}}\right) \times 100$
Early restoration	Percentage of beneficiaries receiving service between July-September 2020 (T2) compared with the pre-pandemic period i.e., October-December 2019 (T0) $\left(\frac{\text{Number of beneficiaries during T2}}{\text{Number of beneficiaries during T0}}\right) \times 100$
Restoration	Percentage of beneficiaries receiving service between October-December 2020 (T3) compared with the pre-pandemic period i.e., October-December 2019 (T0) $\left(\frac{\text{Number of beneficiaries during T3}}{\text{Number of beneficiaries during T0}}\right) \times 100$

Health Management Information System

India's HMIS provides monthly information on the operational status of health services and platforms at the district-, state-, and national-levels. We examined the coverage of key health and nutrition services between October 2019 and December 2020 using HMIS data (Accessed on June 17, 2021 from https://hmis.nhp.gov.in/#!/standardReports).

The following coverage indicators available in the HMIS database that pertained to POSHAN Abhiyaan interventions during the first 1,000 days were included in the analysis: 1) Number of pregnant women given 180 IFA tablets; 2) Number of pregnant women received 4 or more ANC check-ups ; 3) Number of institutional deliveries conducted (including C-Sections); 4) Women receiving 1st post-partum checkup between 48 hours and 14 days; 5) Number of newborns received 6 home-based newborn care (HBNC)

visits after institutional delivery; 6) Number of children aged between 9 and 11 months who received full immunisation; 7) Number of severely underweight children provided health check-up (0-5 years). The number of beneficiaries for a quarter were calculated by adding the number of beneficiaries for each month in that quarter. Similarly, the number of beneficiaries at the national level were computed by adding the number of beneficiaries for all States and UTs.

2.5.3 Analysis of policy guidelines during COVID-19

State-level policy guidance from March to October 2020 was assessed using the available State policy documents in the POSHAN COVID-19 Monitoring Report for 13 States ***(Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Rajasthan, Uttar Pradesh and West Bengal).***

2.5.4 Analysis of data from States on innovations during COVID-19

Data on State-level service delivery adaptations and innovations during the COVID-19 pandemic were collected in the State templates shared by NITI Aayog (Annexure 1A and 1B), and analysed.

2.6 LIMITATIONS

One limitation is inconsistent reporting and missing data across various indicators between States and UTs. For instance, no data were available from West Bengal; thus, West Bengal was excluded from the analysis. Moreover, as this report presents *partial* data received from States and UTs, the overall progress scores for certain States and UTs appear relatively low, which may not appropriately represent the State- or UT-level progress on POSHAN Abhiyaan implementation.

In addition, some States and UTs provided information from other publicly available data sources as opposed to internal monitoring systems. Similarly, some States and UTs used inconsistent data sources for a similar set of indicators.

POSHAN Abhiyaan and its implementation have been rolled out in phases in the country. The availability of funds, supplies, ICDS-Common Application Software roll-out, training and capacity building and other related indicators are dependent on the roll-out of the Abhiyaan in the States/UTs. However, in preparing this report, this differentiation of the phased roll-out was not accounted for.

Lastly, although the WCD and Health templates were designed to collect a comprehensive set of information on various topics, responses to questions that were integral to the scoring framework/rubric were prioritized during the data collection and validation process with States/UTs.

3 What progress have we made to date?

This chapter examines progress on delivering POSHAN Abhiyaan and on nutrition in India more broadly. The POSHAN Abhiyaan Monitoring Framework[2] reinforces the importance of assessing the progress on programme preparedness and coverage of interventions after launching the programme. Therefore, in examining progress on POSHAN Abhiyaan, the team retains a focus on system readiness and aspects of programme coverage as these were lingering areas of challenge identified in the previous progress report and since programme coverage has been disrupted due to the COVID-19 pandemic.

3.1 WHAT PROGRESS HAVE STATES MADE ON DELIVERING POSHAN ABHIYAAN?

To assess the implementation progress in all States and UTs, data were collected using semi-structured questionnaires (Annexure 1A & 1B) from the State/UT WCD and Health Departments on four key themes related to the inputs and activities under POSHAN Abhiyaan for March 2020. These include:

1. Governance and institutional mechanisms
2. Strategy and planning
3. Service delivery and capacities
4. Programme activities and intervention coverage

Chapter 2 described the process of data collection, compilation, and computation of scores. This chapter presents the progress on system capabilities and some areas of implementation of POSHAN Abhiyaan. All results present findings separately for the 19 large states, eight small states, and seven UTs.

In terms of overall implementation in States and UTs (Figure 5), Maharashtra, Andhra Pradesh and Gujarat had the highest achievements, followed by Tamil Nadu, Madhya Pradesh, and Himachal Pradesh. Twelve out of 19 large States had an implementation score of over 70%. Among the eight small States, Sikkim was the highest performer in

overall implementation (more than 75%), followed by Meghalaya, Tripura and Goa. Dadar and Nagar Haveli and Daman and Diu, Chandigarh, and Andaman and Nicobar Islands were ranked the top three UTs, which scored over 70%. Since some States and UTs have incomplete data, it is difficult to comment on the States and UTs that were the lowest performers.

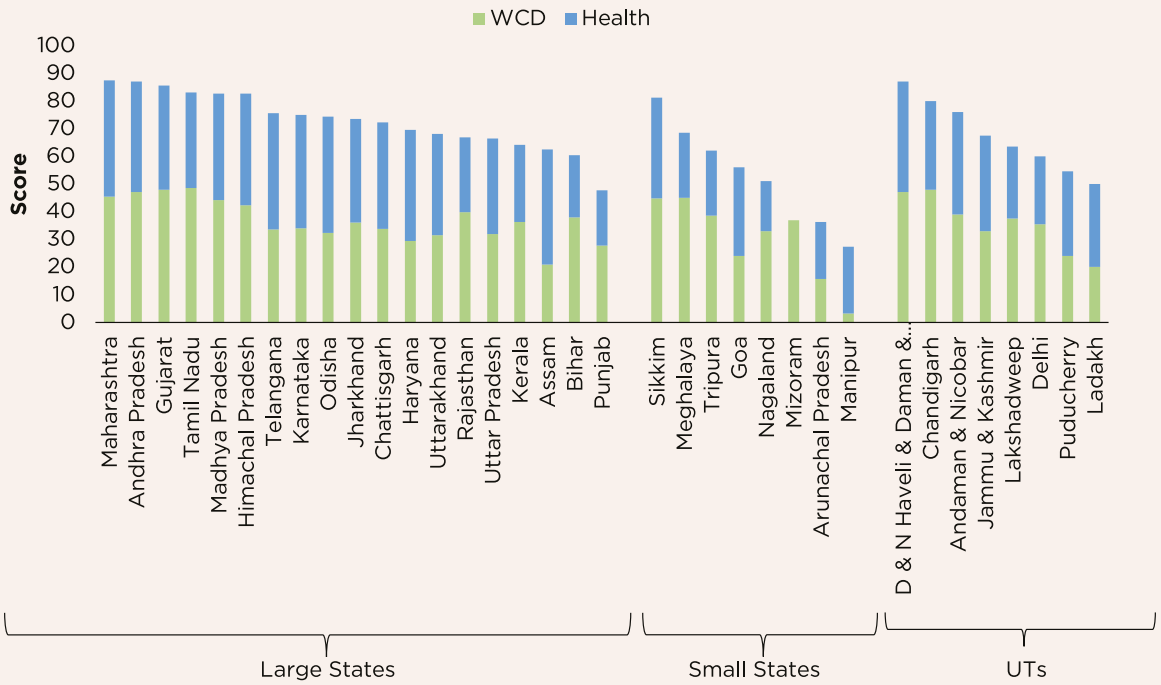

Figure 5: Overall implementation status of POSHAN Abhiyaan* at the national-level in 2020

Maximum Score: 100

**Based on calculated scores from State Template Data*

3.1.1 Monitoring progress on inputs

Programme inputs related to the ICDS and Health platforms are critical for functioning of POSHAN Abhiyaan pillars. These include funding, HR, supplies and infrastructure, which have been categorized under key themes: *governance and institutional mechanism, strategy and planning,* and *service delivery and capacity.*

3.1.1.1 Governance and institutional mechanism

This theme captures two critical components pertaining to governance and institutional mechanisms, as envisaged under POSHAN Abhiyaan:

1. Fund utilization by States/UTs
2. Constitution of committees and resource groups to develop and follow CAP

Fund utilization is an essential component of POSHAN Abhiyaan, which is an interface to initiate effective implementation. Another crucial institutional mechanism is a convergent approach to ensure targeted approach to reduce malnutrition. MoWCD recognized the need for actions of multiple agencies to address malnutrition, and therefore strong

convergence of services on-the-ground was emphasised in the guidelines for POSHAN Abhiyaan. It is of utmost importance to ensure that different inter-related schemes move from their silos to a unified and convergent action. For this, convergence committees were envisaged at the State-, District-, and Block-levels, including State Resource Group (SRG), District Resource Groups (DRG) and Block Resource Groups (BRG) to develop and follow CAPs. Hence, information on fund utilization, formation of CAP committees at the Block- and District-level was collected under this head.

On governance and institutional mechanism, the maximum score given to a State/UT is 12. Encouragingly, the utilization of funds and the constitution of resource groups and committees improved. As a result, States and UTs have scored high on this theme.

- **Large States:** Haryana, Himachal Pradesh, Kerala, Maharashtra, and Tamil Nadu scored the highest (11 out of 12 points), while Assam scored the lowest (1) among all the States due to low formation of committees. Remaining 11 States scored 10 points.
- **Small States:** Meghalaya and Nagaland scored the maximum score of 12 point, while Mizoram and Sikkim scored 11, and Arunachal Pradesh and Tripura scored 9. Complete data for Goa and Manipur were not available.
- **Union Territories:** Four out of the eight UTs including Lakshadweep, Chandigarh, Dadra & Nagar Haveli and Daman & Diu and Jammu and Kashmir scored 10 or more points. Puducherry scored lowest points (7). Complete data for Andaman and Nicobar Island and Delhi were not available, whereas Ladakh received funds from the central share of Jammu Kashmir.

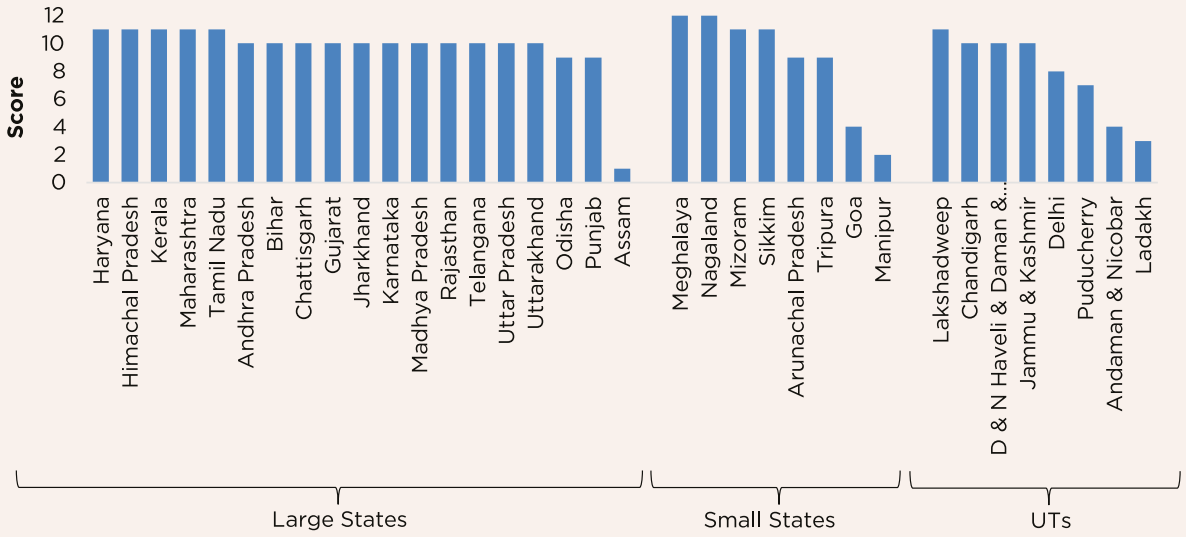

Figure 6: State-wise scores for Government and Institutional Mechanism

Maximum score: 12

Based on State Template Data

Insights from National- and State-level key findings on the two subthemes of governance and institutional mechanisms are as follows:

a. Fund Utilization by States/UTs

All States/UTs have received funds from the Centre except Ladakh, which received a portion of central funds of Jammu and Kashmir.

National-level key findings:

Around 40% of the total funds released under POSHAN Abhiyaan have been utilized by States/UTs till 31st March, 2020. There has been an increase in both the utilization of funds and the number of states that had utilized more than 50% of the funds from the end of FY 2018-19 to the end of FY 2019-20 (Table 4).

Table 4: Utilization of funds: Comparison between FY 2017-18 to 2018-19 and FY 2017-18 to FY 2019-20

Indicator	FY 2017-18 to FY 2018-19	FY 2017-18 to FY 2019-20
% of funds utilized	17%	40%
Number of States that have utilized more than 50% of the total funds released	3	12

State-level key findings:

By the end of FY 2019-20, Nagaland (87%), Meghalaya (78%), Sikkim (71%), Mizoram (67%) and Lakshadweep (65%) were utilizing maximum funds, while Punjab (22%), Puducherry (22%), Tripura (16%), Arunachal Pradesh (9%) and Odisha (8%) utilized the lowest amount of funds released. (Annexure 6-A).

Among the large States, fund utilization was highest in Kerala (58%) and lowest in Odisha (8%). Among small States, fund utilization was highest in Nagaland (87%) and lowest in Arunachal Pradesh (9%); and among UTs, fund utilization was highest in Lakshadweep (65%) and lowest in Puducherry (22%) by the end of FY 2019-20.

Comparing FY 2017-18 to FY 2018-19, while the percent fund utilization improved in most (30 out of 35) States/UTs, the percent of fund utilization declined in 5 States/UTs (Telangana, Mizoram, Daman and Diu and Dadar and Nagar Haveli, and Puducherry) (Figure 7).

An evaluation of centrally-sponsored schemes conducted by DMEO, NITI Aayog shows that fund utilization is high on community-based events and IEC materials, but low for procurement of devices.[3]

3 Development Monitoring and Evaluation Office (DEMO), NITI Aayog, 2020

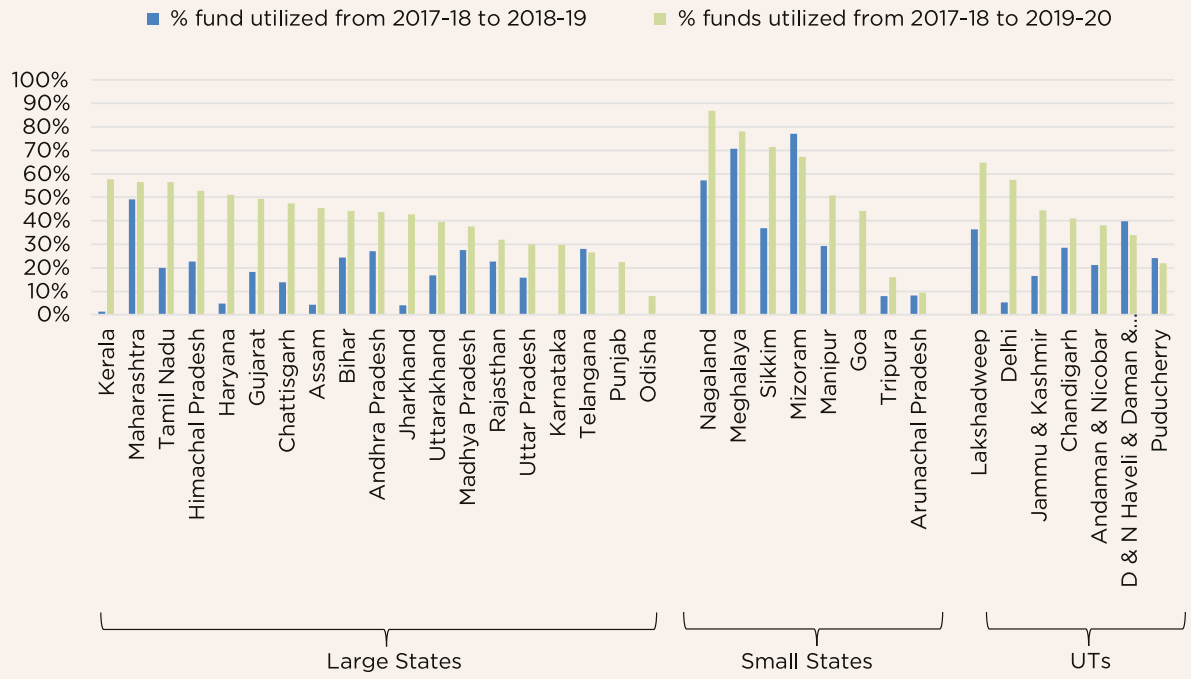

Figure 7: State-wise comparison of the Percentage Funds utilized up to FY 2018-19 and FY 2017-18 and up to FY 2019-20

Note: *Ladakh was excluded because Jammu Kashmir gave a proportion of their central funds to Ladakh after the UT was formed. Due to this, no separate Central Funds were allocated to this Union Territory.*

b. Constitution of Committees and Resource Groups

National-level key findings:

By March 2020, DRGs had been formed in 94% of the districts and BRGs had been formed in 96% of the blocks. Compared with the end of March 2019, there was an increase in the districts with DRGs by 7 percentage points and Blocks with BRGs by 18 percentage points (Figure 8). Additionally, the percentage of districts where CAP Committees have been formed also increased by 7 percentage points from 2019 to 2020.

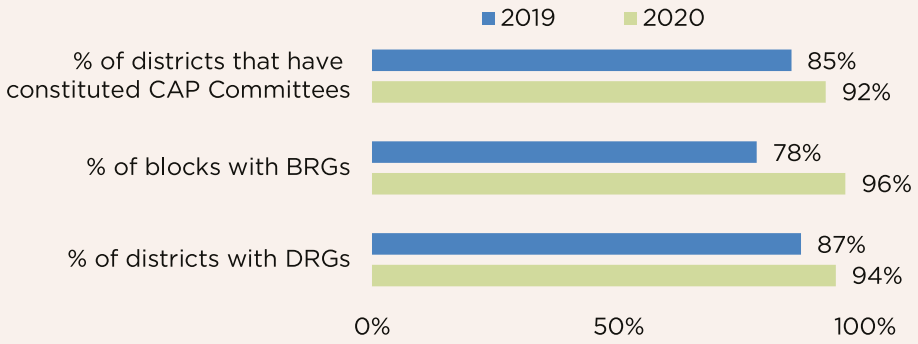

Figure 8: Constitution of committees: Comparison between 2019 and 2020

Note:

To calculate the national estimate, mean of States/UT available in both rounds was computed (excluded Odisha and Ladakh from 2020 national estimate to keep States & UTs common).

For estimating cumulative % for D&N & D&D for the year 2019, mean of both UTs has been calculated & used.

State-level key findings

Most States/UTs had constituted DRGs, BRGs and CAP committees. It is to be noted that DRGs were formed in all districts in all States/UTs except for Delhi, Puducherry, Assam and Ladakh. Similarly, BRGs were formed in all blocks in all States/UTs except for Tripura, Meghalaya, Assam and Ladakh. All States/UTs had 100% districts with CAP committees, except Chhattisgarh, Odisha, Puducherry, Assam and Goa (Annexure 6-A). Complete information for the constitution of committees was not available for Goa, Manipur, Andaman and Nicobar Island and Delhi.

The constitution of DRGs, BRGs, and CAP committees has improved at the national- and state- level. However, there is also a need to ensure that these resource groups and committees plan interventions in a way that the interventions do reach intended beneficiaries.

3.1.1.2 Strategy and planning

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

1. Whether the State/UT CAP has been submitted to the Central Project Management Unit (CPMU) for the year 2020-21
2. Proportion of Districts that developed and submitted the CAP for the year 2020-21

National level key findings

CAPs are paramount to map the way forward for multi-sectoral convergence; therefore, it is noteworthy that around 83% of districts had developed and submitted CAP for 2020-21. The percentage of districts that had developed and submitted CAP in FY 2020-21 improved by 13 percentage points compared with FY 2019-20 (Figure 9).

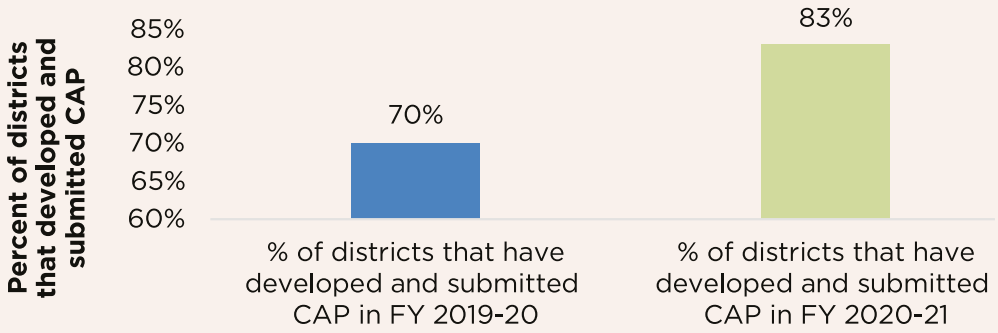

Figure 9: Percentage of districts that have developed and submitted CAP for FY 2019-20 compared to FY 2020-21 at the national level

Note:

To calculate the national estimate, mean of States/UT available in both rounds was computed (excluded Odisha and Ladakh from 2020 national estimate to keep States & UTs common).

For estimating cumulative % for D&N & D&D for the year 2019, mean of both UTs has been calculated & used.

State-level key findings

Although the overall number of States that had developed and submitted CAP has improved, certain States and UTs have very few districts that have submitted CAP. Additionally, the field surveys conducted in 13 States/UTs indicates that, although majority of States/UTs had prepared and submitted CAPs, it is still not clear what actions usually result from the monitoring and review of the CAPs[3].

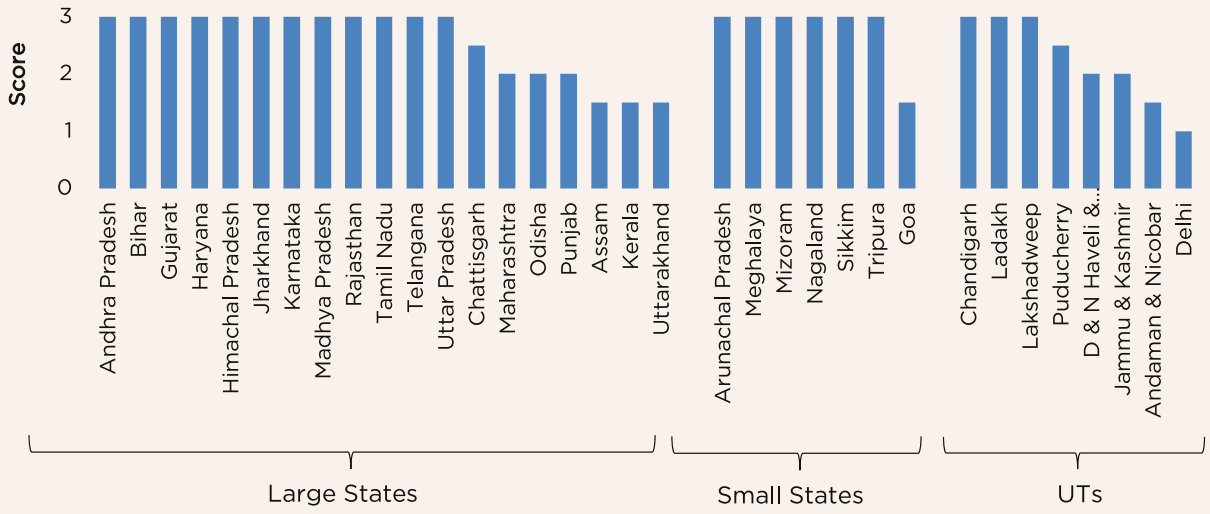

Figure 10: State-wise scores for strategy and planning

Max score: 3

Based on State Template Data

- *Large States:* 15 out of 19 States had submitted CAP to CPMU FY for 2020-21, whereas Kerala, Maharashtra, Odisha and Punjab had not submitted CAP yet. These four States had lower scores because they did not submit CAP.
- Additionally, 13 States had 100% districts that developed and submitted CAP for FY 2020-21. Uttrakhand and Assam had the least number of districts that developed and submitted CAP due to which they scored 1.5 out of 3. On a positive note, 12 States scored maximum possible score.
- *Small States:* All small States submitted CAP to CPMU for FY 2020-21. Information was not available for Manipur and Delhi. Additionally, most small states (6 out of 8) had 100% districts that developed and submitted CAP for FY 2020-21. Goa scored the lowest because none of its districts developed and submitted CAP.
- *Union Territories:* All UTs except Dadar and Nagar Haveli and Daman and Diu, and Jammu and Kashmir submitted CAP to CPMU for FY 2020-21. There were 5 UTs where all districts developed and submitted CAP for FY 2020-21, while the number of districts is very low in Andaman and Nicobar Island and Puducherry.

Annexure 6-B lists the States and UTs where all districts have developed and submitted CAP for FY 2020-21.

3.1.1.3 Inputs for service delivery & capacity

The categories covered under this theme included human resources, infrastructure, supplies, training, and capacity building. Annexure 2 provides a detailed list of indicators that were considered for each of these categories. These inputs are necessary for ensuring delivery of services with adequate coverage, continuity, intensity and quality (C^2IQ).

Departments of Women and Child Development

The sub-themes covered human resources, supplies and training and capacity of the staff. Since human resources are critical for programme implementation, information on the percentage of filled positions for the posts of Joint Project Coordinator, Consultant and Project Associate under POSHAN Abhiyaan was collected across States.

In terms of supplies, data on distribution of mobile phones and growth monitoring devices, including weighing scales for infants and adults and height measuring instruments (e.g. infantometers and stadiometers), were collected for monitoring the supplies under DWCD. Supply of mobile phones and growth monitoring devices are an important input especially for roll-out of ICDS-CAS, and for conducting growth monitoring activities at the Anganwadi Centres. Therefore, adequate supplies are important both for providing services and for monitoring the coverage of the services.

Lastly, as capacity building of human resources is an integral step for ensuring high quality services, this report emphasises assessing the percentage of trained professionals. For assessing this, the percentage of Lady Supervisors and Anganwadi workers trained on e-ILA, and child development project officers (CDPOs) and lady supervisors trained on dashboard/mobile was collected.

As per the score rubric, the maximum score that can be assigned under the service delivery and capacity theme is 23 points. In six States and UTs, data were not available for all the indicators under this theme.

- **Large States:** 16 States had data for all indicators, out of which Gujarat, Tamil Nadu and Andhra Pradesh scored between 22-23 points, whereas Haryana scored 7 points. Complete information was not available for Madhya Pradesh, Odisha and Punjab.
- **Small States:** Meghalaya and Sikkim scored 19 points, whereas Arunachal Pradesh scored only 4 points out of the maximum possible score of 23 points. Complete information was not available for Arunachal Pradesh and Manipur.
- **Union Territories:** Chandigarh and Dadra & Nagar Haveli and Daman & Diu scored the maximum score (23), followed by Andaman & Nicobar (22), whereas Puducherry scored only 7 points. Complete information was not available for Ladakh.

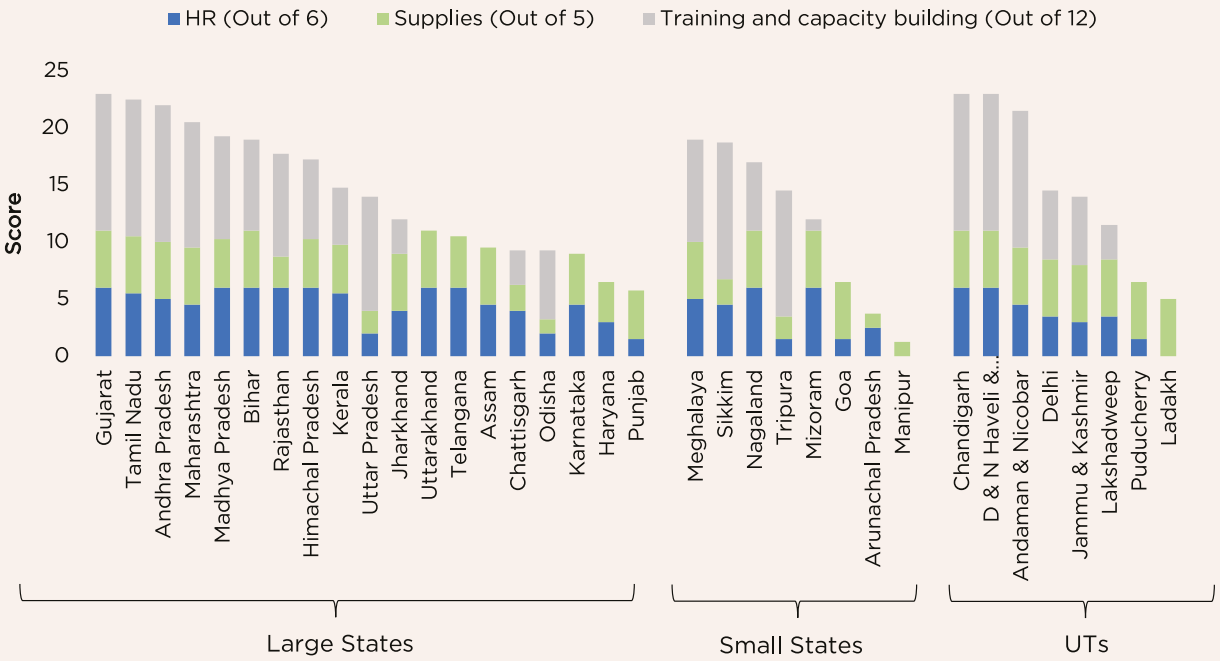

Figure 11: State-wise scores for Inputs for service delivery and capacity: Women and Child Development Department

Max score: 23
Based on State Template Data

Insights from national- and state-level key findings on the three sub-themes of inputs for service delivery for WCD are as follows:

a. Human Resources

State-level key findings:

- *Joint Project Coordinator:* 12 large States (Andhra Pradesh, Bihar, Gujarat, Himachal Pradesh, Jharkhand, Kerala, Madhya Pradesh, Maharashtra, Rajasthan, Tamil Nadu, Telangana, Uttarakhand), 4 small States (Meghalaya, Mizoram, Nagaland, Sikkim), and 4 UTs (Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Delhi, Jammu & Kashmir) had filled 100% positions. While 9 States/UTs had less than 25% positions filled (Annexure 6-C).
- *Consultants:* 7 large States (Assam, Bihar, Gujarat, Himachal Pradesh, Madhya Pradesh, Rajasthan, Telangana), one small State (Mizoram), and 3 UTs (Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu) had filled 100% of the positions. While 10 States/UTs had less than 25% positions filled (Annexure 6-C).
- *Project Associate:* 10 large States (Andhra Pradesh, Bihar, Gujarat, Haryana, Himachal Pradesh, Kerala, Madhya Pradesh, Rajasthan, Telangana, Uttarakhand), 4 small States (Meghalaya, Mizoram, Nagaland, Sikkim), and 4 UTs (Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Lakshadweep) had filled 100% of the positions. While 9 States/UTs had less than 25% positions filled (Annexure 6-C).

States/UTs—namely Punjab (0%), Goa (0%), Tripura (0%), Puducherry (0%), Odisha (33% of Joint Project Coordinator; 0% of Consultants and Project Associates), Uttar Pradesh (29% of Joint Project Coordinator; 0% of Consultants and Project Associates), Arunachal Pradesh (60% of Consultants; 0% of Joint Project Coordinator and Project Associates), and Jammu and Kashmir (100% of Joint Project Coordinator; 0% of Consultants and Project Associates) had least positions filled due to which they scored lower than other States. Annexure 6-C lists the States and UTs with the highest and lowest HR positions filled. Data for Manipur and Ladakh were not available.

b. Supplies

National-level key findings:

Data were analysed on the district-level distribution of supplies nationwide. In March 2020, 71% of mobile phones, 77% of infant weighing scales, 79% of adult weighing scales, 82% of infantometers and 80% of stadiometers were distributed to the districts. Compared with 2019, the distribution of supplies had increased significantly (Figure 12).

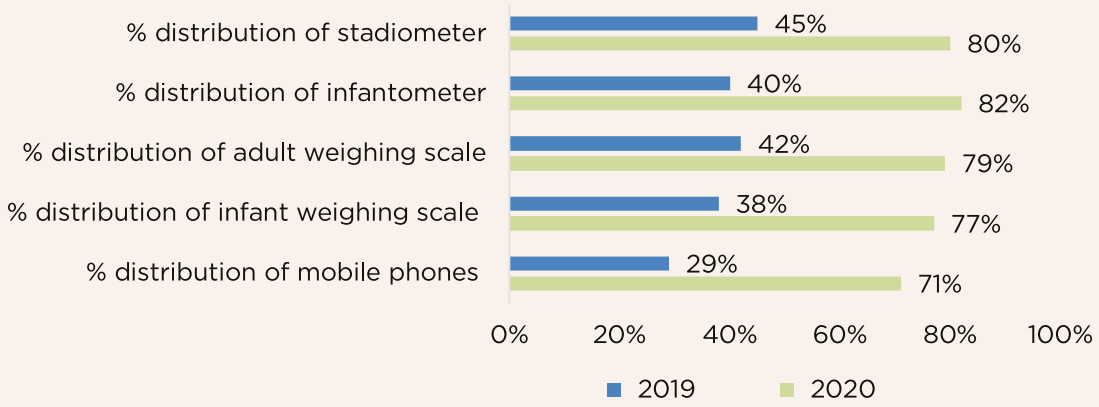

Figure 12: Distribution of supplies to districts: Comparison between 2019 and 2020

Note:

To calculate the national estimate, mean of States/UTs available in both rounds was computed (excluded Odisha and Ladakh from 2020 national estimate to keep States & UTs common).

For estimating cumulative % for D&N & D&D for the year 2019, mean of both UTs has been calculated & used.

State-level key findings:

- *Large States*: 8 States (Andhra Pradesh, Bihar, Gujarat, Haryana, Jharkhand, Maharashtra, Tamil Nadu and Uttarakhand) had distributed 100% of mobile phones, and 10 States (Andhra Pradesh, Gujarat, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, Telangana and Uttarakhand) had distributed 100% of growth monitoring devices. Himachal Pradesh, Kerala, Punjab and Odisha had not distributed any mobile phones. Supplies were lowest in Odisha (0% supplies) and Uttar Pradesh (31% mobile phones; 38% infant weighing scales; 39% adult weighing scales; 0% infantometers and stadiometers were distributed).

- *Small States:* 4 States (Meghalaya, Mizoram, Nagaland and Tripura) distributed 100% of mobile phones, and 4 States (Goa, Meghalaya, Mizoram and Nagaland) had distributed 100% of growth monitoring devices. Supplies were lowest in Arunachal Pradesh (0% mobile phones, infant weighing scale, and adult weighing scale; 2% infantometers; 2% stadiometers were distributed) and Manipur (21% mobile phones; and 0% growth monitoring devices).
- *Union Territories:* 5 UTs (Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Delhi and Ladakh) had distributed 100% of mobile phones, and all UTs had distributed all growth monitoring devices.

Annexure 6-C lists the States/UTs with highest and lowest distribution of supplies to the districts.

c. *Training and Capacity Building*

State-level key findings:

- *Training on e-ILA:* 7 Large States (Andhra Pradesh, Gujarat, Madhya Pradesh, Odisha, Rajasthan, Tamil Nadu and Uttar Pradesh), 3 Small States (Meghalaya, Sikkim and Tripura), and 4 UTs (Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Jammu & Kashmir) had trained 100% LS, while 5 large States (Gujarat, Madhya Pradesh, Odisha, Tamil Nadu, Uttar Pradesh), 1 small State (Sikkim), and 4 UTs (Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Jammu & Kashmir) had trained 100% AWW. In 15 States/UTs, no LS had completed training. Similarly, in 15 States/UTs, no AWWs had completed training.
- *Training on Dashboard/Mobile phones:* 5 Large States (Andhra Pradesh, Bihar, Gujarat, Kerala, Tamil Nadu), 3 Small States (Nagaland, Sikkim, Tripura), and 5 UTs (Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Delhi, Lakshadweep) had trained 100% CDPOs, while 6 large States, 3 small States, and 4 UTs had trained 100% LS. In 9 States/UTs, no CDPOs had completed training. Similarly, in 8 States/UTs, no LS had completed training.

Complete information on training was not available for Madhya Pradesh, Odisha, Punjab, Arunachal Pradesh and Manipur.

Only a few States/UTs had trained adequate staff, while there are States/UTs like Assam, Haryana, and Karnataka where no staff had been trained on e-ILA and Dashboard/mobile phones (Annexure 6-C). According to interviews held with State Officials under ICDS, gaps in training continue to exist due to low basic educational background and comfort levels in using technology among AWWs, especially among older AWWs[3].

The percentage of CDPOs trained on ICDS Dashboard/Mobile nearly doubled, from 30% in 2019 to 59% in 2020 (Figure 13). Complete information for Manipur, Madhya Pradesh, Odisha, Punjab and Arunachal Pradesh was not available.

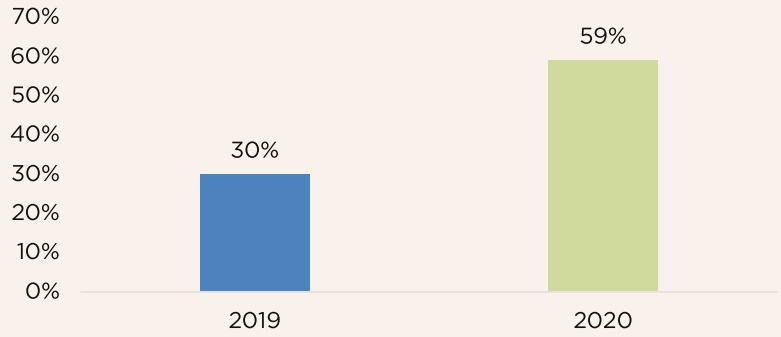

Figure 13: Percentage of CDPOs trained on ICDS Dashboard/Mobile Phones: Comparison between 2019 and 2020

Note:

To calculate the national estimate, mean of States/UT available in both rounds was computed (excluded Odisha and Ladakh from 2020 national estimate to keep States & UTs common).

For estimating cumulative % for D&N & D&D for the year 2019, mean of both UTs has been calculated & used.

As per the Women and Child Development Dashboard (accessed on 27 May 2021), Ministry of Women and Child Development, as on 11 September 2020, ICDS-CAS had been rolled out in 29 States with 359 districts of the country. While all districts had been covered under ICDS-CAS in 16 States and UTs, significant proportions of districts had not been covered in Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan and Uttar Pradesh. Additionally, nearly half (48%) of Anganwadi Workers had received smartphones and 56% Lady Supervisors had received smartphones as on September 2020.[4]

Although the procurement of smartphones by staff and the distribution of mobile phones to the districts have improved, a field survey conducted as a part of an evaluation of centrally-sponsored schemes of WCD[3] found that the ICDS-CAS had faced numerous challenges. First, roll out of ICDS-CAS remained slow due to network issues in many districts. Second, the qualitative survey conducted for 119 AWWs (DEMO) indicates that most AWWs using mobile/tablets continue to maintain records manually, which led to duplication of work. The challenges pertaining to ICDS-CAS made it an inefficient model, leading the ICDS-CAS to be replaced by the POSHAN Tracker, which must be rolled out completely and duplication of record keeping must be avoided to save time and enhance the effectiveness of AWWs.

Overall, the scores indicate that several States/UTs need to strengthen the delivery system for effective service delivery – mostly by improving training and capacity building. To continue progress on POSHAN Abhiyaan, gaps in human resource positions must be closed, and most urgently in States where <25% of the required positions are filled. There is also a need to close the supply gaps in some States. In addition, there are large gaps in staff training on e-ILA modules across several States. There is an urgent need to identify the reasons for such gaps in training and address them.

4 Women and Child Development Dashboard, MOWCD, https://wcd.dashboard.nic.in/ (accessed on 27 May 2021)

Departments of Health and Family Welfare

To examine health-related service delivery and capacity, infrastructure and HR domains were assessed. Information was available for all States and UTs except Mizoram.

The percentage of sanctioned health facilities, including functional sub-centres, community health centres (CHCs), and health and wellness centres (HWCs), were collected from States and UTs. These health facilities are a one-stop shop for essential child and maternal health services; thus, it is extremely important for States and UTs to have as many functional health facilities as sanctioned. In terms of human resources, the percentage of auxiliary nurse midwife (ANM) positions filled was collected from States and UTs.

As per the rubric, a maximum of 12 points was allotted to service delivery, 3 points for HR and 9 points for Infrastructure. Most States/UTs scored well on functional sub-centres and CHCs, but low on functional HWCs.

- *Large States:* Andhra Pradesh, Gujarat, Karnataka and Kerala scored the highest possible score of 12 points, and 14 other states scored between 9 and 11 points. Bihar scored the lowest (6) due to the low number of functional health facilities and low ANM positions filled. Complete information was not available for Punjab.
- *Small States:* Goa scored 12 points, while the others scored between 9 and 11 points. Arunachal Pradesh scored low due to the low number of functional health facilities. Complete information was not available for Mizoram.
- *Union Territories:* Dadra & Nagar Haveli and Daman and Diu scored the highest possible score (12), whereas Delhi and Chandigarh scored 9 points. Complete information was not available for Chandigarh and Delhi.

