Report No: AUS0001183

India
Assam: Improving Nutrition and Development Outcomes in Early Years

State Engagement Report

November 2019

HNP

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(P168656)

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THE WORLD BANK
November 2019

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Acknowledgements

The team thanks the Government of Assam for their partnership and support during the course of the design and implementation of this technical assistance (TA). The leadership and guidance of Alok Kumar, Chief Secretary, Government of Assam, Rajiv Bora, Additional Chief Secretary, Department of Transformation and Development, and Dr. John Ekka has been valuable. We are grateful to R.M. Dubey, Head and Professor, Centre for Sustainable Development Goals (CSDG) for anchoring the TA activities, mobilizing stakeholders including district leaders and teams, and in ensuring timely and successful completion of the TA activities.

We gratefully acknowledge the key role played by the Government of Assam's departments of Women and Child Development, Health and Family Welfare, Education, Water and Sanitation, Social Welfare, Food, Civil Supplies and Consumer Affairs, Agriculture and Panchayat and Rural Development and their representatives in the districts of Barpeta, Udalguri and Goalpara to support multi-sectoral planning and convergence.

We thank the Coalition for Food and Nutrition Security (CFNS), in particular A. R. Nanda, Bhaskar Baruah and Sujeet Ranjan for their technical support in implementation of the TA activities. We acknowledge the support of Manish Sabharwal and Shubhankar Nath in the development of the online dashboard requested by the Government of Assam.

This work has received core financial support from the SAFANSI Trust Fund. We are thankful to the peer reviewers, Deepika Eranjanie Attygalle (Senior Health Specialist, HSAHN), Ziauddin Hyder (Senior Health Specialist, HEAHN) and Emanuela Galasso (Senior Economist, DECPI) for reviewing the draft report and providing valuable inputs to strengthen the report.

List of Acronyms

ACS	Additional Chief Secretary
ASA	Advisory Services and Analytics
ASHA	Accredited Social Health Activist
ASRLM	Assam State Rural Livelihood Mission
ATMA	Agricultural Technology Management Agency
AWC	*Anganwadi* Centres
AWW	*Anganwadi* Worker
ANM	Auxiliary Nurse Midwife
CFNS	Coalition for Food and Nutrition Security
CSDG	Centre for Sustainable Development Goals
CSR	Corporate Social Responsibility
ECD	Early Childhood Development
FSSAI	Food Safety and Standards Authority of India
ICDS	Integrated Child Development Services
ICT	Information and Communication Technology
IFA	Iron Folic Acid
IMR	Infant Mortality Rate
IPC	Inter-Personal Counselling
IYCF	Infant and Young Child Feeding
KPIs	Key Performance Indicators
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MoU	Memorandum of Understanding
NCS	National Crèches Scheme
NCT	Government of The National Capital Territory
NFHS	National Family Health Survey
NIPCCD	National Institute of Public Cooperation and Child Development
NITI	National Institute for Transforming India
NLTA	Non-lending Technical Assistance
NRC	Nutrition Rehabilitation Centres
PDS	Public Distribution System

PHED	Public Health Engineering Department
PW	Pregnant Women
SAM	Severely Acute Malnourished
SBA	Skilled Birth Attendant
SDGs	Sustainable Development Goals
SHG	Self-Help Group
SHSI	Single Holistic Synergized Initiative
SIHFW	State Institute of Health and Family Welfare
T&D	Transformation and Development
TA	Technical Assistance
THR	Take Home Ration
UNDP	United Nations Development Program
UNICEF	The United Nations Children's Fund
VHAI	Voluntary Health Association of India
VHSND	Village Health Sanitation and Nutrition Day
VO	Village Organization
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
YM	Young Mothers

1. Introduction

This report describes the World Bank's technical assistance (TA) engagement with the Government of Assam during September 2018 to September 2019. The technical assistance was provided in response to a request from the Government of Assam and supported the Government of Assam, in particular the Center for Sustainable Development Goals (CSDG), under the state's department of Transformation and Development (T&D). The broad objective of the TA was to support the state to adopt, effectively implement and monitor multi-sectoral approaches to strengthen policies, institutions and programs to improve nutrition and early childhood development outcomes in the state.

The TA activities supported activities at the state level and in the three of Assam's seven aspirational districts[1], Barpeta, Udalgudi and Goalpara, selected for the TA in consultation with the Government of Assam the Government of Assam. These were designed to specifically contribute to the four key areas of support requested by: i) enhance institutional and human capacity of CSDG at the state level and in its district cells; ii) develop and operationalize multi-sectoral result-based approaches; iii) promote knowledge creation and sharing to improve program effectiveness; and iv) strengthen program management information system and monitoring across sectors.

All activities were undertaken with the active engagement of multiple stakeholders that included besides the CSDG, representatives of the Coalition for Food and Nutirtion Security (CFNS), the technical agency appointed by the World Bank: several Government departments such as T&D, Health, Social Welfare, Agriculture, P&RD, Water & Sanitation, Education; development partners; media; independent technical experts and agencies; academia; training organizations; and at the district level engaged district and sub-district officials from various departments; development partners working in the district and frontline workers

The engagement with the Government of Assam was one of the three strategic state engagements for multi-sectoral investments in the Early Years, undertaken under the Programmatic Advisory Services and Analytics (ASA), Investing in Early Years: Toward Realizing the Potential of India's Children and was funded through the SAFANSI Trust Fund.

The report is structured into four sections. Following this Introduction is a section that provides the context and rationale of the TA, including the situation of key health and nutrition indicators in the state as well as in the three aspirational districts. The third section outlines the key points of the TA – its objectives, activities, outputs and outcomes. The fourth and final section discusses the key learnings from this engagement.

[1] *Under the 'Transformation of Aspirational Districts' Program anchored by NITI Aayog, 115 districts from across 28 states have been identified as 'Aspirational Districts'. The Program ranks districts based on a composite index comprising of health, nutrition, education, basic infrastructure and poverty. The districts which have shown relatively less progress across different sectors and thus, require focused policy attention – are termed as aspirational districts.*

2. The Context and Rationale for the Technical Assistance

2.1. Nutrition and Early Childhood Development (ECD) challenges in India and Assam

2.1.1. ***Although India has shown progress in improving child nutrition, the undernutrition burden in the country remains high.*** One-fourth of India's children are born with low birth weight, 35.7 percent of children under five are underweight, 38.4 percent are stunted and 21 percent are wasted. Iron deficiency is wide spread, exists across income quintiles and age groups as over 53 percent of women of child bearing and over 58 percent of children under five are anemic (National Family Health Survey, 2015-16).

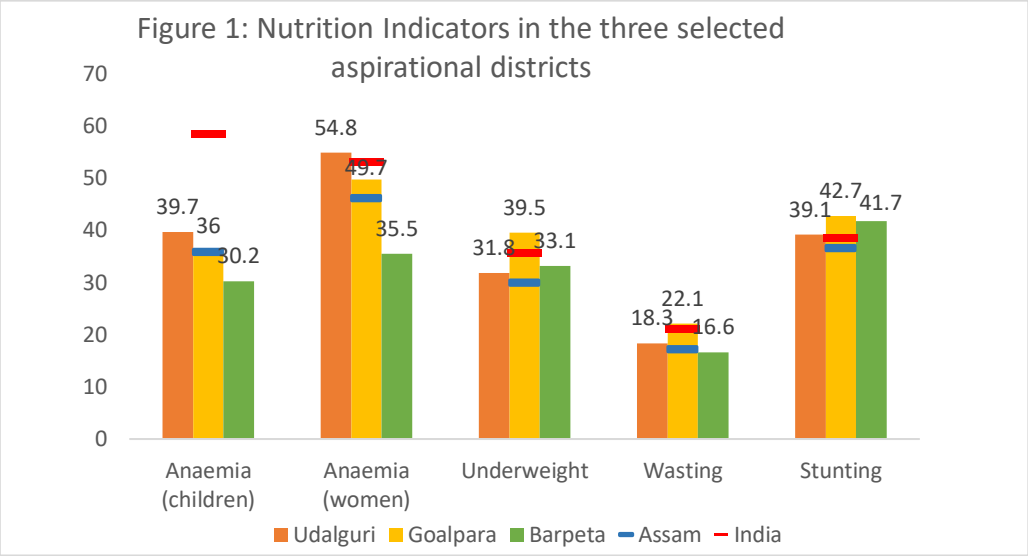
2.1.2. **A*ssam is amongst the bottom five states of the country in terms of health and nutrition indicators.*** The following paragraphs indicate the status of key health and nutrition indicators, underscoring the need for engagement to improve nutrition outcomes in the state:

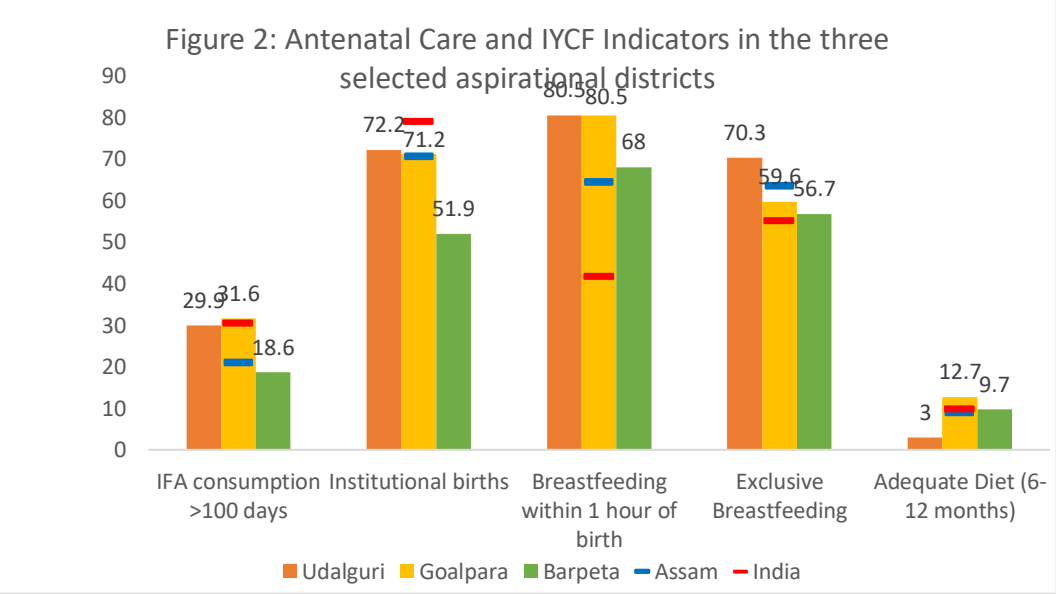
- *High undernutrition levels including micronutrient deficiencies* - around 37 percent of under-five children are stunted (low height/age ratio), 17 percent are wasted (low weight/height ratio) and around 30 percent are underweight (low weight/age) (Fig 1). Although the figures are better than national average but Assam should strive for improved outcomes especially in terms of stunting and underweight. U5 in all the figures refer to under 5 years of age. More than 35 percent of children aged 6-59 months are anaemic; 46 percent of women in the reproductive age group and 25.4 percent in men are anaemic in the state;

