

A Landscape Analysis of Nutrition Initiatives in Madhya Pradesh: Policies, Actors, and Networks

Report

No. 4 | March 2014

Led by IFPRI

Partnership members:

Institute of Development Studies (IDS)

OneWorld South Asia (OWSA)

Public Health Foundation of India (PHFI)

Save the Children

Vikas Samvad



This study was led by PHFI

WRITTEN BY

Vijayluxmi Bose, Sunaina Batra-Dua, Subhadra Menon, Shivani Mathur, Gina Sharma, Kavita Chauhan

SUGGESTED CITATION

Bose, V., S. Batra-Dua, S. Menon, S. Mathur, G. Sharma, and K. Chauhan. 2014. *A Landscape Analysis of Nutrition Initiatives in Madhya Pradesh: Policies, Actors and Networks*. IFPRI: Delhi, India.

ABOUT POSHAN

POSHAN (Partnerships and Opportunities to Strengthen and Harmonize Actions for Nutrition in India) is a 4-year initiative that aims to build evidence on effective actions for nutrition and support the use of evidence in decisionmaking. It is supported by the Bill & Melinda Gates Foundation and led by IFPRI in India.

This Report has been prepared as an output for POSHAN, and has not been peer reviewed. Any opinions stated herein are those of the authors and do not necessarily reflect the policies or opinions of IFPRI.

Copyright © 2014, International Food Policy Research Institute. All rights reserved.

To obtain permission to republish, contact ifpri-copyright@cgiar.org.

Table of Contents

Executive Summary	vi
Introduction.....	1
Data Collection Methods.....	4
Data Analysis	7
Findings.....	8
Conclusions and Recommendations	31
Annex 1 Description of the Current Policy and Programme Landscape in Madhya Pradesh	36
Annex 2 A Protocol for Audience Research under POSHAN	56
Annex 3 Audience Research Questions	61
Annex 4 Thematic Data Analysis Plan	64
Bibliography.....	68
Figures and Tables	
Figure 1 Theory of change	3
Figure 2. Stakeholder map, Madhya Pradesh	16
Figure 3 State NRHM PIP planning process.....	41
Figure 4 Flow diagramme of the S-PIP process	51
Figure 5 Advertisement from the Ministry of Panchayati Raj on special Gram Sabha meetings on nutrition	54
Table 1 Madhya Pradesh child health and nutrition indicators	1
Table 2 Actors identified during the Net-Map meeting (Bhopal, MP, on August 18, 2012).	17
Table 3 Sources of evidence cited as used by stakeholders.....	21
Table 4 eople, agencies, and organisations contributing to knowledge mobilisation in Madhya Pradesh	24
Table 5 Severity of hunger in various states of India.....	37

List of Abbreviations

ABM	Atal Bal Arogya Evam POSHAN Mission
ANM	Auxiliary Nurse Midwife
ASHA	Associated Social Health Activist
AWC	<i>Anganwadi</i> Centre
AWW	<i>Anganwadi</i> Worker
BCC	Behaviour Change Communication
CROMP	Child Rights Observatory of Madhya Pradesh
DAP	District Action Plan
DFID	Department for International Development
DLHS	District Level Health Survey
FRU	First Referral Unit
GHI	Global Hunger Index
GoI	Government of India
GoMP	Government of Madhya Pradesh
IAP	Indian Association of Paediatricians
ICDS	Integrated Child Development Services
IDS	Institute of Development Studies
IEC	Information, Education and Communication
IFA	Iron Folic Acid
IFPRI	International Food Policy Research Institute
IMR	Infant Mortality Rate
ISHI	India State Hunger Index
IYCF	Infant and Young Child Feeding
MGNEGA	Mahatma Gandhi National Rural Employment Guarantee Act
MIS	Management Information Systems
MLA	Member of Legislative Assembly
MMR	Maternal Mortality Ratio
MOHFW	Ministry of Health and Family Welfare
MP	Madhya Pradesh
MPTAST	Madhya Pradesh Technical Assistance Team
NCPCR	National Commission for Protection of Child Rights
NFHS	National Family Health Survey
NGO	Nongovernmental Organisation
NIN	National Institute of Nutrition
NRC	Nutrition Rehabilitation Centre
NREGS	National Rural Employment Guarantee Scheme
NRHM	National Rural Health Mission
PDS	Public Distribution System
PH&FW	Public Health and Family Welfare
PHC	Primary Health Centre
PHFI	Public Health Foundation of India
PIP	Programme Implementation Plan
POSHAN	Partnerships and Opportunities to Strengthen and Harmonise Actions for Nutrition in India
PRI	<i>Panchayati</i> Raj Institutions
RCH	Reproductive and Child Health
RTF	Right to Food Campaign
RUTF	Ready to Use Therapeutic Food

SAM	Severe Acute Malnutrition
SHG	Self-Help Group
SNP	Supplementary Nutrition Programme
SO	Strategic Objective
S-PIP	State Programme Implementation Plan
SRI	Stakeholder Research Interview
SSA	Sarva Shiksha Abhiyan
THR	Take Home Ration
TSC	Total Sanitation Campaign
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VHED	Village Health and Education Day
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee
VHSNC	Village Health Sanitation and Nutrition Committee
WCD	Women and Child Development
WHO	World Health Organization

Executive Summary

The silent scourge of undernutrition and major nutritional deficiencies of public health importance persists across India despite decades of planned programmes and interventions. The maternal and child undernutrition scenario in India represents a complex set of determinants, including poverty, lack of knowledge, and access. Other factors that confound this dangerous interplay of barriers are erosion of conventional food consumption patterns exacerbated by poor hygienic practices, diseases such as malaria and diarrhoea, and lack of access to safe water and sanitation. Women's health issues, including repeated pregnancies, poor infant feeding and childcare, and low awareness of appropriate practices, are also responsible for malnutrition among communities. These determinants impede effective and sustained programme implementation and constantly challenge policy design, providers and field workers' knowledge, and the capacity to effectively deliver services.

Madhya Pradesh fares poorly across indicators of nutrition, relative to other states in India, and there is wide disparity within the state. The prevalence of undernutrition is the highest in Madhya Pradesh (55 percent), followed by Bihar, Orissa, Uttar Pradesh, and Rajasthan as per UNICEF studies (UNICEF 2013), with National Family Health Survey (NFHS-3) data recording 60 percent of children under the age of three years as underweight in the state. According to the India State Hunger Index, Karnataka has the highest prevalence of calorie undernourishment (28.1 percent), while Madhya Pradesh has 23.4 percent, Rajasthan has 14 percent, and Punjab has 11.1 percent. A number of reports and surveys, including the NFHS-3, highlight the need for substantial improvement in the nutritional status of children under six in Madhya Pradesh.

The Madhya Pradesh state-level response has made some progress in alleviating the problem of undernutrition through a dedicated mission called the *Atal Bal Arogya Evam* POSHAN Mission (ABM). As in Maharashtra, where the *Rajmata Jijau* (Mother-Child Health and Nutrition Mission) and Karnataka Nutrition missions exist, the ABM seeks to facilitate significant investment of finances, administration, and human capital essential for addressing undernutrition in a focused manner and for scaling up promising nutrition interventions. This is in addition to several government of India (GoI) policies that address undernutrition, such as the National Nutrition Policy, vitamin A supplementation policy, guidelines related to Infant and Young Child Feeding (IYCF), and the Operational Guidelines for Facility-Based Management of Children with Severe and Acute Malnutrition (SAM), which are followed in most states.

Improving and supporting policy and programme decisions and actions have the potential to accelerate reduction in maternal and child undernutrition at the national level and in two states, namely Madhya Pradesh (MP) and Uttar Pradesh (UP). The aim of the POSHAN initiative is to bring together a range of stakeholders to share information and provide evidence-based knowledge related to nutrition in a usable format to inform and guide policy action and programme implementation. In order to support evidence-based policy formulation, it is important to understand the policy and programme landscape at the state level.

The Health Communication Division at the Public Health Foundation of India (PHFI) has led the state landscape analysis in MP (with inputs from the International Food Policy Research Institute [IFPRI], New Delhi and the Institute of Development Studies [IDS], Sussex) to gain an understanding of the ways in which knowledge and evidence are used in formulation and execution of nutrition policy and programmes, to assess stakeholder perspectives on engagement, and to examine the ways in which knowledge-to-action pathways may be

strengthened in the state in the coming years. This effort is part of the inception or scoping phase of POSHAN.

The landscape analysis included a desk review of the policy and programme interventions of the ABM since it was launched in 2010, its inclusion of the Integrated Child Development Scheme and ongoing efforts of the National Rural Health Mission (NRHM), and a series of interviews among key stakeholders. The findings from the desk review and stakeholder research interviews (SRIs) presented in this report will contribute to a knowledge management strategy that will in turn help shape the landscape within which programme and policy decisions are discussed and implemented in MP and prioritise state-level action for the next phase of the project. The overarching goal of this effort is to develop pathways that will focus attention on evidence and its use, generating demand for more evidence-based programming for improved nutrition in the state and at the national level.

The study sought to identify ways in which extant knowledge was used for decisionmaking and programme planning (with a focus on the ABM and Reproductive and Child Health Programme Phase II [RCH-II]) by a range of stakeholders directly concerned with nutrition programme planning and implementation. These processes have generated an understanding of key issues that facilitate or hinder successful implementation of interventions in terms of extant knowledge, and the evidence and formats in which knowledge and advocacy are acceptable and perceived useful by the leadership and stakeholders.

The study also attempted to understand the environment in which decisionmaking for nutrition programmes was undertaken, the barriers and facilitators to the use of information, and credible and useful formats for information sharing, and thus provide some glimpses of the knowledge sharing and learning environment.

The desk review of nutrition-related policies revealed that MP follows several national policies and guidelines (the National Nutrition Policy, the Policy on the Control of Nutritional Anaemia, the Policy on the Elimination of Vitamin A Deficiency through Vitamin A Supplementation, the IYCF Guidelines, and the Guidelines for the Facility-Based Management of SAM) administered through schemes implemented by the ABM and the RCH-II of the NRHM. These schemes are implemented in a decentralised manner through the Rajiv Gandhi (RG) Mission on Community Health and aim to provide a set of services at the village level, district health societies, and *Rogī Kalyan Samitis* (RKS), which target improved service delivery, health systems strengthening, and community outreach under the NRHM.

The landscape analysis was followed by state assessments in MP. SRIs were preceded by a Net-Map meeting that brought academia, civil society, public health practitioners, and media together for a facilitated process that resulted in a Net-Map indicating key stakeholders and relative power/influence with respect to the nutrition policy, programme environment, and decisionmaking in the state. One-on-one key informant interviews were scheduled based on these preliminary findings and various views and perspectives were shared as a result.

Key Findings from the Landscape Analysis

- Evidence of the use of current data and extant knowledge is sparse in the ABM and NRHM documents (only NFHS-3, DLHS-3, and NIN survey data cited some evidence of state consultations during District Action Plans). However, stakeholders were able to narrate and describe consultations and meetings that led to the development of the plans and programmes. SRIs revealed that this may be related to a culture of

not using data and limited capacities of field staff to conduct data analysis, interpret data, and generate evidence-based information to guide action. Gaps in policy and programme review are related to the underutilisation of extant knowledge and consultation with a broad range of stakeholders. Respect for local knowledge and practices as well as learning from the community, other states, and national and international research and practices were other priorities that were mentioned during SRIs, but are not present in the documents reviewed.

- There is a need for convergent action at the field level, especially in the first 1,000 days of life. Health and Integrated Child Development Services (ICDS) departments need to work more closely with other allied departments, including Water and Sanitation, the National Rural Employment Guarantee Scheme (NREGS), Agriculture, Tribal Affairs, and the Public Distribution System (PDS), to tackle undernutrition. Although convergence is mentioned in the ABM document, the language is recommendatory rather than strategic.
- Knowledge mobilisation to support programme planning and implementation calls for dissemination of concise information using physical knowledge networks and community-based organisations as potential knowledge hubs. Stakeholders mentioned sharing evidence-based information digests and interpretation of data (relevant and informative materials in Hindi and English not only through websites but also through printed/PDF versions) contextualised to the district level as an immediate action to tackle knowledge-practice gaps. Lack of familiarity and limited access to technology-based platforms were cited as a barrier to virtual knowledge-sharing networks.
- A wide range of stakeholders (NGO representatives, public health specialists, and media) are aware of the need for evidence-based decisionmaking and the importance of current knowledge and local initiatives; however, a sustained knowledge-sharing effort is required to put nutrition on the state agenda as it has been in the past, especially with media acting as a powerful advocate for change (nutrition was part of an election manifesto in the state).
- Community mobilisation and information, education, and communication (IEC) are detailed strategies in the ABM vision document. The NRHM documents mention Village Health and Nutrition Days (VHNDs), but if indeed these are being implemented, based on evidence and extant knowledge or examples of good practices, they were not mentioned during SRIs. However, building the capacity of frontline workers for nutrition counselling and community-based management of SAM was identified as a way forward in strengthening knowledge transfer towards assimilation of knowledge, negotiation of multiple priorities and challenges, collection and analysis of data, and data application at the grassroots level.
- The landscape analysis found that although programme guidelines were detailed in the ABM and NRHM documents, a broad, multisectoral view of nutrition security in the state was lacking. The stakeholders pointed out implementation gaps, including lack of uniformity, insensitivity to sociocultural issues, lack of convergence with other programmes, lack of community monitoring, and noninvolvement of the local leadership and community voices in addressing the multiple determinants of undernutrition. These findings have created a strong rationale for using knowledge on nutrition for capacity building, information sharing, and advocacy to strengthen community participation and enhance communities' access to services.

- Civil society representatives felt that they should have a voice in national policy formulation because the state was responsible for implementation. Using, repackaging, and presenting state survey data from the National Institute of Nutrition (NIN) was mentioned as the need of the hour in order to achieve dissemination of information to decisionmakers and programme implementers in user-friendly formats in the local language. Translating knowledge of the specific nutrition needs of tribal populations into policy actions while building dialogue with legislators, media, and panchayats were key issues raised regarding sustainability of state efforts to tackle undernutrition

Introduction

India's report card for improvements in child health and nutrition leaves much to be desired, despite policy and political commitments at the highest level. The country is unlikely to achieve the Millennium Development Goals, as it bears the weight of the greatest global burden of maternal, neonatal, and child deaths and undernourished children. Undernutrition is the cause of one-third to half of the deaths among children aged less than five years (Paul and Singh 2011). However, with investments in child health and nutrition through government schemes and programmes, and overall socioeconomic progress in the country, slow and steady improvements are coming about in most states.

“India has a unique opportunity now to improve the health and nutritional status of its people. The country is in a position to invest increasing amounts of resources in social sectors as a result of economic progress. With recognition of the importance of health and nutrition for national development, the prospects for improved and equitable health and nutrition are now better than they have ever been.”

Source: Paul and Singh 2011.

Madhya Pradesh (MP) is one of the few states in India that has a nutrition mission (*the Atal Bal Evam Arogya POSHAN Mission*, or ABM), bringing health and nutrition under a common umbrella of interventions and representing a unique partnership between two important departments critical for nutrition and early childhood care and development: the Department of Health and the ICDS. The state is also attempting a decentralised model of service delivery (including healthcare services). These developments make MP a very interesting site for this study led by POSHAN. The questions raised by this study were pertinent to the use of knowledge and evidence in programme planning and implementation documents and the degree to which schemes and initiatives resonated with stakeholder needs at the ground level.

Table 1 shows comparative figures of major child health and nutrition indicators for the state.

Table 1 Madhya Pradesh child health and nutrition indicators

Mortality rates	
Infant mortality rate (per 1,000 live births)	70
Neonatal mortality rate (per 1,000 live births)	45
Under-five mortality rate (per 1,000 live births)	94
Malnutrition in children under the age of five years	
Underweight (weight for age)	60
Wasting (weight for height)	35
Stunting (height for age)	50
Severe wasting (weight for height <- 3SD)	12.6

Indicators DLHS-3 (percent)	
Infant and young child feeding practices	
Initiation of breastfeeding within 1 hour (based on births in last five years)	43.1
Mortality rates	
Children (0–5 months) exclusively breastfed	51.5
Children (6–9 months) receiving solid/semisolid food and breast milk (6–23 months)	39.6
Immunisation status	
Fully immunised children (12–23 months)	36.2

Source: ABM Vision Document 2020, p. 6.

MP has also made major changes in governance structures and health system strengthening initiatives to address undernutrition by dividing the two portfolios of Nutrition and Women’s Development, establishing an independent Commissionerate for Nutrition and the ICDS at the state level, and introducing decentralisation of services and universalisation of ICDS at the district level. It is important, therefore, to understand the relevance of planning state-level actions to tackle undernutrition, especially in the context of ABM and the Programme Implementation Plans (PIPs) of the NRHM (RCH).

The overall goal of Partnerships and Opportunities to Strengthen and Harmonise Actions for Nutrition in India (POSHAN) is to improve and support policy and programme decisions and actions to accelerate reductions in maternal and child undernutrition in India. The initiative seeks to bring diverse stakeholders together and actively facilitate dialogue, evidence building, learning, and consensus building, with the goal of moving knowledge into practice in diverse contexts within India. POSHAN will support existing initiatives, action networks, consortia, and coalitions, with the primary goal of strengthening evidence-based dialogue and action.

POSHAN Approach in Madhya Pradesh

As a contribution to the introductory/scoping phase, to understand the policy-programme linkages and the operationalisation of programmes, and to gather inputs on the implementation landscape in the state, PHFI undertook a landscape analysis of nutrition-related initiatives in MP. This was followed by field assessments to identify key partners and stakeholders for the purpose of developing current perspectives regarding opportunities and barriers to knowledge mobilisation. As part of the vision of at-scale delivery of evidence-based, contextually relevant, feasible, high-impact interventions, it is imperative that efforts like POSHAN actively facilitate dialogue, evidence building, and learning. This is the broad approach that POSHAN adopts at the state level.

The landscape analysis identified key stakeholders, existing initiatives, and physical and virtual networks working in food security and nutrition, with the primary goal of strengthening evidence-based dialogue and action. The study also attempted to understand strategies currently used to mobilise evidence-based and actionable

knowledge, some methods of knowledge uptake, stakeholders' awareness of knowledge systems and networks, and new and existing dissemination platforms that are required to make information and knowledge available to policy- and decisionmakers.

Objectives and Methodology

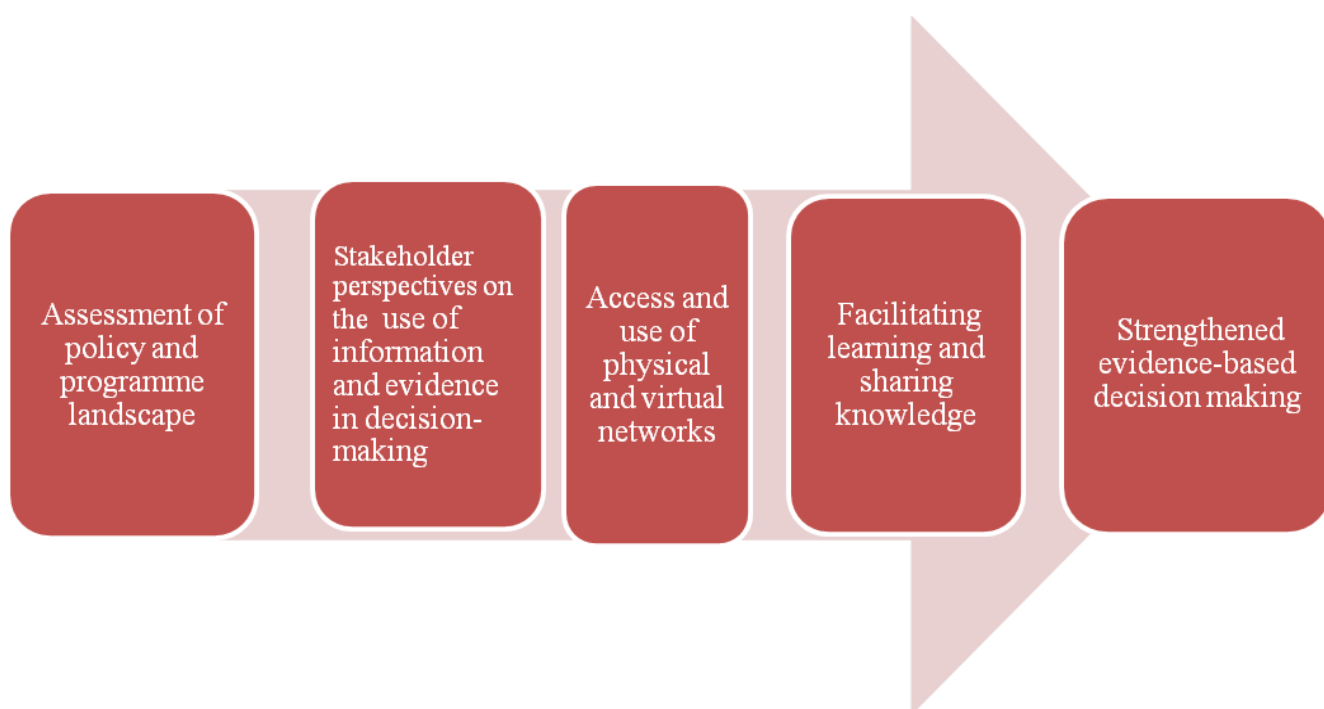
The objectives of the landscape analysis in MP were to:

- synthesise state-level policies and programme guidelines so that they appreciate the use of evidence in shaping policy and implementing programmes, and
- identify stakeholders and obtain an overview of the ways in which they:
 - perceive the need for evidence;
 - practice their ability/facility to use information, knowledge, and evidence;
 - use diverse modes and types of decision support;
 - participate in key knowledge mobilisation and decisionmaking processes; and
 - perceive barriers and opportunities to utilising knowledge for policy or decisionmaking processes.

