Report of the Working Group on Nutrition

For the 12th Five Year Plan (2012 – 2017)

Ministry of Women and Child Development
Government of India

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Abbreviations

AAY	Antyodaya Anna Yojana
AG	Adolescent Girls
AIDS	Acquired Immune Deficiency Syndrome
AIIMS	All India Institute of Medical Sciences
ALMSC	Anganwadi Monitoring and Support Committee
ANC	Ante Natal Care
ANM	Auxiliary Nurse Mid-Wives
APIP	Annual Programme Implementation Plan
APL	Above Poverty Line
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AWTC	Anganwadi Training Centre
BCC	Behaviour Change Communication
BINP	Bangladesh Integrated Nutrition Project
BMI	Body Mass Index
BPL	Below Poverty Line
CED	Chronic Energy Deficiency
CES	Coverage Evaluation Survey
CHC	Community Health Centre
CMU	Central Monitoring Unit
CU	Consumption Unit
DALY	Disability Adjusted Life Years
DFS	Double Fortified Salt
DLHS	District Level Health Survey
ECE	Early Childhood Education
ECCE	Early Childhood Care & Education
FAO	Food & Agricultural Organization
FNB	Food & Nutrition Board
FSSAI	Food Safety & Standards Authority of India
GDP	Gross Domestic Product
GIS	Geographical Information System
Hb	Haemoglobin
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Services
ICMR	Indian Council of Medical Research
ICPS	Integrated Child Protection Scheme
IDA	Iron Deficiency Anaemia
IDD	Iodine Deficiency Disorder
IEC	Information Education & Communication
IFA	Iron Folic Acid
IMNCI	Integrated Management of Neonatal & Childhood Illness
IMS	Infant Milk Substitutes
IPC	Inter Personal Communication

IU	International Unit
IYCF	Infant & Young Child Feeding
IUGR	Intra Uterine Growth Retardation
IVRS	Integrated Voice Response System
JSY	JananiSurakshaYojana
Kg	Kilogram
KSY	Kishori Shakti Yojana
MCPC	Mother & Child Protection Card
MDGs	Millennium Development Goals
MDM	Mid-day Meal
MGNREGS	Mahatma Gandhi National Rural Employment Guarantee Scheme
MLTCs	Middle Level Training Centres
MMR	Maternal Mortality Rate
MMS	Multi-Media Messaging Service
MoHFW	Ministry of Health & Family Welfare
MWCD	Ministry of Women & Child Development
NFHS	National Family Health Survey
NGO	Non-Government Organization
NHE	Nutrition & Health Education
NHM	National Horticulture Mission
NIDDCP	National Iodine deficiency Disorder Control Programme
NIN	National Institute of Nutrition
NIPCCD	National Institute of Public Cooperation & Child Development
NNMB	National Nutrition Monitoring Bureau
NNP	National Nutrition Policy
NPAN	National Plan of Action
NRDWP	National Rural Drinking Water Programme
NRHM	National Rural Health Mission
NRLM	National Rural Health Mission
NSS	National Sample Survey
PHC	Primary Health Centre
P & L	Pregnant & Lactating
PMO	Prime Minister’s Office
PPM	Parts Per Million
PRI	Panchayati Raj Institutions
R & D	Research & Development
RCH	Reproductive & Child Health
RDA	Recommended Dietary Allowances
RDI	Recommended Dietary Intake
RGNCS	Rajiv Gandhi National Crèche Scheme
RGSEAG	Rajiv Gandhi Scheme for the Empowerment of Adolescent Girls
RSBY	RashtriyaSwasthyaBimaYojana
SC	Schedule Caste
SD	Standard Deviation
SGSY	SwarnaJayanti Gram SwarozgarYojana
SHG	Self Help Groups

SMS	Short Message Service
SNP	Supplementary Nutrition Programme
SRS	Sample Registration Survey
SSA	SarvaShikshaAbhiyan
ST	Schedule Tribes
THR	Take Home ration
TINP	Tamil Nadu Integrated Nutrition Project
TOT	Training of Trainers
TPDS	Targeted Public Distribution System
TRC	Training Resource Centre
TSC	Total Sanitation campaign
TT	Tetanus Toxoid
TV	Television
U5	Under Five
UN	United Nations
UT	Union Territory
VAD	Vitamin A Deficiency
VHND	Village Health & Nutrition Days
VHNSC	Village Health Nutrition & Sanitation Committee
WHO	World Health Organization
Wt	Weight

FOREWORD

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FOREWORD

The rapid progress made in economic development has not translated to household food security and good nutrition. Malnutrition continues to be a major public health problem, undernutrition especially among women and young children coexists with overnutrition in the country. The undernutrition levels is persistently and unacceptably high – especially in-utero and in the first two years of life, in adolescent girls and in women across the life cycle.

During the 11th Five Year Plan, Nutrition assumed a central role and has gained highest attention and priority. In view of this highest national priority accorded to combating malnutrition in the country a new policy direction was provided by the Prime Minister's National Council on India's Nutrition Challenges. Initial stages of work along the directions of the PM's Nutrition Council have already begun and have to be taken forward more aggressively during the 12th Five Year Plan.

Therefore, the vision for 12th Five Year Plan on Nutrition would be to move towards *Nutrition Security* - especially the more vulnerable infants and young children, adolescent girls and women, across the life cycle, fulfilling their rights to nutrition, health and human development- to their full potential. For ensuring this, the 12th Five Year Plan would continue to position the development of children at its centre and recognize nutrition as critical for ensuring child survival and development.

In this perspective a Working Group on Nutrition was constituted by Planning Commission to recommend priorities and strategies for Nutrition in the Twelfth Five Year Plan 2012-2017.Five subgroups of the working group were constituted- which deliberated on different facets of nutrition and provided recommendation for improving nutrition outcomes especially among women and children. The Working Group has put forth a set of recommendation and monitorable targets along with enhanced resource for approaches and strategies like Multisectoral interventions and innovative models for nutrition, Institutional arrangements, Institutional capacity development for nutrition,Promotion of Infant and Young Child Feeding, Advocacy,IEC and communication, Capacity building and Nutrition Surveillance.

In this regard, I would like to especially recognize and express my appreciation to Shri D.K. Sikri, former Secretary, MWCD and my predecessor, under whose valuable guidance, leadership and chairpersonship, this report has been formulated.

In this process of collective endeavours, the contribution and support of all the Chairpersons and Members of the various sub-groups, as well as all the members of the Working Group on Nutrition are also greatly appreciated for making valuable recommendations and suggestions towards addressing the nutrition challenges in India. The report has been

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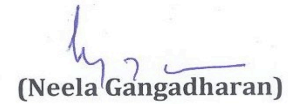
enriched by deeper intellectual insights, field and implementation experiences of the members of the working group whose commitments are visible and well articulated in the final report.

I take this opportunity to acknowledge and accord my sincere appreciation to the Convener of the Working Group on Nutrition, Dr. Shreeranjan Joint Secretary, MWCD for having anchored and synthesized the various dimensions of nutrition into a comprehensive Report. Credit is also mentionable to all members of the Drafting Committee together with the convener for their immense efforts.

I am confident that the recommendations, commitments and resources will help to break the intergenerational cycle of undernutrition and make a dent in the undernutrition rates among children, adolescent girls and women during the Twelfth Plan.



(Neela Gangadharan)

PREFACE

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भारत सरकार
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PREFACE

The rationale for investing in Nutrition is globally well recognized – both as a critical development imperative, and as central to the fulfillment of human rights, especially those of the most vulnerable children, girls and women. It constitutes the foundation for human development, by reducing susceptibility to infections, reducing the related morbidity, disability and mortality burden, enhancing cumulative lifelong learning capacities, and adult productivity. Nutrition status of the most vulnerable age group of children is a sensitive proxy indicator of human development and is also a measure of the effectiveness of national socio economic development strategies

India is going through economic, social and developmental transition and now, it also faces the double burden of malnutrition – undernutrition among vulnerable groups persists, while some segments of population due to change in life style face the risk of non communicable degenerative disease due to overweight or obesity. Both require attention and developmental treatment in planning and action.

The slow decline in undernutrition rates and the time trends showing a decline in intake of food and nutrients, makes undernutrition undoubtedly a major concern demanding the highest priority. Poor nutrition starts before birth, and generally continues into adolescence and adult life and can span generations, often with irreversible situation.

Poor environmental sanitation, lack of safe drinking water, poor care practices and poor access to health services further complicate the picture by increasing susceptibility to infection leading to morbidity and mortality.

The aetiology of nutrition is complex and requires a multipronged synergistic action, through convergence between programmes, Institutions, legislations, policies and interventions. Outcome indicators for different programmes need to be worked out in order to achieve nutrition goals and targets. This is achievable through focused convergent actions on the above mentioned adequacies and factors. Good governance and effective leadership is imperative in bringing such focused action.

Nutrition being not visible, its importance and significance has not entered our socioeconomic consciousness. Therefore advocacy, communication and IEC for nutrition is yet another area which we have to traverse miles and that too with hope and dedication bringing desired nutrition outcomes. Involvement of network of institutions, professional bodies and voluntary action groups in reaching out to different sections of society, ranging from policy makers, administrators and above all reach out to the communities and families.

: 2 :

During the 11th Plan Nutrition acquired high political attention and priority and new policy directions were provided by the Prime Minister's National Council on India's Nutrition Challenges. In view of this, a comprehensive thrust would be required, during the 12th Five Year Plan, to address the different dimensions of the nutrition challenge at various levels. The focus would be on strengthening and restructuring ICDS, putting in place a mulit-sectoral programme on addressing maternal and child undernutrition in 200 high-burden district, launching a nation-wide information, education and communication campaign against malnutrition as well as ensuring strong nutrition focus in sectoral programmes implemented different ministries / departments. These are crucial but challenging tasks that would not only require highest attention from all sectoral Ministries / Department as well as State Governments but also require to be embedded in actions, inputs leading to measurable results from each sector on nutrition related outcomes.

This Working Group Report on Nutrition is an effort by the Ministry of Women and Child Development to formulate acomprehensive approach for addressing the Nutrition Challenges of India during the Twelfth Plan.

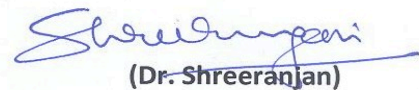
I would also like to extend my deepest gratitude and sincere thanks to former Secretary MWCD, Mr D.K Sikri for his relentless support, guidance and oversight throughout the process.

I extend my gratitude to Smt. Neela Gangadharan, Secretary MWCD for her invaluable leadership which has brought this endeavour to fruition.

The Sub Group members have deliberated in great depth on different issues and aspects of nutrition and have put forth their recommendation. I would like to extend my thanks for the invaluable inputs, deeper and insightful perspectives and suggestions. I would specially thank the Chair and Co-chair persons of the different groups – Dr. Prema Ramchandran, Dr. Arun Gupta, Dr. Vandana Shiva, Dr T. Sundaraman, Dr G.N.V Brahmam and Dr Dinesh Paul.

The Drafting Committee under my Chairpersonship has made commendable efforts to put together this comprehensive document, I would like to thank Smt. Deepika Shrivastava, OSD, Planning Commission for her invaluable inputs and contribution in preparation of the report. I would thank other members of the drafting group Mr. Srinivas Varadan, Consultant (MWCD), Mr. Pravesh Kumar, Consultant (MWCD), Ms. Farheen Khurshid, Consultant (MWCD), Ms. Meenakshi Jha, Consultant (MWCD) who have put immense effort in the synthesising this Working Group Report on Nutrition.

In this endeavour the contribution of Dr. Neelam Bhatia, JD NIPCCD is worth mentioning. I also acknowledge the support received from officials of Food and Nutrition Board- Smt. Kum um Marwah, JTA, Dr. Premi Devi, DTA and other ATAs in coordinating the various subgroup meetings and providing other assistance.



(Dr. Shreeranjan)

1. INTRODUCTION

Nutrition is essential for human development. Nutrition is acknowledged as one of the most effective entry points for human development, poverty reduction and economic development, with high economic returns. It includes both undernutrition as well as over-nutrition and refers to deficiencies, excesses or imbalances in the intake of energy, protein and / or other nutrients. Undernutrition affects survival, development, health, productivity, and economic growth. Undernutrition is a complex and multi-dimensional issue, affected mainly by a **number of generic factors** including poverty, inadequate food consumption, inequitable food distribution, improper infant and child feeding and care practices, inequity and gender imbalances, poor sanitary and environmental conditions; and restricted access to quality health, education and social care services. A **number of other factors**including economic, environmental, geographical, agricultural, cultural, health and governance, political and administrativecomplement these general factors in causing undernutrition of children.

The intergenerational cycle, manifests as low birth weight and is compounded further by gender discrimination and exclusion. Undernutrition in pregnant women, infants and young children leads to growth failure, increased rates of morbidity, increased risks to survival, impaired cognitive development, reduced learning capacity, poor school performance in children, sub-optimal productivity in adults, and reduced economic growth for nations. It is critical to prevent undernutrition, as early as possible, across the life cycle, to avert irreversible cumulative growth and development deficits that compromise maternal and child health and survival, achievement of optimal learning outcomes in primary education and gender equality.

Table-1: FACTORS CONTRIBUTING TO UNDERNUTRITION IN DIFFERENT STAGES OF THE LIFE CYCLE	
During Infancy and Childhood	• Low birth weight • Poor Breastfeeding (Delayed initiation, not exclusive for 0-6m) • Delayed introduction and inadequacy of complementary feeding • Frequent infections • Weak child care services and the vulnerability of children between under 3 years
During Adolescence	• Low calorie intake / consumption • Gender Discrimination • Resultant prevalence of Anemia
Young Women and Pregnant Women	• Inadequate calorie intake • Lack of consumption of protein and iron rich foods • Micronutrient Deficiencies • Early Marriage and child birth • Inadequate birth spacing
Old Age	• Decreased purchasing power. • Poor absorption and frequent infections and other illnesses • Neglect

As discussed earlier, undernutrition is a complex and multi-dimensionalissue, affected by poverty, inadequate food consumption,inequitable food distribution, improper infant and child feedingand care practices, equity and gender imbalances, poorsanitary and environmental conditions and restricted access toquality health,education and social care services (Fig.1). A number of other factors tend to complement these general factors in causing undernutrition of children.

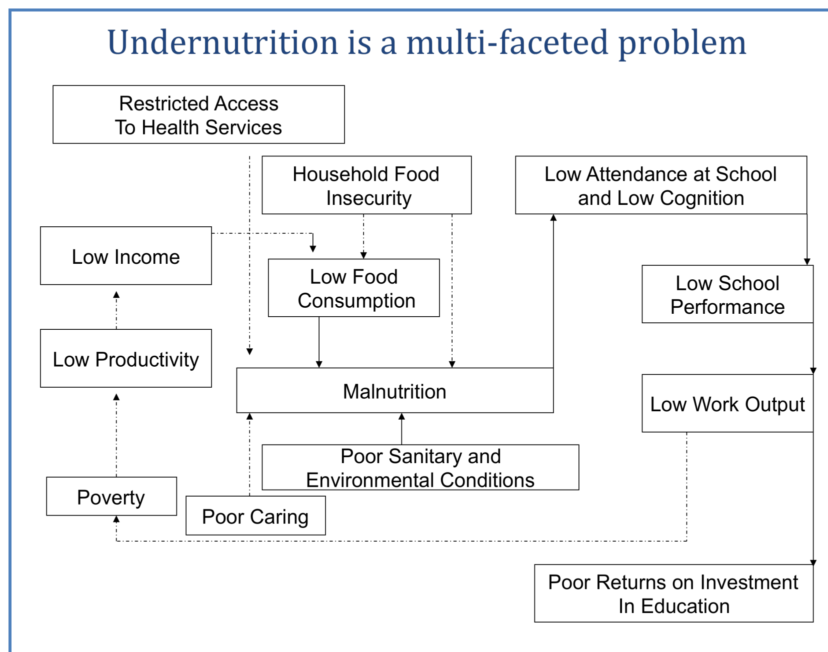


Fig.1: Multi-faceted Problem of Undernutrition

Nutritional outcomes are determined by a complex interaction of factors including caring and feeding practices of children, culturally accepted food baskets, purchasing power at the household level, and macro level food and agricultural policies. For example, practices such as organic farming and kitchen gardens are aimed at addressing nutritional security at the household level. At the same time, a shift from food crops to cash crops can adversely impact access to food both at the household level as well as the national level. Some of the major determinants of undernutrition can be grouped as:

- **Economic:** Poor purchasing power, poverty, livelihood insecurity, major inequities in asset distribution and control, including gender inequities.
- **Environmental:**Lack of safe drinking water, poor sanitation, poor hygiene practices
- **Agricultural:**Failure to include nutrition concerns in major cropping and farming systems, leading to limited availability of nutrient rich foods, seasonal food shortages, inequities in food distribution, conversion to cash crops, and decreases in home gardening
- **Cultural:**Inadequate knowledge of nutrition, cultural beliefs and practices that lead to poor nutrition (e.g., expelling colostrums, restricting food consumption during pregnancy or sickness), cultural shifts to prefer less micronutrient rich foods, discriminatory intra-familial food distribution, high workload for women, inadequate time available for infant and young child feeding and care, early marriage, discrimination against girls and women, other forms of discrimination

- **Health:**Weak health service systems, inadequate human resources, especially in public health nutrition, weak health and nutrition educational systems, poor utilisation of services, recurrent infections, low immunisation rates, lack of awareness of nutrition issues (such as which foods are the most nutritious, or proper infant and young child feeding practices), and many of the poor andvulnerable left “unreached”
- **Political and Administrative:**There are many vertical programmes that are not well coordinated.Lack of a central coordinating mechanism for nutrition extending from the local to national level, lack of a nutrition surveillance system focused on nutritional outcomes, decision making that is not based on data or evidence, diffusion of effort, weak implementation and monitoring systems, lack of accountability, poorgovernance.

Therefore, nutrition security in itself is a wide ranging plethora of factors that need to be addressed in a well coordinated manner. It includes physical, economic and social access to a balanced diet and a clean and healthy environment.It includes fulfilment of the dietary and nutritional needs of a person that supports a healthy and productive life at the national (macro), household and individual levels (micro).

Poor nutrition starts before birth, and generally continues into adolescence and adult life and can span generations. **The intergenerational cycle of undernutrition** ensures that an undernourished and anemic mother gives birth to a low birth weight baby, more susceptible to infections, and more likely to experience growth failure, who goes on to become an undernourished and anemic child, experiencing cumulative growth and development deficits, which are largely irreversible.

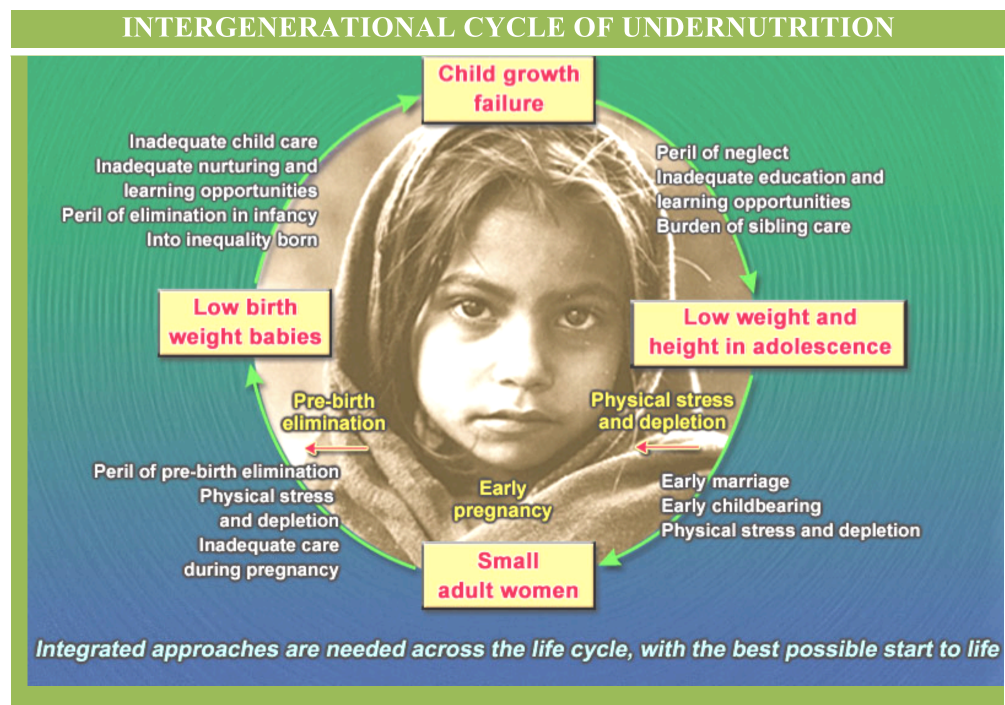


Fig. 2: Intergenerational Cycle of Undernutrition

And then the cycle is perpetuated, with undernourished and anemic adolescent girls and women, facing gender discrimination, early marriage, early and frequent child bearing, being locked in a cycle of multiple deprivations- gender discrimination, social exclusion and poverty.

Nutrition challenges continue throughout the life cycle, particularly for girls and women. A woman with poor nutritional status, as indicated by a low body mass index (BMI), short stature, anaemia, or other micronutrient deficiencies, has a greater risk of obstructed labour, having a baby with a low birth weight, having adverse pregnancy outcomes, adversely affecting lactation, death due to postpartum haemorrhage, and illness for herself and her baby.

In India, maternal and child undernutrition levels remain persistently and unacceptably high. 35.6 % women have low BMI, more than 22 % babies are born with low birth weight, 42.5 % children under five years are underweight, 48 % are stunted, 19.8 % are wasted (NFHS 3 -2005-06) and 69.5 % children (6-59 m) are anaemic. It is important to recognise that underweight prevalence increases sharply from 0 to 6 months, to more than 40% at 18 months. The prenatal under twos period is critical for preventing undernutrition as early as possible across the life cycle- for achieving large scale reductions in current levels. Infant and Young Child Feeding practices remains sub optimal- early initiation of breastfeeding within 1 hour is 25 % (NFHS 3), and 40.6 % as per DLHS 3, linked to JSY, increased institutional deliveries and skilled attendance at birth. Only 46 percent of infants younger than six months are exclusively breastfed, and at completion of 6 months only 28% are exclusively breastfed (NFHS 3 -2005-06). There has been an increase in introduction of complementary feeding in children 6-9 months from 33% to 55% between NFHS 2 and 3, which can be used to build further improvements in young child feeding. In this context, early preventive action is crucial for accelerating reductions in maternal, neonatal, infant and young child undernutrition and related mortality, on a large scale. According to the Registrar General of India (2001), adolescent girls (11-18 years) constitute nearly 16.75 % of the total female population of 49.65 crores which is approximately 8.3 crores and levels of undernourishment and anemia remain high.

Table-2: NUTRITION CHALLENGES IN INDIA: SOME FACTS

Children	Women	Adolescent Girls
• Every fifth child in the world lives in India • 22 % babies are born with low birth weight • 50 out of 1000 live births do not complete their first year of life • 42.5% of children 0-5 years are underweight • 79% children (6-35 months) are anaemic • Prevalance of Bitot Spots in 0.6% preschool children	• More than a third (36%) of women have a BMI below 18.5 ; among women who are thin, 44% are moderately or severely thin • 36.0% women suffer with Chronic Energy Deficiencies • 56.2% women are anaemic • Women suffer from a dual burden of malnutrition with nearly half of them being either too thin or overweight • The percentage of ever-married women age 15-49 who are overweight or obese increased from 11 percent in NFHS-2 to 15 percent in NFHS-3 • As undernutrition decreases, overnutrition increases by about the same amount • Undernutrition declines and overnutrition increases with age of women	• 11-18 years Adolescent Girls (AGs): Approx. 8.32 cr. - (16.75 % of female population) • Undernourished AGs: Approx. 2.75 cr. (33% of 8.32 cr.) • Anaemic : 56 % • 58 % women married and 30% gave first birth before age of 18 years contributing to High MMR and anaemia • Dropout rate (I-X): 63.5% [Mass Education, MDM] • Malnutrition levels are higher among young girls. Almost half of the girls in age 15-19 are undernourished

Nutrition for Faster, More Inclusive and Sustainable Growth:
The rationale for investing in Nutrition is globally well recognized – both as a critical development imperative, and as central to the fulfilment of human rights, especially those of the most vulnerable children, girls and women. It constitutes the foundation for human development, by reducing susceptibility to infections, reducing the related morbidity, disability and mortality burden, enhancing cumulative lifelong learning capacities, and adult productivity.

