Incorporating Nutrition Actions in Rural Livelihoods Projects

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Incorporating Nutrition Actions in Rural Livelihoods Projects: Program Guidance Note

Table of Contents

ACRONYMS ................................................................................................................................. iii

SECTION I: Background and Rationale .......................................................................................... 1

1. Background and Rationale for World Bank Involvement: .................................................... 1
2. Purpose of the Program Guidance Note-why, what and for whom? ................................. 2
3. Malnutrition in India .................................................................................................................. 2
4. Government of India’s Multisectoral Policy and Programs .................................................. 3
5. Why Invest in Nutrition? .......................................................................................................... 3
6. Nutrition is a Multisectoral Problem and Requires a Multisectoral Response: ...... 4
7. Basics in Nutrition ..................................................................................................................... 5
   a. Malnutrition ........................................................................................................................... 5
   b. Consequences of Undernutrition: ....................................................................................... 5
   c. Importance of Nutrition in the First 1,000 Days-Window of Opportunity .................. 6

SECTION II: RURAL LIVELIHOODS AND NUTRITION ................................................................. 6

8. Background of National Rural Livelihood Mission (NRLM) ............................................. 6
9. Nutrition cum Day Care Centers (NDCCs) in Andhra Pradesh ...................................... 7
10. Brief about the Bihar Rural Livelihoods Project (Jeevika) ................................................ 8
11. Nutrition Sensitive Rural Livelihoods .................................................................................... 10
12. Key Principles to incorporate Nutrition in Rural Livelihoods Projects .......................... 10
13. Key Steps ................................................................................................................................ 12

SECTION III: Case Study- Jeevika’s Multisectoral Convergence Pilot in Bihar .................. 13

14. Background of Jeevika’s Multisectoral Nutrition Convergence Pilot in Bihar .... 13
15. Developing the Design of the Multisectoral Convergence Pilot: .................................. 14
16. Sample Checklist that can be used to develop nutrition sensitive interventions 15
17. Design and Planning Stage ....................................................................................................... 16
18. Objectives and Results Framework................................................................. 17
19. Nutrition Sensitive Interventions of the Model ............................................. 17
20. Institutional Arrangements and Delivery Mechanisms .................................. 19
22. Program Impact Pathway: as in the diagram below ....................................... 21
23. Design of an Impact Evaluation....................................................................... 21
24. Key Issues, Opportunities and Challenges:................................................... 22
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist</td>
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<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
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<tr>
<td>AWW</td>
<td>Anganwadi Worker</td>
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<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
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<td>BMGF</td>
<td>Bill and Melinda Gates Foundation</td>
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<td>BRLP</td>
<td>Bihar Rural Livelihood Project</td>
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<td>BRLPS</td>
<td>Bihar Rural Livelihood Promotion Society</td>
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<td>B-TAST</td>
<td>Bihar Technical Assistance Support Team</td>
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<td>CNCCs</td>
<td>Community Nutrition Care Centers</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>FSF</td>
<td>Food Security Fund</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GoB</td>
<td>Government of Bihar</td>
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<td>ICDS</td>
<td>Integrated Child Development Scheme</td>
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<td>IQ</td>
<td>Intelligent Quotient</td>
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<td>JS</td>
<td>Jeevika Saheli</td>
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<td>NDCCs</td>
<td>Nutrition Day Care Centers</td>
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<td>NLTA</td>
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<td>ODF</td>
<td>Open Defecation Free</td>
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<td>PAD</td>
<td>Project Appraisal Document</td>
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<td>PCI</td>
<td>Project Concern International</td>
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<td>PDS</td>
<td>Public Distribution System</td>
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<td>PHED</td>
<td>Public Health Engineering Department</td>
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<td>PGN</td>
<td>Program Guidance Note</td>
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<td>RAS</td>
<td>Regional Assistance Strategy</td>
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<td>SA</td>
<td>South Asia</td>
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<td>SHGs</td>
<td>Self Help Groups</td>
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<td>SNP</td>
<td>Supplementary Nutrition Program</td>
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<td>TTL</td>
<td>Task Team Leader</td>
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<td>VO</td>
<td>Village Organization</td>
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<tr>
<td>WB</td>
<td>World Bank</td>
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<td>WDC</td>
<td>Women Development Corporation</td>
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<td>WSP</td>
<td>Water and Sanitation Program</td>
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SECTION I: Background and Rationale

1. Background and Rationale for World Bank Involvement:

The World Bank is committed to reduce malnutrition and has made investments in multiple sectors, many of which are relevant for nutrition. It is promoting a multisectoral approach as one of its policy and program strategy. This will be done through *nutrition specific interventions*, primarily by the health sector and indirect *nutrition sensitive interventions* which could be implemented through other sectors such as Rural Livelihoods, Agriculture, Food Security, Social Protection, Water and Sanitation, besides others. These sectors will need to explore, plan and implement interventions and investments to maximize nutrition benefits for women and young children. To promote that to happen it is important to support and enable program planners and implementers to move towards a multisectoral approach to nutrition by providing them programmatic guidance and tools as they develop their programs and projects.

India currently has one of the highest prevalence rates of malnutrition in the world. There are significant regional disparities in nutrition indicators across states with 60 percent of malnutrition burden found in the lagging or low income states (Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan and Uttar Pradesh).