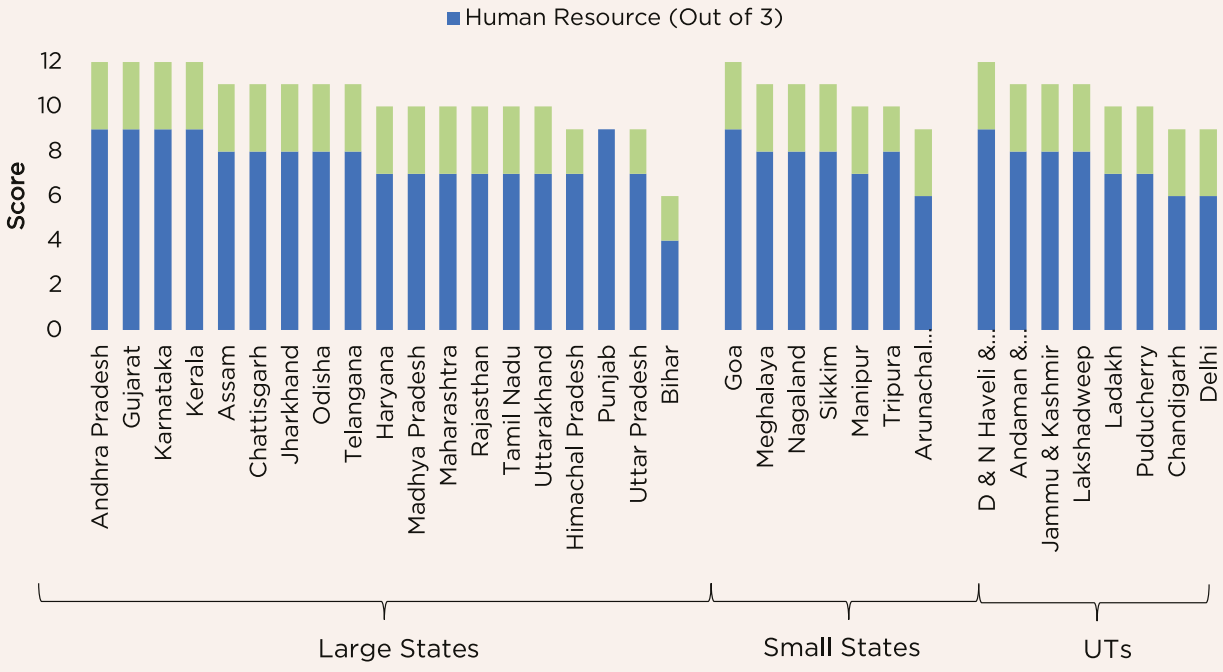

Figure 14: State-wise scores for inputs for service delivery essentials: Health Department

Maximum score: 12

Based on State Template Data

Insights from National- and State-level key findings on the two subthemes of inputs for service delivery for Health are as follows:

a. *Infrastructure*

State-level key findings:

- *Large States:* 13 States (Andhra Pradesh, Assam, Chhattisgarh, Haryana, Himachal Pradesh, Karnataka, Kerala, Madhya Pradesh, Odisha, Tamil Nadu, Telangana, Uttar Pradesh and Uttarakhand) had 100% functional sub-centres, 14 States (Andhra Pradesh, Chhattisgarh, Haryana, Himachal Pradesh, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh, Uttarakhand) had 100% functional CHCs, and 3 States (Andhra Pradesh, Kerala and Punjab) had 100% functional HWCs. Bihar had the lowest number of functional health facilities (60% of sub-centres, 43% of CHCs and 30% of HWCs).
- *Small States:* 2 States (Goa and Sikkim) had 100% functional sub-centres, 4 States (Goa, Manipur, Meghalaya and Sikkim) had 100% functional CHCs, and 2 States (Goa and Nagaland) had 100% functional HWCs. The results indicate that Arunachal Pradesh (63% of sub-centres and 39% of HWCs) and Nagaland (76% of sub-centres and 64% of CHCs were functional) should focus more on infrastructure. Information regarding the health infrastructure was not available for Mizoram.
- *Union Territories:* 6 UTs (Andaman & Nicobar Island, Dadar & Nagar Haveli and Daman & Diu, Delhi, Jammu & Kashmir, Ladakh, Puducherry) had 100% functional sub-centres, 8 UTs (Andaman & Nicobar Island, Chandigarh Dadar & Nagar Haveli and Daman & Diu, Delhi, Jammu & Kashmir, Ladakh, Lakshadweep, Puducherry) had 100% functional CHCs and 3 UTs (Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Lakshadweep) had 100% functional HWCs. Complete information on health infrastructure was not available for Chandigarh and Delhi.

In total, most States had more than 75% functional sub-centres and CHCs, while number of functional HWCs are lower compared to other health facilities. Annexure 6-D lists the States/UTs with the highest and lowest number of functional health facilities.

Additionally, the percentage of functional sub-centres increased slightly, from 92% in 2019 to 94% in 2020. However, the percentage of functional CHCs decreased marginally, from 97% in 2019 to 95% in 2020 (Figure 15). The number of sanctioned CHCs have increased for many States and UTs in 2020, which contributed to an overall reduction in the percentage of functional CHCs in 2020 compared with the previous year.

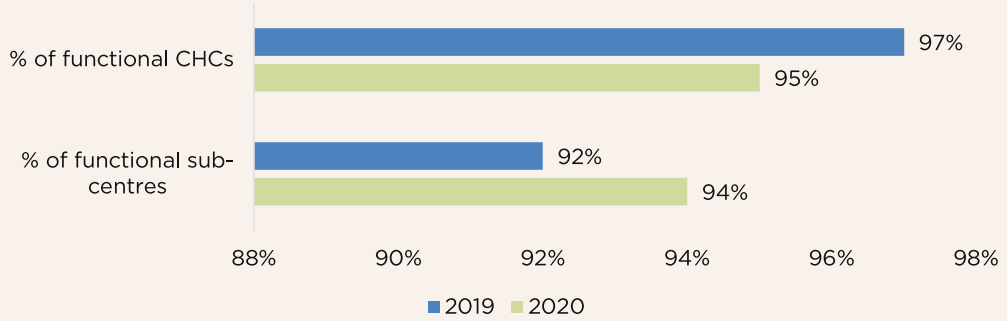

Figure 15: Percentage of functional health facilities: Comparison between 2019 and 2020

Note:

To calculate the national estimate, mean of States/UT available in both rounds was computed (excluded Odisha and Ladakh from 2020 national estimate to keep States & UTs common).

For estimating cumulative % for D&N & D&D for the year 2019, the mean of both UTs has been calculated and used.

b. Human Resources

National level key finding:

According to the State-level data collected, 87% of ANM positions were filled in 2020, which is slightly higher than 85% in 2019 (Figure 16).

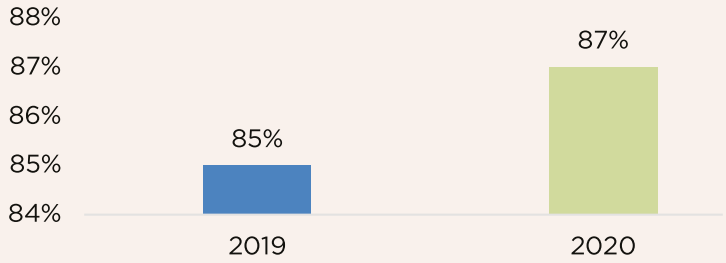

Figure 16: Percentage of ANM positions filled: Comparison between 2019 and 2020

Note:

To calculate the national estimate, mean of States/UT available in both rounds was computed (excluded Odisha and Ladakh from 2020 national estimate to keep States & UTs common).

For estimating cumulative % for D&N & D&D for the year 2019, mean of both UTs has been calculated & used.

State-level key findings:

- *Large States:* 15 States have filled more than 75% of the ANM positions, whereas the data for Punjab were not available. Odisha filled 100% of its ANM positions, Bihar (52%), Uttar Pradesh (61%), and Himachal Pradesh (71%) had filled less than 75% of ANM positions. Information on ANM positions filled was not available for Punjab.
- *Small States:* 6 States (Arunachal Pradesh, Goa, Manipur, Meghalaya, Nagaland and Sikkim) have filled more than 75% of the ANM positions, whereas the data for Mizoram were not available. Tripura (56%) had filled less than 75% of ANM positions. Information on ANM positions filled was not available for Mizoram.
- *Union Territories:* All UTs have filled more than 75% of the ANM positions.

States like Himachal Pradesh, Uttar Pradesh, Tripura and Bihar had the least ANM positions filled (Annexure 6-D). Therefore, there is an urgent need to close the gap in ANM vacancies in these States, as they are a critical work force for delivering a range of maternal health interventions.

3.1.2 Monitoring progress on programme activities and intervention coverage

To assess the progress of States and UTs on programme activities and intervention coverage, data from the WCD Departments on select ICDS activities as well as data from the Health Departments on a set of interventions were analysed. Annexure 2 provides a detailed list of indicators that were considered for calculating the scores.

Departments of Women and Child Development

Activities such as Take-Home Ration and weighing of children aged 0-5 years were selected for assessing the progress of ICDS activities. The data was collected from the States and UTs through the State Template shared with them. Data received for the month of March 2020 in state-filled information was checked for concordance with the MPR data from MoWCD. Annexure 5 presents the concordance check findings.

As per the rubric, a maximum of 12 points were allotted to programme activities and intervention coverage of WCD.

- *Large States:* 15 States had complete information, among which 8 States had the maximum possible score of 12, while Bihar had the lowest score (6 points). Complete information was not available for Assam, Rajasthan, Uttar Pradesh and Uttarakhand.
- *Small States:* Out of 5 small States for which complete information was available, Goa, Sikkim and Tripura scored the highest (12 points). Complete information was not available for Arunachal Pradesh, Manipur and Nagaland.
- *Union Territories:* Among the UTs, 5 UTs scored 12, whereas Jammu and Kashmir scored only 7.

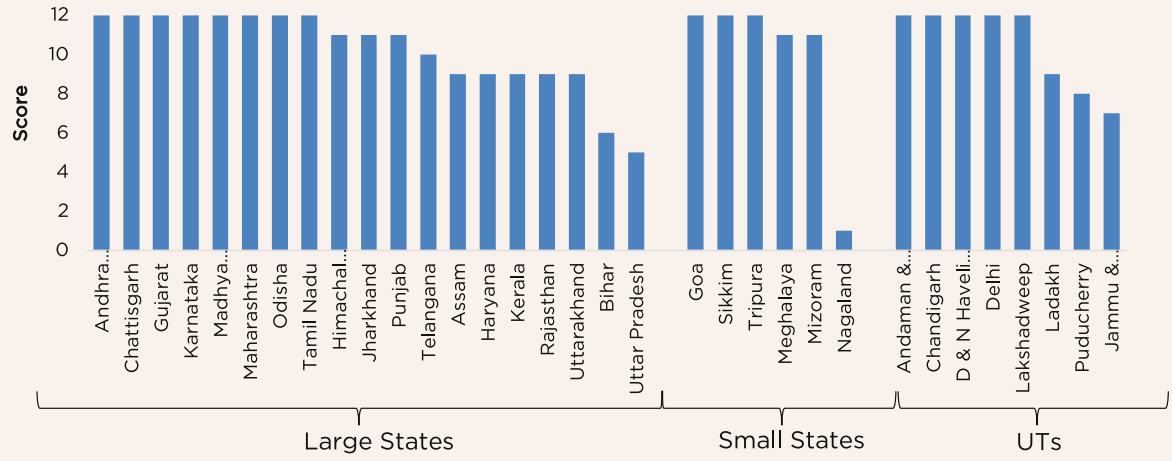

Figure 17: State-wise scores for programme activities and intervention coverage – Women and Child Development Department

Maximum Score: 12 *Based on State Template Data*

State-level key findings:

- *Large States:* 7 States (Gujarat, Jharkhand, Kerala, Maharashtra, Odisha, Rajasthan, Tamil Nadu) had distributed THR to 100% pregnant women registered at AWC, 5 States (Jharkhand, Kerala, Maharashtra, Odisha and Tamil Nadu) had distributed THR to 100% of lactating women registered at AWCs, and 6 States (Jharkhand, Kerala, Maharashtra, Odisha, Tamil Nadu and Uttar Pradesh) had distributed THR to 100% of children 6-36 months of age registered at AWCs. Large States with the lowest THR coverage included Bihar (65% of pregnant women, 62% of lactating women and 52% 0f children), Haryana (63% of pregnant women, 63% of lactating women, and 59% of children) and Punjab (78% of pregnant women, 76% of lactating women, and 65% of children).

  Additionally, in 10 States (Andhra Pradesh, Chhattisgarh, Gujarat, Haryana, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Punjab and Tamil Nadu) more than 75% of children 0-5 years of age who were weighed, while Bihar and Kerala had less than 20% children who were weighed. (Annexure 6-E)

- *Small States:* 3 States (Meghalaya, Mizoram and Tripura) had distributed THR to 100% of pregnant women registered at AWCs, 4 States (Goa, Meghalaya, Mizoram and Tripura) had distributed THR to 100% of lactating women registered at AWCs, and 3 States (Meghalaya, Mizoram and Tripura) had distributed THR to 100% of children 6-36 months of age registered at AWCs. While Sikkim (84% pregnant women, 84% lactating women and 77% children) had the lowest coverage of THR. Additionally, 3 States (Goa, Sikkim and Tripura) had more than 75% of children aged 0-5 who were weighed, whereas Arunachal Pradesh had less than 25% children who were weighed.

- *UTs:* 6 UTs (Andaman & Nicobar Island, Dadar & Nagar Haveli and Daman & Diu, Delhi, Ladakh, Lakshadweep and Puducherry) had distributed THR to 100% of pregnant women registered at AWCs, 5 UTs (Andaman & Nicobar Island, Delhi, Ladakh, Lakshadweep and Puducherry) had distributed THR to 100% of lactating women registered at AWCs, and 5 UTs (Andaman & Nicobar Island, Dadar & Nagar Haveli and Daman & Diu, Delhi, Ladakh, Lakshadweep) had distributed THR to 100% children 6-36 months of age registered at AWCs. Among UTs, the lowest THR coverage was in Jammu and Kashmir (49% pregnant women, 51% lactating women, and 54% children). Additionally, 5 UTs (Andaman and Nicobar Island, Chandigarh, Dadar and Nagar Haveli and Daman and Diu, Delhi, Lakshadweep) had more than 75% of children aged 0-5 who were weighed, while Ladakh had less than 25% children who were weighed.

It is imperative to examine the reasons for low coverage of THR and growth monitoring. States and UTs should assess whether the gaps in THR coverage pertain to supply chain issues or are a result of demand-side challenges. For growth monitoring, States should review if there are gaps in staff training on measuring children, availability of supplies or in community awareness to avail the service, and identify appropriate solutions.

Departments of Health and Family Welfare

Using data on immediate determinants, coverage of ANC, postnatal care, and early childhood interventions, and supplies from the State Health Departments, 14 indicators were constructed to assess State/UTs progress on intervention delivery. Among Programme Activities and Intervention coverage, indicators were divided into following sub-themes:

1. Programme Activities
2. Anaemia Mukt Bharat Strategy

The data was collected from the States and UTs through the State Template shared with them. Data received for the month of March 2020 in state-filled information was checked for concordance with the HMIS data from MoHFW was done on indicators that were comparable. Annexure 5 presents the findings from the concordance check.

Based on the progress on programme activities and implementation of the AMB strategy, States and UTs were ranked on a scale of 38 points. The overall scores are low due to indicators like children receiving 8-10 doses of IFA syrup, IFA received by lactating women, pregnant women who received Albendazole tablet after first trimester, and procurement of haemoglobin meter. Scores were also low for children receiving weekly IFA and conducting home visits for pregnant women amid COVID-19 in March 2020.

- *Large States:* Information was available on all the indicators for 10 States only, among which Maharashtra and Himachal scored the highest (32 points), whereas the remaining 8 States scored between 25 and 31 points. Complete information was not available for Bihar, Gujarat, Himachal Pradesh, Karnataka, Kerala, Odisha, Punjab, Rajasthan and Uttar Pradesh.
- *Small States:* Of the 8 small States, 7 were missing information on at least one indicator. Sikkim was the only small state with complete information and scored the highest (26 points). Mizoram provided no information on health programme activities.
- *Union Territories:* Of 8 UTs, Chandigarh, Delhi and Lakshadweep did not have information on at least one indicator. Dadar and Nagar Haveli & Daman and Diu scored the highest (28 points), whereas the remaining four States scored between 20 and 26 points.

Insights from State-level key findings on the two sub-themes of coverage of programme activities for health are as follows:

a. Programme Activities

A total of 12 indicators were used to assess progress on health-related programme activities.

State-level key findings:

- Among all 34 States and UTs, 27 had more than 75% of newborns who were breastfed within one hour, whereas Rajasthan, Ladakh and Puducherry had less than 25%.

- Only 17 States and UTs had more than 75% of children 12-23 months of age who were fully immunised, while 11 states and UTs had less than 25% children who were fully immunised.
- In terms of children 6-59 months of age provided at least 8-10 doses of IFA syrup, only Himachal Pradesh, Sikkim, and Puducherry covered more than 75% of children while as high as 23 States and UTs had less than 25% coverage.
- Only 13 states and UTs had more than 75% of pregnant women registered for ANC in the first trimester. 19 States had more than 75% of pregnant women who had 4 or more ANC visits. Punjab, Nagaland and Tripura had less than 25% of pregnant women attending 4 or more ANC visits.
- 23 States and UTs had more than 75% of pregnant women who were given 180 IFA tablets, while Punjab and Tripura had less than 25% coverage of IFA for pregnant women. On the other hand, 12 States and UTs had more than 75% of lactating women who were giving 180 IFA tablets, while 9 States and UTs had less than 25% coverage of IFA for lactating women.

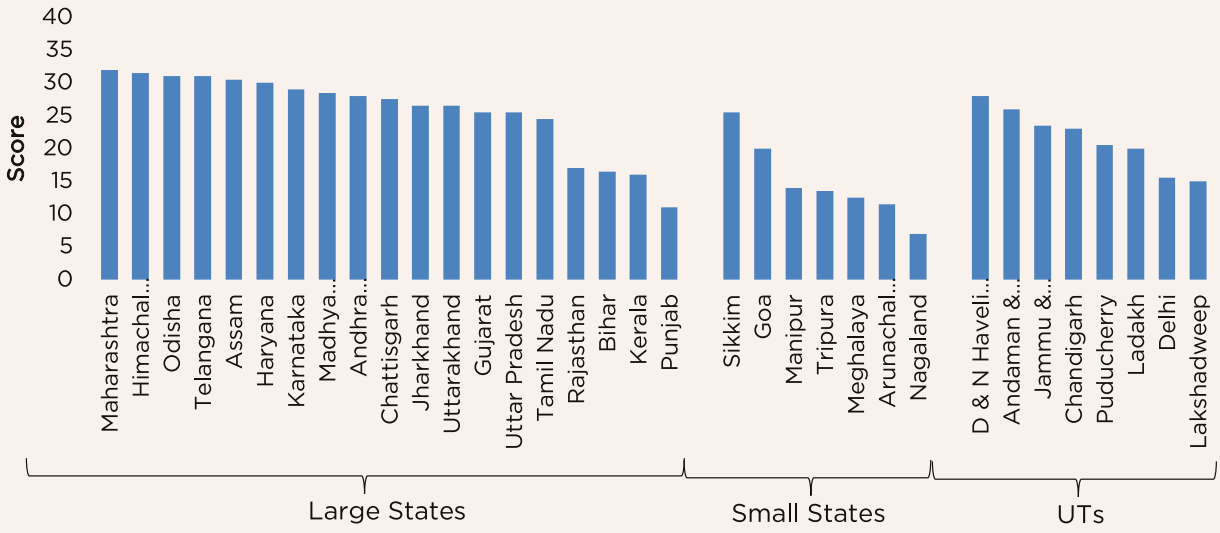

Figure 18: State-wise scores for Programme activities and intervention coverage- Health Department

Maximum score: 38

- The percentage of children who were given weekly IFA tablets is low: only 6 States and UTs had covered more than 75% of children, and coverage is less than 25% in 12 States and UTs.
- In terms of percentage of pregnant women given TT2/Boosters, 21 states had more than 75% coverage of TT2/Boosters, yet Punjab and Tripura had less than 25% of pregnant women who were given TT2/boosters.
- The percentage of pregnant women who were given 1 Albendazole tablet after first trimester is low, as only 5 States and UTs had more than 75% coverage, while 10 States and UTs had less than 25% coverage.

- 16 States and UTs had more than 75% of children (0-59 months) diarrhoea cases treated with ORS, while there were 5 States and UTs that treated less than 25% child diarrhoea cases with ORS.
- 15 States and UTs reported more than 75% of home visits for pregnant mothers to counsel them on practices during pregnancy, whereas less than 25% of home visits for pregnant women were conducted in Madhya Pradesh and Arunachal Pradesh during the COVID-19 pandemic.

Many States and UTs were unable to provide information on all indicators, and information was not available for any indicator for Mizoram. Annexure 6-F lists the best and the worst performing States/UTs on the 14 programme activity indicators.

Overall, there is scope for improvement in coverage for interventions during the first 1,000 days. Interventions like early initiation of breastfeeding, 180 days IFA received by pregnant women, and TT2/boosters received by pregnant women have acceptable coverage across States and UTs. Interventions like child immunisation (12-23 months), women who registered for ANC during the first trimester, women who attended 4 ANC visits, and reported diarrhoea cases that were treated with ORS had performed well in some States and UTs, but gaps still exist in Bihar, Jharkhand, Kerala, Punjab, Rajasthan, Telangana, Uttarakhand, north-east States and UTs. There is a need to focus on interventions like IFA syrup received by children (0-59 months), IFA received by lactating women and pregnant women who received albendazole tablet after first trimester, as many States have less than 25% coverage of these indicators.

b. AMB Strategy

Two indicators were used for assessing progress on the AMB strategy.

State-level key findings:

According to the data collected from the States and UTs, 27 States and UTs have included IFA in the Essential Drug List, while the process is underway in 7 States and UTs. The results show that 9 states have procured digital invasive haemoglobin meters, while the process is in progress in as many as 22 States and UTs. The process is yet to begin in Karnataka, Andaman and Nicobar Island, and Dadar and Nagar Haveli & Daman and Diu. Information was not available for Mizoram for both indicators.

3.2 CONCLUSION AND WAY FORWARD

This chapter assessed State progress on establishing a range of mechanisms to deliver all POSHAN Abhiyaan components (technology, behaviour change communications, capacity building and convergence).

Overall, there is mixed progress among States across multiple indicators on establishing mechanisms to implement POSHAN Abhiyaan, reinforcing the need to bridge gaps in many areas. The key findings and subsequent recommendations are as follows:

- Overall, fund utilization is low, with less than 50% of funds utilised in 23 States and UTs. Thus, there is an immediate need to accelerate its use through channels like recruiting human resources, procurement of devices and conducting CBEs and IEC.
- The constitution of district and block-level convergence action plan committees is not uniform across all States and UTs. This has implications for preparation of convergence action plans, which is the roadmap for achieving convergence. As empirical evidence suggests that implementing interventions across sectors simultaneously reduce stunting[5]; therefore, formation of CAPs is of utmost importance.
- Many States and UTs have also submitted CAP to CPMU, but there is a need to focus on operationalizing the plans in a way that the interventions across sectors reaches same beneficiaries. Outcome-oriented convergence on ground can also be facilitated by training the field level staff on sharing information and data among themselves.
- State scores varied across the service delivery indicators including on HR, infrastructure, supplies, training and capacity building. To continue progress on POSHAN Abhiyaan, attention to state-specific challenges pertaining to insufficient human resources, supplies and infrastructure is required.
- To close the gaps on procurement of smartphones, the Anganwadi Workers (AWWs) can be incentivized for data entry on online application or providing monthly allowance for rental/usage for using their own devices, as an alternative.
- In addition, there are large gaps in staff training on e-ILA modules across several States, due to low attendance at training, unavailability of training materials, lack of trainers, and low educational background of AWWs2. Therefore States/UTs need to address these challenges.
- Among the many ICDS services, priority areas for capacity building include strengthening the quality of growth monitoring and home-based counselling.
- States and UTs had covered many beneficiaries for THR, yet gaps exist. Therefore, there is a need to assess whether the gaps in THR pertain to supply chain issues or demand-side challenges. To address supply-side challenges, de-centralized model and decentralized self-help group model can be explored. E-payments should also be introduced at every stage. To address demand-side challenges, PRI and self-help groups (SHGs) should be involved for community engagement and explaining benefits. Additionally, to increase nutritional status and reduce intra-household consumption, fortification of THR and differentiating the packets for pregnant and lactating women, and children is recommended. With the introduction of POSHAN Tracker, the tracker should be used to monitor the nutrition service delivery of THR through QR code-based check while distributing packets and maintaining inventory. The tracker should also be used to monitor food consumption and take concurrent feedback from beneficiaries.

5 Rajpal et. al 2020

- Programme activities conducted under Department of Health have a mixed performance across the States and UTs. There is low coverage of IFA supplementation across the life stages, due to which it requires special attention. Similar to Kerala, other States and UTs can also implement programmes where IFA is provided to the out-of-school children at the AWC. Additionally, there is a need to assess the challenges on the supply-side and demand-side to improve coverage, especially of IFA supplementation, Albendazole tablets during pregnancy, 4 ANC check-ups, and home visits for pregnant women.
- A new institute called Jan Arogya Samiti (JAS) should be utilized to the fullest in ensuring the accountability in the services being provided at the HWCs, and for ensuring that the benefit reaches to all beneficiaries.
- There is a need to strive for data management at the State and the UT level in order to track their standing with respect to the objective of the Abhiyaan as well as to enable inter-state comparison on performances.

These conclusions resonate with the Development Monitoring and Evaluation Office (DMEO) of NITI Aayog's earlier independent evaluation which identified challenges of low fund utilisation, high numbers of staff vacancies limiting effective programme implementation as well as implementation of training and mentoring of frontline workers[3].

4 Jan Andolan and Multi-Sectoral Interventions

4.1 BACKGROUND

POSHAN Abhiyaan aims to reduce stunting, anaemia and low birthweight in districts with a high burden of malnutrition. It recognizes the need for convergence and coordination such that the benefits of government schemes and programmes reach women and children in the first 1,000 days. The POSHAN Abhiyaan identifies targeted determinants of nutritional outcomes that exist in various schemes and programmes. These include maternal nutrition, newborn care practices, infant feeding and care practices and underlying determinants, such as age at marriage, age at first birth and sanitation.

To eliminate malnutrition from India, implementing a package of interventions with adequate coverage, continuity, intensity and quality must be ensured. To this end, POSHAN Abhiyaan was scaled up based on several key pillars, including technology, improving capacities, convergence of multiple programmes and behaviour change communication. These pillars were introduced to trigger a series of changes that improve nutrition interventions in the ICDS and health systems, address the immediate and underlying determinants of poor nutritional outcomes, and help improve outcomes such as child growth, lower anaemia and other targets of the nutrition mission.

This chapter presents the community involvement in POSHAN Abhiyaan through Jan Andolan 2020, and highlights the multi-sectoral steps taken by various Line Ministries for POSHAN Abhiyaan in FY 2019-2020.

4.2 JAN ANDOLAN

The Honourable Prime Minister intended that the POSHAN Abhiyaan be converted into a Jan Andolan for effective outreach and implementation. The Mission strives to prevent and reduce undernutrition, LBW, and stunting across the life cycle as early as possible, especially in the first three years of life, with interventions up to six years of age. Several programmes across Ministries and Departments have been contributing to tackling

malnutrition and anaemia in the country. POSHAN Abhiyaan seeks to synergise all these efforts to achieve the desired goals and intends to raise community-level awareness into a Jan Andolan.

Objectives: Jan Andolan aims to achieve the following objectives:

- Raise awareness on the impact of malnutrition across sectors and, in turn, create a 'call to action' for each sector to contribute towards reducing malnutrition;
- Mobilise multiple sectors and communities to consume more nutrient-rich food; and
- Promote knowledge, attitudes and behaviours that support optimal breastfeeding, complementary feeding, maternal nutrition and adolescent nutrition to prevent malnutrition, including severe acute malnutrition (SAM) and anaemia.

4.2.1 Poshan Maah

In September 2020, Poshan Maah demonstrated the power of convergent outreach, garnering a gross participation of 379 crore participants across 14 crore activities nationwide. As many as 102 crore men, 128 crore women, and 118 crore children (males and females) were reached through Poshan Maah-related activities. However, it may be noted that this participation consists of repeat and recurrent participants, and should not be treated as absolute number of participants.

Despite the COVID-19 pandemic, there was tremendous enthusiasm and impressive participation in various activities were observed across the country. Considering the current pandemic, various activities were conducted through digital platforms for celebrating the Poshan Maah. Social Media, online activities, podcasts, e-Samvaad, and multiple webinar series were the most extensively used platforms.

Compared with Poshan Maah 2019, participation increased by 51% and the number of activities conducted by 284%, indicating an impressive rise in outreach and engagement associated with Poshan Maah 2020.

The States with the most activities conducted and highest participation levels in Poshan Maah 2020 are Tamil Nadu, Maharashtra, Uttar Pradesh, Bihar, Gujarat, Karnataka and Madhya Pradesh.

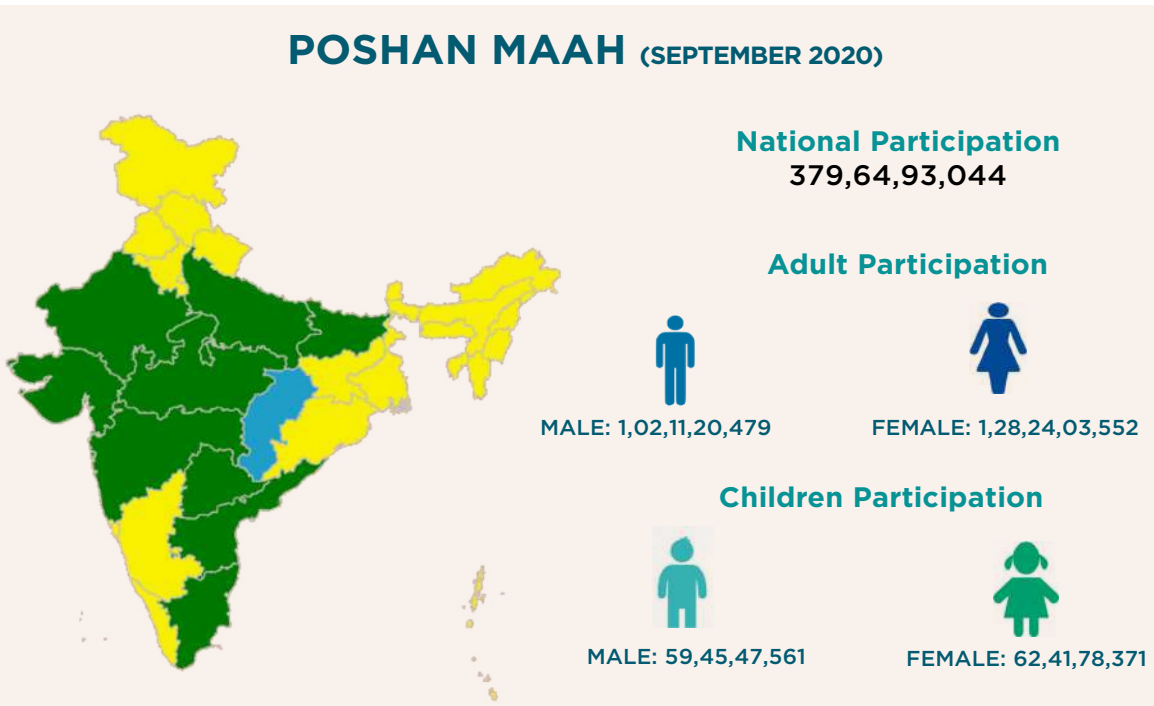

Figure 19: Poshan Maah performance by participation across India, 2020

Note: *The number of participants include repeat and recurrent participation*

The State-level performance of participation in Poshan Maah was computed based on an index that includes factors like total activities, number of AWCs and the number of activities in the States/Districts. Figure 19 summarises the total number of activities and participation under Poshan Maah nationwide.

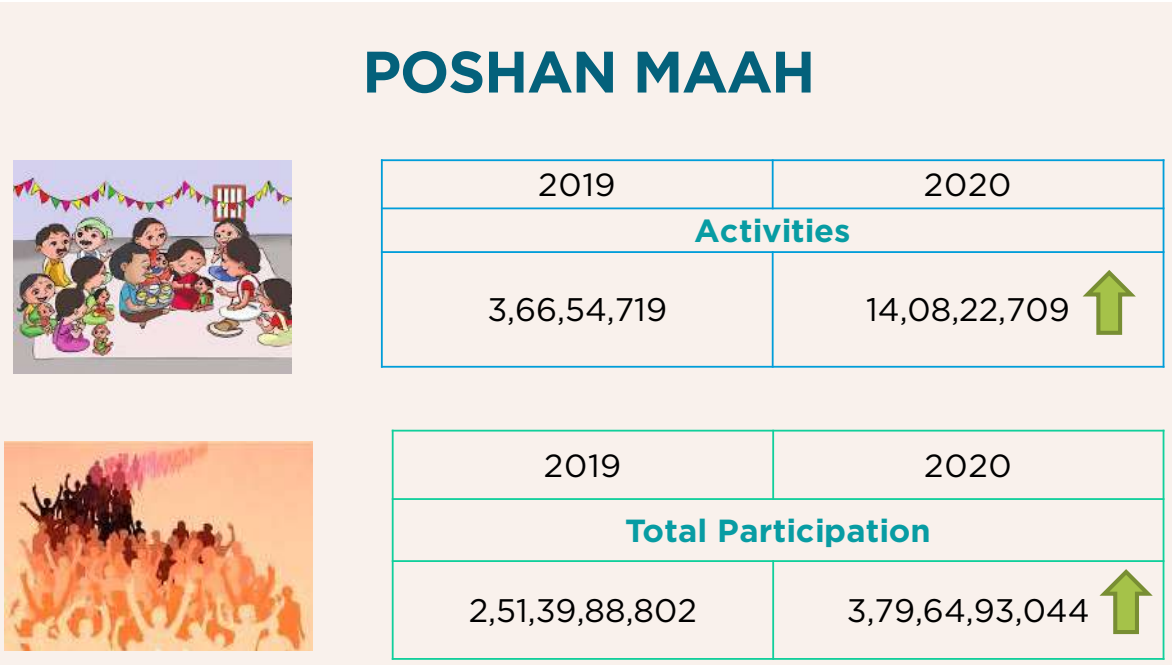

Figure 20: Poshan Maah performance by participation: Comparison between 2019 and 2020

All Ministries facilitated convergence through formal circulars and specific instructions to their line departments in the States and Districts across themes to fight malnutrition. This year, Poshan Maah's primary themes were identifying and tracking children with SAM and promoting kitchen gardens. Figure 21 lists other themes covered under POSHAN Maah 2020. Many Chief Ministers and various state and district officials have taken a pledge to end malnutrition and made it a personal agenda to monitor the progress regularly.

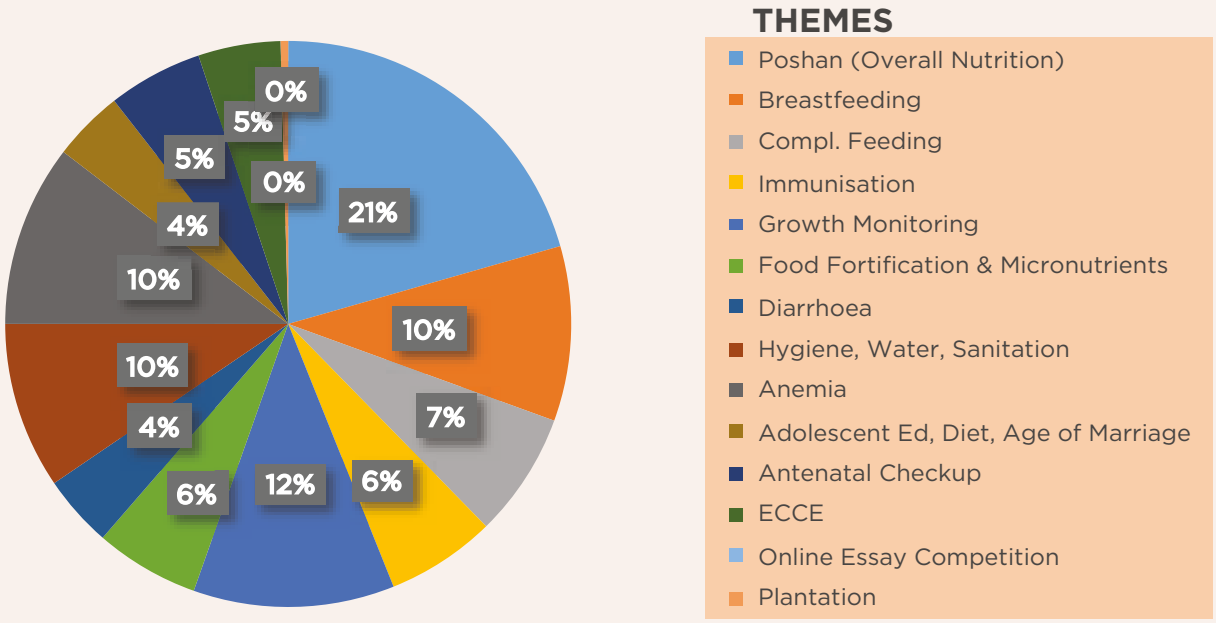

Figure 21: Themes covered under POSHAN Maah, 2020

4.2.2 Convergence of line ministries during Jan Andolan

Various line ministries, including the Ministries of Health and Family Welfare, Drinking Water and Sanitation, Rural Development, Human Resource and Development, Information and Broadcasting, Panchayati Raj, Tribal Affairs, Housing and Urban Affairs, Electronics and Information Technology, Minority Affairs, Ayurveda, Yoga, Naturopathy, Unani, Siddha, Sowa-Rigpa and Homoeopathy (AYUSH), Youth Affairs and Sports, Social Justice and Empowerment, Ministry of Agriculture Cooperation and Farmers Welfare and Ministry of Consumer Affairs, Food & Public Distribution partnered with the MoWCD during Poshan Maah. Grass-root level platforms like Gram Sabhas, SHGs, and field functionaries across various ministries and schemes were used for optimum spread and coverage. Table 5 describes the key activities performed during Poshan Maah by line ministries.

Table 5: Key activities performed during Poshan Maah by Line Ministries

MINISTRY	ACTIVITIES
Ministry of Women and Child Development	The Ministry conducted numerous activities, which included rallies, marathons, Pad Yatra, Cycle Yatra, cultural programmes, Nukkad Nataks, short film shows, exhibitions, and online competitions on nutrition, health, immunisation, and sanitation and health for the celebration of Poshan Maah. The Ministry held four webinars in September. The first webinar featured discussions on the need for a renewed focus on nutrition during COVID-19, the need for innovation and agro-diversity in nutrition, sharing of best practices and success stories in establishing nutri-gardens in Lakshadweep AWC, online tracking and adoption of Severely Malnourished Children in Gujarat, revamping supplementary nutrition preparation and distribution and inclusion of Millets in Odisha, adoption of SAM children by Government Officials in Uttrakhand, and identification drive for SAM children in the UTs of Dadar and Nagar Haveli, and Daman and Dui. The second webinar focused on the Nutrient Requirement for Children and Mothers during the first 1,000 days. The third webinar focused on the importance of sound bone health among Indian children, adolescents, pregnant women, and lactating mothers, and the fourth webinar outlined the prevention and management of enteric infections in 5-14-year-old school children and gave details about the incidence of deaths and Disability-adjusted life years lost due to such infections. On 20 September 2020, the Ministry signed a Memorandum of Understanding with the Ministry of AYUSH for integrating AYUSH systems with ongoing nutrition interventions under the ICDS programme, developing medicinal gardens in identified AWCs and conducting Yoga Classes for women and children at all AWCs.
Ministry of Health and Family Welfare	Amid the COVID-19 pandemic, the 'Rashtriya Poshan Maah' was celebrated in the States and UTs abiding by the norms of social distancing and avoiding mass gatherings. Many States/UTs conducted deworming campaigns under the NDD programme during the 'Rashtriya Poshan Maah'. Albendazole tablet was administered through house-to-house visits for the first time under the NDD programme. The diarrhoea prevention and management activities, and the VHSNDs were also celebrated in the various States/UTs. The States and UTs conducted virtual orientation of the staff and also conducted webinars on the importance of the first 1,000 days of life, anaemia prevention, and breastfeeding and IYCF practices. Children with SAM who were treated were discharged from NRCs and followed up over the telephone. Kitchen gardens/nutri-gardens establishment was also focused in some States. As per the Jan-Andolan dashboard, 3.77 crore persons participated in 8.1 lakh activities conducted by MoHFW and State Health Departments.

MINISTRY	ACTIVITIES
Ministry of Consumer Affairs, Food and Public Distribution	A total of 1,043 activities were undertaken by the Central and State level Department under the Department of Food and Public Distribution, Ministry of Consumer Affairs, Food and Public Distribution to celebrate Poshan Maah 2020. The activities included awareness-raising on nutrition and diet diversification, plantation drive of kitchen and nutri-gardens, cooking recipe competitions, online essays, quizzes, slogans, debates, poster and drawing competitions, webinars and panel discussions on malnutrition, distribution of fortified foods and fruits to the underprivileged women and children, and distribution of mixed micro green seeds.