- *Coverage of health and nutrition remains low.* For example, data from the National Family Health Survey 4 (NFHS 4) presented in figure 2 indicates that only around 50 percent of children below five years of age received the due vitamin A doses, and 47 percent were fully immunized; less than 50 percent of pregnant woman received the recommended four antenatal check-ups

- *Household behaviours and practices critical for health and nutrition are sub-optimal.* For example, merely 8.9 percent of children (6-23 months) in the state receive an adequate diet (Inadequate complementary feeding during the weaning period is thought to be a significant contributor to child malnutrition in India); only around 30 percent of pregnant women consumed Iron Folic Acid (IFA) tablets during pregnancy; less than 50 percent of the households have access to improved sanitation facilities (NFHS-4) (Fig 2).

2.1.3. ***The three aspirational districts selected for the TA are amongst the lowest ranking districts of the state in terms of human development and infrastructure and are prioritized for focussed policy and program action across sectors.*** During the review of the TA for approval, NITI Ayog had urged that the TA also include a few aspirational districts. Assam has seven of the 115 aspirational districts identified by NITI based on a composite index comprising of health, nutrition, education, basic infrastructure and poverty. Of the seven aspirational districts in Assam, in consultation with the Government of Assam, the districts of Barpeta, Udalguri, and Goalpara were selected for district level support. All three districts rank amongst the bottom ten districts of the state for stunting; Goalpara has the highest prevalence of underweight in children in the state and Udalguri has the highest percentage of anemic women and children. Figures 1 and 2 show the nutrition indicators and the status of antenatal care and recommended infant and young child feeding (IYCF) practices in these districts. The situation calls for concerted action across sectors to improve nutrition and health outcomes.





2.1.4. ***The policy and program environment in Assam indicates high commitment to accelerating progress towards the SDGs***. Assam has embraced the SDGs and is the first state in India to have applied the framework of the Global Sustainable Development Agenda 2030 as a guide for the long-term development strategy and plan for the State. The document articulates the focus on people's engagement, partnerships and innovation, adopting the "whole of government" approach – ensuring that all government agencies work in an interconnected way toward the SDGs. Strategies also include: (i) re-orienting, re-aligning and re-prioritizing existing programs; (ii) Integrating, synergizing and re-energizing the different components of SDGs; and (iii) re-defining the structures, retooling the processes and rejuvenate the people. Assam has also established the Centre for SDGs, a knowledge hub for Single Holistic Synergized Initiative (SHSI), that, inter alia, will use knowledge/tools for strategizing, planning and implementation to move the state towards meeting the SDGs has also been setup. The state also has plans to setup district level SDG cell and a robust technology platform for tracking the progress pertaining to the SDGs.

2.1.5. ***Nutrition and ECD remain high priorities for the state Government and the request for technical assistance from the Bank specifically requested support for is committed to improve the indicators in the state.*** As mentioned, the Government of Assam has committed itself to meeting the Sustainable Development Goals (SDGs) in the state, as also to transform the state's food security and nutrition landscape, especially for the vulnerable groups. In February 2016, the Government of Assam released its vision document, Assam 2030 and in October 2016, the Strategic Plan document. In consonance to the vision document, the Assam Government has finalized the 'Assam Agenda 2030 – Strategies and Actions for Achieving the Sustainable Development Goals.'

3. The Technical Assistance Objectives, Activities and Outcomes

3.1. Key points of the TA

3.1.1. **The TA objectives were aligned to support the state's priority of bringing SDGs into the state's policy discourse and accelerate progress towards the SDGs.** The TA aimed to support the Government of Assam, in particular the Government of Assam's Center for Sustainable Development Goals (CSDG) to adopt, effectively implement and monitor multi-sectoral approaches for better policies, institutions and programs to improve early childhood development outcomes in the state, particularly nutrition and health Build the capacity of state to enhance its focus on nutrition as a human development issue. Specifically, it aimed to:

i) enhance institutional and human capacity of CSDG at the state level and in its district cells to accelerate progress towards the SDGs, especially those contributing to improved child nutrition and health;

ii) develop and operationalize multi-sectoral result-based approaches;

iii) promote knowledge creation and sharing to improve program effectiveness; and

iv) strengthen program management information system and monitoring across sectors. The Government of Assam's TA request focussed largely on nutrition and food security, therefore the TA focussed largely on the health and nutrition aspects of Early Childhood Development.

3.2. Preparatory activities to initiate the TA:

3.1.1 **Three key first steps for the TA initiation were valuable in ensuring quality and timely completion of activities and achieving planned outcomes.** One, the appointment of a technical assistance agency with presence in Assam; two, the mapping of key stakeholders in the state who could be brought together for advocacy, capacity and awareness building around issues of food and nutrition; and three, the inception workshop that brought all key players together for joint planning and the demonstration of commitment by the senior officials in the state government, including the Chief Secretary.

3.1.2 **The appointment of a technical assistance agency by the Bank**: The appointment of the Coalition for Food and Nutrition Security (CFNS) as a technical support agency enabled the Bank to provide intensive support to the CSDG on a day-to-day basis. The CFNS, a network established in 2007 brings together the expertise of multi-stakeholders from diverse backgrounds including key Government representatives on its governing board. With experience of high-level advocacy efforts to promote food and nutrition security in India, CFNS is also recognized as an important partner by the Government of Assam. CFNS also had an existing Memorandum of Understanding (MoU) with CSDG, and an established office in Assam. Thus, the selection of a technical agency with on-the-ground presence to provide intensive support required in the Assam context was a strategic decision that served the TA well.

3.1.3 **Mapping of key players in the state for nutrition and ECD:** A thorough stakeholder mapping exercise was undertaken to map the various stakeholders working in the area of health, nutrition and ECD in Assam. The purpose was to identify the stakeholder and to engage with them on continuous basis for awareness building, advocacy and for other commitment-building activities. Stakeholder mapping was done through three different methodologies namely: (i)

secondary research using web portals; (ii) leveraging databases of various networks working in the state; and by (iii) contacting the government departments. The results revealed that although there are more than 60 organizations including non-government organizations and academic institutes working in the field of Public Health Nutrition in Assam but only few such as include UNICEF, Voluntary Health Association of India (VHAI) and Piramal Foundation are predominantly engaged, and interacted minimally with each other. The exercise also brought out that the actors worked in silos, with each focused on delivering its own set of activities. It reiterated the need for better coordination and communication among the nutrition players in the state, and that the CSDG could play a crucial role in bringing all the players together. Further, the results from this exercise helped in engaging with them and leveraging their expertise and to regular engage with them for various activities at state, district and even at the village level.

3.1.4 **Inception workshop and joint planning and agreement on activities, expected outputs and outcomes:** The inception workshop, chaired by the Chief Secretary, Government of Assam, brought together senior officials from across departments, representatives from the selected aspirational districts, development partners, technical experts, academia, research and training institutions. It offered an excellent opportunity to get inputs from the participants on the key activities for the TA, develop approaches to achieve the TA objectives and seek commitment for working together to support Assam's efforts to accelerate progress towards the SDGs. Figure 3 presents the planning framework that lays out the activities, various stakeholders, and the potential for their engagement to achieve expected outputs and outcomes.

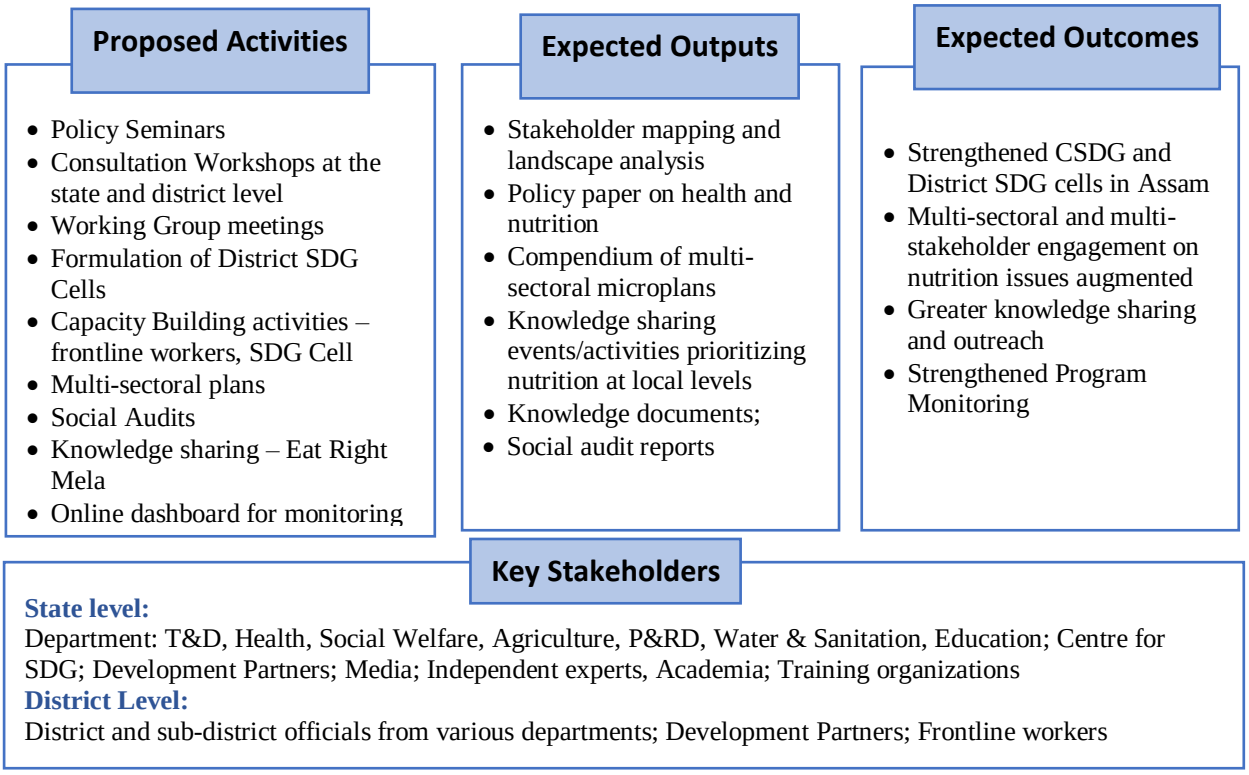


Figure 3: Planning Framework: Activities, Outputs and Outcomes es

3.2 TA activities and key outcomes

The TA activities and outcomes in each of the four key areas are described below:

3.2.1 ***TA to enhance institutional and human capacity of CSDG at the state level and its district cells.*** The TA supported the CSDG in setting up and strengthening the SDG cells in the three aspirational districts of Goalpara, Barpeta and Udalguri. Specific terms of reference for district SDGs cell were developed, clearly articulating the objective and role of the cells and were approved by the Additional Chief Secretary (ACS), Transformation and Development Department. The ACS also nominated one official each from Barpeta and Udalguri district as the head of District SDGs cells, and representatives from the Social Welfare Department were nominated as members of these cells. The following activities were undertaken to strengthen the newly created district SDG cells in Assam:

- *Capacity building for district SDG officials:*

Recognizing the crucial role of district officials in implementation of activities at the ground level, the project aimed to sensitize and build capacity of the SDG officials at the district level on issues pertaining to health and nutrition, including their capacity to convene and lead the development of multi-sectoral nutrition plans and support their implementation and monitoring. For this, a 5-day capacity building workshop on "Adolescent, maternal and child nutrition" was organised at the National Institute of Public Cooperation and Child Development (NIPCCD), Guwahati. The aim of the training was to sensitize the SDG cell officials on the nutrition of women and children, nutrition schemes and programs in the state, management of children with severe acute malnutrition (SAM), growth monitoring, to name a few. The workshop had a strong practical training component wherein the participants were taken to the *anganwadi* centres, nutrition rehabilitation centres (NRC) and trained in conducting in-depth interviews with the pregnant and lactating women on their dietary and caring practices.

The training helped the district level staff to engage with the authorities and with the communities effectively and to contribute richly to the development and review of multi-sectoral plans. It helped them understand the ground-level issues pertaining to health and nutrition.

Pic 1: Capacity Building workshop at district level for SDG cell officials

- *Learning visit to Tamil Nadu:*

A learning cross-visit of a team of eleven officials from the CSDG and district SDG cells, and the Government of Assam to Tamil Nadu was supported. The purpose was to expose the officials to the numerous good practices and processes being implemented in Tamil Nadu to improve the nutrition of young children including promotion of recommended IYCF practices. In particular, the visit also provided first-hand experience of some of the evidence-based best practices in the implementation of Integrated Child Development Services (ICDS) program in

Tamil Nadu. The best practices obsesrved in Tamil Nadu are outlined in Box 2. These highlight the richness of the exposure and learning that was made possible through the cross-visit.

Box 2: Best Practices drawn from Tamil Nadu during the learning visit	
Functional Area	**Best Practices**
Infrastructure	**Location:** *Anganwadi* Centres (AWCs) are located in a central place of the village near the schools and the block/ panchayat office campus. **Buildings:** RCC built with high rise plinth with attached kitchen and store room including child friendly toilets with running water. Children's accessibility with ramps. Tiles fitted floors with fans. **Kitchen & Cooking area:** Well ventilated with cooking slabs and shelves with separate store rooms alongside the kitchen. Separate utensil washing area with platform and Gas connection to every centre. **AWC Interiors:** Vibrant interior with colourful walls adorning paintings of nature, animals, fruits and vegetables, alphabets and numbers. **Timing of the centres:** AWCs time 8 am – 4 pm, AWC also acts as a full day care centre cum crèches for the children **Akshya Pathram:** Common basket for voluntary donation of fruits and vegetables by community for children. **Certification:** ISO certified AWCs *(128 AWCs i.e. 4 each from 32 district in pilot phase)*. The AWCs compulsorily to obtain a Food Safety certificate for quality assurance of food. **Convergence:** Convergence with the education department for pre-school English teaching, F&CS, for fortified foods for supplementary nutrition, Municipal Corporation for water in urban centres, PRIs for community engagement, H &FW for trainings, counselling, education and leadership roles. **Partnerships:** MP/ MLA LADS funds, Corporate Social Responsibility (CSR) funds, Community contributions for building, paintings and other accessories.
Implementation	**Tamil Nadu Civil Supplies Corporation** and Tamil **Nadu Salt Corporation** are the nodal agencies for supply of Rice, Dhal, Oil and Salt at the doorsteps of the *Anganwadi* Centres in order to ensure quality and quantity.
Production of weaning food/ Take Home Ration (THR) by women cooperative in TN	• 25 Women Industrial Cooperative Weaning food manufacturing society registered under Society Act 1860, under the control of ICDS, TN. • 1450 women from widows, destitute and deserted women belonging to poor families enrolled as members of the society. • Set up production plant of weaning food for THR • Raw materials (wheat) allotted from Public Distribution System (PDS) quota. • Catering to all 32 districts.

Post the learning visit, the officials presented the key learning to the state leadership. A significant outcome of the visit was that the state decided to include relevant best practices in the 20,000 new AWCs planned to be constructed across the state, and to also identify the existing AWCs where there could be the possibility to include some of the best practices. The visit gave first-hand experience to the SDG officials on the functioning of AWC and the Poshan Abhiyan in the state. It helped them understand the on-ground challenges, solutions found and how various activities/actions can be adapted for their state.

Box 1: Two key outcomes of the learning visit:

1. The head of District SDG cells, Senior Planning Officer, department of Transformation and Development committed to including a discussion on the multisectoral nutrition plans in the monthly meeting with the District Development Commissioner to ensure regular monitoring of nutritional indicators in the presence of all the key departments and deputy commissioner at district level.

2. The best practices gleaned from the Tamil Nadu visit were shared with the state officials and a decision was made to incorporate these features into the 20,000 new AWC that are to be constructed across the state.

3.2.2 ***TA to develop and operationalize multi-sectoral result-based approaches:*** One of the objectives of the technical assistance was to accord nutrition a priority for the state-level leadership. For this, multiple stakeholders working in the area of nutrition were identified through a stakeholder mapping exercise (please refer to 3.2.3 on pages 5, 6), specifically those from the non-nutrition and health sectors that play an important role in shaping nutrition outcomes were reached out through various means. Following activities were carried out to augment capacity for multisectoral nutrition approaches and actions in the state:

- *Development and Operationalization of district-level multi-sectoral nutrition action plans:* The multisectoral nutrition plans are the planning tools to strategize actions across departments and programs in a comprehensive manner for improving nutrition outcomes for children and mothers, and early childhood development outcomes, thereby contributing to accelerating progress towards SDGs 2 and 3. These are mechanisms to ensure strong nutrition focus through institutional and programmatic convergence.

The TA adopted a robust methodology (briefly described below) to develop these plans. This included:

(i) *Secondary research and review of strategic plans and similar national and international planning documents:* With the explicit purpose of not re-inventing the wheel, and to learn from existing frameworks, the CFNS team reviewed several existing frameworks. These included the Poshan Abhiyaan multisectoral district planning framework, relevant indicators from NFHS 4, planning documents like multisectoral district nutrition plan from Dungarpur district, Rajasthan, as well as the Aspirational District Plan for districts, Assam Agenda 2030.

(ii) *Interviews with relevant district officials from various departments as well as with independent domain experts:* The CFNS and CSDG teams visited the three TA districts

and met with officials from various departments and with community members to gather insights into the local context and issues pertaining to health, nutrition, food security, water and sanitation, social issues, to name a few. Officials met with included Deputy Commissioner; District Development Commissioner & Senior Planning Officer, District Collector, Chief Executive Officer, Zilla panchayat, district officials from the departments of Social Welfare, Health, Agriculture, Public Health Engineering Department (PHED), Agricultural Technology Management Agency (ATMA), Water and Sanitation, Education, Assam Rural Livelihood Mission, Food & Civil Supplies, and representatives of civil society organizations.

(iii) Series of state and district level workshops were held to seek inputs from senior government officials and independent experts on the multisectoral nutrition planning framework.

The final plan developed adopted the lifecycle approach to address child and maternal malnutrition. It had three parts:

Part A: covering essential nutrition interventions for adolescent girls, pregnant and lactating mothers, and infants and young children addressing immediate causes of malnutrition.
Part B: covering multisectoral interventions that address underlying and root causes of malnutrition.
Part C: outlinings cross cutting strategies for system strengthening.

The complete outline of the plan is provided in Annex 1.

Box 3: Key outcomes: Multi-sectoral approaches

1. Multi-sectoral plans adopted by the State Government and integrated in the National Nutrition Mission (Poshan Abhiyan).
2. District SDG cells activated and established functional links with the Department of Social Welfare., e.g., to provide regular, periodic progress updates to the department.

Consultation workshops in each of three districts to share the final version of the plan. All concerned departments participated and deliberated on strategies and approaches for the implementation of the plan in the districts. As an outcome, the ACS, Department of Social Welfare, Government of Assam issued an order for integrating the plans in Poshan Abhiyan. Further, the district SDG cells were instructed to include the plans as an important agenda point for their monthly meetings and to update the senior department officials on the progress for the same.

- *Organization of Policy seminars with multiple stakeholders.* A series of policy seminars were organized during the course of the TA. These served to engage various stakeholders including the Government and the non-Government players to discuss the critical issues pertaining to maternal and child nutrition, health and early childhood outcomes in Assam.