Bihar is a poor state with high malnutrition burden. It is also a priority state for the World Bank Operations and has been selected as the geographical area for trying out the Multisectoral Approach to Nutrition Actions. One of the several Operations of the World Bank underway is the Bihar Rural Livelihoods Project which was the Bank’s first loan to Bihar. The project aims to promote social and economic empowerment of poor rural women on a large scale in Bihar.

Under the World Bank Non Lending Technical Support Assistance (NLTA), Bihar has been selected as the specified geographical area to mainstream nutrition sensitive interventions across multiple sectors and program platforms in three World Bank Operations. The NLTA was based on consultations with government counterparts and client organizations. The technical assistance has been undertaken in two phases. Phase 1 was the scoping and design phase and Phase 2 will be the implementation of the designed interventions. This Program Guidance Note is limited to the Design phase.
2. Purpose of the Program Guidance Note-why, what and for whom?

a. This Program Guidance Note (PGN) is developed to assist the program planners and implementers of Rural Livelihoods Projects and other stakeholders involved from relevant sectors. The purpose is to analyze and design nutrition sensitive interventions within the Rural Livelihoods projects. The PGN is meant for generic guidance and is suggestive rather than prescriptive which can be adapted to specific operational and project contexts. It provides the rationale, need, importance and the how of nutrition actions that can be incorporated into the design of new and or ongoing project/s. It sets out the principles for action related to design of nutrition interventions and to work with multiple stakeholders through a project cycle approach.

b. The PGN will be developed in two phases. Phase 1 which is the present Program Guidance Note is related to the development and design of nutrition sensitive interventions within the Rural Livelihoods project drawing on the experience of designing the Multisectoral Nutrition Convergence pilot by the Bihar Rural Livelihoods project (Jeevika) with technical support from the nutrition team at the World Bank. This would be useful and relevant for similar projects within the framework of the National Rural Livelihoods Mission (NRLM) and the National Rural Livelihoods Project (NRLP) supported by the World Bank. Phase 2 PGN will be developed later as a sequel to this Program Guidance Note and will provide guidance on the implementation, monitoring and evaluation aspects.

c. The PGN is structured into three sections. Section I provides information on the background and rationale, causes and consequences of malnutrition and why it is important to invest in Nutrition. Section II provides information on the National Rural Livelihoods Mission and Projects and key principles to incorporate nutrition within it and some practical steps required to be taken to design and implement Nutrition Actions. Section III draws on from the Case Study of the Jeevika Multisectoral Nutrition Convergence Pilot in Bihar to develop the design of nutrition sensitive interventions using the project cycle approach.

3. Malnutrition in India

India faces a development paradox of economic growth and malnutrition which remains unacceptably high. Around one third of the world’s undernourished children are found in India. Maternal and child malnutrition attributes to more than one third of the mortality of children less than 5 years many of which are preventable through effective nutrition interventions operating at scale. One third of the children are born with low birth weight, 43 percent children less than five years are underweight, 48 percent are stunted and 20 percent are wasted. Micronutrient deficiencies are extremely high and almost 75 percent of below three children are anemic, 62 percent deficient in Vitamin A and over 13 million infants remain unprotected for iodine deficiency disorders.
There are significant disparities in the prevalence of malnutrition based on socio-economic groups and geographical areas. Malnutrition varies across states with some states being worse off than others, with rural areas being worse off than urban areas. Malnutrition is found to be higher in poor, marginalized and vulnerable groups such as scheduled caste and tribes and other disadvantaged groups.

The problem of malnutrition is complex and multi-dimensional affected by several factors such as poverty, gender inequality, inadequate food consumption, inequitable food distribution, inappropriate maternal, infant and child feeding and care practices, poor hygiene and environmental sanitation, limited access to health, education and social services. Other factors which contribute to it include economic, political, social, cultural and geographical, as well as issues related to governance and accountability.

4. Government of India’s Multisectoral Policy and Programs

India has accorded high priority to combating malnutrition given that it remains extremely high despite the multitude of efforts made by the Government. Given the multi-dimensional nature of the nutrition challenge, a plethora of government programs such as the Integrated Child Development Scheme (ICDS), National Rural Health Mission (NRHM), Nirmal Bharat Abhiyan (NBA), Public Distribution System (PDS) and others are being implemented to address nutrition and health challenges. However, these programs operate in their own silos, face implementation challenges and slow progress has been made to improve nutrition outcomes.

The Government has recently made a policy commitment to mobilize multisectoral action to address the multiple causes of malnutrition effectively and is formulating a Multisectoral Strategy jointly by the Ministries of Women and Child Development and Health and Family Welfare. The Multisectoral Program will bring strong nutrition focus in various sectoral plans through institutional and program convergence and provide a platform at all levels to facilitate convergence of the key services and stakeholders to address maternal and child undernutrition. The Multisectoral Nutrition Program will be implemented as a special intervention in 200 high malnutrition burden districts across the country in a phased manner.

5. Why Invest in Nutrition?

As mentioned above, there is a renewed focus on nutrition from the international community and the Indian government- both central and states which have started to give nutrition or malnutrition the attention that it deserves. It is well known that investment in nutrition can lead to sustainable development, economic growth and improve the well being of people. It can significantly
contribute to positive outcomes in maternal and child health, cognitive development and educational attainment and breaks the intergenerational cycle of poverty. There are substantial economic costs of undernutrition which results in losses of direct productivity estimated at more than 10 percent which affects the lifetime individual’s earning capacity and contributes to about 2-3 percent loss to GDP. In terms of human development, malnutrition in early years results in loss of height in adolescence, delay in starting schooling and loss of schooling. It makes children 30 percent more likely to escape poverty as adults. Stunted mothers are three times more likely to have malnourished infants. Much of this under-nutrition is during pregnancy and in the first two years of a child’s life and without appropriate interventions the damage to physical and cognitive development, economic productivity and human development are enormous and largely irreversible.