Contribution to POSHAN's Theory of Change

The POSHAN landscape analysis seeks to understand the ways in which knowledge is used for nutrition policy formulation, programme planning, and implementation in order to create a demand for evidence among stakeholders. The underlying critical assumption is that strengthened evidence-based decisionmaking has a positive impact on tackling undernutrition.

Figure 1 Theory of change



Data Collection Methods

The POSHAN landscape analysis led by PHFI in MP had two components:

- Assessment of the current policy and programme environment in MP through a desk review of policies and government-led nutrition initiatives in the state using secondary data sources
- Primary data collection through stakeholder research interviews to identify key partners and inform the knowledge mobilisation strategy

Desk Review of State Policies and Programmes

A review and summarisation of documents from the ABM and NRHM available online was conducted. The landscape analysis provides an overview of the PIP processes in ICDS and NRHM, and initiatives for reducing maternal and child undernutrition in the state, such as decentralisation and universalisation of ICDS. The most recent documents (pertaining to current plans) were accessed from August–October 2012 and compiled. Unpublished documents, such as the ABM presentation shared with PHFI (by the GoMP), were also included in the landscape analysis. The main activities under this effort were:

- Web search
 - Websites visited:
 - MoHFW (www.mohfw.nic.in)
 - NRHM (www.mohfw.nic.in/NRHM.htm)
 - Madhya Pradesh websites (www.mp.gov.in)
 - Online reports and publications were searched using the following keywords:
 - *Atal Bal Arogya Evam* POSHAN Mission (ABM)
 - Madhya Pradesh Department of Women and Child Development
 - NRHM Programme Implementation Plan 2012–13
 - Madhya Pradesh District Action Plan
 - Madhya Pradesh District Health Action Plan
 - Undernutrition programmes/plans/Madhya Pradesh
 - Childcare
 - Severe acute malnutrition
 - Coverage Evaluation Survey
 - Maternal health and nutrition
 - Reproductive and child health
 - DFID/MPTAST (Madhya Pradesh Technical Assistance Team)
 - UNICEF

All the documents related to ABM and PIPs of the NRHM and ICDS were downloaded. The criteria used to summarise the documents were:

- operationalisation of national policies and programme guidelines for nutrition initiatives in the state;

- use of evidence, extant knowledge, and reference to key events (if any) that informed formulation of programme guidelines; and
- assessment of whether information and facts were contextualised to undernutrition in the state.

Stakeholder Research Interviews (SRI)

The SRI study design received clearance from the PHFI Institutional Ethics Committee. This was followed by a preliminary Net-Map exercise to identify stakeholders in MP. This method is a participatory interview technique, combining social network analysis, stakeholder mapping, and power mapping. It is intended to help visualise and understand situations in which many different actors influence outcomes (<http://netmap.wordpress.com/about>).

The objectives of the Net-map Exercise were to:

- identify government organisations, nongovernment organisations, academics, researchers, media, and public health practitioners for the SRIs in the state; and
- understand the networks of stakeholders in MP.

The Net-Map meeting was conducted in partnership with the POSHAN lead organisation, the International Food Policy Research Institute, New Delhi and the Institute of Development Studies, Sussex.

Study Design

- **Sample selection:** A small group of stakeholders was selected from the stakeholder mapping list, depending on their willingness to take part in the SRIs and their knowledge about nutrition policy and programmes in the state. Since the primary goal of the SRIs was detailed assessments of critical stakeholders to learn more about their engagement with evidence (as represented by information and knowledge), with a view to strengthening decisionmaking, some of the actors on the Net-Map were contacted for stakeholder research interviews. Criteria for selection were familiarity with nutrition issues, state policy formulation, programme planning, and implementation landscape.
- **Recruitment of respondents:** Selected stakeholders were contacted by telephone and email. A mutually convenient date was set for the interview and the PHFI-IFPRI-IDS team conducted the interview (PHFI led the interviews and the other organisations supported them). The stakeholders were selected from varied backgrounds and their verbal/written permission was obtained prior to conducting the interviews. Table 2 shows the list of stakeholders.
- **Questionnaire development:** Following PHFI Institutional Ethics Committee clearance, POSHAN partners developed a set of sub-questions (probes) that were inserted in the questionnaire. These sub-questions were meant to elicit views and opinions of participants and were based on the desk review of the policy and programme development landscape in MP.
- **Interviews:** The interviews were audio recorded after taking verbal consent from respondents. In cases where the interviewee declined audio recording, verbatim notes were taken. In fact, verbatim notes were taken of all the interviews in addition to audio recordings.

- **Transcription of interviews:** Interviews were transcribed and the sections of the interview in Hindi were translated into English. The transcribed text was cross-checked while listening to the audio tape to ensure accuracy.

This study recognises that stakeholder engagement during the course of research and policymaking is essential for strengthening the research-policy interface, and may act as a mediator in facilitating change (Hyder et al. 2010). Based on this understanding, stakeholders represent a primary source of information.

Data Analysis

- **Coding SRI transcripts:** Open coding was used to analyse transcripts. This activity entailed the processes of breaking down, examining, comparing, conceptualising, and categorising data (Strauss and Corbin 1990). An identical process was initiated by POSHAN at the national level and the same code sheet was used for the state SRIs.
- **Ensuring inter-coder reliability:** To ensure the reliability of data, the same SRI transcripts were coded by multiple coders. When coders (using the same codebook) agree on the coding of a text, the codebook is considered a reliable instrument (i.e., one that facilitates inter-coder reliability) for measuring the thematic content of a specific body of texts. Since the written text was already divided into “codable” segments (see Annexure 4), the text does not change, but the interpretation derived from the written text does. This is why inter-coder reliability is essential for reaching a shared meaning of the text. Two coders read and coded the same text, first independently and then together, to arrive at a common code for the assigned text (Bryman and Burgess 2002).
- **Interpretating findings:** The policy and programme implementation findings were interpreted alongside findings from the SRIs and a set of conclusions were derived. These findings shall inform the work that POSHAN plans in the state.

Findings

Madhya Pradesh (MP) is one of the poorest states in India, with a high burden of undernutrition (National Sample Survey Organisation 2007). According to the India State Hunger Index, MP has 23.4 percent prevalence of calorie undernourishment and 60 percent of children less than three years are underweight. Nutrition programmes are administered through multiple government agencies and their schemes, supported by development partners (a detailed description is enclosed in Annexure 1).

The primary foci of the NRHM–RCH II programme are on management of children with severe acute malnutrition (SAM) in Nutrition Rehabilitation Centres, immunisation, and vitamin A supplementation through the services of the ASHA and the primary healthcare facility. Nutrition counselling by the auxiliary nurse midwife and the *anganwadi* worker are not primary functions under the NRHM programme. The state has trained frontline workers on infant and young child feeding (IYCF) counselling skills and breastfeeding in 22 districts. However, nutrition is not mentioned as part of the ASHA’s outreach activities during the Village Health and Nutrition Days (VHNDs), and the NRHM budget does not have an allocation for conducting the VHNDs. The desk review found several studies to support the fact that families are not adequately counselled for admission to the NRCs and that there were gaps in follow-up. The Village Health and Sanitation Committees do not include nutrition within their purview of activities.

The NRHM programme implementation plans (PIPs) mention provision of nutrition counselling as part of a package of services that includes immunisation, disease control, water, and sanitation. The desk review did not indicate a great deal of convergence of these services at the district level, so it may be inferred that provision of these services may be limited to the planning stage.

The strategic objectives in the *Atal Bal Arogya Evam* POSHAN Mission’s (ABM) Vision Document include a mention of nutrition services along with health services. The ABM has several programmes that prioritise nutrition, such as:

- the Infant and Child Nutrition Cell in medical colleges,
- maternal micronutrient supplementation and antenatal checkups,
- special nutrition programmes in 1,000 villages, and
- special programmes for tribal and high-risk districts.

The desk review found that the ABM also administers ICDS programmes such as *Anganwadi Chalo Abhiyan* (which seeks to strengthen delivery of ICDS services), *Bal Sanjeevani Abhiyan* (which addresses undernutrition among children), Take Home Rations (the supply of micronutrient-fortified food to children attending *anganwadis*), and *Sanjha Chulha* (which is a joint initiative with the Mid-Day Meal Programme). Of all these programmes, those that had provision of food at *anganwadi* centres were mentioned during SRIs.

Strengthening and restructuring the ICDS (as recommended by the Midterm Appraisal of the Eleventh Five-Year Plan and the Prime Minister’s National Council on India’s Nutrition Challenges) have found mention in the District Action Plans, but it was not evident as to exactly how much has been successfully implemented in districts and tribal areas. The role of *panchayats* in setting up *anganwadi* centres, encouraging community participation, and monitoring was mentioned in the documents reviewed, but examples were few and far between in the SRIs.

Desk Review Findings

Policy and Programmes

National Policies and Programmes Have Informed Some State-Level Initiatives

The government of MP (GoMP) has undertaken several initiatives in the past few years to address child mortality and malnutrition in the state. These programmes have been implemented by the state NRHM and ICDS, sometimes in synergy and at other times as separate initiatives. The GoMP has followed national policies and guidelines when rolling out the universalisation of ICDS, especially the SNP (covering 1,000 villages with tribal populations that was introduced in the Eleventh Five-Year Plan period), facility-based management of SAM, the anaemia control programme, micronutrient supplementation, and immunisation services. However, apart from providing nutritious food at *anganwadis*, growth monitoring, and some campaigns to encourage communities to access services, there are very few direct nutrition interventions. The state does not have a nutrition policy or infant and child feeding guidelines that are adapted to the needs of tribal populations or malnourished children.

The ABM reflects the state's attempt at restructuring and strengthening the ICDS programme consonant with the recommendations by the Inter-Ministerial Group on ICDS Restructuring, 2011. The National Advisory Council (NAC) also made recommendations for a reformed and strengthened ICDS, adopting a genuinely integrated life-cycle approach to early childhood care and development, and transforming *anganwadi* centres (AWCs) into vibrant, child-friendly, early childhood development (ECD) centres.

Recommendations of the Inter-Ministerial Group on ICDS (GoI) have been used by the state to restructure the ICDS and facilitate service delivery under the umbrella of the ABM. Although the ABM follows the Twelfth Five-Year Plan Comprehensive Working Group (GoI) recommendations that advise strengthening operationalisation of nutrition interventions within a strengthened ICDS programme, and convergence with the NRHM to benefit a maximum number of children, the focus of the programmes and schemes seems to be on malnourished and severely malnourished children, with very few knowledge- and skill-building activities and little focus on measures to prevent malnutrition.

The government of India's response to nutrition is articulated in the key priorities of the Twelfth Five-Year Plan. Institutional arrangements, implementation, and monitoring of multisectoral state and district nutrition plans of action led by state and district nutrition councils; leadership; piloting multisectoral models; efficient governance; strategic partnerships; community mobilisation; involvement of *panchayats*; and strengthening of institutional capacities have been mentioned in the Report of the Working Group on Nutrition for the Twelfth Five-Year Plan. Some of these recommendations have been adopted, and many nutrition-related initiatives have been undertaken at the state level as part of the NRHM and ICDS, based on national policies and programme guidelines. The state has adopted several national policies:

- National Nutrition Policy (1993),
- Policy on the Control of Nutritional Anaemia (1991), and
- Policy on the Elimination of Vitamin A Deficiency through Vitamin A Supplementation.

The National Guidelines on IYCF, 2004 and 2006, focus on the importance of breastfeeding, while the Operational Guidelines on Facility-Based Management of Children

with SAM (2011) are important for treating children. The Policy for Provision of Supplementary Nutrition to Women and Children (1970–1971) is also operational in the state.

Although not directly related to nutrition, various state policies formulated by MP, including the Madhya Pradesh Population Policy, Women's Policy, and Draft Drugs and Medical Supplies Policy, are indicative of the state environment for policy formulation.

Use of Data and Extant Knowledge Is Sparse

Apart from references to NFHS-3 and DLHS-3 data, NIN district-level data, and some findings from the districts, the documents are descriptions and recommendations related to schemes and formulation of PIPs. The DAPs do mention that consultations took place, and the package for tribal and high-risk districts mentions evidence of undernutrition among tribal populations; however, comprehensive programme monitoring and district-level data and evidence are lacking.

Despite sporadic mentions, overall, the evidence of the use of extant knowledge is low in the NRHM-PIPs, and mostly relate to improvement of infrastructure and facility-based care. The NRHM-PIPs provide comprehensive guidelines for inclusion of budget details and programme implementation activities. Much of the PIP for 2012–2013 is devoted to effective implementation of SAM guidelines. Although the focus is on health service delivery, maternal and child nutrition, and the importance of counselling, health education and IEC are mentioned, especially in the context of raising the demand for services among communities.

The NRHM-PIP 2012–2013 covers a mix of services and community-mobilisation efforts without any mention of priorities, human resource allocations, and monitoring indicators. Nutrition is not described in detail, and it has not been given centrality in the PIPs; the focus is on establishment of NRCs in district hospitals. The provision of hot cooked meals at *anganwadis* as opposed to Take Home Rations is contentious, owing to the issues related to raw material supplies, hygiene, and compatibility with local food consumption norms. Because this involves localised monitoring of community programmes, educating providers and workers and sensitising district administration and *panchayat* representatives are critical in delivering effective services and promoting community access to nutrition programmes. The situational analyses of DAPs could include strategies for the district administration, leaders, and providers to address such issues.

The entire ABM document is a description of various schemes and campaigns related to restructuring and strengthening ICDS, with some data but no descriptions of meetings, consultations, or other events that led to their formulation. The tone of the document is that of recommendations for action, with very little indication of guidelines for implementation with respect to diverse client groups, methods for community engagement, monitoring, and evaluation.

Reporting procedures, supervision for the implementation of the Annual ICDS District Plans, and mechanisms for provision of assistance from the state are laid out in the S-PIP. It is evident from the outline that there is ample scope for provision of data and extant knowledge of child health and nutrition in the S-PIPs. However, because the completed S-PIPs were not available at the time of the desk review, it is not apparent whether nutrition programme planning finds such detailed mention in the document.

Convergent Actions for Interventions in the First 1,000 Days Are Lacking

Strategic convergence among departments is vital for dealing with the problem of undernutrition (the impact assessment of the ICDS carried out by DFID in 2009 emphasises this, too). Both the NRHM and the ABM are potential game changers, provided they work together from the planning stage through implementation in synergy with other departments such as *Panchayati Raj*, Water and Sanitation, and the communitisation initiatives of the NRHM. The desk review indicates that the Village Health and Sanitation Committee (VHSC) does not have a nutrition focus, although the potential is clearly present for a broader engagement. Participation of Village Health Sanitation and Nutrition Committees (VHSNCs) in nutrition programmes is mentioned as part of ICDS restructuring. Although NRHM in MP is focusing on the period between pregnancy and age two of the child, only guidelines for facility-based management of SAM children and the VHSC are mentioned in targeted interventions in the documents.

The ABM represents the state's commitment to the universalisation of the Integrated Child Development Services (ICDS) and is responsible for initiatives related to growth monitoring and promotion, promotion of infant and young child feeding, strengthening of the existing supplementary nutrition programme (including the special nutrition programme in 1,000 villages), management of moderately malnourished children, and integrated management of SAM. The strategic objectives described in the ABM document emphasise the need for convergent action, evidence-based intervention, enhancement of human resources, community engagement, and information management. There are mentions of several campaigns that support the popularisation and promote access to ICDS, such as the *Anganwadi Chalo Abhiyan*, the fixing of specific days (*Mangal Diwas*) for certain activities, the provision of supplementary nutrition through cooked meals (*Sanjha Chulha*), and awareness camps (*Jagriti Shivirs*). Of all the schemes cited in the documents, however, stakeholders in the interviews mentioned only the provision of hot cooked meals and Take Home Rations (THR). This may be indicative of the fact that some of these campaigns exist only in some districts or that the actual implementation and outreach may not be uniform in all districts.

Planning for direct and indirect interventions is done through State Programme Implementation Plans (S-PIP) and District Action Plans (DAPs). Recommendations and templates for developing S-PIPs were found during the desk review (web search) for the policy and programme analysis; however, the S-PIPs themselves were not available. Proposed innovations, such as restructuring the *anganwadi* centre (positioned in the ABM document as a vibrant, child-friendly, childcare services centre to be ultimately owned by the women of the community and promoted by *panchayat* representatives), convergent actions through the Village Health and Nutrition Days (VHNDs) of the NRHM, the Total Sanitation Campaign (TSC), and community monitoring of *anganwadis* by *panchayats*, are detailed in the ABM Vision document, but stakeholders said that they were yet to see any evidence of these in the districts. ICDS remained focused on growth monitoring and supplementary nutrition to the exclusion of strategic or innovative community-led planning.

The initiatives described as part of the ABM are a mix of infrastructure strengthening, capacity building, and prevention and management of undernutrition (including management of SAM children). Despite several interventions, nutrition is not a focus area within the RCH-II programme of the NRHM. Even though this flagship health programme of the government of India provides facility-based management and care of SAM children through Nutrition Rehabilitation Centres (NRCs), promotes infant and young child feeding activities, provides vitamin A supplementation through *Bal Suraksha Mah*, and conducts VHNDs, these are indirect nutrition interventions.

The only evidence of convergence mentioned in the ABM documents was the *Sanjha Chulha* programme and plans to develop the AWC as a nodal point for early childhood education and care. Since the ABM document presents a vision, most of the initiatives are mentioned as plans; however, innovation and convergence are at the heart of ICDS restructuring efforts. Strengthening ICDS goals of community outreach and empowerment through a gamut of child-friendly services (especially for tribal areas and vulnerable populations) will re-energise the programme. At the moment, interventions for the first 1,000 days of life mentioned in the ABM and NRHM do not view convergence as essential for newborn care. In fact, at the AWC level, provision of supplementary nutrition (through hot cooked meals and THR) is the only example of convergent activity.

The review of programme implementation guidelines found that there is synergy on paper with the Department of Health and Family Welfare insofar as provision of immunisation and other health-related services by the ANM. Apart from delivering services under ICDS, AWCs also coordinate with PHCs to run programmes of the Department of Health and Family Welfare, such as vaccination, nutrition, and health education. The AWWs and ANMs are required to work in tandem and complement each other's roles and functions.

Knowledge Mobilisation and Translation to the Grassroots Level Remain Challenges

Although BCC is mentioned as being essential in bringing about changes in communities' health-seeking behaviour, the language is merely recommendatory. Platforms such as VHNDs and VHEDs provide opportunities for information provision and focused BCC and counselling, if they are planned in advance and implemented systematically. Several campaigns (for example, *Anganwadi Chalo Abhiyan*) and awareness camps (*Jagriti Shivirs*) have been introduced as part of the ABM. There is mention of strengthening community mobilisation and monitoring through village contact drives and involvement of women's groups and mothers' committees. But these seem to have remained recommendations, as the descriptions are not supplemented by tasks, roles, challenges, and implementation guidelines.

Communitisation is a potential game changer in the overall NRHM outreach process, and within that framework the *Rogi Kalyan Samiti* (RKS) is a body that links the community to health services; however, medical services continue to be the focus, and nutrition (apart from being a part of treatment services) is not seen as a public health focus area. Yet, the RKS is a potential hub of nutrition information, if some elected leaders as well as opinion makers take on the challenge of strengthening existing knowledge, motivation levels, and capacities.

Limited Data and Voices Reflected in Formulation of Implementation Strategies

It is evident that the ICDS PIP considers nutrition status to be an integral part of maternal and child health interventions at state and district levels. While the ABM mentions that outcomes of a restructured and strengthened ICDS would contribute to reduction in IMR and MMR and recommends a package of childcare services to be provided through a vibrant and child-friendly *anganwadi*, there is not enough strategic information on what needs to be done to make this happen. Although the VHND is an important strategy under the ABM Vision document, there is no fund allocation for it in the state PIP for 2012–2013, nor are strategic directives given for the integration of nutrition activities in the VHNDs. The ABM document is a series of descriptions of schemes with very little evidence of the use of extant knowledge, stakeholder voices, or current data and information.