Box 4: Two key achievements from the policy seminars

i. Expansion of mobile creches in tea garden areas to support working mothers by Social Welfare Department
ii. Village Health Sanitation and Nutrition Day (VHSND) - a platform for multisectoral convergence at village level - to be organised on the non-working day (Tuesday) in tea-garden areas (instead of Wednesday)

A total of six policy seminars were organized with participation of senior Government officials from across departments including Health, Education, Social Welfare and PHED, as well as from the districts of Goalpara, Barpeta and Udalguri, development partners, such as UNICEF and United Nations Development Program (UNDP), UN Women, Piramal Foundation and other civil society organizations.

The seminars provided a platform to discuss various issues pertaining to nutrition in the state and provided a number of recommendations to the State Government to improve the health and nutrition outcomes in the state. Key recommendations, inter alia included that Social Audits be mainstreamed in public health programs, model AWCs be constructed in every district, an exercise to map local dietary practices be undertaken, a State Nutrition Resource centre to provide technical guidance to the state on issues pertaining to nutrition be set up. Please see Box 5 for the complete list of recommendation that emerged from the policy seminars.

The consolidated recommendations were shared with the senior Additional Chief Secretary, Department of Social Welfare, who committed to adopting the recommendations wherever feasible. The policy seminars were attended by the representatives of multiple departments which helped not only to sensitize them on issues pertaining to health and nutrition but also to discuss and deliberate the ways in which various departments can work together

Pic 2: Policy seminars

Box 5: List of Recommendations emerging from Policy Seminars

1. Undertake a local food mapping exercise to understand the local dietary practises of various communities especially the tribal population.
2. Promote kitchen gardens to enhance nutritional security at household level (Social Welfare department with support from Self Help group members of Assam State Rural Livelihood Mission and Horticulture department).
3. Social audit of Integrated Child Development Scheme (ICDS) and other food and nutrition schemes should be promoted by the state Government.
4. Learning modules for AWWs, ASHAs to be developed in local languages
5. Solar electrification of AWC and Health sub centres in *char* areas (area of Brahmaputra river and its tributaries)
6. Mobility of ASHA in *char* areas to be improved by providing travel support and other incentives
7. Model *Anganwadi* Centers to be constructed in every district by merging funds from Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), Social Welfare and other sources including CSR, MP/MLA area fund, Panchayat fund, local interested person (NRIs) to act as a good example for other centres to follow.
8. Convergence between Integrated Child Development Scheme (ICDS) and National Crèches Scheme (NCS) to merge *anganwadi* centres and crèches in the pockets where women are engaged in large numbers, e.g., tea plantations, large civil construction sites
9. For *char* and flood affected areas, introduce mobile *anganwadi* centres and crèches.
10. Monitoring of complementary feeding practices at household level by AWWs and ASHAs (currently the Monthly Progress Report (MPR) submitted to *Anganwadi* supervisor by AWW do not have provision for capturing information related to complementary feeding).
11. Integration of Self Help Groups under Rural Livelihood Mission with ICDS and Panchayati Raj Institution for effective delivery of Nutrition Services at AWCs and household level.
12. Design business models for SHGs members in nutrition domain.
13. Social Welfare department to collaborate with Assam State Rural Livelihood Mission to work on Nutrition, Health, Sanitation and to generate awareness

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- *Series of consultation workshops at the State and District level:* To launch the TA and bring together senior officials from various departments, districts and other stakeholders a state inception workshop was organized (please refer to 3.2.4, page 6 for details). Similar consultations were organized in each of the three TA districts. These consultation served as forums to understand the specific district-level challenges and issues in implementing the multi-sectoral plans and to deliberate on ways to address them. These helped to build consensus around the critical importance of multisectoral plans to strengthen planning, as well as to review and monitor progress of programs and actions impinging on health and nutrition. These consultations were chaired by the deputy commissioners of the respective districts and thus received high priority. These meetings also helped in bringing about clarity in the roles and responsibilities, and accountability of respective departments in developing and implementing the multi-sectoral nutrition action plans. For example, in Barpeta district, the decision was taken that the district will review the multisectoral plan every 15 days and the District Social Welfare Officer will update the plan with the help of all the concerned departments.

Box 6: Prominent decisions taken at district-level consultations

i. Udalguri: Nutrition plans to consider the special needs of vulnerable areas especially tea gardens.
ii. Barpeta: District authorities to review the muli-sectoral planning process twice a month.
iii. Goalpara: Setting up of core group to hasten the progress towards the development of the plans.

Pic 3: State and District level consultations (Goalpara and Barpeta)

In summary, these consultations helped build consensus around development and implementation of multisectoral plan at State and District level, their use as tools to review and monitor progress and highlighted the value of using data to improve performance, thereby contribute to improving nutrition and health.

- *Capacity building of frontline workers:* A two-day comprehensive joint training of AAAs (Anganwadi Workers (AWW), ASHA and Auxiliary Nurse Midwife (ANM)) was conducted in two aspirational districts, *Barpeta and Udalguri*, to develop leadership capacity and a full understanding of the critical importance of and the care required during the 'first 1,000 days of life'. The objectives of the training were two-fold - firstly, to sensitize frontline workers on the need to focus on the first 1000 days to improve nutrition, and secondly to build their capacities for effective home visits for counselling. Home visits and counselling is an important part of the job description of AAAs. Since most of the time they visit same households, it is important to align the messages from all three so that same message percolates to the mothers and other family members in effective manner.

Prior to the training a detailed training curriculum was formulated by resource persons from Social welfare, Health, NIPCCD and Food and Nutrition Board members. The training was conducted by state and district level resource person from social welfare, health department and Food and Nutrition Board.

Box 7: Outcome of training of frontline workers

1. Created a repository of training material around health, nutrition and IYCF in vernacular language that could be used by various departments for training their frontline workers.
2. Recommendation given to the respective departments to allocate budgets for the joint training programs.

A total of 62 participants were trained from 20 health/ICDS sectors. The training also helped create a repository of resource materials like tools, audio visual clips, quizzes material collected from various resource persons of various departments. The resource repository has also been shared with NIPCCD, State Institute of Health and Family Welfare (SIHFW), Social Welfare Department, Health Department and the Food and Nutrition board for use in future trainings. The trainings were helpful in bringing about message alignment on issues pertaining to health and nutrition, role clarity of each worker, including their respective roles in joint events like VHSNDs and how they could complement each other rather than duplicate efforts.

Pic 4: Joint training of AAA's (ASHA-AWW-ANM)

3.2.3 ***Promote knowledge creation and sharing to improve program effectiveness.*** The technical assistance contributed towards knowledge creation, assimilation and sharing across various stakeholders and bodies including relevant line departments to help strengthen existing programs, enabling easy access to relevant documents, expertise, and other relevant materials to strengthen the systems for enabling action to improve food and nutrition security. Similarly, the analyses and assessments undertaken focussed on key areas of program improvements. The following activities were conducted to contribute to the knowledge creation and sharing objective:

- *Nutrition working group created to provide strategic direction in nutrition:* the nutrition working group created acted as a think tank for the state to provide technical and operational guidance on various nutrition issues. The group had members from diverse affiliations and backgrounds, e.g., from civil society organizations, academia, government departments, as well as individual technical experts. Majority of the working group members

were extensively engaged with community work at ground level and thus these meetings provided insights of field perspectives and challenges at various levels of program implementation.

A total of six nutrition group meetings were organized and led to consensus on a position paper on "First 1000 days". The position paper was based on a desk review of existing policies and the evidence-base on 'essential nutrition interventions in first 1000 Days'. It was presented to the Government of Assam and the group agreed to continue to advocate for incorporating the key recommendations from position paper in the District Implementation Plan of Health and Social Welfare Department.

Box 8: Outcome of Working Group

Position paper on "First 1000 Days: Essential Nutrition Interventions" was developed to provide technical and operational guidance to the Government of Assam to focus and prioritize first 1000 days.

- *'Eat Right Mela (health fair) in Barpeta district:* The objective of *mela* was to sensitize the people of Barpeta to safe and healthy eating habits and to educate them on simple ways to improve their health and well-being. The *mela* began with a cycle rally attended by more than 150 cyclists and yoga session in the morning, followed by main *mela* activities conducted at the lawns of district library of the district. Around 2,000 people participated in the *mela* and participated in, and learnt through the organized activities, such as street plays, health checkup camps, nutrition counselling, poster making, nutrition quiz and infotainment programs like screening of films and live music performance. The *mela* was inaugurated by the District Collector of Barpeta and saw participation from various Government and non-Government agencies including representation from the Department of Rural Development; Health Department, Social Welfare, Indian Dietetic Association, Piramal Foundation, to name a few. The *mela* celebrations were preceded a press conference and training of 70 street food vendors on issues pertaining to food safety.

The *mela* is an example of leveraging and linking of other nutrition and health related Bank engagements to the TA provided in Assam. The *health melas* are one of the key public-facing strategies of the recently launched Eat Right India Movement by the Food Safety and Standards Authority of India (FSSAI), with whom the Bank has an engagement. The *mela* provided a unique platform to communicate messages around food safety and nutrition to the general public. The Eat Right *Mela* provided opportunity to reach large numbers of people ranging

Pic 5: Glimpses from Eat Right Mela, Barpeta

from government officials of concerned departments, students, women, families, civil society organizations with key message of safe and healthy eating. The women who came for health check-ups were sensitized to all health issues like anemia, consumption of IFA tablets, ANC check-ups, etc. The stalls by the departments of Social Welfare, Agriculture and Assam State Rural Livelihood Mission sensitized people about all the food and nutrition related government schemes and the benefits available under them.

An important outcome of the *mela* was a decision to undertake monitoring of the street food vendors on regular basis by the Food Inspector to ensure that they continue to follow the food safety norms discussed in the trainings. The district administration also committed to organising a refresher course with support from FSSAI. Post the Barpeta *mela*, neighbouring districts requested organization of similar events as it helped to bring not only citizens together on issues of health and nutrition but also brought various departments together.