6. **Nutrition is a Multisectoral Problem and Requires a Multisectoral Response:**

The determinants of malnutrition are multisectoral. Its immediate causes are related to food intake and health, whereas the underlying causes relate to maternal and child care practices, lack of access to health services, availability of clean water and sanitation, girl’s education, social protection and gender issues. The basic causes of undernutrition are due to institutional, economic, political, and social issues such as poverty, governance, leadership, organizational capacity and environmental issues.

The determinants of malnutrition call for convergent actions between sectors including rural livelihoods, agriculture, water and sanitation, health, education and women’s empowerment. Unless the determinants of malnutrition are adequately addressed it will not improve nutrition outcomes and reduce malnutrition. Therefore there is an urgent need to move from rhetoric to action
towards convergent multisectoral action to reduce poverty and demonstrate improvement in nutrition outcomes by bringing together different sectors to work in coordination.

<table>
<thead>
<tr>
<th>Nutrition Specific Interventions</th>
<th>Nutrition Sensitive Interventions</th>
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<td>A term that refers to interventions that directly address inadequate dietary intake or disease which are the immediate causes of malnutrition. These include: promotion of breast feeding, complementary feeding, treatment of malnutrition, micronutrient supplementation and deworming, adolescent and maternal health and nutrition.</td>
<td>These are interventions within sector specific objectives which aim to improve the underlying determinants of nutrition, namely food security, adequate maternal and child care at household and community level, access to health services, hygiene and environmental sanitation, and incorporates specific nutrition objectives and actions. Various actions that would address the determinants of malnutrition are possible in many sectors such as rural livelihoods, agriculture, water and sanitation, education and so on.</td>
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7. Basics in Nutrition

a. **Malnutrition** is poor nutritional status caused by nutritional deficiency (undernutrition) or excess (overnutrition). The focus is on undernutrition which results from inadequate quantity and quality of food, disease and inadequate care and feeding practices that results in underweight (low weight for age), stunting (low height for age) and wasting (low weight for height) and /or micronutrient deficiencies.

Maternal malnutrition: Many children are born undernourished because their mothers are undernourished. The nutritional status of women and girls are affected due to several factors such as limited access to food, traditional and cultural practices where women tend to eat the last and least, early marriage, repeated pregnancies, frequent infections with limited access to health care and sanitation.

b. **Consequences of Undernutrition:**
   - **Single largest cause of child death**
   - **Lost human capital:** Undernourished children have poorer cognitive development, lower school attainment and lower IQ, lower productivity and incomes as adults and are more likely to have undernourished children thereby perpetuating poverty.
   - **Lost economic growth:** It is estimated that undernutrition costs as much as 2-3 percent of GDP in many low income countries.
• **Irreversibly important for the first 1000 days:** Malnutrition experienced during pregnancy and the first two years of life will have severe and irreversible consequences on child development.

• **Nutrition is important throughout the life cycle:** Malnutrition reduces adult workers productivity, exacerbates disease, results in reduced work capacity, and chronic fatigue.

c. **Importance of Nutrition in the First 1,000 Days—Window of Opportunity**

Pregnancy to age 24 months, the first 1,000 days of life is the critical window of opportunity. By the time children reach their second birthday, if undernourished, they could suffer irreversible physical and cognitive damage which could impact their future health, development and well being. The consequences of insufficient nourishment in early childhood can continue into adulthood and be passed on to the next generation as undernourished girls and when women have children of their own. The importance of proper nutrition during this 1000 day period in pregnancy and until 24 months of the child’s life is therefore critical. Effective interventions are known which when provided during the first 1000 days of life can improve undernutrition. These include exclusive breast feeding, appropriate complementary feeding, micronutrient interventions (Vitamin A, iodine and iron), deworming, hand washing and hygiene and food supplementation in food insecure households. It is critical to ensure these interventions reach women and children during the narrow window of opportunity.

**SECTION II: RURAL LIVELIHOODS AND NUTRITION**

8. **Background of National Rural Livelihood Mission (NRLM)**

The National Rural Livelihoods Mission (NRLM) is perhaps the largest poverty reduction initiative and the largest program for women in the world. The World Bank is supporting this program through its National Rural Livelihoods Project, which is its largest single investment in a poverty reduction program. NRLM will be implemented in 12 states that account for 85 percent of the rural poor households in India.

The NRLM reaches down to the household level to support the formation of institutions of the poor at the community level from Self Help Groups (SHGs) to aggregation of these institutions which are federated at village, cluster, block and district levels. These provide a collective space and voice for the poor especially women to work together to leverage resources and services related to livelihoods. These include savings, building assets, adoption of new livelihoods for themselves and their families. The vast resources enable the institutional platforms to engage with many sectors and interact with many service providers. The program was a wide outreach.
Through the National Rural Livelihoods project, the World Bank provides technical and financial support to improve program delivery. The program which is being rolled out in a phased manner will allow the 12 states that have high poverty rates (Bihar, Andhra Pradesh, Tamil Nadu, Madhya Pradesh, Chhattisgarh, Jharkhand, Karnataka, Maharashtra, Orissa, Rajasthan, Tamil Nadu and Uttar Pradesh) to implement large scale pilots, create demonstration sites and best practice to incorporate lessons learned. It provides an excellent program platform to incorporate Nutrition Actions. An example of the model that has incorporated nutrition interventions under the World Bank supported Andhra Pradesh Poverty Reduction project called Nutrition cum Day Care Centers (NDCCs) is given below.