Nutrition status of the most vulnerable age group of children is a sensitive proxy indicator of human development and is also a measure of the effectiveness of national socio economic development strategies.

Linking Nutrition & Development enhances the effectiveness and efficiency of social development investments. This is through inclusion of the most vulnerable and those most at risk, through synergy of multi sectoral action, by catalyzing reforms in health and child care and through strengthening of participatory processes and capacities for assessment, analysis and informed action, that also improve governance processes and mechanisms.

Recognizing the importance of addressing the widespread problem of undernutrition through various health interventions the Planning Commission constituted a Working Group on Nutrition for the 12thFive Year Plan under the Chairpersonship of Secretary, Ministry of Women & Child Development. These Working Groupswererepresented by the senior government officials, representatives of the concerned sector, eminent experts from national institutes in the field of nutrition and health and reputed NGOs from the sector.

The first meeting of the Working Group was held under the Chairpersonship of Shri D.K Sikri, Secretary, Ministry of Women and Child Development in June, 2011 during which five Sub - Groups were constituted.Each of these Sub-Groups was assigned the followingthematic area and was given the mandate for preparing relatedsub-group reports:

Table-3: Sub-groups for Working Group on Nutrition

Sl. No.	Sub – Group	Theme	Chairperson
1.	**Sub Group I**	Review of Extent of Nutrition Problems, Trend Analysis and Strategies	Dr. Vandana Shiva, Navdanya International
2.	**Sub Group II**	Interventions and Institutional Mechanism for Care and Support of Maternal and Child Undernutrition and Support Action Plan	Dr. Shreeranjan, Joint Secretary, MWCD
3.	**Sub Group III**	Behaviour Change & Communication including Promotion of IYCF & IMS Act	Dr. Arun Gupta, BPNI
4.	**Sub Group IV**	Micronutrient Malnutrition and Obesity	Dr. Prema Ramachandran, Director, NFI
5.	**Sub Group V**	Nutrition Surveillance, Mapping, Training and Capacity building	Dr. G. N. V. Bramham, NIN

Detailed terms of reference of the Working Group and the five Sub-groups along with their compositions are given in **Annex – I.**

Most of the Sub-Groups had one meeting with their members and later on interacted with each other electronically. In the second meeting of the Working Group held in October 2011, the Chairpersons of the four Sub-Groups made power point presentations on their report and recommendations. Following the second meeting of the Working Group, the Sub-Groups finalized their reports and submitted the same to the Ministry of Women and Child Development.

2. SITUATIONAL ANALYSIS OF NUTRITION & EMERGING TRENDS

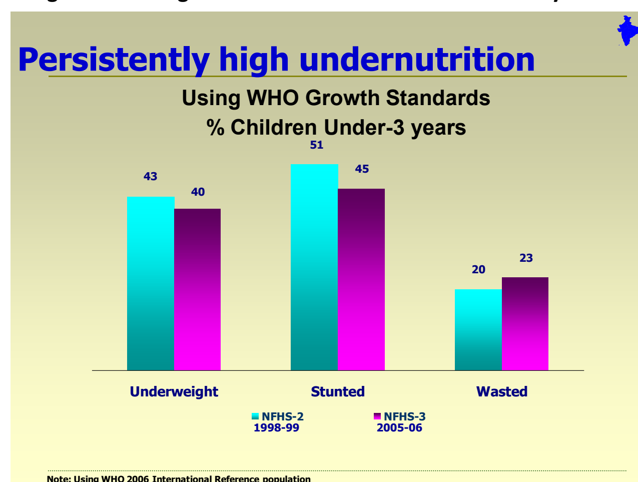
As discussed, undernutrition in infants, young children and adolescents leads to growth failure, lowered resistance to infections, thereby increased rates of morbidity, increased risks to survival, impaired growth and cognitive development, reduced learning capacity and poor school performance. In adult women, it may contribute to adverse out-come of pregnancy and poor lactational performance. It is critical to detect and prevent undernutrition, as early as possible, across the life cycle, to avert irreversible cumulative growth and development deficits that compromise maternal and child health and survival, ultimately impacts on productivity at work and at home, and thereby has adverse consequences for income and economic growth.

While assessing the present nutrition situation, a limitation is faced is that there has been no nationwide survey on undernutrition, the prime concern, since the National Family Health Survey in 2005-06.

2.1 Nutritional Status of Children:

In India, undernutrition levels remain persistently and unacceptably high – especially in utero and in the first two years of life, in adolescent girls and in women across the life cycle, in disadvantaged /excluded community groups and those living in poverty and in areas or conditions of high nutritional vulnerability and where disease load is high. According to NFHS-3, about 42.5% of children 0-5 years were underweight and 48% were stunted and 20% were wasted. In children 0-3 years, 40.4 % were underweight as may be seen in the graph (Fig. 3). Twenty two percent babies were born with low birth weight, 50 out of 1000 live births did not complete their first year of life. The figures were relatively higher in rural communities thanthe urban. There were also large inter-state variations in the patterns and trends in underweight prevalence. Studying the extent of undernutrition amongst states it is found that underweight amongst children was highest in Madhya Pradesh (60%), followed by Jharkhand (57%) and Bihar (56%) and least in Mizoram, Sikkim, Manipur, and Kerala. However, even in these states, however, levels of undernutrition are unacceptably high. Prevalence of stunting is also substantially higher than average (for stunting) in Meghalaya (55%) and Uttar Pradesh (57%). Analysis of regional disparities shows overtime the economically less developed regions of India are becoming concentrated pockets of undernutrition.However recent surveys and studies carried out by individual states like MP is showing a significant declining trend.

Fig.3: Percentage Children Undernourished Under-3 years



Wide disparities in nutrition status exist not only across states, but across and within districts and different community groups. For instance, underweight prevalence in children under 5 years from Scheduled tribe communities was as high as 54.5%, compared to the national average of 42.5%, and 33.7 % in other communities (NFHS 3-2005-06).

2.2 Infant & Young Child Feeding Practices:

Appropriate feeding practices in children under 2 years are crucial for their survival, healthy growth, intellectual and physical development. According to The Lancet, 2008 if breastfeeding (including exclusive breastfeeding for the first six months and continued breastfeeding for the next six months) was universalized it will reduce deaths at 36 months of age by 9.1%.

NFHS-3 data show that the initiation of breastfeeding within one hour is only 24.5% while the exclusive breastfeeding rate in children under six months is only 46.4%. Data from NFHS-3 show that during the first few months Indian children are exclusively breastfed and are relatively free from infections. DLHS 3 shows improvement in children initiated breastfeeding within one hour of birth from 27.8% in DLHS 2 to 40.5% in DLHS 3. Further analysis of data from DLHS shows that underweight rates remain unaltered between birth and three months when most of the infants are exclusively breast fed.

In addition to low weight at birth, according to NNMB-2006, faulty breastfeeding & complementary feeding habits increases the prevalence of undernutrition among 0-6 month old infants (26%) & reaches to 39% in 12-23 months old children (Fig. 4). Similarly, NFHS-3 data also reveals that proportion of children with stunting or underweight increases rapidly with the child's age through age 20-23 months. Percentage of children with undernutrition peaks at age 20 months. Wasting generally decreases throughout the age range of 0-59 months. The rise in malnutrition during the first two years of can be attributed to faulty & poor infant caring and feeding practices. Infant and young child feeding practices have been far from optimal & continue to be a serious challenge to preventing and reducing undernutrition among children.

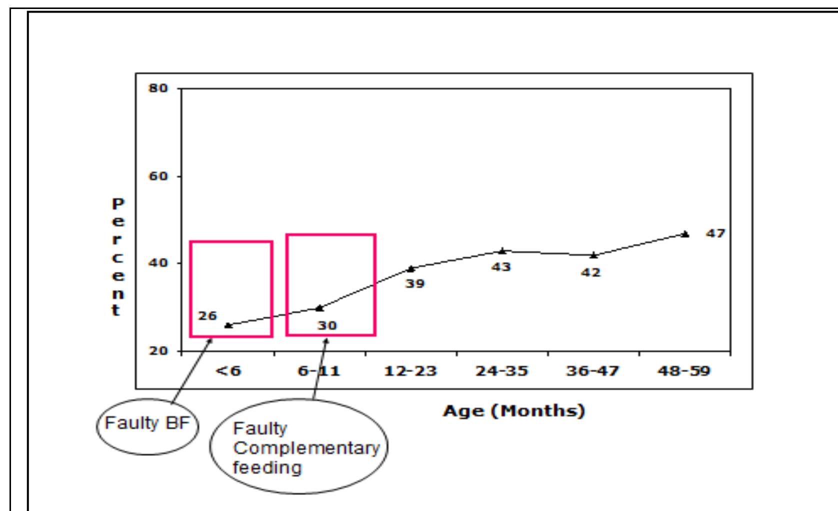


Fig. 4: Prevalence of Underweight among 6-59 months children using WHO Child Growth Standards, *(Source: NNMB-2006)*

Early initiation of breastfeeding (within one hour of birth)and exclusive breastfeeding for the first six months of life provides optimal nutrition for growth & development and protects the Introduction of appropriate complementary feeding after six months also prevents under nutrition in children and growth faltering. But, NFHS 3 data indicated that only half (56%) of children aged 6–9 months are provided with the recommended semi-solid complementary foods and breast milk. Data with respect to complementary feeding suggest that about 50-60 per cent children have timely introduction of complimentary foods but good feeding practices are reported in just about 50 per cent of children at 12-24 months of age (NFHS-3).

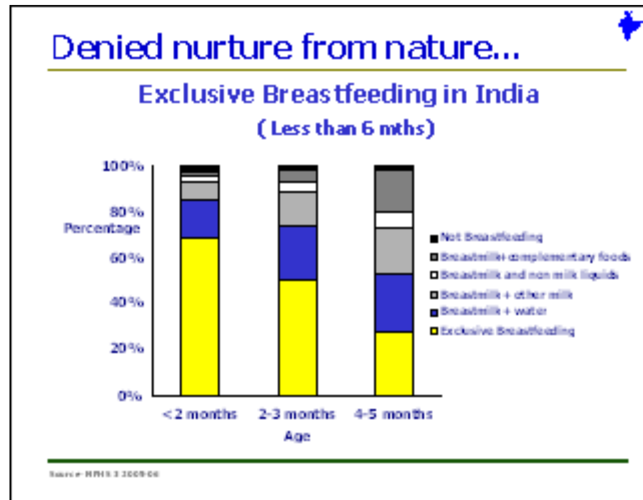


Fig. 5: Exclusive Breastfeeding in India

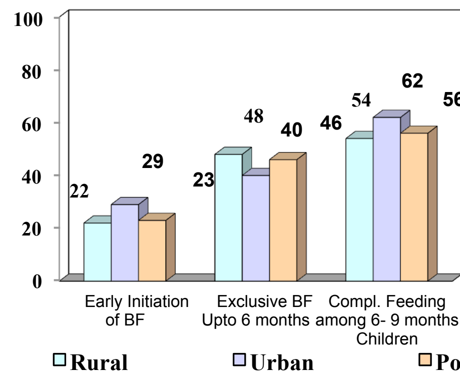


Fig. 6: Infant & Young Child Feeding Practices in India *(Source: NFHS-3)*

Fig. 6 above depicts the status of infant & young child feeding practices in urban, rural &India and reflects a different scenario. From this figure, it can be stated that undernutrition among preschool children may be the result of faulty feeding practices rather than the scarcity of the food. It was also assessed that the low status of woman and their lack of nutritional knowledge and inadequate caring practices are important determinants of high underweight prevalence in children.

2.3 Nutritional Status of Women & Adolescent Girls:

More than one third (36%) of women aged 15-49 have a BMI below 18.5, which indicates chronic energy deficiency, including 16 percent who are moderately to severely thin. The proportion of ever-married women who are thin (33 percent) has declined slightly from 36 percent in NFHS-2. Bihar (45%), Chhattisgarh (43%), Madhya Pradesh (42%) and Orissa (41%) are the states with the highest proportion of undernourished women. Adolescent girls are also

one of the vulnerable groups which require concerted attention. 11-18 years Adolescent Girls constitute 16.75% of female population (Approx. 8.32 crore). Among these, approximate 2.75 cr. are undernourished.

2.4 Micronutrient Deficiencies:

Iron, Vitamin A and iodine deficiencies are major public health problems, among the range of Vitamin and Mineral Deficiencies.

- **Vitamin A**: Sub-clinical Vitamin A deficiency (VAD) is a well-known cause of morbidity and mortality, especially among young children and pregnant women. Vitamin A supplementation has proven successful in reducing the incidence and severity of illness, and has been associated with an overall reduction in child mortality by 25- 35%, especially from diarrhoea, measles and malaria. As per NFHS-3 only one in four children aged 12 – 35 months received the six monthly Vitamin A supplement in the six months before the survey. This figure drops further, to only 18%, among children age 6-59 months. However an increase of 23.4 between DLHS 2 and 3 has been depicted.

- **Iron:** Iron deficiency anaemia (IDA) is common across all age groups, but highest among children, adolescent girls, pregnant and lactating women. The consequences of IDA in pregnant women include increased risk of low birth weight or premature delivery, peri-natal and neonatal mortality, inadequate iron stores for the new-born, lowered physical activity, fatigue and increased risk of maternal morbidity. Prevalence of anaemia among children 6-35 months has increased from 74% in NFHS-2 to 79% in NFHS-3. This increase is largely due to a sharp increase in anaemia among young children in rural areas (NFHS-3). Anaemia is a major health problem for adults as well, affecting 55% of women and 24% of men. The prevalence of anaemia for ever-married women has increased from 52% in NFHS-2 to 56 % in NFHS-3.

- **Iodine**: Iodine Deficiency is the most common cause of preventable mental retardation and brain damage in the world. Iodine deficiency during pregnancy is associated with low birth weight, increased likelihood of stillbirth, spontaneous abortion and congenital abnormalities such as cretinism and irreversible forms of mental impairment. During the childhood period, it impairs physical growth, causes goiter and decreases the probability of child survival. According to NFHS-3, among the households that had their salt tested, just over half (51%) were using salt that was adequately iodized and another half were using salt that was either inadequately iodized or was not iodized at all.

  It has been estimated that 200 million people in India are exposed to the risk of iodine deficiency and more than 71 million suffer from goiter and other iodine deficiency disorders (MoHFW, 2005). As per district level IDD survey conducted by Directorate General of Health Services, ICMR, AIIMS, NIN, Hyderabad, State Health Directorate and other Health institutions, out of 365 districts surveyed covering all States/UTs, 303 districts are endemic where the prevalence of iodine deficiency disorders is more than 10%. Thus, no State/UT is free from IDD. Findings from NFHS 3 also showed that the use of non-iodized salt was high

in rural areas as compared to urban areas due to better transport facility in urban areas. However, CES 2009 shows that the household consumption for iodised salt has increased to 71% (Fig. 7).

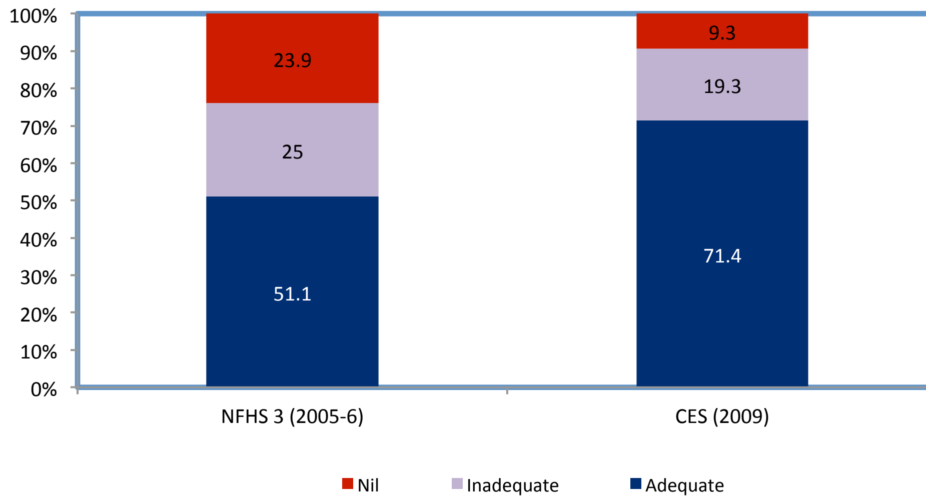


Fig. 7: Household Consumption of Iodised Salt *(Source: CES 2009)*

2.5 The Dual Burden of Malnutrition - Overweight & Obesity : The Emerging Concern

Simultaneously, there is small, but increasing percentage of overweight children who are at greater risk for non-communicable diseases such as diabetes and cardio-vascular heart disease later in life. These levels of undernutrition significantly compromise health and productivity. There was, however, a modest improvement in the situation during the 1990s (NFHS-3). NNMB 2006 report shows an increase in the prevalence of overweight/obesity among rural men (6% vs. 8%) and women (8% vs. 11%) from the year 2000-01. On the other hand, NFHS-3 has reported that overweight /obesity has affected almost 15% of women and 12% of men, which are most common in urban areas, in wealthier households, and among older adults.

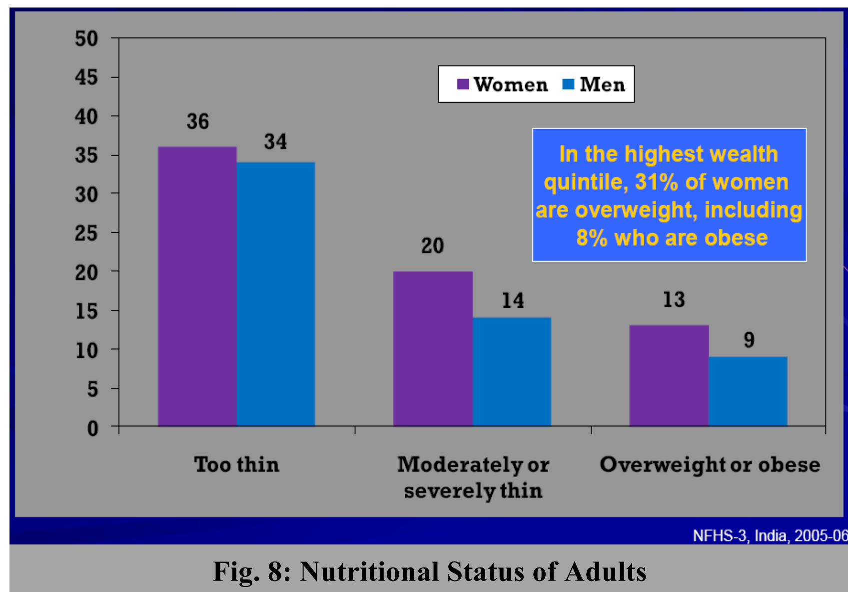


Fig. 8: Nutritional Status of Adults

2.6 Changes in the nutritional status of adults: Dual Burden

Over the past two decades there has been a progressive increase in overnutrition rates in adults. Both under- and overnutrition rates are higher in women than in men. There has been a concomitant increase in fat fold thickness, suggesting that the increase body weight is mainly comprised of body fat. The NFHS-3 survey data show that both under- and overnutrition do exist in populations of all income levels and only approximately 50% of the population is normally nourished in any segment of the population.

Data from NFHS showed that all the states in India have entered the dual nutrition burden era. Prevalence of both under and overnutrition in women is higher than men (Fig.8). Populous states like Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan and Orissa have high undernutrition and low overnutrition rates. States like Delhi, Punjab has low undernutrition and high overnutrition rates. However, there are states like Goa, Tamil Nadu, Himachal have relatively high undernutrition and overnutrition rates.

2.7 Maternal and Child Survival :

Infant & Under-5 Mortality Rates (IMR) is still very high i.e. 50 per 1000 live births (SRS 2011 for the year 2009). U5 mortality rate has declined but at a slow pace. The Registrar General of India has been bringing out data on child mortality on an annual basis and causes of mortality on a 3 years average basis. The under 5 mortality as per NFHS-3 (2005-06) was 74 per thousand, which came down to 69 per thousand in 2008 as per the Sample Registration System Report of 2008 (RGI 2009). There is a sharp gender differential, seen with U5 MR being 73 for girls as against 64 for boys in this report. Therefore, there is a decline in under 5 mortality and the rate of annual decline varies between 1 to 1.5.

Neonatal, infant and child mortality is closely linked to the health & nutritional status of the mother and the care & services she and the infant receive during pregnancy, child birth & lactation. Therefore, child mortality rates in India can only be reduced by addressing maternal and child malnutrition. In the causal matrix of under nutrition, an important underlying determinant is care provided to the child. There is increasing awareness that cultural and behavioural practices with regard to child rearing practices influence child nutrition and survival.

Deaths due to pregnancy and during the child birth are common among women in the reproductive age groups. Reduction of mortality of women has thus been an area of concern.

Maternal Mortality Rate (MMR) is estimated to have declined from 400 maternal deaths per 100,000 live births in 1997-98 to 254 in 2004-06 (SRS, 2009) to 212 (SRS, 2011). However, these achievements have not met the population and health goals set by the Government of India and the changes have been considerably slower than in many other Asian countries such as China, Indonesia, Thailand, Malaysia, the Republic of Korea, and Sri Lanka (NFHS-3).

2.8 Dietary Intake of Households:

NNMB has been collecting information on diet and nutritional status of rural households for 10 States since 1974-1975. It shows that the over the last decade there has been a considerable decline in cereal intake both in urban & rural areas. In the same way, there has been decline in the dietary intake of pulses over the same period, which is the major source of protein in Indian diets. This can be partly attributed to the soaring prices of pulses & therefore inability of the poor people to purchase the adequate amounts of pulses. Intake of milk & milk products, fruits &vegetables continues to be very low. Urban areas also show the same declining trend in the intake of cereal & pulses. On the other hand, there has been higher intake of dairy products, vegetables (especially roots & tubers) & oils in urban areas. Thus, it indicates that during the past three decades there has been progressive reduction in the cereal & pulse intake in the rural & urban areas. Average Intake of Foodstuffs (per CU/day) as % of RDI has been shown in Fig.9.

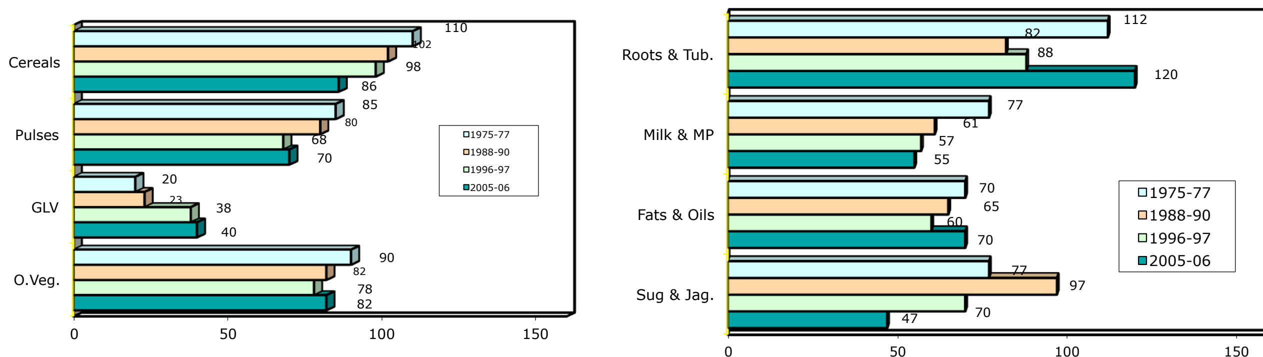


Fig. 9: Average Intake of Foodstuffs (per CU/day) as % of RDI by Period of Survey

(Source: NNMB-2006)

Interstate differences in dietary intake show that cereal forms the main bulk of all dietaries. Cereals intake was sufficient to meet the RDA in majority of the states except in Kerala, which had the lowest intake of cereals & millets. Alternatively, the intake of pulse was less than the RDA in all the states, with Kerala showing the intake of less than 50% of the RDA.

Although India's food production is adequate to meet the needs of the growing population, the country too witnessed an increase in food prices cutting across the whole spectrum of food stuffs. Food grains are still being provided at a highly subsidized cost, especially to the poor families; therefore cereal needs are still perhaps being met without undue hardship to the low income groups. But the steep rise in the prices of pulses, vegetables, oils and dairy products has resulted in further reduction in the already low consumption of these among low and middle income families. The Draft National Food Security Bill, aimed at ensuring that the minimum needs for food grains for the BPL families are met at subsidized cost is currently under consideration. It may be worthwhile to educate the people that if they utilize the savings from purchase of subsidized food grains for buying legumes and inexpensive but nutrient-rich vegetables, their meals could become more balanced. This might be one of the strategies for reducing the adverse impact of food price inflation on nutrition security of the population.