3.2.4 ***TA to strengthen program management information system and monitoring across sectors.*** The technical assistance enhanced the capacity of CSDG and district authorities to effectively manage and monitor programs by effective use of data to guide program actions and policy decisions, including those related to food and nutrition. The TA supported the development of an ICT-enabled real-time monitoring dashboard, and efforts to conduct social audits to improve governance and accountability in two districts. The details of these are outlined below:

- *Online Dashboard to track financial data as well as physical progress of flagship programs contributing to the SDGs:* The TA supported the development of a web-based dashboard to assist the State Government in reviewing the progress of all flagship schemes under each of the departments. Key Performance Indicators (KPIs) specific to each department (total of 11 departments[2]) were finalized in close coordination with the respective department, and these are mapped to the SDG indicators. It also has a complete listing of Head of Accounts, mapped to allocation and release of budget and the achievement of KPIs against targets. This master list includes traffic signal colour coding for performance on both parameters (finance and KPIs). (in relation to the release of budget against allocation and KPI (in relation to achievement against target). It has several useful features such as providing a summary of select KPIs for each department that includes both financial and physical progress, providing trend analysis, sending notifications.

- *Social Audits:*

Social Audits are powerful tools to empower the beneficiaries of government programs to hold service providers accountable to the beneficiaries, and improve transparency and accountability at all level. To build the capacity of government officials on Social Audit and its tools, a two-day workshop was organized by the CSDG in collaboration with CFNS and Voluntary Health Association of Assam (VHAA). It was attended by 30 officials from Social Welfare, ICDS, Health and Family Welfare, Agriculture, Education, ASRLM, Public Health Engineering Departments, CSDGs, CFNS and VHAA from both state and districts level.

[2] *Food and Civil Supplies; Legislative; Disaster Management; PWD (Buildings); Higher Education; Animal Husbandry; Irrigation; Science and Technology; Sericulture; Health and Social Welfare*

After training, two social audits were also conducted in Udalguri and Goalpara districts on Supplementary Nutrition service delivery under the ICDS and on Water and Sanitation facilities. In both the districts, 12 AWWs along with Anganwadi Helpers (AWHs) were interviewed to collect information in regard to AWC infrastructures, and communities were interviewed as well. FGDs were held to draw inferences from the quantitative data collected through structured interviews of beneficiaries and service providers.

This small-scale social audit process in two districts helped the CSDG team to understand the process. It helped them to understand the importance of this activity and the need to mainstream this practice in all concerned departments. It built the capacity of the CSDG staff to lead and assist various departments in measuring and assessing the outcomes & impact at ground level and hold the system accountable. The Social Audit process was intended to make the projects / schemes more effective and efficient to accelerate the progress towards SDGs. A range of communication materials on social audits was developed as part of this TA which formed a rich resource for CSDG and the state government to refer back and to further train the staff on conducting social audits.

Box 9: Social audits helped to:

- Identify systematic gaps in the implementation of ongoing projects / schemes related to nutrition
- The findings helped feed into the development of the multi sectoral plans
- Generate Community awareness on their health and nutrition entitlements and services.

4 Challenges and Learnings

4.1 Challenges

4.1.1 ***For several reasons Assam presents several development challenges; at the same time it presents several opportuinties.*** Assam, the largest amongst the north-eastern states of India, with a population of 31.2 million (Census 2011) provides both challenges and opportunities to development planners. Primarily a rural state, it has not been able to make much progress in agricultural growth. The challenges arise from a combination of several factors – its geography, its proneness to natural disasters (it falls in Zone V – the highest – in terms of environmental vulnerability), a long-running insurgency and ethnic conflict; high unemployment among educated youth and wide variation in development indicators. Of particular concern is the recurring cycle of natural disasters such as flooding, landslides and vulnerability to earthquakes on the one hand and political strife and ethnic violence on the other. Floods have impeded the technological transformation of agriculture in Assam.

4.1.2 ***The combined result is a serious impact on service delivery and livelihoods of people.*** Entire communities are displaced and have become more vulnerable to sliding down the poverty spiral. Assam has had a history of civil strife and has been witness to various separatist movements, which have had an impact on development indicators. Amongst the most vulnerable groups are communities working on tea plantations. Forming nearly 20 per cent of the population, they are often marginalized and experience living conditions significantly poorer than for the general population. These communities have limited access to health and education facilities and most marry at a relatively young age. Further, the water quality is poor largely due to arsenic, fluoride and microbial contamination; and use of non-sanitary toilets, particularly in the tea garden areas where the functionality, maintenance and effective use of toilet facilities is poor.

4.1.3 ***A key challenge for the current TA was the short span of time available for planning and implementing the activities.*** Due to the delays in the internal Government of Assam and Government of India finalization of the request for TA from the World Bank, the time period for implementation of the TA was considerably shortened resulting in a limited time for the implementation of the activities. However, the team benefitted form the Had time permitted, several activities could have been further replicated. Examples include activities like social audits, joint training, eat right melas, district level consultation, cross-visits to further enrich the learnings from the project. However, the team used the Bank's institutional knowledge and agile ways to plan and implement the TA activities and achieve substantive outcomes.

4.2 Learnings

4.2.1 While the TA mapped the key stakeholders, the scope of the TA did not permit engagement with several sets of stakeholders. An important learning is that it is important to engage, involve and collaborate with all pillars of democracy- Executive, Legislature, Civil Society including media and business and build them as 'champions of change' for an effective people's movement to improve nutrition outcomes. For example, sensitization of the state legislatures is critical, as is the sensitization of the elected local government bodies – right from the district to the village level. Similarly, a greater engagement with media can be very powerful as is the use of celebrities, champions, influential voices for endorsement of key nutrition and health messages.

4.2.2 The district and field level engagement highlighted the critical need to strengthen efforts to promote behavior change around Infant and Young Child Nutrition. For example, making counselling during home visits more intensive is necessary. This would require building capacity of frontline workers on inter-personal counseling (IPC) skills, communicating nutrition messages directly and regularly through IT enabled systems such as smart phones/mobiles, and promoting local and context specific foods, address myths and misconceptions around food consumption are some areas requiring attention and action.

4.2.3 Given the scale of the programs and the widespread lack of capacity, an area that emerged as a priority for future action was to harness IT-enabled systems to improve the access of functionaries to the right information when they need it. While IT-enabled learning cannot replace face-to-face learning opportunities, these could certainly help augment passing on key information and messaging at scale.

4.2.4 The TA was successful in acting as a catalytic force to energize different departments to mobilize various actions to improve the progress towards SDGs. However, there is a need for such catalytic actions on a more sustained basis as the goal post is still distant, and loss of momentum and energy is a potential risk.

5 Conclusion

5.1 **The TA engagement opportunity with the Government of Assam, while of a short duration, was a valuable partnership.** It brought together several stakeholders to discuss and strengthen nutrition policies and programs at the state level and in three aspirational districts. While only eight months were available for implementing the TA, the innovative and agile approaches adopted helped to achieve the planned outcomes. Two key strategic approaches proved valuable: (i) the appointment of a strong technical assistance agency with presence in Assam to enable intensive engagement and lend day-to-day support in the TA delivery; and ii) the mapping of key stakeholders in the state and their mobilization into expert groups early on in the TA to collectively support TA activities such as advocacy, capacity and awareness building around issues of food and nutrition. This proved very valuable in leveraging their expertise and to engage with them for various activities at state, district and even at the village level.

5.2 **In the short duration of the TA activities, significant outputs and outcomes were achieved.** Some of the most significant ones are:

- Strengthening the CSDG at the state level and setting up and operationalizing district level SDG cell in three aspirational districts of Assam. This was accomplished through number of capacity building activities, cross visits for learning and organization of policy dialogues and seminars.
- Preparation and implementation of the multi-sectoral nutrition action plans.
- Knowledge sharing and policy advocacy through working group meetings, policy dialogues, engagement with media, to name a few.
- Strengthen the program management information system through the development of ICT enabled real-time dashboard to track flagship schemes of various departments and through conduct of social audits at the district level.

5.3 **Several of the TA outputs have already been adopted by the government to strengthen programs, and tools developed are available for wider use in the state.** The TA delivered many outputs, of which several have already been mainstreamed. For example, the multi-sectoral nutrition action plans developed under the TA have already been integrated in the *Poshan Abhiyan* program by the Government of Assam. Similarly, the capacity built for social audits and range of tools made available can be used by the Government in other districts across the state. The training materials for AAA's (ASHA, AWW and ANM) have been made available to the apex training institute of the government to expand it to other districts. The online dashboard developed will facilitate the program and other leaders in real-time monitoring of their flagship schemes and programs, thereby helping them make informed decisions. A number of knowledge products contextualized to Assam have been developed under the TA which will serve as knowledge tools for the CSDGs to share with other districts across the state.