9. **Nutrition cum Day Care Centers (NDCCs) in Andhra Pradesh**

This World Bank supported pilot program aims to reduce malnutrition and improve nutritional status of pregnant and lactating women and young children from poor households in the long term. The NDCCs are community driven, community owned and community supervised rather than having a top down approach. They have been built on the social infrastructure of women’s Self Help Groups (SHGs) and their Village Organizations (VOs) and federations that have been established across the state for almost two decades. NDCCs aim to provide complete nutrition to pregnant and lactating and their children below two years with three cooked, well balanced meals a day on site to ensure that the food is consumed by the beneficiaries themselves. The cost of the meal is being recovered through a variety of measures with a view to becoming financially sustainable. These include amongst others, payment by beneficiaries (one third of the cost of the meal), linkages with programs like ICDS and Public Distribution System (PDS) to get food in bulk and at subsidized prices and to use fresh foodstuff from the centers own community gardens. The NDCCs seek to ensure provision of antenatal care for all pregnant women, postnatal care for mothers and immunization for young children, increase awareness and behavior change for maternal, infant and young child health and nutrition practices and repayment for services by the NDCC beneficiaries. Since 2007, through a phased incremental approach around 5000 NDCCs have been established in villages across Andhra Pradesh.

It is recommended that a Review of other Nutrition Sensitive Interventions within Multisectoral Projects that are being implemented especially in the Rural Livelihoods sector be carried out to draw lessons learned on what has worked well and why and what has not worked well so that these can be used to inform future nutrition interventions that can be planned and carried out within the framework of the National Rural Livelihoods Mission and Projects.
10. Brief about the Bihar Rural Livelihoods Project (Jeevika)

The Bihar Rural Livelihoods Promotion Society (BRLPS) is an independent society set up by the Government of Bihar (GoB) and supported by the World Bank. The GoB has designated BRLPS as the State Rural Livelihoods Mission for implementation of NRLM at the state level. The BRLPS is implementing Jeevika-Bihar Rural Livelihoods Project (BRLP) to promote social and economic empowerment of the rural poor especially women which is being carried out on a large scale in Bihar.

The objectives of the project are to:

i) Create self managed community institutions of participating households,

ii) Enhance income through sustainable livelihoods,

iii) Increase access to social protection including food security by enabling women to have a voice in implementation of such schemes.

The strategy of the project is to build dynamic, self managed social capital comprising of community institutions of women. The strategy promotes savings, credit and livelihood opportunities where community organizations revolve leveraged funds to meet their various needs. The Self Help Groups (SHGs) are the primary level community organizations which are federated at village level into Village Organizations (VOs) as well as at the cluster and block levels. The project is moving towards a saturation approach to cover all the poor households in the geographical areas of its operation. The BRLP intervenes with the community through the following four themes which include: i) Institution and capacity building, ii) Social development, iii) Microfinance and iv) Livelihoods promotion.

Nutrition Actions within BRLPS

More recently, BRLPS has included Health and Nutrition interventions as a fifth theme which is being incorporated within its Project. Initially this was done with a view to reduce health expenditures and provide food security to its target group of women. Jeevika is presently experimenting with different models and approaches of nutrition interventions which are being carried out in different geographical areas and in collaboration with different sectors and organizations. These are being implemented through Jeevika’s community structures and project infrastructure.

The various models and approaches on Nutrition of the BRLPS include:

i) The Community Health and Nutrition Care Centers (CHNCCs): This pilot was started in 2012 with the objective of setting up community managed Nutrition Care Centers to improve nutrition and health and nutrition seeking behavior among pregnant and lactating women and young children below two years from the poorest and disadvantaged households. It is based on the Andhra Pradesh Nutrition cum Day Care Centers model. The CHNCCs are supported by the Village Organization (VO) structure and targets pregnant and lactating women
and for children 13 to 24 months provides them with nutritious on site meals three times a day at the center. It promotes exclusive breast feeding for children from birth to six months and provides weaning foods for children from 7 to 12 months as well as nutrition and health education, health check up and immunization through monthly check-ups. The beneficiaries are SHG members who pay a subsidized amount for the meals.

ii) **BRLPS administered Supplementary Nutrition Program model for ICDS:** will be piloted in 5 blocks where VOs will administer supplementary feeding program. BRLPS will receive funds from the ICDS which will in turn be transferred to the VOs who will procure food supplies, supervise distribution of take home rations to pregnant and lactating women, prepare and distribute supplementary food to children below six years at the AWCs. This intervention provides the potential to enhance community participation and improve service delivery of the supplementary nutrition component of the ICDS through an open, transparent and accountable process.

iii) **The Gram Varta model:** The purpose of this intervention is to promote positive health, nutrition, water and sanitation practices in the community through the platform of SHGs. Gram Varta is a process of 20 participatory learning and action based meeting cycles delivered through SHGs using participatory methods integrating nutrition, health, water and sanitation messages targeting pregnant women and young children under two years (1000 days window of opportunity). Community meetings by VOs to engage with local service providers in order to seek their participation for improving service delivery. Technical and capacity building support is provided to Jeevika by the Technical Assistance support team (B-TAST) and learning and financial support by the Women Development Corporation (WDC). The first phase will cover 36 Blocks in five districts of Bihar.