4.3 MULTI-SECTORAL INVOLVEMENT

Nutrition is fundamental to human survival and development and is an essential foundation of national development. The launch of POSHAN Abhiyaan has been a watershed movement in the series of enhanced allocations, policy measures and advisories issued by the Government of India towards the goal of eradicating malnutrition in the country. The Abhiyaan has not only given momentum to existing programmes, reoriented policy choices and aligned several sectors towards the common goal of eradicating malnutrition, it has also been instrumental in instigating a range of policy actions under its ambit within a short span of time.

While POSHAN Abhiyaan has an earmarked three-year budget of Rs. 9046.17 crore from 2017-18, it is an overarching framework that seeks to leverage funds, functionaries, technical resources and information, education, and communication (IEC) activities from existing programmes and schemes such as the Integrated Child Development Services (ICDS), PMMVY, National Heath Mission (NHM), Swacch Bharat Mission (SBM), National Rural Livelihood Mission (NRLM), National Rural Employment Guarantee Assurance (NREGA) and the Public Distribution System (PDS). The aim is to align the efforts of every stakeholder in a direction that could positively impact nutrition outcomes.

POSHAN Abhiyaan is a multi-ministerial effort to address malnutrition through tackling its many determinants by strengthening and converging actions to support nutrition in many Ministries. Although efforts are led by the MoWCD, critical actions have also been taken by the Ministry of Health and Family Welfare, Ministry of Consumer Affairs, Food and Public Distribution, Ministry of Drinking Water and Sanitation, as well as others. The summary of actions, as reported by the key Ministries, is provided below.

4.3.1 Ministry of Women and Child Development

The MoWCD has collaborated with other Ministries like Ministry of Health and Family Welfare, Ministry of Youth Affairs and Sports, Ministry of Consumer Affairs, Food Public Distribution, and Ministry of Jal Shakti. The following measures have been taken:

a. **Ministry of Health and Family Welfare:** The Ministry has been working on Intensified Mission Indradhanush 2.0, which provides Pneumococcal Conjugate Vaccines (PCV), Rotavirus Vaccines (RVV), National Deworming Day (NDD), HBNC, Home Based Care for Young Child (HBYC), institutional deliveries, LBW,

antenatal check-up, IFA supplementation, community and home distribution of IFA supplementation, vitamin-A supplementation, and Rashtirya Bal Swasthya Karyakram (RBSK) for meeting the objective of POSHAN Abhiyaan. During the four rounds conducted under Intensified Mission Indradhanush 2.0 from December 2019 to March 2020, around 37.09 lakh children and 7.41 lakh pregnant women were vaccinated. Similarly, more than 49 lakh doses of PCV have been administrated from January 2020 to April 2020, and more than 1.8 crore doses of RVV have been administered from January 2020 to April 2020. NDD has been conducted in 25 States and UTs and have covered around 11.3 crore children. Under HBNC programme 46.92 lakh newborns received complete schedule of home visits by accredited social health activists (ASHA), and 2.5 lakhs sick newborns have been referred to health facilities. While under HBYC, out of 242 districts, 238 have completed trainers' trainings, 1,60,339 frontline workers have been trained, and around 1,83,975 children have received visits in 39 districts, where 22 are Aspirational Districts.

According to the information shared by MOWCD, 94% of the total deliveries reported were conducted in hospitals, 73.4% ANC check-ups were registered in the first trimester, 80% of the pregnant women received 4 or more ANC check-ups, 91% of the pregnant women were given IFA supplementation where the IFA supplementation were home delivered extensively from January to March 2020, and 69.83 lakh children were provided with the first dose of Vitamin A supplementation. Under RBSK, 1.2 crore children 0-3 years of age were screened, and 3.16 lakh children availed services at secondary tertiary care institute, 1.07 crore children 4-6 years of age were screened, and 4.91 lakh children availed services at secondary tertiary care institute.

b. **Ministry of Consumer Affairs, Food and Public Distribution:** The Ministry has requested States to operationalize the blending of fortified rice and its distribution through PDS, with a special provision for pregnant women, lactating mothers, and children 6 months to14 years to free nutritious meal through ICDS network and the Mid-Day Meal Scheme (MDMS). So far, 15 State Governments agreed to implement the pilot scheme.

c. **Ministry of Youth Affairs and Sports:** The Ministry has launched the Fit India Movement, which focuses on improving and promoting physical and mental fitness, healthy lifestyles, preventive health care, sustainable and environment-friendly living, including healthy and balanced diets.

d. **Ministry of Safe Drinking Water:** The Ministry has taken initiative to provide an adequate quantity and quality of safe drinking water to public institutions such as Gram Panchayat buildings, schools, AWCs, and health centres through a functional household tap connection under 'Jal Jeevan Mission'.

Additionally, MWCD emphasised improving the supplementary nutrition programme in the States. With regard to hot cooked meals and THR, most States prepare a mix of regional dishes and staple foods. Additionally, some States have been able to incorporate fortified food items in the Supplementary Nutrition Programme. Some States offer sweets like kheer, whereas others resort to offering a stipulated number of dry snacks with meals.

States have also taken the following measures for POSHAN Abhiyaan:

- **Tracking of severe underweight in Gujarat:** The state has created a unique identification number of the severe underweight children for follow up purposes. Phone calls are being made for tracking of THR, monitoring home visits made by the AWWs and getting feedback from programme guardians for tracking the facilities received by severely underweight children.
- **Identifying drivers of SAM in Dadar and Nagar Haveli and Daman and Diu**: The State engaged District Collectors under the Department of Health and Family Welfare to organize a drive to identify SAM cases. The drive covered four steps: 1) growth monitoring, 2) screening, 3) diet diversity and 4) counselling. The drive measured 25,800 children out of 28,000.
- **Revamping Supplementary Nutrition Programme in Odisha**: The State has engaged 548 SHGs in THR production and distribution, specifically in roasting, weighing, packaging and distribution of grains. This engagement has mitigated any programmatic disruptions as a result of the recent floods. Additionally, the State has also formed a jaanch-committee at every AWC, which promotes transparency.
- '**Sarkar Aapke Dwar' and 'Sanjeevani' Programme in Uttarakhand**: The State has launched the Sarkar Aapke Dwar initiative to sensitise people on malnutrition and its ill effects on growth and overall development of the children. They were also made aware of the totality of causes that can affect the health of a family. The State has also launched Sanjeevani Programme, which provides ₹ 2000 per month for 6 months to each SAM child.

Flexi Funds utilisation indicates that, on average, States/UTs have utilized 37% of the funds earmarked to the States up until 31 March 2020. States have been utilising the Flexi funds for organizing various events and camps that help in meeting the objective of the Abhiyaan, capacity building and training of the AWWs, DPOs, CDPOs and State Officials, procurement of various materials for AWCs, and incorporating technology for effective implementation of POSHAN Abhiyaan. Annexure 4-A provides further details of utilization of flexi funds States and UTs had also taken steps for strengthening the Hot Cooked Meal Programme, and most States and UTs have also taken additional measures to fortify the supplementary nutrition. Annexure 4-D provides state-wise details of the supplementary nutrition programme.

Despite the continuous efforts in making India malnutrition free, MoWD has indicated that the challenges with respect to training and capacity building of field functionaries, and the gaps in infrastructure related to buildings, toilets, and drinking water facilities still exist. The roll-out of ICDS-CAS and procurement of growth monitoring devices remains have room for improvement, and there is low and delayed utilization of funds. Sustaining 'Jan Andolan' activities is also a major challenge for the Ministry.

4.3.2 Ministry of Health and Family Welfare

The National Health Mission (NHM) under the MoHFW plays a vital role in the success of POSHAN Abhiyaan as both the missions share similar goals such as the reduction of

undernutrition, anaemia and the prevalence of LBW. Various health sector interventions that are instrumental in the success of POSHAN Abhiyaan include:

a. **Home-Based Care of Young Child (HBYC):** The HBYC programme involves additional home visits over and above the existing HBNC visits for nutrition promotion. Ministry has sanctioned an amount of Rs. 217.68 crore for the programme to be implemented across 242 Districts including 112 Aspirational Districts. As far as capacity building of frontline workers is concerned, 31 States/UTs have completed the training of trainers, and 27 States/UTs have started the training of frontline workers for HBYC. A total of 1,60,339 frontline workers covering 179 districts across 26 States/UTs have been trained. Additionally, home visits have started in 16 states covering 55 Districts including 31 Aspirational Districts. The Ministry has further included 275 additional Districts under HBYC in the FY 2020-21.

b. **Home-Based New-Born Care (HBNC):** A total of 1.42 crore newborns have received home visits by ASHAs in 2019-20 and 5.68 lakh newborns have been referred. The average HBNC home visit coverage has increased from 71.2% in 2018-19 to 78.6% in 2019-20, and around 90% of round 3 training of the ASHAs has been completed.

c. **Anaemia Mukt Bharat (AMB):** Under the programme, central procurement of IFA supplements has been made available, and the procurement for red and blue IFA tablets is underway in 14 States/UTs. Considering the current COVID-19 pandemic, the comprehensive AMB training toolkit is being converted into an e-learning module for online capacity building of the service providers and programme managers. In FY 2019-20, 1.7 crore children 6-59 months of age were provided weekly IFA syrup every month, and 2.8 crore children 5-9 years of age were provided weekly pink IFA tablets every month. Similarly, 4.5 crore children 10-19 years of age were provided blue IFA tablets every month, and 2.6 crore pregnant women and 1.4 crore lactating women were provided 180 IFA red tablets in FY 2019-20.

d. **National Deworming Day and Mission Indradhanush:** In 2019-20, four rounds of Intensified Mission Indradhanush were conducted from December 2019 to March 2020 in 381 identified districts of 29 States/UTs. In total, 1102.33 lakh (95%) children were covered. States like Jammu and Kashmir, Meghalaya and Himachal Pradesh conducted their first round of vaccination in October-November 2019 and covered 62.45 lakh children. Under various phases of Mission Indradhanush, 3.76 crore children and 94.6 lakh pregnant women have been vaccinated as of March 2020. The full immunisation coverage for 2019-2020 is 92.83%, as per the HMIS.

e. **Intensified Diarrhoea Control Fortnight (IDCF) and severe acute malnutrition (SAM) treatment in Nutritional Rehabilitation Centre (NRC):** In 2019, families of more than 10 crore under-five children were provided with ORS packets, counselling on the use of ORS and zinc and proper nutrition during diarrhoea. An estimated 75% of beneficiaries were covered during this period. Additionally,

as per FY 2019-20, there were 1,072 functional NRCs in 28 States, where 2.25 lakh sick SAM children received treatment.

f. **Rashtriya Kishori Swasthya Karyakram (RKSK) and Ayushman Bharat School Health and Wellness Programme:** The RKSK counsellors and peer educators have been involved in spreading awareness on nutrition. Additionally, information on nutrition and health in schools with adolescent girls attending upper primary senior secondary classes have been taken by rigorously by health and wellness ambassadors (trained school teacher) as a part of Ayushman Bharat School Health and Wellness Programme.

4.3.3 Ministry of Drinking Water and Sanitation

On Independence Day in 2014, the Honourable Prime Minister of India recognised the need for affirmative action for a Swachh Bharat by 2 October 2019. The Mission's resolution was for a clean and Open Defecation Free (ODF) India by October 2019. As of March 2020, a total of 706 Districts and 6.03 lakh villages were declared ODF, and 3.94 lakh villages have been covered with piped water supply. Furthermore, the information provided by States/UTs indicates that, out of 4,588 arsenic affected habitats, 319 have so far been provided with safe drinking water. Moreover, out of 6,233 fluoride affected habitats, 830 have been provided with safe drinking water.

The Ministry has implemented Jal Jeevan Mission–Har Ghar Jal in partnership with States to provide every rural household in the country to have potable water supply through Functional Household Tap Connections by 2024. As of November 2020, the mission has identified a total of 27,544 habitations, including 13,819 arsenic affected and 13,725 fluoride-affected rural habitations, to provide safe drinking water. To date, 3,647 habitations have been covered.

In addition to this, some States have taken the following initiatives:

- ODF Plus activities galore in Kodagu, Karnataka: The district administration of Kodagu in Karnataka has engaged in various activities to ensure ODF sustainability. As a part of Swachh Sundar Shauchalaya, campaigns for creating awareness on the importance of using toilets were held in schools, anganwadis, and community public toilets. In addition, the district adopted the Pay-and-Use model of community toilets so that funds could be gathered for painting the toilets. On World Environment Day 2020, a campaign was held for Liquid Waste Management and Solid Waste Management at household- and Gram Panchayat-levels. Similarly, many mass awareness activities were planned, which included Jathas or street plays, school competitions, clean-up campaigns, tree plantations, marathons and debates, which raised awareness on ODF sustainability.
- Sindhora becomes MP's first Single-Use Plastic Free Gram Panchayat: With a bartan bank in place, Sindhora Gram Panchayat in Indore District of Madhya Pradesh became the State's first single-use plastic free Gram Panchayat. The 70-day campaign began in 425 households on 2 October 2019, and was implemented by an all-woman team. Children, women, and other community members joined

to clean the village, install dustbins at strategic places and plant saplings on roadsides and public spaces. Meanwhile, school children carried out awareness rallies and performed nukkad nataks. A door-to-door campaign, where cloth bags were distributed to homes and residents were asked to refrain from using plastic bags, was also carried out. A logo sticker was affixed to every house to highlight their commitment of not using plastic. In addition, a bartan bank was set up where a whole range of utensils could be borrowed at Rs. 1/- per piece for marriages and other events to reduce the use of plastic.

4.3.4 Ministry of Consumer Affairs, Food, and Public Distribution

The Government of India has approved the centrally sponsored pilot scheme on '**Fortification of Rice and its Distribution under PDS'** for three years beginning in 2019-20, with a total budget outlay of Rs 174.64 crore. Fifteen State Governments—Andhra Pradesh, Kerala, Karnataka, Maharashtra, Odisha, Gujarat, Uttar Pradesh, Assam, Tamil Nadu, Telangana, Punjab, Chhattisgarh, Jharkhand, Uttarakhand and Madhya Pradesh—have consented and identified their respective districts for implementation of the pilot scheme. The States of Maharashtra, Gujarat Andhra Pradesh started distributing fortified rice under the pilot scheme in February 2020, February 2020, and April 2020, respectively. States of Tamil Nadu, Chhattisgarh, Kerala, Uttar Pradesh and Odisha are expected to start soon.

In addition, the Ministry has issued a D.O. letter to the Secretaries of Food, Civil Supplies and Consumer Affairs of all States/UTs emphasizing the nutritional benefits of fortified edible oils. The Ministry has also requested all the States/UTs to distribute fortified wheat flour as per Food Safety and Standards Authority of India (FSSAI) standards through PDS in their respective States/UTs.

However, the Ministry has faced numerous challenges in implementing rice fortification. Since the success of the pilot scheme depends on the rice millers, as the blending of the fortified rice kernels with rice requires rice milling. Thus, bringing the private millers to make investments for the same is a challenge that the Ministry is facing. Additionally, under Targeted Public Distribution System (TPDS), about 350 lakh metric tonnes (LMT) of rice is distributed and thus a total of 3.5 LMT of fortified rice kernels is required. However, the availability of the fortified rice kernel stands at approximately 15,000 MTs/annum currently. Furthermore, the capacity of the National Accreditation Board for Testing and Calibration Laboratories (NABL)-accredited laboratories should be strengthened for the successful implementation of rice fortification.

4.3.5 Initiative by Development Partners

In addition to the steps taken by the Development Partners for implementing POSHAN Abhiyaan during COVID-19, development partners have actively undertaken the regular activities for POSHAN Abhiyaan. Box 3 presents an example of one such project.

BOX 3: IMPROVING THE MICRONUTRIENT PROFILE OF THE ICDS BENEFICIARIES

The United Nations World Food Programme (WFP) has taken many steps to address the gap in the intake of micronutrients, especially in Kerala. Along with the Department of Women and Child Development, Kerala, and the *Kudumbashree Mission* – a federation of women's self-help groups that produce take-home rations (THR) under the ICDS. WFP has piloted projects on fortification of THR and the rice-based hot-cooked meals served to children in Anganwadi Centres (AWC).

Under their project in Waynad, Kerala, the organisation has fortified the THR for children 6-36 months, with 11 micronutrients consisting of calcium, iron, zinc, vitamin A, thiamine, riboflavin, niacin, vitamin B6, vitamin C, folic acid and vitamin B12. The pilot project started in the Mananthavady block of Wayand district, wherein WFP set up a Nutrimix unit, developed awareness material to improve nutrition and feeding practices among children 6-36 months of age, and trained officials for carrying out fortification. Later, the project was scaled-up to all 14 districts, which also included the distribution of IEC materials for improving nutritional intake, and the capacity building and cascade training of Kudumbashree members. With the scale-up, over 4,00,000 beneficiaries are reached with fortified THR every month, and on average, 1,300 metric tonnes (MT) of fortified Nutrimix has been produced and distributed monthly through 33,115 AWCs since May 2019.

Similarly, WFP and the Department of Women and Child Development, Kerala are working towards mainstreaming rice fortification in the ICDS scheme in Kannur Kerala for children 3-6 years of age. WFP facilitated the installation and commissioning of a rice fortification unit in the Supply-Co facility at Thaliparamba in Kannur. The rice received from FCI at SupplyCo is then blended with rice kernels containing eight micronutrients, which are then distributed to Maveli Stores. In addition, the Kudumbashree members are trained for the fortification process, withdrawing samples for testing, and undertaking blending efficiency tests to ensure quality. In January 2020, WFP trained 135 government officials on rice fortification, and the team further addressed the queries of the officials on various aspects of rice fortification. The project has fortified 86.6 MT of FCI rice, which has been distributed across 915 AWCs reaching 14,100 children. Considering the success of the pilot project, the project is now in the process of being scaled up across other districts in Kerala.

Source: World Food Programme

4.4 CONCLUSION AND WAY FORWARD

The actions taken across Ministries to support India's nutrition goals are commendable. They take us closer to achieving the goals of effective convergence, and can support convergent action planning. However, for maximum impact, diverse actions across

Ministries must reach the last mile and ensure that all actions reach all households in the first 1,000 days. To achieve this, we recommend the following:

- Local innovations are essential to ensure that actions of MWCD and MoHFW reach 1,000-day households fully so that each action/intervention is timed and targeted appropriately and delivered with quality. This could require aligning catchment areas and target populations at the local level, tracking of services received and missed across both health and ICDS, and use of local data to support co-coverage. Additionally, since MWCD and MoHFW use different applications for tracking the same beneficiaries leading to duplication, therefore efforts are required to develop a common platform for convergence of AWW, ASHA, and ANM.
- Co-locate critical actions of all ministries in focus districts and focus blocks within districts, especially those actions that address underlying causes of malnutrition such as poor sanitation, gender issues, poverty, food insecurity. This again will require local action
- Convergence and co-location will likely be more challenging in urban areas; this will require close attention to local governance models in urban areas, engagement of private providers and innovations around demand creation.
- The 11th Schedule of Constitution lists 29 subjects within the functions of the Panchayat. The schedule mandates PRIs to take measures for family welfare and women and child development. Therefore, it is recommended that the PRI should be involved in organizing and mobilizing beneficiaries through community-based events.
- There is also a need to design the activities and events in a way that they focus on sustained capacity building of the eligible household through interpersonal dialogue, rather than giving short-lived information. In addition to the FLWs, peer educators, local NGOs/CSOs/community volunteer groups, such as NCC/NSS students and women volunteers from SHGs should also be involved, as this will achieve the dual objective of community engagement without compromising home visits by FLWs.


TAMATAM ICDS
VILLAGE HEALTH
NUTRITION DAY
VILLAGE
DATE

5 Delivering POSHAN Abhiyaan Interventions during a Pandemic: How are States doing?

The COVID-19 pandemic disrupted progress on many activities in 2020, including the delivery of health and nutrition services under the POSHAN Abhiyaan umbrella framework of interventions. This chapter aims to quantitatively examine the impact of the pandemic on the delivery of some of the POSHAN Abhiyaan interventions, drawing on publicly available data. The restoration of key services over the course of the year is also examined.

Various activities conducted under MWCD and MoHFW were disrupted during the peak of the lockdown period (April-June 2020). However, several policy adaptations and interventions have been undertaken by central and State authorities to restore service delivery. This section summarises the stringent actions taken by MoWCD and MoHFW to prevent the spread of COVID-19, analyses the disruption in key health and nutrition services, and reviews strategies adopted by States to continue service delivery amid COVID-19.

For the purpose of examining the adaptations in response of COVID-19 pandemic, the state policy guidance from March until October 2020 for 13 States (Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Rajasthan, Uttar Pradesh and West Bengal) was assessed using the comprehensive guidance issued by MoHFW and state-level documentation. To assess the impacts of COVID-19 on the delivery of health and Integrated Child Development Services (ICDS), MPR and HMIS State/UT-wise data were used for five quarters—that is, from October-December 2019 to October-December 2020. Lastly, administrative data from State/UT Template were utilised to highlight the innovative steps undertaken by the Department of Women and Child Development (DWCD) and Department of Health for the provision of services despite the COVID-19-related disruptions.

5.1 WOMEN AND CHILD DEVELOPMENT SERVICES

To curtail the spread of the pandemic, Anganwadi Centres (AWCs) were closed, and services were disrupted. Operation of ICDS platforms including Anganwadi Centres,

VHSNDs, home visits, counselling and food supplementation for children, and pregnant and lactating were examined for assessing the impact of COVID-19 on implementation of these key women and child services.

5.1.1 Disruptions and policy adaptations of service delivery platforms

During the strict lockdown months, AWCs were closed across states. In November 2020, the MWCD issued guidance to open AWCs and resume services outside containment zones by following COVID-19 safety protocols at the AWCs. VHSNDs were partly operational in a few states following staggered approach and in non-containment zones. Routine services were provided on-demand at health centres. In April 2020, the MoHFW issued guidance on the delivery of health and nutrition services through home visits by FLWs. Several states continued home visits and bundled essential services, such as distribution of food supplements and counselling of beneficiaries, with home visits. This step was taken by most states to ensure continuity of services (Figure 22).

State	Platforms									Interventions across life stages					
	Anganwadi centre open*			Village Health & Nutrition Day			Home visits			Counselling			Food supplementation		
	May	Aug	Sep/Oct	May	Aug	Sep/Oct	May	Aug	Sep/Oct	May	Aug	Sep/Oct	May	Aug	Sep/Oct
Andhra Pradesh															
Assam															
Bihar															
Chhattisgarh															
Gujarat															
Jharkhand															
Karnataka															
Madhya Pradesh															
Maharashtra															
Odisha															
Rajasthan															
Uttar Pradesh															
West Bengal															

*In November 2020, national guidance was issued to open Anganwadi centers.

No information
Partly operational (i.e., for some groups of population or geographic restrictions)
Fully operational
Service suspended

Figure 22: Policy guidance for implementation platforms and interventions across life stages

5.1.2 Insights on disruption and restoration of supplementary nutrition during COVID-19 pandemic

To assess the impact of COVID-19 on ICDS service delivery, State/UT-wise quarterly data were used for five quarters—that is, from October-December 2019 to October-December 2020—on two indicators:

1. Number of children 6 months to 6 years old who received supplementary nutrition; and
2. Number of pregnant and lactating women who received supplementary nutrition

Analyses of disruptions and restorations on ICDS services were conducted using data from the ICDS monthly progress reports (MPR), provided by MWCD. The number of beneficiaries at the national-level for each quarter was calculated by adding the number of beneficiaries for all States and UTs. For assessing the change, the quarters were divided into pre-pandemic period (October-December 2019), disruption period (April-June 2020), early restoration period (July-September 2020) and restoration period (October-December 2020). Section 2.5.2 provides more information on the methodology for analysing the data.

Key findings from changes in coverage of supplementary nutrition

The number of beneficiaries who received supplementary nutrition declined during the lockdown period, which suggests that services were disrupted. The coverage of food supplementation for children 6 months to 6 years of age and pregnant and lactating women was disrupted slightly during the lockdown period. According to the MWCD mandate, food supplements were to be delivered to beneficiary households during the lockdown, which mitigated disruptions. Between the fourth quarter of 2019 (October-December 2019) and the second quarter of 2020 (April-June 2020), the coverage of supplementary nutrition dropped by 2% and 3% for children and for pregnant and lactating women, respectively.

Compared with the pre-pandemic period (October-December 2019), coverage increased during the third quarter (July-September 2020) by 6% for children and by 2% for pregnant and lactating women. This suggests that coverage of supplementary nutrition programme (SNP) was gradually recovering. However, the coverage of supplementary nutrition declined in the fourth quarter (October-December 2020), which was lower than the pre-pandemic period.

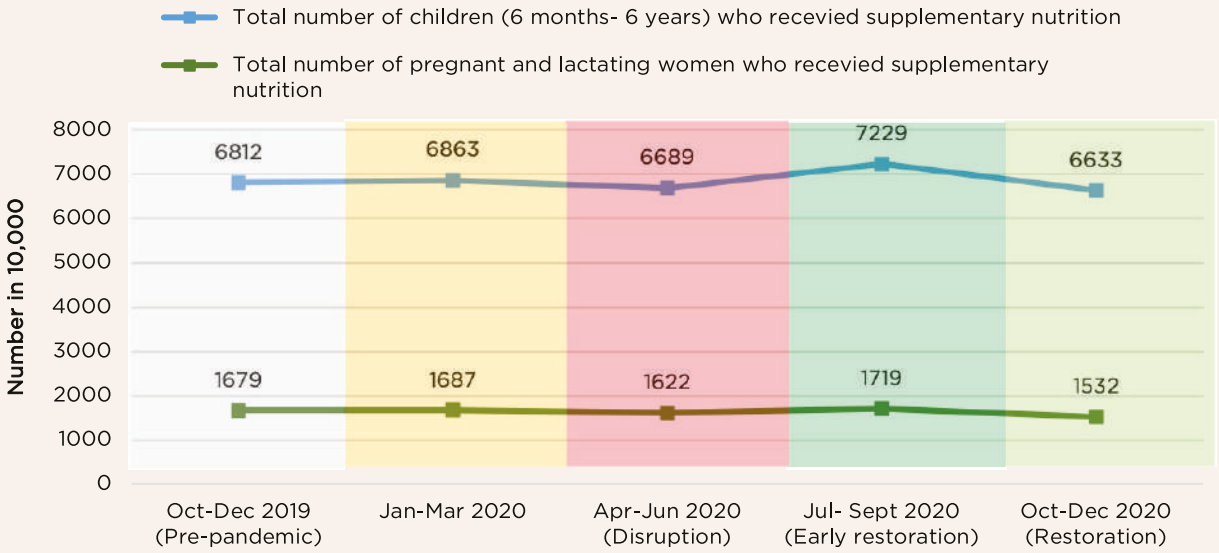

Figure 23: Changes in supplementary nutrition as per MPR data, October 2019 to December 2020

Source: *Monthly Progress Report Data, Ministry of Women and Child Development*

At the State-level, the number of children 6 months to 6 years of age who received supplementary nutrition reduced in 8 States and UTs in April-June 2020 compared with the pre-pandemic period (October-December 2019) (Figure 24). However, despite the lockdown, the coverage of supplementary nutrition was greater than or equal to the pre-pandemic period in 28 States and UTs. During the July-September 2020 reference period, the coverage of supplementary nutrition improved in 6 States/UTs where service had been disrupted. In Madhya Pradesh, Goa and Delhi, the coverage was restored to the pre-pandemic levels. By the end of the fourth quarter (October-December 2020), coverage was greater than or equal to pre-pandemic levels in 32 States and UTs, but it had declined substantially in Uttar Pradesh and Madhya Pradesh.

Compared with the pre-pandemic period (October-December 2019), the number of pregnant and lactating women who received supplementary nutrition declined in 16 States and UTs during the second quarter of 2020 (April-June 2020) (Figure 25). Conversely, coverage increased or remained the same in 20 States and UTs. Early restoration efforts were visible during the July-September 2020 period, as there was an improvement in coverage of SNP in 10 States/UTs, which previously experienced disruption. Additionally, Madhya Pradesh and Delhi recovered to pre-pandemic levels during this quarter. By the end of the fourth quarter (October-December 2020), coverage in 23 States and UTs was greater than or equal to pre-pandemic levels, but it declined in 11 States and UTs.

	State/UTs	Disruption (Q2 of 2020 to Q4 of 2019)	Early Restoration (Q3 of 2020 to Q4 of 2019)	Restoration (Q4 of 2020 to Q4 of 2019)
Large States	Andhra Pradesh	113%	115%	119%
	Assam	100%	103%	103%
	Bihar	68%	76%	102%
	Chhattisgarh	118%	126%	120%
	Gujarat	116%	118%	122%
	Haryana	130%	133%	136%
	Himachal Pradesh	100%	104%	106%
	Jharkhand	75%	67%	87%
	Karnataka	111%	109%	113%
	Kerala	120%	133%	135%
	Madhya Pradesh	52%	112%	85%
	Maharashtra	118%	124%	122%
	Odisha	113%	114%	114%
	Punjab	122%	126%	125%
	Rajasthan	105%	108%	128%
	Tamil Nadu	105%	106%	107%
	Telangana	108%	112%	119%
	Uttar Pradesh	94%	96%	41%
	Uttarakhand	116%	121%	107%
	West Bengal	114%	118%	120%
Small States	Arunachal Pradesh	100%	100%	100%
	Goa	99%	100%	106%
	Manipur	102%	102%	103%
	Meghalaya	98%	99%	99%
	Mizoram	117%	125%	108%
	Nagaland	111%	111%	110%
	Sikkim	120%	127%	132%
	Tripura	110%	110%	110%
Union Territories	Andaman & Nicobar	115%	133%	145%
	Chandigarh	98%	94%	106%
	D & N Haveli & Daman and Diu	117%	129%	124%
	Delhi	99%	125%	136%
	Jammu & Kashmir	180%	750%	161%
	Ladakh	103%	108%	110%
	Lakshadweep	113%	115%	108%
	Puducherry	112%	116%	123%
	All India	**98%**	**106%**	**97%**

Key	
	>= 100%
	<100% and >= 75%
	<75% and >= 50%
	<75% and >= 25%
	<25%

Figure 24: Disruption and restoration of supplementary nutrition among children 6 months to 6 years of age during the COVID-19 pandemic, MPR data, October 2019 to December 2020

Source: *Monthly Progress Report Data, Ministry of Women and Child Development*

	State/UTs	Disruption (Q2 of 2020 to Q4 of 2019)	Early Restoration (Q3 of 2020 to Q4 of 2019)	Restoration (Q4 of 2020 to Q4 of 2019)
Large States	Andhra Pradesh	108%	111%	111%
	Assam	100%	101%	101%
	Bihar	78%	88%	108%
	Chhattisgarh	112%	119%	113%
	Gujarat	95%	99%	100%
	Haryana	120%	119%	121%
	Himachal Pradesh	97%	97%	96%
	Jharkhand	60%	44%	75%
	Karnataka	131%	135%	143%
	Kerala	118%	121%	112%
	Madhya Pradesh	50%	112%	81%
	Maharashtra	101%	102%	98%
	Odisha	108%	109%	109%
	Punjab	119%	111%	114%
	Rajasthan	119%	111%	129%
	Tamil Nadu	97%	99%	100%
	Telangana	122%	131%	131%
	Uttar Pradesh	94%	92%	39%
	Uttarakhand	105%	105%	93%
	West Bengal	115%	116%	117%
Small States	Arunachal Pradesh	100%	100%	100%
	Goa	89%	86%	82%
	Manipur	102%	103%	104%
	Meghalaya	83%	83%	82%
	Mizoram	98%	99%	86%
	Nagaland	101%	101%	101%
	Sikkim	162%	174%	171%
	Tripura	105%	105%	105%
Union Territories	Andaman & Nicobar	116%	136%	138%
	Chandigarh	77%	92%	96%
	D & N Haveli & Daman and Diu	96%	83%	80%
	Delhi	93%	112%	118%
	Jammu & Kashmir	186%	161%	148%
	Ladakh	95%	98%	97%
	Lakshadweep	96%	99%	103%
	Puducherry	92%	99%	95%
	All India	**97%**	**102%**	**91%**

Key	
	>= 100%
	<100% and >= 75%
	<75% and >= 50%
	<75% and >= 25%
	<25%

Figure 25: Disruption and restoration of supplementary nutrition among pregnant and lactating women during pandemic, MPR data, October 2019 to December 2020

Source: *Monthly Progress Report Data, Ministry of Women and Child Development*

Overall, services were disrupted during the lockdown period (April-June 2020), and were eventually restored between July and September 2020. The improvement in SNP services may be attributed to the rigorous steps taken by States and UTs for increasing the provision of take-home rations in response to the pandemic. Although coverage reduced during October-December 2020, coverage was about 90% of what was achieved during the pre-pandemic period.

5.1.3 State innovations in delivering ICDS services (core POSHAN Abhiyaan Interventions)

States adopted different strategies to continue service delivery amid COVID-19. These adaptations varied geographically and by type of service. Most states adapted to ensure that the core ICDS services continued to reach all beneficiaries. Out of 32 states/UTs for which State data were received, 28 states/UTs reported making some adaptations/ innovations to ensure service delivery. Table 6 summarises the type of innovations at the State/UT-level, by services.

Table 6: Summary of ICDS programme delivery innovations in the context of COVID-19, as reported by State Governments

State/UTs	SNP: Additional foods	Innovations for growth monitoring	Innovations for community-based events	Innovations for counselling	Innovations for pre-school education
Andaman & Nicobar Islands	Milk	At AWC & and during home visits	In staggered approach	Home visits and consultation through tele calling	Home visits
Andhra Pradesh	Special supplements for SAM children	Staggered approach in AWC	Virtual CBEs	Home visits and virtual counselling	Virtual classes
Arunachal Pradesh	Eggs	Random sampling in AWC to identify and manage cases of SAM	In staggered approach in AWC	Home visits for vulnerable groups	Parents counselled during home visits
Assam		Home visits		Video conferencing	Virtual classes
Bihar					
Chandigarh	Dry ration & cooked foods to people in need (March to June only)	Home visits	Virtual CBEs	Video messages, posters and calling	Phone-based activities

State/UTs	SNP: Additional foods	Innovations for growth monitoring	Innovations for community-based events	Innovations for counselling	Innovations for pre-school education
Chhattisgarh	Dry rations, eggs and vegetables	During home visits and VHSNDs	During home visits and in community spaces	Video clips shared over social media	Virtual classes
DNH & DD	Special local preparations		In staggered approach in AWC	During home visits	Phone-based activities. Learning material distributed
Delhi	Iron-rich THR	During home visits	Virtual CBEs	During home visits	Phone-based activities
Goa	Micronutrient supplements for children 3 to 6 years and adolescent girls			Through WhatsApp	
Gujarat			Virtual CBEs		Local TV channels
Haryana	Skimmed milk powder	SAM children weighed at home	In staggered approach in AWC	During home visits and in shelter homes for migrant population	Children of migrant labourers provided pre-school education
Himachal Pradesh		Staggered approach in AWC		Use of mobile phones	
Jammu & Kashmir					
Jharkhand					
Karnataka	Milk and eggs Spot feeding for PW/LW			During home visits	Virtual classes and radio
Kerala	Dry rations & delivery of food for quarantined homes	During VHSNDs	Virtual CBEs	WhatsApp based broadcast system-POSHAN vani	Virtual classes and through local TV channels
Ladakh					

State/UTs	SNP: Additional foods	Innovations for growth monitoring	Innovations for community-based events	Innovations for counselling	Innovations for pre-school education
Lakshadweep	Dry rations	Staggered approach in AWC		During home visits	
Madhya Pradesh	Dry rations	Staggered approach during home visits and VHSNDs		Through calling and WhatsApp	
Maharashtra		Once a week/2 week visit to SAM/ MAM children by AWW	Virtual CBEs	Through calling and WhatsApp	Virtual classes
Manipur	Template not received				
Meghalaya	Template not received				
Mizoram	Vegetables from nutri-gardens	Conducted at AWC & and during home visits		Through calling and WhatsApp	Learning material distributed; parents given virtual instructions
Nagaland	Template not received				
Odisha	Dry rations	During VHSNDs and home visits	In staggered approach in AWC	During home visits	Virtual classes
Puducherry			During home visits and in community spaces	Home visits and use of television	
Punjab				Home visits	Virtual classes
Rajasthan	Dry rations			Use of mobile phones	
Sikkim			In staggered approach in AWC	Home visits	
Tamil Nadu					Virtual classes
Telangana	Bananas and special local preparations			Home visits	Virtual classes and through local TV channels

State/UTs	SNP: Additional foods	Innovations for growth monitoring	Innovations for community-based events	Innovations for counselling	Innovations for pre-school education
Tripura	Eggs, jaggery and milk for SAM children	Growth monitoring conducted during home visits	During home visits	Home visits	Learning material provided during home visits
Uttar Pradesh		During VHSNDs		Home visits	
Uttarakhand	Eggs, milk and bananas for 3-6-year olds	Home visits	Home visits	Video conferencing	Virtual classes
West Bengal	Template not received				

Source: *Reported by States in response to questionnaires sent by NITI Aayog in September 2020*

Note: (*1) Dry ration includes rice, wheat, and pulses. (2) All the activities conducted in-person at AWC, homes or community spaces followed COVID-19 protocol.*

Foods in addition to the standard take-home rations

Several States provided specific foods in addition to the standard THR. Most states provided dry rations (e.g., rice, wheat, pulses), whereas some provided milk, eggs or other local preparations. Mizoram provided harvests from nutri-gardens. In most states, all ICDS foods were delivered to homes.

Growth monitoring

During the stringent lockdown period and after it was relaxed, some States continued to conduct growth monitoring, primarily for children affected by severe acute malnutrition (SAM) and moderate acute malnutrition (MAM). Several states conducted growth monitoring in AWCs, during VHSNDs and during home visits following the COVID-19 protocol. Maharashtra ensured visits by AWWs to SAM/MAM children once a week or once every two weeks.

Community-based events

Community-based events (CBEs) resumed gradually after the lockdown was relaxed. In several states, CBEs were transitioned to be conducted during home visits as well as in AWC, maintaining COVID-19 protocols.

Counselling

Several states used phone calls and applications to continue counselling amid the pandemic. Counselling services were also provided during home visits in several states. Two states (Assam and Uttarakhand) used video conferences as a medium to deliver counselling messages. One UT (Puducherry) used the local television channel to share counselling messages.

Pre-school education

States/UTs primarily relied upon virtual media and phone-based activities to deliver pre-school education. Three states/UTs (Dadra & Nagar Haveli & Daman & Diu, Mizoram and Tripura) ensure distribution of learning materials during home visits. Three states (Gujarat, Kerala and Telangana) used local television channels to telecast the curriculum.

BOX 4: STUDY TO ASSESS THE THR PRODUCTION AND DISTRIBUTION ACROSS 12 DISTRICTS IN JHARKHAND AND RAJASTHAN

Due to the disruption in the food systems amid the COVID-19 pandemic, NITI Aayog, IDInsight and CIFF conducted a study to assess the THR production and distribution across 12 districts in Jharkhand and Rajasthan. The first round of surveys was conducted in January 2020 and the second round of surveys was conducted in July-August 2020. Under the study, a qualitative survey was conducted over phone with 114 respondents, which included 15 pregnant women, 13 mothers of children aged 0-6 months, 26 mothers of children aged 6-36 months, 54 Anganwadi Workers, and 6 SHG Members. Pregnant women and mothers were surveyed to understand the demand-side challenges, whereas AWWs and SHGs were surveyed for identifying the supply-side challenges.

According to the study, there has been a 12 percentage point drop in THR access in Jharkhand and a 5 percentage point drop in THR access in Rajasthan from January 2020 to May 2020. In Jharkhand, the demand-side actors indicated that there has been an irregular supply of the THR, while many of the beneficiaries were unable to receive the THR since April 2020. Most of the AWW also indicated that they were unable to distribute the THR since April or earlier, and only few AWW distributed THR in July or August. In addition to COVID-19, the reasons for irregular supply of the THR was because SHGs are not reimbursed timely for the previous deliveries, the price of the raw materials have increased even as reimbursement rates remain fixed, and there have been delays in receiving beneficiary lists from AWWs especially since the lockdown. In Rajasthan, half of the interviewed beneficiaries did not receive THR during lockdown. AWWs also indicated that they missed at least 1 month of THR distribution since the lockdown. Rajasthan also faced challenges like insufficient supply of THR at PDS, delays in reimbursement to AWW for transportation of THR, and difficulty in transporting big packets of THR from suppliers to Anganwadi Centres which further aggravated due to COVID-19.

Addressing delays in funding and payments, providing procurement support, and enhancing trust and communication between demand-side and supply-side actors could help improve the access and distribution of the THR.

Source: IDInsight and NITI Aayog

BOX 5: FRONTLINE HEALTH WORKERS ENABLE RESTORATION OF HEALTH AND NUTRITION SERVICE DELIVERY AFTER EARLY COVID-19 LOCKDOWN: FINDINGS FROM A SEVEN-STATE OBSERVATIONAL STUDY

As the COVID-19 pandemic unfolded, countries took various actions including stringent lockdowns, imposing travel restrictions, and mandating face masks to stem the spread of the pandemic. Early during the pandemic, modelling studies based on Lives Saved Tool (LiST) (Roberton et.al, 2020), suggested that closures to health and nutrition services would have substantial impacts on maternal, child health and nutrition outcomes.

In India, there was an early recognition of the importance of preserving essential services. The first set of policy directives to restart essential nutrition and health services were released in March and early April 2020. The early and adaptive policy guidance signalled a strong intent to resume services rapidly, but little is known about how this has played out on the ground. India drew on its strong cadre of nearly 2.42 million health and nutrition frontline workers (FLWs) across the two national flagship programmes–the Integrated Child Development Services (ICDS) and the National Health Mission (NHM) –to deliver the services.