2.8.1 Protein & Calorie Consumption: As per National Sample Surveys (NSS) reports, the per capita consumption of calories & protein is falling in rural India (similar to NNMB report), and does not indicate any trend in urban India. In rural India, household per capita calorie consumption was 2,221 calories in 1983, and had dropped to 2,047 calories per head in 2004–05, a decline of 8% from 1983. Urban per capita calorie consumption was only 69 calories (3.3%) lower than in 1983. Similarly, the per capita protein consumption fell by 8% for rural areas & urban consumption remained the same over the 20-year period.

According to NNMB, the protein and calorie adequacy status varied from 54.6 per cent in 1975 to 36.6 per cent in 2002. The 2006 NNMB report shows the about 30% of the households consumed adequate amounts of both protein & calorie. The report shows a marginal decline in the average daily intake of cereals & millets, & protein consumption. The protein and calorie adequacy status was stable till 1981 and there afterwards it was gradually declined. Fig. 10shows the distribution of household with protein calorie inadequacy.

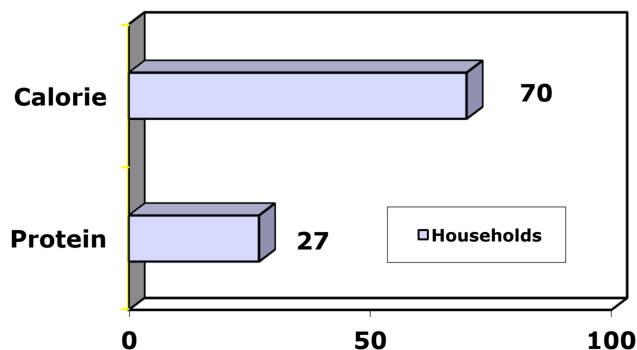


Fig.10: Distribution (%) of Households with Protein & Calorie Inadequacy

(Source: NNMB-2006)

As per the NNMB Report 2006, only one third (30.1%) of the preschool children were meeting the protein calorie adequacy. This clearly indicates the undernutrition as a major problem among the preschool (0-3 years) children in India.

2.8.2 Nutrient Intakes among Children (1-6 years): Projected data from the surveys carried out by NNMB on nutrient intake in pre-school children between 1975 and 2006 has not shown any substantial improvement in their dietary intake over the last two decades. There has not been a major change in energy and protein intake of the children. The median daily intake of nutrients for 1- 6 year Children (as % of RDA) has been depicted in Fig.11. Time trends of the intra familial distribution of food (Fig. 12) indicates that the proportion of families where both the adults and preschool children have adequate food has declined from 30% to 22% over the last 30 years, while the proportion of families with inadequate intake has come down substantially. However, the proportion of families where the preschool children receive inadequate intake while adults have adequate intake has increased to a greater extent. This data suggests the need to strengthen the infant & young child feeding practices.

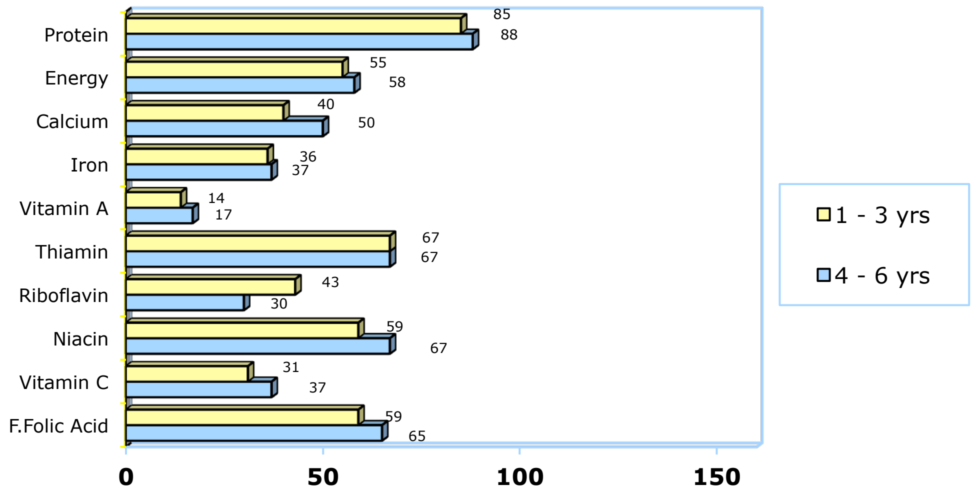
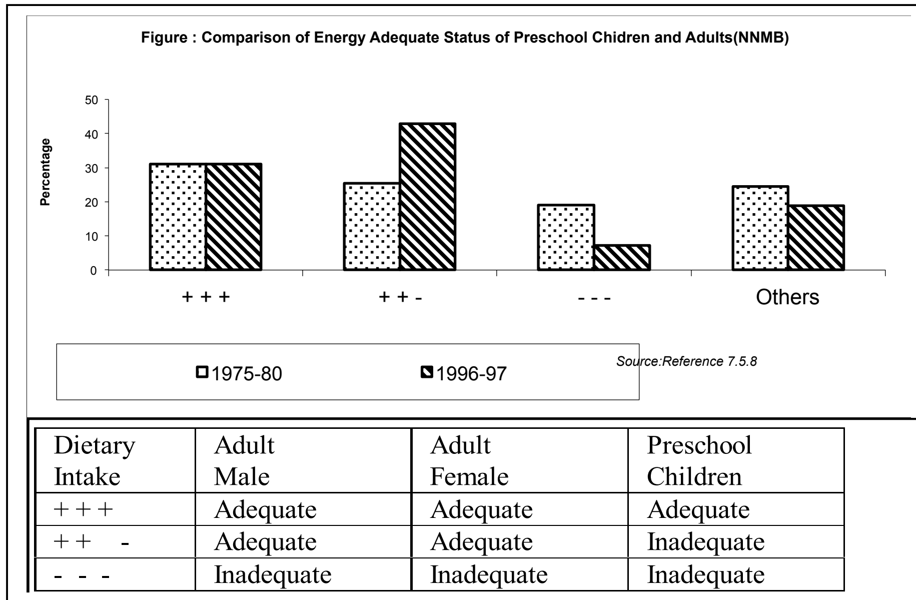


Fig. 11: Median Daily Intake of Nutrients by 1- 6 yr Children (as % of RDA)

(Source: NNMB-2006)



Dietary Intake	Adult Male	Adult Female	Preschool Children
+ + +	Adequate	Adequate	Adequate
+ + -	Adequate	Adequate	Inadequate
- - -	Inadequate	Inadequate	Inadequate

Fig. 12: Comparison of Energy Adequate Status of Preschool & Adults ***(Source: NNMB-2006)***

3. REVIEW OF ELEVENTH FIVE YEAR PLAN, EXISTING POLICIES, LEGISLATIONS AND PROGRAMMES

3.1 Review of Eleventh Five Year Plan

The Eleventh Five Year Plan positions the development of children at its centre and recognizes nutrition as critical for ensuring child survival and development. The 11th Plan accords high priority to addressing maternal and child undernutrition through multi sectoral interventions by different sectors. It highlights the need for universalisation of the ICDS, increased focus on children under 3 years, ICDS implementation in a Mission Mode, strengthening of the district planning process and further research for developing a comprehensive strategy to address micronutrient deficiencies. It also emphasises on improving the nutritional status of adolescent girls and maternity benefits to women, especially those living below the poverty line.Some of the major challenges recognized in the Plan document include: (i) High levels of adult malnutrition affecting a third of the country's adults; (iii) High levels of undernutrition, particularly in women and children; (ii) Inappropriate infant feeding and caring practices; vi) Inadequate access to health care (iv) Micronutrient undernutrition; and (v) Emerging diet-related diseases.

The monitorable targets of the Eleventh Five Year Plan include key nutrition goals:

- Reduce malnutrition among children in the age group0–3 to half its present level; and
- Reduce anaemia among women and girls by 50%by the end of the Eleventh Plan.

The Eleventh Five Year Plan places special attention towards healthcare that includes equitable and comprehensive individual healthcare, improved sanitation, clean drinking water, nutritious food, hygiene, good feeding practices, and development of delivery systems, necessary to address the needs of the people. It also accords highest priority to the health of marginalized groups, like children below the age of three, adolescent girls, women of all ages, elderly persons, the disabled, tribals, and Schedules Castes (SCs) were given highest priority. The monitorable targets for the Eleventh Plan especially in relation to nutrition include the following:

- Reducing malnutrition among children in the age group 0–3 years to half the level;
- Reducing anaemia among women and girls by 50 per cent;
- Reducing Infant Mortality Rate (IMR) to 28 per 1,000 live births;
- Reducing Maternal Mortality Ratio (MMR) to 100 per 1,00,000 live births;
- Providing clean drinking water for all by 2009 and ensuring no slip-backs.

The Eleventh Five year plan recognizes the importance of setting up a high level inter-agency coordination mechanism to enable policy directions to the concerned sectors. The Plan document also suggests various strategies for improving maternal and child nutrition including: (i) High priority to micronutrient malnutrition control, particularly to tackle anaemia; (ii) DLHS of RCH Programme to monitor prevalence of micronutrient deficiencies on priority; (iii) National Nutrition Monitoring Bureau (NNMB) of ICMR to be extended to all States/UTs; (iv) Iron and

Folic Acid Supplementation Programmes under RCH (NRHM) to cover infant and young children, by providing IFA in syrup form, and weekly iron supplements to adolescent girls (10–19 years); (v) Vitamin A Supplementation Programme to cover all children between nine months to five years of age and existing low coverage to be brought to 90% by 2009; (vi) Promotion of breastfeeding; (vii)Promotion of consumption & production of fruits and vegetables in the Community; (viii) Environmental sanitation and hygiene, accessibility to safe drinking water; (ix) Emphasis on research particularly studies for collecting evidence regarding interaction amongst micronutrients, shelf life of fortified foods, regional variations in deficiency etc. and (x) Launch of vigorous awareness campaign utilizing the existing channels of communication. An analysis of achievement against the monitorable targets / strategies of the Eleventh Five Year Plan are given in Table below:

Table-4: Monitorable Targets of Eleventh Plan & its Achievements

Sl. No.	Eleventh Plan Monitorable Targets / Strategies	Achievement
1	Reduce malnutrition among children of age group 0–3 to half of 46%.	No data are available
2	Reducing anaemia among women & girls by 50% by the end of 2012	No data are available
3	Reducing IMR from 57 to 28 per 1,000 live births	50 (SRS Jan-2011)
4	Reducing MMR to 100 per 1,00,000 live births	212 (SRS June-2011)
5	Raise the sex ratio for the age group 0–6 years from 927 in 2001 to 935 by 2011–12 and to 950 by 2016–17	914 (Census 2011)
6	Providing clean drinking water for all by 2009 and ensuring no slip-backs	88% have access to improved source[1] of drinking water (NFHS-3)
7	Ensure that at least 33% of the direct and indirect beneficiaries of all government schemes are women and girl children	No data available
8	IFA Supplementation Programmes under RCH (NRHM) to cover infant & young children, by providing IFA in syrup form, and weekly iron supplements to adolescent girls (10–19 years).	Policy in this regard has been worked out. No recent study with regards to extent of coverage. Scheme for adolescents being finalized.
9	Vitamin A Supplementation Programme had to cover all children between 9 months to 5 years of age and existing low coverage to be brought to 90% by 2009.	No recent study in this regard
10	Promotion of breastfeeding, promotion of consumption & production of fruits and vegetables in the Community, Environmental sanitation and hygiene	DLHS 3 data shows an improvement in the rates of initiation of breast feeding within an hour (was 24.5% as per NFHS-3 and 40.2% by DLHS-3).
11	A high level inter-agency coordination mechanism had to be set up to enable policy directions to the concerned sectors	The Prime Minister Council on India's Nutrition Challenges was set up and met for the first time in November 2010.
12	High priority to micronutrient malnutrition control, specifically to tackle anaemia.	MHFW has come up with the scheme of weekly iron and folic acid supplementation of adolescents.
13	DLHS of RCH Programme to monitor prevalence of micronutrient	No progress in this regard

[1] An improved source of drinking water includes, in addition to water piped into the dwelling, yard or plot, water available from a public tap or standpipe, a tube well or borehole, a protected dug well, a protected spring, and rainwater. Additionally, households that drink bottled water are defined as having an improved source of water only if the source of water they use for cooking and/or hand washing is from an improved source.

	deficiencies on priority.	
14	National Nutrition Monitoring Bureau (NNMB) of ICMR to be expanded to all States/UTs.	No progress in this regard
15	Studies undertaken for collecting evidence regarding interaction amongst micronutrients, shelf life of fortified foods, regional variations in deficiency etc.	Needs to be persued
16	Vigorous awareness campaign.	A vigorous IEC campaign against malnutrition is one of the decisions of the PMs Council on India's Nutrition Challenges. It is under active processing

During the 11th Five Year Plan, Nutrition assumed a central role and has gained highest attention and priority. During the Plan and particularly after the midterm most of the schemes became universal. The commitment of the 11th Plan for introducing two new schemes for pregnant and lactating mothers as well as adolescent girls were fulfilled by launchingtwo new schemes, namely, the Rajiv Gandhi Scheme for the Empowerment of Adolescent Girls (RGSEAG) - SABLA and the Indira Gandhi Matritva Sahyog Yojana (IGMSY) – the Conditional Maternity Benefit Scheme. With regards to the commitment on restructuring and universalizing the Integrated Child Development Services (ICDS) Scheme, the process of strengthening and restructuring ICDS in Mission Mode during 12th Five Year Plan has been initiated.

During the financial year 2010-11, numerous consultations between the government departments, parliamentarians, experts, voluntary organisations / agencies, private sector and other stakeholders were held to seek suggestions on tackling malnutrition in the country. A Joint Strategy note to address India's Nutrition Challenges was prepared by MWCD &MHFW followed by Nutrition Retreat in Planning Commission. The consultations paved the way for the meeting of the Prime Minister Council on India's Nutrition Challenges in November 2010. The decisions taken during the meeting of the Prime Minister's National Council briefly included:(i) Strengthening and restructuring the ICDS Scheme; (ii) Introduction of a multi-sectoral programme to address maternal and child malnutrition in selected 200 high burden districts; (iii) Introducing nation-wide information, education and communication campaign against malnutrition; and (iv) Making nutrition a focus in the programmes in schemes of line Ministries.

Other major developments during the 11th Five Year Plan that have or could have some significant impact on nutrition issue include:

(i) The Draft National Food Security Bill, 2011: The draft Bill seeks to provide that every person shall have access, at all times, to quantitatively and qualitatively adequate, sufficient and safe food. Besides, it has specific entitlements for pregnant and lactating women, children 0-6 years, destitute persons, homeless persons, migrants, emergency and disaster affected persons, persons living in starvation etc.

(ii) Revised Recommended Dietary Allowances (RDA): RDA for Indians, form the basis of several important interventions to improve the nutritional status of the population, including efforts to maintain national self-sufficiency in food production, poverty line

computations, interventions for improving the food and nutrition security of people living below the poverty line and food supplementation programmes aimed at bridging the gaps between dietary intake and requirements of the vulnerable segments of the population. Over the past two decades newer technologies have emerged, which enables more precise estimation of the nutrient requirements. Changes in lifestyles have resulted in alteration in energy requirements. Taking all these into account, the ICMR Expert Committee has revised the RDA for Indians (Table 5).

The recommendations take into account the fact that body weight and physical activity are major determinants of energy requirement. Similarly the Expert Committee has provided recommendations for energy requirements for reference children (+2SD of the NNMB weight for age) as well energy requirements per kilogram, so that the gap between the energy requirement and energy intake can be computed on the basis of current stature. This is an important contribution, because the country has entered the dual nutrition burden era and neither low nor high energy intake is desirable.

TABLE 5: RDI ACTUAL INTAKE AND GAPS FOR INDIANS

Group	Ref wt (Kg)	RDA	Actual intake	Gap
Adult man	60	2730	2000	730
Adult woman	55	2230	1738	492
Pregnant		350more	1726	854
lactating		500 more	1878	852
1 – 3 y	12.9	1060	714	346
4 – 6 y	18	1330	978	352
7 – 9 y	25.1	1690	1230	460
Boys				
10 - 12 y	34.3	2190	1473	717
13 – 15 y	47.6	2750	1645	1105
16 – 17 y	55.4	3020	1913	1107
Girls				
10 – 12 y	35	2010	1384	626
13 – 15 y	46.6	2330	1566	764
16 – 17 y	52.1	2440	1630	810
Infants				
0-6 m	5.4	497		
6 – 12 m	8.4	672		

Data on actual intakes, the RDI and the gap between RDI and actual intake in the various groups is given in Table 5. In view of the revised RDAs it may be noted that various food supplementation programs like SABLA and IGMSY will need to consider this while reviewing the program nutritional norms.

As can be seen in Table 5the gap between the requirements and the intake is highest in the adolescent girls and boys. This is the period of adolescent growth spurt and providing adequate energy intake is essential for optimal growth during growth spurt. Viewed in this context the initiation of the MDM for the upper primary school children is an appropriate step. It might be logical to extend MDM to the secondary school also cover out of school adolescent girls.

In India micronutrient deficiencies are widespread mainly because of the low dietary intake of vegetables. Earlier ICMR recommendation is that atleast 150 grams of vegetables/day should be consumed. The RDI 2010 recommends that 400grams of fruits and vegetables should be consumed. If computed on this basis at least 100grams of vegetables should be provided through food supplementation programs.

(iii) Strengthening of Village Health and Sanitation Committee (VHSC): In order to enhance the role of VHSC, nutrition related functions were added in the roles & responsibilities and the Committee is now expanded as the **Village Health Sanitation and Nutrition Committee (VHSNC)**. The VHSNC has now been made subcommittee of the standing committee of the Panchayat. This will help in reviewing of the health, nutrition and sanitation issues at the village level and engage the community in addressing the underlying causes of undernutrition.

(iv) Using Double Fortified Salt: The Government has decidedto implement Double Fortified Salt (DFS) in its Food Supplementation programme such as ICDS and MDM among others.

(v) Developing Protocol for the prevention and treatment of malnourished and severely undernourished children:These protocolsare in the process of being developed by MoHFW in consultation with the MWCD and the Planning Commission.

(vi) Bringing Nutrition Focus into different sectoral policies & programmes: During the meetings held in the Planning Commission to bring nutrition focus into different sectors, different Ministries have given their commitments for taking proactive measures. For example, the Ministry of Human Resource Development would establish linkages with RGSEAG for addressing undernutrition and anaemia in both out of school and school going girls; the Ministry of Agriculture would strengthen improvement in food and nutrition security; the Ministry of Rural Development has indicated that food security models would be strengthened and linked with PRIs and nutrition related issues would be included in district planning; the Ministry of Food Processing Industries has reiterated its support through training and orientation of Self Help Groups, etc.

Table-6: BRINGING STRONG NUTRITION FOCUS TO SECTORAL PROGRAMMES: ILLUSTRATIVE EXAMPLES
• Village level institutional mechanism established for convergence, anchored in Panchayati Raj Institutions(MoHFW, MoWCD, MoPR, MoRD): NRHM Village Health and Sanitation Committees have been expanded to include Nutrition and ICDS to become Village Health, Sanitation and Nutrition Committees, recognised as sub committees of Gram Panchayats. These Committees will provide the village level institutional mechanism for convergence of NRHM, Total Sanitation Campaign and ICDS and also Drinking Water. • Leadership of Panchayati Raj Institutions(MoPR): MoPR has asked States to mainstream Nutrition in the training of PRIs –especially Women panchayat members, for Malnutrition free panchayats, earmarking certain wards to them. A special gram sabha meeting dedicated to Nutrition is to be held in every gram panchayat. • Tracking Mother- Child Under 3 years for improved Outcomes: (MoHFW, MoWCD) The roll out of the new joint Mother Child Card with new WHO child growth standards in ICDS and NRHM has been completed in 5500 of the 6027 ICDS projects/ blocks so far and would soon be universalised. • Double Fortified Salt for Anemia Control(MoHFW, MoWCD,MoHRD): Guidelines to promote the use of Double Fortified Salt in government feeding programmes have been issued .

- Adolescent Amemia Control (MoHFW, MoWCD, MoHRD): Steps are being taken for establishing linkages of education programmes & schemes such as SSA, NPGEL, KGBV, with SABLA, for addressing health, undernutrition and anaemia in both out of school and school going adolescent girls.
- Hygiene Education (MoDW&S): A major IEC Campaign on hand washing has been launched, with Swachhta Doots going door to door to create awareness and change hygiene practices. A month long intensification of efforts is planned and issues related to safe disposal of Child Excreta and against Open Defecation are also being taken
- AWC construction as admissible work under NREGA; other synnergies outlined

The Ministry of Women and Child Development is responsible for nutrition advocacy and awareness generation with the help of the Food & Nutrition Board (FNB). Being the nodal Ministry of the implementation of the National Nutrition Policy and its Plan of Action, the Ministry of WCD is also responsible for setting up appropriate systems for monitoring the multi-sectoral interventions by the responsible government departments and ministries.

The Ministry of WCD particularly on its part has been implementing various interventions for meeting the challenge of undernutrition in the country. The Integrated Child Development Services (ICDS) Scheme is the biggest intervention of the Ministry in this regard. With three phases of expansion, the ICDS Scheme today has been universalized with special focus on SC/ST and Minority population.

The ICDS program has witnessed several important changes during the 11th Plan period. In order to make the implementation of ICDS Scheme universal in all habitations, Government approved 14 lakh AWCs with special focus on SC/ST and Minority habitations. It has been expanded in three phases in the years 2005-06, 2007-08 and 2008-09. With these expansions, total number of approved AWCs/Mini AWCs has increased from 6 lakh, as on 31.3.2002 to 14.00 lakhs, (approved) as on date. There are 13.67 lakh sanctioned AWCs, and 12.66 lakh AWCs/Mini AWCs operational benefitting 7.84 crore children (6 months to 6 years) and 1.79 crore pregnant and lactating mothers and children under 6 for supplementary nutrition and 3.69 crore children of 3 – 6 years for pre-school non –formal education as on 30.06.2011.

Under the ICDS Scheme, supplementary nutrition is provided to bridge the gap between the Recommended Dietary Allowance and the Average Dietary Intake. In February, 2009 the nutritional norms were increased to provide for increased energy and protein for different categories of beneficiaries as below:

Age Group	Calories (Kilocalories)	Protein (g)
Children (6-72 months)	From 300 to 500	From 8-10 to 12-15
Severely malnourished children (6-72 months)	From 600 to 800	From 20 to 20-25
Pregnant women and Nursing mothers	From 500 to 600	From 15-20 to 18-20

The Cost norms of Supplementary Nutrition Programme (SNP) under ICDS were also revised as below:

Age Group	Cost norms
Children (6-72 months)	From Rs. 2 to Rs. 4
Severely malnourished children (6-72 months)	From Rs. 2.70 to Rs.6
Pregnant women and Nursing mothers	From Rs. 2.30 to Rs. 5

Besides, cost norms, nutritional and feeding norms, training norms have also been revised during the 11th Five Year Plan. There has also been increased focus on children under3 years with the following:

- Revised WHO Child Growth Standards have been introduced under ICDS as well as NRHM for monitoring andpromotion of young child growth and development up to three years of age.
- Joint Mother and Child Protection card, an extremely important tool for not only monitoring the growth of children but also an education tool for mothers has been introduced by the States. The States are in the process of roll out for distributing these cards under ICDS/NRHM.
- A joint letter dated 17th August, 2010 was issued by the Secretary, MWCD and Secretary, MoHFW seeking cooperation in implementing the Infant Milk Substitutes, Feeding bottles and Infant Foods (Regulation of Production, Supply and Distribution) Amendment Act, 2003.

Further, a five - tier monitoring and review mechanism has been introduced at the National, State, District, Block and Anganwadi levels. Instructions for the same have been issued on 31st March 2011. It is envisaged to have a State level Monitoring & Review Committee consisting of 5 Members of Parliament representing the State/ UT on rotational basis will meet twice a year; a District level monitoring and review committee with the Member of Parliament representing the district will meet at least once in a quarter at the District level. Introduction of the Annual Programme Implementation Plan (APIP) to enable State specific planning has also been initiated.

Despite the above due to cumulative low investment and attention to this programme its impact was subdued It has been recognized and acknowledged that investment in early years brings higher returns and saves future.