iv) **Model of collaboration between BRLPS and Project Concern International (PCI) to improve nutrition and health service coverage and outcomes.** The Ananya program is a consortium of development partners funded by the Bill and Melinda Gates Foundation (BMGF) implementing a package of demand and supply side of interventions with a focus to reduce maternal and child mortality and improve health and nutrition outcomes. PCI through its Parivartan program is implementing interventions that aim to catalyze community mobilization and action to bring change in desirable behaviors specifically eight on health and nutrition and four related to water and sanitation through mobilizing and strengthening SHGs.

v) **The Multisectoral Nutrition Convergence Pilot:** Jeevika has developed this pilot with technical support from the nutrition team at the World Bank. The pilot builds on Jeevika’s existing community institutions of Self Help Groups (SHGs) and Village Organizations(VOs) to interface with multiple local service providers through a community based convergence approach to generate demand, improve quality and utilization of services, enhance mutual accountability and improve nutrition especially for women and children. The pilot will start small as a feasibility phase with inbuilt mechanisms for learning, monitoring and scale up.
The above nutrition action models/approaches of Jeevika are at different stages of planning, start up, implementation, and are located in different or in some cases same geographical areas. Some of these models have focused on center-based feeding for the nutritionally vulnerable groups mainly pregnant and lactating women and young children (1000 days window of opportunity) in conjunction with health check-ups and behavior change communication, and in some instances the water and sanitation component has been included. The Jeevika Multisectoral Nutrition Convergence pilot is a systematic attempt of a community based multisectoral convergence approach of working with multiple sectors and stakeholders to generate demand and improve service provision for improved nutrition outcomes.

The various models and approaches adopted by Jeevika are of different scope, size and scale. It provides a unique opportunity for BRLPS to learn from them on what and how to implement nutrition sensitive interventions and to assess the effectiveness and outcomes of these different approaches for future scale up.

This Program Guidance Note draws on the experience of developing the design of the Multisectoral Convergence Pilot by Jeevika with technical support from the World Bank.

11. **Nutrition Sensitive Rural Livelihoods**

A large proportion of malnourished persons reside in rural areas and the most affected amongst them are women and children. Rural livelihoods provide a source of income for the poor especially women through savings and livelihood opportunities. Simply increasing women/household incomes and agriculture production are insufficient to improve nutritional status of family and within it women and young children (especially the 1000 days window of opportunity). Many poor and vulnerable households lack nutrition and health information and awareness and often do not avail of existing services. Investing in nutrition especially for women will not only improve nutrition outcomes for their families and community but will also support rural livelihoods and poverty reduction efforts.

Therefore Rural Livelihoods is an important sector and has the potential to address nutrition especially for women and children on a large scale and would further empower poor and disadvantaged women. Nutrition sensitive Rural Livelihoods policy and projects can influence and improve nutrition outcomes for the rural poor especially women and young children by layering nutrition actions related to food and nutrition security, maternal, infant, child and adolescent health and nutrition practices, create demand for services and its utilization by providing appropriate nutrition support through its community platforms.

12. **Key Principles to incorporate Nutrition in Rural Livelihoods Projects.**
Guiding principles can be kept in mind to incorporate nutrition sensitive interventions into the design and implementation of policies, projects and investments within the National Rural Livelihoods Mission/Rural Livelihoods projects. These can be adapted and used to individual contexts.

- **Incorporate nutrition concerns into the design and implementation of Rural Livelihoods projects, policies and investments and to measure nutrition outcomes.** The way to achieve this principle is to include nutrition objective/s and nutrition sensitive interventions explicitly into the project design and to measure nutrition outcomes and results which should be part of the overall Monitoring, Results and Evaluation framework of the project.

- **Target nutritionally vulnerable groups.** In the rural livelihoods project, the population that is being targeted is the poorest and most marginalized women who are being reached. From a nutrition standpoint, the most nutritionally vulnerable groups within this target group which needs to be prioritized and reached is the target group “1000 days window of opportunity” which starts during pregnancy and closes at about 2 years of age which is the critical period for preventing child malnutrition.

- **Increase year round availability of diverse food basket to the income and food deficit households.** The affect of seasonal food shortage and seasonal income deficits (periods when there is no/little work available) can have negative consequences on food and nutrition security of the household especially for the critical 1000 days window of opportunity. To prevent and mitigate this situation and to reduce the affect of food shortage on families and nutritionally vulnerable within it, it is important to provide access to diverse food basket throughout the year. Information related to when food and income shortages occur, who gets most affected by it and for how long and how severe needs to be obtained. By using a nutrition lens, the project can plan and implement (during periods of food scarcity and otherwise) what provisions need to be made through different mechanisms such as food security fund or alternate income generating activities, what and how much food would be required to meet the food and nutrition needs of the households especially for pregnant women and young children.

- **Improve nutrition knowledge among rural households especially women:** Incorporate nutrition awareness and communication to target behavior change especially related to maternal, infant and child health and nutrition, safe hygiene and sanitation practices for the community especially women.