The burden of nutrition need not be confined to facts and figures but should reflect the knowledge that exists within the Right to Food (RTF) Campaign, district extenders, and *atal bal mitras* (nutritionists) so that nutrition is mainstreamed into the PIPs for years to come. The State Programme Implementation Plans (S-PIPs) are appropriate mechanisms to plan interventions up to the block level and introduce an approach that is evidence based and innovative. The PIP process allows opportunities for POSHAN to provide strategic knowledge management inputs and evidence-based support to programme implementation at the district level. S-PIPs were not available on the MP government website (www.mp.gov.in) at the time of the study.

The ABM Vision document states some strategic objectives aimed at bringing a shift in health- and nutrition-related behaviours and supporting the preventive and promotive aspects of child nutrition and primary healthcare systems so as to achieve an expanded coverage and improve the quality of key health and nutrition services. These reflect the state government's commitment to reducing malnutrition in the state and also point to the need for departments to work closely with one another and set standards and guidelines for effective programme management at the district level. The extent to which convergent planning and action envisaged in this document has actually been implemented at the district level is not known.

The present review indicates that although the MP literature might refer to addressing high rates of malnutrition in a holistic manner through targeted high-impact critical nutrition interventions and the intergenerational reduction of malnutrition in communities through a life-cycle approach, there is very little evidence of the use of extant knowledge and data in the formulation of these schemes and programmes. The operational aspects of the programmes are missing from the documents, and prevention of acute malnutrition through correct feeding practices for infants and capacity building of service providers for nutrition counselling are some of the gaps found during the desk review. Some of these gaps were also mentioned during the SRIs.

Stakeholder Research Findings

Actors and Networks

Overview of the Net-Map Exercise

A preliminary Net-Map group exercise for nutrition stakeholders was held in Bhopal, Madhya Pradesh, on August 18, 2012, with 19 key participants from different organisations from both the state and the district levels of MP. In these interviews, respondents were led through a facilitated process that aimed to map the actors who play a role in shaping maternal and child nutrition policy and programme decisions in the state. Mapping of the overarching question "Who influences policies and programmes related to nutrition in the state of Madhya Pradesh in India?" mainly consisted of two links that captured all the discussions. The first link was the technical information link, which was defined as "either the actor provides information in the form of technical assistance or support to another organisation, or he/she generates information in the form of research and provides research-based information to another organisation." The second link captured funding, which meant "the organisation provides funding of any type or magnitude to another organisation."

This review of state policies, programme guidelines, and PIPs of the ABM and NRHM show that consistent use of up-to-date information and data is lacking. There is limited evidence in the documents that they were developed through a consultative process and that extant

knowledge was used in adapting national programme guidelines down to district contexts. The process of stakeholder research was initiated by a Net-Map meeting, which provided a glimpse of stakeholders and the extant knowledge.

Results of the Net-Mapping Exercise

The Net-Map revealed a complex landscape of 87 actors involved in MP's nutrition policy and programme landscape. The actors represented in the network include experts and influential persons from civil society, academics, development partners, and independent consultants, who support programme decisionmaking and implementation, as well as media, which have shaped some of the discourse related to malnutrition in MP (although they have not influenced programme implementation).

Even though the Net-Map captured a large number of players, only a few were in a position to help influence and shape the policy and programme discourse. The discussions reflected the need for development of an alternative food policy with stewardship from the state, although state government stakeholders did not articulate a similar need. Convergence among sectors for improvement of programme delivery was stated in the Net-Map meeting.

Convergence is articulated in the strategic objectives of the ABM Vision 2020 document (which has very specific recommendations for interlinkages with other departments). Although stakeholders mentioned that a “pro-poor” attitude among governments would help bring about convergence, the landscape analysis shows a need for more critical thinking and synergy of planning and action at the district and block levels. Integration with the NREGS or UNICEF's Water and Sanitation (WASH) programme were some examples mentioned during the SRIs. Use of data and extant knowledge emerged as major lacunae in the review of programme guidelines and schemes of the ABM and NRHM. During the Net-Map discussions it emerged that both trickle-down and bottom-up information sharing were considered key, including the use of national data sources to develop nutrition indicators and the need for evidence-based information relevant to district administration and field workers. Conducting food audits at the local level to map existing patterns of food consumption and nutrition supplementation was also raised as an important issue.

The ABM and NRHM programme documents have detailed plans for outreach to districts; thus, respondents mentioned the need for a stepwise planning process that reaches beneficiaries in far-flung pockets of the state. Operations research and concurrent monitoring of programmes are priorities for a nascent programme like the ABM. It was stated that development partners were bringing national and international expertise to conduct studies, which could then be leveraged for partnerships, knowledge sharing, and capacity strengthening. Systems strengthening was mentioned by respondents—be it for local procurement systems (rather than letting multinational companies enter the food supply arena), regular follow-up of children under ICDS, initiation of programmes to prevent malnutrition, or regulation of pesticide use and adulteration of food.

Analysis of the core nodes: The Right to Food (RTF) Campaign emerged as a core node and therefore appeared to be central to the nutrition landscape in the state. There are 86 other actors who appear in the map as periphery actors, which include many civil society organisations and NGOs that work in tandem with RTF and have an impact on nutrition policies and programmes in the state. SRIs revealed that the RTF shared information about litigation on the right to food through a network that reached districts and some blocks of the state. This has given rise to a body of knowledge about malnutrition that is reflected in media reports and advocacy with the legislature. The RTF network is an example of a good practice because its members are part of the discourse on nutrition at the national and state levels.

Apart from RTF, other actors who have a higher degree of centrality are Asian Human Rights Council, UNICEF, and the People's Alliance. The departments of WCD and PHFW are also reasonably linked, but they are mostly recipients of technical information and funding, unlike the others mentioned above, which are providers. Most of the funding of both departments appear to be from UNICEF. UNICEF also funds other smaller NGOs that are shown on the map. On the other hand, Action Aid and CRY, other international donors, appear to provide funding to smaller organisations that are shown in Figure 2. Sir Dorabji Tata Trust/Sir Ratan Tata Trust (SDTT/SRTT) provides funding to smaller organisations and to *Vikas Samvad*, the importance of which is described below. UNICEF also provides funding to *Vikas Samvad*. Of these networks, DWCD, UNICEF, and *Vikas Samvad* emerged as key players in the nutrition landscape according to the SRIs.

Vikas Samvad also has reasonable centrality. It is an important actor because of its connection through the RTF to all grassroots-level organisations. These include *Aapdha Niwaran Manch*, *Sankalp*, *Sampark*, *Gramin Vikas Trust*, *Jan Swasthya Abhiyan*, *Sahariya Jan Gath Bandhan*, *Manav Adhikar Forum*, *Gram Sudhar Samiti*, and *Bharat Gyan Vigyan Samiti*, among others shown on the map. *Vikas Samvad* works with all these organisations to collect grassroots-level information. It then compiles, analyses, and channels the information through the media to influence policy. It has been instrumental in the functioning of the People's Alliance (the other important actor on the map), which is an autonomous body that brings together all civil society organisations at the local level in MP.

The one individual who was mentioned on the map was Professor Sheila Bhambal, secretary of the Child Rights Observatory, Madhya Pradesh (CROMP). Other individuals (not on the map) with potential influence are Ms. Amita Singh, a home science specialist who supports the DWCD, and Ashish Mandal, director of Action for Social Advancement (ASA), who is also a member of the National Advisory Council. It was perceived by the participants that individuals from the government, though important, are difficult to have on the map because they keep changing positions and posts, and the degree of influence varies from person to person. Other actors who have the potential to shape nutrition policies and programmes in MP but are not on the map (due to absence of links) include ASA, Save the Children, Leader of the Opposition in GoMP, International Fund for Agricultural Development (IFAD), World Vision, *Gramin Vikas Trust*, Regional Ayurveda Research Centre, *Vijaya Raj Trust*, State Institute of Health Management and Communication, National Centre for Human Settlement and Environment, and UNDP. Dr. Bhambal was a knowledgeable and articulate key informant, and there were others in the government and civil society who participated in the nutrition and food security discourse at the state level.

The Net-Map gave an indication of the major stakeholder organisations and key informants, with some indication as to the discourse around nutrition and priority areas for knowledge mobilisation. It helped strengthen the questionnaire and design a set of probes that would deepen the interviews and inform the analysis of the findings from the review of programme guidelines and S-PIPs.

Table 2 Actors identified during the Net-Map meeting (Bhopal, MP, on August 18, 2012)

Government of Madhya Pradesh	Development partners	Civil society/NGOs	Network alliances and people's organisations	Others
<ul style="list-style-type: none"> • WCD ministers • NRHM ministers (principal & chief secretary of health) • Panchayati Raj institutions • Department of Education • Mr. Ajay Singh • Livelihood and Watershed Department • Department of Water and Sanitation • Public Health Engineering Department • Department of Finance • Department of Food and Civil Supplies • MP Rural Livelihood Mission • District collector • Commissioner of ICDS • Mission director ABM/NRHM • Medical officer • State Planning Commission • IIPS • Tribal Advisory Committee • Social Justice Department 	<ul style="list-style-type: none"> • State Commission for Protection of Child Rights • Assemblies Committee on Mahila Bal Vikas • UNICEF • DFID (poorest area civil society) • IFAD • UNDP • CRY • Dorabji Tata Trust • Action Aid • Save the Children • GAIN • Micronutrient Initiative 	<ul style="list-style-type: none"> • Bachpan • Naandi • Valid International • Sampark • Adivasi Adhikar Manch • NIPCCD • Mahila Chetna Manch • CASA • SAMARTHAN • National Centre For Human Settlement and Environment • Action for Social Advancement (ASA) • MUSKAAN • VHAI • MP TAST • Gramin Vikas Trust • Action Against Hunger • Sankalp • Spandan • Parhit • Jan Abhiyan 	<ul style="list-style-type: none"> • Jan Adhikar Manch • Birsa Munda Bhoo Adhikar Manch • RTF • Parvarish • Prayas • Microplanning Mission • Jan Swasthya Abhiyan • Vikas Samvad • Other networks: • MP Apda Niwaran Manch • Manav Adhikar Forum • Sochara • MP Lok Sangharsh Sajha Manch • BGVS • CPH • Jan Pahal • Sajag 	<ul style="list-style-type: none"> • Dr. Sheela Bhambal • BBC WST • Consultants • Media • State Institute for Health Management and Communication • State Health Resource Centre • Regional Medical Centre, Jabalpur • Tribal Research Institute – Regional Ayurvedic Research Centre

- Judiciary/legislature

- Community Development Centre
- Samaj Chetna Adhikar Manch
- Bharat Gyan Vigyan Samiti
- Madhya Pradesh Council for Child Welfare (MPCCW)

Many actors in the government are perceived to be influential and fairly supportive in shaping nutrition policies and programmes in the state. These include the Department of Women and Child Development, the commissioner of ICDS who also heads the *Atal Bal Arogya Evam* POSHAN Mission, the Chief Secretary's Office, the Chief Minister's Office, the Planning Commission, and the Department of Public Health and Family Welfare. All of these actors are mostly recipients of funding and technical information. The other influential actors in the government are the district collector and the Department of Finance, but they are not considered as supportive of nutrition policies and programmes.

It is perceived that private suppliers who provide food products to support government programmes such as the mid-day meal scheme are influential in shaping nutrition policies and programmes, though not supportive of the nutrition agenda. Their influence is seen in convincing the government to use a certain type of fortified product or iodised salt, or in altering the timings of providing meals to children, which may be suited to their convenience.

Lack of knowledge flow from the government to the grassroots level was pointed out as a reason to implement grassroots-level outreach programmes that are culturally relevant and bring the community together. Such programmes were not seen as entirely run by the community but with their involvement. The importance of using district-level data to make policies was highlighted. Administrators of the government are not perceived to be pro-poor. This was pointed out as a major hindrance in making pro-poor policies and programs. The participants strongly believed in reviving the traditional food system linked with a forest-based economy and use of local crops. The examples of replacing peanuts and chickpeas with soya in the Sahariya belt of MP and jaggery with sugar were used to exemplify the argument of how markets determine which nutritious products to consume, threatening the use of nutritious traditional foods. It was also discussed that the efforts of the NRC and ICDS in providing and disseminating knowledge on supplementary nutrition may be nullified by the lack of resources at home to implement that knowledge. The practice of conducting food audits and advocacy against child marriage were pointed out as important measures to prevent malnutrition.

Stakeholder Research Interview Findings

In order to understand the use of evidence and barriers to using knowledge in implementing programme guidelines, a series of SRIs complemented the desk review. These interviews gathered stakeholder views and experiences on the use of evidence in programme planning and implementation of policy guidelines. The findings from the Net-Map exercise were probed through detailed SRIs, where learning about the current state situation and knowledge-to-action pathways were discussed. This section documents these voices, triangulated with the findings from the policy and programme review and the opinions that serve to inform and raise the discourse around nutrition. Some of the key findings (based on inputs from respondents) are detailed below.

Extant Knowledge Has the Potential to Influence Programme Implementation

Some policies formulated at the centre (centrally sponsored schemes) are implemented by states with suitable adaptation. Usually this process has the scope to involve a broader range of stakeholders. Stakeholders felt that academics, medical and public health professionals, and Right to Food activists are requested to advise largely on contextualisation of guidelines. This consultative process was followed in the formulation of the *Atal Bal* Mission and the adaptation of facility-based SAM guidelines. However, community management of SAM requires the same attention. In the supplementary

nutrition arena, food supply is confounded by what one stakeholder referred to as “the politics of food,” where local food suppliers, manufacturers, and multinational food companies are contenders.

Nutrition across the life cycle, community prevention and care of severely undernourished children, and strengthened linkages with the Health Department have been mentioned in the Inter-Ministerial Group recommendations for restructuring ICDS. However, according to the SRI findings, there are implementation challenges at the district level. Apart from some demonstrations of suckling techniques (usually at the institutional care level), none of these innovations was mentioned during SRIs.

We are guided by national-level policies and programmes, to be implemented according to guidelines.

—Senior bureaucrat in GoMP

The SRIs revealed that some extant knowledge is used, although the types varied and were not very systematic or well documented. Within the decisionmaking hierarchy, policy decisions are taken at the highest echelons. It was observed that there is limited trickle down of policy-level discussions and decisions to programme implementers or to frontline workers. When asked about the use of evidence in policy formulation, a senior bureaucrat within the GoMP mentioned that the more “populist” policies may not have been formulated with an evidence base but that data gathered through programme implementation may have been used. SRIs with GoMP stakeholders revealed that in some cases evidence of interventions are sometimes used by district collectors and district societies to make action plans.

Contested Authenticity and Relevance of Evidence for Application

Stakeholders reported use of evidence from a variety of sources. For stakeholders from the government, data generated by large national surveys were felt to be the most authentic, whereas data from NGOs were regarded as unrepresentative due to limitations of sample size or bias. NGO representatives in the stakeholder research indicated that government data did not capture all elements and had not been updated in several years. Thus, the use of nearly decade-old data was cited by nearly all stakeholders.

Among academic institutions, only data from the National Institute of Nutrition was cited as credible, while it was shared that medical colleges and nutrition departments were not at the stage where the data they collect and manage could be used for policy or programme development. Although scientific information is available, stakeholders claim that they are unable to provide scientific data, because they are unable to analyse it as a parallel process.

Table 3 Sources of evidence cited as used by stakeholders

Sources of evidence used (cited by stakeholders)	<p>Commonly cited:</p> <ul style="list-style-type: none"> • DLHS-3 • NFHS-1, 2, and 3 • National Sample Survey Organisation (Census) reports • National Institute of Nutrition surveys • Sample Registration System, Registrar General of India • Annual Health Survey • The <i>Atal Bal</i> Mission Vision document <p>Others:</p> <ul style="list-style-type: none"> • District Action Plans • IAP and WHO guidelines • National Nutrition Monitoring Board • Hungama report • National Guidelines on Management of Severe Acute Malnutrition are referred to, especially by the Health Department • MP-specific guidelines on management of severe acute malnutrition • SUN framework <p>From the field:</p> <ul style="list-style-type: none"> • Information shared by NGO staff, networks, colleagues, consultants, and resource persons for training programmes (annual reports, studies, and publications by Public Health Resource Network, UNICEF, Ministry of Women and Child Welfare, National Council for Protection of Child Rights, and Samarthan) • Local stringers/extenders on the ground • Information shared by and at RCH centres where trainings are conducted • ICDS-generated information
--	--

Limited Application of Data for Programme Development

Stakeholders said that they refer to and use a variety of data from programme implementation sources (ICDS, district collectors, and district societies), research institutions, social work institutes, development research organisations, international publications such as the Lancet Nutrition Series, networks and alliances, the Leadership Agenda for Action of the Nutrition Coalition, the SUN framework, and annual reports, articles, and rejoinders from civil society organisations (although the applicability and scale of research of the latter were somewhat variable).

A senior bureaucrat gave the example of a group of Right to Food campaigners, NGO representatives, and public relations experts who visited a tribal village in Sheopur district to identify food security issues using interdisciplinary methods. Development partners such as UNICEF and MPTAST also generate information and data, and a study by NCPCR has contributed to knowledge generation. Other studies mentioned were those by the Right to Food Campaign, the Madhya Pradesh Planning Commission on NREGS, and the ICDS. The Real Medicine Foundation is conducting a pilot in three districts on behaviour change with support from the Ratan Tata Trust, in collaboration with *Vikas Samvad*. A stakeholder said

that studies conducted should be supported by the state Planning Commission for greater credibility. There should also be efforts to conduct multisite studies.

Some stakeholders said that the data available at present are in the form of facts and figures on nutrition burden and do not indicate the status of programme implementation, making them irrelevant. Extrapolating existing data to guide interventions, given that NFHS-3 data is nearly a decade old, and gathering operational data to inform initiatives remain weak. NIN (2010) survey data require interpretation and packaging for wider dissemination because they would be useful in guiding programme implementation.

Mapping exercises undertaken by the government at the block, village, or *panchayat* level have not informed WCD or health interventions. In the presence of so much extant knowledge, it is difficult to understand why data and information do not translate to programme action. This information is vital to address major knowledge gaps that exist at the district level, such as infant and young child feeding practices, interventions for the first 1,000 days, childcare, and food consumption patterns. For example, there is a need for evidence to advocate for the establishment of an *anganwadi*-cum-crèche supported by a second worker.

Stakeholders stated that action research, concurrent monitoring, use of data to influence programme implementation, and qualitative assessments, including anecdotal evidence, will help stakeholders understand the complex determinants of nutrition in the state. Surveys are useful but should be undertaken by credible people. During the SRIs, some actors felt that state-based institutions and Preventive and Social Medicine departments at medical colleges should be capacitated to conduct research activities. The stakeholder research interviews revealed that there were gaps in service provision at the district level, especially among the tribal populations.

SRIs revealed that AWCs, with a few exceptions, remain infant feeding centres, which are not very well accessed and require guidance and leadership. Also, in the absence of programme monitoring data, implementation research, and documentation of good practices and challenges, a complete assessment of operationalisation of state programme guidelines is difficult.

Suggested research topics include:

- Comparative assessments of programme implementation across states
- Analysis of the progress of ABM implementation (which is of interest to the WCD)
- Operations research on putting systems in place at the village level, including:
 - Community care centres for malnourished children (as is done in Africa),
 - Third-party assessment of AWC service delivery
 - Compliance improvement at NRCs
 - Midterm evaluations for course corrections
 - Independent end-line evaluations of programme achievements
- Analysis of food-mapping surveys on what communities and children eat, complementary feeds, and locally grown foods
- Analysis of results from future research and evidence gathered by POSHAN combined with evidence from other states or countries (Thailand and Bangladesh,

for example) to understand what works and the right direction for MP to move toward

Local Knowledge and Practice Find Limited Space in Programmes to Combat Undernutrition

Inadequate attention has been paid to neglected nutritional needs of displaced tribal populations, whose conventional food practices are being eroded. Among *Sahariyas*, for instance, complete foods like *jowar* and *bajra* (sorghum and millet) are being replaced by wheat. There are examples of local foods where simply adding micronutrients impacts SAM, as shown by the efforts of the Christian Medical College, Vellore and by institutions in Bilaspur. SRIs indicated the need for local practices to inform community-led and community-based interventions. A stakeholder suggested that food demonstrations at the village level may be a useful method for transferring knowledge of appropriate nutrition practices.

Stakeholders said that tribal communities do not access the PDS and thus have enormous out-of-pocket expenses for food. The programme guidelines review showed that a scheme for tribal populations finds mention in the ABM document, yet from stakeholders' views it is apparent that the food grains provided by the PDS are not suited to tribal eating patterns. The Right to Food Campaign, civil society, and media have been highlighting gaps in the provision of supplementary nutrition for many years, and yet this knowledge has not been translated into district- and block-level action to combat undernutrition. There is a need to enhance the scope of the Tribal Affairs Department to include these important issues. The universalisation of ICDS also needs to recognise field realities, such as caste hierarchies and food consumption patterns, as barriers to uniformly administering supplementary nutrition to children at *anganwadis*.