To understand how FLWs are responding to the government guidance and delivering these interventions during the pandemic, phone surveys with 5,500 FLWs were conducted in seven states (Bihar, Chhattisgarh, Madhya Pradesh, Odisha, Tamil Nadu, Telangana and Uttar Pradesh) between August-October 2020, asking about service delivery during April 2020 (T1) and in the August-October 2020 period (T2). Changes were analysed between T1 and T2 periods.

The Anganwadi Centres (AWC) were not opened daily across the states in April (T1). While nearly all FLWs in Telangana and 84% in Chhattisgarh reported opening their AWCs daily, 49% in Bihar, 44% in Odisha, 18% in Uttar Pradesh and only 7% in Tamil Nadu reported doing so. In the post-lockdown period (T2), a much larger proportion of FLWs reported opening the centres. Fewer AWWs in Tamil Nadu (21%) and Odisha (54.2%) reported opening the centres compared with other states.

In April, a majority of FLWs (65% to 100%) in all states distributed food supplements. Nearly all FLWs in all states resumed the service in T2, except in Bihar where only half of FLWs provided this service compared with T1 (Figure 2). Holding of VHSND varied widely across the states in April, with the lowest by FLW Bihar (1.5%) and Uttar Pradesh (9%), and the highest in Odisha (91%). In T2, conducting of VHSND increased in all the states; 84 percentage point increase noted in Bihar, 78 percentage points in Uttar Pradesh and 58 percentage points in Tamil Nadu.

A majority of FLWs in five states conducted home visits (74% to 99%) during the lockdown except for Bihar (51%) and Uttar Pradesh (32%). In T2, home visits increased by 41 percentage points in Bihar and 59 percentage points in Uttar Pradesh. Except in Uttar Pradesh (14%), >50% FLWs reported providing counselling on health and nutrition in April and nearly all FLWs in all states reported reinstatement of the service in T2. Between 40–85% FLWs in reported providing IFA supplements to pregnant women in April, except in Bihar (11%). In T2, IFA provision increased by 11 to 44 pp among states. In April, only 12–22% FLWs reported conducting growth monitoring in five states, but service provision increased by 26–75 pp in T2. In contrast, a majority of FLWs in Chhattisgarh and Odisha conducted growth monitoring in T1 and T2. Except in Bihar (2%), >50% FLWs supported immunisation services for children during the lockdown; service provision increased by 9–83 pp in T2. Majority of FLWs in Chhattisgarh (86%) and Odisha (91%) supported immunisation services in April. In addition to delivering maternal and child nutrition services, FLWs performed several COVID-19 specific duties. The challenges faced by FLWs in delivering services varied by the state. Most FLWs reported personal fears, walking long distances, and beneficiaries' non-cooperation as challenges.

Source: *Avula, R., P.H. Nguyen, S. Ashok, S. Bajaj, S. Kachwaha, A. Pant, M. Walia, A. Singh, A. Paul, A. Singh, B. Kulkarni, D. Singhania, J.E. Alegria, L.F. Augustine, M. Khanna, M. Krishna, N. Sundaravathanam, P.K. Nayak, P.K. Sharma, P. Makkar, P. Ghosh, S. Mala, S. Jain, S.K. Banjara, S. Nair, S. Ghosh, S. Das, S. Patil, T. Mahapatra, T. Forissier, T.N. Lewis, P. Nanda, S. Krishnan, andP. Menon. 2021. "India's 2.42 million frontline health workers enable restoration of health and nutrition service delivery after early COVID-19 lockdowns: An observational study." Unpublished, International Food Policy Research Institute.*

5.2 MATERNAL AND CHILD HEALTH SERVICES

There were disruptions to maternal and child health services delivered by the Departments of Health during the pandemic. With the spread of COVID-19 virus, health care facilities and frontline workers have primarily been involved in providing care to the COVID-19 affected patients. However, to ensure the continuation of critical services at States/UTs irrespective of COVID Status, the MoHFW has issued two guidance documents to the States/UTs viz. enabling delivery of essential health services, including services to pregnant women. While the first document provided provision of RMNCH+A (Reproductive, Maternal, Newborn, Child and Adolescent) services with special focus, the second document mentioned that under no circumstances should there be a denial of essential services.

We examined disruptions and policy adaptations pertaining to interventions during pregnancy period, postnatal period, and early childhood periods were assessed to evaluate the toll of the pandemic on maternal and child health services.

5.2.1 Disruptions to service delivery and policy adaptations

Following the national guidance on essential maternal and child services, in April, several states issued guidelines to provide antenatal care (ANC) services for on-demand and walk-in beneficiaries at health facilities or to provide services only in some areas or using mobile units for caring for pregnant women in migrant camps. Overall, only a few States issued guidance on deworming during pregnancy. Only Bihar and Maharashtra had early guidance on deworming by May 2020. Guidance on institutional deliveries was available by May 2020 in 6 of 13 States. Following the national guidelines, a few States issued guidelines to ensure safe institutional deliveries at all health facilities and maintain due list of expected delivery dates for all pregnant women. Guidelines to provide IFA supplements to pregnant and lactating women were issued in May 2020. States provided IFA supplements either through home visits or through on-demand at health facilities. A few states ensured delivery of IFA supplements to migrant workers visiting the state due to the lockdown. By May 2020, guidance on provision of neonatal tetanus protection was available in 11 of the 13 States. States issued guidelines to provide on-demand immunisation services at health centres at the community-level and through the outreach sessions.

For interventions during the early childhood period, guidelines were available in May 2020. Services like IFA supplementation and health check-up for SAM children were fully functional across most states. Growth monitoring and immunisation services showed a mixed picture with Gujarat completely suspending growth monitoring. Immunization was either fully functional or partly available in 12 out of 13 states. Vitamin A supplementation and provision of ORS/Zinc were fully implemented in few states and information is not available for the remaining states.

State	Interventions during pregnancy & postnatal period														
	Antenatal care			Deworming during pregnancy			Institutional deliveries			IFA supplementation			Neonatal tetanus protection		
	May	Aug	Sep/Oct	May	Aug	Sep/Oct	May	Aug	Sep/Oct	May	Aug	Sep/Oct	May	Aug	Sep/Oct
Andhra Pradesh															
Assam															
Bihar															
Chhattisgarh															
Gujarat															
Jharkhand															
Karnataka															
Madhya Pradesh															
Maharashtra															
Odisha															
Rajasthan															
Uttar Pradesh															
West Bengal															

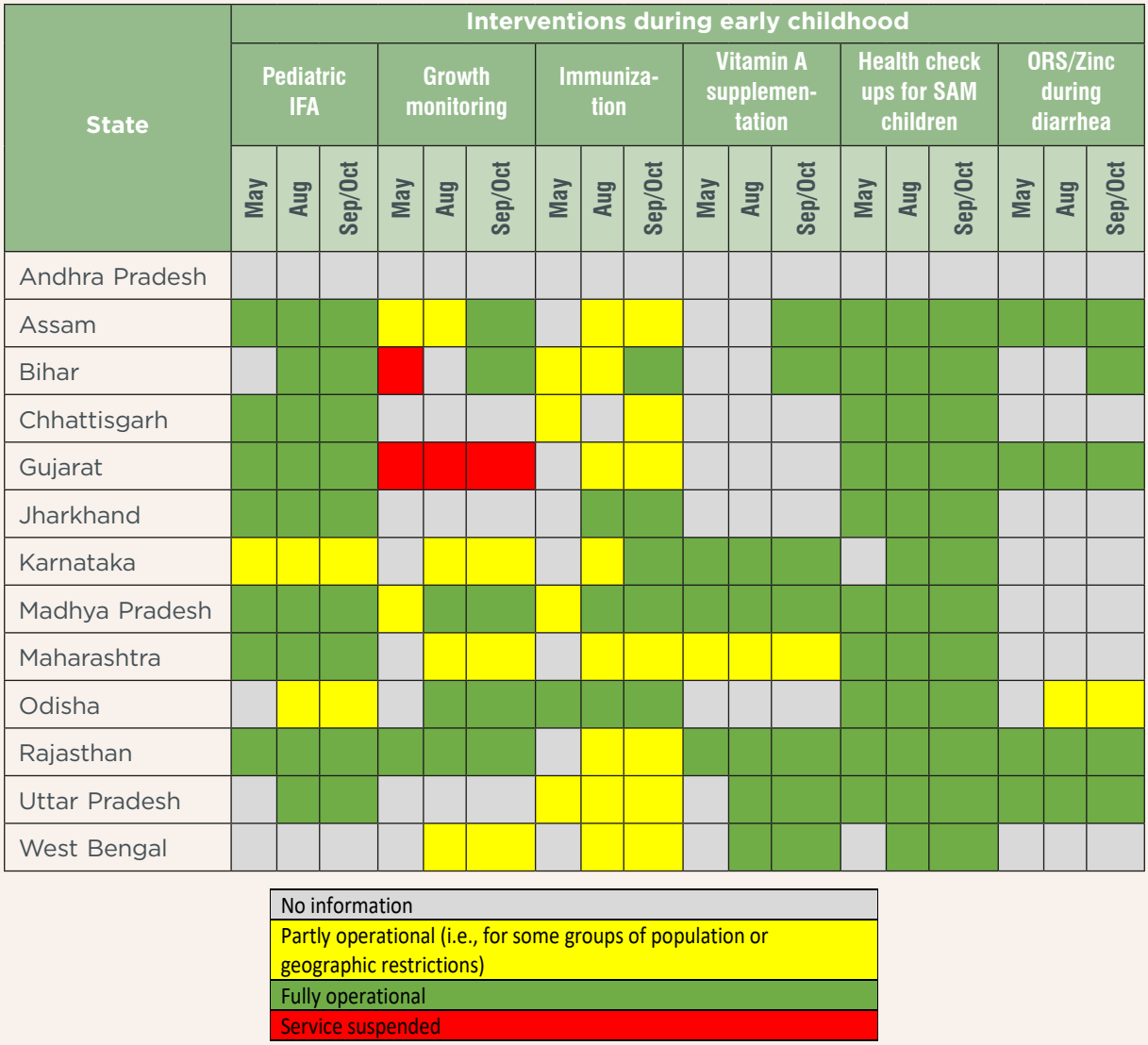

Figure 26: Policy guidance for interventions during pregnancy, postnatal and early childhood period

5.2.2 Insights on disruption and restoration of interventions delivered by the health system during COVID-19 Pandemic

Seven key interventions across the continuum of care were selected for an analysis of disruptions and restorations. These include:

1. Number of pregnant women who were given 180 IFA tablets;
2. Number of pregnant women who received 4 or more ANC check-ups;
3. Number of institutional deliveries conducted (including C-Sections);
4. Women receiving 1st post-partum check-up between 48 hours and 14 days;
5. Number of newborns who received 6 HBNC visits after institutional delivery;
6. Number of children 9-11 months of age who received full immunisation;
7. Number of severely underweight children provided health check-up (0-5 years).

Section 2.5.2 details the methodology used for assessing disruption and restoration for five quarters—that is, from October-December 2019 to October-December 2020 at the national- and state-levels. The periods were divided into pre-pandemic period (October-December 2019), disruption period (April-June 2020), early restoration period (July-September 2020) and restoration period (October-December 2020).

Key findings on changes in the coverage of pregnant women who received 180+ IFA tablets and pregnant women who received four or more ANC check-ups

The number of pregnant women who received 180+ IFA tablets and the number of pregnant women who received four or more ANC visits declined post-March 2020 to lower than the pre-pandemic period by 13% and 24%, respectively (Figure 27). However, the coverage of these services improved significantly post-June 2020, such that the coverage of IFA and ANC visits was only slightly lower than pre-pandemic levels. Over the entire period, the number of pregnant women who received IFA tablets exceeded the number of pregnant women who received four or more ANC visits.

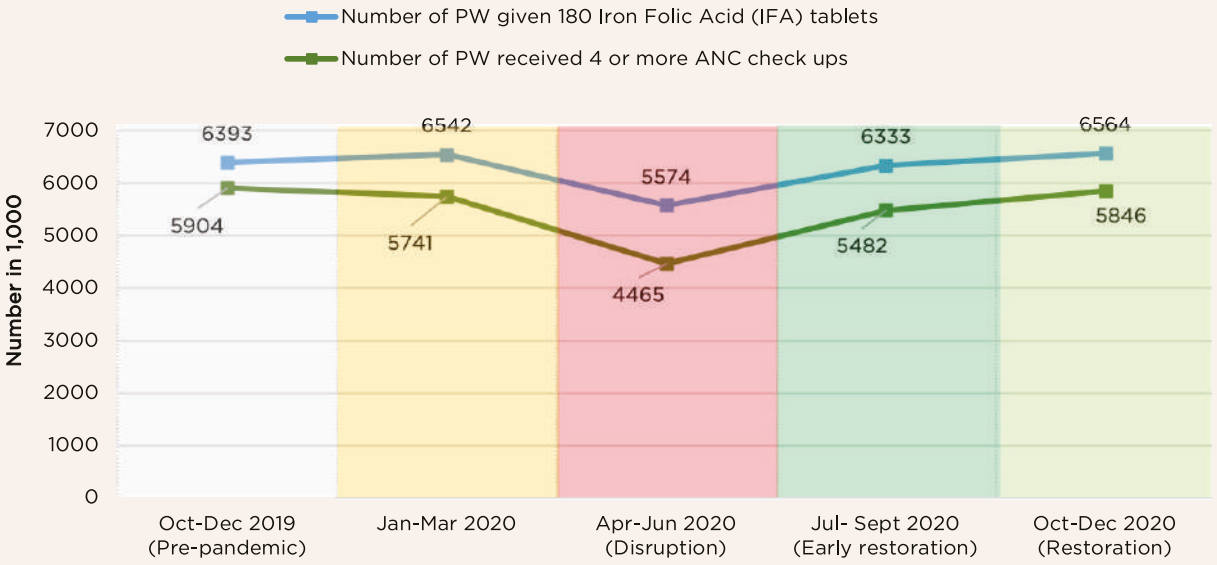

Figure 27: Changes in number of pregnant women received full course of 180 IFA tablets, 4 or more ANC check-ups from October 2019 to December 2020

Source: *HMIS publicly available data, Ministry of Health and Family Welfare*

At the state-level, the *number of pregnant women who received 180+ IFA tablets* reduced in 19 States and UTs, where decline in Uttar Pradesh, Manipur, Delhi, and Chandigarh was highest (Figure 28). During the early restoration period (June-September 2020), IFA coverage improved in 13 States/UTs, which previously experienced disruptions in this area. Similarly, the situation further improved in October-December 2020 in many States, and 22 States and UTs had coverage more than pre-pandemic levels. Coverage, however, remained low in Manipur and Chandigarh. Data were not available for Ladakh for all periods; thus, it was excluded.

	State/UTs	Disruption (Q2 of 2020 to Q4 of 2019)	Early restoration (Q3 of 2020 to Q4 of 2019)	Restoration (Q4 of 2020 to Q4 of 2019)
Large State	Andhra Pradesh	114%	107%	129%
	Assam	119%	107%	95%
	Bihar	75%	100%	93%
	Chhattisgarh	102%	101%	98%
	Gujarat	106%	100%	100%
	Haryana	99%	102%	101%
	Himachal Pradesh	102%	107%	102%
	Jharkhand	97%	106%	115%
	Karnataka	94%	93%	105%
	Kerala	81%	76%	78%
	Madhya Pradesh	102%	108%	104%
	Maharashtra	98%	93%	98%
	Odisha	98%	97%	106%
	Punjab	98%	101%	104%
	Rajasthan	133%	145%	130%
	Tamil Nadu	112%	103%	147%
	Telangana	99%	82%	91%
	Uttar Pradesh	55%	90%	92%
	Uttarakhand	119%	123%	123%
	West Bengal	91%	102%	97%
Small State	Arunachal Pradesh	112%	125%	92%
	Goa	78%	82%	80%
	Manipur	61%	65%	60%
	Meghalaya	106%	136%	115%
	Mizoram	117%	122%	130%
	Nagaland	127%	148%	135%
	Sikkim	128%	123%	116%
	Tripura	78%	80%	107%
Union Teritorries	Andaman & Nicobar Islands	150%	118%	221%
	Chandigarh	61%	78%	65%
	Dadar Nagar Haveli & Daman and Diu	79%	67%	86%
	Delhi	53%	78%	144%
	Jammu & Kashmir	147%	156%	158%
	Lakshadweep	91%	97%	102%
	Puducherry	99%	119%	108%
	All India	**87%**	**99%**	**103%**

Key
>= 100%
<100% and >= 75%
<75% and >= 50%
<75% and >= 25%
<25%

Figure 28: Disruption and restoration of number of pregnant women who received 180+ IFA tablets, HMIS Data, October 2019-December 2020

Source: *HMIS publicly available data, Ministry of Health and Family Welfare*

Compared with the pre-pandemic period, the number of pregnant women who received four or more ANC check-ups reduced in most States and UTs (30 out of 35 States/ UTs) (Figure 29). The largest decline was in Manipur, Nagaland, Delhi and Uttar Pradesh. Positively, in June-September 2020, 26 States and UTs that had reported a decline in the number of pregnant women attending ANC visits the previous quarter had improved. Among these, Gujarat, Himachal Pradesh, Madhya Pradesh and Rajasthan recovered to the pre-pandemic period. The situation further improved in October-December 2020 in many States, and 13 States and UTs were covering more than pre-pandemic levels. However, coverage remained low in Goa, Manipur, Nagaland, Chandigarh, Delhi and Jammu and Kashmir. Ladakh was excluded because data were not available for all periods.

	State/UTs	Disruption (Q2 of 2020 to Q4 of 2019)	Early restoration (Q3 of 2020 to Q4 of 2019)	Restoration (Q4 of 2020 to Q4 of 2019)
Large State	Andhra Pradesh	112%	111%	135%
	Assam	62%	80%	90%
	Bihar	62%	91%	93%
	Chhattisgarh	92%	98%	97%
	Gujarat	97%	101%	104%
	Haryana	75%	93%	94%
	Himachal Pradesh	85%	104%	102%
	Jharkhand	67%	97%	108%
	Karnataka	85%	86%	93%
	Kerala	93%	89%	97%
	Madhya Pradesh	88%	108%	107%
	Maharashtra	96%	96%	97%
	Odisha	95%	98%	107%
	Punjab	82%	99%	95%
	Rajasthan	83%	107%	107%
	Tamil Nadu	109%	100%	112%
	Telangana	80%	82%	90%
	Uttar Pradesh	54%	86%	97%
	Uttarakhand	87%	96%	102%
	West Bengal	65%	92%	98%
Small State	Arunachal Pradesh	71%	88%	95%
	Goa	75%	75%	72%
	Manipur	51%	45%	49%
	Meghalaya	70%	99%	98%
	Mizoram	80%	96%	107%
	Nagaland	52%	60%	67%
	Sikkim	92%	93%	94%
	Tripura	78%	83%	92%
Union Teritorries	Andaman & Nicobar Islands	103%	115%	122%
	Chandigarh	62%	73%	65%
	Dadar Nagar Haveli & Daman and Diu	73%	75%	82%
	Delhi	52%	75%	71%
	Jammu & Kashmir	57%	57%	62%
	Lakshadweep	103%	94%	111%
	Puducherry	113%	141%	167%
	All India	**76%**	**93%**	**99%**

Key	
	>= 100%
	<100% and >= 75%
	<75% and >= 50%
	<75% and >= 25%
	<25%

Figure 29: Disruption and restoration of number of pregnant women who received four or more ANC visits, HMIS Data, October 2019-December 2020

Source: *HMIS publicly available data, Ministry of Health and Family Welfare*

Key findings on changes in coverage of number of institutional deliveries conducted, and number of women receiving 1st post-partum check-up between 48 hours and 14 days

The number of women who delivered in institutional facilities and received post-partum check-ups declined post-December 2019 (Figure 30). This decline continued until April 2020-June 2020, after which coverage of both services increased, yet remained slightly below the pre-pandemic level. By October-December 2020, nearly 5,348,000 beneficiaries delivered in institutional facilities compared to the pre-pandemic levels of 5,498,000. Approximately 3,052,000 beneficiaries received postpartum check-ups between 48 hours – 14 days of birth, compared with the pre-pandemic levels of 3,131,000.

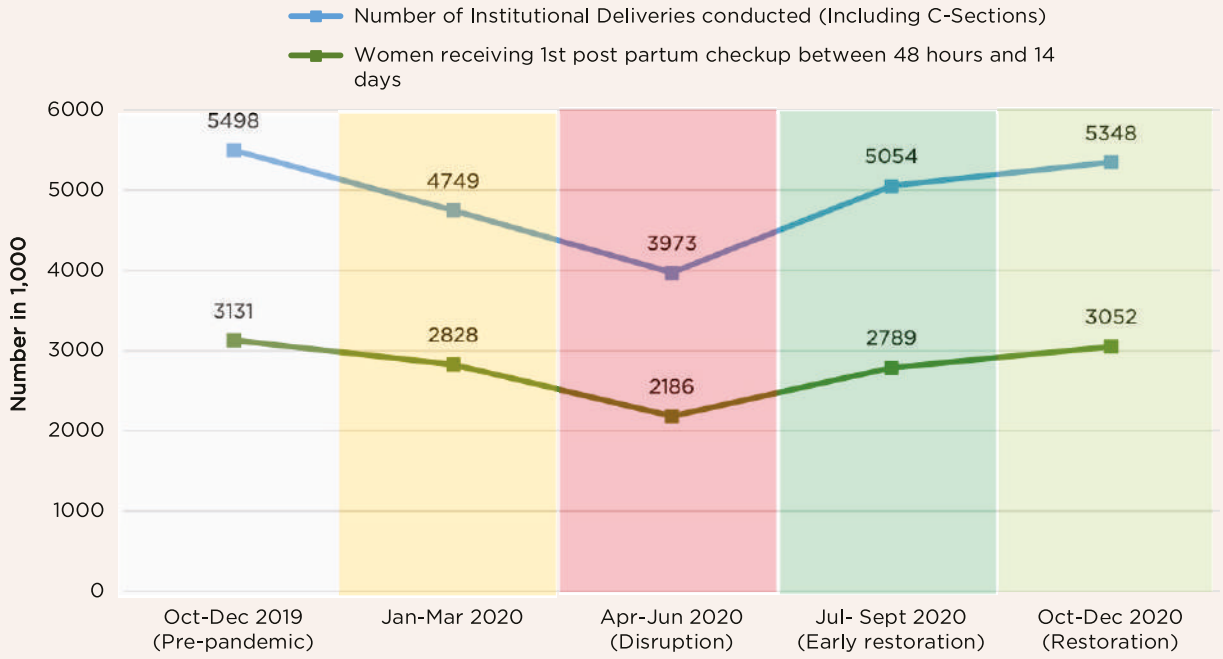

Figure 30: Changes in the number of institutional deliveries conducted and the number of women receiving the first post-partum check-up between 48 hours and 14 days from October 2019 to December 2020

Source: *HMIS publicly available data, Ministry of Health and Family Welfare*

The number of institutional deliveries conducted (including C-section) reduced in most States and UTs (32 out of 35 States/UTs) compared with the pre-pandemic period (Figure 31). The largest decline was in Bihar and Chandigarh. In June-September 2020, there was an improvement 29 States and UTs, which experienced a reduction in previous quarter. Among these, Himachal Pradesh, Madhya Pradesh, Rajasthan, Uttarakhand, Sikkim, and Jammu and Kashmir were able to restore to the pre-pandemic level. Similarly, the situation further improved in October-December 2020 in many States, and 10 States and UTs were covering more than pre-pandemic levels. The coverage remained low in Manipur, Chandigarh, Delhi, and Puducherry, whereas other States and UTs were covering more than 75% of the pre-pandemic level. Data were unavailable for Ladakh for all periods; thus, Ladakh was excluded from this analysis.

	State/UTs	Disruption (Q2 of 2020 to Q4 of 2019)	Early restoration (Q3 of 2020 to Q4 of 2019)	Restoration (Q4 of 2020 to Q4 of 2019)
Large State	Andhra Pradesh	90%	94%	100%
	Assam	60%	81%	97%
	Bihar	49%	84%	92%
	Chhattisgarh	86%	99%	103%
	Gujarat	72%	92%	99%
	Haryana	69%	95%	96%
	Himachal Pradesh	81%	103%	102%
	Jharkhand	79%	99%	105%
	Karnataka	90%	94%	100%
	Kerala	100%	94%	95%
	Madhya Pradesh	79%	105%	105%
	Maharashtra	89%	95%	102%
	Odisha	86%	87%	99%
	Punjab	63%	94%	95%
	Rajasthan	76%	107%	106%
	Tamil Nadu	92%	92%	99%
	Telangana	86%	89%	87%
	Uttar Pradesh	53%	89%	96%
	Uttarakhand	76%	105%	101%
	West Bengal	76%	85%	91%
Small State	Arunachal Pradesh	71%	95%	98%
	Goa	84%	80%	85%
	Manipur	68%	65%	68%
	Meghalaya	74%	91%	94%
	Mizoram	72%	81%	96%
	Nagaland	54%	62%	77%
	Sikkim	96%	113%	120%
	Tripura	78%	84%	92%
Union Teritorries	Andaman & Nicobar Islands	106%	117%	123%
	Chandigarh	50%	58%	57%
	Dadar Nagar Haveli & Daman and Diu	58%	68%	79%
	Delhi	54%	68%	70%
	Jammu & Kashmir	99%	104%	93%
	Lakshadweep	120%	125%	121%
	Puducherry	56%	56%	62%
	All India	**72%**	**92%**	**97%**

Key	
	>= 100%
	<100% and >= 75%
	<75% and >= 50%
	<75% and >= 25%
	<25%

Figure 31: Disruption and restoration of number of institutional deliveries conducted (including C-section), HMIS Data October 2019- December 2020

Source: *HMIS publicly available data, Ministry of Health and Family Welfare*

At the State-level, the number of women who received postpartum check-ups reduced in 30 out of 34 States and UTs compared with the pre-pandemic period (Figure 32). The maximum decline was in Bihar, Uttar Pradesh, Chandigarh, Delhi, and Lakshadweep. During the early restoration period (June-September 2020), there was an improvement in 27 States and UTs where services were disrupted in previous period. States and UTs like Himachal Pradesh, Jharkhand, Rajasthan, Uttarakhand, Meghalaya, Jammu and Kashmir, and Lakshadweep were able to restore to the pre-pandemic level. During the fourth quarter of 2020 (October-December 2020), coverage increased in 26 States and UTs compared with the early restoration period, and coverage was higher than pre-pandemic levels in 17 States and UTs. Coverage remained low in Kerala, Manipur, Andaman and Nicobar Islands, and Delhi. Data were unavailable for Ladakh for all periods and Tamil Nadu was an outlier; hence, they were excluded.

Key findings on changes in coverage of number of fully immunized children 9-11 months of age, number of newborns who received 6 HBNC visits, and number of severely underweight children aged (0-5 years) provided health check-up

Health services to children including full-immunisation to children between 9-11 months and six home-based newborn care (HBNC) visits after institutional delivery declined post-December 2019, whereas providing health check-ups to severely underweight children reduced only after March 2020 (Figure 33). In April-June 2020, full immunisation of children reduced by 24%; HBNC visits reduced by 29%; and health check-ups of severely underweight children reduced by 33% compared with the October-December 2019 pre-pandemic period. Post-June 2020, the delivery of all three services to children improved and exceeded the pre-pandemic levels for HBNC visits and health check-ups for severely underweight children by December 2020. The provision of full immunisation dropped post-September 2020, which resulted in slightly lower level by December 2020 compared with pre-pandemic levels (6,247,000 vs 63,03,000). The reduction in rate of immunization may have resulted due to hesitancy among caregivers to take care of children to healthcare facilities due to fear of exposure to COVID-19 and further engagement and over burdening of health care workers in COVID response had affected the coverage.

	State/UTs	Disruption (Q2 of 2020 to Q4 of 2019)	Early restoration (Q3 of 2020 to Q4 of 2019)	Restoration (Q4 of 2020 to Q4 of 2019)
Large State	Andhra Pradesh	100%	107%	123%
	Assam	57%	77%	91%
	Bihar	43%	78%	91%
	Chhattisgarh	86%	99%	101%
	Gujarat	69%	89%	96%
	Haryana	69%	96%	98%
	Himachal Pradesh	82%	102%	103%
	Jharkhand	78%	100%	108%
	Karnataka	90%	96%	104%
	Kerala	77%	73%	69%
	Madhya Pradesh	106%	140%	143%
	Maharashtra	87%	95%	96%
	Odisha	91%	92%	102%
	Punjab	66%	95%	98%
	Rajasthan	74%	117%	114%
	Telangana	118%	122%	135%
	Uttar Pradesh	46%	79%	91%
	Uttarakhand	92%	143%	142%
	West Bengal	65%	84%	93%
Small State	Arunachal Pradesh	121%	190%	177%
	Goa	86%	76%	80%
	Manipur	58%	58%	51%
	Meghalaya	95%	112%	114%
	Mizoram	55%	75%	96%
	Nagaland	79%	89%	113%
	Sikkim	78%	105%	108%
	Tripura	86%	95%	114%
	Andaman & Nicobar Islands	52%	74%	62%
Union Teritorries	Chandigarh	39%	85%	86%
	Dadar Nagar Haveli & Daman and Diu	61%	83%	175%
	Delhi	40%	46%	54%
	Jammu & Kashmir	98%	103%	93%
	Lakshadweep	5%	119%	120%
	Puducherry	83%	88%	82%
	All India	70%	89%	97%

Key	
	>= 100%
	<100% and >= 75%
	<75% and >= 50%
	<75% and >= 25%
	<25%

Figure 32: Disruption and restoration of number of women who received postpartum check-ups between 48 hours and 14 days, HMIS Data, October 2019-December 2020

Source: *HMIS publicly available data, Ministry of Health and Family Welfare*

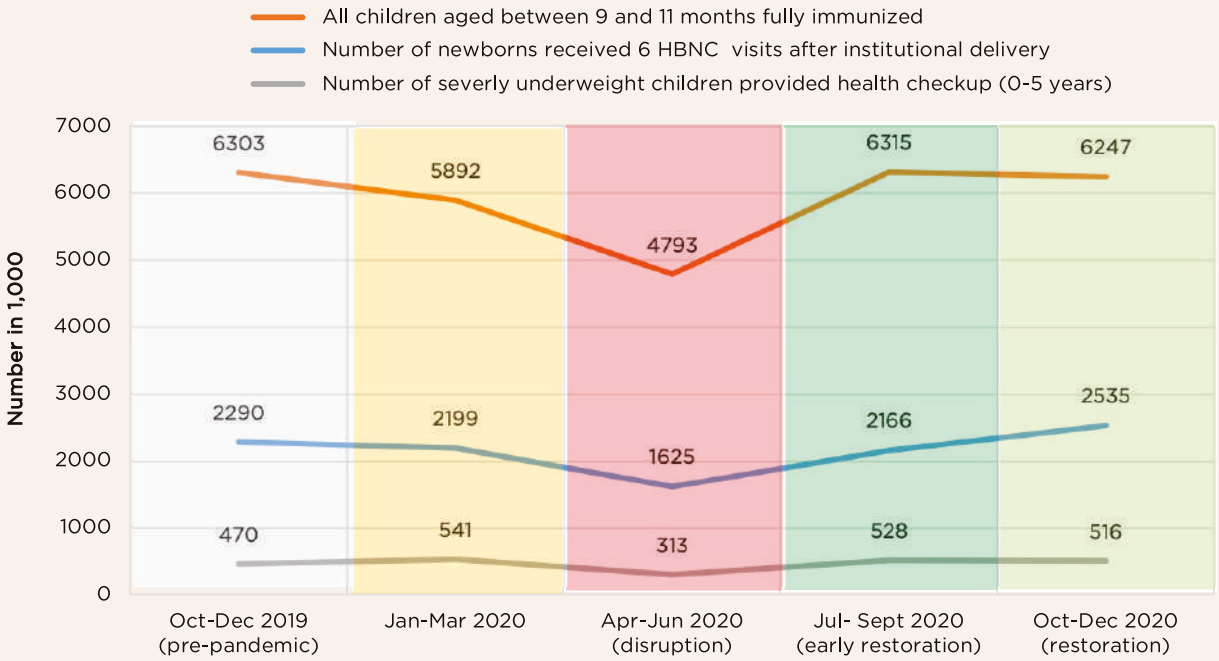

Figure 33: Changes in number of children who received fully immunized (9-11 months), 6 HBNC visits (newborns), and health check-up (severely underweighted children 0-5 years) from October 2019 to December 2020.

Source: *HMIS publicly available data, Ministry of Health and Family Welfare*

The number of children (9-11 months) who are fully immunized reduced in 28 out of 35 States and UTs, compared to the pre-pandemic period (Figure 34). Bihar, Jharkhand, Uttar Pradesh, Sikkim and Delhi reported the largest decline. In June-September 2020, there was an increase in fully immunized children in 27 States and UTs, where there was a decline in previous period. However, the coverage declined slightly by the fourth quarter (October -December 2020) in 23 States and UTs due to which the total number of children fully vaccinated reduced by 1% at the national-level during the fourth quarter of 2020. Data were not available for Ladakh for all periods; therefore, data on Ladakh have been excluded.

	State/UTs	Disruption (Q2 of 2020 to Q4 of 2019)	Early restoration (Q3 of 2020 to Q4 of 2019)	Restoration (Q4 of 2020 to Q4 of 2019)
Large State	Andhra Pradesh	109%	114%	104%
	Assam	76%	94%	100%
	Bihar	64%	100%	100%
	Chhattisgarh	87%	100%	99%
	Gujarat	92%	110%	103%
	Haryana	89%	103%	99%
	Himachal Pradesh	106%	110%	101%
	Jharkhand	70%	103%	104%
	Karnataka	90%	105%	107%
	Kerala	102%	93%	98%
	Madhya Pradesh	91%	110%	101%
	Maharashtra	84%	99%	102%
	Odisha	99%	108%	116%
	Punjab	104%	110%	102%
	Rajasthan	83%	100%	87%
	Tamil Nadu	98%	101%	93%
	Telangana	98%	138%	96%
	Uttar Pradesh	48%	86%	97%
	Uttarakhand	95%	103%	109%
	West Bengal	78%	113%	98%
Small State	Arunachal Pradesh	94%	102%	96%
	Goa	95%	100%	92%
	Manipur	76%	82%	92%
	Meghalaya	98%	115%	101%
	Mizoram	94%	104%	100%
	Nagaland	76%	108%	103%
	Sikkim	68%	57%	67%
	Tripura	77%	93%	100%
Union Teritorries	Andaman & Nicobar Islands	108%	106%	101%
	Chandigarh	83%	102%	87%
	Dadar Nagar Haveli & Daman and Diu	82%	103%	94%
	Delhi	54%	97%	83%
	Jammu & Kashmir	86%	95%	99%
	Lakshadweep	113%	129%	104%
	Puducherry	121%	118%	94%
	All India	**76%**	**100%**	**99%**

Key	
	>= 100%
	<100% and >= 75%
	<75% and >= 50%
	<75% and >= 25%
	<25%

Figure 34: Disruption and restoration of number of children (9-11 months) fully immunised, HMIS Data, October 2019-December 2020

Source: *HMIS publicly available data, Ministry of Health and Family Welfare*

At the State-level, the number of newborns who received HBNC visits reduced in most States and UTs (27 out of 34 States/UTs) compared with the pre-pandemic period of October-December 2019 (Figure 35). Bihar, Uttar Pradesh and Delhi reported the largest decline in this indicator. During the early restoration period (June-September 2020), 24 States and UTs where HBNC visits were disrupted had since improved the coverage. Encouragingly, Jharkhand, Kerala, Madhya Pradesh, Maharashtra, Rajasthan, Arunachal Pradesh, Meghalaya and Chandigarh restored coverage to pre-pandemic levels by June-September 2020. Similarly, HBNC visits further increased in 28 States and UTs due to which the coverage surpassed the pre-pandemic levels at the national level in fourth quarter of 2020. While the coverage remained low in Goa, and Delhi. Data were not available for Dadar and Nagar Haveli and Daman and Diu for all periods and Tamil Nadu was an outlier, hence these large states were excluded.

The *number of severely underweight children who received health check-up* were disrupted in 25 out of 34 States and UTs, compared to pre-pandemic period. However, the provision of the service improved substantially in June-September 2020 in 22 States and UTs, where there were disruptions earlier. Consequently, the services were able to restore to the pre-pandemic period in the third quarter of 2020. There was a slight decrease in health check-ups in October-December 2020, yet the coverage remained above pre-pandemic levels. States and UTs like Himachal Pradesh, Mizoram, Delhi, Sikkim, Tripura, and Uttarakhand had the least coverage in quarter four of 2020 (October- December 2020), compared to the pre-pandemic period. Data were not available for Ladakh for all periods and Tamil Nadu was an outlier; hence; these States have been excluded from this analysis.

	State/UTs	Disruption (Q2 of 2020 to Q4 of 2019)	Early restoration (Q3 of 2020 to Q4 of 2019)	Restoration (Q4 of 2020 to Q4 of 2019)
Large State	Andhra Pradesh	110%	113%	139%
	Assam	69%	73%	98%
	Bihar	49%	84%	95%
	Chhattisgarh	84%	98%	103%
	Gujarat	75%	95%	104%
	Haryana	77%	87%	122%
	Himachal Pradesh	83%	94%	108%
	Jharkhand	81%	109%	116%
	Karnataka	124%	120%	135%
	Kerala	89%	116%	88%
	Madhya Pradesh	92%	132%	148%
	Maharashtra	85%	100%	113%
	Odisha	92%	98%	105%
	Punjab	70%	85%	98%
	Rajasthan	81%	110%	111%
	Telangana	90%	96%	117%
	Uttar Pradesh	49%	91%	113%
	Uttarakhand	78%	96%	127%
	West Bengal	61%	85%	101%
Small State	Arunachal Pradesh	92%	121%	139%
	Goa	174%	16%	11%
	Manipur	64%	69%	83%
	Meghalaya	96%	123%	133%
	Mizoram	121%	124%	146%
	Nagaland	71%	90%	102%
	Sikkim	97%	92%	110%
	Tripura	80%	90%	111%
Union Teritorries	Andaman & Nicobar Islands	138%	219%	225%
	Chandigarh	87%	114%	101%
	Dadar Nagar Haveli & Daman and Diu	92%	90%	106%
	Delhi	24%	29%	55%
	Jammu & Kashmir	91%	98%	94%
	Lakshadweep	106%	133%	106%
	Puducherry	105%	109%	126%
	All India	**71%**	**95%**	**111%**

Key	
	>= 100%
	<100% and >= 75%
	<75% and >= 50%
	<75% and >= 25%
	<25%

Figure 35: Disruption and restoration of number of newborns who received 6 HBNC visits after institutional delivery, HMIS Data October 2019-December 2020

Source: *HMIS publicly available data, Ministry of Health and Family Welfare*

	State/UTs	Disruption (Q2 of 2020 to Q4 of 2019)	Early restoration (Q3 of 2020 to Q4 of 2019)	Restoration (Q4 of 2020 to Q4 of 2019)
Large State	Andhra Pradesh	134%	284%	202%
	Assam	45%	97%	69%
	Bihar	129%	223%	177%
	Chhattisgarh	62%	188%	106%
	Gujarat	48%	104%	57%
	Haryana	149%	139%	211%
	Himachal Pradesh	14%	18%	8%
	Jharkhand	33%	99%	139%
	Karnataka	55%	164%	84%
	Kerala	120%	148%	127%
	Madhya Pradesh	107%	183%	211%
	Maharashtra	63%	81%	85%
	Odisha	72%	82%	77%
	Punjab	85%	130%	98%
	Rajasthan	45%	85%	112%
	Telangana	194%	182%	456%
	Uttar Pradesh	27%	69%	81%
	Uttarakhand	21%	46%	49%
	West Bengal	30%	38%	62%
Small State	Arunachal Pradesh	2%	2%	189%
	Goa	2%	15%	85%
	Manipur	200%	80%	620%
	Meghalaya	54%	104%	76%
	Mizoram	71%	3%	23%
	Nagaland	10%	35%	126%
	Sikkim	471%	17%	48%
	Tripura	30%	52%	40%
	Andaman & Nicobar Islands	22%	50%	58%
Union Teritorries	Chandigarh	59%	37%	51%
	Dadar Nagar Haveli & Daman and Diu	64%	89%	296%
	Delhi	33%	39%	23%
	Jammu & Kashmir	57%	76%	99%
	Lakshadweep	250%	250%	150%
	Puducherry	44%	405%	74%
	All India	**67%**	**112%**	**110%**

Key
>= 100%
<100% and >= 75%
<75% and >= 50%
<75% and >= 25%
<25%

Figure 36: Disruption and restoration of number of severely underweighted children (0-5 years) who received health check-ups, HMIS Data, October 2019- December 2020

Source: *HMIS publicly available data, Ministry of Health and Family Welfare*

Overall, services like pregnant women who received 180+ IFA and children (9-11 months) fully immunized experienced least disruption compared to other services. While, severely underweighted children who received health check-up declined significantly in April-June 2020. Encouragingly, the coverage of IFA to pregnant women, HBNC visits, and health check-up for severely underweight children were restored and exceeded the pre-pandemic coverage. Other services including four or more ANC, institutional delivery, post-partum check-ups, and child immunisation were unable to reach the pre-pandemic level, but it is noteworthy that their coverage was more than 95% of the pre-pandemic period. However, despite restorations, the pre-pandemic levels of coverage of these health services in many states were sub-optimal, and NFHS-5 reveals several coverage gaps.