- **Empower women in nutrition and invest in them.** Increase in rural women’s incomes through livelihood opportunities has contributed to women’s economic empowerment. This can be further strengthened by juxtaposing nutrition and health knowledge and awareness and building capacity of women’s collectives and strengthening their role in decision making including how community resources and household incomes are spent. Women who control income have significant positive effect on child nutrition, family food security, health seeking behavior besides other benefits. Given that women play multiple roles within household and community, it will not only benefit them but also their families and community.
• **Promote interface between demand and supply and seek opportunities to work across sectors.** Through community structures and organizations promoted and strengthened by the rural livelihoods programs (NRLM) these can be enabled to foster linkages and engage with nutrition, health and sanitation programs for mutual accountability. Promote interface between demand and supply through community platforms for convergence with service providers from multiple sectors. This would require multisectoral planning, coordination, geographical overlaps and creating shared structures and commitment for coordination in order to improve nutrition outcomes. Issues around governance and accountability, roles and responsibilities and incentives for coordination will need to be well defined. Actions can be planned taking into account the context, objectives and operating environment

• **Reaching nutrition to the unreached:** The Rural Livelihoods project primarily targets the most impoverished and vulnerable households which are often missed out by service providers and difficult to reach. Discriminated groups require specific measures to help them overcome obstacles that impede their access to and utilization of nutrition, health and sanitation services and to make these services more responsive and accountable to their needs.

• **Develop understanding and capacity on nutrition as a development priority:** Develop capacity of human resources within the project in nutrition (especially on maternal and child nutrition) at all levels (relevant project staff and community cadres) and to ensure training, capacity building support, mentoring and guidance, motivation and recognition is provided for nutrition work especially for front line workers and community cadres.

13. **Key Steps**

• In the case of an ongoing project, review the Project Document to understand the project objectives, results framework, activities, geographical areas covered, implementation arrangements, project status and key issues. Assess what could be possible opportunities and key entry points for incorporating nutrition interventions. For new projects, engage at the outset during the project preparation and design stage to incorporate nutrition actions within it.

• Get commitment and buy-in from the Project Leader (PL) and other related staff and continue to engage with them on an ongoing basis in the development of the design of nutrition sensitive interventions for incorporation within the Rural Livelihoods project. Keep PL and concerned staff in the loop and get their support to problem solve and help make progress during different stages of the project cycle.

• Project site visits and meetings with the project task teams of counterpart organizations at the state, district and block levels. Consultations with key stakeholders from project (concerned state, district and block project staff, VO members and other community members) as well as external stakeholders- from government programs (such as the ICDS, NRHM, PHED and other development
organizations working in the area) to understand the context, programs and issues in the operational area.

- Information and analysis of the context, nutrition problems, opportunities and risks to incorporate nutrition sensitive interventions within the project platform, building on need and what is there.
- Identify key entry points and synergy between the Project and Nutrition Actions identified.
- Provide ongoing technical support in nutrition to the project team in design of the project.
- Develop and build a perspective amongst the team on the importance of nutrition within the project framework.

The Project Leaders and Program Implementers and other Stakeholders of Rural Livelihoods Projects to take action to include in their new and or ongoing project design nutrition objective, nutrition sensitive interventions and measure its progress through relevant output and outcome indicators.

SECTION III: Case Study- Jeevika’s Multisectoral Convergence Pilot in Bihar

14. Background of Jeevika’s Multisectoral Nutrition Convergence Pilot in Bihar

BRLPS (Jeevika) has developed the Multisectoral Nutrition Convergence pilot with technical support from the nutrition team at the World Bank. The model aims to promote community based convergence approach through interface between community organizations (VOs) and local service providers in nutrition, health and sanitation from government programs(ICDS, NRHM and PHED) to generate demand and utilizations of services for improved nutrition outcomes.

The pilot is in its early stages of implementation in Saharsa District within one block of Saur Bazar to cover three panchayats with 29 Village Organizations. The interventions will reach out to the targeted areas covering the most vulnerable disadvantaged households and groups with priority given to pregnant women and young children. Some interventions will cover the entire community. The initial feasibility phase will be for a period to learn from and adjust before it is scaled up.

The nutrition sensitive interventions of the pilot include:
1. Behavior Change Communication (BCC) in nutrition, health, water and sanitation.
2. Household Food and Nutrition Security
3. Convergence and Coordination between community organizations and local service providers
4. Water and Sanitation Component –demand generation and service provision
5. Women’s Empowerment will be cross cutting.
The Approach adopted by the model as well as its geographical location of the pilot is given below:

**Approach adopted by the Pilot:**
- A bottom up, community based participatory approach starting small with plans for scale up through learning and adjustment.
- Promote interface between demand and service provision of nutrition sensitive interventions through a community based convergence approach.
- Leverage resources, expertise and learning’s of the different stakeholders.
- Adopts a multisectoral approach with multiple stakeholders.
- Invest in women and their empowerment.

**Map of Bihar and the Pilot Area**

15. **Developing the Design of the Multisectoral Convergence Pilot:**

A Project Cycle Approach was adopted to develop the design of the model. The design was developed based on context analysis, multi-stakeholder analysis and extensive consultations within Jeevika (with communities and project staff) and consultations with external stakeholders from government and development organizations working in the area.
### Sample Checklist

#### 1. Analysis of the context and nutrition issues in the operational area

**Sample Questions**
- What are the prevalent nutrition problems in the operational area and more widely?
- Which population and target groups suffer the most?
- What are the existing maternal, infant and child care practices?
- What is the role of women in addressing these problems?
- How can increased incomes be used to improve food and nutrition security of households?
- Who are the service providers and development organizations working in nutrition, health, sanitation in the geographical area of operation?
- What are the opportunities and risks for community structures to work with them?