Knowledge Sharing Is Required to Bring Nutrition to Centre Stage

Given the fact that extant knowledge was sparse in the programmes described in the ABM and NRHM documents, knowledge mobilisation was highlighted as one of the key strategies to strengthen programme implementation. Concerted action requires that all stakeholders develop an understanding of malnutrition, by using and sharing data and information; aligning innovative intervention design and implementation formats to community needs; and generating audience-specific information, nutrition education, and training materials. During SRIs, two examples were shared that indicate the importance of knowledge sharing.

The first instance is the reluctance on the part of the state administration to report nutrition-related deaths, often attributing them to diseases and other causes. This could be due to the fact that these interlinkages were not sufficiently documented or explained in the plans and schemes of ABM or NRHM. The second example was the SRI with members of the DFID-funded MPTAST team, who shared that the team had been involved in formulating the ABM and continues to be closely engaged in advising on various aspects of implementation and monitoring. The Technical Assistance Team works through consultants placed within the ABM. In fact, districts under the ABM are divided between UNICEF and MPTAST. UNICEF works in 18 out of 50 districts, and MPTAST is responsible for the rest. Technical support to the ABM from MPTAST includes design of innovative programmes; documentation; reform of human resources governance; organizational development; performance assessments; and transparent posting of policies, manuals, and audits. The

MPTAST team mentioned DAPs, but other stakeholders did not have any information about them.

“Specialists, practitioners, and donors talk about the need for convergence, whereas the government feels this is already being accomplished. It is however, a turf issue.”

—Development partner

Given the differing knowledge levels, orientation to the use of knowledge and data is very important. At the core of these efforts is consistent engagement with persons in positions of responsibility, such as principal secretaries, mission directors, and district programme officers, through their interface with practitioners/implementers and academia. Orientation of specific audiences such as members of Parliament and members of the state Legislative Assembly (MLAs), and identification of possible interlocutors who can build bridges through dialogue with policymakers, are some ideas that may facilitate greater use of knowledge and evidence.

Stakeholders identified the following individuals and positions in the government system as able to facilitate knowledge mobilisation.

Table 4 People, agencies, and organisations contributing to knowledge mobilisation in Madhya Pradesh

Stakeholders mentioned by respondents	Individuals/positions who shape the discourse on nutrition
Community	From <i>Sahariyas</i> /communities living in the jungles of Mandala
Organisations	<i>Vikas Samvad</i> works with a network of organisations Right to Food Campaign Tribal Research Institute UNICEF Swami Vivekananda Institute (Indore)
Politicians	Mr. Digvijay Singh Mrs. Sonia Gandhi Chief minister of MP Minister for Food and Civil Supplies
Government of India	Mr. Sriranjana (joint secretary, Ministry of Women and Child Development) Dr. Mihir Shah (member, Planning Commission)
Government of Madhya Pradesh	ABM’s mission director and staff Mr. Aggarwal (mission director, NRHM) Mr. Anupam Rajan (director, DWCD) Ms. Loveleen Kacker (former principal secretary, WCD) Principal secretary, Health Principal secretary, Rural Development Principal secretary, Agriculture District collector

	Dr. Agnani (commissioner, ICDS) Mr. Kailash Vijaywargi (former spokesperson for GoMP) Consultants supporting the ABM
Autonomous bodies	MP Agro (produces Ready to Use Food [RUTF]) Dr. Vandana Prasad, member of National Commission for Protection of Child Rights
Right to Food Campaign	Ms. Dipa Sinha Ms. Madhuri Krishnaswamy
BPNI	Mr. Arun Gupta, chairperson
Journalists	Chinmaya Mishra (journalist and activist)
NGOs and representatives	NGO Mr. Sachin Jain (Supreme Court Commissioner's office and secretary, <i>Vikas Samvad</i>) Mr. Prashant Dubey (associate coordinator, <i>Vikas Samvad</i>) Ms. Radha Holla (campaign coordinator, IBFAN Asia/BPNI) Valid International (works on RUTF roll- out; partners on CMAM pilots) Mehesha (Children's Right to Food) Ms. Vani Sethi (Urban Health Resource Centre)
Academics/researchers	Prof. John Dreze (economist) Dr. Peter Berman (Harvard School of Medicine) Dr. Ajay Mahal (Monash University) Dr. Anurag Chaturvedi (PHFI) Prof. Balachandran (Cornell University, U.S.A.) Mr. Ganpathy (Public Health Resource Network)
Field workers	<i>Atal bal mitras</i> (community-based outreach workers) 500 <i>Atal Bal</i> Mission managers (nutritionists)
Development partners	UNICEF team from Delhi (including Dr. Victor Aguayo, section chief)

Advocacy and Counselling Are Critical for Shaping the Nutrition Agenda

Advocacy by multiple stakeholders, such as the Right to Food Campaign, civil society, and media, along with MLAs, decisionmakers, and grassroots alliances, is critical for highlighting the malnutrition situation in remote areas. Specifically, media advocacy requires active support of a network of NGOs and local community members and a blend of research, action, and dialogue with GoMP to share evidence. However, stakeholders said that the uneasy relationship between the media and NGOs (the media regard many NGOs as corrupt) is often a barrier.

Apart from advocacy and communication, nutrition counselling with communities was emphasised as an important component of taking nutrition information to the last mile. A focused effort to address misconceptions regarding food taboos, infant feeding, and childcare practices requires consolidating knowledge, good practices, and experiences to improve information-seeking behaviour.

Preferred modes of communication were simple and concise materials in Hindi that went beyond facts and figures to descriptive information and knowledge. Some formats perceived as useful by most stakeholders include:

- evidence-based information digests in Hindi,
- wall writing and local newspapers in Hindi for outreach and for tracking cases of malnutrition,
- information on government schemes through press releases and press conferences,
- programme guidelines and programme benefits presented in user-friendly formats, and
- multi-stakeholder dialogue, including community meetings and open discussions on access to facilities and services.

Prospective Physical Knowledge Platforms

The SRIs have indicated that physical knowledge networks that are accessed by a wide number of stakeholders may facilitate knowledge mobilisation. However, mere knowledge of a network may not translate into use by stakeholders or support programme implementation. The Right to Food Campaign and *Vikas Samvad* consistently appeared in the Net-Map (as major hubs or nodes for advocacy and communication) and the interviews as convening grassroots alliances by sharing knowledge and information with a network of community-based organisations, conducting advocacy for action, and building linkages with the media. These alliances report gaps in service provision and incidence of malnutrition. They also report good practices, such as providing locally grown foods for supplementary nutrition, and effective implementation of initiatives (*Sanjha Chulha* and referrals of SAM children). The SRI discussions highlighted the Child Rights Observatory of Madhya Pradesh (CROMP) as another useful platform to take knowledge mobilisation forward. Networks like the Nutrition Coalition and Public Health Resource Network are known only to a few researchers, academics, and NGO representatives. A brief profile of *Vikas Samvad* and CROMP, as relevant to the POSHAN Knowledge Management Strategy, is provided below.

Vikas Samvad (Centre for Raising People's Voices and Concerns)

- Promotes dialogue with multiple stakeholders (journalists, academics, legislators, political institutions, and civil society)
- Promotes media initiative for change (since 2001); supports the use of knowledge and evidence-based action in the media through fellowships, exposure visits, and documentation assignments. Journalists interviewed during SRIs acknowledged the contribution by stringers who were their “eyes and ears.”
- Performs advocacy around the Right to Food Campaign on nutrition-related issues, such as effective implementation of related schemes, definitional and conceptual clarity on malnutrition, and linkages with other issues like agriculture and land grabbing; supports introduction of cooked mid-day meals in all primary schools and for reform and expansion of the PDS
- Makes data, information, research studies, case studies, and analyses available in usable format and uses existing alliances and opportunities for

Some of the community-based organisations with whom *Vikas Samvad* shares information are:

- Swasthya Adhikar Manch
- *Mukti Morcha* (an organisation of tribal people)
- *Jagrit Adivasi Organisation* (this organisation works on a number of issues, including women's health, PDS, livelihoods, and court hearings, that are instrumental in getting unemployment allowances from MGNREGA)
- The MP *Lok Sangharsh Manch*, which conducted the first public hearing on malnutrition in Satna in 2009

These organisations need to be explored as potential knowledge hubs because they are located within the state.

Child Rights Observatory, Madhya Pradesh (CROMP)

- Comprises a physical network of 500 NGOs that tracks child abuse and rights violations
- Provides the latest news and updates regarding children, education, nutrition, health, abuse, and school forums
- Organises consultations and programmes through a network of NGOs working in different parts of the state
- Shares district information by email
- Investigates, tracks, and uploads to its website events of rights violations
- Organises school forums where children talk about themselves and participate in committees. The children have created their own wall newspaper and the views

Lack of Access to Technology for Nutrition-Related Information Exchange Using Virtual Platforms

Language barriers, lack of time, and capacity to use the Internet were cited as barriers to consistent use of virtual networks as well as lack of uniformity in usage by GoMP officials. Although a senior bureaucrat with a public health background said that he accessed virtual networks for information on nutrition, hard copy documents are still very common. Printed material and office orders are used to pass on information (although scanned copies are sent by email). A single stakeholder said that Internet connectivity between groups of medical officers and NRHM programme staff exists in 50 districts and goes down to the block level. Video conference facilities at the district level were also said to be in place. However, the lack of use of information was evident from views shared on Solution Exchange (some were familiar with just the name and others used it sparsely).

Media as a Powerful Advocate for Change

Media is a proactive stakeholder, and through regular media reports of malnutrition they have put pressure on the government. An observation by a civil society stakeholder went so far as to say that media coverage influenced election manifestos to include the declaration of MP as a “malnutrition-free state” and led to the conceptualisation of the *Atal Bal* Mission. The government approach to media has been conventional—journalists are called when the government has information to provide. Journalists, however, reach out to government for information about malnutrition (especially malnutrition deaths). Although this interface exists, government officials did not mention media as influencers in the policy and programme discourse, while media persons alluded to the fact that some malnutrition exposé reports were suppressed.

Media stakeholders said that they have the will and capacity to use NFHS data and information from the Right to Food Campaign, and have benefited from exposure visits conducted by *Vikas Samvad*. The media stated that they were open to receiving succinct, relevant, and distilled evidence on a regular basis as an opportunity for keeping the media informed and up-to-date on a gamut of nutrition-related issues. The use of grassroots evidence by media was demonstrated by the Right to Food Campaign in Majhgawa and

Satna districts. Feature services like the Sarvodaya Press were mentioned as highlighting district issues.

The focus of media has been limited to malnutrition, related deaths, and gaps in ICDS service provision. There is a need to broaden the perspective of reporting to include determinants of undernutrition in order to drive change by raising the discourse in the public domain. The discourse clearly needs to move from reporting events to advocacy for change in policy and programme implementation.

Building Capacities and Skills of Frontline Workers Is the Way Forward for Knowledge Transfer

Stakeholders spoke about the limited capacities of AWWs in terms of referring children with SAM to facilities, negotiating caste barriers, and providing nutrition counselling. A range of knowledge gaps related to nutrition, entitlements, and childcare practices emerged at district and sub-district levels. In the view of a public health professional, putting the burden of nutrition knowledge on the shoulders of women in communities seemed unfair. Nutrition and childcare were two of the multiple priorities women faced, including looking for livelihoods and caring for families/elders. For them to assimilate new knowledge and apply it to their situation demanded information-processing skills. The same challenge was faced by ASHAs and AWWs (many of whom have low literacy levels).

Stakeholders felt that government frontline functionaries had limited capacity to analyse the data generated. District-level data were collected mechanically, and field data collectors lack experience, exposure, and knowledge. The focus of efforts is merely on reporting, with limited supervision. Thus, more information is created than is used. The applicability of data generated for an AWW or ICDS supervisor should also be examined critically.

Synergies Are Missing in Critical Areas of Programme Implementation

SRI revealed that although different government programmes are designed to provide access to livelihoods, pensions, and better methods of agriculture and horticulture, synergies are missing at the ground level. Stakeholders said that convergence works in some but not in a majority of the areas. There is convergence in capacity-building activities, developing IEC materials, implementing micronutrient programmes (vitamin A supplementation, bi-annual round led by NRHM but implemented by WCD), providing IYCF to some extent, and referring children with SAM from the community to the facility and back again; however, convergence is missing in community mobilisation and monitoring activities.

The MP-TAST advocates for a 360-degree approach to address undernutrition, by re-examining the current approach to supplementary nutrition, matching it with the capacity of malnourished children to absorb a balanced diet, and providing functional systems and technical support to blocks to enable them to track families of malnourished children.

Coordination mechanisms, role clarity, and role definition are critical. Convergence is not about blame sharing but about joint action to achieve effective mobilisation of resources. The ABM document has sections devoted to convergence. Almost every department is mentioned in the list, although ground-level examples of convergence are only mentioned as joint action by ASHAs and AWWs. SRI suggested that ICDS may be empowered to adopt

a life-cycle approach to nutrition that focuses on boosting maternal nutrition, reducing low birth weight among children, and improving nutrition for the girl child; education for appropriate care and development are instrumental to universalisation efforts. In addition, SRIs did not mention any examples of vibrant and engaged Village Health Sanitation and Nutrition Committees, leaving a doubt as to whether the addition of the term *nutrition* in the nomenclature has resulted in systematic and effective implementation of this initiative.

Experience Sharing and Cross-Learning: Glimpses from Stakeholder Research Interviews

Learning across sectors occurs through NGOs sharing innovations that have worked with tribal communities and learning from innovations implemented in districts. An example of an innovation shared comes from the collector in Shahjahanpur, who provided supplementary nutrition by making children’s school uniform pockets larger than usual and filling them with ground nuts. In an area where distributing eggs was controversial, this experiment proved to be a viable solution. Cross-learning from other state missions (such as the Maharashtra Mission) would be useful. Ordinarily, information and knowledge on successful pilots are not shared with policymakers and district counterparts for scale-up and further application.

“The levels of malnutrition remain high and thus our approach has to evolve on a daily basis, incorporating learnings from interventions and progress—there are no readymade prescriptions.”

—Senior GoMP bureaucrat

Intercountry learning from community day care centres for malnourished children, which have been established in Africa, was suggested by a stakeholder. However, in MP, crèches exist only in *anganwadis* (*anganwadis-cum-crèches*), and these need to be scaled up and introduced at the community level. Although there is mention of crèches in the ABM document as a focal point of early childhood care and educational intervention, stakeholders did not share any examples of AWCs that conduct activities other than provision of basic services (mainly food supplementation). A stakeholder suggested that evidence on RUTF from Thailand, Vietnam, African countries, China, and South Africa should be used in the absence of evidence from India.

These experiences need to be researched, documented, and shared with policymakers and programme implementers (especially at district and sub-district levels). These findings may pave the way for a deepened understanding of how evidence is used as well as the barriers and facilitators for decisionmaking regarding policies and programmes.

Conclusions and Recommendations

PHFI led the landscape analysis in Madhya Pradesh to find out the available knowledge on the PIP processes and the scope for using evidence and knowledge within the existing initiatives of the ABM and NRHM. This will contribute to an understanding of the knowledge mobilisation landscape at the state level and provide insights that will lead to strengthening the use of evidence and knowledge in the state.

The analysis found that ABM and NRHM documents had detailed mentions of direct and indirect interventions that impact the health of infants and young children, although the NRHM schemes were mostly facility based, with only passing mentions of community mobilisation. There were details of plans and schemes that would help improve the undernutrition scenario in the state, without any mention of evidence and knowledge that led to their development. The SRIs pointed out many inequities related to poverty, livelihood insecurity, and erosion of conventional food consumption patterns. Displacement of forest-dwelling tribes has led to the erosion of a complete science of nutrition related to seasonal availability of fruits and roots that supplemented their diet. SRIs also pointed out the low awareness and knowledge about nutrition-related issues prevalent in many areas of the state. Planning interventions without keeping these complexities in view will not help reduce the undernutrition burden of the state.

What is evident, both from the policy and programme analysis and from the SRIs, is that the current undernutrition scenario calls for a great deal of strengthening around policy, advocacy, research, knowledge mobilisation, and other points of intervention. It is apparent that there is a need for engagement with multiple stakeholders, some of whom may act as enablers of knowledge use and application. The landscape findings present multiple capacity-building and knowledge-transfer opportunities, partnerships with existing networks, and alliances that will strengthen knowledge and evidence use at all levels, from the policy formulation arena down to the district level. It is also apparent that a multipronged strategy that addresses current knowledge and information needs, engages multiple stakeholders (including those at district levels), and initiates knowledge exchange platforms is a key requirement. The SRIs have identified several communication and advocacy actions that, when informed by evidence and research, will lead to an enabling environment for knowledge mobilisation.

Translation from Policy to Programmes Needs to Have a Strong Evidence Base and Include State Voices

The policy and programme review indicated that nutrition appears in many GoMP programmes; however, nutrition is not specifically the focus of any particular programme, with the notable exceptions of SAM and provision of supplementary nutrition. The state programme documents have listed a series of schemes based on NFHS-3 data with no reference to knowledge-implementation gaps. There is no further reflection of evidence use, thus there is scope for the use of extant knowledge present among stakeholders to strengthen the development and adaptation of programme guidelines. As recommended by a GoMP official during the SRIs, the central government should provide untied funds; set goals, targets, and outcomes; and ask state governments to move a percentage of its population out of the malnutrition zone within a specified time frame using a district-focused approach. This view was supported by that of a civil society stakeholder who felt that the state should have more say in the policy formulation process.

Systematic and Consistent Use of Knowledge Is Required to Bring Nutrition to the Forefront

The GoMP documents reviewed do not emphasise the importance of nutrition or the disadvantages of ignoring this very important aspect of public health. Planning nutrition interventions should be strengthened by cultural- and context-sensitive inputs from a broad range of stakeholders. Use of evidence and knowledge must be systematic, consistent, and include a broad range of stakeholder needs and concerns. There is scope for inclusion of current data, mobilisation of knowledge to support training programmes, and use of evidence-based briefs to update stakeholders in a systematic way.

Greater Engagement with Stakeholders Is Needed at All Levels to Tap Extant Knowledge

The landscape analysis and stakeholder research interviews indicate that only a few stakeholders are consulted by the government and many voices (especially community voices) remain unheard. A broader range of stakeholders therefore need to be consistently involved in evidence generation and programme implementation planning. District-level information, such as food supply for supplementary nutrition, challenges faced in accessing information on correct nutrition practices, and credible research studies, should inform this process.

Application of Data for Policy and Programme Development Should Be Promoted

The landscape analysis and SRIs indicate that knowledge about specific groups, such as tribal communities, and examples of convergence within GoMP departments was absent in the ABM and NRHM documents. Additionally, the data used for development of the S-PIPs and the PIPs were dated. Therefore, there is a need for up-to-date knowledge and lessons from various actors and situations within India and other developing countries to inform state-level planning.

Evidence-based information should be readily available to programme implementers, planners, and stakeholders in a concise, relevant, and systematic manner. Knowledge mobilisation needs to occur at all levels and across sectors by sharing evidence-based information digests with a wide variety of stakeholders and within the entire programme planning and implementation hierarchy. Identification of knowledge-action pathways, examples from other states and countries, and bottom-up approaches are some ways that knowledge may be mobilised for district-level action and to strengthen service provision to communities.

Local Knowledge and Practices Should Drive Actions on Programme Implementation to Combat Undernutrition

Local foods, conventional food habits, and social traditions around food consumption need to be respected. The public health system and the public distribution system need to benefit tribal and disadvantaged communities. It is important to present information in an acceptable manner that promotes ownership and reflects field realities. Involving local, faith-based, and elected leaders from the community and greater involvement of women in community mobilisation activities will be useful.

Leadership and Stewardship Are Key to Scaling Up Successful Innovations

The *Atal Bal* Mission and the NRCs are innovations in the policy and programme landscape. Scaling up successful interventions requires technical support from a variety of stakeholders assisted by academic research; inputs from stakeholder departments, including journalists, civil society, and researchers as partners; advocacy with elected representatives (from legislature to *panchayats*, especially women representatives); and a

broader ownership of health and nutrition programmes. There is also a need to promote long-term ownership of those nutrition initiatives among the district administration and stakeholders to empower communities, promote access to services, and provide integrated nutrition services for women and young children.

Strategic Advocacy, Counselling, and Communication Should Inform Policy Dialogue and Implementation

There needs to be an evidence-based and robust discourse around nutrition. Extant knowledge and available data should be packaged in an interesting manner and interpreted in the context of state goals and priorities. Since district stakeholders, beneficiaries, and service providers have limited access to virtual networks and platforms, printed information briefs that are comprehensible and contextualised are necessary for spreading knowledge and information.

Promoting communication, advocacy, and counselling; keeping stakeholders informed on a regular basis; building capacity of institutions and frontline workers; sensitising bureaucracy; and using knowledge from other countries and practices from other states are important for knowledge mobilisation. Capacity building of field staff on the use of Internet, interpretation of data, management communication, and community mobilisation skills are knowledge-mobilisation activities that will strengthen the use of existing data, critical thinking skills, and decisionmaking skills with regard to nutrition.

Information sharing with media needs to be systematic and encourage reporting on a wide range of issues that will bring about changes in the system and in community information levels and views on nutrition issues. Media discourse needs to shift from malnutrition to food security, food consumption, childcare, and supplementary nutrition practices.