The Proposed restructuring & strengthening of ICDS in a Mission Mode is now in the process as per the decisions of PM's National Council on Nutrition meeting in November 2010 and further announcement on 15thAugust 2011 to the Nation. Several Regional as well as stakeholders' consultations have been held. The Inter Ministerial Group on ICDS Strengthening and Restructuring chaired by Member, Planning Commission and involving different Ministries, representatives of the State Governments and PMO constituted in June 2011 examined the proposals and also considered the NAC recommendations regarding ICDS Reforms and Strengthening. The IMG submitted its final synthesized report based on which approvals are being processed.

Two new schemes, Rajiv Gandhi Schemes for Empowerment of Adolescent Girls (RGSEAG), namely, SABLA which provides a package of services including health and nutrition to adolescent girls in the age 11- 18 years in 200 districts on a pilot basis and the Indira Gandhi Matritva SahyogYojana (IGMSY) which provides better enabling environment for improved health and nutrition to pregnant and nursing mothers in select 52 district as a pilot, are also operating using ICDS infrastructure and system. The above mentioned measures are some of the concrete steps taken in terms of consolidating the ICDS.

3.1.1 Mid Term Appraisal of the Eleventh Five Year Plan

The Mid-Term Appraisal of has found glaring gaps andinconsistencies on nutrition as against the promises made in the Eleventh Five Year Plan. While examining the interventions for better nutritional status, the Mid-Term Appraisal referring to different surveys and reports indicate has highlighted that the progress in addressing undernutrition has beenalmost negligible. It has point out that there has been insufficient focus onchildren under two years of age (the critical windowfor development) and women in the reproductive agegroup. Further, the Mid-Term Appraisal report has noted that we are still far away from universalization ofinterventions despite the fact that Indiahas a number of programmes and schemes to addressissues affecting nutrition. It has also pointed out that if this situation continues,the Eleventh Plan goals related to reduction inmalnutrition among children in the age group of 0–3years and anaemia among women are unlikely to beachieved.

Commenting on the current state of affairs, the Mid Term Appraisal has highlighted that a few systemic changes were made during theEleventh Plan but much more needs to be done if weare to achieve its targets and objectives. Commenting on some of the key interventions, the Mid Term Appraisal has highlighted the following:

(i) Integrated Child Development Service (ICDS) Scheme: On ICDS, the Mid Term Appraisal has reiterated the commitments of the Eleventh Plan on the need for evaluating and restructuring the scheme to ensure that it met the goals that it had set out to achieve. It has noted that the outlay for the programme was increased from Rs 12,147 crore in the Tenth Plan to Rs 44,400 crore in the Eleventh Plan, an increase of 266 per cent to facilitate this restructuring and to ensure universalization of the new, improved ICDS. It has also noted the actions taken for the universalisation and revision of norms for nutrition and honorarium for AWWs and AWHs. However, it has stressed on the need for a systemic revamping of the programme.

The Mid Term Appraisal has noted the significant improvement in the number of beneficiaries for supplementary nutrition between 2006–07 and 2009–10. It has welcomed the directive to provide hot cooked meals as far as possible, which is expected to ensure better attendance at AWCs and also provide greater nutrition security to the children. The MTA has commented on the responsibility of cooking to be with AWWs/AWHs and term that as often problematic because of the lack of cooking infrastructure in AWCs. It has expressed concern over the fact that AWCs are most often perceived only as places where supplementary nutrition is distributed and the fact that other services under the programme are not of much consequence to many beneficiaries, perhaps due to the

quality of services being provided. The multi-tasking that the AWW is expected to do have also been commented upon, noting that AWW is most often ill-equipped (both with skills and equipment), overburdened, underpaid, and lacks guidance and supervision.

The Mid Term Appraisal has noted that currently the scheme is treated as a panacea for all child related activities, which it cannot be. It has highlighted the need to clearly delineating the role of ICDS first and then assigning the targets and responsibilities. It has noted the need to clearly define the specific purpose of the scheme and parameters against which its performance will be measured. The need to focus on impacts and outcomes rather than on outputs has also been highlighted. Alternatives like having certain components of ICDS in certain areas only, conditional cash transfers, and the PPP mode of running ICDS has been suggested. The Mid Term Appraisal suggests that different models and success stories can be studied and attempted and the results monitored with a view to revamping the programme, for the remaining Plan period.

The following specific initiatives have been recommended by the Mid Term Appraisal while revamping the ICDS scheme:

- Ensuring adequate infrastructure—many centres continue to be run from rented premises or in the open with little or no place for the little ones to sit, leave alone play. A large number (45 per cent)of the centres continue to have no toilets and 27per cent lack drinking water facilities.
- Introduction of a second AWW, so that the responsibility can be divided. One worker can ensure adequate support and care for children under three years and adopt a more outreach approach by visiting children and their families in their homes, while the other could focus on the three to six year olds, especially on the pre-school education component. The Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG)would add to the burden of AWWs further.
- Conversion of some AWCs into crèches and introduction of more than one meal for children under three years of age.
- Greater integration but clearer demarcation of responsibility between AWWs, ASHAs, and ANMs. For the field-level staff of ICDS, that is, AWWs and supervisors there should be dual reporting to both ICDS officers as well as health department officers.
- Selection of AWWs and AWHs needs to be done in consultation with the community. They should be appointed on a tenure basis with inbuilt provision for performance-based incentives.
- The single-most important factor that could reduce malnutrition and mortality is, perhaps, early and exclusive breastfeeding, which has not received sufficient attention since there is no budget attached to it and it also has no physical monitorable indicators. This aspect needs urgent attention.
- Collection of malnutrition and growth data from AWCs and independent monitoring of this data on a regular basis. An appropriate nutrition MIS for ICDS should be developed.
- Best practices, like positive deviance aame bhi paribu (we too can), dular, and achal se angan, should be disseminated and debated widely and AWCs should be encouraged to

devise their own practices and strategies based on this information and others' past experience.

- Transparency and accountability of AWCs' activities should be ensured by putting all their data on their websites. Better governance of the programme through proper planning, monitoring, and concurrent evaluation (preferably by a third party) in order to enforce accountability will be the key to success.
- Focus on nutritional counselling and education. The time has perhaps come to make a shift in the communication strategy and moving away from sensitizing and communicating only with the women, to involving the community and the family, particularly the husband and in-laws, as well.
- Mapping of severely malnourished children and providing additional funds where needed. Ensuring regular weighing of children. Nutrition Rehabilitation Centres should be available in PHCs for severely malnourished children.
- Generating awareness about locally available nutritionally rich products.
- Capacity building at all levels by first determining the training needs for each component of ICDS, for different levels of staff, before imparting the training and doing a post-training assessment. Having a small percentage of the staff as 'training reserve' is also strongly recommended.

(ii) Food and Nutrition Board (FNB): Commenting on the FNB, the Mid Term Appraisal has noted that FNB is required to monitor the quality of supplementary nutrition supplied at AWCs as well as analyzing samples of the supplementary food used in ICDS and the Mid-Day Meal (MDM) programmes to examine whether they conform to the standards approved by the Central Government. The outlay for the Eleventh Plan was Rs 50 crore and 82 per cent of this was spent during the first three years of the Plan. Since the Board oversees the quality and nutritional content of the food provided to children through ICDS and MDMs it is expected to perform a significant role, which it is not able to do.

In view of this, the Mid Term Appraisal has recommended following actions for strengthening the role of FNB:

- Evaluating the role and functioning of FNB and making it more relevant in the present context of the universalization of ICDS and MDM and the disturbingly high levels of malnutrition in the country.
- System for concurrent assessment and monitoring the nutrition component of ICDS.
- Messages for vulnerable groups and other IEC activities, including information dissemination about correct food habits.
- Greater involvement of NGOs and appropriated funding of their activities.

Concluding its observations on ensuring better nutritional status for women and children, the Mid Term Appraisal has concluded by suggesting that concerted, focused, and outcome-orientedefforts to address malnutrition during the criticalwindow of development of children under two yearsof age and tackling anaemia amongst women in thereproductive age group are required to ensure that theEleventh Plan goals are achieved.

3.2 Review of Existing Nutrition Policies and Legislations

3.2.1 ***The National Nutrition Policy (NNP):*** The National Nutrition Policy 1993 identified key areas of action in various areas like food production, food supply, education, information, health care, rural development, women and child development, people with special needs and monitoring and surveillance. The Policy advocated a comprehensive inter-sectoral strategy between 14 sectors (which directly or indirectly affect dietary intake and nutritional status of the population) for combating multi-faceted problem of undernutrition and improving nutritional status for all sections of the society. The Policy sought to strike a balance between the short-term direct nutrition interventions and long-term institutional/structural changes to create an enabling environment and necessary conditions for improving nutritional and health status. The core strategy of the NNP is to tackle the problem of nutrition both through direct nutrition intervention for especially vulnerable groups as well as through various development policy instruments which will create conditions for improved nutrition.

The **direct short-term nutrition intervention** suggested by NNP include: (i) Nutrition interventions for specially vulnerable group viz. expanding the safety nets, facilitating behaviour change among mothers, reaching the adolescent girls and ensuring better coverage of expectant women; (ii) Fortification of essential food items with appropriate nutrients; (iii) Popularisation of low cost nutritious foods prepared from indigenous and locally available raw materials; (iv) Control of micronutrient deficiencies among vulnerable groups.

The **indirect long term nutrition interventions** suggested by the Policy are indirect policy instruments leading to institutional and structural changes including: (i) Food security for improved availability of food grains; (ii) Improvement of dietary patterns through production and demonstration; (iii) Policies for effecting income transfers so as to improve the entitlement package of the rural and urban poor - improving the purchasing power and strengthening public distribution system; (iv) Land reforms measures for reducing vulnerabilities of landless and landed poor; (v) Strengthen health & family welfare programme; (vi) Imparting basis health and nutrition knowledge; (vii) Prevention of food adulteration; (viii) Improvement in nutrition surveillance; (ix) Monitoring of nutrition programmes; (x) Research into various aspects of nutrition; (xi) Equal remuneration for women; (xii) Communication through established media – *WCD to have well-established, permanent Communications Division with adequate staff and fund support*; (xiii) Minimum wage administration to ensure its strict enforcement and timely revision and linking it with price rise through a suitable nutrition formula - *A special legislation for providing agricultural women labourers the minimum support, and at least 60 days leave by the 'employer in the last trimester of her pregnancy*; (xiv) Community participation for generating awareness on NNP - active participation of community members in management nutrition programmes & related interventions through beneficiaries committees, participation of women in food production & processing, promoting kitchen gardens, food preservation, preparation of weaning food, generating demand of nutrition services; (xv) Education and literacy; (xvi) Improvement in status of women.

In order to ensure its effective implementation, the NNP envisages:

- Administration of above measures by several ministries/departments of the Government of India and various governmental and non-governmental organisations.
- Close collaboration between the Food Policy, the Agricultural Policy, the Health Policy, the Education Policy, the Rural Development Programme and the Nutrition Policy as each complements the other.
- Special working groups to be constituted in the Departments of Agriculture, Rural Development, Health, Education, Food and women & Child Development to analyse the nutritional relevance of sectoral proposals and to incorporate nutritional considerations in the light of the Nutrition Policy wherever necessary.
- Setting up an Inter-Ministerial Co-ordination Committee under the Chairmanship of Secretary, DWCD (now Ministry of Women & Child Development) to oversee and review the implementation of nutrition intervention measures.
- Setting up a National Nutrition Council headed by the Prime Minister.
- A formal structure at the State level similar to that envisaged under the Government of India including an apex State level nutrition council to be chaired by the Chief Minister, an Inter-Departmental Coordinating Committee headed by the Chief Secretary, Special working groups in the Departments of Agriculture, Rural Development, Health, Education, Food and Women and Child Development
- The State Governments to consider constituting State Co-ordination Committees and State Nutrition Councils as well as such bodies at the district levels.

Although these enabling provisions have been there since 1993, they have not been all implemented in the required zeal and much less in the timelines prescribed.

3.2.2 ***National Plan of Action on Nutrition (NPAN):*** The National Plan of Action on Nutrition 1995 laid down a systematic framework for collaboration among national government agencies, State Governments, NGOs, the private sector and the international community. It is a multi-sectoral framework for implementation of the national nutrition goals to be reached by 2000 AD. The multi-sectoral plan states the objectives and tasks of 14 different sectors namely, Agriculture, Food, Civil Supplies & Public Distribution, Education, Forestry, Maternal & Child Health, Food Processing Industries, Health, Information & Broadcasting, Labour, Rural Development, Urban Development, Welfare, Women & Child Development.

In order to ensure effective implementation of the National Plan of Action on Nutrition, specific implementation strategies have been laid down. Various governmental and non-governmental organizations have been made responsible for administering the measures suggested in the relevant sectoral plan concerning them. Being the nodal Ministry, the Department of Women and Child Development (now MWCD) has been made responsible for coordination and monitoring of the NPAN. Apart from these following specific implementation arrangements have been suggested by the NPAN:

- National Nutrition Council headed by the Prime Minister to serve as the highest body for overseeing the implementation of the National Nutrition Policy and NPAN;

- Special Working Groups to be constituted in all concerned Departments;
- Development of a National Nutrition Surveillance System;
- Mechanism for inter-sectoral planning and coordination at State level including State level Nutrition Council headed by Chief Minister and Inter-departmental Coordination Committee headed by the Chief Secretary
- State Governments to consider constituting similar bodies like Coordination Committees, Nutrition Council etc. at the district level also.
- Task Force on Nutrition Surveillance in the Department of Women and Child Development (now MWCD)
- Development of District Level Nutrition Profiles by the Department of Women and Child Development (now MWCD)

Like National Nutrition Policy, the implementation of NPAN has been tardy. In view of the changes that have taken place in the policy and programme environment, there is a need to review the NPAN. The monitorable targets, strategies and interventions require updating to include use of new WHO child growth standards for assessing progress and review of the role of 14 (now 12) sectors, possible contributions of these and other sectors, in the new programme environment.

3.2.3 ***Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992 and its Amendment Act 2003:***Popularly known as IMS Act, it is a globally well-recognized instrument to promote, protect and support breastfeeding and to ensure optimal infant and young child feeding practices. Following its amendment in 2003, the direct advertisement has stopped, however, commercial interference with infant and young child feeding practices and growth related claims still continues surreptitiously. Besides, promotion in the name of symposia and sponsorships by companies in the health care and other education system are being used as obvert tools for promotion. The implementation of the act suffers due to inadequate enforcement machinery, understanding and the knowledge of the Act, lack of adequate resources and commercial onslaughts. These would need requires to be appropriately regulated and supervised. Enhanced resources, enforcement machinery and coordination mechanisms are required for effective compliance.

3.3 Review of Existing Programmes / Schemes

The Government of India has been implementing a number of programmes, which have the potential to improve the current nutrition security situation, through the Ministry of Women & Child Development (MWCD), Ministry of Health & Family Welfare (MHFW), Ministry of Rural Development, Ministry of Panchayati Raj and the Ministry of Urban Development.The Government also has a number of cross cutting programmes including theNational Rural Health Mission (NRHM), Integrated Child Development Services (ICDS) Scheme, National Food Security Mission, HorticultureMission, National Rural Employment Guarantee Scheme (NREGS), Jawaharlal Nehru NationalUrban Renewal Mission and the Rajiv Gandhi National Drinking Water Mission.

Table-7: Review of Existing Programmes/Schemes		
TARGET GROUP	SCHEMES	EXPANSION
Pregnant and Lactating Mothers	ICDS, RCH- II, NRHM, JSY, Indira Gandhi Matritva Sahyog Yojana (IGMSY) – The CMB Scheme	NRHM (2005-06) JSY (2006-07) ICDS (2008-09)
Children 0 – 3	ICDS, RCH- II, NRHM, Rajiv Gandhi National Creche Scheme	RGNCS (2005-06) ICDS (2008-09)
Children 3 – 6	ICDS, RCH- II, NRHM, Rajiv Gandhi National Creche Scheme, Total Sanitation Campaign (TSC), National Rural Drinking Water Programme (NRDWP)	TSC (2008-09)
School going children 6 – 14	Mid Day Meals (MDM), Sarva Shiksha Abhiyan (SSA)	SSA (2002/2005-06) MDM (2008-09)
Adolescent Girls 11 – 18	Rajiv Gandhi Scheme for the Empowerment of Adolescent Girls (RGSEAG), Kishori Shakti Yojana, , Total Sanitation Campaign (TSC), National Rural Drinking Water Programme (NRDWP)	NRDWP (2010) RGSEAG (2010-11)
Adults	MGNREGS, Skill Development Mission, Women Welfare and Support, Programme, Adult Literacy Programme, TPDS, AAY, Old and Infirm Persons Annapurna, Rashtriya Krishi Vikas Yojana, Food Security Mission, Safe Drinking Water and Sanitation Programmes, National Horticulture Mission, National Iodine Deficiency Disorders Contol Programme (NIDDCP), Nutrition Education and Extension, Bharat Nirman, Rashtriya Swasthya Bima Yojana	NHM (2005-06) MGNREGS (2005-06) NRLM(2010-11) NIDDCP (1992) RSBY (2007) Bharat Nirman (2005)

Along with the new schemes/programmes, several existing schemes/programmes have been expanded / universalized just before or during the Eleventh Five year Plan. Hence, the results are likely to be visible after some time.

The specific gaps and issues related to major government interventions with potential to address the nutrition challenges include:

3.3.1 ***Integrated Child Development Services (ICDS) Scheme:***ICDS is one of the major interventions of the government for addressing the nutrition challenge in the country. However, it is essential to realize that it is not the only one intervention which can by itself bring about dramatic changes in undernutrition. The health services, water & sanitation and others at the grassroots levels extensively use the ICDS platform and its personnel for their effective and timely service delivery. All these put additional strain on the ICDS service delivery. The proposed Rajiv Gandhi Scheme for the Empowerment of Adolescent Girls (RGSEAG) - SABLA and the Indira Gandhi Matritva Sahyog Yojana (IGMSY) - The CMB Scheme will also be implemented using the ICDS platform.

An Assessment of ICDS showed that 81% of children less than 6 year of age were living in an area served by Anganwadi centre (AWC) but still there were problems of access. NFHS III shows that only 26.5 % of children had received Supplementary nutrition and only 12 % regularly received it. A total of 21% of pregnant women and 17 % of lactating mothers received supplementary food. Even where access is good there is no linear or straight forward relationship between performance of ICDS and outcomes in terms of reduction of malnutrition. The ICDS has been largely criticized for its relative lack of focus on both the 0 to 6 month child and the children in 6 month to 3 year period, both of which are the most

vulnerable to slip into malnutrition. Most ICDS activity occurs at the centre itself, where children above three are brought and by the time the child comes there, a crucial period to control undernutrition has elapsed.

A single worker, working for four hours per day, has time to open the centre and feed the children coming to centre and complete her growth monitoring tasks. There is little/ no time left for home visits and counselling, little/no time for providing food supplements to the below three child at home and little/no time for pre-school education or attention to the sick children. The access to the children from the poorest of the poor communities or the most vulnerable varies from region to region.

Other key problems include, weak monitoring and supervision, poor quality training, delay in quality and provision of supplies and food rations. Distribution of dry rations is not so effective in delivering nutrition. The preparation of hot cooked meals on the spot is potentially much better for delivery. But the cooking has to be hygienic which would require a kitchen and other attendant facilities. There is also a concomitant need for greater community participation and enthusiasm and convergence between ICDS and other schemes like Mid Day Meals, ASHA etc.

3.3.2 ***National Rural Health Mission (NRHM) and other Health Sector Interventions:*** There are many health services under NRHM and other health sector interventions that have relevance to the objective of dealing with malnutrition, including: (i) Immunisation Programme; (ii) Care of the sick child – at the community level through the ASHA and at the institutional level through primary health care facilities; (iii) Universal Vitamin A administration; (iv) Paediatric De-worming and Anaemia management; (v) Universal Iodisation of salt programme and the national goitre control programme; (vi) School health programmes with IFA once a week supplementation and six monthly deworming; (vii) Nutrition Rehabilitation centres- for the sick and severely malnourished child; (viii) Programmes of adolescent health which address nutrition counselling and anemia; (ix) National Maternity benefit scheme - now a component of JSY- in terms of Rs 500 component of the JSY package; and (x) State specific programmes of nutrition supplementation notably the Muthu Laxmi maternity benefit scheme of Tamil Nadu and the Velugu programme in Andhra Pradesh. Most of these interventions, except immunization and vitamin A programmes have poor outreach and even these perform at less than 40% coverage in the poor performing states while no focus on malnutrition has emerged in the ASHA programme.

3.3.3 ***Total Sanitation Campaign (TSC):*** Lack of adequate sanitation is a pressing challenge in both rural and urban India. Sanitation-related diseases take a heavy toll of lives, especially children's lives, and are a drain on productivity and incomes. Improving access to sanitation is included in the Millennium Development Goals. The impact of poor sanitation is on public health, especially the incidence of water-borne diseases. These diseases are a result of faecal matter entering the food chain at any of the many points of

vulnerability: at a personal hygiene level; in terms of unsafe disposal of wastes at household level (leaking pits, over-flowing tanks, broken sewers, etc.); unsafe conveyance (ex-filtration from trunk mains, unsafe transportation); or unsafe disposal (into land and water bodies). The TSC concentrates on promoting behaviour change. Some key features of the TSC include:

- A community led approach with focus on collective achievement of total sanitation
- Focus on Information, Education and Communication (IEC) to mobilize and motivate communities towards safe sanitation
- Minimum capital incentives only for BPL households, post construction and usage
- Flexible menu of technology options
- Development of supply chain to meet the demand stimulated at the community level
- Fiscal incentive in the form of a cash prize – Nirmal Gram Puraskar (NGP) – to accelerate achievement of total sanitation outcomes.

The programme is often faced with challenge including: (i) Inadequate focus on hygiene promotion; (ii) Weak supply chain affecting post construction support and O&M; (iii) Weak monitoring system for process parameters; and (iv) Lack monitoring of usage and sustainability of the toilets.

3.3.4 ***Mid Day Meal Scheme (MDMS):*** As part of this scheme, cooked meals with a minimum content of 450 calories and 12 grams of protein are being provided to children in school. 12 crore (120 million) children are so far covered under the Mid-day Meal Scheme, which is the largest school lunch programme in the world. Currently the midday meal is provided only to children who are attending schools, whereas the most vulnerable children in the school going age are those out of school. Apart from this, there is evidence that the midday meal has indeed enhanced enrolment in the schools as well as provided nutrition supplement to school going children. Moreover in the deprived areas the MDM has been able to provide at least one meal in the school to deprived children.

3.3.5 ***Targeted Public Distribution System (TPDS):*** There has been a long tradition of food programmes in India. The largest is the TPDS of subsidized food channelled through special stores. It ran at about 5% of total spending in the early 2000s. The TPDS has been criticized for being an ineffective program, with substantial leakages, and little impact on either reducing expenditure poverty or malnutrition. The TPDS has clearly been ineffective in states such as Bihar and Uttar Pradesh where there is long history of very limited distribution of food grains under the scheme. The correlation between TPDS performance and trends in the reduction of malnutrition does suggest the possibility of casual link (Harris and Kohli Notes on the Differing' States' of Child Undernutrition in rural India, IDS Bulletin, Volume 40, Number 4, July 2009). Lack of consistent data series on the distribution of food under the TPDS to demonstrate the point conclusively is though a problem but whatever information is available shows that states that have done well in reducing undernutrition among children are also states that have made the most extensive use of the TPDS.

3.3.6 ***National Horticulture Mission:*** India is the second largest producer of the fruits and vegetables in the world after China. There is an overall increase in the demand of fruits and vegetables for consumption both in fresh and the processed form. In India, horticulture can be promoted as a means of agro-diversification for the second Green Revolution, providing the much needed impetus to the growth of agricultural sector. In light of this, the National Horticulture Mission has been launched in April 2005 as a centrally-sponsored scheme to promote holistic growth of the horticulture sector through area-based regionally differentiated strategies. The scheme is fully funded by the Government of India. The mission objectives and strategies do not directly aim at addressing nutrition security; however, the potential of enhanced consumption of fruits and vegetables to contribute to nutrition security is high.

3.3.7 ***Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS):***The Mahatma Gandhi National Rural Employment Guarantee Act, which came into force in February 2006, now covers all of rural India. It has generated over 450 crore person-days of employment with a major share of them going to women and Scheduled Caste and Scheduled Tribe families. According to the Ministry of Rural Development, in 2009-2010, upto December 2009, an amount of Rs. 18950 crore has been utilized out of Rs. 39,100 crore, during the same period 160 crore person-days employment has been generated across the country. In financial year 2009-10, 36.51 lakhs works were undertaken, of which 51% constituted water conservation, 16% rural connectivity, 14% land development and provision of irrigation facility to individual beneficiaries constituted around 17%. The other types of work undertaken included drought-proofing, flood protection and land development. Such work is important to strengthen the ecological foundations of sustainable agriculture. The NREGS is probably the world's largest ecological security programme.