Annexure 1A
Outline of the district level multi-sectoral plan

Group	Essential Interventions
Part A- Essential Nutrition Intervention	
Adolescent Girls	Anemia Screening /IFA Supplement Deworming/ BMI Correction Health, Nutrition, Sanitation, Hygiene Education
Pregnant Women	ANC Care Iron and Calcium Supplementation Deworming Supplementary Nutrition/Take Home Ration () Family Planning Counselling Weight& Height Measurement- BMI (for weight gain during pregnancy)
Lactating Mothers	Institutional Delivery Support for Early initiation of breastfeeding Home Delivery by Skilled Birth Attendant (SBA) IFA tablets Calcium tablets ICDS Supplementary Nutrition /Take Home Ration Family Planning Services
0-6 Months Child	Low Birth Weight Care/ Kangaroo Mother Care Continuation of Breastfeeding & Exclusive Breastfeeding Diarrhoea Management (ORS, Zinc and access to safe drinking water and sanitation facility) Care / feeding during illness Weight/ Height Monitoring
6-24 Months Children	Timely Initiation of Complementary Feeding Appropriate Complementary feeding (Dietary Diversity, appropriate Feeding Frequency and adequate density) Vitamin A and IFA Supplementation Full Immunization Deworming (as per guidelines) Supplementary Nutrition (THR of ICDS)SAM and MAM Management
24-59 Months Children	IFA Supplementation Deworming Supplementary Nutrition (ICDS) Vitamin A, IFA
Part B- Interventions addressing underlying and basic causes of Malnutrition	
Water	AWCs, Health Centers, Villages and Households with adequate water supply

Sanitation	AWCs, Health Centers, Villages and Households with adequate sanitation facilities
Behaviour change: appropriate hygiene, sanitation practices	Hand washing with soap and hygiene practices
High school education of Girls	Facilitate girls high school education
Right age of marriage/conception	Prevention of marriage and conception before 18 years of age
Women's Livelihood	Women receiving work for 100 days in a year Livelihood generation support to SHGs Homestead food production through Livelihood programs
Food Security	Regular supply of entitled PDS food Access to pulses ,fish , flesh food Homestead food production, Kitchen Garden, Poultry keeping

PART C- System Strengthening Intervention

Cross Cutting Strategies	Systematic Community based events Monthly VHSND sessions Growth Monitoring sessions Organised Home Visit Social Behaviour Change Communication strategy Supply Chain Management Human Resources Capacity Building Monitoring Evaluation Accountability and Learning (MEAL) Knowledge Management Convergence

Annexure 1B
Multi-sectoral District-level action plan (detailed)

Group: Adolescent Girls				Monitoring					
Essential Interventions	**Department**	**Scheme**	**Resources**	**Indicators**	**Baseline***	**Target***			**Data Source***
						2019-20	**2020-21**	**2021-22**	
School Going Adolescents • Mapping of all private schools, Government schools and junior colleges • Ensuring adequate Albendazole supply at health centers/sub centers one month prior to the biannual dates fixed for Albendazole distribution • Maintenance of the track sheet to ensure every adolescent has received the due dosages • Capacity building of AWWs and nodal	**Lead Departments** Health Education Department	Anemia Mukt Bharat (MoHFW,2018)	Mobile Block Health Team at PHC level to cover the schools, Nodal teachers	**3.1** % of adolescent 10-19 years covered with Albendazole in the first round in February and second round in August each year					

teachers on program issues like stock calculations and dissemination, conducting IEC at regular interval • IEC materials to be given to teachers to hold education sessions in schools • Dissemination of IEC material to all school's/juniors college **Out of School Adolescents** • Listing of all the out of school adolescents by AWW with the help of ASHA • Micro plan for reaching out to out of school children by ASHA and AWW • Ensuring a fixed day distribution of Albendazole to out of school adolescents at AWCs	**Support Department** Social Welfare Department								

• Capacity building of AWWs on program issues like stock calculations and dissemination, conducting IEC at regular interval									
School Going Adolescents • Mapping and inclusion of private schools, Government schools and junior colleges • Regular screening (at least twice a year) for anemia by teachers/ mobile block health team for school going adolescent **Out of School Adolescents** • Listing of all the out of school adolescents by AWW with the help of ASHA	**Lead Department** Education, Health Department	WIFS RBSK ICDS SAG- (out of school adolescent girls)	Mobile Block Health Teams ANMs, ASHAs	**3.2:** % of adolescent girls 10-19 years screened for anemia(school going +non-school going) (throughout the year)					
	Support Department Social Department Education Department								

• Regular screening (at least twice a year) for anemia by AWWs/ mobile block health teams at AWCs for out of school adolescent									
• Ensuring Weekly distribution of IFA tablets with special focus on schools in tea garden areas • Teachers and AWWs to ensure consumption of IFA tablets for school going adolescent and out of school adolescent girls respectively. • Display of pictorial communication materials at school for better consumption outcome.	**Lead Department** Health Department **Support Department** Education Department Social Welfare Department	WIFS SAG-for out of schools adolescent girls	ASHAs, AWWs Nodal Teachers	**3.3:** % of eligible adolescents 10-19 years who receive at least 4 blue iron folate tablets					
Besides IFA and Deworming following interventions should be ensured: • Promote nutrition, health and sanitation education at schools and AWCs	**Lead Department** Health Department **Support Department**			**3.4:** % of adolescent 10-19 years whose BMI is below normal					

• Regular health camps for adolescent girls for measuring BMI followed by counselling sessions • Delay age of marriage and conception >18 years • Promote education and retentions in schools	Education Department Social Welfare Department								
• Ensure tracking of the newly wed girls by ASHAs with the help of AWWs • Ensuring that newlywed adolescent girls enter pregnancy with correct BMI and age more than 18 years • Strengthening of Adolescent Friendly Health Clinics for counselling	**Lead Department** **Health Department**			**3.5:** % of newly wed adolescent girls who have received family planning counselling					

Group: Pregnant Women			Monitoring						
Essential Interventions	**Department**	**Scheme**	**Indicators**	**Baseline***	**Target***			**Data Source***	**Resources**
					2019-20	**2020-21**	**2021-22**		
• AWWs/ASHAs/ANMs to ensure 100% registration of pregnancies • SHGs to assist ASHAs to register the 'Unreached" women in community • Regular organisation of VHSND by AWWs/ASHAS and ANMs for ensuring early registration and ANC check-ups • ANCs posts to be 100% filled • Conduct BCC events on importance of antenatal check-ups and micronutrients. • Organise ANC sessions ninth of every month as per the PMSMA policy of NHM Pregnant women to be weighed and weight to be entered in MCP card and weight gain should be encouraged as per BMI based guidelines	**Lead Department** Health Department **Support Department** Social Welfare Department P&RD (ASRLM)	ICDS NHM ASRLM	**5.1:** % of PW who had full Antenatal care (4 ANC, at least 1 TT, IFA tablet or syrup for more than 180 days)	10.2% (NFHS-4)				Aspirational District Action Plan	ASHAs, ANMs AWWs SHGs

• ASHAs to ensure 100% registration of pregnant women • SHGs to facilitate in identification of unreached pregnant women and ensure their registration for ANCs • Ensuring early registration of pregnancy through incentive of PMMVY • Effective implementation and timely fund release of PMMVY	**Lead Department** Health Department **Support Department** Social Welfare Department P&RD(ASRLM)	ICDS, PMMVY	**5.2:** Out of total ANC registered , % registered within 1st trimester(within 12 weeks)	64.3%(NFHS-4)				Aspirational District Action Plan	ASHAs, AWWs
• Ensuring early registration of pregnancy through incentive of PMMVY • AWWs to ensure 100% registration of pregnant women • Effective implementation and timely fund release of PMMVY	**Lead Department** Social Welfare Department Health Department	ICDS, PMMVY	**5.3:**Out of total ANC registered , % registered within 1st trimester(within 12 weeks)						ASHAs, AWWs
• Ensuring Regular supply of THR	**Lead Department** Social Welfare	ICDS P&RD (ASRLM)	**5.4:** % of PW registered who						ASHAs, ANMs

• Ensuring supply of readymade nutri mix as THR and not raw rice-dal • Ensuring safe and hygienic storage of THR • Involve SHGs in production of THR through micro finance activities • Promotion of kitchen gardens at AWCs • Promote establishment of kitchen garden at household level and poultry keeping by linking with SHG activities	P&RD(ASRLM)		received 21 days of SNP in last month and have access to diversified food through home stead food production						AWWs SHGs
• Regular screening for anemia levels of PW at health centers / VHSND • Ensuring adequate availability (based on projected population of PW) of IFA supplies at health centers and sub centers • Tracking of all eligible pregnant women to ensure timely distribution of IFA tablets through ANMs or ASHAs • Appropriate counselling by service providers at the time of distributing IFA tablets for improving compliance	**Lead Department** Health Department **Support Department** P&RD/Assam RLM	NHM ICDS ASRLM	**5.5:** % of eligible pregnant women who received at least 180 IFA tablets during the Antenatal period						ASHAs, ANMs AWWs SHGs

• Organise treatment of women with severe anemia for treatment • Capacity building of SHGs to engage them in Jan Andolan activities for promoting consumption of IFA. • Regular follow up of PW by ASHA, ANM & AWW for managing side effects and improving IFA compliance • Capacity building of SHGs on basic health & nutrition issues and engaging them for ensuring consumption of IFA									
• Ensuring adequate availability (based projected population of PW) of calcium tablet supplies at health centers and sub centers. • Appropriate counselling by service providers for promoting regular consumption • Tracking of all eligible pregnant women to ensure timely distribution of calcium tablets through ANMs or ASHAs • Regular follow up of PW by ASHA, ANM & AWW for compliance	**Lead Department** Health Department **Support Department** Social Welfare Department P&RD	NHM ICDS ASRLM	**5.6:** % pregnant women who consumed 360 calcium tablets during pregnancy						ASHAs, AWWs SHGs

• Capacity building of SHGs to engage them in Jan Andolan activities for promoting consumption of calcium								
• Adequate number of tablets to be made available at all health facilities providing ANC • Health workers to ensure distribution and consumption of tablet • Appropriate counselling at VHSND for disseminating information and establishing WASH measures	**Lead Department** Health Department **Support Department** Social Welfare Department	ICDS, NHM	**5.7:** % of PW who were given one Albendazole tablet after 1st trimester					ASHAs, AWWs
• Ensuring age of marriage and conception not less than 18 years • Counselling by health and ICDS on adequate and appropriate diversified diet • Care and day rest during pregnancy • Ensure reduction in physical drudgery and domestic violence with help of SHGs	**Lead Department** Health Department **Support Department** Social Welfare Department	NHM ICDS, P&RD (ASRLM)	**5.8:** % of children with low birth weight (< 2.5 kg)				Aspirational District Action Plan	ASHAs and ANMs

Baseline, Target and Data Source to be filled by lead department district officials based on department's target for subsequent years

Group: Lactating Mothers				Monitoring					
Intervention	**Department**	**Scheme**	**Resources**	**Indicators**	**Baseline ***	**Target***			**Data Source***
						2019 -20	**2020 -21**	**2021 -22**	
• ANM, ASHAs, AWWs to mobilise and support PW for institutional deliveries • Ambulance facility to be strengthened – Mrityunjoy 108 services, especially at tea garden areas. • Strengthening the implementation of JSY and PMMVY • Timely payment on performance based incentives to ASHAs for institutional deliveries. • Special higher incentives to ASHAs to be institutionalised in hard to reach areas (border areas) • Engagement of SHGs to promote the importance of institutional deliveries.	**Lead Department** Health Department **Support Department** Social Welfare Department	ICDS, NHM, ASRLM	ASHAs, AWWs, ANMs, SHGs, Trained staff at each health center level	**7.1:** % of institutional deliveries in the last month	51.9 %(NFHS-4)				Aspirational District Action Plan
• Increasing the number of SBAs • Regular trainings for SBAs • Incentives to SBAs for safe deliveries	**Lead Department** Health Department	HBNC		**7.2:** % of deliveries at home attended by skilled birth attendant(Doctor, nurse, LHV, ANM,	12.3 % (NFHS-4)				Aspirational District Action Plan