Prospective Knowledge Platforms Need to Be Tapped

Physical networks and alliances (*Vikas Samvad* and the CROMP) have district-level reach. Their activities have been profiled in the findings of the SRIs as presenting opportunities for nutrition knowledge to reach the grassroots level. As stated in the SRIs, knowledge exchange through discussion fora (like the Solution Exchange) may be limited; however, using a platform that promotes sharing without being complex from a technological viewpoint and bringing together state and district stakeholders are important.

Building Capacities and Skills of Frontline Workers Is the Way Forward for Knowledge Transfer

National-level training institutions (such as the National Institute for Public Cooperation and Child Development) should be strengthened with skills and knowledge so that they in turn can build capacities of state institutions. There is a need to capacitate training institutions and departments of Preventive and Social Medicine in the state to conduct research that is relevant and contextualised to the undernutrition scenario, so that their data are usable by larger audiences. Health and nutrition education for women and enhanced knowledge of frontline workers will enable long-term and sustained change.

Specific issues, such as effective referrals to NRCs and encouraging women to attend *anganwadis*, require knowledge mobilisation with community and *panchayat* representatives; such practices also encourage ASHAs and AWWs to share knowledge and good practices. A public health specialist explained that attendance and stay at NRCs were issues linked to the mother's ability to comprehend the severity of the situation, whether she could spare the time away from livelihood/chores or family commitments to stay with the child, and whether bringing the child in for follow-up was mentioned. This is also related

to the skills and capacities of the AWW to identify children with Grade 2 and Grade 3 malnutrition, conduct referrals, and manage follow-ups. There is, however, a dire need for interventions at the community level for those children who have severe acute malnutrition but do not qualify for admission into a facility. Simplified guidelines that help frontline workers detect SAM cases and arrange for follow-up of children discharged from the facility after treatment are also required.

Nutrition Requires a Wider Agenda and Convergent Action

At the heart of undernutrition are determinants such as poverty, lack of income, lack of access to goods and services, attrition of conventional practices and lifestyles, lack of knowledge, relationship deficits (with government, with district administration, and among stakeholders), and lacunae in understanding maternal and child healthcare issues. Although stakeholders were aware of the need for convergence, there were no concrete approaches and methods forthcoming to address this key issue. This may be due to an overemphasis on vertical programmes, thus ignoring district- and community-specific concerns that restrict the agenda for long-term action. For instance, *panchayats* need to be sensitised on the importance of undernutrition and good childcare practices and work closely with AWCs. In the absence of this sensitisation, community monitoring through *panchayats* may present difficulties.

Understanding the mechanics of convergence and coordination among departments is crucial to effective service delivery. Imparting knowledge about nutrition and sharing evidence-based information on nutrition with a broad range of stakeholders and field workers in formats that are appropriate and interesting emerged as critical needs. Promoting linkages with the departments of Water and Sanitation, Rural Development, and NREGS; supporting district knowledge and information needs; communicating entitlements to beneficiaries using *panchayat* and community leaders; motivating field workers to deliver counselling and services; and sharing good practices from other states and countries are some areas where convergence can contribute to strengthening the nutrition component of state-level interventions.

Convergence would be facilitated if discussions within the Department of WCD and other departments contributed to planning and decisionmaking. Often those in a position to make decisions are not sufficiently engaged. When decisionmakers and people in power (such as the chief secretary or minister) convene meetings, the discussion moves beyond reporting the current situation and recommendations to eliciting responsibility for actions.

The Department of Rural Development or the MGNREGS programme should be part of programme planning and implementation; *panchayat* representatives should monitor ground-level activities (e.g., where AWCs are not functioning or where *panchs/sarpanches* can be motivated to take action).

Scaling up innovations and promoting linkages with the UNICEF Water and Sanitation (WASH) programme (as has happened in Raigarh, near Raipur zone), or with Guna, Shivpuri, or other high-risk areas, demonstrate how convergence can address undernutrition.

The process of intersectoral convergence should be participatory. Setting up a steering committee with membership of all departments, enabling them to understand their responsibilities individually, creating a mechanism of coming together with clear role coordination, and nominating an agency that plays a facilitative role are critical.

Experience Sharing and Cross-Learning

Strengthening knowledge mobilisation initiatives for the government of MP may be done by

- analysing work around NIN surveys and evidence,
- planning and conducting evaluations of the ABM,
- applying examples of what has worked within the country (e.g., the Tamil Nadu Procurement Corporation),
- formulating evidence-based programming that brings together village-level innovations,
- using community-based approaches and models from other states in India on tackling malnutrition effectively, and
- processing documentation.

The state landscape analysis and SRIs are the beginning of POSHAN's journey in MP and present a roadmap for developing specific state-level knowledge mobilisation and information dissemination pathways that will help translate knowledge into targeted and appropriate action.

Specific Activities for POSHAN

Specific activities that POSHAN may undertake as a result of the findings and recommendations of this effort are:

- Roundtables with GoMP officials at the state level to discuss knowledge mobilisation and convergent action. A broad range of stakeholder departments could be convened under the ABM umbrella to discuss how using data and current information can strengthen district action.
- Discussions with district officials on knowledge gaps and needs of tribal populations. This knowledge can support programme monitoring and dissemination of information with regard to nutrition.
- Workshops at the state and district levels. Learning from state- and national-level efforts as well as practices and challenges from other countries may be shared in interesting ways and address knowledge gaps.
- Evidence-based knowledge briefs. These should include documentation of good practices from districts that will inform programme planning at the state level and support ABM at the district level.
- Cooperation with media through write-shops and generation of evidence-based briefs. The aims are to sensitise them on issues related to undernutrition, share good practices, and describe programme implementation challenges.
- Media roundtables at the district level. The goals here are to enlist media persons working in the local language (Hindi), generate learning about district-level nutrition issues, and encourage systematic reporting on a broader range of concerns.
- Strengthening of *Vikas Samvad* and CROMP as knowledge hubs for nutrition. These two organisations have district-level reach, are able to communicate in both English and Hindi, are able to work with the GoMP, and have websites that can be used to communicate to a range of stakeholders.

Annex 1 Description of the Current Policy and Programme Landscape in Madhya Pradesh

This annexure summarises documents from the NRHM and the ABM that relate to direct and indirect health and nutrition interventions in the state. A brief overview of the undernutrition scenario along with data that appear in the documents reviewed is provided.

MP, with a total area of 3,08,144 sq. km., accounts for 9.38 percent of the land area of India and has 50 districts. The population density is 195 per sq. km. (as compared with the national average of 312); the state has 21.4 percent Scheduled Tribe population and 17.9 percent Scheduled Caste population (NFHS-3). Development indices in these sections of the population are lower, adding to the existing burden of ill health and undernutrition in the state.

Overview of Undernutrition in Madhya Pradesh

- MP is one of the poorest states of India, with 32.4 percent of its population living below the poverty line compared to the national average of 21.8 percent (National Sample Survey Organisation 2007).
- Sixty percent of children under the age of three years are underweight.
- According to the India State Hunger Index, Karnataka has the highest prevalence of calorie undernourishment (28.1 percent), MP has 23.4 percent, Rajasthan has 14 percent, and Punjab has 11.1 percent.

India's Global Hunger Index (GHI) 2008 score is 23.7, which gives it a rank of 66th out of 88 countries. This score indicates continued poor performance at reducing hunger in India. The India State Hunger Index (ISHI) 2008 (Comparison of Hunger across States by the International Food Policy Research Institute) was constructed in a similar fashion as the GHI 2008, to allow for comparisons of states within India and for comparisons of Indian states with GHI 2008 scores and ranks for other countries. The ISHI 2008 score was estimated for 17 major states in India, covering more than 95 percent of the population. The key findings of the ISHI scores are:

- ISHI 2008 scores for Indian states range from 13.6 for Punjab to 30.9 for MP, indicating substantial variability among states in India.
- All 17 states have ISHI scores that are significantly worse than the "low" and "moderate" hunger categories. Twelve of the 17 states fall into the "alarming" category, and MP falls into the "extremely alarming" category (see Table 6).
- ISHI scores are closely aligned with poverty, but there is little association with state-level economic growth because high levels of hunger are seen even in the economically better-performing states.

Table 5 Severity of hunger in various states of India

<4.9 (low)	<5.0–9.9 (moderate)	10.0–19.9 (serious)	20.0–29.9 (alarming)	30.0 or more (extremely alarming)
None	None	Punjab Kerala Andhra Assam	Pradesh Haryana Tamil Nadu Rajasthan West Bengal Uttar Pradesh Maharashtra Karnataka Orissa Gujarat Chhattisgarh Bihar Jharkhand	Madhya Pradesh

Source: Menon 2009.

The Madhya Pradesh NFHS report shows that half of children (50 percent) under the age of five years are stunted (too short for their age), which indicates undernourishment over time. Thirty-five percent are wasted (too thin for their height), which may be due either to inadequate recent food intake or a recent illness. Sixty percent of children are underweight, indicating both chronic and acute undernutrition. The figures are startling because they show that in the six-month period when most babies are breastfed, 24 percent of children are stunted, 48 percent are wasted, and 48 percent are underweight. Children in rural areas are maybe more likely to be undernourished, but even in urban areas, 44 percent of children suffer from chronic undernutrition. Almost one-third of children even in the wealthiest households are stunted, 25 percent are wasted, and 37 percent are underweight. In fact, comparisons of the under-three child malnutrition rates between NFHS-2 (1998–1999) and NFHS-3 (2005–2006) indicate that the prevalence of underweight and wasting among children has actually increased in this period. These stark figures have driven the state government to combat malnutrition in a mission mode.

The NRHM targets reduction in the infant mortality rate (IMR) from the present figure of 62 to 35 over the next five years. Specific interventions to improve child health include establishment of more Sick Newborn Care Units, Newborn Care Corners, and Stabilization Units in First Referral Units. Full Immunisation is targeted at above 90 percent for the second phase of NRHM to ensure disease prevention. None of the indicators, however, refer directly to nutrition, although immunisation and provision of services bear an indirect relation by promoting the health and well-being of infants.

Causes of Malnutrition

Many societal, disease, and access-related causes explain the vicious cycle of malnutrition in the state (*Atal Bal Arogya Evam POSHAN Mission Vision Document 2020*). What is less known, however, is that undernutrition is rarely stated as a direct cause of mortality. Undernutrition may be a causal factor for many illnesses and disorders that lead to morbidity and death. Poor cognitive development in children, as a result of malnutrition,

leads to lower levels of productivity in adulthood. Hence, poverty may not only be a fundamental cause of malnutrition; it is also a result of it.

The ABM document mentions some key factors that are responsible for undernutrition in the state:

Societal Factors: The NFHS-3 survey shows that over half of women aged 20–24 years in MP were married by the age of 18 years. Marrying early makes women vulnerable to frequent and closely spaced pregnancies. Anecdotal examples were shared during the SRIs of tribal women who lived with the burden of unwanted pregnancies and bore the brunt of childcare because the men migrated to towns in search of livelihoods. The problem is compounded by high rates of anaemia and low levels of education among women, all of which lead to high rates of child malnutrition, with nearly 60 percent of the children under three being underweight. Young girls, who are themselves malnourished, are likely to enter pregnancy with poor nutritional status and have a low gestational weight gain, which in turn increases the risk of low birth weight babies. Anaemia among women also contributes to the cycle of malnutrition. According to NFHS-3 data, 56 percent of the women in MP have anaemia.

Household Factors: Lack of access to food and consumption of poor-quality food lead to ill health. Unhygienic living conditions and limited access to safe drinking water lead to diseases and increase the prevalence of malnutrition. Health services such as immunisation, deworming, micronutrient supplementation, and antenatal care help protect against diseases and provide support to vulnerable pregnant women, contributing to the overall well-being of children and forming part of the essential interventions that protect women and infants. The lack of access to food seems to have been given only a passing mention, even though the lack of access to nutritious food in the first 1,000 days of life and later, through childhood and adolescence and across the life cycle, has serious long-term consequences for the family and communities as a whole. The programme guidelines did not have any references to the nutritional needs of displaced tribal populations, the importance of providing safe drinking water, and knowledge about preventing childhood diseases among communities.

Immediate Factors: The ABM document states that many children do not have access to the requisite food, both qualitatively and quantitatively. For children less than two years of age, a continuous and consistent supply of age-appropriate energy-giving protein- and micronutrient-rich foods is essential. Similarly, proper foods for severe acute malnourished (SAM) children are essential to rehabilitate them. These supply problems are compounded by lack of knowledge among community and family members on timely introduction of complementary foods, frequency of feeding, quality of diet, and age-appropriate nutritious food required to keep children healthy.

Prevalence of Diseases: According to the ABM document, Madhya Pradesh is one of the three worst malaria-affected states in India, and diarrhoea accounts for about 28 percent of all infant deaths in the state. The ABM seeks to strengthen the ICDS programme to address the high prevalence of communicable diseases among children and low levels of immunisation against vaccine-preventable diseases. Promoting initiation of breastfeeding within the first hour can go a long way in reducing malnutrition by strengthening immunity and safeguarding the child from disease. According to the ICDS III baseline/ICDS II end-line survey 2000–2002 (World Bank 2005), 88 percent of the children are breastfed within the first hour of birth. The State Action Plan of the ABM aims to achieve a target of 95 percent breastfeeding in MP in 2012–2013.

Policy Response

National Rural Health Mission

In 2005, the government of India (GoI) launched India's largest public health programme—the NRHM, an umbrella initiative subsuming many existing schemes, including the Reproductive and Child Health Project (RCH II), National Disease Control Programme, and Integrated Disease Surveillance Project. In the financial year 2011, NRHM constituted 60 percent of total allocations for health in the country. Nutrition programmes are also administered as part of RCH II. There are many health sector initiatives under the NRHM that deal with malnutrition; these are related to care of the sick child (through the ASHA and primary healthcare facility), immunisation, universal vitamin A administration, paediatric deworming, anaemia management, nutrition rehabilitation centres, and nutritional supplementation. The Prime Minister's National Council on India's Nutrition Challenges (2010) recommended that ICDS and the NRHM needed to forge strong relationships with the Total Sanitation Campaign (TSC) at the district and village levels. However, the desk review and the SRIs indicate that the Health Department's focus is on the management of SAM children and providing immunisation and treatment. Nutrition counselling and joint services delivery by the auxiliary nurse midwife (ANM) and AWW are not the primary functions of the NRHM.

Nutrition Initiatives under NRHM

These include awareness generation, information provision, infrastructure support, and treatment-related activities, such as:

- Promoting *Bal Suraksha Mah* (Child Protection Month)
- Organising Village Health and Nutrition Day
- Promoting infant and young child feeding activities
- Setting up Newborn Corners
- Scaling up Sick Newborn Care Units
- Promoting Nutrition Rehabilitation Centres for severe acute malnutrition (SAM)

Several initiatives specific to maternal and child nutrition under NRHM have a direct or indirect bearing on improving undernutrition and early childcare practices, with a focus on capacity building, counselling, delivery of services, and strengthening of infrastructure. In line with the IYCF guidelines, the state NRHM has rolled out training of frontline workers on three-in-one IYCF counselling skills in 22 districts as well as initiatives for building the skills of workers and promotion of breastfeeding practices. Facility-based care has been provided for the management of SAM children through 200 Nutrition Rehabilitation Centres (NRCs) under the ABM. The NRHM has institutionalised a biannual drive named *Bal Suraksha Mah* (Child Protection Month), which is organised across the state to provide all children from nine months to five years of age with vitamin A supplementation, deworming, iron and folic acid supplementation, and immunisation. In terms of human resources, the ASHAs, one allotted for 1,000 population (or each village), act as an interface between the community and the public health system and receive performance-based compensation for promoting primary healthcare and reproductive and child health services (such as universal

immunisation, referral and escort services for institutional deliveries, and other healthcare interventions).

Nutrition is not mentioned as part of ASHA outreach activities, although the Village Health and Nutrition Days (VHNDs) organised by the NRHM provide information dissemination and knowledge mobilisation opportunities for nutrition by the ASHA and the ANM. Most of the other foci of the NRHM are on Basic Emergency Obstetric and Neonatal Care facilities and Primary Health Centres (PHCs) to support essential newborn care, scaling up Sick Newborn Care Units, and setting up Paediatric Intensive Care Units.

NRHM Programme Implementation Plans

Every year, all states and union territories prepare programme implementation plans (PIPs), which are appraised by various divisions in the Ministry of Health and Family Welfare (MoHFW), and the final plan is approved by the National Programme Co-ordination Committee (NPCC) of the NRHM. The desk review found that the NRHM PIP 2012–2013 and the RCH II 2005–2012 PIP mentioned that all sub-centres and facilities would provide nutritional and family planning counselling and conduct VHND and other outreach services. The NRHM (RCH II) PIP mentions nutrition along with immunisation, disease control, water, and sanitation as programmes that address determinants of health and promote better utilisation of resources. In fact, nutrition may be mainstreamed into community mobilisation for better health action, building capacities of PRIs to monitor ICDS.

Decentralised bodies and local self-governance, such as the Village Health and Sanitation Committees and *panchayats*, could jointly monitor use of flexible/untied funds for local health and nutrition promotion activities. A major focus of the NRHM is on NRCs established in District Hospitals (and/or First Referral Units), prioritising tribal and high-focus districts with a high prevalence of child malnutrition. It is recommended that the optimum utilisation of NRCs be ensured through identification and referral of SAM cases in the community through convergence with AWWs under the ICDS scheme. During the SRIs, the capacity of AWWs in general to recognise SAM children and conduct referrals was questioned.

The GoMP allocates funds under the NRHM budget in varied categories to address the problem of undernutrition. The focus for the PIP 2012–2013 has been to effectively treat SAM children. For this, a budget has been allocated not just for infrastructure strengthening but also for capacity building and IEC, and management of diarrhoea, acute respiratory infections, micronutrient malnutrition, and prevention of childhood anaemia. Child Health Nutrition Training has fund allocation within the state PIP. There is no budgetary allowance, however, for holding VHNDs.

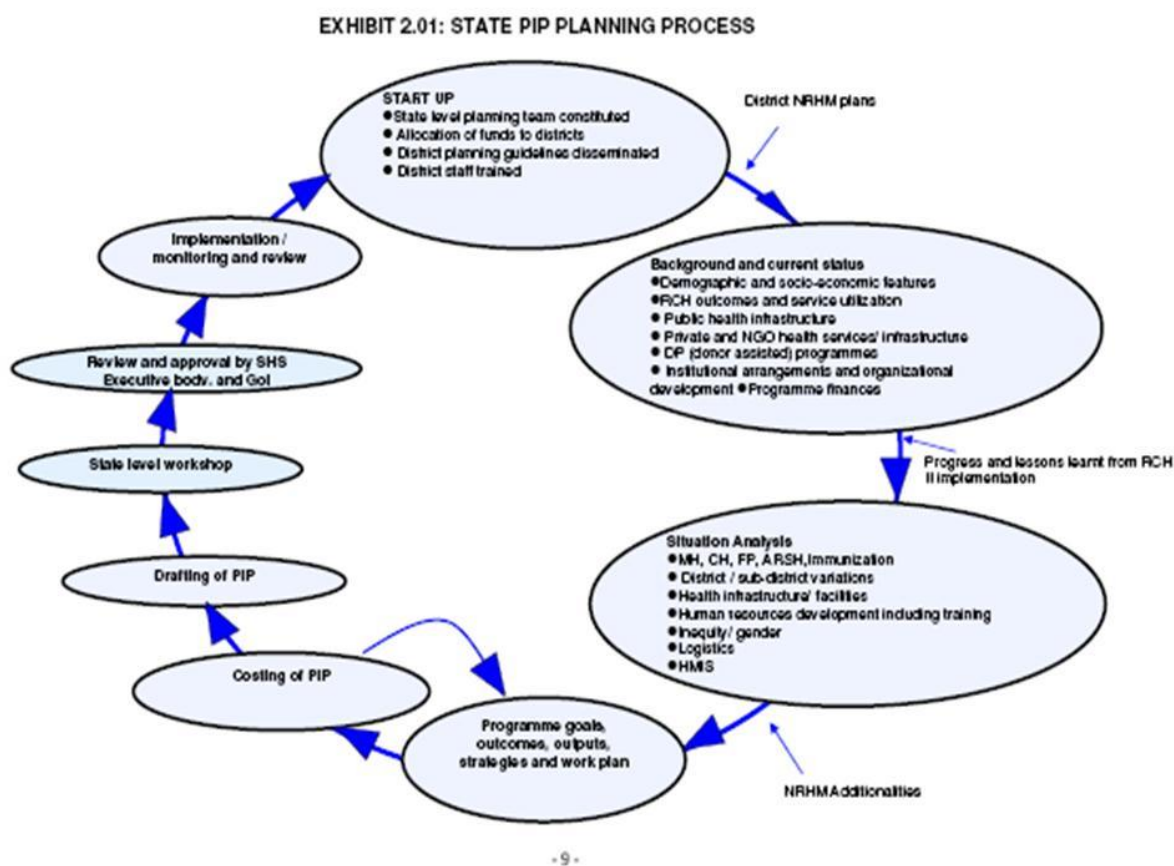
Guidelines for Preparation of NRHM Programme Implementation Plans

The PIP framework indicates that there are several sections that present opportunities for inclusion of nutrition information. Since the PIPs are prepared every financial year (April to March), the situation analysis could include current nutrition information (especially for tribal areas, high-burden districts, and vulnerable populations); the sections on previous performance and lessons learnt present scope for programme monitoring data and information as well as narratives of good practices and challenges. The desk review showed that planned interventions are framed as broad recommendations, whereas they could be much more focused and nutrition activities could be specifically targeted to areas that urgently require intervention. Infrastructure, human resources, behaviour change communication (BCC), monitoring and evaluation, quality assurance, training, gender, and convergence are some essential cross-cutting areas mentioned in the PIP. All these have a

direct bearing on nutrition and can be used to integrate nutrition interventions into the health and ICDS landscape. The PIP mandates that programme management arrangements (i.e., revised organisation charts at state and district levels clearly specifying the state and district programme management units for RCH II and linkages with the Health and Family Welfare Department) be provided along with a detailed work plan, budget, and monitoring and evaluation processes. As the budgets provided in the annexures indicate, nutrition does not have fund allocation under NRHM, and yet it is a focus area under both the ABM and the NRHM. This deficiency needs to be addressed in the PIPs, which should not only provide data on nutrition but also have provision for budget allocations for the purpose of nutrition interventions.