NREGS has been successful in increasing the minimum purchasing power for food security in families living below the poverty line. However, there is still a large majority of population that is unable to avail full 100 days of guaranteed employment. Apart from this, a key provision of the Act is for setting up of creche facility for children of workers. It also provides for employment of one woman worker as a care giver to the child. However, the implementation of this provision has been very weak. It is necessary for the ICDS as well as the NREGS to converge their efforts in order to cover the children of those working under NREGS. Such a creche can be directly linked to the AWC.

3.3.8 ***Rajiv Gandhi Scheme for the Empowerment of Adolescent Girls (RGSEAG) - SABLA:***Merging the erstwhile KSY and NPAG schemes, the Rajiv Gandhi Scheme for the Empowerment of Adolescent Girls has been proposed by the Ministry of WCD with the goal to address the multi-dimensional problems of the adolescent girls**.** The scheme aims at covering the adolescent girls in the age group of 11-18 years under all ICDS projects in the country. In order to give focused attention, the target group is subdivided into two categories, viz. 11-15 & 15-18 years and interventions are planned accordingly. The scheme focuses on all out-of-school adolescent girls who would assemble six days a week

at the Anganwadi Centre (AWC). The others, i.e., the school going girls would meet at the AWC at least twice a month and during vacations/holidays where they will receive life skill education, nutrition & health education, awareness about other socio-legal issues etc. This will give an opportunity for mixed group interaction between school going and out-of-school girls, motivating the latter to join school.

Using the ICDS platform, the scheme will provide an integrated package of services to the adolescent girls including: (i) Supplementary Nutrition; (ii) IFA supplementation; (iii) Health check-up and Referral services; (iv) Nutrition & Health Education; (v) Counseling/Guidance on family welfare, ARSH, child care practices and home management; (vi) Life Skill Education and accessing public services; and (vii) Vocational training (for girls aged 16 and above) and skill development.

3.3.9 ***Indira Gandhi Matritva Sahyog Yojana (IGMSY) – The CMB Scheme:***With the overall vision of contributing towards improved health and nutritional status of mothers and children, the Ministry of WCD has proposed to launch the IGMSY- the Conditional Maternity Benefit Scheme. The scheme would focus on pregnant women of 19 years of age and above for first two live births (benefit for still births will be as per the norms of scheme). All government employees will be excluded from the scheme as they are entitled for paid maternity leave.Using the broad framework of existing ICDS programme, the IGMSY will be implemented as a pilot intervention in selected districts. IGMSY will be implemented through the existing District ICDS Cell. Thus, the District ICDS Cell will have the nodal responsibility for the implementation of the IGMSY in all the selected districts, while at the state level the implementation of the scheme will be done through the State ICDS Cell supported by the additional staff provided under the IGMSY at state and district level.

Cash transfer will be provided to all pregnant and lactating women in selected districts/blocks to contribute towards supporting health and nutritional needs of pregnant and lactating mothers. The scheme will contribute to compensating the woman for the wage loss that she might incur while caring for herself and the child. It will also increase the demand for mother and child health services by providing incentives based on fulfilment of specific conditions relating to mother and child health. According to the proposal, each pregnant and lactating mother will receive a total cash incentive of Rs. 4500/- between the second trimester and till the child attains the age of 6 months subject to fulfilment of conditions laid down in the scheme.

Although there is no dearth of programmes related to nutrition, there are significant gaps in these public sector efforts. It may be that taking account of the problem only at a national and state level is inadequate and there is a need for greater focus on the household and community levels. Among other, some of the key challenges of the current public sector response include:

- Addressing nutrition through comprehensive national approach specifically aimed at improving nutrition, and convergence and synergy between existing programmes.

- Bringing nutrition focus in programmes that have the potential to impact nutrition
- Ensuring improved targeting of programmes mainly to vulnerable groups, such as infants and young children, women, or the neediest.
- Developing professionalism across levels and a ensuring availability of public health nutritionists and managers.
- Putting in place comprehensive national systems to collect and analyse data on nutrition outcomes for monitoring and decision making.
- Improving implementation systems and machinery for improved governance for effective implementation of programmes.

3.4 Unfinished Agenda of the Eleventh Five Year Plan

Although, during the Eleventh Five Year Plan nutrition has received highest attention and priority, the agenda of ensuring better nutritional status for women and children in the country is still unfinished and would require to be taken forward by the 12th Five Year Plan. Some of the key issues that largely highlight the unfinished agenda of the Eleventh Five Year Plan include:

- Low visibility of malnutrition and inadequate attention to preventing this through early action - before and after birth, when growth faltering starts;
- Poor governance structures and inadequate institutional capacity for nutrition;
- Lack of effective convergence of multi-sectoral action and concomitant resource investments for addressing malnutrition comprehensively, including micronutrient malnutrition;
- Inadequate access to food and health care, safe drinking water and environmental sanitation and hygiene;
- Lack of awareness and sub optimal Caring and feeding practices at family and community level, requiring Nutrition Education, skilled counselling support and changes in family care behaviours;
- Need for better linkages with poverty reduction and livelihoods interventions;
- Need for system of nutrition monitoring and surveillance nationwide and or rooted in community action;
- Need for more operational research on nutrition in India that is on the “How“of strategic approaches; and
- Need for requisite safeguards against commercial interference with infant and young child feeding practices and improving compliance with IMS Act.

Further, one of the major changes introduced during the 11th Five Year Plan period was the adoption of WHO Growth Standards replacing the NCHS standards used earlier. This resulted in significant increase in percentage of children severely underweight and a decrease in moderately underweight children. No data set at the state level or the National level is available to depict the actual percentage of children underweight after this transition. Thus there are great difficulties in arriving at correct estimates of change in nutritional status of children. The PM’s Nutrition council met and decided further urgent action.

Besides, no nationwide survey has been conducted to provide substantial statistics of change in the nutritional status of children and the anaemia figures, during the 11th Plan. Annual Health

Survey (AHS), recently initiated, has yet to include the nutritional status as an indicator. At the behest of Ministry of Women and Child Development, these vital indicators for nutrition have been included in AHS, but the estimates will be available only by 2012-13.
Under the above mentioned constraints the Ministry of Women and Child Development has taken the initiative to support base line survey for nutrition indicators in each States and advisories to States have been issued. Premier research institutes like NIN or any other reputed institutions could be involved in such surveys by States/UTs.

Prime Minister's National Council on India's Nutrition Challenges: New Policy Directions

In view of the high national priority accorded to combating malnutrition in the country as well as the policy directions by the Prime Minister's National Council on India's Nutrition Challenges, comprehensive approach that addresses the different sectors and dimensions of the nutrition challenge is required. Several consultations were held by the Prime Minister's Office, the Planning Commission the Ministries of Women and Child Development, Health and Family Welfare, to accelerate action to address India's Nutrition Challenges and a joint Strategy Note was prepared through several consultations with sectors, States and civil society. Planning Commission anchored a Multi-stakeholder Nutrition Retreat and the major recommendations for action from the same were then placed before the Prime Minister's National Council on India's Nutrition Challenges, in its first meeting in November 2010.The decisions of the first meeting of the PM's National Council on India's Nutrition Challenges chaired by the Prime Minister on 24th November 2010 provide the road map for the Twelfth Plan. The Prime Minister expected the Ministry of Women & Child Development and the Planning Commission to take the following decisions forward:

(i) The ICDS requires strengthening and restructuring, with special focus on pregnant and lactating mothers and children under three. The ICDS also needs to forge strong institutional convergence with National Rural Health Mission and Total Sanitation Campaign particularly at the district and village level. It needs to provide flexibility for local action and empower mothers in particular and the community in general to have a stake in the programme.
(ii) A multi-sectoral programme to address the maternal and child malnutrition in selected 200 high-burden districts would be prepared. This programme will bring together various national programmes through strong institutional and programmatic convergence at the State, District, Block and Village levels.
(iii) A nation-wide information, education and communication campaign would be launched against malnutrition.
(iv) The Ministries that deal with Health, Drinking Water Supply and Sanitation, School Education, Agriculture and Food & Public Distribution will bring strong nutrition focus to their programme.

Action on the above decisions of the Prime Minister's National Council on India's Nutrition Challenges has already been initiated. A proposal for ICDS strengthening and restructuring has been developed, endorsed by Inter-ministerial group which are being processed for competent approvals.A multi sectoral programme is being conceptualized by the Ministry of WCD to have a

multi pronged approach for addressing maternal and child undernutrition in the 12th Plan.A nation-wide IEC Campaign has been developed and is in the final stages for being launched.The Planning Commission has been periodically convening and coordinating Inter-ministerial meetings for bringing strong nutrition focus in individual programmes of related Ministries, which are also being anchored in sectoral strategies for the 12th Plan. **Annex - II** summarises the commitments of different sectors to improving nutrition outcomes. All these actions would continue in the 12th Five Year Plan.

4. KEY STRATEGIES, RECOMMENDATIONS ANDFINANCIAL ALLOCATIONS

4.1 Vision & Key Priorities of 12th Five Year Plan on Nutrition

The vision for 12th Five Year Plan on Nutrition would be to ensure *"Nutrition Security for All"* - especially the more vulnerable infants and young children, adolescent girls and women, across the life cycle, fulfilling their rights to nutrition, health and human development- to their full potential.In order to ensure this, the 12thFive Year Plan would continue to positions the development of children at its centre and recognizes nutrition as critical for ensuring child survival and development as well as accord high priority to addressing maternal and child undernutrition through multi-sectoral interventions by different sectors.The focus would be on achieving the following **monitorable targets** during the Plan period:

- Reduction by 25 percentage points in underweight amongst children under three years and under five years;
- Reduction in the prevalence of moderate and severe anaemia in children and pregnant women and adolescents by 50% of the current level;
- Improvement in early initiation of breastfeeding by 50% of the current level;
- Improvement in excusive breastfeeding till six months by 50% of the current level;
- Improvement in introduction of complementary feeding after six months by 50% of the current level; and
- 100% consumption of adequately iodated salt (15PPM) at the household level.

In order to achieve the above-mentioned monitorable targets, the 12th Five Year Plan would focus on following **key priorities**:

- Implementation of the decisions of the PM's National Council on addressing India's Nutrition Challenges.
- Putting in place institutional arrangements under the PM's National Council for the development, implementation and monitoring of Multi-sectoral State/District Nutrition Plans of Action led by State/District Nutrition Councils, especially in high burden States/Districts.
- Visible leadership and focused Plan of action in States/UTs
- Design and piloting of innovative multi-sectoral convergence models for synergistic action.
- Universalisation of core multi-sectoral interventions for addressing nutrition challenges.
- Efficient governance and focus at all levels for operationalizing various mechanisms for nutrition outcomes.
- Strategic approach to Community mobilization and action, through panchayat led models and partnerships with women's SHGs, mothers' committees and other community/youth groups.
- Strengthening Institutional capacity, partnerships and voluntary action groups with a resource network of Nutrition Resource Platforms/ Centres- at national and state levels and piloted at district level.

- Development, implementation and monitoring of a comprehensive communication strategy for changing key care behaviours, supported by skilled interpersonal counselling at field level.
- Institutionalising a Nationwide Nutrition surveillance system, rooted in assessment, analysis and action at family and community levels, using child growth as a driver of change.
- Developing a hierarchy of indicators for food, care, health and environment
- Research and scientific dialogue

4.2 Key Recommendations

Considering the fact that nutrition security in itself is a wide ranging plethora of factors that need to be addressed in a well coordinated manner, there is a need to intensify a range of actions for addressing the nutrition challenge. Some of the specific actions include:

I. **Addressing Household Food Security:** While India is considered food secure and has maintained high agricultural production, it is important to note that 'food security' at the national level has yet to be translated into 'nutrition security' at the household level for every man, woman and child.

a) ***Enacting the Draft National Food Security Bill:*** The Draft National Food Security Bill proposes a system of food entitlements for children 6months-6 years, severely malnourished children 6mths to 6 years pregnant, lactating women and destitute. Subsidized food grains are provided to all BPL and AAY households through Public Distribution System and fair price shops. Food Security Bill is under consideration and it proposes to provide 7 Kg of food grains per person per month at aunit cost not exceeding Rs. 3, 2 or 1 per kg for rice /wheat/coarse grains for BPL and AAY households. The above poverty line households (APL) is conceived to receive 3 kilograms of food-grains per person per month at an unit cost not exceeding 50 per cent of minimum support price for wheat and coarse grains, and derived minimum support for rice. Progressive food entitlements to include overtime oil, pulses and cooking fuel have been proposed.

b) ***Strengthening of food Supplementation programmes****:* Food supplementation programmes like SNP under ICDS, MDM for school children need to be strengthened, food supplementation under ICDS serves children 6-months to 6 years, pregnant and lactating women and adolescent girls, Midday meal programmes serve the school children. It is proposed that the SNP under ICDS will be improved and cost indexed.

c) ***Strengthening Livelihood programmes:*** MNREGS will ensure that at least 200 days of guaranteed employment are provided to one member of each family. This will ensure increasing the purchasing power of the family. ICDS and MNREGS will converge efforts to include crèche facilities to cover the children of working mothers. This will provide support to mothers and care of their children.

d) ***Strengthening Livelihood through National Rural Livelihood Mission (NRLM):*** The Mission focuses on reducing poverty among BPL families by focussing on women Self-help groups

and youth, it creates opportunities for sustained self-employment and serves as safety nets for BPL families, especially women. Endeavours will be made to leverage support from the Mission for increasing purchasing power and food security at the household level. Linkage of SABLA with the National Skill Development Mission will provide vocational training and skill development for adolescent girls and promote livelihood security and improved food and nutrition security.

II. **Strengthening/ Re-activating Institutional Arrangements:**Nutrition is a complex issue which cuts across the sectors. There is admittedly a need for institutional mechanism as well as programme implementation platforms so that there is rigorous review of the sectoral interventions for nutrition outcomes. The National Nutrition Policy 1993 and the National Plan of Action on Nutrition 1995 provide for detailed institutional arrangements for addressing the nutrition challenges in the country. While some of these institutional arrangements have been functional in some States, it has been largely remained on paper. In order to reactivate the intent of the NNP and NNAP, a National Nutrition Strategy will be formulated, taking into account the joint strategy paper prepared by MWCD & MoHFW and other developments in the recent past. Key action points would be included as part of State MOUs, thus, binding all parties towards action in this regard. Such a strategy should be reviewed by the National Development Council Committee at least once every three years. Further, focus would be given on strengthening / re-activating a comprehensive institutional mechanism at all levels, including:

a) **National Level**: Under the guidance and policy direction of the PM’s National Council on Nutrition, the Executive Committee headed by the MOS (I/C) [which may be the same as ICDS National Mission Steering Group headed by the MoS (I/C)]will oversee the implementation of the Nutrition related Programmes. At an operational level, in order to provide ensure multi-sectoral convergence, an Empowered Committee headed by the Secretary - MWCD and comprising of representatives from different Ministries will guide the implementation of a multi-sectoral policies and programmes for nutrition. This Committee will also ensure convergence at the national level and will report to the Executive Committee and thereby to the PM’s Council on the same. This Executive Committee under the chairpersonship of Minster In-charge WCD, may have Member, Planning Commission as Vice Chairperson with representation of some State Ministers and Chief Secretaries, Secretaries of different Ministries, on rotation basis, and. This council may be supported by a strengthened FNB (MWCD) and a nutrition coordinating Policy Support unit in the Planning Commission to bring in inter-sectoral nutrition focus and accountability. This Executive Committee would coordinate nutrition related programs.

b) **State Level**: The CM’s Nutrition Council and the State Executive Committee headed by the Chief Secretary will guide the convergent actions at the state level. The State Executive Committee headed by the Chief Secretary and comprising of representatives from various State Departments will guide and lead the implementation. Comprising of representatives from various State Departments, this Committee will lead issues of convergence at the state level.

c) **District Level**: The District Nutrition Council headed by the concerned District Magistrate / CEO Zila Parishad would be responsible for convergent action at the district level. The district level Programme / Project Officers will be responsible for all related sectoral interventions for ensuring convergent action at the district level.

d) **Gram Panchayat Level**: Secretary of the Gram Panchayat would coordinate with panchayat level Programme / Project personnel as well as related institutional mechanisms in terms of monitoring committees of all related sectoral interventions for ensuring convergent nutrition action at the panchayat level.

e) **Village Level**: The Village Health Sanitation & Nutrition Committees which are sub committees of standing committees of Panchayat, and have representations from health ICDS, TSC and PRI will be responsible for reviewing performance of individual programmes as well as convergent actions which impact nutrition outcomes.

f) **Habitation level**: At the Anganwadi centre level, the anganwadi monitoring and support committee (ALMSC) constituted by WCD, will monitor convergent actions and suggest actions for effective convergence in programme implementation.

The above framework has been deliberated and agreed upon in the Inter-Ministerial Group on ICDS Strengthening and Restructuring. In the context of institutional mechanism for nutrition, the similar arrangements, including State and sub-state level may correlated with the ICDS Mission and monitoring structures. Accordingly, an overview of the proposed institutional arrangement for monitoring and supervision of convergent actions on nutrition is given at **Annex –III.**

III. **Multi-sectoral Approach for Accelerating Action on Determinants of Undernutrition:** As discussed earlier, the National Nutrition Policy advocated a comprehensive inter-sectoral strategy between 14 sectors (which directly or indirectly affect dietary intake and nutritional status of the population) for combating multi-faceted problem of undernutrition and improving nutritional status for all sections of the society. The core strategy envisaged under NNP is to tackle the problem of nutrition through direct nutrition interventions for vulnerable groups as well as through various development policy instruments which will improve access and create conditions for improved nutrition.Both the direct and indirect interventions cannot be undertaken by a single sector, hence there arises the need for a comprehensive multi-pronged response that addresses the different dimensions of the nutrition challenges. In order to achieve this the 12th Five Year Plan would focus on the following:

a) **Multi-sectoral Nutrition Programme:** As mandated by the PM's National Council on India's Nutrition Challenge, a Multi-sectoral Nutrition Programme would be developed and implementedto facilitate convergence of all the key services and stakeholders for holistically addressing the maternal and child undernutrition. It would ensure a platform of coordinated pro nutrition action at the State, District and grassroots levels for addressing maternal and child undernutrition in 200 high burden districts. The Programme will ensure

policy, planning and coherence for integrated nutrition action and bring in strong nutrition focus in sectoral programmes through programmatic and institutional convergence and increased availability and accessibility of essential health and nutrition services to all pregnant, lactating women, children and adolescent girls. It will support pilots and innovative models of convergent multi-sectoral action for nutrition.

The programme will focus on nutrition centric planning at village, block, district and state levels for coordinated nutrition action and address relevant gaps in nutrition related interventions. The programme will have an inbuilt component of nutrition surveillance which will integrate surveillance in policy, planning and action and its expansion throughout states. It will lay strong emphasis on community based care of under three children who are undernourished by providing opportunities for piloting of malnutrition reduction approaches and scaling up of evidence based strategies like the Positive Deviance Approach, Dular, etc.

The Multi-sectoral Nutrition Programme would ensure that the relevant nutrition outcomes are not only integrated into the concerned sectoral plans but also that appropriate resources are allocated for achieving those outcomes. Funds for local gap filling support would be provided at the discretion of the District / State Nutrition Council, which would be allocated as per the needs identified on the basis of the District / State Nutrition Plans. At the national level, an Empowered Committee headed by the Secretary, Ministry of WCD would be set up for approval and budget release, based on the annual State Nutrition Plans submitted by the concerned States / UTs.

b) **Operationalising Convergence through the multi sectoral programme-:**There are several programmes and schemes aiming to directly and indirectly affect nutrition related outcomes. There is a need to bring more coherence among these through processes of convergences among these programmes. Convergence of these would have to be operationalized at programmatic, thematic, operational and institutional levels for ensuring improved nutritional outcomes:

- **Programmatic Convergence:** Each of the relevant programmes / schemes would integrate nutrition component in their respective APIPs / Annual Plans and allocate required resources (both financial and human) for achieving the related outcomes. Strong programmatic convergence will be required to address key nutritional determinants like household food security, care for women and children and environmental factors.

- **Thematic Convergence:** There is a need to bring thematic convergence(themes such as IYCF, maternal, Neonatal, infant and child care, etc) among the concerned Ministries / State Departments as well as the concerned functionaries and service providers at all levels. Any multi-sectoral convergent actions, would have to support and ensure availability and accessibility of the core interventions for thematic areas such as

household food security, strengthened livelihoods, care of adolescent girls, maternal undernutrition, low birth weight, growth monitoring, infant young child nutrition and feeding practices, iron deficiency and anaemia, strengthened health services, nutrition monitoring and surveillance, capacity building trainings and community mobilisation and awareness generation within the pool of existing programmes in a convergent subsets of results.

- **Institutional Convergence:** Various programmes like NRHM Mission, SSA Mission, NRDW Mission, etc. have their respective institutional arrangements. Horizontal linkages between these would have to be enforced at the point of delivery to the household and individuals (may be additionallysupported through the multi-sectoral programme for quick and rapid actions)across levels.

IV. Addressing Undernutrition through life cycle approach- Thrust on Prevention: Age specific under-five child undernutrition provides an important insight into the growth trajectory as growth retardation originates early in the life and most of this early damage is irreversible. The proportion of children underweight rises rapidly for the first 20 months of life. It is observed that wasting and stunting sets in as early as the first month of life.This suggests the onset of child malnutrition takes place very early in life including probably during pregnancy (IUGR).Undernutrition can be reduced through delivery of simple interventions yet essential at key stages of the life cycle –for the mother, at adolescence, before pregnancy, during pregnancy, during lactation, and for the child in utero, in infancy and early childhood. The 12th Five Year Plan would recognize the importance of the life cycle approach, early preventive action and for strengthening the continuum of care across families, communities, anganwadis and health centres through the following strategies:

a) ***Strengthening of ICDS***: The AWC will serve as the first outpost for health,nutrition and early learning activities and provide guidance and support to women right from pregnancy and after birth of the child for the first six years of life. In convergence with Health, ICDSwill ensure that all children get fully immunized, receive food supplementation, growth is monitored monthlyfor under 3s, (quarterly for under 5s) development promoted and micronutrient supplementation provided. Health check-ups and referrals for children who are sick and/ or undernourished will be arranged. For mothers, supplementary nutrition, antenatal care, IFA supplementation, health education, counselling on diet, rest and monitoring of weight gain will be some of the major activities which will be provided through ICDS. Good infrastructure& building, support for more care and counselling as well as clear focus on Under 3s and ECCE for 3-6 years; provision for crèche cum day care centre, will be key areas in ICDS implementation in the 12th Plan. Flexibility in planning and implementation and indicator based defined outcomes, intense monitoring, evaluations and deeper capacity building, training and Information education and communication will be some of the enabling features of ICDS strengthening.

b) ***Infant and Young Child Feeding***:Optimal infant and young child feeding includes early initiation of breastfeeding, exclusive breastfeeding till six months, introduction of age

appropriate feeding of complementary foods with continued breastfeeding after six months of age, for two years or beyond. Continuum of infant feeding practices will be achieved through intensified home based counselling of mothers during pregnancy and after child birth will be undertaken. Additional AWWs / nutrition counsellors will be recruited in 200 high burden districts. Special training of frontline workers – AWWS, additional AWWs/ nutrition counsellors and ASHAs will be provided to improve knowledge and skill set for counselling. Partnership with agencies, organization and professional bodies will be established in order to strengthen the infant feeding practices and increase the rates and coverage.

c) ***Strengthening of convergence between NRHM and ICDS:***The continuum of care will be provided through concerted efforts of both NRHM and ICDS. The VHND held in every village once a month will be further strengthened to cover all children, pregnant and breastfeeding mothers and tracking of this cohort using the joint Mother and Child Protection Card. Referral of sick and severely undernourished children will be facilitated by ICDS. Full package of services to pregnant mothers (ANC, IFA, TT, SNP, counselling) will be ensured at VHND. Services for children will include Immunization, micronutrient supplementation monitoring and promotion of young child growth and development and care of sick and /or undernourished children. Home based essential new born care will be provided by ASHAs and AWWs. Identification and care of under nourished children both facility and community based will be undertaken jointly.

d) ***Improving Health Nutrition and Hygiene Education:*** Promotion of hand washing practices and use of safe drinking water, use of toilets will be undertaken to prevent the cycle of infection and undernutrition. This will contribute to better nutritional status and to mortality reduction. Greater awareness generation on health and nutrition issues will be undertaken by AWWs /ASHAs/ ANMs at village level health education sessions and in contact drives.

e) ***Scaling up SABLA(currently initiated in 200 districts):***Early onset of undernutrition can be prevented by taking care of adolescent girls. The period offers opportunities to break the intergenerational cycle of undernutrition. Scale up of interventions related to adolescent girls is proposed. The Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (*SABLA*) is a scheme to promote due care of adolescent girls with special emphasis on iron and folic acid supplements, balanced diet, family life education, mother and child care education and skill development training to break the intergenerational cycle of malnutrition.

f) ***Scale up of IGMSY(currently in only 52 districts):*** To ensure proper care during pregnancy, institutional delivery, early initiation of breastfeeding and care for first crucial six months,scale up of *Indira Gandhi MatritvaSahyogYojana (*IGMSY) is proposed. It is proposed that the scheme covers all districts with a cash transfer of Rs. 4000per beneficiary. Further, the National Food Security Bill (NFSB) has proposed a cash transfer of Rs. 6000 covering all districts towards maternity benefit. The Ministry will structure the scheme appropriately

and harmonise it with the provisions of the NFSB. The IGMSY is a conditional maternity benefit scheme for pregnant and lactating women.It has been designed keeping in view the need for giving maternity benefit so as to compensate partly for the wage loss and the same time for fulfilment of conditions essential for ensuring safe delivery and promotion of optimal Infant and young child feeding practices –especially early and exclusive breastfeeding for the first six months of life.