5.2.3 State innovations in delivering health services (core POSHAN Abhiyaan interventions)

States adopted different strategies to continue service delivery during COVID-19, which varied by geography and by the type of service. Out of the 34 states for which state data was received, 26 states/UTs reported making some innovations to ensure the delivery of health interventions to the beneficiaries during the COVID-19 pandemic. The table below summarises the state-wise innovation, by services.

Table 7: Summary of health programme delivery innovations in the context of COVID-19, as reported by State Governments

State/UTs	Innovations for distribution of IFA (syrup, pink, red, blue)	Innovations for distribution of ORS and zinc	Innovations for immunisation	Innovations for counselling
Andaman & Nicobar Islands			Mobilization of beneficiaries	
Andhra Pradesh		During IDCF 2020	Token based system to prevent crowd	
Arunachal Pradesh			Tracking system to monitor status	Virtual counselling, distribution of material
Assam	Home distribution	During IDCF 2020	During VHNDs	Use of mobile phones
Bihar	Home distribution			
Chandigarh	By FLWs	During IDCF 2020		
Chhattisgarh	Home distribution	Home distribution	Mobilization of beneficiaries	
DNH & DD				
Delhi	Home distribution	Home distribution		Home visits

State/UTs	Innovations for distribution of IFA (syrup, pink, red, blue)	Innovations for distribution of ORS and zinc	Innovations for immunisation	Innovations for counselling
Goa				
Gujarat	Home distribution	During IDCF 2020 & home distribution		
Haryana	Home distribution	During IDCF 2020		Home visits
Himachal Pradesh	Home distribution	During IDCF 2020	Virtual trainings to handle vaccine among COVID-19	
Jammu & Kashmir	Home distribution & during VHNDs		Mobilization of beneficiaries	Mobile applications and home visits
Jharkhand	Community based, virtual trainings for FLWs	Community based	Wall writing	Virtual counselling
Karnataka			Virtual training sessions conducted. Outreach sessions organized	
Kerala	At AWC for out-of-school	Decentralized ORS depots	Pre-book appointments to prevent crowd	Tele-counselling through toll-free number
Ladakh	Home distribution	Home distribution	Mobilization of beneficiaries	
Lakshadweep				
Madhya Pradesh	Home distribution & tele-monitoring to ensure availability		Virtual training sessions conducted.	In-person small groups
Maharashtra	Home distribution	Home distribution		
Manipur				Mental health counselling to inmates of jails and old age homes
Meghalaya				
Mizoram	Incomplete template received			
Nagaland	Home distribution			
Odisha		During IDCF 2020		

State/UTs	Innovations for distribution of IFA (syrup, pink, red, blue)	Innovations for distribution of ORS and zinc	Innovations for immunisation	Innovations for counselling
Puducherry	Community based	By FLWs	Mobilization of beneficiaries	
Punjab	Home distribution		Conducted maintaining COVID-19 protocol	Through mobile phones & home visits
Rajasthan				
Sikkim	Home distribution	Home distribution	Conducted maintaining COVID-19 protocol	Through mobile phones & home visits
Tamil Nadu				
Telangana				
Tripura				
Uttar Pradesh	IFA distribution combined with Vitamin A			
Uttarakhand				
West Bengal	Template not received			

Source: *Reported by states in response to questionnaires sent by NITI Aayog in Sept 2020*
Note: *IDCF-Intensified Diarrhoea Control Fortnight*

Distribution of IFA (syrup, pink, red, blue)

Several states opted for home distribution of IFA. Few states delivered IFA during community-based events, VHSNDs and through FLWs. Kerala provided IFA at AWCs for out-of-school children. Madhya Pradesh ensured the availability of IFA through tele-monitoring. In Uttar Pradesh, the distribution of IFA syrup was combined with bi-annual Vitamin A supplementation to ensure distribution to all beneficiaries and for reporting purposes.

Distribution of ORS and zinc

Seven states ensured the implementation of Intensified Diarrhoea Control Fortnight 2020 for children under-five years of age. In a few states, ORS and zinc were distributed at beneficiaries' homes or at the community-level. Kerala decentralized the ORS depots from AWC to the level of one household for every 10 houses in a community.

Immunization

Several adaptations were made by States to provide immunisation to beneficiaries ranging from identifying alternate sites for immunisation, following a staggered approach, maintaining COVID-19 protocol, providing information and guidance to FLWs to conduct immunisations using technology.

Counselling

States used different approaches to reach beneficiaries to ensure the most vulnerable population received the services and most of the beneficiaries were covered. Use of mobile phones, virtual and tele counselling and home visits were some of the adaptations made to ensure that counselling services reach the beneficiaries.

5.3 MULTI-SECTORAL INVOLVEMENT AND POLICY ACTION DURING COVID-19

Multiple ministries have been contributing in POSHAN Abhiyaan to address malnutrition through tackling its many determinants, and have taken concerted efforts to continue their regular activities to ensure that POSHAN Abhiyaan is being implemented despite the COVID-19-related disruptions. Similarly, development partners have also shifted their focus in undertaking initiatives for successful implementation of POSHAN Abhiyaan during the pandemic. This section summarises the measures taken by key Ministries and development partners in 2020.

5.3.1 Ministry of Women and Child Development

Best practices, during COVID-19 at the central-level

In the form of Advisories and other formal communications the MoWCD ensured the continuum of care to the beneficiaries even during the challenging COVID-19 times. For example, a letter (on 11 March 2020) was issued to all States/UTs in the view of the COVID-19 outbreak, which indicated that the AWWs and Supervisors should be utilized in surveillance and other community-level activities conducted by MoHFW, mobilization of the self-help groups (SHGs) to create awareness, and proper sanitation and health education to children and their parents. Furthermore, AWWs and helpers were also actively involved in conducting other activities during COVID-19, such as door-to-door surveys, community surveillance, etc. Another formal communication in the form of a DO letter on (19 May 2020) was issued to all States/UTs, which indicated that distribution of food items and nutrition support would be conducted by AWWs once every 15 days for beneficiaries (children, pregnant women and lactating mothers) to ensure continuity of the supplementary nutrition programme.

In view of COVID-19 context, the life cover for AWWs/Anganwadi helpers who are 51-59 years of age was increased from ₹ 30,000/- to 2,00,000/- for a period of three months—that is, up to 30 June 2020.

Additionally, many State-level initiatives were initiated amid COVID-19. One example recognized by MWCD is establishing nutri-gardens in Lakshadweep. In collaboration with the Departments of Women and Child Development, Agriculture Rural Development and Village Panchayats, Lakshadweep promoted Anganwadi Kitchen Gardens and Nutri-Gardens for a continuous supply of green leafy vegetables and fruits during COVID-19 outbreak.

5.3.2 Ministry of Health and Family Welfare

Best practices, especially during COVID-19 times

Continued support was provided to States and UTs through regular video conferences (VC) and webinars on the implementation of various interventions amid COVID-19, including AMB, newborn care provision in the special newborn care units (SNCUs), continuation of breastfeeding and promotion of IYCF practices, implementation of NDD and diarrhoea control and prevention activities, facility-based management of sick SAM children in NRCs. Guidance notes for undertaking various activities were prepared, and intensive awareness generation activities through social media, mid and mass media were also carried out.

5.3.3 Ministry of Drinking Water and Sanitation

Best Practices, especially during COVID-19 times

Empowering migrant labourers through Garib Kalyan Rojgar Abhiyaan, Bihar

A total of 24 labourers were engaged in the construction of a community sanitary complex at Ward No. 8 of Tulapatti Gram Panchayat in Kishanpur Block of Supaul District in Bihar. The move was not only a step towards ensuring better community sanitation practices but also an assurance of employment to many migrants who had to return to Bihar due to COVID-19 outbreak. These migrants were provided with work under the Garib Kalyan Rojgar Abhiyaan.

5.3.4 Initiatives taken by Development Partners during COVID-19 Pandemic

Strengthening the delivery of nutrition benefits and services in the context of COVID-19:

State-level government bodies in the States of Jharkhand, Madhya Pradesh, Gujarat, Uttar Pradesh, and Rajasthan developed a joint recommendation note and supported implementation to strengthen the delivery of nutrition services in the context of COVID-19. Organizations like Alive and Thrive (A&T) in collaboration with WeCan has been actively participating in addressing nutrition-related issues, especially during the COVID-19 pandemic. A&T also collaborated with key development partners namely UNICEF, WHO, World Bank, National Centre of Excellence and Advance Research on Diets, and Ministry of Health and Family Welfare for providing technical inputs in the design and development of social behaviour change communications for MIYCN during COVID-19.

In Bihar, A&T coordinated with State Health Society Bihar and remotely assessed the coverage of ASHA's home visits and IYCF counselling including tele-counselling activities during the national lockdown in April 2020. The assessment was based on telephonic interviews by ASHA facilitators using a standard checklist, which was later analysed by A&T. Similarly, A&T conducted telephonic interviews with frontline workers, pregnant women, and women with children below 2 years in Uttar Pradesh for examining the

effects of COVID-19 on provision and use of health and nutrition services during and after lockdown.

Promoting community involvement for improving health and nutrition related outcomes in Aspirational Districts during COVID-19 times

The onset of COVID-19 and subsequent lockdowns have resulted in a halt in many health and nutrition activities for children as the AWCs were closed. This severely impacted the feeding practices and initiation of complementary feeding, due to which the District administration along with Piramal Foundation decided to organize events such as *Annaprasan Divas* and *Godbharai Divas* at the houses of the beneficiary itself to avoid gatherings of beneficiaries. The initiative was introduced in the Aspirational District of *Sitamarhi, Bihar.* After devising the guidelines and protocols to be followed, the AWWs were motivated to visit the beneficiaries houses for ensuring that nutrition and health are receiving adequate attention. Soon, the AWWs started home-based *Annaprasan Divas* for children who completed six months. At the event, the family prepares soft semi-solid food for the child to mark the celebration of *Annaprasan Divas,* and the AWW further counsel beneficiaries regarding the benefits of breastfeeding and complementary feeding. With the continued efforts of the FLWs, Block Transformation Officers (BTO), and District officials, the AWWs have been able to successfully organize *Annaprasan Divas* in 275 households, and *Godbharai Divas* in 210 households.

District Administration intervened by setting up 'Nutri Gardens' at CHC and AWC with Piramal Foundation where the beneficiaries had access to some fruits and vegetables grown in the garden and were taught about the nutritional value of different fruits and vegetables, and finally encouraged to adopt practicing kitchen gardens within their households. Additionally, the project is a self-sustaining project which ensures access to healthy fruits and vegetables in an affordable way as most inputs are available locally, and villagers do not require any additional skills for setting up the 'Nutri Garden' due to their existing engagement in farming. So far, five Anganwadi sites in the Aspirational District *Chitrakoot, Uttar Pradesh* have been developed functional gardens where beneficiaries visit regularly. Over 300 pregnant women and 280 lactating mothers have visited the gardens and have been counselled on improving their dietary intakes.

In *Sonbhadra, Uttar Pradesh* the DM District Administration along with the technical support of the Piramal Foundation undertook the decision utilizing the District Mineral Funds for purchasing growth monitoring tools for the AWC. In total, 95 lakh were used to purchase 8,500 growth monitoring tools, including stadiometers, infantometers, baby weighing machines, adult weighing machines, and MUAC tapes. After procurement, a series of trainings were conducted to ensure the efficient usage of the tools. Throughout the process, capacity building of 72 ICDS supervisors and CDPO on the use of growth monitoring tools were conducted, and 1653 AWWs were installed with growth monitoring equipment. There has been a significant increase in the growth monitoring of the children, and even during the COVID-19 pandemic, 1,45,140 children were monitored. Additionally, children who were identified as severely acutely malnourished were referred to the Nutritional Rehabilitation Centres for recovery. Finally, the strategy detects early growth retardation so that appropriate steps can be taken for the same.

Field-level relief measures during the COVID-19 pandemic

The centralised kitchens programme in Nashik and Palghar, which is run in collaboration with the Tribal Development Department, Government of Maharashtra and TATA trusts, has expanded its services to provide meals to migrant workers amid the COVID-19 pandemic. Since 3 April 2020, the kitchen in Palghar has been providing hot meals and dry rations to stranded migrants in the shelter camps in Tawa and Talasari blocks. More than 67,000 meals have been served, where around 5,000 people are being served cooked meals each day, and over 400 kilograms worth of dry ration that includes flour, pulses, oil, and spices has been distributed. Similarly, in Nashik, 2,800 dry ration kits were distributed in a week's time to approximately 2,800 families with the collaborative efforts of Trusts, BAIF and Tata AIG volunteers.

Similarly, to address the challenges in the availability of food and nutrition amid the COVID-19 pandemic, relief initiatives for the vulnerable communities across India were undertaken. Under the relief operation, the Tata Trusts combined forces with the associate organisation The India Nutrition Initiative (TINI) to distribute packets of GoMo, a healthy legume-based ready-to-eat snack. As yellow pea is the main ingredient, the snack is rich in protein and fiber, and has been fortified with micronutrients. The packets were distributed across critical pockets, such as slums, construction sites, cancer treatment hospitals, migrant settlements, primitive tribal hamlets in remote parts of the country, etc. Besides, the snack was also distributed to the country's frontline workers namely police personnel, healthcare workers, etc. Around 44 non-governmental organization (NGO) partners freely distributed around 1.7 million GoMo packets across 700,000 households in over 30 Districts in nine States- Maharashtra, Uttar Pradesh, Andhra Pradesh, Telangana, Delhi, Gujarat, Rajasthan, Haryana, and Tamil Nadu.

Capacity building of frontline workers in COVID-19 pandemic

To bring the visibility through the month-long celebration of POSHAN Maah, the network of Centres of Excellence for SAM comprising of the National Centre of Excellence (NCoE-SAM) and State Centre of Excellences for management of SAM (SCoE-SAM) under the Government leadership and guidance from UNICEF, joined hands to accelerate SAM management-related activities during September 2020.

NCoE-SAM and SCoE-SAM conducted various training programmes in many States to build capacity for identifying children with SAM, adhering to the infection prevention and control from the COVID-19 pandemic protocol. In ***Bihar***, SCoE along with Piramal Foundation conducted training on identification and referral of SAM in 5 Aspirational Districts. On the other hand, in ***Chhattisgarh*** SCoE, All India Medical Institute of Science (AIIMS), Raipur conducted telephonic follow-ups of the discharged children from NRCs and counselled the parents regarding the identification of danger signs in children, home-based nutrition and care, and signs and symptoms of COVID-19 and preventive measures. In ***Jharkhand***, a four-day State-level training was conducted to build the capacity and orient the medical college faculties and students, District officials of West Singhbhumand and development partners on the comprehensive community-based management of children with SAM programme. Similarly, online trainings and orientations were conducted for frontline workers under ICDS in ***Odisha and Rajasthan***.

Technical Support: CoE has also provided technical support in the preparation of guidelines and training modules in ***Rajasthan*** for their project AMMA, and support was also provided to ICDS Department of ***Bihar*** for developing a comprehensive guidance note on activities regarding early screening of SAM at a community and facility level under the Health Department. Additionally, an expert consultation was held with the district administration of West Singhbhum for implementation of the CMAM programme in the district adhering to the infection prevention and control from COVID-19 protocols.

5.4 CONCLUSION AND WAY FORWARD

This chapter examined the impact of the pandemic on service disruptions and documented various ways in which services are beginning to be restored across sectors in India.

The findings on service disruptions, drawing primarily on publicly available administrative data highlight substantial disruptions in the early part of the pandemic, with restorations beginning to be apparent in the middle of 2020.

The findings on early restorations and adaptations to service delivery are promising and highlight a positive commitment across all levels – policy, implementation and frontline- to attempt to restore essential services in health, nutrition and social safety nets. A range of adaptations to service delivery are seen across specific platforms and interventions, and these bode well for supporting the path to full restoration. At the same time, available findings on the broader economic impacts of the pandemic highlight that poor families are likely to need a wide range of social protection and economic support for improving food security and care for pregnant and lactating women and young children in the critical 1000-day window.

What implications do these findings have for India's progress on improving nutrition?

- First, millions of babies born in 2020 have likely missed several essential interventions in health and nutrition; therefore, the rapid and full restoration of services is critical to the basic mission goal of delivering essential evidence-based interventions. Efforts to increase household demand for services will also be central to achieving coverage. To this end, demand creation to access and use health and ICDS services should be a key focus of the SBCC pillar of POSHAN Abhiyaan in 2021.
- Second, the insight on economic and food distress suggests that social protection measures must be strengthened and will need to reach families in the 1,000-day period. Improving nutrition is challenging when families are in economic distress. Nutrition-sensitive social protection could play a key role in helping families provide better nutrition for their children.
- Third, addressing the fall-out of the impact on the education sector on adolescent girls will be critical. Evidence has accumulated that education is critical to prevent early marriage, which in turn is critical to prevent early childbearing in India. The risks of increasing early marriage in the context of the pandemic are higher, but little is known about the extent of the challenge. Community engagement

to ensure adolescent girls can return to school and that early marriages are prevented will, therefore, also need sharp focus in 2021. Additionally, RKSK may mobilize community to prevent early marriage of adolescent girls with the help of FLWs.

- Fourth, it is recommended that for providing convergence of WCD and Health services to fight undernutrition, the provision of seamless data sharing between ICDS-CAS/POSHAN Tracker and RCH should be developed. Additionally, conducting joint convergent trainings/activities with the field level staff on how to constantly share data and information is necessary for successful inter-sectoral convergence.
- Fifth, all available services – whether special services in the context of the pandemic or routine services – should be reaching families in the first 1000 days in a timely and targeted manner. At this time, little is known about how to achieve effective household convergence, but the evidence is strong that this is currently poor and therefore, must be a key goal for the efforts to strengthen the convergence pillar of POSHAN Abhiyaan.


कोड-70
जन्म हो या मरण, जरूरी है पंजीकरण
जिला:- सीतामढ़ी

6 Conclusions and Recommendations

This progress report has assessed the implementation of POSHAN Abhiyaan; analysed the impact of the COVID-19 pandemic on nutrition and health services and generated and curated insights on service delivery restorations and adaptations and other related needs across India.

First, on a positive note, the assessment of system readiness and capabilities to deliver POSHAN Abhiyaan interventions demonstrate improvements from the previous POSHAN Abhiyaan progress reports. Despite the improvement, challenges pertaining to low fund utilization, insufficient human resources, and gaps in training and capacity building of the staff. Additionally, the coverage of the service delivery has a mixed performance where many indicators have acceptable coverage, but few indicators are lagging behind. Together, these signal that although progress is along expected lines, but given the complex systems preparedness, focus on accelerating coverage of key interventions is required.

Key recommendations

- Close all implementation system-related gaps in delivery of POSHAN Abhiyaan's core components. These include accelerating the use of funds released for POSHAN Abhiyaan, ensuring adequate number of health facilities and supplies, ensuring that technology integration continues, and ensuring that capacity building of workers is focused both on coverage and quality.
- Maximise convergence-related efforts in the coming years, targeting and focusing all efforts to achieve household convergence of key programs, especially those addressing the determinants that have been slow to move or negatively affected in 2020.
- Create an enabling environment for seamless data sharing between ICDS-CAS/ POSHAN Tracker and reproductive and child health (RCH) services to facilitate convergence between WCD and health services. Additionally, conducting joint convergent trainings/activities with field-level staff on how to constantly share data and information is also necessary.

- With the introduction of POSHAN Tracker, it can be utilised to monitor the supply and delivery of THR. The tracker must be integrated with the RCH portal to identify prevalence of malnutrition. All visits of AWWs should be tracked and best 100 AWWs per month in every state may be incentivized and their photos/ mobile numbers may be displayed on POSHAN tracker.

Second, the analysis of service disruptions, drawing primarily on administrative data highlights substantial disruptions in the early part of the pandemic. Although restorations are apparent beginning in the middle of 2020, the restorations in June 2020 (the last month for which data are available in public domain) indicate that full restoration to December 2019 levels are still not apparent for various services. However, in several states, it appears that higher reach of food supplements was achieved in the immediate post-lockdown period, and this may have important lessons.

Key recommendations

- Given the importance of achieving full-scale coverage of the POSHAN Abhiyaan core interventions, efforts to restore service delivery are imperative, not just to achieve pre-pandemic levels but to go beyond and achieve even greater coverage and quality.
- Services that will need particular attention in the restoration of services will be screening and monitoring of growth of all children, active support to EBF and even greater efforts to support complementary feeding.
- Efforts to increase household demand for services are also going to be central to achieving coverage; therefore, demand creation to access and use health and ICDS services should likely be a key focus of the SBCC pillar of POSHAN Abhiyaan in 2021.

Third, the findings on early restorations and adaptations to service delivery highlight a positive commitment across all levels–policy, implementation and frontline–to attempt to restore essential services in health, nutrition and social safety nets. A range of adaptations to service delivery across specific platforms and interventions bode well for supporting the path to full restoration. At the same time, available findings also highlight the broader economic impacts of the pandemic on incomes and food security, even as recently as October 2020. Addressing the fallout of the impact on the education sector on adolescent girls will also be critical. Evidence has accumulated that education is critical to prevent early marriage, which in turn is critical to prevent early childbearing in India. The risks of increasing early marriage in the context of the pandemic are higher, but little is known about the extent of the challenge.

Key recommendations

- The efforts for convergence with key sectors, especially food and civil supplies (PDS) and rural development (NREGA) will be essential for strengthening social protection to vulnerable families. This will also ensure that the social protection programmes reach families in the first 1,000 days of life. Furthermore, by

incorporating nutri-cereals, fortified rice, and other nutritious foods into social safety nets will help to make these provisions nutrition sensitive.

- Efforts to strengthen social protection to be more nutrition-sensitive and to ensure that major social protection programmes reach families in the first 1000 days using the convergence action planning mechanisms will be essential.
- Community engagement to ensure adolescent girls can return to school and that early marriages are prevented will also warrant urgent attention in 2021.

Despite significant progress on strengthening systems to support the delivery of key POSHAN Abhiyaan interventions in the Health and WCD sectors, more work is needed to close persisting gaps. In addition, the impacts of the COVID-19 pandemic mean that millions of babies born in 2020 have likely missed several essential interventions in health and nutrition. At the same time, there is also evidence of a broad system-wide commitment to nutrition in the range of efforts to restore health and nutrition services – across Ministries, States and development partners. The rapid and full restoration of services is critical to the core POSHAN Abhiyaan goal of delivering essential evidence-based interventions to all women and children.

In closing, this report offers sobering insights on the current state of malnutrition in India, as well as several areas for optimism on the nutritional improvements underway in India. With continued political leadership, system-wide implementation commitment, society-wide support and focused action, India can eliminate malnutrition in all forms.

In 2021, an estimated 20 million babies will be born in India[6]. By investing more deeply in solving the nutrition challenge, we have the power to assure the birth cohort of 2021 tremendous opportunities to strengthen their potential as future citizens. There is no time to lose.

6 UNICEF Press Release, 7 May 2020

7 Key Takeaways from POSHAN Abhiyaan

On 8 March 2018, the Honourable Prime Minister launched the POSHAN (Prime Minister's Overarching Scheme for Holistic Nutrition) Abhiyaan, which brought malnutrition to the centre stage. Malnutrition, particularly in early life (especially during the first 1,000 days) leaves an undeniable mark on child growth and development and can have irreversible consequences. Globally, the success of nutrition programmes has been predicated on a strong commitment on the part of the political and bureaucratic leadership. POSHAN Abhiyaan, with political commitment from the highest level, created a conducive environment to improve nutrition, with particular attention on the first 1,000-day window of opportunity.

NITI Aayog has been involved in the conceptualization and monitoring of POSHAN Abhiyaan, since its inception. The launch of POSHAN Abhiyaan brought together 18 ministries to synchronize their efforts for addressing direct and underlying determinants of malnutrition. The POSHAN Abhiyaan adopted a multi-pronged approach to target malnutrition. POSHAN Abhiyaan simultaneously also created an enabling environment through its key pillars– convergence, information and communication technology (ICT), monitoring, and Jan Andolan– to ensure coverage of high quality services through the first two years of a child's life. Since its inception, the POSHAN Abhiyaan has created mass awareness and generated a spirited environment wherein all actors in the government and society are engaged to overcome malnutrition.

The experience of implementing the POSHAN Abhiyaan over the past three years has highlighted the **following key lessons** that must be carried forward to continue our efforts for reducing malnutrition:

LESSON 1: POSHAN ABHIYAAN HAS HELPED TO BRING A STRONG FOCUS ON IMPROVING NUTRITION OUTCOMES DURING THE FIRST 1,000 DAYS.

The first 1,000 days—the time approximately from conception to the second birthday of the child, constitute the foundation period for optimal child health, growth and neural

development. The sensitive periods of brain development are susceptible to specific nutritional deficiencies that could have long-term deficits. This is the period when children require food with optimal nutrients, hygienic, nurturing and stimulating environments along with optimal health care. Poor nutrition during this critical phase has consequences throughout the lifecycle leading to delays in development, low earnings in adulthood, and increased risk for chronic diseases as well as negatively influence next generations.

POSHAN Abhiyaan shifted the focus of nutrition programmes from merely distributing food supplements to actively engaging all other stakeholders both on demand and supply side. With the clear focus on improving the coverage of key health and nutrition interventions, POSHAN Abhiyaan has contributed to laying a clear focus on:

- Incentivizing Early Registration and Complete Antenatal Care
- Promoting Institutional Deliveries
- Anaemia Prevention and management
- Healthy diets during pregnancy
- Early and Exclusive Breastfeeding
- Introducing Timely and Age appropriate Complementary Feeding, including a focus on the quality of take home rations in the ICDS
- Promoting Dietary Diversity
- Home visits to New-born and young child Care
- Kangaroo Mother Care and Optimal Feeding of low birth weight and small babies
- Introduction of Rota virus vaccine and zinc supplementation along with ORS to achieve zero diarrhoeal deaths
- Introduction of Pnemono-coccal vaccine (in selected states) for upper respiratory tract infections
- Growth monitoring for early identification and management of MAM/SAM children in the community

The assessments of system readiness and capabilities to deliver POSHAN Abhiyaan interventions demonstrated improvements and there is an overall positive trend in the coverage of interventions in most states. Taken together, these signal that progress is along expected lines given the complex systems preparedness and the focus on accelerating coverage of key interventions in the period between 2018 and 2020.

Gaps remain in service delivery and coverage. Geographically targeted diagnostic analyses and related action are critical to close existing gaps in the reach of health and ICDS interventions in the first 1000 days. In addition, ensuring strong linkages between counselling and growth monitoring and distribution of take-home rations in ICDS and ensuring that they reach all the households with a child below two years is critical. Improving the composition and quality of the food supplements and increasing the reach of the take-home rations is essential. The achievement of optimal infant and young child feeding practices, particularly in ensuring appropriate complementary feeding practices,

remains a challenge. Therefore, it is imperative to use all existing programme platforms to emphasize complementary feeding at every possibly contact with families with children under two years of age.

The need of the hour is to sustain the POSHAN Abhiyaan for which actions looking forward must now fully consider gaps in service delivery, convergence between ICDS and health services to deliver the package of essential interventions, and continue to strengthen the focus on key nutrition behaviour such as complementary feeding.

LESSON 2: POSHAN ABHIYAAN HAS ENABLED A NATION-WIDE JAN ANDOLAN CATALYSING NUTRITION RELATED BEHAVIOUR CHANGE AT SCALE FOR POSITIVE IMPACT ON FEEDING AND HEALTH CARE PRACTICES

Jan Andolan, has been an integral part of POSHAN Abhiyaan. It was conceptualized to engage the community and support behaviour change for nutrition through a people's movement with the ownership of the efforts being vested in the community rather than only in government delivery mechanisms.

POSHAN Maahs and Pakhwadas were celebrated with great enthusiasm involving all stakeholders, such as civil society organizations, academic institutions, PRIs and self-help group (SHG) members. These celebrations of POSHAN Maah and Pakhwadas have demonstrated the power of cross-sectoral outreach for behaviour change communication. A focused and coherent SBCC Action Plan with standard messages is essential to take the work of POSHAN Abhiyaan forward. While the Jan Andolan activities are being organized with great zeal, it is imperative that such fervour continues throughout the year and beyond the designated months to facilitate behaviour change.

Despite successful implementation of the campaigns, the key platforms to reach households and children in the first 1,000 days should continue to be home visits, supplemented by community-based events and mass media. Jan Andolan could effectively be utilized to change community level awareness of normative behaviours through concerted messages. The messaging has to be complemented with strengthened delivery systems to implement interventions so that the demand for services from the sensitized communities could be met.

In extending the Jan Andolan, engagement with elected representatives at all levels–from the Parliament to the Panchayats along with local partners–could be a next step to ensure continuity of enabling environment for behaviour change communication as well as synchronized and unified messaging.

Adopting healthy and nutrition behaviours requires more than knowledge; therefore, looking forward, it is critical to invest in understanding household constraints to behaviour change, their access to knowledge and other resources to support behaviour change, and to ensure that the Jan Andolan and other behaviour change efforts of POSHAN Abhiyaan are coupled with additional strategies that remove more barriers.

Building on this momentum, Jan Andolan should be intensified using high reach platforms such as home visits, community-based events, mass media and more with even greater participation of families and communities.

LESSON 3: POSHAN ABHIYAAN DEMONSTRATED THAT THE PROCESSES FOR INTER-SECTORAL CONVERGENCE ARE EFFECTIVELY OPERATIONALIZED THROUGH IN PLACE INSTITUTIONAL MECHANISMS AT MULTIPLE LEVELS

Malnutrition is multi-factorial in nature, and the outcomes of malnutrition are affected by actions in different sectors. It is well recognized that a multi-sectoral approach is therefore essential. Several sectoral policies and programmes exist in India that need to be effectively implemented to ensure reach to the intended beneficiaries. Recognizing the multi-sectoral nature of the malnutrition challenge, convergence was identified as one of the enabling activities for ensuring effective delivery of all sectoral interventions to households in the first 1,000 days.

POSHAN Abhiyaan conceptualized convergence at two levels:

1. Governance level, which creates institutional mechanisms to ensure coherent engagement with multiple departments; and
2. Impact level where "effective convergence" implies successful reach of programmes from relevant sectors that address the key determinants of under-nutrition for the same household, same woman and same child in the first 1,000 days (from pre-conception until the child's second birthday).

The governance level of convergence has been put in place quite firmly with POSHAN Abhiyaan. At this level, after the development of convergence action plans (CAP), States, Districts and Blocks are expected to conduct quarterly review meetings to examine progress and identify actions to meet the targets specified in the action plans. However, it has been found that discussions during such meetings are generic. In addition, CAP committees at lower levels are less empowered to take financial and operational decisions to close implementation gaps. It is challenging to monitor the multiple data reporting structures across different departments, using multiple data platforms, for the same set of beneficiary households, mothers and children. Therefore, it is important to examine the reporting structures and data platforms to optimize and reduce the burden and improve functionality for decision making. At the frontline, to ensure coordination and convergence between the *Anganwadi* workers, ASHA, and ANMs in delivering the services through clear and coordinated directives from the state and district levels.

Although the overarching intent of convergence is clear, the operational guidance does not make it explicit how stakeholders could ensure that multiple programmes reach the same mother–child dyad in the first 1,000-day period. The success of POSHAN Abhiyaan's convergent action planning efforts will lie in the ability of the convergence-related processes to trigger the within- and across-sector actions that lead to effective reach of an agreed upon core set of interventions to all households in the 1,000-day period.

Convergence can only be successful when all interventions reach all target households in the right timeframes. Therefore, it is important to identify a core set of indicators of successful convergence that can be monitored and supported through CAP so that the review meetings become meaningful and enable progress tracking and programmatic support to ensure that the intent of convergence is fully met.

Institutional mechanisms that worked for intersectoral coordination must be strengthened and extended to build coalition on ground with other departments such as agriculture, school education, and more.

LESSON 4: POSHAN ABHIYAAN SHOWED THAT TECHNOLOGY CAN BE LEVERAGED FOR REAL TIME MONITORING OF LARGE SCALE HEALTH AND NUTRITION PROGRAMMES

Integrated Child Development Services-Common Application Software (ICDS-CAS) was introduced in POSHAN Abhiyaan, to facilitate real time monitoring for improving service delivery and programme management through an innovative web and mobile-phone based application. Although there were delays in the initial roll-out ICDS-CAS with low fund utilization, by September 2020, ICDS-CAS had been rolled out in 29 States with 359 districts of the country. Additionally, 48% Anganwadi Workers had received smartphones and 56% Lady Supervisors had received smartphones as of September 2020. Thus, the technological intervention was not fully implemented across the country to completely assess its effects. Additionally, many States would need to accelerate access to mobile phones and training of providers and managers. The gaps in network issues, capacity building and supportive systems such as help desks need attention.

In addition to the procurement issues, ICDS-CAS also faced numerous other challenges. Firstly, roll-out of ICDS-CAS remained slow due to network issues in many districts. Secondly, majority of the AWWs using mobile/tablets continued to maintain records manually as well, which led to duplication of work. Also, there is very little evidence to suggest effective use of data collected on CAS for programme monitoring and course correction. The challenges pertaining to ICDS-CAS limited its effectiveness. Therefore, ICDS-CAS has now been replaced by POSHAN Tracker – a robust ICT enabled platform, to improve governance with regard to real-time monitoring of provisioning of supplementary nutrition for prompt supervisions and management of services has been rolled out successfully across all States/UTs covering all districts. Key points to consider to ensure the success of POSHAN Tracker are to address upfront the network, cloud storage and other technological challenges identified in rolling out ICDS-CAS. In addition, duplication of record keeping (paper and phone) must be limited to save time and enhance the effectiveness of AWWs. To support convergence, creating linkages and other approaches to enable data sharing by both the health and ICDS systems is essential, as they share the same beneficiaries. This could further help in avoiding duplication of efforts, and improve monitoring. Finally, sharpening data use within the ICDS and across the ICDS and other systems in the context of POSHAN Abhiyaan is critical to enable data-driven actions. Regardless of the source of the data, data use is a critical step in improving the impact of technology-enabled data gathering.

Sustained, comprehensive and multidimensional use of technology platforms for educating, counselling, on-site decision making, and work and task planning are all essential to realize the full impact of technology. Additionally, leveraging the use of data in showing clips and movies during home visits to the beneficiaries to further bring about behaviour change is another area for expanding POSHAN Abhiyaan.

LESSON 5: POSHAN ABHIYAAN SUPPORTED THE RESILIENCE OF HEALTH AND NUTRITION SYSTEMS DURING COVID-19 PANDEMIC

The nation-wide lockdown imposed to curb the spread of the COVID-19 pandemic in March-April 2020 resulted in disruption in service delivery of many key health and nutrition services included under the POSHAN Abhiyaan umbrella framework of intervention during the second quarter of 2020. However, analysis of administrative data has demonstrated that services restored to near pre-pandemic levels by December 2020, demonstrating the resilience of health and nutrition systems of the country. It is likely that this restoration was due to the high salience of nutrition on the policy agenda in the pre-COVID era.

To continue the delivery of essential health and nutrition services to women and children along with following protocol, several policy adaptations and interventions were undertaken by MWCD and MoHFW. Although platforms like Anganwadi Centres were not operational during the peak of pandemic, several services were delivered to the beneficiaries at their doorstep during home visits. One such example is the ICDS supplementary nutrition programme (take-home rations), which was almost equal to the pre-pandemic levels even during the lockdown period of April-June 2020, because the services were delivered to the homes of the beneficiaries. Many States and UTs also added additional rations to provide extra care to the beneficiaries amid COVID-19 pandemic.

VHSNDs were also conducted in a staggered approach and in non-containment zones to expand access to ICDS services for beneficiaries and reduce the spread of COVID-19. Similarly, as many health facilities were trying to address the ongoing pandemic, the maternal and child health services were available on-demand, walk-in, or during home-visits. Operational guidelines were also issued to the hospitals for conducting essential procedure for pre and post pregnancy.

Such measures and adaptations that were taken at the State- and Central-levels indicate that the Abhiyaan supported the continuation of service delivery despite the pandemic, and the commendable efforts undertaken by FLWs to provide essential services during the lock-down and immediately after, contributing to service restoration.

Despite these efforts, in the context of the continuing impacts of the COVID-19 pandemic, millions of babies born in 2020 have likely missed several essential interventions in health and nutrition. Since data are not available from ground-up surveys, there remains uncertainty about the impact on client populations for the programmes. However, the broad system-wide commitment to nutrition in the range of efforts to restore health and nutrition services was apparent across Ministries, across States and across development partners. Continued attention to ensure rapid and full restoration of services as well as new adaptations to services in the continuing pandemic is critical to the core POSHAN

Abhiyaan goal of delivering essential evidence-based interventions to all women and all children.

In addition, the pandemic has induced economic and food distress that must be tackled to accelerate progress on nutrition. Improving nutrition is difficult, if not impossible, when families are in economic distress. Nutrition-sensitive social protection could therefore play a key role in putting families back on the path to being able to provide better nutrition for their children. Therefore, all available social safety net and health/nutrition services – whether special services in the context of the pandemic or routine services – should be reaching families in the first 1000 days in a timely and targeted manner. This will also help to achieve convergence goals for the mission.

Innovative approaches to ensure service delivery of the essential health and nutrition services is needed to further improve quality, strengthening the system, and re-energizing the existing programme to tackle the pandemic.

REFLECTION ON POSHAN ABHIYAAN BASED ON EARLY RESULTS AVAILABLE FOR 22 STATES FROM NFHS-5

The early results from POSHAN Abhiyaan has highlighted that there has been an improvement in some of the immediate and underlying determinants, and the coverage of the intervention. The comparison of the NFHS-4 (2015-16) to NFHS-5 (2019-20) for 22 states for which factsheets are available, have painted a mixed picture. Many States have witnessed an improvement in the immediate determinants like infant and child feeding practices, along with consistent improvement in the underlying determinants like water and sanitation, and women's education and early marriage. There has also been an improvement in the coverage of interventions like IFA, institutional births, immunisation, Vitamin A, and diarrhoea cases treated with ORS and zinc. Due to the multi-factorial nature of malnutrition, the improvement in determinants and coverage highlights that the Mission has been able to facilitate positive results. Despite these improvements, it should be noted that the outcome indicators have slowed down and in fact worsened in some States. This calls for conducting deeper analysis of NFHS-5 to provide better insights on the plausible factors that could have resulted in slowing down and understanding the role of immediate and underlying determinants.

In conclusion, the POSHAN Abhiyaan has been a success in terms of creating a momentum among the beneficiaries through Jan Andolan, bring focus towards the importance of first 1,000 days along with providing a package of interventions for the same, demonstrating convergence between different line ministries, leveraging the use of technology for real-time monitoring of nutrition and health, and highlighting resilience amid pandemic.

References

1. Development Initiatives, 2018. 2018 Global Nutrition Report: Shining a light to spur action on nutrition. Bristol, UK: Development Initiatives
2. Menon, P., R. Avula, E. Sarswat, S. Mani, M. Jangid, A. Singh, S. Kaur, A.K. Dubey, S. Gupta, D. Nair, P. Agarwal, and N. Agrawal. 2020. Tracking India's progress on addressing malnutrition: What will it take? POSHAN Policy Note 34. New Delhi: International Food Policy Research Institute.
3. Development Monitoring and Evaluation Office (DEMO), NITI Aayog. 2020. "Evaluation of Centrally Sponsored Schemes in Women and Child Development Sector"
4. Women and Child Development Dashboard, MoWCD, https://wcd.dashboard.nic.in/ (accessed on 27th May 2021)
5. Rajpal, S., W. Joe, R. Kim, A. Kumar, and S. V. Subramanian. 2020. "Child Undernutrition and Convergence of Multisectoral Interventions in India: An Econometric Analysis of National Family Health Survey 2015–16." *Frontiers in Public Health* 8 (April): 1–10. https://doi.org/10.3389/fpubh.2020.00129.
6. UNICEF. 6 May 2020. "Millions of pregnant mothers and babies born during COVID-19 pandemic threatened by strained health systems and disruptions in services- UNICEF". https://www.unicef.org/rosa/press-releases/millions-pregnant-mothers-and-babies-born-during-covid-19-pandemic-threatened
7. Roberton, T., Carter E., Chou, V., Stegmuller, A., Jackson, B., Tam, Y., Sawadogo-Lewis, T., and Walker, N. 2020. "Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study". *The Lancet, Global Health,* Vol. 8, Issue 7, E901-E908.
8. https://doi.org/10.1016/S2214-109X(20)30229-1
9. Chakrabarti, S., P. Singh, and T. Bruckner. 2020. "Association of Poor Sanitation With Growth Measurements Among Children in India." *JAMA Network Open* 3 (4). https://doi.org/10.1001/jamanetworkopen.2020.2791.

10. Dhami, M.V., F.A. Ogbo, U.L. Osuagwu, and K.E. Agho. 2019. "Prevalence and Factors Associated with Complementary Feeding Practices among Children Aged 6-23 Months in India: A Regional Analysis." *BMC Public Health* 19 (1): 1034. https://doi.org/10.1186/s12889-019-7360-6.

11. Kim, R., S. Rajpal, W. Joe, D.J. Corsi, R. Sankar, A. Kumar, and S. V. Subramanian. 2019. "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* 238 (January 2019): 112374. https://doi.org/10.1016/j.socscimed.2019.112374.

12. Lee, H.Y., J. Oh, R. Kim, and S. V. Subramanian. 2020. "Long-Term Trend in Socioeconomic Inequalities and Geographic Variation in the Utilization of Antenatal Care Service in India between 1998 and 2015." *Health Services Research* 55 (3): 419–31. https://doi.org/10.1111/1475-6773.13277.

13. Menon, P., R. Avula, S. Pandey, S. Scott, and A. Kumar. 2019. "Rethinking Effective Nutrition Convergence: An Analysis of Intervention Co-Coverage Data." *Economic & Political Weekly*, no. 24: 18–21.