**Tools:** Review existing documents, consultations with key stakeholders, site visits, Focus Group Discussion with SHGs/VOs members.

#### 2. Consultation with women from SHGs/Village Organizations

**Sample Questions**
- Dietary/food consumption patterns
- Seasonal food availability (households and community) and intra-household food consumption
- Prevalent practices related to maternal, infant and young child feeding, hygiene and sanitation practices
- Awareness and use of nutrition and health services
- Roles and responsibilities of women within household and community and in decision making

**Tools:** Focus Group Discussion with members of SHGs and VOs

#### 3. Consultations with project staff

**Sample Questions**
- What are the nutrition problems in the area?
- What, why and how can nutrition activities be incorporated into the project?
- What are the activities that can be built on and strengthened? E.g. Food Security Fund, kitchen gardens, agriculture/nutrition related livelihoods activities?
- Need and how to collaborate with government services
in the area?
- What are the potential opportunities and risks and suggestions?

**Tools:** Meetings with staff, one to ones

<table>
<thead>
<tr>
<th>4. Consultations with external stakeholders (ICDS, Health, PHED, District leadership and development organizations) to explore the potential for collaboration</th>
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<tbody>
<tr>
<td><strong>Sample Questions</strong></td>
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<tr>
<td>- What is the perception about multisectoral coordination? Who and what (sectors and constituents) to collaborate with and for what purpose?</td>
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<tr>
<td>- How to facilitate coordination and collaboration between community and service providers in nutrition, health and sanitation? (horizontally and vertically)</td>
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<tr>
<td>- What would be the triggers to work multisectorally?</td>
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<td>- How to make coordination and collaboration work over time?</td>
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<td>- What should be the structure, mechanisms, motivation, dynamics and accountability for this coordination? How can it be mutually beneficial?</td>
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<tr>
<td>- How to develop shared understanding and commitment to coordination?</td>
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**Tools:** Consultations with multi-stakeholders, meetings, workshops

17. **Design and Planning Stage**

Drawing from the context analysis, extensive consultations within Jeevika (community and staff) as well as consultations with external stakeholder of government departments and development organizations and keeping in mind the guiding principles, the design of the Multisectoral Convergence Pilot was informed and developed as given in the Design Framework below.
The model adopts a multisectoral convergence approach to address the immediate and underlying causes of undernutrition, informed by consultations and building on and strengthening existing initiatives (Food Security Fund) within Jeevika and to address some of the opportunities and challenges (absence of coordination between community and government programs like the ICDS, health, water and sanitation and others) which are operating in silos in the same geographical areas.

The objectives of the model and its expected outcomes and results are given below.

18. Objectives and Results Framework

19. Nutrition Sensitive Interventions of the Model

i) Behavior Change Communication (BCC) on nutrition, health, water and sanitation. The BCC approach will promote awareness and actions as depicted in the diagram below. Capacity of community cadres (Jeevika Sahelis, other community cadres) and the project staff of Jeevika will be developed in BCC so that they can understand, influence and drive change in behavior on key nutrition, health and sanitation messages. Some of the key messages will focus on the window of opportunity to improve nutrition to include adolescent and maternal health and nutrition, infant and young child feeding and care practices, and those related to health, hygiene and sanitation. These messages will be communicated through one-to-one and one-to-many approaches using and leveraging existing appropriate tools, materials and resources developed by different organizations working in the area. The community cadres will support local service providers in nutrition, health and sanitation for BCC during group meetings and community events.
ii) **Household Food and Nutrition Security**: The purpose is to promote availability of a diverse basket of food to the poorest and most vulnerable households who are food and income insecure. As one of the measures, the existing Food Security Fund (FSF) within Jeevika will be restructured from a nutrition lens to target the poor households including those with pregnant women and young children below two years through the micro-planning process and tool. The FSF will make available the basic food basket of cereals, pulses, oil and other food items as required at reasonable cost throughout the year. Kitchen gardens will be promoted and universalized to ensure availability of fresh fruits and vegetables for consumption within targeted households. Emphasis will be on food availability and intra-household consumption especially by pregnant women and young children. In addition, Jeevika Sahelis will facilitate participation and contributions from mothers with young children (6 to 24 months of age) to encourage them to prepare and feed suitable locally produced nutrient dense foods to their children below two years.

iii) **Institutionalize Convergence and Coordination**: between community (Jeevika Saheli/VO members) and local service providers of government programs (ICDS, NRHM and PHED) for enhanced demand, improved community participation, greater mutual accountability and improvements in nutrition outcomes. Coordination structures and mechanisms at village, block and district levels will be established to provide support. Village Coordination Committees of local service providers (AWWs, ASHAs, ANMs, panchayat reps, school teachers and others) and Jeevika Sahelis and VO representatives will plan, coordinate and monitor activities related to health, nutrition and sanitation for the community through monthly meetings. Building rapport and trust, confidence and close working relationship between community and service providers will be promoted. Recognition, rewards and incentives would be provided for good work in coordination.

iv) **Water and Sanitation Component**: Community mobilization and motivation of households will be undertaken by triggering behavior change to stop open defecation (ODF) and create demand for safe sanitation. In response linkages to services will be made to include building and use of safe toilet facilities. Personal hygiene and sanitation practices will be promoted through BCC actions for individual and collective action and change. Technical support will be provided by Water and Sanitation Program (WSP).
v) **Women’s Empowerment**: will be promoted through their enhanced awareness and capacity to participate in decision making and to access resources and services so that women are able to meet their nutrition, health and sanitation needs as well as for their families and community.