V. Strengthening Institutional Capacity: Enhancing the capacity of existing institutions like NIPCCD, Food and Nutrition Board and ICDS programme will result in better nutrition outcomes. The following sub-sections (i to iii) discuss these in detail:

(i)Strengthening and Restructuring of ICDS - Reinforcing the Nutrition component:ICDS is the only programme which has been responsible for delivery of supplementary nutrition and related services like growth monitoring and counseling. The programme however has not been able to provide the necessary impact on nutrition, due to inadequacy of supportive inputs from other sectors such as health, water and sanitation, low investment, lack of infrastructure, poor skills and capacities, limited mandated community involvement etc.

The strengthening and restructuring of ICDS had been proposed in the Eleventh Plan, the process has been initiated and it is envisaged that a restructured and strengthened ICDS in Mission Mode will be operational in the 12th Five Year Plan. The proposed strengthening and restructuring will recognize the need for early action across the life cycle, for improving nutrition, health and child development outcomes. Special attention will be given from conception to the first three years of life. Some of the programmatic reforms include:

a) **Redesigned service package:** Components such as Child Care and Nutrition Counseling and advocacy and community mobilization will help in improving Maternal Care and Nutrition, Infant and Young Child Caring and Feeding Practices, especially optimal breastfeeding, preventing growth faltering and the early onset of malnutrition and promoting care for development. Correct counseling to pregnant mothers on diet rest and close monitoring of weight gain during pregnancy will also be undertaken in order to prevent intrauterine growth retardation and low birth weight. Additional Anganwadi worker will be appointed in 200 high burden districts to intensify counseling in order prevent undernutrition.

b) **Care Nutrition and hygiene education:** The component of nutrition, health and hygiene will emphasize on monthly education sessions for the mothers adolescents, and community at large. This will empower women with adequate knowledge on nutrition, feeding and caring practices for children and during pregnancy. It will be complemented by the development and implementation of National/State Communication strategies for improved Maternal and Child Care and Nutrition.

c) **AWC cum Crèche:** In order to see that children of working mothers are not neglected, support and care to children will be offered through AWC cum Crèche facilities in such areas.

d) **Nutritional support through improved SNP:** Enhanced nutritional impact will be achieved through revised nutrition and feeding norms; cost indexation of SNP; ensuring provision for Nutritious freshly cooked, culturally appropriate meal, (morning) snack and THR as per norms, guidelines and legislation, in harmony with Supreme Court directives and greater involvement of women's SHGs, and piloting of community kitchens and joint kitchens with Mid-Day Meals.

e) **An innovative new component is *SNEHA SHIVIRS* for promoting community based prevention and care of severely undernourished children**, backed by stronger referral linkages with health is proposed. This will help reduction of severe and moderate undernutrition.

f) **Convergence with flagship programmes:** This will be strengthened through expanding coverage of Monthly Fixed Village Health and Nutrition Days (with NRHM).

g) **Community Mobilization and Monitoring** will be strengthened through village contact drives, involvement of women's groups, mothers' committees, women link volunteers and flexi/untied funds to empower local communities and panchayats for action. Community based monitoring will be done through the universal roll out of the ICDS NRHM family retained mother child card, using new WHO child growth and development standards, Mother - Child cohort tracking jointly by AWWs/ASHAs/ ANMs with monthly growth monitoring of all under threes and quarterly growth monitoring of all 3-5 year olds, at monthly Village Health and Nutrition Days, with active participation of Village Health, Sanitation and Nutrition Committees, recognised as sub committees of panchayats.

h) **ICDS in Mission Mode:** To accelerate the reduction in undernutrition, time bound goals are required to be set- hence transforming ICDS into a "Mission Mode"is proposed. It will aim at providing a decentralized programme with a flexible implementation framework with monitorable outcomes for improved effectiveness, efficiency and accountability. The emphasis is on strengthening the AWC as a village habitation level institution belonging to women in the community. ICDS restructuring seeks to empower states/districts/blocks and villages to contextualize the programme and find innovative solutions, building on local capacities and resources, with concomitant support for capacity development, innovation, social mobilization, communication and community based monitoring.

(ii) Strengthening and Redefining the Role of Food & Nutrition Board: The setting up ofPM's National Council for Nutritional challenges, universalization of ICDS and higher investments in nutrition related interventions are strong indicators of the government's commitment to address malnutrition. In order to cement these efforts further, it is vital to have on board a technical body for steering the programs in the positive direction, vigorous nutrition education & awareness, monitoring quality of supplementary feeding and other nutrition related components of ICDS, capacity building of communities & functionaries for increasing the program's efficacy and initiating strategic alliances for tackling malnutrition. There is also an urgent need for technical support to policy and convergent action for nutrition, both at national

and state levels. The tasks assigned as per the Prime Minister's National Council at the centre and the tasks of providing technical support & guidance to the State Nutrition Councils at the state level require sound expertise.

In view of the above, there is an urgent need to restructure the Food and Nutrition Board, as the nodal national technical body for coordination, technical oversight and quality assurance of nutrition for ICDS. FNB strengthening had also been proposed in the Eleventh Five Year Plan. The Food and Nutrition board would be restructured and strengthened in view of the current nutrition challenges and solutions.The FNB restructuring needs to be done at the national, regional and state levels.For these purposes subject experts in the field of communication, community nutrition, program management, food technology, and social mobilization will be required. The reorganization and strengthening would entail allocation of adequate resources both human and financial with improved infrastructure.

(iii) Strengthening of NIPCCD: NIPCCD which is the apex training Institution of the MWCD for training of ICDS functionaries needs to be adequately strengthened to enable it to play its role effectively. In view of the proposed strengthening and restructuring of ICDS, introduction of new Multi-sectoral Programme on Nutrition and other related schemes aimed at addressing the maternal and child undernutrition including IGMSY and RGSEAG – SABLA, training and capacity building of personnel at all levels is going to be a major and challenging task. To meet thischallenge, NIPCCD would require to be strengthened during the 12th Five Year Plan to fulfil the requirements of training along with adequate qualitative input with regard to different schemes/programmes.

Two new Regional Centres of NIPCCD would be set up in the State of Bihar and Punjab. The organisational set up of NIPCCD post strengthening would require additional posts which will include (i) posts that need to be revived which are presently under the 'deemed abolished' category (ii) additional posts for implementing the other related schemes. There would be six divisions and 18 units at NIPCCD headquarters and Regional Centres which would require two Deputy Directors along with supportive technical and administrative staff. Certain senior level posts would need to be upgraded to provide a better structure to the Institute for carrying out its ever increasing roles and responsibilities.These would be complemented by atleast 10 State Institutes on training either as a distinct institution or as a part but a distinct unit of SIRD or SHFW training centre or existing WCD centre or transformation of state run MLTC. Specifically, NIPCCD will require strengthening in following areas:

a) ***Effective Training & Capacity Building through Collaboration & Linkages****:* NIPCCD will explore and forge partnership with State Governments, international & national organizations & line departments in the areas relevant to the pursuits of the institute, which will help: (i) synergize organizational capacities and achieve excellence in the area of women and children; (ii) develop quality material based on empirical work for informed policy direction of Government; (iii) explore and collaborate with leading institutions in South Asia and Europe (to begin with); and (iv) evolve and sustain faculty exchanges for enlarging and globalizing issues confronting women and children.

b) ***Training Resource Centre***: NIPCCD will create a Training Resource Centre of ICDS (TRC) which will keep a close liaison with the training cells of State Governments to plan Training of CDPOs/ACDPOs and trainers. The TRC will also create a database of the ICDS functionaries trained by it to monitor the requirement of skill training, job training etc. The TRC will draw Annual Action Plan of Training of ICDS functionaries for its headquarters and Regional Centres in consultation with State Training cells.With support of its four Regional Centres and other relevant institutions and voluntary sector, NIPCCD will adopt need-based training strategies.

   Regular training and capacity building of all service providers and functionaries at all levels will be ensured to equip and enhance their skills, knowledge on child care standards to meet the demand as per the above mentioned ICDS restructuring. NIPCCD, AWTCs and MLTCs will be engaged in carrying out training and capacity development in the area of health and nutrition services. The other major initiatives in this area include training of Trainers on New WHO Child Growth Standards in ICDS and Use of Mother and Child Protection Card, Skill Training on IYCF and IMNCI. Growth monitoring being an important to for identifying under nutrition in child as also a means to educate the mother regarding the nutritional status for her child would be strengthened through sensitization of field functionaries.

c) ***Quality of in-service training***: will be improved by standardising training curricula, training materials and training methodology in the light of growing needs for universalization of quality services. For development of focused curricula for continuing in-service training to meet required functional skills and knowledge of ICDS functionaries, it is proposed to develop a capsule training plan of shorter durations with different themes to support functional roles of ICDS functionaries. The major themes of training would include (i) essential nutrition action for improving coverage of under 2s;(ii) decentralised data management and decision making; and (iii) behaviour change communication.

d) ***Revision of Contents***: Curriculum of ICDS functionaries will be revised in the light of new programs & schemes of MWCD to ensure continuous capacity building of functionaries. Vertical training modules and the methodology for the same will be developed. Based on TNA exercise new modules for skill development will be developed on a continuous basis. It is therefore proposed to undertake revision of contents in consultations with States, NIPCCD, subject experts, trainers of MLTCs and AWTCs.

e) ***Innovation in training***: Some states have demonstrated good training practices for ICDS functionaries; these will be considered and replicated to enhance capacity building of ICDS functionaries. A platform that facilitates continued in service training and sharing knowledge across in areas of common needs will be set up. The determinants like resource team and interactive facilities will be used to promote information dissemination continuously to ICDS functionaries.

f) ***Adoption of AWCs***: NIPCCD will adopt two Anganwadis (one rural and one urban) in the vicinity so that the same can also be used as Training lab and as Model Centre.

g) ***Creating internship programme for graduate/post-graduate students***: This will involve deploying educated youth to support building capacities of AWWs. The students will be placed in blocks/Gram Panchayats and will be given responsibility for providing focused training and handholding support to AWWs.

h) ***Nutrition Resource Platform****:* A web portal for easy access to information relating to nutrition and child development will facilitate interactive discussions, provide comprehensive information for all ICDS and related programs & repository of nutrition related resources including research, new publications, government policies, training materials etc. Periodic SMS blasting to all ICDS functionaries on essential maternal and child health interventions and operations are other areas that would be made functional. The platform will also use various forms of communication namely Internet, telephone, integrated voice response system (IVRS), mobile telephone, data processors, conversion instruments, paper based communication, Internet to mobile services, voice call centre, mobile telephony servers etc.

   In order to strengthen knowledge base on nutrition education, national, regional and state level Nutrition Resource Centresand networks are also proposed to be set up involving, NIPCCD, FNB, respective State Governments and other related institutions / agencies.

i) ***Monitoring****:* To meet the new challenges due to rapid growth of ICDS and its universalization, NIPCCD headquarters and its four Regional centres will need regular/permanent structure to monitor ICDS programme implementation as well as to undertake new initiatives. As a monitoring unit for ICDS, the CMUs under NIPCCD will be strengthened to monitor ICDS service delivery. The revised monitoring system would focus on collecting & providing data on real time basis to support programmatic actions. CMU located at NIPCCD would provide support to Central Monitoring cell of MWCD. Monitoring of expanded ICDS and other programmes would be carried out in a more effective and judicious manner with requisite staff strength at NIPCCD.

   At the State, District & Block level, training team would be formed that will be responsible for conducting trainings and handholding support for monitoring the training implementation plan and send progress report to respective ICDS training cells at various levels.

   Cross state and project visits would be planned for AWWs and team of ICDS functionaries from State to Clock level. Inter district project visits for the AWWs where innovations are being taken up would provide opportunity of exposure to good practices. Cross visits for State functionaries along with selected district and block level officials will be arranged in getting the perspective of the innovations and their replication in other component in line

with the restructured ICDS. It will also be responsible establishing linkages with other institutions for training and imparting quality training to workers.

As a resource NIPCCD will be provided appropriate infrastructure and resources to crystallize the concept of Nutrition Resource Platform as envisaged by MWCD. As a monitoring unit for ICDS, the CMUs under NIPCCD will be strengthened to monitor ICDS service delivery.

VI. **Initiation of Strategic Linkages for promoting Nutrition:** Besides the government institutions and programs there are organisations and communities working towards the cause of nutrition. A joint movement and co-operation amongst these can further propel the current efforts to reduce malnutrition. Strategic partnerships and linkages with home science, medical & public health colleges, medical bodies, civil society organisations, community groups etc. should be initiated as voluntary action for sharing of technical knowledge, social mobilisation, increasing nutrition awareness and monitoring. They can be involved in various counselling sessions & awareness campaigns related to IYCF, use of low cost nutritious foods, importance of balanced diet, anaemia, de-worming, micronutrient malnutrition, health of pregnant and lactating mothers, personal hygiene, sanitation, life skill counselling for adolescent girls, early age at marriage, early and frequent child bearing, inadequate family care and support, gender discrimination etc. Various communication channels can be used for this purpose such as exhibitions, displays, street plays, film shows, games, camps etc. Students as part of their extension programme can work in a group of 3-5 & can adopt one AWC and work on all the aspects requiring improvement, up gradation, and enrichment.

VII. **Combating Micronutrient Deficiencies in a Holistic Manner:**There are clear strategies to combat micronutrient deficiencies (Iron, vitamin A and iodine) in children women and adolescent girls.A comprehensive approach would be adopted which includes complementary strategies to address micronutrient malnutrition including: (i) Infant and Young Child Feeding Practices; (ii)Dietary Diversification; (iii)Horticultural interventions; (iv)Nutrient Supplementation; (v) Food fortification; and (vi)Public Health Measures.

a) Supplementation with micronutrients/food:Micronutrient deficiencies, particularly IDA, IDD and Vitamin A would be addressed through intensified actions focussing on: (i) Adopting a comprehensive approach involving improved IYCF practices, dietary diversification, food supplementation, food fortification and horticultural interventions, Iron & Folic Acid supplementation for young children, adolescent girls, pregnant and lactating women also supported by the use of Double Fortified Salt; (ii) Periodic screening for anaemia; (iii) Strengthening Vitamin A supplementation Programme in convergence with NRHM for improved coverage; (iv) Supply of adequatelyIodized salt through TPDS and also double fortified salt; (v) Public health measures – deworming, environmental sanitation, safe drinking water; and (vi) Micronutrient supplements and health check-up for school children through MDM programme.

b) ***Food Fortification:***Micronutrient malnutrition control programmes in the country have focused on nutrient supplementation of some vulnerable groups. This will be complemented by a frontal attack on micronutrient malnutrition through a comprehensive strategy. Fortified wheat flour and Double fortified salt are two successful examples. Efforts will be made to make these available through technology transfers. DFS has been introduced for food supplementation programmes. Public private partnership for production of fortified foods will be explored within a comprehensive policy framework, with requisite safeguards to address micronutrient malnutrition.Regulatory mechanisms for the above will also be developed**.**

c) ***Improved health education and IEC:***This will carried out with the aim to disseminate knowledge on micro nutrients and its prevention as well as advocacy for food diversification to include iron, vitamin A, and carotene rich food in regular dietary intake. Besides, it would also help in ensuring improved dietary intake to meet RDA, improved compliance of IFA and improved iodized salt consumption in every household.

d) ***Monitoring and Surveillance:*** Initiatives for monitoring the programme for preventing and controlling micronutrient deficiencies would include strengthening routine reporting under NRHM/ RCH and ICDS programmes to include percentage of pregnant women, children adolescent girls, anaemic, percentage given IFA tablets, compliance for IFA, Vitamin A supplementation for children as well as mobilising PRIs, Women Self Help Groups and Anganwadi Workers to monitor intake of IFA tablets.

Evaluation of the on-going process and impact is expected to be done as a part of the Annual Health survey /National Health Survey including haemoglobin estimation, questions regarding IFA coverage and intake. In addition as and when large-scale surveys are done, information can be collected on the prevalence of anaemia in pregnancy, childhood, adolescents and the elderly so that it is possible to assess the impact of ongoing interventions.

Wherever possible, (such as during school health check-up) attempts would be made to screen adolescent girls, especially those who are undernourished or have menstrual problems, for anaemia and provide appropriate treatment. Adolescents who are pregnant should receive very high priority for screening and management of anaemia.

VIII. Promoting Optimal Infant and Young Child Feeding Practices: Optimal infant and young child feeding (IYCF) practices form the cornerstone of childcare and development. Despite breastfeeding having numerous recognized advantages, and several initiativesto promote breastfeeding, early and exclusive breastfeeding, rates in most states of the India are low. There are many gaps in policy and programs related to breastfeeding and infant and young child feeding in India and following actions need to be taken urgently:

a) ***Emphasis on IYCF and dissemination of National guidelines on IYCF:***IYCF counselling should be included as one of the services in the ICDS program.It is necessary to recognize IYCF as a scientifically proven intervention to improve child nutrition status and child survival. It needs a comprehensive national policy developed in consultation with all the stakeholders. It also requires a national plan of action and adequate budgetary allocations to bridge various identified gaps in the policy and programs. A national guideline on IYCF needs to be translated locally and widely disseminated.

b) ***Community initiatives for supporting women:***Aggressive marketing of baby food by companies can easily mislead women who don't have access to accurate information. The feeling of 'not enough milk' forces many mothers to resort to other milks or foods during the period of exclusive breastfeeding. An empathetic and skilled health worker must support women at the time of birth to succeed in beginning breastfeeding within an hour of birth and providing prolonged skin-to-skin contact. They should also have access to counselling (one to one or group) and support to continue exclusive breastfeeding for the first 6 months. Women also need counselling for adequate complementary feeding and continued breastfeeding at completion of 6 months.

c) ***Critically addressing the under 6 months:*** The 0-6 months infant is often left out of initial weighing/ child care counselling sessions, because most deliveries take place at home, mothers are superstitious about new-borns being weighed, and also because 0-6 months infants are to be exclusively breastfed and hence no SNP is to be provided to them – and most ICDS records/ reporting is SNP centred. Creation of Nutrition and breastfeeding support centers, initially in all district hospitals- and followed by at CHC, PHC levels in a phased manner – with skilled counsellors to provide lactation management support, and management of all forms of malnutrition, mild , moderate and severe should be done.

d) ***Strengthening ICDS:*** Nutritional counselling as a service would be introduced with an additional Anganwadi worker so as to focus on home visits for children under 2 years and mothers to promote IYCF practices. The home visit strategy, has tremendous potential for empowering families of vulnerable under 3 year olds to improve home level IYCF practices; because it offers an opportunity for one-to-one communication or interpersonal communication (IPC) so important to bring about behaviour change. In the national ICDS program, nutrition-education-communication and home visits are among the several important services that are expected to empower families to improve home level practices for women and child nutrition.

e) ***Enhancing capacity building of field level functionaries on IYCF practices.*** It is imperative to build knowledge and skills, capacity for behaviour change communication, counselling and develop problem solving skills for Anganwadi Workers (AWWs), Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs) for improving the IYCF practices.

f) ***Pre-service curriculum strengthening for doctors and nurses*** will help reduce the need of in-service training and improve knowledge and skill of doctors and nurses, which is seriously lacking. Medical colleges should be involved for this purpose.

g) ***Behaviour change communication:*** An extensive and focused communication campaign on IYCF needs to be launched to address all target groups including counselling to mothers through health and Anganwadi centres. All hospitals, maternity establishments, health and ICDS staff need to be directed to counsel pregnant/lactating mothers at every possible opportunity on the benefits of appropriate IYCF.There is a need to harmonize behavioural change communication goals across all levels and sectors including media.

h) ***Skilled nutrition counselling:*** Recognize and provide resources for skilled nutrition counselling as a service with a support chain from village level to sub centre, PHC, CHC, subdivision, district and state levels, including mother and child cohort tracking and linking with referral services. This also requires a common core counselling strategy and resource kit for ICDS, NRHM, and TSC for joint action on key interventions.

i) ***Protecting breastfeeding and compliance with the Infant Milk Substitutes Act (IMS Act):***The legislation, the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992, and Amendment Act 2003, is in place for last so many years, but it needs an effective implementation. There is a need to ensure that the provisions of the Act are widely disseminated among all stakeholders at all levels in a user-friendly manner. Monitoring the compliance of the IMS Act by the companies is also needed for effective implementation of IMS Act.

j) ***IYCF counselling centres in Health facility:*** It is important that each health facility has few nurses trained in the skills to deal with infant and young child feeding counselling as well as on HIV and infant feeding. They should be properly trained and updated on a regular basis.

k) ***VHND:*** The frontline workers team comprising of ASHA, AWW, ANM, and the PRI representatives, if fully involved in organizing VHND, can bring about changes in child caring practices and promote IYCF practices. Identification of a nodal person to oversee convergence between the ANM and ASHA; and appointment of a Nutrition counsellor/Activist who would serve as a link between ICDS and NRHM is need of the hour.

l) ***IEC and Nutrition messages:*** Designing mass- media campaigns that will cause people to adopt better practices about IYCF practices is required. Content of messages should be appropriately sensitive to local traditions, practices and needs. These messages should be disseminated using all relevant media.

m) ***Introduce Village report cards:*** A PRI committee to check regularity of functioning of AWC, ensuring coverage of all eligible beneficiaries as against the surveyed population, review status of supply of supplementary food to all beneficiaries for at least 21 days in a month, review nutritional status of children 0-1 years, 1-3, and 3-6 years, weighing, availability of

WHO new growth charts and joint MCP card is required. Awards may be given to one village in a block for achieving targets of normally growing children. The government can introduce colorcoded village child health and development cards. Green could signify good progress, yellow, mediocre progress and red, poor progress. These could even spark a community movement. Every village can prominently display these cards. It would depict what progress the village has made. This will link with the concept of a baby/ child friendly panchayats.

n) ***National Nutrition Communication Campaign and role of media:*** There is a need to develop and launch a national nutrition communication campaign linking concerned sectors (e.g. gender related issues, health and hygiene practices). A national movement for promoting IYCF should be initiated by formulating and implementing a national IEC campaign to improve IYCF practices using media. Accordingly, the communication strategy should work towards generating awareness and knowledge on the issue of malnutrition.

o) ***Strengthen National and State Coordination Mechanisms and Capacity for promoting Infant and Young Child Feeding and implementation of the IMS Act:*** The National Breastfeeding Committee under IMS Act needs to be rejuvenated and strengthened, and State Breastfeeding Committees constituted as envisaged, with identified State Nodal Officers within State WCD and Health Departments for IYCF, supported by technical teams at different levels. A National Resource Centre needs to be established, in partnership with appropriate professional networks to enable capacity development for IYCF for both NRHM and ICDS, supporting both the Ministries of WCD and Health and Family Welfare, with State level Resource Units, linked to other training institutions. This could also be assigned to national level partner organization or set up especially to focus on the issue.