14. Reese, H., P. Routray, B. Torondel, S.S. Sinharoy, S. Mishra, M.C. Freeman, H.H. Chang, and T. Clasen. 2019. "Assessing Longer-Term Effectiveness of a Combined Household-Level Piped Water and Sanitation Intervention on Child Diarrhoea, Acute Respiratory Infection, Soil-Transmitted Helminth Infection and Nutritional Status: A Matched Cohort Study in Rural Odisha, ." *International Journal of Epidemiology* 48 (6): 1757–67. https://doi.org/10.1093/ije/dyz157.

15. SK, S., P. Menon, and Aditi. 2020. "Tracking Progress in Anthropometric Failure among Children in India : A Geospatial Analysis Epidemiology." *Epidemiology* 10 (October).

16. Swaminathan, A., R. Kim, Y. Xu, J.C. Blossom, W. Joe, R. Venkataramanan, A. Kumar, and S. V. Subramanian. 2019. "Burden of Child Malnutrition in India: A View from Parliamentary Constituencies." *Economic and Political Weekly* 54 (2): 44–52.

17. Young, M.F., P. Nguyen, S. Kachwaha, L. Tran Mai, S. Ghosh, R. Agrawal, J. Escobar-Alegria, P. Menon, and R. Avula. 2020. "It Takes a Village: An Empirical Analysis of How Husbands, Mothers-in-Law, Health Workers, and Mothers Influence Breastfeeding Practices in Uttar Pradesh, India." *Maternal and Child Nutrition* 16 (2): 1–14. https://doi.org/10.1111/mcn.12892.

18. World Health Organization. Pulse survey on continuity of essential health services during the COVID-19 pandemic. Interim Report. August 2020.

Annexures

ANNEXURE 1A: STATE TEMPLATE-WOMEN AND CHILD DEVELOPMENT

Fourth POSHAN Abhiyaan Monitoring Report: Data Collection Form

WCD TEMPLATE

[Kindly fill information and share latest by 25th Sept 2020]

1. Name of the State/UT: .....
2. Total number of Districts in the State: .....
3. Total number of Districts with ICDS-CAS: .....
4. Total number of Blocks in the State: .....
5. Total number of Blocks with ICDS-CAS: .....
6. Total number of Villages in the State: .....
7. Total number of AWC in the State/UT: .....
8. If UT, does the UT have a State Legislature? Yes || No

HUMAN RESOURCE

HUMAN RESOURCE- POSHAN Abhiyaan(as on 31st March 2020)			
A	Joint Project Coordinator	No. of posts sanctioned	
		No. of posts filled	
B	Consultant	No. of posts sanctioned	
		No. of posts filled	
C	Project Associate	No. of posts sanctioned	
		No. of posts filled	

SECTION I:

NOTE: *You are requested to share our response separately for two months*

		March 2020	July 2020
A. TRAINING & CAPACITY BUILDING			
1.1	No. of District level Resource Groups (**DRGs**) for ILA training been established		
1.2	No. of Block level Resource Groups (**BRGs**) for ILA training been established		
1.3	Total no. of **AWWs enrolled** for e-ILA		
1.4	No. of enrolled AWWs who have **completed e-ILA** training		
1.5	Total no. of **Lady Supervisors enrolled** for e-ILA		
1.6	No. of enrolled Lady Supervisors who have **completed e-ILA training**		
1.7	Staff trained on ICDS-CAS Dashboard/Mobile		
	Staff	**March 2020**	**July 2020**
A	DPOs		
B	CDPOs		
C	LSs		
D	AWW		
1.8	No. of AWWs who have started entry in ICDS-CAS till July 2020:		

		March 2020				July 2020		
1.9	Staff trained on ILA Nos. Trained	**No. of modules**			**Nos. Trained**	**No. of modules**		
		Less than 7	**7-15**	**More than 15**		**Less than 7**	**7-15**	**More than 15**
A	State Level (SRG members)							
B	District Level (DRG members)							
C	Block Level (BRG members)							
D	Sector Level (AWWs)							
B. Convergence								
1.10 A	Has State/UT submitted the Convergence Action Plan (CAP) to CPMU for FY 2020-21 (*If no, give reason*)							Yes || No ||

B	No. of Districts in which **CAP has been formed**							No. of Districts:
C	No. of Districts held **Convergence Committee meeting for the 1st Quarter of FY 2020-21**							No. of Districts:
D	No. of Districts developed &**submitted CAP for FY 2020-21**							No. of Districts:

SECTION II:

NOTE: *You are requested to share our response separately for two months*

		March 2020	July 2020
A. PROGRAMME ACTIVITES- ICDS			
2.1	Total number of **pregnant women** enrolled for Anganwadi services		
2.2	No. of **pregnant women** who received THR for: 15-21 days		
	> 21+ days		
2.3	Total number of **lactating women** enrolled for Anganwadi services		
2.4	No. of **lactating women** who received THR for: 15-21 days		
	> 21+ days		
2.5	Total number of **children 6-36 months old** enrolled for Anganwadi services		
2.6	No. of children **6-36 months** old who received THR for: 15-21 days		
	> 21+ days		
2.7	Total number of children **3 yr-6 yr old** enrolled for Anganwadi services		
2.8	No. of children **3 yr-6 yr old** who received hot-cooked meal for: 15-21 days		
	> 21+ days		

2.9	Total number of children **0-5 years old** enrolled for Anganwadi services		
2.10	No. of children **0-5 years** old who were weighed		
2.11	No. of children **0-5 years** old whose height was taken (measured)		
B. Output Indicators- ICDS			
2.12	% of **newborns** with low birth weight (< 2500 gms)		
2.13	% of children **0-5 years** who were **moderately stunted** (height-for-age)		
2.14	% of children **0-5 years** who were **severely stunted** (height-for-age)		
2.15	% of children **0-5 years** who were **moderately underweight** (weight-for-age)		
2.16	% of children **0-5 years** who were **severely underweight** (weight-for-age)		
2.17	% of children **0-5 years** with **moderately acute malnutrition** (weight-for-height)		
2.18	% of children **0-5 years with severely acute malnutrition** (weight-for-height)		
2.19	% of children who were **initiated breastfeeding** within one hour of birth.		
2.20	% Infants 0-6 months of age who are fed **exclusively with breast milk**.		
2.21	% Children from **6–24 months who were initiated timely** complementary feeding **along with continued breastfeeding**		
2.22	% Children from **6–24 months** consuming **adequate diet**		
C. HOME VISITS by AWW			
2.27	Out of the mandated number of home visits, the % of home visits made by AWWs		
2.28	% of home visits to household with pregnant mothers to counsel on appropriate practices during pregnancy		
2.29	**PMMVY scheme**		
A.	No. of pregnant women targeted		
B.	No. of pregnant women benefited as per the entitlement		
2.30	% of home visits to household with **young infant (less than 6 month)** to counsel on Importance of immediate breastfeeding, initiation of complementary feeding and continued breastfeeding		

D. During COVID-19 times		
2.31	Please specify, any innovative techniques applied for providing services (March – July 2020) during COVID-19 19 times	Provide the innovations in brief (if required, **place the annexure for details**)
A	Counselling	
B	Growth Monitoring	
C	Community Based Events (CBEs)	
D	Pre-school Education	
E	Additional food provided other than THR	
2.32	In how many Districts, AWW is involved in contact tracing of the migrant workers who came back from other cities?	
2.33	During COVID-19 times, mention on what all other activities AWW is involved in?	1. 2. 3.

SECTION III: INNOVATION & FLEXI-PLAN

Sn	Status of Flexi-Plan					
3.1	a. Constitution of State Level Sanctioning Committee (SLSC) (Y/N) (if no, reason and timeline)	b. Date of Meeting of SLSC held (if no, reason and timeline)	c. Status of implementation (Detailed Activities)	d. Funds earmarked (In lakh Rs.)	e. Funds utilised (In lakh Rs.)	f. Balance Funds to be utilized (timeline also to be given)

SN	STATUS OF INNOVATION						
3.2	a. Innovation plan prepared (Y/N) (if no, reason and timeline)	b. Date of Meeting of SLSC held (if no, reason and timeline)	c. Approval of Committee obtained (if no, reason and timeline)	d. Status of imple-mentation and details of major activities	e. Funds earmarked (In lakh Rs.)	f. Funds utilised (In lakh Rs.)	g. Balance Funds to be utilized (timeline also to be given)

SECTION IV: ADDITIONAL INFORMATION

Sn	Information Required
4.1	Specify the main challenges faced in implementation of POSHAN Abhiyaan at State/ UT level during COVID-19 Times: (Provide details as attachment) i. ICDS_CAS ii. ILA & e-ILA iii. HR iv. Growth Monitoring Devices v. Convergence vi. Jan Andolan/ Community Mobilization vii. Any other
4.2	Specify the good practices or innovations State/UT has done in the year 2020 to improve the nutrition indicators during the first 1000 days life cycle especially in COVID-19 times: (Provide details as attachment)

ANNEXURE 1B: STATE TEMPLATE-HEALTH

FOURTH POSHAN Abhiyaan Monitoring Report: Data Collection Form

Health Template

[Kindly fill information and share latest by 25 Sept 2020]

1. Name of the State/UT: .....
2. Total number of Districts in the State: .....
3. Total number of Blocks in the State: .....
4. Total number of Villages in the State: .....
5. If UT, does the UT have a State Legislature? Yes || No

SECTION I:

Sn	Information Required	Response	
	A. INFRASTRUCTURE		
1.1	Number of Health Facilities in the State/UT- (as on 31st March 2020)		
	CHCs	No. sanctioned	
		No. functional	
		No. functional as FRU	
	PHCs	No. sanctioned	
		No. functional	
	Additional PHCs	No. sanctioned	
		No. functional	
	Sub Centres	No. sanctioned	
		No. functional	
	Health and Wellness Centres (HWC)	No. sanctioned	
		No. functional	
1.2	Provide details for HWCs (as on 31st March 2020)		
	Total no. HWCs planned		
	No. of HWCs operational		
	No. of HWCs providing ALL the proposed services		
	B. HUMAN RESOURCES (as on 31st March 2020)		
1.3	a. Lady Health Visitor (LHV)	No. of posts sanctioned	
		No. of LHVs in position	
	b. ANM	No. of posts sanctioned	

		No. of ANMs in position	
	c. ASHA Facilitators	Total no. in State/UT	
		No. of ASHAs per facilitator	
	d. ASHA	Total no. of ASHAs working in State/UTs	

SECTION II:

NOTE: *You are requested to share your response separately for two months*

			March 2020	July 2020
A. PROGRAMME AND OUTPUT ACTIVITES- NHM				
2.1	**A**	Total no. of **pregnant women**		
	B	Total no. of **lactating women**		
	C	Total no. of children **6-59 months**		
	D	Total no. children **12-23 months**		
	E	Total number of children **5-9 years**		
	F	Total no. of adolescent girls **10-19 years**		
	G	Total number of out of school **adolescent girls 10-19 years**		
2.2		Total no. of pregnant women who registered for ANC in the **first trimester**(i.e. in the first 12 weeks of pregnancy)		
2.3		Total no. of pregnant women who received **4 or more ANC check-ups**		
2.4		Total no. of pregnant women given TT2/booster		
2.5		Total no. of pregnant women given one **albendazole tablet after first trimester**		
2.6		Total number of **pregnant women** given 180 IFA tablets during ANC		
2.7		Total no. of **institutional deliveries**		
2.8		Total number of **lactating women** given 180 IFA tablets		
2.9		Total no. of children **12-23 months completely immunized**		
2.10		Total no. of children **6-59 months** who were provided at least **8-10 doses of IFA syrup** per month against the target population		
2.11		Total number of children **5-9 years (girls and boys) given weekly IFA** supplementation per month against the target population		

2.12	Total number of children **10-19 years (girls and boys) given weekly IFA** supplementation per month against the target population		
2.13	Total no. of children **(9-23 months)** who have received 1st dose of **Vitamin-A supplementation**		
2.14	Total no. of diarrhoea episodes reported in children 0 to 59 months of age		
2.15	Total no. of **deaths reported** due to childhood (0-59 months) diarrhoea		
2.16	Total no. of **childhood diarrhoea** cases treated in the facility (inpatient)		
2.17	Total no. of **diarrhoea episodes** reported in children 0 to 59 months of age where only **ORS was given**		
2.18	Total number of childhood (0-59 months) **diarrhoea** cases reported treated with **ORS and zinc**		
2.19	Total no. Number of newborn breastfed within one hour of birth (Early initiation of breastfeeding)		
2.20	No. of children **6 to 59 months** suffering from **ANY anaemia**		
2.21	No. of adolescent girls **15-19 years** suffering from **ANY anaemia**		
2.22	No. of **pregnant women** suffering from **ANY anaemia**		
2.23	AMB programme update		
A	Has IFA been included in the EDL?	Completed/In process/ Remark	
B	Has the State procured digital invasive hemoglobinometers	Completed/In process/ Remark	
B. HOME VISITS by ASHAs (DURING COVID-19 TIMES) MARCH -JULY 2020			
2.24	Out of the mandated number of home visits, the % of home visits made by ASHA during **March-July 2020**		
2.25	% of home visits to household with pregnant mothers to counsel on appropriate practices during pregnancy during **March-July 2020**		
2.26	% of HBNC home visits in **March-July 2020**		
2.27	Please specify, any innovative techniques applied for providing services like	Provide the innovations in brief (if required, place the annexure for details)	
A	Counselling		
B	Immunization		

C	IFA (syrup, pink, red, blue) distribution		
D	ORS and zinc distribution		
E	Total sick SAM admission at NRC		
F	Total sick SAM children discharged with target with gain at NRC		
2.28	In how many Districts, ASHAs is involved in contact tracing of the migrant workers who came back from other cities?		
2.29	During COVID-19 times, mention on what all other activities ASHAs are involved in?	1. 2. 3. 4. 5.	

SECTION III:

SN	INFORMATION REQUIRED	RESPONSE
3.1	Specify the main challenges faced in implementation of POSHAN Abhiyaan at State/ UT level during COVID-19 Times: (Provide details as attachment)	

ANNEXURE 2: RUBRIC

Theme	Sub- Theme	Indicators (as per Template) -USING ONLY MAR 2020 DATA	Weights (TOTAL=100)
WCD template TOTAL-50			**50**
Governance & Institutional Mechanism			**12**
1.1	**Fund Allocation**		**3**
		% utilized by the State/ UT (as on July, 2020)	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
1.2	**Constitution of Committees and Resource Groups**		**9**
		% of districts where DRGs have been formed–**Section 1–A- 1.1 A1.2**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of blocks where BRGs have been formed **Section 1–A–1.2**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of districts where the CAP committees have been formed– **Section 1–B–1.10 B**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
Strategy and Planning			**3**
		Has the State/UT level CAP been submitted to CPMU for the year 2020-21- **Section 1 B–1.10A**	1 if YES; 0 if NO
		% of districts that developed and submitted CAP for the year 2020-21- **Section 1 B–1.10D**	0.5 if <25%
			1 if 25%-<50%
			1.5 if 50%-<75%
			2 if ≥ 75%
Inputs for Service Delivery & Capacities			**23**
3.1	**HR**		**6**
		% of joint project coordinator positions filled–**HR–QA**	0.5 if <25%
			1 if 25%-<50%
			1.5 if 50%-<75%
			2 if ≥ 75%

Theme	Sub- Theme	Indicators (as per Template) -USING ONLY MAR 2020 DATA	Weights (TOTAL=100)
		% of consultant positions filled -**HR-QB**	0.5 if <25%
			1 if 25%-<50%
			1.5 if 50%-<75%
			2 if ≥ 75%
		% of project associate positions filled -**HR-QC**	0.5 if <25%
			1 if 25%-<50%
			1.5 if 50%-<75%
			2 if ≥ 75%
Supplies			**5**
	Mobile phones	% of mobile phones distributed to districts	0.25 if <25%
			0.5 if 25%-<50%
			0.75 if 50%-<75%
			1 if ≥ 75%
	Growth monitoring devices	% of weighing scales-infant distributed	0.25 if <25%
			0.5 if 25%-<50%
			0.75 if 50%-<75%
			1 if ≥ 75%
		% of weighing scales-adult distributed	0.25 if <25%
			0.5 if 25%-<50%
			0.75 if 50%-<75%
			1 if ≥ 75%
		% of infantometers distributed	0.25 if <25%
			0.5 if 25%-<50%
			0.75 if 50%-<75%
			1 if ≥ 75%
		% of stadiometers distributed	0.25 if <25%
			0.5 if 25%-<50%
			0.75 if 50%-<75%
			1 if ≥ 75%
Training and capacity building			**12**
		% of LS who completed training on e-ILA modules - **Section 1. A. -1.6**.	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%

Theme	Sub- Theme	Indicators (as per Template) -USING ONLY MAR 2020 DATA	Weights (TOTAL=100)
		% of AWWs who completed training on e-ILA modules **Section 1. A. -1.4**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of CDPOs who were trained on dashboard/mobile -**Section IA. 1.7B.**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of LS who were trained on dashboard/mobile - **Section IA. 1.7C.**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
Programme activities and intervention coverage			**12**
4.1	**Programme activities- ICDS**		**12**
		% of pregnant women who received THR for 21+ days- **Section II. 2.2.**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of lactating women who received THR for 21 + days- **Section II. 2.4.**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of children 6-36 months who received THR for 21+ days - **Section II. 2.5.**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of children 0-5 years who were weighed-**Section 2 A. 2.10**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
HEALTH TEMPLATE TOTAL-50			**50**
Service delivery essentials			**12**
1.1	**Infrastructure**		**9**

Theme	Sub- Theme	Indicators (as per Template) -USING ONLY MAR 2020 DATA	Weights (TOTAL=100)
		% of sub centres functional. **Section 1 A. 1.1B**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of CHCs functional **Section 1 A. 1.1A**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of HWC functional **Section 1 A. 1.1E**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
1.2	**Human Resource**		**3**
		% of ANM posts filled–**Section I-B 1.3**b	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
Programme activities and intervention coverage			**38**
2.1	**Programme activities**		**36**
		% of newborn breastfed within one hour of birth–**Section 2 A–2.19 [Data for live births from NITI]**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of children (12-23 mo) fully immunized in–**Section 2 A–2.9.**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of children (6-59 mo) who were provided at least 8-10 doses of IFA syrup per month–**Section 2 A–2.10.**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of pregnant women who registered for ANC in the first trimester–**Section 2 A–2.2.**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%

Theme	Sub- Theme	Indicators (as per Template) -USING ONLY MAR 2020 DATA	Weights (TOTAL=100)
		% of pregnant women who received 4 or more ANCs–**Section 2 A–2.3.**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of pregnant women who were given 180 IFA tablets Mar 2020- **Section 2 A–2.6**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of lactating women who were given 180 IFA tablets–**Section 2 A–2.8**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of 5-9 years children who were given weekly IFA tablets–**Section 2 A–2.11**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of pregnant women given TT2/ booster in Mar 2020/ **Section 2 A -2.4**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of pregnant women given one Albendazole tablet after first trimester -**Section 2 A–2.5**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of children (0–59 months) diarrhoea cases reported treated with ORS and Zinc–**Section 2 A-2.18**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
		% of home visits to household with pregnant mothers to counsel on appropriate practices during pregnancy during March-July 2020; **Section 2 B-2.25**	0 if <25%
			1 if 25%-<50%
			2 if 50%-<75%
			3 if ≥ 75%
2.2	**AMB strategy**		**2**

Theme	Sub- Theme	Indicators (as per Template) -USING ONLY MAR 2020 DATA	Weights (TOTAL=100)
		Has IFA been included in the EDL? **Section 2 A -2.23A**	0 Yet to begin
			0.5 In process
			1 Completed
		Has the State procured digital invasive hemoglobinometers **Section 2 A -2.23B**	0 Yet to begin
			0.5 In process
			1 Completed

ANNEXURE 3: STATE SCORE DASHBOARD OVERALL

		WCD Domain 1: Governance & Institutional Mechanism	WCD Domain 2: Strategy and Planning	WCD Domain 3: Service Delivery & Capacities	WCD Domain 4: Program activities and intervention coverage	Overall WCD score_ Sum of all 4 domains	Health Domain 1: Service delivery essentials	Health Domain 2: Program activities and intervention coverage	Overall Health score: Sum of 2 domains	Total implementation score
	Max value	***12***	***3***	***23***	***12***	***50***	12	***38***	***50***	***100***
Large States	Andhra Pradesh	10.00	3.00	22.00	12.00	47.00	12.00	28.00	40.00	87.00
	Assam	1.00	1.50	9.50	9.00	21.00	11.00	30.50	41.50	62.50
	Bihar	10.00	3.00	19.00	6.00	38.00	6.00	16.50	22.50	60.50
	Chattisgarh	10.00	2.50	9.25	12.00	33.75	11.00	27.50	38.50	72.25
	Gujarat	10.00	3.00	23.00	12.00	48.00	12.00	25.50	37.50	85.50
	Haryana	11.00	3.00	6.50	9.00	29.50	10.00	30.00	40.00	69.50
	Himachal Pradesh	11.00	3.00	17.25	11.00	42.25	9.00	31.50	40.50	82.75
	Jharkhand	10.00	3.00	12.00	11.00	36.00	11.00	26.50	37.50	73.50
	Karnataka	10.00	3.00	9.00	12.00	34.00	12.00	29.00	41.00	75.00
	Kerala	11.00	1.50	14.75	9.00	36.25	12.00	16.00	28.00	64.25
	Madhya Pradesh	10.00	3.00	19.25	12.00	44.25	10.00	28.50	38.50	82.75
	Maharashtra	11.00	2.00	20.50	12.00	45.50	10.00	32.00	42.00	87.50
	Odisha	9.00	2.00	9.25	12.00	32.25	11.00	31.00	42.00	74.25
	Punjab	9.00	2.00	5.75	11.00	27.75	9.00	11.00	20.00	47.75
	Rajasthan	10.00	3.00	17.75	9.00	39.75	10.00	17.00	27.00	66.75
	Tamil Nadu	11.00	3.00	22.50	12.00	48.50	10.00	24.50	34.50	83.00
	Telangana	10.00	3.00	10.50	10.00	33.50	11.00	31.00	42.00	75.50
	Uttar Pradesh	10.00	3.00	14.00	5.00	32.00	9.00	25.50	34.50	66.50
	Uttarakhand	10.00	1.50	11.00	9.00	31.50	10.00	26.50	36.50	68.00
Small States	Arunachal Pradesh	9.00	3.00	3.75	0.00	15.75	9.00	11.50	20.50	36.25
	Goa	4.00	1.50	6.50	12.00	24.00	12.00	20.00	32.00	56.00
	Manipur	2.00	0.00	1.25	0.00	3.25	10.00	14.00	24.00	27.25
	Meghalaya	12.00	3.00	19.00	11.00	45.00	11.00	12.50	23.50	68.50
	Mizoram	11.00	3.00	12.00	11.00	37.00	0.00	0.00	0.00	37.00
	Nagaland	12.00	3.00	17.00	1.00	33.00	11.00	7.00	18.00	51.00
	Sikkim	11.00	3.00	18.75	12.00	44.75	11.00	25.50	36.50	81.25
	Tripura	9.00	3.00	14.50	12.00	38.50	10.00	13.50	23.50	62.00
UTs	Andaman & Nicobar	4.00	1.50	21.50	12.00	39.00	11.00	26.00	37.00	76.00
	Chandigarh	10.00	3.00	23.00	12.00	48.00	9.00	23.00	32.00	80.00
	D & N Haveli & Daman & Diu	10.00	2.00	23.00	12.00	47.00	12.00	28.00	40.00	87.00
	Delhi	8.00	1.00	14.50	12.00	35.50	9.00	15.50	24.50	60.00
	Jammu & Kashmir	10.00	2.00	14.00	7.00	33.00	11.00	23.50	34.50	67.50
	Ladakh	3.00	3.00	5.00	9.00	20.00	10.00	20.00	30.00	50.00
	Lakshadweep	11.00	3.00	11.50	12.00	37.50	11.00	15.00	26.00	63.50
	Puducherry	7.00	2.50	6.50	8.00	24.00	10.00	20.50	30.50	54.50

Governance & Institutional Mechanism, WCD

		% utilized by the State/ UT (as on March, 2020)	1.1: Fund Allocation	% of districts where DRGs have been formed	% of blocks where BRGs have been formed	% of districts where the convergence action plan committees have been formed	1.2: Constitution of Committees and Resource Groups	Domain 1: Governance & Institutional Mechanism
	Max value	***3***	***3***	***3***	***3***	***3***	***9***	***12***
Large States	Andhra Pradesh	1.00	1.00	3.00	3.00	3.00	9.00	10.00
	Assam	1.00	1.00	0.00	0.00	0.00	0.00	1.00
	Bihar	1.00	1.00	3.00	3.00	3.00	9.00	10.00
	Chattisgarh	1.00	1.00	3.00	3.00	3.00	9.00	10.00
	Gujarat	1.00	1.00	3.00	3.00	3.00	9.00	10.00
	Haryana	2.00	2.00	3.00	3.00	3.00	9.00	11.00
	Himachal Pradesh	2.00	2.00	3.00	3.00	3.00	9.00	11.00
	Jharkhand	1.00	1.00	3.00	3.00	3.00	9.00	10.00
	Karnataka	1.00	1.00	3.00	3.00	3.00	9.00	10.00
	Kerala	2.00	2.00	3.00	3.00	3.00	9.00	11.00
	Madhya Pradesh	1.00	1.00	3.00	3.00	3.00	9.00	10.00
	Maharashtra	2.00	2.00	3.00	3.00	3.00	9.00	11.00
	Odisha	0.00	0.00	3.00	3.00	3.00	9.00	9.00
	Punjab	0.00	0.00	3.00	3.00	3.00	9.00	9.00
	Rajasthan	1.00	1.00	3.00	3.00	3.00	9.00	10.00
	Tamil Nadu	2.00	2.00	3.00	3.00	3.00	9.00	11.00
	Telangana	1.00	1.00	3.00	3.00	3.00	9.00	10.00
	Uttar Pradesh	1.00	1.00	3.00	3.00	3.00	9.00	10.00
	Uttarakhand	1.00	1.00	3.00	3.00	3.00	9.00	10.00
Small States	Arunachal Pradesh	0.00	0.00	3.00	3.00	3.00	9.00	9.00
	Goa	1.00	1.00		3.00	0.00	3.00	4.00
	Manipur	2.00	2.00				0.00	2.00
	Meghalaya	3.00	3.00	3.00	3.00	3.00	9.00	12.00
	Mizoram	2.00	2.00	3.00	3.00	3.00	9.00	11.00
	Nagaland	3.00	3.00	3.00	3.00	3.00	9.00	12.00
	Sikkim	2.00	2.00	3.00	3.00	3.00	9.00	11.00
	Tripura	0.00	0.00	3.00	3.00	3.00	9.00	9.00
UTs	Andaman & Nicobar	1.00	1.00			3.00	3.00	4.00
	Chandigarh	1.00	1.00	3.00	3.00	3.00	9.00	10.00
	D & N Haveli & Daman & Diu	1.00	1.00	3.00	3.00	3.00	9.00	10.00
	Delhi	2.00	2.00	3.00	3.00		6.00	8.00
	Jammu & Kashmir	1.00	1.00	3.00	3.00	3.00	9.00	10.00
	Ladakh	0.00	0.00	0.00	0.00	3.00	3.00	3.00
	Lakshadweep	2.00	2.00	3.00	3.00	3.00	9.00	11.00
	Puducherry	0.00	0.00	2.00	3.00	2.00	7.00	7.00

Score:	*< 25% : 0*	*25%-50% : 1*	*50%-75% : 2*	*> 75% : 3*

Strategy and Planning, WCD

		Convergence action plan submitted to CPMU for the year 2020-21	% of districts that developed and submitted CAP for the year 2020-21	Domain 2: Strategy and Planning
	Max value	*1*	*2*	*3*
Large States	Andhra Pradesh	1.00	2.00	3.00
	Assam	1.00	0.50	1.50
	Bihar	1.00	2.00	3.00
	Chattisgarh	1.00	1.50	2.50
	Gujarat	1.00	2.00	3.00
	Haryana	1.00	2.00	3.00
	Himachal Pradesh	1.00	2.00	3.00
	Jharkhand	1.00	2.00	3.00
	Karnataka	1.00	2.00	3.00
	Kerala	0.00	1.50	1.50
	Madhya Pradesh	1.00	2.00	3.00
	Maharashtra	0.00	2.00	2.00
	Odisha	0.00	2.00	2.00
	Punjab	0.00	2.00	2.00
	Rajasthan	1.00	2.00	3.00
	Tamil Nadu	1.00	2.00	3.00
	Telangana	1.00	2.00	3.00
	Uttar Pradesh	1.00	2.00	3.00
	Uttarakhand	1.00	0.50	1.50
Small States	Arunachal Pradesh	1.00	2.00	3.00
	Goa	1.00	0.50	1.50
	Manipur			0.00
	Meghalaya	1.00	2.00	3.00
	Mizoram	1.00	2.00	3.00
	Nagaland	1.00	2.00	3.00
	Sikkim	1.00	2.00	3.00
	Tripura	1.00	2.00	3.00
UTs	Andaman & Nicobar	1.00	0.50	1.50
	Chandigarh	1.00	2.00	3.00
	D & N Haveli & Daman and Diu	0.00	2.00	2.00
	Delhi	1.00		1.00
	Jammu & Kashmir	0.00	2.00	2.00
	Ladakh	1.00	2.00	3.00
	Lakshadweep	1.00	2.00	3.00
	Puducherry	1.00	1.50	2.50

Score: *No : 0; Yes : 1*	*< 25% : 0*	*25%-50% : 1*	*50%-75% : 2*	*> 75% : 3*

Inputs for Service Delivery & Capacities, WCD

		% of joint project coordinator positions filled	% of consultant positions filled	% of project associate positions filled	3.1: HR	% of mobile phones distributed to districts	% of weighing scales-infant distributed	% of weighing scales-adult distributed	% of infantometers distributed	% of stadiometers distributed	3.2: Supplies	% of LS who completed training on e-ILA modules	% of AWWs who completed training on e-ILA modules	% of CDPOs who were trained on dashboard/ mobile	% of LS who were trained on dashboard/ mobile	3.3: Training and capacity building	Domain 3: Service Delivery & Capacities
	Max value	*2*	*2*	*2*	*6*	*1*	*1*	*1*	*1*	*1*	*5*	*3*	*3*	*3*	*3*	*12*	*23*
Large States	Andhra Pradesh	2.00	1.00	2.00	5.00	1.00	1.00	1.00	1.00	1.00	5.00	3.00	3.00	3.00	3.00	12.00	22.00
	Assam	1.50	2.00	1.00	4.50	1.00	1.00	1.00	1.00	1.00	5.00	0.00	0.00	0.00	0.00	0.00	9.50
	Bihar	2.00	2.00	2.00	6.00	1.00	1.00	1.00	1.00	1.00	5.00	2.00	0.00	3.00	3.00	8.00	19.00
	Chattisgarh	0.50	2.00	1.50	4.00	0.75	0.50	0.50	0.25	0.25	2.25	1.00	0.00	1.00	1.00	3.00	9.25
	Gujarat	2.00	2.00	2.00	6.00	1.00	1.00	1.00	1.00	1.00	5.00	3.00	3.00	3.00	3.00	12.00	23.00
	Haryana	0.50	0.50	2.00	3.00	1.00	0.25	0.25	1.00	1.00	3.50	0.00	0.00	0.00	0.00	0.00	6.50
	Himachal Pradesh	2.00	2.00	2.00	6.00	0.25	1.00	1.00	1.00	1.00	4.25	1.00	1.00	2.00	3.00	7.00	17.25
	Jharkhand	2.00	0.50	1.50	4.00	1.00	1.00	1.00	1.00	1.00	5.00	0.00	0.00	2.00	1.00	3.00	12.00
	Karnataka	1.00	2.00	1.50	4.50	0.50	1.00	1.00	1.00	1.00	4.50	0.00	0.00	0.00	0.00	0.00	9.00
	Kerala	2.00	1.50	2.00	5.50	0.25	1.00	1.00	1.00	1.00	4.25	0.00	0.00	3.00	2.00	5.00	14.75
	Madhya Pradesh	2.00	2.00	2.00	6.00	0.50	0.75	1.00	1.00	1.00	4.25	3.00	3.00		3.00	9.00	19.25
	Maharashtra	2.00	1.00	1.50	4.50	1.00	1.00	1.00	1.00	1.00	5.00	3.00	3.00	2.00	3.00	11.00	20.50
	Odisha	1.00	0.50	0.50	2.00	0.25	0.25	0.25	0.25	0.25	1.25	3.00	3.00			6.00	9.25
	Punjab	0.50	0.50	0.50	1.50	0.25	1.00	1.00	1.00	1.00	4.25	0.00	0.00		0.00	0.00	5.75
	Rajasthan	2.00	2.00	2.00	6.00	0.50	0.25	0.50	0.75	0.75	2.75	3.00	3.00	1.00	2.00	9.00	17.75
	Tamil Nadu	2.00	2.00	1.50	5.50	1.00	1.00	1.00	1.00	1.00	5.00	3.00	3.00	3.00	3.00	12.00	22.50
	Telangana	2.00	2.00	2.00	6.00	0.50	1.00	1.00	1.00	1.00	4.50	0.00	0.00	0.00	0.00	0.00	10.50
	Uttar Pradesh	1.00	0.50	0.50	2.00	0.50	0.50	0.50	0.25	0.25	2.00	3.00	3.00	1.00	3.00	10.00	14.00
	Uttarakhand	2.00	2.00	2.00	6.00	1.00	1.00	1.00	1.00	1.00	5.00	0.00	0.00	0.00	0.00	0.00	11.00

Small States	Arunachal Pradesh	0.50	1.50	0.50	2.50	0.25	0.25	0.25	0.25	0.25	1.25	0.00	0.00			0.00	3.75
	Goa	0.50	0.50	0.50	1.50	1.00	1.00	1.00	1.00	1.00	5.00	0.00	0.00	0.00	0.00	0.00	6.50
	Manipur				0.00	0.25	0.25	0.25	0.25	0.25	1.25					0.00	1.25
	Meghalaya	2.00	1.00	2.00	5.00	1.00	1.00	1.00	1.00	1.00	5.00	3.00	0.00	3.00	3.00	9.00	19.00
	Mizoram	2.00	2.00	2.00	6.00	1.00	1.00	1.00	1.00	1.00	5.00	0.00	0.00	0.00	1.00	1.00	12.00
	Nagaland	2.00	2.00	2.00	6.00	1.00	1.00	1.00	1.00	1.00	5.00	0.00	0.00	3.00	3.00	6.00	17.00
	Sikkim	2.00	0.50	2.00	4.50	0.75	0.25	0.25	0.75	0.25	2.25	3.00	3.00	3.00	3.00	12.00	18.75
	Tripura	0.50	0.50	0.50	1.50	1.00	0.25	0.25	0.25	0.25	2.00	3.00	3.00	3.00	2.00	11.00	14.50
UTs	Andaman & Nicobar	0.50	2.00	2.00	4.50	1.00	1.00	1.00	1.00	1.00	5.00	3.00	3.00	3.00	3.00	12.00	21.50
	Chandigarh	2.00	2.00	2.00	6.00	1.00	1.00	1.00	1.00	1.00	5.00	3.00	3.00	3.00	3.00	12.00	23.00
	D & N Haveli & Daman & Diu	2.00	2.00	2.00	6.00	1.00	1.00	1.00	1.00	1.00	5.00	3.00	3.00	3.00	3.00	12.00	23.00
	Delhi	2.00	1.00	0.50	3.50	1.00	1.00	1.00	1.00	1.00	5.00	0.00	0.00	3.00	3.00	6.00	14.50
	Jammu & Kashmir	2.00	0.50	0.50	3.00	1.00	1.00	1.00	1.00	1.00	5.00	3.00	3.00	0.00	0.00	6.00	14.00
	Ladakh				0.00	1.00	1.00	1.00	1.00	1.00	5.00	0.00	0.00	0.00	0.00	0.00	5.00
	Lakshadweep	0.50	1.00	2.00	3.50	1.00	1.00	1.00	1.00	1.00	5.00	0.00	0.00	3.00	0.00	3.00	11.50
	Puducherry	0.50	0.50	0.50	1.50	1.00	1.00	1.00	1.00	1.00	5.00	0.00	0.00	0.00	0.00	0.00	6.50

Score:	*< 25% : 0*	*25%-50% : 1*	*50%-75% : 2*	*> 75% : 3*

Programme activities and intervention coverage, WCD

		% of pregnant women who received THR for 21+ days	% of lactating women who received THR for 21+ days	% of children 6-36 mo who received THR for 21+ days	% of children 0-5 years who were weighed	Domain 4: Program activities and intervention coverage
	Max value	***3***	***3***	***3***	***3***	***12***
Large States	Andhra Pradesh	3.00	3.00	3.00	3.00	12.00
	Assam	3.00	3.00	3.00		9.00
	Bihar	2.00	2.00	2.00	0.00	6.00
	Chattisgarh	3.00	3.00	3.00	3.00	12.00
	Gujarat	3.00	3.00	3.00	3.00	12.00
	Haryana	2.00	2.00	2.00	3.00	9.00
	Himachal Pradesh	3.00	3.00	3.00	2.00	11.00
	Jharkhand	3.00	3.00	3.00	2.00	11.00
	Karnataka	3.00	3.00	3.00	3.00	12.00
	Kerala	3.00	3.00	3.00	0.00	9.00
	Madhya Pradesh	3.00	3.00	3.00	3.00	12.00
	Maharashtra	3.00	3.00	3.00	3.00	12.00
	Odisha	3.00	3.00	3.00	3.00	12.00
	Punjab	3.00	3.00	2.00	3.00	11.00
	Rajasthan	3.00	3.00	3.00		9.00
	Tamil Nadu	3.00	3.00	3.00	3.00	12.00
	Telangana	3.00	3.00	3.00	1.00	10.00
	Uttar Pradesh	0.00		3.00	2.00	5.00
	Uttarakhand	3.00	3.00	3.00		9.00
Small States	Arunachal Pradesh				0.00	0.00
	Goa	3.00	3.00	3.00	3.00	12.00
	Manipur					0.00
	Meghalaya	3.00	3.00	3.00	2.00	11.00
	Mizoram	3.00	3.00	3.00	2.00	11.00
	Nagaland				1.00	1.00
	Sikkim	3.00	3.00	3.00	3.00	12.00
	Tripura	3.00	3.00	3.00	3.00	12.00
UTs	Andaman & Nicobar	3.00	3.00	3.00	3.00	12.00
	Chandigarh	3.00	3.00	3.00	3.00	12.00
	D & N Haveli & Daman & Diu	3.00	3.00	3.00	3.00	12.00
	Delhi	3.00	3.00	3.00	3.00	12.00
	Jammu & Kashmir	1.00	2.00	2.00	2.00	7.00
	Ladakh	3.00	3.00	3.00	0.00	9.00
	Lakshadweep	3.00	3.00	3.00	3.00	12.00
	Puducherry	3.00	1.00	3.00	1.00	8.00

Score:	*< 25% : 0*	*25%-50% : 1*	*50%-75% : 2*	*> 75% : 3*

Service delivery essentials, Health

		% of sub centres functional	% of CHCs functional	% of HWCs functional	1.1: Infrastructure	% of ANM posts filled	1.2: Human Resource	Domain 1: Service delivery essentials
	Max value	***3***	***3***	***3***	***9***	***3***	***3***	***12***
Large States	Andhra Pradesh	3.00	3.00	3.00	9.00	3.00	3.00	12.00
	Assam	3.00	3.00	2.00	8.00	3.00	3.00	11.00
	Bihar	2.00	1.00	1.00	4.00	2.00	2.00	6.00
	Chattisgarh	3.00	3.00	2.00	8.00	3.00	3.00	11.00
	Gujarat	3.00	3.00	3.00	9.00	3.00	3.00	12.00
	Haryana	3.00	3.00	1.00	7.00	3.00	3.00	10.00
	Himachal Pradesh	3.00	3.00	1.00	7.00	2.00	2.00	9.00
	Jharkhand	3.00	3.00	2.00	8.00	3.00	3.00	11.00
	Karnataka	3.00	3.00	3.00	9.00	3.00	3.00	12.00
	Kerala	3.00	3.00	3.00	9.00	3.00	3.00	12.00
	Madhya Pradesh	3.00	3.00	1.00	7.00	3.00	3.00	10.00
	Maharashtra	3.00	3.00	1.00	7.00	3.00	3.00	10.00
	Odisha	3.00	3.00	2.00	8.00	3.00	3.00	11.00
	Punjab	3.00	3.00	3.00	9.00			9.00
	Rajasthan	3.00	3.00	1.00	7.00	3.00	3.00	10.00
	Tamil Nadu	3.00	3.00	1.00	7.00	3.00	3.00	10.00
	Telangana	3.00	3.00	2.00	8.00	3.00	3.00	11.00
	Uttar Pradesh	3.00	3.00	1.00	7.00	2.00	2.00	9.00
	Uttarakhand	3.00	3.00	1.00	7.00	3.00	3.00	10.00
Small States	Arunachal Pradesh	2.00	3.00	1.00	6.00	3.00	3.00	9.00
	Goa	3.00	3.00	3.00	9.00	3.00	3.00	12.00
	Manipur	3.00	3.00	1.00	7.00	3.00	3.00	10.00
	Meghalaya	3.00	3.00	2.00	8.00	3.00	3.00	11.00
	Mizoram				0.00			0.00
	Nagaland	3.00	2.00	3.00	8.00	3.00	3.00	11.00
	Sikkim	3.00	3.00	2.00	8.00	3.00	3.00	11.00
	Tripura	3.00	3.00	2.00	8.00	2.00	2.00	10.00
UTs	Andaman & Nicobar	3.00	3.00	2.00	8.00	3.00	3.00	11.00
	Chandigarh		3.00	3.00	6.00	3.00	3.00	9.00
	D & N Haveli & Daman & Diu	3.00	3.00	3.00	9.00	3.00	3.00	12.00
	Delhi	3.00	3.00		6.00	3.00	3.00	9.00
	Jammu & Kashmir	3.00	3.00	2.00	8.00	3.00	3.00	11.00
	Ladakh	3.00	3.00	1.00	7.00	3.00	3.00	10.00
	Lakshadweep	2.00	3.00	3.00	8.00	3.00	3.00	11.00
	Puducherry	3.00	3.00	1.00	7.00	3.00	3.00	10.00