Figure 3 shows a detailed diagram of the PIP process. The PIP follows a systematic process. Preparatory activities include team constitution, fund allocation, dissemination of planning guidelines, and staff training. This is followed by a situational analysis that leads to the generation of programme goals, strategies, and outcomes, which are summarised in a comprehensive work plan. Costing of the PIP is an essential component of the process. The next step is holding a state-level workshop where the proposed plan is reviewed and approved by the State Health Society. The PIP is shared with the executive body of the NRHM at the centre. After the final approval is given by the state government, it is implemented and activities are monitored.

Figure 3 State NRHM PIP planning process



Targeted Nutrition Interventions under NRHM

To improve child health in the state, the NRHM in MP is focusing on the period between pregnancy and age two of the child, which is globally considered the crucial window of opportunity for reducing undernutrition. However, it is only guidelines for facility-based management of SAM children and the Village Health and Sanitation Committee (VHSC) that find mention in the interventions.

Management of Children with Severe Acute Malnutrition (SAM)

As mentioned earlier, facility-based management of SAM is a major focus area for NRHM. The MoHFW has adopted a set of operational guidelines for the provision of in-facility care and management of SAM children and MP follows these, adapting them to the state's needs. Operational guidelines cover services provided at facilities, NRCs (planning at the state and district levels along with specifications), capacity building, monitoring and evaluation, and production of targeted IEC materials. The GoMP has placed special emphasis on identification, referral, and treatment of SAM children, and special fund allocations have been made for the SAM programme. NRCs have been set up under the NRHM to manage and treat children suffering from SAM and continue to provide extra nutritional care beyond 14 days from the referral (when they are just out of the SAM category) to prevent relapse. It is recommended that adequate and specific provisions be made at the AWC level to improve the nutritional status of the children immediately after their discharge from the NRC. This is one area where convergence between the Ministry of Health and ICDS is operationalised at the district and some sub-district levels in the state.

Since management of SAM children is an important intervention to improve the status of child health, it forms an important part of the NRHM PIP. *The Bal Shakti Yojana* (Management of Severe Acute Malnutrition [SAM]) at NRCs has been implemented by the state along with the establishment of a Tertiary-Level Severe Malnutrition Treatment Unit (SMTU) and provision of IEC materials for SAM sensitisation, with financial and human resource support.

The gaps in implementation of SAM services are documented in a study conducted by the National Commission for Protection of Child Rights (NCPCR) in Shivpuri (Pohri block) of MP, in 2011 (NCPCR 2011). Study findings indicate that the process of early identification of SAM children, their timely referral, and follow-up of the children who have received NRC care is totally missing. Even when SAM children are detected, the families are not adequately counselled for admission in the NRC. There are no data to suggest that families have been advised of NRC admission except for verbal assurance. Accordingly, children in the SAM category, discharged from NRC and lost to follow-up, need to be traced and monitored. Otherwise, their chances of relapse are high.

Village Health and Sanitation Committee (VHSC)

The VHSC is an integral part of the communitisation process of the NRHM. The guidelines for the formulation of VHSCs are provided under the NRHM at the centre and are followed by the states. These committees provide an opportunity for community representatives to interface ICDS and NRHM providers and frontline workers and provide mechanisms for technical support and guidance. Essentially, the primary roles of the VHSCs are to

disseminate information and encourage and empower the community with the knowledge and skills required for fostering healthy families and communities. This is done by addressing health-seeking behaviour and promoting positive health outcomes. They also endeavour to generate community demand for healthcare services and act as social monitors on the quality and appropriateness of healthcare services.

Atal Bal Arogya Evam POSHAN Mission (ABM)

The ABM is a focal mission for innovation and up-scaling of successful interventions. Integration, coordination, and stakeholder engagement are the mission's goals for reducing malnutrition and mortality of children aged less than five years. The mission also provides oversight to the existing nutrition and health services and ensures that corrective actions are taken to strengthen service delivery, including timely and appropriate utilisation of financial resources and mobilisation of additional resources to achieve mission goals.

Strategic Objectives of the ABM

The state government has developed strategic objectives (SOs) for the *Atal Bal* Mission that include integration of planning by key departments, such as Women and Child Development (WCD), Public Health and Family Welfare (PH&FW), *Panchayat* and Rural Development, School Education, and Public Health Engineering, at the state, district, and sub-district levels; involvement of stakeholders in design and implementation of strategies to achieve enhanced coverage and programme outreach; and development of interventions that strengthen the capacity of lead departments (WCD and PH&FW) at all levels to implement evidence-based, high-quality programmatic interventions, with special emphasis on the most marginalised and vulnerable segments of the population. All these strategies would receive techno-managerial guidance and support through a revised and need-based Human Resources Management and Development strategy to optimise overall performance and enhance the coverage and quality of the healthcare and nutrition services. The SOs refer to provision of strategic guidance to the departments of WCD and PH&FW in developing a strategy to catalyse and involve community-level structures and organisations for greater community engagement and empowerment. The SOs include guidance to the departments of WCD and PH&FW to manage information for analysis of programme performance, and also identify research areas for evidence-based planning. This will lead to context-specific innovations through an integrated effort by the departments of WCD, PH&FW, *Panchayat* and Rural Development, Public Health Engineering, School Education, and Tribal Welfare.

Components of the *Atal Bal* Mission (with Special Reference to Nutrition)

Apart from the integrated management of SAM, the ABM focuses human and financial resources on household food security and intrahousehold food distribution, universalisation of ICDS, growth monitoring and promotion, infant and young child feeding, strengthening of the existing supplementary nutrition programme, and management of moderately malnourished children. Approximately five interventions are state-level initiatives based on national policies and programme guidelines and are administered under the ABM.

Direct and indirect interventions aligned to national policies include:

- *Establishment of Infant and Young Child Nutrition Cell (IYCN-cell):* Dedicated cells established at medical college hospitals with UNICEF support in Rewa and Jabalpur districts. Reinforcement of IYCF practices, breastfeeding counsellors, and “yashodas” in identified districts with support from UNICEF and the Norway India Partnership Initiative (NIPI).
- *Promotion of three-in-one IYCF practices:* Through training of frontline field workers (ANM and AWW) in IYCF counselling skills in all districts.
- Skill enhancement training of all delivery point personnel in Navjaat Shishu Suraksha Karyakram (NSSK): Training on early initiation of breastfeeding (IBF) and exclusive breastfeeding (EBF).
- *Maternal micronutrient supplementation and antenatal checkups:* All pregnant women are registered and immunised, and supplementation of IFA tablets is ensured. Promotion of institutional deliveries and referral transport through *Janani Express*.

Most of the schemes described above are facility based and focus on supplementation rather than direct nutrition interventions. Most of the other schemes do not focus on the first 1,000 days, but provide a broad range of services to control illnesses, which adds to the existing burden of undernutrition. These include schemes for improving routine immunisation in the state; providing timely and adequate supply of oral rehydration solution, zinc tablets, and co-trimoxazole for diarrhoea management; effectively managing newborn and childhood illnesses; and integrating the management of neonatal and childhood illnesses (IMNCI)/home-based newborn care (HBNC).

Four schemes within the ABM are interventions that directly address malnutrition and food security:

- *Nutrition Rehabilitation Centres (managed under the ABM):* For the management of SAM in under-five children, a facility-based model is being operationalised. At the time of the review, 224 NRCs were included in the ABM document, with plans for scale-up in all 313 blocks of the state. These units have dedicated staff and provide facility-based treatment and care to SAM children as per Indian Association of Paediatrics (IAP)/WHO protocols. Supplementary suckling techniques (SST) that help re-initiate lactation in mothers who have developed lactation failure or mother’s milk insufficiency (MMI) are an integral part of NRCs.
- *Special Nutrition Programme in 1,000 Villages:* As a scheme to address undernutrition in tribal populations, *Adiwasi Kshetron Mein Vishesh POSHAN Aahar Yojna* was introduced in the Eleventh Five-Year Plan to provide nutritious food three times a day to severely malnourished children registered in AWCs in identified malnourished clusters of 25 villages each in the tribal areas of certain districts.

These AWCs remain open for six hours instead of four hours a day. Approximately Rs.8.5 crores has been spent on the scheme per annum.

- *Special Package for Tribal and High-Risk Districts*: One hundred and forty-two blocks in the state that have a high percentage of malnutrition among young children have been identified for a special package of services. The ABM document cites reports of high malnutrition prevalence among tribal children in districts with high tribal populations and high-risk sectors as the rationale for the development of this special package of services. These services would be delivered in a focused and comprehensive manner with the objectives of addressing food security, availability of safe drinking water, and provision of health and nutrition services in identified districts. The recommended package of services includes provision of nutritious meals to children (ready-to-eat breakfast, hot cooked lunch, and Take Home Rations [THR]), with the option that the third meal can either be eaten in the AWC or provided as THR. This scheme is supported by incentives to workers who undertake home visits, provide counselling, and make efforts to declare their village free of severely underweight children. *Anganwadi-cum-crèches* in these areas are open for at least eight hours daily to take care of children of working mothers (forest workers, daily wage labourers, migrant workers, agricultural labourers, and others) with an additional full-time worker and financial allocation to cover the cost of additional food and other expenses.
- *Antyodaya Anna Yojana (AAY)*: This scheme is described as “an important milestone in providing food grains to the poor” in the ABM document. The total number of families to be covered under this scheme was placed at 1 crore at the time of its launch in 2000. A survey in MP from December 2004 to January 2005 on the functioning of this scheme shows that it has made a significant contribution to the survival of some vulnerable families. However, with the poor outreach of the public distribution system to tribal areas and the insufficient coverage of the AAY within each village, the scheme fails to make a significant difference to the food security of the poorest sections of the tribal population.

To support these schemes, the ABM strategy has linkages with the state IEC Bureau, Health Department, media, civil society organisations, and academic training institutions. In view of the fact that SRIs indicated that tribal areas were underserved and undernutrition was a major problem, and that apart from provision of food at AWCs and some growth monitoring activities, nutrition did not find a place in district-level activities, the outreach and efficacy of these programmes require evaluation from the programmatic and beneficiary perspectives.

Integrated Child Development Services (ICDS)

The ICDS is a scheme sponsored by the centre and administered by the state government as part of the *Atal Bal* Mission. The entire cost of the ICDS programme, except for the cost of supplementary nutrition, is sponsored by the central government. The ICDS programme provides nutrition and health services for children under six years and pregnant and lactating women, as well as preschool activities for children aged three to five years. These services are provided through community-based AWCs. According to the findings of NFHS-3, among the 80 percent of children under six years in MP who are in areas covered by an AWC, only half received services of some kind from a centre. About one-third of children under age six years received immunisations (38 percent), supplementary food (36 percent), and health checkups (32 percent).

Initiatives under ICDS

These include specific research, campaigns, and service delivery:

- Anganwadi Chalo Abhiyan
- Bal Sanjeevani Abhiyan
- Sanjha Chulha
- Take Home Rations
- Mapping current nutritional status by National Institute of

Twenty-nine percent of children between the ages of three and five years received early childhood care or preschool services. Almost two in five children received growth monitoring services at an AWC. More than 60 percent of mothers of children who were weighed at an AWC received counseling from an AWW after the child was weighed (NFHS-3, pp. 17–18). As part of the revised central ICDS guidelines, 50 percent of the cost of supplementary feeding is currently supported by the state government. Still, there are components of ICDS related to early childhood care that are largely neglected by most states. MP, however, has envisioned that the AWC must be the focal point for early childhood care, including health checkups and counselling.

The ABM is the nodal agency for delivery of ICDS services. The NFHS-3 data (presented in Table 2 of this report) is the evidence base, and the National Institute of Nutrition (NIN) district-level data have been used to plan these interventions. Universalisation of ICDS under the ABM includes setting up AWCs and mini AWCs in all villages and small pockets to improve accessibility for most habitations, ensuring that each village, *majra* (town), and *tola* (unit) has an AWC. When the Vision Document was drafted, there were 78,929 AWCs and 12,070 mini AWCs functional in the state, in accordance with the central government norms. AWCs were to support community mobilisation campaigns, such as:

- *Anganwadi Chalo Abhiyan*: This programme was initiated in 2009 to strengthen the delivery of ICDS services (monthly growth monitoring) and to improve the attendance of children at AWCs.
- *Bal Sanjeevani Abhiyan*: This programme addresses the high prevalence of undernutrition among children below five years of age. According to the ABM Vision Document, MP has conducted 12 biannual rounds for six years to detect malnutrition, provide vitamin A supplementation, and deliver immunisation as part of the *Bal Sanjeevani Abhiyan*. This programme covers all children in the state and has streamlined growth monitoring activities.
- *Bal Shakti Campaign*: This programme provides free medical treatment and hospitalisation services to severely malnourished children (grade 3 and grade 4 malnutrition). Parents and caregivers of malnourished children are given nutrition and health counselling while the child is being treated. As a result of this campaign, severe malnutrition in the state has declined from 5.7 percent in 2001 to 0.96 percent by 2006.

These schemes are consonant with the ICDS restructuring recommendations of the GoI. However, demand generation for services aligned to community needs is also an important requirement. The ABM and NRHM clearly need to focus on early childhood care as a package rather than mere provision of services. These interventions have been developed on the basis of district-wise profiles and causal analyses of the nutritional status of children under five years developed by NIN, which provides baseline data for district planning.

Direct nutrition interventions under the ICDS are:

- *Take Home Rations (THR)*: Nutritious and micronutrient-fortified food is distributed for six days in *anganwadi* centres for children aged 6 months to 36 months; fund allocations for AWWs have increased and the timing of *anganwadis* has also been extended from three to five hours a day.
- *Organisation of Mangal Diwas activities*: The *Mangal Diwas* (held on a Tuesday every month) picks themes related to maternal and child nutrition and provides opportunities for discussion and learning. One of the outcomes is that popular perception among the community about AWCs being a *dalia* (porridge) distribution centre has now changed. Though an appraisal of the *Mangal Diwas* programmes has not been carried out, experiences from the field show that the programme has received response from the community and awareness about childhood malnutrition has increased.
- *Sanjha Chulha*: To address the delivery of the supplementary nutrition programme, the ICDS has initiated a joint supplementary feeding programme called *Sanjha Chulha* with Mid-Day Meals (MDM) for children attending AWCs. *Sanjha Chulha* is a joint feeding programme that provides two hot cooked meals, breakfast and lunch, to children in the age group of three to six years. These meals are prepared with the assistance of local self-help groups. The initiative has allowed AWWs and helpers to spend more time with children and conduct preschool education activities and home visits.
- *Project Shaktiman*: This programme was initiated in 2007–2008 with the goal of reducing malnutrition among tribal children. The project covers 19 districts and benefits about 60,000 children in 997 villages in 38 blocks.
- *Breastfeeding promotion*: Promotion of appropriate breastfeeding practices includes three-in-one IYCF counselling skills training. The programme is publicised through radio programmes, periodic release of informative magazines and materials, cinema slides, mothers' meetings and counselling, distribution of IEC materials to AWCs, and organised competitions in various institutions.
- *Jagriti Shivir*: District- and village-level women's awareness camps help sensitise women on health and nutrition issues and mobilise community support for government schemes.
- *Home visits*: Home visits, particularly visits to families of moderately and severely malnourished children discharged from NDCs and women who have received

MP is the first state in India to implement the new WHO Growth Standards that are being used in AWCs. These standards make it easier for the AWWs to map and plot the nutritional status of children. A web-enabled management information system (MIS) system has been designed and piloted to reduce human error and support correct and timely reporting. Despite these innovations, up-scaling these interventions to all districts in the state and

sharing good practices and challenges during the yearly planning cycle still remain challenges.

Nutrition initiatives undertaken by the ABM (with development partner support):

- Supply of growth monitoring charts, weighing scales, and MUAC tapes to all AWCs is ensured with assistance from DFID.
- Training videos on correct method of weighing, growth plotting, and MUAC measurement were developed for the AWC with support from UNICEF.
- Implementation of the approved District Action Plans (DAP) under ABM is also under way with financial support from DFID.

The DAP is an initiative under the Rajiv Gandhi Mission for Community Health started in 2001 under the Department of Public Health and Family Welfare. DAPs have the following components:

- Additional nutritious diet to severely underweight children besides the Supplementary Nutrition Programme (SNP) provided through ICDS
- Convergent and decentralised planning
- Strengthening ICDS services, including capacity building of AWWs to enhance their knowledge and skills
- Involvement of different sectors of society (through *Atal Bal Mitra*)
- Behaviour change communication and public awareness
- Monitoring and evaluation

ICDS Strengthening and Restructuring

Strengthening and restructuring of the ICDS scheme to improve nutrition and child development were reflected in the midterm appraisal of the Eleventh Plan (Planning Commission 2011). The Prime Minister's National Council on India's Nutrition Challenges that met on November 24, 2010, decided to strengthen and restructure ICDS, with special focus on pregnant and lactating mothers and children under three years, using strong institutional convergence to provide flexibility for local action and to empower mothers in particular, and the community in general, to have a stake in the programme.

ICDS restructuring aims to achieve three monitorable outcomes by the end of the Twelfth Five-Year Plan (2012–2017):

- Prevent and reduce young child undernutrition (percentage of underweight children 0–3 years) by 10 percentage points.
- Improve care and nutrition of girls and women.
- Reduce anaemia prevalence in young children, girls, and women by one-fifth.

These outcomes would also reduce IMR, MMR, and incidence of low birth weight in convergence with the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls and the NRHM. To achieve the above outcomes, the Inter-Ministerial Group on ICDS restructuring report has called for systemic reforms and new initiatives to transform and re-energise the ICDS system. Some of the programmatic reforms specified, which are also reflected in the ICDS restructuring initiatives in MP, are highlighted below:

- Reposition the AWC as a vibrant, child-friendly, early childhood development centre that will ultimately be owned by the community and become a focal point for provision of health, nutrition, and early childcare services supported by infrastructure and amenities, and not merely to provide supplementary nutrition arrangements.
- Redesign and reinforce the package of ICDS services to promote childcare and nutrition counselling for mothers of children less than three years, provide regular and prioritised home visits at critical contact points, improve maternal care and nutrition, promote infant and young childcare and feeding practices (especially optimal breastfeeding, preventing growth faltering), prevent the early onset of malnutrition, and promote care for development. This would mean redefinition of the roles of the AWWs, ASHAs, and ANMs to reflect these convergent functions. The package includes skilled interpersonal counselling complemented by state communication strategies for improved maternal and childcare and nutrition; behaviour change communication for improved infant and young child feeding; and health, hygiene, and psychosocial care of girls and women.
- Enhance nutritional impact with revised nutrition and feeding norms, ensuring provision of nutritious, freshly cooked, culturally appropriate meals (morning snack and THR), guidelines, legislation, greater involvement of women's self-help groups (SHGs), and cost indexation of the SNP. Initiatives such as community and joint kitchens for mid-day meals (for reaching pregnant and breastfeeding mothers and children below three years more effectively) in the family and community have been recommended. SRIs revealed that the provision of hot cooked meals has been a success in some districts through the *Sanjha Chulha* initiative; however, challenges of providing culturally appropriate and acceptable food rations through the public distribution system (especially in tribal areas) and the inability of ASHAs and AWWs to provide nutrition information and counselling are weaknesses within the programme.

Nutrition across the life cycle, prevention and care of severely undernourished children, and strengthened linkages with the Health Department have also been mentioned in the Inter-Ministerial Group recommendations for restructuring ICDS. Innovations such as learning-by-doing sessions, nutrition counselling at AWCs for mothers of undernourished children, using positive role model mothers/peers whose children are growing well, and demonstrating and promoting optimal caring and feeding behaviours need to be introduced and up-scaled.