IX. Nutrition Communication & Education and Community Mobilisation: One of the decisions of Prime Minister's Council on India's Nutrition challenges is to launch vigorous nationwide nutrition awareness campaign utilizing all available channels of communication. Accordingly, the communication strategy would work towards generating awareness and knowledge on the issue of malnutrition. Awareness regarding malnutrition as a problem, its consequences, knowledge about appropriate nutrition and care during pregnancy, infancy and young childhood is widely lacking in the country so a comprehensive nutrition communication program would be developed based on the following:

a) ***Multi-layered and Multi-level Strategy:*** Vigorous nutrition education would be carried out utilising all available channels. As part of the communication program, different forms of media in co-ordinated multi-channel approach at three levels: National, State and local level would be employed stage wise. Besides mass media, other mediums like local folk media, community radio would be used for wider dissemination of nutrition messages, programmes, and benefits. The nutrition communication strategy would link across sectors - for promoting optimal Infant and Young Child Caring and Feeding practices and care of girls and women, and would also use opportunities provided by the Bharat Nirman Campaign and Sakshar Bharat. This would include different aspects related to care

behaviours i.e health, hygiene, psychosocial care and early learning, supporting improved parenting, with shared responsibilities of both parents and family support for care.

b) ***Nutrition Education*** is also to be integrated appropriately/strengthened in the school education curriculum framework at national levels and linked to Mid Day Meals, so that children also promote nutrition relevant practices in the community and through the Child to Child approach. This will be incorporated in Sakshar Bharat.Similarly the nutrition component in the medical and nursing education curriculum will also be strengthened, networking medical colleges, nursing colleges and councils.

c) ***Education of girls and women's literacy*** is to be promoted, responding to their nutrition, development and protection needs. Retention of girls in elementary and secondary schools, availing of MDM, health care, IFA supplementation and deworming interventions, increased duration of schooling, improved life skills and subsequent linkages to the Skill Development Mission, will be long term approaches for addressing gender discrimination, early marriage and early child bearing.

d) ***Community mobilisation:*** It is also realized that community mobilisation level would imply greater sensitization and involvement of Panchayati Raj Institutions and Village Health Sanitation and Nutrition Committees. Nutrition orientation of grass root workers, functionaries, PRIs, village elderly etc would create an understanding about the importance of nutrition and their pivotal role in the prevention of malnutrition especially amongst children.

e) ***Institutional structures:***The available institutional structures and resources under national programs would be utilised for increasing the opportunities for dissemination of nutrition related information. Besides the national mass nutrition awareness program, synergies will have to be built and key nutrition messages would be integrated in the IEC/BCC activities under each national program.

f) ***Capacity building for Nutrition Education:***Orientation of the functionaries and volunteers should be done so that each of the 'change agent' understands his/her role in the communication strategy and comprehends the nutrition messages, becomes familiar with the techniques required for effective IPC and usage of tools for communication. Workshops and/or orientation activities at various levels through the master trainers along with the partner organizations and voluntary nutrition groups will have to be carried out for the functionaries of involved departments and programs.

g) ***Timeline & Resource Allocation:*** To give impetus initially about Rs. 500 crores may be provided for this purpose. In addition to this the respective sectoral programs should bring nutrition into focus in the IEC components. The approach should be to subsequently to mainstream the nutrition campaign into ICDS and other focus areas such as horticulture, NRHM/RCH II, FSSAI, information and broadcasting programs, etc. through the respective ministries.It is crucial that adequate resources both human and financial are provided to

effectively implement the communication strategy. Accordingly FNB, NIPCCD and MWCD would be strengthened and provided with professional mass communication team to carry forward a communication program on a national scale.

X. Capacity building for Nutrition: Capacity building and sensitization for nutrition has been a neglected area, however appropriate training has to be imparted in order to have desired impact on nutrition outcomes.This is needed at district and block management levels and service provider and supervision levels. A resource center of WCD and health must coordinate the trainings at the state level. A shared training space and team at the district and block level would also be essential. Since training capacities inside the departments may be limited, it would be useful to secure the participation of NGOs who can play this role. Capacity building is needed for programme management, for supervision, for cooks to prepare nutritious food, and for SHGs or their federation and for panchayats to manage the preparation and delivery of hot cooked meals with whatever micro-nutrient supplements required. But above all capacity building is needed to the anganwadi workers and to the ASHA for counselling families on nutrition and related behavioural Issues.

Strengthening and restructuring of ICDS has proposed the revision of the current training of ICDS functionaries, and special modules will be incorporated for skill training on counselling for IYCF, communication skill for imparting health and nutrition education. It is also proposed that resource centres will be set up at NIPCCD and its strengthening and linkages with other institutions of different sectors will improve the quality of training especially for instructors and supervisors. Upgrading of MLTCs, AWTCs with proper teaching aids will be undertaken, and field level evaluation of trainings is proposed. The main areas where knowledge and skills in counselling have to be built are described below:

a) ***Nutrition counselling for the child:*** This makes a substantial contribution to malnutrition reduction, even without nutrition delivery services;Along with food supplementation health communication messages on nutrition would be better accepted. Counselling skills of workers -AWWs. ASHAs, ANMs, additional AWW/ counsellor would be enhanced in order to improve group counselling and interpersonal communication for promoting optimal IYCF practices and counselling of pregnant and lactating mothers on proper diet.

b) ***Training on Safe Water and Sanitation Issues:*** Training to AWWs, ASHAs and other para-medical staff needs to be imparted using modules on safe drinking water and sanitation. The modules may cover the issues of construction and use of toilets by rural households, safe handling of water, adoption of hygienic practices specially hand washing practices inside and outside the household, testing of local water sources for chemical and bacteriological contamination, boiling or treating water with cost-effective models of domestic filters at household level to ensure portability.

c) ***Addressing Familial Factors:*** Counselling, and social mobilisation is also needed to address importance familial determinants of child nutrition - age of marriage, age of first child birth, spacing of children, access to care in pregnancy and sickness, and all the supportive

circumstances needed for child growth and development. The importance of growth monitoring and the interpretation and growth curves would be stressed upon, along with promotion of care for development.

Counselling and behaviour change communication would additionally address issues of personal and domestic hygiene, safe drinking water and sanitation including safe disposal of stools and hand washing after defecation and handling of stools, the prevention of diarrhoea and frequent respiratory infections and malaria, the detection and management of anaemia, the need for periodic deworming. Counselling is also essential in adolescents, school children, pregnancy and nursing mothers to address malnutrition and anaemia and to address low birth weight. Counselling skills are needed not only in AWWs and ASHAs, but also with members of SHGs, VHSCs etc. who can serve as additional community health volunteers.

Nutrition Education appropriate communication skills development and knowledge up gradation of frontline workers would help to address issues related to diversion of family income to non-food expenses. Importance of nutrition diet feeding practices and habits and concerns related to consumption of junk food and over-nutrition may be disseminated with ease by trained workers.

XI. Monitoring and Nutrition Surveillance System: Effective monitoring of national nutrition actions requires both monitoring and assessment of processes and outcomes. Efforts would be made to put responsive and dynamic Nutrition Surveillance System (NSS) in place in order to capture nutrition related information. It would help assess the current situation, analyse the causes/reasons of the problem & based on the analysis and available resources, and suggest the actions to improve the situation.It would provide information on nutritional practices of vulnerable groups being reached underICDS-NRHM and related programmes of different sectors keeping the multi factorial nature of nutrition. It would take following measures in a synergistic manner to achieve optimal results:

a) The critical indicators of infant, child and maternal mortality and nutrition related to antenatal, postnatal and early childhood care would be constantly monitored to ensure better child survival and optimal child nutrition in case of each mother-child cohort tracked, with the aid of Mother and Child Protection Card (MCPC), linked to the NSS network.

b) The Kishori card being linked to the NSS database willensure better health and nutrition among adolescent girls, through consistent and continuous data inputs on BMI and IFA intervention for adolescent girls and regularity of organising NHE & LSE sessions for them and ensuring attendance of these sessions by adolescent girls.

c) The Geographical Information System (GIS) Mapping will be used to generate data at the Anganwadi level for monitoring at Block/ District level and the cumulative databasewill be built-up the National Nutrition Database for National Nutrition Surveillance and policy inputs.

d) It will help in mapping of undernourished endemic zones of the country in terms of identifying districts and term them as 'high risk and vulnerable'districts. Special focus within National NSS on household food security in difficult survival environments like, remote hilly, tribal areas and drought prone areas, deserts, etc. and BPL population pockets. This will help in decision making and plan focused nutrition interventions.

e) Central Monitoring Unit (CMU) set-up under ICDS will be utilized for NSS as well for a comprehensive, non-repetitive assessment and correction of field situation with respect to health and nutritional status of the vulnerable groups of the population.

f) A set of indicators will be finalized under National NSS like those indicators which needs be reported monthly, quarterly etc. These could be finalized during the ground-work/ preparatory phase of the operationalization of the NSS and be harmonized with the prescribed reporting patterns under the NRHM, IGMSY and SABLA.

g) Baseline Surveys of nutrition and health related indicators of children under six years of age, adolescent girls and women will be undertaken by all States/ UTs before the commencement of XII Five Year Plan, with the support of Technical Institutions like NIN, Medical Colleges and Home Science Colleges, to establish the benchmark of nutrition indicators for the National NSS and Database.

h) National level TOT Workshopwill be organised by NIPCCD for National level stakeholders and all State/UTpartners, followed by the subsequent State/ District level TOT Programmes for uniform and consistent administration of survey tools/ formats for baseline. The Baseline Survey data shall also be the basis of strategies to promote and improve nutrition and to transform health and nutrition related service inputs into positive nutrition and health outcomes in children, adolescent girls and women.

i) National NSS Design and Database format will be finalized after assessment of existing experimental/State level models operating in certain States and an experience sharing exercise through a National level Workshop of stakeholders and experts.

j) Training and capacity building for development and maintenance of the National NSS and Database will be crucial for successful nutrition surveillance to achieve the goal of optimal nutrition for population groups and all stakeholders for effective role management and output expected from the functionaries at all levels**.**A two-day TOT programme may be undertaken at State level for stakeholders in each State/ UT to familiarize with the National NSS, followed by district and block training programmes within the State/ UT. Six-monthly State level workshops at State level and District level to firm up concepts and fine operational details for effective inputs into the NSS database.

k) At central level there will be endeavour to create surveillance system which will monitor set of indicators which have direct impact on nutrition outcomes. Working Group on Nutrition Surveillance may be set up, comprising of public health experts, health and child care providers, health and child care managers, nutritionists, sociologists, health economists, anthropologists to guide the initiatives.

l) National NSS (in reference to the unique beneficiary identification number) that would enable assessing the functional efficacy of referral system under ICDS, IGMSY and SABLA towards establishing optimal nutrition.The National NSS will have an inherent component of self-evaluation and accountability and responsiveness. However, the same standards and structures of Monitoring and Accountability framework shall be built into the system.

m) Separate periodic and annual reports of the National Nutrition Surveillance will be used for Policy formulation/ review and also to facilitate designing Special Nutrition Intervention Programmesat the level of Central/ State Government for nutritionally vulnerable population groups in difficult areas/ circumstances requiring special inputs to reach optimal nutrition level.

n) A Nutrition surveillance cell may be established to monitor nutrition security related sectoral indicators periodically. NNMB, NFHS, DLHS, NSSO survey data would also be used to corroborate with the sector specific information.

o) Community based monitoring including social auditing mechanism involving ICDS, Health and Panchayati Raj institutions. Such monitoring mechanismswill help provide information at block, district, and State level to project the nutrition scenario of the State with disaggregated data.

p) Independent Nutrition Survey will be undertaken every at least every two years covering all vulnerable groups including school children and adolescents to arrive at state level estimates.

XII. Addressing theDual Burden of Malnutrition: Increasingly, health systems in many developing countries are simultaneously confronting under- and over-nutrition—not only at the national level, but also within households.Both undernutrition and over-nutrition are linked with a range of adverse health conditions. Importantly, however, underweight and overweight are both forms of malnutrition, a term that encompasses either a lack of or excess in energy and/or nutrients. Dual burden present a unique challenge for public health, programs should promote nutritious foods and a healthy lifestyle to address both types of malnutrition at the same time. The following action would be required to be taken:

a) Health system will be responsible for screening persons for over-nutrition, while ICDS and health will be responsible for screening for undernutrition using the BMI for age.

b) Health system would also support personalized advice for early detection of overweight and diet counselling as well as monitoring the improvement and providing focussed care to those who are facing problems in modifying their lifestyles.

c) High-quality diets—those that consist of sufficient energy and nutrients but are limited in fats, sodium, and sugars—benefit those at risk of either undernutrition or overnutrition would be promoted.

d) Eating more fruits and vegetables would be promoted to help the overweight (by reducing the risks of heart disease and diabetes) while also helping the undernourished (by improving their nutrient intake).

e) An increase in physical activity with adequate energy and protein intake would be promoted to help build critical muscle mass and contribute to a healthy body composition in both groups.

f) Appropriate advocacy for prevention in over-nutrition would be important to arrest the increasing rise in non-communicable diseases.

g) Nutrition and health education through all available modes of communication emphasising the need for: (i) eating balanced diets with just adequate energy and plenty of vegetables; and (ii) adopting healthy lifestyles with at least moderate physical activity, would be carried out.

h) Health interventions including, (i) screening persons for over-nutrition whenever they access health care;(ii) using of BMI for adults and BMI-for-age in children and adolescents for early detection of over-nutrition;(iii) identification of over-nourished persons and personalised advice regarding modification of dietary intake and life style; and (iv) monitoring the improvement and providing focussed care to those who are facing problems in modifying their lifestyles, would be carried out by the health system.

4.3 Financial Requirements

Such a transformational and comprehensively coordinated and Nutrition focussed action would requireadditional budgetary support on following dimensions:

a) Multi-sectoral Nutrition Programme in 200 High Burden districts (say about 1000 croreper annum, Rs. 5000 crore for 12th Plan);

b) Besides above, State / UTs would also have to be supported for preparing nutrition action plans including even those districts that are not high-burden but require concerted action in terms of preventive as well as convergent multi-sectoral actions. For this, a budgetary provision of Rs. 50 lakh to 10 crore per State, depending on the number of districts and incidence of undernutrition. A lump-sum allocation of Rs. 200 crore per annum is proposed for additional support towards intensive action to programmes that directly and indirectly bring nutrition related outcomes in particular in respect of household Food security, environmental improvements in water and sanitation, comprehensive care for health, Nutrition and systems of care support and practices, building leadership, capacities, awareness and embedding nutrition oriented behaviours and choices (investment for this should be part of respective programmes and schemes such as ICDS, IGMSY, NRHM, SABLA, etc.).

c) Support to key activities and strengthening of systems and institutions(IYCF(200 croreper annum), IEC Campaign (Rs. 200 croreper annum), Voluntary action and social mobilisation (Rs. 100 crore per annum), FNB strengthening (Rs. 25 crore p.a), strengthening and involving NIPCCD, NRP, Nutrition surveillance etc. (Rs.25-30 crore), support to institutions/surveys/ special action plans etc., Rs. 200 croreper annum, Rs. 200 croreper annum for community based management of severely undernourished children. Rs. 50 crore for research including operational research, quality control,assessments and national set upetc.

d) These could be clubbed under Nutrition Mission or Nutrition promotion and action plan. About Rs. 2000 croreper annumand Rs.10000 crore for 12thplan may be allocated.

e) This could be made as Additional central assistance and for every rupee invested for programmes under the umbrella, an additional rupee can be contributed to the states/UT. The weightage could be 60% on reduction in Key nutrition indicators and 40% on additional investment. The benchmark could be through a baseline survey where on ascertaining an annual rate of improvement future state and district specific rates on success could be established.

Table-8: PROPOSED FINANCIAL ALLOCATION FOR NUTRITION IN THE 12TH FIVE YEAR PLAN

Sl. No.	Item	Proposed Budget (Rs. In Crore)					
		Year 1	Year 2	Year 3	Year 4	Year 5	Total
1.	**Multi-sectoral Nutrition Programme in 200 High-burden Districts**	1000.00	1000.00	1000.00	1000.00	1000.00	5000.00
2.	**Additional support for intensive action to programmes**	200.00	200.00	200.00	200.00	200.00	1000.00
3.	**Strengthening of Systems**						
3.1	Breastfeeding, IYCF Promotion & IMS Act enforcement	250.00	250.00	250.00	250.00	250.00	1000.00
3.2	IEC Campaign	200.00	200.00	200.00	200.00	200.00	1000.00
3.3	Voluntary action and social mobilisation	100.00	100.00	100.00	100.00	100.00	500.00
3.4	Nutrition Resource Platform & Centres	20.00	20.00	20.00	20.00	20.00	100.00
3.5	Nutrition Surveillance	20.00	20.00	20.00	20.00	20.00	100.00
3.6	Innovations, community based care & support	200.00	200.00	200.00	200.00	200.00	1000.00
3.7	Operational research, quality control, assessments and national set up etc.	10.00	10.00	10.00	10.00	10.00	50.00
4.	**Strengthening of Institutions**						
4.1	FNB Strengthening & regular activities	35.00	35.00	35.00	35.00	35.00	175.00
	TOTAL	**2035.00**	**2035.00**	**2035.00**	**2035.00**	**2035.00**	**10175.00**

Annexure - I

TERMS OF REFERENCE OF THE WORKING GROUP AND THE FIVE SUB-GROUPS ALONG WITH THEIR COMPOSITIONS

No. PC/SW/1-23(1)2010-WCD
Government of India
Planning Commission
(WCD Division)
***

Yojana Bhavan, Sansad Marg,
New Delhi – 110 001 Dated: 25.05.2011

ORDER

Subject: Setting up of Working Group on 'Nutrition' for Twelfth Five Year Plan (2012-17)

It has been decided by the Planning Commission to set up a Working Group on **'Nutrition'** for the Twelfth Five Year Plan under the Chairpersonship of **Secretary**, Ministry of **Women & Child Development**. The composition of the Working Group will be as follows:

1.Secretary Ministry of Women & Child Development 6th Floor,A Wing,Shastri Bhawan **New Delhi 110001.**	**Chairperson**
2.Mission Director(NRHM) Department of Health & Family Welfare 244 A,Nirman Bhavan, **Maulana Azad Marg, New Delhi**	**Member**
3.Senior Adviser(WCD) Planning Commission **New Delhi.**	**Member**
4.Senior Adviser/Adviser Health & Family Welfare **Planning Commission, New Delhi-1**	**Member**
5.Joint Secretary Department of Food Processing Industries Panchseel Bhavan, August Kranti Marg **New Delhi-49**	**Member**
6.Joint Secretary Department of Drinking Water Supply 9th floor, Paryavaran Bhawan, **CGO complex, New Delhi-110003**	**Member**

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7.Joint Secretary **Member**
Ministry of Panchayati Raj,
Krishi Bhawan
New Delhi

8.Joint Secretary **Member**
Ministry of Agriculture
Krishi Bhawan
New Delhi -110001

9.Joint Secretary **Member**
Horticulture Mission,
Min. of Agriculture
New Delhi- 110001

10.Joint Secretary **Member**
6th floor,
Ministry of Information & Broadcasting,
Shastri Bhawan, New Delhi

11.Joint Secretary **Member**
Ministry of Finance,
Vijay Chowk Road, New Delhi-110001

12. Joint Secretary **Member**
Ministry of Consumer Affairs,
Food & Public Distribution,
Krishi Bhawan, New Delhi

13.Joint Secretary **Member**
Department of AYUSH,
Ministry of Health & Family Welfare,
Nirman Bhawan, New Delhi-110001

14.Pr.Secretary **Member**
Department of Health & Family Welfare
Government of Bihar
1st floor , Vikas Bhawan, Bailey Road,
Patna- 800015

15. Secretary **Member**
Department of Women & Child Development
Government of Chhattisgarh
DKS Bhawan,Raipur-492001

-3-

16.Pr. Secretary **Member**
Dept. of Women & Child Development
Govt. of Madhya Pradesh
Mantralaya, Vallabh Bhawan
Bhopal-462001

17. Secretary **Member**
Department of Women & Child Development
Government of Karnataka
Bangalore-560001

18. Secretary **Member**
Department of Social Welfare
Government of Jammu & Kashmir
Srinagar

19.Secretary **Member**
Department of Social Security & Welfare
Government of Nagaland
Kohima-793001

20. Secretary **Member**
Department of Social Welfare
Daman & Diu Administration
Silvasa-396230

21.D.D.G **Member**
Registrar General of India
West Block 1 Wing-1, IInd Floor R.K. Puram
New Delhi-110066

22. Director General **Member**
NSSO,
East block-6level-4-7
R.K.Puram, New Delhi- 110066

23. OSD(WCD& Nutrition) **Member**
Planning Commission,
New Delhi

24. Adviser Nutrition **Member**
DGHS,
3rd Floor A-wing
Nirman Bhawan, New Delhi- 110 011

-4-

25. Representative **Member**
FSSAI
FDA Bhawan, Kotla Road,
Near Bal Bhawan
New Delhi-110002

26. Dr.T.Sudaraman **Member**
Executive Director
National Health System Resource Centre
National Institute of Health & Family Welfare Campus
Baba Gang Nath Marg, Munirka
New Delhi-110067

27. Director **Member**
National Institute of Nutrition
Jamia-Osmania,
Hyderabad-500007

28.Director **Member**
NIPCCD
5,Siri Institutional Area
Haus Khas, New Delhi -110 016

29.Director **Member**
NIHFW
Baba Gang Nath Marg, Munirka
New Delhi-110067

30. Dr. Prema Ramchandran **Member**
Director, NFI,
C-13,Qutub Institutional Area
New Delhi - 110 016,

31.Dr Arun Gupta **Member**
BP-33.Pitampura
Delhi-110034
BPNI, New Delhi

32.Sh. Manoj Kumar **Member**
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502, Trendset Towers, Road No.2,
Hyderabad-500034

-5-

33.Representative **Member**
MS Swaminathan Research Foundation
3rd Cross Street
Institutional Area Taramani,
Chennai 600113

34.Ms.Vandana Shiva **Member**
Navdanya International,A-60,
Hauz Khas, Delhi -110016

35.Dr.Vandana Prasad **Member**
Public Health Resource Network
PHRN 5A,Jungi House,ShahpurJat, ,
New Delhi-110049

36.Mr.Mukesh Kumar **Member**
BTAST
10 ,IAS colony, Kidwaipuri,
Patna-800001

37.Dean **Member**
College of Home Science
G.B. Pant Nagar University of Agriculture & Technology
Pantnagar - 263145
Dist. Udham Singh Nagar, Uttarakhand

38. Dean **Member**
Faculty of Family & Community Science
College of Home Science
M.S. University of Baroda,
Sayajigunj, Pratapgunj
Vadodara, Gujarat

39.Prof.O.P.Shukla **Member**
HOD, National Defense Academy
Khadakwasla, Pune-411023

40. Sh.Biraj Patnaik **Member**
GB Pant Social Science Institute
Jhusi,**Allahabad-211019(UP)**

41.Dr.K.Ashok Rao **Member**
Swami Sivanand Memorial Institute
Road No31,East Avenue,
East Panjabi Bag,New Delhi

42.Ms.Rekha Sinha **Member**
International Life Science Institute
Y-40B,Hauz Khas, New Delhi-110016

43.Joint Secretary (ICDS) **Member Secretary**
Ministry of Women & Child Development
Shastri Bhavan, New Delhi

II. The Terms of Reference of the Working Group:

i) To assess the magnitude of the problem of under nutrition, vitamin and mineral deficiencies, related nutrional disorders and health problems in different segments of the population, and in different regions of the country, along with trend analysis of nutrition related indicators.

ii) To review progress during the Eleventh Plan in achieving monitorable targets for reducing child under-nutrition and anemia in girls and women. To suggest how nutrition related policies and programmes can be made more effective and interventions accelerated.

iii) To recommend multi-sectoral interventions and innovative models for preventing and reducing Maternal and Child Under-nutrition in districts and states with poor nutrition and health indicators (especially in selected 200 high burden districts). (*These would include interventions related to health, drinking water, sanitation and hygiene, among others*).

iv) To recommend how optimal Infant and Young Child Feeding Practices can be promoted effectively-especially early and exclusive breastfeeding for the first six months of life.

v) To formulate a strategic approach to Nutrition Communication, including improving the monitoring and promotion of young child growth and development and counseling to change key family care behaviors, in a gender sensitive perspective.

vi) To suggest how nutritional support can be strengthened especially for the most vulnerable community groups, in the light of the upcoming interventions for enhancing household food security. Issues and interlinkages related to changes in occupational patterns,, migration, homelessness, urban poverty and public policy will also be examined in this context.

vii) To suggest a comprehensive approach for addressing Micronutrient Malnutrition, including Vitamin A Deficiency, Anemia, Iodine Deficiency Disorders and deficiencies of other micronutrients such as zinc.