				Other health personnel)					
• Ensuring Regular supply of THR • Ensuring safe and hygienic storage of THR • Involve SHGs in production of THR through micro finance activities	**Lead Department** Social Welfare Department **Support Department** P&RD	ICDS, ASRLM	AWWs SHGs	**7.3:** % of lactating mothers received 21 days of SNP(THR) in last month					
Baseline, Target and Data Source to be filled by lead department district officials based on department's target for subsequent years									

Group: Children (0-6 months)				Monitoring					
Essential Intervention	**Department**	**Scheme**	**Resources**	**Indicators**	**Baseline ***	**Target***			**Data Source***
						2019 -20	**2020 -21**	**2021 -22**	
• Ensuring early initiation of breastfeeding in 100% institutional deliveries • AWW to support early initiation of breastfeeding in home deliveries • No marketing of Infant formula • Lactation Management Training to the SBAs • Ensure early initiation of Breast Feeding in 100% institutional deliveries • IEC material on breast-feeding to be displayed on ANC ward/ delivery ward and other health facilities. • ANMs/ ASHAs to provide breastfeeding counselling during ANC contact at VHSND	**Lead Department** Health Department **Support Department** Social Welfare Department	NHM- JSY PMMVY MAA AWWs	ASHAs, ANMs, AWWs, Health Centers	**9.1:** % of children initiated breastfeed within one hour birth	68%(NFHS-4)	100 %	100%	100%	Aspirational District Action Plan
	Lead Department Health Department	NHM, MAA		**9.2:**	56.7%(NFHS-4)				

• Educating the mothers and other family members about the importance of exclusive breastfeeding • Every immunisation contact should be utilised for breastfeeding counselling and assessing status. • 10 steps to breastfeeding to be displayed in every health centres/ VHSND forums. • Lactation support services/ lactation counsellors to be provided at health centers for timely management of any lactation problem • ANMs/ ASHAs to provide breastfeeding counselling during VHSND and ANC check ups • Support for breastfeeding to working mothers in areas like tea garden areas	**Support Department** Social Welfare Department		ANMs, ASHAs, AWWs	% of children under 6 months exclusively breastfed					
• Ensuring supply of adequate ORS packets and zinc tablets at AWCs and with ASHAs • VHSND to be used for creating knowledge about diarrhoea management and preparation of	**Lead Department** Health Department **Support Department**	NHM PHED	ANMS, ASHAs	**9.3:** % of children 0-60 months with diarrhoea in the last two weeks who					Aspirational District Action Plan

ORS and minimum 14 days consumption of zinc tablets. • Home visits to children with diarrhoea treated by health workers for counselling of family members on diarrhoea management/demonstration • Demonstration on VHSNDs regarding regular hand washing with soap before cooking and eating • Ensuring the coverage of safe drinking water facility • Promote the usage of sanitation toilets	Social Welfare Department PHED			received ORS and Zinc					
• Weighing machine to be made available at all AWCs/VHSND forums for regular weight and height measures, • Trainings of all AWWs and ASHAs on weight measurement and plotting • Counselling on promotion of mothers by AWWs with the help of ASHAs on importance of growth monitoring	**Lead Department** Social Welfare Department **Support Department** Health Department	ICDS	AWWs, ASHAs and VHSNC members	**9.4:** % of Children 0-60 months that have their weight measured, monitored(entered in growth chart) every month in the last quarter					

• Prioritised home visits to children whose growth have faltered by AWWs and ASHAs • Identification of children suffering from severe acute malnutrition (SAM) and taking appropriate actions.									
Baseline, Target and Data Source to be filled by lead department district officials based on department's target for subsequent years									

Group: Children (6-24 months)				Monitoring					
Intervention	**Department**	**Scheme**	**Resources**	**Indicators**	**Baseline***	**Target***			**Data Source***
						2019-20	**2020-21**	**2021-22**	
• Organize Annaprashan Diwas once in a month in AWCs to promote complementary feeding and demonstrate healthy recipes • AWWs and ASHAs to counsel mothers and family members on adequate diet- quality and quantity • Encourage preparation of traditional nutrimix through home level preparation • Measles fist dose contact with mother to be utilised for assessing the status of complementary feeding of child • Undertake regular home visits for counselling on complementary feeding at home level by ASHAs,as per the policy on Home Based Care in Young Children,NHM	**Lead Department** Social Welfare Department Health Department **Support Department** Assam RLM	ICDS NHM	AWWs, ASHAs and VHSNC members	**11.1:** % of children who were initiated complementary feeding(Solid or semi- solid food and breast milk) after 6 months					

• Recipe demonstration by AWWs or in VHSND • List of locally available complementary foods to be given to children • Regular trainings for AWWs and ASHAs to ensure knowledge and skill retention on complementary feeding									
• Counselling by ICDS and health workers to stress on diet diversity • Promote establishment of SSBs at household level of such children and poultry keeping by linking with SHG activities. • Training of SHGs to counsel on adequate diet- dietary diversity and minimum meal frequency • SHGs to establish kitchen gardens and provide support to AWCs on demonstration days	**Lead Department** ICDS, Health P&RD **Support Department** Social Welfare department	ICDS, ASRLM	AWWs, SHGs	**11.2:** % of children consuming at least 4+ food groups					
• Ensuring adequate stock availability (based on population projection) at health centres	**Lead Department** Health department	NHM ICDS	AWWs, ASHAs	**11.3:** % of children (9-24months) who received at least one	41.1% (NFHS-4)				

• Institutional Bi-annual distribution of Vitamin-A on two fixed months, 6 months apart from each other • AWW to prepare due lists of children 9-60 months with the help of ASHAs and ANMs • Children not covered in 6 monthly drive to be administered vitamin A doses on VHSND	**Support Department** Social Welfare department			dose of vitamin Ain the preceding 6 months					
• AWW to prepare list of beneficiaries with the help of ASHA and ANM • Ensuring adequate stock availability (based on population projection) at health centres • Ensuring mechanism for distribution of syrup to mothers during VHSNDs by ANM/ASHAs	**Lead Department** Social Welfare Department **Support Department** Health	Anemia Mukt Bharat	AWWs, ASHAs	**11.4:** % children 6-24 months provided (IFA) syrup (Bi weekly) in the preceding month					
• ASHA to get list of children to be fully immunised from AWW • Home visits by ASHAs to follow up for mobilizing caregivers for	**Lead Department** Health Department	NHM, ICDS, ASRLM	ASHAs, AWWs and SHGs	**11.5:** Children age 12-23 months fully immunized	34.1 % (NFHS-4)				

attending immunization sessions. • Tracking and micro planning to reach out all children at household level- head count survey specially at tea garden areas • Ensuring migratory population and temporary settlements are also included in the immunization plan • Engagement of SHGs/ community influencers/leaders to promote awareness regarding full immunization and mobilizing caregivers to attend immunization sessions on fixed days • Scaling up eVIN	**Support Department** Social Welfare Department, P&RD			(BCG, measles, and 3 doses each of polio and DPT) (%)					
• Introduction of policy for production of Nutrimix as THR supply to ICDS. • Regular supply of THR to ICDS and weekly supply to children Capacity building of SHGs to take up THR as a micro finance activity	**Lead Department** Social Welfare department **Support Department** P&RD	ICDS	AWWs, SHGs	**11.6:** % children 6-24 months registered who received SNP (THR) for 21 days in the last month					

• Regular growth monitoring at AWCs • Training of AWWs to identify MAM and SAM cases	**Lead Department** Social Welfare Department **Support Department** Health Department	ICDS, NHM	AWWs, ASHAs VHSND committee members	**11.7:** % of children 6-36 months screened for MAM and SAM during last month					
• Counselling on home based care and adequate feeding by AWWs and ASHAs • Behavioural change sessions on child health and nutrition by AWWs	**Lead Department** Social Welfare Department **Support Department** Health Department	ICDS, NHM	AWWs, ASHAs	**11.8:** % of children with MAM that receive appropriate interventions at community level					
• Identifying SAM children who fail appetite test or with bilateral oedema, • Financial support to mother bringing child for treatment at NRCs • Follow up after discharge from NRC • Ensure availability of dieticians at NRC at all times	**Lead Department** Health **Support Department** Social Welfare Department	ICDS, NHM	AWWs, ASHAs	**11.9:** % of children with SAM and medical complications treated at Nutrition Rehabilitation Centres (NRCs)					

• Induction training for NRC team (doctor, dietitian/ nutritionist, nurses, cook and helpers) to gain proper techniques and skills									
• Provision of double THR ration of ICDS to SAM cases with no medical complications • Monitoring w eight gain • Imparting nutrition and health education through food demonstration and preparation • Promotion of kitchen garden to ensure household level food security • Capacity building of primary caregiver to look after the child at home	**Lead Department** Social Welfare Department **Support Department** Health Department			**11.10** % of children with SAM and without medical complications treated at community level					
• Ensuring adequate Albendazole supply • Maintenance of track sheet to ensure every child receives the due 6 monthly dosages • Dissemination of IEC material to community centres	**Lead Department** Social Welfare **Support Department** Health	ICDS WIFS		**11.11:** % of children (6-24 months) who received Albendazole					

Baseline, Target and Data Source to be filled by lead department district officials based on department's target for subsequent years