ICDS restructuring efforts in the state also include up-scaling and expanding coverage of Monthly Fixed VHNDs under NRHM as well as the Total Sanitation Campaign; strengthening village contact drives; involving community-level groups, volunteers, and *panchayats*; and growth monitoring through the ICDS-NRHM Mother and Child Protection Card (to be conducted jointly by AWWs, ASHAs, and ANMs). Monthly growth monitoring of all children less than three years and quarterly growth monitoring of all three- to five-year-olds will be done at Monthly Fixed VHNDs, with the active participation of VHSNCs and community monitoring of the nutrition status of children. The SRIs raised issues related to the capacities of field workers to conduct these activities due mainly to challenges related to literacy, exposure, and training. As part of ICDS restructuring it was recommended that greater powers, responsibilities, and resources be given to *panchayats* for addressing maternal health, childcare, and nutrition, and achieving greater involvement in management and supervision of AWCs. However, in the absence of political will and to position nutrition as key to overall child health and development, the actual role of

panchayats remains unclear. The SRIs did not mention any community monitoring initiatives by *panchayats*.

Convergence with related sectors, such as NRHM, TSC, National Rural Drinking Water Programme (NRDWP), *Sarva Shiksha Abhiyan* (SSA), and Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), is also recommended to strengthen the ICDS programme. This convergence could take place through joint planning; inclusion of young child-related concerns in the relevant sections of state/district annual PIPs/DAPs; joint monitoring of key results, indicators, definition of roles, and accountabilities; setting up or strengthening institutional mechanisms such as VHSNCs at the village level; and resource mobilisation for improvement of AWCs from other programme allocations.

While the documents reviewed show that most of these recommendations have been adopted under the NRHM and ABM in MP, there are major infrastructure and logistical leadership issues, as well as convergence, education, and capacity-building priority issues hindering the implementation of these initiatives. Most of these so-called “softer” issues, essential to successful programme implementation, demand a level of knowledge and understanding that does not seem to be present in the ICDS field functionaries and frontline workers. Some of these activities, such as screening and identifying malnourished children, providing referral and follow-up after treatment at NRCs, maintaining records, interpreting MIS data, conducting meetings, and providing counselling, require knowledge transfer through systematic training and resource materials that are comprehensible and useful to field functionaries. BCC has been mentioned in the restructuring recommendations and the ABM document; however, the SRIs did not mention any BCC strategies or programmes (except a study done by Real Medicine Foundation and *Vikas Samvad*). Scaling up of IYCF has been done by the WCD and Department of Health, and here convergence is being implemented by the ABM (*Sanjha Chulha*).

Overview of State Project Implementation Plans (S-PIPs) and Restructuring Initiatives under ICDS

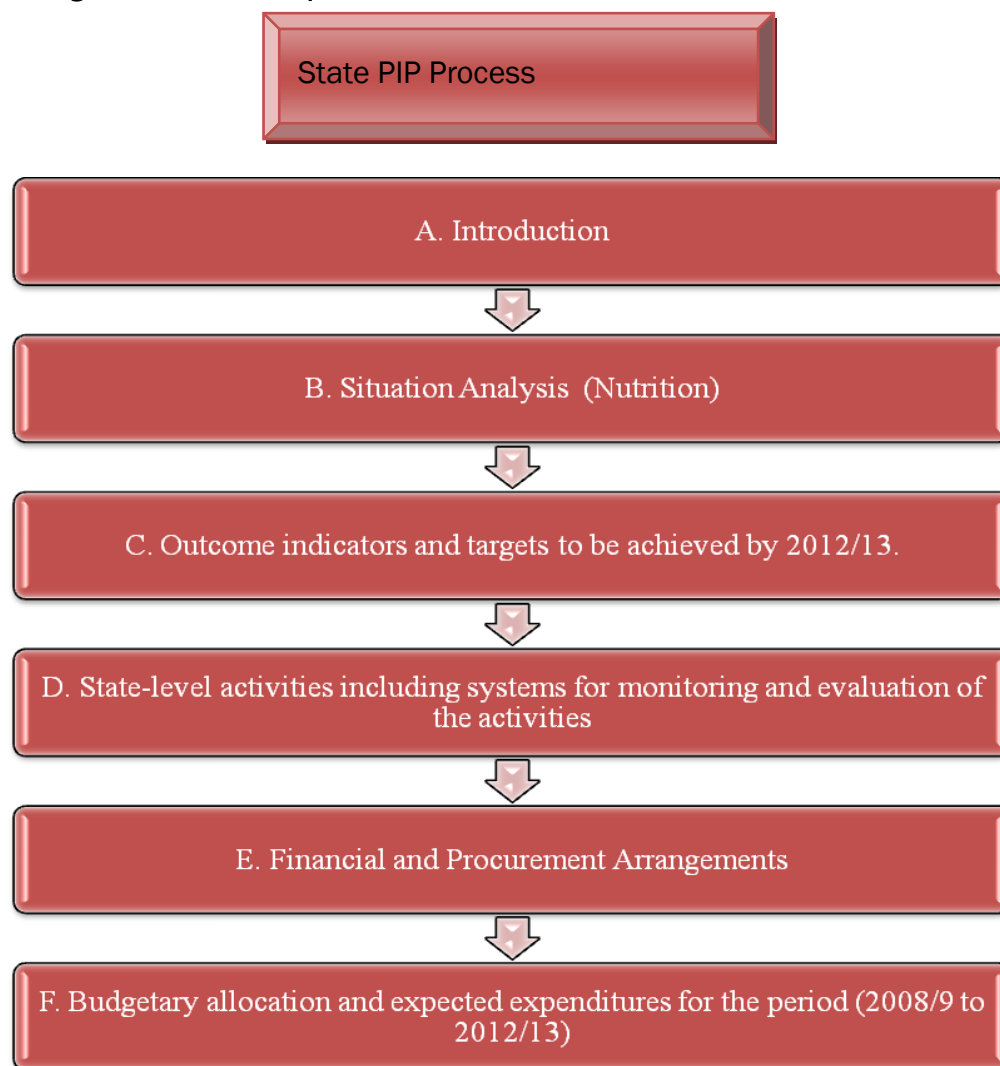
The ICDS PIPs address both undernutrition and service provision through a comprehensive package of services. Planning for the International Development Association (IDA)-assisted ICDS-IV project is to begin with the preparation of S-PIPs and DAPs that include focused strategies and activities aimed at reducing child malnutrition and improving early childhood development. While the S-PIPs will be developed for the five-year project period, the selected high-burden districts are required to submit DAPs every year.

The S-PIP will focus on state-level activities (applicable to all districts) and a district plan, to include all activities that are to be implemented in the high-burden districts during the five-year project cycle.

Outline of S-PIP

To ensure consistency and uniformity in the documentation of project plans across states, a template has been outlined by the Ministry of WCD with assistance from the World Bank and IDA. The steps are delineated below in the flowchart developed by the authors.

Figure 4 Flow diagramme of the S-PIP process



The format of the S-PIPs is presented as a set of recommendations by the central government to the states (described below). The S-PIPs were not available on the website at the time of the desk review.

The introduction of the S-PIP includes a state profile and key features that are relevant to programme planning and implementation. It draws attention to issues such as migration, low levels of female literacy that may require development of a nonverbal BCC strategy, and a high percentage of tribal and backward areas that may need a separate tribal or backward area plan to reach vulnerable populations. This would be followed by evidence-based and data-driven situation and gap analyses on the implementation of the ICDS programme in the state as a whole, and concentration on selected high-burden districts. Assessment of institutional capacity would include an outline of the current status of ICDS functioning in the state (both quantitative and qualitative information), in terms of total number of projects and AWCs, disaggregated by rural, urban, and tribal areas; total coverage and beneficiaries, disaggregated by sex and caste; staffing and infrastructure status; availability of resource centres and training institutions (ICDS, Health and Education departments); and potential institutions available to support implementation (NGOs, community-based organisations, PRIs). There is a detailed description of the current

nutrition status of the population in the state's high-burden districts, with special emphasis on the status of children below three years (the key target group for nutrition interventions under the programme). Other items of information presented in the S-PIP include details of ICDS activities to improve child nutrition status and resource materials to be made available to help the AWW, supervisor, child development project officer (CDPO), and health functionaries deliver quality services, such as the IEC materials to be developed for facilitating BCC. The S-PIP recommends the enumeration of successful interventions and good practices that have been carried out by the state, NGOs, or development partners, and their effectiveness, problems, and scalability in all high-burden districts. The information should include supporting data sources (the DLHS-RCH and the ICDS MIS, as well as any studies conducted by the state or any other agencies). Detailed monitoring and appraisal processes and technical assistance provided to high-burden districts to prepare their annual plans are to be mentioned.

Convergence and Coordination with Other Departments and Schemes under ICDS

Intersectoral convergence and coordination among departments under ICDS is instrumental for streamlining programme activities and implementing various schemes. This means that departments such as Health and Family Welfare, *Panchayati Raj* and Rural Development, Education, and Civil Supplies work together to meet the different needs of target groups. This is reflected in the Twelfth Five-Year Plan Comprehensive Working Group's recommendations to strengthen operationalisation of nutrition interventions, including a strengthened ICDS programme and convergence with the NRHM and *Sarva Shiksha Abhiyan* (Education for All).

The review of programme implementation guidelines found that there is synergy on paper with the Department of Health and Family Welfare insofar as provision of immunisation and other health-related services by the ANM. Apart from delivering services under ICDS, AWCs also coordinate with PHCs to run programmes of the Health and Family Welfare Department, such as vaccination, nutrition information, and health education. The AWWs and ANMs work in tandem and complement each other's roles and functions. AWWs promote immunisation, maintain immunisation records, refer sick children to healthcare facilities, and encourage mothers to seek antenatal care. ANMs conduct general health checkups of ICDS beneficiaries, administer vaccines, dispense medicines and contraceptives, and provide assistance and guidance to AWWs in discharging their health-related duties. Hence, in areas where there is close coordination between ANM/ASHA/multipurpose worker (MPW), AWW, and the *anganwadi* supervisor at the village level, nutrition may be mainstreamed into programme activities.

Conducting Village Health Education Days (VHEDs) is another platform for convergent action and for interaction between service providers and the community and ensures linkages between the Health Department and ICDS to promote maternal and child survival programmes. The documents reviewed mentioned that a VHED is organised once a month in all AWCs on a fixed-day basis and information on its conduct can be obtained from supervisors and AWWs.

During health checkups and growth monitoring, sick or malnourished children in need of prompt medical attention are referred to PHCs or sub-centres. The AWW lists all such cases in a separate register and refers them to the medical officer at the PHC/sub-centre. Beneficiaries with referral slips are attended to on a priority basis, and AWWs follow up on referred cases. This activity too requires a level of literacy, capacity, and knowledge for the referrals to be systematic and effective. The SRIs indicated that referrals were more

effective in areas where convergent action among field-level functionaries (especially health and ICDS) was prevalent.

PRIs in MP have a three-tier system, with *Gram Panchayats* at the village level, *Janpad Panchayats* at the intermediate (block) level, and *Zila Panchayats* at the district level. Additionally, there is the *Gram Sabha*, which is the basic unit in the *Panchayati Raj* mechanism. The role of *panchayats* is to help plan, coordinate, monitor, and, wherever required, regulate the implementation of various ICDS schemes. Recruitment of the AWWs, construction of AWCs, supply of supplementary nutrition, monitoring of AWCs, and overall support to the AWW are some of the responsibilities assigned to the *Gram Panchayat*. According to the ICDS norms, priority is given to the *Gram Panchayat* to construct an *anganwadi* building. At the time of the desk review, *Gram Panchayats* were in the process of constructing AWC buildings in 27 districts under the backward grant scheme. The advertisement shown on the next page indicates the Ministry of *Panchayati Raj's* commitment to community monitoring initiatives and to mainstreaming nutrition into the activities of the local self-government at the village level.

State Policy Initiatives

Other state-level policies have been proactively formulated by the government of MP, although not directly linked to nutrition. These are as follows:

- The MP Population Policy sets out specific targets for replacement-level fertility and IMR and maternal mortality ratios (MMR) that were to be achieved by 2011. It seeks to increase the involvement of *Panchayati Raj* institutions (PRIs), private sector organisations, and nongovernmental organisations (NGOs) in promoting people's participation in population stabilisation efforts and in reorganising management and administration of the family welfare programmes.
- The MP Women's Policy aims to ensure participation of women in the development process. Other objectives include providing protection to women in every field, promoting empowerment, and ensuring results-oriented implementation of policies, programmes, and schemes for their welfare. The policy seeks to prevent female foeticide. Policy instruments include enforcement of laws and greater social awareness.
- The MP Decentralised Drug Policy (2009) was formulated so that the district-level procurement could be done according to requirements, procured items could be inspected for quality, and payments could be released on time. Keeping this in mind, the MP Decentralised Drug Policy was proposed with the objectives of providing quality drugs and medicines at the right time to all patients in the healthcare institutions of the state; ensuring proper utilisation of drugs, goods, and equipment; and simplifying the procurement procedure for advanced and modern equipment in the medical and health institutions.

Figure 5 Advertisement from the Ministry of Panchayati Raj on special Gram Sabha meetings on nutrition

Ministry of Panchayati Raj
Government of India
www.panchayat.nic.in

Panchayati Raj

Smt. Sonia Gandhi
Hon'ble Chairperson of
NAC & UPA

Dr. Manmohan Singh
Hon'ble Prime Minister of India

Shri V. Kishore Chandra Deo
Hon'ble Minister for
Panchayati Raj & Tribal Affairs

**Towards Strengthening
Panchayati Raj Institutions & Combating
India's Nutritional Challenges**

A Special Gram Sabha

All Gram Panchayats are requested to hold special Gram Sabha meetings on nutrition on any day in August 2012. Functionaries in charge of Integrated Child Development Services (ICDS), Health, Sanitation, Drinking Water, Public Distribution System, Mid-Day Meal, Agriculture, Horticulture, Dairy and Fisheries should attend these meetings and discuss about their programs. The District and Block level officials will coordinate these meetings so that above functionaries are able to participate in all Gram Sabha meetings.

Active Gram Sabha - for Empowered People and Accountable Panchayats

davp_30/10/13/0009/1213

The NREGS entitlements to poor rural households are seen as essential support to the overall empowerment of women. Poor health and undernutrition can affect women's work output, aggravating a vicious cycle of poverty, disease, and days spent away from work. Moreover, working women often find it difficult to take care of children. Therefore, NREGA is empowered to provide crèches at work sites. The ABM document, however, states that possibilities of setting up *anganwadi*-cum-crèches will be explored for children under five years whose parents are working.

The ICDS and the Department of Education are jointly evolving a means for effective coordination to run AWCs. In an impact assessment carried out by DFID to assess component- and scheme-wise impact of ICDS in MP (Poverty Monitoring and Policy Support Unit 2010), it was observed that in many places where there was no *anganwadi* building, schools provide spaces for childcare centres. At the village level, the school administration ensures enrolment of all children from AWCs to the primary school. In the recent past, ICDS has collaborated with the PDS and schools to implement the *Sanjha Chulha* programme.

The ICDS and PDS in MP are closely linked for supplying supplementary nutrition. MP Agro supplies the weaning food *panjiri*, whereas the supply of supplementary nutrition is in coordination with the PDS. As part of the SNP, wheat and rice quotas are acquired from the GoI and allotted to the Department of Food and Civil Supplies by the Department of WCD. After getting the allotment, the Food and Public Distribution Corporation sends the cereals to the respective PDS shops, from where women's SHGs or other institutions selected by the district administration procure food. In villages where *Sanjha Chulha* has been introduced, women's SHGs involved in preparing mid-day meals also procure food from the PDS at subsidised rates.

The ABM document states that BCC is instrumental in addressing the health and nutrition gaps in the state. The document positions social mobilisation interventions as central to addressing nutrition and health issues. It states that there is need for a strategy involving print, radio, electronic, and virtual media to bring about desired changes in families and communities. BCC must be targeted to improve knowledge, attitudes, and practices of families and change social norms. Advocacy must be conducted at family, society, community, and political levels to create an enabling environment for programme innovations and to foster empowerment of women and rights-based entitlements for children.

In consonance with ICDS restructuring, the NRHM has adopted a convergent approach for maternal and child nutrition interventions under the District Health Plan. The AWC under the ICDS at the village level will be the nodal centre for health action. Under the NRHM PIP for 2012–2013, intersectoral convergence has been positioned as an essential strategy to meet the health and nutrition needs of the state. Effective coordination with key departments—namely, water, sanitation, hygiene, nutrition, infant and young child feeding, gender, education, and women's empowerment—and convergence with the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (SABLA), SSA, and ICDS, will ensure a streamlined implementation of the PIP.

Annex 2 A Protocol for Audience Research under POSHAN

Purpose of the study

The Public Health Foundation of India (PHFI) is one of the partners in POSHAN, a collaborative initiative with IFPRI and the Institute of Development Studies (IDS). POSHAN has the overall purpose of improving and supporting policy and programme decisions and actions to accelerate reductions in maternal and child undernutrition in India, through an inclusive process of evidence synthesis, knowledge generation, and knowledge mobilisation.

One of the specific objectives of POSHAN is to mobilise evidence-based and actionable knowledge to inform policy formulation and support programme planning for nutrition at the national level and in three to four states. Towards this end, PHFI is undertaking a detailed assessment of critical stakeholders and audiences to learn more about their engagement with evidence (as represented by information and knowledge), and its movement into the realms of policy and practice. The primary goal of this effort is to develop in-depth understanding of current contexts and backdrops in which the larger goal of strengthening evidence and knowledge-based decisionmaking can be achieved in coming years. A critical assumption of this is that strengthened evidence-based decisionmaking has a significant impact on tackling undernutrition.

Objectives

This study is aimed at mapping opportunities and challenges at the national and state level in India of knowledge mobilisation in the context of policies, programmes, and strategies to tackle undernutrition in India, with a view to reducing knowledge-action gaps. Towards this end, an audience research study protocol (the terms *audience* and *stakeholder* are used interchangeably and have the same meaning in this particular context) has been developed to better understand how key stakeholders:

- perceive and pursue evidence and their ability/facility to use information, knowledge, and evidence;
- use diverse modes and types of decision support;
- are a part of key knowledge mobilisation and decisionmaking processes; and
- view barriers to utilising knowledge for policy/decisionmaking processes.

The study also aims to develop:

- a broad understanding of strategies currently used to mobilise evidence-based and actionable knowledge and knowledge uptake, and
- an awareness of knowledge systems and networks and new and existing dissemination platforms that are required to make information and knowledge available to policy- and decisionmakers.

Background Information and Rationale

This study is one of the first activity phases of POSHAN and will be utilised to design a dissemination strategy to shape the landscape within which programme and policy decisions are discussed and made in India, to ensure greater attention to evidence of impact and operational success, and to create greater demand for more evidence-based and successful programming for improved nutrition in India.

PHFI contextualises this effort within our larger mandate of strengthening India's overall response to the country's public health challenges. Linkages with Transform Nutrition, another initiative at PHFI also aimed at transforming thinking and action on nutrition to accelerate the reduction of undernutrition, will be explored in taking forward the work under POSHAN, and the stakeholder research within Transform Nutrition is particularly relevant to the efforts under audience research for POSHAN.

The audience research study protocol described below is informed by a set of desk reviews and a stakeholder mapping exercise conducted with representatives from government, civil society organisations, research, and academia in January 2012. Net-Map is an interview technique developed by the International Food Policy Research Institute (IFPRI 2007) that examines the power, goals, and perspectives of various stakeholders, and looks at how these stakeholders interact with each other. The method involves listing all the actors involved in maternal and child nutrition issues at the national and regional levels, determining how they are linked, examining how influential each actor is in the development of the plan, and finally looking at ways to improve the process.

Methodology

In designing an effective dissemination strategy to strengthen and harmonise actions for nutrition in India, and as part of the effort to build a baseline, the following methods will be the mainstay of the audience and stakeholder research conducted as part of POSHAN and Transform Nutrition:

- One-on-one in-person audience/stakeholder interviews with a small set of key nutrition actors
- Policy process case study interviews (also administered as one-on-one interviews)

The methodology to be followed is detailed below:

1. The first round of audience research will be conducted at the national level and the second at the level of one state (Madhya Pradesh).
2. Questionnaire pre-testing will be conducted with a maximum of four persons, representative of the overall stakeholder interviewee group. A mid-level government official, a senior nutrition expert, a media person, and a civil society representative will be selected for the pre-test.
3. Respondents (please see Table 2) will be contacted via letter/email and telephone introducing the project and audience research study objectives.
4. Availability and willingness to participate in the audience research will be confirmed through verbal informed consent (if a particular respondent declines to participate in the interview, the same will be noted and another person will be selected from the sampling frame using the replacement technique).
5. The audience research interviews will proceed as follows:
 - a. Information gathering will use face-to-face interviews, telephone interviews, and/or group discussions.
 - b. If a respondent is genuinely unable to participate, then he/she will be requested to ask a colleague or subordinate to participate in the study.
 - c. Depending on the level of detail received, a follow-up discussion may be planned to obtain additional information.