Score:	*< 25% : 0*	*25%-50% : 1*	*50%-75% : 2*	*> 75% : 3*

Programme activities and intervention coverage, Health

		% of newborn breastfed within one hour of birth	% of children (12-23 mo) fully immunized	% of children (6-59 mo) provided at least 8-10 doses of IFA syrup	% of pregnant women who registered for ANC in the first trimester	% of pregnant women who received 4 or more ANCs	% of pregnant women who were given 180 IFA tablets Mar 2020	% of lactating women who were given 180 IFA tablets	% of 5-9 years children who were given weekly IFA tablets	% of pregnant women given TT2/ booster in Mar 2020	% of pregnant women given 1 Albendazole tablet after first trimes	% of children (0-59 mo) diarrhoea cases reported treated with ORS	% of home visits to household with pregnant mothers to counsel on practices during pregnancy	2.1: Program activities	Has IFA been included in the EDL?	Has the State procured digital invasive hemoglobinometers?	2.2_AMB strategy	Domain 2: Program activities and intervention coverage
	Max value	***3***	***3***	***3***	***3***	***3***	***3***	***3***	***3***	***3***	***3***	***3***	***3***	***36***	***1***	***1***	***2***	***38***
	Score:	*< 25% : 0 25%-50% : 1 50%-75% : 2 > 75% : 3*	*< 25% : 0 25%-50% : 1 50%-75% : 2 > 75% : 3*	*< 25% : 0 25%-50% : 1 50%-75% : 2 > 75% : 3*	*< 25% : 0 25%-50% : 1 50%-75% : 2 > 75% : 3*	*< 25% : 0 25%-50% : 1 50%-75% : 2 > 75% : 3*	*< 25% : 0 25%-50% : 1 50%-75% : 2 > 75% : 3*	*< 25% : 0 25%-50% : 1 50%-75% : 2 > 75% : 3*	*< 25% : 0 25%-50% : 1 50%-75% : 2 > 75% : 3*	*< 25% : 0 25%-50% : 1 50%-75% : 2 > 75% : 3*	*< 25% : 0 25%-50% : 1 50%-75% : 2 > 75% : 3*	*< 25% : 0 25%-50% : 1 50%-75% : 2 > 75% : 3*	*< 25% : 0 25%-50% : 1 50%-75% : 2 > 75% : 3*		*Yet to begin : 0 In process : 0.5 Com-pleted: 1*	*Yet to begin : 0 In process : 0.5 Completed: 1*		
Large States	Andhra Pradesh	3.00	3.00	0.00	3.00	3.00	3.00	2.00	1.00	3.00	1.00	3.00	1.00	26.00	1.00	1.00	2.00	28.00
	Assam	3.00	3.00	1.00	3.00	3.00	3.00	3.00	0.00	3.00	2.00	3.00	2.00	29.00	1.00	0.50	1.50	30.50
	Bihar	3.00	0.00	0.00	2.00	2.00	3.00	1.00	0.00	3.00	1.00			15.00	1.00	0.50	1.50	16.50
	Chattisgarh	3.00	0.00	0.00	3.00	3.00	3.00	2.00	0.00	3.00	3.00	3.00	3.00	26.00	1.00	0.50	1.50	27.50
	Gujarat	3.00	0.00	0.00	3.00	3.00	3.00	0.00	3.00	3.00	3.00	3.00		24.00	1.00	0.50	1.50	25.50
	Haryana	3.00	3.00	2.00	3.00	2.00	3.00	1.00	0.00	3.00	2.00	3.00	3.00	28.00	1.00	1.00	2.00	30.00
	Himachal Pradesh	3.00	3.00	3.00	3.00	2.00	3.00		3.00	3.00	2.00	3.00	2.00	30.00	1.00	0.50	1.50	31.50
	Jharkhand	3.00	3.00	0.00	2.00	3.00	3.00	3.00	0.00	3.00	1.00	1.00	3.00	25.00	1.00	0.50	1.50	26.50
	Karnataka	3.00	3.00	0.00	3.00	3.00	3.00	3.00		3.00	2.00	3.00	2.00	28.00	1.00	0.00	1.00	29.00

	Kerala	3.00	0.00	0.00	3.00	3.00	3.00	0.00		2.00	0.00	0.00		14.00	1.00	1.00	2.00	16.00
	Madhya Pradesh	3.00	3.00	0.00	2.00	3.00	3.00	3.00	2.00	3.00	2.00	3.00	0.00	27.00	1.00	0.50	1.50	28.50
	Maharashtra	3.00	3.00	1.00	3.00	3.00	3.00	2.00	1.00	3.00	2.00	3.00	3.00	30.00	1.00	1.00	2.00	32.00
	Odisha	3.00		1.00	3.00	3.00	3.00	3.00	1.00	3.00	3.00	3.00	3.00	29.00	1.00	1.00	2.00	31.00
	Punjab	3.00	1.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	3.00	3.00	10.00	0.50	0.50	1.00	11.00
	Rajasthan	0.00		0.00	2.00	2.00	1.00	3.00		3.00	2.00	3.00		16.00	0.50	0.50	1.00	17.00
	Tamil Nadu	2.00	0.00	0.00	3.00	3.00	3.00	0.00	2.00	3.00	1.00	3.00	3.00	23.00	1.00	0.50	1.50	24.50
	Telangana	3.00	3.00	2.00	2.00	2.00	3.00	2.00	2.00	3.00	1.00	3.00	3.00	29.00	1.00	1.00	2.00	31.00
	Uttar Pradesh	3.00	3.00	0.00	2.00	3.00	3.00	3.00	0.00	3.00	1.00	3.00		24.00	1.00	0.50	1.50	25.50
	Uttarakhand	3.00	3.00	0.00	2.00	2.00	3.00	2.00	3.00	3.00	0.00	1.00	3.00	25.00	1.00	0.50	1.50	26.50
Small States	Arunachal Pradesh	3.00	0.00	0.00	1.00	1.00	2.00	1.00	0.00	2.00	0.00		0.00	10.00	1.00	0.50	1.50	11.50
	Goa	3.00		0.00	2.00	3.00	2.00	3.00		1.00	1.00	3.00		18.00	1.00	1.00	2.00	20.00
	Manipur	3.00	1.00	0.00	2.00	2.00	1.00	1.00		2.00	0.00	1.00		13.00	0.50	0.50	1.00	14.00
	Meghalaya	3.00	3.00	0.00	1.00	1.00	1.00	0.00		2.00	0.00	0.00		11.00	1.00	0.50	1.50	12.50
	Mizoram													0.00			0.00	0.00
	Nagaland	2.00	0.00	0.00	1.00	0.00	1.00	0.00	0.00	1.00	0.00			5.00	1.00	1.00	2.00	7.00
	Sikkim	2.00	2.00	3.00	3.00	2.00	2.00	3.00	0.00	3.00	1.00	0.00	3.00	24.00	1.00	0.50	1.50	25.50
	Tripura	3.00	3.00	0.00	0.00	0.00	0.00	0.00	3.00	0.00	0.00		3.00	12.00	1.00	0.50	1.50	13.50
UTs	Andaman & Nicobar	3.00	3.00	1.00	2.00	3.00	2.00	1.00	2.00	3.00	2.00	0.00	3.00	25.00	1.00	0.00	1.00	26.00
	Chandigarh	3.00	0.00	0.00	2.00	3.00	3.00	3.00	3.00	3.00	2.00			22.00	0.50	0.50	1.00	23.00
	D & N Haveli & Daman & Diu	3.00	3.00	1.00	3.00	3.00	3.00	0.00	0.00	3.00	3.00	2.00	3.00	27.00	1.00	0.00	1.00	28.00
	Delhi	2.00	0.00		2.00	3.00	3.00	1.00		1.00	1.00		1.00	14.00	1.00	0.50	1.50	15.50
	Jammu & Kashmir	3.00	3.00	0.00	2.00	3.00	2.00	3.00	0.00	2.00	0.00	1.00	3.00	22.00	1.00	0.50	1.50	23.50
	Ladakh	0.00	3.00	0.00	2.00	2.00	3.00	3.00	0.00	2.00	0.00	2.00	2.00	19.00	0.50	0.50	1.00	20.00
	Lakshadweep	3.00	0.00	0.00	2.00	3.00	3.00			2.00	1.00			14.00	0.50	0.50	1.00	15.00
	Puducherry	0.00	0.00	3.00	1.00	2.00	3.00	0.00	3.00	1.00	3.00	0.00	3.00	19.00	0.50	1.00	1.50	20.50

ANNEXURE 4: POSHAN ABHIYAAN II MONITORING REPORT: DATA COLLECTION FORM FOR MOWCD

S.No.	INFORMATION REQUIRED *[May share Annexures, Figures or % wherever available]*	RESPONSE
1	**Details on Flexi-Funds (till 31st March,2020):**	
	a. State/UT wise utilization of Flexi-funds (in lakhs)	₹ 6067.84 *(Details are annexed at **Annexure 4-A**)*
	b. Any innovative aspect taken for utilising Flexi Fund	
2.	**Convergent activities undertaken by MoWCD jointly by other Line Ministries and Departments for supporting POSHAN Abhiyaan (till 31st March,2020)**	Details are annexed at **Annexure 4-B** *(As reported by Partnering Ministries and Departments)*
3.	**Details on supplementary nutrition: (till 31st March,2020)**	
	a. State-wise information on the type and content of Supplementary Nutrition as THR and Hot- cooked Meal	Details are annexed at **Annexure 4-D**
	b. State-wise information on the fortified Supplementary Nutrition (THR and Hot-cooked Meal) provided under ICDS	Details are annexed at **Annexure 4-D**
	c. Information on the proportion of malnourished children who received increased rations under SNP rules	14,23,136 *(Details are annexed at **Annexure 4-E**)*
	d. Any other (specify)	
4.	**Best practices/Innovations** made by MoWCD, especially during COVID-19 times that can be scaled-up for strengthening Nutritional indicators in all States/UTs (Give State specific details)	Details are annexed at **Annexure 4-C** *(Best practices/Innovations along with DO letter issued to all States/UTs by this Ministry)*
5.	Challenges faced (if any):	• Manpower Shortages- vacancies at various levels • Training and capacity building of field functionaries • Slow roll-out of ICDS-CAS and procurement of GMDs • Sustaining "Jan Andolan" activities • Enhanced Engagement with elected representatives • Multiple IT Platforms • Low and delayed utilization of funds • Convergence essential for expanding • Shortage of Anganwadi buildings, toilets and drinking water facilities

6.	State/UT wise Details on **POSHAN Maah 2020**:	
	• No. of participants	3,65,95,20,157
	• No. of events	13,90,00,170
	• No. of SAM children identified	Not available
	• No. of SAM children referred	Not available
	• Other details of the event	Need to be specified

ANNEXURE 4-A

Flexi-Funds

S.No.	State/UTs	Flexi Fund approved by SLSC committee	Status of implementation/ funds earmarked (Rs. in lakh)	Funds Utilised (Rs. in Lakh)	Activities
1	**A&N Islands**	Yes	Implementation Initiated (Rs.26.88)	Rs.18.92	• Organizing Suposhan Diwas once in a month during the month of February & March, 2020–nukkad natak, healthy baby showers, cooking champs etc. • Celebration of Bal Sabha₹ in all AWC- Awards, Prizes, refreshments • Diploma course on Nutrition at IGNOU – Capacity Building of AWC/Mukhya Sevikas.
2	**Andhra Pradesh**	Yes	Implementation Initiated (Rs.650.54)	Rs.408.84	• ICDS Workshop • Anganwadi Level Monitoring Support Committee • Printing of IEC Materials • Printing of Sri Mitra Books • Sub-Centre Level Meeting • Multi-Sectoral CAP • Improving Health and Nutrition Status (Tribal Areas) “100 Days Care” IEC Material • Need based modules (ILA- Sectoral Level) • Growth Monitoring Slip Books • Project Management Expense • IEC video films

S.No.	State/UTs	Flexi Fund approved by SLSC committee	Status of implementation/ funds earmarked (Rs. in lakh)	Funds Utilised (Rs. in Lakh)	Activities
3	**Arunachal Pradesh**	Under process	Proposal received	Rs.4.47	• 14.2 kg cylinder security deposit & other charges for 778 LPG connection • Gas Stove-778 • Refilling quarterly in a year @appox Rs.900 X 4 cylinders
4	**Assam**	Yes	Implementation Initiated (Rs.1264.34)	Rs.8.32	• Digital Media Campaign • Capacity Building of State, District & Block Officials • Pico Projector • Learning Corner Development • Solar Kit • Digital Platform
5	**Bihar**	Yes	Implementation Initiated (Rs.1159.07)	Rs.669.78	• Refresher Training of AWW on ICT-RTM • Refresher Training of LS on ICT-RTM • Gap Training Orientation of Master trainers • Solar Fan/Light System at AWC • Configuration cost of smart phone • LCD display monitor with battery and inverter to AWC • BALA (Building as a learning aid)
6	**Chandigarh**	Yes	Implementation Initiated (Rs.46.21)	Rs.46.21	• Stainless Utensils • Water Purifiers
7	**Chhattisgarh**	Yes	Under Process	—	—

S.No.	State/UTs	Flexi Fund approved by SLSC committee	Status of implementation/ funds earmarked (Rs. in lakh)	Funds Utilised (Rs. in Lakh)	Activities
8	**Dadra & Nagar Haveli**	Yes	Implementation Initiated (22.1)	Rs.10.85	• Procurement of ECCE Material • Training and Capacity Building of AWW (Physical and Motor skill development, Language development, listening skill, Speaking skill, Reading preparation, Word wall, Teaching learning materials, stories etc.)
9	**Daman and Diu**	Yes	Implementation Initiated (Rs. 13.83)	Rs.3.00	• ECCE Material-Tool Kit
10	**Delhi**	Yes	Under Process (Rs.300)	Rs.29.29	• Incentives to AWWs and AWHs for improving nutritional status of stunted and wasted children
11	**Goa**	No	Proposal yet to be received	—	—
12	**Gujarat**	Yes	Implementation Initiated (Rs.1439.02)	Rs.755.88	• Children Nutrition Park at "Statue of Unity" at Kevadiya Colony • Setting up of State Management Centre (SMC) • State level meetings, workshops and training • ICDS CAS Dashboard training • e-ILA orientation and certificate printing • ILA refresher training • Strengthening of District and Help desk team of POSHAN Abhiyaan

S.No.	State/UTs	Flexi Fund approved by SLSC committee	Status of implementation/ funds earmarked (Rs. in lakh)	Funds Utilised (Rs. in Lakh)	Activities
					• Supportive supervision of POSHAN Abhiyaan components • Strengthening of Financial Management system at State
13	**Haryana**	Yes	Implementation Initiated (Rs.333)	Rs.24.00	• Kitchen Gardening (Rs.1.89 core) • Strengthening of monitoring mechanism at Block Level & District Level (Rs.1.44 crore)
14	**Himachal Pradesh**	Yes	Implementation Initiated	Rs.231.02	• Swachhta Kit @ 1146 per AWC/ Mini AWC
15	**Jammu and Kashmir**	No	Proposal yet to be received	—	—
16	**Jharkhand**	Yes	Under Process	—	• Mobile based application for supportive supervision • Printing of e-ILA certificates.
17	**Karnataka**	Yes	Under Process (Rs.1151.34)	Rs.117.62	• Strengthening of CDPO offices • Strengthening of DD offices • Orientation of Balvikas Samithies
18	**Kerala**	Yes	Implementation Initiated (Rs.501)	Rs.150.82	• Setting up of DPMUs & Expenses • Setting up of BPMUs • Smartphones and Data Plan to AWW and operating Staff • Mobile Configuration & MT CAS Training
19	**Ladakh**	No	—	—	—

S.No.	State/UTs	Flexi Fund approved by SLSC committee	Status of implementation/ funds earmarked (Rs. in lakh)	Funds Utilised (Rs. in Lakh)	Activities
20	**Lakshadweep**	Yes	Implementation Initiated (Rs.22.79)	Rs.4.30	• Poshan Maah 2018-19 (Rs.4.3 Lakh) • Printing traditional culinary art book (Rs.5.5 Lakh)
21	**Madhya Pradesh**	Yes	Implementation Initiated (Rs.2605.17)	Rs.250.31	• "Angan" Nutrition Care Centre Angan–Camp to established community-based management of severe underweight children • Electricity Facility through Solar Panel at AWC • Poshan Sakhi: This proposal aimed to utilize the second-best opportunity in life to prevent and prevent malnutrition and anaemia.
22	**Maharashtra**	Yes	Implementation Initiated (Rs.1811.12)	Rs.608.24	• Sensitization of elected representatives of PRIs and Urban local bodies • Joint workshops of health & ICDS to promote behaviour change communication • Training of Supervisors on supervisor Application of CAS • Induction-cum-training of State, District, and Block-Helpdesk staff • Training of State, District officials and CDPOs on Dashboard

S.No.	State/UTs	Flexi Fund approved by SLSC committee	Status of implementation/ funds earmarked (Rs. in lakh)	Funds Utilised (Rs. in Lakh)	Activities
					• Review Meeting of District and Block level help desk • Travel cost of ICDS officials (JPCs and Nodal officer) to Delhi/ other lo cation for GOI meetings • Quick research study on cultural no rms to understand the factors inhibiting behaviour change communication in order to achieve the goals of POSHAN Abhiyaan. The State is going to sign MoU with T.H. Chan Research Center, Mumbai under Harvard University
23	**Manipur**	Yes	Under Process (Rs.61.6)	Under process	• Plan for slogan, essay and drawing competition on safe drinking water/ healthy eating habits • Promoting Nutri Garden in 16 POSHAN Abhiyaan Districts • Provision of electricity to 500 pucca AWC @ Rs.5,000/- per AWC
24	**Meghalaya**	Yes	Implementation Initiated	Rs.150.24	• Printing of Flip Books: 6170 nos. • Printing of takeaways

S.No.	State/UTs	Flexi Fund approved by SLSC committee	Status of implementation/ funds earmarked (Rs. in lakh)	Funds Utilised (Rs. in Lakh)	Activities
25	**Mizoram**	Yes	Implementation Initiated (Rs.88.5 6)	Rs.88.56	• POSHAN related travel expenses. Specially for the District and Block staff recruited under POSHAN Abhiyaan • Expenses at ILA training at sectoral levels and other miscellaneous POSHAN activity-related Expenses • District and Block IT infrastructure and equipment
26	**Nagaland**	Yes	Implementation Initiated	Rs.213.55	• One Time Grant to AWC for CBE • Purchase of Smokeless Chullas for Peren Districts • Establishment of 22 Nutri-Gardens • ILA Takeaways for 21 Modules (25 Takeaways) • ICDS-CAS Training for AWWs, LS, DPOs, CDPOs & State Officials
27	**Odisha**	—	—	—	—
28	**Puducherry**	Yes	Implementation Initiated (10.95)	Rs.8.50	• Configuration of Mobile Devices • Printing of Takeaways to the AWW • ICDS-CAS Training to AWW • Painting of AWC with the POSHAN Abhiyaan themes • Provision of I.D. Cards to AWWs
29	**Punjab**	Yes	Under Process (Rs.292.4)	Under Process	• Upgradation of AWC to Model AWC

S.No.	State/UTs	Flexi Fund approved by SLSC committee	Status of implementation/ funds earmarked (Rs. in lakh)	Funds Utilised (Rs. in Lakh)	Activities
30	**Rajasthan**	Yes	Implementation Initiated (Rs. 1288.21)	Rs.246.92	• Configuration of Smartphones & ICT-RTM (LS & AWWs) • Refresher Training on CAS & ILA • Strengthening of CDPO offices • Strengthening of DDs Offices • Web Based Monitoring Information System • Printing of Monthly Single Register • Maintenance & Repair/AMC (Growth Monitoring Devices) • Orientation Workshops • Orientation of PRIs • Exposure/Study Visit/Review Monitoring
31	**Sikkim**	Yes	Implementation Initiated (Rs 49.98)	Rs.49.98	• Celebration of 3rd Anniversary of Launching of POSHAN Abhiyaan • POSHAN Phagwada • Provision of VC Lab at SPMU • World Breast Feeding Week • International Yoga Day • World Health Day • Village Health Sanitation and Nutrition Day

S.No.	State/UTs	Flexi Fund approved by SLSC committee	Status of implementation/ funds earmarked (Rs. in lakh)	Funds Utilised (Rs. in Lakh)	Activities
32	**Tamil Nadu**	Yes	Implementation Initiated (Rs.516.95)	Rs.248.73	• Electricity to 220 AWC • Printing and Supply of Handbook on Growth Monitoring Devices • Printing and supply of guidelines in Tamil language • Expenditure on convening the Convergence Plan Committee meeting at State/Districts/ Blocks • Procurement of LCD Projector for 32 Districts • Imparting orientation, induction & sensitization training • Promoting Kitchen Garden in 655 AWC • Six-seater table chair kit • Mobile configuration & preparation of devices training to Help Desk Personnel (Phase I & II Districts)
33	**Telangana**	—	—	—	—
34	**Tripura**	Under process	Proposal received	—	—
35	**Uttar Pradesh**	Yes	Implementation initiated (Rs. 20 42.03)	Rs.1401.97	• Suposhan Swasth Mela • Flip Book
36	**Uttarakhand**	Yes	Implementation initiated (Rs.697.12)	Rs. 317.52	• Hydroponic Farming • Solar Cooker • Recipe Book
37	**West Bengal**	No	Proposal yet to be received	—	—
Total					**Rs.6067.84**

ANNEXURE 4-B

Convergence activities undertaken by partner Ministries/ Departments under POSHAN Abhiyaan

S. No.	Ministry	Activity
1.	**Ministry of Youth Affairs & Sports** **Dept. of Sports**	• The Department supports and encourages balance and nutritious diet for a good health. • The Department has launched Fit India Movement in August, 2019, which cover all aspects having a bearing on fitness and healthy living viz., physical fitness, mental fitness, healthy life style, preventive health care, sustainable and environment friendly living, etc. including healthy eating habits, healthy and balance diet. • The Department has rationalized the diet and food supplement charges under which financial assistance towards diet, food supplements are provided to all athletes whether Senior, Junior or Sub Junior athletes. Earlier Senior, Junior athletes and SAI trainees had different diets which has been done away with to ensure parity amongst all level of trainees.
2.	**Ministry of Health & Family Welfare**	• Intensified Mission Indradhanush 2.0 was launched in December 2019 and 4 rounds were conducted from December 2019 to March 2020. During these rounds about 37.09 lakh children and 7.41 lakh pregnant women were vaccinated. • Pneumococcal Conjugate Vaccine (PCV) vaccination is in 6 States-HP, Bihar, MP, Rajasthan, UP, and Haryana. Introduced PCV on its own. In last 6 months: ◆ PCV expanded to 17 Districts of Rajasthan, to cover entire State. ◆ Expansion in UP to remaining 56 Districts started. Already covering 19 Districts. ◆ More than 49 lakh doses administered from January 2020 to April 2020 • Rotavirus vaccine (RVV) has already been expanded to the entire country, by September 2019. More than 1.8 crore doses administered from January 2020 to April 2020. • National Deworming Day (NDD) was conducted in 25 States/ UTs11.3 Cr children were covered with average 94% coverage as per the target set by States and UTs • Under Home Based Newborn Care (HBNC) programme 46.92 lakhs newborns received complete schedule of home visits by ASHA. 2.5 lakhs sick newborns referred to health facilities • Under Home Based Care for Young Child (HBYC) programme: ◆ Out of 242 Districts, 238 Districts have completed trainers training

S. No.	Ministry	Activity
		◆ 1,60,339 frontline workers are trained covering 179 Districts across 27 States/UTs ◆ 1,83,975 children received scheduled visits in 39 Districts (including 22 Aspirational Districts) from 11 States/UTs. • Institutional Deliveries: 94% deliveries reported in the hospitals against total number of reported deliveries. (i.e. 1.97 crore deliveries conducted in hospital out of total 2.08 crore deliveries reported); 70% of delivery reported in public health facilities. • LBW: 12.6% of the newborn were reported as LBW as per HMIS • Antenatal Check-up: 71% ANC registered in the 1sty trimester; 80% PW received 4 or more ANC check-ups • IFA supplementation: 91% PW given 180 IFA tablets. • Community and Home distribution of IFA supplementation from Jan-May' 20 through community and home distribution: 6-59 months- 1.62 Cr; 5-9 years: 1.38 Cr; 10-19 years: 1.83 Cr • Vitamin-A supplementation: 69.83 lakhs children were provided with 1st dose of vitamin-A supplementation • RBSK: As reported by State/UTs in Q-4 of January 2020 to March 2020: • 0-3 years' children: 1.2 crores were screened; 5.95 lakhs children were identified with any of 4Ds including 18,607 defects at birth, 32,144 developmental delays, 1.9 lakhs Deficiency and 3.54 lakhs diseases; 3.16 lakhs children availed services at secondary tertiary care institute • 4-6 years' children: 1.07 crores were screened; 9.21 lakhs children were identified with any of 4Ds including 12,034 defects at birth, 51,721 developmental delays, 2.5 lakhs Deficiency and 6.07 lakhs diseases • 4.91 lakhs children availed services at secondary tertiary care institute States/UTs. States/UTs have been requested to operationalize the blending of fortified rice and its distribution through PDS as early as possible. So far • 15 State Governments i.e. Andhra Pradesh, Kerala, Karnataka, Maharashtra, Odisha, Gujarat, Uttar Pradesh, Assam, Tamil Nadu, Telangana, Punjab, Chhattisgarh, Jharkhand, Madhya Pradesh & Uttarakhand have consented for implementation of the Pilot Scheme. • Out of these 15 States, Maharashtra (from Feb. 2020), Gujarat (from Feb. 2020) & Andhra Pradesh (from April 2020) have started distributing of fortified rice under the Pilot Scheme.

S. No.	Ministry	Activity
		• Targeted Public Distribution System (TPDS)/National Food Security Act, 2013 (NFSA): Covers all States & UTs; Poorest of poor entitled 35 kg foodgrains per family per month; priority household entitled to 5 kg foodgrains per person per month at uniform subsidized price Rs. 3/2/1 per kg for rice/wheat/coarse grains respectively. • Special provisions for pregnant women, lactating mothers and children aged 6 months-14 years entitled to free nutritious meal through ICDS network and MDMS. • Higher nutritional norms have been prescribed for malnourished children up to 6 years of age. • Pregnant women and lactating mothers are entitled to receive cash maternity benefit of Rs. 6,000 for the wage loss during the period
5.	**Ministry of Jal Shakti** **Dept. of Drinking Water & Sanitation**	Provision for providing safe drinking water in adequate quantity of prescribed quality to public institutions such as Gram Panchayat buildings, schools, AWC, health centres through functional household tap connection under "Jal Jeevan Mission".
6.	**National Service Scheme**	• Poster making competition on nutritional values • Seminars and workshops on poshan and its benefits • Wall paintings in public places on theme of poshan/nutrition • Nukkad Nataks, Rallies and door-to-door campaign in NSS adopted villages/slums on importance of nutrition, girl education, hygiene and sanitation, Anaemia, etc. • Classroom lectures on adolescent healthy diet • Awareness sessions on eating disorder, lack of physical activity, malnutrition, obesity, impact of fast food/soft drink/ packaged food, importance of balanced diet • Activities: 587 activities undertaken • Volunteers: 1,56,101 volunteers were involved • Participation: 1,74,532 beneficiaries participated
7.	**Nehru Yuva Kendra Sangathan**	• Display of banners and other publicity material highlighting core issues of poshan covering 9,354 villages • 3,565 meetings were held with eminent citizens to sensitize the villagers about importance of poshan • 369 gosthi, lectures and discussions were conducted by eminent resource persons on focus areas of poshan. • Door to door campaign in 289 villages focusing on general cleanliness & hygiene, prevention of anaemia, regular de-worming methods, Say No to Tobacco use, alcohol & drugs and maintenance & adequate sanitation facilities in the village • Distribution of IEC material on Poshan Maah in 289 villages. Total 1,368 activities which included Rallies, Run, Pad Yatra, Cycle Yatra, • Cultural Programmes, Nukkad Nataks, Short Film Shows, Exhibitions, Competitions were conducted to focus public attention on focus areas of Poshan Maah

S. No.	Ministry	Activity
8.	**Dpt. of School Education & Literacy**	• Developed cadre of 3,20,373 Poshan Monitors • 7,40,045 Poshan Report cards prepared
9.	**Dept. of Agriculture, Cooperation & Farmers' Welfare, Ministry of Agriculture & Farmers Welfare**	• Nutri-cereals comprising Jowar, Bajra, Ragi/Mandua, Kutki, Kodo, Sawa/Jhangora, Kangni/Kakun and Cheena have been implemented in the National Food Security Mission since 2018-19 in 202 Districts of 14 States. • Promotion of nutri-cereals through Kisan Goshthis, training at KVK level, SAU and State Agriculture Dept. Provision of safe grain storage. • Other interventions include cluster front line demonstrations, creation of seed hubs, distribution of seed kits, print & electronic publicity, etc. • Establishment of three "Centres of Excellence" across the country. Provision of setting up of processing units. • Bio-fortified and high-yielding crop distribution through seeds and FLD.
10.	**Ministry of Tribal Affairs**	• Evaluation undertaken on "Scheduled Tribe Component Relevance and Effectiveness in GoI Funded Schemes" which included POSHAN Abhiyaan, Anganwadi Services-ICDS, PMMVY, NIPCCD, etc. **Department of Animal Husbandry & Dairying:** • "Eklavya Kamdhenu Project" envisions to establish „Gaushalas" under "Rashtriya Kamedhenu Aayog" in EMRSs with a view to provide Desi cow's milk and milk products for self-sustainability towards milk consumption among school children to improve their nutritional status. • In addition, community nutrition approaches in and around the EMRS school will be used to further address dietary diversity in tribal households.
11.	**Ministry of Minority Affairs**	• Interventions in the form of trainings, community mobilisation or assisting States in creation of AWC.
12.	**Ministry of AYUSH**	• Generating nutrition awareness through Health and Nutrition camps and lectures through its national institutes. • The Ministry has also shared yoga protocol for pregnancy, children and adolescent with MoWCD to incorporate it into POSHAN Abhiyaan. • The Ministry is actively participating in the Poshan Pakhwada and Poshan Maah every year. • Introduction of Yoga activities in schools in collaboration of Department of School Education and Literacy, MHRD • Introduction of poshan awareness in AYUSH Health and Wellness Centres in collaboration with local AWC. • Awareness programme for Herbal plants with high nutritional value in AYUSH Health and Wellness Centres

S. No.	Ministry	Activity
13.	**Ministry of Panchayati Raj**	• Held special gram sabha with the participation from community resource persons, ANMs, Sakhis etc for: • Identification of pregnant women and local nutritional food in GP area • Discuss list of available supplementary foods in the Anganwadi for disbursement to beneficiary • Discuss subjects of education, safety, reproductive health, equal opportunity • Highlight the importance of sanitization, immunisation and institutional delivery • Undertaking of Poshan Jan Andolan • Implementing the centrally sponsored scheme of RGSA to strengthen PRIs through capacity building & training
14.	**Ministry of Rural Development**	• Provision of providing funds for convergence with MGNREGS e.g. AWC buildings. • Under the provision of MGNREGA, in case the number of children below the age of five years accompanying the women working at any site is five or more, provisions shall be made to depute one of such women workers to look after such children. The person so deputed shall be paid wage rate. • The most marginalized women in the locality, women in exploitative conditions, or bonded labour or those vulnerable to being trafficked or liberated manual scavengers should be employed for providing child care services. • Under the mandate of MGNREGA, the District Programme Coordinator shall ensure that at least 60% of the works to be taken up in a District in terms of cost shall be for creation of productive assets directly linked to agriculture and allied activities through development of land, water and trees. • A convergence Framework for scientific planning and execution of water management works with the use of latest technology has been mandated in consultation with an agreement of the MoJS and the MoAFW was issued
15.	**Ministry of New & Renewable Energy**	• Providing solar panel to Anganwari Kendras: MNRE Scheme for off- grid solar PV Ph-III was closed on 31.3.2020 and now available only for NE States.
16.	**Ministry of Housing & Urban Affairs**	• An advisory was issued to all the States/UTs requesting to incorporate AWC in DPRs for In-Situ Slum Redevelopment (ISSR) and Affordable Housing in Partnership (AHP) projects wherever gaps exist. • An advisory was issued to the States requesting to use the allocated budget for ODF (IHHT, CT/PT, Urinal) under Swachh Bharat Mission-Urban (SBM-U) for construction of Toilets/Urinals in AWC situated within the jurisdiction of the Municipal Corporations in their States/UTs.

S. No.	Ministry	Activity
17.	**NITI Aayog**	• CSR funding in health & nutrition programmes: Mobilisation of Rs.70.4 crore in 57 Aspirational Districts • Involvement of PRI in Jan Andolan for nutrition: Training modules have been developed and 1st ToT has been conducted by NIRD, Hyderabad; Training roll-out in 25 Aspirational Districts covering 1 lakh members; 15,000 members sensitised on risk migration and COVID-19 awareness in 25 Aspirational Districts. • Periodic surveys undertaken for monitoring progress of POSHAN Abhiyaan in 25 Aspirational Districts • Rice fortification to be undertaken by Dept. of Food & Public Distribution in 15 Districts as a pilot programme. • Biannual monitoring reports on POSHAN Abhiyaan and quarterly monitoring reports on PMMVY • Evaluation study conducted on strengthening of ICDS; draft report with recommendations shared with MoWCD • Promotion of healthy diets through local food systems

ANNEXURE 4-C

Best practices/innovations made by MoWCD, especially during COVID-19 times that can be scaled-up for strengthening Nutritional indicators in all States/UTs, following are the activities that have been undertaken by CD-Section during the COVID-19 pandemic

- Regarding initiatives taken by AWW in view of the COVID-19 outbreak, an advisory DO letter dated 11th March, 2020 was issued to all States/UTs forwarding therewith the tasks assigned to this Ministry regarding COVID-19 as under:
  - Facilitate utilization of AWW and Supervisors in surveillance and other community level activities by MoH&FW.
  - Facilitate mobilization of SHGs to create awareness.
  - Proper sanitation at AWC and health education to children and their parents.

Further, AWW and Anganwadi Helpers are also actively involved in conducting other activities during COVID-19 such as door to door survey, community surveillance, etc.

- Regarding functioning of AWC during the present circumstances, the distribution of food items and nutrition support by AWWs, once in 15 days, at the doorstep of beneficiaries – children, women and lactating mothers has been permitted as per the guidelines issued by Ministry of Home Affairs. Regarding this, a letter dated 16.04.2020 followed by a DO letter dated 19.05.2020 was issued to all States/UTs by this Ministry.
- Regarding special initiatives taken under Anganwadi Services, it is stated that in view of the special circumstances prevailing in the country due to the COVID-19 pandemic, the life cover for AWW/Anganwadi Helpers in the age group of 51-59 years (closed group as on 01.06.2017) has been increased from ₹ 30,000/- to ₹ 2,00,000/- primarily for a period of three months i.e. upto 30.06.2020.Further, POSHAN Abhiyaan was itself set up for improving the nutritional standards of children in the country. Therefore, POSHAN Abhiyaan may also incorporate some points in the point no. 4 mentioned as above.

Best practices shared by some of the States/UTs, can be scaled-up for strengthening Nutritional indicators

1. Lakshadweep – Establishing Nutri-gardens in and around Anganwadi

Key highlights

- Lakshadweep has 107 Anganwadi spread over 10 Islands. There is no COVID-19 case reported in entire UT, still the adverse effect of COVID-19 is on the supply of green leafy vegetables/fruits can be seen.
- The concept of **Anganwadi Kitchen** gardens was initiated in Lakshadweep, with each Anganwadi adopting 15 houses. To initiate the same, UT's main focus was on Convergence of WCD, Agriculture, Rural Development & Village Panchayats.

- In March 2020, UT has started distributing the seeds. So far, 99 clusters at UT level already initiated Anganwadi Kitchens. Each having 30 families i.e. 3000 households (besides 1600 around the AWC) benefitted. Lakshadweep has targeted to cover 4600 households & 107 AWC with a budgetary provision of around Rs.3200/- per target household. UT promotes organic foods from last 15 years. Since the land is scarce, and sandy, so they grow in coconut canopies – the Grow Bags.
- Lakshadweep has aimed to feed all 65,000 population through this initiative, and to actively initiate the same, 440 SHGs are involved in fruits and vegetables promotion across the UT. To implement it effectively, 60 multi-skill employee are trained in the field of Nutri-gardens who support all the so far formed 99 clusters. UT's idea is to make the Nutri-garden profitable, so that peoples' economic factors can be addressed across the UT. **Vegetable exchange programme** has also been initiated by the UT.

2. Gujarat – Online tracking and adoption of severe underweight children through Jan Bhagidari

Key highlights

- Gujarat's focus during Poshan Maah 2020 is Community Participation and Ownership. State emphasized on key 5 points needed to address malnutrition– First 1000 days; Anaemia, Diarrhoea, Sanitation and Complementary feeding while banking on effective Convergence with 8 Departments.
- Key interventions undertaken by the State are namely **EkBalak, EkPalak** – which is being initiated by the Chief Minister and followed by other officials, **Mukhya Mantra SuposhitGujatarNidhi–**to improve the overall malnutrition scenario of the State, and**State Management Centres–**to communicate with the Field Functionaries and other stakeholders.
- Key results of such interventions includes–70,000 severe underweight children adopted by **PaalakWali (Guardians)**, Unique IDs of 1.08 lakh severe underweight children have been created for follow up purpose, Phone calls are being made for tracking of THR, monitoring of home visits made by AWWs and getting feedback of Paalakwalis, Badges, certificates and guidelines distributed to Paalakwalis to motivate them, and Communication established through **State Management Centre (SMC)**.
- Other nutrition specific initiatives taken by the State includes– **PuShTI (Poshan Umbrella for supply chain through Tech-innovation)** for ensuring transparency, quality, efficiency and accountability in THR distribution. This has also been recognized as a best practice by NITI AYOG. Promotion of anaemia prevention in pregnant women and adolescent girls through the use of iron utensils and promotion of Nutri garden. Also, 1870 **low cost hand wash models** being installed at AWC and community places to improve hygiene practices without wasting water.

3. Odisha – Revamping Supplementary Nutrition Programme & Introduction of Millets in SNP

Key highlights

- State has highlighted the decentralized model of supplies of SNP across 72,000 AWC, while focusing on the unaffected distribution of THR during the recent floods. For this, the State has engaged 548 SHGs in THR production and distribution i.e. for roasting, weighing, package and distribution of grains. Additionally, the State has also formed **ajaanch-committee** at every AWC which is responsible to promote transparency.
- State has also shared that they have made guidelines for financial engagement of SHGs. Every 23rd of the month is dedicated for packaging and better monitoring. This additionally streamlines end to end tracking of indents and payments of online bills. Also, quality is the key factor monitored consistently by the State. For this, IT interventions are focused to make the Supply Chain robust. Geo-tagging, with pictures is an added feature of the same, which works from production to distribution. State has mentioned that the system has enhanced transparency, accountability, quality, monitoring, and thus the improved nutrition status. Nutrition distribution is tracked at multi- level from Field Functionaries to CDPO to SHG, while effectively engaging them all for the jobs assigned to each one of them.
- State further has multi-sectoral plan and additional plans for hard to reach areas. State's adoption system for SAM and MAM is in place and the focus is on complementary feeding for which **fish-based food distribution** is being taken as a pilot. **Creshes** have also been initiated in several areas of the State. Similarly, to reach out to the children who can't reache the AWC, a system is being formulated – AWC to ***pada***. State has also distributed **baby furniture** through District mineral funds

4. Uttarakhand – Adoption of SAM children by Government officials, Public Representative and public

Key highlights

- Uttarakhand has discussed on adoption of SAM by officials, public representatives and public. State has further stated that Nutrition is multi-disciplinary in the State, and it includes sanitation, hygiene etc. In continuation to last year's initiative by the Hon'ble Chief Minister, officials were requested to adopt one child each which resulted in adoption of 9177 SAM/MAM children. Similarly, 1962 children freed from SAM/MAM category and 385 children upgraded.
- The schemes and efforts of government were made more reachable and the concept of ***'Sarkar Aapke Dwar'*** (Govt. at your doorstep) was actualized. People were sensitized towards malnutrition and its ill effect on the growth

and overall development of their children and were made aware of the totality of the causes that can affect health of a family. Convergence helps addressing the multi- dimensional problems of SAM and MAM. Under Flexi-fund the State has promoted distribution of sprouted food. State has also launched ***Sanjeevani* Programme** (on 3rd Sep, 2019) in which Rs.2,000 per month for 6 months given to each child. Under this programme, prescriptions from PHC, along with the edibles are being distributed to target children.