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viii) To recommend how capacity can be strengthened at different levels for promoting nutrition, linking different training institutions, resource Centres, home science colleges, medical colleges and voluntary agencies, among others.

ix) To recommend measures for operationalsing a National Nutrition Surveillance System, identification and mapping of areas, pockets, community groups with high nutritional vulnerability, with interventions for addressing severe under-nutrition, linked to the health system.

x) To examine emerging issues related to over-nutrition and obesity in the context of the "dual burden" of malnutrition, related health hazards and possible control measures.

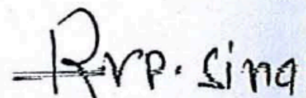
III. The Chairman of the said Working Group may co-opt other experts and constitute sub-groups for specific tasks as may be considered necessary

IV. The Working Group would be serviced by Ministry of Women & Child Development.

V. Non-official members will be entitled to TA/DA as admissible to Grade-I Officers of the Government of India and this expenditure will be borne by the Planning Commission as per SR 190(a).

VI. Travel is allowed only by Air India's flights in Economy Class or AC-II Tier by train.

VII. The said Working Group shall submit its report by the **31st August, 2011.**



Dr.R.V.P.Singh
011- 23096523
09868140600
Ramvinay@nic.in

To
The Chairman and Members including Member Secretary of the Working Group

-8-

Copy to:

1. PS to Deputy Chairman, Planning Commission
2. PS to MOS, Planning Commission
3. PS to Member Secretary, Planning Commission.
4. Ps to All Members of Planning Commission.\
5. All Pr.Advisers/ Senior Consultants/Advisers/Head of Divisions, Planning Commission
6. Plan Coordination Division, Planning Commission
7. Information Officer, Planning Commission
8. Secretary, Ministry of Women & Child Development

Rvp. Singh

Dr.R.V.P.Singh
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Composition and Terms of Reference of the Sub-Groups

SUB-GROUP I: REVIEW OF EXTENT OF NUTRITION PROBLEMS, TREND ANALYSIS & STRATEGIES		
1.	Ms. Vandana Shiva , Navdanya International, A-60, HauzKhas, Delhi	Chairperson
2.	Dr. B. Sesikeran, Director, National Institute of Nutrition , Jamia - Osmania, Hyderabad	Co-chairperson
3.	Shri. JeetLal Gupta, Commissioner cum Secretary, Department of Social Welfare, Govt. of Jammu & Kashmir, Srinagar	Member
4.	Shri. V. K. Verma, Principal Secretary (MoHFW), Government of Bihar 1st floor, VikasBhawan, Bailey Road, Patna	Member
5.	Dr Uma Joshi, Dean, Faculty of Family & Community Science, M.S. University of Baroda, Sayajiganj, Pratapgunj, Vadodara, Gujarat	Member
6.	Dr. Rama Narayanan, M S Swaminathan Research Foundation, 3rd Cross Street, Institutional Area Taramani, Chennai	Member
7.	Mr S. B. Dongre, Director, Food and Vegetable Products, FSSAI, FDA Bhawan, Kotla Road, Near BalBhawan, New Delhi	Member
8.	Ms. DeepikaShrivastava, OSD (WCD & Nutrition) Planning Commission, New Delhi	Member
9.	Prof. O.P. Shukla, HOD, National Defense Academy, Khadakwasla, Pune - 411023	Member
10.	Kumkum Marwah, JTA, FNB, MWCD, Jeevan Deep Building, New Delhi	Coordinator

Terms of Reference:

1. To assess the magnitude of the problem of under nutrition, vitamin and mineral deficiencies, related nutritional disorders and health problems in different segments of the population, and in different regions of the country, along with trend analysis of nutrition related indicators.
2. To review progress during the Eleventh Plan in achieving monitorable targets for reducing child under-nutrition and anaemia in girls and women. To suggest how nutrition related policies and programmes can be made more effective and interventions accelerated.

SUB-GROUP II: INTERVENTIONS & INSTITUTIONAL MECHANISM FOR CARE & SUPPORT OF MATERNAL & CHILD UNDER NUTRITION & SUPPORT ACTION		
1.	Dr. Shreeranjan, Joint Secretary (ICDS), Ministry of Women & Child Development, ShastriBhawan, New Delhi	Chairperson
2.	Dr. T. Sudararaman, Executive Director , National Health System Resource Centre, National Institute of Health & Family Welfare Campus, Baba Ganj Nath Marg, Munirka, New Delhi	Co-chairperson
3.	Ms. Anuradha Gupta, Joint Secretary (NRHM) , Ministry of Health & Welfare, Nirman Bhavan, New Delhi	Member
4.	Mr. C. Vishwanath, Joint Secretary , Ministry of Consumer Affairs, Food & Public Distribution, Krishi Bhawan, New Delhi	Member

5.	Mr. Jayaraman, Deputy Secretary , Ministry of Consumer Affairs, Food & Public Distribution, KrishiBhawan, New Delhi	Member
6.	Dr. Amarjit Singh, Joint Secretary , Ministry of Human Resource Development, ShastriBhawan , New Delhi	Member
7.	Shri J. S. Mathu, Secretary, Ministry of Drinking Water Supply, ParyavaranBhawan, CGO Complex, New Delhi	Member
8.	Mr. Hrusikesh Panda, Additional Secretary, Ministry of Panchayati Raj, KrishiBhawan, New Delhi	Member
9.	Shri. Sanjeev Chopra, Joint Secretary, Ministry of Agriculture, KrishiBhawan, New Delhi	Member
10.	Shri. N. C. Thur, Secretary, Department of Social Welfare, Government of Nagaland, Kohima - 793001	Member
11.	Dr. D. C. Katoch, Joint Adviser, Department of AYUSH , Ministry of Health & Family Welfare, NirmanBhawan, New Delhi	Member
12.	Ms. Deepika Shrivastava, OSD (WCD & Nutrition) ,Planning Commission, New Delhi	Member
13.	DrArun Gupta, IFBAN, 33 Pitampura, Delhi	Member
14.	Mr. BirajPatnaik, Office of Supreme Court	Member
15.	Dr. Vandana Prasad, Public Health Resource Network, PHRN 5A, Jungi House, ShahpurJat, New Delhi - 110049	Member
16.	Dr. K. Ashok Rao , General Secretary ,Swami Sivanand Memorial Institute, Road no 31, East Avenue, East Punjabi Bagh, New Delhi	Member
17.	DrNeelam Bhatia, Joint Director , NIPCCD, 5 Siri Institutional Area, HauzKhas, New Delhi	Member
18.	Representative, Ministry of Finance, Vijay Chowk Road , New Dellhi	Member
19.	Dr. Neelam Bhatia, Joint Director, NIPCCD, 5 Siri Institutional Area, HauzKhas, New Delhi	Coordinator
20.	Dr. Prema Devi, DTA, FNB, MWCD, Jevan Deep Building, New Delhi	Coordinator

Terms of Reference:

1. To recommend multi-sectoral interventions and innovative models for preventing and reducing maternal and child under-nutrition in districts and states with poor nutrition and health indicators (especially in selected 200 high burden districts). These would include interventions related to health, drinking water, sanitation and hygiene among others.
2. To suggest how nutritional support can be strengthened especially for the most vulnerable community groups in the light of the upcoming interventions for enhancing household food security. Issues and interlinkages related to changes in occupational patterns, migration, homelessness, urban poverty and public policy will also be examined in this context.

SUB-GROUP-III: BEHAVIOUR CHANGE & COMMUNICATION INCLUDING PROMOTION OF IYCF & IMS ACT		
1.	Dr. Arun Gupta, IFBAN, 33 Pitampura, Delhi	Chairperson
2.	Mr. Dinesh Paul, Director, NIPCCD, 5 Siri Institutional Area, HauzKhas, New Delhi	Co-chairperson
3.	Shri. K. D. P. Rao, Secretary, Ministry of Women & Child Development, Government of Chhattisgarh, DKS Bhawan, Raipur - 492001	Member
4.	Ms. AlkaDewan, Secretary, Department of Social Welfare, Daman & Diu Administration, Silvasa – 396230	Member
5.	Ms. SupriyaSahu, Director, Ministry of Information & Broadcasting, ShastriBhawan, New Delhi	Member
6.	Dr. MeerambikaMahapatra, Reader, NIHFW , Baba GanjNathMarg, Munirka, New Delhi	Member
7.	Dr A.S. Bawa, Director , Defence Food Research Laboratory, Khadakwasla, Pune - 411023	Member
8.	Mr. Prabhath, ATA, FNB, MWCD,Jevan Deep Building, New Delhi	Coordinator

Terms of Reference:

1. To recommend how optimal infant and young child feeding practices can be promoted effectively-especially early and exclusive breastfeeding for the first six months of life.
2. To formulate a strategic approach to Nutrition Communication , including improving the monitoring and promotion of young child growth and development and counseling to change key family care behaviors, in a gender sensitive perspective.

SUB-GROUP-IV: MALNUTRITION & OBESITY		
1.	DrPremaRamachandran, Director, Nutrition Foundation of India, Jamia – Osmania, Hyderabad – 500 007	Chairperson
2.	Dr. B. Sesikaran/ Dr. G N V Brahmam, Director/ Scientist-F, National Institute of Nutrition,Jamia - Osmania, Hyderabad	Co-chairperson
3.	Shri A. L. Meena, Joint Secretary, Ministry of Food Processing Industries, PanchsheelBhavan, August KrantiMarg, New Delhi	Member
4.	Shri. AtanuPurkayastha, Joint Secretary (Plant Coordination), Ministry of Agriculture, KrishiBhawan, New Delhi	Member
5.	Shri. C. N. Seetharam, Secretary, Department of Women & Child Development, Government of Karnataka, Bangalore – 560001	Member
6.	Dr. T. Sundararaman, Executive Director , National Health System Resource Centre, National Institute of Health &Family Welfare, Baba GanjNathMarg, Munirka, New Delhi	Member
7.	Dr. B. K. Tiwari, Adviser Nutrition, DGHS, NirmanBhawan, New Delhi	Member
8.	Sh. Manoj Kumar, Naandi Foundation, Road No. 2, Banjara Hills Hyderabad - 500034	Member
9.	Dr Rita S. Raghuvanshi, Dean , College of Home Science, G .B. Pant Nagar University	Member

	of Agriculture & Technology, Pantnagar - 263145	
10.	Ms. RekhaSinha, International Life Science Institute, Y-40 B, HauzKhas, New Delhi	Member
11.	Dr. Vandana Prasad, Public Health Resource Network (PHRN) , 5A, Jungi House, ShahpurJat, New Delhi - 110049	Member
12.	Ms. Anita Makhijani, ATA, FNB, MWCD, Jeevan Deep Building, New Delhi	Coordinator

Terms of Reference:

1. To suggest a comprehensive approach for addressing Micronutrient Malnutrition, including Vitamin A Deficiency, Anaemia, Iodine Deficiency Disorders and deficiencies of other micronutrients such as zinc.
2. To examine emerging issues related to over-nutrition and obesity in the context of the "dual burden" of malnutrition, related health hazards and possible control measures.

SUB-GROUP-V: NUTRITION SURVEILLANCE, MAPPING, TRAINING & CAPACITY BUILDING		
1.	Dr. B. Sesikaran Director, National Institute of Nutrition, Jamia - Osmania, Hyderabad	Chairperson
2.	Mr. Dinesh Paul, Director, NIPCCD, 5 Siri Institutional Area, HauzKhas, New Delhi	Co-chairperson
3.	Shri. B. R. Naidu, Principal Secretary, Dept. of Women & Child Development, Government of Madhya Pradesh, Mantralaya, VallabhBhawan, Bhopal - 462001	Member
4.	Mr. Bhaskar Mishra, Registrar General of India, West Block 1 Wing-1, 2nd floor R. K. Puram, New Delhi	Member
5.	Shri. Probir Choudhary, DDG, NSSO , Ministry of Statistics & PI, East Block, R.K.Puram, New Delhi	Member
6.	Dr. B. K. Tiwari, Adviser Nutrition, DGHS, NirmanBhawan , New Delhi	Member
7.	Mr. Mukesh Kumar, Team Leader, CARE India, Bihar Health Sector Project, Patna	Member
8.	Dr. G. N. V. Brahmam, Scientist-F , National Institute of Nutrition, Jamia - Osmania, Hyderabad	Member
9.	Mr. Surendra Singh, ATA, FNB, MWCD, Jeevan Deep Building, New Delhi	Coordinator

Terms of Reference:

1. To recommend how capacity can be strengthened at different levels for promoting nutrition, linking different training institutions, resource centres, home science colleges, medical colleges and voluntary agencies, among others.
2. To recommend measures for operationalising a National Nutrition Surveillance System, identification and mapping of areas, pockets, community groups with high nutritional vulnerability, with interventions for addressing severe under-nutrition, linked to the health system.

Annexure - II

KEY INDICATIVE ACTION POINTS FOR DIFFERENT MINISTRIES/SECTORS

MINISTRY/ DEPARTMENT	INDICATIVE ACTION POINTS	REFERENCE
1. Ministry of Women & Child Development	• Outcome oriented ICDS PIPs introduced in selected states in current FY • Inter Ministerial Group on ICDS Restructuring constituted (in mission mode with flexibility in implementation) and 2 meetings held on 12 July and 28 July 2011. Final report to be submitted. • ICDS Restructuring to strive to give greater powers to PRIs • State and district level nutrition multisectoral action plan framework developed, for 200 high burden districts, in close coordination with other sectors and presented to PMO on 30 May 2011 - To be finalised • State and District level Nutrition Councils to be set up in the above, along with interdepartmental coordination committees, thematic working groups • Nationwide communication strategy to be finalised for nutrition, in consultation with MoI&B and others; extended to district, block and village levels through interpersonal communication campaign, inbuilt in ICDS Restructuring • Universalise roll out of the new common Mother Child Card with new WHO child growth standards in ICDS, NRHM • Expedite roll out of RGSEAG SABLA in 200 districts, IGMSY in 52 districts, with an evaluation framework • Link revision of the National Policy for Children with the upcoming 12 th plan approach paper/chapter	• Minutes of PM's Council Meeting of 24/11/2010 • Minutes of the follow up meeting of 8 /12/2010 • PMO ROD of 20 May 2011
2.Ministry of Health & Family Welfare	• NRHM Village Health and Sanitation Committees expanded to include Nutrition and ICDS (in consultation with MoWCD) and states advised that these be sub committees of panchayats (MoHFW circular of 25 July 2011). Similar convergence mechanisms needed at other levels • Double Fortified Salt introduced in government feeding programmes, after PMO meeting • Expert Group constituted to prepare recommendations related to universal salt iodisation for human consumption • With MoWCD, State and district level nutrition multi-sectoral action plan framework developed for 200 high burden districts, presented to PMO on 20 May 2011- To be finalised • Protocol being developed for prevention & treatment of malnourished, severely malnourished children to be followed in health centres, and training packages • Strengthen the Nutrition component of NRHM PIPs – especially in high burden states- including nutrition status of under 3s as a lead progress indicator • Pending ICDS restructuring, issue guidelines for involving ASHAs in tackling malnutrition • Universalise roll out of the new common Mother Child Card with new WHO child growth standards in ICDS, NRHM	• Minutes of PM's Council Meeting of 24/11/2010 • Minutes of the follow up meeting of 8 /12/2010 • PMO ROD of 20 May 2011 • P 13015/10/2008 Nut & IDD dated 23rd February 2011 • MoHFW Z.18015/8/2011-NRHM-II dated 25 July 2011
3.Ministry of Human Resource Development: Department of School Education and Literacy	• Establish linkages with RGSEAG, for addressing undernutrition and anemia in both out of school and school going adolescent girls, also giving out of school girls a second chance education and learning opportunities • Strengthen ICDS convergence and linkages with primary schools, synchronization of timings/location of AWCs, where feasible and appropriate.	• MoHRD OM F.no.-3-3/2010-MDM-1-1(EE-5) dated 13/09/2010 • MoHRD letter no. F.No.3-3/2010-MDM-1-1 (EE-5) dated 15th February 2011

	• Strengthen linkages of ICDS SNP with Midday Meals in schools and specific piloting of community kitchens in innovative models within 200 districts initiative • Strengthening of nutrition education component in school curriculum and Sakshar Bharat	
4.Ministry of Agriculture	• Strengthen improvement in food and nutrition security through National Food Security Mission, National Horticulture Mission (NHM)and Horticulture Mission for North East and Himalayan States (HMNEH) • Strengthen convergence of Rashtriya Krishi Vikas Yojana with other schemes such as MGNREGA, BRGF, SGSY for improving livelihood and food security of nutritionally vulnerable groups • Support for kitchen gardens in AWCs as village demonstration sites	• MoA letter F.no.-1(4)/2010-NGRCA dated 19/11/2010 • MoA letter F.No.33-125/2009-Hort dated 30 March 2011 • MoA letter F.No.1(4)/2010-NGRCA dated 15 June 2011
5.Ministry of Consumer Affairs, Food & Public Distribution Department of Food & Public Distribution	• Expedite finalisation of draft National Food Security Act, with other sectors • Ensure food & nutrition security at the household level by making the essential food grains (rice, wheat, and coarse grains), edible oils and sugar available through the Targeted Public Distribution System. • Effective implementation of TPDS along with reform measures, tools / measures for strengthened monitoring, on an ongoing basis • Support for piloting of community grain banks in high burden districts, based on district plans in identified states	• Mo CA F&PD OM .no.-8-3/2009-BP II dated 22/06/2010 • Mo CA F&PD OM .no.-8-3/2009-BP II dated 7March 2011
6.Ministry of Food Processing Industries	• Promote processing of locally available nutritious foods through training of women's SHGs/Federations (564 FPTCs in 2010-11) and use this for nutrition communication • Cater to cluster development for nutritious food preparation	• MoFPI OM F.no.-1/FF/2010 dated 25/08/2010 • Letter No. 1/Food Fortification/2010 dated 7April 2011
7.Ministry of Rural Develoment Department of Rural Development	• Strengthen implementation of the enabling provisions for women and child care under MGNREGA, with piloting in remote and tribal areas • Amendment of MGNREGA guidelines to include AWC construction as a permissible work to be considered • Encourage use of BRGF funds for strengthening nutrition interventions, AWC and HSC construction • Link Women's SHGs, NRLM with provision of SNP in ICDS where locally feasible	• MoRD OM F.No. 1- 12011/9/2010-SGSY C dated 23/07/2010
Ministry of Drinking Water & Sanitation	• Progressively ensure provision of toilets and safe drinking water supply in all AWCs. HSCs and schools • Strengthen component for ensuring hygiene improvement under TSC • Training and IEC activities under TSC, NRDWP, NRHM and ICDS to be linked and coordinated, including training of Village Water and Sanitation Committees	• MoRD letter no. A-11012/19/2010-DWS(Coord) dated 23/06/2010
8.Ministry of Panchayati Raj	States advised on 31 January 2011 to - • Mainstream Nutrition in the training of PRIs –especially Women panchayat members for malnutrition free panchayats, earmarking certain wards to them • Ssupport the development of innovative district models run by PRIs within the 200 high burden districts initiative • Share best practices to support the devolution of powers related to nutrition programmes- to PRIs in all states • States asked to hold a special Gram Sabha meeting dedicated to Nutrition in every gram sabha between 15 -31 August 2011. • Re above-one of the first positive responses has come from J & K. Others include AP, Karnataka, Assam, Bihar, Chhattisgarh, Haryana, HP, MP, Maharashtra, Sikkim Jharkhand, Tripura A&N islands.In process in Punjab, Rajasthan, TN, Orissa • Mo I&B advised to coordinate publicity of the above through Akashvani and Doordarshan	• Minutes of PM's Council Meeting of 24/11/2010 • Minutes of the follow up meeting of 8 /12/2010 • PMO ROD of 20 May 2011 • MoPR DO No.N-11019/5/2010-WCD/PMEYSA dated 16 /11/2010 • Circular to states N-11019/5/2010-WCD /PMEYSA dated 31st January 2011 • Circular to states N-11019/5/2010-WCD /PMEYSA dated 29 June 2011 • Letter N-11019/25/2010-WCD /PMEYSA dated 8 July 2011

	• Especially in disturbed and other special areas- ○ Gram panchayat should be the actual delivery agency for PDS of food grains ○ Ward Sabha and Ward members should take up issues of absentee school teachers, dropout children and missing children-including girls ○ Supervision and monitoring to be led by gram panchayat or its sub committee • States which donot have gram panchayats like bodies should constitute the same	• Note of AS MoPR handed over on 28 July 2011
9. Ministry of Housing and Urban Poverty Alleviation **Department of Urban Poverty Alleviation**	• Allocation of land/building for AWC especially in urban poor settlements • Inclusion of nutrition safety nets in resettlement plans for migrant and unrecognised urban poor groups • To support the development of innovative city model/s run by ULBs within the 200 high burden districts initiative, linked to JNNURM • Piloting of community canteens for urban poor, based on plans • All actions by Ministry can be effected only through State Governments, as Urban Water Supply and Sanitation is a State Subject and a function of the Urban local bodies	• Letter no. Z-16024 / 22 /2010-PHE- II dated 15 June 2010 • DO No. A-46020/127/2010-Coord dated 15 April 2011
10. Ministry of Urban Development	• Progressively ensure access to physical amenities like potable water supply, sewerage, sanitation and drainage for all -including the urban poor through JNNURM –to be placed in 12th Plan Working Group • Nutrition related concerns to be integrated in the second phase of JNURM, during the Twelfth Plan period, with the incorporation of child friendly criteria	• DO No. A-46020/127/2010-Coord dated 15 April 2011
11.Ministry of Social Justice & Empowerment	• Strengthening nutrition interventions in existing MSJE schemes, with appropriate budgetary allocation • MSJE may obtain technical advice and engage with technical institutions such as NIN, FNB on the quality and nutritional value of food being provided in institutions being run under the Ministry for the disadvantaged child groups, including those with disabilities, SC/ST/ OBC. • Piloting of community destitute feeding centres, based on district plans	• Not yet received
12.Ministry of Labour & Employment	• Undertake review relating to provisions for special target groups like women and children, seasonal/migrant labour to strengthen nutrition related components • Strengthen implementation of provisions for maternity protection and child care support • Strengthen implementation of Rashtriya Swasthya Beema Yojana and also use RSBY cards as an opportunity for nutrition education/IEC to BPL families • Take up with MoHRD to ensure that some states which are not getting the benefit of MDM obtain the same	• letters dated 25th January 2011 and 18th March 2011 • DO No.Y-12015/1/2000-CL(Pt)
13.Ministry of Information & Broadcasting	• Facilitate a nationwide IEC and intensive media campaign along with MoWCD • Review of Uplinking/Downlinking guidelines 2005 to consider makingit mandatory for the private satellite television channels to carry advertisements/public messages in the public interest • Allocate free time for communicating nutrition messages during the prime time on Doordarshan • Facilitate use of Community Radio Services for conveying important messages on health & nutrition	• Minutes of PM's Council Meeting of 24/11/2010 • MoI&B DO No. 3105/65/2020-BC-III dated 23/06/2010 • PMO ROD of 20 May 2011
14.Ministry of Tribal Affairs	• Nutrition interventions for Tribal Areas to be reflected as a part of Tribal Sub Plan – especially in selected high burden districts • Special focus to be given to PTGs (particularly vulnerable tribal groups) • Construction of AWCs as a comprehensive mother and child care centre, and HSCs to be funded from Tribal Sub Plan- esp in LWE areas with large infrastructure gaps • MoTA may obtain technical advice and engage with technical institutions, such as NIN, FNB on the quality of food	• Not yet received

	and their nutritional value being provided in institutions being run under the Ministry	
15.Ministry of Minority Affairs	• Construction of physical infrastructure for Anganwadi services and Health care services under MSDP	• MoMA letter No.3/58/2010-pp-I (Pt) dated 21 June 2011
16 .Ministry of Environment and Forests	• Inclusion of nutrition safety nets in resettlement plans for displaced populations • Review and strengthen steps for enhancing nutritional security through improved forest/crop diversification and environmental security	• Not yet received
17.Ministry of Youth Affairs and Sports	• Mobilise youth groups for nutrition communication campaign (IEC) • Strengthen youth groups for supporting malnutrition free panchayats/communities through training /orientation	• Not yet received although commitment made
18. Ministry of Statistics and Programme Implementation	• Share best practices/ examples of the use of MPLADs funds for nutrition interventions, AWC construction etc. • Position nutrition status of children under 3 years as a lead progress indicator for reviews at national/state/division/district levels, for relevant sectors	• MoSPI letter dated 25th February 2011

Annexure - III

INSTITUTIONAL ARRANGEMENTS: LINKAGE WITH NUTRITION COUCILS AT DIFFERENT LEVELS