Participant Selection (Study Population)

The selection of respondents is based on extant knowledge of key influencers and decisionmakers and partly supported by the stakeholder Net-Map results generated in January 2012. The stakeholder mapping in India was guided by the need to understand the profile of the most influential stakeholders in shaping policies and programme decisions with regard to maternal and child nutrition (in the first 1,000 days of life) in India.

The Net-Map results have been used to facilitate stakeholder selection for interviews (inclusion and exclusion). The proposed audience will include key policymakers and influencers at the central and select state levels. This is a purposive selection and includes:

Primary Audiences

- Instrumental in formulating nutrition policies
- Influential in informing policymakers
- Involved in enabling information and knowledge sharing
- Credible information sources

Secondary Audiences

- Departments/organisations that need to have an inclusive nutrition agenda
- Nutrition champions who have influenced the nutrition agenda in the country
- Civil society organisations and networks advocating for a nutrition-inclusive agenda

Sample Size Estimation

The broad parameters of the sampling are as follows:

- Audience/stakeholder research with core influential nutrition actors but also others from media, private sector, civil society, and academia (N=60; subset of 25 for interviews on sources of knowledge and information); this would include audiences from the state of Madhya Pradesh
- Policy process interviews: core government of India staff (N=10)

Expected age range of participants: Not relevant to the study

Recruitment: Described above in No. 1–5 of Methodology section

Data Collection

Interviews and information collation will be systematic and unbiased.

Data from audience research will be analysed according to certain preset categories related to key subthemes as described in the questionnaire and attention also paid to emergent issues and divergent views. Transform Nutrition stakeholder panel interviews will focus on the positioning of nutrition in policies and programmes of the government of India. The audience research will:

- capture the use of information and evidence in the policy formulation process and knowledge/information flows, and
- investigate the use of primary and secondary data sources, methods, and practices of information and knowledge sharing.

Questionnaire Response Analysis

Coding and qualitative analysis of data relevant to the audience research needs will be conducted. Verbatim notes or transcribed recordings of interviews with stakeholders will comprise data. Transcriptions of text interviews (raw data) will be processed as narratives supported by summaries of categorised information. The descriptive record of research will be coded according to audience research analysis categories as determined by those who emerge through early interviews and as part of the analysis.

Rabiee (2004) and Yin (1989) state that data analysis consists of examining, categorising, tabulating, or otherwise recombining the evidence to address the initial goal of a study. Rabiee also emphasises that the reflection, setting, and nonverbal communication expressed during the interview add a valuable dimension to the construction and analysis of data. Incoming information may also need to be viewed as part of a continuum consisting of raw data, descriptive statements, and interpretation (Krueger 1994). Using Framework Analysis (Ritchie and Spencer 1994), a thematic framework will be identified by carefully examining transcripts from which descriptive statements will be formed. Data will be sifted and sorted according to the categories, then rearranged according to the appropriate thematic context. The data will then be coded and interpreted according to the context, internal consistency, extensiveness of comments, frequency of comments, and reference to the big picture.

Data analysis and interpretation will be closely monitored to ensure quality, high fidelity, and accurate representation of audience views and knowledge.

Are there any potential risks, and what are the steps to minimise such risk?

None of the interviews is risky in any way, because they tap available knowledge and information.

What are the provisions to maintain privacy and confidentiality?

Issues of confidentiality are discussed with the interviewee before the interviews and consent is obtained before beginning the interview. All data will be treated confidentially when presented to external nonproject audiences. Interview records and transcripts will remain confidential and PHFI will maintain electronic copies of the originals.

What are the potential benefits to the field/society/participant, if any?

There are no immediate benefits to the participants because this is just administering questions and recording responses. However, the research will generate information that will be shared back with the participants of the interviews, either through a dissemination workshop in June or in writing, and will thus enable participants to benefit from the overall findings of the study. These findings are expected to be significantly relevant to any actor in the nutrition policy arena in India.

What is being used for the informed consent form and process?

Given that interviewees are high-level officials, we will not be administering a full informed consent procedure because we feel this may adversely affect interview dynamics with such individuals. Each interviewee will be informed about the research purpose through a letter jointly signed by IFPRI, IDS, and PHFI.

References

1. Dinesh, L. et al. 2011. National Commission for the Protection of Child Rights (NCPDR), Shivpuri (Pohri block) Visit Report, January 8, 2011.
2. Flick, U., ed. 2007. *Managing Quality in Qualitative Research: The Sage Qualitative Research Kit*. Thousand Oaks, CA: Sage Publications.
3. Krueger, R.A. 1994. *Focus Groups: A Practical Guide for Applied Research*. Thousand Oaks, CA: Sage Publications.
4. National Advisory Council. 2011. Recommendations for a Reformed and Strengthened Integrated Child Development Services (ICDS). Accessed at <http://nac.nic.in/pdf/icds.pdf>.
5. NFHS-3 2005–2006. Madhya Pradesh, Ministry of Health and Family Welfare.
6. Planning Commission. 2011. Report of the Inter-Ministerial Group on ICDS Restructuring, Chaired by Member Planning Commission Dr. (Ms.) Syeda Hameed New Delhi. http://planningcommission.gov.in/reports/genrep/rep_icds2704.pdf
7. Pope, C., S. Ziebland, and N. Mays. 2000. "Qualitative Research in Healthcare: Analysing Qualitative Data." *British Medical Journal* 320: 114.
8. Poverty Monitoring and Policy Support Unit. 2101. *Impact Assessment of ICDS in Madhya Pradesh 2009–2010*. State Planning Commission of Madhya Pradesh. Study supported by DFID.
9. Prochaska, J.O., and C.C. DiClemente. 1983. "Stages and Processes of Self-Change of Smoking: Toward an Integrative Model of Change." *Journal of Consulting and Clinical Psychology* 51: 390–395.
10. Prochaska, J.O., C.C. DiClemente, and J.C. Norcross. 1992. "In Search of How People Change." *American Psychologist* 47: 1102–1114.
11. Prochaska, J.O., and W.F. Velicer. 1997. "The Transtheoretical Model of Health Behaviour Change." *American Journal of Health Promotion* 12: 38–48.
12. Rabiee, F. 2004. "Focus Group Interview and Data Analysis." *Proceedings of the Nutrition Society* 63: 655–660.
13. Ritchie, J., and L. Spencer. 1994. "Qualitative Data Analysis for Applied Policy Research." In *Analysing Qualitative Data*, edited by A. Bryman and R.G. Burgess, 173–194. London: Routledge.
14. Schiffer, E. 2007. "The Power Mapping Tool, a Method for the Empirical Research of Power Relations." Environment & Technology Division, IFPRI. IFPRI Discussion Paper 00703. Washington, DC: International Food Policy Research Institute.
15. World Bank. 2005. "India's Undernourished Children."
16. Yin, R.K. 1989. *Case Study Research: Design & Methods*, 2nd ed. London: Sage Publications.

Annex 3 Audience Research Questions

Nutrition in the Overall Programme Policy Agenda

- What is the importance of nutrition in the current policy and programme agenda? Where would you rate it on a scale of one to ten?
- What are the three priority issues in nutrition you consider crucial to the programme and policy landscape?
- Do current policies and programmes address these priority issues? If not, what additional interventions would you suggest in the present context?
- Who are the key stakeholders (individuals, institutions, networks) impacting nutrition for the first 1,000 days?
- Please indicate three key actions you would like to see undertaken for an impactful nutrition response (e.g., centralise activities, convergence under a central body, separate department in the ministry).
- What are the mechanisms to influence policy through successful nutrition interventions?
- Do you think nutrition would get more attention if it were made the mandate of a larger ministry (e.g., department of Agriculture or Health and Family Welfare) or if the current ministry's agenda were strengthened and prioritised?

Policy Formulation Process

- Who are the persons/institutions critical to drafting policy? Who supports them?
- What and who has influenced your views when making policy decisions (such as personal experiences, compelling evidence reports, demonstration results from state programmes, news stories in the media, campaigns)?
- Are existing policy documents (e.g., National Plan of Action for Children or the National Nutrition Policy) used as a base, consulted, or referred to while developing new policies or guidelines?
- Do you refer to similar policy documents/guidelines of other or related ministries for more clarity or as precedence while framing new policies?
- Are current national/international documents, case studies, or research findings on the subject taken into consideration while framing policy interventions?
- How are the existing policies assessed over time? For example, why are you thinking of ICDS restructuring? What made you to take this up? And how do you alter policies based on information you get?

Information and Knowledge Sources

- What types of information and knowledge are typically needed in situations where you have been involved in formulation of nutrition policies?
- What type of information do you really look out for (e.g., statistical factsheets, programmatic information, narration of good practices)?
- What sources of information do you (individually or as a part of institutional policy) treat as credible while framing policies (e.g., government agencies, UN agencies,

international agencies, NGO reports, coalitions, libraries, media) when taking policy decisions or when framing or developing guidelines for programmes?

- What types of criteria do you use in judging information that is passed to you, or that you come across, as being credible?
- How much of this information is used as evidence in formulating guidelines or policies? What other considerations are usually applied when formulating guidelines?
- What are your usually preferred channels to receive (or seek) information?
- Where do you usually go if you need some information rapidly? [Probe for details about individuals, institutions, websites, books, reports.]
- What is your preferred format for receiving information (e.g., handouts, full print reports, electronic format with links, presentations, emails, reports, one-to-one briefings, workshops, advocacy kits)?
- If you are involved in the generation or collation of new information with a specific policy-related requirement, then what to you is the most appropriate method for this knowledge generation?

Knowledge Sharing Networks

- Are you associated with any nutrition-related networks? If so, which ones and in what ways are you associated?
- If you are not associated with any such networks, why?
- Which existing web-based or physical (on-the-ground) knowledge platforms do you find beneficial and easy to use? Why?
- What are the gaps and barriers you face in accessing information and knowledge?
- Can a knowledge network better support your work? How?

Perceptions, Opinions, Knowledge, Attitudes, and Practices Among Current and Potential Champions (Nutrition and Non-nutrition)

- What do you see as the nutrition activities or interventions that most need to be prioritised or scaled up in India? For which populations?
- What are the biggest barriers to implementing or scaling up these activities (e.g., not seen as cost-effective, lack of knowledge about the approaches, lack of political will, competing priorities, lack of capacity, lack of awareness/visibility, lack of accountability)?
- What are the significant policy and programme developments designed to tackle undernutrition within the first 1,000 days in the next five years? What kinds of interventions do you suggest this might involve?
- How do you see the role of the states in successful actualisation of nutrition policies and programmes?
- Does any of the work in which you are involved seek to address undernutrition within the first 1,000 days? How?

- Which individuals, constituencies, or groups do you see as the main advocates for tackling nutrition in the ways you've just mentioned/1,000 days? Who do you see as not very active in advocating for nutrition?
- Currently, what five issues do you think are at the top of the policy agenda?
- Are you familiar with policy and programme interventions designed to tackle undernutrition within the first 1,000 days? What kinds of interventions might this involve?
- Considering the current economic, social, and political context, do you think nutrition is a priority for concerted action in the near term? Whose priority is it, and at what level?
- Looking ahead, how likely do you think it is that there will be significant policy and programme developments in nutrition in the next five years?

On Convergence

- Which are some key ministries or departments that need to work together for better implementation of nutrition programmes in India (nationally and in states)?
- What are some key areas of convergence that will help better implementation of nutrition programmes in India (e.g., preschool and primary education, public distribution system, maternal and child health interventions, midday meal scheme)?

Annex 4 Thematic Data Analysis Plan

Thematic analysis question		Code	Output
1.	<ul style="list-style-type: none"> a. What is the profile of respondents? b. What did the respondents have to say about their work in policy formulation/knowledge mobilisation? 	Job_Desc	<ul style="list-style-type: none"> a. Profile of respondents b. Interpretation of the interview from the lens of the job undertaken by the interviewee (e.g., perspectives on the use of evidence in policymaking could be different for a bureaucrat, scientist, and activist)
2.	Descriptions of the process of policymaking	Policy_Process	<ul style="list-style-type: none"> a. How are policy decisions arrived at? b. Steps leading to the making of policies c. Agenda setting (nutrition) d. Field realities of undernutrition may or may not influence the policymaking
3.	Who are the people/agencies/organisations that influence policymaking?	PolicyMaking_Influence	<ul style="list-style-type: none"> a. Descriptions of influential people and institutions on policy formulation b. Leadership in policy formulation
4.	Use of information/evidence in policymaking	Evidence_Use	<ul style="list-style-type: none"> a. Discourse around evidence usage in policies b. Role of programmatic information and policy research information in policymaking
4.1	Credibility	Evidence_credible	<ul style="list-style-type: none"> a. Descriptions of what or whom the interviewee perceives to be credible sources b. How credible sources of information are viewed to influence policymaking
4.2	Quality	Evidence_quality	<ul style="list-style-type: none"> a. Descriptions of what is perceived to be quality information/evidence

			b. Providers of credible/quality information/evidence
4.3	Relevance	Evidence_relevance	Descriptions of what is perceived to be relevant information to be used in policymaking (in country and internationally)
5	Sources of information/evidence (availability and access to evidence)	Evidence_Source	a. Policymaking sources (including individuals) b. Sources referred to by stakeholders
5.1	Virtual knowledge networks	Evidence_VirtualKN/ Systems	a. Use of virtual knowledge network as a source of information b. Interviewee's view on strength/weakness or is he/she indifferent to knowledge network? c. Specific network mentioned
5.2	Physical knowledge networks	Evidence_PhysicalKN	a. Use of physical knowledge network as a source of information b. Interviewee's view on strength/weakness or is he/she indifferent to knowledge network? c. Specific network mentioned
5.3	Data sources	Evidence_Datasources	a. Specific mention of the use of information/data as a source of information
5.4	People	Evidence_People	People as a source of information (informal networks or formal advisors)
5.5	Academic research outputs (research briefs, documents, journals, etc.)	Evidence_academic	Evidence from academic research outputs as a source of information
6.	Opinions about Nutrition Coalition	Opinion_NutritionCoalition	Opinions about ease of access, credibility, and familiarity

7.	Opinions about Solution Exchange	Opinion_SolutionExchange	Opinions about ease of access, credibility, familiarity
8.	Barriers to using evidence in policymaking	UseEvidence_Barriers	Description of different types of barriers to using evidence in policymaking (e.g., lack of information, lack of technical expertise, lack of capacity)
9.	Facilitators to using evidence in policymaking	UseEvidence_Facilitators	Description of the facilitators for using evidence in policymaking (e.g., access to information); sources: academic reports, knowledge networks, or people; technical expertise
10.	Convergence to improve action/implementation	Convergence	<p>a. Descriptions of issues that cut across sectors, programmes, departments, and ministries that are recognised, are functional, or dysfunctional; implications for programme and policy implementation (e.g., issues of capacity gaps, or corruption; complexity of the issue)</p> <p>b. Descriptions of text where convergence is required for effective implementation (e.g., with handwashing, water sanitation, agriculture sector)</p>
11.	How best to communicate evidence?	Evidence_Communicate	<p>a. Descriptions of needs of interviewees related to their preferred communication channels/modes for gathering and disseminating information</p> <p>b. What messages to give? Types of messages, messages with caveats? What kinds of topical information, format for communication?</p> <p>c. If the preferred mode of communication is advocacy</p>
12.	Research/knowledge needs/topics	Research	Research ideas proposed by

			interviewees
13.	Learning methods, process, cross-learning	Learning	Interviewees' description of how different individuals, scientists, departments, and ministries share learning from their experiences

Bibliography

Atal Bal Arogya Evam Poshan Mission (ABAEPM) Undated. *Atal Bal Aarogya Evam Poshan Mission Vision Document 2020*. Madhya Pradesh: Department of Women and Child Development.

Bryman, A., and R.G. Burgess. 2002. "Analysing Qualitative Data." Edition published in the Taylor & Francis e-Library, www.tlu.ee/~katrinka/gigapeedia/data%20analysis.pdf.

Central Project Management Unit, Ministry of Women and Child Development. 2008. ICDS-IV PROJECT (IDA-ASSISTED) [2008-2009 to 2012-2013]. Guidelines and Processes to Be Followed for the Preparation of State Project Implementation Plans and District Annual Plans. Government of India. [http://wcd.nic.in/icds_iv_pip_guidelines_revised_\(feb_08\).pdf](http://wcd.nic.in/icds_iv_pip_guidelines_revised_(feb_08).pdf)

CORT, UNFPA. 2007. Assessment of ASHA and Janani Suraksha Yojna in Madhya Pradesh. Vadodra: CORT.

Department of Public Health and Family Welfare. 2006. *State Programme Implementation Plan: Reproductive and Child Health RCH-II*. Government of Madhya Pradesh. <http://www.health.mp.gov.in/nrhm/pip-rch-ii.pdf>

The Global Nutrition CRSP. 2012. *Agriculture, Food Security and Nutrition in Nepal—Taking Stock and Defining Priorities*. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health.

Government of India. 2013. *Budget Briefs, NRHM, GOI, 2012-2013*. New Delhi: Accountability Initiative, Centre for Policy Research.

Government of Madhya Pradesh. 2012. *Approach and Salient Features of the Eleventh Five-Year Plan: 2007-2012*. Retrieved on June 25, 2012, from www.mp.gov.in/spb/fiveyearplan/Volumelsep07/Chapter-4-salient%20features%20final.pdf.

Hyder, A., S. Syed et al. 2010. "Stakeholder Analysis for Health Research: Case Studies from Low- and Middle-Income Countries." *Public Health* 124: 159-166.

International Institute for Population Sciences (IIPS) and Macro International. 2000. *District-Level Household and Facility Survey (DLHS 3)—2007-2008*. Mumbai: International Institute for Population Sciences.

Jain, J & M. Shah. 2005. "Antyodaya Anna Yojana and Mid-Day Meals in MP." *Economic & Political Weekly.*, Vol 40, No. 48, November 26, pp. 5076-5088

Lokshin, M., M. Das Gupta, M. Gragnolati, & O. Ivaschenko 2005. "Improving Child Nutrition? The Integrated Child Development Services in India." *Development and Change* Volume 36, Issue 4, July, pp 613-640.

Menon, P., A. Deolalikar, & A. Bhaskar, 2009. *India State Hunger Index: Comparison of Hunger Across States*. Washington DC: IFPRI.

Ministry of Health and Family Welfare, Government of India. 2006. *National Family Health Survey (NFHS-3 2005-2006) India—Madhya Pradesh*. Mumbai: International Institute for Population Sciences.

Ministry of Health and Family Welfare, Government of India. 2011. *Operational Guidelines on Facility-Based Management of Children with Severe Acute Malnutrition*. Retrieved on October 21, 2012, from [http://mohfw.nic.in/NRHM/Documents/CH/Operational%20Guidelines%20on%20Facility%](http://mohfw.nic.in/NRHM/Documents/CH/Operational%20Guidelines%20on%20Facility%20)

20Based%20Management%20of%20Children%20with%20Severe%20Acute%20Malnutriti on.pdf.

Ministry of Health and Family Welfare, Government of Madhya Pradesh. 2012. "State-Specific Targets for 5 Years." In *NRHM PIP 2012–2013*.

Novick, L., and G. Mays. 2001. *Public Health Administration: Principles for Population-Based Management*. Gaithersburg, MD: Aspen Publishers.

Paul, V.K., H. Singh et al. 2011. "Reproductive Health and Child Health and Nutrition in India: Meeting the Challenge." *The Lancet* 377 (January 22).

Planning Commission. 2011. *Report of the Inter-Ministerial Group on ICDS Restructuring*. New Delhi: Planning Commission.

SAM India Project. Retrieved on July 17, 2012, from www.samindiaproject.org/resources.asp.

State Health Mission, Department of Health and Family Welfare. 2012. *National Rural Health Mission: Meeting People's Health Needs in Rural Areas, Programme Implementation Plan 2006–2012*. Bhopal: Government of Madhya Pradesh.

Strauss, A., and J. Corbin. 1990. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Thousand Oaks, CA: Sage Publications.

UNICEF. 2009. *Coverage Evaluation Survey*. Madhya Pradesh Fact Sheet. UNICEF. http://www.unicef.org/india/MP_Fact_Sheet.pdf

UNICEF. 2013. "Undernutrition: A Challenge for India." Retrieved on April 10, 2013, from www.unicef.org/india/nutrition_1556.htm.

WHO. *Health Sector Reforms in India: Initiatives from Nine States*. Geneva: WHO.

WHO. 2012. *Landscape Analysis on Countries' Readiness to Accelerate in Nutrition: Country Assessment Tools*. Geneva: WHO.

World Food Programme. 2011. *India Biennial Report 2010–2011*. http://www.wfp.org/sites/default/files/India_Biennial_Report_2010_2011.pdf

POSHAN

Led by IFPRI 

IFPRI-NEW DELHI

INTERNATIONAL FOOD POLICY RESEARCH INSTITUTE

NASC Complex, CG Block,
Dev Prakash Shastri Road,
Pusa, New Delhi 110012, India
T+91.11.2584.6565 to 6567
F+91.11.2584.8008