Group: Children (24-59 months)				Monitoring					
Intervention	**Department**	**Scheme**	**Resources**	**Indicators**	**Baseline***	**Target***			**Data Source***
						2019-20	**2020-21**	**2021-22**	
• Organising biannual administration of vitamin A supplements • AWW to prepare due lists of children with the help of ASHA and ANM • Left out children to be given doses on VHSND • Ensuring adequate stock availability (based on population projection) at health centres	**Lead Department** Social Welfare Department **Support Department**	NHM ICDS	AWWs, ASHAs	**13.1:** % of children (24-59months) who received Vitamin A	41.1% (NFHS-4)				
• AWW to prepare list of beneficiaries with the help of ASHA and ANM • Ensuring adequate stock availability (based on population projection) at health centres • Ensuring mechanism for distribution of syrup to mothers during VHSND	**Lead Department** Social Welfare Department **Support Department** Heath Department	NHM : Anemia Mukt Bharat		**13.2:** % children 24-59 months provided (IFA) syrup (Bi weekly) in last month					
• Ensuring supplementary feeding to ICDS enrolled children 24-36 months	**Lead Department** Social Welfare Department			**13.3:** % children 24-36 months registered who received					

• Engagement of SHGs to ensure production of vegetables as micro finance activity • etc for SNP for 24-36 months children enrolled with ICDS Provision of additional SNP to severe underweight children				SNP (THR) for 21 days in the last month					
Baseline, Target and Data Source to be filled by lead department district officials based on department's target for subsequent years									

Part B: Multi-sectoral Interventions				Monitoring					
Intervention	**Department**	**Scheme**	**Resources**	**Indicators**	**Baseline**	**Target**			**Data Source**
						2019-20	**2020-21**	**2021-22**	
Wash									
Drinking Water									
• Categorization of AWCs based on current status- Drinking facility available, available but not functional and not available. In first phase dysfunctional supplies can be made functional and in second phase new supplies could be installed • Testing of water supply at AWCs	**Lead Department** PHED **Support Department** Social Welfare Department	NRDWP		**14.1:** % of Anganwadi with adequate, functional and safe drinking water supply	Out of 2970 AWCs in Barpeta only 1689 AWCs have proper access to adequate, functional and safe drinking water	100%	100%	100%	ICDS Barpeta
• Categorization of health Centers based on current status- Drinking facility available, available but not functional and not available. In first phase dysfunctional supplies	**Lead Department** PHED	NRDWP		**14.2:** % of health centres with adequate, functional	321 health centres	100%	100%	100%	

can be made functional and in second phase new supplies could be installed	**Support Department** Health Department			and safe drinking water supply					
• Water purification units to be set up. • Workshops and trainings of village water committee to undertake minor repair work and maintenance of water systems	**Lead Department** PHED **Support Department** **P**&RD	NRDWP SKPY		**14.3:** % of villages/wards with adequate, functional and safe drinking water supply					
• Categorization of households based on current status- Drinking facility available, available but not functional and not available. In first phase dysfunctional supplies can be made functional and in second phase new supplies could be installed • Strengthening the implementation **Swatch Khuwa Pani Yojana** particularly in the riverine/ char areas.	**Lead Department** PHED	NRDWP		**14.4:** % of households with improved drinking water sources	97.8% (NFHS-4)	100%	100%	100%	PHED
Sanitation									
• Mapping and prioritizing the left out pockets	**Lead Department**	SBM		**14.5:** % of villages/ wards which	100%	100%	100%	100%	PHED

• SBCC activities to promote usage of sanitation facilities • Plan for maintenance of community toilets • Hands on trainings on sanitation to village masons	PHED			are open defecation free					
• Mapping and prioritizing the left out pockets with special focus on tea garden areas • SBCC activities to promote usage sanitation facilities	**Lead Department** PHED	SBM		**14.6:** % of Households with access to safe sanitation facilities	34.9% (NFHS 4)	100%	100%	100%	PHED
• Construction of toilets in AWCs under Swachh Bharat Mission • Categorization of AWCs based on current status- Sanitation facility, available and functional, available but not functional and not available. In first phase dysfunctional facilities can be made functional and in second phase new facilities could be constructed • Convergence with MGNREGA for construction and maintenance of sanitation facility	**Lead Department** PHED	SBM MGNREGA		**14.7:** % of Anganwadi and with adequate and functional sanitation facilities	Out of 2970 AWCs in Barpeta only 1689 AWCs have proper access to adequate, functional and safe drinking water	100%	100%	100%	ICDS Barpeta
	Support Department Social Welfare Department Education P& RD			**14.8:** % of schools with adequate and functional					

				sanitation facilities					
• Categorization of health centers based on current status- Sanitation facility-available and functional, available but not functional and not available. In first phase dysfunctional facilities can be made functional and in second phase new facilities could be constructed	**Lead Department** PHED **Support Department** Health Department			**14.9:** % of health centres with adequate and functional sanitation facilities	321 Health facilities	100%	100%	100%	
Personal Hygiene									
• Providing adequate supplies (soap, bucket and mugs) to every AWCs • Hand washing posters to be demonstrated at AWCs • Community radio to generate awareness among people • SHGs to create awareness regarding hygiene practices at community level • Swachhagrahis to demonstrate hygiene practices on VHSND	**Lead Department** Social Welfare Department **Support Department**	ICDS	SHGs, AWWs	**14.10:** % of Anganwadis with adequate and functional Hand washing facilities with water and soap available		100%	100%	100%	ICDS Barpeta
• Hand washing posters to be demonstrated at health centres • Community radio to generate awareness among people • SHGs members to be part of monitoring team in health centres	**Lead Department** Health Department			**14.11:** % of health centres with adequate and functional Handwashing facilities with		100%	100%	100%	Department of Health, Barpeta

				water and soap available					
Education									
• Awareness programs through SSA • Counselling of girls parents by members of SHGs on importance of girl education • Improvement of sanitation facilities at schools for girls • Addressing the root cause for high girls dropout rate	**Lead Department** Education Department	SSA		**14.12** % of women with 10 or more years of schooling	23.9 % (NFHS-4)				Assam Agenda 2030
Social Causes									
• SHGs should be sensitised and linked to local NGOs & CBOs for creating awareness in the community for the subject • BCC activities in the vulnerable communities like tea garden areas • Promotion of higher education among adolescent girls	**Lead Department** Social Welfare Department **Support Department** P&RD			**14.13:** **%** of women age 20-24 years married before 18 years	43.2 % (NFHS-4)				
Livelihood									
• Generating awareness of MGNREGA among women -	**Lead Department** P&RD	MGNREGA		**14.14:** % of women with job cards who worked					

• Strengthening of Women's participation in Gram Sabha Planning Meeting				for 100 days in last year					
Food and Nutrition Security									
• Inclusion of all eligible families in PDS	**Lead Department** Food & Civil Supplies	PDS		**14.15:** % of families linked with PDS					

PART C: Cross-cutting strategies		
Program Management	**Activities**	**Accountability**
15.1: **VHSND**	• Conduct regular joint VHSNC meeting by ANM,AWW for execution of health and nutrition activities • Ensure participation of ICDS supervisors and Panchayati Raj members in the meeting • Identify all households with pregnant women and children 0-24 months and mobilise them to attend VHNSDs • Promote regular use of mother-child protection (MCP) card (renaming it "Mother and Child Health and Nutrition Card (MCHNC)") for entry of data and monitoring progress as well as for counselling	**Lead Role** Health Department **Support Department** Social Welfare Department
15.2: **Growth Monitoring**	• Establish procurement system and ensure functional weighing machines at all AWCs • Undertake Weight and height measurement of all the children at regular interval – every month for children aged between 6-24 months and once in 3 months for children aged above 24 months. • Identify SAM children with and without medical complications and actions for their management • Organise regular training to AWWs for recording , plotting and interpretation of growth • ICDS and health functionaries to educate, counsel and support mothers and families for optimal nutrition, healthcare and development of children	**Lead Role** Social Welfare Department
15.3: **Quality Home Visits**	• Home visit calendar of AWW, ASHA and ANM should be planned and reviewed • Home visit tools should be designed for AAAs for effective communication, counselling and information gathering • AWW and ASHAS to make home visits for educating mothers and other family members to play an effective role in child's growth and development with special emphasis on 0-24 months child.	**Lead Role** Social Welfare and Health Department

15.4: **Social Behaviour Change Communication(SBCC)**	• Development of SBCC strategy for the state' • Hire a special expert team /organisation to develop SBCC strategy and provide rollout support. SBCC support training, advocacy and communication materials to be standardised	**Lead Role** Health and Social Welfare Department
15.5: **Human Resources**	• Filling up the positions of all health and ICDS functionaries at all level • Appointment of a consultant District Nutrition Coordinator for 5 years. • Appointment of Block Nutrition Coordinators	**Lead Role** Health and Social Welfare Department
15.6: **Supply Chain Management**	• Population based estimates for stock planning of health supplies • Streamlining system for timely procurement of required supplies	**Lead Role** Concerned Department
15.7: **Capacity Building**	• Establishment a state Nutrition Resource Centre (SNRC) --Identification of such an institute to conduct capacity building trainings • Training of HR team including • mid-level managers of health and ICDS functionaries • Roll out of ILA module in local languages/ exposure visits	**Lead Role** Social Welfare and Health Department
15.8: **Monitoring Evaluation Accountability and Learning (MEAL)**	• Establish an MIS system and link to SNRC for analysis of MPR and HMIS data • Ensure inclusion of nutrition linked Multisectoral indicators in the line department monthly progress report • Deputy Commissioner to review the status of indicators as a part of regular monitoring with health, ICDS and Multisectoral departments.	**Lead Role** Deputy Commissioner and heads of in line department
15.9: **Knowledge Management**	• Documentation of progress made and analysis of on-going best practices • Regular dissemination of information on analysis of local data ,progress and way forward	**Lead Role** Concerned departments
15.10: **Convergence**	• Formation of convergence committee for nutrition at district and block levels • Coordination meeting of all the line departments including Health, Social Welfare, PHED, Agriculture, Education, P&RD, Food and Civil Supplies in the presence of Principal Secretary, BTC	**Lead Role** Office of Commissioner

This material has been funded thanks to the contributions of (1) UK Aid from the UK government, and (2) the European Commission (EC) through the South Asia Food and Nutrition Security Initiative (SAFANSI), which is administered by the World Bank. The views expressed do not necessarily reflect the EC or UK government's official policies or the policies of the World Bank and its Board of Executive Directors.