5. DNH and D&D – Identification Drive for SAM Children

Key highlights

- D&NH and D&D are tribally dominated territories and has high prevalence of malnutrition amongst children, as compared to national average. State shared that during COVID-19 they have 100% coverage for THR and the consumption issues are also being addressed. State has esp. engaged District Collectors with the H&FW as a result of which 25,800 out of 28,000 children measured during the said drive. This drive covers 4 steps namely– Growth Monitoring, Screening (MOs/paediatricians), diet diversity, and counselling of all concerned.
- UT has also shared that the locally used ICD based systems is being developed and functional. Micro-plan for each AWC to identify each SAM is in place. They have prepared SoP of the same and trained the AWWs through nodal officers. To create transparency, parents are also involved in the activity.
- In the joint drive, H&FW takes upper arm circumference while WCD for height & weight, finally, an MO looks after the same. Children then categorized on the basis of complications for referral (to NRC) or no-referral. ICT based tool is in place with H&FW to measure the impact of this programme.

ANNEXURE 4-D

Supplementary Nutrition Programme details from States/UT

S.No.	States	Morning Snack (MS)/Hot Cooked Meal (HCM)	Take-Home Ration	Fortified food items used in SNP
1	**A&N**	MS–Green gram whole, egg, boiled groundnut and milk. HCM–Khichdi, rajma rice, rice kheer Quantity–20-120gms + 1 egg per day	THR given in the form of HCM	Fortified edible oil used in SNP for other items action has been initiated.
2	**Andhra Pradesh**	Rice, Dal, Oil, Vegetables, Eggs Curry, Boiled Channa Quantity–(3-6 y) Snacks -15g. HCM–95g, eggs–4 per week	6m-3y & SAM Children – Balamrutham (Weaning Food), Egg PW&LM–one full meal consisting of dal, rice, oil, milk, eggs & veggies.	Double Fortified Salt (DFS), fortified oil, rice (two pilot Districts- West godavari and krishn) supplied by Civil supplies dept.
3	**Arunachal Pradesh**	MS-biscuit/kheer/Instant Poha 2 days each & HCM–Rice-50gm, Dal-15gm, oil-5 gm	Energy Food (Rice & Pulse base)/ Quantity-100gm, PM & LM-Instant poha & Kheer-150	HCM–No, THR–yes
4	**Assam**	Khichdi, payas, suji halwa, Quantity- 80g	6m -3 y- rice and peas; SAM–rice and mixed pulse-based micronutrient fortified energy dense food; P W&LM–Rice and mixed pulse-based micronutrient fortified energy dense food–110g	HCM–No, THR–yes
5	**Bihar**	MS-milk powder-18 g, water-150ml & boiled egg -1 pc & Germinated Chana +jaggery-60gm once in a week each & rice flake & Jaggery-60g m four days in a week,	Given in the form of dry ration (food grain)- Rice -2500gm, Pulse-1250 gm, soyabadi-500gm or egg-8 pc/ month, SAM-Rice-3750gm, masoor-1750gm, egg-12/month or soyabadi-875gm/ month, PW&LM-Rice-3500gm, pulse-1500gm, egg -7 or soyabadi-450g/ month	DFS pilot in 6 Districts and plan to cover entire State in June 2019.

S.No.	States	Morning Snack (MS)/Hot Cooked Meal (HCM)	Take-Home Ration	Fortified food items used in SNP
		HCM-Khichidi-Rice-60gm, Pulse-25gm, Vegt-20 gm, oil-5gm thrice in a week & rice pulao–Rice-60gm, chana-20gm, vegt-20gm, oil-5gm once in a week & Suji Halwa-Suji-60gm, G.nut-10 gm, sugar-30gm. oil-5gm once in a week & Ra shiya-Rice-60gm, Jaggery-30gm, G.nut-10gm once in a week		
6	**Chandigarh**	Murmura, Halwa, Sweet Dalia, Kadi Rice, Aloo Nutri with gravy, Rice, Khichadi, Ghiya Chana dal, Aloo chana, Quantity-60-200gms	6m-1 y in the form of weaning foods , 1-3 years in the form of cooked food , murmura mixture, kadhi rice sweet dalia, ghia chana dal rice, halwa, aloo chana black, khichdi, moog dal and rice kadhi chawl, nutri aloo with gravy); SAM–HCM, PW&LM–HCM	fortified food is supplied in AWC
7	**Chhattisgarh**	MS- RTE, poha, HCM–Roti, rice, mixed dal, sabzi, fortified oil, achar, papad, salad, jaggery, Quantity–approx. 120g-150g as per menu	THR in powder form	Fortified oil and salt
8	**Dadar & Nagar Haveli**	Boiled Egg/ fruit, Vegetable khichdi, Sheera, S prouted moong and ground nut, Sukhdi and fruit, vegetable dalia, sprouted channa, lapsi; Quant ity- 100g–250 g	THR for 6 m to 3 years–under process, currently HCM is provide d similar to 3 -6 years, SAM–RUTF , PW&LM–Dry Ration (Rice, wheat, Jaggery, Ground nut, Tuvar Dal, Raosted sing chana, oil, moong dal, moong)	DFS and oil are used

S.No.	States	Morning Snack (MS)/Hot Cooked Meal (HCM)	Take-Home Ration	Fortified food items used in SNP
9	**Daman & Diu**	Veg khichdi, sukhdi + boiled egg,, Boiled chana + banana, sujhdi+ boiled moong, roasted peanut chana+ lapsi, boiled chana+ boiled egg, boiled ground nut + banana), Quantity- 30-60g	6m- 3y- Presently given Hot cooked meal, SAM–not mentioned, PW & LM- Dry ration given as THR (Wheat, Rice, ground nut chikki, tuvar dal, whole moong, desi chana, ragi, DFS	DFS and fortified oil with Vit A & D used in the recipes
10	**Delhi**	Boiled Bengal gram and green peas, sweet & namkeen dalia, khichadi, halwa, veg. pulao, kal a chana, dal with rice; Quantity–HCM–270g, M S–50g	6m–3 y -Panjiri , Weaning Food, S AM–not mentioned, PW&LM- not mentioned	no
11	**Goa**	Monday -Mix Laddu, Tuesday Gram dal sweet, Wednesday–Sweet Idli, Thrusday- Green peas usal, Friday–Ground nut Chikki, Sat- Moong K hichdi; Quantity- 82g-126g	6m- 3y -THR given in form of cereal grains and pulses with salt and jaggery	DFS and edible fortified oil are supplied to AWC, however, wheat and rice are procured under WBNP of Ministry.
12	**Gujarat**	MS–(Sukhadi, Vaghreli Khichadi, Sheero, Mut hiya with GLVs, Sheero/Suk, Hadi sweet pudla) HCM–(Thepla+ Tuver Dal, Thepla+dudhi chan a veg, Veg pula+Chana dal, Bhat and Veg Dushi Dhebra+Chana Veg Khichadi) Quantity- 50g-120g	6m- 3y & SAM -Balshakti (weaning food) Wheat, Besan, Soyabean Fl our, Sugar, Oil), PW&LM–Matrush akti	Fortified Oil and double fortified salt is used in SNP. Foritified wheat flour is in process
13	**Haryana**	MS–Channa Murmura & Groundnut mixture + Panjiri. HCM–Bharwa Parantha, Aloo poori, meethe Chawal, Pulao meetha Dalia, Gulgule; Quantity - MS- 25-50g, HCM -110-120g	6m-18m–THR given in the form of Panjiri, 1.5y-3 y- HCM is given similar to 3-6 yr, SAM-paushtik panjiri as THR (Weekly/ Fortnightly), 200 g, PW&LM–HCM–Bharwa Parantha, Aloo poori, meethe Chawal, Pulao meetha Dalia, Gulgule	DFS, Fortified panjiri supplied in urban projects of the State, Fortified Wheat Flour supplied in 2 blocks of District Ambala (naraingarh, barara) on pilot basis through HAFED, from march. Wheat

S.No.	States	Morning Snack (MS)/Hot Cooked Meal (HCM)	Take-Home Ration	Fortified food items used in SNP
				Flour to be supplied in Distcrit Ambala and karnal, F. Edible oil to be supplied in all distrcits and panjiri plant by HAFED
14	**Himachal Pradesh**	MS- Nutrimix, Oat bisuits, ajwain biscuits, HCM–rice khichdi, meetha rice, sweet dalia, p anner curry, Quantity- not mentioned	6m-3 y-(Foritifed Panjiri,+ F. Oat biscuit, Rice Pularo+ F. Oat biscui t, Sweet Dali + F. Ajwain biscuit), SAM–not mentioned, PW&LM–Foritifed Panjiri,+ F. Oat biscuit, Rice Pulao+ F. Oat biscuit, Sweet Dali + F. Ajwain biscuit, Sprouted grams+ F. Oat biscuit	Fortified panjiti, Foritified biscuits, DFS, Fortified refined oil is used in SNP
15	**J&K**	moong rice khichdi, chana pulao, matter pulao, moongi rice khichdi , chana pulao, matter pulao; Quantity -60-210gms	6m-3y–THR is given in the form of HCM, SAM-not mentioned, PW& LM – not mentioned	fortified salt
16	**Jharkhand**	Morning snacks–seasonal fruits, sweet dalia- 58 g, eggs, HCM khichdi–103 g	6m- 3y -THR given in the form of panjiri (wheat flour, ragi flour, soya flour, Bengal gram, oil & sugar), SAM- 1.5 times of normal child, PW&LM–THR given in the form upma (wheat semolina, soyabean, toor dal, sugar, oil, spice, vitamin & mineral mix) -150 gm	DFS & fortified oil are used
17	**Karnataka**	Recipe varies from District to District, Ragi Kheer, wheat upma, Moong dal, Gram dal kheer, sprouted grams, Chithranna, rice sambhar, Quantity- not mentioned	6m-3 y -Nutrimix Powder (in flour fo rm- milk powder, ragi, wheat, moo ng dal, sugar) , Rice kheer mix, S AM–not mentioned, P&L–Not men tioned	no

S.No.	States	Morning Snack (MS)/Hot Cooked Meal (HCM)	Take-Home Ration	Fortified food items used in SNP
18	**Kerala**	MS–Ragi porridge, Nutritive laddoo, Ground nut chikki, Rice flake and jaggery, sprouted green gram. HCM–Broken wheat upma with ground nut, Rice flakes with bengal gram dal and jaggery, veg. Sambar, payasam with green gram, gooseberry chutney, rice dal khichdi with veg., Quantity- not mentioned	6m- 3y–THR – Amrutham Nutrimix (weaning food), P&L–Provided with raw food as THR (broken wheat/ sesame, jaggery, green gram, coconut oil, sandal etc.)	fortified salt is used in all AWC, steps have been initiated for rice fortification on pilot basis in Kannur District, Amrithum nutrimix is fortified with 11 micronutrients
19	**Lakshad-weep**	biscuits, Horlicks milk, Quantity- not mentioned	6m–3 y–in form of THR rice, green gram, Bengal gram, SAM- not mentioned, P&L–not mentioned	HCM- yes, THR- not mentioned
20	**Madhya Pradesh**	roti sabzi dal+ meethi lapsi, kheer, poori,aloo matter\ aloo chana + poshtic khichdi, roti sabzi dal+meethi lapsi, veg. Pulao, kadhi pakoda+ namkeen dalia, roti sabzi dal+upma, roti sabzi dal\ chawal sambar + meethi lapsi, Quantity–57g to 155g	6m–3 y- halwa premix bal ahar pre mix , khichdi, atta besan ladoo & kehu soya barfi , SAM–not mentio ned, P&L–not mentioned	Yes
21	**Maharashtra**	Chiwda, Murmura, laddu, shira, chakli, lapsi, usal khichdi, Quantity- 150-160gms	6m-3y- in form of raw grains & groceries supplied through State consumer federation from 1st May, SAM–not mentioned, P&L–In form of raw materials (wheat, dal, spices F. soyabean oil, DFS, Chawal, mataki)	Micronutrient fortified THR has been discontinued, only RAW THR is given
22	**Manipur**	morning snacks sangom kheer, HCM khichdi (micronutrient pulse & rice, oil, groundnut, turme rice powder, salt), Quantity- 10gm morning snacks per child per day & 40gms per child per day	6m -3y–Raw material, RTE lentil, mustard oil, groundnut, turmeric powder, salt, rice SAM- same as 6m- 3y, P&L -same as 6m-3y	No info.

S.No.	States	Morning Snack (MS)/Hot Cooked Meal (HCM)	Take-Home Ration	Fortified food items used in SNP
23	**Meghalaya**	Ms- Milk, HCM–Fortified suji, Fortified Cheera, kitchdi, dried peas/bengal gram, Quantity- 75-8 0g	6m-3y–Ready to eat fortified food items given–Fortified atta, milk powder, RTE kheer, SAM–not mentioned, P&L–Ready to eat for tified food items given–RTE kheer, RTE khichdi, f. Suji, F, cheera	Fortified atta , suji, cheera and fortified edible oil, DFS given
24	**Mizoram**	high protein biscuit, roasted ground nut, fresh fruits HCM–Khitchdi, parantha and chann, high protein soya noodles, Quantity-58-137g	6m–3y-Energy dense fortified food, SAM- not mentioned, P&L–not mentioned	DFS and fortified oil distributed in SNP
25	**Nagaland**	MS-biscuit & cornflake-100gm per day, HCM-Rich rice food-50gm, healthy chow-40gm per day	THR-Surho kheer mix & Balbhog kheer 75gm each per day including SAM, PM, LM-THR-surho kheermix & Balbhog kheer- 100gm & 80gm per day	yes
26	**Orissa**	MS-Chuda Badam Laddu-35 gm, HCM-Rice & egg curry, Rice-80gm, Egg-1 pc, Oil-3ml, potato-20gm, onion-10gm	THR-Chhatua-88gm, Maize Halwa- 60gm, egg-3pc weekly, PM,LM- Chhatua-196gmBadam Laddu-24.4 gm & egg-3pc weekly, SAM-THR- Chhatua-4.9kg, Baddam Laddu-61 0gm	not mentioned
27	**Puducherry**	Rice khichdi, ragi putu, boiled egg, Quantity–1 20g	6m–3 y -Micronutrient Fortified Food supplements, SAM-not mentioned, P&L–Micronutrient Fortified Food supplements	Not mentioned
28	**Punjab**	(3-6y- Halwa+ Kheer, Sweet Dalia + Milk, Halwa+ Panjiri), PW&LM–Sweet Dalia, Kheer, Panjiri), Quantity- 100-140g	6m–3 y–Sweet Dalia, Kheer, Panjiri given as HCM, SAM 3-6 years-Sweet Dalia, Kheer, Panjiri, Halwa, 120-203g P&L–Sweet Dalia, Kheer, Panjiri given as HCM	currently fortified panjiri and Ghee are used, fortification of other food items will be finalized after decision of Hon'ble High Court.

S.No.	States	Morning Snack (MS)/Hot Cooked Meal (HCM)	Take-Home Ration	Fortified food items used in SNP
29	**Rajasthan**	Rice Puffed and roasted Channa with jaggery, Halwa, HCM Khichdi, Dalia, Quantity- 55gm morn. Snacks per day per beneficiaries, 80gm HCM per day per beneficiary	6m–3 y–Yes in the form of baby mix (whole wheat, bengal gram, soyabean, sugar, edible oil, SAM- not mentioned, P&L–in the form of baby mix (whole wheat, bengal gram, soyabean, sugar, edible oil	DFS & BSF oils are used
30	**Sikkim**	HCM as morning snacks, HCM as khichdi in day time, HCM khichdi @ 150gm per day per child kheer @150 gms every Thursday	6m-3y THR given in form of poshtik ahaar (wheat, maize, soyabean, bengal gram, sugar & multi vitamin s), SAM- not mentioned, P&L–not mentioned	food is fortified with multi-vitamins by FS SAI guidelines
31	**Tamil Nadu**	Tomato rice+ boiled egg, Mixed rice with Black Bengal/ Green Gram, Veg. Pulav+ boiled egg, lemon rice+ boiled egg, Dal Rice with boiled potato, mixed rice, Quantity- 20-80g	6m-3y -Complementary food- Sathumavu (Amylase rich Weanin g Food), SAM–Complementary food-Sathumavu (Amylase rich Weaning Food) supplied weekly, P&L–Complementary food-Sathumavu (Amylase rich Weaning Food)	Complementary weaning food fortified as per ICDS guideline
32	**Telangana**	Snack Food (MUKURU) Ready to eat food in sa vory form at AWC +HCM Mini HCM) Rice, dal, Vegetable + Egg; Quantity- 25g/ day (MS) + 14 0g/day(HCM)+ 4 eggs per week	6m–3 y–Balamrutham -(Ready to eat food in powder form) and Egg s, SAM- same as 6m -3y, P&L One full meal consists of Rice, Dal, Oil, Vegetables	No
33	**Tripura**	Monday–Khichuri+gram Dal with seasonal veg etables & Soyabean + Salty Sujir Haloa, Tues day- Chola/Bengal Gram with Muri, Wednesday 1 Boiled Egg, Thrusday–Chirar Polao, Friday Chola/Bengal Gram with Muri, Saturday -1 (One) Boiled Egg. Quantity- 30-90 g	6m-3 y–in form of Raw rice, masoor dal, raw egg, soyabean, semolina, bengal gram and rice flakes, SAM–(rice , dal, soyabean, semolina, bengal gram, rice flakes,) + 10 eggs, P&L–rice, dal, soyabean, semolina, bengal gram, rice flakes,) + 10 eggs	DFS, F. Oil is used

S.No.	States	Morning Snack (MS)/Hot Cooked Meal (HCM)	Take-Home Ration	Fortified food items used in SNP
34	**Uttar Pradesh**	RTE as morning snacks energy dense ladoo premix, Energy dense meetha dalia, micronutrient fortified enegy dense namkeen dalia, HCM roti, dal, veg., tahri, milk, soyabean, Quantity- morning snacks 400-450gm per month	6m–3 y–yes in form of RTE Micronutrient Fortified energy dense weaning food, (wheat, sugar, bengal gram, groundnut, soyabean, veg. oil) meetha dalia, fortifed namkeen dalia in the form of RTE weaning dense foods, energy dense meetha dalia, fortified namkeen dalia, SAM–Not mentioned, P&L-energy dense ladoo premix, Energy dense meetha dalia, micronutrient fortified enegy dense namkeen dalia	with minerals & vita mins
35	**Uttrakhand**	**MS**- Bhuna Chan, Ata & Suji Halwa, Buni Moon g phali, poha, boiled channa, **HCM–**Dal+Rice, Nutrila rice, namkeen parantha, meetha dalia, namkeen dalia, khichdi; Quantity- MS- 30g, HC M- 110g	6m–3 y–Raw ingredients (Broken wheat, dal, peanuts, seasonal fruit), SAM–Dry ration, P&L–Raw ingredients (Broken wheat, dal, peanuts, seasonal fruit)	DFS
36	**West Bengal**	MS–Poushtik ladoo(@ 48g), Boiled egg, banana; HCM (@ 75-100g)-Rice +egg curry with potato, Rice + dal+ veg with soya nuggets, Veg. Khichdi + soya nuggets	HCM provided in place THR	not used

ANNEXURE 4-E

Status of Malnourished Children reported by the States/UTs

S.No.	State/UTs	No. of Malnourished Children
1	**Andhra Pradesh**	55607
2	**Bihar**	389174
3	**Chhattisgarh**	159833
4	**Goa**	60
5	**Gujarat**	93672
6	**Haryana**	4342
7	**Himachal Pradesh**	2568
8	**Jammu & Kashmir**	6198
9	**Ladakh**	20
10	**Jharkhand**	13283
11	**Karnataka**	10915
12	**Kerala**	5587
13	**Madhya Pradesh**	104868
14	**Maharashtra**	81242
15	**Odisha**	22641
16	**Punjab**	600
17	**Rajastham**	8645
18	**Tamil Nadu**	4534
19	**Telangana**	35700
20	**UttarPradesh**	397000
21	**Uttarakhand**	1800
22	**West Bengal**	9996
23	**Delhi**	250
24	**Puducherry**	0
25	**Andaman & Nicobar**	50
26	**Chandigarh**	336
27	**Dadar & Nagar Haveli & daman & Diu**	1245
28	**Lakshadweep**	0
29	**Arunachal Pradesh**	0
30	**Assam**	11298
31	**Manipur**	17
32	**Meghalaya**	615
33	**Mizoram**	271
34	**Nagaland**	275
35	**Sikkim**	30
36	**Tripura**	464
	Total	**1423136**

ANNEXURE 5: CONCORDANCE CHECK BETWEEN STATE TEMPLATE INDICATORS AND MPR/HMIS DATA

Concordance check between state template and MPR data was conducted on the WCD programme activity indicators. After the verification of data was conducted for the States and UTs where the State data was greater than or less than to MPR data by 10%, the final concordance between the indicators are as follow:

Indicator	Data received from States	Data from MPR	State to MPR data
THR received by children aged 6-36 months for March 2020	36695223	36097901	101.7%
THR received by pregnant women and lactating women for March 2020	11533093	11663940	98.8%

Concordance check between state template and HMIS data was conducted on the health programme activity indicators. After the verification of data was conducted for the States and UTs where the State data was greater than or less than to MPR data by 10%, the final concordance between the indicators are as follow:

Indicator	Data received from States	Data from HMIS	State to HMIS data
Total no. of pregnant women who registered for ANC in first trimester	1564077	1573680	99.4%
Total No. of pregnant women who received 4 or more ANC check-ups	1686736	1698898	99.3%
Total No. of pregnant women given TT2/ Boosters	2187310	1848705	118.3%
Total No. of pregnant women given 1 Albendazole tablet after 1st trimester	993136	989949	100.3%
Total No. of pregnant women given 180 IFA tablets during ANC	1957920	1997765	97%
Total No. of lactating women given 180 IFA tablets	1368423	984072	139.1%
Total No. of children 6-59 months who were provided at least 8-10 doses of IFA syrup per month	13273124	14288047	93%
Percentage of newborn breastfed within one hour of birth (Early Initiation of Breastfeeding)	81.98	85.37	96%

ANNEXURE 6: TOP AND BOTTOM PERFORMING STATES/UTS BASED ON INDICATORS USED IN RUBRIC

The performance of States/UTs is based on a rubric which comprises of 4 themes, which consists of number of indicators (Annexure 2). The top and bottom performing States are as follows:

ANNEXURE 6-A: GOVERNANCE & INSTITUTIONAL MECHANISM

a. Fund utilization by States/UTs

Performance of top 5 and bottom 5 States/UTs are as follows:

Top 5 performing States/UTs		Bottom 5 performing States/UTs	
State/ UT	**Fund Utilized**	**State/UT**	**Fund Utilized**
Nagaland	87%	Punjab	22%
Meghalaya	78%	Puducherry	22%
Sikkim	71%	Tripura	16%
Mizoram	67%	Arunachal Pradesh	9%
Lakshadweep	65%	Odisha	8%

b. Constitution of Committees and Resource Groups

Apart from the following States/UTs, all the remaining States/UTs have constituted committees and resource groups in 100% districts. The bottom performing States/UTs are:

Constitution of DRGs		Constitution of BRGs		Constitution of CAP committees	
State/UT	**% districts with DRGs**	**State/UT**	**% districts with BRGs**	**State/UT**	**% districts with CAP**
Delhi	82%	Tripura	97%	Chhattisgarh	96%
Puducherry	50%	Meghalaya	89%	Odisha	93%
Assam	0%	Assam	1%	Puducherry	50%
Ladakh	0%	Ladakh	0%	Assam	18%
—	—	—	—	Goa	0%

ANNEXURE 6-B: STRATEGY AND PLANNING

a. % of districts that developed and submitted CAP for FY 2020-21

States/UTs where 100% districts that developed and submitted CAP for FY 2020-21 are as follows:

Category of State	State with 100% districts that developed and submitted CAP for FY 2020-21	Total
Large States	Andhra Pradesh, Bihar, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Punjab, Rajasthan, Tamil Nadu, Uttar Pradesh	13
Small States	Arunachal Pradesh, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura	6
Union Territories	Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Jammu & Kashmir, Ladakh, Lakshadweep	5

The 5 States/UTs with the least number of districts that developed and submitted CAP for FY 2020-21 are as follows:

State/UT	% districts that developed and submitted CAP for FY 2020-21
Puducherry	50%
Assam	18%
Uttarakhand	0%
Goa	0%
Andaman & Nicobar Island	0%

ANNEXURE 6-C: INPUTS FOR SERVICE DELIVERY AND CAPACITY- DEPARTMENT OF WOMEN AND CHILD DEVELOPMENT

a. *Human Resources*

States/UTs that filled 100% HR positions are as follows:

Category of State	100% Joint Coordinator positions filled	Total
Large States	Andhra Pradesh, Bihar, Gujarat, Himachal Pradesh, Jharkhand, Kerala, Madhya Pradesh, Maharashtra, Rajasthan, Tamil Nadu, Telangana, Uttarakhand	12
Small States	Meghalaya, Mizoram, Nagaland, Sikkim	4
Union Territories	Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Delhi, Jammu & Kashmir	4
Category of State	**100% Consultant positions filled**	**Total**
Large States	Assam, Bihar, Gujarat, Himachal Pradesh, Madhya Pradesh, Rajasthan, Telangana	7
Small States	Mizoram	1
Union Territories	Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu	3
Category of State	**100% Project Associate positions filled**	**Total**
Large States	Andhra Pradesh, Bihar, Gujarat, Haryana, Himachal Pradesh, Kerala, Madhya Pradesh, Rajasthan, Telangana, Uttarakhand	10
Small States	Meghalaya, Mizoram, Nagaland, Sikkim	4
Union Territories	Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Lakshadweep	4

The following States/UTs had not filled any positions for Joint Coordinator, Consultant, and Project Associate:

Joint Coordinator	Consultant	Project Associate
Punjab	Punjab	Punjab
Goa	Goa	Goa
Tripura	Tripura	Tripura
Puducherry	Puducherry	Puducherry
Haryana	Odisha	Odisha
Chhattisgarh	Uttar Pradesh	Uttar Pradesh
Andaman & Nicobar Island	Jammu & Kashmir	Jammu & Kashmir
Arunachal Pradesh	Sikkim	Arunachal Pradesh
Lakshadweep	-	Delhi

a. *Supplies*

States/UTs that distributed 100% of supplies are as follows:

Category of State	100% mobile phones distributed to districts	Total
Large States	Andhra Pradesh, Bihar, Gujarat, Haryana, Jharkhand, Maharashtra, Tamil Nadu, Uttarakhand	8
Small States	Meghalaya, Mizoram, Nagaland, Tripura	4
Union Territories	Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Delhi, Ladakh	5
Category of State	**100% weighing scale (adult) distributed**	**Total**
Large States	Andhra Pradesh, Gujarat, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, Telangana, Uttarakhand	10
Small States	Goa, Meghalaya, Mizoram, Nagaland	4
Union Territories	Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Delhi, Jammu & Kashmir, Ladakh, Lakshadweep, Puducherry	8
Category of State	**100% weighing scale (infant) distributed**	**Total**
Large States	Andhra Pradesh, Gujarat, Himachal Pradesh, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Punjab, Tamil Nadu, Telangana, Uttarakhand	11
Small States	Goa, Meghalaya, Mizoram, Nagaland	4
Union Territories	Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Delhi, Jammu & Kashmir, Ladakh, Lakshadweep, Puducherry	8
Category of State	**100% infantometer distributed**	**Total**
Large States	Andhra Pradesh, Bihar, Gujarat, Haryana, Himachal Pradesh, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Punjab, Tamil Nadu, Telangana, Uttarakhand	13
Small States	Goa, Meghalaya, Mizoram, Nagaland	4
Union Territories	Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Delhi, Jammu & Kashmir, Ladakh, Lakshadweep, Puducherry	8
Category of State	**100% stadiometer distributed**	**Total**
Large States	Andhra Pradesh, Gujarat, Haryana, Himachal Pradesh, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Punjab, Tamil Nadu, Telangana, Uttarakhand	12
Small States	Goa, Meghalaya, Mizoram, Nagaland	4
Union Territories	Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Delhi, Jammu & Kashmir, Ladakh, Lakshadweep, Puducherry	8

The least performing States/UTs on distribution of supplies are as follows:

Mobile Phones	Weigh-scale (Adult)	Weigh-scale (Infant)	Infantometer	Stadiometer
Odisha	Odisha	Odisha	Odisha	Odisha
Arunachal Pradesh	Arunachal Pradesh	Arunachal Pradesh	Arunachal Pradesh	Arunachal Pradesh
Kerala	Manipur	Manipur	Manipur	Manipur
Himachal Pradesh	Haryana	Haryana	Uttar Pradesh	Uttar Pradesh
Punjab	Sikkim	Sikkim	Chhattisgarh	Sikkim
—	Rajasthan	—	—	—

Training and Capacity Building

States/UTs that have trained 100% staff on e-ILA and dashboard/mobile phones are as follows:

Category of State	100% LS trained on e-ILA	Total
Large States	Andhra Pradesh, Gujarat, Madhya Pradesh, Odisha, Rajasthan, Tamil Nadu, Uttar Pradesh	7
Small States	Meghalaya, Sikkim, Tripura	3
Union Territories	Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Jammu & Kahsmir	4
Category of State	**100% AWW trained on e-ILA**	**Total**
Large States	Gujarat, Madhya Pradesh, Odisha, Tamil Nadu, Uttar Pradesh	5
Small States	Sikkim	1
Union Territories	Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Jammu & Kashmir	4
Category of State	**100% CDPOs trained on Dashboard/Mobile**	**Total**
Large States	Andhra Pradesh, Bihar, Gujarat, Kerala, Tamil Nadu	5
Small States	Nagaland, Sikkim, Tripura	3
Union Territories	Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Delhi, Lakshadweep	5
Category of State	**100% LS trained on Dashboard/Mobile**	**Total**
Large States	Andhra Pradesh, Bihar, Gujarat, Madhya Pradesh, Tamil Nadu, Uttarakhand	6
Small States	Meghalaya, Nagaland, Sikkim	3
Union Territories	Andaman & Nicobar Island, Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Delhi	4

States/UTs that had 0% staff trained on e-ILA and dashboard/mobile phones are as follows:

Category of State	0% LS trained on e-ILA	Total
Large States	Assam, Haryana, Karnataka, Kerala, Punjab, Telangana, Uttarakhand	7
Small States	Arunachal Pradesh, Goa, Mizoram, Nagaland	3
Union Territories	Delhi, Ladakh, Lakshadweep, Puducherry	4
Category of State	**0% AWW trained on e-ILA**	**Total**
Large States	Assam, Haryana, Karnataka, Kerala, Punjab, Telangana, Uttarakhand	7
Small States	Arunachal Pradesh, Goa, Meghalaya, Mizoram, Nagaland	4
Union Territories	Delhi, Ladakh, Lakshadweep, Puducherry	4
Category of State	**0% CDPOs trained on dashboard/mobile phones**	**Total**
Large States	Assam, Haryana, Karnataka, Kerala, Uttarakhand	5
Small States	Goa, Mizoram	2
Union Territories	Jammu & Kahsmir, Ladakh	2
Category of State	**0% LS trained on dashboard/mobile phones**	**Total**
Large States	Assam, Haryana, Karnataka, Punjab	4
Small States	Goa	1
Union Territories	Jammu & Kashmir, Ladakh, Puducherry	3

ANNEXURE 6-D: SERVICE DELIVERY ESSENTIALS- DEPARTMENT OF HEALTH

a. *Infrastructure*

Out of sanctioned health facilities, 100% facilities are functional in the following States/ UTs:

Category of State	100% sub-centres functional	Total
Large States	Andhra Pradesh, Assam, Chhattisgarh, Haryana, Himachal Pradesh, Karnataka, Kerala, Madhya Pradesh, Odisha, Tamil Nadu, Telangana, Uttar Pradesh, Uttarakhand	13
Small States	Goa, Sikkim	2
Union Territories	Andaman & Nicobar Island, Dadar & Nagar Haveli and Daman & Diu, Delhi, Jammu & Kashmir, Ladakh, Puducherry	6
Category of State	**100% CHCs functional**	**Total**
Large States	Andhra Pradesh, Chhattisgarh, Haryana, Himachal Pradesh, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh, Uttarakhand	14
Small States	Goa, Manipur, Meghalaya, Sikkim	4
Union Territories	Andaman & Nicobar Island, Chandigarh Dadar & Nagar Haveli and Daman & Diu, Delhi, Jammu & Kashmir, Ladakh, Lakshadweep, Puducherry	8
Category of State	**100% HWCs functional**	**Total**
Large States	Andhra Pradesh, Kerala, Punjab	3
Small States	Goa, Nagaland	2
Union Territories	Chandigarh, Dadar & Nagar Haveli and Daman & Diu, Lakshadweep	3

Out of sanctioned health facilities, following States/UTS had lowest number of functional health facilities:

Sub-centres functional		CHCs functional		HWCs functional	
State	**% sub-centre**	**State**	**% CHCs**	**State**	**% HWCs**
Punjab	77%	Tripura	88%	Maharashtra	36%
Nagaland	76%	Assam	82%	Ladakh	33%
Lakshadweep	71%	Punjab	82%	Puducherry	33%
Arunachal Pradesh	63%	Nagaland	64%	Bihar	30%
Bihar	60%	Bihar	43%	Haryana	26%

Human Resource

Performance of top 5 and bottom 5 States/UTs on ANM positions filled are as follows:

Top 5 performing States/UTs		Bottom 5 performing States/UTs	
State/ UT	**ANM position filled**	**State/UT**	**ANM position filled**
Arunachal Pradesh	100%	Karnataka	78%
Nagaland	100%	Himachal Pradesh	71%
Lakshadweep	100%	Uttar Pradesh	61%
Odisha	100%	Tripura	56%
Assam	99%	Bihar	52%

ANNEXURE 6-E: PROGRAMME ACTIVITIES AND INTERVENTION COVERAGE-DEPARTMENT OF WOMEN AND CHILD DEVELOPMENT

a. *Take Home Ration*

States/UTs that distributed THR to 100% beneficiaries registered at AWCs are as follows:

Category of State	THR distributed to 100% pregnant women	Total
Large States	Gujarat, Jharkhand, Kerala, Maharashtra, Odisha, Rajasthan, Tamil Nadu	7
Small States	Meghalaya, Mizoram, Tripura	3
Union Territories	Andaman & Nicobar Island, Dadar & Nagar Haveli and Daman & Diu, Delhi, Ladakh, Lakshadweep, Puducherry	6
Category of State	**THR distributed to 100% lactating women**	**Total**
Large States	Jharkhand, Kerala, Maharashtra, Odisha, Tamil Nadu	5
Small States	Goa, Meghalaya, Mizoram, Tripura	4
Union Territories	Andaman & Nicobar Island, Delhi, Ladakh, Lakshadweep, Puducherry	5
Category of State	**THR distributed to 100% children (6-36 months)**	**Total**
Large States	Jharkhand, Kerala, Maharashtra, Odisha, Tamil Nadu, Uttar Pradesh	6
Small States	Meghalaya, Mizoram, Tripura	3
UTs	Andaman & Nicobar Island, Dadar & Nagar Haveli and Daman & Diu, Delhi, Ladakh, Lakshadweep	5

States/UTs with least distribution of THR are as follows:

Pregnant women		Lactating women		Children (6-36 months)	
State	**% covered**	**State**	**% covered**	**State**	**% covered**
Karnataka	80%	Punjab	76%	Sikkim	77%
Punjab	78%	Haryana	63%	Punjab	65%
Bihar	65%	Bihar	62%	Haryana	59%
Haryana	63%	Jammu & Kashmir	51%	Jammu & Kashmir	54%
Jammu & Kashmir	49%	Puducherry	49%	Bihar	52%

b. Children (0-5 years) weighed:

Top and bottom performing States/UTs on % of children (0-5 years) registered under AWC weighed at AWC are as follows:

Top performing States/UTs		Bottom performing States/UTs	
State/ UT	**Children weighed**	**State/UT**	**Children weighed**
Karnataka	100%	Nagaland	44%
Lakshadweep	100%	Telangana	37%
Maharashtra	100%	Kerala	18%
Odisha	100%	Bihar	16%
Sikkim	100%	Ladakh	15%
Tamil Nadu	100%	Arunachal Pradesh	4%

ANNEXURE 6-F: PROGRAMME ACTIVITIES AND INTERVENTION COVERAGE- DEPARTMENT OF HEALTH

a. *Programme Activities:*

Top 5 and bottom 5 performing States/UTs on the 14 indicators that were used in rubric are as follows:

Top States/UTs		Bottom States/UTs		Top States/UTs		Bottom States/UTs	
% of newborn breastfed within one hour of birth				**% of children (12-23 mo) fully immunized**			
Gujarat	100%	Nagaland	67%	Haryana	100%	Lakshadweep	5%
Lakshadweep	100%	Sikkim	50%	Uttar Pradesh	96%	Delhi	4%
Odisha	96%	Rajasthan	7%	D &N Haveli Daman & Diu	95%	Kerala	3%
Assam	96%	Puducherry	4%	Telangana	94%	Arunachal Pradesh	2%
Andhra Pradesh	96%	Ladakh	0%	Andaman & Nicobar	93%	Nagaland	1%
% of children (6-59 mo) provided at least 8-10 doses of IFA syrup per month				**% of pregnant women who registered for ANC in first trimester**			
Himachal Pradesh	100%	Manipur	0%	Tamil Nadu	95%	Ladakh	59%
Sikkim	100%	Tripura	0%	D &N Haveli Daman & Diu	95%	Goa	52%
Puducherry	98%	Arunachal Pradesh	0%	Chhattisgarh	93%	Arunachal Pradesh	41%
Telangana	65%	Goa	0%	Assam	91%	Meghalaya	39%
Haryana	58%	Nagaland	0%	Odisha	90%	Puducherry	36%
Andaman & Nicobar	44%	Rajasthan	0%	Maharashtra	88%	Nagaland	31%
D &N Haveli Daman & Diu	43%	Lakshadweep	0%	Gujarat	96%	Punjab	7%
Maharashtra	39%	Delhi	0%	Kerala	85%	Tripura	7%
% of pregnant women who received 4 or more ANCs				**% of pregnant women who were given 180 IFA Tablets**			
Chhattisgarh	100%	Ladakh	62%	Chhattisgarh	100%	Jammu & Kashmir	65%
Kerala	100%	Manipur	60%	Kerala	100%	Andaman & Nicobar	64%
Chandigarh	100%	Rajasthan	58%	Chandigarh	100%	Manipur	50%
Maharashtra	97%	Meghalaya	46%	Karnataka	100%	Rajasthan	46%

Top States/UTs		Bottom States/UTs		Top States/UTs		Bottom States/UTs	
D &N Haveli Daman & Diu	95%	Arunachal Pradesh	25%	Uttar Pradesh	100%	Meghalaya	44%
Karnataka	93%	Nagaland	19%	Telangana	100%	Nagaland	29%
Lakshadweep	90%	Tripura	6%	Maharashtra	100%	Punjab	6%
Andhra Pradesh	90%	Punjab	6%	Gujarat	99%	Tripura	3%
% of lactating women who were given 180 IFA Tablets				**% of 5-9 years children who were given weekly IFA tablets**			
Assam	100%	Puducherry	12%	Himachal Pradesh	100%	Jammu & Kashmir	3%
Chandigarh	100%	Meghalaya	8%	Gujarat	100%	Ladakh	2%
Goa	100%	Gujarat	6%	Puducherry	100%	Chattisgarh	0%
Jharkhand	100%	Tamil Nadu	3%	Uttarakhand	100%	Arunachal Pradesh	0%
Jammu & Kashmir	100%	Punjab	2%	Tripura	97%	Haryana	0%
Rajasthan	100%	Kerala	2%	Chandigarh	94%	Nagaland	0%
Sikkim	100%	Tripura	1%	Madhya Pradesh	75%	Sikkim	0%
% of pregnant women given TT2/Boosters				**% of pregnant women given 1 Albendazole tablet after first trimester**			
Andhra Pradesh	100%	Delhi	41%	Puducherry	93%	Ladakh	10%
Chhattisgarh	100%	Nagaland	40%	Gujarat	86%	Manipur	6%
Jharkhand	100%	Puducherry	28%	D & N Haveli Daman & Diu	81%	Kerala	5%
Odisha	100%	Punjab	7%	Chgattisgarh	80%	Punjab	3%
Tamil Nadu	99%	Tripura	7%	Odisha	76%	Tripura	0%
% of children (0-59 mo) diarrhoea cases reported treated with ORS & Zinc				**% of home visits to household with pregnant mother to counsel on appropriate measures**			
Gujarat	100%	Andhra Pradesh	75%	Puducherry	100%	Jharkhand	80%
Chhattisgarh	100%	Ladakh	69%	Jammu & Kashmir	98%	Andaman & Nicobar	80%
Odisha	100%	D & N Haveli & Daman & Diu	57%	Uttarakhand	98%	Maharashtra	75%
Karnataka	100%	Jharkhand	35%	Chhattisgarh	97%	Ladakh	71%
Madhya Pradesh	100%	Jammu & Kashmir	29%	Haryana	96%	Karnataka	67%

Top States/UTs		Bottom States/UTs		Top States/UTs		Bottom States/UTs	
Himachal Pradesh	100%	Uttarakhand	28%	D & N Haveli & Daman & Diu	90%	Assam	55%
Maharashtra	100%	Manipur	26%	Tripura	90%	Himachal Pradesh	51%
Haryana	100%	Andaman & Nicobar	23%	Telangana	88%	Andhra Pradesh	47%
Assam	100%	Kerala	22%	Punjab	86%	Delhi	34%
Telangana	100%	Meghalaya		Sikkim	84%	Arunachal Pradesh	18%
Goa	100%	Sikkim		Odisha	82%	Madhya Pradesh	0%
Uttar Pradesh	100%	Puducherry		Tamil Nadu	81%	-	-