![Improved Nutritional Status Diagram]

20. **Institutional Arrangements and Delivery Mechanisms**

The pilot is being implemented through the existing institutional arrangements of Jeevika. The following will be involved:

*At Community level:* Community cadres will be the main implementers of the pilot. Jeevika Sahelis are the nodal persons in the community for implementation of the activities of the pilot. She will be supported by the Health and Nutrition committee (3-4 members per VO) and Procurement committee members (3-4 members per VO for FSF) and community mobilizers and village resource persons. JS is responsible to the VO. The roles and responsibilities of the community cadres and structures have been defined.

*At Block and District levels:* The District Health and Nutrition Manager would be responsible for the pilot under the overall leadership of the District Project Manager. Need based support as required will be provided by other relevant project staff (Area Coordinator and Community Coordinator) at the block level to support the community cadres.

Technical support in nutrition for development of the design and implementation has been provided by the WB Consultants.

The organogram at community and block level is provided below.

**Structure at Community**

**Structure at District Level**
Role of Jeevika Sahelis:
The Jeevika Saheli is a community cadre responsible for carrying out health, nutrition, and sanitation activities related to the pilot through the community institutions of Self Help Groups and Village Organisations (VOs) set up by the Jeevika. The Jeevika Saheli is oriented and trained for activities to be carried out by her.
1. Deliver Behavior Change Communication messages at fortnightly SHG meetings, and initiate discussions on relevant topics among women members and its follow up.
2. Mobilize the community to participate and access health, nutrition, and sanitation services.
3. Coordinate with front line nutrition and health workers through participating as a member in the monthly village coordination meetings and its follow up to achieve and improve coordination.
4. Work with other community cadres and the Village Organization’s Health, Nutrition, and Sanitation sub-committee to support the implementation of activities related to the pilot such as kitchen garden, food security fund, and safe sanitation.

The Jeevika Saheli is responsible for implementation of activities on the ground for two Village Organizations. The work of the Saheli is overseen and reviewed by the Village Organization’s subcommittee on health, nutrition, and sanitation.

21. Capacity Building:
A capacity building approach to strengthen capacity of community cadres and concerned project staff on different components of the pilot will be undertaken.
Ongoing basic training and mentoring support will be provided to Jeevika Sahelis and other community cadres. Technical support is provided by Consultants.

22. Program Impact Pathway: as in the diagram below

![Diagram of Multisectoral Convergence Model]

23. Design of an Impact Evaluation

**Evaluation:** An external Impact Evaluation is planned for rigorous evaluation of the pilot. Funding from SIEF is likely to be approved soon (seed funding was received to develop the proposal). The evaluation will be conducted by the International Food Policy Research Institute (IFPRI) and the Oxford Policy Management (OPM). The impact evaluation will have a treatment group which will receive the interventions package of the multisectoral nutrition convergence pilot and a control group which will provide the counter factual. Both groups will have the same structure of community based organizations that include women’s Self Help Groups and their federation of Village Organizations (VOs) thus providing a robust and best possible counter factual. Treatment and control VOs will be randomly selected. Bias due to spillovers could take place. To minimize this, assignment of treatment and control groups will be clustered and specific attention will be given to ensuring that there is adequate space between clusters of both groups. Clustering will also ensure internal validity. A quantitative baseline will set base parameters and subsequent midline and end line will be undertaken. The evaluation period is for three years. This evaluation and its results will be extremely useful from a policy and program perspective as there are few initiatives operational on ground and evidence on their impact is scarce. With established community platforms and infrastructure available, this provides a unique opportunity to test this model and provide evidence on the efficacy and impact of a multisectoral approach in Nutrition.
24. **Key Issues, Opportunities and Challenges:**

This pilot has generated a lot of issues and learning’s based on the design development phase that need to be taken cognizance of in multisectoral approach to nutrition. There will be a lot more issues that will emerge once the pilot is implemented. Some of the key issues are as below:

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<tr>
<th>Key Issues</th>
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<tr>
<td>The model has been developed in an ongoing Rural Livelihoods Project, which will be first piloted before it is scaled up.</td>
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<tr>
<td>It is important to provide suitable investments (technical, human and financial) for nutrition actions.</td>
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<td>Provide technical support in nutrition to the project staff to develop design and initially to help start -up implementation and provide ongoing mentoring and capacity building support.</td>
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<td>Develop perspective and understanding among the project team about the importance of nutrition as a development priority and its relevance to the project</td>
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<td>Identify within institutional structure, those responsible for implementing nutrition actions(among project staff and community cadres) with clarity of their roles and responsibilities and accountability</td>
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<td>Address issues related to ownership, commitment and time among staff for nutrition interventions. Competing priorities and workloads can de-prioritize nutrition interventions.</td>
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<tr>
<td>Provide suitable Incentives, Reward and Recognition for carrying out nutrition actions</td>
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<td>Leadership and Champions within the organization can provide impetus to nutrition actions</td>
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<tr>
<td>Setting up institutional coordination structures and mechanisms to work multisectorally with multiple stakeholders requires organizational commitment and responsibility, is time intense and requires a different way of working. It has to add value for all concerned stakeholders.</td>
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